NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday, 27 Jul 2018 9:15 AM — 11:30 AM BST
Venue	Northgate Room, Quince House, West Suffolk Hospital
Description	A meeting of the Board of Directors will take place on Friday, 27 July 2018 at 9.15 in the Northgate Room, 2nd Floor, Quince House at West Suffolk Hospital
Organiser	Karen McHugh

Agenda

AGENDA

Agenda Open Board 27 Jul 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: Nick Jenkins (Paul Molyneux in attendance), Tara Rose
   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

NHS
West Suffolk
NHS Foundation Trust

5. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 29 June 2018
   Presented by Sheila Childerhouse

   Item 5 - Open Board Minutes 2018 06 29 June 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 July 18.doc

9:35 DELIVER FOR TODAY

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8. Alliance and community services report
   To RECEIVE update
   Presented by Dawn Godbold

   Item 8 - WSFT Community Board cover sheet July V2 2018.doc

   Item 8 - WSFT Board paper community and alliance update July V5.doc

   Item 8 - Appendix 1 Patient Scenario WSFT Board Report 180727.docx

   Item 8 - Appendix 2 Community and Alliance WSFT 180727 Board Paper Final 100718 PH Data PH radar.xlsx

   Item 8 - Appendix 3 Community and Alliance WSFT Board 180727 FINAL 100718 MH Data & MH radar.xlsx

   Item 8 - Appendix 4 Community and Alliance WSFT Board 180727 Final 100718 CYP Data & CYP radar (Top Level only).xlsx

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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_June_2018_Draft_v1.docx

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10. Transformation report – Q1
    To ACCEPT an update
    Presented by Helen Beck

    Item 10 - Transformation Board Report July 18 FINAL V2.doc

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11. Finance and workforce report
    To ACCEPT the report including plans for winter 2018-19
    Presented by Craig Black

    Item 11 - Finance report Cover sheet - July 2018.docx

    Item 11 - Finance Report June 2018 FINAL.docx

10:35 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 - Board Report - Staffing Dashboard - June 2018 data.doc

    Item 12 - WSFT Dashboard - June 2018.xls

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13. Mandatory training report
    To ACCEPT the report
    Presented by Jan Bloomfield

    Item 13 - Mandatory Training Trust Board Jul 18.docx

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14. National patient survey report
    To ACCEPT a report
    Presented by Rowan Procter

    Item 14 - CQC Adult Inpatient Survey 2017 - Board report.docx

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

11:00 BUILD A JOINED-UP FUTURE

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

Item 16 - Consultant appointment report - July 2018.doc

11:10 GOVERNANCE

17. Trust Executive Group report
To ACCEPT a report
Presented by Stephen Dunn

Item 17 - TEG report.doc

Item 17 - Annex CQC report June 2018 FINAL.docx

18. Quality & Risk Committee report
To RECEIVE the report
Presented by Sheila Childerhouse

Item 18 - Quality and Risk Committee cover sheet.docx

Item 18 - Q&R Minutes - 2018 06 29 June.docx

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

Item 19 - Items for next meeting.doc

11:25 ITEMS FOR INFORMATION

20. 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

21. Date of next meeting
To NOTE that the next meeting will be held on Friday, 28 September 2018 at 9:15 am in the Northgate Room.
Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

22. 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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MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 29 JUNE 2018

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

Action

GENERAL BUSINESS

18/138 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

Apologies for absence were received from Jan Bloomfield and Angus Eaton.

The Chair welcomed everyone to the meeting and explained that Jan Bloomfield was taking part in a 60 miles walk over the next two days to raise money for MyWish; all donations would be gratefully received.

18/139 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

- John Ellis introduced himself as a local resident and acknowledged the funding pressures that the NHS was under. He referred to the number of patients whose elective surgery had been cancelled or deferred over the winter period due to external pressures and asked how many people were affected and if this would support WSFT's current submission for investment in its emergency department.

  He also referred to the control total and CIP target; it appeared that the Trust had no alternative but to accept the revised control, with a projected year end deficit of £13.8m. He asked if the CIP target of £12.2m was considered to be achievable and, if so, if this would result in an increased risk to patient care an additional burden on staff.

  The Chair proposed that these issues were addressed under agenda items 9 and 11.

- Joe Pajak referred to the alliance and community services report and noted that the word 'education' was only referred to once. He asked if the board considered that there was enough engagement from the local education authority and if this translated into actions. He also noted that the Trust ambitions did not show 'support a healthy start' and 'support a healthy life' as being relevant to this report.

  Dawn Godbold confirmed that this was an oversight and that these two ambitions should be showing as relevant to this report. She acknowledged the need to focus on children as well as adults and explained that currently discussions were taking place about including more information on children and young people in this report and the strategy. There were two parts to education; core skills and training across all aspects of care for which was a local group focussing on this. There was also a stream around culture and behaviours and organisational development. A work stream through the STP was looking at changing the way the workforce worked across the system.

  Joe Pajak referred to the lack of special needs education for people between the age of 19 and 25. It was acknowledged that this was very important as this was a vulnerable group.

  Alan Rose asked Joe Pajak what was behind his question about education. Jo Pajak explained that this country was very weak on the integration of health and education and said that people should not be afraid to challenge around the curriculum in terms of health education etc.

  Nick Jenkins explained that he had invited Tim Coulson, CEO of the largest education provider in west Suffolk to attend the young people's and children's strategy development group.

  The Chief Executive referred to the document, 'Protecting and improving your health together', which summarised what WSFT was trying to achieve around prevention and integrating health and care providers. He explained that Dr Helena Jopling, consultant in healthcare public health, had been employed by the Trust to develop this work. He also referred to the recent press release about WSFT's dermatologists working with West Suffolk College's students on skin cancer awareness, which was a good example of integration between health and education.

- June Carpenter referred to the Chief Executive's report and the issues around hospital transport. Helen Beck explained that this would be discussed in more detail in the closed session of this meeting. She explained that this was a new contract that was held and delivered through the CCG; however it was a very important part of the service to WSFT's patients, therefore the Trust was involved in trying to address the issues. She explained the underlying issues in terms of the volumes that the new provider was expected to deliver and that these were greater than in the contract, therefore urgent action was being taken and the CCG was reviewing this issue. There was also an issue around the co-ordination of services and this was also being addressed. Daily calls were taking place between WSFT, the provider, Ipswich hospital and the CCG and feedback was now being received from clinical areas that the situation was improving and the number of issues as a result of this was reducing. WSFT would continue to work with the other organisations until it was satisfied that this had been resolved. Helen Beck expected that this improvement would continue over the next few months.

  The board agreed that they should continue to focus on this until it had been fully resolved. **Helen Beck**

- Liz Steele noted that there had been an increase in PALs referrals and asked for assurance that there was not a trend or specific area that was causing this ongoing increase. Rowan Procter explained that she saw this as a real positive and that the team were addressing issues at an early stage. She assured the board that there was not a trend or issue with a particular area or member of staff.

18/140 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

18/141 DECLARATION OF INTERESTS

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

18/142 MINUTES OF THE MEETING HELD ON 25 MAY 2018

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

18/143 MATTERS ARISING ACTION SHEET

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

Item 1588 – consider if there was capacity to scan women with high risk pregnancy elsewhere, including private sector. Craig Black explained that the Trust had been unable to identify any capacity with local private providers but would continue to investigate this. The plan around increasing capacity would continue to be implemented and should be completed by this time next year.

The completed actions were reviewed and there were no issues.

18/144 CHIEF EXECUTIVE'S REPORT

The Chief Executive referred to the announcement of a substantial increase in funding for the NHS, ie £3.4b over the next five years as from 2020. This was still slightly below the historic level of increase but he considered this to be a major investment for the NHS. It would be important to make sure that the increase in funding was reciprocated by transformation and an improvement in services.

There was a proposal to work the NHS plan and how the money would be spent into the autumn budget submission and it was important that the Trust was involved nationally to ensure this supported the strategic direction of travel.

There had been a very good discussion yesterday on e-Care benefits realisation.

He referred to the discussion at the last board meeting on caesarean section rates and reported that department of health had recently published data on these nationally and WSFT was noted to have the lowest rate in the country.

The CQC had published their report on the Norfolk & Norwich which they had found to be inadequate. As a result the organisation was being put into special measures, which would be difficult for the organisation and its staff. The executive team and Trust executive group (TEG) had discussed this report and the importance of not becoming complacent about the care the Trust provided.

Gary Norgate thanked the Chief Executive for an inspirational report and said there was much to be proud of and noted how much the Trust was doing. He asked about

the capacity of the executive team and staff groups to drive all these initiatives and if there was a list of priorities to manage each one, eg emergency department, capital programme, e-Care, winter pressures. He asked for assurance that there was the bandwidth to manage and implement all these important projects.

The Chief Executive said that there was a very good executive team and staff groups across the Trust. People were engaged and committed to doing their best; however he considered that the organisation was probably at the limit of its capacity if it was to continue to do this well and it would be a risk to take on any more. Currently he felt that the Trust was making good progress although this would be a challenge, as usual, come the winter.

The Chair had some concerns that NHSI were hoping that WSFT would support other organisations and this might be a challenge moving forward.

Craig Black said that one of the ways of gaining assurance around looking at change, was about delivering today, investing in staff and delivering for the future. Currently this was a balanced, but if it changed it would need to be addressed.

DELIVER FOR TODAY

18/145 ALLIANCE AND COMMUNITY SERVICES REPORT

Dawn Godbold explained that there was a great deal happening and continuing to happen within community services. She highlighted areas which represented examples where the system was maturing and people were starting to work in a different way. An example of this was the agreed investment to enhance three services and bring them together with an additional new shared post between the lymphoedema service and the community health team's leg ulcer service, which could also enable further integration with the dermatology outpatient leg ulcer service. Investment had also been agreed to enhance the community matron role in each locality.

Good progress was being made on falls with the use of the same tool across the system (Rockwood frailty tool), which was a terrific achievement.

Richard Davies considered this to be a very good report which demonstrated the difference that integration could make. However, he was concerned about the capacity of services, eg the fire service undertaking falls assessments which he considered to be a good idea but might uncover issues that could cause additional work and create frustration. He asked if there was the capacity to address the needs/issues that were identified by this initiative. Dawn Godbold acknowledged that this would be a challenge, although in the long term it should have benefits. Consideration needed to be given as to what other community groups were available to assist in this, eg falls prevention groups. It was agreed that fire service was a great example of integration across the system.

Dawn Godbold referred to the progress being made with IT and the commitment of the Trust in supporting and recognising the investment and work required to integrate health and social care and also update the equipment that the community teams were working with.

She highlighted the message to the Buurtzorg team from the local reverend, referring to the care they had provided for a couple in his parish. This demonstrated the difference and uniqueness of this model.

It was noted that a case would need to be built to demonstrate the benefits/results of paying an increased rate for health and care support.

Alan Rose noted the high ratio of staff to patients in the Buurtzorg model, which would be unsustainable. He asked if there was guidance as to how many patients a Buurtzorg team could support. Dawn Godbold stressed that this provided 24 hour care seven days a week. A team of twelve should be able to support 50-60 patients (Dutch model). It was noted that the outcome for the couple referred to by the reverend would have been very different if they had not been supported by the Buurtzorg team. Dawn Godbold explained that Health Watch Suffolk and the Kings Fund were evaluating this model and the Nuffield trust wanted to do an evaluation of phase 2. WSFT was also part of a national learning network.

The Chair asked when the outcome of this evaluation would come back to the board so that some sort of judgement could be made on the value for money of a larger scheme. The same would also be true for the county council cabinet. Dawn Godbold explained that the initial report from the Kings fund was expected within the next couple of weeks. It was proposed to bring more information to the September board meeting. The Chair requested that any information available before this should be circulated to the board. **D Godbold**

Dawn Godbold highlighted the new model of support that was being explored for care homes.

This report also provided an update on paediatric speech and language therapy. A CEO level escalation call had taken place which had been very constructive. There was a real commitment to improve the service with a new proposal around the new model. This would be taken to the children's alliance in September and a summary of the business case would come back to the board in October. **D Godbold**

Gary Norgate considered this to be an excellent report which provided good assurance and great examples of alliance working. He referred to children in care initial health assessments and asked what controls triggered escalation and if this escalation was timely or should have been earlier. Dawn Godbold said that she felt that the right controls were in place, although some of the controls related to partners not WSFT, which could be frustrating. She explained the actions that had been agreed which each addressed different parts of the pathway and should result in overall improvement. Further assistance was required from the CGG in relation to out of county children.

Catherine Waller agreed that this was a very good report. She explained that she had attended the N&SFT board meeting yesterday and suggested that there was an opportunity to put in more quality measures similar to those that partners already had and asked if this had been considered. Dawn Godbold confirmed that this was the case and explained that each locality would have a shared summary dashboard to give an indication as to how they were functioning. Public health were looking at what these measures should be.

It was suggested that an insight should be provided into one area at each board meeting. The Chair agreed and said that consideration needed to be given as to how to provide this information.

18/146 INTEGRATED QUALITY & PERFORMANCE REPORT

Rowan Procter explained that there had been a serious incident where a community patient with a pressure ulcer developed sepsis.

Community nurses did not have all the equipment to enable them to ascertain whether there was a pressure ulcer issue or sepsis issue. As a result thermometers used within the hospital had been issued to community staff.

WSFT had been successful in becoming part of the pressure ulcer collaboration, falls collaboration and nutrition collaboration.

Individuals from the tissues viability team in the hospital and community were now working as a team and had identified nursing homes with a high number of pressure ulcers. They were working with staff on repositioning of patients and training them in the positive effects of this. This should have ongoing benefits with patients admitted to hospital.

Similar work would be undertaken with falls and nutrition. The senior nursing team were taking the lead on this and were very engaged.

Gary Norgate asked about sepsis. He noted the numbers and that the target had been missed for the period and asked Rowan Procter if there was a risk of a never event with the incident she referred to. She explained that the majority of these were patients who had come into A&E; a key piece of work had been undertaken in this area and an improvement was being seen. This incident did not meet the criteria for a never event, but was a serious incident.

Richard Davies referred to pain management quarterly internal reporting and asked if more information was available on this. Rowan Procter said that she would bring this to the meeting next month. **R Procter**

Nick Jenkins explained the issues relating to the syringe driver that was used previously and the risks around this. In 2010 the National Patient Safety Agency issued an alert that these should not be used and asked trusts to phase these out within five years. WSFT and the community stopped using these by 2011 and since then have used the recommended type of syringe driver.

Alan Rose asked if the Trust or Nick Jenkins had been approached by the media or NHS centrally to provide information on this. Nick Jenkins reported that NHSI had sent a request for information to clarify the issue around compliance with the 2010 instruction and this information had been returned to them. He was confident that WSFT had appropriate safeguards in place to ensure that this type of incident would not occur within the Trust.

Tara Rose confirmed that a response had been prepared to provide assurance if any requests were received from the media etc.

It was requested that this information should be shared with the governors. The Chair stressed the importance of highlighting this was an historic issue. **N Jenkins**

Gary Norgate commented on the good progress being made and the very good transparency and the amount of information and data provided to the board. He asked what the real risks were and the potential harm related measures that should be discussed by the board as a matter of priority. Craig Black explained that these were shown in section 2 of this report, ie integrated quality & performance dashboard and this was where the focus should be.

Alan Rose referred to the data on isolation and noted the lack of single rooms relating to infection control. He asked if this was a serious issue for the infection control team and if anything else could be done to help provide more single rooms.

Craig Black explained that there was an estates plan which would improve capacity and single rooms but this was not currently feasible.

An infection control model had also been brought into the scope of e-Care which would enable the Trust to prioritise/identify the requirement for single rooms. Rowan Procter explained that currently there was a side room list on e-Care which the infection control team went through each morning to look at whether this was appropriate or not for each patient. This had been on the risk register for a long time and the CQC were also aware of the issue.

Catherine Waller referred to responses to complaints within the appropriate timescale and noted that this was still red. She asked for assurance that there was the capacity to address this. Rowan Procter explained that there had been long term sickness and vacancies in this department but it was hoped that this would improve.

Helen Beck referred to the significant improvement in May for A&E performance (93.5%) which had been maintained in June. This was mainly due to a reduction in demand and moving GP expected patients to the correct area which had resulted in a significant improvement in flow through the emergency department. During the past week when activity had increased this performance had been maintained and the team involved had been congratulated.

The underlying problem was a shortage of middle grade doctors in the emergency department. This meant that there was not the capacity on the floor at night to manage demand, which resulted in overnight breaches. At a lot of work was being undertaken to look at alternative models to address this. There was a new associate director of operations and new head of nursing for the division who were working very well together and owning this problem with support from the executive team.

Cancer performance was maintaining the 85% target despite operational pressures. There had been a significant increase in two week waits for dermatology and breast care. Both of these had low conversions to cancer (two conversions from every 100 referrals),.therefore Helen Beck was not concerned this would cause a risk to treatment times or patient safety

RTT performance had improved and WSFT was no longer an outlier nationally for this performance standard. However this position was not yet sustainable and there was still an issue with 52 weeks breaches in specialties where a single clinician provided the service.

Helen Beck referred to the question from the public about cancelled operations over the winter period, ie January/February and explained that these were routine operations not urgent or cancer patients. The figure of 350 in March referred to lost opportunities rather than the number of people cancelled. All patients whose operations had been cancelled had been re-booked and by now would have had their procedure unless they had elected to delay their date.

The figure of 1648 patients reported as being on the waiting list was the total of patients on an inpatient pathway which would include patients referred in May. This was not a backlog figure but a total figure of people waiting for treatment in inpatients and outpatients.

The Chief Executive considered it to be a great achievement for the Trust to have recovered its RTT performance, although this still remained a challenge. A lot of people had worked very hard across the organisation to achieve this. Gary Norgate agreed and said that the data that was now available was also providing assurance to the board.

18/147 DISCHARGE SUMMARY REPORT

Nick Jenkins explained that for the last three months a dedicated full time member of the e-Care team had focussed on coaching performance improvement for discharge summaries and working to address the issues.

A conversation had also been had with the CCG and a presentation given to their executive team and what it was considered a discharge summary should be. It was agreed that currently the requirement was not particularly realistic and the CCG had agreed to look at improving this. WSFT was now working with the CCG and GPs to establish the content of a discharge summary, which should only be relevant information, and when this should be received.

Significant progress was being made in achieving this in a timely fashion. However there were still challenges with the data quality issue for the IQPR in some specialties, eg cardiology and patients in the medical treatment unit.

With the changeover of junior doctors there was a plan to implement the new discharge summary and highlight the importance of correctly completing these. From August there would be a training package on discharge summaries for F1 doctors, supported by the Royal College of Physicians.

Richard Davies was very pleased that this continued to remain a focus. He asked if there was a timeline for when this would be resolved. He also referred to the inbox and GP liaison service and asked if there was scope for this to become more permanent.

Nick Jenkins considered that discharge summaries would be an ongoing issue but that the problems would decrease and require less focus within six months. Inbox was very helpful and working well to provide the organisations with greater assurance with information being collected in one place. Currently this was being managed by one IT support individual which had highlighted that ideally there should be a permanent member of staff managing this. GPs were very keen on this initiative and the CCG had indicated that they might provide some funding towards this post.

18/148 FINANCE AND WORKFORCE REPORT

Craig Black explained that since the last board meeting the Trust had gone back to NHSI accepting the revised offer of the control total. At the last closed board meeting there had been a very animated discussion about whether to accept this control total. There had previously been a gap of £8.5m between planned performance and the control total. NHSI had relaxed the control total by £5.7m towards WSFT and expected WSFT to improve their plan by the remaining 2.8m.

There was now a planned deficit of £10.2m for 2018-19, including £3.7m Provider Sustainability Funding (PSF), subject to the Trust achieving its control total and A&E targets.

The financial position after month two was £186k behind the new plan. The main reason for this was an increase in expenditure on nursing staff and continuation of the additional capacity which had been open April. This situation had improved in June and it was expected to see a further improvement in the next report.

Work had been undertaken on staffing plans for next winter to ensure there were sufficient staff to support the required capacity.

Page 8 and 9 of this report showed the position on vacancies for trained nurses and the proposed changes for the next few months to address the requirement throughout the winter to meet the increase in capacity.

The graphs showed new start nurses, and use of bank and agency. They also showed how, as nurses were recruited, the number of vacancies would reduce and also the required recruitment for registered nurses and unregistered nurses.

He explained that there was a significant risk around the recruitment of nurses and that the Trust would be continuing with its overseas recruitment drive and other initiatives.

Gary Norgate asked if this plan was affordable. Craig Black confirmed that this was in the budget but that it required a level of control on the use of bank and agency nurses.

Catherine Waller asked if this assumed that the Trust would cancel or not book operations during December/January. Helen Beck explained that if this level of staffing was achieved elective work would not need to be cancelled, but this would depend on demand and capacity. The aim was to achieve 92% RTT performance sustainably by October and the Trust would continue to try to maintain this.

The Chief Executive said that this was a very good piece of modelling but explained that it was contingent on the assumptions that had been made. It was also contingent on moving to bay nursing and overseas recruitment of nurses etc.

The Chair proposed that this should be monitored on a monthly basis. **R Jones**

Craig Black referred to the increased cost improvement plan (CIP) as a result of the change in the control total. This was principally being met by releasing the £1.5m contingency in the original plan, which meant there was now no contingency available to exceed the current staffing plan over the winter.

Alan Rose recalled that the board had only agreed the plan on the condition that Nick Jenkins and Rowan Procter and their teams did not reduce the standard of quality and safety in the CIP programme and that this remained the key focus. The Chair agreed and stressed that quality and safety continued to be paramount.

Gary Norgate asked about the implications of the graph on page 5, if A&E was above plan but below last year. Craig Black explained that this reflected moving GP expected patients directly to AMU. This would reduce the number of attendances and activity in A&E and help to reduce the pressure in this area.

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INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

18/149 NURSE STAFFING REPORT

Rowan Procter explained that information was triangulated throughout the month on a daily basis. G5 had high medication errors but she explained that over the last two months the acuity in this ward had significantly increased. It was hoped that bay nursing would help to improve this, as well as red tabards for nurses undertaking drug rounds and there being non-registered nurses in bays at all times.

Gary Norgate asked if there was a correlation between the percentage of bank and agency nurses and performance indicators. Rowan Procter confirmed that this was looked at and whether that was a high bank and agency fill rate. Where necessary issues were addressed, particularly around agency staff.

18/150 NURSE STAFFING STRATEGY

Rowan Procter explained that the reflection that the team had made when producing this report was how much had been done throughout the year.
This would go to the nursing and midwifery council so that they could see what had been achieved.

The board considered this to be a very good report.

18/151 LEADERSHIP PROGRAMME

Denise Pora explained that this report had been produced in response to a request from the board. She highlighted the activity and investment that had been made, together with the quality and proposed impact measures. She explained that Angus Eaton had advised her on this and the board's requirement for assurance.

The Chair said that this paper was very encouraging and highlighted the work that WSFT was doing around both leadership and culture.

Alan Rose explained the importance of the NEDs having exposure to the next tier of leaders, below board level, and asked that this should be included as part of the plan, ie presentations at board meetings etc. Craig Black agreed and explained that individuals and teams below board level worked very hard and took on responsibility as well as the executive directors.

R Jones / J Bloomfield

Nick Jenkins explained that a clinical director would be attending each board meeting as part of their development so that they had been exposed to board members.

The Chief Executive said that this was very important and innovative initiative and agreed that more NED involvement and engagement was a good idea. The 5 o'clock club had been very positive and successful and a great opportunity for people. The Chair said that this being open to everyone was very important.

Denise Pora clarified the content of the total spend of £19291.

Dawn Godbold confirmed that this initiative had been explained to the system executive group and a number of other individuals.

The Chair thanked Denise Pora for all the work that she was doing on this.

18/152 MEDICAL REVALUATION ANNUAL REPORT

Nick Jenkins explained that it was a requirement that this report was presented to the board annually to provide assurance. Doctors were required to be appraised as part of this process and he reported that there were no significant problems.

The Chief Executive noted that a great deal of work had gone into this report and passed on the board's thanks to Paul Molyneux.

18/153 PUTTING YOU FIRST AWARD

Rowan Procter reported that the award for this month had been received by Dan Harvey, tissue viability nurse practitioner, and Chloe Wheeler, rehab assistant practitioner, OT/F3/trauma and orthopaedics.

The nomination for Dan explained that he was in constant demand to see patients across the hospital, but despite his heavy workload it was never too much trouble for

him to make time to see the patients the department needed his help with. He always listened to patients and staff and had a friendly and approachable manner, putting the patients at ease in what could be complex and difficult wound care.

As well as looking after patients he had set up and offered staff training sessions and his extensive knowledge had proved invaluable. He went above and beyond to deliver the very best in patient care.

Chloe Wheeler was nominated for going 'above and beyond' her role in trauma and orthopaedics. She was a fantastic support, not only to OTs and physios on the trauma and orthopaedics wards but also to other areas of the therapy team.

She actively encouraged and supported others, plus she had a fantastic bedside manner and a way of communicating with patients to get the most out of the time she was interacting with them. She had a natural gift for communication and being thorough in her assessments and interactions with patients. It was hoped that this nomination would encourage her to actively pursue getting her OT qualification

The Chair said that these two nominations and individuals encapsulated everything that was celebrated about WSFT.

18/154 CONSULTANT APPOINTMENT REPORT

The board noted appointment of Dr William Petchey, Consultant Nephrologist.

BUILD A JOINED UP FUTURE

18/155 e-CARE REPORT

Craig Back explained that this report provided an assessment of some of the benefits of the business case and would be submitted to NHS Digital.

He explained that with some benefits it was difficult to attribute to a cause. The next stage of the benefits assessment was to aim to attribute a percentage to e-Care.

The Chair noted the hours saved in terms of health care assistants (HCAs).

Gary Norgate recalled a conversation about the additional investment of £20m required for e-Care versus the free system being put in by Ipswich hospital. He acknowledged that he had concerns at the time but considered this to be a worthy investment now that the benefits could be seen.

Craig Black explained that the benefits that the original business case was based on had been exceeded, although more money had been spent as a result of GDE.

Gary Norgate noted to the population health work which was very exciting and that the progress was all due to e-Care and GDE.

Rowan Procter referred to the soft benefits that could not be quantified and that she, or any other member of staff, could now refer directly to e-Care rather than look at a patient's notes if asked for information about their care.

The Chief Executive explained that these benefits were validated with NHS Digital and were quite conservative. The work on population health continued to be progressed and this was also very important and encouraging.

Craig Black explained that there was still a lot to do and a lot more to achieve. He commended Sarah-Jane Relf for this report.

Catherine Waller asked if this report took into account additional costs as a result of issues that had arisen or not gone to plan. Craig Black explained that go-live had been delayed which had resulted in £0.75m of additional costs being incurred. He confirmed that financial performance of this project was monitored on a regular basis.

The Chair said that learning from what went wrong could often be more useful than learning from what went right.

18/156 ANNUAL LICENCE CERTIFICATION REPORT – GENERAL CONDITION 6 & CONTINUITY OF SERVICES CONDITION 7

Richard Jones explained that this was the second part of the annual report which included confirmation of the training provided for governors.

The board approved the six corporate governance statements and certification for training of governors.

GOVERNANCE

18/157 TRUST EXECUTIVE GROUP REPORT

Gary Norgate thanked the team for the work that had been undertaken on annual leave.

The Chief Executive explained that there had been a continued focus on appraisals.

18/158 COUNCIL OF GOVERNORS REPORT

The Chair reported that the presentation from Helen Jopling had been very well received and the governors were very enthusiastic about this work.

Alan Rose asked if new governors had received the training referred to in the corporate governance statement. Richard Jones confirmed that this was the case.

18/159 AUDIT COMMITTEE REPORT

The board received and noted the content of this report.

18/160 REMUNERATION COMMITTEE REPORT

The board received and noted the content of this report.

18/161 ANNUAL GOVERNANCE REVIEW

Richard Jones explained that this was an annual review and that it was proposed to repeat this with the well-led assessment framework. This would form part of the information submitted to the CQC when they next came into came into assess the Trust. The board agreed with this proposal.

The Chair requested that individuals should be given sufficient time to complete this. Richard Jones agreed and said the aim was for completion by September. **R Jones**

18/162 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were noted. It was noted that the maternity refurbishment capital programme should be on the agenda for the closed meeting.

ITEMS FOR INFORMATION

18/163 ANY OTHER BUSINESS

The Chair apologised for not attended the volunteers' tea party as she had to attend another event. She recorded her appreciation of all the volunteers and how much they were valued. When undertaking quality walkabouts all areas spoke highly of the volunteers.

18/164 DATE OF NEXT MEETING

The next meeting would take place on Friday 27 July 2018 at 9.15am in the Northgate Room.

RESOLUTION TO MOVE TO CLOSED SESSION

18/165 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 – 27 July 2018

Agenda item:	6			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	19 July 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
1583	Open	25/5/18	Item 8	Consider how to publicise the West Suffolk Alliance strategy and how the outcomes can be monitored by the Board	Included stand in medicine for members events. Will form part of deliver plan to be received by the Board in September.	DG	28/09/18	Green
1597	Open	29/6/18	Item 5	Monitor progress with transport service at future meetings	Scheduled for August Scrutiny Committee for more detailed review to include CCG representation	HB	28/09/18	Green
1598	Open	29/6/18	Item 8	Schedule report on initial assessment and findings for Buurtzorg test and learn in September		DG / RJ	28/09/18	Green
1600	Open	29/6/18	Item 9	Review the issues behind sustained poor performance for the pain audit	**More detail will be provided in the next IQPR supported by the new patient observations machines used on the wards which will automatically send vital sign recordings to the patient record.**	RP	28/09/18	Green
1603	Open	29/6/18	Item 14	Develop programme of subjects / presentations for Board and subcommittees which provides greater exposure of participants of the leadership programme		RJ/JB	28/09/18	Green
1604	Open	29/6/18	Item 24	Report annual governance review findings at the end of September.		RJ	28/09/18	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
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. **AGENDA ITEM**	JB	27/07/18	Complete
1584	Open	25/5/18	Item 9	Agreed to structure the commentary in the IQPR based on what the executive team are worried about, rather than just the RAG rating. Also identify indicators for 'deep dive' to test improvement actions and provide assurance e.g. return to work interviews	Review of IQPR is currently taking place. **Updated summary of IQPR**	CB	27/07/18	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1587	Open	25/5/18	Item 14	In the context of the incidents which identified human factors as a contributory factor, develop a proposal to extend the human factors training focused within surgery across the organisation	A Human Factors project group has been established including clinical leads Miss Sue Deakin, Dr Kaushick Bhowmick and Governance Manager Hannah Sullivan. The aim of the project is to scale up human factors development from the Surgical Division to Trust wide to reduce harm to patients as a result of human factors. Including:• Undertake baseline trust-wide patient safety culture assessment• Develop a human factors strategy • To expand the human factors training faculty to represent the whole trust • To offer human factors training to all staff groups - clinical and non-clinical • To identify and develop longer term work streams to incorporate human factors consideration into such as; medical devices and equipment, design of healthcare systems, incident Investigation and areas of non-compliance.	RP	27/07/18	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1589	Open	25/5/18	Item 20	Confirm the timescale for rolling out wider access to the e-Care patient portal	Two parts of the original pilot for patient portal are now complete. This was for staff (registering as patients) and rheumatology patients. There were 8 objectives of the original pilot all of which were achieved. As part of evaluation we undertook a survey of pilot users with a 20% response rate. The responses to the survey were overwhelmingly positive with exciting ideas for future developments. 12 respondents have also agreed to be part of a user reference group. The final part of the pilot (dietetics using to test the messaging function) was started later and will run until the end of July. Next phase of rollout will be twofold. Firstly we will work with a number of departments (such as rheumatology, pre assessment unit) to test the new Clipboard functionality from Cerner) allows creation of forms for users to complete and ability for user to input directly into record. Secondly to roll out to new departments and we are currently speaking to clinicians to ascertain where this should be. It is expected full roll-out will be completed by March 2019 (this will be reliant on implementation of self-registration).	CB	27/07/18	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1591	Open	25/5/18	Item 2	The experience care strategy was approved subject to some developments (what good looks like, include external factors)	Reviewed and being finalised, including changes to the delivery plan **AGENDA ITEM Q&RC report**	RP	27/07/18	Complete
1599	Open	29/6/18	Item 8	Provide a summary of the business case discussed with county council for the provision of paediatric speak and language and children in care services.	Included in community service report	DG	27/07/18	Complete
1601	Open	29/6/18	Item 9	Share the briefing note on syringe drivers with the governors.	Circulated to Governors on afternoon of 29 June.	NJ	27/07/18	Complete
1602	Open	29/6/18	Item 11	Establish monthly progress reporting on delivery of the winter 2018-19 workforce plan	Part of workforce report on monthly basis	RJ	27/07/18	Complete
1605	Open	29/6/18	Item 26	Provide detailed commentary on the issues and actions for 'top 5' priorities from Board reports.	See updated introduction to the IQPR	Execs	27/07/18	Complete

7. Chief Executive’s report

To ACCEPT a report on current issues from the Chief Executive

Presented by Stephen Dunn

Board of Directors – 27 July 2018

Agenda item:	7			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	20 July 2018			
Subject:	Chief Executive's Report			
Purpose:	X	For information		For approval

Executive summary:

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

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

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

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

Recommendation:

To receive the report for information

Chief Executive's Report

I was immensely proud to welcome **Rt Hon Matthew Hancock MP** to the West Suffolk Hospital for his first official speech in his new role as Secretary of State for Health and Social Care. As part of his speach to a group of around 50 staff he promised to keep listening to the 3.1 million people who dedicate their lives to caring for the health of other and paid tribute to our hospital and community services – saying that he'd fight for us and champion us!

We are certainly popular for visits at the moment, as **chief executive of the Care Quality Commission**, Sir David Behan, and Dr Kathy McLean, **executive medical director and chief operating officer of NHS Improvement**, have both visited West Suffolk Hospital this month to deliver engaging talks at our leadership forum, the Five o'clock Club. Sir David Behan, who has held the top role at the CQC for six years, said that the Trust's journey to outstanding "has been hard won and many years in the making". After I gave David a brief tour of the hospital he gave an engaging talk to Trust staff to share his reflections of good leadership after a 40-year-career as part of the Trust's leadership forum, the 'Five o'clock Club'. He said: "It's been a pleasure to visit the Trust today and to meet some of its fantastic people. What stands out at the West Suffolk is the culture – one that is of openness and learning, and where leaders support their people. The outstanding rating is a reflection of that."

I am delighted and proud that our staff and the care and services they provide are receiving the recognition they deserve. Maintaining this high profile is so important at a time when we a striving to continue our digital journey, through further investment in technology and transform our emergency care, with a £15m investment in our emergency department. We would love to finish the job in becoming a true Global Digital Exemplar system and we are keen to support the policy process in developing the 10 year NHS plan. In shaping and responding to the NHS 10 year plan we will update our strategy and operational plans accordingly. Critical to this response is transformation and a key part of our strategy is development of an integrated model for service delivery which we are doing across our local area.

We marked **NHS70** with lots on offer for staff and patients to celebrate the cherished national health service, and indeed our local organisation. Our healthcare system is the envy of many across the world; yes, we don't always get it right, but I think it's a special thing to be part of a system that provides free healthcare for all – regardless of wealth, individuality or diversity. We're incredibly proud to be one of just three trusts chosen to represent staff in a series of national videos about he NHS, produced by NHS Improvement.

As part of the celebrations some staff were bound for the big smoke in honour of NHS70, with the Trust's My WiSH Charity heading to the House of Commons as one of 10 Midlands and East teams chosen as regional champions in the prestigious NHS70 Parliamentary Awards. Nominated by local MP Jo Churchill, My WiSH was shortlisted in The Patient and Public Involvement Award category. Although the charity did not win the category overall, the team said it was "an absolute honour"' to attend this prestigious event. Hot on their heels I accompanied Shining Lights employee of the year Tracey Green, our mortuary and bereavement services manager, to a special NHS70 service at Westminster Abbey, London. Tracey said: "It was an absolute honour and privilege to hear other peoples' stories and for me personally, what with my employee of the year award, it was an honour to represent the Trust. We had a fantastic day and I really enjoyed being part of the NHS70 celebrations."

As the NHS turns 70 years old, our staff have once again rated us as one of the **best places to receive treatment and best places to work**. In the most recent NHS Staff Friends and Family Test (FFT), 884 of the 940 (95%) WSFT staff surveyed said they would recommend the Trust as a place to receive treatment, the fifth highest percentage recorded in England, and 84% said they

would recommend it as a place to work, which is the third highest percentage recorded in England – both well above the national averages of 80% and 63% respectively.

I'm really glad that our staff are happy to recommend the Trust they work in – our staff know the Trust inside and out, so it's a really honest way for us to track how we're doing. This test was conducted in January to March, which was a particularly busy time period for our staff, so to score so highly in this quarter is a real testament to the quality of our Trust and the people that work in it. Many of our staff are also our patients, and live in the community that we serve as a healthcare provider, so it's really important to us that they're happy with the care they are able to provide and the quality of care that they see across both our hospital and community services.

For **June's performance** there were 62 falls and nine Trust acquired pressure ulcers. There was one C. difficile case in the month. The Trust failed to deliver two cancer targets in June; two week wait from referral to date first seen and the 2 week wait for breast due to a large number of referrals in the month. The 4 hour wait performance for the emergency department has been maintained at 94% but attendances are still continuing to follow the trend, with a 4% year-on-year increase for June. RTT performance against the 18 week standard has seen a significant improvement over recent months with performance of 91.3% for June. A weekly focus remains on those patients waiting longer than 52-weeks for treatment, with 10 long waiting patients reported in the month.

A big thank you to the **Breast Screening team** who just rolled their sleeves up and got stuck in to calling and imaging the patients affected by the national system error calling ladies aged around 70 in the Breast Screening programme which was in the news earlier this year. I heard at a meeting this morning that the backlog has now been completely dealt with - no fuss or bother, just good team working. Well done to them all.

We continue with our preparations for **winter 2018-19**. This includes capacity modelling, building new physical capacity and staff recruitment plans. The recruitment plans included additional nursing assistants to support the implementation of bay based nursing.

The **month three financial position** reports a deficit of £3.2m. This is £0.3m worse than planned, predominantly due to provider sustainability funding (PSF) funding being behind plan as a result of ED performance in Q1. The Trust has now agreed a control total to make a deficit of £13.8m which will provide PSF of £3.7m should ED and financial targets be met. Therefore the Trust is now planning on a net deficit of £10.1m for 2018-19. In order to achieve the control total the 2018-19 budgets now include a stretch cost improvement programme (CIP) of £2.8m bringing the total CIP plan to £12.2m (5%). The Trust is currently applying for the cash support from the Department of Health (DH) to support this revenue deficit, and also the planned capital programme of £28.1m.

During July we received feedback from an unannounced **MHRA inspection** for pathology services, which are provided by partners North East Essex and Suffolk Pathology Services (NEESPS). The results were disappointing in terms of the inspector's assessment of progress against the two major concerns which remained in place – validation of the information system and workforce planning. It was emphasised that nothing in the inspector's findings had identified patient harm but highlighted the inability to demonstrate effective safety systems. Prior to the inspection concerns regarding the service had triggered a quality walkabout that had brought a number of issues to the attention of Executive and Non-Executive Directors. We are working with NEESPS to ensure we respond to the challenge that remains - the creation and execution of the plans that will deliver a high quality, effective and sustainable pathology service.

Chief Executive blog
The power of leadership
https://www.wsh.nhs.uk/News-room/news-posts/The-power-of-leadership.aspx

Deliver for today

Hello My Name Is Day
Monday 23 July is international #hellomynameis day, marking two years since Dr Kate Granger MBE passed away. It is a day to both celebrate her life and her campaign, but also to ensure we are using the principles of Hello My Name Is in our day to day life and work; the simple act of introducing yourself improves the relationship and communication between you and another human being.

Invest in quality, staff and clinical leadership

Shinning a light on Pride
Across the globe, people have been came together in their thousands to celebrate June as Pride Month, when the world's lesbian, gay, bisexual and transgender (LGBT) communities gather and celebrate belonging and the freedom to be themselves. During the month Tara Rose spoke to three LGBT Trust colleagues about Pride and why it matter, how they want to support the LGBT community at the Trust, and the small things others can do to make a difference. This was shared as part of the Green Sheet.

The East Anglian regional NHS retirement fellowship
There was a great turnout to celebrate NHS70 from the East Anglian regional NHS retirement fellowship groups. Ex-NHS and social care staff congregated at The Athenaeum to reminisce and celebrate the beloved NHS.

Build a joined-up future

New Haverhill to West Suffolk Hospital bus service
A new bookable community bus service linking Haverhill with West Suffolk Hospital will be launched next month, Suffolk County Council has announced. The service, which passengers can book through the online community transport service called 'RIDE', will be provided by The Voluntary Network - Suffolk County Council's Connecting Communities operator in West Suffolk. It follows demand for a new way for people to travel from Haverhill to the hospital. A six-month pilot will start on 1 August, linking the town's bus station with West Suffolk Hospital 18 miles away. Villages close to the A143 will also have opportunities to use the service which will operate, on demand, Monday to Friday, between 7.00am and 7.00pm. Passengers will be charged fares in line with local bus services. A full return trip will cost £8.

National news

Deliver for today

Prime Minister sets out 5-year NHS funding plan
The NHS will receive increased funding of £20.5 billion per year by the end of 5 years. This does not include social care.

Reflections on the Q4 financial and performance figures
NHS Improvement has published the 2017/18 year-end financial and performance results for the trust sector. The big picture is that NHS trusts and foundation trusts have worked extremely hard to meet an unplanned for rise in demand for emergency care, and that the service is now at the limits

of what it can reasonably be expected to deliver in terms savings without restricting patient access or reducing quality.

The NHS at 70: are we expecting too much from the NHS?
This paper explores the public's expectations of the NHS, the balance between meeting those expectations and living within a constrained budget, and the question of who is responsible for keeping us healthy. It was produced for the BBC by The King's Fund, the Health Foundation, the Institute for Fiscal Studies and the Nuffield Trust.

Guide to reducing long hospital stays
This guidance from NHSI describes the tools and behaviours necessary to avoid long hospital stays, and includes the SAFER care bundle and the six A's for managing emergency admissions.

Invest in quality, staff and clinical leadership

Patient experience improvement framework
An evidence-based framework centred around Care Quality Commission key themes to enable board and senior teams in providers to continuously improve the experience of patients.

Ideas for the NHS long-term plan from the Centre for Ageing Better
This paper sets out the case for why NHS England should make some bold commitments to healthy ageing in its long-term plan and suggests some ideas for actions it could take and some areas for action with others.

Build a joined-up future

Better health and care for all: a 10-point plan for the 2020s
This final report of the Lord Darzi Review puts forward a 10-point plan to secure the future of the NHS and social care. It includes a recommendation to invest in health, not just in health care by embracing a 'health in all policies' approach across government and tackling public health issues such as obesity, smoking and alcohol consumption.

Horizontal or vertical: which way to integrate? Approaches to community services integration and consequences for emergency hospital activity
In 2010 the Transforming Community Services policy required a complete break of commissioner and provider functions. But what should PCTs do with the community services they delivered? Vertically integrate with an acute trust, horizontally integrate with a mental health trust or set up a stand-alone community health trust? This report examines the impact this choice had on the level and growth in emergency hospital use in older people and considers the wider implications for the NHS as it develops new models of care and integrated care systems.

Risk and reward sharing for NHS Integrated Care Systems
Risk and reward sharing is a key feature of the policy agenda for Accountable care Systems in the US and Integrated Care Systems in England. It offers a commissioner the opportunity to co-opt and incentivise a provider to moderate growth in healthcare demand by sharing in the savings or cost over-runs. If the NHS is to make best use of risk and reward sharing then it must be aware of the complexities and hazards inherent in these arrangements, as well as the potential benefits.

9:35 DELIVER FOR TODAY

8. Alliance and community services report

To RECEIVE update

Presented by Dawn Godbold

WSFT Board Meeting - 27 July 2018

Agenda item:	8			
Presented by:	Dawn Godbold, Director of Integration and Community Services			
Prepared by:	Dawn Godbold, Director of Integration and Community Services			
Date prepared:	19/07/2018			
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. There are many examples of excellent joint working happening at a local level.

The Alliance is developing a delivery plan to support the ambitions set out in the strategy that will describe our timelines and key actions for transformation.

Work has progressed on the development of the measures and metrics proposed to be used to determine effectiveness at both local and STP level.

Main Points:

This paper outlines:

- Integration between acute and community services – a patient case scenario example
- Development of the West Suffolk Alliance
- Progression of Measures / Metrics and Outcomes
- Transformation funding opportunities

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 update to board						
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications							
Recommendation: The Board is asked to note the progress being made.							

Community Services and Alliance Update

West Suffolk NHS Foundation Trust Board

27 July 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 continues to progress well. This paper describes the progress being made on:

- Integration between acute and community services
- Development of the West Suffolk Alliance
- Update on the development of the Alliance measures/metrics and outcomes

2.0 Acute and Community Integration

2.1 Clinicians continue to work together across organisational boundaries and progress continues to be made at local level where teams and individuals are breaking down si8los to work together and improve the experience of the people and their families who use our services

2.2 See Appendix 1 for a patient story scenario depicting an integrated working example. This example has been selected as it illustrates the importance of co-ordinating services across care boundaries, access to patient records and the ability to leverage actions across the health and care system.

2.3 The example also illustrates where there are further opportunities to more formally join into one cohesive offer the various services that support discharge, reablement and return to independence that currently exist separately across health and social care.

3.0 I.T Progress

3.1 An independent review of SystmOne is being commissioned; a report will be produced that sets out options for how we can optimise the use of the systm1 units and templates making efficiencies for clinicians.

3.2 Testing of the Health information Exchange (HIE) has begun, this will enable community clinicians who use SystmOne to be able to view the health record of any patients who have been an in-patient at WSFT.

3.3 Work has begun to explore the potential use of a mobile App in the community heart failure and cardiac rehabilitation services. This would enable community clinicians to directly send ECG recordings to the hospital for interpretation saving time and improving accuracy. It would also automatically upload vital observation recordings to the patients record in systm1 saving clinician time and reducing the risk of error.

3.4 The procurement process for some community IT equipment has been combined with the current WSFT process which will save both time and money.

4.0 Buurtzorg Test and Learn Update

4.1 A presentation was made on the 12th July to the Suffolk Health and Wellbeing Board by one of the team and members of the steering group. The update was well received, and the Board were fully supportive of the concept and continued testing.

4.2 The funding challenge was acknowledged and a pledge made by the board to assist wherever possible with identifying and securing the necessary monies to continue.

5.0 West Suffolk Alliance Development

5.1 The Alliance Steering group met on the 26th June 2018 and the System Executive Group met on the 4th July 2018 and received information on:

- SystmOne priorities
- Buurtzorg test and learn
- Haverhill locality challenges
- Social prescribing project
- Population Health model
- Transformation monies
- STP ambitions

5.2 Work on the delivery plan continues. A small working group from across the system continues to meet weekly to develop this. A proposed submission deadline to the STP board for the plan is being suggested as the end of September.

5.3 The series of roadshows/meetings to engage community staff within the Trust and seek views on integration is going well. The discussions are identifying issues for improvement as well as things that are going well. A simple 'you said/we did' template is being used to feedback to staff as a result of the sessions.

5.4 As a direct example of the above, new pathways for direct referral from community staff into the hospital for the orthotics service and the frailty service are being explored. This will avoid unnecessary delay for patients but will also save both community staff and GP time in completing multiple referrals.

5.5 The second in a series of 3 system wide and cross county workshops to develop the mental health service offer has been held with WSFT executive attendance. The model will enhance the integration of the community health teams into the neighbourhood teams.

5.6 A workshop to explore the needs of the Alliance from an IT perspective will be held on the 26th July 2018.

5.7 An Alliance wide communications and engagement group has been formed. The group will take the lead on developing the system wide communication plan and advise on how we improve the involvement and engagement of people who use our services in shaping our transformation and delivery plans.

5.8 Following on from the successful implementation of a professional therapy support matrix across community and acute therapies, this has now also been rolled out to Suffolk County Council therapists. This means all therapists irrespective of employer will have the same access to professional support and supervision.

5.9 The Alliance has agreed to use the Mildenhall locality to concentrate on further embedding the integrated neighbourhood team model (INT). This locality has been chosen as it already has some co-location of health and care teams, plans for a health and wellbeing hub are already in progress and there is good local enthusiasm and capability for the community resilience element of the INT model.

5.10 Concentrating on getting the model enhanced and further embedded in one locality at a time will ensure each INT is tailored to its individual locality and allows us to learn and adapt the model as necessary.

5.11 It has been agreed to form a clinical/professional forum for the Alliance. The purpose of this forum will be to:

- Establish trust and relationships
- Identify areas for improvement with existing pathways and resolve
- Identify and develop new opportunities for pathways / innovation
- Provide a framework for the clinical scrutiny / oversight / assurance of Alliance and system wide transformation projects that are underway

5.12 The new forum will have a core membership from across the system with additional invitees according to subject matter.

5.13 The forum will interface with the Alliance Steering group, the Transformation Delivery Group (TDG) and the System Executive Group (SEG)

5.14 The existing primary care locality meetings have been broadened to include system wide topics and invites extended to other partners depending on the subject matter. The topics raised and discussed will form the priorities for each locality level delivery plan.

6.0 Measures/Metrics/Outcomes

6.1 Work has progressed on the metrics and radar charts so that we can understand our starting points and our progress. As previously advised it will be possible to use this methodology with any given set of metrics depending on what we wish to measure and at locality, Alliance or STP level.

6.2 The attached files in Appendix 2, 3 and 4 are the radars for physical health, mental health, and children and young people, at CCG/Alliance and STP level developed so far. Where we cannot get the data for the STP we have used Suffolk data, and this is clearly flagged.

6.3 The performance is all indexed to England as 100, and includes the highest and lowest performance nationally for each indicator, and who is achieving both those levels. This provides a picture of what good and bad look like relative to our local performance.

6.4 For some indicators (prevalence rates, prescribing spend) it is possible to argue that either low or high levels are good – so this needs further discussion to agree how we should interpret those.

6.5 Further work will include consideration to how we might show financial measures and performance, and which indicators we might want to include at a local level.

7.0 Transformation Funding

7.1 We have been given the opportunity to bid for one-off transformation funding for any initiatives which may help to transform the local health and care landscape and support people to stay well within their own communities.

7.2 The NHS Ipswich and East Suffolk and NHS West Suffolk Clinical Commissioning Groups are making funding available to all organisations operating in their catchment areas.

7.3 Initiatives put forward for funding will be judged against four key criteria:

- How do they fit with the vision and objectives of our local strategy?
- What outcomes are they expected to achieve?
- What are the financial costs associated with them and the proposed return on investment?
- How easy are they to deliver?

8.0 Children in Care Initial Health Assessment – options to increase service capacity

8.1 Following an escalation telephone conference with regards to the Initial Health Assessment Children in Care pathway it was agreed to submit a paper outlining the challenges and seeking support to resolve to the West System Executive Group on 1st August 2018.

8.2 A number of options are being explored to improve resilience, increase capacity and reduce delays in paperwork completion/notification.

9.0 Conclusion

9.1 The Board is asked to note the progress being made on individual initiatives and collaborative working across the system.

Appendix 1 WSFT Board Report – community and Alliance update - 27 July 2018

Patient Story: Scenario demonstrating integrated working across health and social care organisations

- Last week concerns were raised from the family of a patient who was residing in a spot purchased discharge to assess pathway 3 bed at Glastonbury Court. There was a high chance that this patient may need to be transferred back to hospital due to the level of concerns raised by the family over the discharge of this patient. The concerns from the family included their father being unsafe when using his gas cooker at home and his stair mobility. The planned discharge date was in 2 days' time.

- This patient had no history of dementia and the acute episode of delirium had resolved however the family had reported that their father has had difficulties operating the gas cooker for the past 6 months. Unfortunately, the family were not willing to consider disconnecting the gas cooker or using a microwave. The family indicated that they would complain over the discharge if a kitchen and a stair mobility assessment was not undertaken prior discharge. The stair mobility assessment had been repeated by the Glastonbury Court physiotherapist to reassure the family that the patient remains to be safe and independent.

- The family were aware that a care package was being organised to support the discharge which was being provided by the Support to go home team (STGH) which would then be transferred to HomeFirst reablement team (social services) the following week.

- As the HomeFirst team was going to be involved with this patient the Bury HomeFirst occupational therapist was contacted immediately. This occupational therapist was from the WSFT on a rotation into social services. By good fortune she was in the hospital at the time and could view the eCare notes to obtain a detailed history of the patient. The HomeFirst occupational therapist then contacted the physiotherapist from Glastonbury, HomeFirst care coordinator and family the following morning with a plan for discharge confirmed for the original date.

- The outcome was that the patient was successfully discharged home The HomeFirst occupational therapist met the patient and family at the property on the day of discharge for the kitchen assessment, repeat stair mobility and to undertake a home environment assessment.

- Follow up calls were made between the Home first and the STGH occupational therapist to handover and a written handover with goals was emailed to HomeFirst from the STGH team to assist with the reablement approach.

- The HomeFirst occupational therapist will continue to be involved with this patient and family as needed for up to 6 weeks which provides consistency, less therapy handover and duplication. Community therapy referrals were not required.

- This patient is achieving their goals with independent and safe use of the gas cooker noted during visits. Care is expected to be significantly reduced. To date the family are very pleased with the services offered and no complaint has been received. This is a good example of the right person providing the required intervention at the right time and place.

ADULT PHYSICAL HEALTH :

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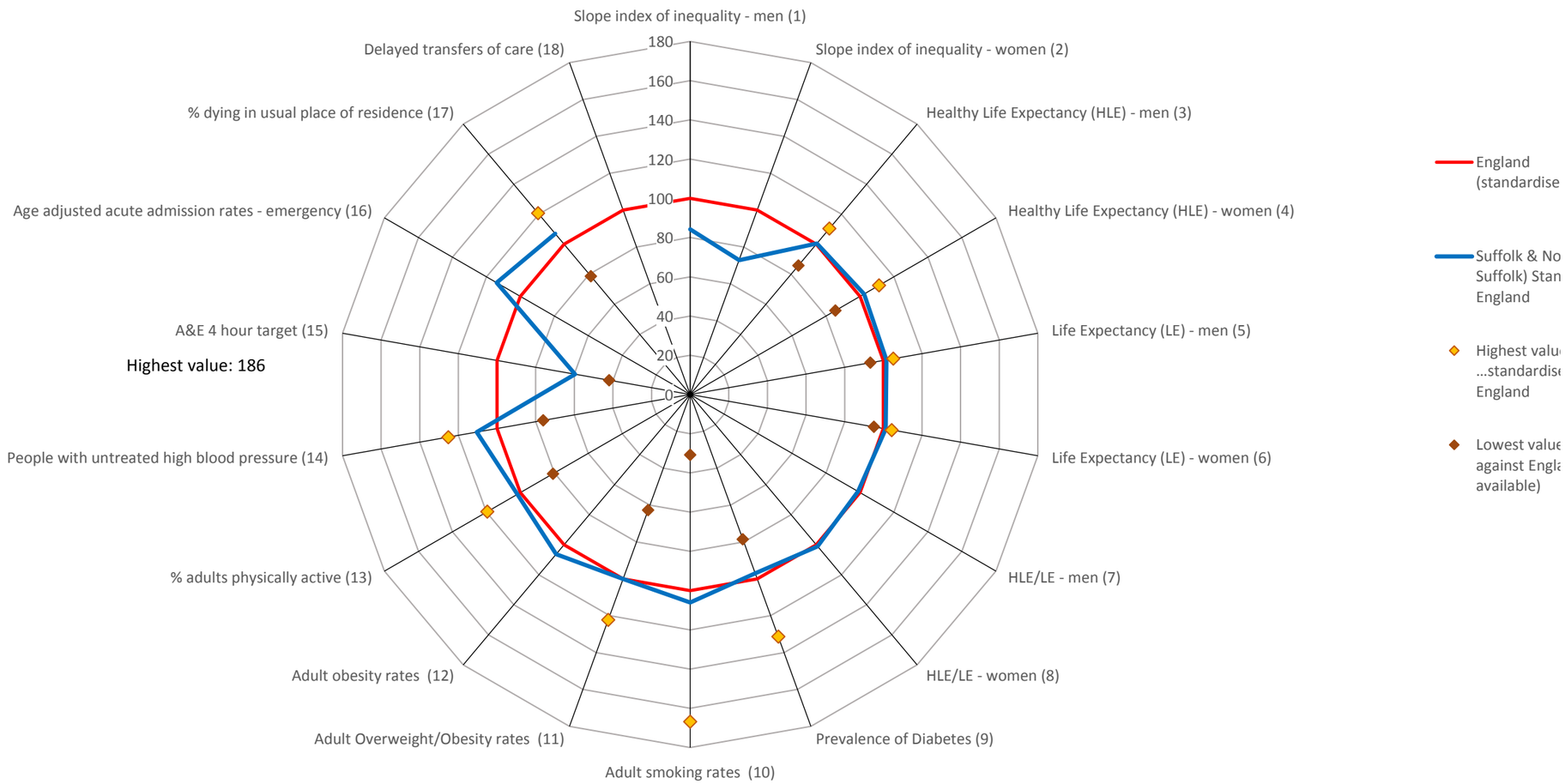

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Indicators plotted:

Inequality in life expectancy at birth Yrs – (1) Male (2) Female :
Absolute gap in LE between most & least deprived quintiles (Suffolk)
Healthy Life Expectancy (HLE) – (Suffolk) Yrs (3) men
Highest value: Richmond Upon Thames
Lowest value: Manchester
(4) women
Highest value: Wokingham
Lowest value: Manchester
Life Expectancy at birth (LE) – (Suffolk) Yrs (5) men
Highest value: Kensington & Chelsea
Lowest value: Blackpool
(6) women
Highest value: Manchester
Lowest value: Camden
HLE/LE Ratio – (7) men (8) (Suffolk)
9) % *Prevalence of Diabetes*
Highest value: The Black Country STP
Lowest value: Hampshire & IoW STP
10) % *Smoking Prevalence in Adults - current smokers (APS)*
Highest value: Redditch (District)
Lowest value: Christchurch (District)
11) Percentage of adults (aged 18+) classified as overweight or obese
Highest value: Knowsley (District)
Lowest value: City of London (District)
12) % Obesity QOF prevalence
13) % adults physically active
Highest value: Exeter (District)
Lowest value: Barking & Dagenham (District)
14) % Hypertension: QOF prevalence (all ages)
Highest value: South West London STP
Lowest value: Norfolk & Waveney STP
15) % >4hrs from arrival @ A&E to admission, transfer or discharge (CCG figs are for the appropriate Hospital Trust for that CCG)
Highest value: Shropshire, Telford & Wrekin STP
Lowest value: Somerset STP
16) Emergency admission for acute conditions that should not normally require hospitalisation per 100,000
17) % dying in usual place of residence (DiUPR)
Highest value: Devon STP
Lowest value: South East London STP
18) Total delayed transfers of care (DToC) per 100,000 Data awaited

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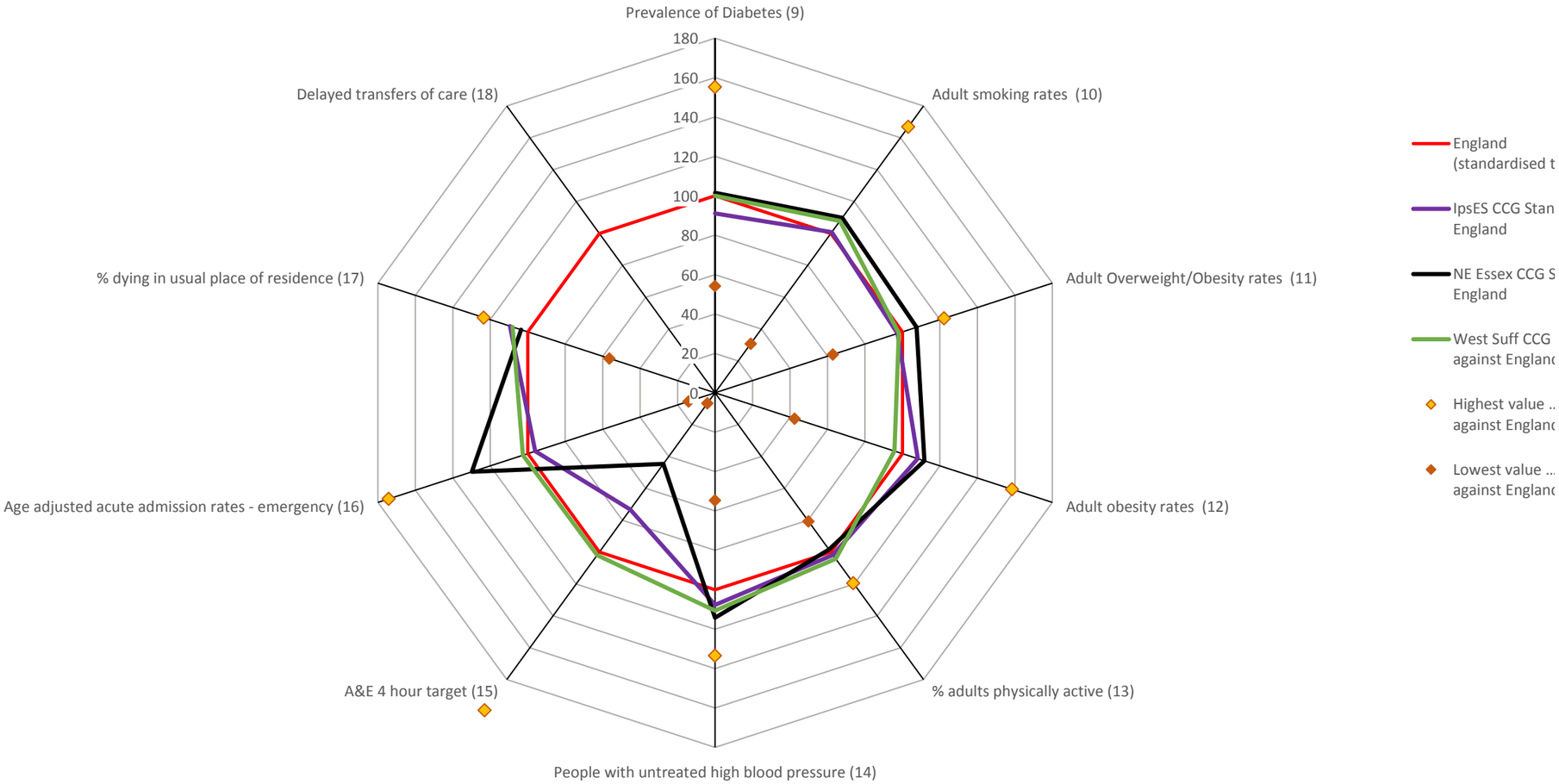

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14) Hypertension: QOF prevalence (all ages) %
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Highest value: Stockport CCG
Lowest value: x76 NHS Trusts (≤ 1)
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Highest value: NHS South Devon & Torbay CCG
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Data awaited

Indicators plotted:
1) Mental Health 2016/17 actual spend as a proportion of overall CCG allocation
2) Cost of GP prescribing for psychoses and related disorders
3) People with SMI who have received the complete physical health check
4) % of referrals that have finished course of treatment waiting <6 weeks for first treatment Highest value

Coventry and Warwickshire STP - Lowest value STP: Leicester, Leicestershire & Rutland STP

9) People on Care Programme Approach (CPA)
Suicide Rate per 100,000 population PHOF 4.10 10+yrs
10) AS mortality rate from suicide & injury of undetermined intent per 100,000 population
11) New cases of psychosis, estimated incidence rate per 100,000 population age 16-64 yrs

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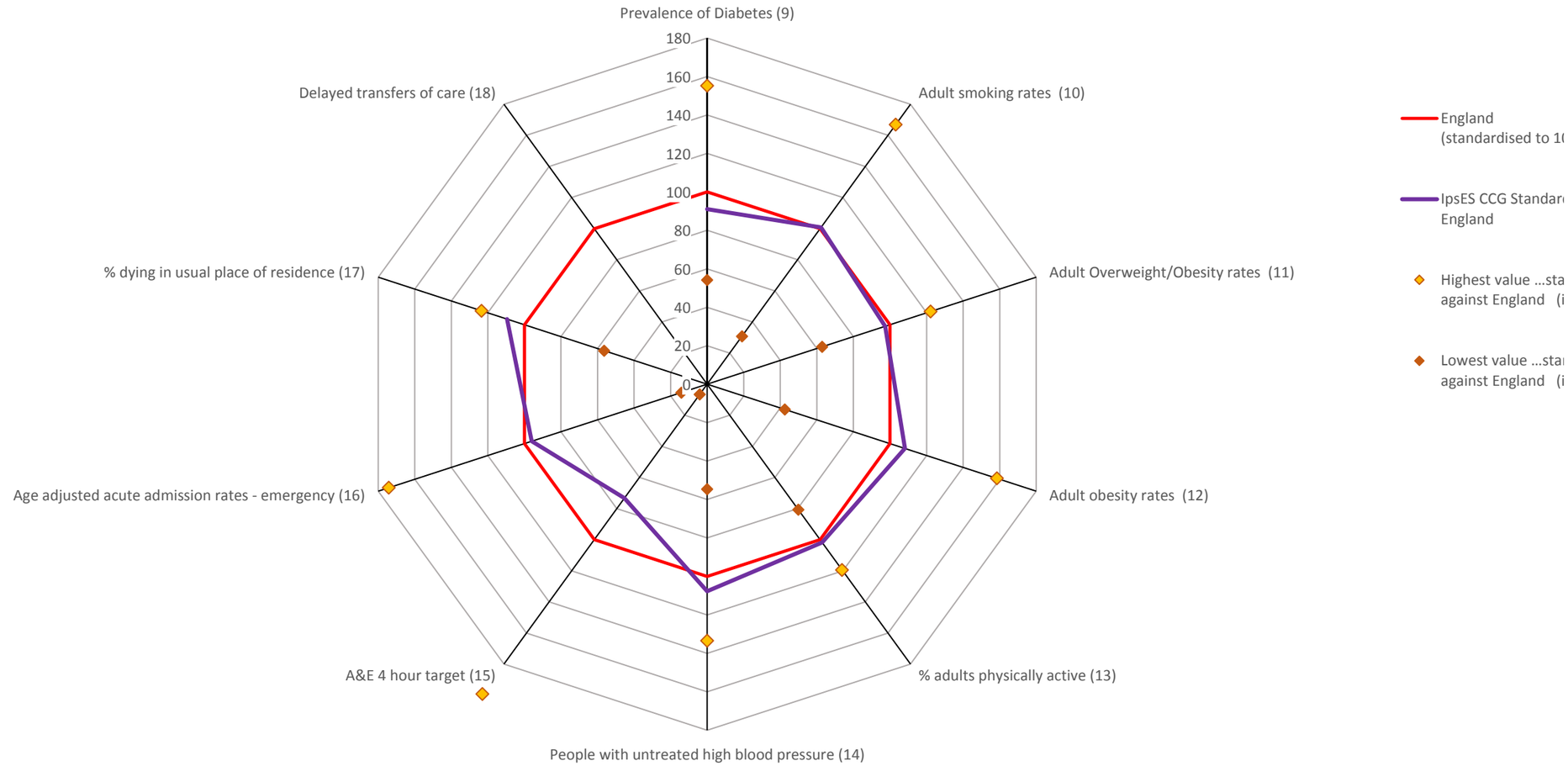

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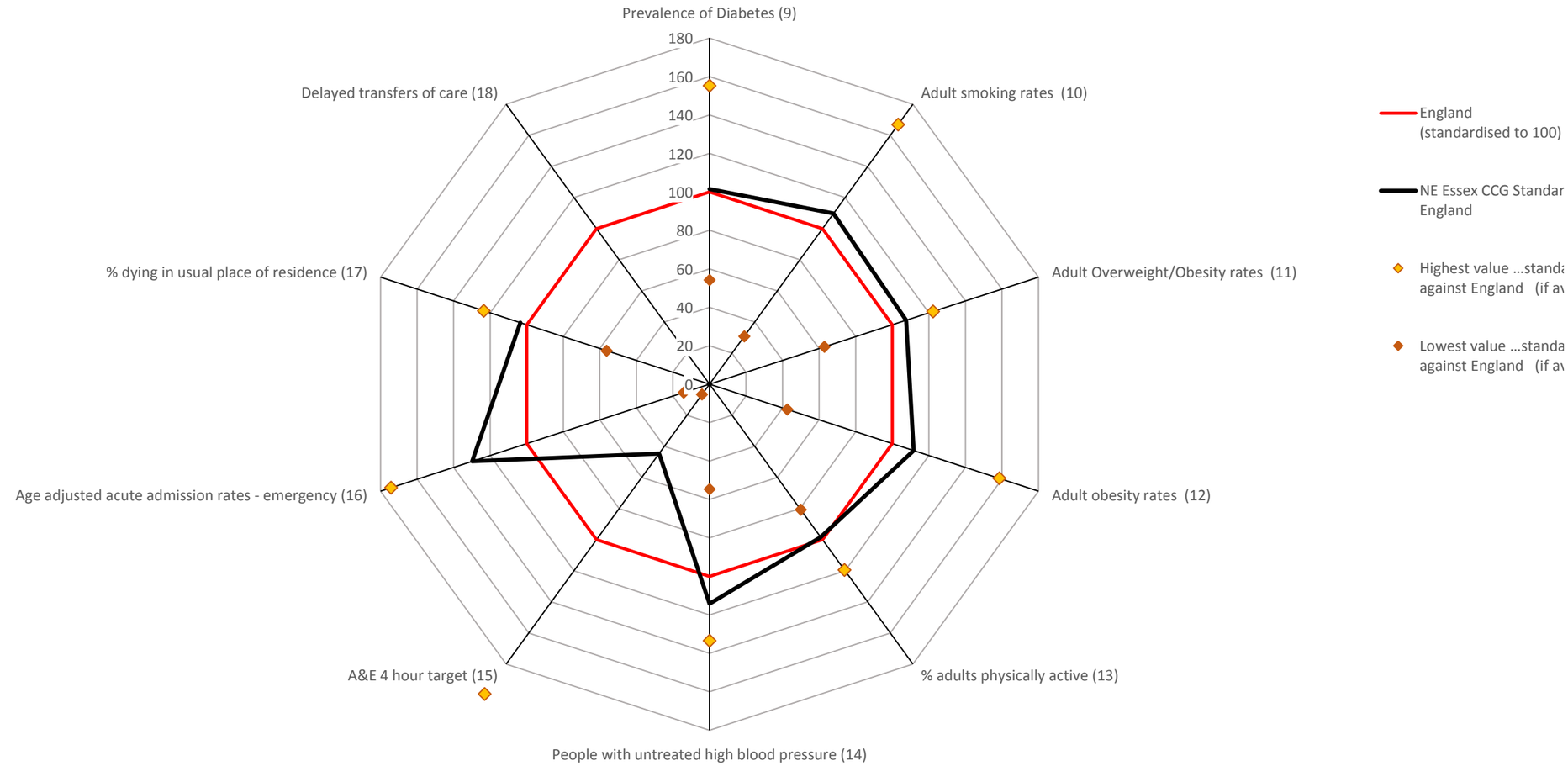

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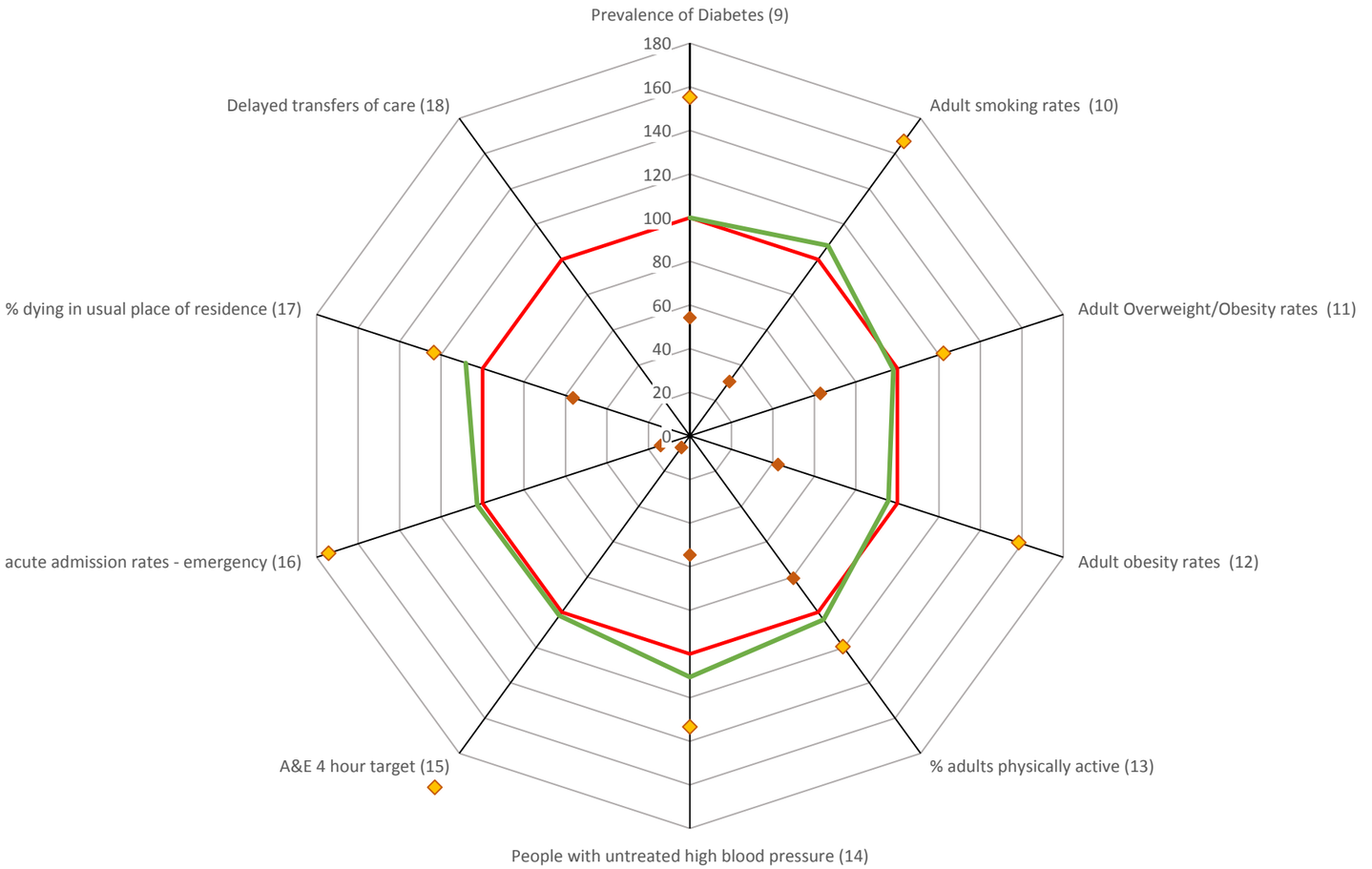

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1	**Metric Group**	**Metric (Persons)**	**Data Type**	**Source**	**Age range**	**Date range**	**England**	**STP (or Suffolk)**	**IpsES CCG**	**NE Essex CCG**	**West Suff CCG**	**Suffolk & North East Essex STP (or Suffolk) Standardised against England**	**IpsES CCG Standardised against England**	**NE Essex CCG Standardised against England**	**West Suff CCG Standardised against England**	**England (standardised to 100)**	**Highest STP value of**	**Highest value of ...standardised against England (if available)**	**Highest value STP**	**Lowest STP value of**	**Lowest value ...standardised against England (if available)**	**Lowest value STP**	**Highest value CCG**	**Highest value ...standardised against England (if available)**	**Highest value CCG**	**Lowest value CCG**	**Lowest value ...standardised against England (if available)**	**Lowest value CCG**	**Source**
2	Slope index of inequality - men (1)	Inequality in life expectancy at birth - Male : Absolute gap in LE between most & least deprived quintiles (Suffolk)	Years	PHOF	At birth	2012 - 14	-7.60	-6.40				84.21				100													PHOF
3	Slope index of inequality - women (2)	Inequality in life expectancy at birth - Female : Absolute gap in LE between most & least deprived quintiles (Suffolk)	Years	PHOF	At birth	2012 - 14	-5.90	-4.30				72.88				100													PHOF
4	Healthy Life Expectancy (HLE) - men (3)	Healthy Life Expectancy (HLE) - men (Suffolk)	Years	PHOF	At birth	2015 - 16	63.30	63.60				100.47				100	69.88	110.39	Richmond Upon Thames (County/Area)	54.34	85.85	Manchester (County/Area)	69.88	110.39	Richmond Upon Thames (County/Area)	54.34	85.85	Manchester (County/Area)	PHOF
5	Healthy Life Expectancy (HLE) - women (4)	Healthy Life Expectancy (HLE) - women (Suffolk)	Years	PHOF	At birth	2016 - 16	63.90	65.40				102.35				100	71.08	111.24	Wokingham (County/Area)	54.64	85.51	Manchester (County/Area)	71.08	111.24	Wokingham (County/Area)	54.64	85.51	Manchester (County/Area)	PHOF
6	Life Expectancy (LE) - men (5)	Total Life Expectancy (LE) - men (Suffolk)	Years	PHOF	At birth	2014 - 16	79.53	80.82				101.62				100	83.68	105.21	Kensington & Chelsea (County/Area)	74.23	93.33	Blackpool (County/Area)	83.68	105.21	Kensington & Chelsea (County/Area)	74.23	93.33	Blackpool (County/Area)	PHOF
7	Life Expectancy (LE) - women (6)	Total Life Expectancy (LE) - women (Suffolk)	Years	PHOF	At birth	2014 - 16	83.14	84.20				101.27				100	86.75	104.34	Manchester (County/Area)	79.08	95.11	Camden (County/Area)	86.75	104.34	Manchester (County/Area)	79.08	95.11	Camden (County/Area)	PHOF
8	HLE/LE - men (7)	HLE/LE - men (Suffolk)	Ratio	PHOF	At birth		0.80	0.79				98.87				100													PHOF
9	HLE/LE - women (8)	HLE/LE - women (Suffolk)	Ratio	PHOF	At birth		0.77	0.78				101.06				100													PHOF
10	Prevalence of Diabetes (9)	Prevalence of Diabetes	Percent	PHOF	17+ yrs	2016/17	6.70	6.50	6.1	6.8	6.7	97.01	91.04478	101.4925	100	100	8.80	131.34	The Black Country	5.26	78.51	Hampshite & Isle of Wight	10.40	155.22	NHS Bradford City CCG	3.63	54.18	NHS Richmond CCG	PHOF
11	Adult smoking rates (10)	Smoking Prevalence in Adults - current smokers (APS)	Percent	Local Tobacco Control Profiles	18+ yrs	2017	14.87	15.77	14.99	16.32	16.02	106.05	100.807	109.7512	107.733692	100	24.81	166.85	Redditch (DISTRICT)	4.58	30.80	Christchurch (DISTRICT)	24.81	166.85	Redditch (DISTRICT)	4.58	30.80	Christchurch (DISTRICT)	Local Tobacco Control Profiles
12	Adult Overweight/Obesity rates (11)	Percentage of adults (aged 18+) classified as overweight or obese	Percent	PHOF	18+ yrs	2016/17	61.29	61.36	59.68	65.92	60.1	100.12	97.37537	107.5567	98.0606558	100	74.95	122.29	Knowsley (DISTRICT)	38.47	62.77	City of London (DISTRICT)	74.90	122.21	Knowsley (DISTRICT)	38.5	62.82	City of London (DISTRICT)	PHOF
13	Adult obesity rates (12)	Obesity QOF prevalence	Percent	PHOF	18+ yrs	2016/17	9.65	10.26	10.44	10.78	9.24	106.32	108.1865	111.7098	95.7512953	100							15.3	158.55	NHS Durham Dales, Eastington & Sedgefield CCG	4.1	42.49	NHS Richmond CCG	PHOF
14	% adults physically active (13)	% adults physically active	Percent	PHOF	19+ yrs	2016/17	66.00	67.12	67.14	64.9	68.74	101.70	101.7273	98.33333	104.151515	100	78.8	119.39	Exeter (DISTRICT)	53.34	80.82	Barking & Dagenham (DISTRICT)	78.8	119.39	Exeter (DISTRICT)	53.3	80.76	NHS Barking & Dagenham (DISTR	PHOF
15	People with untreated high blood pressure (14)	Hypertension: QOF prevalence (all ages)	Percent	PHOF	All	2016/17	13.83455973	15.28854998	14.90	15.80	15.30	110.51	107.7013	114.2067	110.592605	100	17.33	125.27	South West London	10.53	76.11	Norfolk & Waveney	18.46	133.43	NHS West Norfolk CCG	7.55	54.57	NHS Tower Hamlets CCG	PHOF
16	A&E 4 hour target (15)	>4hrs from arrival @ A&E to admission, transfer or discharge (CCG figs are for the appropriate Hospital Trust for that CCG)	Percent	NHS Digital	All	Qtr 4 17/18	15.02	8.95	11	6.7	15.3	59.63	73.253	44.61774	101.888268	100	28	186.46	Shropshire, Telford & Wrekin	6.3	41.95	Somerset	29.90	199.11	Stockport NHS Trust	1	6.66	x76 NHS Trusts (less than of equal to 1)	NHS Digital
17	Age adjusted acute admission rates - emergency (16)	admission for acute conditions that should not normally require ho	per 100,000	QOF CCG Outcomes Set 3.1	All	2016/17	1357.00	1546.977969	1,302.8	1,762.2	1,392.2	114.00	96.0059	129.86	102.593957	100							2365	174.28	NHS Bradford City CCG	192.2	14.16	NHS Crawley CCG	QOF CCG Outcomes Set 3.1
18	% dying in usual place of residence (17)	% dying in usual place of residence (DIUPR)	Percent	End of Life Profile	65+ yrs	2016	67.87	72.63	74.332	70.275	73.381	107.02	109.5211	103.5435	108.119935	100	81.91	120.69	Devon	53.47	78.78	South East London	83.85	123.55	NHS South Devon And Torbay CCG	38.26	56.37	NHS Tower Hamlets CCG	End of Life Profile
19	Delayed transfers of care (18)	Total delayed transfers of care (DToC)	per 100,000	Awaits Roy E	All	2015/16	12.10	Awaited								100													Awaited
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ADULT MENTAL HEALTH : Suffolk & North East Essex STP

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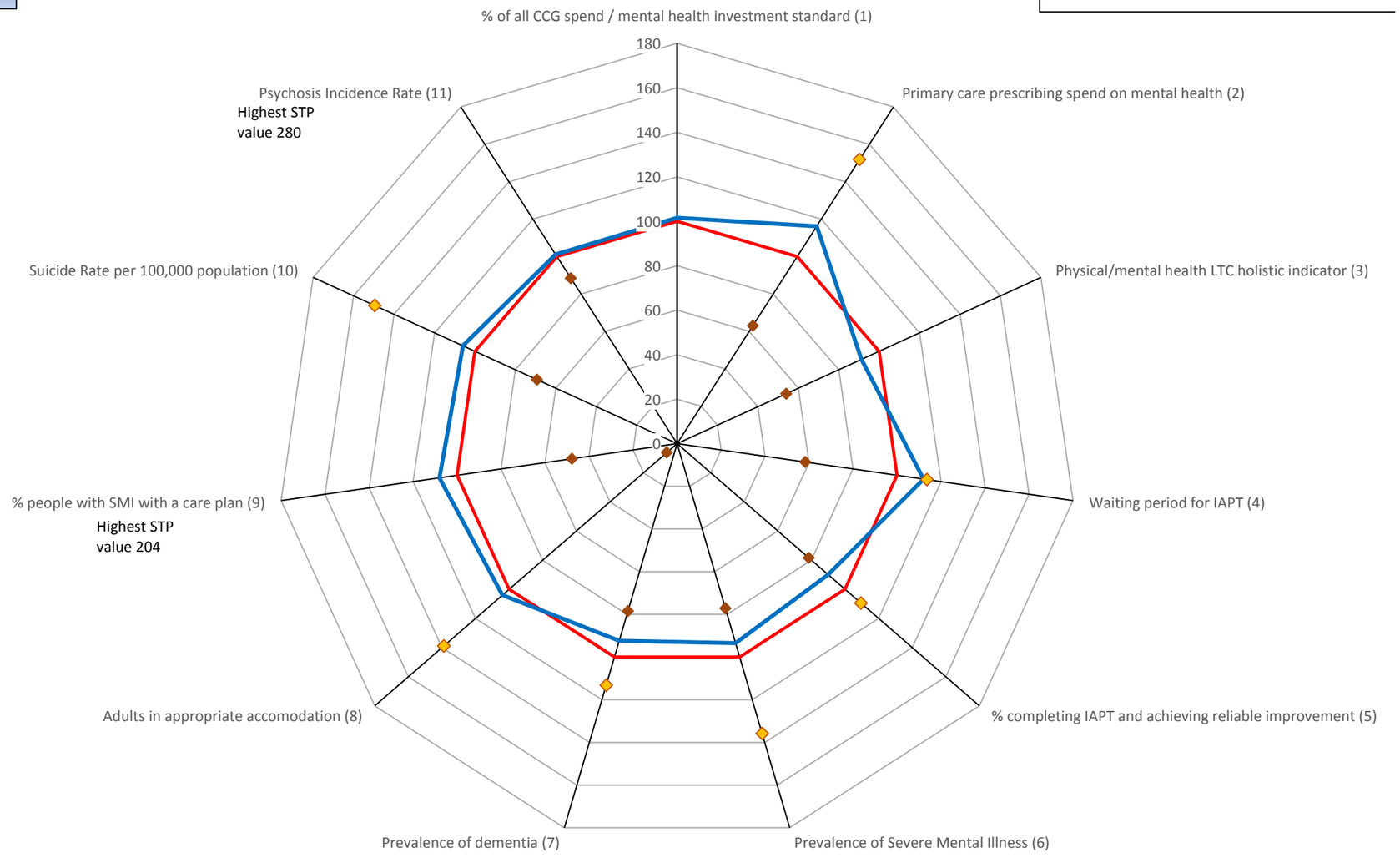

Indicators plotted:

1) *Mental Health 2016/17 % actual spend as a proportion of overall CCG allocation*
2) *Cost of GP prescribing for psychoses and related disorders (Net Ingredient cost (£) per 1,000 population)*
Highest value: Norfolk & Waveney STP
Lowest value: Surrey Heartlands STP
3) *% People with SMI who have received the complete physical health check*
Highest value: Northumberland, Tyne and Wear and North Durham STP
Lowest value: Somerset STP
4) *% of referrals that have finished course of treatment waiting <6 weeks for first treatment*
Highest value: Coventry and Warwickshire STP
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Lowest value: Lancashire & Cumbria STP
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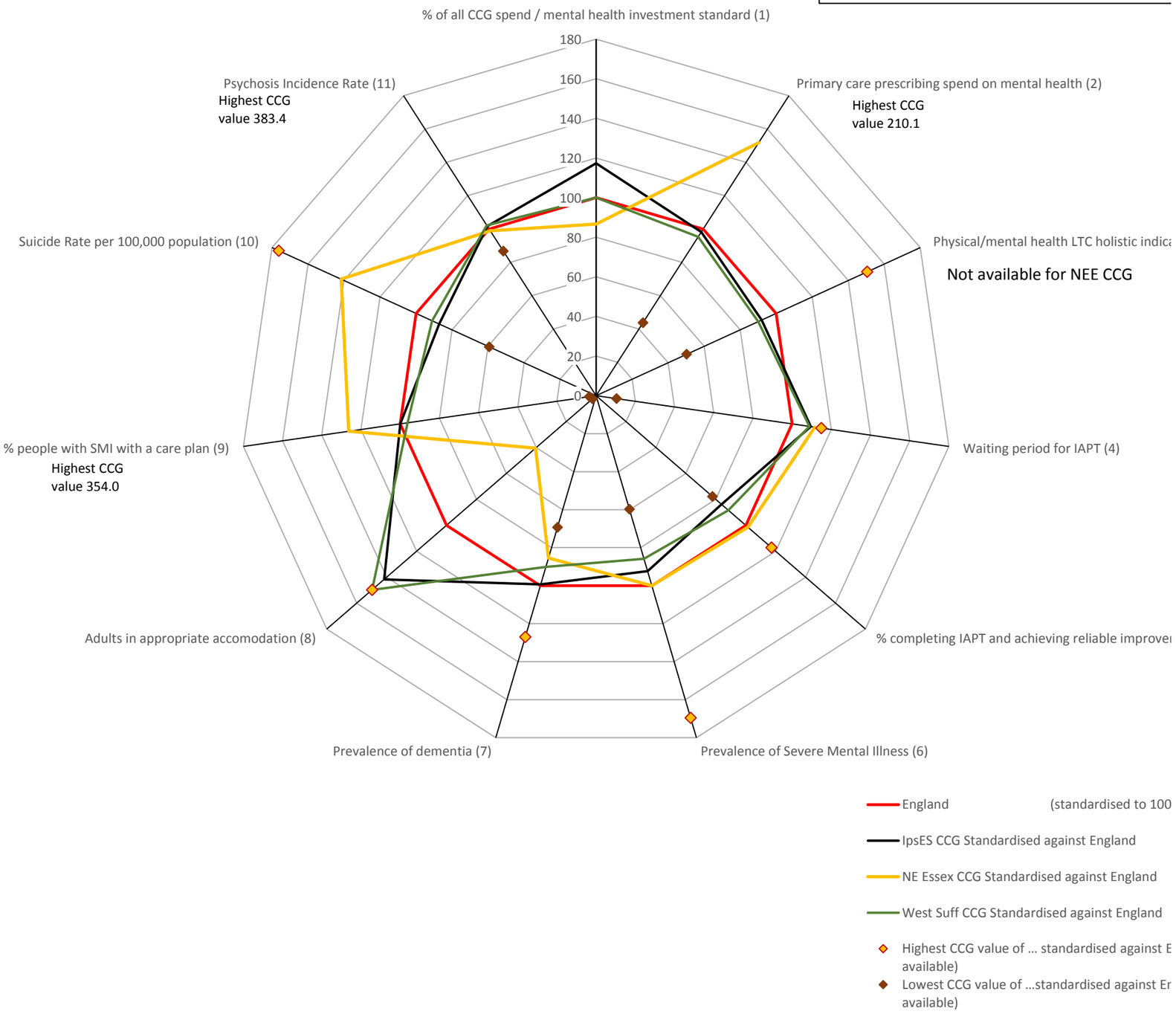
ADULT MENTAL HEALTH: All SNEE CCGs



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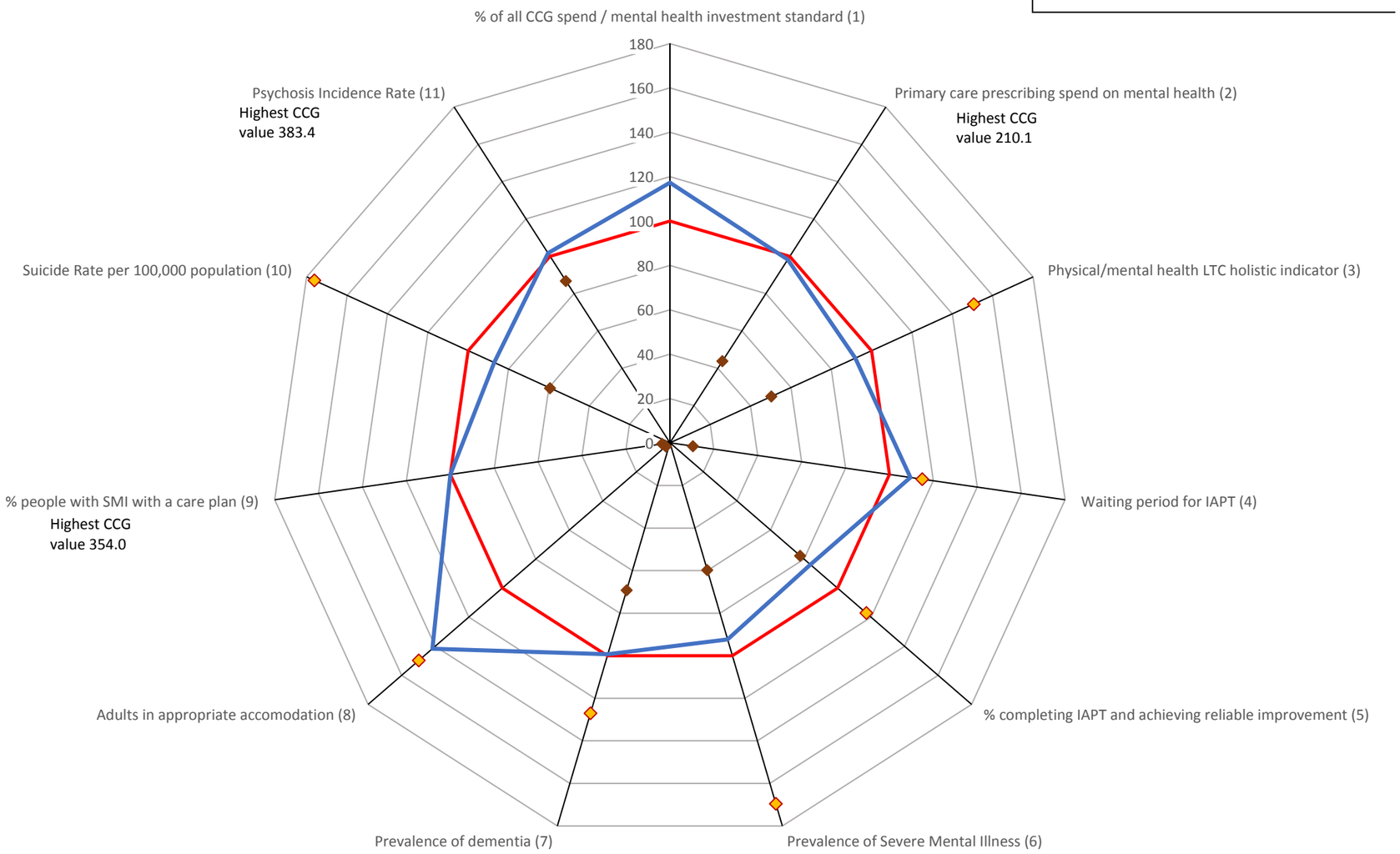
ADULT MENTAL HEALTH: Ipswich & East Suffolk CCG



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ADULT MENTAL HEALTH:
North East Essex CCG

Produced 05/07/18 M J Rowe
SCC Public Health, Knowledge & Intelligence Team

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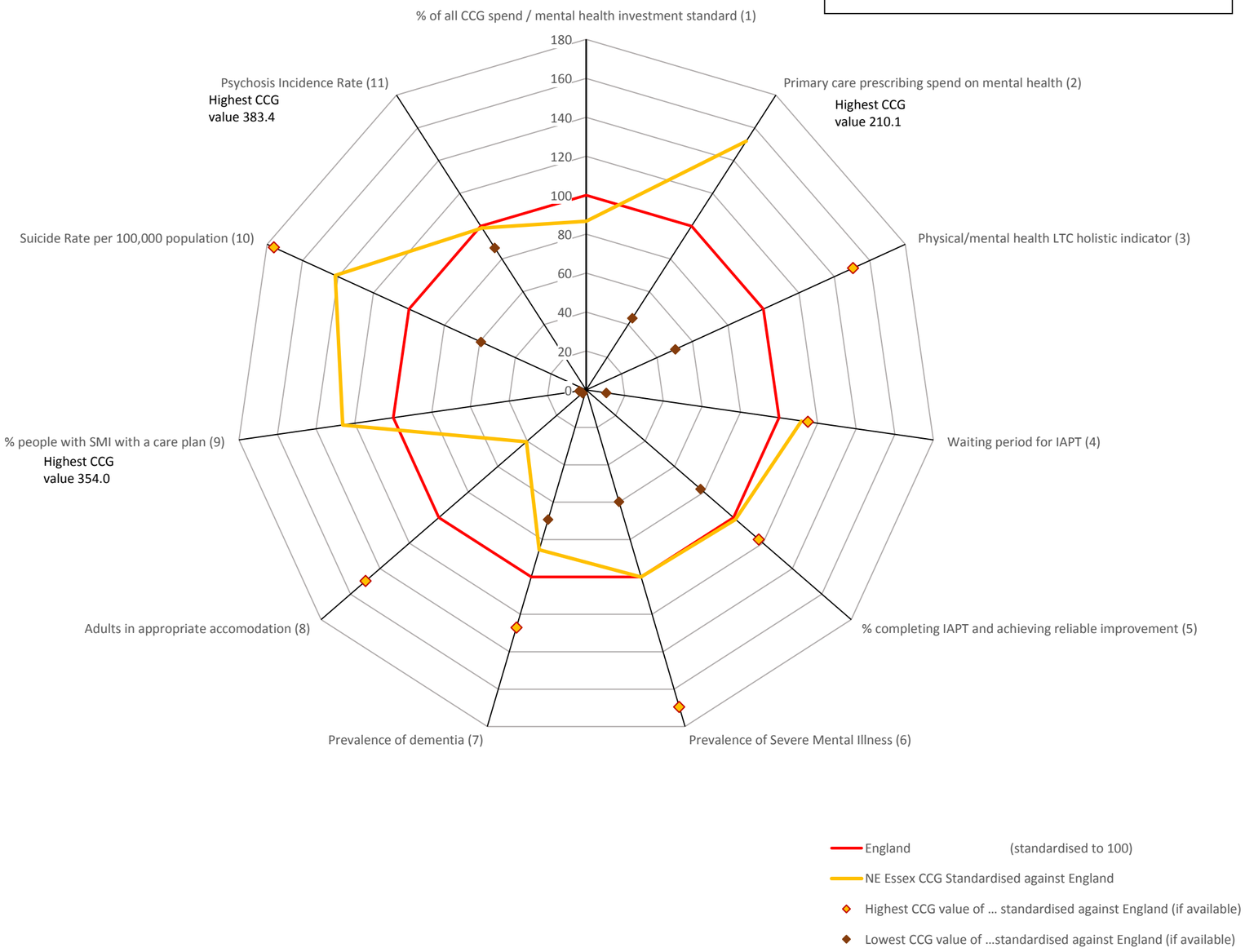

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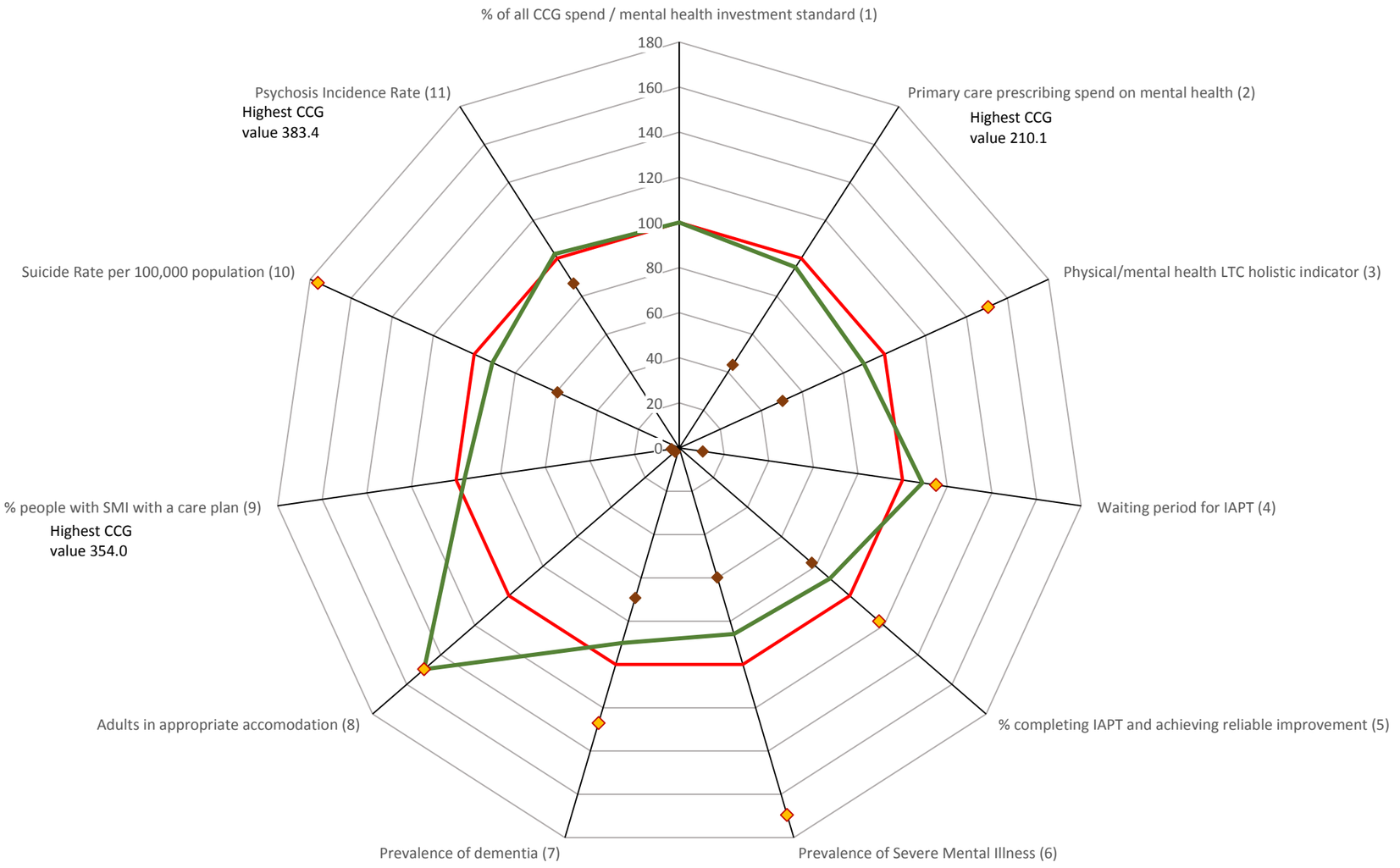
ADULT MENTAL HEALTH: West Suffolk CCG



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Metric Group	Metric Plotted	Data Type	Age range	Date range	England	STP	IpsES CCG	NE Essex CCG	West Suff CCG	Suffolk & North Essex STP	Standardise d against England	Standardise d against NE Essex CCG	Standardise d against West Suff CCG	Standardise d against England (standardis ed to 100)	Value Highest of	Highest STP value of ...standardised against England (if available)	Highest value STP	Lowest Value of	Lowest STP value ...standardised against England (if available)	Lowest value STP	Highest value CCG	Highest CCG value ...standardis ed against England (if available)	Highest value CCG	Lowest value CCG	Lowest CCG value ...standardis ed against England (if available)	Lowest value CCG	Source
% of all CCG spend / mental health investment standard (1)	Mental Health 2016/17 **actual** spend as a proportion of overall CCG allocation	Percent	All ages	2017/18	12.70	12.90	14.9	11	12.7	101.5748	117.3228	86.61417	100	100													Mental Health Five Year Forward View Dashboard (England figure is 15/16)
Primary care prescribing spend on mental health (2)	Cost of GP prescribing for psychoses and related disorders:	Net Ingredient Cost (£) per 1,000 population (quarterly)	18+ yrs	2017/18 Q2	62.30	72.40	61.2	94.6	59.4	116.2119	98.23435	151.8459	95.3451043	100	94.60	151.85	Norfolk & Waveney STP	39.30	63.08	Surrey Heartlands STP	130.9	210.11	NHS Norwich CCG	27.3	43.82	NHS Bracknell & Ascot CCG	PHOF - SMI Profile
Physical/mental health LTC holistic indicator (3)	People with SMI who have received the complete physical health check	Percent	All ages	2014/15	34.80	31.73	32		31.3	91.1648	91.95402		89.9425287	100	44.00	126.43	Northumberland, Tyne and Wear and	18.80	54.02	Somerset	52.4	150.57	NHS Halton CCG	17.5	50.29	NHS Surrey Downs CCG	MH & Wellbing JSNA
Waiting period for IAPT (4)	Waiting < 6 weeks for a course of treatment (waiting time standard measure): % of referrals that have finished course of treatment waiting <6 weeks for first treatment	Percent	18+ yrs	Jan'18	87.00	97.50	95.3	97.1	94.7	112.069	109.5402	111.6092	108.850575	100	98.84	113.61	Coventry and Warwickshire STP	50.70	58.28	Leicester, Leicestershire & Rutland	100	114.94	x24 CCGs	9.1	10.46	NHS Barnet CCG	Common MH Disorders Profile
% completing IAPT and achieving reliable improvement (5)	Rate of reliable improvement: % (quarterly) of people who have achieved "reliable improvement" of those who have completed IAPT treatment	Percent	18+ yrs	17/18 Q3	70.40	63.30	59.0	71.4	62.2	89.91477	83.80682	101.4205	88.3522727	100	77.10	109.52	Herefordshire and Worcestershire STP	55.20	78.41	Norfolk & Waveney	82.5	117.19	NHS Swale CCG & East Staffordshire CCG	54.7	77.70	NHS Thameside & Glossop CCG	Common MH Disorders Profile
Prevalence of Severe Mental Illness (6)	Severe mental illness recorded prevalence (QOF): % of practice register (all ages)	Percent	All ages	2016/17	0.92	0.86	0.85	0.92	0.79	93.47826	92.3913	100	85.8695652	100	1.25	135.87	North Central London STP	0.71	77.17	Surrey Heartlands STP	1.56	169.57	NHS Blackpool CCG	0.55	59.78	NHS Wokingham CCG	SMI Profile
Prevalence of dementia (7)	Prevalence of dementia (aged 65+)	Percent	65+	Sep-17	4.33	4.00	4.3	3.7	3.9	92.37875	99.30716	85.45035	90.0692841	100	4.90	113.16	North Central London STP	3.40	78.52	Cornwall and the Isles of Scilly STP	5.5	127.02	NHS Salford CCG	3	69.28	NHS Medway CCG	MH, Dementia & Neurolgy Profile
Adults in appropriate accomodation (8)	Stable and appropriate accommodation: % of people on CPA (aged 18-69) (end of quarter snapshot)	Percent	18-69	2017/18 Q3	60.70	63.10	86	24.6	90.9	103.9539	141.6804	40.52718	149.752883	100	84.30	138.88	Derbyshire STP	3.70	6.10	Lancshire & South Cumbria STP	90.9	149.75	West Suffolk CCG	1.5	2.47	IoW CCG	PHOF
% people with SMI with a care plan (9)	People on Care Programme Approach (CPA)	Rate per 100,000 population	18+ yrs	2017/18 Q3	374.00	404.00	374	472	360	108.0214	100	126.2032	96.2566845	100	707.00	189.04	Greater Manchester STP	179.00	47.86	Hampshire & IoW STP	1324	354.01	NHS Bradford CCG	13	3.48	IoW CCG	PHOF - SMI Profile
Suicide Rate per 100,000 population (10)	PHOF 4.10 **10+yrs**; AS mortality rate from suicide & injury of undetermined intent per 100,000 population	ASR per 100,000 population	10+ yrs	2013-15	10.10	10.70	8.8	14.3	9.2	105.9406	87.12871	141.5842	91.0891089	100	15.10	149.50	Cornwall & Isles of Scilly STP	7.00	69.31	Hertfordshire & West Essex	17.8	176.24	North Durham CCG	6	59.41	Wokingham CCG	PHOF - SMI Profile
Psychosis Incidence Rate (11)	New cases of psychosis: estimated incidence rate per 100,000 population age 16-64 yrs	ASR per 100,000 population	16-64 yrs	2011	18.10	18.30	18.4	17.9	18.5	101.105	101.6575	98.89503	102.209945	100	50.20	277.35	NE London STP	16.00	88.40	Cornwall and the Isles of Scilly STP	69.4	383.43	NHS City & Hackney CCG	15.7	86.74	NHS East Riding of Yorkshire CCG	PHOF - SMI Profile

ADULT MENTAL HEALTH : **Suffolk & North East Essex STP area**

STP by calc from CCGs

Count	Denominator
9365.00	404021.00
7658.00	350664.00
5504.00	248798.00
22527.00	1003483.00
6298.00	7647.00
5217.00	6444.00
3686.00	4600.00
15201.00	18691.00
5463.00	5922.00
3797.00	4130.00
2484.00	2690.00
11744.00	12742.00
51.00	118.00
53.00	96.00
49.00	79.00
153.00	293.00

CHILDREN & YOUNG PEOPLE HEALTH :

Suffolk & North East Essex STP

Indicators plotted:

1) % *Smoking at Time of Delivery (current method)*
Highest value: Blackpool
Lowest value: Kensington & Chelsea

2) *Year 6: % Prevalence of Obesity (Suffolk)*
Highest value: Barking & Dagenham
Lowest value: Rutland

3) Estimated % prevalence of MH disorders in children & young people (5-16)
Highest value: Kingston upon Hull
Lowest value: Richmond upon Thames

4) % 16-17 year olds who are NEET (Suffolk)
Highest value: Haringey
(but Windsor & Maidenhead higher outlier)
Lowest value: Harrow (Isles of Scilly lower outlier)

5) % Children in low income families (under 16s)

6) % with 3 or more risky behaviours (Suffolk)
Highest value: Gateshead
Lowest value: Tower Hamlets

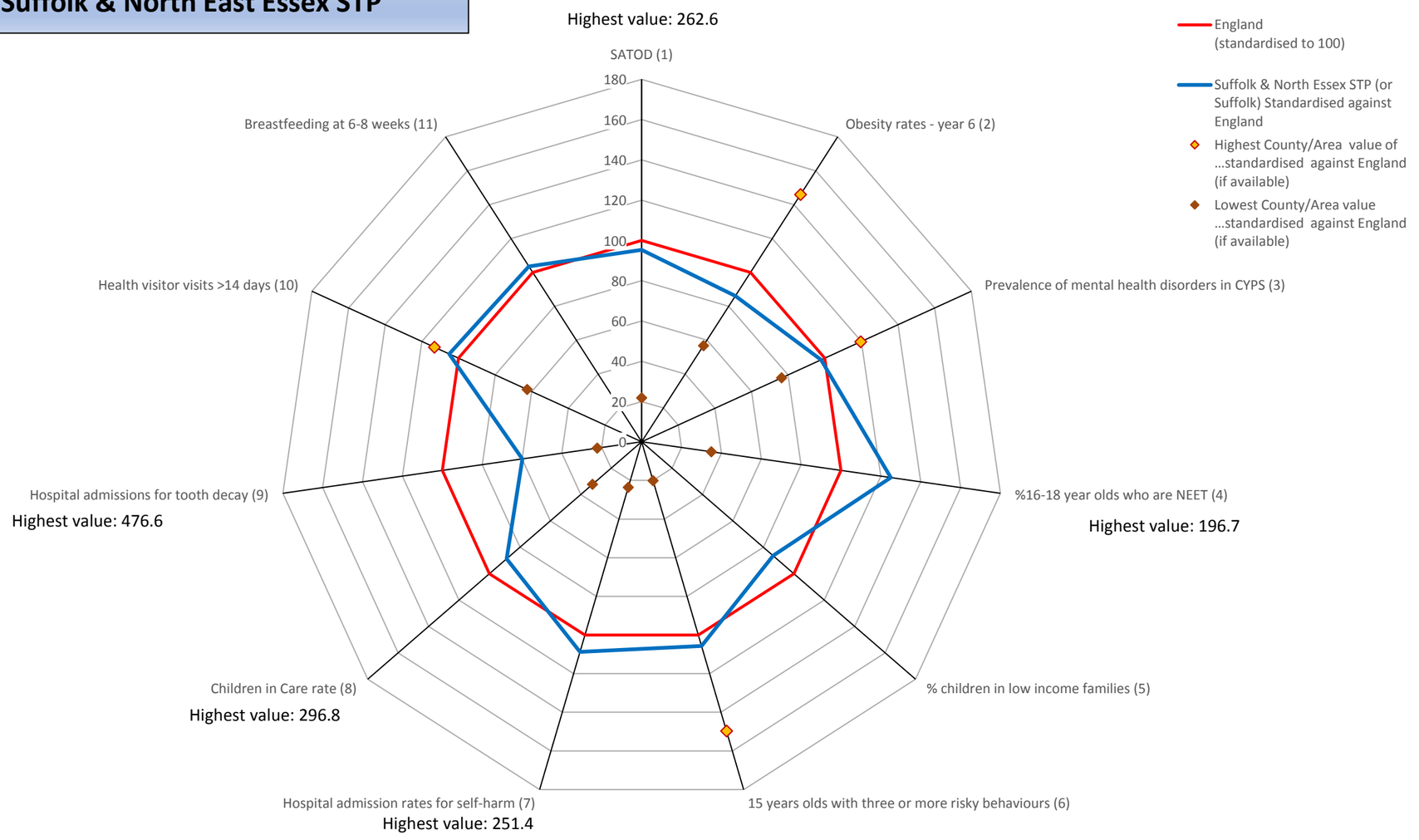
7) Hospital admissions as a result of self-harm (10-24 years) DSR per 100,000
Highest value: Blackpool
Lowest value: Kensington & Chelsea

8) Children in Care (Suffolk) per 100,000
Highest value: Blackpool
Lowest value: Wokingham

9) Hospital admissions for dental caries (0-4 years) per 100,000
Highest value: Rotherham
Lowest value: Coventry

10) % Health visitor visits less than 14 days (Suffolk)
Highest value: Bradford
Lowest value: South Gloucestershire

11*) % Breastfeeding at 6-8 weeks after birth*



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	A	B	D	F	G	H	I	M	Q	R	S	T	U	V	W	AD
1	**Metric Group**	**Metric Plotted**	**Data Type**	**Age range**	**Date range**	**England**	**STP (or Suffolk)**	**Suffolk & North Essex STP (or Suffolk) Standardised England (standardised to 100)**		**Highest value of**	**Highest County/Area value of ...standardised against England (if available)**	**Highest value**	**Lowest value of**	**Lowest County/Area value ...standardised against England (if available)**	**Lowest value**	**Source**
2	SATOD (1)	Smoking at Time of Delivery (current method)	%	All ages	2016/17	10.70	10.20	95.33	100	28.10	262.62	Blackpool (County/Area)	2.33	21.78	Kensington & Chelsea (County/Area)	PHOF
3	Obesity rates - year 6 (2)	Year 6: Prevalence of Obesity (Suffolk)	%	10-11 yrs	2016/17	19.98	17.2	86.09	100	29.17	146.00	Barking & Dagenham (County/Area)	11.34	56.76	Rutland (County/Area)	PHOF
4	Prevalence of mental health disorders in CYPS (3)	stimated prevalence of MH disorders in children & young people (5-1	%	5-16 yrs	2015	9.2	9.01	97.93	100	11.00	119.57	Kingston upon Hull (County/Area)	7.03	76.41	Richmond upon Thames (County/Area)	PHOF
5	%16-18 year olds who are NEET (4)	% **16-17** year olds who are NEET (Suffolk)	%	16-17 yrs	2016	6	7.5	125.00	100	11.80	196.67	Haringey (County/Area) but Windsor&Maidenhead 44.8%	2.1	35.00	Harrow (County/Area) but Isles of Scilly at 0%	DoE
6	% children in low income families (5)	Children in low income families (under 16s)	%	<16 yrs	2015	16.8	14.5108645	86.37	100							PHOF
7	15 years olds with three or more risky behaviours (6)	% with 3 or more risky behaviours (Suffolk)	%	15 yrs	2014/15	15.9	16.8	105.66	100	23.8	149.69	Gateshead (County/Area)	3.2	20.13	Tower Hamlets (County/Area)	PHOF
8	Hospital admission rates for self-harm (7)	Hospital admissions as a result of self-harm (10-24 years)	DSR per 100,000	10-24yrs	2016/17	417.4	453.85	108.73	100	1049.2	251.37	Blackpool (County/Area)	98.24	23.54	Kensington & Chelsea (County/Area)	PHOF
9	Children in Care rate (8)	Children in Care (Suffolk)	Per 100,000	<18yrs	2017	62	55	88.71	100	184.00	296.77	Blackpool (County/Area)	20	32.25806452	Wokingham (County/Area)	PHOF
10	Hospital admissions for tooth decay (9)	Hospital admissions for dental caries (0-4 years)	Per 100,000	0-4 yrs	2014/15 -16/17	240.2	143.64	59.80	100	1144.80	476.60	Rotherham (County/Area)	53.47	22.26	Coventry (County/Area)	PHOF
11	Health visitor visits >14 days (10)	Health visitor visits **less than** 14 days (Suffolk)	%	≤ 14 d	2015/16	87	91.4	105.06	100	98.40	113.10	Bradford (County/Area)	54.4	62.53	South Gloucestershire (County/Area)	PHOF
12	Breastfeeding at 6-8 weeks (11)	Breastfeeding at 6-8 weeks after birth	%	n/a	Qtr 4 16/17 & '16/'17 national/Suffolk	44.4	46	103.60	100							

9. Integrated quality and performance report

To ACCEPT the report

Presented by Rowan Procter and Helen Beck

Trust Board – 27 July 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 and Efficiency			
Date prepared:	July 2018			
Subject:	Trust Integrated Quality & Performance Report			
Purpose:	x	For information		For approval
Executive summary:	The attached report provides an overview of the key performance measures for the Trust. A detailed section is included from page 17 onwards.			

Trust priorities	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	x		

Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		x					

Previously considered by:	Monthly at Trust Board

Risk and assurance:	To provide oversight and assurance to the Board of the Trusts performance.
Legislation, regulatory, equality, diversity and dignity implications:	Performance against national standards is reported.
Recommendation: The Trust Board notes the monthly performance report.	

Key points of note:

This summary presents the top three areas that are receiving further attention.

ED Performance

Performance in ED against the 4 hour wait standard has shown improvement recently, just missing the target of 95% for May and June 2017, however prior to this the 95% target has not been achieved since June 2017. Unprecedented demand on ED over the winter period saw a decline in performance and intensive focus from Executives has been in place in ED. Further actions are in place to ensure sustainable performance moving forward and planning ahead into winter. A dedicated ED action plan is in place, which is monitored through weekly and monthly ED meetings to monitor and drive progress. The involvement of ECIST has commenced to assist with an in depth view of demand and capacity and seeking solutions to ensure our capacity meets the demand in ED.

RTT – 18 weeks

Performance in this area has been challenged for many months and was exacerbated with the cancellations over the winter period. A focused effort from teams has seen the position recover and performance against the 92% target was achieved for May, albeit it with caution. Performance in June demonstrated a slight deterioration to 91.3% as predicted. Detailed demand and capacity work is ongoing to allow specialty level trajectories to be developed to deliver a sustainable position.

Cancer Standards

Whilst the 62 day cancer standard continues to be achieved, this is being closely monitored to ensure delivery is continued. Performance for 2 week breast referrals continues to be challenged due to increase in demand despite additional sessions being offered. All the cancer standards are being closely monitored.

NHS
West Suffolk
NHS Foundation Trust

Integrated quality and performance report



Month Three: June 2018

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CONTENTS

EXECUTIVE SUMMARY

DETAILED SECTIONS

1 EXECUTIVE SUMMARY

This Month the Ward Level Dashboard has been replaced with Divisional level data as presentation was unreadable.

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 June 2018. There was one case of hospital-attributable Clostridium difficile for June 2018; The Trust compliance with decolonization increased in June 2018 to 90%.

NHS Patient Safety Alerts (PSAs) – A total of 7 PSAs have been received in 2018/9, with 5 in June 2018. All the alerts have been implemented within timescale to date.

Patient Falls (All patients) - 62 patient falls occurred in June 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 June 2018, 9 cases occurred, with YTD total of 22. *(RAP included in main report).*

ARE WE EFFECTIVE?

Cancelled Operations for non-clinical reasons - The rate of cancelled operations for non-clinical reasons was recorded at 1.5% in June 2018. (*RAP included in the main report*).

Cancel Operations Patients offered date within 28 Days – The rate of cancelled operations where patients were offered a date within 28 Days was recorded at 100% in June 2018 compared to 90.9 % In May 2018.

Discharge Summaries- Performance to date is below the 95% target to issue discharge summaries (inpatients and ED). A&E has achieved a rate of 86.1% in June 2018 whereas inpatient services have achieved a rate of 72.1% (Non-Elective) and 78.0% (Elective. (*RAP included in the main report*).

ARE WE CARING?

Mixed Sex Accommodation breaches (MSA) – 1 MSA breach occurred in June 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 – June 2018 Reported Performance at 93.88% and overall for Quarter 1 90.97%. Quarter 1 was particularly challenging with the effect of winter continuing into April impacting the Quarterly Position.

Cancer – Cancer performance (provisional figures) of 85.2% is above the national requirement. *(RAP included in the main report).*

Referral to Treatment (RTT) - The percentage of patients on an incomplete pathway within 18 weeks for June was 91.4%. The total waiting list is at 16634 in June. In June 10 patients breached the 52 week standard. *(RAP included in the main report).*

ARE WE WELL LED?

Appraisal - The percentage figure is up to 69.3% from 67.3% last month. A number of actions are in place including, a targeted approach from senior staff, increased training for appraisers and tightening up of monitoring processes.

Sickness Absence – The percentage is down slightly by 0.02%. Estates and Facilities remain the highest percentage at 4.84%, however this is made up of both long term and short term sickness. HR continues to work closely with the divisions to address issues.

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?

2. INTEGRATED QUALITY & PERFORMANCE REPORT DASHBOARD

This dashboard provides an Overview of Performance against key targets that form the key lines of enquiry and KPIs of NHS Improvement and the CQC. These are reviewed in further detail in the individual sections of the report, which are aligned to the CQC. Exception reports are included in the detailed section of this report.

INTEGRATED QUALITY & PERFORMANCE REPORT			TRUST TOTAL													
Are we..	Ref.	KPI	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Av/YTD
1. Safe	1.01	NHS E / I Patient Safety Alerts - Total	NT	0	1	2	1	0	1	0	1	0	0	2	0	5	7
	1	NHS E / I Patient Safety Alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2
	1	Emergency C-Section Rate	14%	11.5%	8.5%	12.9%	11.9%	11.2%	9.8%	10.6%	14.1%	10.1%	19.4%	16.4%	11.4%	10.6%	12.8%
	1	All relevant inpatients undergoing a VTE Risk assessment	95%	88.8%	85.8%	89.7%	88.0%	94.8%	96.9%	94.7%	96.9%	97.6%	97.3%	98.2%	94.1%	96%	96%
	1.1	Clostridium Difficile infection - Hospital Attributable	16	0	1	0	2	6	4	0	1	0	2	1	0	1	2
	1.1	MRSA Bacteraemias - Hospital Attributable	0	0	0	0	2	0	0	0	0	1	0	0	0	0	0
	1.1	Patient Safety Incidents Reported	NT	418	506	466	467	520	588	479	627	553	535	486	579	465	0
	1.08	Never Events	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
2.Effective	2	Canc. Ops - Cancellations for non-clinical reasons	1%	1.1%	1.0%	1.2%	1.0%	1.4%	1.9%	1.3%	0.8%	1.2%	0.9%	0.6%	0.8%	1.5%	1.0%
3. Caring	3.01	Compliments (Logged by Patient Experience)		26	56	28	17	33	87	151	64	20	45	21	93	44	158
	3	Formal Complaints	20	10	6	16	16	17	13	8	12	19	9	13	13	11	37
	3	Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	1	0	0	1	0	0	1	1
	3	IP - Extremely likely or Likely to recommend (FFT)	90%	98.9%	98.3%	98.0%	98.3%	98.6%	96.0%	97.7%	97.1%	98.1%	98.0%	99.0%	99.0%	98.0%	97.8%
	3.1	OP - Extremely likely or Likely to recommend (FFT)	90%	96.9%	94.9%	95.1%	96.0%	95.9%	96.0%	98.6%	95.1%	96.2%	95.0%	97.0%	97.0%	97.0%	97.0%
	3.1	A&E - Extremely likely or Likely to recommend (FFT)	85%	95.3%	95.0%	94.7%	92.3%	94.9%	94.0%	94.0%	96.4%	94.9%	94.0%	94.0%	93.0%	94.0%	93.7%
	3.1	Maternity - Extremely likely or likely to recommend (FFT)	90%	100.0%	100.0%	ND	ND	98.8%	100%	97.3%	100.0%	93.0%	100.0%	98.0%	99.4%	96.7%	98.0%
	3.1	Community - Extremely likely or likely to recommend	80%	100.0%	ND	ND	ND	97.3%	100%	95.7%	95.2%	97.4%	96.0%	94.0%	98.0%	97.0%	96.3%
4. Responsive	4.01	A&E under 4 hr. wait	95%	95.5%	92.5%	90.1%	88.9%	87.4%	90.4%	83.3%	83.8%	85.2%	85.4%	84.9%	93.7%	93.9%	90.8%
	4	RTT: % incomplete pathways within 18 weeks	92%	83.4%	83.9%	85.9%	85.7%	87.0%	88.9%	89.0%	90.2%	89.6%	89.5%	90.4%	92.2%	91.4%	91.3%
	4	52 week waiters	0%	15	35	26	29	26	21	15	14	13	24	19	14	10	43
	4	Diagnostics within 6 weeks	99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%
	4.1	Cancer: 2w wait for urgent GP Referrals	93%	96.6%	94.5%	96.0%	91.4%	83.4%	97.9%	97.2%	98.0%	97.5%	94.7%	95.9%	94.9%	91.6%	94.1%
	4.1	Cancer 2w wait breast symptoms	93%	88.8%	98.1%	100%	98.3%	100%	100%	99.1%	97.1%	92.9%	86.7%	96.7%	82.6%	85%	88%
	4.1	Cancer 31 d First Treatment	96%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	99.1%	100%	100%	100%
	4.1	Cancer 31 d Drug Treatment	98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.1	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%	86.0%	84.6%	85.8%	86.9%	93.9%	89.5%	87.1%	86.6%	79.8%	87.8%	93.3%	85.1%	85.2%	87.9%
	4.1	Cancer 62 d Screening	90%	90.0%	100%	100%	90.9%	100%	83.3%	100%	93.3%	85.7%	95.5%	72.7%	100%	100%	90.9%
	4.1	Incomplete 104 day waits		ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	3	1.5	0	2.0

NHS West Suffolk NHS Foundation Trust

INTEGRATED QUALITY & PERFORMANCE REPORT			TRUST TOTAL													
Are we..	Ref.	KPI	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Av/YTD
5. Well Led	5.01	NHS Staff Survey (Staff Engagement score -Annual)		NA	NA	NA	NA	NA	NA	NA	NA	4.0%	NA	NA	NA	NA	NA
	5	Staff F&F Test % Recommended - care (Qrtly)	75%	95.0%	NA	NA	95.0%	NA	NA	ND	NA	NA	ND	NA	NA	NA	NA
	5	Staff F&F Test % Recommended - place to work (Qrtly)	75%	83.0%	NA	NA	82.0%	NA	NA	ND	NA	NA	ND	NA	NA	NA	NA
	5	Turnover (Rolling 12 mths)	<10%	10.3%	9.9%	10.0%	9.8%	9.0%	9.1%	9.3%	9.3%	8.7%	8.8%	8.4%	8.4%	8.5%	8.4%
	5.1	Sickness Absence	<3.5%	3.6%	3.6%	3.6%	3.6%	3.6%	3.5%	3.5%	3.6%	3.7%	3.7%	3.8%	3.8%	3.70%	3.77%
	5.1	Executive Team Turnover (Trust Management)	<10%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0%	0%
	5.1	Agency Spend		255	216	126	150	82	213	245	353	306	373	276	188	330	265
	5.1	Monitor Use of Resources Rating		3	3	3	3	3	3	3	3	3	3	3	3	3	3
6. Productive	6.01	I&E Margin	Var	-4.3%	-3.9%	0.1%	-3.0%	-2.6%	-2.5%	-2.6%	-2.3%	-2.6%	20.0%	-10.3%	-7.5%	-6.30%	-8.03%
	6	Capital service cover	Var	- 2.50	- 2.18	- 1.04	- 0.88	- 0.32	0.52	0.24	0.38	0.07	0.68	0.48	1.64	- 0.80	0.44
	6	Liquidity (days)		- 15.72	- 10.94	- 11.03	- 12.70	- 15.14	9.64	11.39	6.06	6.84	7.86	12.34	16.83	15.36	14.84
	6.1	Long Term Borrowing (£m)	4%	45.7	45.7	45.7	47.6	47.6	56.7	58.7	64.4	64.1	65.4	67.6	69.8	69.0	68.8
	6.1	CIP (Variance YTD £'000s)CIP (Variance YTD £'000s)	1.9	-40	10	0	-54	-10	-74	-22	-419	-469	-539	-54	-47	-75	-58.7
7. Maternity	7.01	Total number of deliveries (births)	210	213	215	233	236	205	194	180	199	211	206	198	203	201	602
	7.02	% of all caesarean sections	<22.7%	15.9%	15.5%	22.3%	18.2%	17.1%	17.0%	18.3%	22.1%	17.1%	30.1%	28.2%	22.4%	18.2%	22.9%
	7.03	Midwife to birth ratio	1.3	1.29	1.30	1.33	1.33	1.29	1.28	1.26	1.28	1.29	1.29	1.27	1.30	1.28	1.28
	7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.05	Completion of WHO checklist	100%	84.0%	94.0%	82.0%	98.0%	98.0%	98.0%	93.0%	93.0%	94.0%	97.0%	86.0%	85.0%	88.0%	86.3%
	7.06	Maternity SIs	NT	0	0	0	1	1	0	1	2	0	1	2	2	0	4
	7.07	Maternity Never Events	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.08	Breastfeeding Initiation Rates	0.8	87.5%	77.3%	84.8%	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	79.0%	76.1%	76.3%	80.7%	77.7%
8. Community	8	No of avoidable serious injuries or deaths from falls - Community	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
	8.02	Community - Extremely likely or likely to recommend	80%	100%	ND	ND	ND	97.3%	100%	95.7%	95.2%	97.4%	96.0%	94.0%	98.0%	97.0%	96.3%
	8.03	RTT 18 weeks Non-Consultant led services - Community	90%	99.0%	98.8%	94.7%	99.4%	93.7%	94.4%	98.4%	98.7%	100%	99.4%	99.2%	97.6%	100%	98.9%
	8.04	Urgent Referrals for Early Intervention Team (EIT) - Community		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100%	100%	100%	100%
	8.05	Nursing & therapy Red referrals seen within 4hrs - Community		100%	100%	NA	100%	NA	NA	100%	100%	96.4%	100%	96%	100%	100%	98.8%
	8.06	Nursing & therapy Amber referrals seen within 72hrs - Community		99.4%	98.6%	95.6%	98.6%	90.9%	96.9%	100%	99.3%	98.0%	97.6%	98.8%	99.4%	99.5%	99.2%
	8.07	Safeguarding Children Mandatory Compliance (Community)	98%	96.9%	96.9%	97.1%	96.8%	95.3%	96.1%	96.0%	95.9%	95.7%	97.0%	98.2%	95.8%	95.3%	96.4%
	8.08	Safeguarding Adults Mandatory Training Compliance (Community)	98%	96.8%	96.6%	96.2%	96.1%	94.3%	95.3%	94.0%	94.1%	93.2%	95.6%	96.0%	95.0%	94.9%	95.3%

3. IN THIS MONTH – JUNE 2018, MONTH 3

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

From Month Year	Jun-2018	To Month Year	Jun-2017

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

In this month.... June 2018

Mth We Received.....	Jun-18	Jun-17	Variance	Var. %	Traffic
GP Referrals	5,781	6,549	-768	-11.7%	↓
Other Referrals	4,527	5,297	-770	-14.5%	↓
Ambulance Arrivals	1,711	1,752	-41	-2.3%	↓
Cancer Referrals*	1,126	1,057	69	6.5%	↑
Urgent Referrals*	2,428	2,614	-186	-7.1%	↓

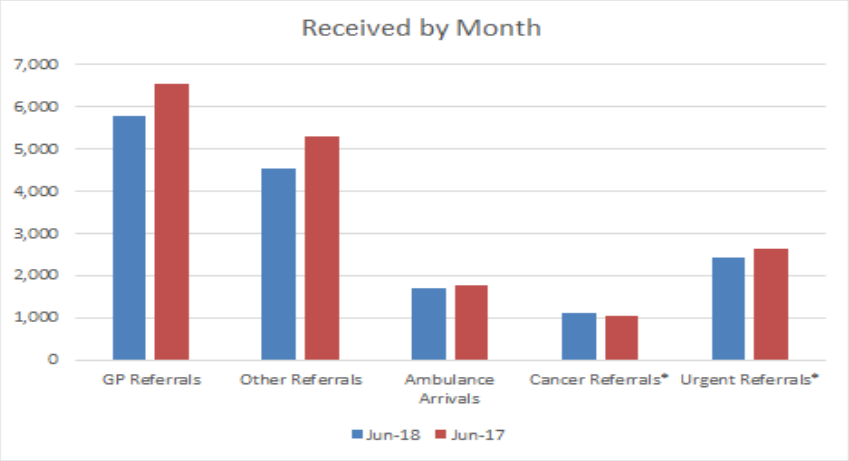
YTD We Received.....	2018	2017	Variance	Var. %	Traffic
GP Referrals	18,508	19,331	-823	-4.3%	↓
Other Referrals	14,316	15,905	-1,589	-10.0%	↓
Ambulance Arrivals	5,387	5,160	227	4.4%	↑
Cancer Referrals*	3,270	2,885	385	13.3%	↑
Urgent Referrals*	7,701	7,641	60	0.8%	↑

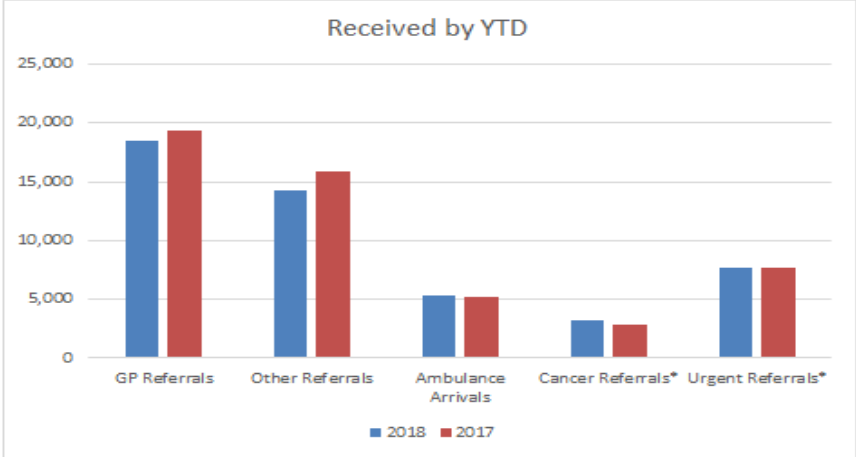
Mth We Delivered.....	Jun-18	Jun-17	Variance	Var. %	Traffic
A&E Attendances	6,161	5,922	239	4.0%	↑
A&E - To IP Admission Ratio	25.0%	28.3%	-3.3%	-3.3%	↓
Outpatient Attendances	22,602	25,623	-3,021	-11.8%	↓
Inpatient Admissions	5,841	5,776	65	1.1%	↑
Inpatient Discharges	5,877	5,735	142	2.5%	↑
New Births	201	213	-12	-5.6%	↓
RTT Total Incompletes	16,739	19,931	-3,192	-16.0%	↓

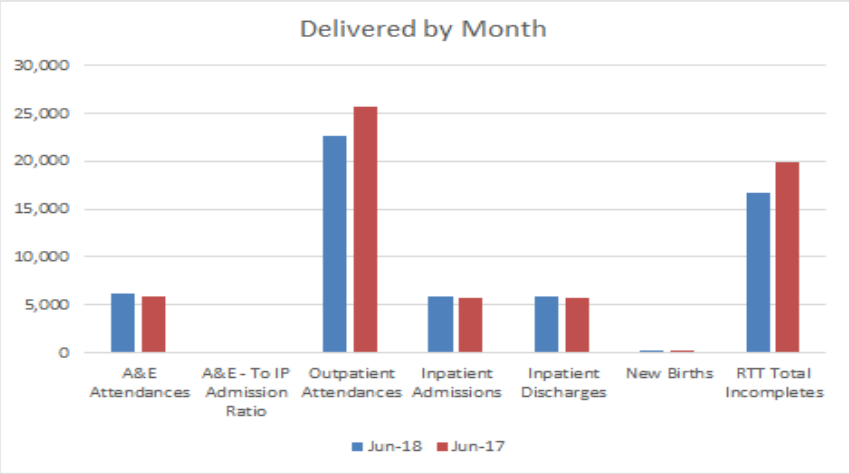
YTD We Delivered.....	2018	2017	Variance	Var. %	Traffic
A&E Attendances	18,626	17,471	1,155	6.6%	↑
Outpatient Attendances	73,660	73,164	496	0.7%	↑
Inpatient Admissions	17,523	16,995	528	3.1%	↑
Inpatient Discharges	17,568	16,992	576	3.4%	↑
New Births	602	620	-18	-2.9%	↓

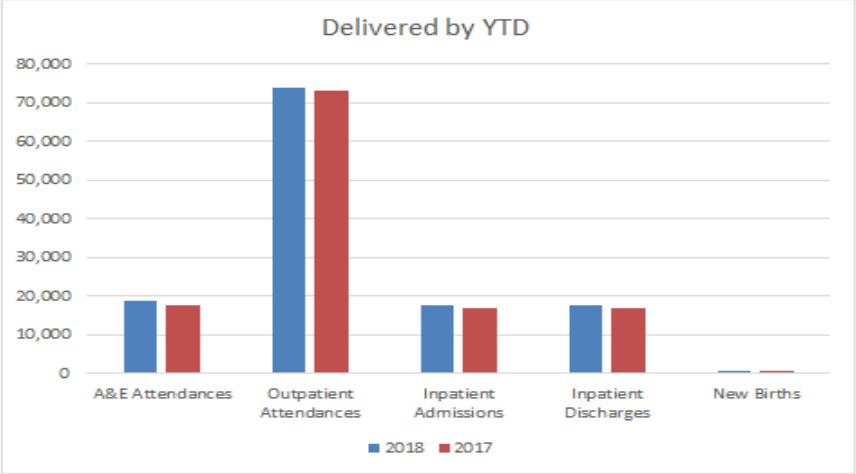
* - Included in Referrals Above

GP and other referrals demonstrate a reduction year on year however Cancer Referrals are showing signs of increasing. A&E attendances continue to show an increase however incomplete RTT pathways are lower than last year.



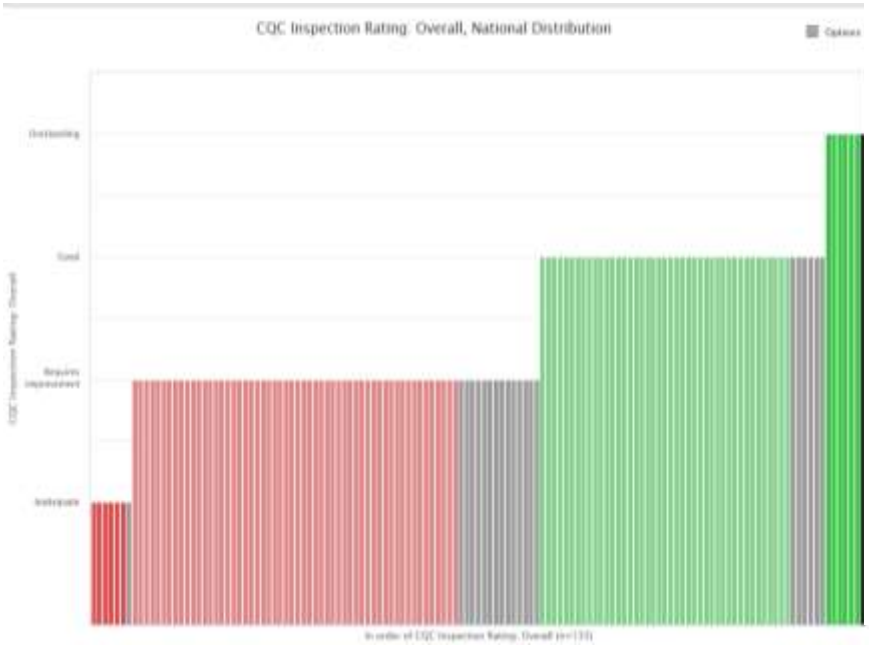


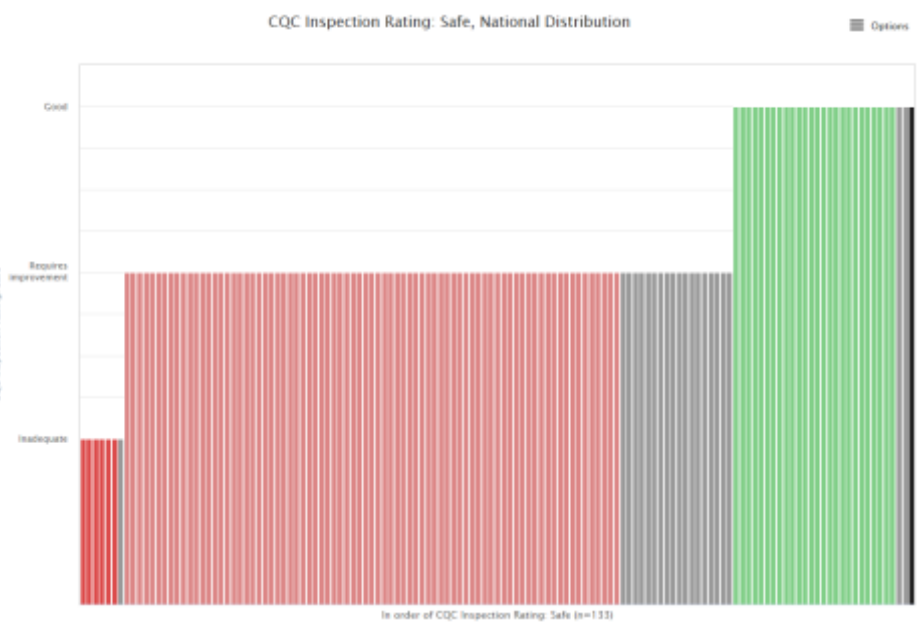


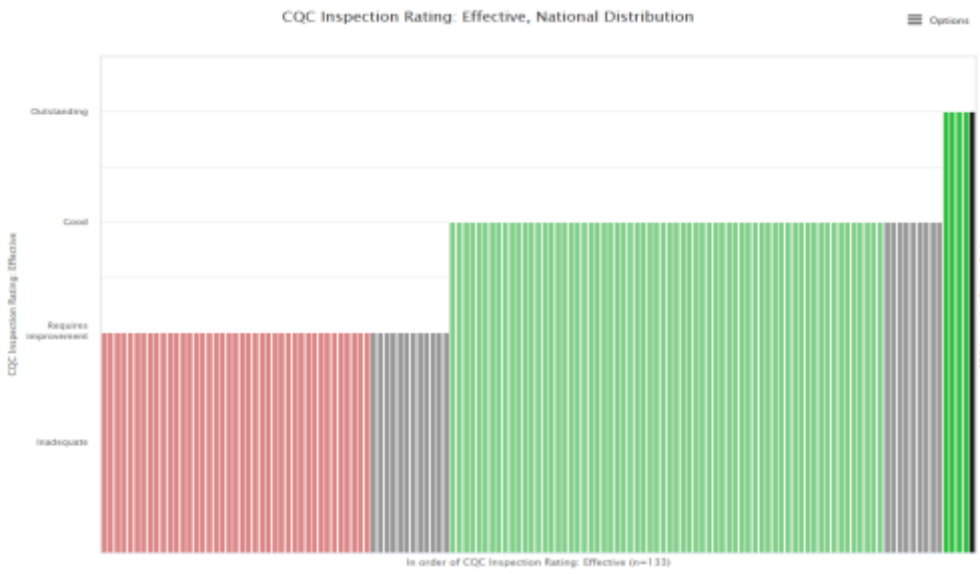


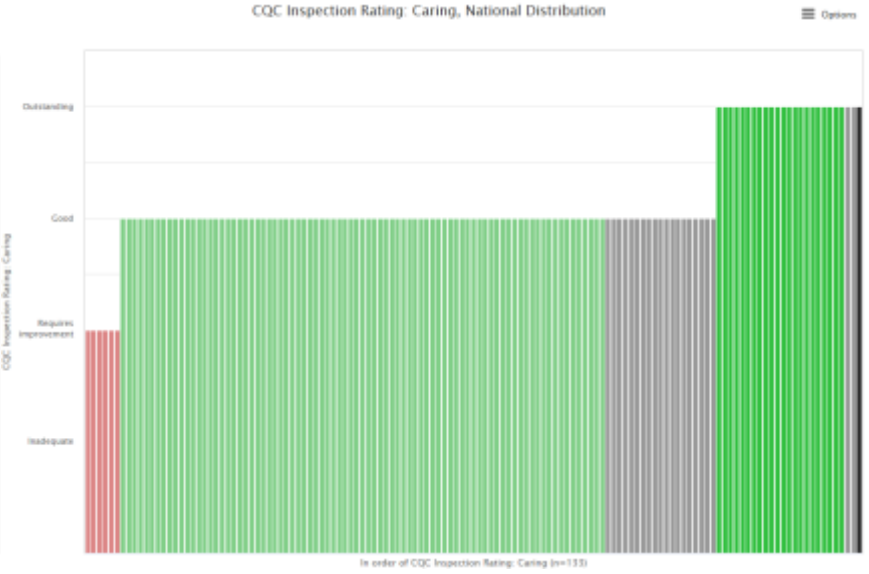
4. PEER REVIEW/BENCHMARKING

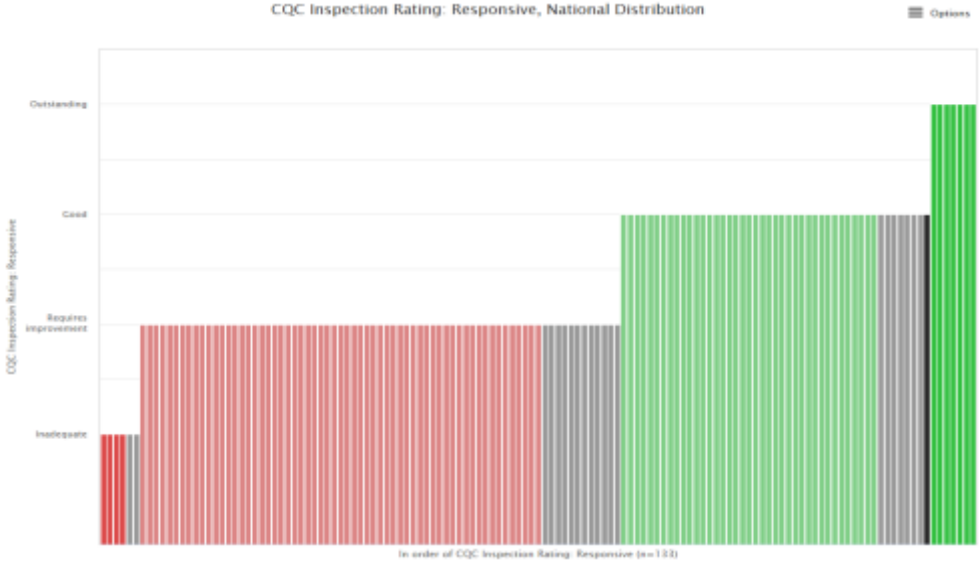
The CQC have launched the Model Hospital website which highlights comparative indicators in a number of key areas. The graphs below provide oversight of the Trust's latest available comparative performance against these key areas from June 2018. *(Source – Model Hospital)*

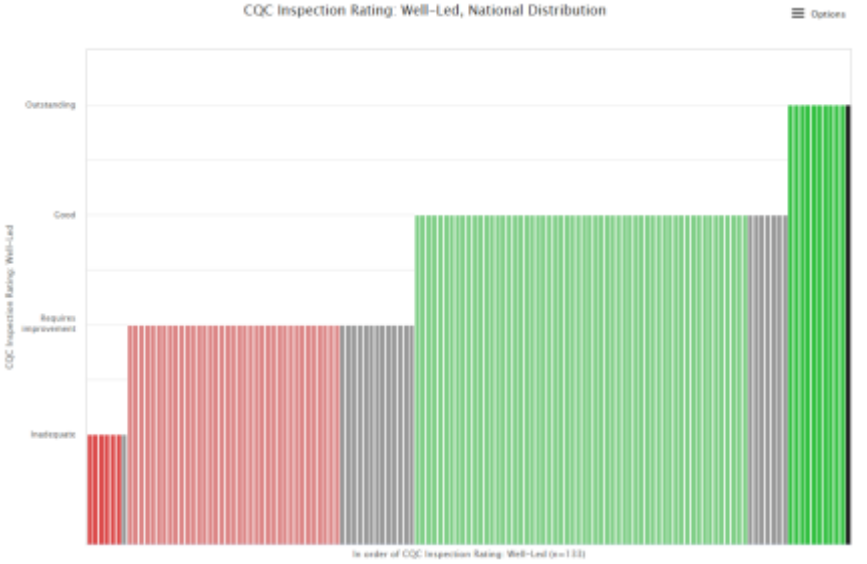





CQC Inspection Rating: Effective, National Distribution
Options
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Effective
In order of CQC Inspection Rating: Effective (n=133)


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


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


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

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*).

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 from June 2018. Appendix 1 *(Source – Model Hospital-Latest available)*

Quality of Care, Single Oversight Framework

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

Friends and Family Test scores	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Staff Friends and Family Test % Recommended - Care	Q2 2017/18	94.1%	-	-		No variation available	
A&E Scores from Friends and Family Test - % positive	Feb 2018	94.9%	86.9%	86.9%			
Inpatient Scores from Friends and Family Test - % positive	Feb 2018	98.8%	97.0%	96.3%			
Community Scores from Friends and Family Test - % positive	Jan 2018	95.1%	95.1%	97.1%			
Maternity Scores from Friends and Family Test -question 2 Birth % positive	Feb 2018	92.0%	96.9%	97.7%			

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

Caring	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Written Complaints Rate	31/12/2017	11.95	21.05	22.74			

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			

DETAILED REPORTS

5. 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	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	YTD(Apr18-Mar19)
Safe	Dashboard	1.01	NHS E / I Patient Safety Alerts - Total	NT	0	1	2	1	0	1	0	1	0	0	2	0	5	7
		1.02	NHS E / I Patient Safety Alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	2	0	2
		1.03	Emergency C-Section Rate	14%	11.5%	8.5%	12.9%	11.9%	11.2%	9.8%	10.6%	14.1%	10.1%	19.4%	16.4%	11.4%	10.6%	12.8%
		1.04	All relevant inpatients undergoing a VTE Risk assessment	95%	88.8%	85.8%	89.7%	88.0%	94.8%	96.9%	94.7%	96.9%	97.6%	97%	98.2%	94.1%	95.6%	96.0%
		1.05	Clostridium Difficile infection - Hospital Attributable	16	0	1	0	2	6	4	0	1	0	2	1	0	1	2
		1.06	MRSA Bacteraemias - Hospital Attributable	0	0	0	0	2	0	0	0	0	1	0	0	0	0	0
		1.07	Patient Safety Incidents Reported	NT	418	506	466	467	520	588	479	627	553	535	486	579	465	0
		1.08	Never Events	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	100%	100%	100%	100%	94.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.10	HII Compliance 1b: Central venous catheter on-going care	100%	100%	100%	96.0%	100%	100%	100%	100%	100%	100%	100%	100%	95.0%	100%	98.3%
		1.11	HII Compliance 2a: Peripheral cannula insertion	100%	100%	100%	97.0%	100%	98.0%	97.0%	100%	100%	100%	100%	100%	100%	100%	100%
		1.12	HII Compliance 2b: Peripheral cannula on-going	100%	98.0%	93.0%	97.0%	99.0%	99.0%	97.0%	96.0%	99.0%	100%	100%	100%	98.0%	97.0%	98.3%
		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%	95.0%	100%	100%	100%	100%	100%	100%	95.0%	100%	100%	100%	100%	100%
		1.15	HII Compliance 5: Ventilator associated pneumonia	100%	100%	100%	100%	100%	100.0%	78.0%	100%	100%	100%	100%	100%	100%	100%	100%
		1.16	HII Compliance 6a: Urinary catheter insertion	100%	100%	100%	100%	100%	78.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.17	HII Compliance 6b: Urinary catheter on-going care	100%	94.0%	88.0%	99.0%	97.0%	91.0%	92.0%	95.0%	100.0%	99.0%	97.0%	100%	95.0%	92.0%	95.7%

Are we..		Ref.	KPI	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	YTD(Apr18-Mar19)
Safe	Incidents	1.18	Safety Thermometer: % of patients experiencing new harm-free care-Trust	100%	98.9%	98.6%	98.2%	97.2%	97.6%	98.4%	98.5%	97.9%	97.7%	98.5%	99.2%	97.8%	98.7%	98.6%
		1.19	Safety Thermometer: % of patients experiencing new harm-free care - Community	100%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	99.4%	98.1%	99.0%	98.9%
		1.20	No of SIRIs	NT	7	7	6	5	11	14	10	20	11	6	8	11	0	19
		1.21	RIDDOR Reportable Incidents	NT	5	0	3	0	2	0	3	0	2	1	2	4	1	7
		1.22	Total No of E. Coli (Trust level only)	NT	2	2	1	2	1	2	2	2	1	3	1	2	0	3
		1.23	No of Inpatient falls - Trust		56	75	69	44	56	73	69	76	82	72	68	72	62	202
		1.24	No of Inpatient falls - WSH	<48	50	66	64	39	47	56	60	68	74	64	55	61	50	166
		1.25	No of Inpatient falls - Community Hospitals		6	9	5	5	9	17	9	8	8	8	13	11	12	36
		1.26	Falls per 1,000 bed days (Locally derived estimate)		4.6	6.3	5.7	3.7	3.9	5	5.1	5.6	6.52	5.17	6.13	6.76	4.84	5.91
		1.27	No of Inpatient falls resulting in harm - Trust	NT	22	17	18	10	23	18	23	28	26	20	24	24	22	70
		1.28	No of Inpatient falls resulting in harm - WSH	NT	20	14	18	10	19	15	19	27	25	19	18	19	22	59
		1.29	No of Inpatient falls resulting in harm - Community Hospitals	NT	2	3	0	0	4	3	4	1	1	1	6	5	0	11
		1.30	No of avoidable serious injuries or deaths resulting from falls - Trust	0	0	0	1	0	0	1	0	0	1	0	ND	0	0	0
		1.31	No of avoidable serious injuries or deaths resulting from falls - WSH	0	0	0	1	0	0	0	0	0	1	0	ND	0	0	0
		1.32	No of avoidable serious injuries or deaths from falls - Community	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
		1.33	Number of medication errors	NT	69	78	70	69	70	78	63	72	49	76	60	85	43	188
		1.34	No of ward acquired pressure ulcers	NT	18	9	13	14	18	17	12	30	15	9	4	9	9	22
		1.35	No of Community 'In our Care' pressure ulcers	NT	NA	NA	NA	NA	13	14	6	24	15	14	12	19	16	47
		1.36	% of patients with avoidable ward acquired pressure ulcers YTD	<+30%	30.0%	30.0%	34.0%	33.0%	32.0%	28.0%	28.0%	29.0%	28.0%	ND	29.0%	ND	ND	29.0%
		1.37	% of patients with avoidable Community 'In our Care' pressure ulcers		NA	NA	NA	NA	ND	ND	ND	ND	ND	ND	0%	0%	0%	0%
	Reporting	1.38	MRSA Quarterly Std (including admission and LOS screens)	90%	92.0%	NA	NA	93.0%	NA	NA	90.0%	NA	NA	92.0%	NA	NA	88.0%	88.0%
		1.39	MRSA Bacteraemias - Community Attributable	0	0	0	1	ND	0	0	0	0	0	1	2	2	0	4
		1.40	Clostridium Difficile infection - Community Attributable		0	0	1	1	1	0	0	0	0	2	0	0	0	0%
		1.41	MRSA - Decolonisation	95%	95.0%	95.0%	90.0%	91.0%	98.0%	85.0%	91.0%	94.0%	86.0%	95.0%	85.0%	91.0%	90.0%	88.7%
		1.42	MRSA - RCA Reports	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		1.43	MSSA (Hospital)	NT	0	0	1	1	0	1	1	1	0	0	0	2	2	4
		1.44	SIRI final reports due in month submitted beyond 60 working days	0	0	0	0	4	5	4	0	0	1	3	3	3	0	6
		1.45	SIRIs reported >2 working days from identification as red	0	0	0	1	2	3	6	5	7	3	ND	0	1	0	1
		1.46	Green, Amber & Red Active / Accepted risk assessments not in date	0	ND	9	0	1	5	0	2	1	4	0	1	3	3	7
		1.47	Datix Risk Register Red / Amber actions overdue	0	ND	22	0	0	0	0	0	0	1	3	1	4	3	8
		1.48	Rapid access chest pain clinic access within 2 wks.	100%	100%	95.5%	97.1%	97.5%	96.3%	100%	100%	100%	100%	99.1%	57.5%	97.3%	97.3%	84.0%
		1.49	Verbal Duty of Candour outstanding at month-end	0%	0	0	2	0	1	2	0	2	2	1	1	1	2	4
		1.50	Hand Hygiene Audits	95%	99.0%	100%	99.0%	98.0%	99.0%	99.0%	99.0%	99.0%	100%	100%	100%	99.0%	99.0%	99.3%
		1.51	Quarterly antibiotic audit	98%	90.6%	NA	NA	93.8%	NA	NA	93.0%	NA	NA	89.0%	NA	NA	92.2%	92.2%
		1.52	Serious Incident RCA actions beyond deadline for completion	0	3	4	1	7	2	9	14	9	8	4	9	4	4	17
		1.53	% of Green Patient Safety incidents investigated	NT	54.0%	53.0%	68.0%	58.0%	67.0%	56.0%	55.0%	59.0%	74.0%	68.0%	68.0%	64.0%	61.0%	64.3%
		1.54	Quarterly Environment/Isolation	90%	91.0%	NA	NA	92%	NA	NA	92.0%	NA	NA	91.0%	NA	NA	92.0%	92.0%
		1.55	Quarterly VIP score documentation	90%	84.0%	NA	NA	80%	NA	NA	87.0%	NA	NA	80.0%	NA	NA	86.0%	86.0%
		1.56	Isolation data (Trust Level only)	95%	90.0%	90.0%	88.0%	88.0%	90.0%	88.0%	88.0%	90.0%	90.0%	89.0%	86.0%	88.0%	87.0%	87.0%
		1.57	Pain Mgt. Quarterly internal report	80%	NA	61.0%	NA	NA	61.3%	NA	NA	58.8%	NA	NA	NA	NA	NA	NA
		1.58	Nutrition Risk Assessment 48hrs	95%	89.0%	82.0%	85.0%	90.0%	89.0%	87.0%	93.0%	92.0%	89.0%	90.0%	90.0%	93.0%	88.0%	90.3%
		1.59	Median NRLS (national reporting & Learning system) upload 6 month rolling average (No. of days)	41	65	65	58	55	48	61	66	75	65	63	46	38	36	40

SAFE – DIVISIONAL LEVEL ANALYSIS

Indicator	April			May			June		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
HII compliance 1a: Central venous catheter insertion	100	100		100	100		100	100	
HII compliance 1b: Central venous catheter ongoing care	100	100		100	88		100	100	
HII compliance 2a: Peripheral cannula insertion	100	100	100	100	100	100	100	100	100
HII compliance 2b: Peripheral cannula ongoing	100	100	100	100	96	100	100	95	100
HII compliance 4a: Preventing surgical site infection preoperative	100			100			100		
HII compliance 4b: Preventing surgical site infection perioperative	100			100			100		
HII compliance 5: Ventilator associated pneumonia	100			100			100		
HII compliance 6a: Urinary catheter insertion	100	100		100			100	100	
HII compliance 6b: Urinary catheter on-going care	100	100		100	93		100	86	
HII compliance 7: Clostridium Difficile- prevention of spread									
Total no of MRSA bacteraemias: Hospital	0	0	0	0	0	0	0	0	0
Quarterly MRSA (including admission and length of stay screens)							98	77	92
Hand hygiene compliance	100	100	100	99	100	100	98	100	99
Total no of MSSA bacteraemias: Hospital	0	0	0	1	1	0	0	0	0
Total no of C. diff infections: Hospital	0	1	0	0	0	0	0	0	0
Quarterly Antibiotic Audit							94.4	91.4	100.0
Quarterly Environment/Isolation							92	93	92
Quarterly VIP score documentation							83	86	96

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Indicator	April			May			June		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
No of patient falls	11	44	0	10	55	0	6	46	0
No of patient falls resulting in harm	5	13	0	4	17	0	2	20	0
No of avoidable serious injuries or deaths resulting from falls									
No of ward acquired pressure ulcers	1	2	0	2	7	0	1	8	0
Nutrition: Assessment and monitoring	100.0	83.0	100.0	100.0	91.0	90.0	92.0	87.0	100.0
No of SIRIs	0	3	0	1	1	3	0	0	0
No of medication errors	13	37	2	17	46	9	11	20	2
Cardiac arrests	1	2	0	0	4	0	0	2	0
Cardiac arrests identified as a SIRI	0	0	0	0	0	0	0	0	0
Pain Management: Quarterly internal report	75.1	63.7	45.6						
VTE: Completed risk assessment (monthly Unify audit)	92.5	91.5	93.0	93.9	94.1	97.3	95.1	95.1	94.5
Quarterly VTE: Prophylaxis compliance									
Safety Thermometer: % of patients experiencing new harm-free care	99.4	98.5	100.0	100.0	94.0	100.0	100.0	97.7	100.0

Indicator	April			May			June		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	100.0	99.0	100.0	99.0	100.0		99.0	96.0	100.0
In your opinion, how clean was the hospital room or ward that you were in?	99.0	93.0	100.0	100.0	98.0		99.0	97.0	100.0
Did you feel you were treated with respect and dignity by staff	100.0	97.0	100.0	100.0	98.0		99.0	98.0	100.0
Were staff caring and compassionate in their approach?	100.0	99.0	100.0	100.0	98.0		99.0	96.0	100.0
Did you experience any noise in the night time that you think could have been avoided?	88.0	90.0	100.0	89.0	92.0		92.0	83.0	100.0
Did you find someone in the hospital staff to talk about your worries and fears?	99.0	100.0	100.0	100.0	93.0		100.0	100.0	100.0
Were you involved as much as you wanted to be in decisions about your care and treatment?	98.0	92.0	92.0	100.0	93.0		99.0	95.0	100.0
Did staff talk in front of you as if you were not there?	100.0	94.0	100.0	100.0	93.0		100.0	94.0	100.0
Were you given enough privacy when discussing your condition or treatment?	100.0	96.0	100.0	99.0	98.0		100.0	98.0	100.0
Were you given enough privacy when being examined or treated?	100.0	99.0	100.0	99.0	100.0		100.0	100.0	100.0
Did you get enough help from staff to eat your meals?	100.0	97.0	100.0	99.0	97.0		100.0	99.0	100.0
How many minutes after you used the call button did it usually take before you got the help you needed?	88.0	87.0	100.0	91.0	79.0		93.0	80.0	100.0
Number of Inpatient surveys completed	209	146	6	232	141		240	129	2
Same sex accommodation: total patients	0	0	0	0	0	0	0	2	0
Complaints	2	7	1	5	4	1	5	4	0
Environment and Cleanliness	93.1	90.5	93.2	93.1	92.9	94.8	96.0	96.8	99.2

5. Exception reports – Safe

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

There was a reduction in the overall score in June due to 4 wards / departments poor compliance with weighing patients weekly. This is being addressed by the Matrons / CSM for these areas and an action plan put in place.
The Trust has recently been involved with the NHSi Nutrition collaborative and in the areas where focussed work was conducted around nutrition screening and assessment, there were improvements made. The plan is for this work to be rolled out across the Trust with the support and involvement of the Quality Improvement lead and this has been established as a Trust priority.
Work is also in progress to install bed weighing devices built into the floor. This will assist with weighing patients on admission specifically as they will be positioned near to admission areas.
NHSi have invited the Trust to share our experience and work for the next phase of the collaborative

Indicator	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Nutrition Risk Assessment 48hrs	89%	82%	89%	93%	89%	87%	93%	92%	89%	90%	90%	93%	88%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To work in collaboration with the Quality improvement lead to refine an improvement measurement tool. A meeting is being set up for this action	HoN	May-18	Jul-18

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

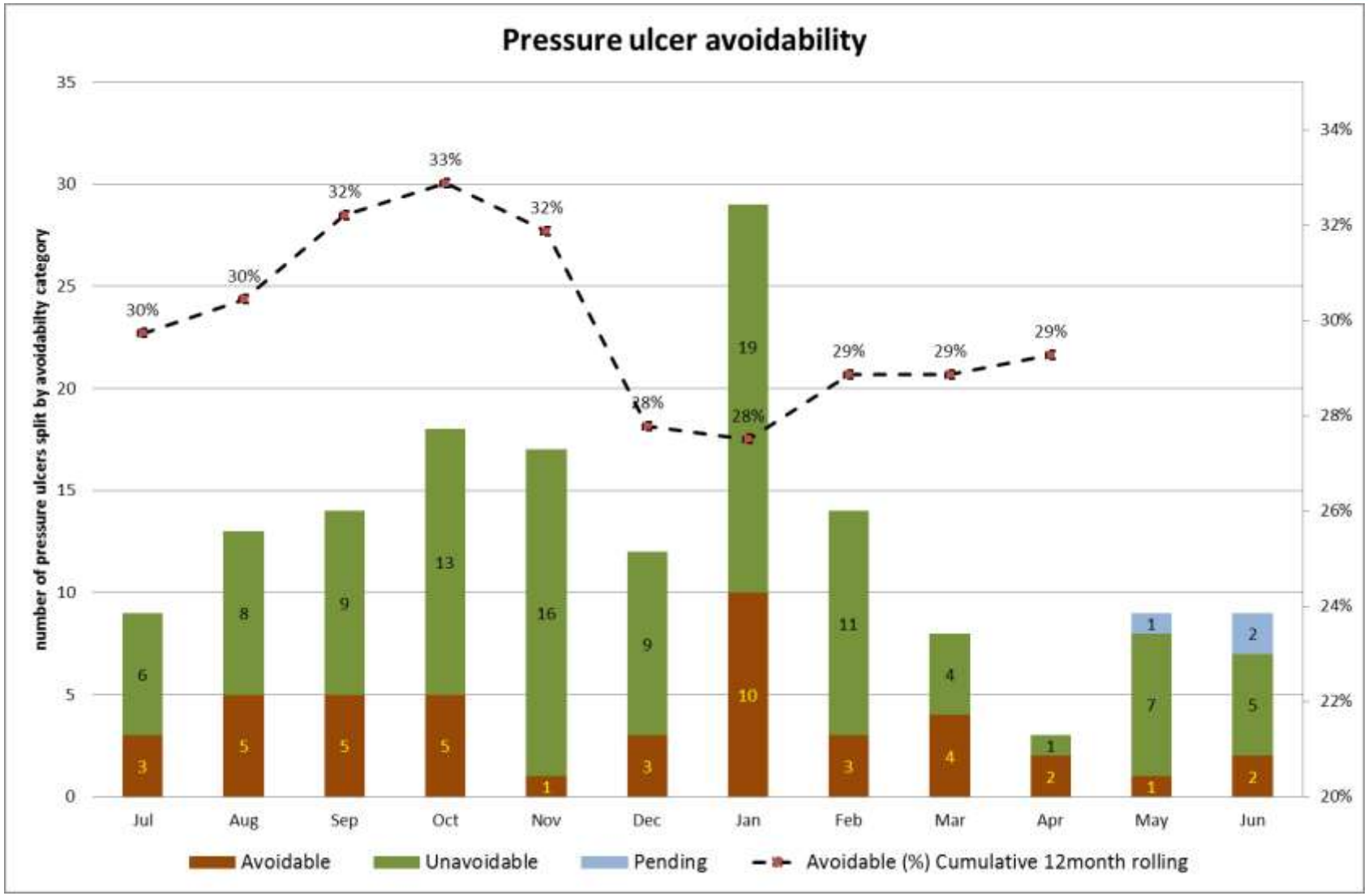
Summary of Current performance & Reasons for under performance

There has been one grade 3 HAPU reported in June and nine grade 2 HAPUs. In comparison, in June 2017, which was also a very hot month, there were 16 HAPUs reported in total, indicating a positive improvement this year, despite staffing deficits.
There is continued effort to raise awareness of pressure ulcer prevention by the Tissue Viability team and link workers, specifically focussing on heel protection and promoting repositioning of patients, a significant challenge during the warmer weather.
The Trust is involved in the Pressure Ulcer Prevention NHSi collaborative and is actively working with the Quality Improvement lead to focus on reducing the incidence of pressure damage within the acute and the community setting. Part of this work will involve a review and implementation of the NHSi guidance on classification of pressure damage.

Indicator	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%
Total Pressure Ulcers	10	13	15	18	17	12	29	14	8	3	9	10
% of patients with avoidable ward acquired pressure ulcers YTD	30%	34%	33%	32%	28%	28%	29%	28%	29%	29%	TBC	TBC

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
The trust has been working to develop a tool to ensure consistant classification of avoidable vs non-avoidable. this is due to be trialed over the next few months	Governance	Jun-18	Oct-18
To develop standards for record keeping for nursing staff	HON	May-18	Aug-18
Review and implementation of the NHSi guidance on classification of pressure damage	HON	Jul-18	Mar-19


Pressure ulcer avoidability
number of pressure ulcers split by avoidability category
35
30
25
20
15
10
5
0
34%
32%
30%
28%
26%
24%
22%
20%
30%
30%
32%
33%
32%
28%
28%
29%
29%
29%
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
3
6
5
8
5
9
5
13
1
16
3
9
10
19
3
11
4
4
2
1
1
7
1
2
2
5
Avoidable
Unavoidable
Pending
Avoidable (%) Cumulative 12month rolling

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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

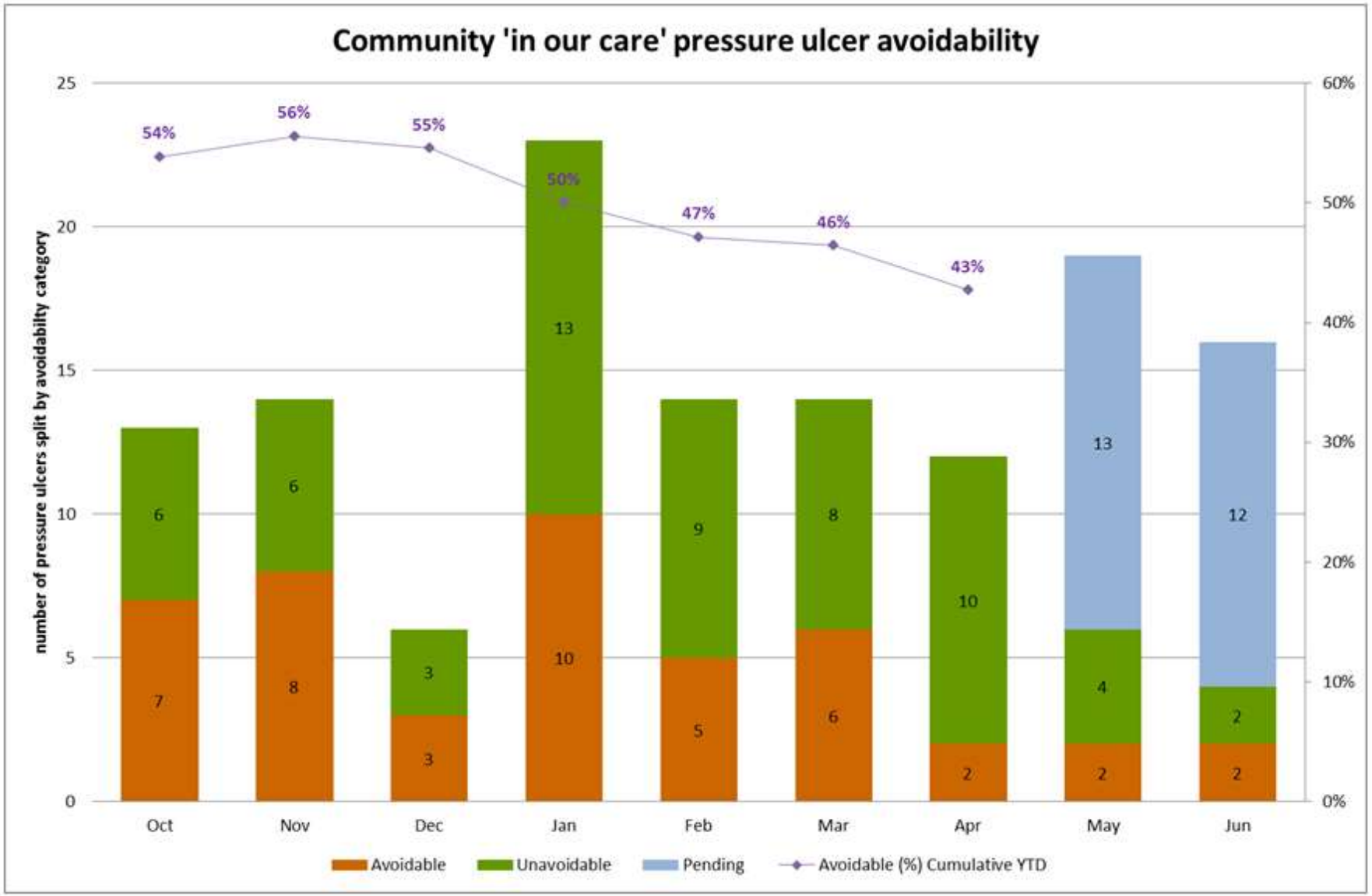
Indicator	Pressure Ulcers (Tissue Viability)
Standard	Community 'In our care' (IOC)
Name	Rowan Procter
Month	01-May-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Pressure Ulcers – June saw an increase in pressure ulcers reported in our care within the Bury Rural team, this will be investigated further to ensure that support/themes are picked up as required.
The Pressure Ulcer Collaborative is underway; we are participating in this with a focus on repositioning in a residential home in Bury Town; this is the team with a high incidence of PU's in recent months, often occurring in two large residential settings – this joint piece of work will focus on training staff.
Newly formed Community Quarterly Pressure Ulcer Group met for the first time on 05.07.18; much progress being made around consistency of reporting, ensuring actions and lessons learned achieved.

Indicator	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Total Pressure Ulcers	13	14	6	24	15	14	12	19	16
% of patients with avoidable IOC pressure ulcers YTD	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Active encouragement to achieve timely investigations and learning from incidents by Head of Nursing	HON	Jan-18	complete


Community 'in our care' pressure ulcer avoidability
number of pressure ulcers split by avoidability category
25
20
15
10
5
0
60%
50%
40%
30%
20%
10%
0%
54%
56%
55%
50%
47%
46%
43%
6
6
13
9
8
13
12
7
8
3
10
5
6
10
4
2
3
2
2
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Avoidable
Unavoidable
Pending
Avoidable (%) Cumulative YTD

28

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

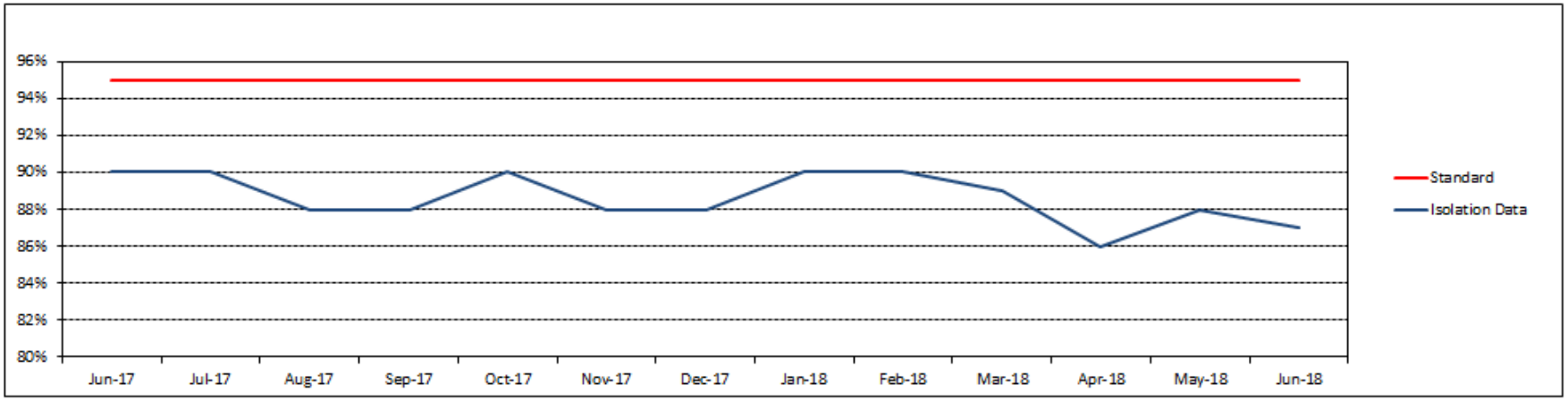
Summary of Current performance & Reasons for under performance

3 patients could not be accomodated in single rooms with symptoms sugestive of infection due to demand/capacity and higher risk assessed infections in the ward single rooms

Indicator	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Isolation Data	90%	90%	88%	88%	90%	88%	88%	90%	90%	89%	86%	88%	87%

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

Description	Owner	Start	End
there are ongoing actions to address this and these are monitored through the Infection Prevention Control Committee and the issue is recorded on the Trust Risk Register.	AH	May-18	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Background

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

The Trust score for JUNE 2018 for new harm free care was 97.96%. 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 APR 2012 to JUNE 2018 and the Trust results for JUNE 2018. The National average for MAY was 97.8%

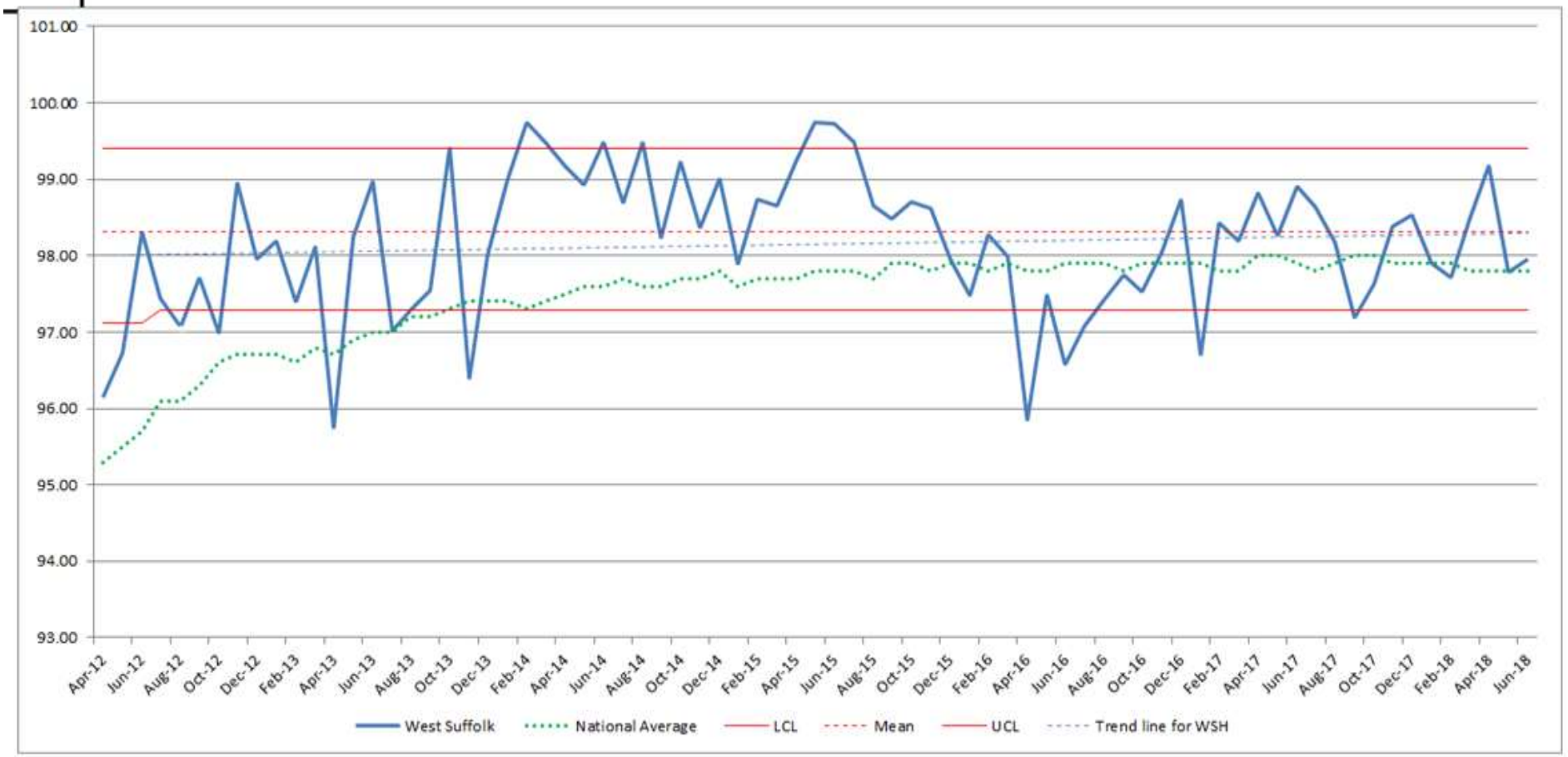
RAG rating is defined by the Trust's score compared to the National average. The national average for JUNE was 97.8%

Indicator	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Safety Thermometer - Harm-Free Care	98.6%	98.2%	97.2%	97.6%	98.4%	98.5%	97.9%	97.7%	98.5%	99.2%	97.8%	98.0%

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

West Suffolk Safety Thermometer Data

April 2012- June 2018



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	HII Compliance
Standard	100%
Name	Rowan Procter
Month	Jun18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

HII 2b Cannula Ongoing care at 91%. Two clinical areas have dropped % as cannula's have remained insitu but with no treatment being received via the cannula therefore cannula should be removed. Matrons to monitor this within the two clinical areas and educate accordingly.HII6b (Urinary catheters) - Performance dipped due to one clinical area scoring 50% as no date recorded on drainage bag of 4 of the 5 patients audited. Focus work to be undertaken by Matron in relation to education of clinical staff regarding importance of documentation of date.

Indicator	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
HII compliance 2b: Peripheral cannula ongoing	93%	97%	99%	99%	97%	96%	99%	100%	100%	100%	98%	91%
HII compliance 6b: Urinary catheter on-going care	88%	99%	94%	91%	92%	95%	100%	99%	97%	100%	95%	91%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor	HON	Mar-18	May-18

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-Jun-18
Data Frequency	Monthly
CQC Area	Safe

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 are two Amber incident with verbal DoC still pending. The Executive Medical Director and Chief Nurse are aware of both cases. One due in March had a decision made to complete the investigation before undertaking DoC. A second case requires conclusion of the investigation to ascertain whether actual harm has occurred with WSH care. At the conclusion of the investigation harm grading will be confirmed and duty of candour (if appropriate) will be undertaken.

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

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 DoC 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. Data will be reported from Q2	LAMS / HoN	May-18	Jun-18

6. DETAILED REPORTS - EFFECTIVE

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

Are we.		Ref.	KPI	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	YTD(Apr 18-
Effective	Dashboard	2.02	Canc. Ops - Cancellations for non-clinical reasons	1%	1.1%	1.0%	1.2%	1.0%	1.4%	1.9%	1.3%	0.8%	1.2%	0.9%	0.6%	0.8%	1.5%	1.0%
	Incidents/Reports	2.05	Cardiac arrests	NT	4	2	3	6	4	ND	ND	7	ND	ND	3	4	2	9
		2.06	Cardiac arrests identified as a SIRI	NT	1	0	0	0	0	0	0	0	0	0	1	0	0	1
		2.07	CAS (central alerts system) alerts overdue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		2.08	% of relevant patients with Personal Health Plan (PHP)	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		2.09	NICE guidance baseline and risk assessments not completed within 6 months of publication		ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	56	55	48	159
		2.10	WHO Checklist (Qrtly)	100%	99.0%	NA	NA	99.0%	NA	NA	99.0%	NA	NA	98.0%	NA	NA	99.0%	99.0%
		2.11	National clinical audit report baseline & risk assessments not completed within 6 months of publication		ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	22	23	17	62
		2.12	Av. Elective LOS (excl. 0 days)		2.7	2.54	2.79	2.73	2.93	2.85	2.98	3.06	2.27	3.29	3.34	2.55	2.59	2.83
		2.13	Av NEL LOS (excl 0 days)		7.66	7.47	7.93	7.54	8.23	7.66	7.57	8.40	8.13	8.1	7.96	7.63	6.80	7.46
		2.14	% of NEL 0 day LOS		20.3%	18.6%	17.4%	17.5%	18.8%	16.6%	14.7%	13.2%	13.4%	13.51%	14.3%	15.6%	16.0%	15%
		2.15	NHS number coding	99%	99.7%	99.4%	99.5%	99.6%	99.6%	99.7%	99.6%	99.7%	99.7%	99.71%	99.7%	99.8%	99.8%	100%
		2.16	Fractured Neck of Femur : Surgery in 36 hours	85%	96.3%	85.0%	97.0%	97.0%	96.0%	84.0%	100%	100%	96.0%	93.0%	89.0%	79.0%	100%	89.3%
		2.17	Discharge Summaries (OP 85% 3d)	85%	57.0%	57.0%	57.0%	55.0%	58.0%	58.0%	58.0%	60.0%	58.0%	56.0%	62.0%	57.0%	63.0%	60.7%
		2.18	Discharge Summaries (A&E 95% 1d)	95%	87.5%	86.7%	85.7%	85.9%	83.6%	84.2%	82.6%	84%	83.4%	82.3%	81.5%	82.5%	86.1%	83.4%
		2.19	Non-elective Discharge Summaries (IP 95% 1d)	95%	76.7%	70.4%	73.0%	73.0%	73.3%	69.2%	74.5%	70.2%	69.8%	70.8%	72.1%	71.0%	72.1%	71.7%
		2.20	Elective Discharge Summaries (IP 85% 1d)	85%	74%	74%	72%	69%	73%	68%	69%	73%	71%	73%	72.2%	71.2%	78.0%	73.8%
		2.21	All Cancer 2ww services available on C&B	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		2.22	Canc. Ops - Patients offered date within 28 days	100%	93.2%	88.5%	75.0%	92.0%	84.6%	98.1%	76.7%	94.7%	96.6%	91.7%	85.7%	90.9%	100%	92.2%
		2.23	Canc. Ops. - No. Cancelled for a 2nd time	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0

EXCEPTION REPORTS – EFFECTIVE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	NICE and AUDIT
Standard	Baseline assessment submitted within six months
Name	Nick Jenkins
Month	01-May-18
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

NICE baseline assessments

7 baseline assessments were completed in June 2018 and 0 guidelines were published in December 2017 that require a completed baseline assessment, resulting in a reduction from 55 to 48 baseline assessments not completed within 6 months of publication. This makes this indicator AMBER

National clinical audit baseline assessments

9 baseline assessments were completed in June 2018 and 3 reports were published in December 2017 that require a completed baseline assessment, resulting in a reduction from 23 to 17 baseline assessments not completed within 6 months of publication. This indicator remains RED

Indicator	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Completion of baseline assessment for issued NICE guidance	56	55	48									
Completion of baseline assessment for published National audits	22	23	17									

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Review at the monthly Clinical Directors meeting to highlight areas of non-compliance requiring targeted CD follow up.	CDs	Apr-18	2018
Targeted one to one sessions with Clinical leads organised by the Trust's Clinical Audit Co-ordinator to assist in completion of baseline assessments	Governance	2018	2018
Pre-populated baseline assessment templates provided where an issued document is particularly large / complex	Governance	2018	2018
Provide detail of activity in month (to CDs meeting and in IQPR) to provide more accurate picture	Governance	Jul-18	Jul-18
Review at specialist committees	Chairs	Apr-18	2018

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Discharge Summaries (Inpatients)
Standard	85%
Name	Sarah -Jane Relf
Month	01-Jun-18
Data Frequency	Monthly
CQC Area	Effective

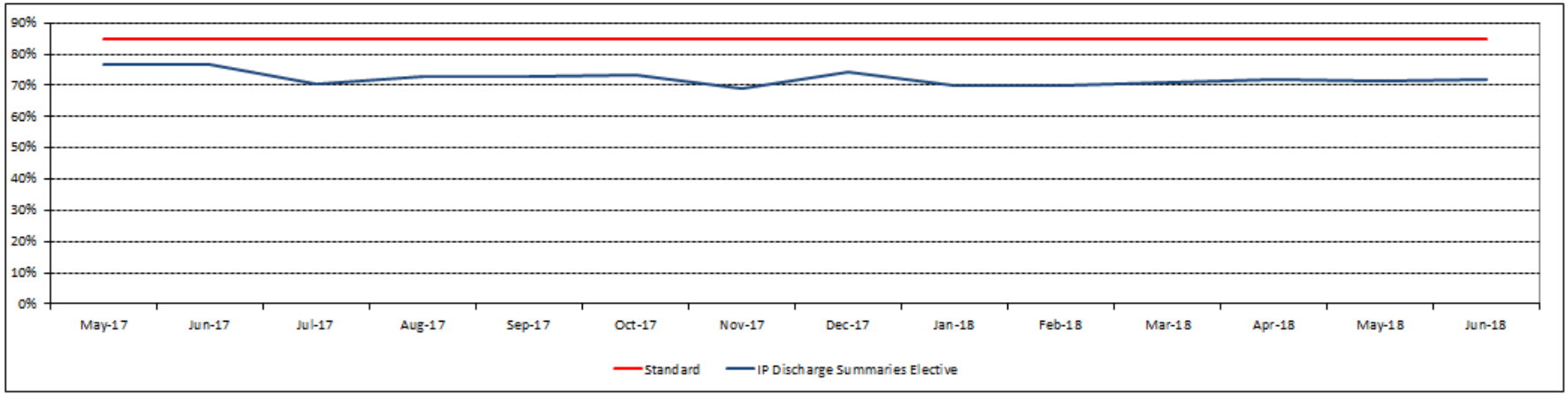
Summary of Current performance & Reasons for under performance

We continue to work with wards to improve their timeliness. This includes live reporting on outstanding discharge summaries which is available to each ward area. As reported at previous board we are working with reporting to understand disparities in what is recorded within the performance report. This meeting takes place on 20 July 2018 and verbal update will be provide to board.

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	May-18	Jun-18
Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
IP Discharge Summaries Elective	76.8%	76.7%	70.4%	73.0%	73.0%	73.3%	69.2%	74.5%	70.2%	69.8%	70.8%	72.1%	71.2%	72.1%

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

Description	Owner	Start	End
1) Monitor improvements. 2) Monitor the impact of the implementation of the workflow module in e-Care, due end of March.	NJ	Dec-17	Ongoing



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

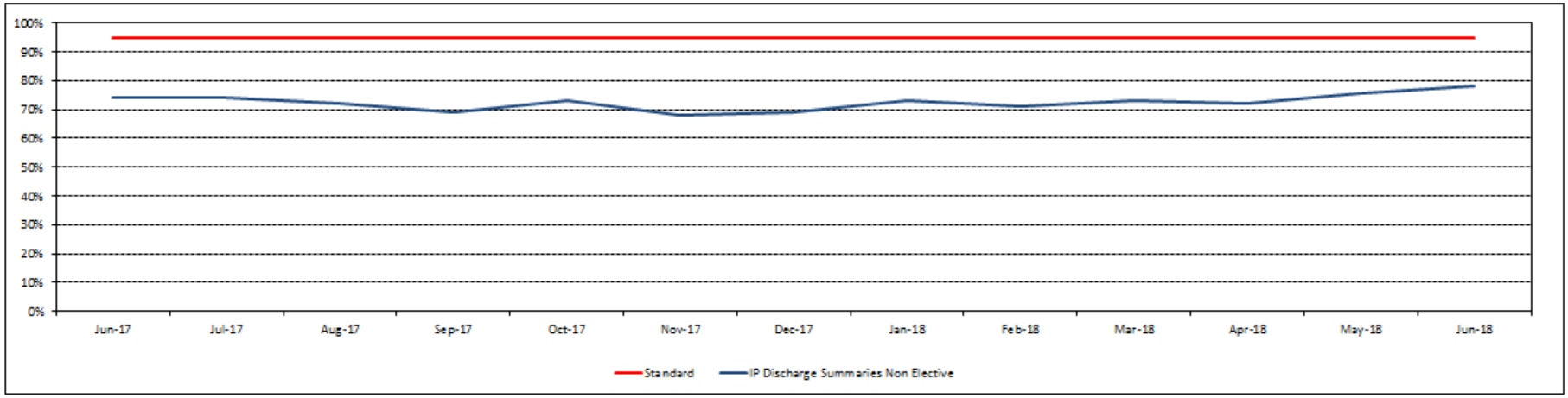
Indicator	Discharge Summaries (Inpatients)
Standard	95%
Name	Sarah -Jane Relf
Month	01-Jun-18
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

The board have received a separate detailed report outlining the actions we are taking to address our underperformance for distribution of discharge summaries. The report also highlights several examples where significant progress has been made. We are also aware of a disparity between how the hospital are communicating with GPs and CCG requirements. For example in cardiology day case a letter is sent to the GP rather than a discharge summary. However performance for this area is included within these reports. We therefore need to understand whether these workflows are robust and therefore the reporting needs to change, or whether the workflows need themselves need to amend. When these reviews are concluded this should have a significant impact on the reporting figures shown here.

Indicator	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
IP Discharge Summaries Non Elective	74.0%	74.0%	72.0%	69.0%	73.0%	68.0%	69.0%	73.0%	71.0%	73.0%	72.2%	75.7%	78.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
1) Monitor improvements. 2) Monitor the impact of the implementation of the workflow module in e-Care, due end of March.	NJ	Dec-17	Ongoing



7. 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	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	YTD(Apr 18-Mar19)
3. Caring	Dashboard	3.01	Compliments (Logged by Patient Experience)		26	56	28	17	33	87	151	64	20	45	21	93	44	158
		3.02	Formal Complaints	20	10	6	16	16	17	13	8	12	19	9	13	13	11	37
		3.03	Mixed Sex Accommodation Breaches	0	0	0	0	0	0	0	1	0	0	1	0	0	1	1
		3.04	IP - Extremely likely or Likely to recommend (FFT)	90%	98.0%	98.3%	98.0%	98.3%	98.6%	96.0%	97.7%	97.1%	98.1%	98.0%	99.0%	99.0%	98.0%	97.8%
		3.05	OP - Extremely likely or Likely to recommend (FFT)	90%	96.9%	94.9%	95.1%	96.0%	95.9%	96.0%	98.6%	95.1%	96.2%	95.0%	97.0%	97.0%	97.0%	97.0%
		3.06	A&E - Extremely likely or Likely to recommend (FFT)	85%	95.3%	95.0%	94.7%	92.3%	94.9%	94.0%	94.0%	96.4%	94.9%	94.0%	94.0%	93.0%	94.0%	93.7%
		3.07	Maternity - Extremely likely or likely to recommend (FFT)	90%	100%	100%	ND	ND	98.8%	100%	97.3%	100%	93.0%	100%	98.0%	99.4%	96.7%	98.0%
		3.08	Community - Extremely likely or likely to recommend	80%	100%	ND	ND	ND	97.3%	100%	95.7%	95.2%	97.4%	96.0%	94.0%	98.0%	97.0%	96.3%
	Other Friends and Family Test Scores	3.09	IP overall experience result	85%	94.2%	94.3%	92.9%	92.8%	96.0%	96.0%	95.0%	94.0%	95.0%	96.0%	97.0%	97.0%	97.0%	97.0%
		3.10	OP overall experience result	85%	88.1%	89.3%	90.5%	88.6%	95.0%	94.0%	95.0%	96.0%	97.0%	96.0%	97.0%	97.0%	97.0%	97.0%
		3.11	A&E overall experience result	85%	94.0%	94.0%	95.0%	94.0%	93.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	93.0%	94.0%	93.7%
		3.12	Short-stay overall experience result	85%	99.7%	99.0%	99.4%	98.9%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	100%	99.0%	99.0%	99.3%
		3.13	Short-stay Extremely likely or Likely to recommend (FFT)	90%	99.7%	99.5%	99.0%	99.0%	99.0%	97.0%	100.0%	99.4%	99.7%	99.0%	100%	99.0%	98.0%	99.0%
		3.14	Maternity - overall experience result	85%	100%	100%	100%	100%	100%	98.0%	95.0%	100%	93.0%	100%	99.0%	95.0%	96.0%	96.7%
		3.15	Maternity postnatal community - extremely likely or likely to recommend (FFT)	90%	100%	ND	ND	100%	100%	ND	ND	ND	ND	ND	100%	97.0%	96.0%	97.7%
		3.16	Maternity birthing unit - extremely likely or likely to recommend (FFT)	90%	100%	ND	ND	100%	100%	100%	ND	100%	100%	ND	100%	ND	ND	100%
		3.17	Maternity antenatal community - extremely likely or likely to recommend (FFT)	90%	100%	ND	ND	100%	96.4%	ND	ND	ND	ND	ND	100%	100%	94.0%	98.0%
		3.18	Children's services overall result	85%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	97.0%	99.0%	96.0%	97.3%
		3.19	F1 Parent - overall experience result	85%	99.0%	95.0%	100%	100%	99.0%	95.0%	98.0%	98.0%	98.0%	98.0%	96.0%	99.0%	96.0%	97.0%
		3.20	F1 - Extremely likely or likely to recommend (FFT)	90%	100%	92.0%	100%	100%	100%	94.0%	97.0%	100%	100%	100%	82.0%	100%	98.0%	96.0%
		3.21	F1 Children - Overall experience result	85%	94.0%	ND	ND	ND	ND	ND	ND	ND	ND	ND	85.0%	97.0%	96.0%	92.7%
		3.22	Rosemary ward - extremely likely or likely to recommend (FFT)	90%	ND	ND	ND	ND	100%	100%	100%	78.0%	85.0%	100%	79.0%	100%	88.00%	89.0%
		3.23	King suite - extremely likely or likely to recommend	90%	ND	ND	ND	ND	100%	100%	94.0%	93.0%	100%	100%	ND	100%	100%	ND
		3.24	Community paediatrics - extremely likely or likely to recommend (FFT)	90%	ND	ND	ND	ND	96.0%	100%	97.0%	100%	97.0%	95.0%	94.0%	95.0%	100%	96.3%
		3.25	Community health teams - extremely likely or likely to recommend (FFT)	90%	ND	ND	ND	ND	100%	100%	100%	90.0%	100%	90.0%	100%	100%	100%	100%
		3.26	Community specialist nursing teams - extremely likely or likely to recommend (FFT)	90%	ND	ND	ND	ND	100%	100%	95.0%	100.0%	93.0%	100%	92.0%	98.0%	100%	96.7%
		3.27	Stroke Care - Overall Experience Result	85%	98.0%	99.0%	ND	99.0%	100%	85.0%	ND	98.0%	95.0%	100%	95.0%	92.0%	100%	95.7%
		3.28	Stroke Care - extremely likely or likely to recommend	90%	95.2%	100%	100%	95.4%	100%	100%	ND	100%	100%	100%	100%	100%	100%	100%
	Complaint Handling	3.29	Complaints acknowledged within 3 working days	90%	100%	100%	93.0%	94.0%	100%	100%	87.0%	92.0%	100%	100%	92.00%	100%	100%	97.3%
		3.30	Complaints responded to within agreed timeframe	90%	75.0%	100%	85.0%	67.0%	81.0%	82.0%	50.0%	60.0%	17.0%	54.0%	31.0%	70.0%	50.0%	50.3%
		3.31	Number of second letters received	1	2	1	1	1	2	0	1	0	0	1	2	2	6	10
		3.32	Ombudsman referrals accepted for investigation	0	0	1	0	0	0	0	1	1	1	0	0	0	0	0
		3.33	No. of complaints to Ombudsman upheld	0	ND	ND	ND	ND	ND	0	0	0	0	0	0	0	0	0
		3.34	No. of PALS contacts	NT	169	176	137	167	190	167	124	161	178	205	183	231	214	628
		3.35	No. of PALS contacts becoming formal complaints	<=5	0	1	4	2	3	4	1	3	6	1	4	4	4	12

8. DETAILED REPORTS - RESPONSIVE

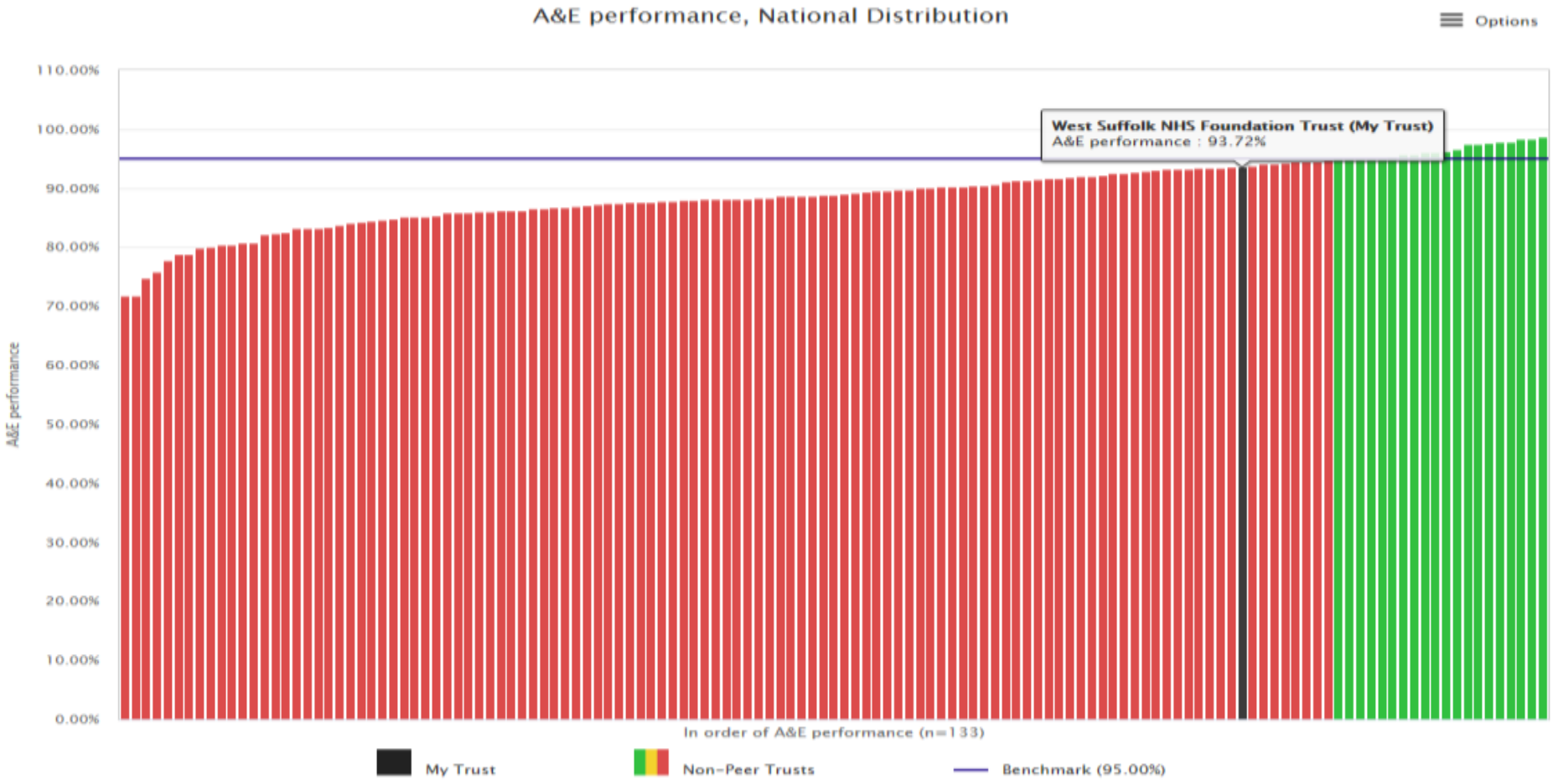
Are we safe? | Are we effective? | Are we caring? | Are we responsive? | Are we well-led? | Are we productive?

Are we..		Ref.	KPI	Target	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	YTD(Apr18-Mar19)
4. Responsive	Dashboard	4.01	A&E under 4 hr. wait	95%	95.5%	92.5%	90.1%	88.9%	87.4%	90.4%	83.3%	83.8%	85.2%	85.4%	84.9%	93.7%	93.9%	90.8%
		4.02	RTT: % incomplete pathways within 18 weeks	92%	83.4%	83.9%	85.9%	85.7%	87.0%	88.9%	89.0%	90.2%	89.6%	89.5%	90.4%	92.2%	91.4%	91.3%
		4.03	52 week waiters	0	15	35	26	29	26	21	15	14	13	24	19	14	10	43
		4.04	Diagnostics within 6 weeks	99%	100%	99.5%	100%	100%	100%	100%	100%	100%	99.8%	99.3%	99.7%	99.6%	99.8%	99.7%
		4.05	Cancer: 2w wait for urgent GP Referrals	93%	96.6%	94.5%	96.0%	91.4%	83.4%	97.9%	97.2%	98.0%	97.5%	94.7%	95.9%	94.9%	91.6%	94.1%
		4.06	Cancer 2w wait breast symptoms	93%	88.8%	98.1%	100%	98.3%	100%	100%	99.1%	97.1%	92.9%	86.7%	96.7%	82.6%	84.9%	88.0%
		4.07	Cancer 31 d First Treatment	96%	100%	100%	100%	100%	100%	99.3%	100%	100%	100%	100%	99.1%	100%	100%	100%
		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%	86.0%	84.6%	85.8%	86.9%	93.9%	89.5%	87.1%	86.6%	79.8%	87.8%	93.3%	85.1%	85.2%	87.9%
		4.11	Cancer 62 d Screening	90%	90.0%	100%	100%	90.9%	100%	83.3%	100%	93.3%	85.7%	95.5%	72.73%	100%	100%	90.9%
		4.12	Incomplete 104 day waits		ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	3.0	1.5	0	1.5
	A&E	4.13	Number of Delayed Transfer of Care - (DTOCs)	NT	511	481	565	337	250	279	314	326	393	321	208	206	203	206
		4.14	A&E time to treatment in department (median) for patients arriving by ambulance - CDM	NT	52	52	50	62	59	41	62	57	75	64	70	47	46	54
		4.15	A&E - Single longest Wait (Admitted & Non-Admitted)	6 hrs.	10.10	13.53	11.46	12.01	15.44	22.04	16.48	18.11	17.18	19.50	18.14	10.30	12.22	13.55
		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		6	5	5	14	10	17	50	122	30	46	17	4	8	29
		4.18	A&E - To inpatient Admission Ratio	27%	28.3%	27.9%	29.2%	30.5%	30.4%	30.0%	32.8%	31.9%	32.1%	29.6%	27.9%	25.8%	25.0%	26.2%
		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%	91.7%	91.0%	89.9%	90.3%	87.7%	88.2%	89.4%	85.7%	89.6%	93.5%	92.7%	94.4%	92.8%	93.3%
		4.21	A&E - Amb. Handover above 30m	30m	31	39	19	15	40	84	110	72	87	74	88	84	ND	172
		4.22	A&E - Amb. Handover above 60m	60m	9	7	16	30	21	46	54	38	30	17	29	3	ND	32
	RTT	4.23	RTT - 18w Admitted (Completed)	90%	70.3%	72.9%	69.7%	73.8%	72.0%	70.9%	69.9%	72.6%	73.5%	74.1%	73.4%	71.1%	76.9%	73.8%
		4.24	RTT - 18w Non-admitted (Completed)	95%	87.3%	87.6%	85.8%	87.3%	84.9%	85.8%	90.6%	88.7%	93.9%	93.42%	92.8%	94.5%	93.3%	93.6%
		4.25	RTT waiting List		19931	18676	17346	17236	16694	16641	16195	15363	15804	15396	16223	16481	16634	16446
		4.26	RTT waiting list over 18 weeks		3316	2629	2441	2467	2171	1843	1775	1504	1650	1614	1560	1294	1443	1432
		4.27	RTT 18 weeks Non-Consultant led services - Community	90%	99%	98.8%	94.7%	99.4%	93.7%	94.4%	98.4%	98.7%	100%	99.4%	99.2%	97.6%	100%	98.9%
		4.28	RTT 52 weeks Non-Consultant led services - Community		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Stroke	4.29	Stroke - % Patients scanned within 1 hr.	77%	72.1%	81.6%	79.2%	78.1%	75.7%	74.4%	75.6%	86.7%	76.7%	70.0%	73.7%	63.6%	77.7%	71.7%
	4.30	Stroke - % patients scanned within 12 hrs.	96%	95.4%	94.7%	95.8%	90.2%	97.3%	92.3%	95.6%	98.3%	100%	97.5%	94.7%	97.7%	100%	97.5%
	4.31	Stroke - % Patients admitted directly to stroke unit within 4h	75%	76.2%	77.8%	78.7%	82.5%	72.2%	72.5%	60.0%	75.4%	79.3%	72.5%	57.9%	73.2%	84.1%	71.7%
	4.32	Stroke - % greater than 80% of treatment on stroke unit	90%	88.1%	94.4%	97.9%	92.5%	88.9%	92.5%	91.1%	93.0%	96.6%	87.5%	81.6%	82.9%	100%	88.2%
	4.33	Stroke - % of patients treated by the SESDC	48%	75.0%	46.4%	33.3%	51.4%	50.0%	30.8%	32.4%	61.5%	50.0%	51.4%	54.8%	48.7%	58.5%	54.0%
	4.34	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start	80%	95.4%	92.1%	87.5%	85.4%	83.3%	82.1%	88.9%	93.3%	83.3%	95.0%	79.0%	81.8%	97.8%	86.2%
	4.35	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72h	75%	90.2%	87.9%	89.6%	92.1%	77.1%	76.3%	77.5%	93.0%	86.2%	86.8%	94.6%	92.5%	88.6%	91.9%
	4.36	Stroke -% of eligible patients given thrombolysis	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.37	Stroke -% of stroke survivors who have 6mth f/up	50%	ND	ND	ND	58.0%	ND	ND	ND	61.0%	ND	ND	ND	ND	ND	ND
	4.38	Stroke -Provider rating to remain within A-C	C	ND	ND	ND	ND	ND	ND	ND	C	ND	C	C	ND	ND	C
Other	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community		ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	100%	100%	100%	100%
	4.40	Nursing & therapy Red referrals seen within 4hrs - Community		100%	100%	NA	100%	NA	NA	100%	100%	96.4%	100%	96.4%	100%	100%	98.8%
	4.41	Nursing & therapy Amber referrals seen within 72hrs - Community		99.4%	98.6%	95.6%	98.6%	90.9%	96.9%	100%	99.3%	98.0%	97.6%	98.8%	99.4%	99.5%	99.2%
	4.42	Nursing & therapy Green referrals seen within 18 wks -Community		98.3%	98.6%	98.2%	98.6%	99.3%	97.8%	98.0%	99.8%	99.9%	99.9%	99.3%	99.9%	100%	100%
	4.43	Wheelchair waiting times – Child (Community)		50.0%	35.7%	50.0%	47.4%	43.8%	75.0%	72.7%	55.6%	61.9%	42.2%	90.9%	100%	95.2%	95.4%
	4.44	Wheelchair waiting times - Adult (Community)		86.1%	88.2%	85.9%	70.3%	69.8%	83.5%	70.5%	71.4%	73.6%	72.5%	75.6%	78.3%	80.0%	77.9%
	4.45	Sepsis - 1 hr neutropenic sepsis	100%	63.2%	68.8%	82.6%	62.5%	79.0%	73.9%	53.9%	80.0%	75.0%	58.3%	63.6%	80.0%	57.9%	67.2%

EXCEPTION REPORTS – RESPONSIVE

A&E performance has improved from 93.72% May to 93.88% in June, with Q1 overall performance at 90.97%. The chart shows performance of West Suffolk against the peers and national median as at May 2018 (*Source: Model Hospital – July 2018)*



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

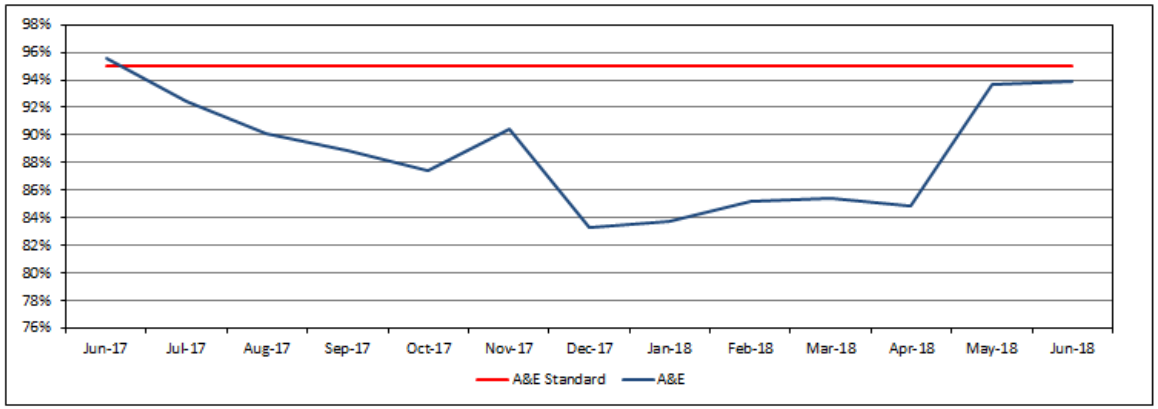
Indicator	A&E 4 hour wait
Standard	95%
Name	Darin Geary
Month	01-Jun-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Performance has improved significantly due to improved flow within the organisation, medically expected patients going to F8 directly and a more focus approach to flow within ED.
The main reason for 4-hour breaches continues to be delay to be seen by a clinical decision maker (CDM), with a majority of the delays being out of hours. Staffing gaps is the key driver of this, however this has also improved recently.

Indicator	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
A&E Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
A&E	95.5%	92.5%	90.1%	88.9%	87.4%	90.4%	83.3%	83.8%	85.2%	85.4%	84.9%	93.7%	93.9%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
As part of the ED Action plan, medical staffing has been reviewed. Actions being implemented include recruiting additional consultants, recruitment to the vacant ACP posts (new staff due to start in July and August), changes to the junior doctor rota to increase night doctor cover from one to two (starting in August) and starting the Middle grade and junior doctor early shifts one hour earlier to improve handover and doctor cover (again starting in August). In addition, work in continuing on reviewing the triage process, developing an ED escalation policy and further implementation and adherence to the Internal Professional Standards.	HB	Jul-17	TBC



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

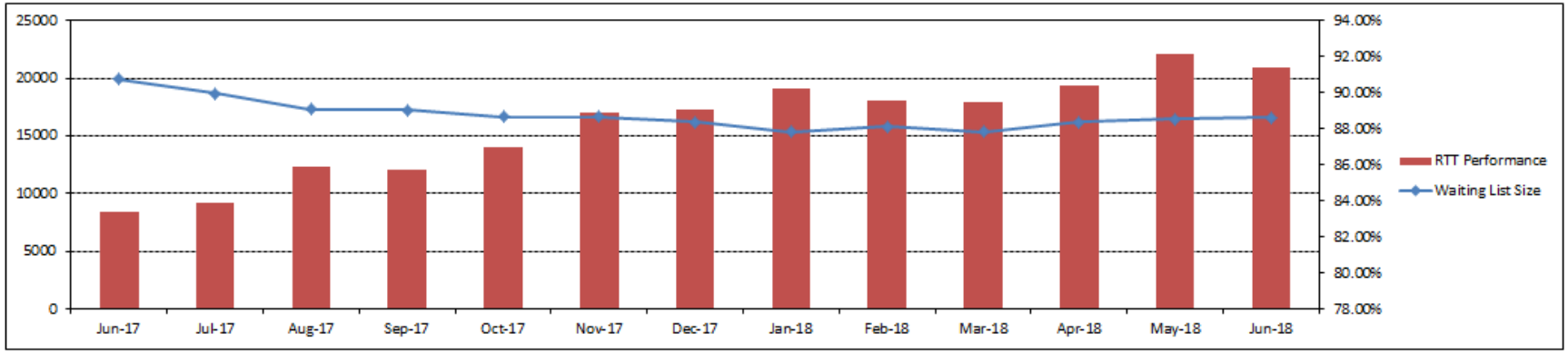
Indicator	RTT - Incomplete waiting list
Standard	92%
Name	Simon Taylor
Month	01-Jun-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

June has seen a slight dip in performance to 91.38% compared to 92.15% last month. The overall waiting list has grown in June to 16,634 compared to 16,481 in May, with a significant increase in the total waiting list in T&O of 211. This is being investigated to try and establish the underlying issues resulting in this increase for T&O. Capacity issues are still present in some specialities including T&O, Vascular Surgery, and Ophthalmology.

Indicator	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Waiting List Size	19931	18676	17346	17236	16694	16641	16195	15,363	15,804	15396	16223	16481	16634
RTT Performance	83.36%	83.92%	85.93%	85.69%	87.00%	88.92%	89.04%	90.21%	89.56%	89.52%	90.40%	92.15%	91.38%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
1. Targeted work is being undertaken to reduce the back log in challenged specialties. 2. There is a specific focus to review the vascular surgery pathway to ensure appropriate referrals to treatment are in place and a meeting with operational colleagues in the Regional Vascular Network at CUHFT has taken place with further engagement and work planned around this speciality which is being monitored at the Trust Access Meeting. 3. Work is underway to look at options to reduce and manage the backlog and capacity constraints within ophthalmology. Options were discussed at the recent Planned Care Board and more detailed plans are now being worked up.	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-Jun-18
Data Frequency	Monthly
CQC Area	Responsive

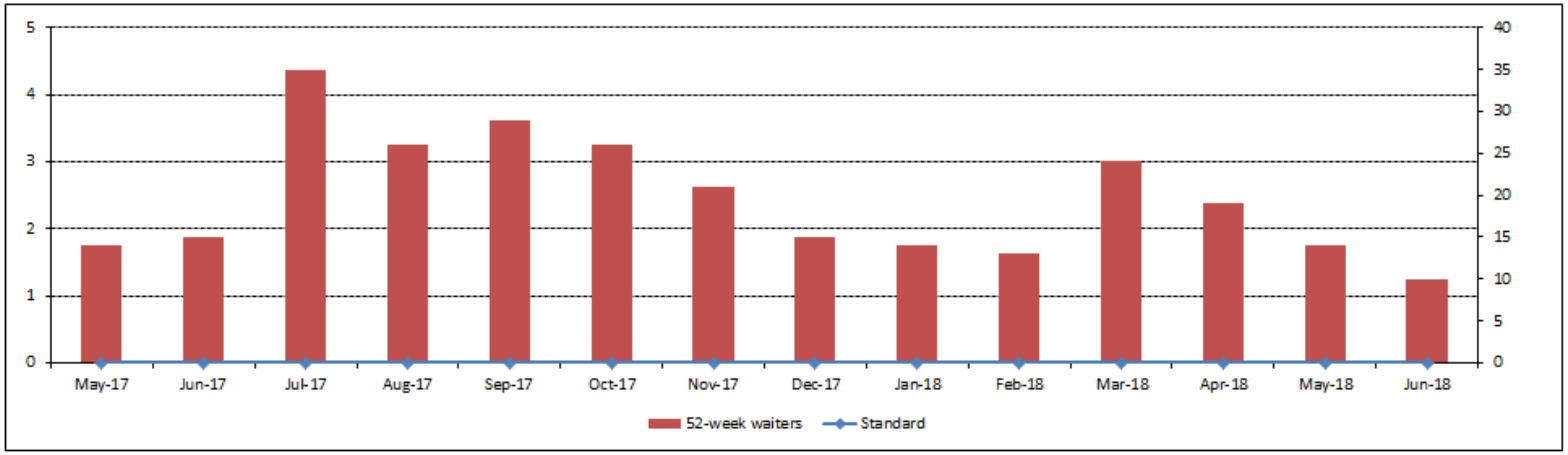
Summary of Current performance & Reasons for under performance

At the end of June, 10 patients had waited over 52 weeks. Six of which have either now been treated or have a date for treatment scheduled. The remaining four are yet have TCI dates allocated or diagnostics to be completed. The weekly access meetings continue to focus 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	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0	0
52-week waiters	14	15	35	26	29	26	21	15	14	13	24	19	14	10

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

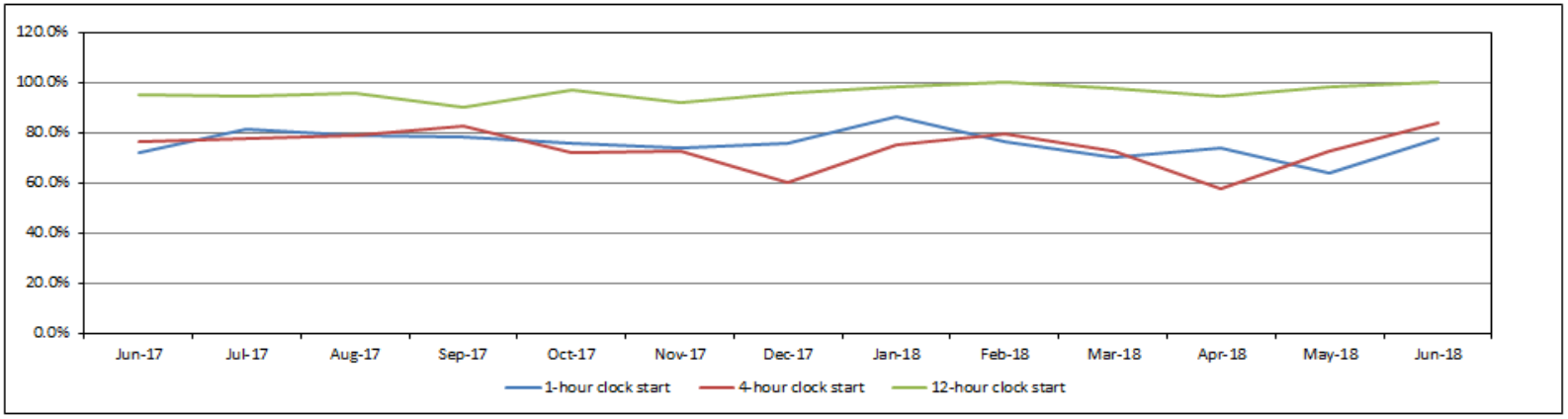
There have been some issues with the triage of our stroke patients, with nine out of fifteen breaches being caused by delays in triage and identification of stroke symptoms. This has therefore caused delays in the referral of patients to the Emergency Stroke Outreach Team. This in turn, for some of our stroke patients has caused a delay in the patient being admitted directly to the Stroke Unit within 4 hours. Jane Allen has met with ED Management, and we are currently working with them in identifying any breaches, looking at any issues in the referral process. The Stroke Team are also in the process of arranging further training for ED staff.

Indicator	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
1-hour clock start	72.1%	81.6%	79.2%	78.1%	75.7%	74.0%	76.0%	86.7%	76.7%	70.0%	74.0%	64.0%	77.7%
4-hour clock start	76.2%	77.8%	78.7%	82.5%	72.2%	73.0%	60.0%	75.4%	79.3%	72.5%	58.0%	73.0%	84.1%
12-hour clock start	95.4%	94.7%	95.8%	90.2%	97.3%	92.3%	96.0%	98.3%	100%	97.5%	94.7%	98.0%	100%

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

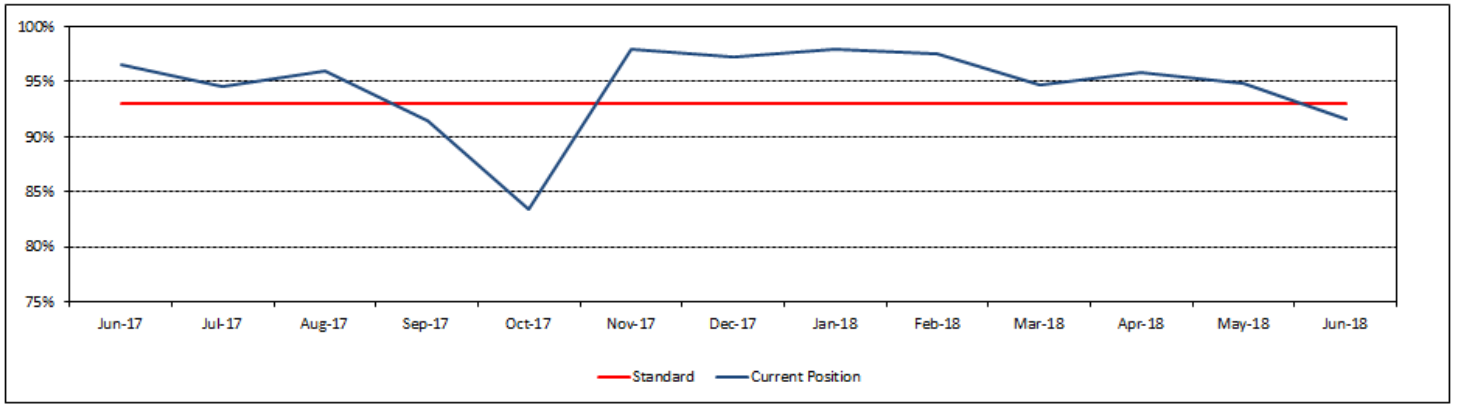
Indicator	Cancer: 2w wait for urgent GP Referrals
Standard	93%
Name	Sam Dhungana
Month	01-Jun-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current Position - 91.6% against a threshold of 93%. There have been some breaches across all teams, however significantly high incoming Skin 2 WW referrals in late May/early June with no additional capacity to see within 14 days, only 80% of the 280 referrals were managed to be seen within 2 weeks. There were 87 breaches in total and of these, 56 breaches were in skin. 4 of the breaches were due to patient choice with the remaining 52 due to inadequate capacity.

Indicator	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	96.6%	94.5%	96.0%	91.4%	83.4%	97.9%	97.2%	98.0%	97.5%	94.7%	95.9%	94.9%	91.6%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
The Trust experienced very high incoming 2 WW referrals in late May and June, 1135 and 1035 referrals seen respectively, in these 2 months. Dermatology opened extra clinics and also converted non Rapid Access to RA slots. This is ongoing. The service is considering appointing a locum to cover the current locum when they are away. Skin Nurse Practitioner and the Plastic surgeons are helping run additional RA clinics along with lists on Saturdays to allow RA diagnostics. In some patients, treatment will be given and save 62 days waiting times. Service is continuing to work with the CCG to improve referral criteria and pathways for local GPs. In spite of the under performance in June, the trust is reporting above 94% for the quarter. We have also raised the issue of ongoing high numbers of 2 WW referrals with the CCG GP leads as well.	HB		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

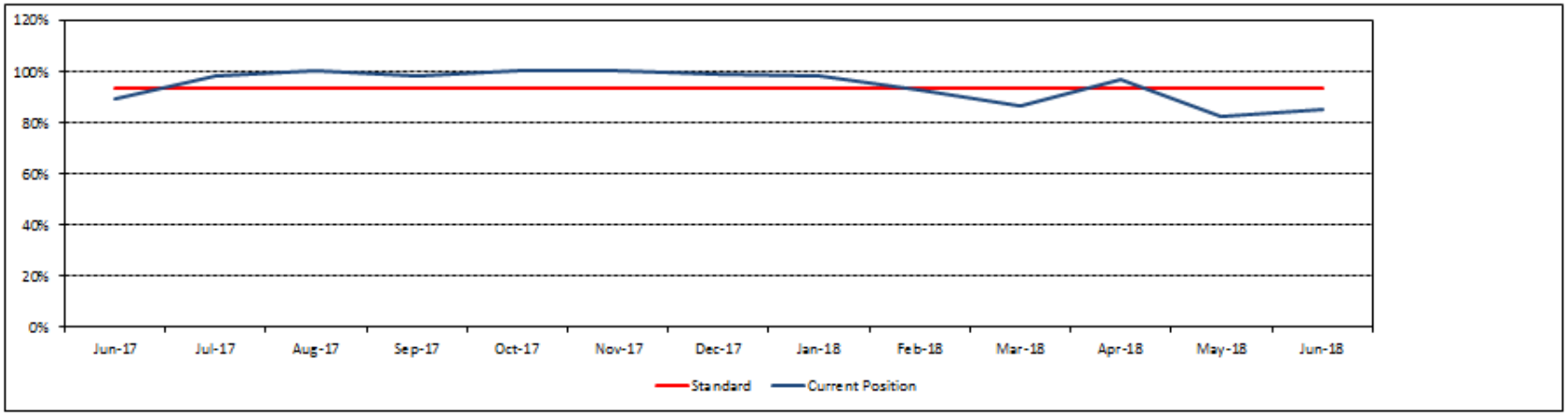
Indicator	Cancer: 2-week wait Breast Referrals
Standard	93%
Name	Sam Dhungana
Month	01-Jun-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current Performance: 84.9%. During June, 99 Patients were seen, of which there were 15 breaches, 5 of which were due to patient choice and 10 due to inadequate capacity.

Indicator	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	89%	98%	100%	98%	100%	100%	99%	98%	92.9%	86.7%	96.7%	82.6%	84.9%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
The breast service opens up extra clinics to manage the additional demand where staffing level permits and during June 9 extra sessions were opened. There was a meeting with the Suffolk CCG GP leads on 26th June to discuss the issues of the quality of 2 WW referrals and they are sending a GP communication out highlighting the need of appropraite selection in the Breast 2 WW referral form to help clarify the referral type.	HB		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Sepsis - 1-hr neutropaenic sepsis
Standard	100%
ED Name	Hannah Sullivan
Month	01-Jun-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

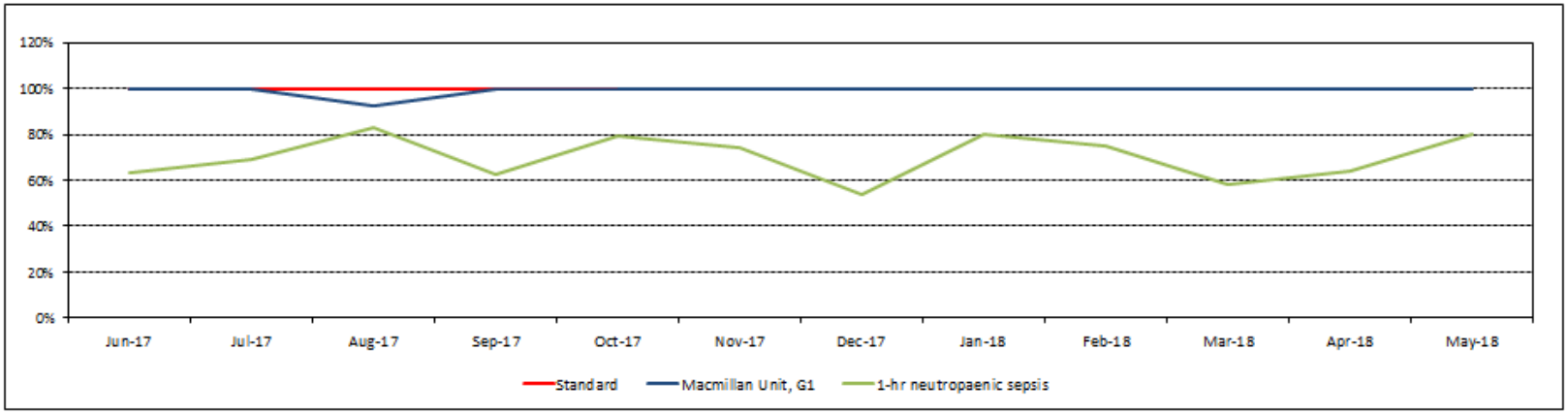
Macmillan – 100%. ED – 38.5%. Overall Trust figure (including AMU) of 57.9% against a threshold of 100%.

The performance figure for 1 hour door to needle from diagnosis of neutropenic sepsis. June's data showed a significant drop of 22.1% on last month's 80% performance. Recent months performance has not demonstrated consistent practice. The Emergency Department 's neutropenic sepsis patient breaches will be undergoing detailed review with the newly appointed ED matron. These issues have been escalated to the Emergency Department Clinical and Nursing management to address within the departments.

Indicator	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Macmillan Unit, G1	100%	100%	92.3%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Emergency Dept, ED	41.6%	58.3%	70.0%	40.0%	66.7%	62.5%	14.2%	50.0%	44..4%	28.6%	50.0%	71.4%	38.5%
Acute Medical Unit, AMU	NA	NA	0%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
1-hr neutropaenic sepsis	63.2%	68.8%	82.6%	62.5%	79%	73.9%	53.8%	80%	75%	58.3%	64%	80%	57.9%

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

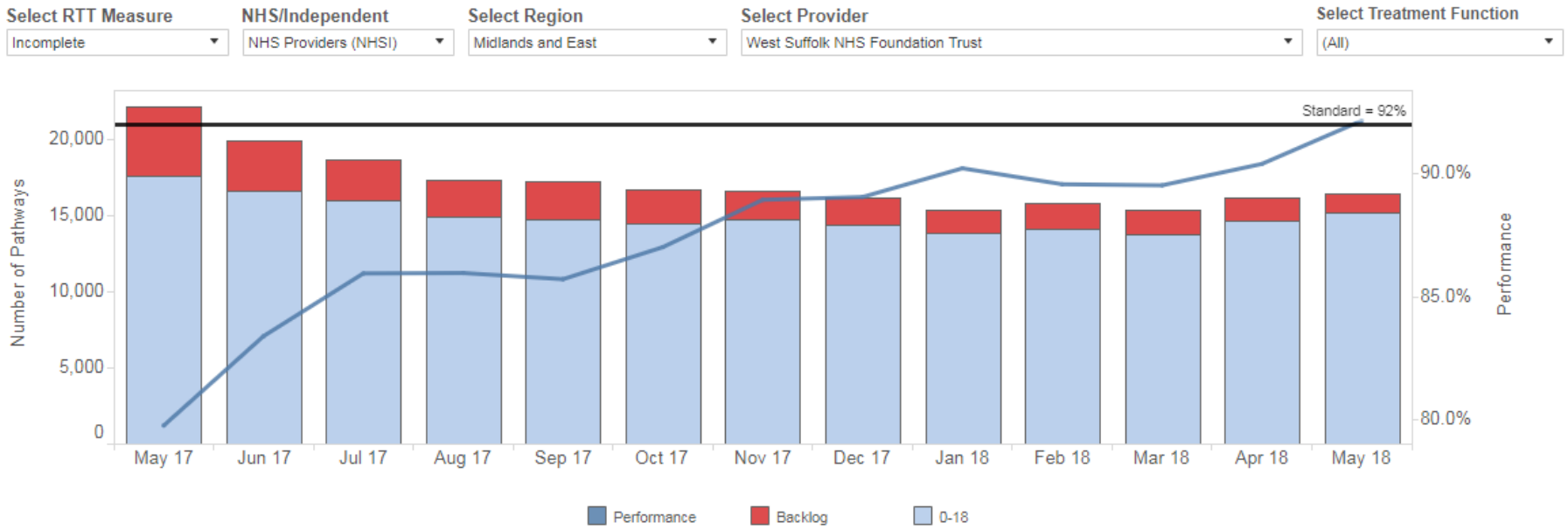
Description	Owner	Start	End
1.To achieve the backlog of Neutropaenic Sepsis Concise RCA's from June 2017 and complete ongoing. 2.Undertake a review of the changes made to the Neutropaenic Patient Pathway. If the patient has received a documented review by the onclogy specialist nurses prior to arrival,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



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.

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



	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	May 18
Incomplete	79.7%	83.4%	85.9%	85.9%	85.7%	87.0%	88.9%	89.0%	90.2%	89.6%	89.5%	90.4%	92.2%
Admitted	67.8%	70.3%	72.9%	69.7%	73.8%	72.0%	70.9%	69.9%	72.6%	73.5%	74.1%	73.4%	70.9%
Non Admitted	87.0%	87.3%	87.6%	85.9%	87.3%	84.9%	85.8%	90.6%	88.7%	93.9%	93.4%	92.8%	94.5%

9. 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	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	YTD(Apr18-Mar19)
5. Well Led	Dashboard	5.01	NHS Staff Survey (Staff Engagement score -Annual)	NT	NA	NA	NA	NA	NA	NA	NA	NA	4.0%	NA	NA	NA	NA	NA
		5.02	Staff F&F Test % Recommended - care (Qrtly)	75%	95.0%	NA	NA	95.0%	NA	NA	ND	NA	NA	ND	NA	NA	NA	NA
		5.03	Staff F&F Test % Recommended - place to work (Qrtly)	75%	83.0%	NA	NA	82.0%	NA	NA	ND	NA	NA	ND	NA	NA	NA	NA
		5.04	Turnover (Rolling 12 mths)	<10%	10.3%	9.9%	10.0%	9.8%	9.0%	9.1%	9.3%	9.3%	8.7%	8.8%	8.4%	8.4%	8.54%	8.4%
		5.05	Sickness Absence	<3.5%	3.6%	3.6%	3.6%	3.6%	3.6%	3.5%	3.5%	3.6%	3.7%	3.7%	3.8%	3.8%	3.7%	3.8%
		5.06	Executive Team Turnover (Trust Management)	<10%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
		5.07	Agency Spend		255	216	126	150	82	213	245	353	306	373	276	188	330	265
		5.08	Monitor Use of Resources Rating		3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Agency, WTE & vacancies	5.09	Agency Spend Cap		378	378	378	378	378	378	378	378	378	378	ND	ND	ND	ND
		5.10	Bank Spend		1512	1197	1234	1112	1195	1179	1326	1078	1093	996	1340	1361	ND	1351
		5.11	Bank/agency Spend percentage		3.7%	4.9%	3.6%	4.7%	3.8%	4.0%	5.0%	5.7%	ND	6.4%	4.2%	ND	ND	4.2%
		5.12	Proportion of Temporary Staff		10.0%	12.2%	11.4%	10.6%	10.1%	10.9%	8.0%	11.1%	11.3%	11.0%	12.5%	11.9%	9.7%	11.4%
		5.13	Locum and Medical agency spend		361	381	347	270	357	381	508	495	487	468	398	319	468	395
		5.57	Additional sessions		199	245	283	180	198	233	238	136	186	167	253	238	207	233
		5.14	Total Vacancies		6.4%	8.3%	6.8%	7.6%	7.8%	8.0%	8.0%	7.1%	7.9%	ND	8.0%	ND	ND	8.0%
		5.15	Corporate & Admin Costs as %	<7%	9.5%	9.5%	9.5%	9.5%	8.6%	8.6%	11.1%	13.3%	10.7%	ND	9.7%	ND	ND	9.7%
		5.16	% Staff on Maternity/Paternity Leave		2.0%	1.9%	1.9%	2.0%	2.0%	2.0%	2.0%	1.9%	2.0%	1.9%	2.0%	2.3%	2.38%	2.21%
	Other	5.17	Grievance reviews		ND	ND	ND	6	6	6	5	5	5	4	5	4	4	13
		5.18	Recruitment Timescales - Av no. of weeks to recruit	7	5.00	5.40	6.40	6.70	6.90	6.90	6.40	5.40	5.40	5.40	5.40	5.60	5.40	5.47
		5.19	DBS checks	95%	92.6%	98.0%	98.4%	98.5%	97.5%	97.5%	98.5%	98.5%	98.0%	97.0%	98.0%	97.5%	98.0%	97.8%
		5.20	Staff appraisal Rates	90%	92.0%	ND	ND	53.1%	50.8%	55.8%	62.0%	65.0%	62.3%	63.0%	67.0%	67.3%	69.3%	67.9%
		5.21	Trust Participation in on-going National Audits (Qtrly)	90%	94.0%	NA	NA	96.0%	NA	NA	96.0%	NA	NA	96.0%	NA	NA	ND	NA

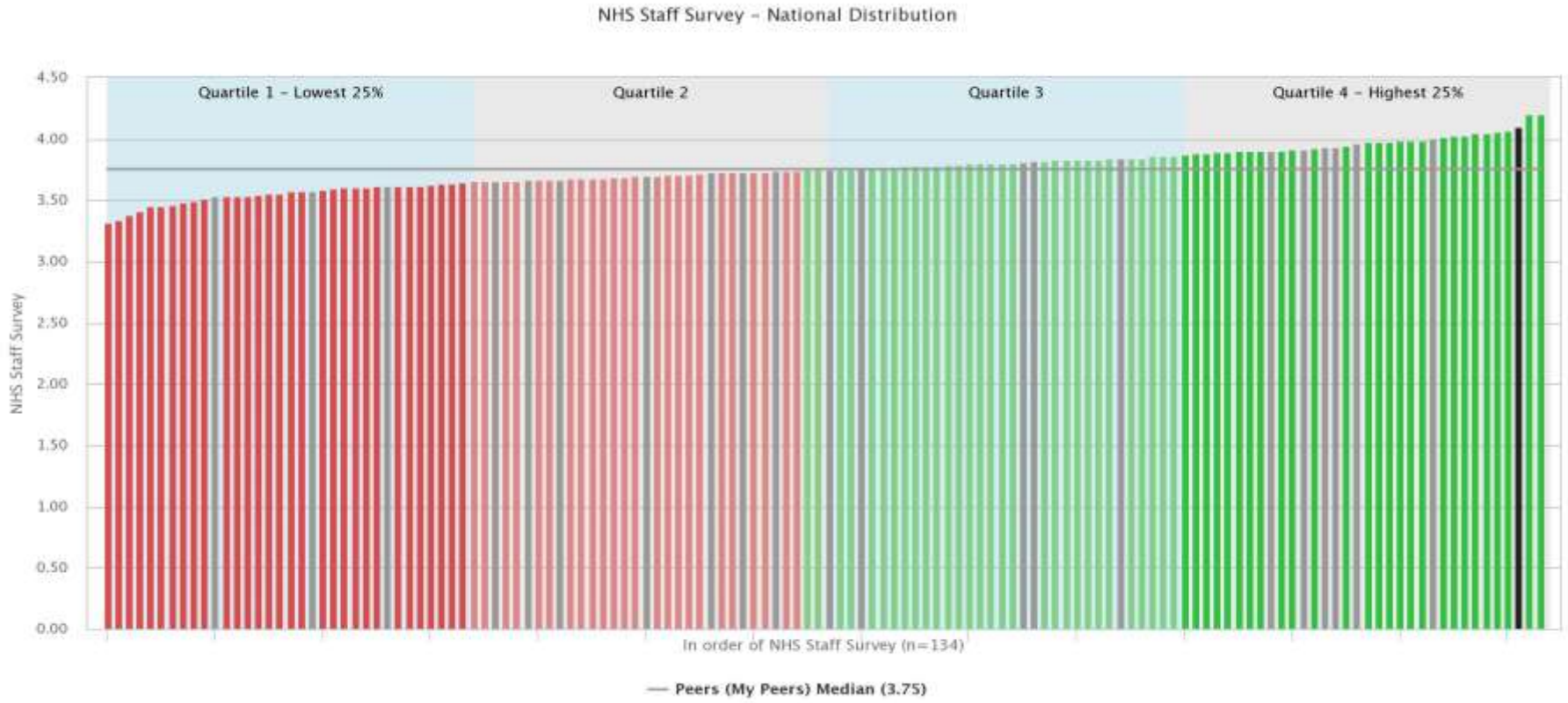
5. Well Led	Training	5.22	Infection Control Training (classroom)	85%	95.3%	95.3%	95.7%	94.5%	94.7%	95.0%	95.0%	94.0%	94.0%	95.0%	94.0%	95.0%	94.0%	94.3%
		5.23	Infection Control Training (eLearning)	185%	90.1%	90.2%	88.0%	83.4%	85.1%	88.0%	88.0%	90.0%	90.0%	90.0%	90.0%	90.0%	91.0%	90.3%
		5.24	Manual Handling Training (Patient)	80%	83.9%	82.9%	82.8%	80.2%	80.4%	84.0%	84.0%	79.0%	79.0%	79.0%	74.0%	76.0%	77.0%	75.7%
		5.25	Manual Handling Training (Non Patient)	80%	82.9%	83.3%	81.6%	85.5%	84.4%	88.0%	88.0%	89.0%	89.0%	88.0%	88.0%	88.0%	83.0%	86.3%
		5.26	Staff Adult Safeguarding Training	80%	90.2%	90.2%	89.5%	89.1%	90.2%	92.0%	92.0%	92.0%	92.0%	92.0%	91.0%	91.0%	92.0%	91.3%
		5.27	Safeguarding Children Level 1	90%	87.4%	87.5%	86.6%	86.5%	88.0%	89.0%	90.0%	91.0%	91.0%	90.0%	90.0%	90.0%	89.0%	89.7%
		5.28	Safeguarding Children Level 2	90%	89.7%	89.9%	87.2%	87.9%	88.6%	90.0%	92.0%	92.0%	92.0%	91.0%	91.0%	90.0%	91.0%	90.7%
		5.29	Safeguarding Children Level 3	90%	81.0%	80.9%	76.3%	73.4%	78.6%	83.0%	86.0%	86.0%	88.0%	83.0%	95.0%	94.0%	94.0%	94.3%
		5.30	Health & Safety Training	80%	89.5%	89.4%	88.7%	89.1%	89.8%	91.0%	91.0%	92.0%	92.0%	91.0%	90.0%	90.0%	91.0%	90.3%
		5.31	Security Awareness Training	80%	89.6%	89.8%	88.7%	88.7%	89.6%	90.0%	91.0%	91.0%	91.0%	90.0%	90.0%	90.0%	91.0%	90.3%
		5.32	Conflict Resolution Training (eLearning)	80%	85.2%	85.8%	79.6%	80.0%	81.4%	82.0%	95.0%	76.0%	85.0%	84.0%	86.0%	87.0%	87.0%	86.7%
		5.33	Conflict Resolution Training	180%	77.2%	77.2%	75.7%	74.5%	76.5%	76.0%	75.0%	88.0%	76.0%	76.0%	69.0%	70.0%	70.0%	69.7%
		5.34	Fire Training (eLearning)	280%	87.2%	86.9%	85.4%	85.0%	85.0%	85.0%	84.0%	84.0%	84.0%	82.0%	80.0%	82.0%	81.0%	81.0%
		5.35	Fire Training (classroom)	80%	90.1%	90.4%	90.4%	89.3%	90.0%	91.0%	91.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
		5.36	IG Training	80%	84.6%	84.4%	85.0%	83.6%	87.0%	86.0%	87.0%	84.0%	84.0%	82.0%	86.0%	86.0%	83.0%	85.0%
		5.37	Equality and Diversity	80%	94.7%	94.6%	92.6%	92.3%	93.0%	94.0%	94.0%	88.0%	88.0%	83.0%	81.0%	80.0%	79.0%	80.0%
		5.38	Majax Training	80%	87.8%	87.9%	86.9%	86.5%	88.0%	88.0%	89.0%	90.0%	90.0%	88.0%	88.0%	88.0%	89.0%	88.3%
		5.39	Medicines Management Training	80%	87.7%	87.7%	87.1%	87.1%	86.0%	87.0%	88.0%	89.0%	89.0%	88.0%	87.0%	87.0%	88.0%	87.3%
		5.40	Slips, trips and falls Training	80%	87.1%	86.8%	85.1%	84.9%	86.0%	88.0%	88.0%	87.0%	87.0%	87.0%	85.0%	85.0%	86.0%	85.3%
		5.41	Blood-borne Viruses/Inoculation Incidents	80%	86.1%	86.3%	84.4%	83.8%	85.0%	86.0%	87.0%	86.0%	86.0%	86.0%	85.0%	86.0%	87.0%	86.0%
		5.42	Basic life support training (adult)	80%	85.1%	84.6%	83.5%	81.7%	81.0%	81.0%	82.0%	80.0%	80.0%	78.0%	75.0%	76.0%	76.0%	75.7%
		5.43	Blood Products & Transfusion Processes (Refresher)	80%	82.9%	81.7%	79.1%	79.5%	80.0%	78.0%	80.0%	75.0%	75.0%	72.0%	73.0%	72.0%	73.0%	72.7%
		5.44	Mandatory Training Compliance		NA	NA	NA	NA	86.3%	88.1%	88.7%	84.6%	83.2%	82.8%	83.3%	84.0%	85.0%	84.1%
		5.55	Safeguarding Children Mandatory Compliance (Community)	98%	96.9%	96.9%	97.1%	96.8%	95.3%	96.1%	96.0%	95.9%	95.7%	97.0%	98.2%	95.8%	95.3%	96.4%
		5.56	Safeguarding Adults Mandatory Training Compliance (Community)	98%	96.8%	96.6%	96.2%	96.1%	94.3%	95.3%	94.0%	94.1%	93.2%	95.6%	96.0%	95.0%	94.9%	95.3%

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

EXCEPTION REPORTS – WELL LED

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 in June 2018 *(Source –Model Hospital).*



10. DETAILED REPORTS – PRODUCTIVE

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

Are we..		Ref.	KPI	Target	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	May-18	Jun-18	YTD(Apr18-Mar19)
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%	0.2	-10.3%	-7.5%	-6.3%	-8%
		6.02	Distance from Financial Plan	Var	NA	NA	NA	NA	NA	NA	NA	0.2%	0.2%	0.6%	0.1%	2.5%	5.3%	18.5%	1.6%	8%
		6.03	Capital service cover	Var	ND	- 3.19	- 2.50	- 2.18	- 1.04	- 0.88	- 0.32	0.52	0.24	0.38	0.07	0.680	0.48	1.64	- 0.80	0.44
		6.04	Liquidity (days)		ND	- 12.15	-15.72	-10.94	- 11.03	- 12.70	-15.14	9.64	11.39	6.06	6.84	7.860	12.34	16.83	15.36	14.8
		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	67.6	69.8	69.0	68.8
		6.06	CIP (Variance YTD £'000s)	1.9	40	0	-40	10	0	-54	-10	-74	-22	-419	-469	-539	-54	-47	-75	-59
	Activity	6.07	A&E Activity		5578	5971	5922	6124	5831	5743	6065	5985	5959	6033	5639	6172	5967	6498	6161	18626
		6.08	NEL Activity		2409	2440	2429	2375	2385	2466	2586	2491	2528	2539	2406	2557	ND	ND	ND	0
		6.09	OP - New Appointments		5125	6244	6148	5706	5635	5633	6182	7230	5482	6769	5849	6324	6033	6930	6379	19342
		6.10	OP- Follow-Up Appointments		9541	11667	11542	11147	11333	11116	11815	12668	9769	12673	11103	11609	11142	12248	11520	34910
		6.11	Electives (Incl Daycase)		2593	3004	2898	2796	2829	2786	2868	3157	2545	2841	2632	2871	ND	ND	ND	0
		6.12	Financial Position (YTD)	Var	-937	-2906	-2758	-3290	-3300	-3953	-4114	-5170	-6600	-6525	-6525	-287	-1760	-2793	-3159	-7712
		6.13	Financial Stability Risk Rating	Var	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	9
		6.14	Cash Position (YTD £000s)	Var	7,955	5093	2689	7460	3300	4846	2654	3518	4924	6870	3600	3600	5,322	4550	2239	12111

EXCEPTION REPORTS – PRODUCTIVE

There are no exceptions as the finance report contains full details.

11. DETAILED REPORTS- MATERNITY

		Ref.	KPI	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	YTD(Apr18-Mar19)
Maternity	Dashboard	7.01	Total number of deliveries (births)	213	215	233	236	205	194	180	199	211	206	198	203	201	602
		7.02	% of all caesarean sections	15.9%	15.5%	22.3%	18.2%	17.1%	17.0%	18.3%	22.1%	17.1%	30.1%	28.2%	22.4%	18.2%	22.9%
		7.03	Midwife to birth ratio	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3	1.3
		7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		7.05	Completion of WHO checklist	84.0%	94.0%	82.0%	98.0%	98.0%	98.0%	93.0%	93.0%	94.0%	97.0%	86.0%	85.0%	88.0%	86.3%
		7.06	Maternity SIs	0	0	0	1	1	0	1	2	0	1	2	2	0	4
		7.07	Maternity Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		7.08	Breastfeeding Initiation Rates	87.5%	77.3%	84.8%	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	79%	76.1%	76.3%	80.7%	77.7%
	Safe	7.09	Elective Caesarean Sections	4.3%	7.0%	9.4%	6.4%	5.9%	7.2%	7.8%	8.0%	7.1%	10.7%	11.8%	10.9%	7.6%	10.1%
		7.10	Emergency Caesarean Sections	11.5%	8.5%	12.9%	11.9%	11.2%	9.8%	10.6%	14.1%	10.1%	19.4%	16.4%	11.4%	10.6%	12.8%
		7.11	Grade 1 Caesarean Section (Decision to delivery time met)	100%	100%	100%	100%	0.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)	93.0%	83.0%	57.0%	82.0%	88.0%	50.0%	80.0%	83.0%	83.0%	81.0%	82.0%	93.0%	90.0%	88.3%
		7.13	Homebirths	2.4%	3.3%	2.6%	2.1%	3.9%	2.6%	3.3%	3.0%	2.4%	0.5%	2.6%	5.0%	1.5%	3.0%
		7.14	Midwifery led birthing unit (MLBU) births	17.3%	18.8%	15.5%	15.3%	17.1%	16.0%	15.0%	19.1%	18.0%	14.1%	16.4%	11.4%	11.4%	13%
		7.15	Labour Suite births	80.3%	77.9%	82.0%	82.6%	79.0%	81.4%	81.7%	77.9%	79.6%	85.4%	81.0%	83.0%	86.9%	84%
		7.16	Induction of Labour	40.9%	36.6%	38.2%	34.3%	35.1%	43.8%	43.9%	37.2%	41.2%	37.4%	41.0%	37.8%	40.9%	40%
		7.17	Instrument Assisted Deliveries (Forceps & VentoUse)	4.9%	4.2%	3.0%	4.7%	4.2%	7.2%	5.9%	7.0%	7.6%	6.8%	13.0%	9.5%	10.1%	10.9%
		7.18	Critical Care Obstetric Admissions	0	1	0	1	0	0	0	2	0	1	1	2	1	4
		7.19	Eclampsia	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Effective	7.20	Shoulder Dystocia	3	5	3	7	6	4	5	4	5	8	5	6	4	15
		7.21	Post-partum Hysterectomies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		7.22	Women requiring a blood transfusion of 4 units or more	0	0	0	0	0	0	ND	ND	ND	ND	0	0	1	1
		7.23	3rd and 4th degree tears (all deliveries)	6	10	4	4	6	3	8	9	7	2	9	4	6	19
	Caring	7.24	Maternal death	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		7.25	Stillbirths	0	0	0	1	2	1	0	2	0	0	1	1	0	2
		7.26	Complaints	1	2	1	0	0	0	1	0	0	1	0	ND	0	0
		7.27	No. of babies admitted to Neonatal Unit (>36+6)	17	18	13	15	15	11	9	8	16	12	18	10	9	37
	Responsive	7.28	No. of babies transferred for therapeutic cooling	0	0	0	0	1	0	1	0	0	0	1	0	0	1
		7.29	One to one care in established labour	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	91.0%	93.0%	92.3%	92.1%
		7.30	Reported Clinical Incidents	46	64	43	52	61	57	49	63	46	48	46	56	48	150
		7.31	Hours of dedicated consultant cover per week	99	99	96	99	99	108	90	102	93	93	94	90	93	277
		7.32	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	30
		7.33	OPD cover for Theatre 2	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	ND	ND	ND	ND
		7.34	No. of women identified as smoking at booking	37	32	30	37	27	28	17	26	21	30	26	31	22	79
		7.35	No. of women identified as smoking at delivery	26	32	27	25	25	24	26	21	22	24	23	26	14	63
		7.36	UNICEF Baby friendly audits	10+	10+	10+	10+	10+	10+	10+	10+	ND	10+	ND	ND	10	10
		7.37	Proportion of parents receiving Safer Sleeping Suffolk advic	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	62.9	77.8	81.8	74.2
	Other	7.38	No. of bookings (First visit)	244	272	245	265	259	245	193	279	253	274	240	251	237	728
		7.39	Women booked before 12+6 weeks	97.5%	94.9%	99.6%	92.8%	99.0%	97.0%	97.0%	96.0%	96.0%	ND	95.4%	96.0%	96.6%	96.0%
		7.40	Female Genital Mutilation (FGM)	0	0	0	0	0	0	0	0	1	0	0	0	0	0

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

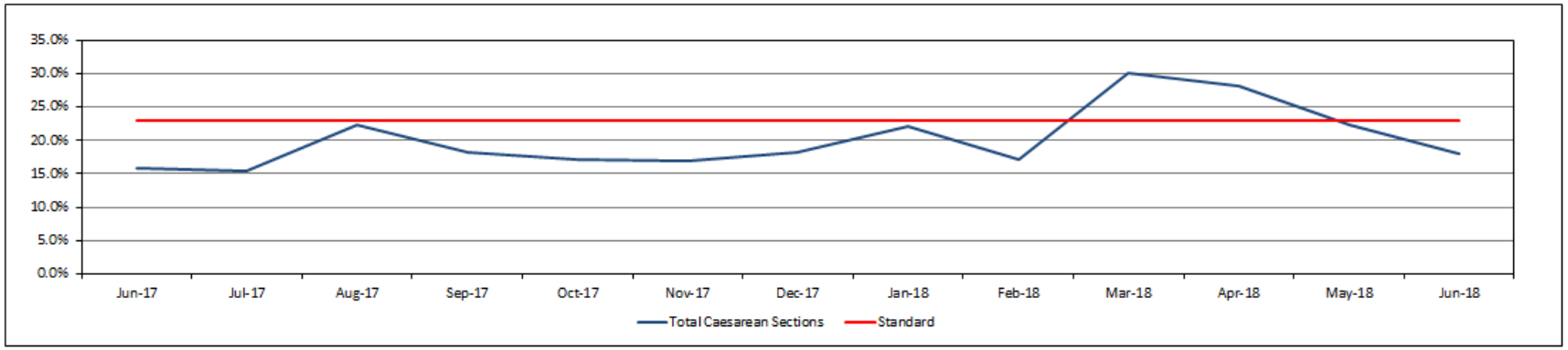
Indicator	Total Caesarean Sections
Standard	23%
Name	Jane Lovedale
Month	01-Jun-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The total caesarean section rate has for the second month continued to show a downward trend following the unexpected rise in March and April of this year. In June the figure was 18% down further from May data which was 22.4%. The service continues to monitor our total CS rate at the Monthly Womens Health Governance Meeting. Emergencg CS are monitored at the weekly case management meeting feedback from this meeting is included in the Risky Business Monthly publication.

Indicator	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard	23%	23%	23%	23%	23%	23%	23%	23%	23%	23%	23%	23%	23%
Total Caesarean Sections	15.9%	15.5%	22.3%	18.2%	17.1%	17.0%	18.3%	22.1%	17.1%	30.1%	28.2%	22.4%	18.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue monotoring of total CS rate at the monthly Womens Health Governance meeting. All Emergency CS ar monitored weekly and learning fedback in the monthly Risky Business publication.	HOM	on-going	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

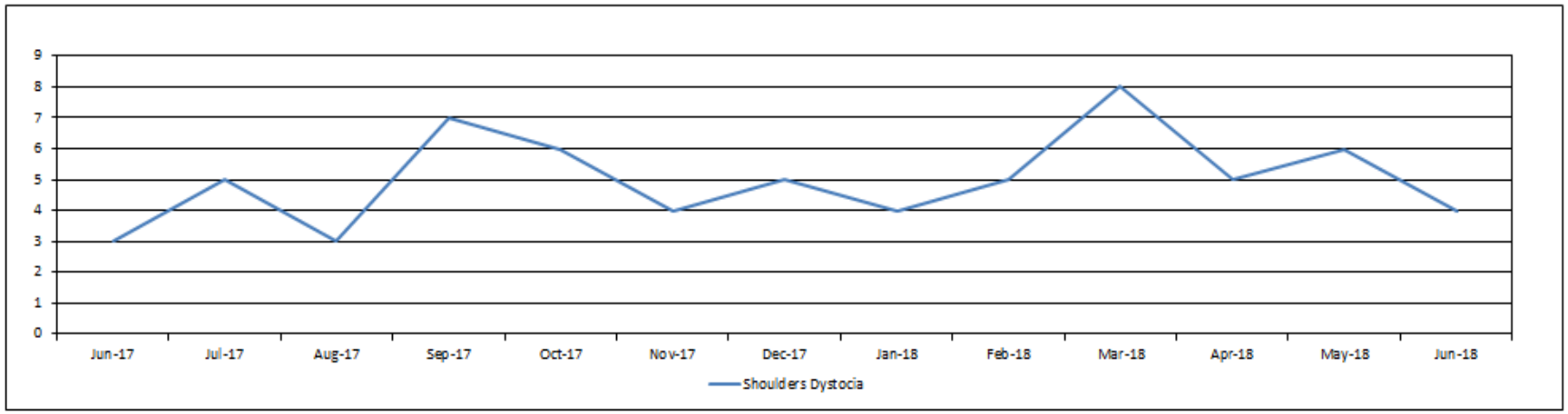
Indicator	Maternity - Shoulders Dystocia
Standard	2
Name	Jane Lovedale
Month	01-Jun-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

This month the maternity service reported four cases of Shoulder dystocia's during delivery, showing a reduction from from last month's of 6 cases reported. Risk assessments for the prediction of shoulder dystocia are insufficiently predictive to allow prevention of the large majority of cases. The importance is preventing maternal and neonatal injury such as post partum haemorrhage, significant perineal tears and nerve or # in neonatas during the manouevres undertaken to release the shoulders. Therefore the main focus is on staff training in awarenes of early signs of SD and training for the emergency. All staff undergo multiprofessional training annually. Most importantly there has been no significant injuries to mothers or babies of this months reported incidents.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor all incidents of shoulder dystocia monthly. Multiprofessional annual training in place.	RS	Jul-17	Ongoing



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Total women delivered who breastfed babies within first 48 hours
Standard	80%
Name	Jane Lovedale
Month	01-Jun-18
Data Frequency	Monthly
CQC Area	Maternity

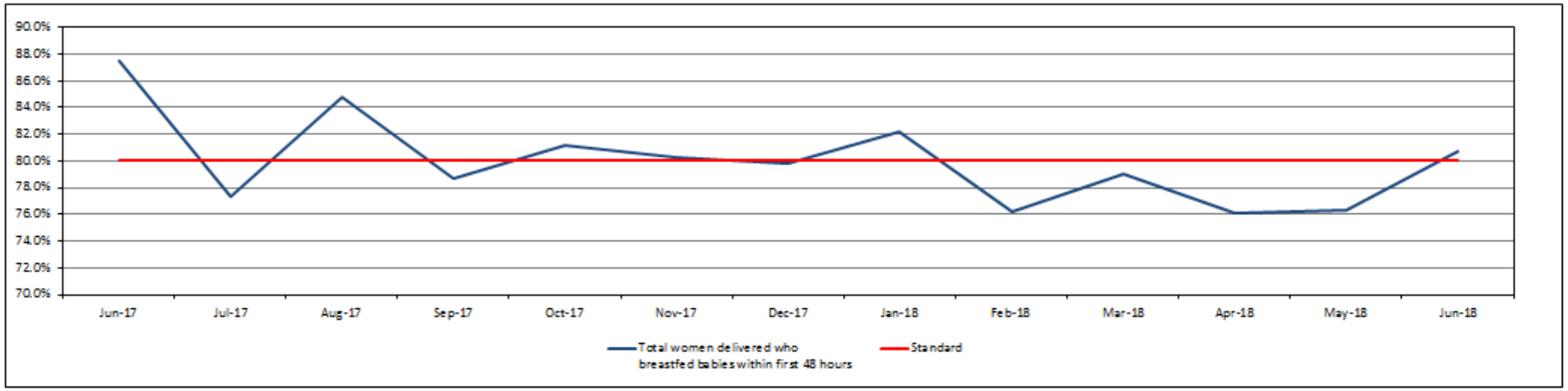
Summary of Current performance & Reasons for under performance

While improving our breast feeding initiation rate continues to be a challenge, this month's figures shows a significant rise to 80.7%. June figure was 76% The service has seen some occasional dips to below 80%, but overall for the last year we have been either over 80% or at the upper end of 70%. While the service continues with ongoing initiatives to achive over 80% it must be highlighted that the WSH has achieved each month over the past 12 months above 73.6% which is the mean overall proportion of babies recieving breast milk at their first feed for England and Scotland (NMPA) .

Indicator	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Total women delivered who breastfed babies within first 48 hours	87.5%	77.3%	84.8%	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	79%	76.1%	76%	80.7%

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

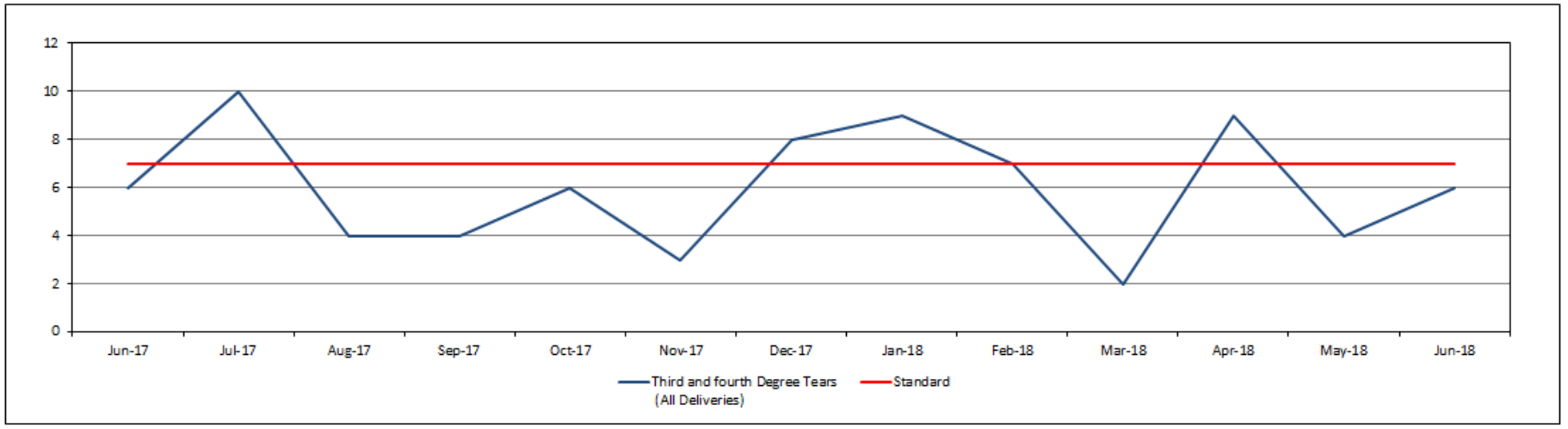
Summary of Current performance & Reasons for under performance

The maternity service continues to maintain the focus on keeping this rate of 3rd and 4th degree tears low. Both May na dJune has seen a reduction from the previous month.All 3rd and 4th degree tears are on the maternity services trigger list for datix and therefore are indvidually investigated as to the type of delivery appropriate position at delivery. Midwifery mandatory annual training includes perineal injury and repair . This year's training focus in on reducing 3rd and 4th degree tears by adopting the Peaches acronym for for quality improvement in OASI. This ongoing focus throughout the year is aimed at adopting the principles for reducing the number of significant tears.

Indicator	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Standard	7	7	7	7	7	7	7	7	7	7	7	7	7
Third and fourth Degree Tears (All Deliveries)	6	10	4	4	6	3	8	9	7	2	9	4	6

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

Description	Owner	Start	End
Quality improvement plan at midwifery manadatory training focussing on the principles of Peaches acronym for the reduction in OASI.	RP	Mar-18	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

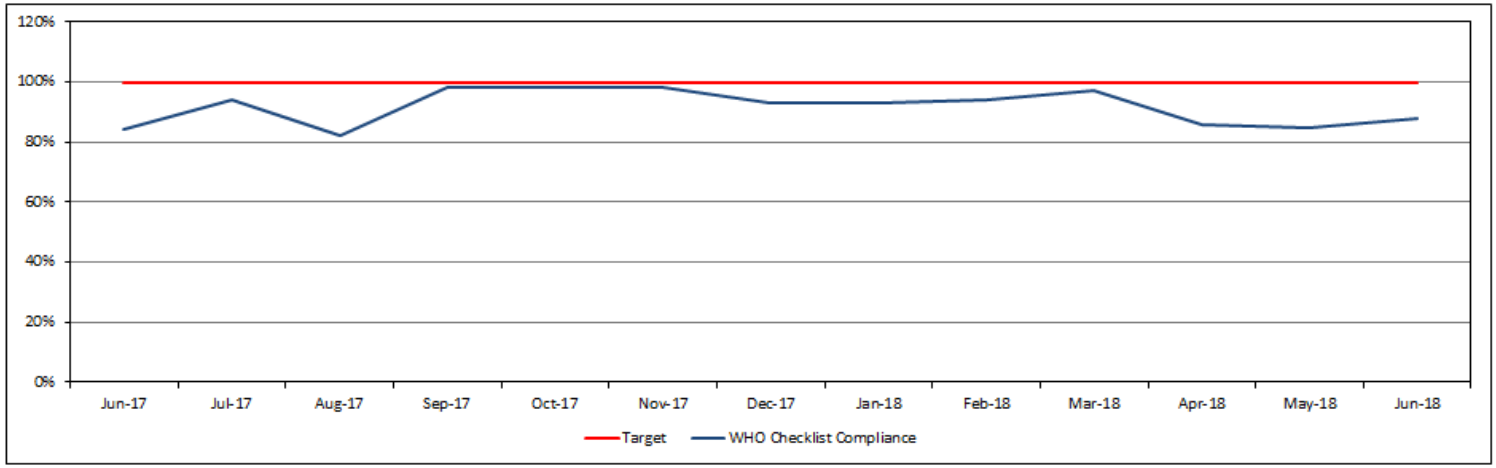
The completion of the WHO safer surgery checklist has been an ongoing issue to achieve 100% compliance. It has been recognised that the maternity service does not follow the trust process. The maternity service is currently in discussion with regards to adopting the trust method of calculating compliance which assesses individual elements on the checklist rather than rejecting the whole checklist if one element is incomplete. The Maternity service will continue to monitor all theatre cases each month using the Trust process and include on the dashboard for discussion.Focus will be placed on any individual elements of non compliance within the checklists.

Indicator	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
WHO Checklist Compliance	84%	94%	82%	98%	98%	98%	93%	93%	94%	97%	86%	85%	88%

Actions in place to recover the performance

Expected timeframes for improvement

Description	Owner	Start	End
The Maternity service to follow the Trust process for monitoring monthly WHO safety check list.	RP	Feb-18	



COMMUNITY

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

- Our FFT score for June has remained at 97% out of 131 responses, with Glastonbury Court again scoring 100%, alongside the Children's Services.
- This report reflects 1 formal complaint this month relating to the Lymphoedema Service however this complaint is currently on hold whilst consent to respond is being sought from the patient. The complainant has been issued with a "zero tolerance" letter as a result of inappropriate engagement with professionals.
- The community health teams has continued to meet all targets for response times for 4 hour, 72 hour and 18 weeks
- The activity for the Neighbourhood Nursing and Care Team (previously described as Buurtzorg) is now included in this report.
- There has been no further reduction on community hospital length of stay, following improvements seen in preceding four months
- Despite the reduction in April and May, the number of DTOC's in community beds has increased this month to 18 patients with a total of 147 bed days lost as a result.
- The falls data highlights that there has been no harm from all falls reported this month.
- Paediatric speech and language therapy continues to demonstrate a positive impact on those children who had previously been waiting for over 10mths for intervention. The total number of children on the caseload and waiting for assessment and therapy is higher than last month but within the anticipated levels of activity.
- The wheelchair service has maintained achievement of 100% against the new18 week assessment to provision target for children. There is a focused action plan in place to improve performance against this target for the adult pathway. Activity relating to Personal Wheelchair budgets is now included in this report.
- The response time for input to Education Health and Care Plans (EHCPs) is below the 90% target this month. Further analysis of this data is being undertaken as this performance is impacted on by a number of factors (delay in initial notification, clinician availability and complexity of need etc) and this new KPI and associated context will be discussed with the CCG's Designated Clinical Officer for SEND (new in post).
- The community equipment service sustained their improved performance and achieved all KPI's
- Challenges continue in the Children in Care Service to complete initial health assessments on time. Work on the system wide (SCC,CCG,WSFT) agreed set of actions for improvement is being sustained.
- There is a reduction in compliance with adult safeguarding training and infection control. Senior Operational Leads are focusing on this with service leads to improve compliance rates. Additional Infection Control sessions are being scheduled.

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. Transformation report – Q1

To ACCEPT an update

Presented by Helen Beck

Trust Board - 27 July 2018

Agenda item:	10			
Presented by:	Helen Beck - Chief Operating Officer			
Prepared by:	Lesley Standring – Head of Operational Improvement, WSFT Sandie Robinson - Associate Director of Transformation, CCG Jane Rooney - Head of Planned Care Transformation, CCG John Connelly - Head of PMO, WSFT Sheila Broadfoot - CQUIN Lead, WSFT			
Date prepared:	18 July 2018			
Subject:	Transformation Board Report			
Purpose:	√	For information		For approval

Executive summary:
This report provides an update from the last reporting period and relates to the programs of work being undertaken by the joint transformation teams, the Trust PMO and progress against CQUIN. The report also notes the creation of the Head of Operational Improvement role which has been created to provide internal focus on the range of patient flow and demand management initiatives.

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

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

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

Recommendation:
The board is asked to note the content of the report and progress in a number in a number of key system wide transformation initiatives

1.0 Update on Hospital Transformation

Lesley Standring has recently being appointed as the Head of Operational Improvement. Lesley has been working as part of the joint transformation team and will continue to maintain close links with this team but will lead on internal initiatives to support ongoing improvements in patient flow. Her role includes bringing together current action plans into one overarching plan with a robust system for monitoring and escalation. The first highlight report will be presented to the Executive Team and TEG in August.

1.1 Red to Green/SAFER

Each ward manager has completed a self-assessment to show progress against the SAFER standards. The hospital as a whole performs well and the identified actions have been incorporated into the overarching plan.

2.0 Integrated Care Programme Project highlights

2.1 EndPJParalysis

Due to challenges with staffing levels on the wards we have been delayed in joining the new national campaign promoting getting patients up, dressed and mobilised but have plans to address this over the next few weeks. The campaign involves use of an App where wards upload their data daily and this feeds into a national report charting improvements.

2.2 Demand Management

The Early Intervention Team is continuing to deliver against the admission avoidance trajectory and is responding to the stretch percentage split of community referrals into the team. The HALO has been a valuable resource educating the crews about EIT resulting in an increase in number of ambulance referrals to a high of 22 in June.

The team has led an STP project drawing on national evidence of good practice around managing high volume urgent care service users. A proposal is expected to be shared at the end of July with local partners before being presented to the STP in September.

2.3 Care Homes

A system wide programme of work across Suffolk has produced a draft overarching Care Home Strategy 2018 – 2023 for Suffolk building on the NHSE 2016 Enhancing Health in Care Homes framework. The strategy outlines a model of demand management which is aligned to the core offer within the Alliance Plan. The model is being presented to system leaders throughout July for approval to secure urgent support for a phased implementation approach starting with 5 key priority areas:

- Trusted Assessment between care homes providers and acute trust – the care home link role at WSFT has made an excellent start to delivering this approach
- Medicine optimisation – one dedicated wte clinical pharmacist already provides this support in west Suffolk and further STP funding will become available to increase the capacity
- GP Local Enhanced Service to align practices to care homes
- Enhance EIT to support reactive care to care homes and implementation of *6 priority line as part of IUC contract
- Review mental health crisis and DIST support

2.4 Trusted Assessor

This is a nationally mandated requirement of the High Impact Change Model and aims to support timely discharge of patients back to care homes. The care home link role at WSFT has now been enhanced by applying a trusted assessment framework with a clear model of delivery that improves governance. A paper outlining the model and its future development stretching to more care homes was presented to the Transformation Delivery Group on 18 July.

2.5 Discharge to Optimise and Assess

Pathway 0 interventions are being progressed as business as usual by the Head of Operational Improvement

Pathway 1 is the main focus for transformation this year and a design workshop took place on 19 July with excellent system engagement and over 50 partners attending. This pathway will require significant change across acute and community, as this second largest pathway shifts assessment of long term care needs and reablement to the individuals home. The ongoing funding decision of Support to go Home and the alignment with Homefirst will provide an opportunity to get the first phase of the pathway live in autumn this year.

Pathway 2 supports patients who cannot be discharged home from the acute trust but have reablement potential, which can be met in a community assessment bed. Glastonbury Court and Newmarket Hospital are providing excellent support to this pathway.

Pathway 3 supports patients who are unable to safely return home and have a combination of sub-acute and complex care needs. This pathway supports patients following CHC 5Qs and with complex protracted delirium. The delirium pathway is currently in development.

Evaluation it is important that the implementation of all four pathways demonstrates movement towards the ambitions of the D20A business case and in particular a shift towards Pathways 0 and 1. An evaluation framework is currently being developed to present to Alliance partners.

2.6 Respiratory

As part of the Rightcare programme for non-elective activity the team are working with lead clinicians to develop an integrated respiratory pathway with a focus on COPD. The COPD service is currently facing significant workforce challenges, which currently pose a risk to any further developments – this is being escalated through operational channels.

2.7 Integrated Urgent care (IUC)

On behalf of the STP the team is working with the new IUC provider on securing the successful transition to the new contract due on 1 November. As part of the mobilisation a gap analysis and improvement plan of the Directory of Services (DOS) is currently in progress.

3.0 Planned Care Programme Project Highlights

3.1 100 Day challenge

The 100 day challenge programme concluded in June 2018 with a close event to celebrate the success of the programme and discussion on the sustainability of the various work streams. Three areas had been the focus for the programme: Cardiology, ENT and urology. This was a national programme supported by NHSE.

NHSE and the senior local leaders who attended the event commended the clinical engagement and progress made during the 100-day period. Various innovations that had been put in place during the programme were considered and these will now be either rolled out from the pilot sites to the whole of

West Suffolk, be changed to encompass learning from the programme or will be discontinued where they have been found to be ineffective

Other specialties within the Trust have expressed an interest in working with the 100-day methodology and this will be considered through the Planned Care Board.

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

'RightCare' is about the whole health system taking an evidence-based approach to focus on key areas that will improve health outcomes for the population, reduce unwarranted variation in care and save money. Updated benchmark data packs have been received and reviewed and have identified additional opportunities in gastroenterology.

Projects that were commenced last year are being taken forward with refreshed plans that were submitted to NHSE at the end of June. A new project on gastroenterology will be submitted to NHSE in September.

Within the current projects, the following are being progressed:

- Work on atrial fibrillation which has now been identified as a priority area for West Suffolk
- Links to stroke, heart failure and CVD are being reviewed
- The health population programme is aiming to have a longitudinal patient record, the proposed pilot specialties are diabetes and CVD.
- A revised headache pathway is likely to be in place by the end of November 2018
- The STP is working to roll out a digital innovation called 'My COPD'. This web-based self-management platform, (or app), will support patients to manage their long-term conditions through education, rehabilitation and symptom reporting.

3.3 Treatment and Care Funding – Diabetes Management

Following confirmation of funding for Year 2 of this programme, work continues across the STP with primary and secondary care to improve achievement of the 8 care processes and increase uptake of structured education.

A revised approach to engaging patients in structured diabetes education is being discussed across the STP. Initially it was thought that his would be achieved by incentivising GPs. The idea was not well received by the GP community and alternatives are now being looked at to increase the attendee numbers at education sessions.

3.4 Integrated Pain Management Service (IPMS)

In January 2018, West Suffolk CCG issued a Prior Information Notice (PIN) advertising their intention to deliver an Integrated Pain Management Service through an alliance with West Suffolk Foundation Trust and Suffolk GP Federation. There was some interest to the PIN from an external provider, but they were unsuitable as they were unable to deliver an integrated pain service as per the specification.

Following this, there have been numerous conversations to progress the implementation of an integrated service. Whilst the clinical specification is clear, the structure and governance of any future organisation is still being debated. There is a further shadow board meeting on July 25th 2018.

The Single Point of Access for Pain referrals is firmly embedded and referral trends indicate that the shared care arrangements appear to be working effectively.

3.5 Ophthalmology

Evolutio has been awarded the contract to support the ophthalmology service in West Suffolk. This will be in place from September 1st and mobilisation of the service has now commenced

Implementation of the NHSE high impact interventions has also commenced with full support and joint working between the project team and the clinicians.

3.6 Stroke

Work to review stroke services is being undertaken at STP level with input from all the involved Trusts. The following areas are to be reviewed:

- Provision of speech and language therapy across the STP
- Post stroke rehabilitation – Early Supported Discharge
- Acute care pathway and high acute stroke unit (HASU) review
- Training and education
- Workforce
- Ambulance/ED pathway
- Primary and secondary prevention agenda

Work streams on ESD and workforce are already in progress with HASU review expected to commence shortly. Clinicians from across the STP are involved

3.7 Demand Management

The demand management programme has identified an initial focus on dermatology and vascular procedures. Prioritisation has been done to reflect RTT pressures as well as QIPP (Quality, Innovation, Production & Prevention) targets and internal Trust pressures. Work is now underway to review gastroenterology pathways and gynaecology.

A system-wide dermatology service redesign is ready for implementation to increase the utilisation of teledermatology in the community and thus ensure that only appropriate patients are referred to secondary care. The output of this piece of work will be that patients are seen in the right place, by the right person at the right time.

Work has also commenced to on Clinical Threshold procedures or Low Priority procedures. This will fall into two areas. Trust activity has shown that procedures being carried out are not always being approved through a gatekeeping process. Thus the review will look at the internal CCG/Trust process with the objective of preventing procedures from being carried out when they do not meet the clinical threshold.

As part of the national agenda on clinical thresholds, we will also work with STP colleagues to review all existing policies over the next 12-18 months and to implement nationally recommended policies that we are not currently following.

4.0 PMO Update

4.1 Audit Report

The Trust has retained the highest rank for the second consecutive year with the auditors RSM giving ‘Substantial Assurance’ to the Board regarding the organisations ability to deliver cost improvement programmes.

4.2 PMO Development

The PMO and the ADO's are currently working together to develop the PMO Manager Work Plans to ensure effective joint working and efficient resource management by clarifying the purpose of the role, prioritising project delivery and risk assessing the divisional CIP programme's as the process will specify which projects do not have a specified project management resource.

4.3 CIP Programme Performance

There is presently a £6M gap against the £12.2M 2018/19 CIP target which has been agreed with NHSI. The PMO will work with the divisions to review pipeline opportunities and build on the recent work undertaken as part of the executive review of divisional CIP programmes. The ADO's are currently working with the PMO and the Deputy Director of Finance to allocate the £2.8M cross cutting target to the divisions.

4.4 Medical e-Rostering

The implementation process is underway with Allocate on site supporting the initial build process in July. The first phase testing of the job planning and annual leave modules in surgery are planned in August before the build commences in the other divisional units. Data inputters have been appointed to load the relevant workforce information. The PMO is working with HR to develop the Business as Usual options which will be appraised by an executive panel in September. In the meantime, an Allocate Business Manager has been seconded internally on a one-year basis to develop the organisational knowledge to manage and derive system benefits on a business as usual footing beyond the lifecycle of the project which is expected to complete in December 2018.

4.5 Procurement: Category Towers

The contracts for all eleven category towers and been successfully re-tendered and awarded. The Trust currently uses the NHS Supply Chain under a single contract with DHL until 1st October 2018, and this will move over to the new suppliers in due course.
Category one has been implemented and the contracts for the next five Medical Category Towers (2 to 6) launched in June 2018 are now migrating into the Category Towers and mobilising as follows:

1. Ward Based Consumables (DHL)
2. Sterile Interventions Equipment and Associated Consumables (CPP)
3. Infection Control and Ward Care (DHL)
4. Orthopaedics, Trauma and Spine, Ophthalmology (CPP)
5. Rehabilitation Disable Services, Women's Health and Associated Consumables (CPP)
6. Cardio-Vascular, Radiology, Audiology and Pain Management (HST)

5.0 CQUIN Projects 2018-19

Staff CQUINs title:	Progress	RAG
1a) Staff Health & Wellbeing: Improve two specific results by 5% from 2016 on the national Staff Questionnaire re: H&W provision & MSK & Stress not 'due to work'.	H&W provision – target increase to 45% (2017-8 was 43%). Staff H&W initiatives in place. MSK – target reduce to 17% (2017-8 was 21%). Stress – target reduce to 28% (2017-8 was 33%). Rely on staff own perception to interpret and decide whether: 'Work was main cause of' Stress or MSK.	 Q4
1b) Food & Drinks sold at WSFT: Continue changes made 2016-7 re: items high in fat, sugar or salt and new targets for 3 changes 2017-8.	All in place including liaison with W H Smith. 10% sales max of sugary drinks (no ban); by March 2019 20% of shelf allowed re: >250kcal sweets & 25% shelf re: >400kcal sandwich/wraps/salads. Submit data for NHS Digital.	
1c) Flu vaccination of staff: 75% uptake by end of February.	2017-8 was WSFT 74% (total incl Community 70.99%). Campaign plans started. NHSE further requirement tbc.	Q3
Patient CQUINs title:	**Progress**	**RAG**
2a) Sepsis screening of all ED and inpatients. Target 90%	eCare adds symptoms together & prompts 'Suspected Sepsis' when relevant. From Q4 (Jan) to use NEWS 2 criteria - eCare updates planned for Sept 2018. Paediatrics yet to have alerts.	
2b) Severe/ High Risk Sepsis treatment ED & Inpatients: IV anti-biotic within 1 hour of diagnosis. Target 90%	Timely treatment improvements required. May ED 60%, Inpatient 65%. Drop since April (73% & 83%). Sepsis/ eCare Group: taking forward incl review eCare alerts. Paediatrics yet to have alerts (tbc option if alerts change). Sepsis Nurse post approved.	Q1-4
2c) Severe/ High Risk Sepsis - ED & Inpatients: antibiotic prescription review & assessment. Q4 target 90%	2018-9 – predicted will be met. Note: additional criteria – review within 72 hours & additional documentation & IV to oral switch assessment. Data to be submitted to Public Health England. TBC: eCare, 72 hour review prompt issue = less recording.	
2d) Higher % reduction in 'total all' & Carbapenem Antibiotic use vs 2016. Increase usage within Access group AWaRe (Access, Watch & Reserve).	Note: Total antibiotics & Carbapenems increased 2017-8 re: Tazocin shortage. Challenge to reduce 2% & 3% in 2018-9. New: Increase (for in & outpatients), proportion >55% or by 3% vs 2016 antibiotics within the Access group of AWaRe category: Any issues on this are under review.	Q4
4) Mental Health need in ED – Selected 2 cohorts: reduced ED attendance. Outcomes information. Increased use of MH on ECDS, including audit & improvement plan.	NSFT & ED: Maintain reduced attendance of year 1 cohort. Year 2 cohort of frequent attenders, ID, plans, data: reduce 20%. Use of 'MH diagnosis' to increase. All recorded robustly via ECDS. Audit this and create data quality plan Q1, with goals to be met Q2-4. Data on cohorts to be submitted to NHS Digital. Project evaluation: data tbc on patient experience, clinical outcomes. ED meeting to confirm all goals met.	
6) Advice & Guidance to GP pre referral via eRS. Specialties offering A&G covered at least 75% of referrals received 2016-7 (aim A&G reduce referrals).	Phased monitoring for a further 11 specialties offering A&G to GPS via eRS. Daily checks on eRS queries in place & reminders sent.7 specialties started in 2017-8 & 2 in Q1 2018-9: improving compliance of 2 day turnaround. Clinician ideally responds direct on eRS: work arounds in place. If GPs do not receive a timely response: they may resort to refer.	
9) Adult Inpatients – preventing ill health (excluding Maternity):	eCare now live including: Form; NRT drop down list; Referral links; links to page with documents on the Pink Book.	Q1
Targets By Q4 **9a)** Tobacco Screening 90%	Form location on eCare issue – no prompts to complete ('ad hoc' so that all roles can access, rather than a role related task). Baseline: 0%	
9b) Tobacco Brief Advice (if yes) 90%		
9c) Tobacco Referral and Medication Offer 30%	Q1 – i) Information systems review & create data capture; ii) training schedule including staff groups identification, all teaching materials, messages and any feedback; iii) baseline data.	Q4
9d) Alcohol Screening 50%		
9e) Alcohol Brief Advice Or Referral (if high score) 80%	Q2-3 % to improve; Q4 high national % targets shown opposite. Education & communication being progressed.	
10) STP (Suffolk Transf) Support	Local CQUIN. Predict met re: evidence of meetings.	

11. Finance and workforce report

To ACCEPT the report including plans for winter 2018-19

Presented by Craig Black

Board of Directors – June 2018

Agenda item:	11			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	23rd July 2018			
Subject:	Finance and Workforce Board Report – June 2018			
Purpose:	x	For information		For approval

Executive summary:
The Trust has agreed a control total to make a deficit of £13.8m in 2018-19 which will enable Provider Sustainability Funding (PSF) of £3.7m should A&E and Financial targets be met. Therefore the Trust is now planning on a net deficit of £10.1m for 2018-19.

In order to achieve the control total the 2018-19 budgets now include a stretch CIP of £2.8m bringing the total CIP plan to £12.2m (5%). We have utilised the 2018-19 contingency of £1.5m in order to meet this stretch CIP. Our revised operating plan has been submitted on this basis.

The reported I&E for June 2018 is a deficit of £366k, against a planned deficit of £301k. This results in an adverse variance of £65k in month (£251k YTD). This overspend predominantly relates to our failure to meet the A&E performance target resulting in a shortfall against our PSF plan of £165k YTD, meaning we are behind our control total by £86k YTD.

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

June 2018 (Month 3)

Executive Sponsor : Craig Black, Director of Resources
Author : Nick Macdonald, Deputy Director of Finance and Louise Wishart, Assistant Director of Finance

Financial Summary

I&E Position YTD	£3.2m	loss
Variance against plan YTD	-£0.3m	adverse
Movement in month against plan	-£0.1m	adverse
EBITDA position YTD	-£1.1m	
EBITDA margin YTD	-123.4%	adverse
Total STF Received	£384k	accrued
Cash at bank	£2,239k	

Executive Summary

- The Trust has agreed a control total of a deficit of £13.8m with NHS Improvement for 2018/19. As a result of this the Trust will have access to £3.7m PSF (formerly STF) this year. The planned deficit for the year is therefore £10.2m.
- We therefore have a CIP target of £12.2m (5%)
- The planned deficit for the year to date was £2.9m but the actual deficit was £3.2m, an adverse variance of £0.3m.

Key Risks

- Securing cash loan support from DH for the 2018/19 revenue and capital plans.
- Delivering the £12.2m cost improvement programme.
- Containing the increase in demand to that included in the plan (3.2%).

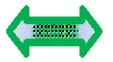
SUMMARY INCOME AND EXPENDITURE ACCOUNT - June 2018	Jun-18 Budget £m	Jun-18 Actual £m	Jun-18 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m	Year end forecast Budget	Year end forecast Actual	Year end forecast Variance F/(A)
NHS Contract Income	15.8	15.9	0.1	47.3	47.5	0.2	190.3	190.3	0.0
Other Income	2.9	2.9	0.0	8.3	8.1	(0.2)	33.4	33.4	0.0
Total Income	18.7	18.8	0.2	55.6	55.5	0.0	223.7	223.7	0.0
Pay Costs	12.9	12.7	0.3	37.9	38.7	(0.8)	151.4	151.4	0.0
Non-pay Costs	5.6	6.3	(0.7)	18.1	18.0	0.2	74.3	74.3	0.0
Operating Expenditure	18.5	19.1	(0.5)	56.1	56.7	(0.6)	225.7	225.7	0.0
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	0.1	(0.2)	(0.3)	(0.5)	(1.1)	(0.6)	(2.0)	(2.0)	0.0
Depreciation	0.7	0.6	0.1	2.1	1.7	0.3	8.2	8.2	0.0
Finance costs	0.3	0.2	0.1	0.9	0.7	0.2	3.6	3.6	0.0
SURPLUS/(DEFICIT) pre PSF	(0.9)	(1.0)	(0.2)	(3.5)	(3.5)	(0.1)	(13.9)	(13.9)	0.0
Provider Sustainability Funding (PSF)									
PSF - Financial Performance	0.4	0.6	0.3	0.4	0.4	0.0	2.6	2.6	0.0
PSF - A&E Performance	0.2	0.0	(0.2)	0.2	0.0	(0.2)	1.1	1.1	0.0
SURPLUS/(DEFICIT) incl PSF	(0.3)	(0.4)	(0.1)	(2.9)	(3.2)	(0.3)	(10.2)	(10.2)	0.0

FINANCE AND WORKFORCE REPORT – June 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 – June 2018

Income and Expenditure Summary as at June 2018

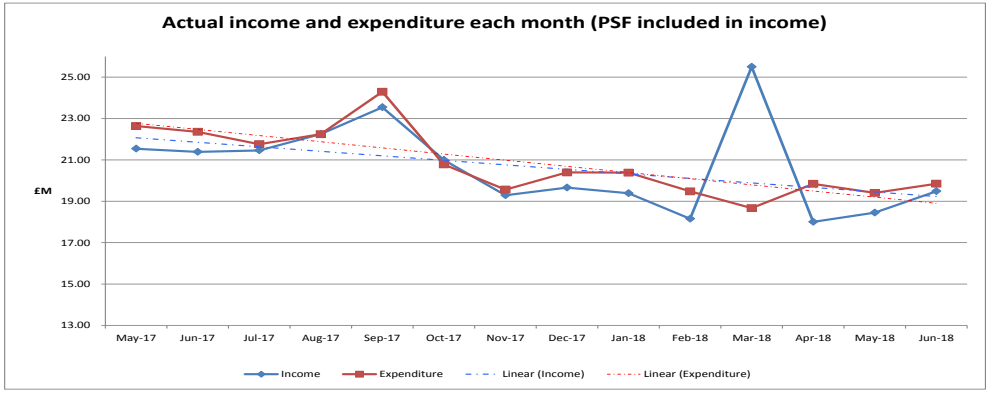
The Trust has agreed a control total to make a deficit of £13.8m in 2018-19 which will enable Provider Sustainability Funding (PSF) of £3.7m should A&E and Financial targets be met. The Trust is planning on a net deficit (after PSF) of £10.1m for 2018-19.

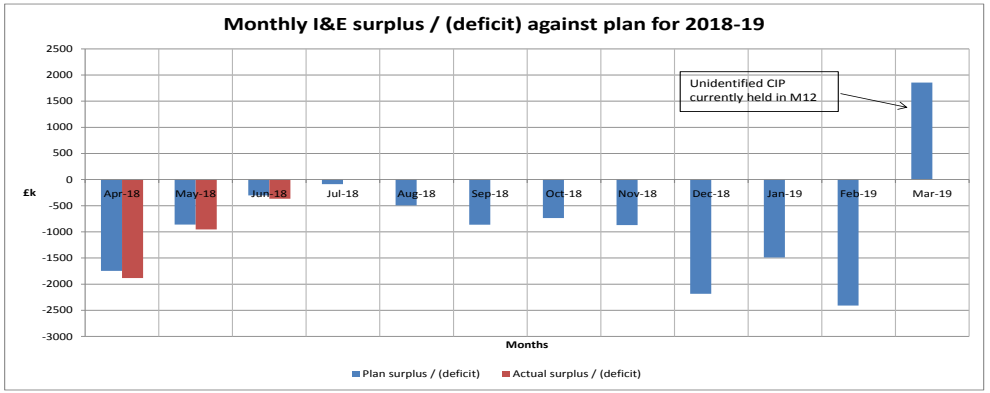
In order to achieve the control total the 2018-19 budgets include a stretch CIP of £2.8m bringing the total CIP plan to £12.2m (5%). We have utilised the 2018-19 contingency of £1.5m in order to meet this stretch CIP.

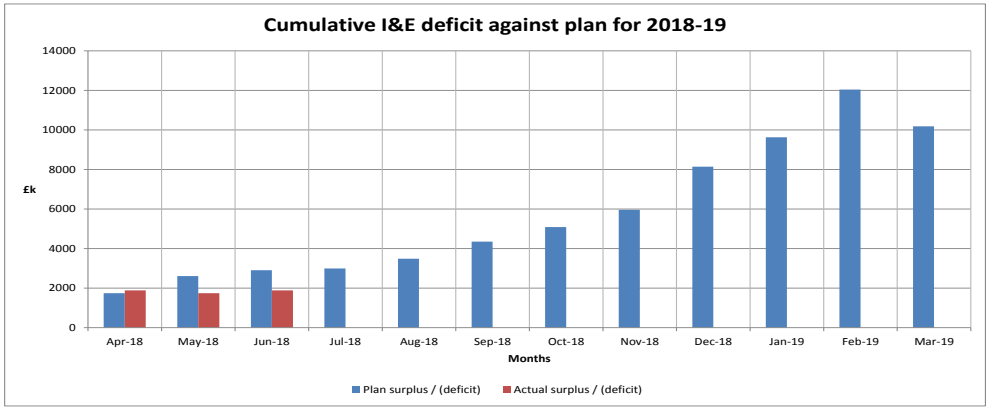
The reported I&E for June 2018 is a deficit of £366k, against a planned deficit of £301k. This results in an adverse variance of £65k in month (£251k YTD). This overspend predominantly relates to underperformance against the A&E performance and therefore PSF income being £165k below planned. We have appealed for this funding to be awarded in spite of our performance and are currently awaiting the outcome of that appeal.

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)	(301)	(366)	(65)	↓	Amber
YTD surplus / (deficit)	(2,908)	(3,159)	(251)	↑	Amber
Forecast surplus / (deficit)	(10,180)	(10,180)	0	↔	Green
EBITDA (excl STF) YTD	(489)	(1,143)	(654)	↑	Red
EBITDA (%)	(0.9%)	(2.0%)	(1.2%)	↓	Red
Clinical Income YTD	(47,305)	(47,492)	186	↓	Green
Non-Clinical Income YTD	(8,807)	(8,442)	(365)	↑	Red
Pay YTD	37,916	38,705	(789)	↑	Red
Non-Pay YTD	21,105	20,388	717	↑	Green
CIP target YTD	2,120	2,045	(75)	↑	Amber



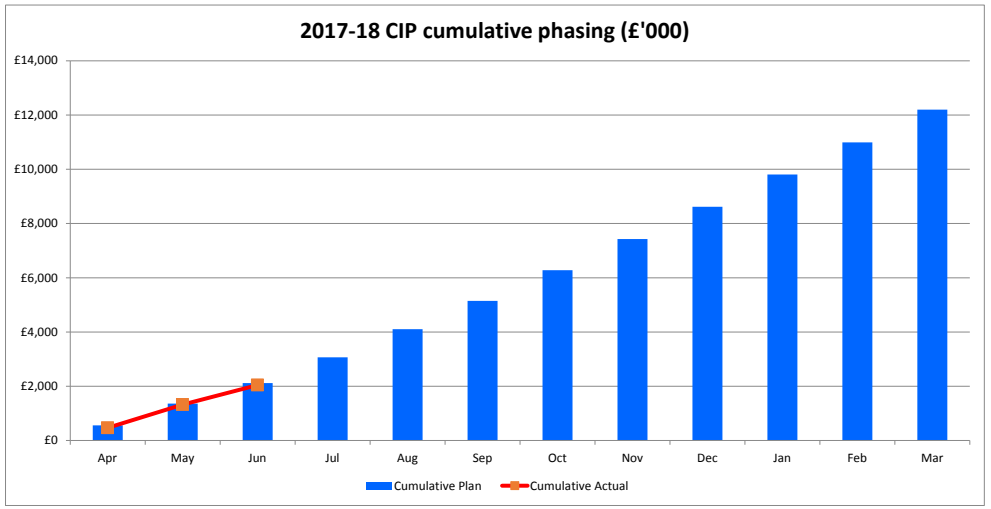


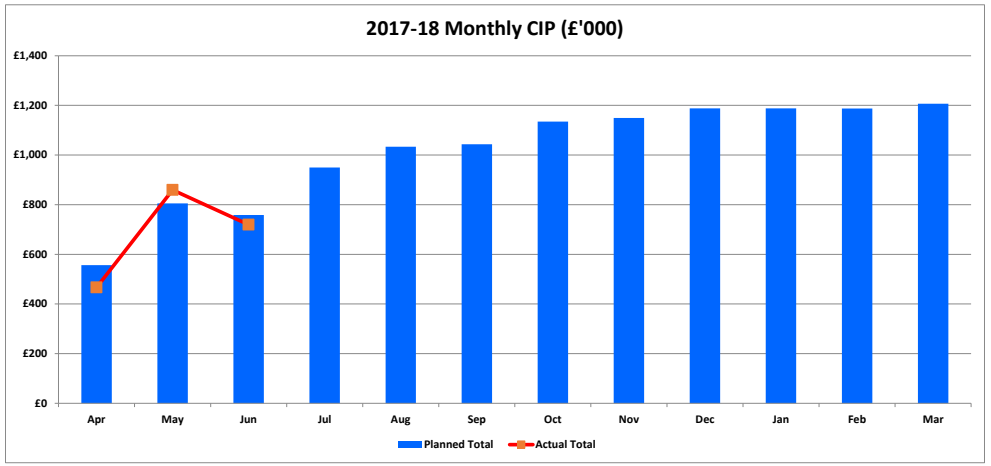


Cost Improvement Programme (CIP) 2018-19

The June position includes a target of £2,120k YTD which represents 17.4% of the 2018-19 plan. There is currently a shortfall of £75k YTD against this plan.

Recurring/Non Recurring	Summary	2018-19 Annual Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Clinical Income	652	122	98
	Activity growth	234	52	47
	Private Patients	78	20	3
	Other Income	890	136	71
	Consultant Staffing	1,004	17	-
	Nursing productivity	111	49	-
	Staffing Review	953	211	155
	Additional sessions	244	27	3
	Temporary Pay	1,022	230	240
	Agency	98	27	24
	Pay controls	20	5	-
	CNST discount	265	66	92
	Community Equipment Service	643	160	210
	Drugs	154	36	75
	Contract renegotiation	69	15	17
	Procurement	775	126	127
	Other	228	19	9
	Service Review	517	55	44
	Patient Flow	810	-	-
	Cancelled CIPs	235	20	-
Recurring Total		**9,000**	**1,393**	**1,215**
Non-Recurring	Capitalisation	1,500	375	375
	Additional sessions	268	10	10
	Contract review	105	10	33
	Other	1,327	332	412
Non-Recurring Total		**3,200**	**727**	**830**
Grand Total		**12,200**	**2,120**	**2,045**



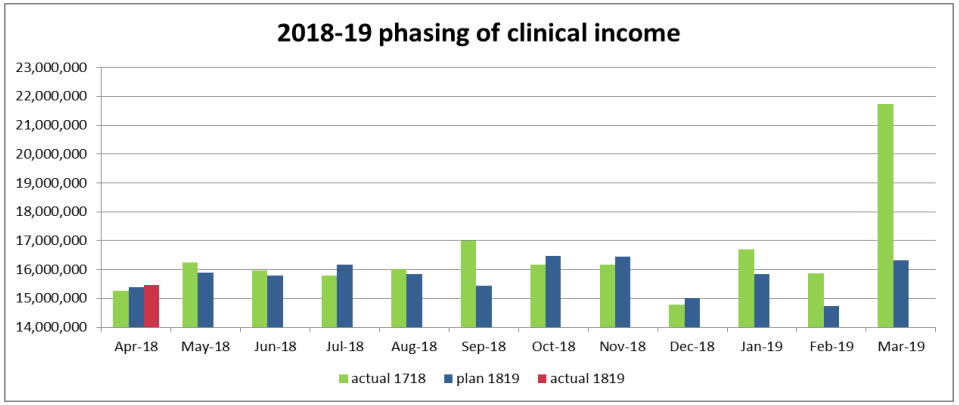


In order to deliver the Trust's control target deficit of planned deficit of £13.8m deficit in 2018-19 we need to deliver a CIP of £12.2m (5%).

FINANCE AND WORKFORCE REPORT – June 2018

Income Analysis

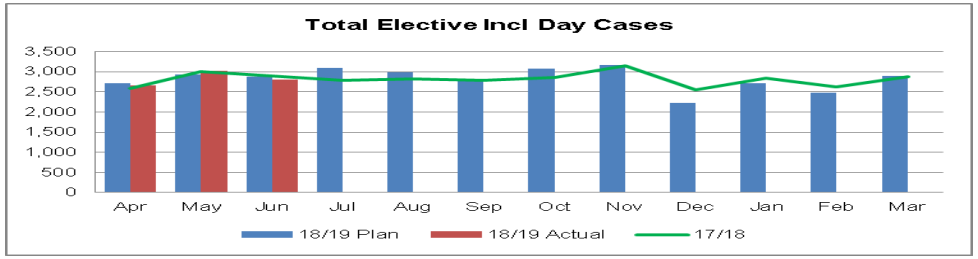
The chart below summarises the phasing of the clinical income plan for 2018-19, including Community Services. This phasing is in line with activity phasing which is how the income is recognised.

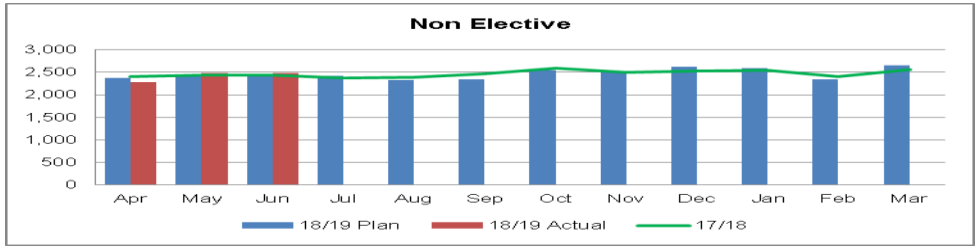


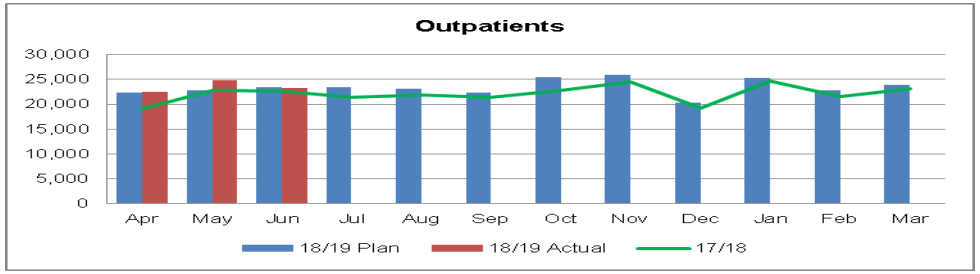
The income position was ahead of plan for June, with over performance being seen within Other Service (Neonatal Care Unit and Excluded Drugs). Inpatient activity was behind plan during June.

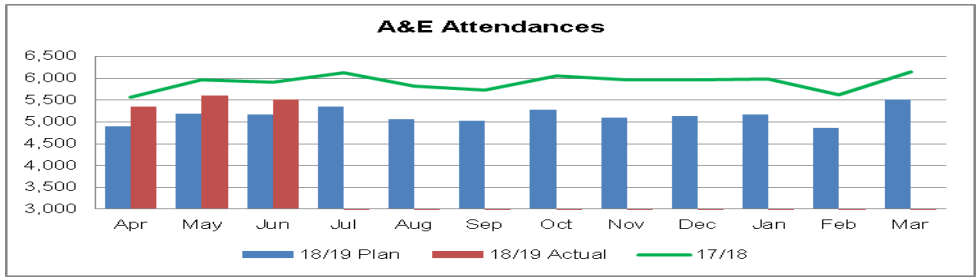
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	709	655	(54)	2,093	2,002	(91)
Other Services	2,341	2,873	532	7,212	7,970	758
CQUIN	317	310	(7)	941	933	(9)
Elective	2,946	2,709	(236)	8,750	8,140	(610)
Non Elective	5,403	5,293	(110)	16,158	16,097	(61)
Emergency Threshold Adjustment	(356)	(339)	17	(1,063)	(1,052)	11
Outpatients	2,843	2,806	(36)	8,316	8,502	186
Community	1,633	1,633	0	4,899	4,899	0
Total	**15,835**	**15,942**	**106**	**47,305**	**47,492**	**186**

Activity, by point of delivery



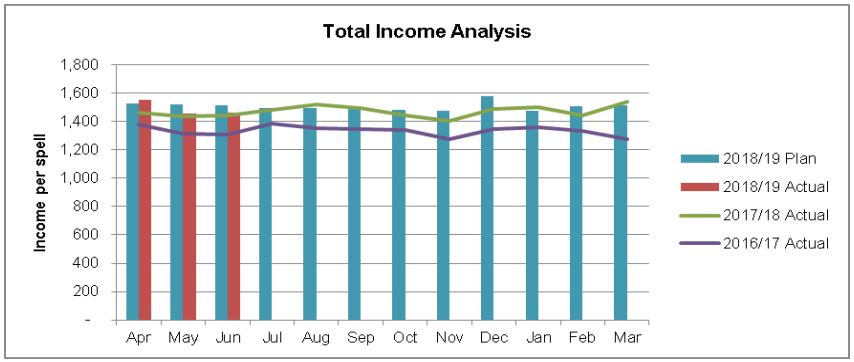


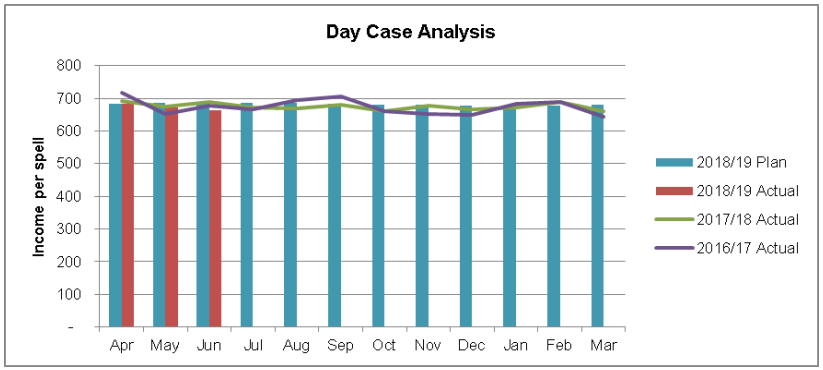


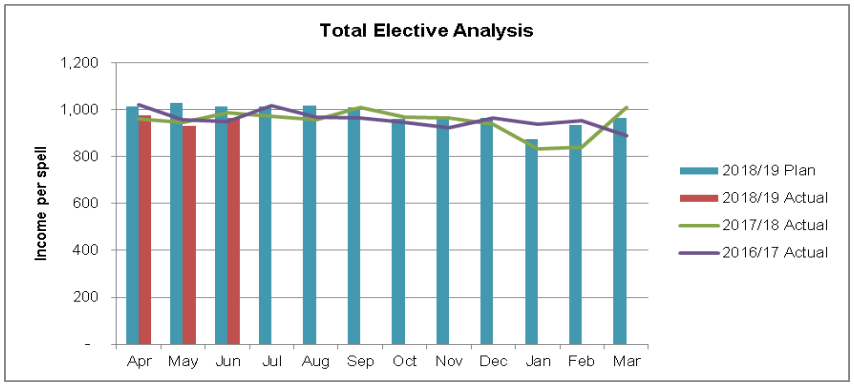


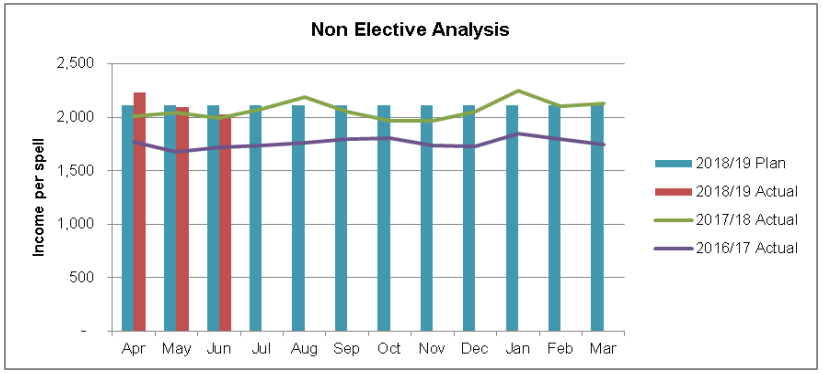
Trends and Analysis

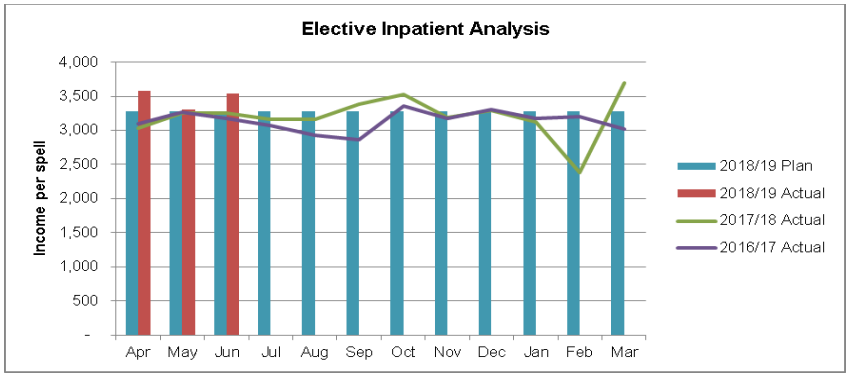
FINANCE AND WORKFORCE REPORT – June 2018

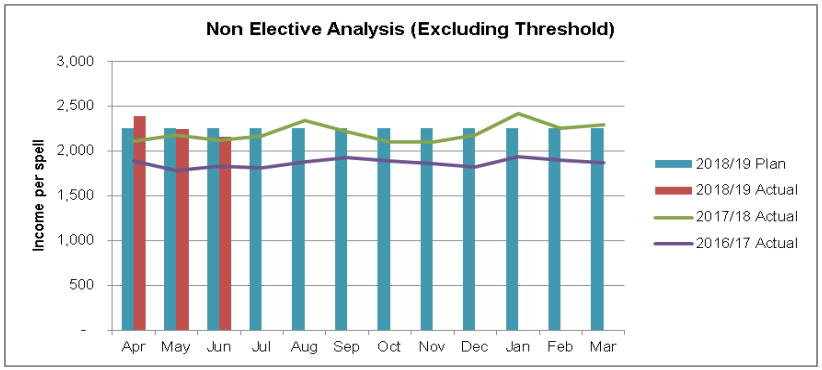












FINANCE AND WORKFORCE REPORT – June 2018

Workforce

Monthly Expenditure (£) Acute services only				
As at June 2018	Jun-18	May-18	Jun-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**11,092**	**11,109**	**11,151**	**33,367**
Substantive Staff	9,943	9,928	9,935	29,779
Medical Agency Staff (includes 'contracted in' staff)	167	76	132	374
Medical Locum Staff	224	225	229	705
Additional Medical sessions	248	298	230	845
Nursing Agency Staff	89	88	81	304
Nursing Bank Staff	231	459	162	1,037
Other Agency Staff	20	(6)	49	55
Other Bank Staff	117	104	120	367
Overtime	102	165	88	406
On Call	60	58	55	181
Total temporary expenditure	1,259	1,466	1,147	4,274
Total expenditure on pay	**11,201**	**11,394**	**11,083**	**34,052**
Variance (F/(A))	(110)	(285)	68	(685)
Temp Staff costs % of Total Pay	11.2%	12.9%	10.4%	12.6%
Memo : Total agency spend in month	276	157	262	733

Monthly Whole Time Equivalents (WTE) Acute Services only			
As at June 2018	Jun-18	May-18	Jun-17
	WTE	WTE	WTE
Budgeted WTE in month	**3,130.9**	**3,134.7**	**2,980.9**
Employed substantive WTE in month	**2771.73**	**2765.43**	**2724.3**
Medical Agency Staff (includes 'contracted in' staff)	11.48	9.43	11.13
Medical Locum	20.84	17.4	16.46
Additional Sessions	17.79	24.6	18.21
Nursing Agency	17.55	17.33	12.5
Nursing Bank	73.62	68.2	52.86
Other Agency	5.71	7.4	16.41
Other Bank	56.46	49.2	57.73
Overtime	30.59	56.39	40.19
On call Worked	7.33	7.74	8.42
Total equivalent temporary WTE	**241.4**	**257.7**	**233.9**
Total equivalent employed WTE	**3,013.1**	**3,023.1**	**2,958.2**
Variance (F/(A))	117.8	111.6	22.7
Temp Staff WTE % of Total Pay	8.0%	8.5%	7.9%
Memo : Total agency WTE in month	34.7	34.2	40.0

Sickness Rates	3.79%	3.77%	3.62%
Mat Leave	2.56%	2.13%	2.1%

Monthly Expenditure (£) Community Service Only				
As at June 2018	Jun-18	May-18	Jun-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,516**	**1,516**	**1,123**	**4,548**
Substantive Staff	1,473	1,504	1,056	4,437
Medical Agency Staff (includes 'contracted in' staff)	12	15	13	33
Medical Locum Staff	3	3	4	9
Additional Medical sessions	1	0	0	1
Nursing Agency Staff	6	9	0	26
Nursing Bank Staff	12	23	11	49
Other Agency Staff	13	17	15	44
Other Bank Staff	8	7	9	22
Overtime	6	8	4	22
On Call	3	3	1	9
Total temporary expenditure	63	85	57	215
Total expenditure on pay	**1,536**	**1,589**	**1,114**	**4,652**
Variance (F/(A))	(20)	(73)	9	(104)
Temp Staff costs % of Total Pay	4.1%	5.4%	5.1%	4.6%
Memo : Total agency spend in month	30	42	28	103

Monthly Whole Time Equivalents (WTE) Community Services Only			
As at June 2018	Jun-18	May-18	Jun-17
	WTE	WTE	WTE
Budgeted WTE in month	**485.56**	**485.56**	**380.57**
Employed substantive WTE in month	**473.95**	**465.73**	**344.1**
Medical Agency Staff (includes 'contracted in' staff)	0.74	0.42	1.0
Medical Locum	0.35	0.35	0.4
Additional Sessions	0.00	0.00	0.0
Nursing Agency	1.01	1.96	0.0
Nursing Bank	3.78	3.95	3.8
Other Agency	4.41	3.93	5.4
Other Bank	3.02	2.23	2.3
Overtime	2.02	2.43	2.1
On call Worked	0.04	0.00	0.0
Total equivalent temporary WTE	**15.37**	**15.27**	**14.9**
Total equivalent employed WTE	**489.32**	**481**	**359.0**
Variance (F/(A))	-3.76	4.56	21.6
Temp Staff WTE % of Total Pay	3.1%	3.2%	4.2%
Memo : Total agency WTE in month	6.2	6.3	6.4

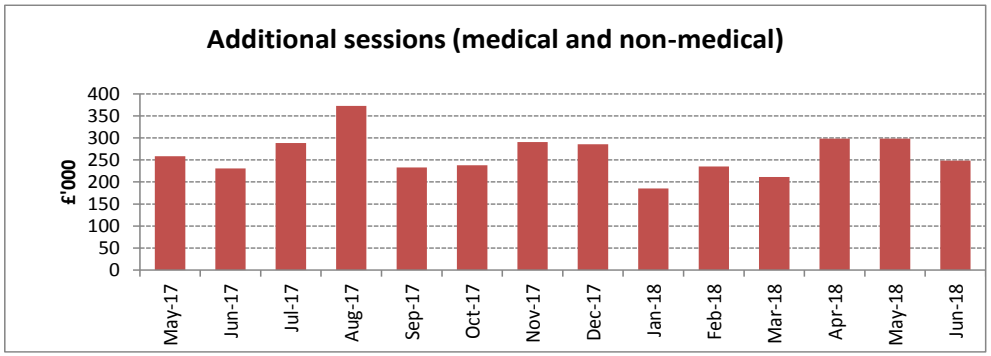
Sickness Rates (Feb / Jan)	3.67%	3.62%	3.55%
Mat Leave	3.11%	1.13%	1.1%

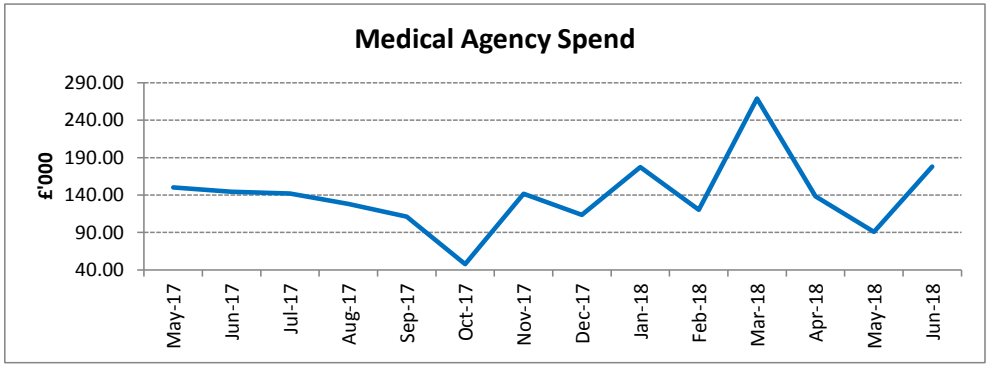
* Note the Acute tables includes Collaborative Procurement Hub staff on WSH Contracts
* Note that pay costs and WTE are gross, ie do not net off income or WTE relating to salary costs recharged to other organisations.

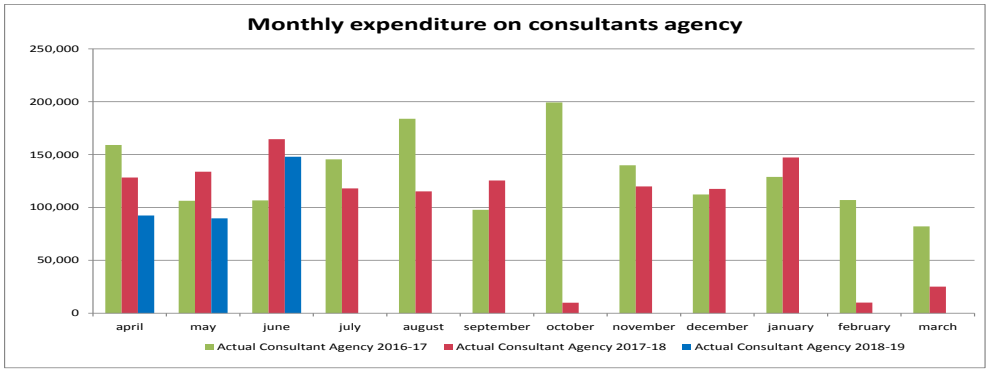
FINANCE AND WORKFORCE REPORT – June 2018

Pay Trends and Analysis

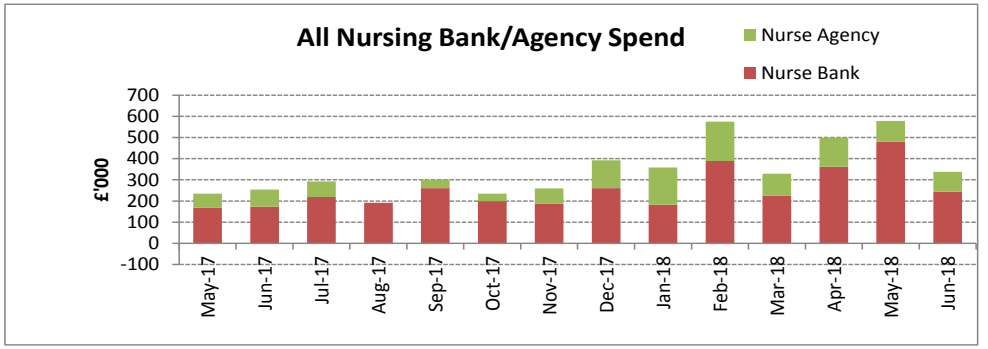
The Trust spent £130k more than budget on pay in June (£789k overspent YTD)

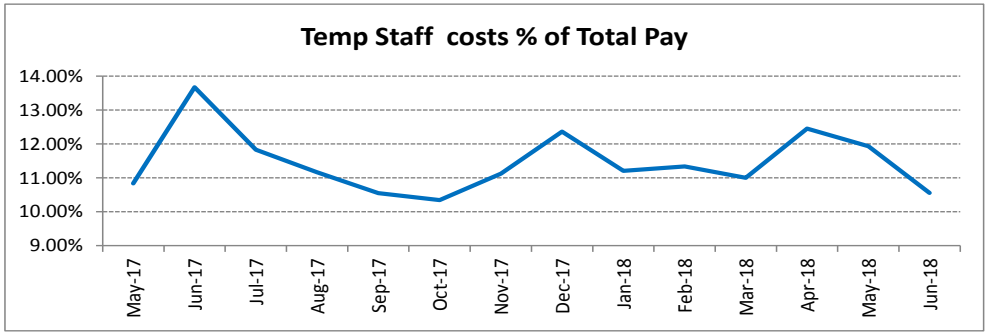






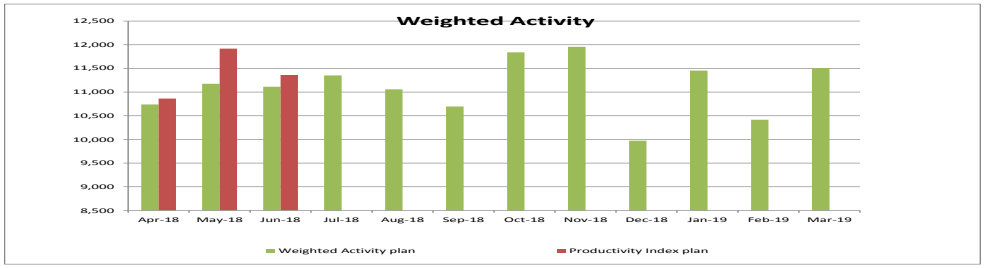
Medical Staff Agency Costs by Speciality	M3 - YTD £'000
Urology	123.5
Anaesthetics	97.1
Cardiology	86.0
Gastroenterology	73.5
Eau Medical Staff	69.1
Medicine - Junior Doctors	65.3
Ophthalmology	61.7
Medicine - Consultants	56.5
Obstetrics	52.2
Trauma & Orthopaedic	26.4
Xray - Wsh	60.2
General Surgery	40.2
Histopathology	34.5
E.N.T.	32.3
Diabetes	22.0
Dermatology	20.4
Plastic Surgery	18.4
Total	**939.1**

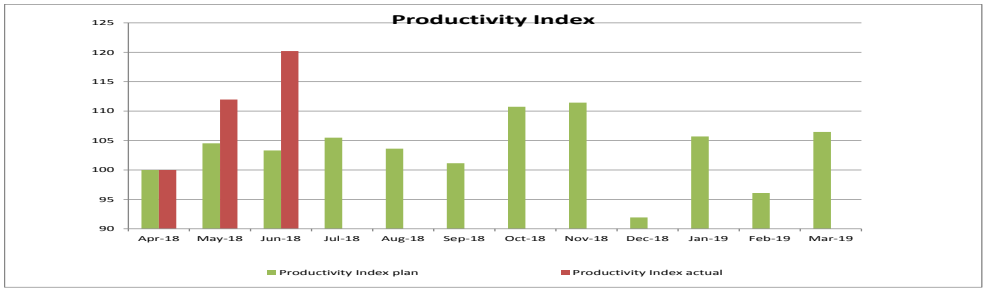




FINANCE AND WORKFORCE REPORT – June 2018

Staffing Productivity





Staffing and recruitment

Staffing levels for winter 2018-19 are predicated on the following assumptions

- Turnover is as planned
- Bay based nursing service changes as planned
- New winter capacity opened as planned
- Recruitment is as planned (especially overseas)
- Maximum 18.3 wte registered and 35.3 wte unregistered bank staff
- Maximum of 24.3 wte registered agency staff used

Recruitment progress - 2018

The tables below present progress against our recruitment target, adjusting for leavers and starters

Registered Nurses				
	Leavers 2018	Starters 2018	% Turnover	
			Predicted (Based on 2017)	Actual 2018
January	1	3	0.84%	0.26%
February	2	2	2.15%	0.52%
March	4	6	0.88%	1.03%
April	1	5	0.44%	0.26%
May	2	0	0.67%	0.52%
June	2	2	1.59%	0.53%

Nursing Assistants				
	Leavers 2018	Starters 2018	% Turnover	
			Predicted (Based on 2017)	Actual 2018
January	2	8	1.51%	0.53%
February	4	5	1.00%	1.07%
March	5	6	1.04%	1.35%
April	2	8	1.54%	0.54%
May	1	0	0.78%	0.27%
June	3	12	0.26%	0.80%

Registered Nurses	
Planned Recruitment for 2018*	132.8
March 2018 - Current position against December's plan	128.8
April 2018 - Current position against December's plan	124.8
May 2018 - Current position against December's plan	126.8
June 2018 - Current position against December's plan	126.8

Nursing Assistant	
Planned Recruitment for 2018*	99.9
March 2018 - Current position against December's plan	91.9
April 2018 - Current position against December's plan	85.9
May 2018 - Current position against December's plan	86.9
June 2018 - Current position against December's plan	77.9

The following table shows the progress against the posts to which we are recruiting

June	July	August
Apprentice Nurse Interviews (4 & 5 June)	9 x conditional offers made to NA positions	6 x Philippine cohort Nurses potentially starting
3 x Philippine cohort nurses start		6 x External Apprentice Nurses commencing 6 August 2018
9 x conditional offers made to NA positions		
112 x conditional offers - overseas recruitment		

September	October	November
5 x Philippine cohort Nurses potentially starting	2 x Philippine cohort Nurses potentially starting	2 x Philippine cohort Nurses potentially starting
14 x Newly qualified Nurses to receive their pins and commence as Band 5's		
11 x Internal Apprentice Nurse commencing 3 September 2018		

Interviews / Philippine Cohort estimated start date	Conditional offers made /Philippine Cohort potential start dates	Confirmed appointments

FINANCE AND WORKFORCE REPORT – June 2018

Summary by Directorate

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Jun-18 Budget £k	Jun-18 Actual £k	Jun-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	(5,797)	(5,647)	(150)	(17,093)	(17,267)	174
Pay Costs	3,419	3,576	(156)	10,376	10,834	(458)
Non-pay Costs	1,336	1,379	(43)	4,101	4,147	(46)
Operating Expenditure	**4,755**	**4,955**	**(199)**	**14,477**	**14,981**	**(504)**
SURPLUS / (DEFICIT)	**1,041**	**692**	**(349)**	**2,616**	**2,286**	**(330)**
SURGERY						
Total Income	(5,091)	(4,948)	(144)	(15,023)	(14,861)	(162)
Pay Costs	2,937	2,925	13	8,813	8,955	(143)
Non-pay Costs	1,138	1,166	(28)	3,406	3,430	(24)
Operating Expenditure	**4,075**	**4,091**	**(15)**	**12,219**	**12,385**	**(166)**
SURPLUS / (DEFICIT)	**1,016**	**857**	**(159)**	**2,804**	**2,476**	**(328)**
WOMENS and CHILDRENS						
Total Income	(2,008)	(1,977)	(31)	(5,997)	(5,826)	(171)
Pay Costs	1,122	1,126	(4)	3,366	3,440	(74)
Non-pay Costs	159	165	(6)	479	477	2
Operating Expenditure	**1,281**	**1,290**	**(10)**	**3,846**	**3,917**	**(72)**
SURPLUS / (DEFICIT)	**728**	**687**	**(41)**	**2,151**	**1,908**	**(243)**
CLINICAL SUPPORT						
Total Income	(834)	(825)	(8)	(2,467)	(2,482)	15
Pay Costs	1,341	1,259	82	4,005	3,913	92
Non-pay Costs	957	820	136	2,905	2,839	66
Operating Expenditure	**2,298**	**2,079**	**218**	**6,909**	**6,752**	**158**
SURPLUS / (DEFICIT)	**(1,464)**	**(1,254)**	**210**	**(4,443)**	**(4,270)**	**173**
COMMUNITY SERVICES						
Total Income	(3,195)	(3,172)	(22)	(9,428)	(9,371)	(57)
Pay Costs	1,987	1,989	(3)	5,968	6,035	(67)
Non-pay Costs	1,100	1,024	77	2,607	2,569	38
Operating Expenditure	**3,087**	**3,013**	**74**	**8,575**	**8,604**	**(29)**
SURPLUS / (DEFICIT)	**108**	**159**	**52**	**853**	**767**	**(86)**
ESTATES and FACILITIES						
Total Income	(382)	(344)	(38)	(1,145)	(1,066)	(79)
Pay Costs	752	742	10	2,255	2,210	44
Non-pay Costs	617	615	2	1,828	1,653	175
Operating Expenditure	**1,368**	**1,357**	**11**	**4,083**	**3,864**	**219**
SURPLUS / (DEFICIT)	**(987)**	**(1,013)**	**(26)**	**(2,938)**	**(2,798)**	**140**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	(2,371)	(2,568)	197	(5,840)	(5,060)	(778)
Pay Costs	1,050	1,120	(71)	3,134	3,318	(184)
Non-pay Costs (net of contingency and reserves)	1,076	1,170	(94)	3,690	2,872	819
Finance & Capital	989	773	217	2,967	2,400	567
Operating Expenditure	**3,115**	**3,063**	**52**	**9,791**	**8,590**	**1,202**
SURPLUS / (DEFICIT)	**(743)**	**(494)**	**249**	**(3,952)**	**(3,529)**	**422**
TOTAL (including penalties, contingency and reserves)						
Total Income	(19,678)	(19,482)	(196)	(56,992)	(55,934)	(1,057)
Contract Penalties	0	0	0	0	0	0
Pay Costs	12,608	12,737	(130)	37,916	38,705	(789)
Non-pay Costs	6,382	6,339	44	19,017	17,987	1,029
Finance & Capital	989	773	217	2,967	2,400	567
Operating Expenditure (incl penalties)	**19,979**	**19,848**	**131**	**59,900**	**59,093**	**807**
SURPLUS / (DEFICIT)	**(301)**	**(366)**	**(65)**	**(2,908)**	**(3,159)**	**(251)**

*Note that Cross Cutting CIP's and Growth funding have not yet been fully allocated to the divisions.

Medicine (Nicola Cottington)

The division was £349k behind plan for the month, (£330k YTD).

Contract income for the month was £104k behind plan, though remains ahead for the year to date by £85k.ED attendances were 6.6% above plan in the month and yet income was £54k less than target. The GP streaming fill rates (8.8 patients per day) are only half of the plan.

Expenditure was overspent by £245k, the majority of which was on Medical Staffing costs (£230k), with nursing cost underspent by £85k. Medical Staffing faced a number of challenges, from GP expecteds in AMU, Middle grade shortages in ED and RTT demands in Cardiology. This was compounded by sickness/vacancy issues in Haematology, which may take some time to resolve.

Non pay was overspent by £42k due to patient transport, mobile angiography charges and security.

CIP performance continues below plan (£94k versus a planned £127k) with the delayed in the biosimilars proposal being the main cause. NHSE have signalled that this change in practice should commence in October 2018, with a possible mitigation being a mandated switch for Adalimumab, rather than a gradual switch. Some new schemes have been added to the pipeline to help improve the position.

Surgery (Simon Taylor)

The division has underperformed by £159k in month (£328k YTD).

Clinical income under achieved against plan by £144k in the month. Critical care overachieved by £77k against plan, Elective care by £127k and Daycases by £62k. Orthopaedics activity was below plan by £136k. All other specialties except Vascular also fell short of the plan.

Pay is underspent by £13k. The underspend relates to Admin and Clerical (£10k) and Nursing (£6k).

Non-pay is overspent by £28k. This is largely due to a correction on Leases, due to issues with lease invoices received as well as Medical and Surgical consumables in ETC. Non pay would have been more over spent if Surgery had been able to fully deliver the Elective plan as growth funding has yet to be allocated.

CIP has overachieved by £3k YTD, mainly due to non-recurrent savings.

Women and Children's (Rose Smith)
In June the division is behind plan by £41k (£243k YTD.

Income reported £31k behind plan in-month and is £171k behind plan YTD. In month both inpatient and outpatient activity were behind plan whilst YTD inpatient activity is behind the poor performance. However, YTD antenatal activity has been higher than expected which implies that the Trust can expect higher volumes of inpatients over the coming months.

Pay reported a £4k overspend in-month and is £74k overspent YTD. 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. Year to date, the medical staffing issues in Obstetrics & Gynaecology have been a persistent issue.

Non pay reported a £6k overspend in-month and a £2k underspend YTD. The YTD underspend reflects the fact that inpatient activity has been lower than expected in the first three months of the financial year.

Clinical Support (Rose Smith)
In June, the division underspent by £210k (£173k YTD).

Income for Clinical Support reported £8k behind plan in-month and is £15k ahead of plan YTD. In month, the Radiology Department saw a higher number of direct access and breast screening patients. This has also dictated the year to date position.

Pay is £82k underspent in-month and is £92k underspent YTD. In month, the majority of the underspend relates to non-recurrent vacancies for consultants in Pathology and vacancies for Allied Health Professionals in Radiology. This performance is not likely to continue in future months as consultants have been appointed to the vacant posts in Pathology and plans are in place to recruit Allied Health Professionals for Radiology. Year to date, the majority of the underspend relates to resolving an estimated bill for Ultrasound agency staff in the Trust's favour. This benefit is also non-recurrent in nature, so the favourable performance against the year to date budget is not likely to continue.

Non pay reported a £136k underspend in-month and is £66k underspent YTD. In month, the Pharmacy Service made fewer stock adjustments and the Radiology Service resolved the billing for the PACS system in the Trust's favour. The smaller YTD underspend reflects the fact that, despite the in-month performance, the underlying pressures from the HODS element of the Pathology contract continue to put pressure on the division's budget. If the negotiations concerning the HODS element of the pathology contract are not resolved in the Trust's favour, the budget for the NEESPS contract will be overspent in the coming months.

Community Services (Dawn Godbold)
The division reported a £52k underspend in month (£86k overspent YTD).

Overall income reported a £22k under performance in month and £56k under performance YTD. £20k relates to the Integrated Therapies Dietetic Service as well as a credit note for £13k issued to IHT to relating to last year's estimated activity within Community Equipment Service. This under-recovery has been offset against additional income to cover additional staffing within the Paediatric Complex Nursing Team.

Pay reported a £3k over spend in month and £67k overspend YTD. Main overspends include:

- Ward overspends on both Glastonbury and Rosemary, due to
  - additional hours and bank being used to cover staff sickness, phased returns and vacancies,
  - 3 additional beds opening on Rosemary Ward in June resulted in overspends on Rosemary Ward and Glastonbury Court of £7k and £4k respectively.
- Additional recruitment with the Paediatric Complex Nursing Team, at a cost of £12k, (CCG funded)

Non pay reports a £77k underspend in month and £38k underspend YTD. This is due to a one off credit of £97k with Central Equipment Service against April and May variable invoices.

Use of Resources (UoR) Rating

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

The key features of the UOR ratings are as follows:

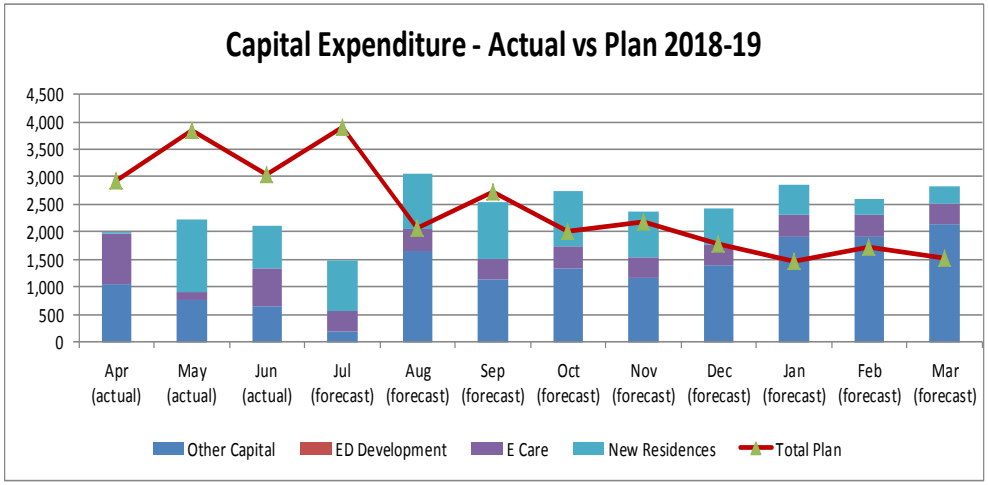
- 1 is the highest score and 4 is the lowest
- The I&E margin ratio is based on a control total basis rather than normalised surplus (deficit).
- The Agency rating measures expenditure on agency staff as a proportion of the ceiling set for agency staff. A positive value indicates an adverse variance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

Metric	Value	Score
Capital Service Capacity rating	-0.803	4
Liquidity rating	-15.364	4
I&E Margin rating	-5.60%	4
I&E Margin Variance rating	1.60%	1
Agency	-41.22%	1
Use of Resources Rating after Overrides		**3**

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

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

Capital Progress Report



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	Actual	Actual	Actual	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	131	675	380	380	380	380	380	380	380	380	384	5,146
ED Development	0	0	0	0	0	0	0	0	0	0	0	0	0
New Residences	37	1,329	773	901	1,027	1,027	1,027	819	663	559	300	313	8,774
Other Schemes	1,047	760	647	184	1,658	1,120	1,346	1,163	1,382	1,916	1,916	2,125	15,266
Total / Forecast	1,999	2,220	2,096	1,465	3,065	2,527	2,753	2,362	2,425	2,855	2,596	2,822	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 reconfiguration of ED has been removed from the 2018/19 plan because a bid is being submitted for Wave 4 capital funding which, if successful, will be available during 2019/20

At this point in the year the phasing of schemes is subject to change. Expenditure on e-Care for the year to date is £1,722k with a forecast for the year of £5,144k.

The forecast for the year is behind the plan submitted to NHSI so shows a favourable variance. This is because the timing of the implicit finance lease equipment additions in radiology and endoscopy has changed, there is slippage on Residences compared to plan plus most of the MModal (voice recognition) cost was incurred in 2017/18 instead of 2018/19. The next phase of the roof preplacement programme commenced slightly later than the original plan forecast.

The forecasts for all projects have been reviewed by the relevant project managers. All of the schemes that are still due for completion during the year and therefore the expenditure will catch up with the plan later in the financial year. Therefore there are no significant financial risks to the budgets reported. Year to date the overall expenditure of £6,315k is below the plan of £9,818k.

Statement of Financial Position at 30th June 2018

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2018 * £000	Plan 31 March 2019 £000	Plan YTD 30 June 2018 £000	Actual at 30 June 2018 £000	Variance YTD 30 June 2018 £000
Intangible assets	23,852	27,909	25,033	25,546	513
Property, plant and equipment	94,170	111,399	98,647	97,260	(1,387)
Trade and other receivables	3,925	3,925	3,925	3,925	0
Other financial assets	0	0	0	0	0
Total non-current assets	**121,947**	**143,233**	**127,605**	**126,730**	**(875)**
Inventories	2,712	2,700	2,900	2,680	(220)
Trade and other receivables	21,413	19,500	22,050	21,071	(979)
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	3,601	1,050	1,050	2,239	1,189
Total current assets	**27,726**	**23,250**	**26,000**	**25,990**	**(10)**
Trade and other payables	(26,135)	(27,498)	(26,038)	(25,646)	392
Borrowing repayable within 1 year	(3,114)	(3,357)	(3,164)	(3,083)	81
Current ProvisionsProvisions	(94)	(26)	(26)	(94)	(68)
Other liabilities	(963)	(1,000)	(5,500)	(4,059)	1,441
Total current liabilities	**(30,306)**	**(31,881)**	**(34,728)**	**(32,882)**	**1,846**
Total assets less current liabilities	**119,367**	**134,602**	**118,877**	**119,838**	**961**
Borrowings	(65,391)	(90,471)	(68,912)	(69,025)	(113)
Provisions	(124)	(158)	(192)	(124)	68
Total non-current liabilities	**(65,515)**	**(90,629)**	**(69,104)**	**(69,148)**	**(44)**
Total assets employed	**53,852**	**43,973**	**49,773**	**50,690**	**917**
Financed by					
Public dividend capital	65,803	66,103	65,803	65,803	(0)
Revaluation reserve	8,021	8,021	8,021	8,021	0
Income and expenditure reserve	(19,974)	(30,152)	(24,051)	(23,133)	918
Total taxpayers' and others' equity	**53,850**	**43,972**	**49,773**	**50,690**	**917**

Non-Current Assets

There is some slippage on the capital programme mainly on Residences and medical equipment.

Trade and Other Receivables

These have decreased by £0.5m in June and are ££1.0m below plan. Included within the total is £5.3m for 2017/18 Sustainability and Transformation Fund which has since been received in July.

Cash

Cash is £1.1m higher than plan at the end of June and loan drawdowns continue to be delayed as long as possible.

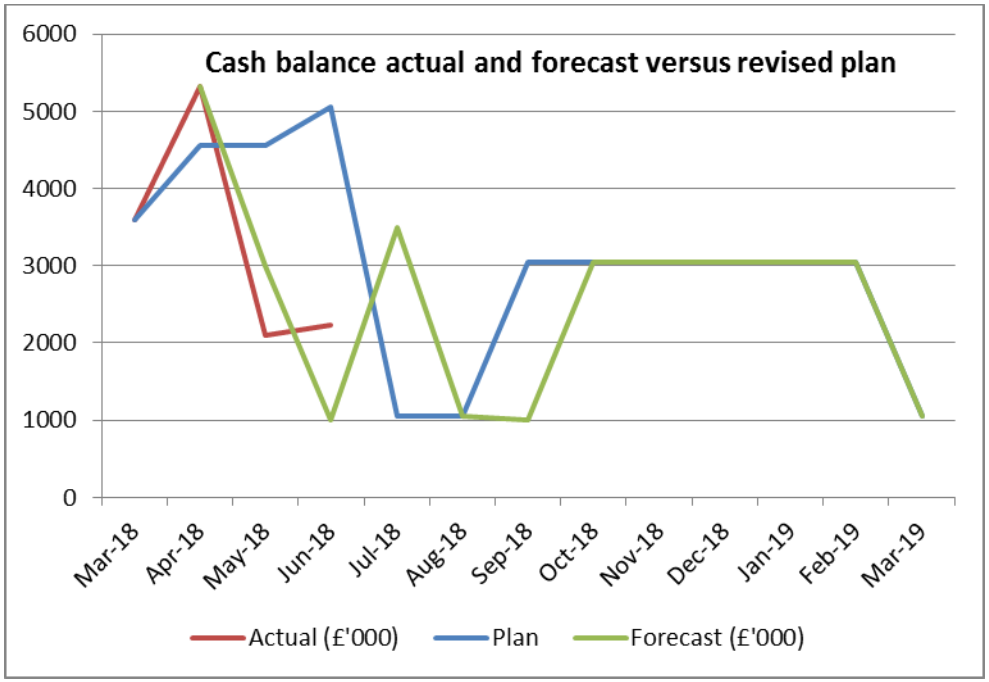
Other liabilities

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 lower than planned due to the final negotiations of the timing of payments from the CCG not being finalised until July.

Income and Expenditure Reserve

As the I & E deficit is better than planned there is a favourable variance on the I % E Reserve of £0.9m.

Cash Balance Forecast for the year



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

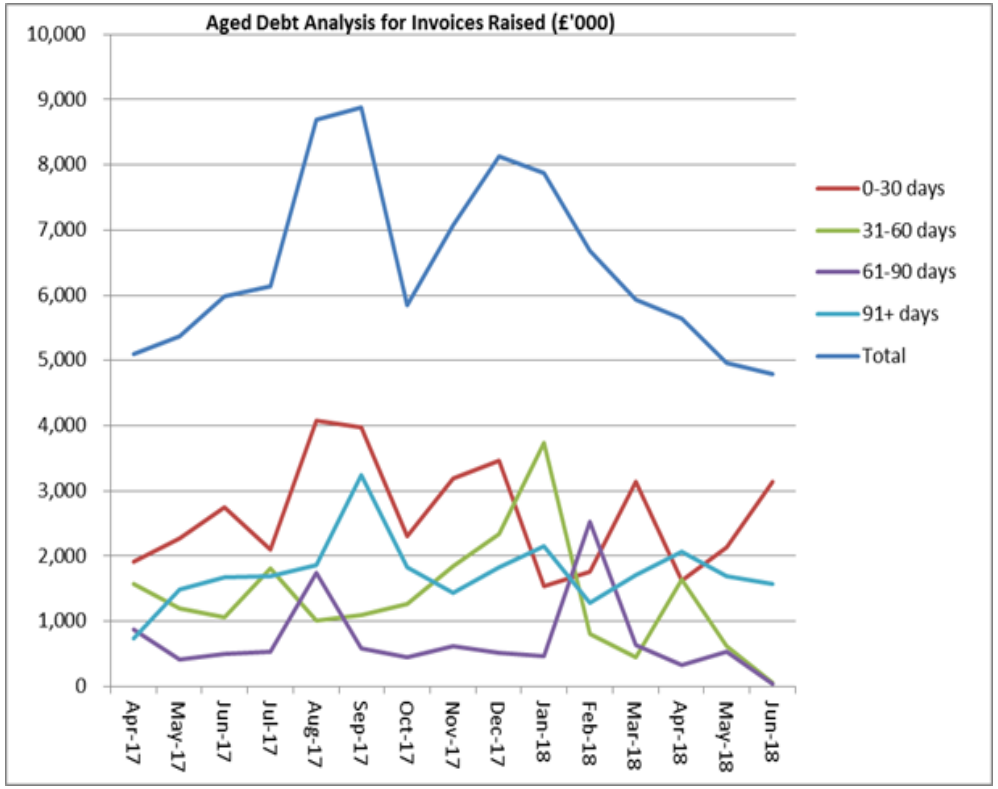
The Trust is required to keep a minimum balance of £1 million.

The 2017/18 STF (£5.3m) has been paid earlier than expected in July. The timing of agreement from DH on the planned borrowing for capital is still uncertain and a significant risk. It is assumed the cash reserves will reduce until the capital loan or PDC funding is 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 £0.2m in June.

There has been a significant debt 31-90 days old but more recent debt 0-30 days has increased by £1.0m.

The overall level of invoices raised but unpaid is lower than at any time since March 2017.

10:35 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 – 27th July 2018

Agenda item:	12			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Sinead Collins, Clinical Business Manager			
Date prepared:	19 July 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 June's and progress of nurse staffing review made below.

Observations

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
A&E	4 medication errors	High agency & bank use. High RN & NA vacancy. High amount of overtime. High sickness
F7	3 falls with harm	High agency & bank use. High RN vacancy.
F8	5 medication errors	High agency & bank use. High amount of overtime.
Theatres	-	High RN vacancy & bank use. High amount of sickness. High amount of overtime
Recovery	-	High sickness
DSU	-	High sickness & bank use.
G1	-	High bank use.
G3	4 falls with harm & 4 falls with harm	High bank use & NA vacancy.
G4	3 falls with harm	High bank use. High amount of overtime. High sickness
G5	-	High agency & bank use. High RN vacancy. High amount of overtime
G8	-	High bank & agency use. High sickness. High RN & NA vacancy.
F1	-	High bank use & RN vacancy. High amount of overtime
F3	-	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 & bank use. High RN vacancy. High amount of overtime.
F9	4 falls with harm	High agency & bank use. High RN & NA vacancy. High amount of overtime. High sickness.
F10	-	High bank use. High RN vacancy. High amount of overtime. High sickness.
Maternity	5 medication errors on F11	High bank use & sickness. High midwife vacancy.
F12	-	High agency & bank use. High sickness.
F14	-	High bank use.
Kings Suite	-	High bank use. High amount of overtime. High sickness.
Rosemary Ward	4 falls with harm	High bank use & amount of overtime.

Vacancies – In West Suffolk Hospital, there are significant vacancies in registered staff, and is 100.52 WTE and there is an unregistered vacancy of 31.85WTE. The registered figure is worse than last month, while unregistered figure has improved. HR and operations are working on different method to recruit and retain nursing staff and planning for winter pressures.
The Admission Prevention Service has considerable vacancies and has resulted in the service hours being reduced. Action is being taken to improve the situation

Roster effectiveness – Out of 26 areas, 16 are over the Trust standard of 20% (Day surgery unit & ward are counted as one area). This is 10 areas more than May, which could be explained due to rise in sickness and annual leave.
We don't collect this information in the community

Sickness – Out of 27 areas, 17 are over the Trust Standard of 3.5% (seven more than last month) (Day surgery unit & ward are counted as one area).
In the community, 5 out of the 8 areas are over the Trust Standard (same as last month).

Updates in June

Some information sources have switch this month:
- CHPPD calculated has been altered to include unregistered care and explains the increase in number compared to previous months.
- Unify do not require the fill rate for Theatres, DSU and MTU, and to stream line the process, we have removed from this dashboard as well

Community vacancy figures may not be accurate for a few areas due to information not provided by the local teams. It has been agreed to put figures at zero due to this but the issue has been escalated

Community Children's establishment is being reviewed.

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Jun-18			Establishment for the Financial Year 2017/18						Data for June 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	111.5%	84.3%	123.7%	103.8%	10.42%	7.45%	365	-8.13	-4.20	6.20%	N/A	24.80%	N/A	4	0
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	68.6%	71.2%	106.8%	96.0%	8.64%	5.13%	93	-10.20	-1.35	3.60%	6.90	15.60%	1	2	3
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	98.4%	86.3%	90.8%	142.3%	17.61%	3.34%	172	-1.40	2.36	2.50%	13.2	23.00%	0	5	2
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	N/A	N/A	N/A	N/A	0.40%	0.00%	0	-3.19	0.00	2.20%	38.30	17.40%	1	3	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	N/A	N/A	N/A	N/A	4.26%	0.00%	416	-7.94	-1.60	10.80%	N/A	27.80%	0	0	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	147.3%	89.6%	71.1%	N/A	2.37%	0.00%	12	-0.30	-0.10	5.80%	N/A	23.30%	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	52.06	78.00%	22.00%	N/A	1 - 1.5	N/A	N/A	N/A	N/A	N/A	2.77%	0.00%	0	-1.50	-1.00	10.10%	N/A	27.10%	0	0	0
	Day Surgery Wards													12.89%	0.00%	4	0.00	0.10	5.80%		26.10%			
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	99.6%	89.7%	74.8%	N/A	2.65%	0.00%	66	-0.60	-0.70	3.50%	14.3	17.70%	0	0	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	113.6%	95.3%	139.0%	N/A	4.82%	0.00%	79	0.57	2.00	4.40%	10.3	23.40%	0	2	1
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	94.2%	85.8%	92.6%	99.0%	14.53%	0.68%	57	1.40	-5.50	2.90%	5.4	18.10%	2	4	4
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	81.4%	85.7%	120.7%	108.6%	17.88%	0.00%	248	-2.93	-2.94	8.50%	6.5	25.00%	2	1	3
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	81.7%	89.1%	97.7%	109.0%	10.43%	2.83%	264	-3.81	-2.93	3.50%	5.5	18.70%	2	1	0
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	63.7%	78.3%	117.4%	97.5%	17.22%	12.94%	90	-11.22	-3.89	10.30%	7.2	25.10%	1	0	1
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	122.0%	110.9%	103.3%	N/A	22.90%	0.00%	107	-5.11	1.60	3.60%	12.2	21.40%	N/A	0	N/A
WSFT	F3	Trauma and Orthopaedics	34	40.47	59.07%	40.93%	48.48	7	11	82.7%	89.9%	150.4%	106.8%	7.05%	2.58%	518	-4.60	-2.70	3.10%	6.3	21.10%	1	0	0
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	90.1%	93.4%	108.3%	204.2%	15.50%	8.43%	93	-3.83	-1.90	4.20%	9.2	19.10%	0	1	1
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	95.4%	100.0%	93.4%	113.1%	5.36%	0.49%	81	-1.90	-0.93	1.80%	6.3	18.50%	0	3	1
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	84.8%	88.4%	112.4%	113.6%	4.23%	2.34%	627	-5.20	-1.77	3.40%	5.3	18.50%	0	2	0
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	64.2%	85.4%	89.3%	123.9%	16.13%	2.33%	278	-10.51	-3.00	5.70%	5.7	18.90%	0	1	4
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	82.4%	70.6%	95.6%	95.6%	11.73%	0.26%	109	-6.50	-2.50	10.90%	7.3	24.50%	0	0	2
WSFT	F11	Maternity	29	61.55	72.14%	27.86%	N/A	7.25	14.5	110.0%	89.3%	87.2%	64.5%	11.84%	0.00%	45	-7.32	0.70	5.40%	N/A	20.80%	0	1	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms					1	1													0	0	0
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre					1 - 2	1 - 2													0	1	0
WSFT	F12	Infection Control	8	16.42	68.59%	31.41%	9.61	4	4	77.7%	64.7%	37.5%	123.0%	10.41%	1.76%	12	-2.60	0.10	6.50%	9.2	22.80%	0	0	0
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	98.8%	98.4%	N/A	N/A	8.92%	0.00%	89	-1.10	-0.40	3.60%	12.3	26.40%	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	N/A	N/A	N/A	N/A	0.00%	0.00%	0	-0.20	0.00	0.50%	N/A	15.50%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	119.0%	93.0%	30.1%	29.0%	2.04%	0.00%	32	-1.20	-1.40	2.80%	29.4	19.40%	N/A	0	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	120.1%	100.0%	96.9%	84.9%	4.63%	0.00%	157	-0.10	-0.70	4.90%	6.60	22.60%	0	1	0
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	109.4%	92.9%	99.8%	110.3%	6.28%	0.0%	220	-1.10	0.80	12.30%	4.80	28.80%	0	0	0
										96.37% AVG	88.36% AVG	97.22% AVG	106.95% AVG	9.07% AVG	1.81% AVG	4234 TOTAL	-100.52 TOTAL	-31.85 TOTAL	5.31% AVG		21.84% 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		1240.63		We are unable to collect this information this month		To be confirmed if can measure	0.00	0.00	5.99%	No equivalent tool for community nurses	37	0	0	1
Community	Bury Rural	Community Heath Team		11.20	10.71%	89.29%				624.00					0.00	0.50	3.17%		25	4	0	0
Community	Mildenhall & Brandon	Community Heath Team		14.50	20.07%	79.93%				836.60					0.00	0.00	3.24%		31	0	0	0
Community	Newmarket	Community Heath Team		11.25	28.00%	72.00%				574.03					0.00	0.00	0.42%		17	0	0	0
Community	Sudbury	Community Heath Team		25.92	32.25%	67.75%				1084.32					3.60	0.00	5.41%		24	1	0	4
Community	Haverhill	Community Heath Team		13.20	32.05%	67.95%				757.57					4.00	0.00	4.68%		17	0	1	1
Community	Admission Prevention Service	Specialist Services		13.73	25.13%	74.87%				57.60					4.88	0.72	6.73%		1	0	0	0
Community	Children	Community Paediatrics		32.89	47.07%	52.93%				1295.12					0.00	0.00	4.27%		0	N/A	1	0
										6469.87 TOTAL		#DIV/0! AVG	#DIV/0! AVG		12.48 TOTAL	1.22 TOTAL	4.24% AVG		152 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)
	Medication errors are not always down to nursing and can be pharmacist or medical staff as well
	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
TBC	To be confirmed

Target - 3.5%

13. Mandatory training report

To ACCEPT the report

Presented by Jan Bloomfield

Board of Directors – 27th July 2018

Agenda item:	13			
Presented by:	Jan Bloomfield, Executive Director Workforce & Communications			
Prepared by:	Rebecca Rutterford, Workforce Development Manager			
Date prepared:	16th July 2018			
Subject:	Mandatory Training			
Purpose:		For information	☑	For approval

Executive summary:
Appendix A is the April 2018 Mandatory Training Report, this represents data taken from the system on 10th July 2018.
Appendix B The Recovery Plan outlines the actions currently in place to improve take up of mandatory training across the Trust in those areas below the relevant target.
Appendix C provides performance impact assessments for those areas below target, compiled by the subject matter experts for each area.
Appendix D The National CQUIN 2015-6 target for Dementia staff training states that the Trust should include quarterly reports to Provider Boards of:
• Numbers of staff who have completed the training;
• Overall percentage of staff training within each provider'.
Appendix E shows mandatory training figures for SCH Community staff. SCH Community currently records training in a system called Staff Pathways.

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

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

Previously considered by:	Mandatory Training Steering Group
Risk and assurance:	Risk to patient safety due to untrained staff. Mandatory Training recovery plan and impact assessments included.
Legislation, regulatory, equality, diversity and dignity implications	Legislation, regulatory, equality, diversity all included.

Recommendation:
Acceptance of the recovery plan to improve compliance

Increase in target

An increase in the compliance target has shown a greater number of subjects not meeting target which was expected. 6 of these subjects are only 2% away from meeting the new stretch target. Subjects which previously met target have not been included in the action plan while the size of the compliance gap and how to achieve the new target is assessed with the subject leads.

IT

Access to the e-learning system, OLM (Oracle Learning Management) continues to be problematic. Internet Explorer 11 (IE11) is due to be released to the majority of computers by autumn which should resolve the majority of performance issues. Until this time work arounds for Internet Explorer 8 to function have been developed by IT and there are fixes in place to allow staff to be able to complete their eLearning.

A meeting with the OLM account manager has been arranged to escalate the issues we have been experiencing. Investigations are also being carried out into how other regional Trusts manage their eLearning, and what other learning management systems can offer us.

New eLearning software has been purchased called Storyline by Articulate, to replace the existing PowerPoint based eLearning presentations. Articulate is compatible with most learning management systems including OLM and the intention is to create more interactive learning, whilst reducing system errors. Training on the system is provisionally booked for October and work will follow to update the existing packages.

Agenda for Change Review

“In 2013, agreement was reached that allowed employers to link pay progression to their appraisal processes so that it is no longer automatic. The 2018 agreement would move to that system for all employers from April 2019. By establishing this link, the importance of good appraisals, line management and staff development will be strengthened allowing greater staff engagement and a tighter focus on the training and skills staff need to deliver the best patient care.” ***NHS Workforce Bulletin issue 627***

It is hoped that this agreement will help significantly improve mandatory training compliance which is linked to individual’s appraisals. Work will start to ensure we have a robust system in place to implement the new agreement.

Appendix A

NHS West Suffolk NHS Foundation Trust

Subject Matter - High Level Mandatory Training Analysis July 2018

Competence Name	Trust Target	Expired	In Date	Total	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	90% Stretch Target agreed for all subjects apart from IG which has a national 95% target
179|LOCAL|Infection Control - Classroom|	90%	70	1298	1368	96%	94%	95%	95%	95%	94%	94%	95%	94%	95%	94%	95%	
NHS|MAND|Safeguarding Children Level 3 - 1 Year|	90%	19	277	296	76%	73%	79%	83%	86%	86%	88%	83%	95%	94%	94%	94%	
179|LOCAL|Safeguarding Children Level 2|	90%	146	1546	1692	87%	88%	89%	90%	92%	92%	92%	91%	91%	90%	91%	91%	
179|LOCAL|Safeguarding Adults|	90%	267	2756	3023	89%	89%	90%	91%	92%	92%	92%	92%	91%	91%	92%	91%	
179|LOCAL|Health & Safety / Risk Management|	90%	281	2742	3023	89%	89%	90%	91%	91%	92%	92%	91%	90%	90%	91%	91%	
NHS|CSTF|Preventing Radicalisation - Levels 1 & 2 (Basic Prevent Awareness) - 3 Years|	90%	293	2730	3023	N/A	N/A	N/A	N/A	N/A	N/A	84%	86%	87%	88%	90%	90%	
179|LOCAL|Security Awareness|	90%	451	4177	4628	89%	89%	90%	90%	91%	91%	91%	90%	90%	90%	91%	90%	
179|LOCAL|Infection Control - eLearning|	90%	161	1486	1647	88%	83%	85%	87%	88%	90%	90%	90%	90%	90%	91%	90%	
NHS|MAND|Safeguarding Children Level 1 - 3 Years|	90%	326	2697	3023	87%	86%	88%	89%	90%	90%	91%	90%	90%	90%	89%	89%	
179|LOCAL|Fire Safety Training - Classroom|	90%	329	2694	3023	90%	89%	90%	91%	91%	91%	90%	90%	90%	90%	90%	89%	
179|LOCAL|Medicine Management (Refresher)|	90%	173	1406	1579	87%	87%	86%	87%	88%	89%	89%	88%	87%	87%	88%	89%	
179|LOCAL|MAJAX|	90%	350	2674	3024	87%	86%	88%	88%	89%	89%	90%	88%	88%	88%	89%	88%	
179|LOCAL|Conflict Resolution - elearning|	90%	87	655	742	80%	80%	81%	82%	85%	87%	85%	84%	86%	87%	87%	88%	
179|LOCAL|Blood Bourn Viruses/Inoculation Incidents|	90%	224	1625	1849	84%	84%	85%	86%	87%	87%	86%	86%	85%	86%	87%	88%	
179|LOCAL|Slips Trips Falls|	90%	355	2216	2571	85%	85%	86%	88%	88%	88%	87%	87%	85%	85%	86%	86%	
179|LOCAL|Information Governance|	95%	496	2527	3023	85%	84%	87%	86%	87%	85%	84%	82%	86%	86%	83%	84%	
179|LOCAL|Moving and Handling Non Clinical Load Handler|	90%	74	352	426	82%	86%	84%	84%	88%	88%	89%	88%	88%	88%	83%	83%	
179|LOCAL|Fire Safety Training - eLearning|	90%	574	2449	3023	85%	85%	85%	85%	84%	85%	84%	82%	80%	82%	81%	81%	
179|LOCAL|Moving & Handling - elearning|	90%	200	798	998	75%	75%	75%	76%	75%	77%	77%	78%	75%	76%	79%	80%	
179|LOCAL|Equality and Diversity|	90%	627	2396	3023	93%	92%	93%	94%	94%	94%	88%	83%	81%	80%	79%	79%	
179|LOCAL|Moving and Handling - Clinical|	90%	368	1133	1501	83%	80%	80%	80%	84%	82%	79%	79%	74%	76%	77%	75%	
179|LOCAL|Basic Life Support - Adult|	90%	517	1588	2105	84%	82%	81%	81%	82%	82%	80%	78%	75%	76%	76%	75%	
179|LOCAL|Blood Products & Transfusion Processes (Refresher)|	90%	362	1028	1390	79%	79%	80%	78%	80%	77%	75%	72%	73%	72%	73%	74%	
179|LOCAL|Conflict Resolution|	90%	333	804	1137	76%	75%	76%	76%	75%	77%	76%	76%	69%	70%	70%	71%	
NHS|CSTF|Preventing Radicalisation - Levels 3, 4 & 5 (Prevent Awareness) - No Specified Renewal|	90%	1093	849	1942	N/A	N/A	N/A	N/A	N/A	N/A	4%	9%	17%	26%	36%	44%	

Apr 18 new starters	Attended	Not Attended	Grand Total	% Compliance
179|LOCAL|Trust Induction|	26	5	31	84%

Mandatory Training Recovery Plan July 2018

Appendix B

Subject	Jul 2018 %	Method	Actions	Completion date	Responsibility	Progress
Information Governance	84%	E-learning	IG team to target non-compliant staff directly with the training slides and compliance test.	Oct 2018	Sara Ames	• The IG team continue to offer one off training sessions to departments that require it and offer alternative training media/sessions for those who can't access the online module. Compliance increase is likely to be slower than others as it's a yearly requirement for all staff. The target for Information Governance has the highest target of all subjects at 95%
Equality & Diversity	79%	E-learning	Equality & Diversity was introduced as a mandatory training subject in May 2015, with a three yearly renewal. As the three yearly renewal is now upon us, a large number of staff are all becoming non-compliant. This has resulted in a substantial dip in compliance. Investigation and targeted emails to be sent to managers.	Oct 2018	Denise Pora	• The Equality & Diversity package is now working as expected and staff are able to complete their training. • Workforce Development Manager has sent a detailed compliance report to the lead showing the least compliant areas. Equality & Diversity Lead has contacted all area managers who are more than 20% below target.
Basic Life Support	75%	Face to face	Identify trends or key areas where compliance has dropped.	Oct 2018	Julie Head	• Sufficient courses have been provided to cover staff requirements but the impact of cancelling some mandatory training sessions and courses not being fully attended have had an impact on compliance. • List of non-compliant staff have been provided for the BLS trainers to target.
Moving & Handling–e-learning	80%	E-learning	Manual Handling Advisor to email mangers encouraging staff to be compliant and complete the eLearning package.	Oct 2018	Neil Herbert	• Manual Handling Advisor has targeted all non-compliant staff. • Previous 80% target would have been met.

Subject	Jul 2018 %	Method	Actions	Completion date	Responsibility	Progress
						Further push towards new 90% stretch target.
Moving & Handling - Clinical	75%	Face to face	All mandatory training dates are decided at the beginning of year. The Moving and Handling Team ensure that all sessions are covered by either the service lead or Advisor/Trainer. Some departments use their key workers to update supporting the Moving and Handling Team	Oct 2018	Neil Herbert	• Sufficient courses have been provided to cover staff requirements but the impact of cancelling some mandatory training sessions and courses not being fully attended have had an impact on compliance. • At present it is the medical and surgical divisions with the highest number of non-compliant staff. The lead has emailed ward managers in both divisions highlighting the non-compliance and requesting the staff be booked onto training.
Blood Products and Transfusion Processes	74%		The Blood Transfusion Nurse Specialists have sought to understand the deteriorating compliance since figures started to drop in Autumn 2017. During 2017/18 20 additional face: face transfusion updates were provided to Theatre registered practitioners & midwives. Additional face: face training sessions for Paediatric doctors, A&E doctors, general & theatre Porters were introduced in January 2018. A review of the training matrix has been requested to ensure only those staff that participate in transfusion have the requirement attached to their record.	Oct 2018	Gilda Bass/Joanne Hoyle	• Sufficient access to e-learning or face: face training is provided • HTT/HTC to consider utilising 2 yearly national learn Blood e-learning modules
Conflict Resolution	71%	Face to Face	A proposal was agreed at TEG to amend our current Conflict Resolution training to Managing Challenging Behaviour (MCB) which incorporates the main learning outcomes of Conflict Resolution, ensuring we remain compliant with the Core Skills Training Framework learning outcomes, but also	Oct 2018	Darren Cooksey	• The project plans to transition Conflict Resolution to Managing Challenging Behaviour has begun, including: finalising the program, bringing the training in house and ensuring we have sufficient cover to provide the training required, reviewing the training requirements and booking the courses.

Subject	Jul 2018 %	Method	Actions	Completion date	Responsibility	Progress
			techniques and skills of breakaway.			
Prevent WRAP (Workshop to raise awareness of Prevent)	44%	Face to Face	A national target of 85% to be reached by March 2018 has been set for all staff who are involved in assessing patients. Restrictions with trainer requirements and a vacancy for the subject lead post has resulted in a delay in rolling out a training package.	Oct 2018	Sara Ames	• Train the trainer programmes are now underway, training courses have been organised and advertised in the Green Sheet and extra courses provided where there was demand. • WRAP has been added to Registered and Non-Registered inductions. • An eLearning package has been made available to support staff to fit the training into their role. • Prevent trainers are targeting existing meetings to offer training to the attendees. • Lead is working with Peter Harris to put on doctor training.

Performance impact assessments

Appendix C

Subject	Issues	Performance Concerns	Lead
179|LOCAL|Moving and Handling –e-learning	• Poor uptake	• Potential staff injury • Financial implication such as sick pay, staff cover, court costs, compensation.	Moving and Handling Advisor
179|LOCAL|Moving and Handling - Clinical|	• Mandatory Training being cancelled due to demands on wards • Release of staff on clinical areas	• Potential staff injury resulting in RIDDOR absenteeism. • Financial implication such as sick pay, staff cover, court costs, compensation. • Inability to discuss both new techniques and remind staff of current best practise	Moving and Handling Advisor
179|LOCAL|Basic Life Support - Adult|	• Mandatory Training being cancelled due to demands on wards • Release of staff on clinical areas	• Staff not updated in essential skills & changes in resuscitation guidelines • The potential that patients may not receive correct treatment during emergency • Trust reputation / poor press if patients do not receive BLS / treatment appropriate for them	Resuscitation Lead
179|LOCAL| Conflict Resolution|	• Staffing levels and the Ward/ Departments ability to backfill will affect the numbers attending • Release of staff on clinical areas.	• Failure to recognise body language indications of possible aggression. • Failure to recognise warning signs when an aggressor is agitated or distressed. • Failure to recognise danger signs which may indicate imminent attack. • Failure to employ applicable communication skills • Litigation consequences • Potential staff injuries resulting in RIDDOR absenteeism. • Poor staff morale	Portering and Security manager
179|LOCAL|Information Governance|	• Annual training replaced 3 yearly training in 2014 • 95% compliance target explicit in 2015/16 IG toolkit	• Increased risk of IG breaches and vulnerability to ICO fine if staff awareness of IG is poor. • IG toolkit compliance will be unsatisfactory (level 1 only) if we cannot demonstrate achievement of 95% target.	IG Manager

Subject	Issues	Performance Concerns	Lead
179|LOCAL|Equality and Diversity|	• Large number of staff have reached their three yearly renewal at the same point. • Technical OLM system issues prevented staff from completed the eLearning course for a month. • Increase of target from 80% to 90%	• Failure to meet public sector equality duty and requirements of 2010 Equality Act. Risk of unlawful practices by staff resulting in litigation • Discrimination by/against staff and service users resulting in reduced quality of care, poor impact on staff motivation, failure to retain staff, reputational damage resulting in failure to recruit staff and impact on community confidence in Trust.	Deputy Director or Workforce (Organisation Development)
NHS|CSTF|Preventing Radicalisation - Levels 3, 4 & 5 (Prevent Awareness) - No Specified Renewal|	• Only reported as a mandatory requirement 3 months ago. • Been a lack of trainers still recently	• Not being aware of all the ways in which your organisation may be vulnerable to its learners becoming radicalised • Not identifying the levels of risk proportionate to your organisation • Not ensuring that all relevant policies and procedures are in place to mitigate that risk Not regularly reviewing these risks and checking to ensure relevant procedures are being carried out.	Prevent Lead
179|LOCAL| Blood Products & Transfusion Processes (Refresher)|	• Failure of staff to use on line training package provided • Not clear of process within Trust to ensure mandatory training is complied with and consequences	• Staff unaware of updated national/local guidelines to minimise the risks of transfusion. • Potential "never event" of ABO incompatible transfusion resulting in patient harm • Potential Litigation • Non-compliance with DoH circular 'Better Blood Transfusion'.	Blood Transfusion Committee

Appendix D – Dementia Training Figures

2018/19

Month	Number require training	Total number trained	% Compliance
April	759	715	94.20%
May	751	703	93.61%
June	741	694	93.66%
Q1.	**2251**	**2112**	**93.82%**

1045
Appendix E – SCH Community
Mandatory Training – as at June 2017

West Suffolk	June-2018							
Topic	All			Enabling**	Operations*	Facilities	Paediatrics	Wheelchairs
	Compliant	NonCompliant	% Compliancy					
Conflict Resolution	464	65	87.71%	100.00%	86.54%	76.19%	90.91%	66.67%
Dementia Compliance	494	35	93.38%	100.00%	91.92%	76.19%	98.27%	58.33%
Equality and Diversity	493	36	93.19%	100.00%	93.08%	95.24%	94.37%	66.67%
Fire	478	51	90.36%	100.00%	87.31%	76.19%	96.54%	58.33%
Health & Safety	494	35	93.38%	100.00%	91.92%	95.24%	96.10%	66.67%
Infection Control	462	67	87.33%	100.00%	85.38%	61.90%	92.21%	75.00%
Information Governance	484	45	91.49%	100.00%	88.08%	80.95%	96.10%	91.67%
Learning Disabilities	486	43	91.87%	100.00%	90.38%	90.48%	94.37%	75.00%
Life Support	387	49	88.76%	N/A	86.07%	N/A	92.93%	75.00%
Mental Capacity	131	49	72.78%	100.00%	73.26%	N/A	N/A	57.14%
Moving and Handling	449	80	84.88%	100.00%	82.69%	100.00%	86.58%	66.67%
Safeguarding Adults	502	27	94.90%	100.00%	98.08%	95.24%	93.07%	58.33%
Safeguarding Children	504	25	95.27%	100.00%	97.69%	95.24%	93.94%	66.67%
Overall % for all topics	**5828**	**607**	**90.57%**	**100.00%**	**89.07%**	**85.71%**	**93.80%**	**68.03%**
*** Enabling = Informatics, Business support, Quality,*								
** Operations = Newmarket Hospital, Specialist nurses & CHT Teams*								

14. National patient survey report

To ACCEPT a report

Presented by Rowan Procter

Board of Directors – 27th July 2018

Agenda item:	14			
Presented by:	Rowan Procter, executive chief nurse			
Prepared by:	Cassia Nice, patient experience lead Anna Wilson, project support officer			
Date prepared:	17th July 2018			
Subject:	National CQC adult inpatient survey 2017			
Purpose:	X	For information		For approval

Executive summary:
The survey was sent to 1250 adult patients from each trust who were inpatients throughout July 2017, counting back from the last day of July until 1250 patients had been selected for the sample. Of West Suffolk NHS Foundation Trust patients who were eligible to respond, 515 provided a completed survey which equates to a 42% return.

148 acute and specialist NHS trusts across England conducted this survey. National benchmarking allows results to be categorised as having been within the 'better', 'about the same' or 'worst' performing Trusts in the country on each particular question.

To make any necessary improvements and share good practice the patient experience team has met with the senior nursing team to analyse results and create an action plan which will be monitored by the Patient Experience Committee.

Trust priorities	**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:	None
Risk and assurance:	All acute and specialist trusts are required to participate in the survey following national criteria and centralised analysis.
Legislation, regulatory, equality, diversity and dignity implications	Results are available to the public on the CQC website and will be used by the CCQ as part of their Intelligence Monitoring processes.
Recommendation: The Trust Board are asked to receive the report and note the results.	

CQC Inpatient Survey 2017

1. About this survey

- Fifteenth survey of adult inpatients
- Involved 148 acute and specialist NHS trusts across England
- Responses were received from 72,778 people across the country
- National response rate was 41%

2. Methodology

This report shows how a trust scored for each question in the survey, compared with the range of results from all other trusts that took part.

The 'about the same,' 'better' and 'worse' categories are based on an analysis technique called the 'expected range' which determines the range within which the trust's score could fall without differing significantly from the average, taking into account the number of respondents for each trust and the scores for all other trusts.

3. Performance compared to other trusts

Better on 1 question:

Q65. Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?

Worse on 0 questions

About the same on all other questions

4. Performance compared to our own 2016 results

Where there has been a ***statistically significant decrease** from the 2016 score:

Q58 Did a member of staff tell you about medication side effects to watch for when you went home?

*a statistically significant differences means that the change in result is very unlikely to have occurred by chance - *CQC*

5. Results – West Suffolk NHS Foundation Trust compared to all other trusts

↑ Highlights an improvement in our own score from previous year
↓ Highlights a deterioration in our own score from previous year
The absence of an arrow represents a maintained score, negligible difference (0.1) or a new question

Survey of adult inpatients 2017
West Suffolk NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
The Accident & Emergency Department (answered by emergency patients only)							
S1	Section score	8.6	7.5	9.2			
Q3	While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.3	7.4	9.1	302	8.1	↑
Q4	Were you given enough privacy when being examined or treated in the A&E Department?	9.0	7.5	9.5	334	8.8	↑
Waiting list or planned admissions (answered by those referred to hospital)							
S2	Section score	8.6	8.2	9.7			
Q6	How do you feel about the length of time you were on the waiting list?	7.9	6.3	9.7	156	7.7	↑
Q7	Was your admission date changed by the hospital?	8.8	8.1	9.9	159	8.9	
Q8	Had the hospital specialist been given all necessary information about your condition/illness from the person who referred you?	9.2	8.3	9.6	161	9.0	↑
Waiting to get to a bed on a ward							
S3	Section score	8.1	5.8	9.7			
Q9	From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	8.1	5.8	9.7	512	8.0	

Survey of adult inpatients 2017
West Suffolk NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
The hospital and ward							
S4	Section score	8.1	7.3	8.9			
Q11	Did you ever share a sleeping area with patients of the opposite sex?	9.5	7.5	9.8	512		
Q13	Did the hospital staff explain the reasons for being moved in a way you could understand?	6.9	5.2	8.9	116		
Q14	Were you ever bothered by noise at night from other patients?	5.5	4.8	8.4	511	5.8	↓
Q15	Were you ever bothered by noise at night from hospital staff?	7.8	7.1	9.1	509	8.1	↓
Q16	In your opinion, how clean was the hospital room or ward that you were in?	9.1	8.3	9.7	513	9.3	↓
Q17	Did you get enough help from staff to wash or keep yourself clean?	8.5	7.0	9.3	296	8.2	↑
Q18	If you brought your own medication with you to hospital, were you able to take it when you needed to?	7.5	5.7	8.7	322	7.1	↑
Q19	How would you rate the hospital food?	6.4	4.7	8.0	494	6.7	↓
Q20	Were you offered a choice of food?	8.9	7.8	9.7	506	8.9	
Q21	Did you get enough help from staff to eat your meals?	7.8	5.3	9.4	106	7.2	↑
Q22	During your time in hospital, did you get enough to drink?	9.6	8.9	9.9	497		
Q71	Did you feel well looked after by the non-clinical hospital staff?	9.3	8.2	9.7	457		
Doctors							
S5	Section score	8.7	8.1	9.5			
Q23	When you had important questions to ask a doctor, did you get answers that you could understand?	8.2	7.6	9.2	461	8.2	
Q24	Did you have confidence and trust in the doctors treating you?	9.0	8.5	9.8	510	9.0	
Q25	Did doctors talk in front of you as if you weren't there?	8.9	7.9	9.6	508	8.7	↑

Survey of adult inpatients 2017
West Suffolk NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
Nurses							
S6	Section score	8.2	7.2	9.2			
Q26	When you had important questions to ask a nurse, did you get answers that you could understand?	8.6	7.3	9.3	441	8.6	
Q27	Did you have confidence and trust in the nurses treating you?	9.1	8.0	9.6	509	9.1	
Q28	Did nurses talk in front of you as if you weren't there?	9.2	8.0	9.6	509	9.0	↑
Q29	In your opinion, were there enough nurses on duty to care for you in hospital?	7.7	6.5	9.1	506	7.4	↑
Q30	Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	6.5	5.4	8.7	511	6.8	↓

Survey of adult inpatients 2017
West Suffolk NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
Your care & treatment							
S7	Section score	8.2	7.5	9.0			
Q31	Did you have confidence and trust in any other clinical staff treating you?	8.6	7.8	9.6	319		
Q32	In your opinion, did the members of staff caring for you work well together?	8.8	8.0	9.5	484	8.9	
Q33	Did a member of staff say one thing and another say something different?	8.4	7.3	9.0	509	8.3	
Q34	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.6	6.6	8.5	500	7.5	
Q35	Did you have confidence in the decisions made about your condition or treatment?	8.4	7.7	9.4	502	8.4	
Q36	How much information about your condition or treatment was given to you?	8.9	8.3	9.6	483		
Q37	Did you find someone on the hospital staff to talk to about your worries and fears?	5.9	4.3	7.7	269	5.6	▲
Q38	Do you feel you got enough emotional support from hospital staff during your stay?	7.1	6.1	8.6	276	7.3	▼
Q39	Were you given enough privacy when discussing your condition or treatment?	8.4	8.0	9.4	501	8.4	
Q40	Were you given enough privacy when being examined or treated?	9.5	9.1	9.8	502	9.3	▲
Q42	Do you think the hospital staff did everything they could to help control your pain?	8.3	7.4	9.2	312	8.4	
Q43	If you needed attention, were you able to get a member of staff to help you within a reasonable time?	8.0	6.7	9.1	444		

Operations & procedures (answered by patients who had an operation or procedure)							
S8	Section score	8.0	7.6	9.0			
Q45	Did a member of staff answer your questions about the operation or procedure in a way you could understand?	8.8	8.6	9.5	250	8.9	
Q46	Were you told how you could expect to feel after you had the operation or procedure?	7.3	6.8	8.7	263	7.4	
Q47	Afterwards, did a member of staff explain how the operation or procedure had gone in a way you could understand?	7.9	7.0	8.9	266	8.3	▼

Survey of adult inpatients 2017
West Suffolk NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
Leaving hospital							
S9	Section score	7.3	6.3	8.4			
Q48	Did you feel you were involved in decisions about your discharge from hospital?	7.3	6.1	8.5	491	7.3	
Q49	Were you given enough notice about when you were going to be discharged?	7.3	6.3	8.5	506	7.3	
Q51	Discharge delayed due to wait for medicines/to see doctor/for ambulance.	6.5	5.0	8.7	473	6.1	↑
Q52	How long was the delay?	7.6	6.4	9.2	471	7.5	
Q54	Did you get enough support from health or social care professionals to help you recover and manage your condition?	6.8	5.3	8.0	239	6.6	↑
Q55	When you left hospital, did you know what would happen next with your care?	6.8	6.1	8.4	412	7.0	
Q56	Were you given any written or printed information about what you should or should not do after leaving hospital?	6.5	5.6	9.3	475		
Q57	Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.5	7.6	9.6	334	8.2	↑
Q58	Did a member of staff tell you about medication side effects to watch for when you went home?	4.4	3.7	7.6	268	5.4	↓↓
Q59	Were you told how to take your medication in a way you could understand?	8.4	7.5	9.7	299	8.5	
Q60	Were you given clear written or printed information about your medicines?	8.4	6.9	9.4	323	8.1	↑
Q61	Did a member of staff tell you about any danger signals you should watch for after you went home?	5.5	4.3	8.3	336	6.1	↓
Q62	Did hospital staff take your family or home situation into account when planning your discharge?	7.6	6.1	8.3	306	7.9	↓
Q63	Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	6.7	5.3	7.9	306		
Q64	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.0	6.5	9.8	450	8.0	
Q65	Did hospital staff discuss with you whether additional equipment or adaptations were needed in your home?	9.2	6.6	9.3	193	9.0	↑
Q66	Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	8.6	7.2	9.2	260	8.1	↑

Survey of adult inpatients 2017
West Suffolk NHS Foundation Trust

		Scores for this NHS trust	Lowest trust score in England	Highest trust score in England	Number of respondents (this trust)	2016 scores for this NHS trust	Change from 2016
Overall views of care and services							
S10	Section score	4.4	3.8	6.0			
Q67	Overall, did you feel you were treated with respect and dignity while you were in the hospital?	9.2	8.5	9.7	509	9.2	
Q69	During your hospital stay, were you ever asked to give your views on the quality of your care?	1.6	0.7	3.6	446	1.2	↑
Q70	Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	2.6	1.4	5.1	366	2.6	
Overall experience							
S11	Section score	8.3	7.5	9.2			
Q68	Overall...	8.3	7.5	9.2	493	8.3	

The full analysis report can be found by following this link.

15. Putting you first award

To NOTE a verbal report of this month’s winner

Presented by Jan Bloomfield

11:00 BUILD A JOINED-UP FUTURE

16. Consultant appointment report

To RECEIVE the report

Presented by Jan Bloomfield

BOARD OF DIRECTORS – 27th July 2018

Agenda item:	16			
Presented by:	Jan Bloomfield, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	19th July 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 Respiratory
DATE OF INTERVIEW:	Tuesday, 26th June 2018
REASON FOR VACANCY:	Fast Track Post
CANDIDATE APPOINTED:	[redacted]
START DATE:	Permanent Start Date: 26th June 2018 (previously Fixed Term)
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	1 1 1

POST:	Consultant Radiologist
DATE OF INTERVIEW:	Thursday 28th June 2018
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	4 1 3

11:10 GOVERNANCE

17. Trust Executive Group report

To ACCEPT a report

Presented by Stephen Dunn

Board of Directors – 27 July 2018

Agenda item:	17			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	27 July 2018			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

Executive summary

2 July 2018

Steve Dunn provided an introduction to the meeting including celebrating the **NHS' 70th birthday**. It was confirmed that plans for the increased national NHS funding will be announced in the autumn. Steve confirmed that he is visit community locations as part of a programme of sessions of the summer.

The May **integrated quality and performance report** (IQPR) was reviewed. This recognised improved performance for May in terms of ED and RTT. It was noted that we are taking part in national collaboration events for pressure ulcers, falls and nutrition.

An update was received on **winter staffing** for 2018-19. A range on initiatives were described to support recruitment of registered and unregistered nurses; including overseas recruitment and apprenticeships. The push on recruitment was needed to staff the additional capacity being created for the winter.

The meeting reflected on **CQC learning and preparedness** in the context of a review of the recent Norfolk & Norwich CQC report (Annex). Area for improvement were considered and action agreed. It was recognised that the new business planning template will support divisional and service level strategy and planning.

The **Quality Group report** was received summarising the work that has been happening since the end of last year. Assurance is received through a range of activities such as quality walkabout, table top audits and the outcome of task and finish groups. A range of training events have also be held building our quality improvement capacity and capabilities. The quality priorities, generated from within the organisation by speciality groups, were reviewed.

The meeting approved the **business case** for two obstetrics and gynaecology (O&G) consultant posts. Funding will be sourced from additional session and locum costs, as well as the transfer of activity and programmed activities (PAs) from existing substantive O&G consultants.

Plans for testing our **emergency plans** were reviewed and approved.

An assessment of compliance with **GDPR** was received. The outstanding areas were reviewed and it was noted that the key area for further development is e-Care compliance with consent requirements. This is currently being discussed and work in progress.

The **annual report and accounts** were received for information. It was noted that the Board approved these at the end of May 2018.

16 July 2018

Steve Dunn provided an introduction to the meeting reflecting on **Matt Hancock's** appointment as the Secretary of State for Health. He also recognised the recent visits by Princess Anne, Jeremy Hunt, while Secretary of State for health and David Behan, outgoing CEO of the CQC and the forthcoming visit by Kathy McLean, Executive Medical Director and Chief Operating Officer for NHS Improvement.

Steve highlighted the positive results of the recent **junior doctor survey** which rated the WSFT as the best in the region. Steve also thanks the teams for their continued focus on planning for **annual leave** during the summer.

Feedback was received on the recent unannounced **MHRA inspection**. The results were disappointing in terms of the inspector's assessment of progress against the two major concerns which remained in place – validation of the information system and workforce planning. It was emphasised that nothing in the inspector's findings had identified patient harm but highlighted the inability to demonstrate effective safety systems.

A new **business planning framework** was approved and it was agreed that while still developmental a first draft of divisional plans will be received at the performance review meetings (PRMs) in September. The new presentation template for the division's PRMs was received and noted.

The **red risk report** was reviewed with discussion and challenge for individual areas. No new red risks were received. The key identified were:

- **System financial and operational sustainability** will impact of the quality of patient services (linked to operational performance and CIP planning and transformation)
- **Winter planning (new)** to ensure safe staffing and capacity for winter 2018-19.

Risks relating to pathology services will be updated in light of the MHRA inspection findings.

A detailed report for the **emergency department (ED) improvement plan** was received. A ranmge of short, medium and longer term actions were reviewed. This included a focus on demand and capacity (particularly during the evening), professional standards and wider system actions. Lobbying continues for the capital to support proposed development of the ED.

The **nursing strategy** was received and noted. The significant achievements were recognised.

A report was received setting out the Trust's responsibilities for private patient activity under **competitors and markets authority (CMA**) regulations. The existing arrangements and actions were noted and would be further considered by the clinical directors through the updated fee paying services policy.

A report from the **capital strategy group** was received, it was noted that the investments to support winter planning are proceeding at risk pending agreement of the capital funding by NHSI.

An summary report from the **sustainability and transformation partnership (STP)** was received and the basis of the STP priorities reviewed. Developments for cancer and stroke services will continue to be reviewed.

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

a) Anti-fraud policy – updated to ensure consistency with the Trust's disciplinary policy
b) Chaperone policy – to reflect guidance endorsed by CUH following the Dr Bradbury investigation and to provide clarity on the professional role and the role of a chaperone.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		**X**		**X**		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	The Board receives a monthly report from TEG						
Risk and assurance:	Failure to effectively communicate or escalate operational concerns.						
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation: The Board note the report							

TEG – 2nd July 2018

Agenda item:	17			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Rowan Procter, Executive Chief Nurse			
Date prepared:	22nd June 2018			
Subject:	CQC learning and preparedness			
Purpose:		For information		For approval

Executive summary:

The aim of this report is to learn from other CQC reports and agree key items for change and improvement.

Norfolk & Norwich University Hospitals (NNUH) have had their recent CQC report issued and there are clear lessons to be learnt for WSFT.

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

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

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

Recommendation:

Note report and agree recommendations

NNUH CQC Report

Headlines

The NNUH rating went down to inadequate and has been put into special measures.

Ratings for Norfolk and Norwich hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Jun 2018	Requires improvement ↓↓ Jun 2018	Good ↓ Jun 2018	Requires improvement ↓ Jun 2018	Inadequate ↓↓ Jun 2018	Inadequate ↓↓ Jun 2018
Medical care (including older people's care)	Requires improvement Aug 2017	Good Mar 2016	Good Mar 2016	Requires improvement Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Surgery	Inadequate ↓ Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Inadequate ↓ Jun 2018	Inadequate ↓ Jun 2018
Critical care	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Maternity	Requires improvement Aug 2017	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017
Services for children and young people	Requires improvement Aug 2017	Good Mar 2016	Good Mar 2016	Good Aug 2017	Good Aug 2017	Good Aug 2017
End of life care	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018
Outpatients	Requires improvement Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Diagnostic imaging	Requires improvement Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Overall*	Inadequate ↓ Jun 2018	Requires improvement →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Inadequate ↓ Jun 2018	Inadequate ↓ Jun 2018

Action the trust MUST take to improve

For the overall trust:

- The trust must ensure that mandatory training attendance improves to ensure that all staff are aware of current practices.
- The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty safeguards.
- The trust must ensure that staff annual appraisal completion improves.
- The trust must ensure that there is an effective process for quality improvement and risk management in all departments.

- The trust must ensure that local audit findings are utilised to identify actions for improvement and that these are monitored, and reviewed.
- The trust must review the bed management and site management processes within the organisation to increase capacity and flow and ensure effective formalised processes are in place to ensure patient safety in all escalation areas.
- The trust must improve the relationship and culture between the site management team and the senior nursing and clinical teams to ensure open dialogue where patient safety is equally weighted to operational pressure to reduce risk to patients and staff.
- The trust must embed the recently formalised processes for review and assessment of escalation areas to reduce the risk to patient safety.
- The trust must review process for whistleblowing and take definitive steps to improve the culture, openness and transparency throughout the organisation.
- The trust must improve the functionality of the board and ensure formalised processes are in place for the development and support of both current and new executive directors.
- The trust must ensure consistency processes are in place for recruitment, fit and proper person's regulation and line management at executive level.
- The trust must improve the level of oversight, scrutiny and challenge from the chair and non-executive directors (NEDS).

In Urgent and Emergency services:

- The trust must ensure that action plans are monitored and that action is taken following the investigation of serious incidents.
- The trust must ensure that there are effective systems and processes in place to ensure assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated.
- The trust must ensure that staff compliance with mandatory training improves significantly. This includes basic life support, paediatric life support, Mental Capacity Act (2005), Deprivation of Liberty Safeguards (DoLS), prevention and management of aggression (PMA), and infection, prevention and control training.
- The trust must ensure staff compliance improves for major incident training.
- The trust must ensure that the premises for urgent and emergency services protect patients from potential harm and used for the intended purpose. This includes all areas of the service for both children and adults.
- The trust must ensure that there is a system in place, which is adequately resourced, to ensure that patients are assessed, treated and managed in a time frame to suit their individual needs.
- The trust must action its plans to expand the children's and adults emergency department, including the provision of a high dependency unit for children outside of the resuscitation department.
- The trust must review its nursing and medical staffing numbers for the urgent and emergency services and plan staffing acuity accordingly.
- The trust must ensure that there is one registered children's nurse at all times within the children's emergency department and take necessary action to increase the number of registered children's nurses employed.
- The trust must ensure a good skill mix within the children's ED nursing workforce.
- The trust must ensure audio and visual separation between adults and children being assessed and waiting within the emergency department and minor injuries unit.
- The trust must ensure that there are a sufficient number of environments which protect patients from potential harm within the urgent and emergency service, for the assessment and treatment of patients living with mental health concerns, including those who are detained under the Mental Health Act (1983).
- The trust must ensure emergency equipment, including ligature cutters and children's resuscitation equipment is readily available.
- The trust must ensure that oxygen cylinders are stored safely, that oxygen is readily available in all patient areas, and that this equipment is properly maintained.

- The trust must ensure that patient venous thromboembolism (VTE) risk assessments are completed.
- The trust must ensure that necessary risk assessments and healthcare records are complete for mental health patients.
- The trust must ensure that computers are locked and that patient healthcare records are stored securely.
- The trust must improve staff compliance with level three children's safeguarding training.
- The trust must improve its performance times in relation to national time of arrival to receiving treatment (which is no more than one hour), four-hour target and monthly median total time in A&E.
- The trust must ensure that there is a medical lead appointed for the service.
- The trust must ensure that mental capacity assessments are carried out for all patients who lack mental capacity, ensuring appropriate patient care plans are in place accordingly.
- The trust must ensure that the healthcare records for patients' subject to restraint are complete and in line with the trust's policy and procedure.
- The trust must ensure that there is a local audit programme in place for the service, that action plans are in place and necessary improvements are made to practice following audit.
- The trust must ensure that lessons learnt from concerns and complaints are used to improve the quality of care.
- The trust must ensure that patients are treated with dignity and respect at all times.

In Surgery:

- The trust must ensure that staff caring for children in the recovery area have appropriate level safeguarding training in line with national guidance and trust policy.
- The trust must ensure that safeguarding training compliance for both medical and nursing staff improve in line with the trust's targets.
- The trust must ensure temperature charts for blood and medicine fridges are appropriately completed and records held in line with national requirements.
- The trust must ensure that the environment, equipment storage, medicines management and infection control procedures are appropriate in the interventional radiology unit.
- The trust must ensure that leadership, culture and behaviours within the operating theatre department are actively addressed.
- The trust must ensure that there is effective governance, safety and quality assurance processes within the theatre department that are structured, consistent, and monitored to improve practice and reduce risk to patients.
- The trust must ensure that the World Health Organisation (WHO) and five steps to safer surgery checklist is completed appropriately, and that learning from incidents and regular monitoring processes become embedded to empower staff to challenge and report any poor practice.

In End of Life Care:

- The trust must review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance.
- The trust must review its Mental Capacity Assessment and Deprivation of Liberty Safeguarding process and the way this is documented within patients' notes.

In Outpatients:

- The trust must ensure that incidents are reported and investigated in a timely way by trained investigators.
- The trust must ensure that medicines are stored securely and in line with national guidance.
- The trust must ensure that equipment is maintained and fit for use.
- The trust must ensure staff complete appropriate mandatory training including safeguarding training to a level appropriate to their job role.

- The trust must ensure that patient records are stored securely.
- The trust must ensure that there is an effective process for quality improvement and risk management.

In Diagnostic Imaging services:

- The trust must ensure that medicines and contrast media are stored securely and in line with national guidance.
- The trust must ensure staff complete appropriate mandatory training including safeguarding training to a level appropriate to their job role.
- The trust must ensure that resuscitation equipment is checked in accordance with trust policy.
- The trust must ensure that incidents are investigated in a timely way.
- The trust must ensure that observational audits of the quality of the World Health Organisation (WHO) and five steps to safer surgery checklists are undertaken.
- The trust must ensure that specialist personal protective equipment, such as the integrity of lead aprons, is checked on a regular basis.
- The trust must ensure that the call bell system within nuclear medicine is fit for purpose.
- The trust must ensure that there is an effective process for quality improvement and risk management.

Observations

Following the WSFT CQC full visit March 2016 we have not fully sustained and delivered on a number of areas;

- Checklist completion, e.g. resus trolleys, drug fridge
- WHO checklist
- Appraisal rates
- Mandatory training rates
- Incident investigation on green incidents and then NRLS upload
- Care of a child in ED
- ED performance
- Mental Health patients
- Completion of EPARS

Recommendations

1. **Matron Performance meetings**

These will be monthly held by the Head of Nursing, each ward will present the following and with an action plan to deliver areas under performing;

- Quality Indicators
- Perfect Ward App
- Finance, Vacancy and Establishment
- Sickness and Performance Issues
- Appraisals and Mandatory Training
- Risk
- Complaints and Patient Experience
- Quality Innovation

Should this be a joint approach with the ADO and HoN with the Service Manager and Senior Matron.

2. WSFT CQC preparedness

Each area triumvirate team to review their action plan and confirm any items for exception reporting to performance review meeting and/or Quality Group.

The CQC guidance on how they regulate trusts states:

"*We aim to inspect each trust at least once between June 2017 and Spring 2019 in our next phase of regulation, and approximately annually after that. However, we may come back any time in the year if we think it is necessary. Our contact with your trust will be frequent and targeted. We will use information from our relationship management meetings and CQC Insight to inform our discussion about when and what to inspect.*

We will use a trust's previous ratings as a guide to setting maximum intervals for re-inspecting its core services alongside its inspection of the well-led key question:
• one year for core services rated as inadequate
• two years for core services rated as requires improvement
• three and a half years for core services rated as good
• five years for core services rated as outstanding

Based on this we would expect a visit in 2018/19 looking at **Well-led** however the Trust has no **Core areas** rated as requires improvement we cannot accurately predict which areas they would look at.

The assumption is therefore that they would look at some or all of those core areas which included a **Requires Improvement** namely:

- Urgent & Emergency services
- Critical Care
- Maternity

There will also be a need to update and submit a Provider Information Report (PIR) which has a relatively short turn-around from request to submission. Preparation of this in advance would be advantageous.

Elements of preparedness

1. Provider Information Request (PIR) preparation and review:
    a. Data
    b. Narrative

2. Preparedness in 'high risk area' (defined as areas graded as *Requires Improvement* in most recent inspection report)

3. Trust-wide general preparedness in all areas, including Community services

Element	Plan	Lead	Timescale
PIR data	Review 2017/18 data capture and ensure all leads are aware of potential short notice request for comparative data-set for this year.	Sinead Collins	End July 2018
PIR narrative	Review of all narrative items with leads to ensure reflective of current status	Rebecca Gibson	End July 2018

Preparedness in 'high risk area'	• Self-assessment against the requirements of Safe, Effective, Caring, Responsive, Well led.
	• Review of actions (deep dive audit) from 2016 report to ensure completion can be evidenced.
	• Consider options for external review of:
	  • Urgent & Emergency services - SAFE
	  • Critical Care - RESPONSIVE
	  • Maternity – WELL LED
		ADOs	Oct '18

Trust-wide general preparedness	• Divisional self-assessment against the requirements of Safe, Effective, Caring, Responsive, Well led. • Review of actions (deep dive audit) from 2016 and 2018 reports to ensure completion can be evidenced. • [Following divisional self-assessment] Agree and implement programme for ongoing self-assessment and peer review to assess ongoing compliance (this will incorporate the wide range of quality checks and assurance already in place)	ADOs Rebecca Gibson Paul Morris / Rebecca Gibson	Oct '18 Oct '18 Nov '18
	• Matron Performance meetings to be held monthly by the Head of Nursing, each ward will present the following and with an action plan to deliver areas under performing; Quality Indicators, Perfect Ward App, Finance, Vacancy and Establishment, Sickness and Performance Issues, Appraisals and Mandatory Training, Risk, Complaints and Patient Experience and Quality Innovation	ADO / HoN with Service Manager and Senior Matron.	From Jul '18

18. Quality & Risk Committee report

To RECEIVE the report

Presented by Sheila Childerhouse

Board of Directors – Friday 27 July, 2018

Agenda item:	18			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Ruth Williamson, PA			
Date prepared:	20 July, 2018			
Subject:	Quality and Risk Subcommittee Reports			
Purpose:		For information	X	For approval

Executive summary:

A presentation was received from Lynne Saunders, Head of Midwifery, outlining the work being undertaken by the service to meet the requirements of the "Better Births - improving outcome of maternity services in England" report.

A further presentation was received from Marcos Martinez del Pero, Clinical Lead, ENT, detailing the success of the department's 100 Day Challenge, aimed at improving elective care referrals, outpatient arrangements and shared decision-making.

Reports from the subcommittees of the Quality and Risk Committee were received. These reports are submitted for assurance and governance.

(a) **Corporate Risk Committee (18/05/2018)**
No issues were identified for escalation.

(b) **Clinical Safety & Effectiveness Committee (11/06/18)**
No issues were identified for escalation. Noted report received from newly appointed Point of Care Testing Lead, identifying work required to be undertaken.

(c) **Patient Experience Committee (15/06/2018 - cancelled)**
A number of last minute apologies received, resulting in cancellation of the meeting. As a consequence, the focus and remit of this committee is to be revisited.

Quality Group
Report being finalised for CQC preparedness, taking in to account learning from other Trusts in the region.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X						
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		X					
Previously considered by:	**-**						
Risk and assurance:	-						
Legislation, regulatory, equality, diversity and dignity implications	-						

Recommendation:

To receive the report and minutes for information and assurance.

QUALITY & RISK COMMITTEE
Minutes of the meeting held on Friday 29 June, 2018,
Commencing at 2.00 p.m. in the Northgate Meeting Room, Quince House, WSFT

COMMITTEE MEMBER		Attendance	Apologies
Sheila Childerhouse **(SC)**	Chair (Chair)	**X**	
Stephen Dunn **(SD)**	Chief Executive	**X**	
Craig Black **(CB)**	Director of Resources	**X**	
Nick Jenkins **(NJ)**	Medical Director	**X**	
Helen Beck **(HB)**	Interim Chief Operating Officer	**X**	
Jan Bloomfield **(JBl)**	Director of Workforce & Communications		**X**
Rowan Procter **(RP)**	Chief Nurse	**X**	
Gary Norgate **(GN)**	Non-Executive Director		**X**
Richard Davies **(RD)**	Non-Executive Director	**X**	
Richard Jones **(RJ)**	Trust Secretary & Head of Governance	**X**	
Alan Rose **(AR)**	Non-Executive Director	**X**	
Angus Eaton **(AE)**	Non-Executive Director		**X**
Catherine Waller **(CW)**	Honorary Non-Executive Director		**X**
In attendance			
Ruth Williamson **(RW)**	PA to Medical Director (Minutes)		
Presentations			
Lynne Saunders **(LS)**	Head of Midwifery		
Marcos Martinez Del Pero **(MP)**	Clinical Lead, ENT		

Action

Local Maternity Board and Better Births Maternity Services June 2018

LS advised that following a review by Baroness Cumberlege, the "Better Births - improving outcome of maternity services in England" report had been produced, providing a 5 year forward view for maternity services. Within this were seven main areas of recommendation.

1. ***Personalised Care*** – use of framework, adapting to a woman's needs either reducing or increasing visits, choice of venue etc.

   AR asked if there was any private care provision within West Suffolk. LS advised that there was one within the STP - "One to One", based on the southern boundary, assisting with approximately 300 deliveries a year. There were also a couple of independent midwives, providing support in Lakenheath, for expectant mothers not wishing to receive care on the base.

2. **Continuity of Care** – this was likely to be the most challenging to achieve. Previously carried out in the 1980's via group practices, this was an expensive model of care. It was believed that the current generation of midwives did not want to work in what is a very demanding manner, 24/7 and therefore other ways of providing will need to be considered. DG suggested the possibility of "Buurtzorg for Babies".

3. **Safer Care** – involving challenging safety targets, including a reduction in stillbirths by 50%.

4. **Better Postnatal and Perinatal Mental Health Care** – noted Suffolk-wide perinatal mental health team has won a bid for monies to expand the service and amount of care provided. Noted post-natal care was not at quite the same level

   NJ advised that a quarter of all maternal deaths had been reported as being mental health related; with the death occurring before the baby was a year old. However, by this time very ill mothers were likely to be with another organisation. He asked how this Trust linked in with the Norfolk & Suffolk NHS Foundation Trust. LS confirmed that the trust was working well jointly, although it was early days and working across two organisations could be difficult. Noted the Trust has engaged in regional training on perinatal mental health. The obstetric and psychiatric teams are working together, including joint clinics, which will support improving outcomes for women, enabling concerns to be picked up sooner and provide better access to psychiatrists. Although at present a 9-5, Monday to Friday service, there are pathways for out of hours.

   SC asked whether multi-professional working included health visitors. LS advised that the Trust does work with health visitors, including a small amount of antenatal education. However, most joint working was in respect of vulnerable families with safeguarding concerns and therefore for those women without these concerns this was limited.

5. **Multi Professional Working** – (working across boundaries with obstetricians etc.). LS advised that a lot of skill based training was being undertaken as a multidisciplinary team, including theatres, anaesthetics and the ambulance service. This has improved the team's skill base for emergency situations. A project undertaken by the labour suite, as part of their leadership course, has resulted in "Take 5", five very brief messages utilised at the 8 am MDT handover.

6. **Working across boundaries**. No examples available as yet.

7. **Payment system –** aimed to give women a choice on how the money is spent, (a form of **p**ersonalised budget). No further detail available at present. CB asked whether this would drive greater choice. LS questioned how this would work in practice, i.e. would the mother know how to or even possibly want to spend the funds, particularly if a first baby. Also what would happen if a large amount was spent on one particular thing leaving no funds for anything else. CB believed the principle was that by the exercising of choice this would incentivise providers to deliver an enhanced service in range or quality. It has been found from payment by results that people exercising choice did not change referral patterns.

8. **Local Maternity System Board -** consisting of three maternity units within the STP, working together to take "Better Births" forward and ensure equity of care. Led by the CCG, with inclusion of other organisations, resources and continuity of care are to be focused on improving public health - smoking, obesity, mental health, drugs and alcohol.

SD asked the level of exposure to health-coaching by midwives. LS advised that at present this was limited. However, the department was linking in with Helena Jopling in order to move forward.

AR asked whether this report overlapped with the CQC templates and best practices. LS did not consider there to be any clash.

Noted the request for refurbishment of the inpatient area is reverting to the Board for approval in July, as the quote received is for an additional £500k to the figure detailed in the capital programme.

CB expressed his and the committees grateful thanks to LS's for all her efforts.

LS left at 2.40

100 Day Challenge – Eat, Nose & Throat

MDP advised that the focus of the 100 Day Challenge had been placed on service delivery and the streamlining of referrals. The service has been struggling to meet its 18 week target, having last year stood at 40 weeks.

MDP sought the opinion of GP friends whose main request was for direct access to diagnostics. Consideration has also been given to providing access to MRIs, (already happening in East Suffolk), expansion to advice and guidance and audiology. AR asked whether the advice and guidance on offer was for GP practices or patients. Noted this was support for the practices.

Some initial concern expressed by consultants regarding liability for provision of advice if not seen the patient. However trust is placed in the GP to provide sufficient information and a "caveat" is included in any correspondence.

AR asked if this was effectively a change in job plan. MDP advised this was more a change in the clinic template, i.e. 30 minutes before commencement of a clinic was utilised to make calls to GPs or dictate letters of advice. The aim of this advice was to reduce the need for patients to attend a clinic at the hospital.

MDP has also visited nine GP practices, spoken to MRI, Urology etc. which has proved very useful. One of the suggestions received was the sharing of equipment in Thetford for microsurgery. The practice has GPs/nurses trained by the hospital in this field. Further discussions are taking place.

MDP advised that a couple of GP practices have expressed an interest in performing micro suction, (procedure undertaken when a patient cannot have their ears syringed and is currently undertaken at the hospital). DG asked how effective this would be in terms of the investment required. District nurses spend a significant amount of time syringing ears and asked if micro suction was the more effective option. MDP advised it was not more effective, but required for those who could not be syringed.

Moving forward consideration being given to:

1. Outsourcing of audiology to external organisations such as Specsavers; however it should be noted that they do not offer the same level of care as the Trust.
2. Provision of advisory leaflets on Rhinitis to local pharmacies.
3. Anaesthetising of day surgery patients in day surgery, rather than theatre.

Noted ENT is currently the top performing speciality in respect to RTT. SD offered his thanks and those of the committee to MDP and team for the superb effort.

RP joined at 3.05 pm.

MDP left at 3.15.

1. **Apologies for Absence**

Apologies received as detailed above.

2. **Minutes of Previous Meeting**

The minutes of the meeting held on 29 March 2018 were accepted as a true and accurate reflection of the meeting.

3. **Matters Arising Action Sheet**

Completion of matters arising references 39 and 40 was duly noted.

4. **Reports from Sub-Committees**

a. ***Clinical Safety & Effectiveness Committee (CSEC) - (11 June, 2018)***

HB advised of the report received on point of care testing (POC), from the recently appointed lead. A large piece of work is required to be undertaken as a result.

The Annual Report, TOR and quality improvement plan were duly noted.

b. ***Corporate Risk Committee (CRC) - (18 May, 2018)***

The report was accepted as read.

The Annual Report, TOR and quality improvement plan were duly noted.

c. ***Patient Experience Committee - (PEC) – (15 June, 2018)***

AR commented on the fact that the last committee was cancelled with only a couple of days' notice, despite only meeting on a quarterly basis. He queried the value and power of the committee and whether the right processes were happening in the background.

RP advised that a large number of apologies had been received at very short notice.

RJ confirmed that the focus of the group needed to be revisited to ensure the same remit as other committees, such as Clinical Safety and Effectiveness. RP to arrange a meeting with JBL, committee Chair and AR to discuss. **RP**

The Annual Report, TOR and annual complaints report were duly noted.

5. **Quality Group Report**

RP advised that a report is being finalised on issues raised in the Norfolk and Norwich University Hospitals Trust recent CQC report in relation to mandatory training and appraisals which have some similarities to this Trust. Also looking at Norfolk Community Health & Care Foundation Trust's outstanding report to see how this can be utilised for our own community and CQC preparedness work.

SD referred to Page 4 of the report and Table 1, CQC insight “worse category indicator” which detailed staff appraisal and Table 2 detailing an improvement "previously worse and now improved” relating to transfers around intensive care. He stressed the need to redouble efforts in these areas.

6. **Any Other Business**

No further business was noted.

7. **Reflection on Meeting and Identify Any Issues for Escalation or Capture/Review on the Risk Register**

SC was concerned that one of today’s presentations had been heard previously by some attendees. However, it was noted that today’s presentation was more detailed than that made previously.

AR asked if there were any other 100 Day initiatives and if these could be presented at future meetings. Noted that the committee has an extensive waiting list of presentations to be undertaken and therefore it would not, at present, be able to accommodate another on the initiative. Agreed RJ and SC to look at programme of upcoming talks to ascertain which would be appropriate for governors to attend. **RJ/SC**

8. **Date and Time of Next Meeting**

Please note the meeting will start at 14:00 in the Northgate Meeting Room, Quince House, WSFT.

28 September, 2018

The meeting closed at 3.25 p.m.

19. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

Presented by Richard Jones

Board of Directors – 27 July 2018

Agenda item:	19			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	19 July 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 – 28 September 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	✓		Written	Matrix	HB/RP
Finance & workforce performance report	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Nurse staffing report	✓		Written	Matrix	RP
Learning from deaths	✓		Written	Matrix	NJ
Quality and learning report, including quality priorities	✓		Written	Matrix	RP
Safe staffing guardian report	✓		Written	Matrix	NJ
Education report - including undergraduate training and stepped increase in Cambridge graduate trainees	✓		Written	Matrix	JB
Equality annual report	✓		Written	Matrix	JB
Safeguarding children annual report	✓		Written	Matrix	RP
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
Estates strategy	✓		Written	Matrix	CB
Digital programme board report	✓		Written	Matrix	CB
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	AE
Council of Governors report	✓		Written	Matrix	SC
Scrutiny Committee report		✓	Written	Matrix	GN
Board development plan	✓		Written	Matrix	RJ
Annual governance review report		✓	Written	Action point	RJ
Risk management strategy and policy	✓		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

11:25 ITEMS FOR INFORMATION

20. 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

21. Date of next meeting

To NOTE that the next meeting will be held on Friday, 28 September 2018 at 9:15 am in the Northgate Room.

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

22. 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