Board of Directors (In Public)

Schedule	Friday, 28 Sep 2018 9:15 AM — 11:45 AM BST
Venue	Northgate Room, Quince House, West Suffolk Hospital
Description	A meeting of the Board of Directors will take place on Friday, 28 September 2018 at 9.15 in the Northgate Room, 2nd Floor, Quince House at West Suffolk Hospital
Organiser	Karen McHugh

Agenda

AGENDA

Agenda Open Board 28 Sep 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
   For Reference - 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
   For Reference - Presented by Sheila Childerhouse

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

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

   Item 5 - Open Board Minutes 2018 07 27 July Draft.docx

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6. Matters arising action sheet
   To ACCEPT updates on actions not covered elsewhere on the agenda
   For Report - 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
   For Report - Presented by Stephen Dunn

   Item 7 - Chief Exec Report Sept 18.doc

9:35 DELIVER FOR TODAY

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8. Alliance and community services report
   To ACCEPT the report
   For Report - Presented by Dawn Godbold

   Item 8 - Alliance and community services Board cover sheet September V3 2018.doc

   Item 8 - Appendix 1 West Suffolk Alliance Year One Delivery Plan 2018 v9 1 060918.docx

   Item 8 - WSFT Board paper community and alliance update September 2018 V7.doc

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

   Item 9 - Integrated Quality & Performance Report_September_2018_Draft_v1.docx

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

    Item 10 - Board report Cover sheet - M4.docx

    Item 10 - Finance Report July 2018 Final.docx

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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11. Nurse staffing report
    To ACCEPT a report on monthly nurse staffing levels
    For Report - Presented by Rowan Procter

    Item 11 - Nurse staffing Board Report - August 2018 data.doc

    Item 11 - WSFT Dashboard - Aug 2018.xls

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12. Learning from deaths
    To ACCEPT the report
    For Report - Presented by Nick Jenkins

    Item 12 - Learning from deaths- Q1 Board report.docx

    Item 12 - Learning from deaths - Q1 Board report dashboard.pdf

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13. Quality and learning report
    To ACCEPT a report
    For Report - Presented by Rowan Procter

    Item 13 - Quality and Learning report - Sept 2018.docx

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14. Safe staffing guardian report
    To ACCEPT a report
    For Report - Presented by Nick Jenkins

    Item 14 - Guardian of safe working report Cover Sheet Sept 2018.doc

    Item 14 - Guardian Quarterly Report 1 April 18 - 30 June 18 final.docx

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15. Education report

To RECEIVE report

For Report - Presented by Jan Bloomfield

- Item 15 - Education paper Trust Board SEPT18.docx
- Item 15a - Updated signed WSFT self assessment June 2018.pdf
- Item 15b - Appendix A - WSFT Library Annual Report 2017-18.pdf
- Item 15c - Library report appendices - A4 Provision mapping of library services and resources.pdf
- Item 15c - Library report appendices - AHP analysis of quantitative data.pdf
- Item 15c - Library report appendices - AHP Showcase survey results.pdf
- Item 15c - Library report appendices - APPROVED FINAL - Knowledge cafe poster V2.pdf
- Item 15c - Library report appendices - AR graphs.pdf
- Item 15c - Library report appendices - Impact quotes.pdf
- Item 15c - Library report appendices - Lit searches.pdf

16. Annual reports:

16.1. Equality and diversity annual report

For Report - Presented by Jan Bloomfield

- Item 16.1 - Trust Board Annual EDI report.docx

16.2. Safeguarding children

For Report - Presented by Rowan Procter

- Item 16.2 - Safeguarding children coversheet.doc
- Item 16.2 - Safegauarding children annual report 2018.docx
- Item 16.2 - SCdevelopment plan July2018.docx

16.3. Infection control

For Report - Presented by Rowan Procter

- Item 16.3 - IPC Board report September 2018.doc

17. Consultant appointment report
    To RECEIVE the report
    For Report - Presented by Jan Bloomfield

    Item 17 - Consultant appointment report - September 2018.doc

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

11:15 BUILD A JOINED-UP FUTURE

19. Estates strategy
    To APPROVE the document
    For Approval - Presented by Craig Black

    Item 19 - Estates Strategy Coversheet Final.docx

    Item 19 - Estates & Facilities Strategy 2018 version 20 19 09 18.docx

20. Digital programme board report
    To ACCEPT a report
    For Report - Presented by Craig Black

    Item 20 - Digital programme board for September 2018.doc

11:30 GOVERNANCE

21. Trust Executive Group report
    To ACCEPT a report
    For Report - Presented by Stephen Dunn

    Item 21 - TEG report.doc

    Item 21a WSFT EPRR Core Standards Report v0.3.pdf

22. Audit Committee report
To RECEIVE the report
For Report - Presented by Angus Eaton

- Item 22 - Audit Committee Report Coversheet August 2018.doc
- Item 22 - Audit Committee Annual Report approved.doc
- Item 22 - Audit Committee Terms of Reference Board approval.doc
- Item 22 - NHS News Briefing June 2018.pdf

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23. Council of Governors report
To ACCEPT the report
For Report - Presented by Sheila Childerhouse

- Item 23 - CoG Report to Board Sept 2018.doc

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24. Use of Trust seal
To ACCEPT the report
For Report - Presented by Richard Jones

- Item 24 - Use of Trust Seal Report and Coversheet 28 Sept 2018.doc

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25. Agenda items for next meeting
To APPROVE the scheduled items for the next meeting
For Approval - Presented by Richard Jones

- Item 25 - Items for next meeting.doc

11:40 ITEMS FOR INFORMATION

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

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27. Date of next meeting
To NOTE that the next meeting will be held on Friday, 2 November 2018 at 9:15 am at Sudbury Community Health Centre.
For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

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

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For Approval

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MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 27 JULY 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	•	
In attendance			
Sue Deakin	Clinical Director, Surgery		
Dawn Godbold	Director, Community Integration		
Georgina Holmes	FT Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Paul Molyneux	Deputy Medical Director (deputising for Nick Jenkins)		
Mike Palmer	Clinical Director, Theatres & Anaesthetics		
Tara Rose	Head of Communications		
Catherine Waller	Intern Non Executive Director		

Action

GENERAL BUSINESS

18/166 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

Apologies for absence were received from Nick Jenkins.

The Chair welcomed everyone to the meeting and apologised that the lift was out of order, which was not an ideal situation. She introduced and welcomed Paul Molyneux who was attending the meeting in Nick Jenkins absence.

She informed the meeting that Jan Bloomfield would be retiring and said that she was an exemplary example of commitment to public service. She would leave an enormous void as she had been pivotal in creating the current culture at WSFT.

The Chief Executive agreed and said that she had delivered a huge number of initiatives which had culminated in the Trust having the best staff survey in the NHS over the past two years. She had been a great support to him with her experience of corporate affairs and had done an outstanding job. Everyone would be very sorry to see her leave.

18/167 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

- Joe Pajak referred to the unannounced MHRA inspection of pathology services which a number of governors were very concerned about. He asked why there had been an unannounced inspection and requested further assurance around the two major concerns, ie validation of the information system and workforce planning.

  The Chief Executive explained that WSFT had been aware that there would be a further unannounced inspection to look at progress against the issues that had been identified during the initial and subsequent visits. In January last year critical deficiencies had been identified and these had now been re-categorised as major deficiencies. WSFT had been very surprised at the findings of this inspection as it was considered that things had been moved forward. However, it appeared that there had been some communications issues with the regulators about what had and had not been agreed. He said that it was very disappointing that the Trust was in this position again.

  The Chair agreed and said that this highlighted the need to keep a tight grip on this sort of partnership.

- Liz Steele referred to PALs and noted a theme relating to noise at night and moving patients/beds around late at night. She asked for assurance that bed movements were being kept to reasonable levels and that departments which would be caring for these patients the next day were notified of the move.

  Rowan Procter explained that movements at night had to be recorded but staff tried to not move patients after 10.00pm or before 6.00am unless there was a clinical reason. She confirmed that the relevant department should be notified if a patient was moved and that e-Care would assist with this.

- John Ellison, a west Suffolk resident, referred to the Chief Executive's report which indicated that the Trust was close to the limit in being able to make savings and also the lack of progress with the £15m bid for funding for development of the emergency department. He asked what the prospects were for the forthcoming autumn/winter and the pressures that were likely to occur again, not only in the emergency department, but also non-emergency procedures. Craig Black confirmed that there was a cost improvement plan (CIP) which represented 5% of turnover; this meant the organisation had to out-perform not only previous savings but also the entire economy in delivering this scale of savings.

  The bid for funding for the emergency department had been re-submitted on 7 July and feedback from the previous bid had been very positive, therefore he was optimistic. He explained that this would not address the issues for next winter as the development of the emergency department was a four year programme. However, the cath lab would be ready and would result in an increase in capacity. In addition 50% of the new acute assessment unit (AAU) would be ready in December which would result in an increase in capacity and there was a staffing plan to manage this.

  The Chief Executive stressed that a huge amount of work was being undertaken to look at winter plans for next year and the decision had been taken to advance the capital programme to assist with this.

- Barry Moult referred to the discharge summary report. He was not assured that the Trust had a grip on this and was concerned that it was still having an impact on patient care. He asked what the time line was for addressing the issues.

Helen Beck explained that a project manager had been appointed to manage and focus on this. They had identified areas where people were doing something slightly different which meant that the system was not capturing the relevant information. This meant that GPs were receiving discharge summaries, or they were aware of these patients but this was not being recorded. Discussions were currently being had the CCG to agree to exclude this cohort of patients.

If these technical issues were resolved performance would improve dramatically and this should also help to identify further issues.

Paul Molyneux confirmed that there was considerable focus on this as part of the next junior doctor induction.

Angus Eaton asked about the timeline. Helen Beck explained that, subject to approval being given by the CCG, the improvement would be instantaneous as this cohort of patients would be excluded from the report. Therefore an improvement should be seen in the next report.

Gary Norgate explained that linking e-Care to GPs was currently being developed. It was hoped that by December this would be in operation which would also help improve the situation. Mmodal would also assist in the speed and efficiency of the production of discharge summaries.

Alan Rose assured Barry Moult that the NEDs would be focussing on this over the next few months, even when board meetings were not taking place.

Rowan Procter explained that Margaret Rutter had requested that the following questions be asked in her absence:-

- A recent report indicated that dehydrated patients were causing a new crisis in the NHS and delaying hospitals in catching up with delays caused by the winter crisis. She asked for assurance that if this was the case no patient was made to suffer needlessly.

  Rowan Procter assured the board that this was being focussed on and staff were being extra vigilant and ensuring that patients were kept hydrated and had access to water at all times. However, some patients were being admitted to hospital with dehydration.

- A report by the Royal College of Paediatrics and child health stated that one in every hundred child inpatients was being cared for overnight on an adult ward. She asked for assurance that staff had guidance on how to respond to such an event occurring.

  Rowan Procter explained that a certain age group, ie 16 -18 years tended to 'fall between the gap' as to whether they were admitted to a children's or adults' ward. This was looked at on an individual basis, depending on the reason for admission.

18/168 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

18/169 DECLARATION OF INTERESTS

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

18/170 MINUTES OF THE MEETING HELD ON 29 JUNE 2018

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

Page 3, 18/144, 2nd para to be amended to read, "In light of the NHS plan and its associated increase in funding, it was considered to be important that WSFT increased its national involvement in order to stay aligned strategically and ensure access to any additional funding where appropriate."

Page 8, 18/148, 3rd para, 2nd sentence to be amended to read, "…..and continuation of the additional capacity which had been open in April."

Page 10, 18/152, title should read Medical Revalidation Annual Report

Page 12, 18/157, to be amended to read, "Gary Norgate thanked the team for the work that had been undertaken to address the issues around annual leave".

18/171 MATTERS ARISING ACTION SHEET

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

Item 1597 – monitor progress with transport service at future meetings. Helen Beck reported that significant progress appeared to be being made and positive feedback was now being received. She would forward data to Gary Norgate as chair of the scrutiny committee. **H Beck**

Item 1600 – review the issues behind sustained poor performance for the pain audit. Rowan Procter reported that the audit for the next quarter showed visible progress.

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

Item 1587 – 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. Sue Deakin reported on the number of staff who had been through human factors training and the progress that had been made. A new strategy was also being produced.

18/172 CHIEF EXECUTIVE'S REPORT

The Chief Executive highlighted the recent visitors to the Trust, including Matthew Hancock who had made his first major policy speech, outlining three new priorities within the NHS. One of these was to support staff, and the Chief Executive noted that WSFT had come out as the third best place to work in the friends and family test. Another of the priorities was around technology and the Chief Executive had been asked to lead a piece of work on setting out what technology components the NHS plan was likely to incorporate.

Matthew Hancock had been very supportive of the £15m bid for development of the emergency department.

The Trust had marked the 70th birthday of the NHS in a number of ways and the Chief Executive and Tracey Green, WSFT employee of the year, attended a service at Westminster Abbey to celebrate the occasion. He said that after 70 years WSFT could be proud to say that it was now one of the best hospitals in the country, which was a massive achievement.

Jan Bloomfield reported that Ruth May, Executive Director of Nursing for NHSI would be visiting the Trust on 3 August and would be partaking in a similar session to a 5 o'clock club at 1.00pm which everyone was welcome to attend.

Gary Norgate asked who had implemented the new bus service that had been set up between Haverhill and WSFT, which was good for alliance working. Jan Bloomfield explained that Jean le Fleming had worked very hard on this and building relationships with the county council.

Gary Norgate referred to the guide to reducing long hospital stays and better health and care; he asked if there was anything new or innovative within this. Helen Beck said that she did not think that there was anything very different, although a diagnostic virtual ward was currently being scoped, which was different. It was basically about making sure that staff continued to do everything they were already doing as robustly as possible.

Angus Eaton referred to Matthew Hancock's three priorities and said that the work that WSFT was doing on prevention should not be under estimated. It was proposed that more detail on prevention should be included in this report. **S Dunn**

DELIVER FOR TODAY

18/173 ALLIANCE AND COMMUNITY SERVICES REPORT

Dawn Godbold highlighted the patient story in appendix 1. She explained that the services described in this scenario had previously been set up and working separately. They were now working collaboratively in a different way and were empowered to make changes. This also demonstrated further opportunities for what could be done by more services working together, eg working with the domiciliary care market and shared crisis response services.

The report provided a general update on Buurtzorg and a more detailed report would come back to the board in September. The health & wellbeing board had been very supportive and had said they would assist in identifying and securing funding for this to continue.

It was proposed to form a clinical/professional forum across the system. This would enable people to get to know who their colleagues were and build relationships and trust. It would also enable greater clinical oversight and scrutiny of some of the system wide changes, with clinical sign off.

Appendix 1 also illustrated the measures, metrics outcomes which were being developed for general health, mental health and children & young people's health at STP, CCG and WSFT level. The next stage was to look at metrics for each of the six localities in the west Suffolk area and to measure how well they were working together and collaborating, ie system maturity.

The Chair said that this was a very helpful report and it was good to see the metrics.

Alan Rose asked about the development of the six localities in west Suffolk and when they would all have an integrated team that was operational. Dawn Godbold explained that they all had an integrated team but were being developed at different stages in different areas, depending on the locality. He asked her if she had any concerns about any areas. She confirmed that she did not have any concerns and explained that there was very good engagement from primary care and Nick Jenkins would be attending the primary care locality meetings when he was able to.

These meetings needed to be developed into more of a system discussion, rather than just focussing on primary care.

Richard Davies considered this to be a very good report with a lot of collaborative progress that appeared to be very successful. He referred to the metrics and asked if Dawn Godbold considered this to be the right kind of data to demonstrate that the relevant information was being captured. Dawn Godbold agreed that different data needed to be captured to show the success of collaboration, particularly from a financial aspect and to identify cost savings.

Craig Black explained that a lot of the financial metrics would come out of the population health analysis which would enable comparison between different locality teams. These systems were currently being set up.

Catherine Waller said that this report, particularly the metrics, really showed how community services were evolving. She asked how this information was being used to drive performance and how this fitted with the bid for transformation funding. Dawn Godbold explained that transformation funding was money made available by west Suffolk CCG and was about local innovation and transformation. WSFT was putting in a bid around the use of technology in care homes relating to admission avoidance, as well as a number of other bids. She explained that it was too early to know how to use the metrics to drive performance and this would need further evaluation and development.

Helen Beck stressed that the maturity of west Suffolk community services should not be underestimated. She and Dawn Godbold had visited Norfolk and attended their primary care working group and had been very surprised at their lack of progress and patient focus. There had been no concept of prevention or working differently. She was the only representative for acute trusts on this group??

Gary Norgate agreed that this was a very good report with an encouraging patient story. He was particularly pleased to see what was being done to improve IT services and links between the hospital and community; he asked if any assistance with this was required. Dawn Godbold explained that a lot of assistance was required and this was being provided and there was now very good support from WSFT's IT team, which the community staff would be benefitting from.

18/174 INTEGRATED QUALITY & PERFORMANCE REPORT

Rowan Procter highlighted the work that was being undertaken on pressure ulcers in the community which was very positive and had resulted in a reduction in numbers. WSFT had also been working with the CCG to understand which pressure ulcers were attributable to the hospital rather than the community.

There had been an increase in isolation breaches this month which was a concern and could result in moving beds at night, which was disruptive to patients. This was due to the lack of single rooms which had been on the board assurance framework (BAF) for some time.

There had been two breaches of duty of candour. One of these was a conscious decision not to cause further distress to the family at the time and was not considered to be a serious incident. The second was waiting for a decision on whether harm had occurred whilst the patient was in the care of WSFT.

Alan Rose referred to responses to complaints, which he considered to be a shared responsibility. He had had a discussion with the patient experience team and noted

that 10-15 complaints were received per month. However, only 50% of complaints were being responded to within the target time. The team was looking into this and also into how many complaints were received about the complaints process. He asked for this action to be noted and explained that he would be spending further time in this area. The Chief Executive noted that the number of complaints received per month had decreased significantly in the past few years and a considerable amount of work had been undertaken on response letters.

Richard Davies was pleased to see that the number of pressure ulcers was reducing and the learning from this taken out into the community. He referred to nutrition assessment and monitoring which had been an ongoing issue and asked about compliance with monitoring and why this was not happening. Rowan Procter said that there was no obvious problem but that this was multi-factorial. One of the issues was weekly weighing of patients and the Trust was looking at installing weighing pads in strategic areas to make this a better patient experience; this would also link directly to e-Care. 'Vital links' would also record input and output. Charitable funds had been used to buy scales for specific areas. As part of the nutrition collaborative WSFT would be learning from best practice from other areas.

Gary Norgate referred to the cancer two week wait breast referrals target which had been missed for the last two months. He asked, if extra sessions were not solving the problem, what the root cause was. Helen Beck explained that the root cause was the spike in demand in May and June. It was very difficult to initiate a demand management initiative in breast services as the guidance was to refer any concerns to secondary care; therefore managing demand was very challenging. The team continued to focus on this and they had also had to manage the screening back log. Instances of conversions to cancers were very low and patients could be rapidly moved into the treatment phase.

Gary Norgate asked if it was expected that 'red' would continue to be the norm in this area and if the Trust should be recruiting additional staff or re-modelling the service. Helen Beck said that this was a very important indicator, therefore 'red' could not be the norm. However, recruiting additional consultants in this speciality was not quick or easy to do, if this was considered to be the appropriate course of action. There would be further focus on looking at capacity in this area.

Richard Davies stressed that it was important to note that guidelines had been changed and GPs were not referring unnecessarily. Alan Rose asked about the change in guidelines and if was legitimate to go back to the commissioners and revisit the contract as there had been a change to the service. Craig Black explained that was part of the block contract; however WSFT had had a discussion with the commissioners but it was a matter of prioritisation of money in the system.

Gary Norgate referred to appraisals and asked if there was a sustainable goal that could be set. It was noted that this was discussed and focussed on in divisional performance meetings. A timescale for this would be included in future reports. **J Bloomfield**

Catherin Waller referred to sepsis and asked if this was an issue. Helen Beck explained that new senior staff had been recruited who were focussing on this area from a performance and safety culture. They had identified ways of addressing this and engaging and developing staff in this area. Rowan Procter explained that that a different process had been implemented with pre-triage and triage to prioritise patients showing signs of sepsis and ensure intervention in a timely manner. The Chief Executive noted that 'vital links' would also assist with this.

Richard Davies asked why neutropaenic patients were going through A&E. Rowan Procter explained that WSFT did not have a 24/7 acute oncology facility.

18/175 TRANSFORMATION REPORT Q1

Helen Beck explained that the CIP programme number was different to the finance report as it related to the stretch target and allocation of cross cutting CIPs; she apologised for this confusion.

Catherine Waller referred to procurement and Category Towers and asked if there was Brexit planning in this area. Craig Black explained that the Department of Health was planning for this. He did not consider that this would be within WSFT's area of procurement as this would principally be drugs. The Trust would need to look at this within its own organisation but there was a danger of individual organisations stock piling and creating a national shortage.

Richard Jones said that the supplier risk report had been looked at, but the risk around ability to supply was being looked at rather than individual companies. The risk rating for this was being re-visited by the audit committee.

The Chief Executive said that this was a very important point and that this was being looked at nationally. However, there needed to be more understanding of how it could affect WSFT. It was proposed that this considered in greater detail at a future audit committee meeting. **R Jones**

18/176 FINANCE AND WORKFORCE REPORT

Craig Black reported that after month three WSFT was £85k behind plan, pre-Provider Sustainability Funding (PSF). The Trust was currently forecasting that it would not receive sustainability funding relating to A&E performance in quarter one. Although it exceeded the national target of 90% in quarter one, it was below quarter one performance for last year of 95%. WSFT had appealed against this as it penalised good performance.

The focus within the organisation was on CIPs and further detail was available if requested. All CIP schemes were underpinned by detailed plans and signed off by Nick Jenkins and Rowan Procter. The plan was to achieve the stretch CIP by removing the contingency, and through year-end adjustments around deposits relating to equipment in the community which would bridge the gap.

£2m of the CIP programme had been achieved to date. The stretch CIP would be achieved through non-recurring savings. It was noted that the programme was phased and required a greater delivery of CIPs at the end of the year than the start of the year.

Cash remained a concern as the Trust had proceeded at risk with the capital programme and the development of AAU, as the first priority was for there to be sufficient capacity to safely manage the organisation in the winter. This was predicated on the loan application that had not yet been formally agreed and was still in the process of being negotiated. If the loan was not agreed there would be significant cash problems by the end of this year.

Angus Eaton asked for assurance around the CIP and that the underlying momentum was actually happening further down the organisation. Helen Beck considered that this was the case and there was a huge focus on this. Cross cutting CIPs were currently in the process of being allocated and the assistant directors of operations (ADOs), finance and performance managers and clinical directors were fully aware of the importance of these and were engaged in working them through. However, decisions on ways to achieve these were getting tougher and would continue to be extremely challenging.

Alan Rose asked if the project management office (PMO) was now fully matured and embedded in achieving the programme. Helen Beck confirmed that this was the case and a number of the staff had worked alongside KPMG and were fully embedded in the divisions and functioning well. The team had been together less than a year and were continuing to grow and mature.

Craig Black said that there was a risk that the PMO function could sit back from the organisation and just report. Therefore it was important to ensure that the team got out into the organisation and helped to deliver some of these schemes. Helen Beck confirmed that this was happening and the time that the team spent in the divisions and the time that they spent reporting was being looked at.

Alan Rose asked about ideas for long term cost savings two to three years ahead. Helen Beck explained that there were always savings that would deliver in years two and three and ideas were already being looked at, particularly where integration might help and also outpatient transformation and pharmacy.

Gary Norgate referred to page 5 and noted that A&E attendance numbers were lower than last year. Craig Black explained that this referred to income, which was an analysis of volume and price. Therefore this indicated that activity was up but price was down quite significantly, which meant that fewer investigations of patients were being undertaken in A&E. This was being looked at further to confirm that this was the case. Gary Norgate asked for a further report on this.

C Black

He also noted that elective income was significantly different to the plan and asked why this was. Craig Black explained that the volume of elective work was down on last year; however he would look into this with regard to the average price which could reflect the mix in specialities.

C Black

It was confirmed that AAU was included in the figures for staffing and recruitment on page 9.

Gary Norgate asked what the driver was for the increase in aged debt. Craig Black explained that some of this was Tricare, which related to Lakenheath and this being focussed on. He explained that this was also looked at by the audit committee.

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INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

18/177 NURSE STAFFING REPORT

Rowan Procter highlighted G8 and F9 as having the highest number of vacancies. She explained that a member of staff had been seconded from G3 to work on G8. There had been some concern that staff did not have the time to report and that there was under reporting in these areas, but this did not appear to be the case. Further nursing staff would be joining the Trust in the coming months which should help to address the issue.

Rowan Procter explained that she was not concerned that staff were leaving as they did not like working at WSFT, but that this was due to the development they had benefited from whilst working for the Trust.

Gary Norgate referred to medication errors and asked what an acceptable number was. Rowan Procter explained that five medication errors in AAU was not a concern and there was not a trend or medication errors that had caused harm. She said that it was reassuring that these had been identified and reported on Date; she considered that reporting was a positive and that errors were not being missed.

Angus Eaton noted that high bank and agency used was given as a reason for a number of nurse sensitive indicators and suggested that this should be more precisely recorded, ie RAG rated. **R Procter**

Jan Bloomfield reported that all nursing assistant vacancies had been filled and that the team was now recruiting for additional staff for winter. This was a great achievement by both the nursing and HR teams.

Gary Norgate asked if roster effectiveness and non-productive time was a concern, as this was rated as red or amber in the majority of wards. Rowan Procter explained that that this was being looked at in greater detail on a weekly basis. It was proposed that further information on this be provided in this report. **R Procter**

18/178 MANDATORY TRAINING REPORT

Jan Bloomfield reported that adult and child safeguarding was now above 90%. The board had previously agreed to stretch the target of 80% to 90%. Those areas that were below 80% were being focussed on and given greater scrutiny, as well as those not yet at 90%. Mandatory training was a key focus at performance meetings with the assistant directors of operations (ADOs).

The Trust had recently invested in Articulate which was a more interactive tool to support e-learning, as well as looking at other trusts and they used for e-learning.

The Chair said that she was very pleased about the safeguarding training performance.

Catherine Waller referred to mental capacity mandatory training for community staff which was showing as low and asked if this was a concern and if there was a parallel in the acute setting. Jan Bloomfield explained that this was adult mental health in the acute setting. Dawn Godbold explained that training for this was provided externally and there had been an issue with trainers, but this was being addressed.

18/179 NATIONAL PATIENTS SURVEY REPORT

Rowan Procter said that it was disappointing that performance had decreased in certain areas encapsulating the time nurses spent with patients. This was a reflection of the pressure that staff were under. It was hoped that bay based nursing would help improve this and would be a positive development as individuals would be able to spend more time with patients.

Alan Rose agreed that this was disappointing considering that WSFT was an outstanding Trust. He noted that out of 70 questions only one was above average.

The Chief Executive agreed and referred to food which he considered to be very good at WSFT. This suggested that these indicators needed more forensic focus through the patient experience committee with focussed work to help improve this.

Rowan Procter explained that these were the results of a survey undertaken in 2017. The Trust now had the ‘perfect ward’ which would help identify issues that required improvement. She referred to the low response rate and said that the results should not be taken as actual fact and there was a ‘health warning’ relating to the questionnaire.

Jan Bloomfield noted that this did not correlate with the friends and family survey.

Gary Norgate commented on how low the scores for the whole of the NHS were for some of the indicators eg questions 69 and 70. He suggested that the way these were worded needed to be looked at.

The Chief Executive agreed but said that this needed to be managed carefully in order not to create negativity. Rowan Procter explained that these questions were set and could not be changed. She was disappointed that patients said that they were not given emotional support. The Chair agreed that this needed to be improved.

Alan Rose suggested that there was a need to reflect on the way in which people generally communicated across the organisation and focus on areas that were not so good in order to maintain the high standards the Trust aspired to.

It was agreed that this should be given further consideration by the patient experience committee, including how to communicate these results across the Trust. **R Procter**

18/180 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that the award for this month had been received by Trudy Wright, bereavement support officer, and Sara Carnell, complex care lead, specialist children's nursing team

Trudy Wright was nominated for her continual hardworking, unwavering performance within the bereavement service, and her upbeat attitude. From junior doctors to executives, she was seen as a constant source of information. She showed compassion and understanding with the relatives of loved ones and maintained professionalism during extremely emotional times.

Sara Carnell was nominated for her response when the mother of a complex care child injured her back, making her unable to provide care for her child. A number of the complex care team staff responded by working flexibly and undertaking additional hours. However Sara's contribution and leadership, in particular, meant that this child avoided being taken into care, out of county, and resulted in him being supported to remain in the family home.

The board congratulated both Trudy and Sara on their commitment and compassion towards patients and their relatives.

BUILD A JOINED UP FUTURE

18/181 CONSULTANT APPOINTMENT REPORT

The board noted the appointment of the following:-

Dr Carolina Capriano, Consultant Respiratory
Dr Elliott Rees, Consultant Radiologist

Jan Bloomfield explained that consultant radiologists were very difficult to appoint. Richard Davies said that he had been part of the interview panel and considered this to be an excellent appointment.

It was noted that Dr Carolina Capriano had been appointed through the fast track process.

GOVERNANCE

18/182 TRUST EXECUTIVE GROUP REPORT

There had been considerable focus on winter planning and staffing at both meetings in July.

The other area of focus was CQC learning and preparedness. The Chief Executive recommended that board members should read the CQC report on the Norfolk & Norwich. He stressed that the difference between requiring improvement and outstanding was not that great and WSFT needed to continue to focus on areas that required improvement. The Chair agreed and said that she had found this report to be very shocking.

Alan Rose said that he was pleased to see that there was a series of actions for areas which needed to sustain their outstanding ratings.

Gary Norgate considered this to be a timely report which provided assurance that this was being focussed on. However, he felt that pathology should be highlighted as a concern. Rowan Procter explained that the problem was that this was not a WSFT service therefore it was not in the Trust's board assurance framework (BAF). Gary Norgate acknowledged this but said that without this service WSFT would fail.

Rowan Procter explained that the CQC would not inspect pathology as it was not registered as a WSFT service; however a different group was looking at pathology.

Gary Norgate suggested that discharge summaries should be included in this plan. **R Procter**

18/183 QUALITY & RISK COMMITTEE REPORT

The board noted the content of this report.

Alan Rose highlighted the action for the responsibilities of the patient experience committee to be reviewed. **J Bloomfield**

Jan Bloomfield confirmed that the inpatient survey would be looked at by the patient experience committee and an action plan developed, with particular focus on one or two areas.

18/184 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were noted.

ITEMS FOR INFORMATION

18/185 ANY OTHER BUSINESS

There was no further business.

18/186 DATE OF NEXT MEETING

The next meeting would take place on Friday 28 September 2018 at 9.15am in the Northgate Room. An update on pathology services would be provided to board members in August.

RESOLUTION TO MOVE TO CLOSED SESSION

18/187 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

For Report

Presented by Sheila Childerhouse

Board of Directors – 28 September 2018

Agenda item:	6			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	20 September 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
1604	Open	29/6/18	Item 24	Report annual governance review findings at the end of September.	Questionnaires issued. Report will be drafted for meeting in November.	RJ	02/11/18	Green
1613	Open	27/7/18	Item 10	Review Brexit impact as part of the Trust's emergency preparedness arrangements (including review of supplier risk). Update to Audit Committee in 2 November 2018	Building into supplier and business continuity plans	RJ	02/11/18	Green

Closed 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. Part of deliver plan on the agenda.	DG	28/09/18	Complete
1598	Open	29/6/18	Item 8	Schedule report on initial assessment and findings for Buurtzorg test and learn in September	Included in the presentation to Q&RC on 28/8.	DG / RJ	28/09/18	Complete
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	Quality presentations to Q&RC structured to include wider presenters - community teams (Sept) and orthopaedics (Jan '19). Subject matter experts present at subcommittees.	RJ/JB	28/09/18	Complete
1610	Open	27/7/18	Item 6	Send Gary Norgate the CCG data on patient transport provider	E-Zec presentation circulated on 31/7/18	HB	08/08/18	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1611	Open	27/7/18	Item 7	Include more detail on prevention with the report	Prevention reflected in updated CEO report	SD	28/09/18	Complete
1612	Open	27/7/18	Item 9	Set out appraisal timescale for appraisal improvement (with performance and date)	Appraisal performance is monitored at divisional performance review meetings (PRMs) and the Trust has restructured reporting on the same principles as RTT to profile staff requiring appraisal on a rolling basis. We expect to see continued improvement over the next three months (8% improvement delivered to date). Q2 staff FFT reports that 86% of staff indicated that they have had an appraisal in the last 12 months.	JB	28/09/18	Complete
1614	Open	27/7/18	Item 11	Investigate average performance data to better understand ED and elective activity	Included in Finance report	CB	28/09/18	Complete
1615	Open	27/7/18	Item 12	Development of nurse staffing report: (a) Nurse staffing report states 'High agency and bank usage', be more specific with an assessment of risk as RAG rating (b) Drill down 'roster effectiveness' data and provide assessment of risk/impact in the report	Included in staffing report	RP	28/09/18	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1616	Open	27/7/18	Item 13	Report back on the options review for the provision of e-learning. Include barriers to staff achieving mandatory training compliance (inc. IT and community)	Following a review with the ESR lead and IT, two main issues have been identified as the cause of user issues with e-learning. 1 the current server not being compatible for hosting e-learning. 2 a number of computers not having the required version of Internet Explorer for ESR to run. IT are currently updating all computers both on site and in the community to the required specification of Internet Explorer. Investigation into suitable servers and the associated cost is in progress. IT work arounds are currently in place to enable staff to complete their e-learning.	JB	28/09/18	Green
1617	Open	27/7/18	Item 14	Include on PEC agenda a detailed review of the latest national patient survey results and the proposed action (including how to complain and emotional support during stay). Also consider how to communicate these results within the Trust - tool to make a step change.	Areas for improvement were discussed and it was confirmed that an action plan is being developed with the senior matrons/heads of nursing. The actions will be monitored through the Patient & Carer Engagement Group and an update brought to PEC. The in-house patient survey questions would also be reviewed to 'test' progress in the prioritised areas. Caution was expressed at not becoming complacent following an outstanding CQC inspection. It was agreed that the report should also be presented to the TEG.	RP	28/09/18	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1618	Open	27/7/18	Item 17	Include discharge summaries in the list of issues being considered as part of CQC preparedness	Incorporated into the Quality Group programme	RP	28/09/18	Complete
1619	Open	27/7/18	Item 18	Review the responsibilities of PEC as part of meeting in September	Initial discussions have taken place on the committee's responsibilities and the structure of the agenda. A 'deep dive' approach was successfully trialled at the September meeting - reviewing in detail the approach to engaging on the end of life experience for families and carers as part of the learning from death reviews. This 'deep dive' approach will be used to gain assurance on the effectiveness of engagement and learning strategies for the patient journey as part of a structured programme. This will be reflected in the agenda and terms of reference which will be updated at the next meeting.	JB	28/09/18	Complete

7. Chief Executive’s report

To ACCEPT a report on current issues from the Chief Executive

For Report

Presented by Stephen Dunn

Board of Directors – 28 September 2018

Agenda item:	7			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	20 September 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

You will likely have heard the Government's pledge of an additional £145m to NHS trusts across the country to support their winter plans. We're delighted that we've been told we'll receive £2.3m of that pot to support our **new acute assessment unit (AAU),** currently in the first phase of development and due to open in December. The unit will help to ease pressure on the emergency department – leaving it to just care for those with major conditions, or minor injuries that can be treated quickly. Patients attending the AAU will be seen by a multi-disciplinary team, from consultants and nurses to assistant nurse practitioners and physician associates, who all have quick and easy access to other services like diagnostics – meaning patients should have their diagnosis and treatment much faster than in the traditional emergency department set-up. I spoke about this on BBC Suffolk the week before last.

Secretary of State and local MP Matthew Hancock also welcomed our news, saying: "I know how much pressure hospitals are under, particularly in the winter months – so this extra capacity to be able to treat the patients who need it most urgently is greatly welcomed. This funding will help enable West Suffolk Hospital to continue to provide first-rate care to patients, with bigger and more enhanced emergency care facilities, this is a big win for the hospital and for the local community."

We expect winter to still be a real challenge for us, but this funding is most welcomed and appreciated. We continue with our preparations for **winter 2018-19**. This includes capacity modelling, maximising the new physical capacity and staff recruitment plans. The recruitment plans included additional nursing assistants to support the implementation of bay based nursing. Next month will see the launch of the annual staff flu vaccination programme, and the occupational health team, together with infection prevention and our stalwart peer vaccinators, will be endeavouring to give as many staff as possible this absolutely vital and potentially life-saving vaccine. At this month's Core Brief, medical director and flu champion Nick Jenkins gave a heads-up on the season to come, reminding staff that an estimated 8,000 people die of flu every year in England alone, and that flu can cause severe complications, even in the healthiest of us.

I've often said that for one of the smaller hospital trusts in the region, we punch well above our weight. We've proved that yet again, with data from NHS England showing that west Suffolk is the best performing area in the country for **minimising excess bed days** (the term used to describe where people are still in hospital when they no longer need to be there). Latest figures from NHS England show the NHS West Suffolk Clinical Commissioning Group (CCG) area has fewer excess bed days — for its size of population than any of the other 194 CCGs in the country. In 2017 there were 12.2 excess bed days per 1000 population in west Suffolk, against a national average of 37.8. We know that reducing delays and getting people out of hospital and back into their own home or care home as soon as medically safe to do so is a priority, and it's only through close working between us and partners at the CCG and Suffolk County Council that we've been able to achieve this. It just shows that by working together as a system we really can make positive change for patients which will help with winter pressure and support our integration ambitions.

Since October last year **community teams** have been part of the Trust, helping us to become a fully integrated health and care provider. They and our allied health professionals are at the forefront of innovation in terms of the care we provide to our patients to aid prevention. Examples include our early intervention team, a 'one stop shop' to help people retain their independence and avoid hospital admission; and our community cardiac rehab team, which offers a supportive programme of health education and exercise that empowers people to take some control over their heart disease and to live healthy lives. We've been bringing acute and community services closer together and working more collaboratively with our social care colleagues and other partners in the health and social care system as part of a 'West Suffolk Alliance'. This is to ensure we deliver joined-up care that's centred on individuals' needs and goals, is closer to home, and helps people to stay well and manage their health and wellbeing. Helena Jopling, our public health consultant is working with staff and GPs to design services to meet the demographics and specific clinical

needs of the local population. Changing the way we work together to make effective use of our resources so that health and social care locally is sustainable for the future is vital.

As part of the '**West Suffolk Alliance'** work happening across west Suffolk, more than 60 system partners, including West Suffolk NHS Foundation Trust acute and community staff, social care and voluntary sector representatives, attended a fantastic system design workshop to develop the approach to discharge to optimise and assess.

At the end of July, we reopened the **X-ray department based at the Healthy Living Centre** in Thetford. The service closed in September 2017, but NHS South Norfolk Clinical Commissioning Group, which commissions the service, remained committed to it and approached us to be the new provider. We're absolutely delighted to have been able to reinstate this community based service to our Thetford patients. Working closely with local GPs, the department can provide basic x-rays such as chest, neck, spine, hands and feet, and the results are then sent to our consultant radiologists at West Suffolk Hospital, who review the patient's images and advise on the next steps of care. We really are committed to working closely with our community services; this shows that with a little effort and perseverance, we can make a difference. This really will benefit patients, as some will be able to avoid making a trip to hospital at all, saving them both time and money, and making their care that bit closer to home.

For **August's performance** there were 75 falls and ten Trust acquired pressure ulcers. There was one C. difficile case in the month. The Trust failed to deliver on the target for cancer two week wait from GP referral for August. The 4 hour wait performance for the emergency department for August is 87.57% but attendances continue to follow an increasing trend, with an 11% (adjusted) year-on-year increase for August. Performance in the last two week's has significantly improved, with the Trust's performance being the best in the region. RTT performance against the 18 week standard has seen deterioration this month with performance of 89.6% and 11 long waiting patients reported for August. A weekly focus remains on those patients waiting longer than 52-weeks for treatment.

The **month five financial position** reports a deficit of £5.6m. This is £0.6m worse than planned, predominantly due to provider sustainability funding (PSF) funding being behind plan as a result of ED performance. 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.

We continue to work with North East Essex and Suffolk Pathology Services (NEESPS) to address the deficiencies identified by the MHRA during their unannounced inspection in July 2018. NEESPS are responsible for the provision of **pathology services** for West Suffolk NHS Foundation Trust and East Suffolk and North Essex Foundation Trust (ESNEFT). The focus for improvement includes ensuring that staffing is in place to deliver a sustainable blood bank service and implementation of software changes, including appropriate validation, for systems that support results reporting and quality assurance. We have also worked with ESNEFT, as co-owners of NEESPS, to strengthen the governance arrangements between all parties. Executive and non-executive members of the Board have undertaken a quality walkabout of the laboratory. This has allowed us to see the areas first-hand, talk with staff and gain an understanding of the challenges the service is facing. As a Board we recognise that maintaining this visible leadership will be vital to driving the required improvements.

As previously reported a commitment has been made for a funding for the NHS of 3.4% a year over the next five years. NHSI has been tasked with developing a **long term plan for the NHS** to set out how this funding will be used to drive improvement. This is likely to be published in

November this year. As part of this work 14 chief executives have been chosen to work with national leads to co-design the future vision and plan. I am delighted, and humbled, to have been asked to lead the digital workstream for this work. On the 19 September we hosted a meeting with Simon Eccles, NHS national chief clinical Information officer (CCIO) to talk about our digital journey and the wider NHS' digital future.

You may remember that we recently trialled an innovative alternative to pagers, an app called **Medic Bleep**, to try and improve communications between colleagues and save our clinicians' times. We heard news earlier this month that we, along with the Eastern Health Academic Science Network (EHASN) and app-creators Medic Creations, have been shortlisted for a National Health Service Journal award for our involvement in the pilot. We're in the 'Using Technology to Improve Efficiency' category; we won't find out until November whether or not we've won (and competition tends to be very stiff!), but this is a fantastic acknowledgement. As a global digital exemplar trust, we're always on the lookout for new technology and thinking about how we can digitally enhance what we do. It's great to be recognised as a Trust that is trying new approaches to communication and patient care. Work is onoging to implement Medic Bleep across the Trust, so watch this space.

I joined some of our fantastic estates team for the 'topping out' on our project to build three new **staff accommodation blocks** at West Suffolk Hospital. The topping out marks a milestone in the construction process when the building becomes watertight and work starts to progress in earnest on fitting out the interior. This new accommodation will help to attract new joiners to our Trust, and will ensure that our clinicians who live on site have a good experience and comfortable home to return to after a long shift. But alongside that, the blocks help support our commitment to sustainability as they have some serious eco-friendly credentials, including solar panels, dual-flush toilets, LED lighting double glazing and high levels of insulation. We hope that they'll be completed sometime in February, and I'm looking forward to seeing the finished thing!

On the 12 September, more than 350 staff, governors, members and the public joined us in the Apex, Bury St Edmunds, to celebrate our **annual members' meeting**. Guests heard a reflection from myself about the year we've had, a look back at healthcare across the ages from chair Sheila Childerhouse, and a fantastic clinical talk about eye health from Dr Raj Hanspal. The event also held a number of stalls and displays from those in and outside the Trust, including our patient advice and liaison service (PALS) and patient portal teams, My WiSH Charity, and West Suffolk Physio (our private physiotherapy service), plus a fantastic exhibition by the Suffolk NHS Retirement Fellowship that included historic equipment and photos, to celebrate 70 years of the NHS and 40 years of the Fellowship. It was fantastic to see and welcome so many of our community. We are truly lucky to have such supporters of our Trust and our people.

Chief Executive blog
Prevention, workforce and technology: https://www.wsh.nhs.uk/News-room/news-posts/Prevention-workforce-and-technology.aspx

Deliver for today

Palliative care summer conference
More than 130 delegates from across Suffolk attended the first summer palliative care conference in July at Kesgrave Conference Centre. It was organised by the community education hub and West Suffolk NHS Foundation Trust palliative care team, supported by St Elizabeth Hospice, Ipswich Hospital NHS Trust and St Nicholas Hospice.

Urology department honours former chief executive
Our newly refurbished urology department has been named after former chief executive, Johanna Finn, in recognition of her impact on the NHS and the Trust. An experienced leader, committed to local health services and the Suffolk community, Johanna worked across health and related education services during a 45-year-long career. The Trust was delighted to welcome her back to the hospital for the official opening of the unit.

Falls kit: new Razer chairs
The Trust now has a number of Razer chair fall recovery devices for use with patients who have fallen and have been assessed as having no new injuries requiring investigation.

Invest in quality, staff and clinical leadership

Top acute trust in the East for doctors' training
We have scored top in the East of England for doctors' overall training satisfaction in acute trusts, in the General Medical Council's (GMC) national training survey 2018. The GMC asks doctors in training, from foundation doctors to specialists, questions based on a number of criteria, including clinical supervision, educational supervision, induction, teamwork and supportive environment. The doctors surveyed by the GMC at the Trust rated their overall satisfaction as 79.41%, with clinical supervision during training scored 89.79%. Mr Peter Harris, director of post-graduate medical education and consultant obstetrician and gynaecologist at WSFT, said: "Our Trust consistently ranks in the top five trusts in the East of England for training, and I'm really glad to see us top this year. It is the culmination of many years' work, from people across the organisation; from our brilliant clinical and educational supervisors, medical staffing team and education centre staff.

Quality improvement coaches
To enable us to build our quality improvement (QI) capacity and capability, we are aiming to train at least 50 people to be quality improvement coaches. QI coaches will be people who are skilled in quality improvement and coaching/facilitation, and will coach colleagues and teams across the organisation to develop their own projects and see them to fruition. Projects will vary from supporting organisational wide quality priorities to individual and team projects. Coaches will be recruited not only for their aptitude for improvement science and coaching/facilitation, but also from roles where there is the flexibility to be able to give time to others.

Former patients meet staff who saved them
The Trust's critical care team recently held its 15th annual open evening for former patients. Every year patients who have needed extra support from the team are invited back to meet staff who cared for them and discuss different experiences. Critical care follow-up sister, Janet Thomas, works with the team to develop comprehensive programmes of rehabilitation and support for those who have been through the critical care unit. Now about to retire, she is leaving a legacy of best practice behind her.

Build a joined-up future

'Bystander' CPR - Would you know what to do?
Educating patients and their carers is an essential part of cardiac rehabilitation. Members of our community cardiac rehab team have been working with the British Heart Foundation (BHF) and, through its Heartstart programme, are now training patients and their families to enable them to deal with an emergency. As part of the BHF's Nation of LifeSavers and CPR campaign, this training is now delivered as part of the West Suffolk community cardiac rehab programme. To date, the team has trained 50 people, with further dates arranged. To find out more about Heartstart visit:
https://www.bhf.org.uk/how-you-can-help/how-to-save-a-life/how-to-do-cpr/heartstart-training

NHS Improvement director shadows volunteers
During August, our volunteer team was joined by a new recruit. Ruth May, executive director of nursing at NHS Improvement, donned a volunteer uniform and took to the floor. Ruth, who shadowed our bleep volunteers, said: "It was a real pleasure meeting some of the wonderful NHS volunteers at West Suffolk Hospital. They showed me the huge benefits of volunteering - for the individual themselves, the patients they come into contact with and the staff they support.

Education Centre renaming honours local philanthropist
A generous legacy given to the West Suffolk Hospital more than 70 years ago was remembered last week at a renaming ceremony at the Hospital's Education Centre. In 1950 Robert Drummond, a local farmer from Coney Weston, left £11,000, a sizeable amount of money at that time, to West Suffolk Hospital. This generous bequest was used to build a social and sports centre named Drummond Hall on the old Hospital Road site in 1956, for staff to use and enjoy. When the new hospital in Hardwick Lane was opened in 1973, the Drummond name came with it with the development of a new Drummond Sports and Social Centre on the site.

National news

Deliver for today

Reducing emergency admissions: unlocking the potential of people to better manage their long-term conditions
This briefing summarises research that explores the link between how well people feel able to manage their long-term conditions - such as asthma, diabetes and depression - and their use of health care. The findings show that avoidable health care use would fall and people's quality of life would improve, if they were better supported to manage their long-term conditions. The briefing points to solutions and calls for national policy-makers and the local NHS to take action now, including by prioritising support for self-management in the NHS long-term plan.

Invest in quality, staff and clinical leadership

Understanding new models of integrated care in developed countries: a systematic review
There is evidence that new models of integrated care may enhance patient satisfaction, perceived quality and increase access, but the evidence regarding other outcomes is unclear.

The good childhood report 2018
This report examines the state of children's wellbeing in the UK. It finds that one in six (16 per cent) of more than 11,000 children aged 14 surveyed reported self-harming. It looks at the reasons behind the unhappiness that increases the risk of children self-harming. The report urges the government to make sure that every child can talk to a counsellor in their school.

Affordability of the UK's Eatwell Guide
This report from independent think tank The Food Foundation finds that around 3.7 million children in the UK are part of families who earn less than £15,860. It goes on to claim that to meet the costs of the government's nutrition guidelines, such households would have to spend 42 per cent of their after-housing income on food, making a healthy diet unaffordable.

Trends in new HIV diagnoses and people receiving HIV-related care in the United Kingdom
This report highlights trends found in annual HIV surveillance data published by Public Health England. The analysis shows that new HIV diagnoses have continued to decline over the past decade, with a substantial decrease over the past two years. This recent reduction has been mostly driven by fewer HIV diagnoses among gay and bisexual men, which have decreased by almost a third since 2015.

NICE Impact: falls and fragility fractures
Annually, almost a third of over 65s fall at least once and there are an estimated 500,000 fragility fractures. This report considers how NICE's evidence-based guidance might contribute to improvements in the prevention and management of falls and fragility fractures.

National Audit of Dementia: Spotlight audit 2017-18
The key findings of the NAD audit included:

- A high proportion of patients with dementia admitted as emergencies to hospital did not receive an initial assessment for delirium, even after adjustment.
- Questions about initial screen or assessment for delirium are inconsistently interpreted
- Over a quarter of patients have no confusion or cognitive tests recorded
- Delirium not included in discharge correspondence

NHS could free up £480m by limiting use of temporary staffing agencies (NHS Improvement)
The NHS could free up £480m to reinvest into NHS services and improve patient care if trusts filled temporary vacancies with workers from a 'staff bank' instead of using expensive staffing agencies. Temporary staff, such as doctors and nurses supplied by agencies, cost on average 20% more than those from the NHS's own 'staff banks' despite doing the exact same job.

Build a joined-up future

Joined-up listening: integrated care and patient insight
This article from the King's Fund highlights the opportunity that integrated care presents for using insight from people and populations to design services that meet their needs and reflect their priorities. This necessitates breaking down silos within and between organisations to listen to what patients are saying across their entire pathway of care.

A taxing question: how to pay for free personal care
This report, produced in conjunction with Grant Thornton UK LLP and The Social Market Foundation, looks at various funding options for older people's social care, including what each option would cost the individual, and what the funding situation might look like in ten years' time.

9:35 DELIVER FOR TODAY

8. Alliance and community services report

To ACCEPT the report

For Report

Presented by Dawn Godbold

WSFT Board Meeting - 28 September 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:	18/09/2018			
Subject:	Community Services and West Alliance update			
Purpose:	x	For information		For approval

Executive summary:

Work continues to progress integration internally between acute and community services and externally across the system as a whole. There are many examples of progress with joint working happening at local levels contained within the paper.

Work continues on the West Alliance Delivery Plan, the latest version has been shared with the WSFT Scrutiny Committee and the System Executive Group.

Conversations have commenced between WSFT and the GP Federation to explore opportunities to integrate community and practice nurse resource and activity for one of the practices in Haverhill.

Main Points:

This paper outlines:

- Integration between acute and community services – a patient case scenario example
- Discussions with Primary Care and the GP Federation to explore a range of improvement ideas for development
- An I.T. update in relation to SystmOne, Pillar 3 community services digital programme and innovation ideas being explored
- An update on the Buurtzorg Neighbourhood Nursing and Care Team initiative
- Development of the West Suffolk Alliance
- Latest working draft of the Delivery Plan
- An update on developments within Quality and Governance
- An update in relation to the Children in Care Initial Health Assessment

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.							

All about people and places

Contents:

West Suffolk Alliance "Plan on a Page" 2018-2023

STP Priorities & Outcomes		*STP Delivery Programmes & Enablers*	*West Suffolk System Outcomes*	*Alliance Ambitions*	*Specific Actions to deliver the ambitions*	*Transforming Services Programmes*
Deprivation	• Every person in health and care considers improving MH their responsibility • Eradicate child poverty in the STP • Reduce inequality in life expectancy in all STP districts to that of the best	• Alliance development • Cancer • Mental Health • Urgent & Emergency Care • Planned Care • Primary Care • Prevention • Digital & IT • Workforce • Communication & Engagement • Estates	• Local people have an excellent experience of care and support; • Health and care inequalities will be reduced; • Reduction in the incidents of avoidable harm; • Money is used for the best effect across the health and care system; • Local people are supported to stay well; • Local people with health and care needs are supported to avoid deteriorating health and managing crisis; • Local people's health and wellbeing is optimised after a period of ill health or injury; • Local people are supported to have a good death.	• **To strengthen support for people to stay well and manage their wellbeing and health in their communities.**	• Introducing different ways of working that help people to manage health and care problems earlier • Developing local integrated teams • Delivering short-term care to people in a crisis • Bringing al or our system elements together and transform services so the meet local needs • Working with the private, voluntary and wider public sector to ensure our communities can thrive.	• Integrated care • Planned/ • Elective Care • Children & Young People • Mental Health & Learning Disabilities • Cancer • Primary Care • Maternity • Prevention
Zero Suicide	• Wellbeing Hubs in all our schools • Enable easy access to those with mental health/emotional concerns • One year of zero suicides			• **To focus with individuals on their needs and goals.**	• Testing new ways of delivering health and care services that break down traditional organisational barriers • Creating person centred plans so that people will have one plan that explains how services will meet their wellbeing and health needs • Coordinating help for people and checking we can share their records across relevant professionals • Supporting self-care and self-management • Using feedback from people to inform our redesign options and how we spend the West Suffolk pound	
Obesity	• Access to local bariatric services including surgery for our population in line with national guidance • Eliminate obesity in staff working in education, health and care within 5 years. • Educate people that obesity causes cancer, diabetes and cardiovascular disease.			• **To change both the way we work together and how services are configured.**	• Developing a Five Year Delivery Plan showing how we will deliver the outcomes agreed as a system, delivering what works best for people in West Suffolk • Health and care leaders will be meeting regularly with partners to plan how we deliver our vision and track actions against our Delivery Plan • Moving towards an Integrated Care System where we can truly use our resources flexibly to meet local need • Expanding our collaboration with the voluntary and community sector organisations, and district and borough councils, working closer together to improve people's wellbeing and health	
Unplanned Cancer Admissions	• No patient diagnosed with cancer through an unplanned hospital admission • 100% uptake of screening for breast, bowel and cervical screening • Reduce cancer incidence in Tendring to the STP average within 5 years					
End of Life	• At least half the number of people dying in hospitals • Every patient making choices for end of life care has all the information they need. • Guarantee the best experience for everyone at the end of life			• **To make effective use of resources**	• Increasing the proportion of our health and care spend that is spent in the community, whilst achieving value of money • Working to get a whole system understanding of health and care resources and how best to use them to support an Integrated Care System • Working together to address the financial pressures within each of our Alliance organisations • Developing and implementing plans for IT & digital solutions, estates, communication & engagement, workforce, and organisational development • Taking every opportunity to use our assets together to reduce duplication and drive out in efficiency, through sharing public sector buildings as we aim to develop community 'hubs' in each of our localities and consolidate corporate functions	
Ageing and Living Alone	• Good neighbour or similar schemes available in every local community • Create multi skilled place based roles to meet the needs of patients better • Become a world-leading region for technology to address loneliness.					

Our Vision: ***"Coordinating services around the individual – so that it feels like one service"***

Our Members: West Suffolk Hospital, Suffolk County Council, Norfolk & Suffolk Foundation Trust, Suffolk GP Federation, working with West Suffolk CCG, our wider district and borough councils, voluntary and community partners.

West Suffolk Alliance Strategic Ambitions:

1. We will strengthen support for people to stay well and manage their wellbeing and health in their communities; by	
a)	…building our Connect programme across all six localities, setting up delivery groups, embedding the locality lead role, with shared decision- making, plan with local priorities and a common data set.
b)	…developing and embed social prescribing services.
c)	…developing new volunteer roles in the community.
d)	…identifying who is most at risk from poor health and health crisis and target support to keep them well.
e)	…developing the SEND local offer so that young people have access to up to date local information to support them to live good lives.
f)	…developing collaborative working with GP practices to facilitate primary care networks, locality hubs, and integration with Connect.
g)	…working with partners to develop opportunities that make it easier for people to take physical activity and keep active.
h)	…supporting communities to stay safe and healthy; preventing ill-health
2. We will focus with individuals on their needs and goals; by	
a)	…developing integrated pathways between acute, mental health and primary care.
b)	…taking the lessons from the Buurtzorg Test and Learn to develop a model that works for people across all of West Suffolk.
c)	…introducing care-coordination and trusted assessment, and start to develop a single shared customer plan.
d)	…streamlining and co-ordinate services for children and young people with ADHD, autism and behavioural issues.
e)	…delivering and implementing the service specification for Integrated Community Paediatric Services.
f)	…delivering the projects contained within the multi-agency Children's Emotional Health and Wellbeing Plan.
g)	…supporting the local implementation of the Better Births agenda in line with the direction of travel across the STP, ensuring that every child has the best start in life.
h)	…improving access to urgent care by implementing an integrated care response for people in crisis including mental health.
i)	…developing responsive services to support people when they come out of hospital or if they need short-term health and care support at home.
j)	…supporting Family Carers.
k)	…supporting and developing processes for working closely with voluntary and community organisations.
3. We will change both the way we work together and how services are configured; by	
a)	…developing a specification for an integrated therapies approach
b)	…ensuring every person in health and care considers improving mental health their responsibility
c)	…finalising the outcomes framework and measures to monitor our system together, taking action where we are not making sufficient progress
d)	…further expanding the Alliance to include other local partners and members
e)	…developing an engagement strategy
4. We will make effective use of resources; by	
a)	…developing the Alliance Communications strategy
b)	…developing mechanisms to enable people who use health and care services to be involved in developing them
c)	…developing and agreeing a Financial strategy
d)	…developing and agreeing an Estates strategy
e)	…developing and agreeing an IT strategy
f)	…developing and agreeing a workforce and OD strategy

Programme Summary

Delivery Programme 1: Alliance Development

SRO: Dawn Godbold

Programme Lead(s): Anna Crispe, Kate Vaughton, Kate Dodd, Jane Payling, Jackie Grimwood, Mike Bone, Bernadette Lawrence

Project	Project Lead(s)	Project Resource
Outcomes Framework	Helena Jopling	
Wider Partnerships		
Engagement Strategy		
Communications		
Engagement		
Finance		
Estates		
Digital & IT		
Workforce & OD		

Delivery Programme 2: Connect

SRO: Dawn Godbold/Bernadette Lawrence/Kate Vaughton/Davina Howes

Programme Lead(s): Sandie Robinson, Tania Farrow, David Pannell, Nerinda Evans, Lynda Bradford, Alison Amstutz, Caroline Angus, Abhijit Bagade

Project	Project Lead(s)	Project Resource
Programme 2(a) Integrated Neighbourhood Teams:		
Locality profiles	Helena Jopling	
Locality Leadership		
Connect plans for localities		
• Haverhill		
• Newmarket		
• Mildenhall		
• Bury Town		
• Bury Rural		
• Sudbury		
Risk Stratification		
Primary Care	Lois Wreathall	
Buurtzorg		
Care co-ordination		
Single shared customer plan		
Integrated Therapies		

Programme 2(b) Wider Community Projects:		
Social Prescribing	Lauren White-Miller	
Volunteering		
Self-help models		
Family Carers	Trisha Stevens	
Voluntary Sector		
Community Pharmacy	Tania Farrow	
Medicines Management - Prescribing	Linda Lord	

Programme 2(c) Primary Prevention:		
Smoking	Caroline Angus	
Obesity/Weight management	Caroline Angus	
Hypertension	Abhijit Bagade	EP/GL
Atrial Fibrillation	Abhijit Bagade	
Making Every Contact Count		
NHS health checks		

Delivery Programme 3: Mental Health

SRO: Pete Devlin/Richard Watson; GP Clinical Lead: Dr Roz Tandy

Programme Lead(s): Eugene Staunton, Margaret Little

Project	Project Lead(s)	Project Resource
Access to Mental Health Services	ES/ML/HN-M	
SMI Patient Support	Hannah Nemann-May	
Dementia	Gail Cardy	
Crisis Support	Lorraine Parr	
Psychiatric Liaison	Lorraine Parr	
Early Intervention in Psychosis	Lorraine Parr	
Crisis Resolution Home Treatment Teams	Lorraine Parr	
Out of Area Placements	Richard Cracknell	
Suicide Prevention		
Learning Disability		
First Response Service		
Medicines Management - Prescribing	Linda Lord	

Delivery Programme 4: Maternity

SRO: Lisa Nobes; GP Clinical Lead: Dr Godfrey Reynolds

Programme Lead(s): Lynne Saunders

Project	Project Lead(s)	Project Resource
Maternity (Better Births)	Lynne Saunders	

Delivery Programme 5: Children's Services

SRO: Allan Cadzow; GP Clinical Lead: Dr Godfrey Reynolds

Programme Lead(s): Eugene Staunton, Sara Blake

Project	Project Lead(s)	Project Resource
SEND Local Offer	Sara Blake	
Paediatric Pathways	Caroline Ratcliffe	
Integrated Behavioural Pathways	Jo John	
CYP community health services	Sara Blake	
Emotional Health and Wellbeing	Jo John	

Delivery Programme 6: Developing Responsive (Urgent Care) Services

SRO: Richard Watson/Bernadette Lawrence; GP Clinical Lead: Dr Firas Watfeh

Programme Lead(s): Sandie Robinson/ Rob Kirkpatrick

Project	Project Lead(s)	Project Resource
Integrated Rehabilitation/Reablement		
Home Care Procurement		
Urgent and Emergency Care Demand Management		

Delivery Programme 7: Developing integrated pathways/patient journeys

SRO: Helen Beck/Richard Watson; GP Clinical Lead: Dr Bahram Talebpour

Programme Lead(s): Jane Rooney

Project	Project Lead(s)	Project Resource
Respiratory	Juliet Estall	
Respiratory (Responsive Services)	Hannah Pont	
Respiratory (Medicines Management - Prescribing)	Linda Lord	
Cardiology	Claire Jay	
Neurology	Renu Mandal	
MSK	Martin Bate	
Integrated Pain Management Service	Renu Mandal	
Ophthalmology	Claire Jay	
Stroke (STP-wide)	Claire Jay	
Diabetes (STP-wide)		
Diabetes (Medicines Management – Prescribing)	Linda Lord	
Vascular	Tracey Morgan	
End of Life		
Care Prospectus		

Delivery Programme 8: Cancer (pan-STP)

SRO (local): tbc (STP lead:Sam Heppelwhite); GP Clinical Lead: Dr Pete Holloway

Programme Lead(s): Nerinda Evans

Project	Project Lead(s)	Project Resource
Macmillan Navigator role		
Waiting Time Standards		
Early Diagnosis		
Radiotherapy		
Rapid Assessment and Diagnostic Pathway		
Breast Cancer		
Cancer Waiting Times		

Alcohol brief advice		
Physical Activity		
Sexual Health	Alison Amstutz	
Personal and community resilience		

Governance *(to be added)*

INSERT DIAGRAM

Draft Role Descriptions

Senior Responsible Officer (SRO)

- Responsible for programme delivery
- Ensures resources available and relevant people involved
- Prioritises within Programme
- Leads development of detailed delivery plan (inc. years 2-5)
- Reports into Alliance Board using monthly highlight report
- Ensures connectivity to other Delivery Programmes and STP
- Models Alliance values and ensures they are upheld throughout the design and delivery of the programme

Clinical Lead

- Provides clinical leadership for the development of the programme, working alongside wider primary and acute clinical partners
- Stimulates clinical innovation in care pathway re-design
- Sustains clinical relationships to support high quality, safe, delivery
- Monitors and challenges clinical performance as part of a wider team
- Represents the Alliance in wider (STP, Regional) clinical conversations
- Assumes leadership and accountability for quality targets

Programme Lead

- Day to day delivery of milestones
- Co-ordinating resources
- Working with SRO on barriers and risks

Enabling/Cross-cutting lead

- Work across all the Delivery Programmes so that action in the lead area is part of the relevant DP
- Link through to STP workstream and ensure connectivity to Alliance Delivery Plan
- Lead on innovation and opportunities in their area

Delivery Programme 1: Alliance Development

SRO: Dawn Godbold

Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Outcomes framework	3c		Develop and trial the data set and radar charts providing feedback for a review of these in Spring 2019.			JR				
			Work with wider partners to broaden out system view and include other factors such as housing, employment, loneliness and rural isolation							
Wider partnerships	3d		Build Alliance through including other local partners							
			Review SEG membership to ensure partner representation							
Engagement & Co-production	3e, 4b		Develop an engagement strategy, so that we co-producing our changes with people in West Suffolk							
			Agree how people who use services will be involved in developing transformed health and care services							
			Review available resources, agree, and integrated approach to the use of these.							
Communications	4a		Develop an internally and externally-facing communications strategy							
			Supply standard Alliance materials for all partners to use							
			Make sure that team managers have regular Alliance messages to share with their teams							
Finance	4c		Work with the STP workstream to understand how we can understand the totality to finance across the health and care system in West Suffolk.							
			Find a way to show whether we are moving funding from acute to community.							
			Develop a joint approach to community funding							
			Test pooled budgets in at least one area							
Estates	4d		Ensure that (as a minimum) our teams have opportunities to hot desk in each other's offices							
			Collocate three teams by the end of Year 1							
Digital & IT	4e		**STP Digital Ambitions** **1) Enabling our Practitioners** • Fit for Purpose Tools • Trained and Supported Staff • Connected network • Digitised records • Read access to other records • Workflow between Records 2) **Empowering the citizen** • Access to record online • Access to free wi-fi • Personal health record • Interact with services and professionals using multiple channels **3) Accelerate Digitisation** • Meet relevant digital standards • High Performing Digital Maturity Assessment (DMA) • Partners Support one another • Progress towards international excellence		-	MBo			Freeing up time to care Empowerment, inclusion, self- care Enable us to operate as a system	
Workforce & OD	4f		Recruit care workers into Level 1 and 2, and leadership qualification programmes, providing mentoring for participants in the programmes.						Improved access to qualifications amongst the health and social care workforce. Map career pathways and qualification routes to enable workers to move into	6000 qualifications achieved across Norfolk and Suffolk within 2.5 years. Recruitment of 12 mentors.

			Create system roles that blend current disciplines, including managers being able to cover across adult care and community health					leadership and specialist roles. Deliver direct intervention to support progression through personalised mentoring. Directly support retention of staff.	
			Understand transformation capacity across all our teams						
			Joint transformation resource to deliver change						
			Engage with national health and care recruitment campaign						
			Deliver New Registered Professional Programme – Preceptorship						
			Making West Suffolk and attractive place to work in health and care services						
			Skills for Care funding – enhanced provider training – home care staff equipped with skills to support people with complex needs						
			Develop Alliance culture across all our teams.						

Delivery Programme 2a: Connect: Integrated Neighbourhood Teams

SRO: Dawn Godbold/Bernadette Lawrence/Kate Vaughton

Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Locality Profiles	1a		Map of each area produced showing needs of our local populations *Note: Data available on deprivation and demographics down to LSOA level, and on admissions/LTC registers to start to develop each locality plan.*			JR			Reduced inequalities in life expectancy	Outcome measures as detailed in "Adult Physical Health" radar charts (STP and CCG-level)
			Agree data strategy that will allow data sharing across organisations and development of WS Alliance profile							
			Produce a local health needs and assets assessment for each of the 6 localities.							
			Map of workforce across health and care							
Locality leadership	1a		Appoint one day a week lead role *Note: Currently on hold as reviewing need. Consideration appointing one as a 'test' and then refine*	LS: Connect 6 Integrated Neighbourhood Teams					Success as defined in the Connect principles: • The experience of the local population is improved by working in partnership with them • Health and wellbeing is improved by promoting and enabling self-care • The patient/customers journey through all parts of the health and social care system is integrated and coordinated • Ill health and crisis intervention is prevented	• Good levels of community engagement in developing and engaging in responses • Improvement in years of healthy life expectancy • Reduction in GP attendance • A reduced proportion of customer in receipt of ongoing (Tier 3) support • Increases in people receiving an integrated Tier 1 response • Reduction in A&E attendances • Reduction in emergency/ out of hours GP calls • Increase in Tier 2/ reablement interventions • Reduced hospital admissions
			Recruit to band 4 locality "Connect Link Workers" posts in all Connect localities							
			Develop a robust governance and delivery infrastructure				**Dec 18**: agree scope for triumvirate (comm health/SCC/NSFT) model of locality operational management **April 19:** commence implementation of shared operational management structure			
			Involvement of a wider range of partners							

Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Connect plans for all localities	1a		• Build the Integrated Neighbourhood Team (INT): The INT is one key element of Connect and brings health and social care together to provide a single coordinated care response that is underpinned by prevention, self-care, early intervention, reablement and rehabilitation rather than longer term treatment and lifelong service dependency. • Integrate health and care therapies to remove duplication in assessment and maximise recruitment and workforce development. • The reconfiguration of Newmarket Hospital and relocation of Oakfield GP Surgery (two year programme of work)	TP: Connect Locality	ICW01	HP/LE/KS	**Jul18:** Newmarket Business Case Approved **Mar19:** Programme plan for Newmarket Locality approved **Oct18:** Appoint 6 WTE Locality Coordinators **Apr19:** Implementation of care coordination across all Connect localities		This project is a key enabler to delivering more proactive care and therefore does not have associated metrics relating to demand management in 2018/19.The key deliveravbles by March 2019 are: INTS and Integrated Therapy 1) Co-located Health and Care teams within the 6 localities 2) One integrated management structure in 1 (or 2) INTs 3) Single approach to shared caseloads supported by single assessment and shared care planning 4) My Care Wishes implemented - focus on frailty score greater than 7 (recored on sytmone) and EOL 5) Extended rotational opportunities for acute and community physiotherapy Newmarket 1) Building work at NCH commenced 2) Plan agreed with stakeholders for utilisation of NCH estate as a health and wellbeing hub 3) Programme plan agreed with alliance partners on locality priorities and board in place with locality lead	
			Discharge to Optimise and Assess: Ensure all pathways will be supported by a system pull based approach by an integrated approach to reablement across the end to end pathway of care and will include a range of responses depending on the needs of the individual	TP: Discharge to Optimise and Assess	ICW02	LS/JM/ SL	**Aug18:** Pathway 0 - Date for your Diary embedded across all hospital sites **Dec18:** Pathway 0 - Reablement training completed to support endpjparalysis **Jul18:** Pathway 1 - Baseline assessment, metrics and data sources completed **Sep18:** Pathway 1 - Alignment of Support to Go Home and Homefirst completed **Jan19:** Pathway 1 - 100 day challenge completed **Aug18:** Pathway 3 - evaluation of test and learn and options signed off for delirium pathway **Oct18:** Pathway 3 - Delirium pathway implemented **Jan19:** Evaluation/Data – Mid-year evaluation **Dec18:** Communications - Engagement programme completed		Pathway 0 embedded into BAU, Pathway 1 implemented across all INTs. Pathway 2 embedded as BAU, Pathway 3 Delirium pathway operational at Newmarket Hospital	1. Reduction of stranded patients < 140 2. System delayed transfers of care <3.5% 3.Reduction of readmissions to < 18% 4. Reduction of complex care packages at 6 weeks post discharge 5. Reduction in medically optimised excess days 6. Change to baseline: 0 78.1% 85% 1 18.3% 11.5% 2 2.8% 2.9% 3 0.8% 0.7%
			Demand Management within Care Homes: Ensure care homes receive the most appropriate support model to enable residents to remain in their care home when it is safe to do, and an active member of the health and social care economy.	TP: Demand Management within Care Homes	ICW03	CT	**Sep18:** Governance agreed **Sep18:** System-wide care home strategy and business case signed off **Sep18:** Medicines optimisation project: Pharmacists and Techs in post **Oct18:** Identify priorities for winter delivery and fast track service developments ready for winter **Sep18:** Mobilise all service developments **Mar19:** Commence regular	**Jul19:** Provide 6 monthly service evaluation and implement recommendations **Jan20:** Provide 1 year service evaluation and implement recommendations **Mar20:** Business as Usual - project closure	• Reduction in the unnecessary use of 999 ambulances to provide clinical advice and assessment • Reduction in ED attendances across Suffolk • Reduction in acute admissions within WSCCG and maintenance of current level in IES • Care home staff empowered to deliver urgent care themselve and how to access the right service for the residents needs • Trusted assessment between care homes and acute providers of care	Reduction in the number of care home residents who: 1. Have an ambulance call out but no conveyance 2. Are admitted to hospital for less than one day 3. Die in acute hospital 4. DTOC due to care home unable to complete timely assessment of need Increase in the number of

Project	Alliance Ambition	STP priority/ outcomes	Priority actions	Local Strategy (LS)/ Transformation Project (TP) etc.	PMO Ref	Proj. Lead	Year 1 Timescales in detail	Year 2 to 5 Timescales in outline	What success looks like (what will be different in each locality i.e. 'end state')	Outcome measures
							evaluation cycle in place to enable quarterly review of impact			care home residents who: 1. have a completed My Care Wishes folder 2. have optimised medications 3. remain in their home to receive urgent care 4. have dementia diagnosed
			Falls and Fragility Fractures: • Promote healthy ageing, falls and fragility fracture prevention across the life course • Optimise case finding opportunities so that there is a shift from a reactive to a proactive approach to prevention and management of falls and fragility fractures • Deliver timely and appropriate response to management of falls and fragility fractures through an integrated pathway • Reduce the number of presentations to emergency departments as a result of falls and fragility fractures	TP: Falls Fragility Fracture and Bone Health	ICW05	RB/SH	**Sep18:** Triage in place for urgent ambulance notifications to EIT/INTs **Nov18:** Relocation and Relaunch of Frailty Service **Mar19:** Case finding implemented across core services including INTs, EIT and FAU **Mar19:** Falls Pathway outlining core range of interventions implemented across the above.	**Jul19:** HALO CQUIN approved to drive EEAST utilisation of EIT	By March 2019: • Falls pathway embedded across all localities - all 6 INTs and EIT undertaking proactive falls case finding and reporting on SystmOne. • Falls assessment integrated into Frailty Scoring on ecare within WSFT and communicated on discharge summaries. • Dedicated falls clinic at Sudbury and Newmarket reinstated. • EEAST referrals to CCC triaged and priotised into red referrals to EIT and all others to INTs. • Falls Champion in every INT and care home in place.	Reduction in the number of ambulance conveyances for patients that have fallen by 10% (178) Reduction in NEL fallers by 89 from 17/18 baseline based on ambulance conveyances assuming 50% would have been admitted
			Global Digital Programme to produce a single longitudinal record for the population by the end of 18/19.				**Mar19:** x% of population	**Mar20:** whole population		
			Offer skype consultations and monitoring							
			Access to Wi-Fi for public and professionals at key sites.						***Better connectivity for practitioners in customer homes:*** When a practitioner enters the customers house their laptop/device instantly can connect to our servers securely which will allow them greater access to SCC systems when visiting the customer. The practitioner will be able to utilise the broadband connection on their laptop to fire up a VPN / Direct Access connection – essentially enabling them to access SCC network / systems in the customer's home. There will also be the possibility of video conferencing facility for remote worker / customer engagement to explore	
Connect plans for each locality: Haverhill	1a		Accelerate actions to address the needs of people with drug and alcohol problems	LS: Connect 6 Integrated Neighbourhood Teams	ICW01					
			Collaborative working across GP surgeries			DP				
			Explore options for greater integration of nursing resource between primary and community services							
			Take forward the CICSO Haverhill 100% Connected Community Project						To have embedded a digital solution to support practitioners dealing with those people requiring a review or new into care that require a care and support plan.	
Connect plans for each locality: Newmarket	1a		Develop the Newmarket hospital site into a new health and wellbeing 'hub'	LS: Connect 6 Integrated Neighbourhood Teams TP: Connect Locality	ICW01					
			Recruit to joint health and social care team lead post							
Connect plans for each locality:	1a		Options for joint working in Brandon developed and progressed	LS: Connect 6 Integrated	ICW01					

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Mildenhall				Neighbourhood Teams						
Connect plans for each locality: Bury Town	1a		Engagement in the further development of the public sector village on the Western Way site, including future provision and co-location of public services.	LS: Connect 6 Integrated Neighbourhood Teams	ICW01					
Connect plans for each locality: Bury Rural	1a			LS: Connect 6 Integrated Neighbourhood Teams	ICW01					
Connect plans for each locality: Sudbury	1a		Develop public sector village on the back of Hardwick House relocation	LS: Connect 6 Integrated Neighbourhood Teams	ICW01					
			Ensure that Connect Sudbury is an integral part of the Babergh District Councils Vision for Prosperity for the town.							
			Sudbury Vision to be shared with Alliance partners at a future meeting.							
Primary Care	1f		Develop and embed primary care networks in each locality			LW	**Jun 18:** Commence programme of regular existing locality meetings with wider participation to determine priorities			100% of GP practices to be part of a collaborative arrangement
			Undertake review of how GP practices are currently integrating with Connect and make proposals as to how this could be enhanced			LW				
Buurtzorg	2b		Implement phase 2 of the Buurtzorg (Neighbourhood) model of care		ICW01					
Single shared customer plan	2c		Establish clear data and information sharing arrangements							
			Develop a single assessment process for health and adult social care assessments							
			Implement Trusted assessment : • *Develop a single assessment process for health and social care assessments* • *Establish clear data and information sharing arrangements to facilitate the shared assessment*	TP: Trusted Assessment	ICW08	CB	**Aug18:** Implementation of Trusted Assessment policy to all organisations **Nov18:** Trusted Assessment framework in place to support Discharge to Optimise and Assess Pathway 1	Trusted Assessor role expanded to support the top 10 care homes	Local system partners will have a practical approach to supporting patient flow, discharge and onward referral by establishing a trusted assessment process and associated documentation for use across the system. Improve patient experience by ensuring that a person tells their story once and ensuring the information captured during an assessment is appropriately recorded and shared with other professionals directly involved in their care. Reduction in the amount of time spent (re)assessing patients	This project is an enabler and as such does not have specific KPIs. The measureable outcomes are associated with quality improvement.
Integrated Therapies	1a, 3a	-	Develop specification for an integrated therapies approach	TP: Connect Locality	ICW01	LE	**Apr18:** Approval of higher level strategy and 18/19 priorities **Jun18:** Complete set up of 2018/19 priorities **Oct18:** Rollout of Strategy **Oct18:** Rotational therapy in place across acute and community **Oct18:** Single therapy workforce recruitment in place		Single approach to shared caseloads supported by a single assessment and shared care planning My Care Wishes fully implemented Workforce will be placed where the greatest need is and not limited by organisational boundaries Integrated health and care plan for the person receiving the services/support	
		-	Continue to streamline equipment ordering process							

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		-	Move to a single integrated approach to the community equipment contract						Sharing of resources, integrated recruitment and a single clinical governance structure Trusted assessment embedded within all service delivery models	
			Develop a single clinical governance structure				**Apr19:** Sharing of data and consent			

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Delivery Programme 2b: Connect: Wider Communities					**SRO: Davina Howes**					
Project	**Alliance Ambition**	**STP priority/ outcomes**	**Priority actions**	**Local Strategy (LS)/ Transformation Project (TP) etc.**	**PMO Ref**	**Proj. Lead**	**Year 1 Timescales in detail**	**Year 2 to 5 Timescales in outline**	**What success looks like (what will be different in each locality i.e. 'end state')**	**Outcome measures**
Social Prescribing			Sustain the Haverhill (LifeLink) project and continue to establish links with DWP/skills programme			LW-M	**Nov18:** Increase headcount in Haverhill		Improved wellbeing for participants Positive lifestyle changes: Increased opportunity for local people in employment, volunteering and training/education • Increased support and connections within the community • Reduced social isolation and feelings of loneliness • Reduced demand on primary healthcare • Growing number of volunteering opportunities/ groups	Warwick and Edinburgh Mental Wellbeing scale, case studies and 6 month check in after exit Number of visits to GP before and after participation Number of visits to A&E before and after participation Increased numbers of participants / users of groups
	1b		Develop social prescribing in other areas within west Suffolk starting with Mildenhall, Brandon and Sudbury *Note: Subject to successful Transformation funding bid.*			LW-M	**Oct18-Dec19:** Engagement with key stakeholders and community. Co-design model within Mildenhall, Brandon and Sudbury partners. **Jan19:** Social prescribing model to be determined for each locality and recruitment initiated **Apr19:** Launch *Note: Likelihood is that there will be different timescales in each area and it can't all be achieved at once. Need to review these once we know funding is in place. If CCG funding isn't provided West Suffolk councils will continue to develop social prescribing using just its own funding. However, at present Babergh and Mid Suffolk councils would not be able to commit to this for the Sudbury locality. This will need to be reflected in the delivery plan.*			
			Alliance partners to work together to ensure that Social Prescribing schemes piloted through transformation monies/external funding are sustainable in the long run. This may involve setting up a pooled budget and/or mainstreaming some of the costs within core CCG, Public health, district council and GP practice budgets.			LW-M				
			Support the creation and maintenance of community spaces such as village halls and community centres, establishing good neighbour schemes and residents associations, encouraging parents support groups, financial support for organisations such as the Coffee Caravan, supporting community events which bring together communities and increase capacity within them.	LS: Suffolk Prevention Strategy 2016-2021		LW-M				
			Recognising that social isolation and loneliness can impact on all people (not just the elderly), provide support and opportunities for all ages. • Using the measurement of isolation and loneliness produced by Public Health, target activities to specific location/communities/ages, including digital solutions • Raise the profile and benefits of volunteering to combat isolation (benefits to the volunteer) and cross reference to action in the Suffolk Volunteering Strategy			LW-M				
			Utilise Community Transport and access to public transport to address social isolation (all ages)			LW-M				
			Develop local campaigns and initiatives that enable connections between local people their families and the local community • Increase number of Good Neighbour Schemes, Meet Up Mondays across the County • Joint campaigns/communications to encourage communities to support each other. • Co-ordinate with national campaigns to encourage more people to volunteer and be good neighbours			LW-M				

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Community Pharmacy	1d, 1f, 1h		**National Pharmacy Flu Vaccination Service:** • Flu messaging to patients should recognise the availability of both services • Encourage GPs and community pharmacies to work together to deliver better system outcomes for patients			TF				
	1d, 1f, 1h		**Safer Consulting in Minor Ailments Training:** • Support training by facilitating GP peer support and highlighting the benefits of training to GPs to build confidence in referral to pharmacies. • Direct referral pathways from pharmacies to GP practices and from practices to community pharmacy for MURs/NMS (medication support) should be developed to consolidate the role of community pharmacy within primary care.			TF			More support provided for patients	
	1d, 1f, 1h		**Think Pharmacy First Messaging:** • Continue to build on the work already done in terms of highlighting the role of pharmacy teams in supporting minor conditions management • Look at which low acuity conditions are current being dealt with by GPs and OOH and look to develop PGDs that allow pharmacists to treat these conditions within appropriate parameters. These are utilised in other areas and examples can be provided on request • Consolidate the self-care messages by funding the provision of consistent materials to patients such as those provided by the Self-Care forum			TF				
	1f, 2a		**Digital Minor Illness Referral Service Pilot:** • West Suffolk system to support the ambition of Suffolk LPC to be an early adopter as the service rolls out.			TF			North East Community Pharmacy Referral Service pilot show referral rates of 12% for in-hours and 12% for out of hours. This means that up to 76% of people referred to CPRS/DMIRS pharmacies are kept away from higher acuity NHS locations	
	1f, 2a		**Healthy Living Pharmacies:** • Develop a local framework which meets the needs of the local system. Level 2 looks at prevention and the aspirational level 2 looks at protection. • Agree appropriate training and funding			TF			Over 90% of community pharmacies in Suffolk are now Level 1 Healthy Living Pharmacies. This is a national framework, supported by RSPH which focuses on proactive promotion of public health messaging	HLP is a tiered framework and Levels 2 and 3 are commissioner led. An outline framework for Suffolk was identified but has never been commissioned.
	2h		**National Urgent Medicines Supply Advanced Service (NUMSAS):** • Work with the LPC to identify areas with poor geographical coverage with the aim of increasing pharmacy sign up • LPC to look at encouraging sign up in pharmacies with extended opening hours • DoS leads to provide regular updates on the value of the service to the local system • System to work towards making pharmacy the default setting for urgent medicine supply			TF			Evidence shows that the service can significantly reduce pressure on OOH services	Increase the number of pharmacies signed up to deliver the service (currently 25 across Suffolk)
			Electronic Medicines Optimisation Pathway (EMOP): • Work across the system to maximise patient outcomes as the process beds in. This includes the hospitals, community pharmacy and GPs • System wide ownership of the outcomes to demonstrate the value of community pharmacy in			TF	**Jul16:** Launch secure web platform at WSFT			Currently focussed on patients requiring compliance aids but to be extended to all patients who require medication support.

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			pathway redesign • Support the implementation across all STP hospital trusts, including NSFT							
Medicines Management - Prescribing			**Analgesics:** Review the prescribing of analgesics that are Prescription Only, with a particular focus on opioids and gabapentinoids.	TP: Analgesics	18-PW01	LL	**May18:** Launch Polypharmacy LES 2018-19, including a special focus on medication reviews for patients taking high dose opioids and gabapentinoids **May18:** Launch PMS Development Framework2018-19, including a metric on review of patients taking high dose opioids and gabapentinoids **May18:** Launch GMS Prescribing Scheme 2018-19, mirroring the PMS Development Framework metric		• Ensure safe, appropriate and cost-effective prescribing • Adherence to the WSCCG Pain Ladders • Adherence to prescribing guidelines produced by the Medicines Management Team, e.g. Opioid Tapering Resource Pack	
			Appliances: • Work with stoma nurses to update the formulary and update guidance currently in GP practice • Work with continence nurses to update the formulary and update guidance currently in GP practice •Work with practice nurses, SCH district nurses and Tissue viability nurses (TVN) to update the formulary and update guidance currently in GP practice. Could expand to merge primary care and community formularies • Support training in these areas for prescribing clerks and practice nurses in order for appropriate quantities to be prescribed - Work with Speech and Language Therapy to develop formulary for GP prescribing of Tracheostomy and Laryngectomy Appliances. - Work with Nursing Home staff to implement training programme for general appliance management and woundcare.	TP: Appliances	18-PW02	LL	**May18:** Stoma - Publish updated guidance **Jul18:** LES Contracts - Implement and promote amendments to practices **Dec18:** Implement and promote Wound care ES guidance to practices **Dec18:** Continence - Publish Formulary **Dec18:** Continence - publish and circulate guidance to GP's and prescribing clerks **Dec18:** Tracheostomy - Publish Formulary **Mar19:** Community Services Contracts - Implement and promote amendments to practices **Mar19:** Nursing Homes training and education		• Reduction in quantity of prescribing. • Cost effective products are used first line. Ensure Services are streamlined for appliance provision.	
			Gonaderolin analogues: Review the prescribing of Leuteinising hormone-releasing hormone (LHRH) agonists in the treatment/management of prostate cancer.	TP: Gonaderolin analogues	18-PW04	LL	**Aug18: S**hared care agreement **Oct18:** Nursing Homes training and education		• Agreement with urologists at WSFT on SCA and preferred formulary choices of LHRH agonists. • Prescribing of cost-effective choices in both primary and secondary care. • Prescribing of 12 weekly/3monthly/6 monthly preparations where clinically appropriate. • Production of switch guidance for GPs	
			Low Value Medicines: Review the prescribing of the 18 Low Value Medicines (LVMs), which are all now listed as items which should not be routinely prescribed in primary care	TP: Low Value Medicines	18-PW05	LL	**Jun18:** Glucosamine and chondroitin – comms. campaign and social media messages to gain support from then public **Jul18:** Dosulepin and trimipramine - identify potential further strategies to reduce prescribing **Jul18:** Doxazosin MR - identify potential further strategies to reduce prescribing		• Reduced prescribing, in line with recommendations from NHSE and NHS Clinical Commissioners, July 2017 (Items which should not routinely be prescribed in primary care: Guidance for CCGs)	
			Miscellaneous prescribing: Review the prescribing of: • Oral contraceptives: ensure switch protocol is actioned. • Vitamin B12 in injectable form: often prescribed in packs of 5 instead of as single amps. Often prescribed monthly, instead of every 3 months. • All forms of iron supplement: check step-down after recommended treatment period. Prophylaxis should be	TP: Miscellaneous prescribing	18-PW07	LL			Cost-effective prescribing of: • Combined oral contraceptives. • Injectable B12 preparations. • Iron supplements. • High strength vitamin D preparations. • Prednisolone.	

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			purchased otc. No combination or MR iron preparations. Use of ferrous fumarate not usually justified. • High strength vitamin D preparations: check use of recommended products. Ensure step-down after recommended treatment period. Prophylaxis should be purchased otc. • Prednisolone soluble tablets and oral solution, inc. specials. • Rosuvastatin as Crestor brand. • Tadalafil as Cialis brand - 10mg and 20mg strengths only.							
			Self-care: Review the prescribing and over the counter (OTC) purchase of: • Treatments for any condition that is considered to be self-limiting. • Treatments for any condition that lends itself to self-care. • Common items that can be purchased OTC, at a lower cost than would be incurred by the NHS. • Common items for which there is little evidence of clinical effectiveness. • Treatments for the 37 conditions listed in NHSE "Conditions for which over the counter items should not routinely be prescribed in primary care: Guidance for CCGs." • OTC preparations included in the Prescqipp 'DROP list.'	TP: Self-care	18-PW10	LL	**Oct18:** Agreement of action plan		• Reduced GP prescribing in the treatment of minor and/or self-limiting conditions. • Empowered patients and promote appropriate self-care for conditions which lend themselves to this. • Use of community pharmacies as the first port of call for medical advice and treatment of the conditions listed. • Minimised GP prescribing of items for which there is limited evidence of clinical effectiveness.	
			Dietetics: • Ensure sip feeds and powder-style feeds are prescribed and used appropriately in nursing and care homes throughout Suffolk. • Ensure prescribing adheres to the products and quantities as recommended in the infant formula policy and gluten free formulary.	TP: Dietetics	18-PW11	LL	**Mar18:** Ongoing review of care home residents by community dietitians where MUST is 2 or higher with high risk factors **Jan19:** Review the CCGs' gluten free formulary in January 2019		• Reduction of waste • Reduction of products prescribed • Appropriate prescribing of ONS, infant formula and gluten free food • Adherence to OptimiseRx / ScriptSwitch messages on prescribing of dietetic products	
Volunteering	1c		Establish xx community volunteer roles through the Care Force 6 programme	LS: Family Carers Strategy			HJ to provide timescales			
			Parish nurses: Explore role interface with community nursing and community volunteer roles to maximise use of resource.							
Self-management support	2c		All appropriate staff are trained in health coaching. Health coaching is embedded into pathways and services			HJ				
			All appropriate staff are trained and can use the Signs of Safety model			SG				
Family Carers	2j		Develop an integrated Family Carers strategy	LS: Family Carers Strategy TP: Family Carers;	ICW04	TS	**Jul18:** Development of an integrated Family Carers Strategy **Jan19:** Mapping of carer services **Feb19:** Procurement model agreed for future commissioning of Carer services for 2021		Jointly commissioning services for family carers from 2020/21	
			Co-produce future model of support for family carers and ensure this feeds through into commissioning intentions.							
Voluntary Sector	2k		Ensure VCS's distinctive offer, and social & economic value are incorporated into commissioning & procurement							
			Develop a mechanism to capture the voice of the wider Voluntary, Community and Care Sector; to consider how they would like to be kept informed, engaged or involved in commissioning & procurement decisions							

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			Ensure that there is a resilient community and voluntary sector and that staff are aware of how to signpost for support and advice							
			District council community teams continue to provide the necessary support to local voluntary and community sector organisations to ensure there is capacity and resilience to support individuals in their homes							
			Connect/Locality teams to engage with District Council community teams to ensure they are aware of local provision and staff can signpost to support as appropriate.							

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Delivery Programme 2c: Connect: Primary Prevention						**SRO: tbc**				
Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Smoking Cessation	1h		Following the second PHE cLeaR self-assessment in Q1 2018 implement identified priorities Alliance to agree an action plan including measures and timescales. Action plan to go to HWB meeting 18/19 Enforcement of smokefree policies within NHS Trusts including increased access to NRT for smokers being admitted for care Improve recording of smoking status at time of delivery (CO verified) and support offered to pregnant smokers	LS: Prevention Programme 2018/19 – pan Suffolk		CA	**Mar19:** Develop action plan in partnership with Tobacco Control Alliance members, following cLeaR reassessment and reprioritisation			**KPI smoking prevalence** **KPI** Smoking status at time of delivery
Obesity/Weight management children and adults:	1h		Identify and provide brief advice to children (parents/carers) and adults with excess weight to access appropriate support Embed referral pathways for obese patients to access support to lose weight prior to elective surgery Improve the effectiveness of Tier 3 and Tier 4 provision, and align to Tier 1 and Tier 2 pathways Agree a Suffolk Food charter across the public, voluntary and private sector with actions that can be monitored Continue to embed and develop Suffolk Healthier Food Award Schemes (Eat Out Eat Well, Take Out Eat Well) Offer a programme to support increasing numbers of at risk people each year to reach a healthy weight (children and adults)	LS: Prevention Programme 2018/19 – pan Suffolk		CA				**KPI** reduce Child excess weight in 10 -11 year olds **KPI** reduce % of adults classified as overweight or obese
Hypertension Detection and Management:	1h		Increase opportunistic testing of blood pressure within primary care (GP and pharmacy), the IHLS and the wider community Increase the targeting of the NHS health check to reduce inequalities Ensure appropriate referral or sign-posting if hypertension suspected at health check or other opportunistic BP testing Encourage the use of BP monitors in GP waiting rooms and other venues both health and community sector Improve the number of patients diagnosed with hypertension having appropriate treatment Encourage call recall in primary care Support adherence to treatment and lifestyle by increasing self-monitoring of BP or accessing BP monitors in other community venues	LS: Prevention Programme 2018/19 – pan Suffolk		AB	**Aug18:** Review hypertension pathway work in IESCCG with WSCCG. **Oct18:** Share results of the BP machine in GP surgeries project (Phase 2 with 9 funded machines). **Ongoing:** Encourage call recall in primary care			**KPI** Patients with hypertension in whom last BP measure in last 12 months is <=150/90 **KPI** Hypertension QOF prevalence
Atrial Fibrillation Detection and Management	1h		Raise awareness of underdiagnoses of atrial fibrillation within primary care for example via CCG shut down training sessions	LS: Prevention Programme 2018/19 – pan Suffolk		AB	Nov18: Plan know your pulse campaign		Improved detection of those with Atrial Fibrillation Improved care of those already diagnosed	KPI AF QOF prevalence

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			Train staff in contact with patients (e.g. One Life Suffolk) and audit inclusions of pulse rhythm check (as per specification) and ensure appropriate referral if irregular as could be AF						with Atrial Fibrillation	KPI Those with AF currently treated with anticoagulation therapy (AF:CADS2DS2-VASc>=2)
			Scope potential for assessment as part of other programmes for example flu vaccination							
			Scope potential for self assessment within community (devices)							
			Scope potential for portable device assessment within primary care/community							
			Encourage GPs to use the available stroke assessment tool							
			Ensure that those with Atrial Fibrillation who could benefit from anticoagulants have been offered treatment							
			Encourage practices to run GRASP-AF to show them the actions they could take to optimise treatment of people with AF							
MECC (Making Every Contact Count)	1h		Encourage staff to complete the MECC training programme provided through the IHLS (One Life Suffolk)	LS: Prevention Programme 2018/19 – pan Suffolk			Sep18: Review of uptake linked to lifestyle referrals and MECC training Sep18: Review of GP link practitioners/ engagement embedded with OneLife Suffolk		Increased number of staff trained in MECC and actively giving brief intervention advice	KPI Number of referrals to OneLife Suffolk
			Increase appropriate referral to the IHLS (One Life Suffolk) for advice and support							
			Promote healthy lifestyle champion training within the public sector, voluntary sector and within communities							
			Develop and test "prevention link workers" between HLS and GP practices across Suffolk							
NHS health checks	1h		Promote NHS Health Check to eligible population	LS: Prevention Programme 2018/19 – pan Suffolk			Oct18: Health Checks review of targeting/uptake to most deprived LSOAs			KPI over 20% of health checks are delivered to individuals living in the 20% most deprived LSOAs KPI Increase in the number of referrals to Onelife Suffolk following an NHS Health Check KPI % or eligible population offered and received an NHS Health Check
			Ensure all those receiving an NHS Health Check receive information about Dementia risk (What's good to your heart is good for your brain)							
Alcohol brief advice				LS: Prevention Programme 2018/19 – pan Suffolk						10% of the population to receive alcohol screening (and brief intervention where required) at next GP appointment. 30% of alcohol related admissions to A&E to receive screening (accredited screening tool) and brief intervention where required
Physical Activity	1g		Actively engage in the governance structures of the Most Active County Partnership in order to influence the implementation of the physical activity health needs assessment recommendations	LS: Prevention Programme 2018/19 – pan Suffolk					Increased numbers of patients discharged from integrated therapies (physiotherapy and reablement) Increased signposting and referral to those who are physically inactive or have a long	**KPI** Number of referrals to OneLife Suffolk **KPI** Improve numbers of patients discharged from integrated therapies
			Scope integrations of physical activity into the commissioning intentions of mental health commissioners							

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			Implement evidence-based programmes through the healthy lifestyle service to ensure at least 3,000 individuals at high risk are participating in physical activity each year						term condition that would benefit from an increase in physical activity Improved pathways between rehabilitation and reablement services into community based physical activity support	(physiotherapy and reablement)
			Increase signposting and referral to those who are physically inactive or a long term condition that would benefit from an increase in physical activity participation							
			Improve pathways between rehabilitation and reablement services into community based physical activity support							
			Implement the parkrun UK and the Royal College of General Practitioners 'parkrun practice' initiative with GP practices local to parkrun events							
			Extend the Active Wellbeing service launched in July 2018, which is helping older people to become and stay more physically active, to other locations. This service is currently working with the GP surgeries in Long Melford and Lavenham and funds are in place to extend this to Glemsford next year (subject to available funding)							
			Extend the Active Schools programme, which is set to launch in October and will work with primary schools to reduce excess weight and improve children's physical activity levels, to other locations (subject to available funding)							
			Implement a quality standard for exercise on referral schemes operating across the West Suffolk Alliance area and increase the number of referrals in to accredited schemes							
			Provide healthcare professionals across the West Suffolk Alliance area with the knowledge and skills to incorporate physical activity into routine clinical care by implementing Public Health England Physical Activity Clinical Champion training across the West Suffolk Alliance area.							
Sexual Health						AA				
Personal and community resilience			Increase personal and community resilience	LS: Prevention Programme 2018/19 – pan Suffolk						

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Delivery Programme 3: Mental Health						**SRO: Pete Devlin/Richard Watson**				
Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Access to Mental Health services	2a, 2h, 3b		Mental Health model: • Work with Public Health to develop revised Needs Assessment and case for change • Facilitate co-production with Suffolk Users Forum (SUF), Suffolk Parents and Carers Network (SPCN), Suffolk Family Carers (SFC) and Health watch Suffolk on survey/engagement events with the Suffolk system • Develop revised Mental Health model and strategy including commissioning options	TP: New Suffolk Mental Health Model	18-MH-P1	ES/ML	**Jun18:** Develop revised MH JSNA **Oct18:** Develop VCS led co-production proposal **Oct18:** Develop MH Model **Nov18:** Develop Commissioning Options **Nov18:** Develop Report and Recommendations to Governing Bodies		Mental health model that delivers excellent services to patients whilst addressing physical and mental health needs.	Co-produced new mental health model to take forward and implement after November 2018
			IAPT & Wellbeing • Continue to develop the service to meet national access target of 19% for those with common MH conditions and increase stretch to 25% intervention rate • Develop IAPT approaches to support Long Term Conditions • Develop and implement the Living Life to the Full pilot with Ipswich (13 GP Practices)	TP: IAPT & Wellbeing	18-MH-P2	HN-M LP	Aug18: Commence Living Life to the Full Pilot Mar19: Develop LTC proposed element if IAPT		Local delivery of the NHS Five Year Forward View for Mental health, specifically implementation of IAPT approaches to support Long Terms Conditions. Embedded services that offers short-term psychological treatments for common mental health difficulties, i.e. depression, anxiety and stress, and will focus on empowering people to self-help and manage. Robust way of working across organisations, which integrates physical and mental health services by creating integrated care pathways.	Intervention Rate: 19% and move to 25% by 2021 50% Recovery Rate for IAPT
SMI Patient Support	2a, 2h, 3b		Physical Health Checks: Support for SMI Patients to include: • Develop and implement revised model to ensure 60% of SMI have an annual health check and on the GP register (50% of SMI register receiving in primary care; 10% of SMI register receiving in secondary care) - including how physical health checks are delivered across primary/secondary care	TP: SMI (Physical Health Checks)	18-MH-P3	HN-M	**Jun18:** Develop and agree SMI physical health checks by May 2018 and implement by end of June 2018		Annual physical health checks provided for people with SMI to provide an opportunity to detect physical conditions and health risk behaviours, and to offer appropriate interventions. Improved physical health care for people with an SMI within primary care services	Percentage of SMI have an annual health check and on the GP register (50% of SMI register receiving in primary care; 10% of SMI register receiving in secondary care)
			Individual Placement Support (IPS): • No Suffolk service at present. Discussions to take place with NE Essex (national beacon) as part of STP approach to support a business case submission ready for Wave 2 (expected December 2018).	TP: SMI (Individual Placement Support)	18-MH-P4	MG-R	**Mar19:** Agree IPS Plan and Approach		Embed a high performing and high IPS fidelity service, which is recognised as a 'National Centre of Excellence' by the Centre for Mental Health.	Achieve 25% increased access to Individual Placement and Support (IPS) services in 2018/19 (*for services in Wave 1 pilots)*
Dementia	2a, 2h, 3b		• Ensure recovery plan developed and delivers a minimum of 66.7% dementia diagnosis rate • Continue to improve post diagnostic dementia care • Promote Dementia Hubs and Dementia Friendly Communities. • Support the continued development of a network of local Dementia Action Alliances across our market towns and larger villages	TP: Dementia	18-MH-P5	GC	**Jul18:** Implement West Suffolk Dementia LES Mar19: Develop and deliver Dementia Diagnosis Recovery Plan		Increased diagnosis rates for those living with dementia, ensuring that they are not passed round the system un-necessarily, have reduced repeat admissions to hospital, given the support they require to live healthy, and are supported emotionally to reduce anxiety and support them individually through their journey. Carers and families of those living with dementia will be well supported so they do not become ill and are able to support the person living with dementia with the appropriate services so they do not end up in crisis.	Achieve 66.7% dementia diagnosis rate in CCG
Crisis Support	2a, 2h, 3b		Develop new model for Suffolk Crisis as part of new overall Mental Health model of care to include:	TP: Crisis Response Model	18-MH-P6	LP	**Oct18:** Develop revised MH Crisis Model		To have developed a scope of what a 24/7 crisis response service for Suffolk would look like, having considered the agencies and elements of service required to deliver this in line with national best practice.	Teams are able to offer 24/7 community crisis response, including rapid response for people with urgent and emergency needs

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Psychiatric Liaison	2a, 2h, 3b		Implement an increased investment and staffing model in IHT and WSFT and continue to review	TP: Psychiatric Liaison	18-MH-P7	LP	**Jun18:** Revised PLS Service in place at both acute hospitals		An embedded 24 hour mental health liaison service that sees patients in ED within 1 hour of referral to the psychiatric liaison team, and patients on general wards are seen within 24hours of referral	Deliver Core 24 mental health liaison standards for adults in 50% of acute hospitals *(subject to hospitals being able to successfully recruit)*
Early Intervention in Psychosis	2a, 2h, 3b		Develop and implement new model for Early Intervention in Psychosis (EIP) which meets national standards	TP: Early Intervention in Psychosis	18-MH-P8	LP	**Jul18:** Confirm EIP business case		53% of people (all age) with first episode psychosis starting treatment within 2 weeks of referral and the treatment is a NICE-recommended package of care.	Achieve 60% of people by 2020/21 receiving treatment in 2 weeks in line with NICE recommendations for requiring early intervention for psychosis
Crisis Resolution Home Treatment Teams	2a, 2h, 3b		Crisis Resolution Home Treatment Teams (CRHTTs) to meet the ambition of all areas providing CRHTTs resourced to operate in line with recognised best practice by 2020/21	TP: Crisis Resolution Home Treatment Teams	18-MH-P9	LP	**Xxx18:** Agree Plan for Crisis Resolution Home Treatment Team		Expansion of CRHTT's to enable patients to receive community-based crisis response and intensive home treatment as an alternative to admission. The NHS England expectation is that the CRHTT will be provide their core provision against Core Fidelity standards.	By: 20021: Respond to referrer within 30 mins Offer an assessment within 4 hours to more than 90% of patients Offer same day assessment for at least 50% of appropriate referrals received before 6pm
Out of Area Placements:	2a, 2h, 3b		Continue to review all patients who are placed out of area to ensure that have appropriate packages of care	TP: OOA Inappropriate Mental Health placements	18-MH-P10	WS/ BH	**Xxx18:** Agree OOA Placements Action Plan **Aug18:** Obtain and renew Lark reopening delivery plan from NSFT			Number of bed nights for inappropriate OOA for PICU to be 0 by Dec 2018 Number of bed nights for inappropriate OOA for Acute to be 0 by Dec 2018. Number of non-Suffolk CCG patients in local inpatients provision and bed days to exceed the average from last year.
Suicide Prevention	2a, 2h, 3b		Continue to deliver on the Suffolk Suicide Prevention Strategy	LS: Suffolk Suicide Prevention Strategy			**Mar19:** Continue to deliver the Suicide Prevention Strategy		Role of CCG as partner organisation is to work with system as a whole to promote, enable and deliver the suicide strategy.	Achieve a 10% reduction in suicides by March 2019.
Learning Disability	2a, 2h, 3b		Complex case team launched to manage Delayed Transfers of Care, Chaotic Lifestyles Reviews, out of Area Reviews and advice for complex cases.			WS/ BH			Ensure we focus on areas of high spend.	
			Supported housing framework for Day, Evening and Weekend provision reopened for new entrants						Improved service for those requiring support urgently, preventing placement breakdown	
			Housing Strategy/pathway plan developed and launched						Strategic approach to housing to ensure cost effectiveness and the delivery of good outcomes, including promoting progression and independence.	
Medicines Management - Prescribing	2a, 2h, 3b		Review the prescribing of * Benzodiazepines and Z drugs * Antidepressants		18-PW06	LL			Taper/withdraw benzodiazepines and Z drugs where possible Taper/withdraw antidepressants where appropriate	

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Delivery Programme 4: Maternity						**SRO: Lisa Nobes**				
Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Maternity – Implementing "Better Births"			Work with Maternity Voices Partnership and Healthwatch to co-produce pathways of care at a local level that provide choice, continuity of care and that mean that every child has the best start in life.	LS: Suffolk & North East Essex Local Maternity Strategy					• Safer, more personalised and seamless provision of services. • Every woman has access to information to enable her to make decisions about her and her baby's care. • Support is centred around women's individual needs and circumstances including perinatal mental health. • High performing teams with cultures which promote innovation and continuous learning. • New service models will be co-produced with Maternity Voices Partnership and Healthwatch. • Ensuring every child has the best start in life will start with the maternity pathway.	**STP KPIs:** • Birth Friends & Family Test • Number of formal complaints received • Number of serious incidents • Babies who require transfer for therapeutic cooling • Percentage of normal vaginal deliveries • Percentage of C-sections undertaken
			Ensure all pregnant women have a personalised care plan							Reduce still birth rates by 20% and make 50% reduction by 2030
			Ensure all women have a choice-based personalised care plan and choice of care closer to home							
			Ensure more women are able to give birth in midwifery led settings (at home and in midwifery units)							
			Reduce rates of still birth, neonatal death, maternal death and brain injury during birth							
			Invest in and learning from incidents and sharing this learning through their local maternity system and with others							
			Full engagement in the development and implementation of the NHS improvement and Neonatal health and safety collaborative							
	2g		Perinatal mental health: Expand the current service to support women with moderate to severe mental ill health.	LS: Local Transformation Plan (LTP) in response to the recommendations set out in the Future In Mind Report TP: Perinatal mental health	18-CYP-P12	CR	**Oct18:** Agree final pathway and ensure alignment with published national pathways **Oct18:** Agree and develop operational policy for expanded service **Dec18:** Implement expanded Specialist Perinatal Mental Health service		Team fully recruited to and revised service model implemented with a community specialist PNMH team focussed on meeting the needs of women with severe PNMH.	Outcome measures as detailed in "Children and Young People's Health" radar charts (STP-level)
			Continuity of carer • Engagement events with Alliance partners and Midwifery workforce • Confirm pathway design • Develop staffing model and training needs assessment for CoC model • Birthrate plus modelling completed to confirm staffing needs • Deliver training programme • "Go live" with Phase One of CoC model • Confirm evaluation framework		-	LS	**Nov18** **Nov18** **Dec 18** **Feb19** **Mar19** **Mar19** **Jan19** **Oct18:** Complete audit to establish baseline position **Oct18:** Complete survey of midwives to establish opportunity for job planning **Oct18:** Target elective caesarean section women **Oct18:** Identify 3rd cohort of women to achieve 10% target	**Jun19:** 3 month evaluation of model **Jul 19:** LMS event to discuss challenges, successes and learning from early implementer cohorts **Sep19:** 6 month evaluation with report to inform future plans of expanding CoC **Mar20:** One year evaluation with report and revised plan for full CoC rollout **Mar20:** Monitor and evaluate delivery and activity of model	Positive FFT, patient surveys, reduction in complaints, improved patient experience	National target 20% by March 2019 **Oct18:** Improve homebirth rate to 10%
			Safer Care				**Aug18:** Undertake survey of smoking history **Sep18:** Participate in 'Healthy Pregnancy' initiative **Oct18:** Improve feedback loop from		Smoking reducing still births 20% by 20/20 50% by 2025	6%

Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
							One Life referrals to re-engage women **Jan19:** Explore option to train own staff in smoking cessation			
			Post-natal care: improving quality				**Oct18:** Complete audit to establish baseline position			
			Multi-disciplinary training				**Aug18:** PROMPT multi-disciplinary training in place Community ambulance programme			

Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Delivery Programme 5: Children's Services:						**SRO: Allan Cadzow**				
Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
SEND local offer	1e		Develop a multi-agency plan and system response to findings of DfE and NHSE inspection	LS: SEND TP: SEND - Priority 3	18-CYP-17	SB	**Sep18:** SEND Sufficiency Plan for Specialist Education to SCC Cabinet **Dec18:** SEND Sufficiency Plan for Health will be written by end of December 2018			
			Speech and Language Therapy and Communication: • *Review the current service provision and agree new Suffolk model/joint commissioning arrangements.*	TP: Speech, Language and Communication	18-CYP-16	SB	**Sep18:** Costed model and options produced **Nov18:** Implementation Action Plan in place		Children who require specialist interventions are referred and when they are they receive timely and good quality interventions which meet their needs. Parents are supported and enabled to provide ongoing support to help meet their child's needs.	Referral to assessment target in SLC service met. Reduced waiting time for therapy Increased activity levels within Early Help and Schools intervention
Paediatric pathways	2a, 2f		Create a new paediatric waiting area and paediatric clinical area as part of the GP streaming project.	West Suffolk Alliance Children and Young People's Strategy 2018 - 2023 West Suffolk Alliance Children and Young People's Strategy 2018 - 2023	18-CYP-P13	CR			Children are assessed and treated in a child friendly environment separate from adults. 'See and Treat' patients and medically unwell paediatric patients will be seen in the new paediatric area by the ED team with support of the paediatric team if needed.	
			Establish a dedicated paediatric resuscitation bay within the ED resuscitation area.		18-CYP-P13	CR			ED patients requiring observation for more than four hours or requiring admission will be transferred to the CAU or F1 ward for further management	
	2a, 2e		By 2023 WSFT will be facilitating outpatient care pathways to improve patient and family choice and decrease inpatient pressures without detriment to the quality or safety of healthcare provided to CYP		18-CYP-P13	CR				
	2a		Establish joint clinics with the WSH's link paediatric nephrologist from Nottingham on a quarterly basis; together with joint paediatric urology clinics with visiting surgeons from both Cambridge and Norfolk & Norwich University hospitals.		18-CYP-P13	CR			The aspiration is to combine this with a local day theatre operating list in the near future, preventing the need altogether for these patients to travel further afield for their care.	
	2a, 2e		WSFT will undertake paediatric clinics in primary care settings following a pilot period which was aimed at establishing whether clinical referral to an acute setting can be prevented. In eight of the 24 GP practices on the West Suffolk Hospital (WSH) catchment, GPs were able to book patients directly into clinics delivered by WSFT consultants in their own practices once a month for up to 10 patients.		18-CYP-P13	CR	**Sep18:** Work to establish the resource pressure on the Trust and the implications of extending the offering across all 24 GP practices in mid-2018 will facilitate understanding and allow the detailed development of this line of activity across the duration of the strategy timeline.			
	2a, 2e		**Integrated information management:** WSFT's vision is for parents and carers, and children and young people themselves, once they are old enough, to take ownership of their own care records to alleviate the frustration of		18-CYP-P13	CR			By creating ways to facilitate CYP and their parents or carers and ensuring that WSH healthcare providers have access to a shared formal care records, WSFT proposes to reduce unnecessary risks in the handover of care, especially within emergency settings	

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			the same questions being asked multiple times.							
	2a, 2e		**Access to good personal health information:** WSFT will establish ways to share on-line health records and to provide an information channel via which other sources of information, both age appropriate and condition appropriate, can be filtered		18-CYP-P13	CR				
	2a, 2e		**Safe and sustainable preventative and care services:** Establish ways that these CYP and their families as well as children with more common conditions have access to the appropriate expertise in the right place in order that improved outcomes can be assured whilst maximising quality of life		18-CYP-P13	CR				
Integrated Behavioural Pathways	2d		Agree a system-wide pathway supporting ASD, ADHD, Conduct Disorder and Behaviour	LS: Suffolk Children's Emotional Wellbeing Plan TP: Neuro-developmental & Behaviour	18-CYP-14	JJ	**Sep18:** New model proposal to SEND Board **Oct18:** Agreement of a system-wide pathway supporting ASD, ADHD, Conduct Disorder and Behaviour **Nov18:** Implementation Plan developed		• Parents know the way in – they don't experience the complexity • No wrong door • Needs-led service which is child and family-centred • Early help/prevention through to specialist • Equality of access – empowerment of the family • Evidenced based help earlier • Skills/offer throughout pathways to enable those with relationships to help early • Supporting and equipping parents • Those with multiple behaviour problems have their needs met as well as those with single issue	Outcome measures as detailed in "Children and Young People's Health" radar charts (STP-level)
Children and young people's community health services	2e		Delivery and implementation of service specification for integrated community paediatric services	TP: Integrated Community Paediatric Service	18-CYP-18	SB	**Oct18:** Delivery and implementation of service specification for Integrated Community Paediatric Services **Mar19:** Business case and implementation plan developed	**Apr19:** Service implementation	ICPS will have accommodated what is required from the service as part of integrated pathways and support for SLC and Neurodevelopment and Behaviour pathways. It will be able to cope with the demand for its services within the envelope of resources available and be able to deliver on the service specification and KPI's.	
Children's emotional health and wellbeing	2f		Launch Wellbeing Hub	LS: Children's Emotional Health and Wellbeing Plan TP: Emotional Wellbeing Hub	18-CYP-P11	JJ	**Apr 18:** Launch Wellbeing Hub **Aug18:** Wellbeing Hub transitioned to Business As Usual		The Hub will provide empathetic advice and guidance, and provide a place to access help from the Suffolk health and care system; specifically • Timely, effective help for all children & young people and their families • No bounce and no wrong door • Service users don't have to retell their story repeatedly • Young people will be supported to access the services they need	Outcome measures as detailed in "Children and Young People's Health" radar charts (STP-level) Achieve 32% of children and young people (0-18) with a mental health diagnosis are receiving NHS funded treatment
			Launch CYP crisis service	LS: Suffolk Local Transformation Plan TP: Crisis Response Pilot	18-CYP-P15	JJ	**Jun 18:** Launch CYP crisis service **Nov18:** Crisis Pilot will be in place		A telephone line that is answered out-of-hours to offer support to CYP and families. Staff who are trained to meet the needs of children and young people in crisis. The possibility for CYP to be visited at home rather than having to attend A&E Follow-up support offered in the hours and days after a crisis.	
			Eating disorders							
			Children in care –				**Sep18 – Apr19**			

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			At least 10 Semi-independt living in dual placements established - Systematic screening of those at risk of placement breakdown or where cost of placement is very high cost - Start pilot for increased capacity for Intensive Support for age 3 – 10 care avoidance. - Deliver Mockingbird second hub - Start Operational delivery of outcomes based contract for at risk of care (SIB) - Catalyst Project identification of risk of care							
			Youth Justice mental health							
			Transition							
			Families and schools: Supporting with children with emotional wellbeing							
			Delivery of 7 day a week complex children's nursing service				**Dec18**			
			IT development to achieve paper light records and mobile working including SystmOne				**Dec18**			

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Delivery Programme 6: Developing Responsive (Urgent Care) Services						**SRO: Richard Watson/Bernadette Lawrence**				
Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Integrated rehabilitation/ reablement	2i		Develop comprehensive responsive service that integrates all existing out of hospital urgent care provision, including the Early Intervention Team, Home First, Support to go Home etc.	TP: Recommissioning of the Responsive Home Care Provision	ICW06	CS/JH/ RB/HP	**Aug18:** Development of Services Specification **Dec18:** Service Specification and commissioning approach signed off by SCC Cabinet key stakeholders **Mar19:** Responsive Services Delivery Modelling		Crisis Management in the Community • Any referral is immediately assessed and triaged and where needed an assessment will be conducted within a 2-4 hour period, resulting in a holistic care plan. • In some cases this will mean an intensive period of intervention to manage the crisis, conduct an assessment and identify a short term plan (likely to range from 3 - 7 days) which will aim to start the support the same day wherever possible • There will be a 24/7 response; focusing on very urgent need during night hours and a full response in day time. (exact hours for night and day to be determined) • Trusted Assessment will be in place to minimise duplication - with access to specialised input when required and a shared documentation. • Seamless delivery to patient/customer that is short term (up to 6 weeks) • Locality based - close to home - connecting seamlessly with the Integrated Neighbourhood Teams • An integrated team to include health & social care professionals - physio-therapists, OT, HCA, nurse, geriatrician, generic worker, paramedics, mental health input, social workers, voluntary sector, • End of Life care - community based support and links with local hospice team	
			Ensure effective and early links are made with Housing Teams to support the transition to home – including housing options advice, home adaptations and housing standards support, such as heating advice.							
Home Care procurement	2i		Home Care services re-procured through SCC						Stablise the market, ensure access to care.	

Urgent & Emergency Care demand management			The delivery of the programme in 2018/19 is about making many of the schemes BAU within WSFT. These include:
			• Front door reconfiguration to move:
			  • AAU (including AEC) to the front door ensuring GP expecteds continue to bypass ED
			  • Implement Frailty Service to ensure the GP streaming service is fully utilised.
			• continued stretch of EIT to ensure the admisison avoidance element of the service is protected and not absorbed by the increasing early intervention activity created by the above reconfiguration. This will be aligned to the HALO cquin to improve EEAST utilisation of the service through myDOS
			• The Discharge Waiting Area has been moved frequently in 2018 and requires a dedicated protected area that shuts overnight
			• Repeated users of urgent care services - this is a high profile requirement for all ICS to implement focusing on top 100 users
				TP: Urgent & Emergency Care demand management	ICW09	LS	**Oct18:** EEAST CQUIN agreed
							Nov18: SAFER 100 day challenge to increase pre noon discharges
							Sep18: Repeated users proposals approved
							Mar19: Repeated users model implemented
										1. Removal of circa 4000 GP expecteds needing to travel through ED: November 2018
										2. Reduction in LOS for over 75s: focus on stranded patient numbers < 7 days 31 March 2019
										3. Increase in pre noon discharges - to 33% or more of all discharges or 8 a day 7 days a week: November 2018
										4. 10% reduction in urgent care activity (part year effect) for repeated users: 31 March 2019

Integrated Urgent Care mobilisation			Implement mandated national specification delivering a STP wide fully functionally integrated 24/7 urgent care access, clinical advice and treatment service bringing together Out of Hours primary care and NHS 111.		ICW10	SR	**Oct18:** DOS governance process in place and updates completed **Nov18:** Mobilisation		Delivery of all key service requirements: 1. Consult and complete model with 50%+ receiving clinical assessment from MDT (not just GPs): 1 November	

Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
									2. 100% of population have access to an IUC CAS: national requirement by March 2018 3. NHS111 online available to 100% of population: national requirement by March 2018 4. Transfer of revised GP streaming model to Care UK: 1 April 2019 5. Transfer of Mental Health crisis response to Care UK: 1 April 2019 6. Plans developed and implemented to transfer (or not) CCC functionality to Care UK: 1 April 2019	

Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Delivery Programme 7: Developing integrated pathways and patient journeys						**SRO: Helen Beck/Richard Watson**				
Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Respiratory	2a	-	Implementation of My COPD programme across WSFT and community		PCW02	JE	**Sep18:** MyCOPD roll-out to patients		• Improved symptom management essential to stabilise the disease and reduce hospitalisation and wasted prescribing. • Reduced exacerbations • Improved Quality of Life • Access to self-management and pulmonary rehabilitation 24/7 • Opportunities for educational sessions for hard-to-reach patients • Closer working between practices and community respiratory specialist nurses to prioritise specialist intervention in a more dynamic way	Exacerbations reduced by 25-30% Reduction in A&E attendances by 25-30% Improved quality of life (measured by CAT) ?Measurable how?
Respiratory (Responsive services)				TP: Respiratory Services - Rightcare scheme	ICW07	HP	**Jul18:** Pathway redesign complete and signed off **Aug18:** Capacity aligned to new model and implementation commenced **Aug18:** Recruitment to COPD service vacancies completed **Dec18:** Flu campaign implemented **Mar19:** Dysphagia support to care homes implemented as part of care homes training programme	**Dec19:** Evaluation completed of respiratory pathway pre winter pressures	West Suffolk Alliance partners will have in place: • 6 INTs with access to respiratory expertise and a trained INT workforce on respiratory prevention and management • A COPD pathway that in integrated with the Early Intervention Team to provide a 2 hour response to urgent care and aligned to the INTs for complex case management support • A streamlined delivery model that delivers a service to mobile active patients in locality based clinics • An interface model with WSFT that supports early supported discharge using trusted assessment • A rotational integrated model of therapy provision delivering community based intervetnions rather than acute based OPA • An alliance led campaign that drives a systematic approach to flu vaccination	Reduce COPD and Flu related admissions by 65 admissions
Respiratory (Medicines Management - Prescribing)			Review the prescribing of: • Inhaler devices • Other drugs used for treatment of respiratory conditions, e.g. carbocisteine		18-PW09	LL	**Jul18:** Asthma - Develop, launch and distribute revised joint WSFT-WSCCG adult asthma prescribing guidelines		• Joint WSFT/WSCCG adult asthma treatment guidelines developed • Adherence to national and local adult prescribing guidelines for asthma and COPD • Cost effective inhaler devices are prescribed • Step treatment down when possible • Reduced prescribing of inhaled corticosteroids • Reduced the prescribing of carbocisteine • Teach and regularly check correct inhaler technique • Excessive use of SABA inhalers addressed	
Cardiology	2a	-	Implement EASHN AF monitoring pilots.	TP: Cardiology	PCW01	CJ	**Mar19:** EASHN Alivecor project implemented and monitored	**Mar20:** Palpitations pathway implemented **Mar20:** Hypertension pathway implemented	Patients will be empowered to navigate the health and care system and make best use of resources available to them. Patients get the right support at the right time and in the best place because pathways are seamless, clear and focused on value.	Reduction in AF stroke from 2019 to 2021 inclusive
			Implementation of the AF Detect, Protect, Perfect project	TP: Cardiology			**Aug18:** AF business case agreed by		Services will be centred around the patient	

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				LS: Stroke prevention			SEG **Mar19:** AF protect and perfect implemented **Mar 19:** AF detection implemented		where possible and professionals use evidence and best practice to inform redesign changes. Care becomes more cost effective and there is a reduced variation in spend against the CCG peer group. Patients will be empowered to navigate the health and care system and make best use of resources available to them. Patients get the right support at the right time and in the best place because pathways are seamless, clear and focused on value.	
			Refresh Heart Failure Pathway	TP: Cardiology			**Mar19:** Refreshed heart failure pathway implemented			Improved treatment for heart failure within Suffolk that improves the CCGs ranking nationally on treatment
			Implement Palpitations pathway	TP: Cardiology				**Mar20:** Palpitations pathway implemented		Reduction in the number of referrals to secondary care
			Implement Hypertension pathway	TP: Cardiology LS: Stroke prevention				**Mar20:** Hypertension pathway implemented		Reduction in strokes and cardiology events through improved hypertension control
Neurology	2a	-	Review emergency pathway for management of epilepsy and explore opportunities for enhanced management of LD patients with epilepsy.		PCW08	RM	**Aug18:** Produce detailed Project Initiation Document	2020—in line with Rightcare	Development of a joint STP-wide transformation plan.	
			Review capacity for Neuro Rehabilitation and develop a commissioning framework							
			Implement a revised headache pathway							
MSK	2a	-	Integrated MSK service	TP: Integrated MSK service	PCW04	MB	**Feb19:** Mobilise integrated service		• Provide an integrated multidisciplinary approach across the system • Reduce inappropriate referrals to secondary care and release the costs associated with inappropriate secondary care activity - to be quantified • Improve patient experience of MSK services, • Encourage best practice for MSK treatment and management	
			Single Point of Referral: • Service audit to be completed • Revise and review the integrated physiotherapy service	TP: MSK (SPoR)	PCW06	MB	**Sep18:** Final evaluation presented to Planned Care Board		• Maintain the single point of access for all referrals	
Integrated Pain Management Service (IPMS)	2a	-	Develop integrated pain service	TP: Pain (IPMS)	PCW10	RM	**Sep18:** IPMS Final Contract and Provider signed off by WSCCG Governing Body **Oct18**: E-referral in place for all referrals.		A single pain management service in West Suffolk led by one single provider/ alliance.	
Ophthalmology	2a	-	Implementation of High Impact Interventions 1 & 2	TP: Ophthalmology	PCW09	CJ	**Sep18:** Community service mobilised and strategic partnership commenced **Mar19:** HII principles embedded		Services will be centred around the patient where possible and professionals use evidence and best practice to inform redesign changes. Care becomes more cost effective and there is a reduced variation in spend against the CCG peer group. Patients will be empowered to navigate the health and care system and make best use of resources available to them. Patients get the right support at the right time and in the best place because pathways are seamless, clear and focused on value.	564 additional procedures to have been undertaken by Oct 18 Demand and capacity plan undertaken with associated actions in place Pilot of minor eye service undertaken with test of outcome of reducing admissions
			Implementation of HII 3 Demand and Capacity review with associated actions through strategic partnership							
			WSFT and WSCCG working together with procured services to deliver integration of all services within a strategic partnership							
Stroke (STP-wide)	2a	-	Evaluate at STP level, the current stroke acute care pathways and HASU arrangements to identify opportunities for potential pathway and HASU redesign.	TP: Stroke	PCW11	CJ		**Mar 20:** HASU/ASU STP arrangements complete		Agreement across the STP and regionally on the HASU/ASU units in the STP
			Strategy for prevention and detection and optimising of treatment implemented				**Mar19:** Strategy for prevention, detection and optimising treatment is implemented			Reduction in AF strokes
			To support the STP wide review of Stokes services including thrombectomy pathways, workforce, training					**Mar 20:** Stroke strategy and elements complete	Robust 7 day working and able worforce to manage the demand for stroke care.	

Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
			and education and stroke strategy.							
			Procure a new ESD and post stroke rehabilitation service					**Dec19:** ESD Service and Rehabilitation framework procured	Improved integration of the current ESD, community and acute services	
Diabetes (STP-wide)	2a	-	Structured Education places to 600	TP: Diabetes	-	JE			Improved care of existing diabetes patients by increasing the number of Structured education places available and to help patients achieve their three NICE treatment targets (BP, HbA1c & Cholesterol).	For 18/19 the goal is to create 600 Structured Education places whilst maintaining an attendance rate of at least 60% Improve on 17/18 levels from the NDA dataset
			Implement behavioural change management within first phase practices							
			Support Diabetes dashboard or analyst to ensure accurate / responsive feedback							
			Roll out Diabetic consultant visit to practices							
			Support links with OneLife for ongoing support after structured education (Prevention)							
			Develop and implement GP incentive scheme							
			Implement National Diabetes Prevention Programme: Procure and work with a new lifestyle provider across the STP who will receive referrals for pre-diabetic (NDH) patients.							Maximise our allocation of referrals and subsequent initial assessments/achieving patient goals to become non-diabetic
Diabetes – Medicines Management	2a		Implement and/or maintain safe, appropriate and cost-effective prescribing of: • Blood glucose testing strips (BGTS) • Needles for insulin devices • Lancets • Hypoglycaemic agents, including insulin • Flash Glucose Monitoring Systems, e.g. FreeStyle Libre		18-PW03	LL	**Sep18:** Flash Glucose monitoring systems, e.g. FreeStyle Libre **Mar19:** Biosimilar insulin glargine (Abasaglar) - Embed biosimilar prescribing strategy		• Appropriate and cost effective prescribing of BGTS, needles and lancets, in line with WSCCG/WSFT policies and guidelines • Safe, appropriate and cost effective prescribing of hypoglycaemic agenta in line with WSCCG/WSFT treatment guidelines • Increased prescribing of biosimilar insulin glargine (abasaglar) as a % of all insulin glargine • Compliance with East of England recommendations/limitations regarding criteria for prescribing Flash Glucose Monitoring Systems, e.g. FreeStyle Libre	Cost effective prescribing of BGTS, needles and lancets, in line with WSCCG/WSFT policies and guidelines Cost effective prescribing of hypoglycaemic agenta in line with WSCCG/WSFT treatment guidelines Increased prescribing of biosimilar insulin glargine (abasaglar) as a % of all insulin glargine No prescribing of Flash Glucose Monitoring Systems other than in line with EoE PAC recommendations
Vascular	2a	-	• Align Vascular LPP and tighten up process for approval in line with STP. • Reduce follow-ups for vascular against agreed set of clinical criteria.	TP: Vascular	PCW12	TM	**Oct18:** Launch process	**Jun19:** LPP alignment	• Improved symptom management • Improved management of patient expectations • Clear and robust clinical criteria and shared decision making	Reduction in secondary care referrals by 30%.
High cost packages of social care										
End of Life:	1a, 1c, 2i		Review utilisation and issue of MCW folders	LS: End of Life Strategy		RP				
			Rollout of Red Bag pilot initiative							
Care Prospectus	1a		SCC care prospectus published				**Oct18**: Care Prospectus published			

Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Delivery Programme 8: Cancer (Pan-STP)						**SRO (local): tbc**		**(STP Lead: Sam Heppelwhite)**		
Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Macmillan Navigator role	1c, 2i, 2k	4	Work with Macmillan and other stakeholders to implement this role							
Waiting Time Standards	2a	4	Ensure all eight waiting time standards for cancer are met, including the 62 day referral-to-treatment cancer standard						Patients get timely access for assessment and first definitive treatment.	
			Implement the '10 high impact actions' for meeting the 62-day standard in all trusts, with oversight and coordination by Cancer Alliances.							
Early Diagnosis	2a	4	Support progress towards the 2020/21 ambition for 62% of cancer patients to be diagnosed at stage 1 or 2, and reduce the proportion of cancers diagnosed following an emergency admission							62% of cancer patients to be diagnosed at stage 1 or 2 Reduce the proportion of cancers diagnosed following an emergency admission.
Radiotherapy	2a, 2h	4	Support the implementation of the new radiotherapy service specification							
			Ensure that the latest technologies, including the new and upgraded machines funded through the national Radiotherapy Modernisation Fund, are available for all patients.							
Rapid Assessment and Diagnostic Pathway	2a, 2h	4	Implement the national rapid assessment and diagnostic pathways for lung, prostate and colorectal cancers						Patients get timely access to the latest diagnosis and treatment.	
Breast Cancer	1d,	4b	Progress towards the 2020/21 ambition for all breast cancer patients to move to a stratified follow-up pathway after treatment.				**Mar19:** All Cancer Alliances should have in place clinically agreed protocols for stratifying breast cancer patients and a system for remote monitoring.		Around two-thirds of patients should be on a supported self-management pathway, freeing up clinical capacity to see new patients and those with the most complex needs	
Cancer Waiting Times	2a, 2h	4	Implement the new cancer waiting times system in April 2018 and begin data collection in preparation for the introduction of the new 28 day Faster Diagnosis standard by 2020.				**Apr18:** Implement the new cancer waiting times system in			

Notes

Initials	Name	Title	Organisation
JE	Juliet Estall		
MB	Martin Bate		
RM	Renu Mandal		
TM	Tracey Morgan		
DP	David Pannell		
SR	Sandie Robinson	Associate Director - Redesign	West Suffolk CCG
DH	Davina Howes	Head of Families & Communities, St Eds BC	
CA	Caroline Angus		
AB	Abhijit Bagade		
HJ	Helena Jopling	Public Health Consultant	West Suffolk Hospital
PD	Pete Devlin	Operations Director, Mental Health and Learning Disability	ACS, Suffolk County Council and Norfolk and Suffolk Foundation Trust
CJ	Claire Jay		
TL	Tracy Lindeman		
KW	Kevin Wegg	CISCO (Haverhill) Project Manager	
CH	Chris Hooper		
LP	Lorraine Parr		
GC	Gail Cardy		
HN-M	Hannah Neumann-May		
LW-M	Lauren White-Miller		

Initials	Name	Title	Organisation
SH	Sarah Hedges		
HBo	Helen Bowles		
KS	Katy Snelgrove		
LB	Lynda Bradford		
JK	Jill Korwin		
SB	Sara Blake	AD Transformation Children and Young People	Ipswich and East and West Suffolk CCG and Suffolk County Council
NJ	Nick Jenkins	Medical Director	West Suffolk Hospital
ES	Eugene Staunton	Associate Director Redesign	West Suffolk CCG
MBo	Mike Bone		
JR	Jeptepkeny Ronoh	Consultant in Public Health Medicine – West Suffolk Locality	Suffolk County Council
PL	Paul Little		
ACz	Allan Cadzow		
HB	Helen Beck		
JRo	Jane Rooney		
RK	Rob Kirkpatrick		
TF	Tania Farrow		
CR	Caroline Ratcliffe		
RC	Richard Cracknell		

STP Priority (as at 31/08/18)	**STP Outcome Measure (as at 31/08/18)*…subject to amendment***	**Alliance or STP enabling programme?**
1. Deprivation	a) Every person in health and care considers improving MH their responsibility	Alliance
	b) Eradicate child poverty in the STP	STP
	c) Reduce inequality in life expectancy in all STP districts to that of the best	Alliance
2. Zero Suicide	a) Wellbeing Hubs in all our schools	STP
	b) Enable easy access to those with mental health/emotional concerns	Alliance
	c) One year of zero suicides	Alliance
3. Obesity	a) Access to local bariatric services including surgery for our population in line with national guidance	STP
	b) Eliminate obesity in staff working in education, health and care within 5 years.	STP & Alliance
	c) Educate people that obesity causes cancer, diabetes and cardiovascular disease.	STP & Alliance
4. Unplanned Cancer Admissions	a) No patient diagnosed with cancer through an unplanned hospital admission	STP & Alliance
	b) 100% uptake of screening for breast, bowel and cervical screening	Alliance
	c) Reduce cancer incidence in Tendring to the STP average within 5 years	Alliance
5. End of Life	a) At least half the number of people dying in hospitals	Alliance
	b) Every patient making choices for end of life care has all the information they need.	Alliance
	c) Guarantee the best experience for everyone at the end of life	Alliance
6. Ageing and Living Alone	a) Good neighbour or similar schemes available in every local community	Alliance
	b) Create multi skilled place based roles to meet the needs of patients better	Alliance
	c) Become a world leading region for technology to address loneliness.	STP & Alliance

Questions?

Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Delivery Programme 2a: Connect: Integrated Neighbourhood Teams					**SRO: Dawn Godbold/Bernadette Lawrence/Kate Vaughton**					
Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Locality leadership	1a		Appoint one day a week lead role *Note: Currently on hold as reviewing need. Consideration appointing one as a 'test' and then refine* ***Questions requiring clarity/decision:*** *We need to be very clear about what is needed in this space and not think that a post will be the solution. I've (DH) already suggested to Kate and Dawn that one of their locality teams (e.g Mildenhall) works with my locality officer to identify what we know, what we are trying to achieve and how the teams can work together. From there, we can establish what resource is missing.* *I'm(JS) not clear what sort of resource is intended here. Would the post be about local system leadership/place shaping and priority setting (such as, say Phil Aves role for Lowestoft Rising) or is it intended to be a locality manager role with operational responsibility for integrating health, community health and social care teams. These are clearly very different things.*	LS: Connect 6 Integrated Neighbourhood Teams				Success as defined in the Connect principles: • The experience of the local population is improved by working in partnership with them • Health and wellbeing is improved by promoting and enabling self-care • The patient/customers journey through all parts of the health and social care system is integrated and coordinated • Ill health and crisis intervention is prevented	• Good levels of community engagement in developing and engaging in responses • Improvement in years of healthy life expectancy • Reduction in GP attendance • A reduced proportion of customer in receipt of ongoing (Tier 3) support • Increases in people receiving an integrated Tier 1 response • Reduction in A&E attendances • Reduction in emergency/ out of hours GP calls • Increase in Tier 2/ reablement interventions • Reduced hospital admissions
			Recruit to band 4 locality "Connect Link Workers" posts in all Connect localities ***Questions requiring clarity/decision:*** Need to understand this more before recruiting. *This feels to be recreating the roles that were dis-established only a few months ago. Another option would be to allow each locality delivery group to determine what kind of resource they needed. This could be a full-time coordinator post or it could be the maximum flexibility to resource specific pieces of work that unlock opportunities/address barriers*							
			Develop a robust governance and delivery infrastructure				**Dec 18**: agree scope for triumvirate (comm health/SCC/NSFT) model of locality operational management **April 19:** commence implementation of shared operational management structure			
			Involvement of a wider range of partners ***Questions requiring clarity/decision:*** *This needs mapping – what partners and for what purpose? Need to learn the lesson here of Connect when different partners were engaged, and then not. Suggest that we need to find ways for the Alliance to engage with partners, as opposed to partners engaging with the Alliance. Communication and engagement with partners (especially the voluntary sector) and the local community should feature as a key strand within this.*							

Project	*Alliance Ambition*	*STP priority/ outcomes*	*Priority actions*	*Local Strategy (LS)/ Transformation Project (TP) etc.*	*PMO Ref*	*Proj. Lead*	*Year 1 Timescales in detail*	*Year 2 to 5 Timescales in outline*	*What success looks like (what will be different in each locality i.e. 'end state')*	*Outcome measures*
Connect plans for all localities	1a		• Build the Integrated Neighbourhood Team (INT): The INT is one key element of Connect and brings health and social care together to provide a single coordinated care response that is underpinned by prevention, self-care, early intervention, reablement and rehabilitation rather than longer term treatment and lifelong service dependency. • Integrate health and care therapies to remove duplication in assessment and maximise recruitment and workforce development. • The reconfiguration of Newmarket Hospital and relocation of Oakfield GP Surgery (two year programme of work) ***Questions requiring clarity/decision:*** *How does Connect link with the Alliance? What's the role and purpose of Connect? Is this clear to those involved and wider partnerships? What's happening with Connect in each of these localities now that the Project Manager role no longer exists?* *The original vision for the Connect programme was to bring together the full range of efforts across the statutory, voluntary and communities sector to develop a coordinated approach in defined geographic localities (the 6 connect areas), to improving and maintaining the health and wellbeing of individuals and communities.* *Within that wider vision, Integrated Neighbourhood Teams are the model that brings health, social care and other services (e.g. housing advice and support) together to provide a single coordinated care response that is underpinned by prevention, self-care, early intervention, reablement and rehabilitation rather than longer-term treatment and lifelong service dependency. The INT brings together physical, mental health and social care practitioners into one joined up team who will work with all the General Practices within the locality to provide a joined-up service to the local population (including people living in nursing and care homes).* *Questions – is that still the vision and if it is how far is each locality away from realising it? Has a gap analysis/ progress review been undertaken this year? How much of the Connect plan for each locality should be prescribed (top-down) by the Alliance partners and how much should be shaped and determined locally. The plans should articulate what resources are required for each locality and why (see above).*	TP: Connect Locality	ICW01	HP/LE/KS	**Jul18:** Newmarket Business Case Approved **Mar19:** Programme plan for Newmarket Locality approved **Oct18:** Appoint 6 WTE Locality Coordinators **Apr19:** Implementation of care coordination across all Connect localities		This project is a key enabler to delivering more proactive care and therefore does not have associated metrics relating to demand management in 2018/19.The key deliveravbles by March 2019 are: INTS and Integrated Therapy 1) Co-located Health and Care teams within the 6 localities 2) One integrated management structure in 1 (or 2) INTs 3) Single approach to shared caseloads supported by single assessment and shared care planning 4) My Care Wishes implemented - focus on frailty score greater than 7 (recored on sytmone) and EOL 5) Extended rotational opportunities for acute and community physiotherapy Newmarket 1) Building work at NCH commenced 2) Plan agreed with stakeholders for utilisation of NCH estate as a health and wellbeing hub 3) Programme plan agreed with alliance partners on locality priorities and board in place with locality lead	
			Accelerate actions to address the needs of people with drug and alcohol problems ***Questions requiring clarity/decision:*** *My (DH) team has helped reshape the paper for Haverhill (drafted by the GP Fed). The focus should be on assets, not just need. There are undoubtedly problems in relation to accessing services for substance misuse in Haverhill with only very limited provision in town. West Suffolk councils, with Public Health, have provided funding for a temporary substance misuse outreach post. BUT, funding is only temporary and the commissioners have indicated that they will not have this as part of their recommission. Without funding, I don't*	LS: Connect 6 Integrated Neighbourhood Teams						

Project	Alliance Ambition	STP priority/ outcomes	Priority actions	Local Strategy (LS)/ Transformation Project (TP) etc.	PMO Ref	Proj. Lead	Year 1 Timescales in detail	Year 2 to 5 Timescales in outline	What success looks like (what will be different in each locality i.e. 'end state')	Outcome measures
			think actions can be accelerated. How as an alliance are we going to address this? If we going to include this in the delivery plan, then we need to be realistic about what's achievable.							

Delivery Programme 2b: Connect: Wider Communities — SRO: Davina Howes

Project	Alliance Ambition	STP priority/ outcomes	Priority actions	Local Strategy (LS)/ Transformation Project (TP) etc.	PMO Ref	Proj. Lead	Year 1 Timescales in detail	Year 2 to 5 Timescales in outline	What success looks like (what will be different in each locality i.e. 'end state')	Outcome measures
Volunteering	1c		Establish xx community volunteer roles through the Care Force 6 programme ***Questions requiring clarity/decision:*** *What is this and how does it link to wider Volunteering Initiatives in the area? Is Community Action Suffolk involved – they have a volunteering lead.* *Is this something CAS could be asked to lead on behalf of the Alliance?*	LS: Family Carers Strategy			HJ to provide timescales			

Community Services and Alliance Update

West Suffolk NHS Foundation Trust Board

28 September 2018

1.0 Introduction

This paper updates the Board of the work underway on: integration between acute and community services, development of the Alliance for the west of Suffolk and whole system working.

2.0 Acute and Community Integration

2.1 A successful appointment has been made to the newly created Senior Matron post. This post will support the Head of Nursing post previously created and will further strengthen the quality and governance resource for the division. This investment by the trust gives the integrated services division parity with the other trust divisions.

2.2 Opportunities to improve patient pathways, experience and staff satisfaction continue to be identified and changes made. The benefits realised are illustrated below in a simple case study:

2.2.1 M.S. is a 66 year old lady on Rosemary Ward, Newmarket Hospital at present. She has been repatriated from a spinal injury unit in Sheffield and has fairly complex needs to be met on her return home to Sudbury. The community health team lead visited the ward to provide a tangible link between the inpatient unit and community team in terms of understanding the capacity of the community team, networking with the ward manager and ward team, meeting the patient at Newmarket Community Hospital to understand her perspective and reduce her anxieties.

2.2.2 A plan was developed to focus on this lady's needs and explore how best to support her to move towards more independence, utilising the skills of the ward team she knew and trusted in Newmarket Community Hospital.

2.2.3 The community team lead also recognised that an introduction to the community neurological specialist nurse would be of benefit, the community specialist nurse met the lady before her discharge and will contribute to the discharge plan and offer follow up support once home.

2.2.4 The ward manager undertook to make a urological referral to West Suffolk Hospital to expedite a procedure which had been identified by Sheffield but did not appear to be organised.

2.2.5 Better communication with the ward and a case conference is planned to ensure this lady is confident about her care going forward and that any further needs are identified and plans in place to address these.

2.2.6 While the patient remains in Newmarket Community Hospital the community team lead has worked with the community team, the education hub and specialist nurse at West Suffolk Hospital to identify refresher training for the receiving community team to enable a safe and timely discharge home for this lady.

2.3 The series of primary care locality meetings continues with a range of ideas for improvement being suggested. Currently being explored is:

- Harmonising drug administration charts between hospital and community to avoid GP's having to re-write charts
- End of Life requests for GP visits following discharge to improve the information sharing and prioritisation of requests
- A review of the usage of 'just in case' medications to avoid waste and improve understanding

2.4 Discussions to explore opportunities to work more closely with primary care are going well, with some good examples being raised by GP's about how we could improve communication and patient experience by making some small changes to discharge information / processes. There have also been some informal discussions about workforce development opportunities.

2.5 The series of meetings by the CEO and other members of the executive team to engage community staff within the Trust and seek views on integration are well underway. 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. Examples of improvements as a direct result of the sessions are:

- Exploration of direct referral from community staff to consultant for some conditions
- Ideas to help tackle the obesity agenda
- Suggested improvements for the diabetic pathway
- Ideas to improve pull based discharge from the community
- Useful feedback on how we might improve discharge planning

2.6 As part of the work to improve the respiratory offer in August we held our first oxygen assessment clinic at Sudbury Health Centre; this was run jointly by a COPD nurse (community based) and a respiratory physiotherapist (acute based). Previously this would have involved two separate visits by both the nurse and physiotherapist this will reap benefits, increasing clinical time available to patients and a reduction in travelling costs.

- The clinic was very successful with 6 patients being seen for a review from an integrated approach. On average only 2-3 oxygen review sessions can be carried out by visiting patients at home, so by delivery a joint clinic locally this enabled 2-3 days' worth of assessments being carried out in one day at the clinic
- Feedback from patients was very positive and they liked the idea of coming into a clinic rather than waiting in at home all day, with all patients seen requesting future assessments to be carried out at the clinic.
- Staff also reported a positive experience and felt part of a team. They enjoyed the session and felt it was a valuable learning experience with the potential to teach other healthcare professionals about oxygen therapy.

- It is planned to hold future clinics at Sudbury Health Centre and Newmarket Hospital once a month and to source a venue in the Bury area once new staff are in post, so this is likely to be in November.

- Oxygen assessments generally had a historic 6-month backlog; however, during the summer, through different ways of working it has been possible to get up-to-date with these to be in a position to concentrate on admission avoidance and assisted discharges heading into the winter period.

- Gas analysers purchased have also made efficiency savings.

2.7 We are exploring the possibilities to advertise vacancies on both the NHS and Social Services recruitment websites as a further way of developing true integrated working. We currently have two Band 5 Occupational Therapy posts which are being considered for joint advertising.

3.0 I.T Progress

3.1 Improvements to the procurement process for new kit continue to be embedded. All staff who had been waiting for laptops have now received them.

3.2 A new 'Pillar Three community services digital programme group' has been established as part of the Global Digital Exemplar work, the group will hold its first meeting on 9th October. The formation of this group will ensure the digital agenda for community has the same level of attention and awareness as the other programmes of work.

3.3 SystmOne support and optimisation: It has been agreed to undertake (county wide) a complete review of SystmOne from an Alliance perspective. An individual to undertake the review has been identified and a start date is being agreed. The review will include: how system 1 is being configured, the range of units being used, clinical time/ease of use, quality of information, ease of reporting.

3.4 Roll out of Wi-Fi across community sites is underway, this will enable staff to access 'live ' information and work more remotely from shared bases/sites

3.5 IT Innovation ideas being explored:

- Wound care apps for nurses to use to take 3D digital photography of wounds to aid assessment and grading of wounds
- Scheduling of appointments visits – looking at other areas to learn from how they have implemented this. If effective it will save clinical time and offer a more flexible service for patients
- EBME integrations – exploring the option of linking equipment to Systm1. This would mean clinical information automatically uploads into the clinical record. The heart failure team in particular could benefit from this

4.0 Buurtzorg Test and Learn Update

4.1 In West Suffolk, the West Suffolk partners began the process of testing and adapting a Buurtzorg inspired model – the Neighbourhood Nursing and Care Team in 2017. The team began taking patients in February 2018 and this early test phase will continue until January 2019. The aim of the early pilot is in establishing a stable operational blueprint inspired by the Buurtzorg Model, through a process of adaptation and review, from which the aim is to

establish a pilot to fully assess what impacts and outcomes can be realised in the English health and care system.

4.2 It is recommended that the next pilot phase be delivered over a 12-month period (following on from the early pilot phase) from February 2019 to January 2020 and that the established Test and Learn Team would continue. Partners are being asked to match fund the £50k secured in the early phase and this will be topped up from the Transformation funding.

4.3 Health Watch Suffolk and the Kings fund have commenced the evaluation of the test and learn. This is now expected to be shared by the end of November, there has been a slight delay to the evaluation commencing due to changes of personnel at Health Watch and difficulties accessing information, both of these issues are now resolved.

4.4 Planning has now commenced to move from the 'test and learn phase' to the next phase, the 'pilot phase 1 '. This phase will commence in February 2019, in order to be able to move to the next phase we require:

- An agreed functional model
- An effective self -organising team
- A functioning back office
- A functioning mentor/coaching offer
- Funding secured

4.5 A number of things in order to achieve the above are being undertaken by the steering group:

- A review of referrals, activity, sources of referral, audit of tasks
- A review of the personal care activities
- Impact on the existing community health team
- Additional senior nursing post
- Improved access to the mentor/coach
- Exploring the model being tested in Hertfordshire – Dacorum Holistic Team – to contrast and compare

4.6 It is clear that the system design elements of the Test and Learn to enable the model to work within the English health and care context are complex. Whilst the existing Dutch Buurtzorg model provides a framework to work to, learning to date is that what we are creating for West Suffolk will essentially be a new model; a model inspired by Buurtzorg, but adapted to our context and circumstance.

4.7 This Test and Learn period represents an opportunity for experimentation and learning. The Test and Learn is iterative, and the priority is in developing, testing and adapting the model to identify the best way of applying the principles of the Buurtzorg in the English context. The Test and Learn phase aims to be complete by early 2019, and plans are now underway to establish a pilot of an established and stable model which can be evaluated to test the impact of the approach on patients, staff and the wider system, and seek to establish an economic model for delivering the model at scale. £200k has been secured from the NHS Transformation fund to support the next phase.

4.8 The feedback from the mid-term King's Fund workshop was to encourage all members of the project to recognise and celebrate the considerable achievements made to date, and to be mindful that a key learning point from studies of transformational change is the amount of time taken to embed different ways of working, is described always in terms of years, rather than months.

5.0 West Suffolk Alliance Development

5.1 The Alliance Steering group met on the 28th August 2018 and the System Executive Group met on the 5th September 2018 and received information on:

- West Alliance Delivery Plan latest draft
- An update on the maternity services 'better birth initiative'
- The 1st draft of the children's and young people's work to go into the strategy document
- Transformation funding bids process/recommendations
- User facing technology

5.2 Work on the delivery plan continues. A small working group from across the system continues to meet weekly to develop this. The latest working draft of the Delivery Plan is enclosed as Appendix 1 with the programme summary listed on page 3/4.

5.3 The latest full version of the delivery plan was shared with WSFT Scrutiny Committee on 12th September 2018.

5.4 The Alliance presented to the Health and Wellbeing Board on 6th September to update the group on Alliance development, system working and gave some examples of integration and the positive impact it is starting to have on both people who use our services and our collective workforce.

5.5 The Alliance continues to work closely with estates colleagues on the 'One Public Estate' agenda. Discussions have commenced with the borough council and Abbey Croft Leisure to explore the possible co-location of some services into the leisure centre at Brandon.

5.6 The GP Federation and WSFT have commenced discussions to integrate community and practice nurse resource and activity. There will be opportunities to share resource creating capacity, providing continuity of care and sharing of skills and knowledge. An initial 'nursing forum' is being organised by the local operational manager and the Head of Nursing jointly with the lead practice nurse and Deputy Director of Nursing of the GP Federation.

6.0 Quality and Governance development

6.1 The operational managers, Head of Nursing and the quality and governance team continue to work together to strengthen the support provided to the division where appropriate.

6.2 To support the community health teams in the recognition and identification of sepsis, a working group consisting of staff from both the community health teams and the acute hospital, including from Critical Care and Infection Prevention, has been set up. The group have been developing bespoke education sessions for community nursing teams, which will be delivered by staff both from the hospital and community settings. In addition a sepsis recognition tool has been identified for use and a review of the equipment currently available to our community teams for monitoring and recording patient observations is underway.

6.3 A review of the Infection Prevention Audit programme has been made. Recommendations were made to change the community audits to those detailed in the 4th Edition of 'Saving Lives: High Impact Interventions', developed by the Infection Prevention Society and NHS Improvement in 2017 for use in both acute and community healthcare settings. The Community Infection Prevention Nurse will continue to work with the community health teams to support them with the transition to the new audit programme going forward.

7.0 Discharge to Optimise and Assess

7.1 Good progress continues to be made on delivery of all four pathways:

7.2 Pathway 0: Testing "Date for your diary" leaflet on two wards prior to final sign-off and roll-out. Reablement training to ward staff continues to take place.

7.3 Pathway 1: 100 Day Challenge approach in place with move from 'design' to 'pre-test and learn' phase on wards F3 and G5 from 17 September 2018. The plan is to enter full test-and-learn phase on these two wards from 1 October 2018.

8.0 Transformation Funding

8.1 The process for bidding for the transformation funding has been completed. The recommendations made by the system wide panel were endorsed and agreed by the system executive group on 5th September. The recommendations will now be considered by the CCG governing body on 26th September.

8.2 Any organisation was able to bid and a total of 52 bids were received totalling £6.1 million against an available pot of £1.4 million

8.3 Initiatives put forward for funding were 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?

8.4 A full list of the schemes supported by the CCG governing body will be included in the October board paper.

9.0 Children in Care Initial Health Assessment

9.1 A paper was submitted to the West System Executive Group on 1st August 2018 outlining the challenges for the service and a range of options were discussed.

9.2 A subsequent meeting agreed to explore the following options:

- Move whole pathway (initial assessments and reviews) to one provider either health or social care
- Investigate the Hertfordshire model that has 2 dedicated GP's
- Explore electronic options to avoid paperwork delays
- Explore GP hub model

9.3 The discussions on these options have continued well. A new service model has been scoped and will be discussed further with GPs.

10.0 Conclusion

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

9. Integrated quality and performance report

To ACCEPT the report

For Report

Presented by Rowan Procter and Helen Beck

Trust Board – September 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:	September 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

Unprecedented demand on ED has continued in August making the 4hr target a challenge. The figures for ED are being reported twice to account for the move of GP expected patients. Prior to May 2018 GP expected patients would have reported to ED so an adjusted figure is reported in addition which adds the GP expected patients back into the ED attendance numbers to allow a true like for like comparison year on year.

Actual Ed attendances excluding the GP expected demonstrate a 4% increase on last year, but the adjusted attendance figure demonstrates an 11% increase in attendances.

Actions are in place to deliver change to ensure sustainable performance moving forward and planning ahead into winter. A dedicated ED action is monitored through weekly and monthly ED meetings. 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. Executive led root cause analysis (RCA) meetings are held when performance falls below 87% to understand the reasons and seek to identify solutions.

RTT – 18 weeks

Over recent months a focused effort has been delivered by teams which has delivered performance improvement in this area. Performance has deteriorated for August to 89.3%. Detailed demand and capacity work is ongoing to allow specialty level trajectories to be developed to deliver a sustainable position.

Cancer Standards

All the cancer standards are being closely monitored to deliver against the targets, with one target missed for August. Whilst the reasons for the breaches were mixed, high demand remains an ongoing challenge.

NHS
West Suffolk
NHS Foundation Trust

Integrated quality and performance report



Month Five: August 2018

Putting you first

CONTENTS

EXECUTIVE SUMMARY

DETAILED SECTIONS

1 EXECUTIVE SUMMARY

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 August 2018. There was one case of hospital-attributable clostridium difficile for August 2018; The Trust compliance with decolonization decreased in August 2018 to 97.0%.

NHS Patient Safety Alerts (PSAs) – A total of 12 PSAs have been received in 2018/9, with 4 in August 2018. All the alerts have been implemented within timescale to date.

Patient Falls (All patients) - 75 patient falls occurred in August 2018. (*Exception report included in the main report*).

Pressure Ulcers- The number of ward-acquired pressure ulcers continues to be above the local Trust plan of 5 per month. In August 2018, 10 cases occurred, with YTD total of 38. (*Exception report included in the 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 August 2018. (*Exception report 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 91.9% in August 2018 compared to 87.0% In July 2018. (*Exception report included in the main report*).

Discharge Summaries- Performance to date, whilst below the 95% target to issue discharge summaries, is showing improvement (inpatients and ED). A&E has achieved a rate of 88.4% in August 2018 whereas inpatient services have achieved a rate of 76.9% (Non-Elective) and 70.8% (Elective.) (*Exception report included in the main report*).

ARE WE CARING?

Mixed Sex Accommodation breaches (MSA) – 0 MSA breaches occurred in August 2018. (*Exception report included in the main report*).

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

ARE WE RESPONSIVE?

A&E 4 hour wait – August 2018 reported performance at 87.57% with an 11% year on year increase in attendances. (*Exception report included in the main report*).

Cancer – Cancer has experienced a challenging few months with significant increases in demand. Whilst the challenge of demand and capacity continues, one area failed the target for August which is an improved position on July. The failing

area for August was 2 week wait for urgent GP referrals. (*All figures are provisional and exception reports are included in the main report*). It is worth noting that the diagnostics within 6 weeks also missed the target for August.

Referral to Treatment (RTT) - The percentage of patients on an incomplete pathway within 18 weeks for August was 89.35%. The total waiting list is at 16601 in August. In August 11 patients breached the 52 week standard. (*Exception report included in the main report*).

ARE WE WELL LED?

Appraisal - The appraisal rate for August 2018 is 75.18%. Actions are in place within divisions to improve compliance, such as targeting those staff who the system shows as having no appraisal on record. The amount of annual leave traditionally taken in August has resulted in fewer appraisals, affecting the compliance figures.

Sickness Absence – Sickness absence remains static at 3.8%, 0.2% worse than this time last year. Mechanisms remain in place to support managers to tackle both long term and short term sickness absence.

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	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Av/YTD
1. Safe	1.01	NHS E / I Patient Safety Alerts - Total	NT	1	0	1	0	1	0	0	2	0	5	1	4	12
	1.02	NHS E / I Patient Safety Alerts outstanding	0	0	0	0	0	0	0	0	0	2	0	3	0	5
	1.03	Emergency C-Section Rate	14%	11.9%	11.2%	9.8%	10.6%	14.1%	10.1%	19.4%	16.4%	11.4%	10.6%	12.4%	12.4%	12.6%
	1.04	All relevant inpatients undergoing a VTE Risk assessment	95%	88.0%	94.8%	96.9%	94.7%	96.9%	97.6%	97.3%	98.2%	94.1%	95.1%	93.0%	93.7%	94.8%
	1.05	Clostridium Difficile infection - Hospital Attributable	16	2	6	4	0	1	0	2	1	0	0	1	1	3
	1.06	MRSA Bacteraemias - Hospital Attributable	0	2	0	0	0	0	1	0	0	0	0	0	1	1
	1.07	Patient Safety Incidents Reported	NT	467	520	588	479	627	553	535	486	579	465	469	521	2520
	1.08	Never Events	0	0	0	1	0	0	0	0	0	0	0	0	0	0
2.Effective	2.02	Canc. Ops - Cancellations for non-clinical reasons	1%	1.0%	1.4%	1.9%	1.3%	0.8%	1.2%	0.9%	0.6%	0.8%	1.4%	1.8%	1.5%	1.2%
3. Caring	3.01	Compliments (Logged by Patient Experience)		17	33	87	151	64	20	45	21	93	44	49	33	240
	3.02	Formal Complaints	20	16	17	13	8	12	19	9	13	13	11	20	9	66
	3.03	Mixed Sex Accommodation Breaches	0	0	0	0	1	0	0	1	0	0	1	0	0	1
	3.04	IP - Extremely likely or Likely to recommend (FFT)	90%	98.3%	98.6%	96.0%	97.7%	97.1%	98.1%	98.0%	99.0%	99.0%	98.0%	99.0%	99.0%	97.8%
	3.05	OP - Extremely likely or Likely to recommend (FFT)	90%	96.0%	95.9%	96.0%	98.6%	95.1%	96.2%	95.0%	97.0%	97.0%	97.0%	97.0%	98.0%	97.2%
	3.06	A&E - Extremely likely or Likely to recommend (FFT)	85%	92.3%	94.9%	94.0%	94.0%	96.4%	94.9%	94.0%	94.0%	93.0%	94.0%	96.0%	95.0%	94.4%
	3.07	Maternity - Extremely likely or likely to recommend (FFT)	90%	ND	98.8%	100%	97.3%	100%	93.0%	100%	100.0%	100.0%	100.0%	100%	95.0%	99.0%
	3.08	Community - Extremely likely or likely to recommend	80%	ND	97.3%	100%	95.7%	95.2%	97.4%	96.0%	94.0%	98.0%	97.0%	90.0%		94.8%
4. Responsive	4.01	A&E under 4 hr. wait	95%	88.9%	87.4%	90.4%	83.3%	83.8%	85.2%	85.4%	84.9%	93.7%	93.9%	89.0%	87.6%	89.8%
	4.02	RTT: % incomplete pathways within 18 weeks	92%	85.7%	87.0%	88.9%	89.0%	90.2%	89.6%	89.5%	90.4%	92.2%	91.4%	91.4%	89.3%	90.9%
	4.03	52 week waiters	0%	29	26	21	15	14	13	24	19	14	10	9	10	62
	4.04	Diagnostics within 6 weeks	99%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	99.9%	98%	99.3%
	4.05	Cancer: 2w wait for urgent GP Referrals	93%	91.4%	83.4%	97.9%	97.2%	98.0%	97.5%	94.7%	95.9%	94.9%	91.6%	97.6%	89.5%	93.9%
	4.06	Cancer 2w wait breast symptoms	93%	98.3%	100%	100%	99.1%	97.1%	92.9%	86.7%	96.7%	82.6%	84.9%	92.7%	95.9%	90.6%
	4.07	Cancer 31 d First Treatment	96%	100%	100%	99%	100%	100%	100%	100%	99.1%	100%	100%	100%	100%	99.8%
	4.08	Cancer 31 d Drug Treatment	98%	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%
	4.10	Cancer 62 d GP referral	85%	86.9%	93.9%	89.5%	87.1%	86.6%	79.8%	87.8%	93.3%	85.1%	86.5%	84.8%	88.4%	87.6%
	4.11	Cancer 62 d Screening	90%	90.9%	100%	83.3%	100%	93.3%	85.7%	95.5%	72.7%	100%	100%	88.9%	100%	92.3%
	4.12	Incomplete 104 day waits		ND	ND	ND	ND	ND	ND	ND	3	1.5	0	1	3	5.5

INTEGRATED QUALITY & PERFORMANCE REPORT			TRUST TOTAL														
Are we..	Ref.	KPI	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Av/YTD
5. Well Led	5.01	NHS Staff Survey (Staff Engagement score -Annual)		NA	NA	NA	NA	NA	4.0%	NA	NA	NA	NA	NA	NA	NA
	5.02	Staff F&F Test % Recommended - care (Qrtly)	75%	95.0%	NA	NA	ND	NA	NA	ND	NA	NA	95%	NA	95%	NA
	5.03	Staff F&F Test % Recommended - place to work (Qrtly)	75%	82.0%	NA	NA	ND	NA	NA	ND	NA	NA	83%	NA	82%	NA
	5.04	Turnover (Rolling 12 mths)	<10%	9.8%	9.0%	9.1%	9.3%	9.3%	8.7%	8.8%	8.4%	8.4%	8.5%	8.6%	8.6%	8.5%
	5.05	Sickness Absence	<3.5%	3.6%	3.6%	3.5%	3.5%	3.6%	3.7%	3.7%	3.8%	3.8%	3.7%	3.8%	3.8%	3.8%
	5.06	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%
	5.07	Agency Spend		150	82	213	245	353	306	373	276	188	330	323	471	318
	5.08	Monitor Use of Resources Rating		3	3	3	3	3	3	3	3	3	3	3	3	3
6. Productive	6.01	I&E Margin	Var	-3.0%	-2.6%	-2.5%	-2.6%	-2.3%	-2.6%	20.0%	-10.3%	-7.5%	-6.3%	-7.30%	-6.80%	-7.64%
	6.03	Capital service cover	Var	-0.88	-0.32	0.52	0.24	0.38	0.07	0.68	0.48	1.64	-0.80	-0.93	0.87	0.25
	6.04	Liquidity (days)		-12.70	-15.14	9.64	11.39	6.06	6.84	7.86	12.34	16.83	15.36	16.67	14.36	15.11
	6.05	Long Term Borrowing (£m)	4%	47.6	47.6	56.7	58.7	64.4	64.1	65.4	67.6	69.8	69.0	70.7	74.2	68.8
	6.06	CIP (Variance YTD £'000s)CIP (Variance YTD £'000s)	1.9	-54	-10	-74	-22	-419	-469	-539	-54	-47	-75	-100	-120	-79.2
7. Maternity	7.01	Total number of deliveries (births)	210	236	205	194	180	199	211	206	198	203	201	172	208	982
	7.02	% of all caesarean sections	<22.6%	18.2%	17.1%	17.0%	18.3%	22.1%	17.1%	30.1%	28.2%	22.4%	18.2%	17.1%	17.0%	20.6%
	7.03	Midwife to birth ratio	1.3	1.33	1.29	1.28	1.26	1.28	1.29	1.29	1.27	1.30	1.28	1.27	1.29	1.28
	7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.05	Completion of WHO checklist	100%	98.0%	98.0%	98.0%	93.0%	93.0%	94.0%	97.0%	86.0%	85.0%	88.0%	94.0%	95.0%	89.6%
	7.06	Maternity SIs	NT	1	1	0	1	2	0	1	2	2	0	1	0	5
	7.07	Maternity Never Events	NT	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.08	Breastfeeding Initiation Rates	0.8	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	79.0%	76.1%	76.3%	80.7%	85.1%	76.2%	78.9%
8. Community	8.01	No of avoidable serious injuries or deaths from falls - Community	0	0	0	1	0	0	0	0	0	0	0	0	0	0
	8.02	Community - Extremely likely or likely to recommend	80%	ND	97.3%	100%	95.7%	95.2%	97.4%	96.0%	94.0%	98.0%	97.0%	90.0%	98.0%	95.4%
	8.03	RTT 18 weeks Non-Consultant led services - Community	90%	99.4%	93.7%	94.4%	98.4%	98.7%	100%	99.4%	99.2%	97.6%	100%	98.7%	99%	98.9%
	8.04	Urgent Referrals for Early Intervention Team (EIT) - Community		NA	NA	NA	NA	NA	NA	NA	100%	100%	100%	100%	100%	100%
	8.05	Nursing & therapy Red referrals seen within 4hrs - Community		100%	NA	NA	100%	100%	96.4%	100%	96.4%	100%	100%	98.2%	100%	98.9%
	8.06	Nursing & therapy Amber referrals seen within 72hrs - Community		98.6%	90.9%	96.9%	100%	99.3%	98.0%	97.6%	98.8%	99.4%	99.5%	97.4%	99.4%	98.9%
	8.07	Safeguarding Children Mandatory Compliance (Community)	98%	96.8%	95.3%	96.1%	96.0%	95.9%	95.7%	97.0%	98.2%	95.8%	95.3%	94.7%	95.1%	95.8%
	8.08	Safeguarding Adults Mandatory Training Compliance (Community)	98%	96.1%	94.3%	95.3%	94.0%	94.1%	93.2%	95.6%	96.0%	95.0%	94.9%	94.3%	94.9%	95.0%

3. IN THIS MONTH – AUGUST 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	Aug-2018

To Month Year	Aug-2017

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

In this month.... August 2018

Mth We Received.....	Aug-18	Aug-17	Variance	Var. %	Traffic
GP Referrals	5,852	5,689	163	2.9%	⇧
Other Referrals	4,705	4,788	-83	-1.7%	⇩
Ambulance Arrivals	1,669	1,764	-95	-5.4%	⇩
Cancer Referrals*	1,041	929	112	12.1%	⇧
Urgent Referrals*	2,464	2,391	73	3.1%	⇧

YTD We Received.....	2018	2017	Variance	Var. %	Traffic
GP Referrals	31,144	30,780	364	1.2%	⇧
Other Referrals	25,900	25,700	200	0.8%	⇧
Ambulance Arrivals	8,882	8,683	199	2.3%	⇧
Cancer Referrals*	5,327	4,736	591	12.5%	⇧
Urgent Referrals*	13,212	12,624	588	4.7%	⇧

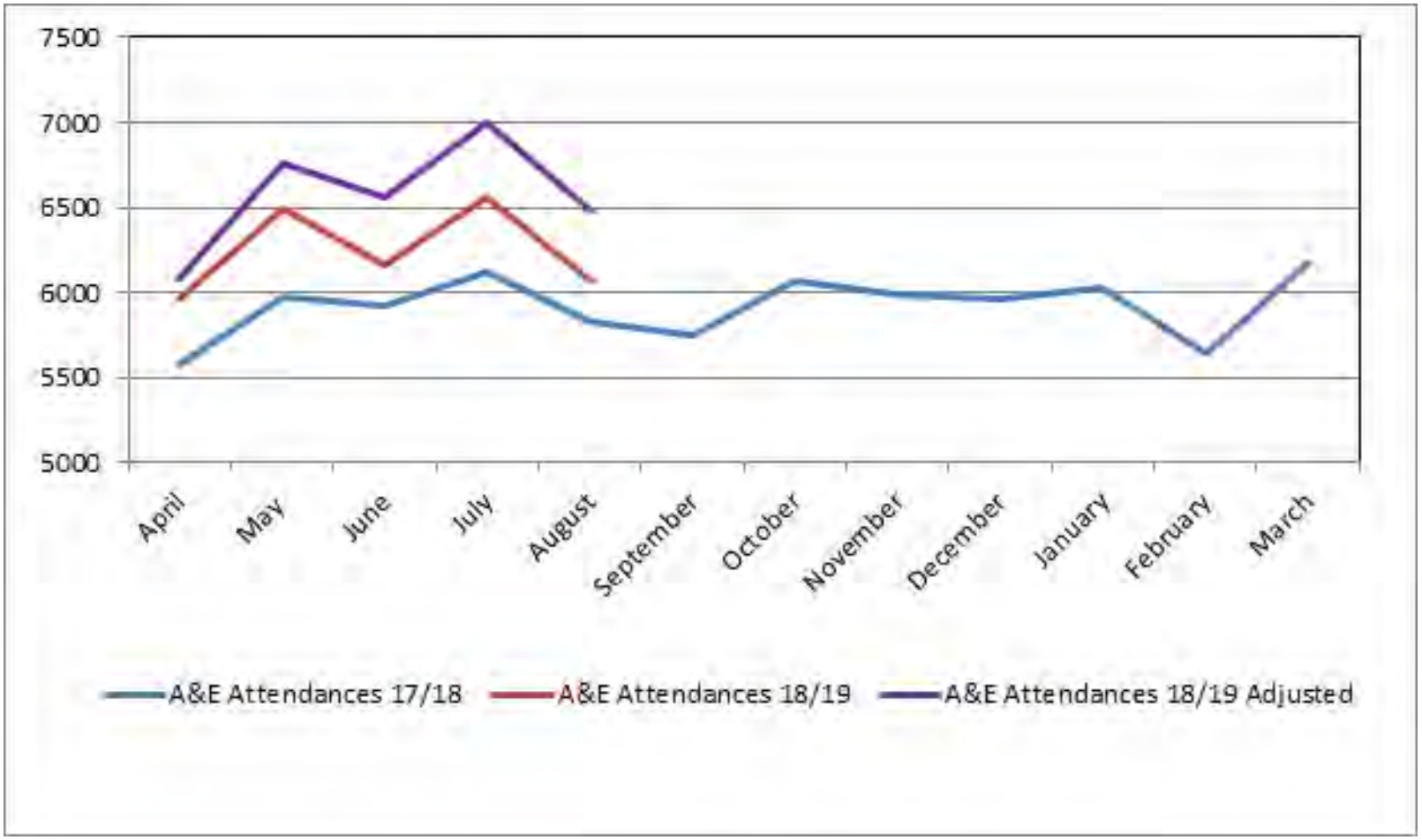
Mth We Delivered.....	Aug-18	Aug-17	Variance	Var. %	Traffic
A&E Attendances	6,072	5,831	241	4.1%	⇧
GP Expected	410	0	410		
ED Attendances(Adjusted)	6,482	5,831	651	11.2%	⇧
A&E - To IP Admission Ratio	25.7%	29.2%	-3.5%	-3.5%	⇩
Outpatient Attendances	16,936	16,968	-32	-0.2%	⇩
Inpatient Admissions	5,732	5,690	42	0.7%	⇧
Inpatient Discharges	5,775	5,678	97	1.7%	⇧
New Births	208	233	-25	-10.7%	⇩
RTT Total Incompletes	16,601	17,346	-745	-4.3%	⇩

YTD We Delivered.....	2018	2017	Variance	Var. %	Traffic
A&E Attendances	31,262	29,426	1,836	6.2%	⇧
Outpatient Attendances	89,624	84,088	5,536	6.6%	⇧
Inpatient Admissions	29,242	28,274	968	3.4%	⇧
Inpatient Discharges	29,287	28,272	1,015	3.6%	⇧
New Births	982	1,068	-86	-8.1%	⇩

* - Included in Referrals Above

*The adjusted figure adds ED attendances and GP expected together to reflect the position in 2017 when these were reported together.

A&E Attendances Year chart (Adjusted)



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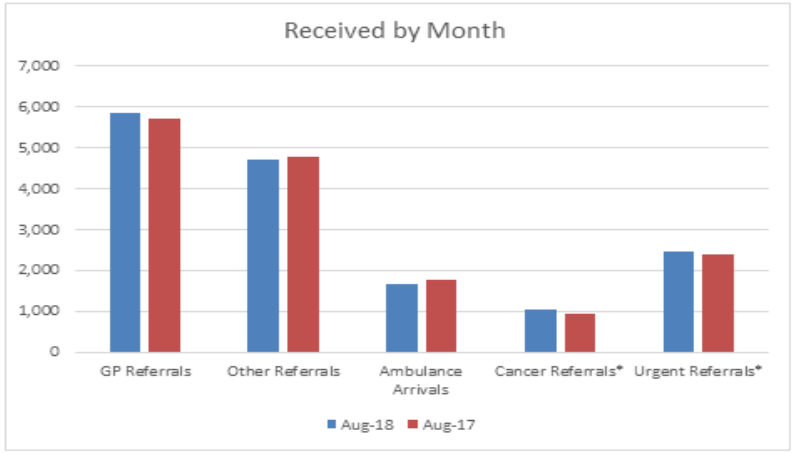
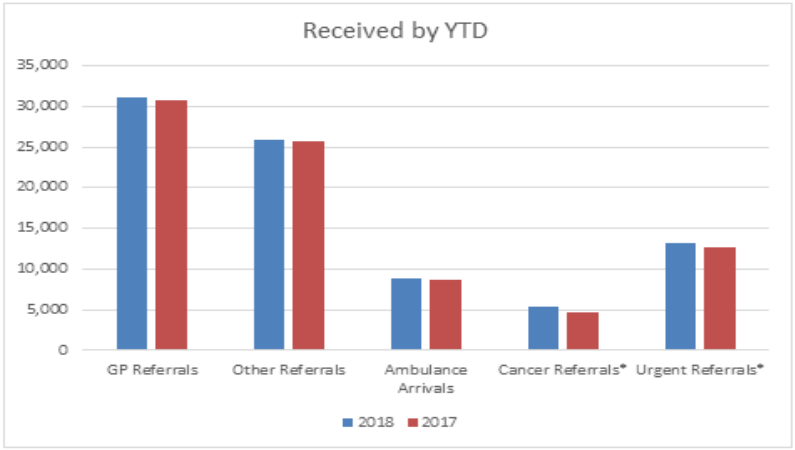
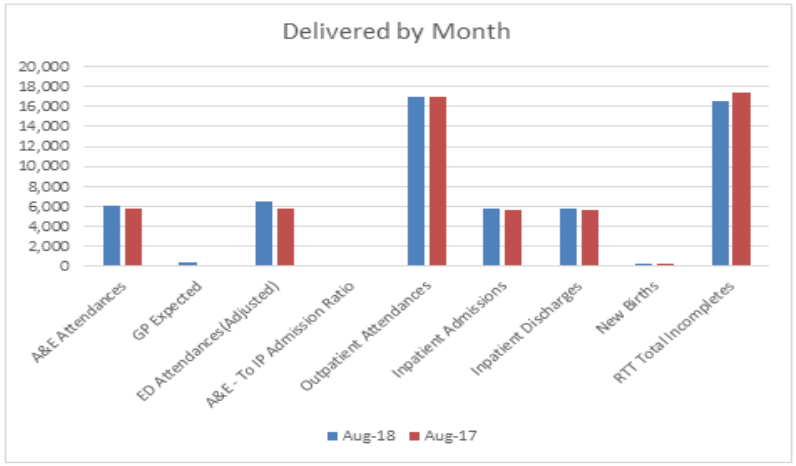
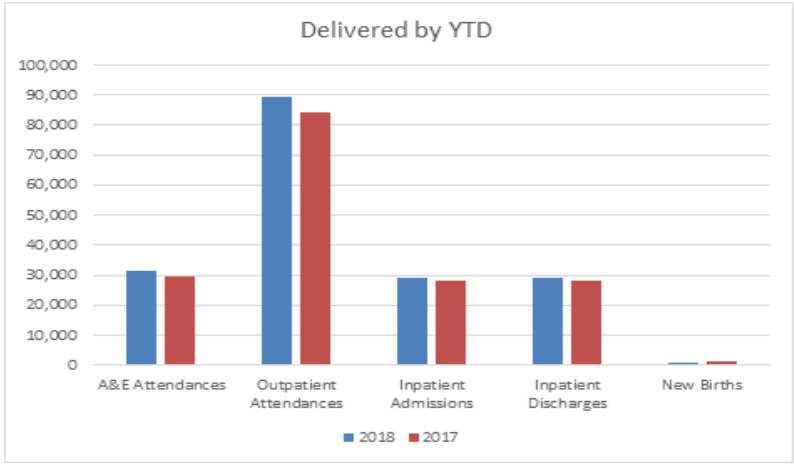
GP and other referrals demonstrate a reduction year on year however cancer referrals are showing signs of increasing. A&E attendances continue to show an increase however incomplete RTT pathways are lower than last year.



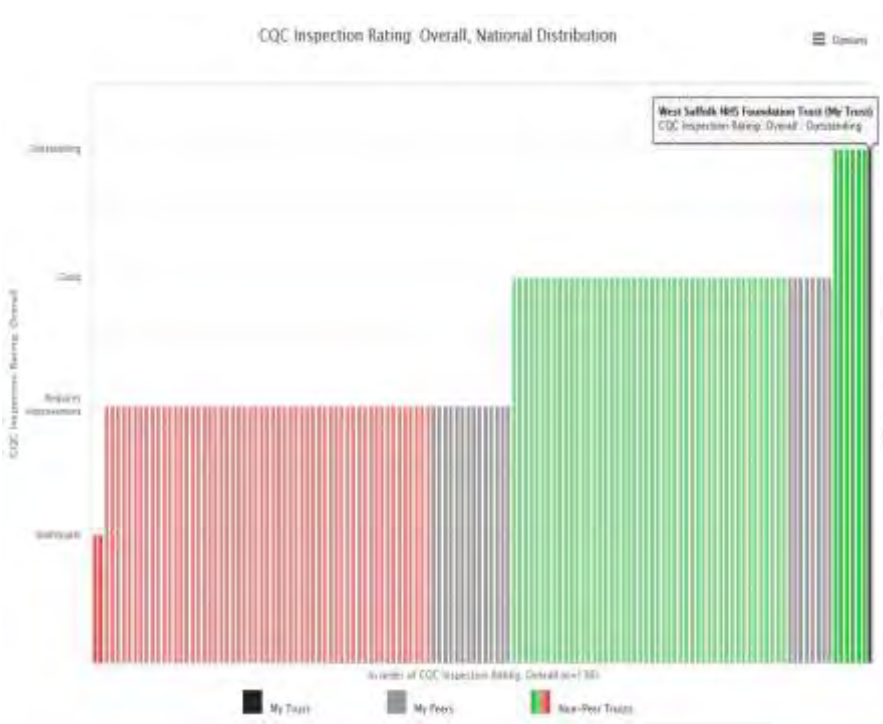


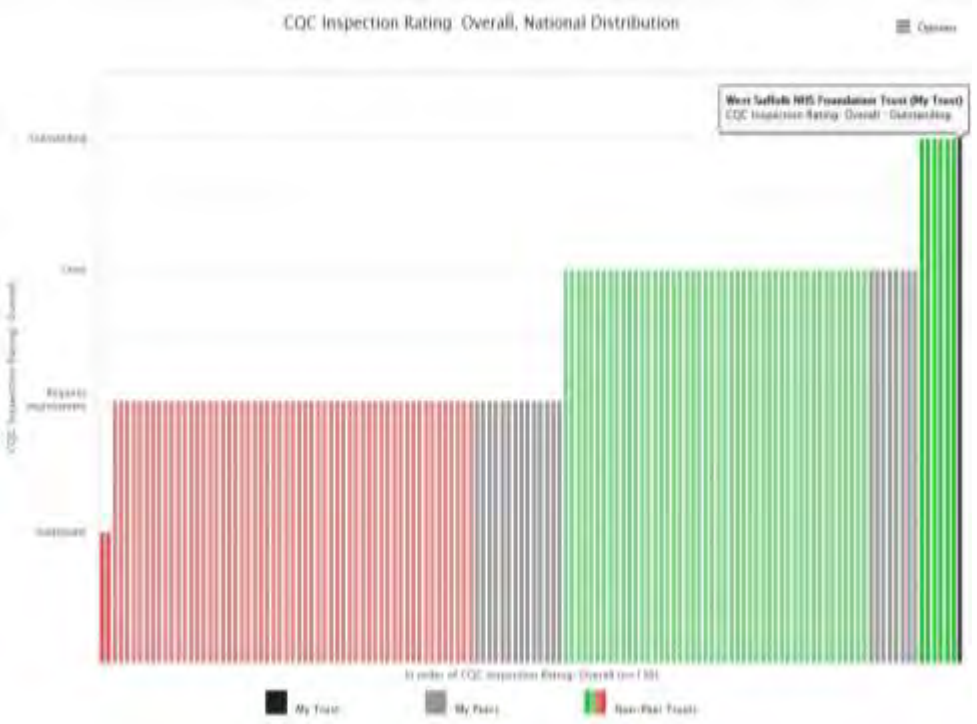


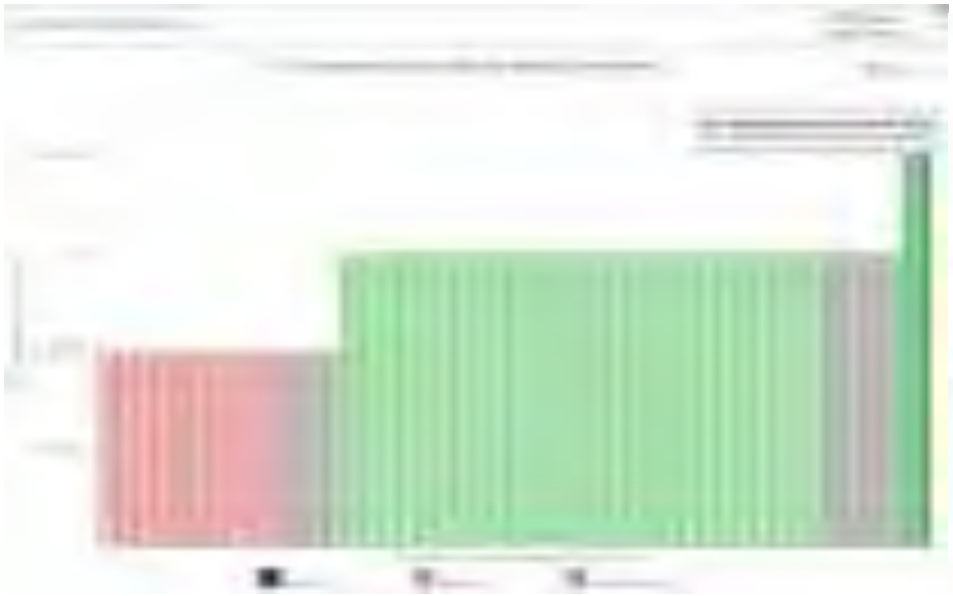


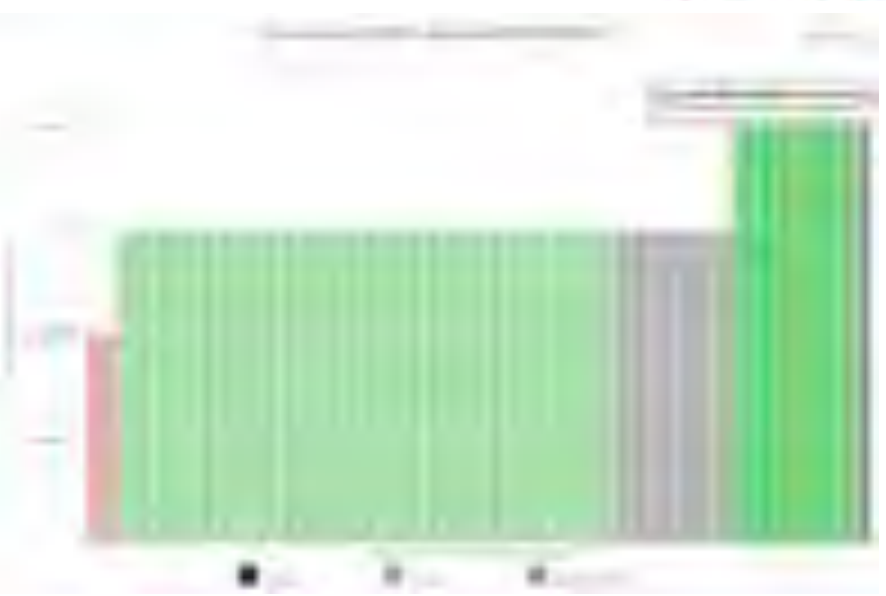
4. PEER REVIEW/BENCHMARKING

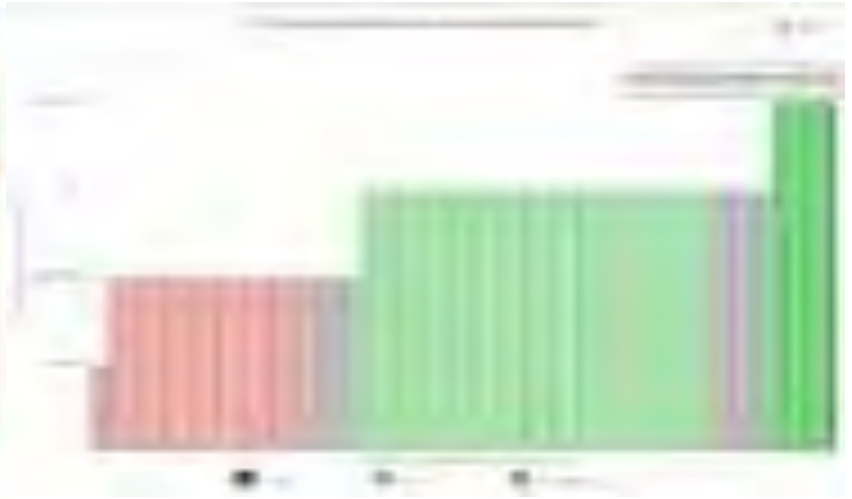
The CQC have launched the Model Hospital website which highlights comparative indicators in a number of key areas. The graphs below provide oversight of the Trust's latest available comparative performance against these key areas from August 2018. *(Source – Model Hospital – September 2018)*











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 August 2018. Appendix 1 *(Source – Model Hospital-Latest available- September 2018)*

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	Q4 2017/18	94.0%	-	-		No variation available	
A&E Scores from Friends and Family Test - % positive	Jun 2018	95.9%	90.9%	89.0%			
Inpatient Scores from Friends and Family Test - % positive	Jun 2018	98.6%	97.5%	96.4%			
Community Scores from Friends and Family Test - % positive	Jun 2018	96.9%	97.9%	96.9%			
Maternity Scores from Friends and Family Test -question 2 Birth % positive	Apr 2018	100.0%	100.0%	98.4%			

Organisational health	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
CQC Inpatient Survey	Sep 2015/16	8	-	-		No variation available	No trendline available

Caring	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Written Complaints Rate	31/03/2018	12.48	24.95	24.93			

Safe	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Never events	31/03/2018	1	1	1			
Emergency c-section rate	Jun 2018	9.05%	13.60%	15.87%			
VTE Risk Assessment	Q4 2017/18	97.24%	95.79%	95.71%			
Clostridium Difficile - infection rate	To Jun 2018	12.50	8.63	12.75			
MRSA bacteraemias	To Mar 2018	0.74	0.00	0.63			
Potential under-reporting of patient safety incidents	31/05/2018	46.51	47.38	-		No variation available	No trendline available
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Jun 2018	127	126	129			
Meticillin-sensitive staphylococcus aureus (MSSA) rates to quality indicators	Jun 2018	7	7	9			

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

Effective	Period	Trust Actual	Peer Median	Benchmark Value	Info	Variation	Trend
Summary Hospital Mortality Indicator (SHMI)	31/10/2017	0.89	-	0.00			

NHS
West Suffolk
NHS Foundation Trust

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	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	YTD(Apr18-Mar19)
Safe	Dashboard	1.01	NHS E / I Patient Safety Alerts - Total	NT	2	1	0	1	0	1	0	0	2	0	5	1	4	12
		1.02	NHS E / I Patient Safety Alerts outstanding	0	0	0	0	0	0	0	0	0	0	2	0	3	0	5
		1.03	Emergency C-Section Rate	14%	12.9%	11.9%	11.2%	9.8%	10.6%	14.1%	10.1%	19.4%	16.4%	11.4%	10.6%	12.4%	12.4%	12.6%
		1.04	All relevant inpatients undergoing a VTE Risk assessment	95%	89.7%	88.0%	94.8%	96.9%	94.7%	96.9%	97.6%	97%	98.2%	94.1%	95.1%	93.0%	93.7%	94.8%
		1.05	Clostridium Difficile infection - Hospital Attributable	16	0	2	6	4	0	1	0	2	1	0	0	1	1	3
		1.06	MRSA Bacteraemias - Hospital Attributable	0	0	2	0	0	0	0	1	0	0	0	0	0	1	1
		1.07	Patient Safety Incidents Reported	NT	466	467	520	588	479	627	553	535	486	579	465	469	521	2520
		1.08	Never Events	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	100%	100%	94.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.10	HII Compliance 1b: Central venous catheter on-going care	100%	96.0%	100%	100%	100%	100%	100%	100%	100%	100%	95.0%	100%	91.0%	97.0%	96.6%
		1.11	HII Compliance 2a: Peripheral cannula insertion	100%	97.0%	100%	98.0%	97.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.12	HII Compliance 2b: Peripheral cannula on-going	100%	97.0%	99.0%	99.0%	97.0%	96.0%	99.0%	100%	100%	100%	98.0%	97.0%	98.0%	96.0%	97.8%
		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%	100%	100%	100%	100%	100%	95.0%	100%	100%	100%	100%	100%	100%	100%
		1.15	HII Compliance 5: Ventilator associated pneumonia	100%	100%	100%	100%	78.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.16	HII Compliance 6a: Urinary catheter insertion	100%	100%	100%	78.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.17	HII Compliance 6b: Urinary catheter on-going care	100%	99.0%	97.0%	91.0%	92.0%	95.0%	100.0%	99.0%	97.0%	100%	95.0%	92.0%	97.0%	97.7%	96.3%
	Incidents	1.18	Safety Thermometer: % of patients experiencing new harm-free care-Trust	100%	98.2%	97.2%	97.6%	98.4%	98.5%	97.9%	97.7%	98.5%	99.2%	97.8%	98.7%	99.2%	88.03%	96.6%
		1.19	Safety Thermometer: % of patients experiencing new harm-free care - Community	100%	NA	NA	NA	NA	NA	NA	NA	NA	99.4%	98.1%	99.0%	99.3%	96.9%	98.5%
		1.20	No of SIRIs	NT	6	5	11	14	10	20	11	6	8	11	0	5	0	24
		1.21	RIDDOR Reportable Incidents	NT	3	0	2	0	3	0	2	1	2	4	0	1	1	8
		1.22	Total No of E. Coli (Trust level only)	NT	1	2	1	2	2	2	1	3	1	2	0	1	0	4
		1.23	No of Inpatient falls - Trust		69	44	56	73	69	76	82	72	68	72	62	42	75	319
		1.24	No of Inpatient falls - WSH	<48	64	39	47	56	60	68	74	64	55	61	50	31	63	260
		1.25	No of Inpatient falls - Community Hospitals		5	5	9	17	9	8	8	8	13	11	12	11	12	59
		1.26	Falls per 1,000 bed days		5.7	3.7	3.9	5.0	5.1	5.6	6.5	5.2	6.1	6.8	4.8	2.8	5.73	5.26
		1.27	No of Inpatient falls resulting in harm - Trust	NT	18	10	23	18	23	28	26	20	24	24	22	13	24	107
		1.28	No of Inpatient falls resulting in harm - WSH	NT	18	10	19	15	19	27	25	19	18	19	22	11	20	90
		1.29	No of Inpatient falls resulting in harm - Community Hospitals	NT	0	0	4	3	4	1	1	1	6	5	0	2	4	17
		1.30	No of avoidable serious injuries or deaths resulting from falls - Trust	0	1	0	0	1	0	0	1	0	ND	0	0	0	ND	0
		1.31	No of avoidable serious injuries or deaths resulting from falls - WSH	0	1	0	0	0	0	0	1	0	ND	0	0	0	ND	0
		1.32	No of avoidable serious injuries or deaths from falls - Community	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
		1.33	Number of medication errors	NT	70	69	70	78	63	72	49	76	60	85	43	56	61	305
		1.34	No of ward acquired pressure ulcers	NT	13	14	18	17	12	30	15	9	4	9	9	6	10	38
		1.35	No of Community 'In our Care' pressure ulcers	NT	NA	NA	13	14	6	24	15	14	12	19	16	13	19	79
		1.36	% of patients with avoidable ward acquired pressure ulcers YTD	<+30%	34.0%	33.0%	32.0%	28.0%	28.0%	29.0%	28.0%	ND	29.0%	28%	28%	ND	ND	29.0%
		1.37	% of patients with avoidable Community 'In our Care' pressure ulcers		NA	NA	ND	ND	ND	ND	ND	ND	42.0%	ND	ND	ND	ND	42.0%
		1.60	% of patients at risk of falls (with a Falls assessment)		74.8%	74.1%	73.2%	71.7%	74.3%	73.8%	71.1%	71.7%	71.1%	71.6%	72.2%	74.6%	72.8%	72.5%

Are we..		Ref.	KPI	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	YTD(Apr18-Mar19)
	Reporting	1.38	MRSA Quarterly Std (including admission and LOS screens)	90%	NA	93.0%	NA	NA	90.0%	NA	NA	92.0%	NA	NA	88.0%	NA	NA	88.0%
		1.39	MRSA Bacteraemias - Community Attributable	0	1	ND	0	0	0	0	0	1	2	2	0	0	0	4
		1.40	Clostridium Difficile infection - Community Attributable		1	1	1	0	0	0	0	2	0	0	1	4	5	0
		1.41	MRSA - Decolonisation	95%	90.0%	91.0%	98.0%	85.0%	91.0%	94.0%	86.0%	95.0%	85.0%	91.0%	90.0%	81.0%	97.0%	88.8%
		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	1	1	0	1	1	1	0	0	0	2	2	0	0	4
		1.44	SIRI final reports due in month submitted beyond 60 working days	0	0	4	5	4	0	0	1	3	3	3	0	0	0	6
		1.45	SIRIs reported >2 working days from identification as red	0	1	2	3	6	5	7	3	ND	0	1	0	1	0	2
		1.46	Green, Amber & Red Active / Accepted risk assessments not in date	0	0	1	5	0	2	1	4	0	1	3	2	0	3	9
		1.47	Datix Risk Register Red / Amber actions overdue	0	0	0	0	0	0	0	1	3	1	4	3	0	10	18
		1.48	Rapid access chest pain clinic access within 2 wks.	100%	97.1%	97.5%	96.3%	100%	100%	100%	100%	99.1%	57.5%	97.3%	97.3%	96.2%	96.7%	89.0%
		1.49	Verbal Duty of Candour outstanding at month-end	0%	2	0	1	2	0	2	2	1	1	1	2	2	0	6
		1.50	Hand Hygiene Audits	95%	99.0%	98.0%	99.0%	99.0%	99.0%	99.0%	100%	100%	100%	99.0%	99.0%	99.0%	100%	99.4%
		1.51	Quarterly antibiotic audit	98%	NA	93.8%	NA	NA	93.0%	NA	NA	89.0%	NA	NA	92.2%	NA	NA	92.2%
		1.52	Serious Incident RCA actions beyond deadline for completion	0	1	7	2	9	14	9	8	4	9	4	4	7	4	28
		1.53	% of Green Patient Safety incidents investigated	NT	68.0%	58.0%	67.0%	56.0%	55.0%	59.0%	74.0%	68.0%	68.0%	64.0%	61.0%	68.0%	59.0%	64.0%
		1.54	Quarterly Environment/Isolation	90%	NA	92.0%	NA	NA	92.0%	NA	NA	91.0%	NA	NA	92.0%	NA	NA	92.0%
		1.55	Quarterly VIP score documentation	90%	NA	80.0%	NA	NA	87.0%	NA	NA	80.0%	NA	NA	86.0%	NA	NA	86.0%
		1.56	Isolation data (Trust Level only)	95%	88.0%	88.0%	90.0%	88.0%	88.0%	90.0%	90.0%	89.0%	86.0%	88.0%	87.0%	88.0%	91.0%	88.0%
		1.57	Pain Mgt. Quarterly internal report	80%	NA	NA	61.3%	NA	NA	58.8%	NA	NA	NA	NA	NA	86.0%	NA	86.0%
		1.58	Nutrition Risk Assessment 48hrs	95%	85.0%	90.0%	89.0%	87.0%	93.0%	92.0%	89.0%	90.0%	90.0%	93.0%	88.0%	91.0%	88.0%	90.0%
		1.59	Median NRLS (national reporting & Learning system) upload 6 month rolling average (No. of days)	41	58	55	48	61	66	75	65	63	26	31	62	68	ND	47

SAFE – DIVISIONAL LEVEL ANALYSIS

Indicator	June			July			August		
	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	89		100	92	
HII compliance 2a: Peripheral cannula insertion	100	100	100	100	100	100	100	100	100
HII compliance 2b: Peripheral cannula ongoing	100	95	100	100	100	90	100	94	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	100	
HII compliance 6b: Urinary catheter on-going care	100	86		100	96		100	95	
HII compliance 7: Clostridium Difficile- prevention of spread									
Total no of MRSA bacteraemias: Hospital	0	0	0	0	0	0			
Quarterly MRSA (including admission and length of stay screens)	98	77	92						
Hand hygiene compliance	98	100	99	99	99	100	100	100	100
Total no of MSSA bacteraemias: Hospital	0	0	0	0	0	0			
Total no of C. diff infections: Hospital	0	0	0	1	0	0			
Quarterly Antibiotic Audit	94.4	91.4	100.0						
Quarterly Environment/Isolation	92	93	92						
Quarterly VIP score documentation	83	86	96						

Indicator	June			July			August		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
Patient Satisfaction: In-patient overall result	98.0	94.0	100.0	98.0	95.0	98.0	96.0	94.0	96.0
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	99.0	96.0	100.0	99.0	98.0	95.0	99.0	99.0	100.0
In your opinion, how clean was the hospital room or ward that you were in?	99.0	97.0	100.0	99.0	98.0	98.0	97.0	95.0	97.0
Did you feel you were treated with respect and dignity by staff	99.0	98.0	100.0	100.0	99.0	99.0	100.0	99.0	100.0
Were staff caring and compassionate in their approach?	99.0	96.0	100.0	99.0	99.0	99.0	99.0	98.0	100.0
Did you experience any noise in the night time that you think could have been avoided?	92.0	83.0	100.0	91.0	88.0	98.0	87.0	89.0	87.0
Did you find someone in the hospital staff to talk about your worries and fears?	100.0	100.0	100.0	100.0	96.0	100.0	98.0	99.0	94.0
Were you involved as much as you wanted to be in decisions about your care and treatment?	99.0	95.0	100.0	98.0	93.0	93.0	96.0	93.0	93.0
Did staff talk in front of you as if you were not there?	100.0	94.0	100.0	100.0	96.0	98.0	100.0	95.0	98.0
Were you given enough privacy when discussing your condition or treatment?	100.0	98.0	100.0	100.0	97.0	98.0	100.0	99.0	100.0
Were you given enough privacy when being examined or treated?	100.0	100.0	100.0	100.0	100.0	100.0	100.0	99.0	100.0
Did you get enough help from staff to eat your meals?	100.0	99.0	100.0	98.0	99.0	100.0	97.0	94.0	83.0
How many minutes after you used the call button did it usually take before you got the help you needed?	93.0	80.0	100.0	88.0	83.0	100.0	83.0	74.0	95.0
Number of Inpatient surveys completed	240	129	2	259	221	43	252	177	23
Same sex accommodation: total patients	0	2	0	0	0	0	0	0	0
Complaints	5	4	0	6	7	3	2	5	2
Environment and Cleanliness	96.0	96.8	99.2	93.9	93.2	95.8	93.3	92.8	95.6

5. Exception reports – Safe

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

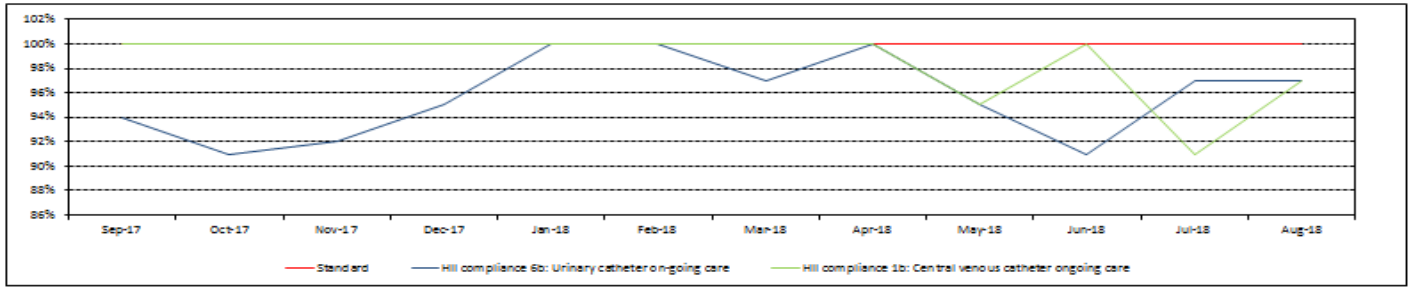
Indicator	HII Compliance
Standard	100%
Name	Rowan Procter
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

1b: There has been a slight improvement in the ongoing care of central venous catheters in August, but the failing is due to a single ward area. Although this ward has seen an improvement from its performance last month, in regard to the documentation of care, further improvement is required. The Head of Nursing for this area has met with the Senior Matron and a plan is in place to provide the ward with additional support from a practice development nurse to educate and encourage the nursing staff to improve the documentation of care. This ward cares for a high number of these devices and although the care is not being questioned, it is the documented evidence that care is being provided that is the main issue. All other wards and departments are achieving 100% in this audit.
6b: Performance, this month, for the ongoing care of urinary catheters has remained unchanged, however this month has seen two wards failing in the audit as a result of poor compliance with documenting evidence that the care had been performed. For one ward, this is the second month of poor performance, however, there has been an overall improvement in documentation from the previous month. This ward is undergoing increased scrutiny by the Head of Nursing and Senior Matron and additional staff education and support is being put in place to ensure there are improvements in documentation and evidence of appropriate care delivery. All other wards and departments are achieving 100% in this audit.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
HII compliance 6b: Urinary catheter on-going care	94.0%	91.0%	92.0%	95.0%	100%	100%	97.0%	100%	95.0%	91.0%	97.0%	97.0%
HII compliance 1b: Central venous catheter ongoing care	100%	100%	100%	100%	100%	100%	100%	100%	95.0%	100%	91.0%	97.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Pilot on ward to improve the care and documentation of urinary catheters	Infection prevention team	Aug-18	Nov-18
Continue to monitor	Head of Nursing/ Matron	Complete	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Falls
Standard	NA
Name	Rowan Procter
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Safe

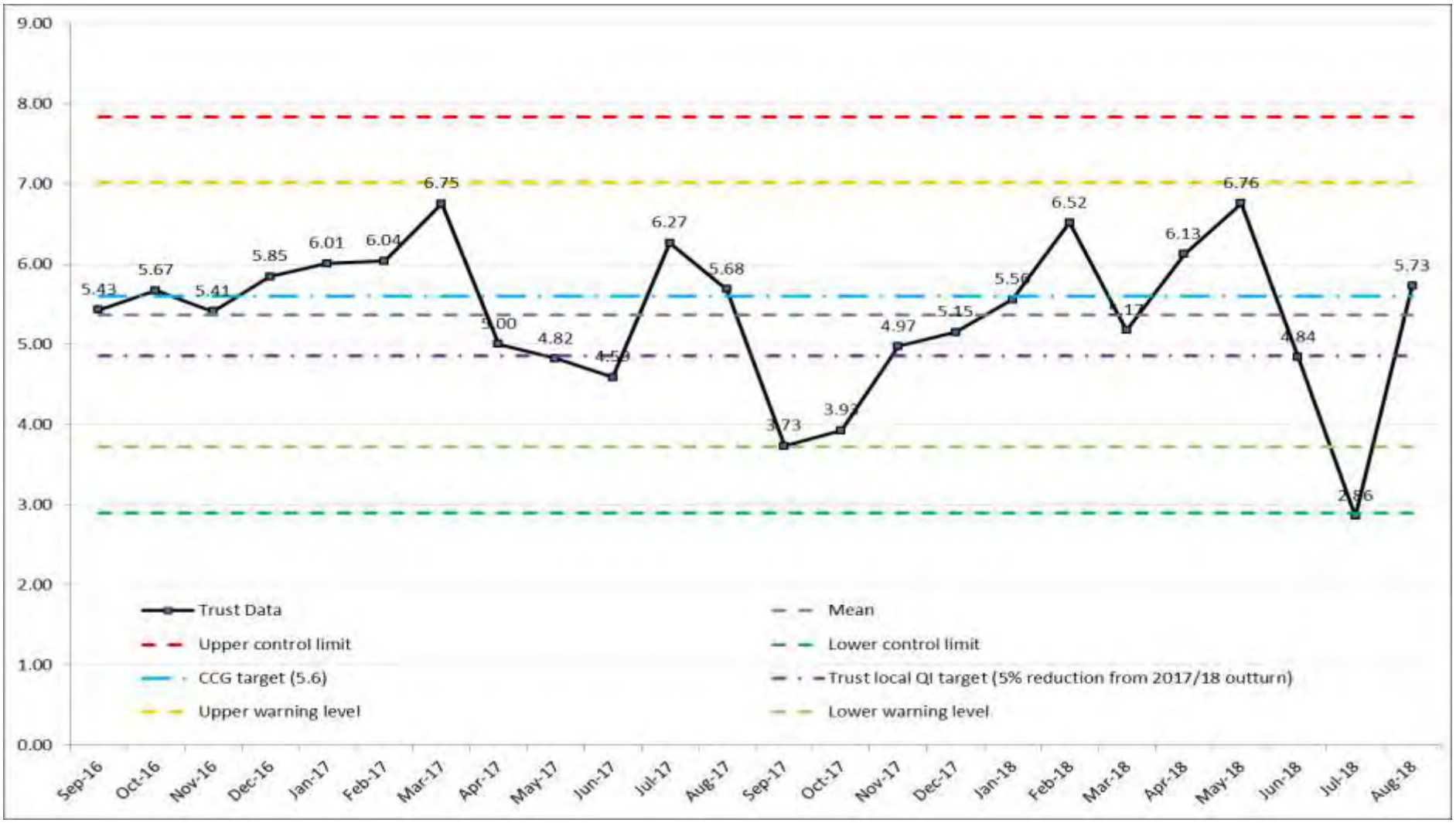
Summary of Current performance & Reasons for under performance

Number of falls for August in total is 79. Of these falls 75 were recorded as inpatient falls with four falls occurring within 'Support to go home' service (3) and CHT Bury Town (1) and therefore not recorded as 'inpatient' falls. Further breakdown of the 75 falls reveal that 12 were accounted to the community beds and 63 occurred within the acute trust. Eight patients fell more than once in August and four patients were assisted to the floor. Within the NHSI collaborative work we are focusing on the frequent faller and plan for September to pilot within two clinical areas new symbols to highlight this high risk patient group. During August we did not achieve our target of a 5% reduction in falls as shown within the SPC chart of falls per 1000 days at 5.73. Data is now provided for the indicator "% of patients at risk of falls (with a falls assessment)". We are looking towards benchmarking ourselves for this indicator, however following discussions with NHSI falls leads there are no national benchmarking standards or targets, so we will undertake our own benchmarking based on the previous years performance. Unfortunately Rosemary Ward, Newmarket Hospital again experienced a high number of falls, with one patient falling on 3 occasions and another falling on 4. Most of these falls occurred overnight and were unwitnessed. All preventative measures were taken to reduce the risk for these 2 patients, who were known to be at high risk of falling. Unfortunately, a high number of vacancies has resulted in the use of staff (particularly overnight) who are unfamiliar with the unit, though we consistently try to increase the availability of Nursing Assistants who are based upon the ward.
The NHSi Falls Collaborative is supporting with this area, with consideration of a tool for use with repeat fallers. We have also requested the support of a Clinical Nurse Specialist for Older People, who will visit the ward twice weekly to support with ensuring that all falls prevention measures are in place. We are investigating the coloured blanket project, which aims to reorientate patients back to the correct bed with the use of colour coded blankets.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Falls per 1000 bed days (WSH only)	3.73	3.93	4.97	5.15	5.56	6.52	5.17	6.13	6.76	4.84	2.86	5.73
% of patients at risk of falls (with a Falls assessment)	74.1%	73.2%	71.7%	74.3%	73.8%	71.1%	71.7%	71.1%	71.6%	72.2%	74.6%	72.8%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
The current Slips, Trips and Falls policy to be reviewed and amended to accurately reflect current best practice and support the accurate recording, interventions and investigations in line with the current documentation systems used (eCare / Datix).	Falls Group	Jun-18	Sep-18
The Falls Group and the sub Focus Group are currently exploring the option of the 'Catch a Falling Star' falls study day, focusing on the prevention of falls and appropriate treatment post fall. This has successfully been implemented in a London Trust with good results and could be tailored for the specific purposes of the WSFT. The option of a Falls Prevention video for patients to watch (as used in Michigan – Bronson Healthcare Group) is being explored to try and assist in the reduction of falls. AUG18 Update. the falls group which met on the 28th August felt that this was not the direction to take. It was felt that a complete review was required of the current falls training package delivered which will take place following the completion of the NSHI falls collaborative work. If the business case for a Falls Prevention Nurse is successful then they would lead on this education	Falls Group	May-18	complete
NHS Improvement falls collaborative work re implementation of an improvement project within the trust. July UPDATE. Work continues with NHSI falls collaborative, with aim to reduce the frequent faller cycle of harm with a 10% reduction in falls in patients who have fallen more than twice in an admission period within G8 and Rosemary Ward in Newmarket Hospital.	HoN (Med)	Jun-18	Dec-18
Falls per 1000 bed day data provided as an estimate for two years up to May 2018 will be provided on a monthly basis going forward.	HoN (Med)	Jun-18	complete
Work commencing on improving the training package to staff around falls. This has Physio involvement	HoN (Med)	Jul-18	Nov-18
Trust looking into sourcing improved slipper socks which have grips over whole foot rather than just under foot	HoN	Jul-18	Sep-18
Trust is piloting the use of new symbols for the frequent fallers	HoN	Sep-18	Dec-18
Request for support of a Clinical Nurse Specialist for Older People, to support ensuring that all falls prevention measures are in place	HoN	Sep-18	Dec-18
Newmarket are looking into having different brightly coloured blankets covering the patients beds for those patients that are deemed high risk of falls to allow the patient to recognise their bed spaces. This has been undertaken at Brighton & Sussex University Hospital which has seen an reduction in falls since implementation. If this is a success at Newmarket we would look towards piloting this within the Trust.	HoN (Comm)	Sep-18	Dec-18
SPC chart below has RAG rating based on: Red (Above upper SPC warning line), Amber (above CCG target of 5.6 and below upper SPC warning line), Green (below CCG target). Year end QI target (5% reduction on 2017/18 outturn at year end) shown as purple line on graph below.			

FALLS September 2016 to August 2018



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-Aug-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

August saw a slight increase in the number of hospital acquired pressure ulcers (HAPUs), from six in total in July, to ten this month. Of these ten, only one was a grade 3 HAPU, with the majority being grade 2. August also saw an increase in the number of falls, and this deterioration of both measures is likely due to the consistently poor staffing levels throughout August, due to a lack of Bank and Agency staff to fill the ongoing vacancy gaps.

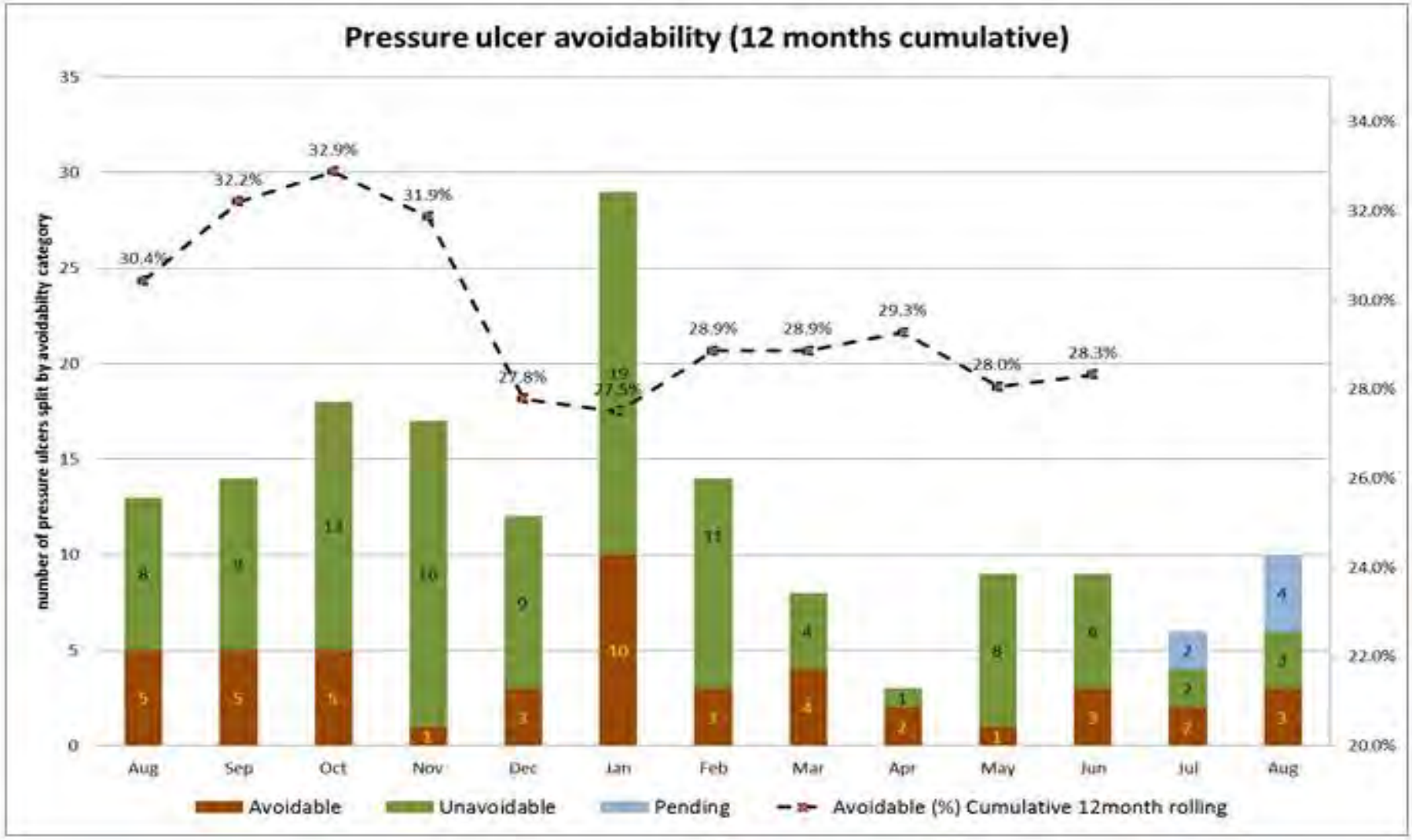
Work continues with the NHSi Pressure Ulcer collaborative, focussing on the repositioning of patients. This is an integrated project with acute and the community services, involving supporting and educating selected wards and care settings of concern. This is additional to the ongoing educational and development program the Tissue Viability (TV) team are continuing to promote across the organisation, via formal and informal sessions.

The Pressure Ulcer prevention leads are also working closely with the TV Nurses and Governance teams to review the NHSi guidance on pressure ulcer classification and integrate this into our reporting and investigating processes. Part of this is to review the data produced from the patient safety dashboard and Perfect Ward reviews, ensuring it is relevant and pertinent as a quality assurance measure, as pressure ulcer prevention is one of the quality priorities for the organisation.

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Target	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	TBC	TBC	TBC	TBC	TBC
Total Pressure Ulcers	13	15	18	17	12	29	14	8	3	9	9	6	10
% of patients with avoidable ward acquired pressure ulcers (YTD 17/18, 12 months cumulative 18/19)	34.0%	33.0%	32.0%	28.0%	28.0%	29.0%	28.0%	29.0%	29.3%	28.0%	28.3%	TBC	TBC

Due to the process required to ascertain whether a pressure ulcer is avoidable or not, there will be a short delay in data being available to allow the full review process to be completed

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
The trust has been working to develop a tool to ensure consistent classification of avoidable vs non-avoidable. this is due to be trailed 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
Review of the information within the Patient safety report and Perfect Ward audit to ensure quality improvement and assurance	HoN	Sep-18	Mar-19


Pressure ulcer avoidability (12 months cumulative)
number of pressure ulcers split by avoidability category
35
30
25
20
15
10
5
0
34.0%
32.0%
30.0%
28.0%
26.0%
24.0%
22.0%
20.0%
30.4%
32.2%
32.9%
31.9%
27.8%
27.5%
28.9%
28.9%
29.3%
28.0%
28.3%
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Avoidable
Unavoidable
Pending
Avoidable (%) Cumulative 12month rolling

28

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

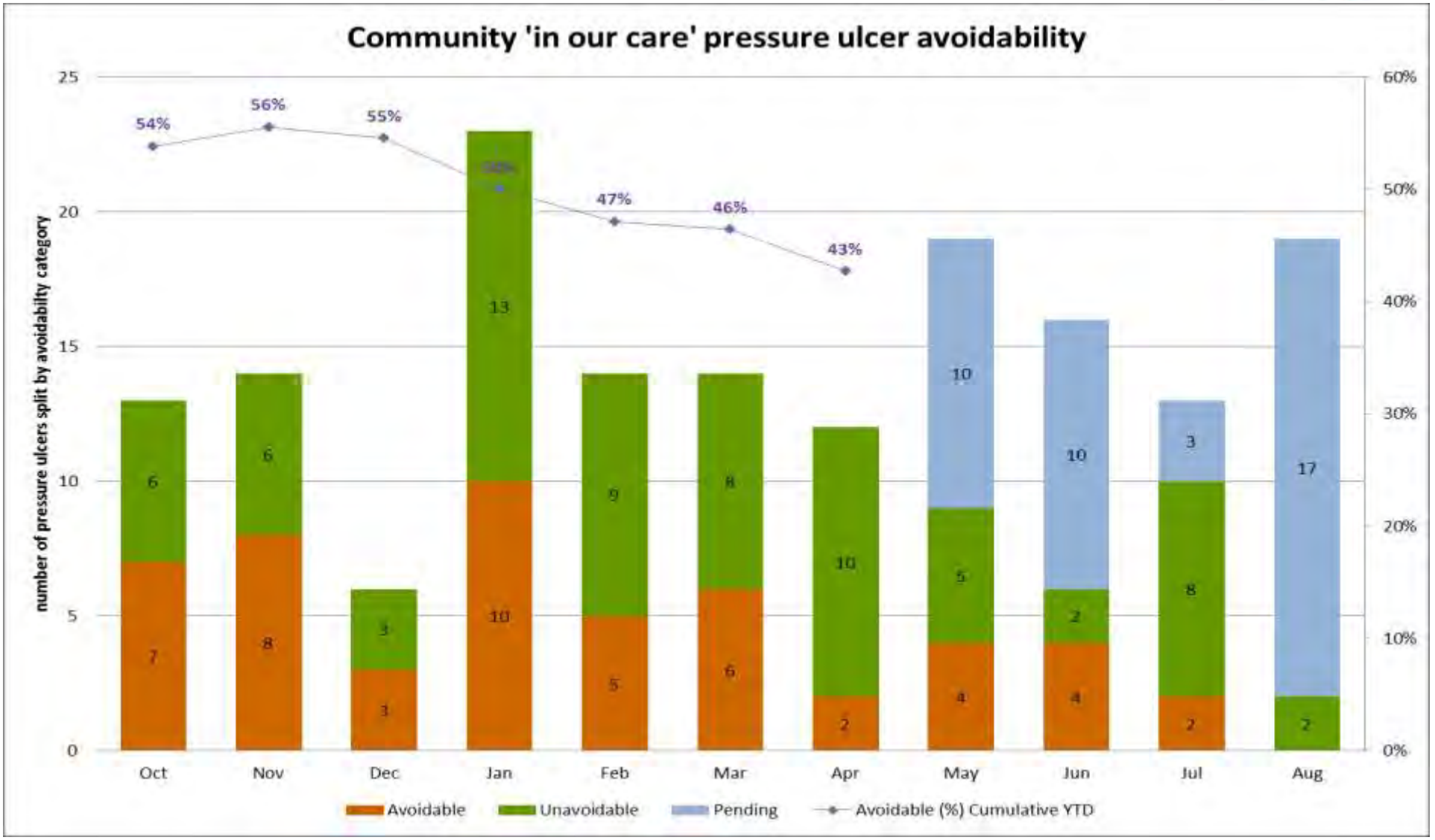
Summary of Current performance & Reasons for under performance

Incidence of community reported pressure ulcers (in our care) during August has increased, following a reduction last month; with 11 Grade II and 7 Grade III pressure ulcers reported. 2 suspected Deep Tissue Injuries await review and categorisation.
As noted previously, NHSi Pressure Ulcer Collaborative work continues – Repositioning Roadshows are about to take place around the hospital and in the community; the MAP system which has been purchased for ongoing use, will allow staff to understand how pressure is distributed across the body and how even minimal repositioning can have a positive impact upon the distribution of this, thus reducing the risk of pressure sores. Acute and Community Tissue Viability Teams are working together on this initiative. NHSi are due to visit the trust on 21 September to support the initiative. Staffing through the community teams has been particularly challenging during August, with sickness reported as well as annual leave; a Demand and Capacity review is to be undertaken to demonstrate the high volume of referrals to teams. Community colleagues are working together with acute to ensure that the new NHSi guidance around reporting of pressure ulcers is approached with consistency, scrutiny is also being given to the NHSi Pressure Ulcer Curriculum guidelines, which will underpin ongoing education in this area

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Target	<30%	<30%	<30%	<30%	<30%	<30%	TBC	TBC	TBC	TBC	TBC
Total Pressure Ulcers	13	14	6	24	15	14	12	19	17	13	14
% of patients with avoidable IOC pressure ulcers YTD	54.0%	56.0%	55.0%	50.0%	47.0%	46.0%	43.0%	TBC	TBC	TBC	TBC

Due to the process required to ascertain whether a pressure ulcer is avoidable or not, there will be a delay in data being available to allow the full review process to be completed

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
The trust has been working to develop a tool to ensure consistent classification of avoidable vs non-avoidable. this is due to be trailed 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
Review of the information within the Patient safety report and Perfect Ward audit to ensure quality improvement and assurance	HoN	Sep-18	Mar-19


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%
47%
46%
43%
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Avoidable
Unavoidable
Pending
Avoidable (%) Cumulative YTD

30

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

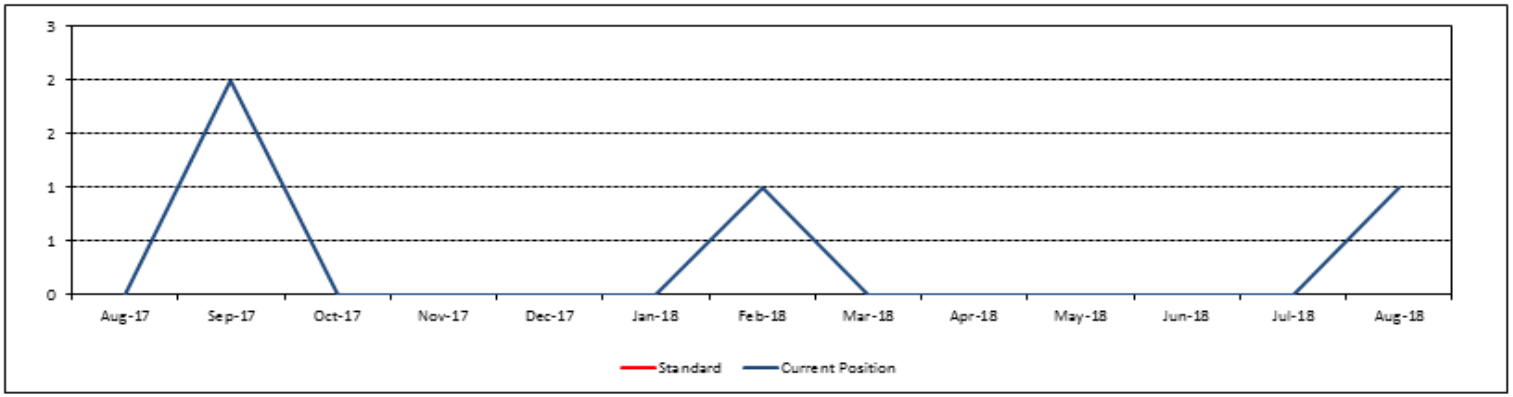
Indicator	MRSA Bacteraemias - Hospital Attributable
Standard	0
Name	Anne How
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

The Trust recorded one case of MRSA bacteraemia classified as a contaminant in August 2018. The blood cultures were taken in the Emergency Department and had this been an infection it would have been attributed to the CCG. The culture was deemed a contaminant due to the nature of the culture results and because the patient recovered without any MRSA specific antimicrobial therapy. This is documented in the discharge letter. Both NHS England and Improvement deemed these incidences as avoidable and the ruling is that contaminants must sit with the acute Trust. The incidence has been discussed with the Emergency Department an audit of the blood culture procedures will be undertaken. Additional Training for the doctor who obtained the cultures will be arranged should he still be in the Trust.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	0	2	0	0	0	0	1	0	0	0	0	0	1

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

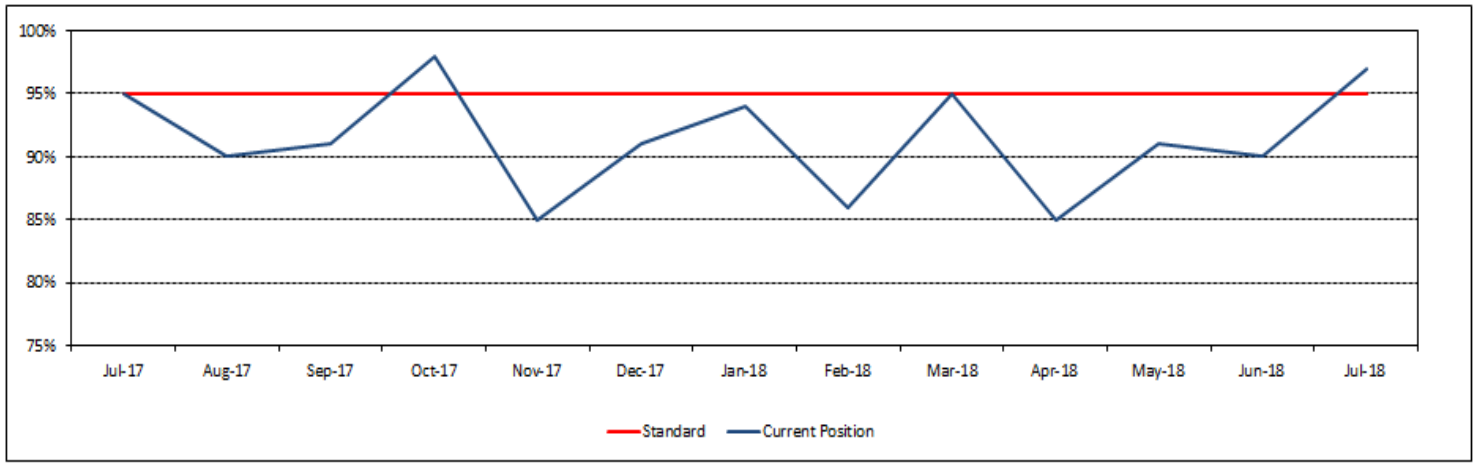
Indicator	MRSA - Decolonisation
Standard	95%
Name	Anne Howe
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

The decolonization audit result in August 2018 is 97%. In order to support the ward teams the Infection Prevention team monitored all of the decolonization records in real time (Mon- Friday) to ensure the required interventions were achieved and provided support and education on the importance of each element of the regimen.

Month	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	95.0%	90.0%	91.0%	98.0%	85.0%	91.0%	94.0%	86.0%	95.0%	85.0%	91.0%	90.0%	97.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

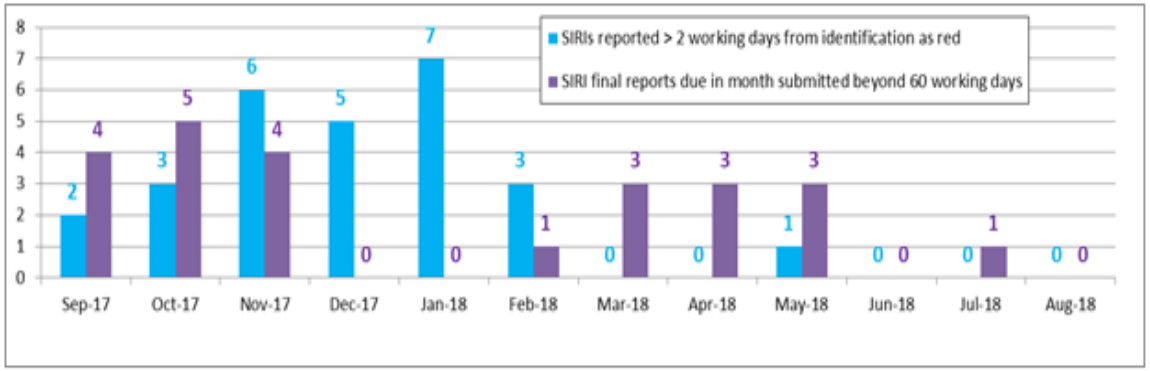
Indicator	Timeliness of SI submission
Standard	0
Name	Rowan Procter
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

All new SIs in August were reported within the two day deadline and the one final report due in August was submistted within the 60 day deadline. In the previous month there was one pressure ulcer report sent two days later than the 60 day deadline. NHSI have issued a document stating that pressure ulcer cases should not be considered as an SI unless they meet the criteria of a serious incident. A meeting with the CCG in September will allow full clarification but until then the Trust and CCG have agreed that cases are only reported if they are categorised as a grade 4 (of which there were none in July/August).

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	2	3	6	5	7	3	ND	0	1	0	0	0
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	4	5	4	0	0	1	3	3	3	0	1	0

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to aim for 100% compliance	Governance	Jul-05	Ongoing



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Duty of Candour (DoC)
Standard	0
Name	Rowan Procter
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Safe

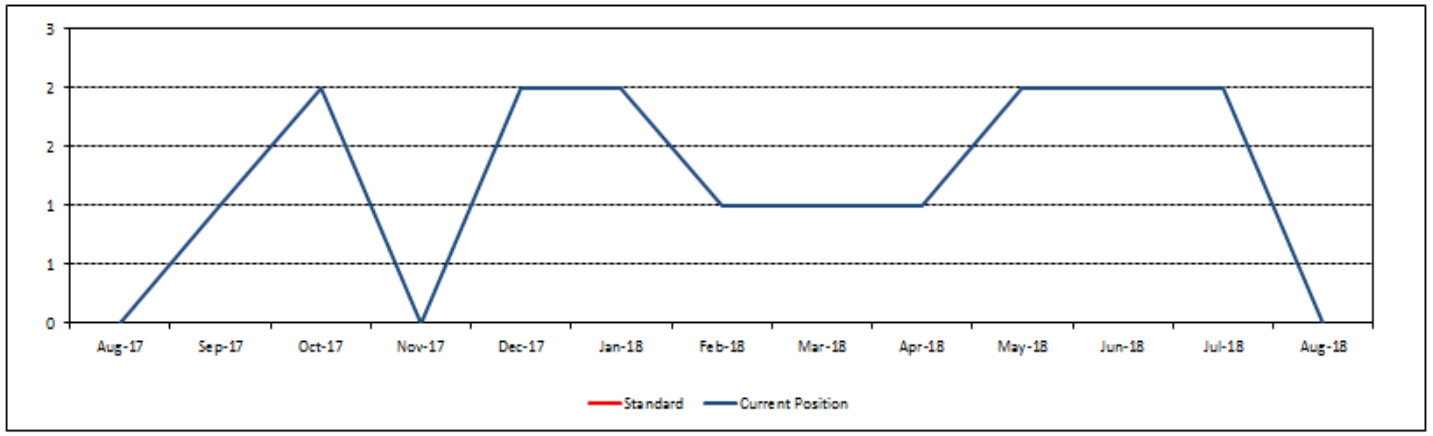
Summary of Current performance & Reasons for under performance

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 now in place and is now included in the data (shown as Tustwide and split by Hospital/community).

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	0	1	2	0	2	2	1	1	1	2	2	2	0

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	Complete	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

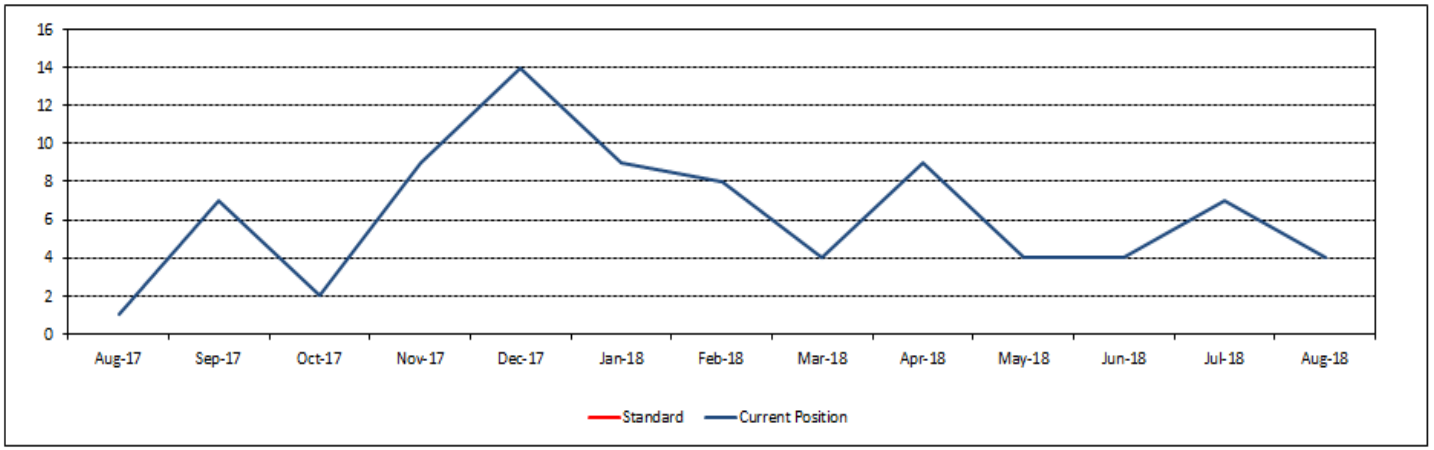
Indicator	Timeliness of RCA action completion
Standard	0
Name	Rowan Procter
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Four actions remain overdue including two which relate to discussion of a case at a meeting rather than an action to change practice. These will be completed by next month. The other two actions are currently in progress and it is envisaged that they will be completed soon.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	1	7	2	9	14	9	8	4	9	4	4	7	4

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Clinical Directors meeting have agreed to take greater oversight of RCA action completion	Clinical Directors	Jul-05	Ongoing
Discussion with Senior matrons and Ward Managers at Nursing & Midwifery and Clinical Council (NMCC)	NMCC	Jul-05	Ongoing



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

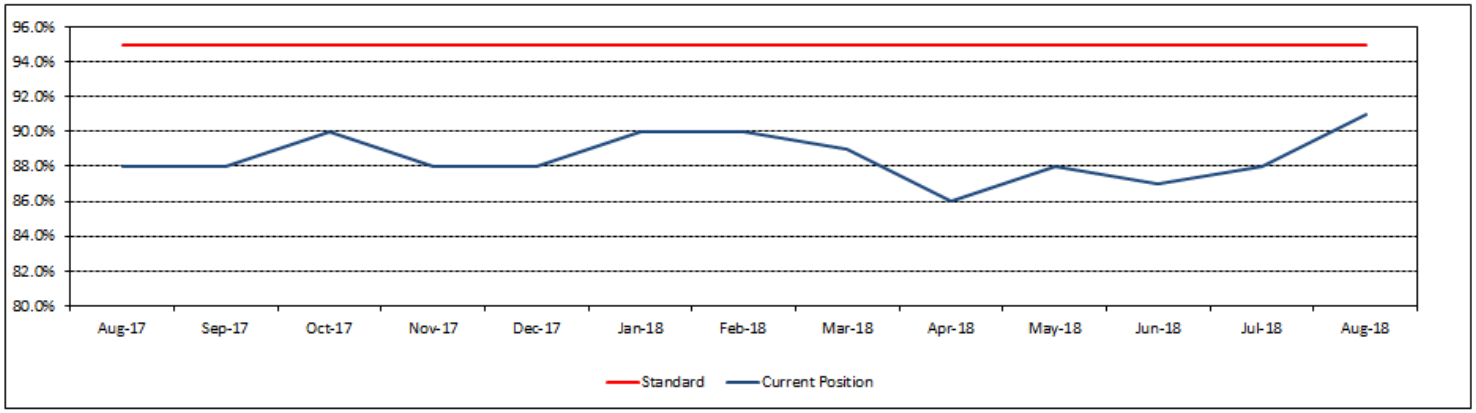
Indicator	Isolation data (Trust Level only)
Standard	95%
Name	Anne Howe
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Compliance with Isolation is at 91%. The side room capacity is monitored daily (Mon to Fri) by the Infection Prevention Nurses(IPN) and occupancy is risk assessed throughout the day, including a daily review of patients on the IPN ward visits and this information is provided to the site capacity/bed flow meetings. Wards were advised on the measures required to mitigate onward transmission. F12 Adult isolation ward has been utilized for optimum use throughout August to ensure that patients with the highest infection risk are managed there if at all possible including patients with Tuberculosis following the temporary relocation of F10 to G9. The process of capturing the information with regard to patients requiring isolation is under review in order to increase the accuracy of the reporting,(triggered by an update of the single room occupancy list). We will trial the new system shortly.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Current Position	88.0%	88.0%	90.0%	88.0%	88.0%	90.0%	90.0%	89.0%	86.0%	88.0%	87.0%	88.0%	91.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

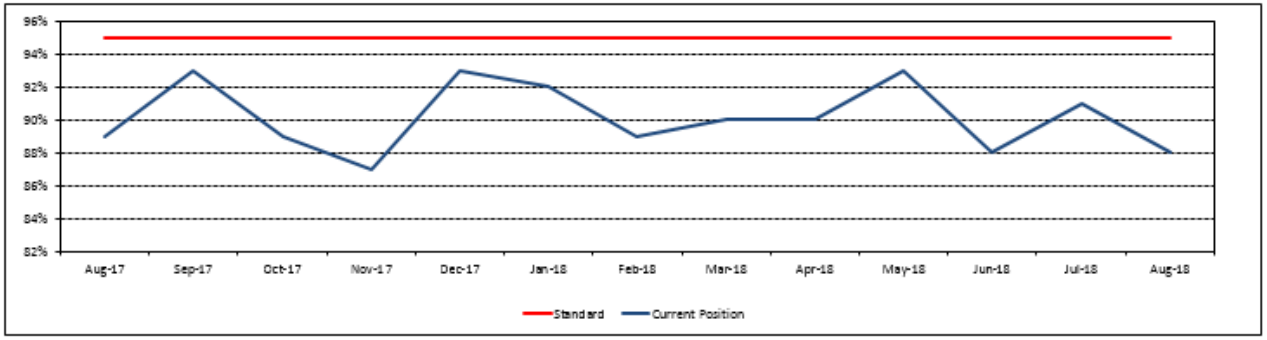
Indicator	Nutrition - Asssessment & Monitoring
Standard	95%
Name	Rowan Procter
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Overall Trust performance has decreased this month from 91% to 88% due to multiple wards failing in compliance with recording timely risk assessments and weighing patients. This is likely due to increased staffing deficits in August, and is reflective of the increase in the number of falls and hospital acquired pressure ulcers in the organisation during the month. The issue of poor compliance continues to be addressed by the Senior Matrons and Ward Managers at ward level, with an increased focus on ensuring risk assessments are performed accurately, care plans are in place and care is being implemented. Going forward, from September, this will be measured, and assurance gained, via reports from the patient safety dashboard and Perfect Ward audits. In addition, there will be a more in depth quarterly review which will be conducted in collaboration with the Dietetics team. It is envisaged, that these changes, which were driven by the work conducted as part of the NHSi Nutrition Collaborative earlier this year, will increase the focus on accurate and timely assessments, with a key part of this being the recording of actual weights.
Improving Nutrition for inpatients and those in our care in the community setting is a Trust priority and the Nutrition Lead, along with key multiprofessional team members, will continue to work with the quality improvement team to promote this and look at new initiatives, such as, Ward G8 developing a case to trial a dedicated Nutrition role to ensure the patient needs are being met and working with the Housekeeping Manager to look at the development of a Ward Host role to support nutrition and hydration in the Ward areas.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	89.0%	93.0%	89.0%	87.0%	93.0%	92.0%	89.0%	90.0%	90.0%	93.0%	88.0%	91.0%	88.0%

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 took place in August and actions agreed.	HoN	complete	
To adjust the Perfect Ward documentation audit to gain assurance that risk assessments are accurate, care is implemented and weights are recorded	HoN	Aug-18	Sep-18
To redesign a robust quarterly audit which will be conducted by the Senior nursing team in collaboration with Dietetics. This will be presented to the Nutrition Steering	HoN	Aug-18	Oct-18
Embed and review the new reporting and assurance measures	HoN	Aug-18	Oct-18
Work with the Nursing Assistant Education leads to promote the importance of weighing patients.	HoN	Aug-18	Oct-18
Reform the Nutrition Collaborative team to review the action plan and review key priorities for Acute services and the Community	HoN	Aug-18	Oct-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

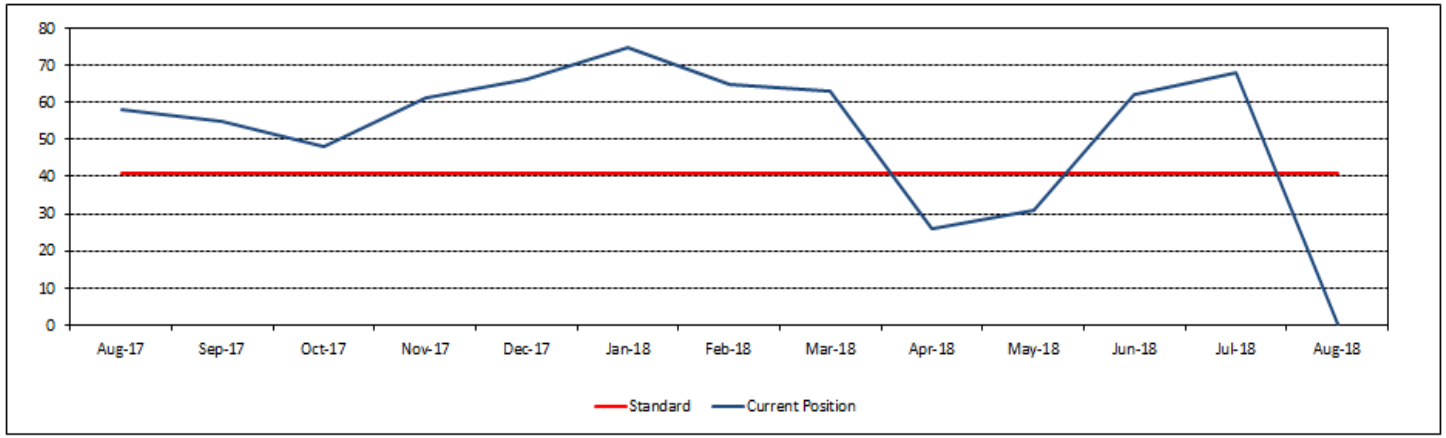
Indicator	Median NRLS upload 6 month rolling average
Standard	41%
Name	Rowan Procter
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

The timescales for NRLS upload are linked to timely investigation and final approval. There are currently 514 incidents showing as "overdue" on Datix (>12 days) which is a deterioration from last month. The next NRLS close-down deadline is 30th November and the Deputy Chief Nurse / Head of Patient Safety is leading a plan to improve this position.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	41	41	41	41	41	41	41	41	41	41	41	41	41
Current Position	58	55	48	61	66	75	65	63	26	31	62	68	ND

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Targeted follow up with leads (Matrons, CDs)	Governance	ongoing	
Monitor against a peer based comparison (peer group is all non-specialist acute trusts)	Governance	ongoing	



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	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	YTD(Apr 18-
Effective	Dashboard	2.02	Canc. Ops - Cancellations for non-clinical reasons	1%	1.2%	1.0%	1.4%	1.9%	1.3%	0.8%	1.2%	0.9%	0.6%	0.8%	1.4%	1.8%	1.5%	1.2%
	Incidents/Reports	2.05	Cardiac arrests	NT	3	6	4	7	9	7	ND	ND	3	4	2	7	3	19
		2.06	Cardiac arrests identified as a SIRI	NT	0	0	0	0	0	0	0	0	1	0	0	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	56	55	48	47	41	247
		2.10	WHO Checklist (Qrtly)	100%	NA	99.0%	NA	NA	99.0%	NA	NA	98.0%	NA	NA	99.0%	NA	NA	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	22	23	17	18	18	98
		2.12	Av. Elective LOS (excl. 0 days)		2.79	2.73	2.93	2.85	2.98	3.06	2.27	3.29	3.34	2.55	2.59	2.85	3.26	2.92
		2.13	Av NEL LOS (excl 0 days)		7.93	7.54	8.23	7.66	7.57	8.40	8.13	8.1	7.96	7.58	6.90	7.39	7.91	7.55
		2.14	% of NEL 0 day LOS		17.4%	17.5%	18.8%	16.6%	14.7%	13.3%	13.3%	13.7%	13.7%	15.3%	15.9%	15.1%	13.5%	14.7%
		2.15	NHS number coding	99%	99.5%	99.6%	99.6%	99.7%	99.6%	99.7%	99.7%	99.7%	99.7%	99.8%	99.8%	99.8%	99.8%	99.8%
		2.16	Fractured Neck of Femur : Surgery in 36 hours	85%	97.0%	97.0%	96.0%	84.0%	100%	100%	96.0%	93.0%	89.0%	79.0%	100%	94.4%	100%	92.5%
		2.17	Discharge Summaries (OP 85% 3d)	85%	57.0%	55.0%	58.0%	58.0%	58.0%	60.0%	58.0%	56.0%	62.0%	57.0%	63.0%	54.0%	ND	59.0%
		2.18	Discharge Summaries (A&E 95% 1d)	95%	85.7%	85.9%	83.6%	84.2%	82.6%	84.0%	83.4%	82.3%	81.5%	82.5%	86.1%	86.4%	88.4%	85.0%
		2.19	Non-elective Discharge Summaries (IP 95% 1d)	95%	73.0%	73.0%	73.3%	69.2%	68.9%	70.2%	69.8%	70.8%	73.5%	75.7%	78.1%	76.6%	76.9%	76.1%
		2.20	Elective Discharge Summaries (IP 85% 1d)	85%	72.2%	69.3%	73.3%	68.0%	74.5%	72.8%	71.2%	72.9%	72.1%	71.2%	72.1%	69.5%	70.8%	71.2%
		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%	75.0%	92.0%	84.6%	98.1%	76.7%	94.7%	96.6%	91.7%	85.7%	90.5%	100%	87.0%	91.9%	91.0%
		2.23	Canc. Ops. - No. Cancelled for a 2nd time	0	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	Canc. Ops - Cancellations for non-clinical reasons
Standard	1%
Name	Simon Taylor
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Effective

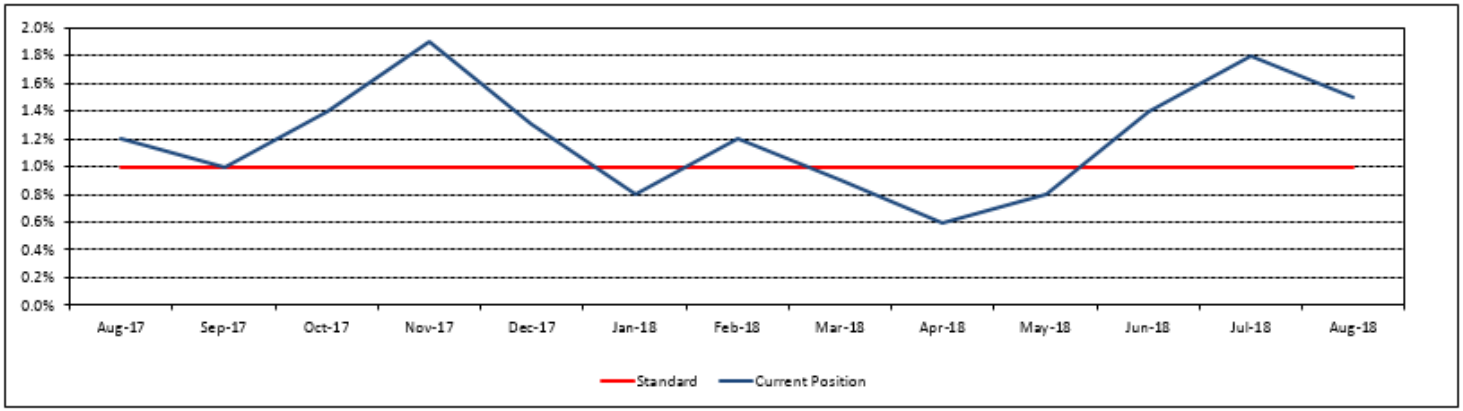
Summary of Current performance & Reasons for under performance

August saw a slight reduction in the number of patients cancelled on the day of surgery compared to July. Cancellations in August were related to anaesthetic consultant availability and equipment problems.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Current Position	1.2%	1.0%	1.4%	1.9%	1.3%	0.8%	1.2%	0.9%	0.6%	0.8%	1.4%	1.8%	1.5%

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

Description	Owner	Start	End
Equipment issues addressed and anaesthetic staffing plan in place.	ST	Aug-18	Dec-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

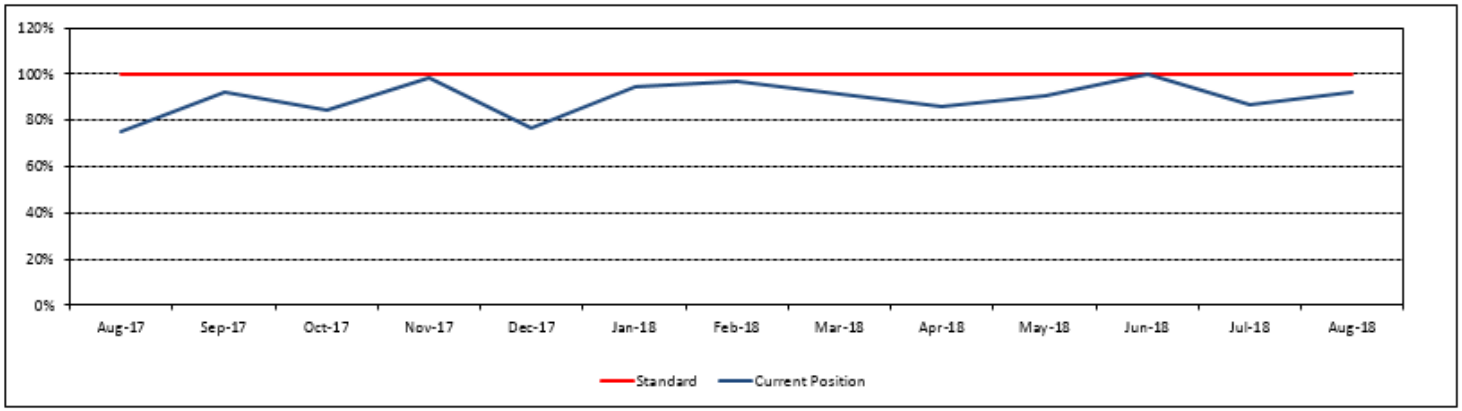
Indicator	Canc. Ops - Patients offered date within 28 days
Standard	100%
Name	Simon Taylor
Month	01/08/208
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

We were unable to re-book three cancelled patients within 28 days in August due to capacity constraints within the services. One, an ophthalmology patient, has been rebooked for the 27th of September; the remaining two were urology patients both cancelled to accommodate an emergency case. Both of the patients have been re-booked for the 5th and 12th of October respectively.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	75.0%	92.0%	84.6%	98.1%	76.7%	94.7%	96.6%	91.7%	85.7%	90.5%	100%	87.0%	91.9%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Focus remains in place for patients who have been cancelled, this is reviewed at the weekly Trust Access Meeting.	HB	Jul-17	TBC



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	NICE and AUDIT
Standard	0%
Name	Nick Jenkins
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

NICE baseline assessments

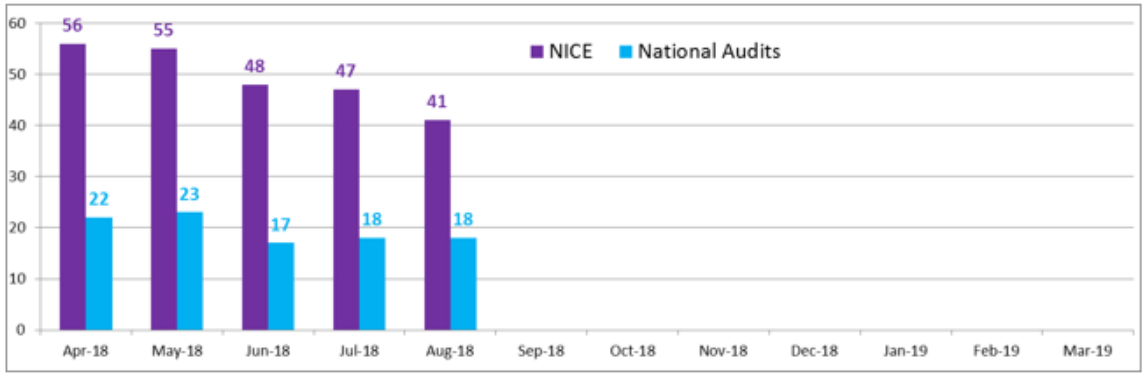
8 baseline assessments were completed in August 2018 and 2 guidelines were published (six months ago) in February 2018 that require a completed baseline assessment, resulting in a reduction from 47 to 41 baseline assessments not completed within 6 months of publication. This indicator remains AMBER

National clinical audit baseline assessments

0 baseline assessments were completed in August 2018 and 0 reports were published (six months ago) in February 2018 that require a completed baseline assessment, resulting in a maintenance of 18 baseline assessments not completed within 6 months of publication. This indicator remains RED.

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	0	0	0	0	0
NICE	56	55	48	47	41
Standard	0	0	0	0	0
National Audits	22	23	17	18	18

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	2018	2018
Review at specialist committees	Chairs	2018	2018



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

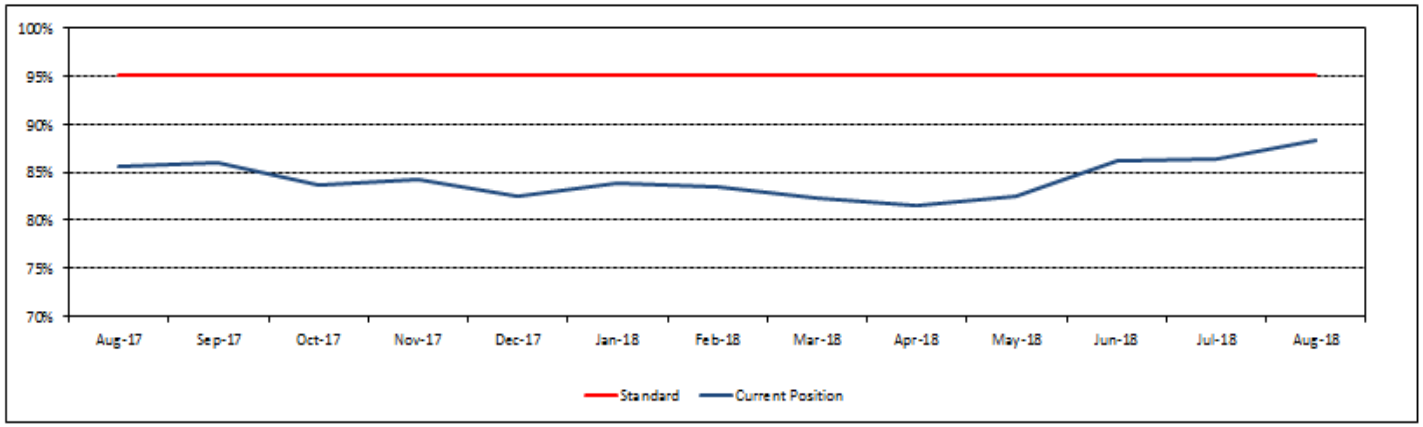
Indicator	Discharge Summaries (A&E 95% 1d)
Standard	95%
Name	Georgia Horobin
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

We continue to make good progress in ensuring discharge summaries are always sent after an ED episode. At the beginning of the year we had a peak of 83 summaries outstanding per week. This has now been reduced significantly and sustained performance since the beginning of the year. However this performance report confirms that we still have challenges in ensuring that the summaries are sent within the required contractual timescales. We will continue to work on this with direct coaching support at the elbow for all staff involved in the depart process. In addition a senior GP colleague from the CCG will be joining us from October for one session per week to support us with improving performance. This will include educational work with junior doctors around the impact of late delivery of discharge summaries on the continued care of the patient in primary care.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	85.7%	85.9%	83.6%	84.2%	82.6%	84.0%	83.4%	82.3%	81.5%	82.5%	86.1%	86.4%	88.4%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

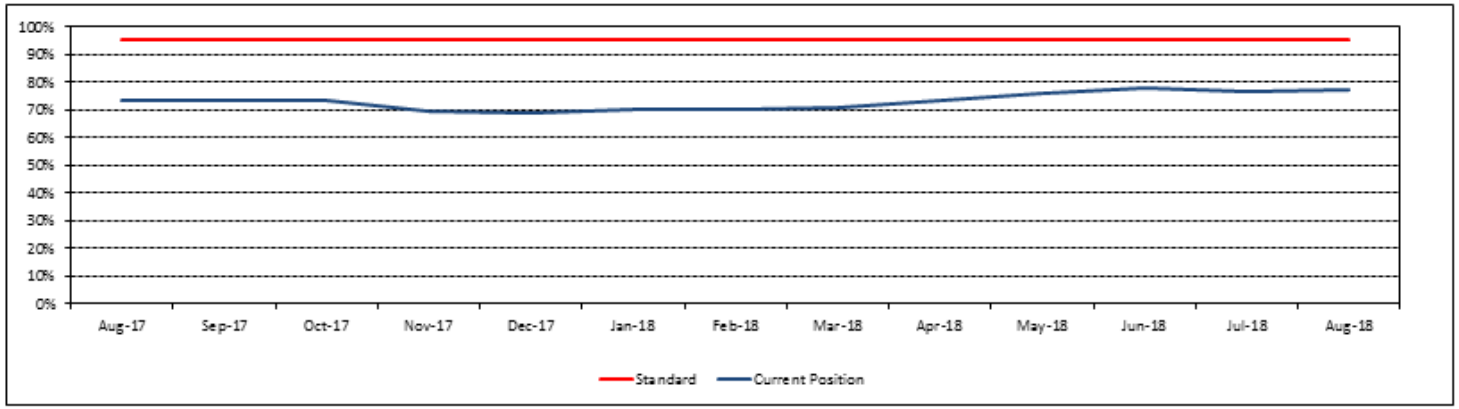
Indicator	Non-elective Discharge Summaries (IP 95% 1d)
Standard	95%
Name	Georgia Horobin
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

We continue to make good progress in ensuring discharge summaries are always sent after an inpatient episode. At the beginning of the year we had a peak of 132 summaries outstanding per week. This has now been reduced significantly and sustained performance since the beginning of the year. However this performance report confirms that we still have challenges in ensuring that the summaries are sent within the required contractual timescales. We will continue to work on this with direct coaching support at the elbow for all staff involved in the depart process. This includes targeting specific poor performing areas. In addition a senior GP colleague from the CCG will be joining us from October for one session per week to support us with improving performance. This will include educational work with junior doctors around the impact of late delivery of discharge summaries on the continued care of the patient in primary care.
In addition we are working with the CCG to remove infusion MTU summaries for the figures for elective inpatient summaries which are currently inappropriately included. When implemented this will immediately improve the figures (for example if they had been excluded for July the performance would have been 79.5% not 69.5%)

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	73.0%	73.0%	73.3%	69.2%	68.9%	70.2%	69.8%	70.8%	73.5%	75.7%	78.1%	76.6%	76.9%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

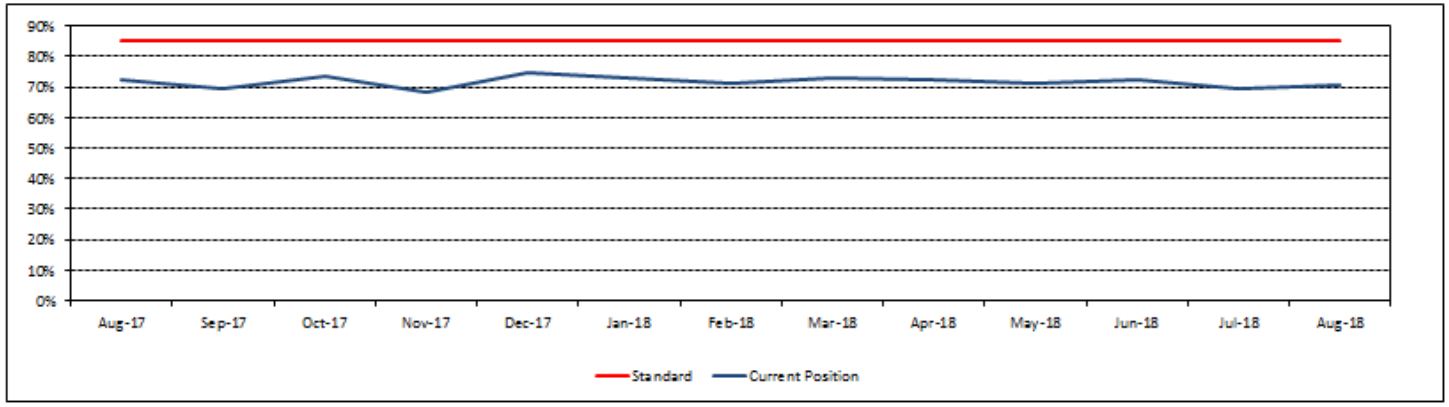
Indicator	Elective Discharge Summaries (IP 85% 1d)
Standard	85%
Name	Georgia Horobin
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

We continue to make good progress in ensuring discharge summaries are always sent after an inpatient episode. At the beginning of the year we had a peak of 132 summaries outstanding per week. This has now been reduced significantly and sustained performance since the beginning of the year. However this performance report confirms that we still have challenges in ensuring that the summaries are sent within the required contractual timescales. We will continue to work on this with direct coaching support at the elbow for all staff involved in the depart process. This includes targeting specific poor performing areas. In addition a senior GP colleague from the CCG will be joining us from October for one session per week to support us with improving performance. This will include educational work with junior doctors around the impact of late delivery of discharge summaries on the continued care of the patient in primary care.
In addition we are working with the CCG to remove infusion MTU summaries for the figures for elective inpatient summaries which are currently inappropriately included. When implemented this will immediately improve the figures (for example if they had been excluded for July the performance would have been 79.5% not 69.5%)

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Current Position	72.2%	69.3%	73.3%	68.0%	74.5%	72.8%	71.2%	72.9%	72.1%	71.2%	72.1%	69.5%	70.8%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



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	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	YTD(Apr 18-Mar19)
3. Caring	Dashboard	3.01	Compliments (Logged by Patient Experience)	28	17	33	87	151	64	20	45	21	93	44	49	33	240
		3.02	Formal Complaints	16	16	17	13	8	12	19	9	13	13	11	20	9	66
		3.03	Mixed Sex Accommodation Breaches	0	0	0	0	1	0	0	1	0	0	1	0	0	1
		3.04	IP - Extremely likely or Likely to recommend (FFT)	98.0%	98.3%	98.6%	96.0%	97.7%	97.1%	98.1%	98.0%	99.0%	99.0%	98.0%	99.0%	99.0%	97.8%
		3.05	OP - Extremely likely or Likely to recommend (FFT)	95.1%	96.0%	95.9%	96.0%	98.6%	95.1%	96.2%	95.0%	97.0%	97.0%	97.0%	97.0%	98.0%	97.2%
		3.06	A&E - Extremely likely or Likely to recommend (FFT)	94.7%	92.3%	94.9%	94.0%	94.0%	96.4%	94.5%	94.0%	94.0%	93.0%	94.0%	96.0%	95.0%	94.4%
		3.07	Maternity - Extremely likely or likely to recommend (FFT)	ND	ND	98.8%	100%	97.3%	100%	93.0%	100%	100%	100%	100%	100%	95.0%	99.0%
		3.08	Community - Extremely likely or likely to recommend	ND	ND	97.3%	100%	95.7%	95.2%	97.4%	96.0%	94.0%	98.0%	97.0%	90.0%	98.0%	95.4%
	Other Friends and Family Test Scores	3.09	IP overall experience result	92.9%	92.8%	96.0%	96.0%	95.0%	94.0%	95.0%	96.0%	97.0%	97.0%	97.0%	97.0%	95.0%	96.6%
		3.10	OP overall experience result	90.6%	88.6%	95.0%	94.0%	95.0%	96.0%	97.0%	96.0%	97.0%	97.0%	97.0%	97.0%	96.0%	96.8%
		3.11	A&E overall experience result	95.0%	94.0%	93.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	93.0%	94.0%	95.0%	97.0%	94.6%
		3.12	Short-stay overall experience result	99.4%	98.9%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	100%	99.0%	99.0%	98.0%	99.0%	99.0%
		3.13	Short-stay Extremely likely or Likely to recommend (FFT)	99.0%	99.0%	99.0%	97.0%	100.0%	99.4%	99.7%	99.0%	100%	99.0%	98.0%	98.0%	99.0%	98.8%
		3.14	Maternity - overall experience result	100%	100%	100%	98.0%	95.0%	100%	93.0%	100%	99.0%	98.0%	96.0%	100%	97.0%	97.4%
		3.15	Maternity postnatal community - extremely likely or likely to recommend (FFT)	ND	100%	100%	ND	ND	ND	ND	ND	100%	97.0%	96.0%	100%	100%	98.6%
		3.16	Maternity birthing unit - extremely likely or likely to recommend (FFT)	ND	100%	100%	100%	ND	100%	100%	ND	100%	ND	ND	100%	100%	100%
		3.17	Maternity antenatal community - extremely likely or likely to recommend (FFT)	ND	100%	96.4%	ND	ND	ND	ND	ND	100%	100%	94.0%	97.0%	100%	98.2%
		3.18	Children's services overall result	ND	ND	ND	ND	ND	ND	ND	ND	96.0%	99.0%	96.0%	96.0%	98.0%	97.0%
		3.19	F1 Parent - overall experience result	100%	100%	99.0%	95.0%	98.0%	98.0%	98.0%	98.0%	96.0%	99.0%	96.0%	96.0%	91.0%	95.6%
		3.20	F1 - Extremely likely or likely to recommend (FFT)	100%	100%	100%	94.0%	97.0%	100%	100%	100%	92.0%	100%	96.0%	95.0%	94.0%	95.4%
		3.21	F1 Children - Overall experience result	ND	ND	ND	ND	ND	ND	ND	ND	85.0%	97.0%	96.0%	99.0%	98.0%	95.0%
		3.22	Rosemary ward - extremely likely or likely to recommend (FFT)	ND	ND	100%	100%	100%	78.0%	85.0%	100%	79.0%	100%	88.0%	76.0%	100%	88.6%
		3.23	King suite - extremely likely or likely to recommend	ND	ND	100%	100%	94.0%	93.0%	100%	100%	ND	100%	100%	75.0%	100%	93.8%
		3.24	Community paediatrics - extremely likely or likely to recommend (FFT)	ND	ND	96.0%	100%	97.0%	100%	97.0%	95.0%	94.0%	95.0%	100%	100%	100%	97.8%
		3.25	Community health teams - extremely likely or likely to recommend (FFT)	ND	ND	100%	100%	100%	90.0%	100%	90.0%	100%	100%	100%	66.0%	89.0%	91.0%
		3.26	Community specialist nursing teams - extremely likely or likely to recommend (FFT)	ND	ND	100%	100%	95.0%	100%	93.0%	100%	92.0%	98.0%	100%	77.0%	90.0%	91.4%
		3.27	Stroke Care - Overall Experience Result	ND	99.0%	100%	85.0%	ND	98.0%	95.0%	100%	100%	100%	100%	100%	100%	100%
		3.28	Stroke Care - extremely likely or likely to recommend	100%	95.4%	100%	100%	ND	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Complaint Handling	3.29	Complaints acknowledged within 3 working days	93.0%	94.0%	100%	100%	87.0%	92.0%	100%	100%	92.0%	100%	100%	100%	88.0%	96.0%
		3.30	Complaints responded to within agreed timeframe	85.0%	67.0%	81.0%	82.0%	50.0%	60.0%	17.0%	54.0%	31.0%	70.0%	50.0%	40.0%	83.0%	54.8%
		3.31	Number of second letters received	1	1	2	0	1	0	0	1	2	2	6	2	1	13
		3.32	Ombudsman referrals accepted for investigation	0	0	0	0	1	1	1	0	0	0	0	0	0	0
		3.33	No. of complaints to Ombudsman upheld	ND	ND	ND	0	0	0	0	0	0	0	0	0	0	0
		3.34	No. of PALS contacts	137	167	190	167	124	161	178	205	183	231	214	275	233	1136
		3.35	No. of PALS contacts becoming formal complaints	4	2	3	4	1	3	6	1	4	4	4	4	2	18

Are we.		Ref.	KPI	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	YTD(Apr 18-Mar19)
	Complaint Handling	3.29	Complaints acknowledged within 3 working days	93.0%	94.0%	100%	100%	87.0%	92.0%	100%	100%	92.0%	100%	100%	100%	88.0%	96.0%
		3.30	Complaints responded to within agreed timeframe	85.0%	67.0%	81.0%	82.0%	50.0%	60.0%	17.0%	54.0%	31.0%	70.0%	50.0%	40.0%	83.0%	54.8%
		3.31	Number of second letters received	1	1	2	0	1	0	0	1	2	2	6	2	1	13
		3.32	Ombudsman referrals accepted for investigation	0	0	0	0	1	1	1	0	0	0	0	0	0	0
		3.33	No. of complaints to Ombudsman upheld	ND	ND	ND	0	0	0	0	0	0	0	0	0	0	0
		3.34	No. of PALS contacts	137	167	190	167	124	161	178	205	183	231	214	275	233	1136
		3.35	No. of PALS contacts becoming formal complaints	4	2	3	4	1	3	6	1	4	4	4	4	2	18

EXCEPTION REPORTS –CARING

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Rosemary ward - extremely likely or likely to recommend (FFT)
Standard	90%
Name	Cassia Nice
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Caring

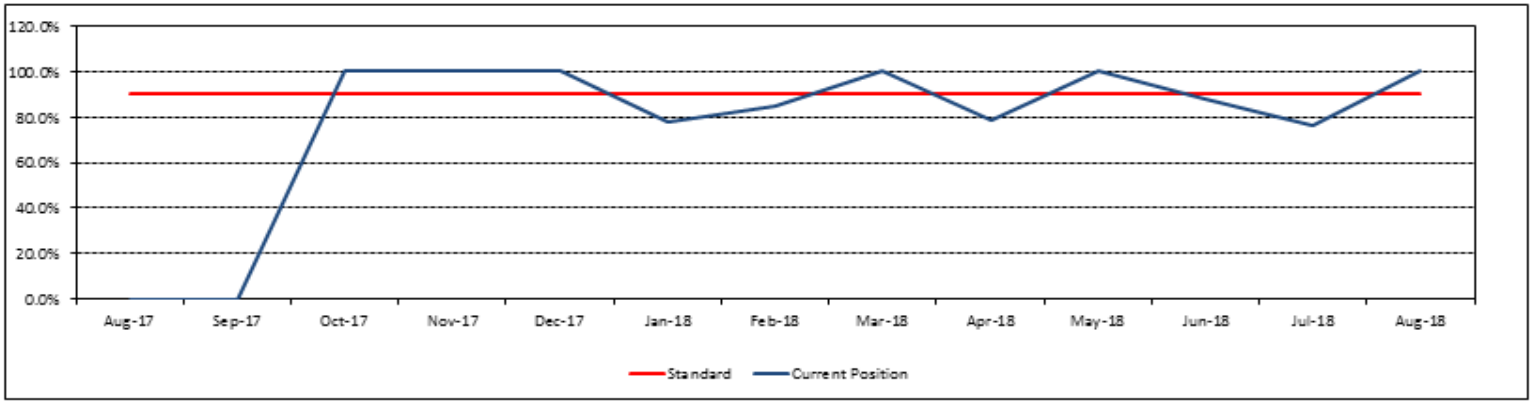
Summary of Current performance & Reasons for under performance

In July one respondent stated that they would be unlikely to recommend to F&F, this was a patient who was an amputee whose family felt that the therapy provided was not sufficient or specific enough to meet the patient needs. Several meetings took place during the patient's admission to maintain relationships and confidence. Due to a low number of responses this one negative result has impacted greatly on the result in July.

Staff have been reminded to give as many patients as possible the opportunity to complete a satisfaction survey. The improvement can be seen in August.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Current Position	ND	ND	100%	100%	100%	78.0%	85.0%	100%	79.0%	100%	88.0%	76.0%	100%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	King suite - extremely likely or likely to recommend
Standard	90%
Name	Cassia Nice
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Caring

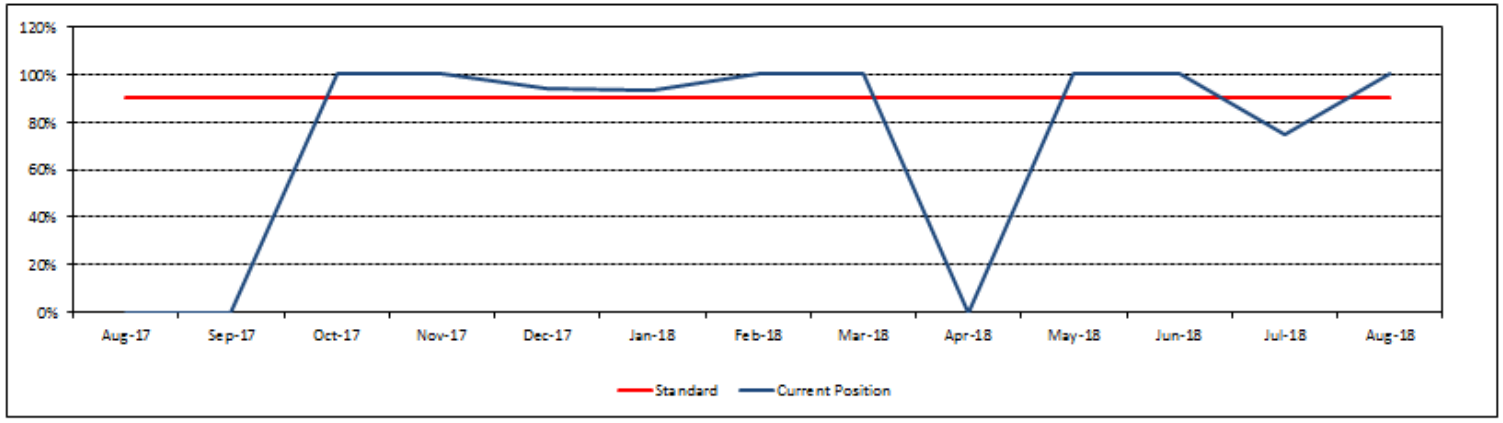
Summary of Current performance & Reasons for under performance

Two patients said they were unlikely to recommend King Suite in July. Feedback included comments around the food and one comment that staff were a little strict. Head of Nursing has met with the Home Manager to discuss the food served to patients. King Suite is a re-enablement unit, with a proactive approach, staff are always mindful of patient preference should they decline to participate in activities of daily living.

The unit also conducted an additional 9 surveys in August which ensures the results are more accurate of the overall patient experience. The unit will continue to collect an appropriate number of surveys from patients.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	ND	ND	100%	100%	94.0%	93.0%	100%	100%	ND	100%	100%	75.0%	100%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Community specialist nursing teams - extremely likely or likely to recommend (FFT)
Standard	90%
Name	Cassia Nice
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Caring

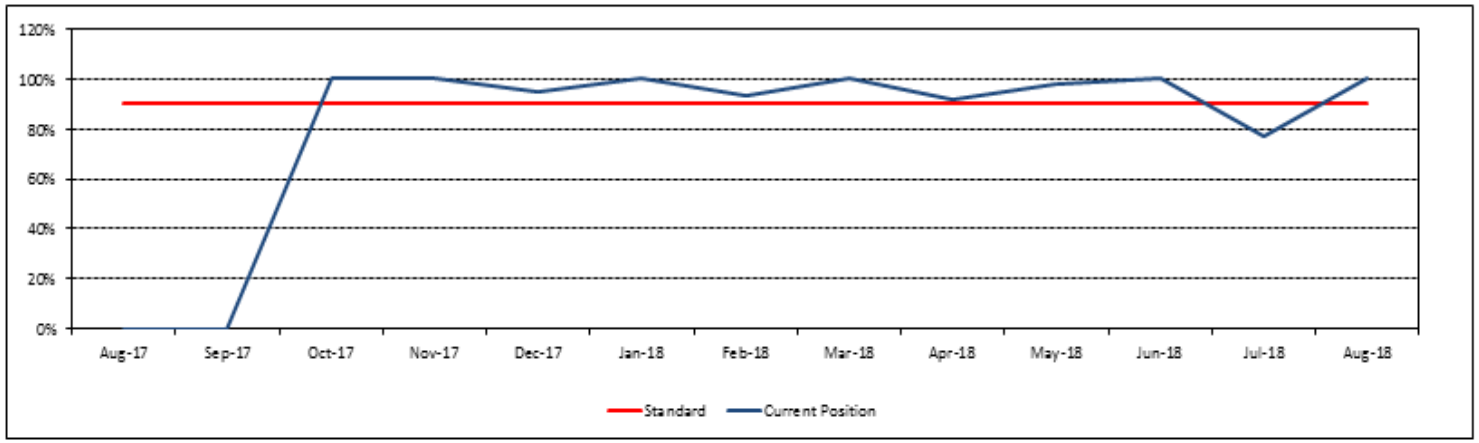
Summary of Current performance & Reasons for under performance

Low response rate has impacted the score. Reminded to increase survey distribution. Low response rate has impacted the score. Reminded to increase survey distribution.

Nursing teams are handing the surveys out to most patients but low returns could continue to be an issue due to many patients having mobility issues and some housebound. Community surveys are currently given with a freepost envelope therefore returns are inconsistent. Working with community services to explore alternative ways of collecting surveys whilst maintaining confidentiality and anonymity.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	ND	ND	100%	100%	95.0%	100%	93.0%	100%	92.0%	98.0%	100%	77.0%	100%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Community health teams - extremely likely or likely to recommend (FFT)
Standard	90%
Name	Cassia Nice
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Caring

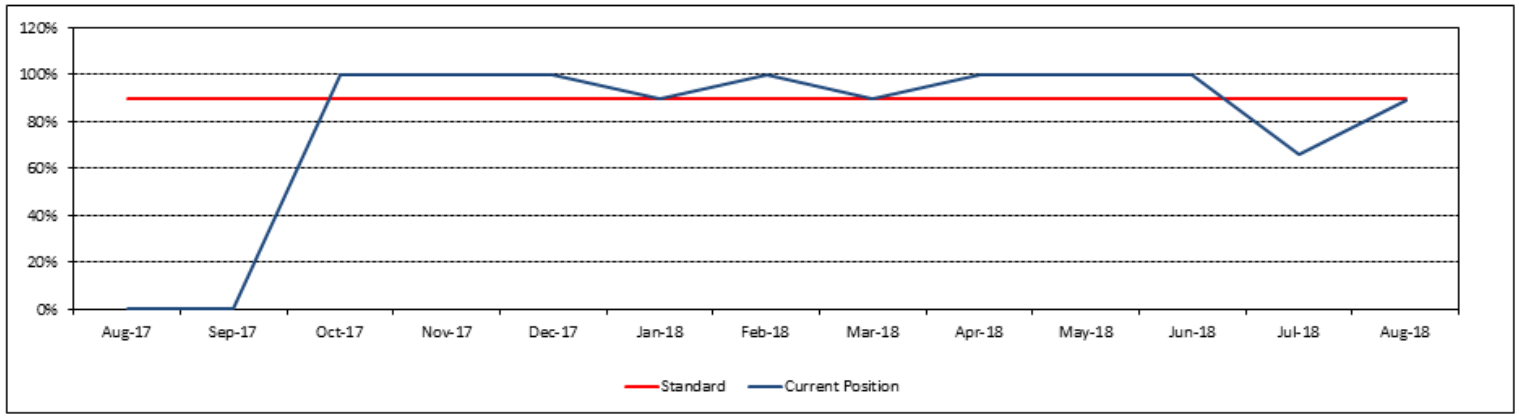
Summary of Current performance & Reasons for under performance

This was again due to poor response returns. The teams have been reminded again to ensure surveys are given to all patients and this has been escalated to the head of nursing for community and local area managers.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	ND	ND	100%	100%	100%	90.0%	100%	90.0%	100%	100%	100%	66.0%	89.0%

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

Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

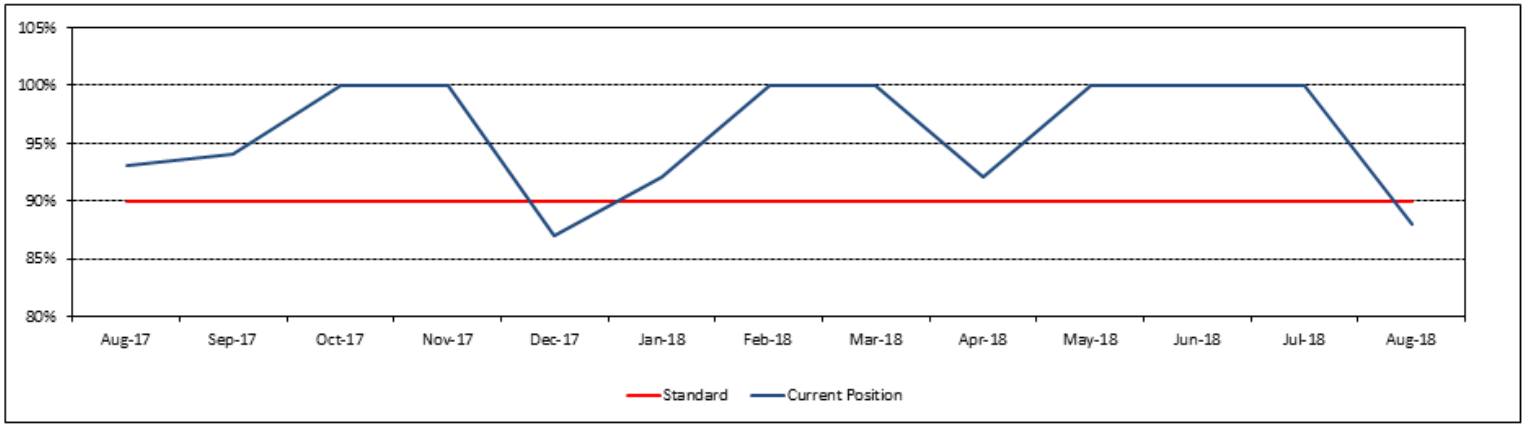
Indicator	Complaints acknowledged within 3 working days
Standard	90%
Name	Cassia Nice
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Only one acknowledgement late due to a delay in clinical team passing complaint over to the patient experience team for logging. Not a usual occurrence

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	93.0%	94.0%	100%	100%	87.0%	92.0%	100%	100%	92.0%	100%	100%	100%	88.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

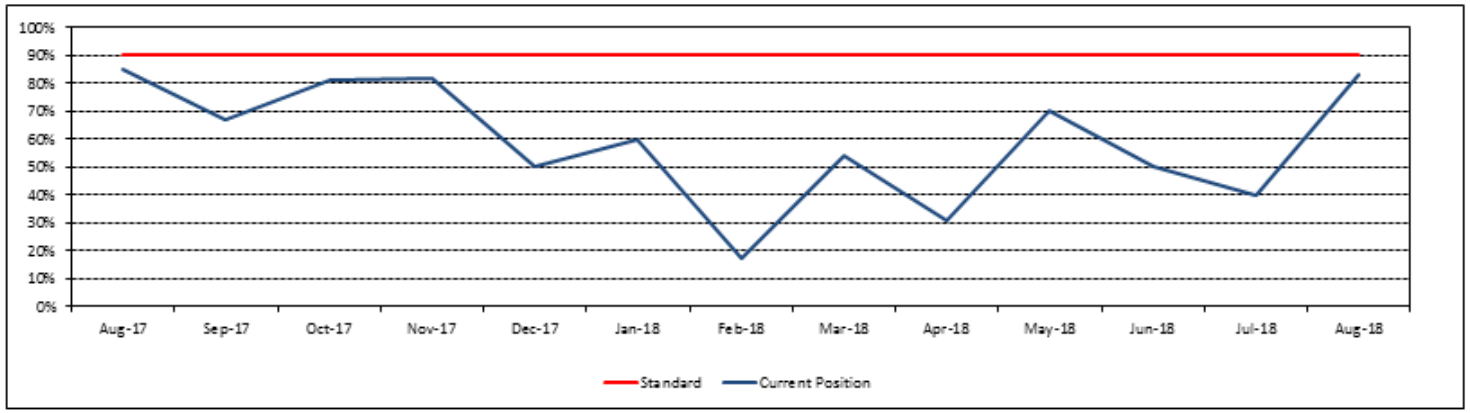
Indicator	Complaints responded to within agreed timeframe
Standard	90%
Name	Cassia Nice
Month	01-Jul-18
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

13 out of 15 complaints were responded to within their timescale. This is an improvement in comparison to previous months and, due to a new way of working, it is hoped that this will continue to improve and consistently meet the target going forward. This is being closely monitored by the patient experience lead and chief nurse with input from a non-executive director.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	85%	67.0%	81.0%	82.0%	50.0%	60.0%	17.0%	54.0%	31.0%	70.0%	50.0%	40.0%	83.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Number of second letters received
Standard	1
Name	Cassia Nice
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Caring

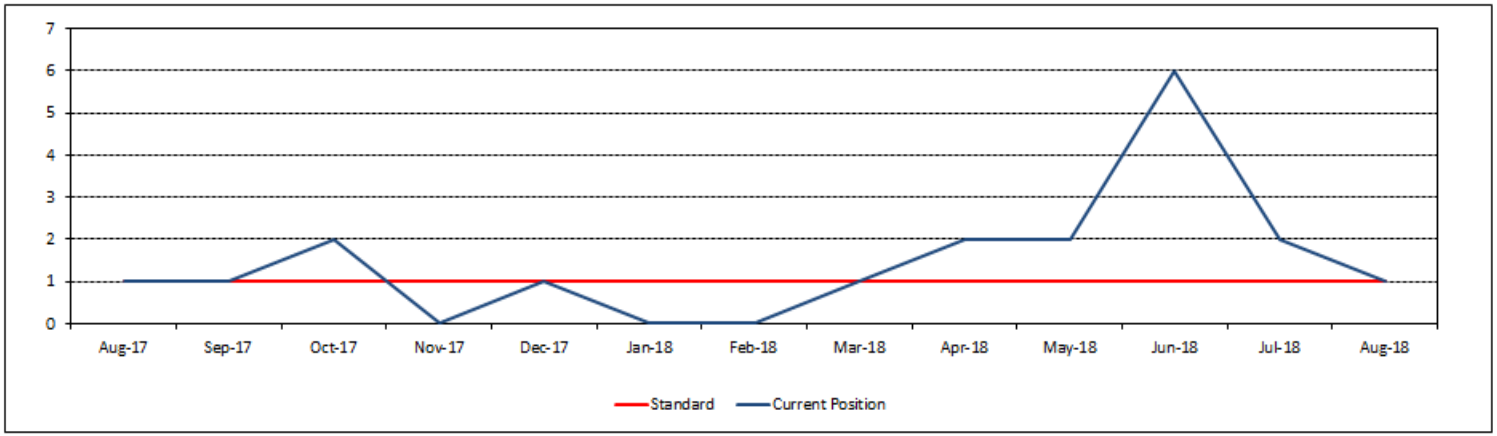
Summary of Current performance & Reasons for under performance

The number of second letters received reduced to one in August, an improvement from June (6) and July (2). This indicator is now RAG rated Green.

The Patient Experience Lead has trained the team in complaint response writing to ensure investigations are robust and responses of a high standard. Following this change to the way of working there has been a significant improvement in complaints responded to within agreed timeframe (83% in August compared with 40% in July). This will continue to be closely monitored.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	1	1	1	1	1	1	1	1	1	1	1	1	1
Current Position	1	1	2	0	1	0	0	1	2	2	6	2	1

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



8. DETAILED REPORTS - RESPONSIVE

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

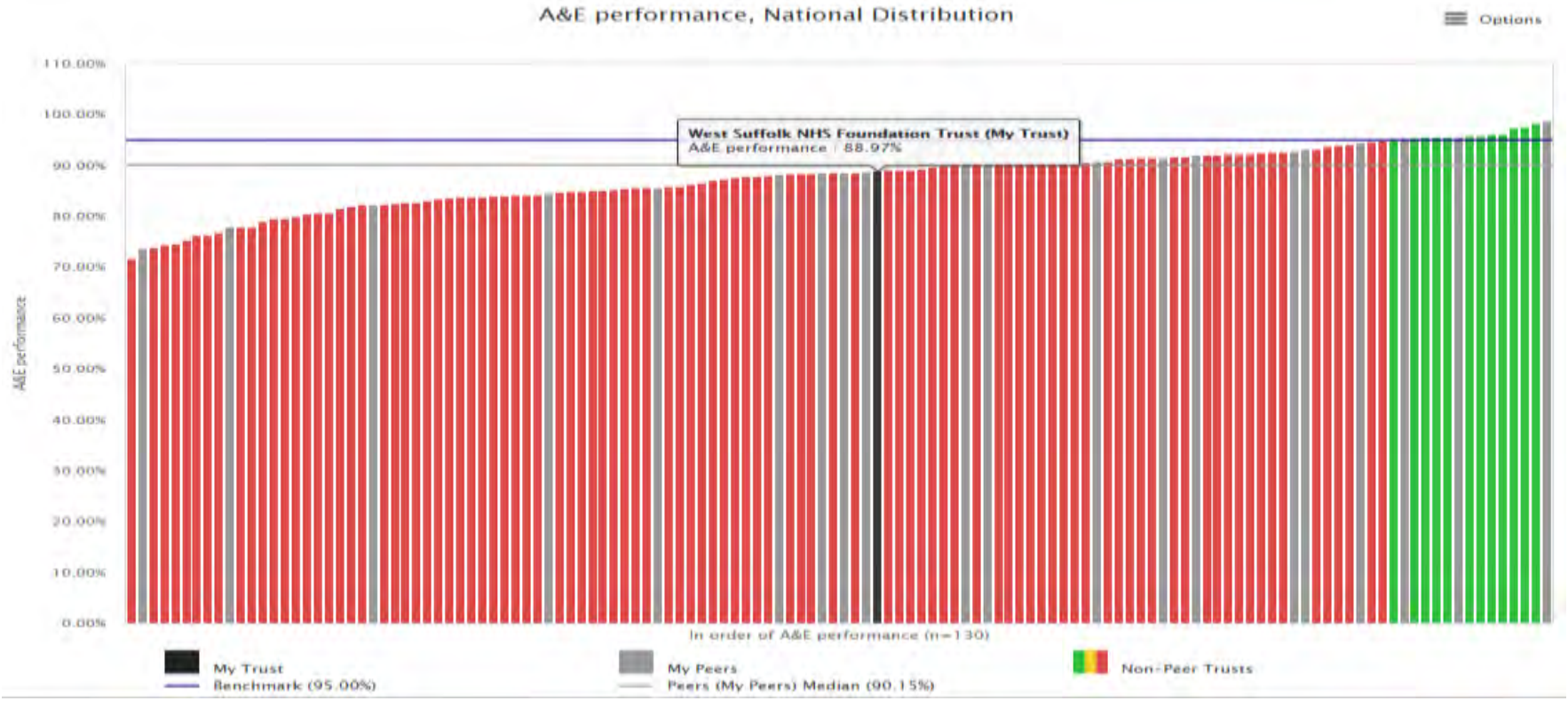
Are we..		Ref.	KPI	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	YTD(Apr18-Mar19)
4. Responsive	Dashboard	4.01	A&E under 4 hr. wait	95%	90.1%	88.9%	87.4%	90.4%	83.3%	83.8%	85.2%	85.4%	84.9%	93.7%	93.9%	89.0%	87.6%	89.8%
		4.02	RTT: % incomplete pathways within 18 weeks	92%	85.9%	85.7%	87.0%	88.9%	89.0%	90.2%	89.6%	89.5%	90.4%	92.2%	91.4%	91.4%	89.3%	90.9%
		4.03	52 week waiters	0	26	29	26	21	15	14	13	24	19	14	10	9	10	62
		4.04	Diagnostics within 6 weeks	99%	100%	100%	100%	100%	100%	100%	99.8%	99.3%	99.7%	99.6%	99.8%	99.9%	97.6%	99.3%
		4.05	Cancer: 2w wait for urgent GP Referrals	93%	96.0%	91.4%	83.4%	97.9%	97.2%	98.0%	97.5%	94.7%	95.9%	94.9%	91.6%	97.6%	89.5%	93.9%
		4.06	Cancer 2w wait breast symptoms	93%	100%	98.3%	100%	100%	99.1%	97.1%	92.9%	86.7%	96.7%	82.6%	84.9%	92.7%	95.9%	90.6%
		4.07	Cancer 31 d First Treatment	96%	100%	100%	100%	99.3%	100%	100%	100%	100%	99.1%	100%	100%	100%	100%	99.8%
		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%	85.8%	86.9%	93.9%	89.5%	87.1%	86.6%	79.8%	87.8%	93.3%	85.1%	86.5%	84.8%	88.4%	87.6%
		4.11	Cancer 62 d Screening	90%	100%	90.9%	100%	83.3%	100%	93.3%	85.7%	95.5%	72.7%	100%	100%	88.9%	100%	92.3%
		4.12	Incomplete 104 day waits		ND	ND	ND	ND	ND	ND	ND	ND	3.0	1.5	0	1.0	3.0	1.7
	A&E	4.13	Number of Delayed Transfer of Care - (DTOCs)	NT	565	337	250	279	314	326	393	321	208	206	203	130	242	198
		4.14	A&E time to treatment in department (median) for patients arriving by ambulance - CDM	NT	50	62	59	41	62	57	75	64	70	47	46	41	40	49
		4.15	A&E - Single longest Wait (Admitted & Non-Admitted)	6 hrs.	11.46	12.01	15.44	22.04	16.48	18.11	17.18	19.50	18.14	10.30	12.22	14.49	15.54	14.14
		4.16	A&E -Waits over 12 hours from DTA to Admission	12 Hrs.	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		4.17	A&E - Admission waiting 4-12 hours from dec. to admit		5	14	10	17	50	122	30	46	17	4	8	31	31	91
		4.18	A&E - To inpatient Admission Ratio	27%	29.2%	30.5%	30.4%	30.0%	32.8%	31.9%	32.1%	29.6%	27.9%	25.8%	25.0%	23.9%	25.7%	25.6%
		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%	89.9%	90.3%	87.7%	88.2%	89.4%	85.7%	89.6%	93.5%	92.7%	94.4%	92.8%	91.3%	90.1%	92.3%
		4.21	A&E - Amb. Handover above 30m	30m	19	15	40	84	110	72	87	74	88	84	13	21	ND	206
		4.22	A&E - Amb. Handover above 60m	60m	16	30	21	46	54	38	30	17	29	3	5	31	ND	68

NHS
West Suffolk
NHS Foundation Trust

Are we..		Ref.	KPI	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	YTD(Apr18-Mar19)
4. Responsive	RTT	4.23	RTT - 18w Admitted (Completed)	90%	69.7%	73.8%	72.0%	70.9%	69.9%	72.6%	73.5%	74.1%	73.4%	71.1%	76.9%	74.7%	74.0%	74.0%
		4.24	RTT - 18w Non-admitted (Completed)	95%	85.8%	87.3%	84.9%	85.8%	90.6%	88.7%	93.9%	93.4%	92.8%	94.5%	93.3%	93.9%	91.0%	93.1%
		4.25	RTT waiting List		17346	17236	16694	16641	16195	15363	15804	15396	16223	16481	16739	16715	16601	16552
		4.26	RTT waiting list over 18 weeks		2441	2467	2171	1843	1775	1504	1650	1614	1560	1294	1443	1433	1775	1501
		4.27	RTT 18 weeks Non-Consultant led services - Community	90%	94.7%	99.4%	93.7%	94.4%	98.4%	98.7%	100%	99.4%	99.2%	97.6%	100%	98.7%	99.0%	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%	79.2%	78.1%	75.7%	74.4%	75.6%	86.7%	76.7%	70.0%	73.7%	63.6%	77.7%	76.3%	84.4%	75.2%
		4.30	Stroke - % patients scanned within 12 hrs.	96%	95.8%	90.2%	97.3%	92.3%	95.6%	98.3%	100%	97.5%	94.7%	97.7%	100%	89.5%	100%	96.4%
		4.31	Stroke - % Patients admitted directly to stroke unit within 4h	75%	78.7%	82.5%	72.2%	72.5%	60.0%	75.4%	79.3%	72.5%	57.9%	73.2%	84.1%	75.0%	79.6%	73.9%
		4.32	Stroke - % greater than 80% of treatment on stroke unit	90%	97.9%	92.5%	88.9%	92.5%	91.1%	93.0%	96.6%	87.5%	81.6%	82.9%	100%	88.9%	88.6%	88.4%
		4.33	Stroke - % of patients treated by the SESDC	48%	33.3%	51.4%	50.0%	30.8%	32.4%	61.5%	50.0%	51.4%	54.8%	48.7%	58.5%	50.0%	53.9%	53.2%
		4.34	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start	80%	87.5%	85.4%	83.3%	82.1%	88.9%	93.3%	83.3%	95.0%	79.0%	81.8%	97.8%	92.1%	97.8%	89.7%
		4.35	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72h	75%	89.6%	92.1%	77.1%	76.3%	77.5%	93.0%	86.2%	86.8%	94.6%	92.5%	88.6%	89.2%	79.6%	88.9%
		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	58.0%	ND	ND	ND	61.0%	ND	ND	ND	57.0%	ND	ND	ND	57.0%
		4.38	Stroke -Provider rating to remain within A-C	C	ND	ND	ND	ND	ND	C	ND	C	C	ND	ND	ND	ND	C
	Other	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community		ND	ND	ND	ND	ND	ND	ND	ND	100%	100%	100%	100%	100%	100%
		4.40	Nursing & therapy Red referrals seen within 4hrs - Community		NA	100%	NA	NA	100%	100%	96.4%	100%	96.4%	100%	100%	98.2%	100%	98.9%
		4.41	Nursing & therapy Amber referrals seen within 72hrs - Community		95.6%	98.6%	90.9%	96.9%	100%	99.3%	98.0%	97.6%	98.8%	99.4%	99.5%	97.4%	99.4%	98.9%
		4.42	Nursing & therapy Green referrals seen within 18 wks -Community		98.2%	98.6%	99.3%	97.8%	98.0%	99.8%	99.9%	99.9%	99.3%	99.9%	100%	100%	100%	99.9%
		4.43	Wheelchair waiting times – Child (Community)		50.0%	47.4%	43.8%	75.0%	72.7%	55.6%	61.9%	42.2%	90.9%	100%	95.2%	90.9%	100%	95.4%
		4.44	Wheelchair waiting times - Adult (Community)		85.9%	70.3%	69.8%	83.5%	70.5%	71.4%	73.6%	72.5%	75.6%	78.3%	80.0%	54.9%	100%	77.7%
		4.45	Sepsis - 1 hr neutropenic sepsis	100%	82.6%	62.5%	79.0%	73.9%	53.9%	80.0%	75.0%	58.3%	63.6%	80.0%	57.9%	80.0%	72.2%	70.8%

EXCEPTION REPORTS – RESPONSIVE

A&E performance has decreased from 88.97% in July to 87.57% in August, with Q1 overall performance at 90.97%. The chart shows performance of West Suffolk against the peers and national median as at August 2018 (*Source: Model Hospital – September 2018)*



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

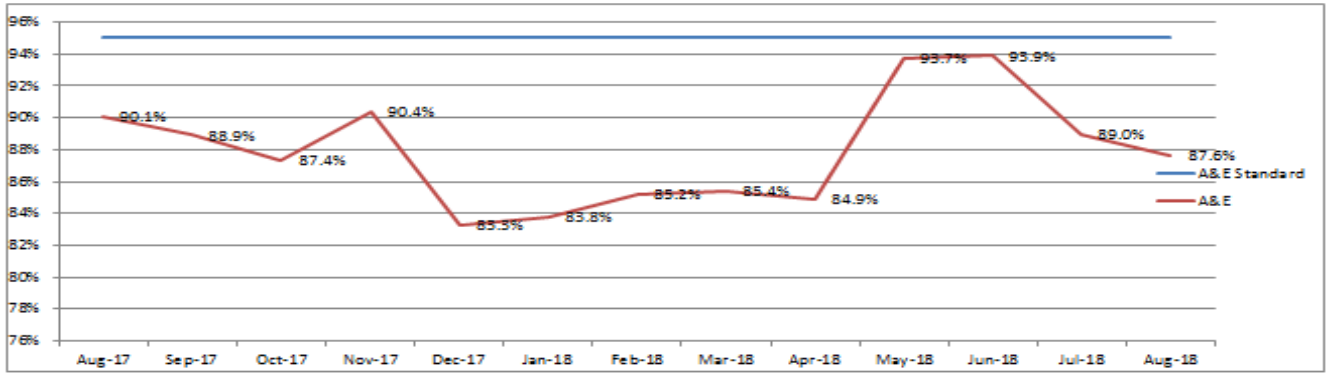
Summary of Current performance & Reasons for under performance

Demand continues to be much higher that last year despite GP GP expected patients going to AMU directly. 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 continue to be the key driver of this. Bed availability is also a factor, due in part to the increase in demand and subsequent admissions.

Indicator	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
A&E Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
A&E	90.1%	88.9%	87.4%	90.4%	83.3%	83.8%	85.2%	85.4%	84.9%	93.7%	93.9%	89.0%	87.6%

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

Description	Owner	Start	End
A range of improvement actions are incorporated in the ED recovery action plan, including those below: Medical staffing has been reviewed. Actions being implemented include recruiting additional consultants (interviews taken place), trainee ACPs started 1st August, changes to the junior doctor rota to increase night doctor cover from one to two (started in August) and starting the Middle grade and junior doctor early shifts one hour earlier to improve handover and doctor cover (again started in August). The triage process review has been completed. This consisted of senior clinical audit and concluded that there was an opportunity to improve workflow within E-care. Currently the mandatory ECDS data collection is undertaken within triage, impacting on waits for triage. The department are redesigning the workflow to achieve improvement. In addition, observations are now being taken as soon as a patient arrives in the department. This alleviates pressure on triage and also facilitates identification of sick patients. The Trust have worked with ECIST to undertake a demand and capacity analysis resulting in a series of actions including ECIST-facilitated group consultant job planning in September. Senior leadership support to ED has been strengthened, including senior manager presence in the department at weekends to understand the issues and support resolution of these.	DG	Jul-17	TBC



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	RTT: % incomplete pathways within 18 weeks
Standard	92%
Name	Helen Beck
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Responsive

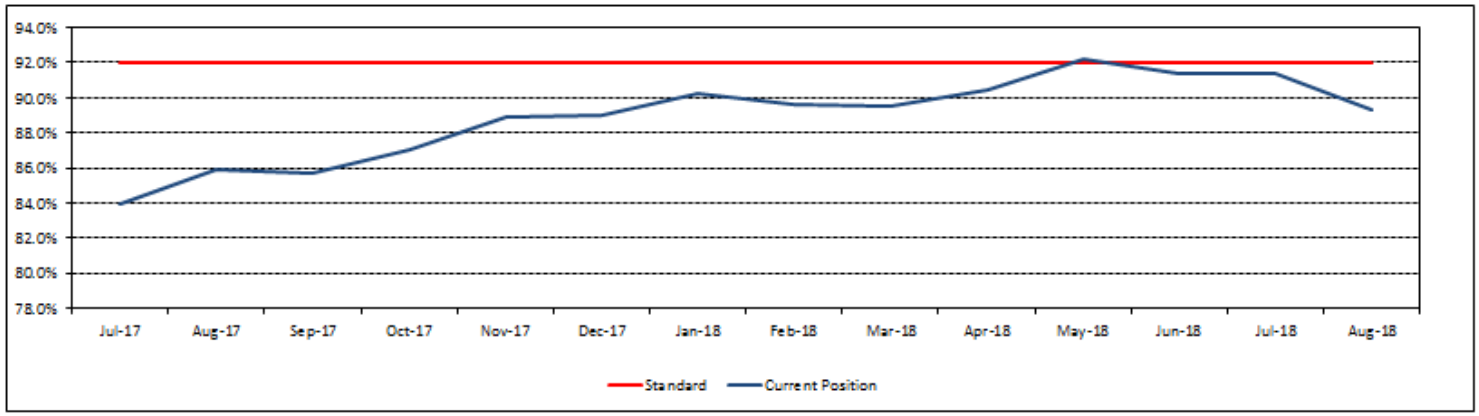
Summary of Current performance & Reasons for under performance

August has seen a dip in performance from 91.4% to 89.3%. Whilst the overall pot size has stayed fairly static, the number of patients waiting over 18 weeks has risen from 1433 in July to 1799 in August. Ophthalmology has seen a particular increase in patients waiting over 18 weeks over the past 2 months, this is mostly due to patients waiting over 18 weeks for cataract surgery. There has also been increases in General Surgery, which is mostly attributed to Vascular surgery patients. Gynaecology and Gastroenterology. The increase in Gynaecology is spilt across Uro-Gynae and General Gynaecology and is attributed to staffing constraints. Gastroenterology has had staff shortages which have impacted performance.

Month	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Current Position	83.9%	85.9%	85.7%	87.0%	88.9%	89.0%	90.2%	89.6%	89.5%	90.4%	92.2%	91.4%	91.4%	89.3%

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

Description	Owner	Start	End
Targeted work is being undertaken to reduce the back log in challenged specialities. An options paper for cataract patients has been developed and is awaiting a decision. Gastroenterology have now recruited a locum and have plans for a new permanent consultant. A focus on Vascular surgery remains, with a full service review pending following most recent audit results. Gynaecology have recruited a consultant who will be mostly focused on rapid access. Allocated PA's and rotas are being reviewed in Gynaecology to provide capacity where it is most needed. A full service review is also pending.	HB	Jul-17	TBC



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

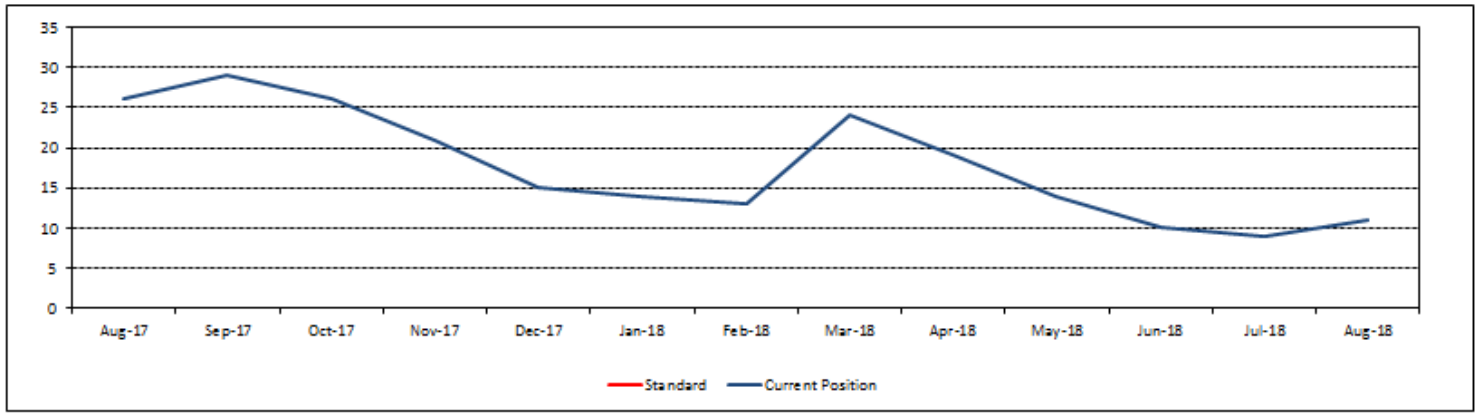
Indicator	52 week waiters
Standard	0
Name	Helen Beck
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

There are 11 patients waiting over 52 weeks in August. 3 in Colorectal, 1 Gastroenterology, 1 Gynaecology, 2 Urology and 4 Vascular. 2 of the Vascular patients have already been completed and 8 have dates to come in for surgery in September. The remaining 1 colorectal patient did have a TCI date which had to be cancelled due to medical issues, the patient is returning to clinic imminently to discuss surgical options. 5 of the 11 patients, had been incorrectly coded on their pathway and were discovered within the month and pathways amended, causing them to breach 52 weeks, however these were escalated and have been given priority to be treated.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	26	29	26	21	15	14	13	24	19	14	10	9	11

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Long waiting patients are monitored on a weekly basis by the senior team to ensure proactive management. A clinical harm review process is in place to provide assurance that long waiting patients are not being exposed to harm. A trust wide RTT training strategy is currently being developed to reduce the risk of pathways being incorrectly coded.	HB	Jul-17	TBC



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

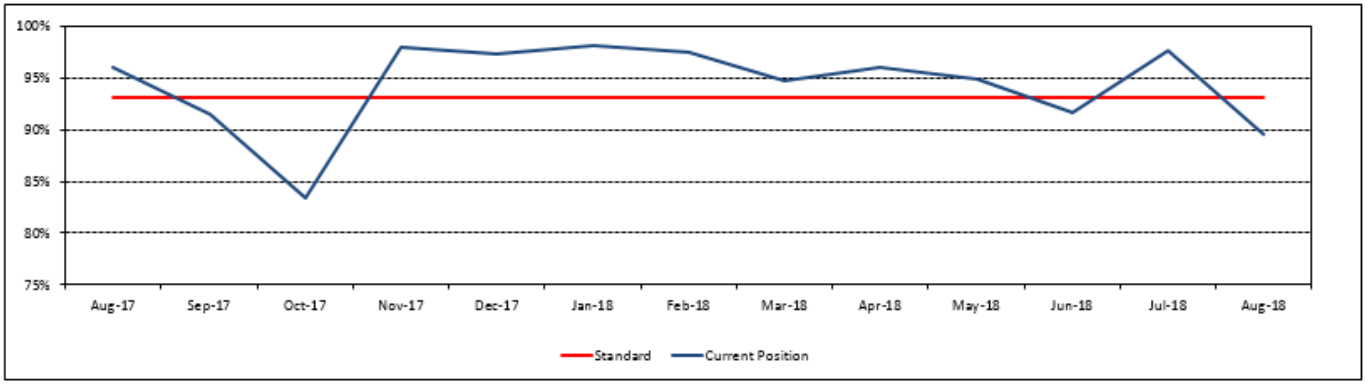
Indicator	Cancer: 2w wait for urgent GP Referrals
Standard	93%
Name	Sam Dhungana
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current performance:89.5% This underperformance is largely owing to limited capacity in dermatology service to see patients within 14 days, resulting into only 49.6% site specific performance . The dermatology service: The current locum has needed to take a period of leave for 3 months from mid-August and is planned to return on the 26th October. This has results in a reduction of capacity. The Trust has been out for a locum since May unfortunately there are no appropriate candidates available. There is also planned sick leave for one of the consultants, this was planned over 6 months ago. The consultants and the surgical nurse are doing additional clinics and we have managed to reduce the wait for 2WW patients down to 3 weeks. Many patients are reluctant to have their OPA's brought forward when offered a new date. These events have coincided with an increase in the numbers of RA referrals which have added to the demand pressures experienced by the service. As, many dermatology 2 WW referrals received in July, August have been booked past the 14 days as to breach in September and October. All other specialities except Upper GI -91%, did performed well in August.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	96.0%	91.4%	83.4%	97.9%	97.2%	98.0%	97.5%	94.7%	95.9%	94.9%	91.6%	97.6%	89.5%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
This is an unfortunate position and the dermatology service is working hard to find a suitable locum and also reorganising outpatient clinics utilising the support from other professionals - Surgical Nurse Practitioner, Plastic Surgeon available to help run clinics to offer patients earlier than originally booked out patient dates in September and October. So far patient up take of this offer has been limited. The Dermatology service have been working with the CCG on a referrals guidance and telederm for the last 18 months. The referrals guidelines were formal agreed by the Trust last week and the launch of these and a relaunch of telederm is planned for October which the CCG are leading on.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

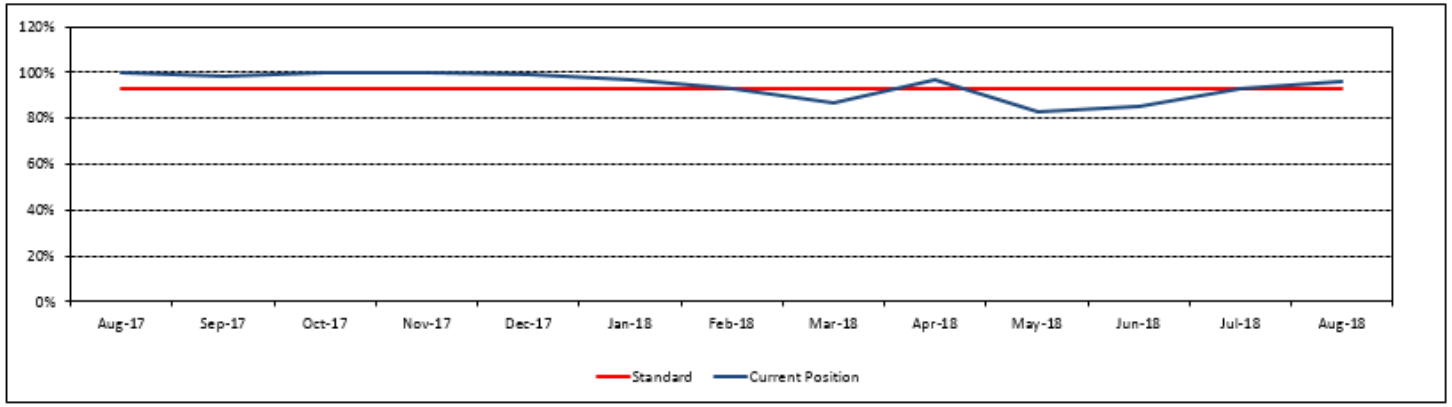
Indicator	Cancer 2w wait breast symptoms
Standard	93%
Name	Sam Dhungana
Month	01-Jul-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current performance: 95.9% It is recovered position since last report. All four breaches were due to patient choice/cancellation reasons.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	100.0%	98.3%	100.0%	100%	99.1%	97.1%	92.9%	86.7%	96.7%	82.6%	84.9%	92.7%	95.9%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
The performance this month shows good recovery since last report. However, due to extraordinary screening recall patients requiring to undergo screening assessment, the Breast unit are required to prioritise these patients and there will be no further capacity to run extra clinics to see 2 WW patients should there be any sudden increase in the numbers of incoming 2 WW Breast symptomatic referrals.			



62

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

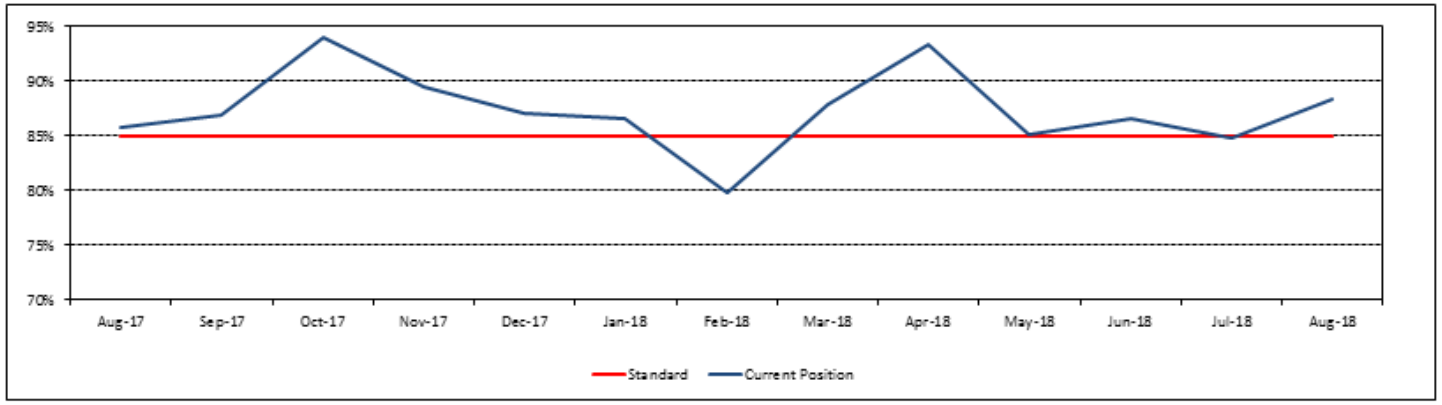
Indicator	Cancer 62 d GP Referral
Standard	85%
Name	Sam Dhungana
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current Performance: 88.4% This is a recovered position well above the operational standard. This was in spite of number of breaches spread across the specialities- Colorectal, Lung and Skin one each and 3 Urology locally in the Trust and 2 H/N and one skin patient in the shared pathway.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Current Position	85.8%	86.9%	93.9%	89.5%	87.1%	86.6%	79.8%	87.8%	93.3%	85.1%	86.5%	84.8%	88.4%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
August position is a recovered position from previous month. All 62 days breach RCAs been sent over to the relevant clinician in the MDT and the services for review and for learning opportunities to prevent future recurrences.			



63

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

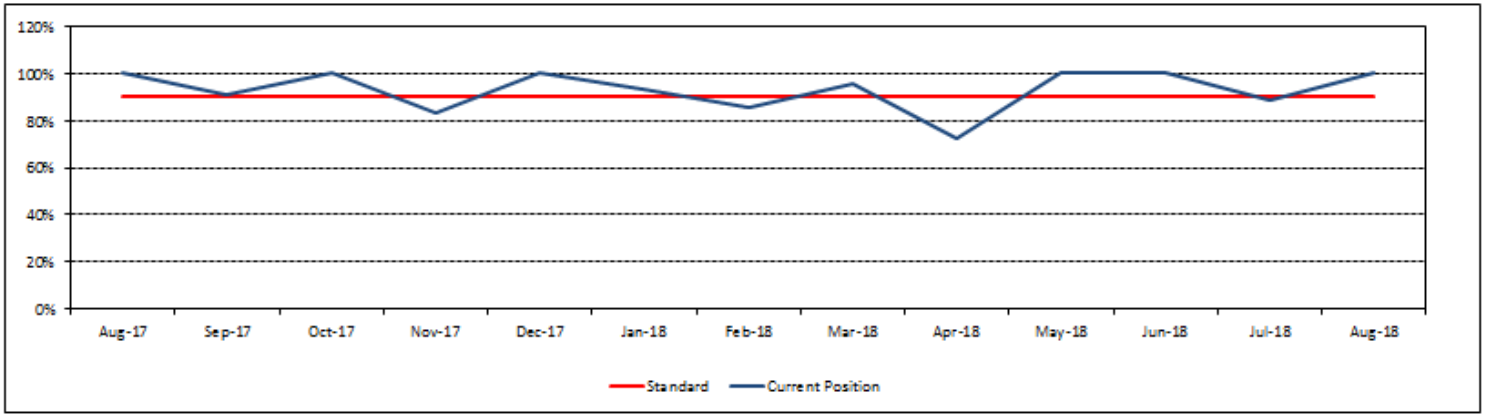
Indicator	Cancer 62 d Screening
Standard	90%
Name	Sam Dhungana
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current Performance 100% This is fully recovered position with no breaches to report in August. All 12 patients treated this month were Breast cancer screening referrals.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	100%	90.9%	100%	83.3%	100%	93.3%	85.7%	95.5%	72.7%	100%	100%	88.8%	100%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Performance recovered from the last month. Owing to small cohorts of patient in this standard, any delay in the pathway risks underperformance particularly if the patient was on a shared pathway - such as Bowel cancer. Cancer services keeps both the Breast and Colorectal teams well informed of the breach date as soon as a screening referral is received and escalates potential delay issues with the diagnostics and other services with a view to get their support in offering these patients an earlier appointment/TCI date where possible.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

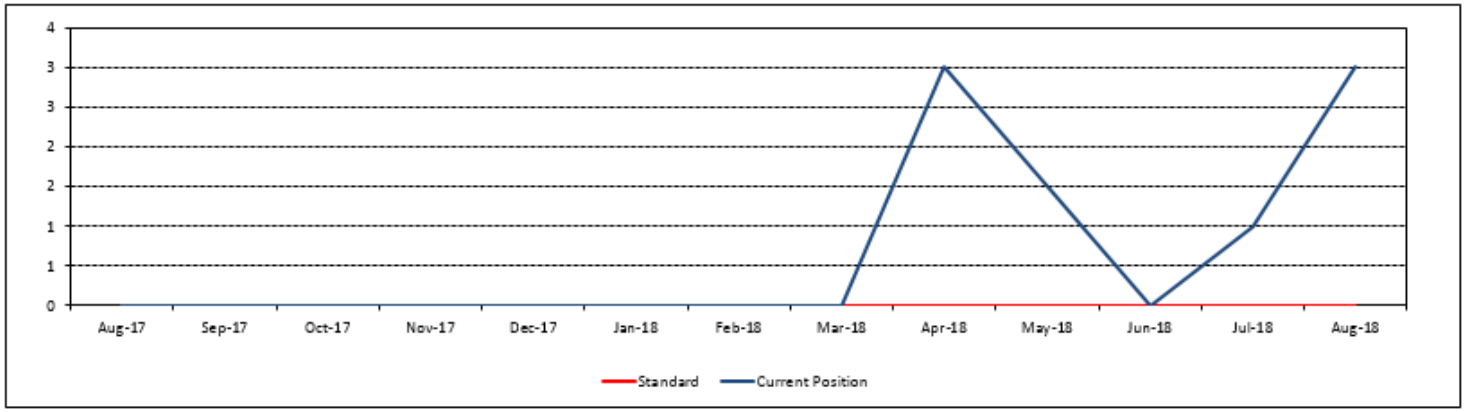
Indicator	Incomplete 104 day waits
Standard	0
Name	Sam Dhungana
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

There was combination of diagnostic and patient exercising their choice reasons contributing to long wait and the delay in treatment. Skin patient - 124 days had low suspicion on original diagnostic that required second opinion as well and patient wanted full excision to happen only after their return from the holidays. Lesion fully excised. RCA review outcome is awaited.
Urology- 112 day patient suffered from an urgent medical condition requiring admitted care treatment at another hospital. They did not wanted treatment to commence until they return from their holidays. The medical comorbidity also changed the treatment options available. They are however treated with intent to cure. RCA review outcome is awaited.
Urology -142 day Delay in getting tissue diagnosis and patient preferred to explore surgical treatment at the centre but repatriated back to west Suffolk to start on hormones as the patient agreed to have Radiotherapy.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	ND	ND	ND	ND	ND	ND	ND	ND	3.0	1.5	0	1.0	3.0

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Cancer Pathway Coordinator highlight the breach date on all RA patients from the first seen event and continue to escalate potential delays to relevant teams and services involved in the care of patients. Recently weekly Cancer PTL with pathway tracking comment is also distributed to all divisions to help them service /operational managers review the pathways and offer help to expedite. This is in addition to routine escalation of delays in the pathways to reduce patient waits and avoid potential breach. Clinicians are requested to undertake case review of long waiting patients. Some of the pathways are complex and the wait is medically required. All breach RCAs are sent across to involved clinician and the services to see learning opportunities and also to confirm whether the delay resulted in any harm to patient. They are required to follow the Datix incident reporting system if long wait resulted in causing harm to the patient.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

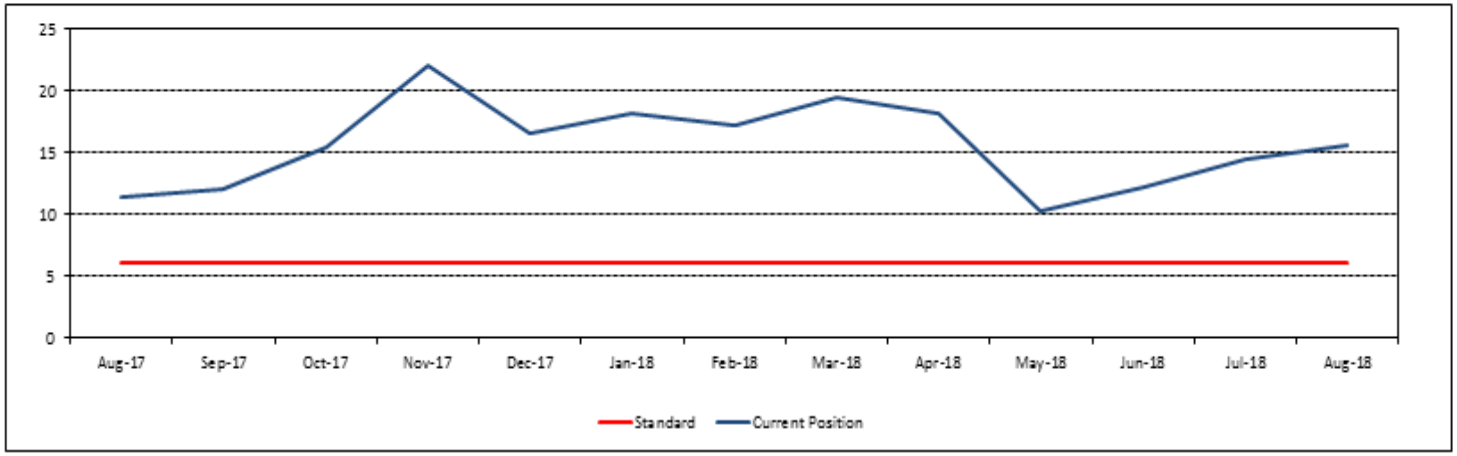
Indicator	A&E - Single longest Wait (Admitted & Non-Admitted)
Standard	6 Hours
Name	Darin Geary
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

This patient remained in ED due to clinical reasons.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	6	6	6	6	6	6	6	6	6	6	6	6	6
Current Position	11.46	12.01	15.44	22.04	16.48	18.11	17.18	19.50	18.14	10.30	12.22	14.49	15.54

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To review this exception reporting with ADO for Medicine as a majority of delays are clinically focused with some operational issues.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

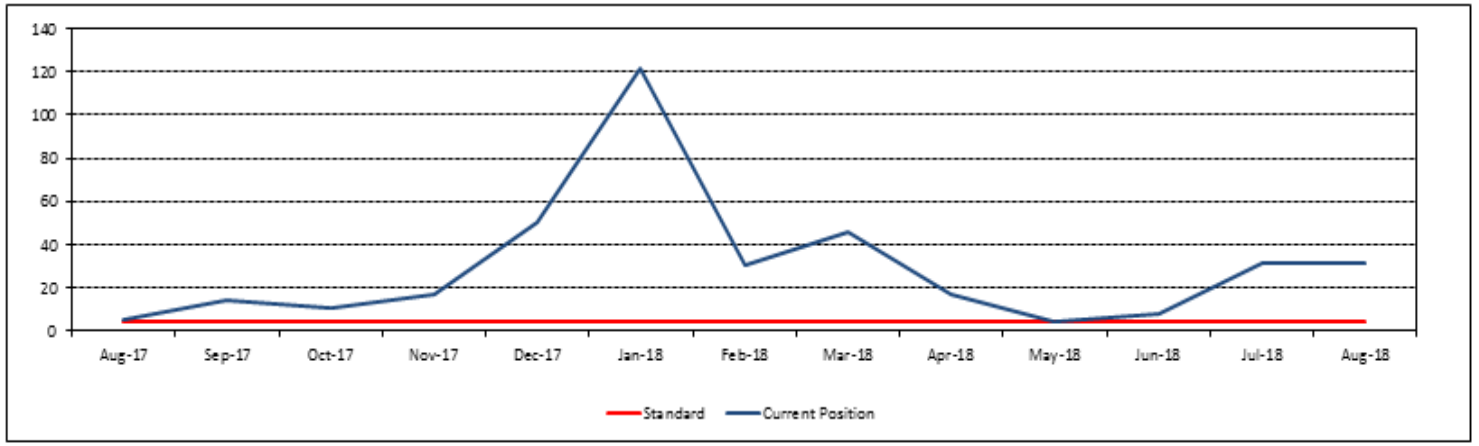
Indicator	A&E - Admission waiting 4-12 hours from dec. to admit
Standard	4
Name	Darin Geary
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Delays caused by lack of beds within organisation.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	4	4	4	4	4	4	4	4	4	4	4	4	4
Current Position	5	14	10	17	50	122	30	46	17	4	8	31	31

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
ED not able to influence. Suggest sending report to Patient Flow.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Stroke - % Patients admitted directly to stroke unit within 12h
Standard	96%
Name	Jane Allen
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Responsive

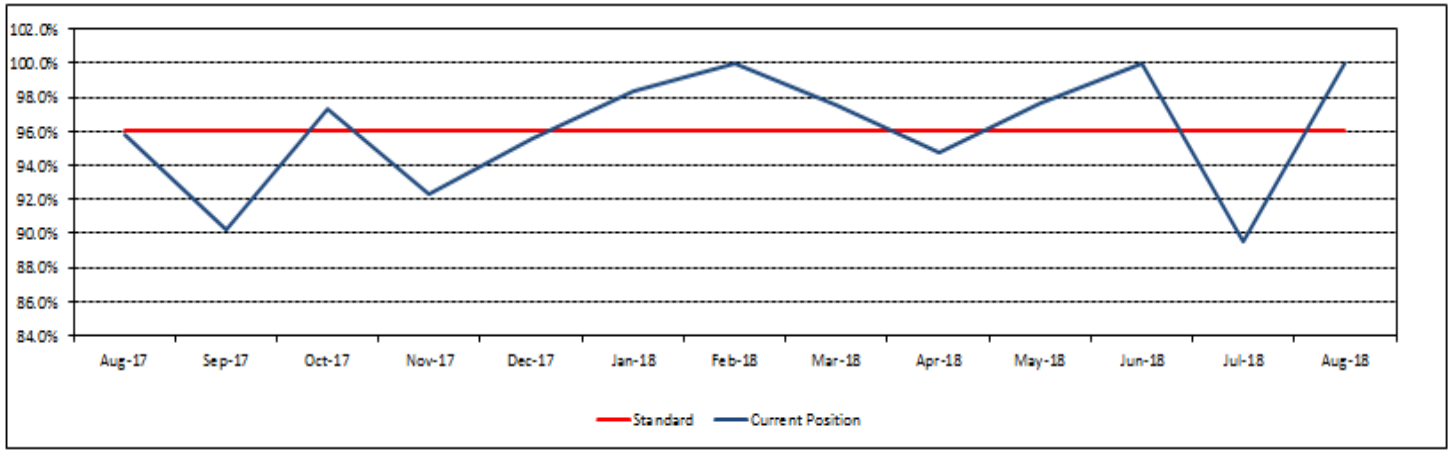
Summary of Current performance & Reasons for under performance

Monthly breach review meeting with the service manager from ED and ESOT, looking for themes and solutions has contributed to meeting the target.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%
Current Position	95.8%	90.2%	97.3%	92.3%	95.6%	98.3%	100%	97.5%	94.7%	97.7%	100%	89.5%	100%

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

Description	Owner	Start	End
Monthly breach review meeting with the service manager from ED and ESOT, looking for themes and solutions.	JA	Jul-18	Nov-18



9. DETAILED REPORTS – WELL-LED

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

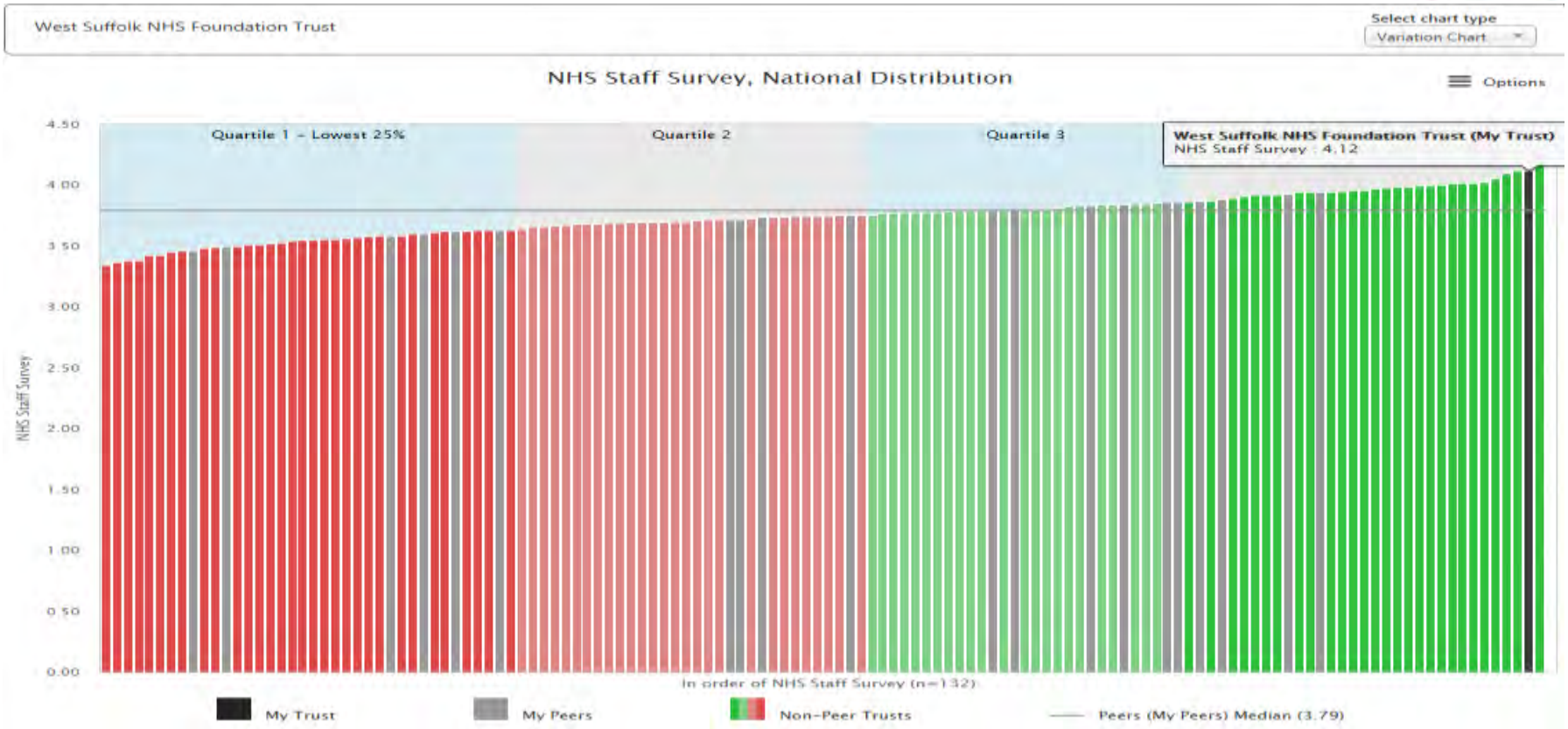
Are we		Ref.	KPI	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	YTD(Apr18 Mar19)
5. Well Led	Dashboard	5.01	NHS Staff Survey (Staff Engagement score -Annual)	NT	NA	NA	NA	NA	NA	NA	4.0%	NA	NA	NA	NA	NA	NA	NA
		5.02	Staff F&F Test % Recommended - care (Qrtly)	75%	NA	95.0%	NA	NA	ND	NA	NA	ND	NA	NA	95%	NA	95.0%	NA
		5.03	Staff F&F Test % Recommended - place to work (Qrtly)	75%	NA	82.0%	NA	NA	ND	NA	NA	ND	NA	NA	83%	NA	82.0%	NA
		5.04	Turnover (Rolling 12 mths)	<10%	10.0%	9.8%	9.0%	9.1%	9.3%	9.3%	8.7%	8.8%	8.4%	8.4%	8.5%	8.6%	8.6%	8.5%
		5.05	Sickness Absence	<3.5%	3.6%	3.6%	3.6%	3.5%	3.5%	3.6%	3.7%	3.7%	3.8%	3.8%	3.7%	3.8%	3.8%	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		126	150	82	213	245	353	306	373	276	188	330	323	471	318
		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	ND	ND	ND	ND	ND	ND
		5.10	Bank Spend		1234	1112	1195	1179	1326	1078	1093	996	1340	1361	ND	ND	ND	1351
		5.11	Bank/agency Spend percentage		3.6%	4.7%	3.8%	4.0%	5.0%	5.7%	ND	6.4%	4.2%	ND	ND	ND	ND	4.2%
		5.12	Proportion of Temporary Staff		11.4%	10.6%	10.1%	10.9%	8.0%	11.1%	11.3%	11.0%	12.5%	11.9%	9.7%	11.3%	12.7%	11.6%
		5.13	Locum and Medical agency spend		347	270	357	381	508	495	487	468	398	319	468	624	524	467
		5.57	Additional sessions		283	180	198	233	238	136	186	167	253	238	207	161	270	226
		5.14	Total Vacancies		6.8%	7.6%	7.8%	8.0%	8.0%	7.1%	7.9%	ND	8.0%	ND	ND	ND	ND	8.0%
		5.15	Corporate & Admin Costs as %	<7%	9.5%	9.5%	8.6%	8.6%	11.1%	13.3%	10.7%	ND	9.7%	ND	ND	ND	ND	9.7%
		5.16	% Staff on Maternity/Paternity Leave		1.9%	2.0%	2.0%	2.0%	2.0%	1.9%	2.0%	1.9%	2.0%	2.3%	2.38%	2.43%	2.60%	2.33%
	Other	5.17	Grievance reviews		ND	6	6	6	5	5	5	4	5	4	4	3	3	19
		5.18	Recruitment Timescales - Av no. of weeks to recruit	7	6.4	6.7	6.9	6.9	6.4	5.4	5.4	5.4	5.4	5.6	5.4	5.4	5.0	5.4
		5.19	DBS checks	95%	98.4%	98.5%	97.5%	97.5%	98.5%	98.5%	98.0%	97.0%	98.0%	97.5%	98.0%	98.0%	98.0%	97.9%
		5.20	Staff appraisal Rates	90%	ND	53.1%	50.8%	55.8%	62.0%	65.0%	62.3%	63.0%	67.0%	67.3%	69.3%	75.8%	75.2%	70.9%
		5.21	Trust Participation in on-going National Audits (Qtrly)	90%	NA	96.0%	NA	NA	96.0%	NA	NA	96.0%	NA	NA	ND	ND	NA	NA

Are we		Ref.	KPI	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	YTD(Apr18 Mar19)
5. Well Led	Training	5.22	Infection Control Training (classroom)	85%	95.7%	94.5%	94.7%	95.0%	95.0%	94.0%	94.0%	95.0%	94.0%	95.0%	94.0%	95.0%	95.0%	94.6%
		5.23	Infection Control Training (eLearning)	85%	88.0%	83.4%	85.1%	88.0%	88.0%	90.0%	90.0%	90.0%	90.0%	90.0%	91.0%	90.0%	87.0%	89.6%
		5.24	Manual Handling Training (Patient)	80%	82.8%	80.2%	80.4%	84.0%	84.0%	79.0%	79.0%	79.0%	74.0%	76.0%	77.0%	75.0%	79.0%	76.2%
		5.25	Manual Handling Training (Non Patient)	80%	81.6%	85.5%	84.4%	88.0%	88.0%	89.0%	89.0%	88.0%	88.0%	88.0%	83.0%	83.0%	81.0%	84.6%
		5.26	Staff Adult Safeguarding Training	80%	89.5%	89.1%	90.2%	92.0%	92.0%	92.0%	92.0%	92.0%	91.0%	91.0%	92.0%	90.0%	89.0%	90.6%
		5.27	Safeguarding Children Level 1	90%	86.6%	86.5%	88.0%	89.0%	90.0%	91.0%	91.0%	90.0%	90.0%	90.0%	89.0%	89.0%	88.0%	89.2%
		5.28	Safeguarding Children Level 2	90%	87.2%	87.9%	88.6%	90.0%	92.0%	92.0%	92.0%	91.0%	91.0%	90.0%	91.0%	91.0%	89.0%	90.4%
		5.29	Safeguarding Children Level 3	90%	76.3%	73.4%	78.6%	83.0%	86.0%	86.0%	88.0%	83.0%	95.0%	94.0%	94.0%	94.0%	89.0%	93.2%
		5.30	Health & Safety Training	80%	88.7%	89.1%	89.8%	91.0%	91.0%	92.0%	92.0%	91.0%	90.0%	90.0%	91.0%	91.0%	89.0%	90.2%
		5.31	Security Awareness Training	80%	88.7%	88.7%	89.6%	90.0%	91.0%	91.0%	91.0%	90.0%	90.0%	90.0%	91.0%	90.0%	89.0%	90.0%
		5.32	Conflict Resolution Training (eLearning)	80%	79.6%	80.0%	81.4%	82.0%	95.0%	76.0%	85.0%	84.0%	86.0%	87.0%	87.0%	88.0%	82.0%	86.0%
		5.33	Conflict Resolution Training	80%	75.7%	74.5%	76.5%	76.0%	75.0%	88.0%	76.0%	76.0%	69.0%	70.0%	70.0%	71.0%	73.0%	70.6%
		5.34	Fire Training (eLearning)	80%	85.4%	85.0%	85.0%	85.0%	84.0%	84.0%	84.0%	82.0%	80.0%	82.0%	81.0%	81.0%	84.0%	81.6%
		5.35	Fire Training (classroom)	80%	90.4%	89.3%	90.0%	91.0%	91.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	89.0%	90.0%	89.8%
		5.36	IG Training	80%	85.0%	83.6%	87.0%	86.0%	87.0%	84.0%	84.0%	82.0%	86.0%	86.0%	83.0%	84.0%	82.0%	84.2%
		5.37	Equality and Diversity	80%	92.6%	92.3%	93.0%	94.0%	94.0%	88.0%	88.0%	83.0%	81.0%	80.0%	79.0%	79.0%	79.0%	79.6%
		5.38	Majax Training	80%	86.9%	86.5%	88.0%	88.0%	89.0%	90.0%	90.0%	88.0%	88.0%	88.0%	89.0%	88.0%	88.0%	88.2%
		5.39	Medicines Management Training	80%	87.1%	87.1%	86.0%	87.0%	88.0%	89.0%	89.0%	88.0%	87.0%	87.0%	88.0%	89.0%	87.0%	87.6%
		5.40	Slips, trips and falls Training	80%	85.1%	84.9%	86.0%	88.0%	88.0%	87.0%	87.0%	87.0%	85.0%	85.0%	86.0%	86.0%	86.0%	85.6%
		5.41	Blood-borne Viruses/Inoculation Incidents	80%	84.4%	83.8%	85.0%	86.0%	87.0%	86.0%	86.0%	86.0%	85.0%	86.0%	87.0%	88.0%	85.0%	86.2%
		5.42	Basic life support training (adult)	80%	83.5%	81.7%	81.0%	81.0%	82.0%	80.0%	80.0%	78.0%	75.0%	76.0%	76.0%	75.0%	79.0%	76.2%
		5.43	Blood Products & Transfusion Processes (Refresher)	80%	79.1%	79.5%	80.0%	78.0%	80.0%	75.0%	75.0%	72.0%	73.0%	72.0%	73.0%	74.0%	74.0%	73.2%
		5.44	Mandatory Training Compliance		NA	NA	86.3%	88.1%	88.7%	84.6%	83.2%	82.8%	83.3%	84.0%	85.0%	84.0%	84.0%	84.1%
		5.55	Safeguarding Children Mandatory Compliance (Community)	98%	97.1%	96.8%	95.3%	96.1%	96.0%	95.9%	95.7%	97.0%	98.2%	95.8%	95.3%	94.7%	95.1%	95.8%
		5.56	Safeguarding Adults Mandatory Training Compliance (Community)	98%	96.2%	96.1%	94.3%	95.3%	94.0%	94.1%	93.2%	95.6%	96.0%	95.0%	94.9%	94.3%	94.9%	95.0%

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 2 Trusts in England in August 2018 *(Source –Model Hospital September 2018).*


West Suffolk NHS Foundation Trust
Select chart type
Variation Chart
NHS Staff Survey, National Distribution
Options
Quartile 1 - Lowest 25%
Quartile 2
Quartile 3
West Suffolk NHS Foundation Trust (My Trust)
NHS Staff Survey : 4.12
4.50
4.00
3.50
3.00
2.50
2.00
1.50
1.00
0.50
0.00
NHS Staff Survey
In order of NHS Staff Survey (n=132)
My Trust
My Peers
Non-Peer Trusts
Peers (My Peers) Median (3.79)

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

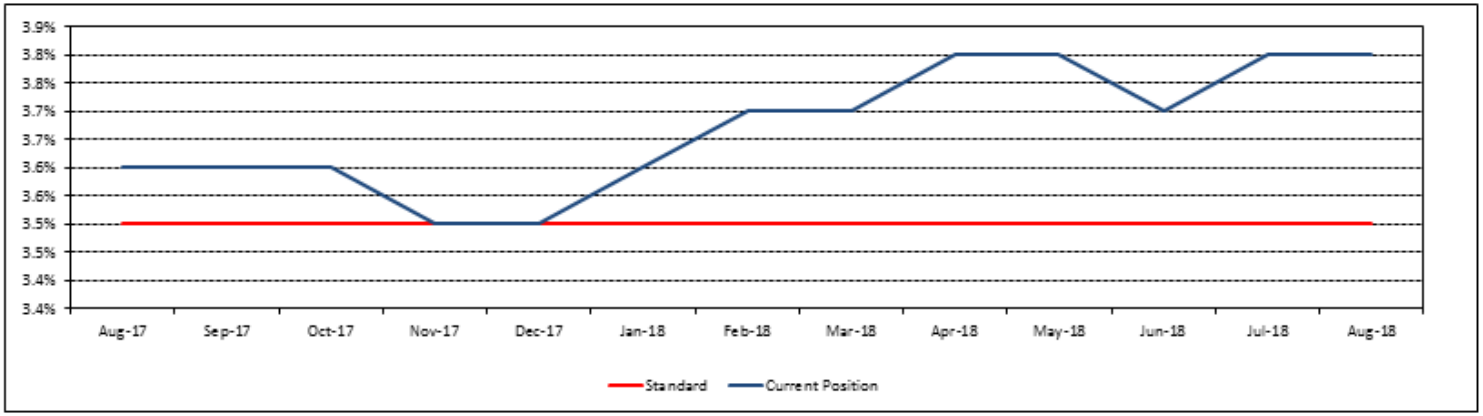
Indicator	Sickness Absence
Standard	3.5%
Name	Denise Needle
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Sickness absence remains static at 3.8%, 0.2% worse than this time last year. Mechanisms remain in place to support managers to tackle both long term and short term sickness absence.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
Current Position	3.6%	3.6%	3.6%	3.5%	3.5%	3.6%	3.7%	3.7%	3.8%	3.8%	3.7%	3.8%	3.8%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

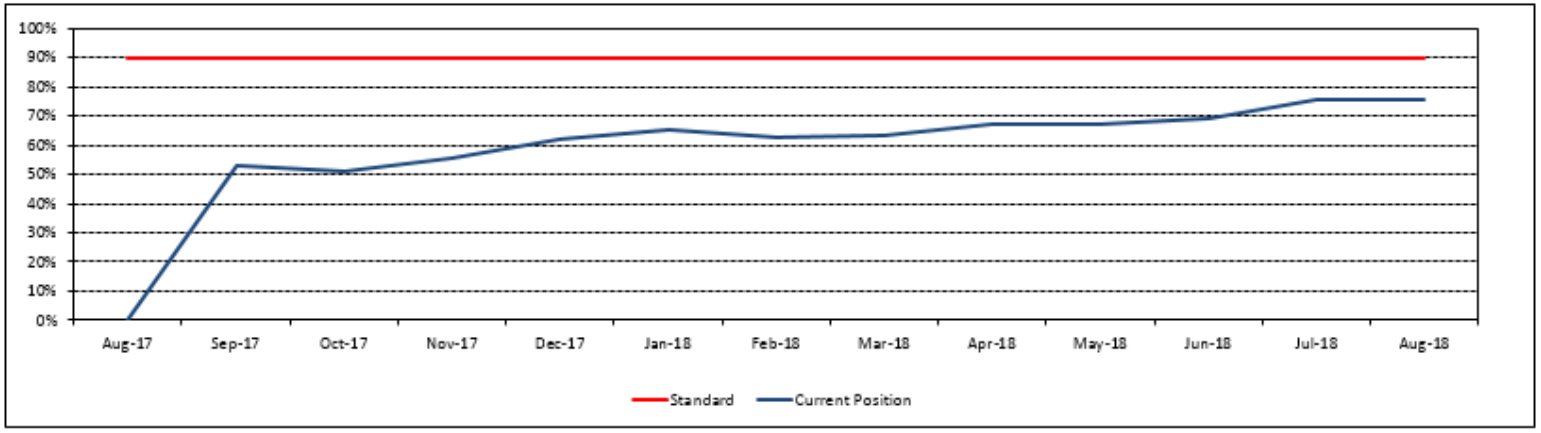
Indicator	Staff appraisal Rates
Standard	90%
Name	Denise Needle
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

The appraisal rate for August 2018 is 75.18%. Actions are in place within divisions to improve compliance, such as targeting those staff who the system shows as having no appraisal on record. The amount of annual leave traditionally taken in August has resulted in fewer appraisal, effecting the compliance figures

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	ND	53.1%	50.8%	55.8%	62.0%	65.0%	62.3%	63.0%	67.0%	67.3%	69.3%	75.8%	75.2%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Actions remain in place to support managers to manage both short term and long term absence.	DN		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

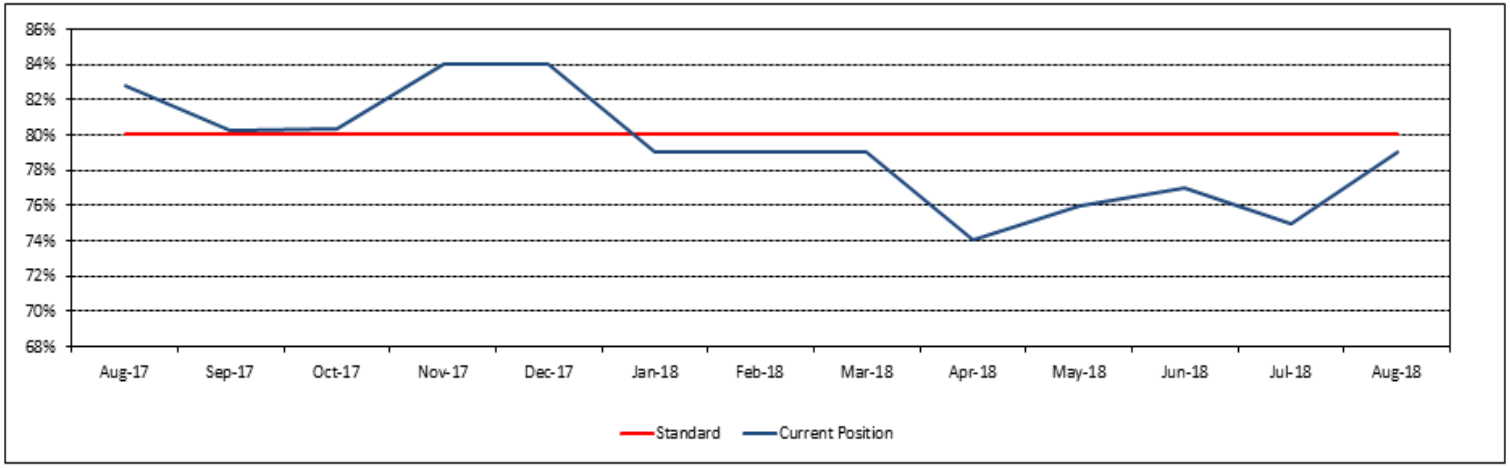
Indicator	Manual Handling Training (Patient)
Standard	80%
Name	Neil Herbert
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

The Moving and Handling teams current performance is in line with what it has been for the last 6 years. More training sessions are being provided and we have cancelled no sessions. Since the inheritance of community workforce time to provide extra sessions would be difficult as well as the Moving and Handling team now providing Display Screen Assessment advice for the acute and the community. The reasons for under performance is the attendance to the sessions which was poor at he beginning of the year. When there is staff shortages on the wards often nurses who are on training are asked to work.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Current Position	82.8%	80.2%	80.4%	84.0%	84.0%	79.0%	79.0%	79.0%	74.0%	76.0%	77.0%	75.0%	79.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To continue to provide as many sessions as possible to clinical staff and hope that the trusts latest recruitment drive see staff being released for training.	Neil Herbert	Sep-18	On-going



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

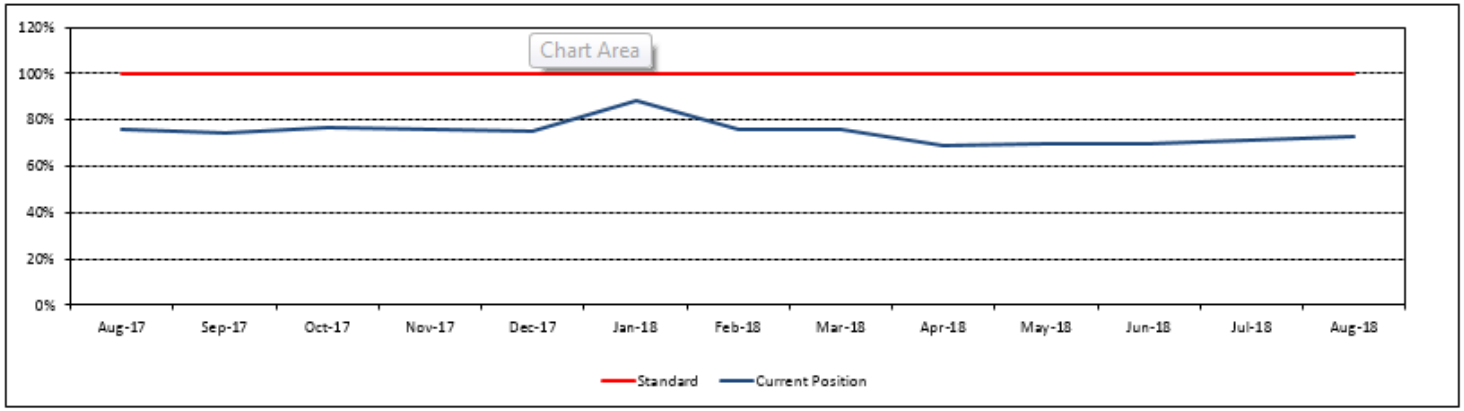
Indicator	Conflict Resolution Training
Standard	100%
Name	Darren Cooksey
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

The primary reason is for not achieving 80% for staff attending CRT is due to department not releasing staff to attend the session, when the department are under pressure i.e. short staffed, staff will be taken off the sessions as they are required on the ward .
The following ward have been targeted and the managers and associated Matrons have been sent an e-mail by the ASMS identifying which of their staff are out of date on their wards. It is hoped this will prompt the wards to send their staff on the training sessions .

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	75.7%	74.5%	76.5%	76.0%	75.0%	88.0%	76.0%	76.0%	69.0%	70.0%	70.0%	71.0%	73.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

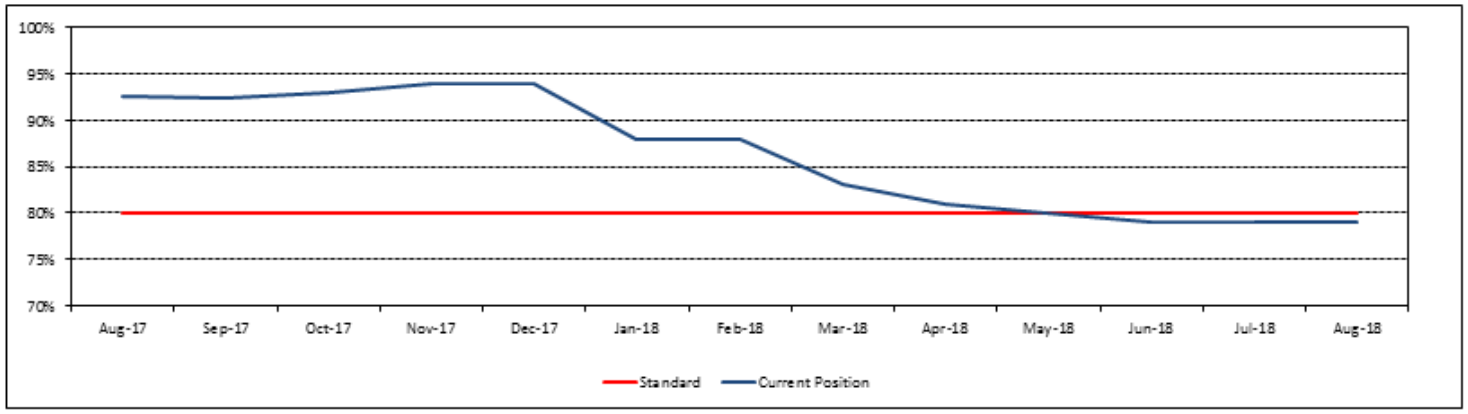
Indicator	Equality and Diversity
Standard	80%
Name	Ian Beck
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

The Equality and Diversity mandatory training package was not working for some weeks and this meant staff were unable to complete their training. 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.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Current Position	92.6%	92.3%	93.0%	94.0%	94.0%	88.0%	88.0%	83.0%	81.0%	80.0%	79.0%	79.0%	79.0%

Actions in place to recover the performance	Expected timeframes fo		
Description	Owner	Start	End
The Equality & Diversity package is now working as expected and staff are able to complete their training. Deputy Director of Workforce (Organisation Development) 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. Equality and diversity mandatory training is to be provided at Trust induction from November 2018.	IB	Jul-18	Mar-19



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Basic life support training (adult)
Standard	80%
Name	Julie Head
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Well Led

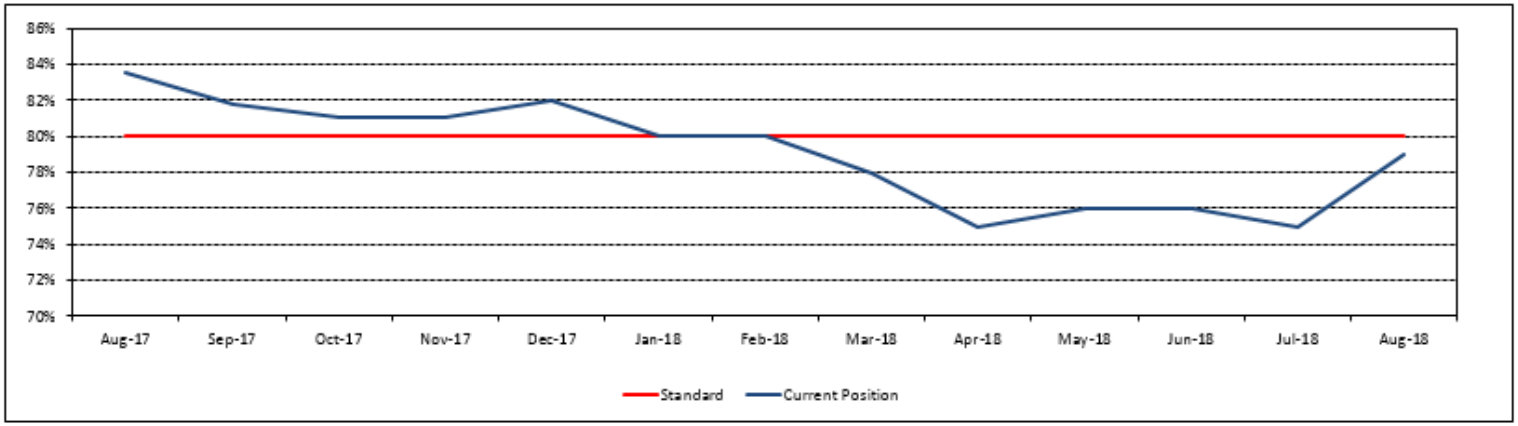
Summary of Current performance & Reasons for under performance

Currently we are under resourced within resuscitation services education. This risk will increase, with particular emphasis regarding community services joining the organisation and accessing our education.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Current Position	83.5%	81.7%	81.0%	81.0%	82.0%	80.0%	80.0%	78.0%	75.0%	76.0%	76.0%	75.0%	79.0%

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

Description	Owner	Start	End
A VAF for a band 6 WTE Resuscitation Trainer has been requested. This is awaiting response	JH & ST	Jul-18	TBA



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

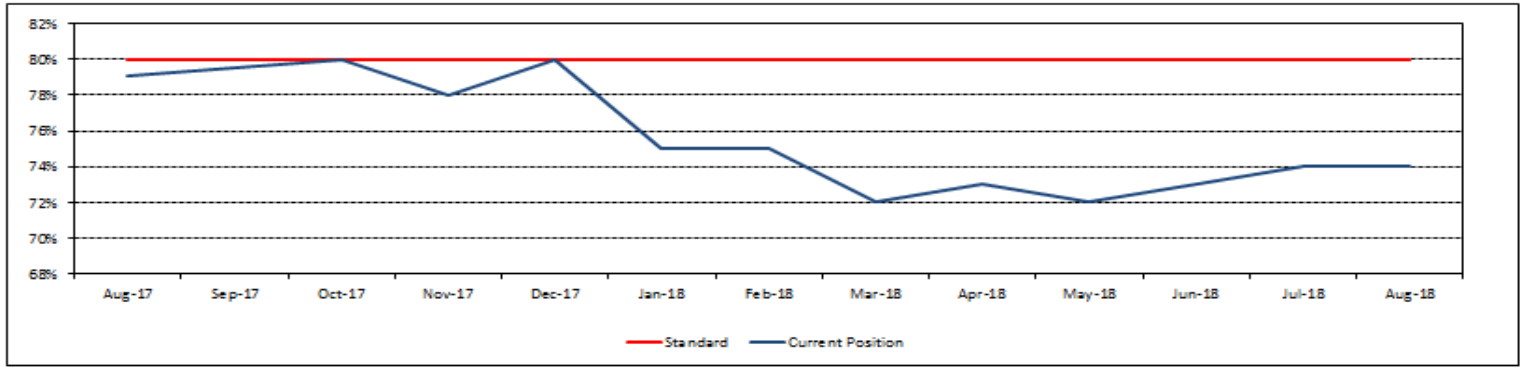
Indicator	Blood Products & Transfusion Processes (Refresher)
Standard	80%
Name	Gild Bass
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Detailed investigations & data analysis have been undertaken to identify the reason for staff non compliance but to date no obvious reason can be found for the continual deterioration in compliance beyond the fact that clinical staff are not completing their e-learning as per Trust policy.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Current Position	79.1%	79.5%	80.0%	78.0%	80.0%	75.0%	75.0%	72.0%	73.0%	72.0%	73.0%	74.0%	74.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
1) Review & revise training/competency matrix.	G Bass/J Hoyle	Aug-18	Sep-18
2) Additional face to face updates have been implemented for Theatre staff, Porters, Midwifery, A&E Drs & Paediatric Drs.	G Bass/J Hoyle	Jan-17	Ongoing
3) Monthly reports are sent to CDs & senior managers highlighting staff that are non-compliant.	G Bass/J Hoyle	Oct-10	Ongoing
4) Personalised reports sent to Matrons listing which nursing staff need to complete their mandatory training	G Bass/J Hoyle	Aug-18	Aug-19



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	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	YTD(Apr18-Mar19)
6. Productive	Dashboard	6.01	I&E Margin	Var	-3.9%	0.1%	-3%	-2.6%	-2.5%	-2.6%	-2.3%	-2.6%	0.2	-10.3%	-7.5%	-6.3%	-7.3%	-6.8%	-7.6%
		6.02	Distance from Financial Plan	Var	NA	NA	NA	NA	0.2%	0.2%	0.6%	0.1%	2.5%	5.3%	18.5%	1.6%	0.2%	0.2%	5.2%
		6.03	Capital service cover	Var	- 2.18	- 1.04	- 0.88	- 0.32	0.52	0.24	0.38	0.07	0.680	0.48	1.64	- 0.80	- 0.93	0.87	0.25
		6.04	Liquidity (days)		-10.94	- 11.03	- 12.70	-15.14	9.64	11.39	6.06	6.84	7.860	12.34	16.83	15.36	16.67	14.36	15.1
		6.05	Long Term Borrowing (£m)	3.5%	45.7	45.7	47.6	47.6	56.7	58.7	64.4	64.1	65.4	67.6	69.8	69.0	70.7	74.2	70.3
		6.06	CIP (Variance YTD £'000s)	1.9	10	0	-54	-10	-74	-22	-419	-469	-539	-54	-47	-75	-100	-120	-79
	Activity	6.07	A&E Activity		6124	5831	5743	6065	5985	5959	6033	5639	6172	5967	6498	6161	6564	6072	31262
		6.08	NEL Activity		2375	2385	2466	2586	2491	2528	2539	2406	2557	2273	2474	2471	2475	2372	12065
		6.09	OP - New Appointments		5706	5635	5633	6182	7230	5482	6769	5849	6324	6033	6930	6379	6598	6007	31947
		6.10	OP- Follow-Up Appointments		11147	11333	11116	11815	12668	9769	12673	11103	11609	11142	12248	11520	11750	10929	57589
		6.11	Electives (Incl Daycase)		2796	2829	2786	2868	3157	2545	2841	2632	2871	2665	3019	2799	2871	2788	14142
		6.12	Financial Position (YTD)	Var	-3290	-3300	-3953	-4114	-5170	-6600	-6525	-6525	-287	-1760	-2793	-3159	-4420	5641	-6491
		6.13	Financial Stability Risk Rating	Var	3	3	3	3	3	3	3	3	3	3	3	3	3	3	15
		6.14	Cash Position (YTD £000s)	Var	7460	3300	4846	2654	3518	4924	6870	3600	3600	5,322	4550	2239	6852	7231	26194

EXCEPTION REPORTS – PRODUCTIVE

The finance report contains full details.

11. DETAILED REPORTS- MATERNITY

		Ref.	KPI	Target	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	YTD(Apr18-Mar19)
Maternity	Dashboard	7.01	Total number of deliveries (births)	210	233	236	205	194	180	199	211	206	198	203	201	172	208	982
		7.02	% of all caesarean sections	<22.6%	22.3%	18.2%	17.1%	17.0%	18.3%	22.1%	17.1%	30.1%	28.2%	22.4%	18.2%	17.1%	17.0%	20.6%
		7.03	Midwife to birth ratio	1.30	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	0
		7.05	Completion of WHO checklist	100%	82.0%	98.0%	98.0%	98.0%	93.0%	93.0%	94.0%	97.0%	86.0%	85.0%	88.0%	94.0%	95.0%	89.6%
		7.06	Maternity SIs	NT	0	1	1	0	1	2	0	1	2	2	0	1	0	5
		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	80%	84.8%	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	79.0%	76.1%	76.3%	80.7%	85.1%	76.2%	78.9%
	Safe	7.09	Elective Caesarean Sections	10%	9.4%	6.4%	5.9%	7.2%	7.8%	8.0%	7.1%	10.7%	11.8%	10.9%	7.6%	4.7%	7.8%	8.6%
		7.10	Emergency Caesarean Sections	<13%	12.9%	11.9%	11.2%	9.8%	10.6%	14.1%	10.1%	19.4%	16.4%	11.4%	10.6%	12.4%	9.2%	12.0%
		7.11	Grade 1 Caesarean Section (Decision to delivery time met)	100%	100%	100%	0.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)	80%	57.0%	82.0%	88.0%	50.0%	80.0%	83.0%	83.0%	81.0%	82.0%	93.0%	90.0%	58.0%	64.0%	77.4%
		7.13	Homebirths	2%	2.6%	2.1%	3.9%	2.6%	3.3%	3.0%	2.4%	0.5%	2.6%	5.0%	1.5%	2.4%	1.5%	2.6%
		7.14	Midwifery led birthing unit (MLBU) births	>13%	15.5%	15.3%	17.1%	16.0%	15.0%	19.1%	18.0%	14.1%	16.4%	11.4%	11.4%	18.8%	17.0%	15.0%
		7.15	Labour Suite births	77.5%	82.0%	82.6%	79.0%	81.4%	81.7%	77.9%	79.6%	85.4%	81.0%	83.0%	86.9%	78.2%	80.6%	81.9%
		7.16	Induction of Labour	29.3	38.2%	34.3%	35.1%	43.8%	43.9%	37.2%	41.2%	37.4%	41.0%	37.8%	40.9%	37.6%	36.4%	38.7%
		7.17	Instrument Assisted Deliveries (Forceps & VentoUse)	>14	3.0%	4.7%	4.2%	7.2%	5.9%	7.0%	7.6%	6.8%	13.0%	9.5%	10.1%	10.0%	12.6%	11.0%
		7.18	Critical Care Obstetric Admissions	0	0	1	0	0	0	2	0	1	1	2	1	0	1	5
		7.19	Eclampsia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Effective	7.20	Shoulder Dystocia	2	3	7	6	4	5	4	5	8	5	6	8	5	6	30
		7.21	Post-partum Hysterectomies	0	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	ND	ND	ND	ND	0	0	1	2	0	3
		7.23	3rd and 4th degree tears (all deliveries)	12	4	4	6	3	8	9	7	2	9	4	6	4	7	30
	Caring	7.24	Maternal death	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		7.25	Stillbirths	NT	0	1	2	1	0	2	0	0	1	1	0	1	0	3
		7.26	Complaints		1	0	0	0	1	0	0	1	0	ND	0	3	1	4
		7.27	No. of babies admitted to Neonatal Unit (>36+6)	NT	13	15	15	11	9	8	16	12	18	10	9	7	ND	44
	Responsive	7.28	No. of babies transferred for therapeutic cooling	0	0	0	1	0	1	0	0	0	1	0	0	0	0	1
		7.29	One to one care in established labour	100%	100%	100%	100%	100%	100%	100%	100%	100%	91.0%	93.0%	92.3%	97.0%	97.0%	94.1%
		7.30	Reported Clinical Incidents	50	43	52	61	57	49	63	46	48	46	56	48	27	39	216
		7.31	Hours of dedicated consultant cover per week	60	96	99	99	108	90	102	93	93	94	90	93	93	90	460
		7.32	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	10	50
		7.33	OPD cover for Theatre 2	100%	100%	100%	100%	100%	100%	100%	100%	100%	ND	ND	ND	ND	ND	ND
		7.34	No. of women identified as smoking at booking	NT	30	37	27	28	17	26	21	30	26	31	22	19	21	119
		7.35	No. of women identified as smoking at delivery	NT	27	25	25	24	26	21	22	24	23	26	14	15	27	105
		7.36	UNICEF Baby friendly audits	10	10+	10+	10+	10+	10+	10+	ND	10+	ND	ND	10	ND	ND	10
		7.37	Proportion of parents receiving Safer Sleeping Suffolk advice	80%	ND	ND	ND	ND	ND	ND	ND	ND	62.90%	77.80%	81.8%	88.0%	80.0%	78.1%
	Other	7.38	No. of bookings (First visit)	NT	245	265	259	245	193	279	253	274	240	251	237	252	236	1216
		7.39	Women booked before 12+6 weeks	95%	99.6%	92.8%	99.0%	97.0%	97.0%	96.0%	96.0%	ND	95.4%	96.0%	96.6%	94.4%	96.0%	95.7%
		7.40	Female Genital Mutilation (FGM)	NT	0	0	0	0	0	0	1	0	0	0	0	0	0	0

EXCEPTION REPORTS – MATERNITY

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

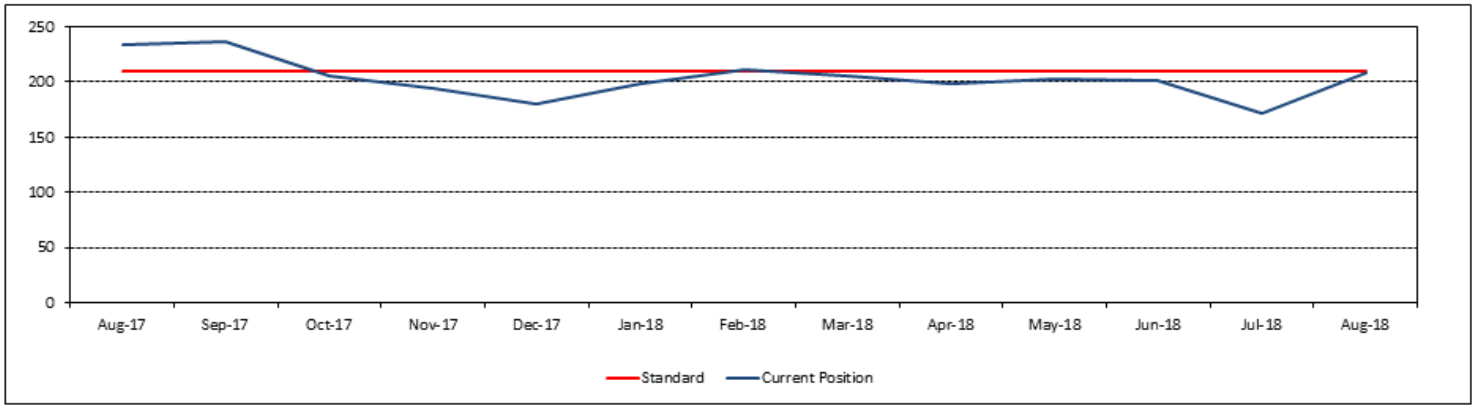
Indicator	Total number of deliveries (births)
Standard	210
Name	Lynne Saunders
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The maternity service is very aware of the reduced number of babies born during the last few months. The service is monitoring this closely and is commencing projects to attract some mothers who currently chose to birth at neighbouring units to West Suffolk Hospital.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	210	210	210	210	210	210	210	210	210	210	210	210	210
Current Position	233	236	205	194	180	199	211	206	198	203	201	172	208

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Close monitoring ongoing.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

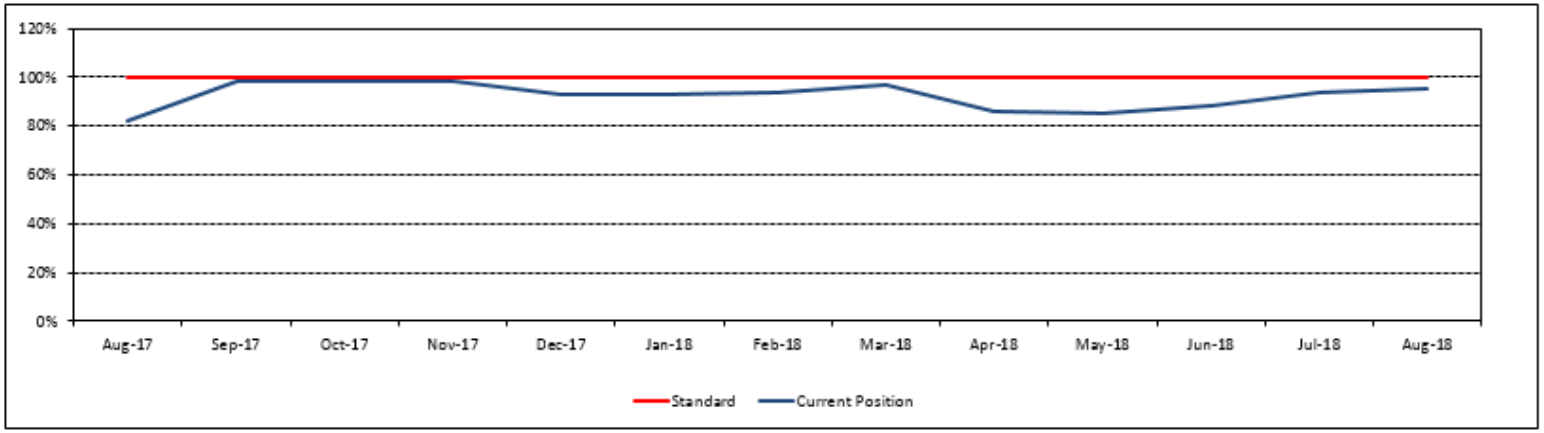
Indicator	Completion of WHO checklist
Standard	100%
Name	Lynne Saunders
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The maternity service undertakes a continuous audit of all WHO forms for every woman who goes to theatre. August continues to show an increase in compliance to 95%, however there are still issues around operating theatre practitioners and scrub nurses signatures. Theatre leads have been informed of the results.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	82.0%	98.0%	98.0%	98.0%	93.0%	93.0%	94.0%	97.0%	86.0%	85.0%	88.0%	94.0%	95.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Highlight unsigned elements of the form to all staff involved.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

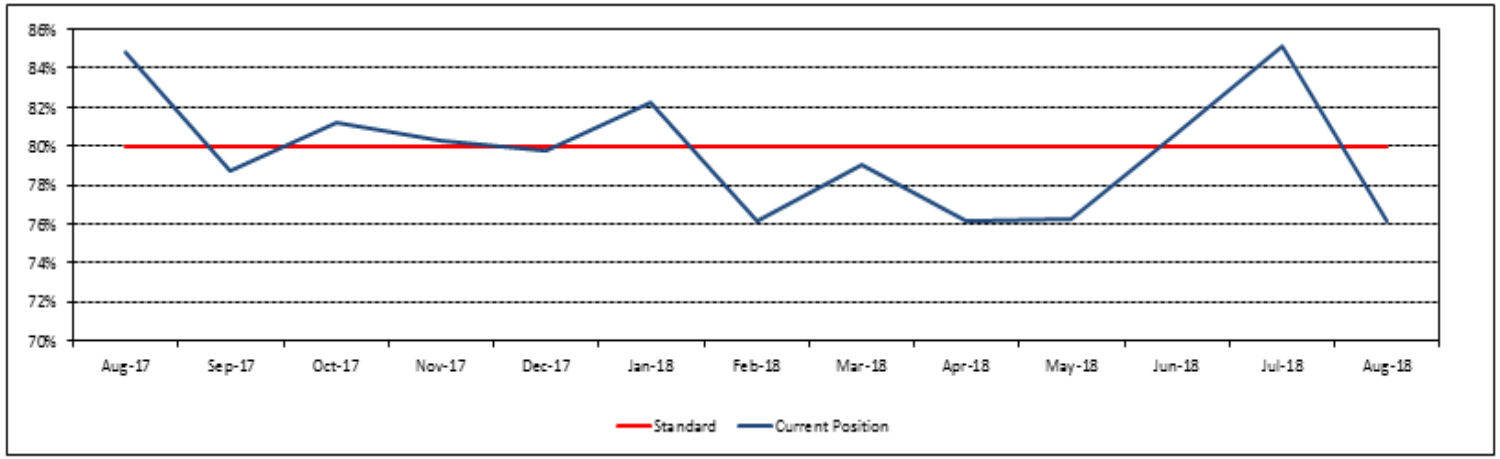
Indicator	Breastfeeding Initiation Rates
Standard	80%
Name	Lynne Saunders
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

There has unfortunately been a small reduction to 76.2% of women who chose to initiate breastfeeding. The maternity service continues to undertake a number of initiatives to encourage women to consider breast feeding their babies.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Current Position	84.8%	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	79.0%	76.1%	76.3%	80.7%	85.1%	76.2%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to highlight monthly on the Take 5 communication.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

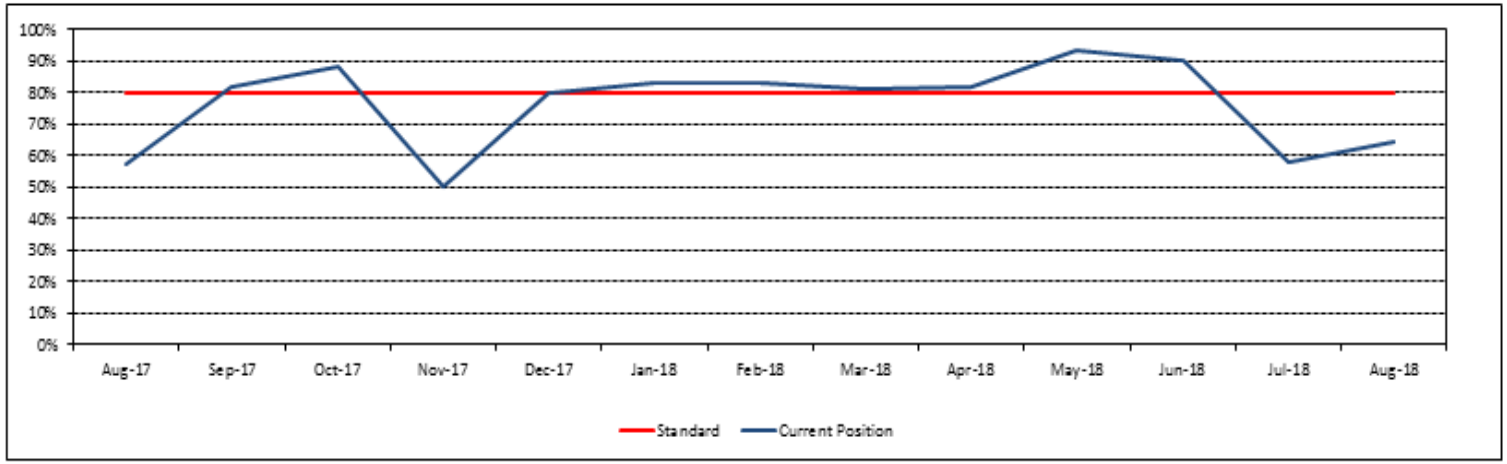
Indicator	Grade 2 Caesarean Section (Decision to delivery time met)
Standard	80%
Name	Lynne Saunders
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

A grade 2 caesarean section (CS) would be expected to be performed within 75 minutes of the decision. There was a small improvement in the decision to delivery (D to D) this month however it remains below the target of 80%. All cases are reviewed on an individual basis and it has been agree that they will all be presented by a consultant obstetrician at the Clinical Governance Steering Group quarterly in order to be able to address trends and themes more robustly.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Current Position	57.0%	82.0%	88.0%	50.0%	80.0%	83.0%	83.0%	81.0%	82.0%	93.0%	90.0%	58.0%	64.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor weekly . Plan to Audit and present 3 monthly at the Clinical Governance steering Group.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

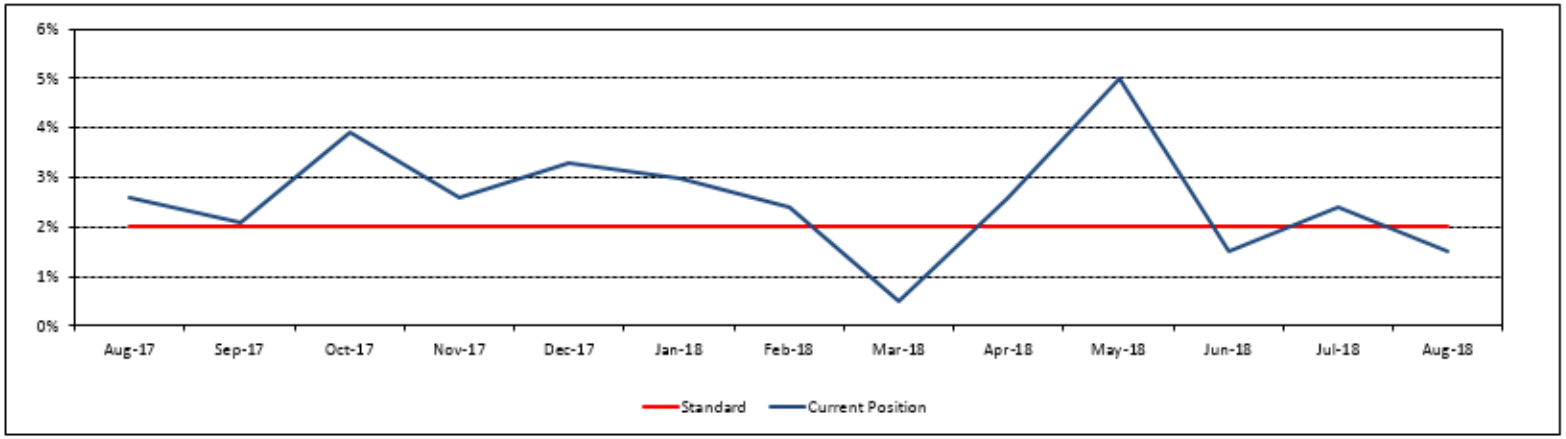
Indicator	Homebirths
Standard	2%
Name	Lynne Saunders
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

All women have a choice in the place of birth. The West Suffolk maternity service has maintained an average of 2.8% per month for the past year. This is significantly higher than the national average of 1.3% in Britain for planned and unplanned(NMPA 2017), we do not include our unplanned home deliveries in this percentage. Despite month on month variation we continue to promote choice for women who are low risk and provide a 24 hour service in order for women to achieve this choice of birth.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Current Position	2.6%	2.1%	3.9%	2.6%	3.3%	3.0%	2.4%	0.5%	2.6%	5.0%	1.5%	2.4%	1.5%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to promote homebirths to low risk women.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

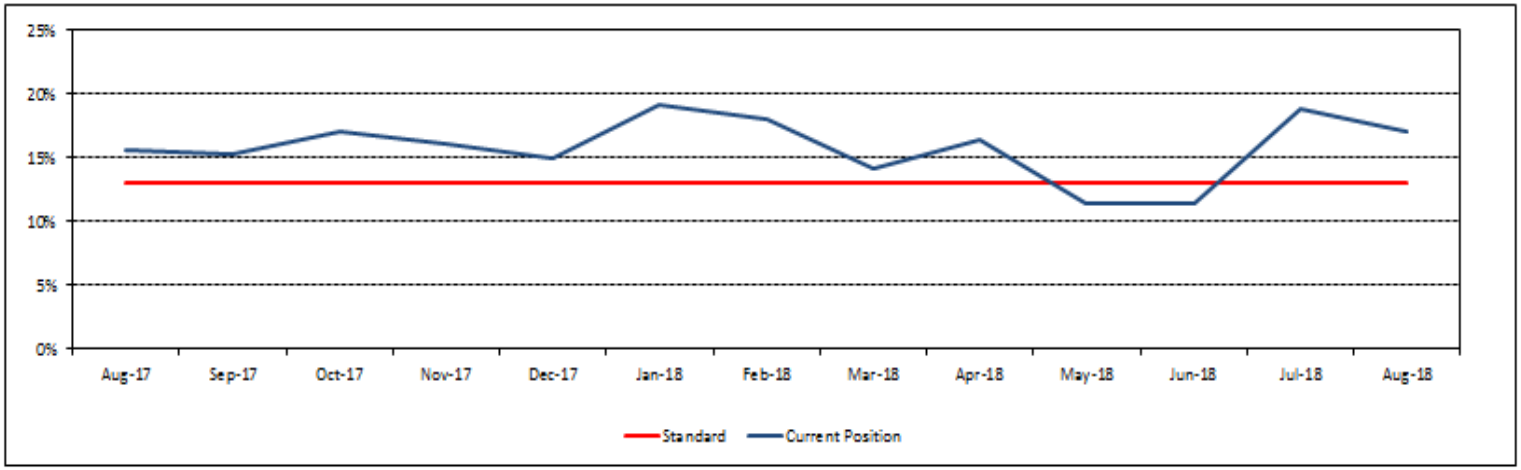
Indicator	Midwifery led birthing unit (MLBU) births
Standard	13%
Name	Lynne Saunders
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

There has been a fall in the number of births in the MLBU over the last year. One of the reasons for this is thought to be the introduction of GROW and the increased identification of growth restricted babies and transfer of these women to consultant care. Although there may be other factors. The birthing Unit has a newly appointed manager with a plan to review the criteria for inclusion for delivery on the birthing unit and this may have an impact on the numbers, although the service is about to undergo refurbishment therefore with the use of MLBU for high risk women this may not be so clear until this has been completed.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%
Current Position	15.5%	15.3%	17.1%	16.0%	15.0%	19.1%	18.0%	14.1%	16.4%	11.4%	11.4%	18.8%	17.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor and review the criteria. For inclusion to the MLBU.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

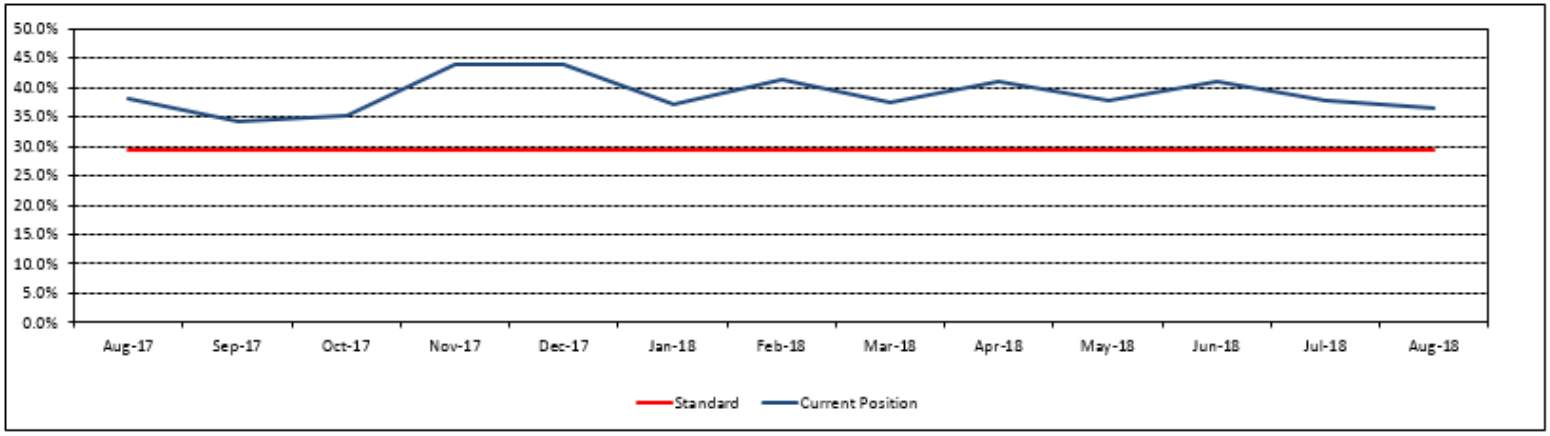
Indicator	Induction of Labour
Standard	29.3%
Name	Lynne Saunders
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Induction of labour has been consistently higher than the standard of 29.3%. Audits have not been found to demonstrate unwarranted inductions. With the introduction of Grow to identify babies with reduced growth, a significant increase of gestational diabetes requiring induction of labour as well as our rates of offering vaginal birth after caesarean section have all likely had an impact on the induction of labour rates. Although this has been above the standard expected our normal delivery rates remain high therefore this has not increased either our instrumental or CS rates. Induction of labour has been included in the National Maternity and Perinatal Audit due to be published next year. It will be interesting to see if other units have seen an increase in these figures.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%
Current Position	38.2%	34.3%	35.1%	43.8%	43.9%	37.2%	41.2%	37.4%	41.0%	37.8%	40.9%	37.6%	36.4%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor monthly. Further audit of the indications for IOL			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

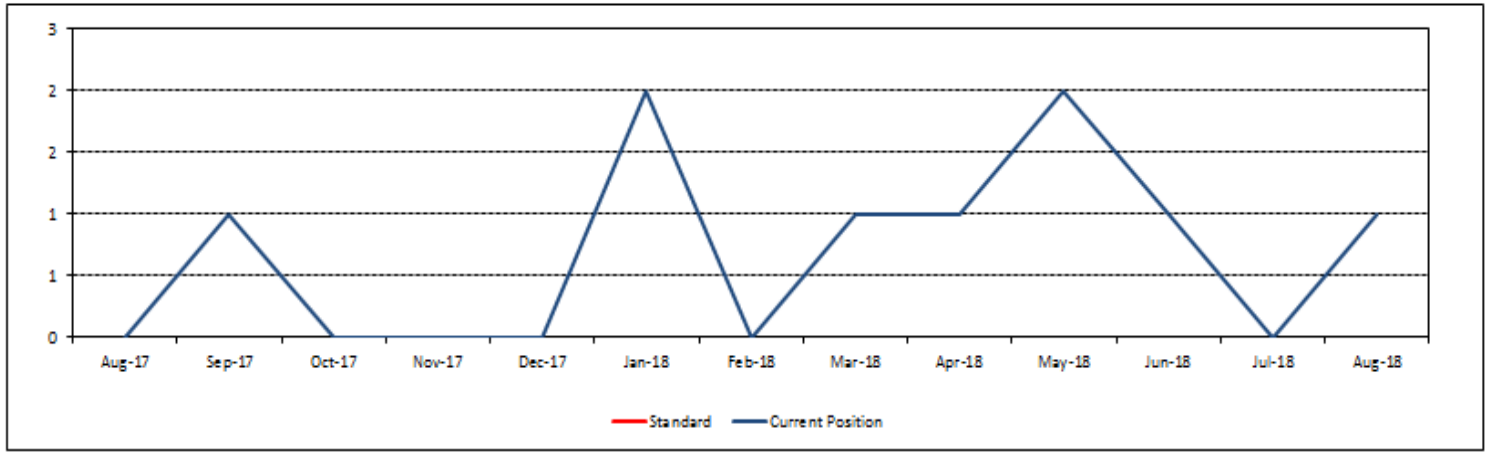
Indicator	Critical Care Obstetric Admissions
Standard	0
Name	Lynne Saunders
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The maternity service had one lady transferred to critical care in August 2018. The maternity service undertakes a clinical review of all cases where critical care is needed, if this is not planned. This review is planned but not yet completed. Any learning identified will be shared via the maternity services newsletter Risky Business and if appropriate with individual staff.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	0	1	0	0	0	2	0	1	1	2	1	0	1

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

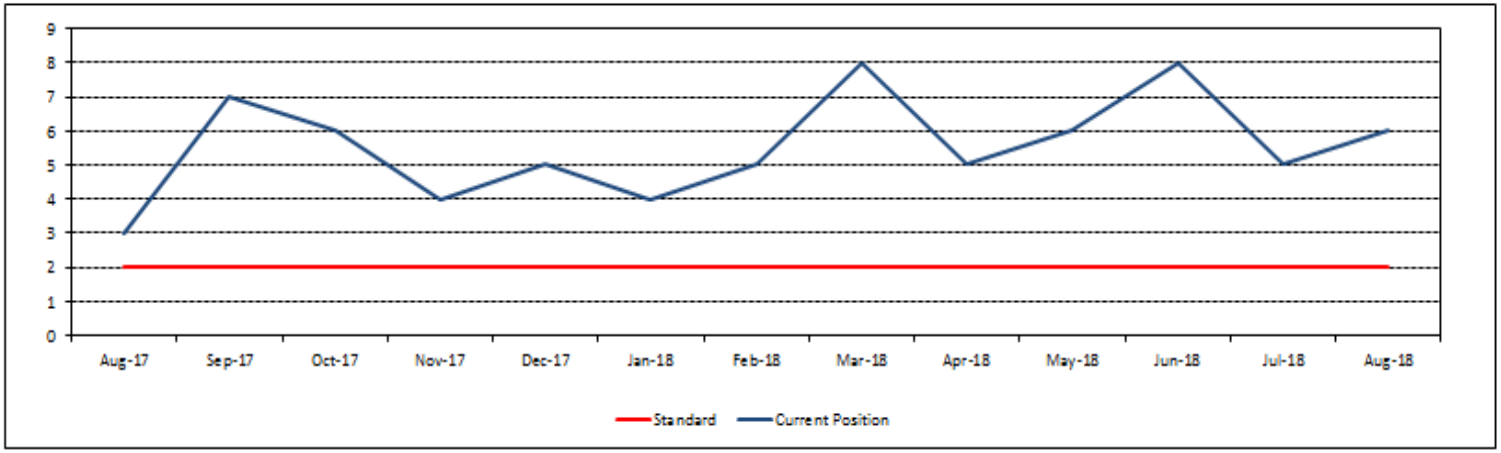
Indicator	Shoulder Dystocia
Standard	2
Name	Lynne Saunders
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

This months figures 6 reports of shoulder dystocia is an increase from last month. Shoulder dystocia is not included in the national maternity perinatal audit therefore it is difficult to compare with other trusts of a similar size . The RCOG note risk assessments for the prediction of shoulder dystocia are insufficiently predictive to allow prevention in the large majority of cases and therefore the correct management of this obstetric emergency is essential in preventing maternal or fetal injury. However we do as recommended offer IOL to all women with diabetes All cases of shoulder dystocia are reported on Datix and undergo investigation. The current rate will be discussed when the dashboard is presented at the next Women's Health Governance meeting and a decision made if any further investigation/action is required.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	2	2	2	2	2	2	2	2	2	2	2	2	2
Current Position	3	7	6	4	5	4	5	8	5	6	8	5	6

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue with multi-professional training annually for all staff and live drills in the management of shoulder dystocia.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

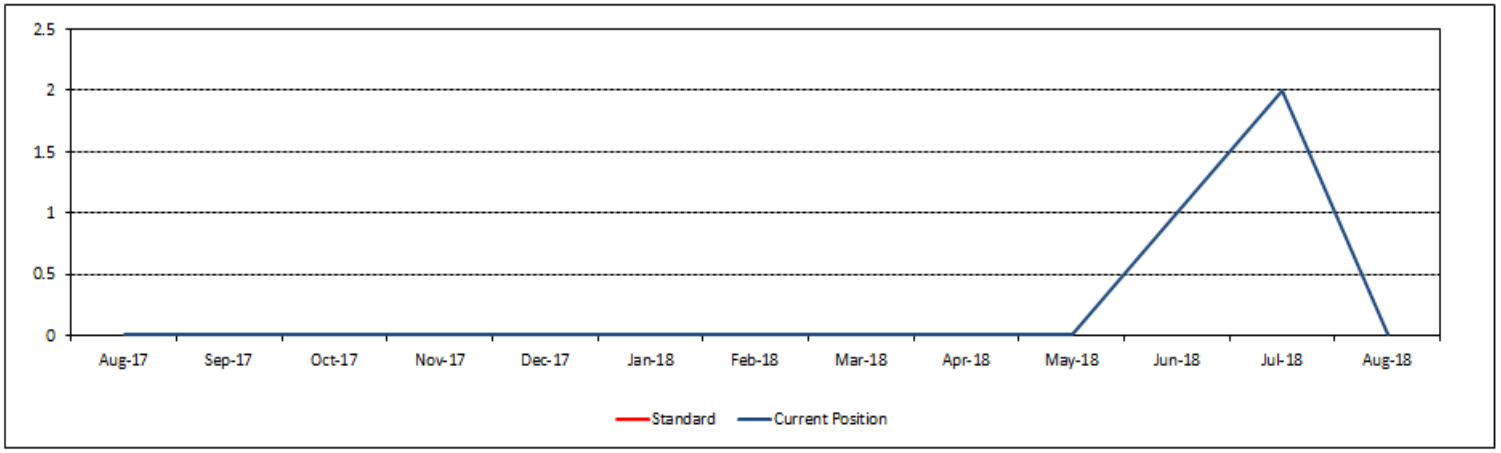
Indicator	Women requiring a blood transfusion of 4 units or more
Standard	0
Name	Lynne Saunders
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Although declining, deaths from obstetric haemorrhage remains a leading cause of direct maternal death. (MBRRACE 2016) Some women are at particular increased risk of major haemorrhage and processes in place are key to good management e.g. appropriate place of delivery, use of prophylactic uterotonics. It is unusual for women to require 4 or more units of blood even in cases of major haemorrhage. There were no reported cases of women requiring a 4 or more unit blood transfusing in August 2018, an improved position on the previous 2 months.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	0	0	0	0	ND	ND	ND	ND	0	0	1	2	0

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor, ensure any learning identified at the clinical review is addressed.	LS		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

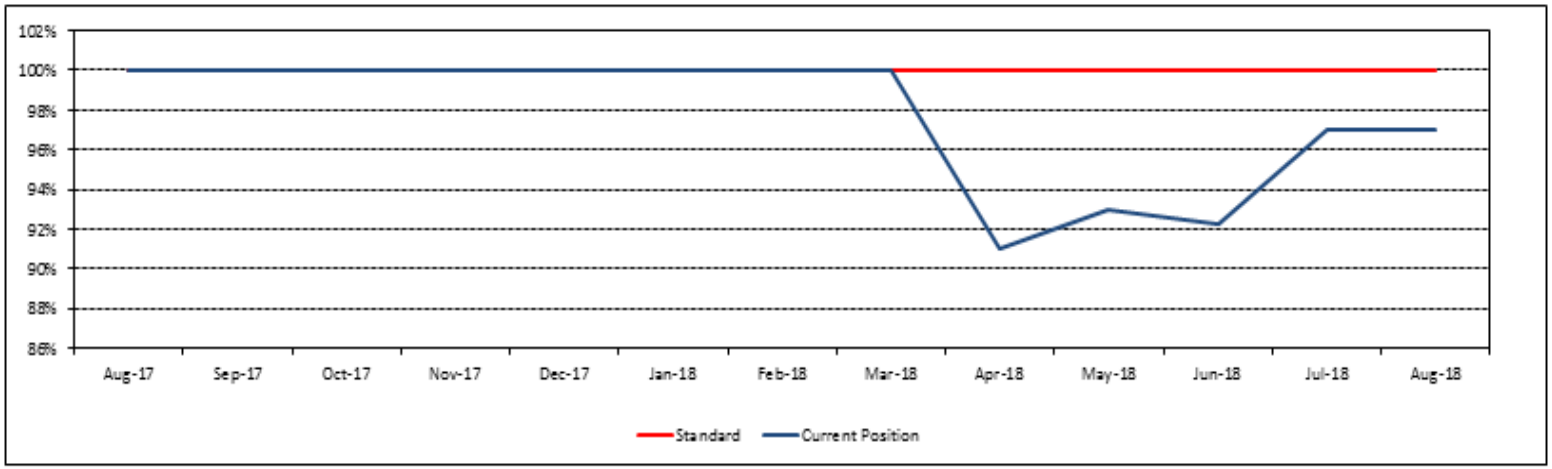
Indicator	One to one care in established labour
Standard	100%
Name	Lynne Saunders
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

There has been a recent change to the way in which data for this indicator has been collected. We have identified some issues with the data entry that results in one to one care not being recorded. Checking of data for June and July has identified that there are no concerns that women are not receiving one to one care in labour. At present the data for August 2018 has not been checked.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	100%	100%	100%	100%	100%	100%	100%	100%	91.0%	93.0%	92.3%	97.0%	97.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

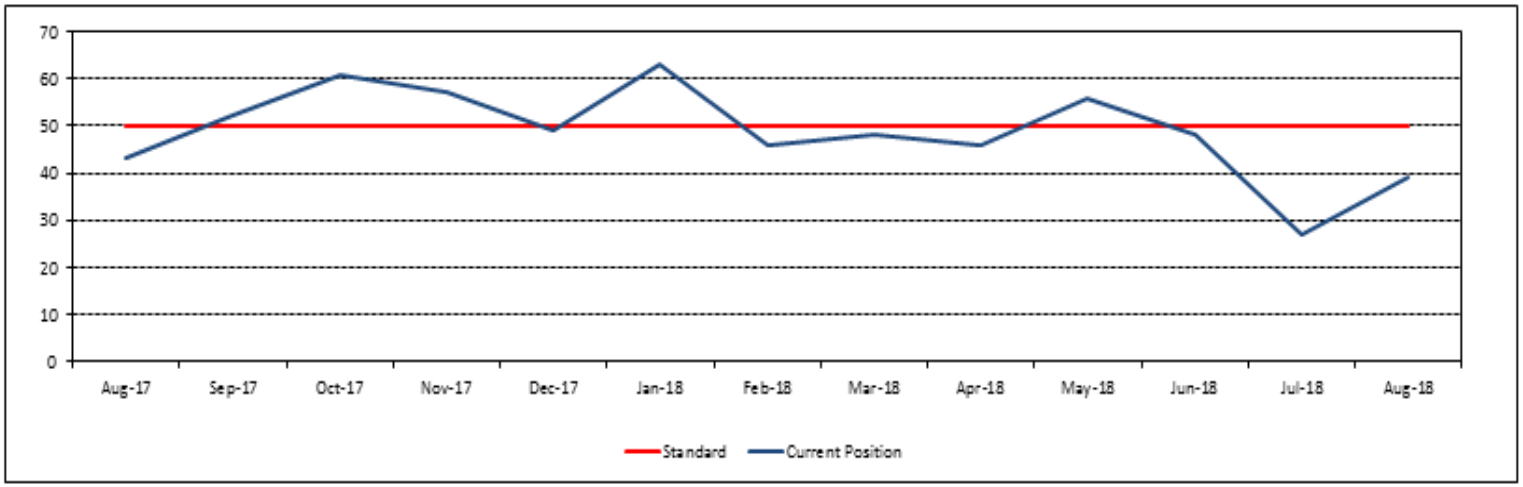
Indicator	Reported Clinical Incidents
Standard	50
Name	Lynne Saunders
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Over the last two months the maternity service has noted a reduction in the reporting of clinical incidents. There have been no significant changes to the service to indicate why this has occurred. Staff in the maternity risk department continue to remind staff of the importance of reporting clinical incidents and support staff in doing do should they so need. At present there is no identified cause for this on going reduction in clinical incident reporting.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	50	50	50	50	50	50	50	50	50	50	50	50	50
Current Position	43	52	61	57	49	63	46	48	46	56	48	27	39

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

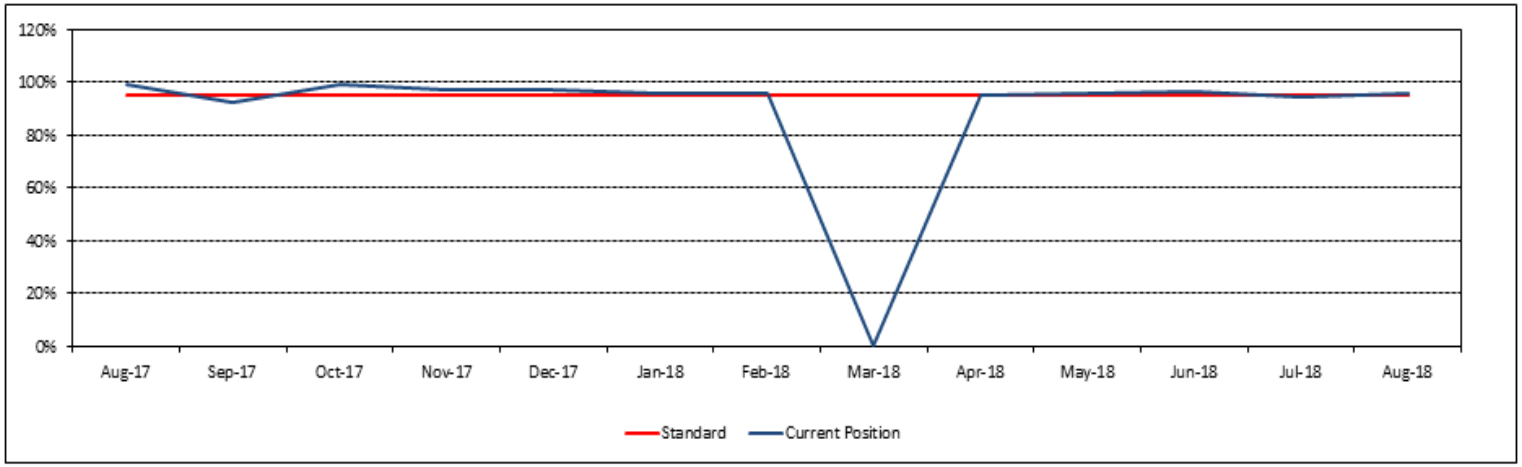
Indicator	Women booked before 12+6 weeks
Standard	95%
Name	Lynne Saunders
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The service achieved the target this month of 95% for women booking for antenatal care by 12 + 6 weeks.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	99.6%	92.8%	99.0%	97.0%	97.0%	96.0%	96.0%	ND	95.4%	96.0%	96.6%	94.4%	96.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Community midwifery Hub introduced in May will allow women to refer for antenatal care directly to the midwife.			



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Community Contract Preface

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

- Our FFT remains high at 98% from 99 responses. Glastonbury Court, Newmarket hospital and Paediatric services all scoring 100%.
- There no formal complaints received during August.
- There were no pressure ulcers occurring in our care in our in-patient units.
- All response time targets were met.
- The average LOS in our community beds increased slightly on the previous month but remain good.
- There were 18 patients whose discharge was delayed from our beds in August with a total of 159 days being lost. This is a slight increase on the previous month but remains a reasonable level.
- The total number of children waiting for the SLT service in community clinics has decreased again this month.
- The total number of children waiting for SLT in schools appears high due to summer break
- The wheelchair service achieved 100% for 18 week wait for children.
- The Children in Care Initial Health Assessment targets continue to be a challenge, discussions to explore a new model are progressing well.

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

APPENDIX 1: PEER HOSPITAL LIST USED BY CQC

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

10. Finance and workforce report

To ACCEPT the report including plans for winter 2018-19

For Report

Presented by Craig Black

Board of Directors – July 2018

Agenda item:	10			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	23rd August 2018			
Subject:	Finance and Workforce Board Report – July 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. The Trust is planning on a net deficit (after PSF) of £10.1m for 2018-19.

The reported I&E for July 2018 is a deficit of £1.261m, against a planned deficit of £1.073m. This results in an adverse variance of £188k in month (£439k YTD). This overspend predominantly relates to underperformance against the A&E performance and therefore PSF income being £236k below planned.

Recruitment of ward based registered nurses is behind plan due to a number of withdrawals of newly qualified nurses starting in September (either due to them going elsewhere or failing to meet the required standard). This needs to improve in order to fully staff the capacity being made available to provide additional capacity for winter

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
July 2018 (Month 4)

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	£4.4m	loss
Variance against plan YTD	-£0.4m	adverse
Movement in month against plan	-£0.2m	adverse
EBITDA position YTD	-£1.8m	
EBITDA margin YTD	-110.7%	adverse
Total STF Received	£555k	accrued
Cash at bank	£6,852k	

Executive Summary

- The Trust has agreed a control total of a deficit of £13.8m with NHS Improvement for 2018/19. (£10.2m after PSF).
- The planned deficit for the year to date was £4.0m but the actual deficit was £4.4m, an adverse variance of £0.4m.
- Recruitment of ward based registered nurses is behind plan due to a number of withdrawals of newly qualified nurses starting in September (either due to them going elsewhere or failing to meet the required standard).

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%)
- Cost pressures associated with pay award
- Recruitment of Registered Nurses to ensure the Trust is fully staffed for the additional capacity required for winter

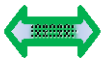
SUMMARY INCOME AND EXPENDITURE ACCOUNT - July 2018	Jul-18 Budget £m	Jul-18 Actual £m	Jul-18 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m	Year end forecast Budget	Year end forecast Actual	Year end forecast Variance F/(A)
NHS Contract Income	16.3	16.4	0.2	63.6	63.9	0.4	190.3	191.0	0.7
Other Income	3.0	3.0	0.0	11.2	11.0	(0.2)	33.8	37.3	3.5
Total Income	**19.2**	**19.4**	**0.2**	**74.8**	**74.9**	**0.2**	**224.1**	**228.4**	**4.3**
Pay Costs	13.4	13.2	0.3	51.3	51.9	(0.5)	151.4	157.5	(6.0)
Non-pay Costs	6.1	6.8	(0.7)	24.3	24.8	(0.6)	74.7	75.3	(0.6)
Operating Expenditure	**19.5**	**20.0**	**(0.4)**	**75.6**	**76.7**	**(1.1)**	**226.1**	**232.7**	**(6.6)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**(0.3)**	**(0.6)**	**(0.3)**	**(0.8)**	**(1.8)**	**(0.9)**	**(2.0)**	**(4.4)**	**(2.3)**
Depreciation	0.7	0.6	0.1	2.7	2.3	0.4	8.2	6.9	1.3
Finance costs	0.3	0.2	0.1	1.2	0.9	0.3	3.6	2.7	1.0
SURPLUS/(DEFICIT) pre PSF	**(1.3)**	**(1.4)**	**(0.1)**	**(4.8)**	**(5.0)**	**(0.2)**	**(13.9)**	**(13.9)**	**(0.0)**
Provider Sustainability Funding (PSF)									
PSF - Financial Performance	0.2	0.2	0.0	0.6	0.6	0.0	2.6	2.6	0.0
PSF - A&E Performance	0.1	0.0	(0.1)	0.2	0.0	(0.2)	1.1	0.0	(1.1)
SURPLUS/(DEFICIT) incl PSF	**(1.1)**	**(1.3)**	**(0.2)**	**(4.0)**	**(4.4)**	**(0.4)**	**(10.2)**	**(11.3)**	**(1.1)**

FINANCE AND WORKFORCE REPORT – July 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 – July 2018

Income and Expenditure Summary as at July 2018

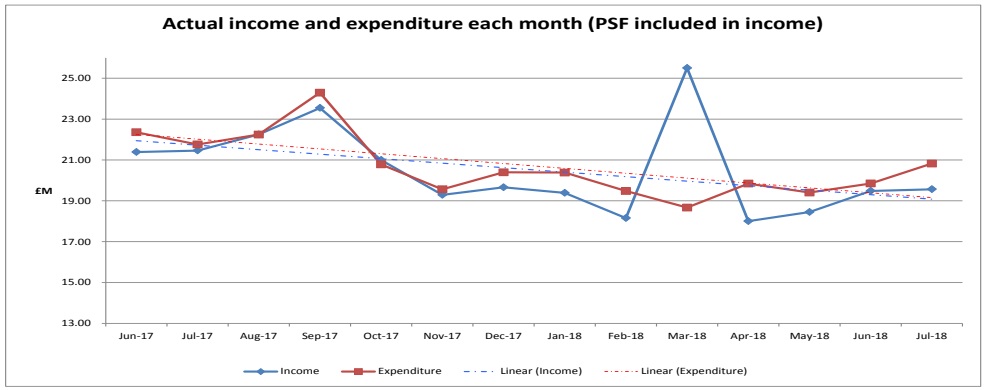
The Trust has agreed a control total to make a deficit of £13.8m in 2018-19 which will enable Provider Sustainability Funding (PSF) of £3.7m should A&E and Financial targets be met. The Trust is planning on a net deficit (after PSF) of £10.1m for 2018-19.

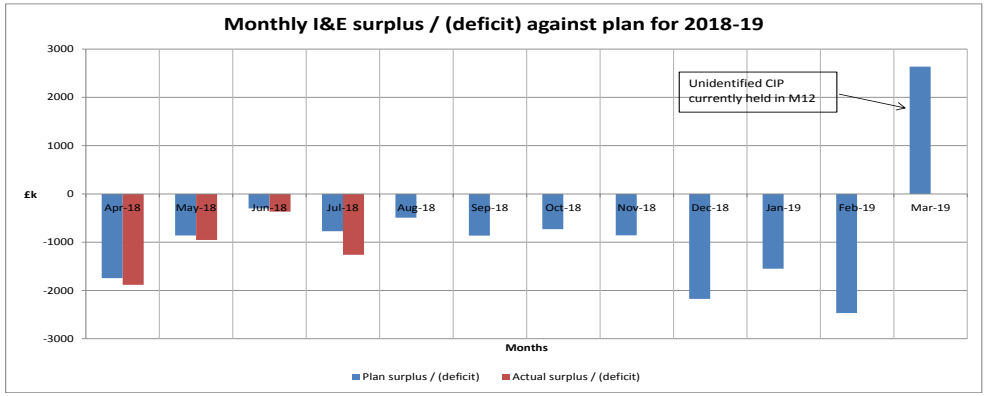
In order to achieve the control total the 2018-19 budgets include a stretch CIP of £2.8m bringing the total CIP plan to £12.2m (5%). We have utilised the 2018-19 contingency of £1.5m in order to meet this stretch CIP.

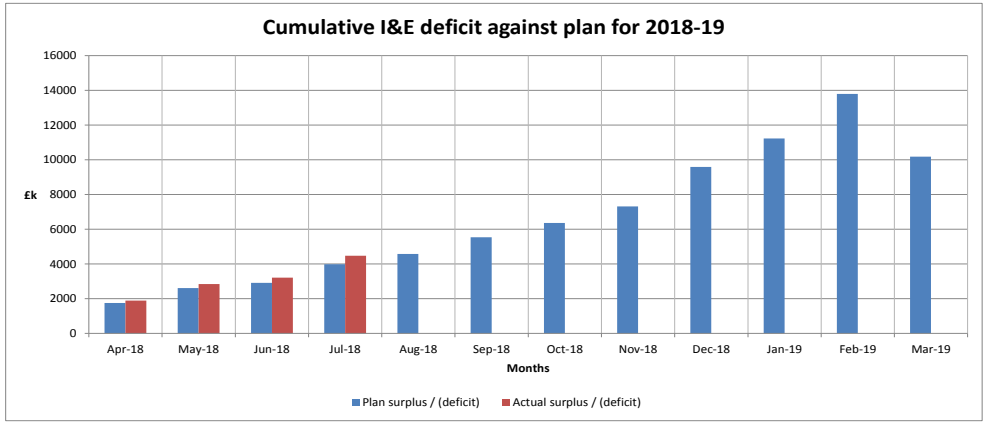
The reported I&E for July 2018 is a deficit of £1.261m, against a planned deficit of £1.073m. This results in an adverse variance of £188k in month (£439k YTD). This overspend predominantly relates to underperformance against the A&E performance and therefore PSF income being £236k below planned.

Summary of I&E indicators

Income and Expenditure	Plan / target £'000	Actual / forecast £'000	Variance to plan (adv) / fav £'000	Direction of travel (variance)	RAG (report on Red)
In month surplus / (deficit)	(1,073)	(1,261)	(188)	↑	Amber
YTD surplus / (deficit)	(3,981)	(4,420)	(439)	↑	Amber
Forecast surplus / (deficit)	(10,180)	(10,180)	0	↔	Green
EBITDA (excl STF) YTD	(816)	(1,770)	(954)	↑	Red
EBITDA (%)	(1.1%)	(2.3%)	(1.3%)	↑	Red
Clinical Income YTD	(63,562)	(63,914)	352	↑	Green
Non-Clinical Income YTD	(12,014)	(11,584)	(431)	↑	Red
Pay YTD	50,689	51,882	(1,193)	↑	Red
Non-Pay YTD	28,868	28,035	833	↑	Green
CIP target YTD	3,145	3,045	(100)	↑	Amber



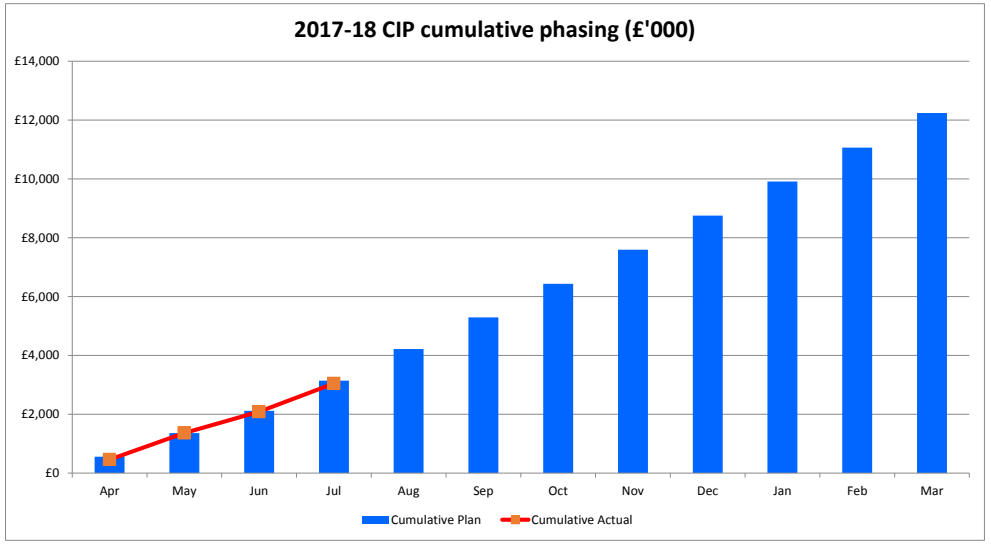


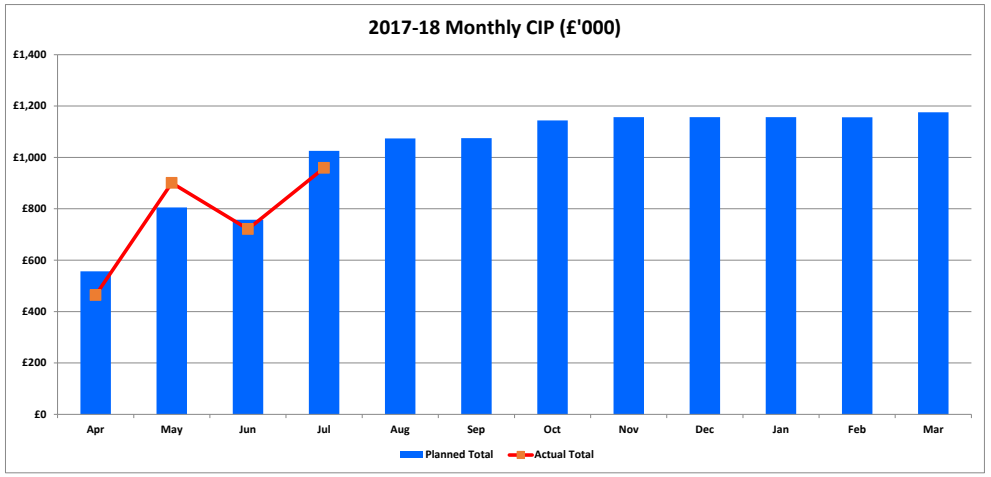


Cost Improvement Programme (CIP) 2018-19

The July position includes a target of £3,145k YTD which represents 25.36% of the 2018-19 plan. There is currently a shortfall of £100k YTD against this plan.

Recurring/Non Recurring	Summary	2018-19 Annual Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Clinical Income	529	162	132
	Activity growth	234	72	63
	Private Patients	78	26	11
	Other Income	890	191	104
	Staffing Review	840	27	1
	Consultant Staffing	111	2	-
	Nursing productivity	80	281	271
	Additional sessions	58	4	4
	Temporary Pay	712	264	357
	Agency	98	36	31
	Pay controls	-	-	-
	CNST discount	265	88	123
	Community Equipment Service	643	214	285
	Drugs	167	56	106
	Contract renegotiation	69	21	21
	Procurement	828	210	184
	Other	178	19	22
	Service Review	366	73	64
	Patient Flow	629	110	-
	(blank)	163	21	17
	Cancelled CIPs	324	54	-
	Divisional Cross Cutting allocations (T	1,729	229	174
Recurring Total	**Divisional Cross Cutting allocations (**	**8,989**	**2,159**	**1,971**
Non-Recurring	Capitalisation	1,550	510	500
	Additional sessions	268	13	13
	Contract review	105	20	38
	Other	1,327	442	522
Non-Recurring Total		**3,250**	**986**	**1,074**
Grand Total		**12,239**	**3,145**	**3,045**



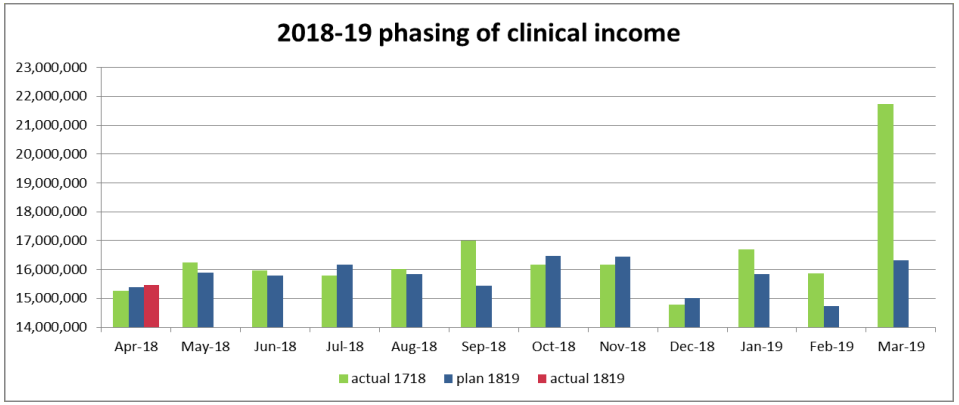


In order to deliver the Trust's control target deficit of planned deficit of £13.8m deficit in 2018-19 we need to deliver a CIP of £12.2m (5%).

FINANCE AND WORKFORCE REPORT – July 2018

Income Analysis

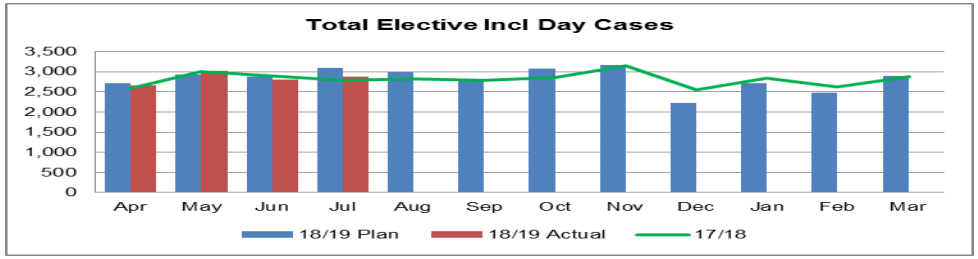
The chart below summarises the phasing of the clinical income plan for 2018-19, including Community Services. This phasing is in line with activity phasing which is how the income is recognised.

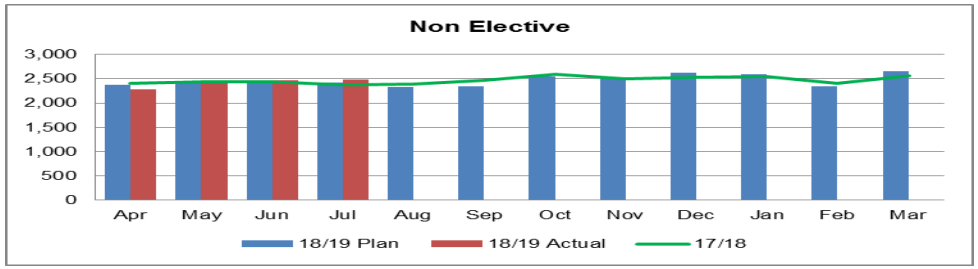


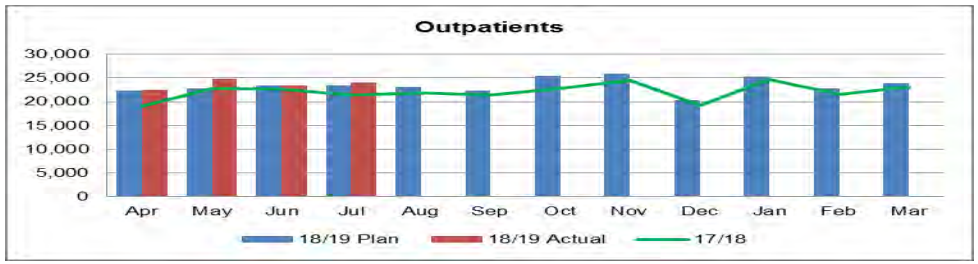
The income position was ahead of plan for July. The main area of underperformance against the plan was seen within Elective activity.

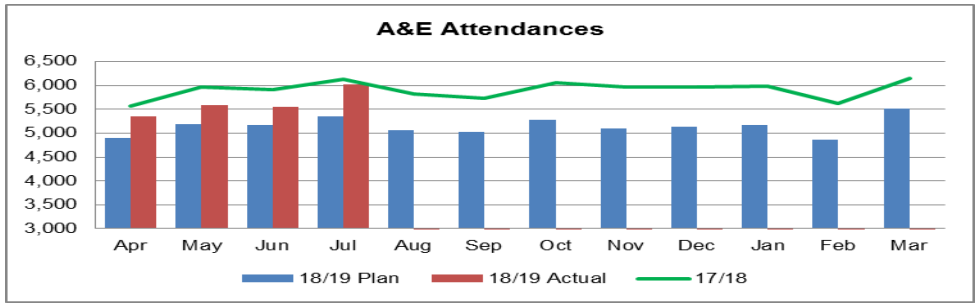
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	734	801	68	2,827	2,987	160
Other Services	1,998	2,436	439	7,742	8,764	1,022
CQUIN	324	317	(8)	1,265	1,254	(11)
Elective	3,154	2,699	(455)	11,904	10,829	(1,075)
Non Elective	5,418	5,421	4	21,576	21,407	(169)
Emergency Threshold Adjustment	(356)	(364)	(8)	(1,420)	(1,387)	33
Outpatients	2,843	2,969	126	11,159	11,551	392
Community	2,142	2,142	0	8,509	8,509	0
Total	**16,256**	**16,422**	**165**	**63,562**	**63,913**	**352**

Activity, by point of delivery

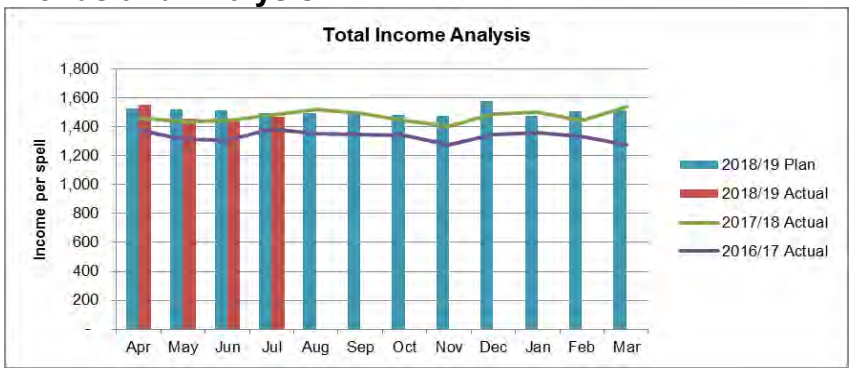


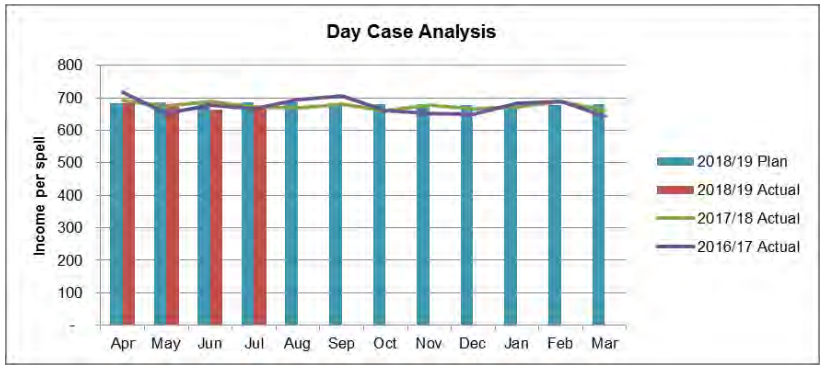


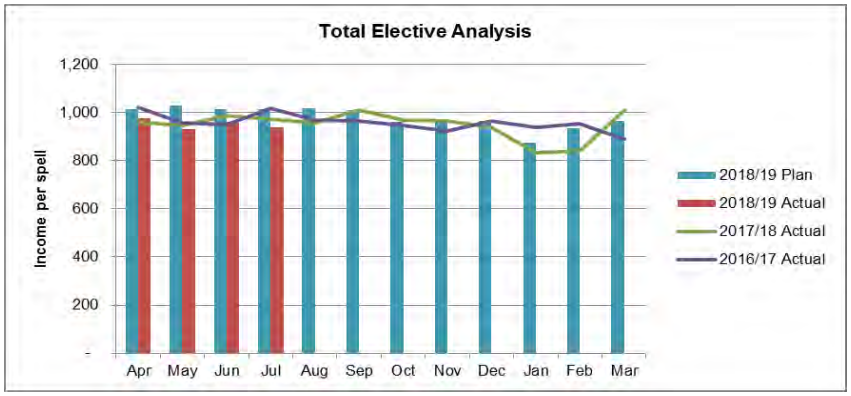


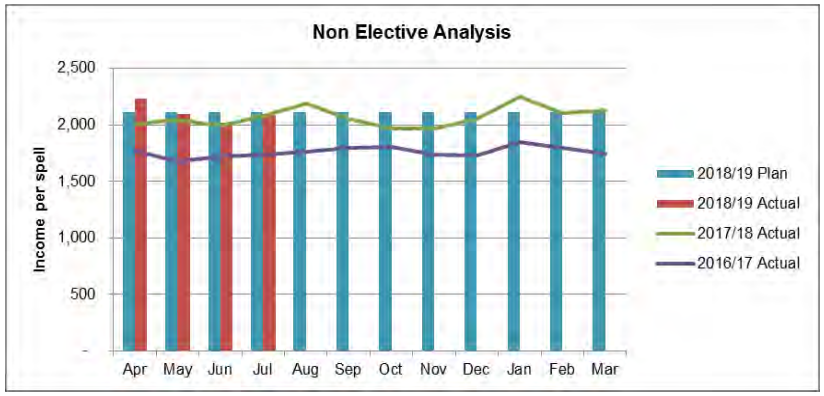


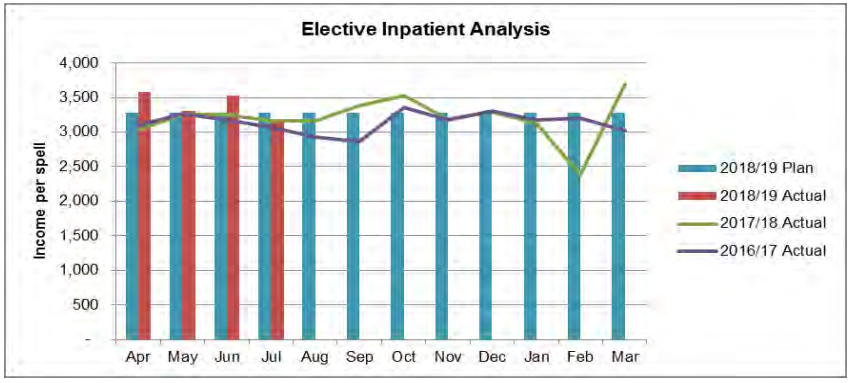
Trends and Analysis

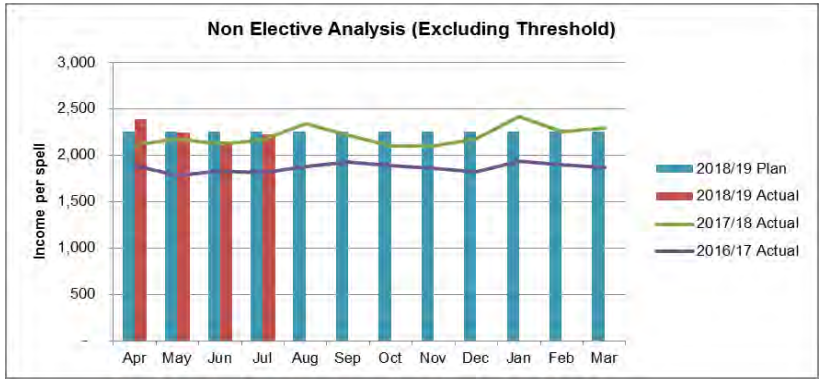










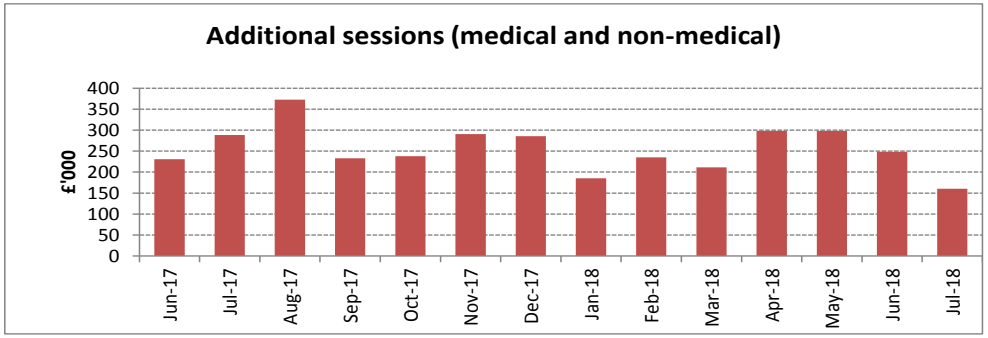


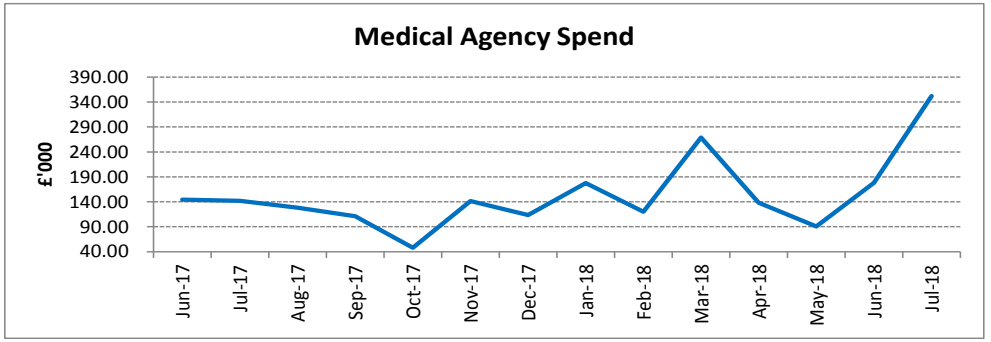
FINANCE AND WORKFORCE REPORT – July 2018

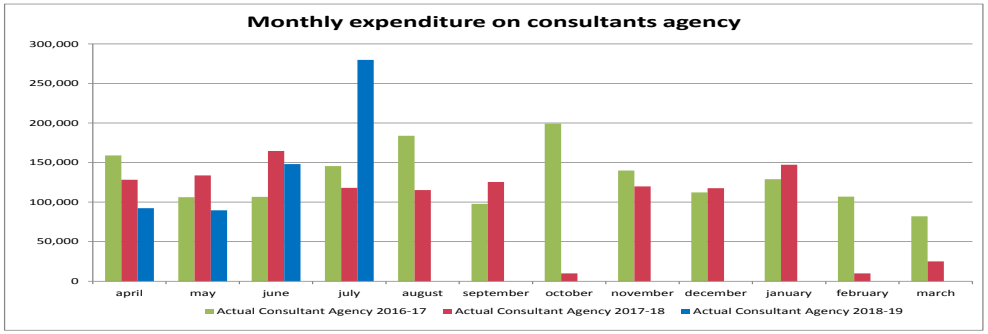
Workforce

Pay Trends and Analysis

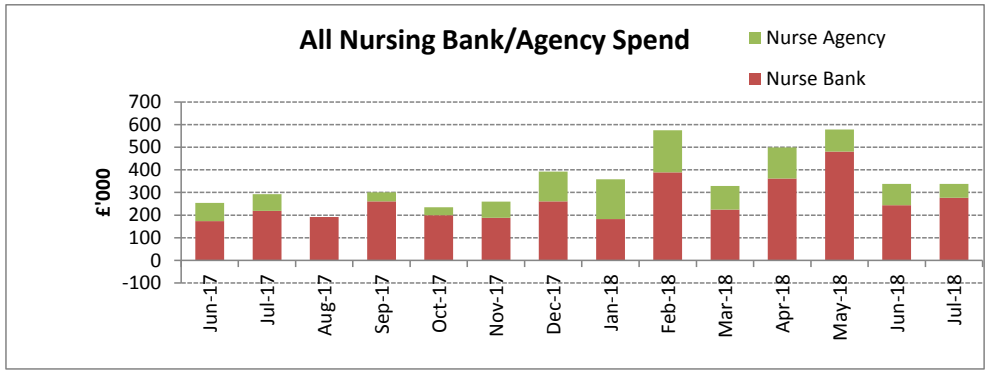
The Trust spent £404k more than budget on pay in July (£1,193k overspent YTD)





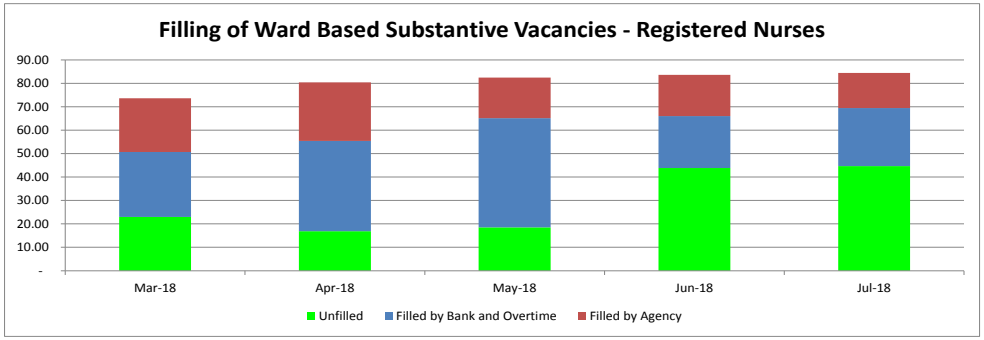


Medical Staff Agency Costs by Speciality	M4 - YTD £'000	M4 £'000
Urology	143.4	19.9
Anaesthetics	125.8	28.8
Xray - Wsh	118.0	57.9
Clinical Haematology	116.0	65.4
Cardiology	105.2	19.2
Gastroenterology	105.0	31.5
Eau Medical Staff	78.1	9.0
Medicine - Consultants	75.2	18.7
Medicine - Junior Doctors	74.5	9.2
Obstetrics	64.4	12.2
Ophthalmology	52.5	(9.3)
General Surgery	50.4	10.2
Histopathology	49.4	14.9
Chest Medicine	49.0	44.6
Diabetes	45.1	23.1
Dermatology	30.5	10.1
E.N.T.	25.7	(6.6)
Plastic Surgery	19.5	1.1
Total	**1,327.7**	**360.0**



FINANCE AND WORKFORCE REPORT – July 2018

Staffing and recruitment



Unfilled posts have increased from 26.89 wte in March to 44.38 wte in July 2018.

In July use of bank/overtime and agency is broadly in line with plan. We planned to use 40.62 wte of bank and agency staff and actually used 40.25 wte (against a maximum assumption of 42.6 wte).

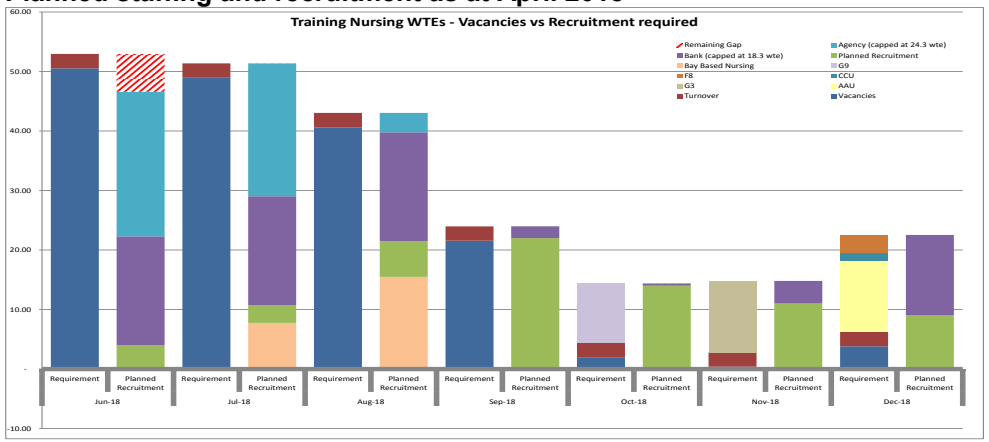
Ward based registered nurse vacancies as at July 2018

Ward	July - Vacancies	July - Bank and overtime	July - Agency	July - Unfilled / (overstaffed)	December - Vacancies	Dec > July Increase (decrease) in vacancies	March - Unfilled / (overstaffed)
Accident & Emergency	11.72	3.28	5.40	3.04	6.33	5.39	0.62
C.C.U.	1.21	0.12	0.00	1.09	2.18	(0.97)	1.36
Ward F9	9.00	1.66	0.50	6.84	5.82	3.18	5.74
Ward F10	4.45	0.05	0.21	4.19	4.96	(0.51)	3.84
Ward F12	2.61	0.03	0.12	2.46	2.87	(0.26)	1.56
Ward G1 Hardwick Unit	2.78	0.18	0.00	2.60	1.75	1.03	2.21
Cardiac Ward	0.00	0.13	0.28	(0.41)	3.86	(3.86)	2.59
Ward G4	3.11	0.29	0.07	2.75	2.12	0.99	1.27
Ward G5	4.68	0.90	0.65	3.13	3.19	1.49	(0.24)
Ward G8	10.02	1.03	4.00	4.99	5.83	4.19	4.49
Ward F1 Paediatrics	5.27	3.40	0.00	1.87	2.70	2.57	1.98
Ward F3	4.56	3.07	0.59	0.90	2.20	2.36	0.05
Ward F4	2.10	2.05	0.00	0.05	2.67	(0.57)	3.58
Ward F5	1.96	0.49	0.33	1.14	2.33	(0.37)	(0.01)
Ward F6	6.12	4.46	1.07	0.59	4.01	2.11	5.24
Gynae Ward (On F14)	0.52	0.63	0.00	(0.11)	0.14	0.38	0.32
Neonatal Unit	1.46	0.39	0.00	1.07	2.85	(1.39)	1.16
Ward F8 Ambulatory Core	0.17	1.59	1.60	(3.02)	2.96	(2.79)	(4.03)
Ward F7 Short Stay	10.20	0.00	0.14	10.06	6.64	3.56	1.88
Ward G9 Escalation Ward	1.00	0.00	0.00	1.00	(1.00)	2.00	(5.45)
Community - Glastonbury Court	0.67	0.84	0.00	(0.17)	1.56	(0.89)	0.27
Newmarket Hosp-Rosemary ward	1.02	0.70	0.00	0.32	(0.44)	1.46	(1.54)
Total	**84.63**	**25.29**	**14.96**	**44.38**	**65.53**	**19.10**	**26.89**

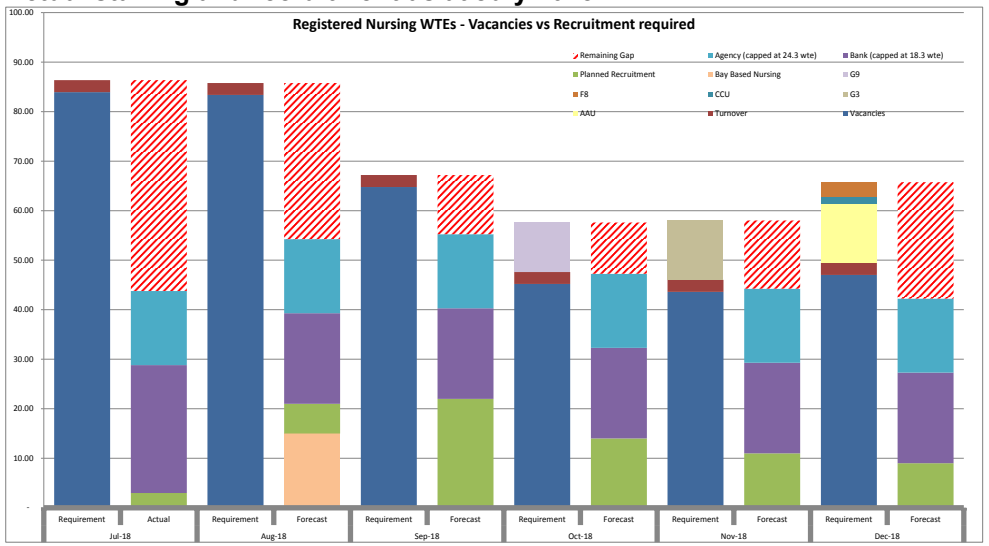
Vacancies have increased by 19.1 wte between December 2017 and July 2018.

Ward based Registered Nurses	Dec-17	Jul-18	Net
Movement in vacancies	**65.53**	**84.63**	**19.10**
Leavers (since January)			33.75
Starters (since January)			(11.00)
Initiatives (bay based nursing)			(3.65)
Total			**19.10**

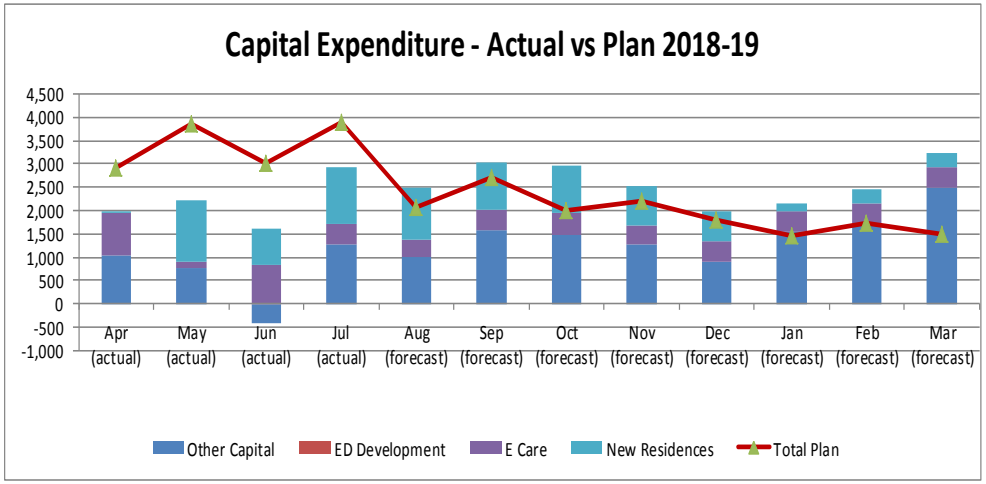
Planned staffing and recruitment as at April 2018



Actual staffing and recruitment as at July 2018



Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Forecast £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2018-19 £'000
E Care	916	131	825	457	380	408	480	430	430	430	430	434	5,751
ED Development	0	0	0	0	0	0	0	0	0	0	0	0	0
New Residences	37	1,329	773	1,210	1,108	1,027	1,027	819	663	169	300	313	8,774
Other Schemes	1,047	760	-405	1,259	1,009	1,596	1,469	1,262	904	1,554	1,719	2,486	14,661
Total / Forecast	1,999	2,220	1,193	2,926	2,497	3,031	2,976	2,511	1,997	2,153	2,448	3,233	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

Expenditure on e-Care for the year to date is £2,329k with a forecast for the year of £5,728k.

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. A number of projects are likely to slip by the year end the value is in the order of £660k although this is still to be finalised. The projects affected are

- Fire compartmentation
- Site Electrical Infrastructure Capacity
- Roof replacement programme
- Vacuum plant

Year to date the overall expenditure of £8,339k is below the plan of £12,913k.

Statement of Financial Position at 31st July 2018

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2018 * £000	Plan 31 March 2019 £000	Plan YTD 31 July 2018 £000	Actual at 31 July 2018 £000	Variance YTD 31 July 2018 £000
Intangible assets	23,852	27,909	25,293	25,630	337
Property, plant and equipment	94,170	111,399	100,839	98,401	(2,438)
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**	**130,057**	**127,956**	**(2,101)**
Inventories	2,712	2,700	2,850	3,008	158
Trade and other receivables	21,413	19,500	23,000	15,907	(7,093)
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	3,601	1,050	1,050	6,852	5,802
Total current assets	**27,726**	**23,250**	**26,900**	**25,766**	**(1,134)**
Trade and other payables	(26,135)	(27,499)	(28,617)	(26,219)	2,398
Borrowing repayable within 1 year	(3,114)	(3,357)	(3,382)	(3,083)	299
Current ProvisionsProvisions	(94)	(26)	(26)	(94)	(68)
Other liabilities	(963)	(1,000)	(6,000)	(3,845)	2,155
Total current liabilities	**(30,306)**	**(31,882)**	**(38,025)**	**(33,241)**	**4,784**
Total assets less current liabilities	**119,367**	**134,601**	**118,932**	**120,481**	**1,549**
Borrowings	(65,391)	(90,471)	(69,462)	(70,724)	(1,262)
Provisions	(124)	(158)	(158)	(124)	34
Total non-current liabilities	**(65,515)**	**(90,629)**	**(69,620)**	**(70,848)**	**(1,228)**
Total assets employed	**53,852**	**43,972**	**49,312**	**49,634**	**322**
Financed by					
Public dividend capital	65,803	66,103	65,803	66,008	205
Revaluation reserve	8,021	8,021	8,021	8,021	0
Income and expenditure reserve	(19,974)	(30,152)	(24,512)	(24,394)	118
Total taxpayers' and others' equity	**53,850**	**43,972**	**49,312**	**49,634**	**322**

Non-Current Assets

There is some slippage on the capital programme mainly on Residences and medical equipment although ECare is ahead of plan.

Trade and Other Receivables

These have decreased by £5.2m in July because the 2017/18 Sustainability and Transformation Fund (STF) Q4 plus bonus payment has been received. The plan assumed this would be received in August which is the main cause of the £7.1m variance compared to plan in July.

Cash

The cash balance is £5.8m higher than plan in July because the 2017/18 STF Q4 payment was received a month earlier than expected.

Trade and Other Payables

This is money owed to other organisations. Payables have increased by £0.6m but are £2.4m less than estimated in the plan for July.

Other liabilities

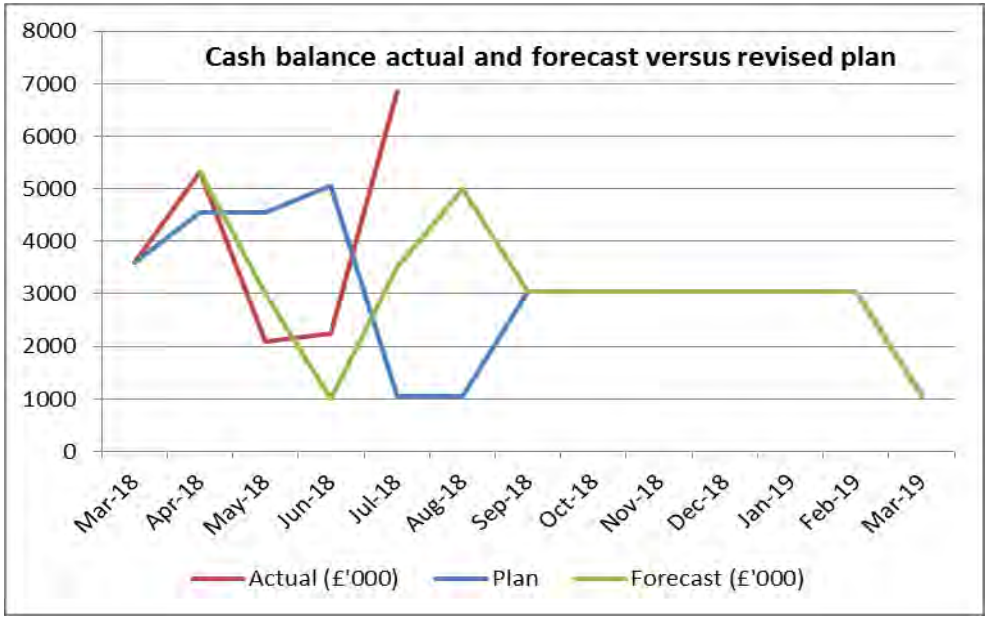
This balance reflects the difference between the income received, mainly for patient care, and the amount that we are able to recognise following the delivery of service. The timing of payments from the CCG has been accelerated in August so the actual liability will be in line with the plan at that point.

Borrowing

The increase in borrowing in July related to capital expenditure and is the final drawdown of the loan agreed in 2015. There is no new capital PDC funding or borrowing in place yet. £10.2m is required to fund the 2018/19 capital programme; the PDC application is with NHSI and remains a significant risk until this is approved. In August borrowing to fund the control total deficit has been drawn down for the first time in 2018/19 and the intention is to borrow £10.2m for this reason by March 2019.

The Trust is required to make a £0.8m loan repayment to DH in August relating to previous borrowing as well as a £0.4m interest payment.

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) was been paid earlier than expected in July with no notice.

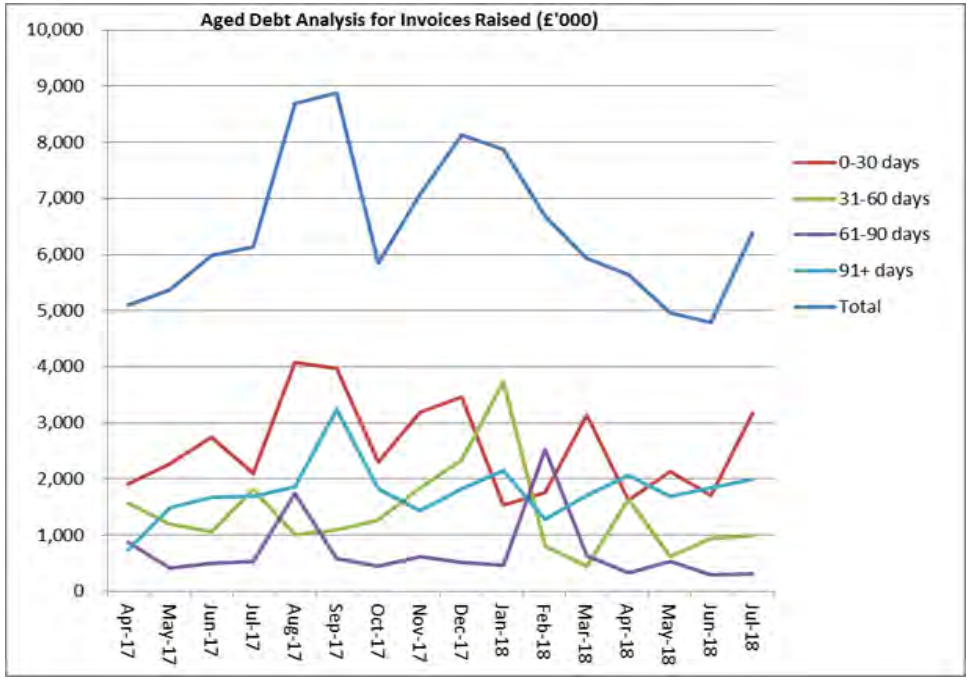
The timing of agreement from DH on the planned PDC funding or borrowing for the 2018/9 capital programme is still uncertain and a significant risk. It is assumed the cash reserves will reduce until the capital loan or PDC funding is received.

The Trust will be borrowing cash from DH equivalent to its control total deficit of £10.2m in 2018/19. £4.3m of this is being drawn down in August. A £0.2m contribution towards the cost of the pay award was received from DH in August and £0.8m is now expected in August for the same reason.

Debt Management

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

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



The overall level of invoices raised but not paid has decreased by £1.6m in July. This is due to a recharge for the Managed Service element of the Cath Lab project

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

11. Nurse staffing report

To ACCEPT a report on monthly nurse staffing levels

For Report

Presented by Rowan Procter

Trust Board – 28 September 2018

Agenda item:	11			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Sinead Collins, Clinical Business Manager			
Date prepared:	19 September 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 August's and progress of nurse staffing review made below.

Observations

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
A&E	8 medication errors	High agency & bank use. High RN & NA vacancy. High amount of overtime. High sickness
F7	5 medication errors	High agency & bank use. High RN vacancy. High sickness
F8	7 medication errors	High agency & bank use. High amount of overtime.
CCS	5 medication errors	High RN vacancy
Theatres	-	High RN vacancy. High amount of sickness. High amount of overtime
DSU	-	High sickness & bank use.
CCU	-	High sickness & bank use. High amount of overtime
G1	-	High amount of sickness & overtime
G3	-	High bank use & NA vacancy. High amount of overtime
G4	5 falls (with harm)	High bank use. High amount of overtime. High RN & NA vacancy
G5	3 falls (with harm)	High agency & bank use. High RN & NA vacancy. High amount of overtime. High sickness
G8	-	High bank & agency use. High sickness. High RN & NA vacancy. High amount of overtime.
F1	-	High bank use & RN vacancy.
F3	-	High RN vacancy. High amount of overtime. High bank & agency use.
F4	-	High agency & bank use.
F5	-	High bank use.
F6	-	High agency & bank use. High RN vacancy. High amount of overtime. High sickness
F9	-	High bank use. High RN vacancy. High amount of overtime. High sickness.
F10	5 medication errors	High bank use. High RN vacancy. High amount of overtime. High sickness.
Maternity	4 medication errors on F11	High bank use & sickness. High midwife vacancy.
F12	-	High agency & bank use.
F14	-	High amount of overtime.

NNU	-	High sickness.
Kings Suite	-	High agency & bank use. High amount of overtime.
Rosemary Ward	3 falls (with harm)	High agency & bank use. High amount of overtime. High sickness.
Bury Town CHT	10 pressure ulcers (in our care)	-
Bury Rural CHT	4 pressure ulcers (in our care)	-
Mildenhall & Brandon	3 pressure ulcers (in our care)	-
Newmarket CHT	-	High sickness.
Sudbury CHT	3 pressure ulcers (in our care)	High RN vacancy. High sickness.
Children CHT	-	High Band 4 vacancy

Vacancies – In West Suffolk Hospital, there are significant vacancies in registered staff, and is 104.47 WTE and there is an unregistered vacancy of 29.13WTE. The registered and unregistered figure is better than last month. HR, nursing directorate and operations are developing different methods to recruit and retain nursing staff. They are also using bay base nursing establishment from October and this will adjust the vacancy figures from that month onwards as well as planning for winter pressures.

Band 4 specialist nursery nurses have 2.0 WTE vacancies to cover package agreed by CCG in the Complex Care Team.

Roster effectiveness – Out of 26 areas, 25 are over the Trust standard of 20% (Day surgery unit & ward are counted as one area). This is 9 areas worse than July, which could be explained due continued summer holidays, and continued high sickness.
Roster effectiveness is a sum of Sickness (Trust standard <3.5%), Annual leave (Trust Standard 12% - 16%) and Study Leave (Trust Standard 2.5% - 3.5%) – It is not a sum of the maximum % but of average Roster effectiveness has not been 'drilled' down any further than sickness due to annual & study leave % are based on appropriate management of staff.
We don't collect this information in the community

Sickness – Out of 27 areas, 20 are over the Trust Standard of 3.5% (two 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 (one more than last month).

Community Workforce
The workload of the teams has stayed relatively the same in regards to Patient Facing Contact hrs but Children's have seen an increase of over 100hrs. Admission Prevention Service is still seeing a decreased amount of Patient Facing Contact, as agreed at Trust Board level due to sickness and vacancies.

Updates in August

Community vacancy figures have improved in accuracy but a local team has not provided the information and been agreed to put figures at zero.

Oversea nurses numbers
At present 170 conditional offers have been made (this is from the recruitment campaign in December 2017 and June 2018 plus separate Skype interviews).

The arrivals consist of:

- August & September cohort (starting 31 August 2018) = 12
- October cohort = 3 confirmed with a possible further 3

The fill rate has now been RAG rated as it can be used as patient safety measure. NHS England has requested exception reporting around those areas where compliance around expected hour's vs actual hours for registered nurses (aggregated monthly data) are less than 80%. This report provides details of where compliance was less than 85%, our Trust now identified internal target (Amber rated) along with those areas where compliance was less than 80%, national target (Red rated)

Fill rate has been RAG rated instead of Bank and Agency Use due to it being a better form of analysing risk.

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Aug-18			Establishment for the Financial Year 2017/18						Data for August 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	80.4%	100.3%	110.2%	107.4%	10.19%	11.24%	291	-8.83	-4.20	7.50%	N/A	29.10%	N/A	8	0
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	60.6%	68.7%	102.6%	96.9%	12.55%	6.19%	88	-11.20	-1.37	6.20%	6.2	25.20%	2	5	2
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	92.9%	106.2%	90.4%	119.8%	18.03%	3.99%	227	-0.40	3.66	2.10%	7.8	25.30%	0	7	2
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	93.8%	87.4%	N/A	N/A	0.24%	0.00%	56	-4.14	0.00	3.80%	30.1	22.50%	1	5	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	93.5%	100.2%	N/A	N/A	2.95%	0.00%	220	-5.86	-0.60	6.00%	N/A	23.90%	0	0	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	142.5%	75.4%	80.0%	N/A	1.40%	0.00%	0	-0.90	-0.10	3.20%	N/A	20.90%	0	0	N/A
WSFT	Day Surgery Unit	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC	52.06	78.00%	22.00%	N/A	1 - 1.5	N/A	61.1%	N/A	84.7%	N/A	2.98%	0.00%	0	-0.30	-1.20	3.30%	N/A	23.80%	0	0	0
	Day Surgery Wards													7.75%	0.00%	25	0.80	0.00	11.90%		32.40%			
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	98.7%	81.6%	71.6%	N/A	7.78%	0.00%	112	-0.60	-0.70	5.10%	12.8	22.00%	0	0	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	102.0%	99.2%	115.2%	N/A	6.25%	0.00%	125	-1.14	1.00	8.60%	8.3	28.20%	0	2	1
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	83.0%	79.3%	82.0%	104.0%	15.52%	0.00%	169	-0.33	-5.53	4.70%	4.8	22.20%	1	1	1
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	79.9%	80.5%	112.3%	102.4%	18.92%	0.42%	376	-4.23	-3.37	3.70%	5.8	26.00%	0	1	5
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	69.7%	77.9%	103.4%	119.5%	21.41%	1.90%	156	-6.18	-5.14	5.90%	5.1	22.50%	1	0	3
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	74.2%	74.0%	98.7%	94.8%	21.49%	13.04%	130	-12.18	-3.71	10.90%	6.0	30.50%	0	2	2
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	94.1%	84.9%	103.2%	N/A	20.90%	0.00%	75	-5.99	1.50	3.40%	8.7	21.80%	N/A	2	N/A
WSFT	F3	Trauma and Orthopaedics	34	40.47	59.07%	40.93%	48.48	7	11	75.8%	81.9%	146.1%	112.6%	8.48%	4.38%	456	-4.60	-1.70	3.40%	5.4	27.70%	1	1	2
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	83.4%	100.3%	99.6%	241.0%	14.19%	7.48%	43	-2.90	-0.90	3.40%	6.7	23.00%	0	0	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	86.7%	89.2%	96.6%	134.2%	8.43%	0.00%	12	-0.72	-1.12	3.30%	5.8	22.80%	1	2	0
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	74.9%	77.6%	99.3%	111.0%	6.13%	2.24%	419	-4.68	-1.10	5.50%	4.8	21.20%	1	0	1
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	67.5%	73.5%	89.5%	124.0%	19.30%	0.48%	300	-9.55	-2.60	13.00%	4.8	29.80%	1	2	1
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	82.4%	70.4%	106.8%	102.8%	13.46%	0.25%	158	-7.30	0.40	9.60%	7.0	25.20%	1	5	1
WSFT	F11	Maternity	29					7.25	14.5													0	4	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms	61.55	72.14%	27.86%	N/A	1	1	113.1%	93.9%	71.5%	62.3%	8.91%	0.00%	23	-5.64	0.60	5.20%	N/A	21.40%	0	0	0
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre					1 - 2	1 - 2													0	2	0
WSFT	F12	Infection Control	8	16.42	68.59%	31.41%	9.61	4	4	85.9%	67.0%	32.5%	106.5%	7.55%	1.89%	35	-2.60	-0.45	4.80%	8.1	20.40%	1	0	0
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	102.3%	99.4%	N/A	N/A	2.04%	0.00%	135	-0.30	-0.40	2.80%	13.5	15.80%	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	86.1%	N/A	80.4%	N/A	0.00%	0.00%	0	-0.20	0.00	3.70%	N/A	21.60%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	98.7%	86.0%	19.4%	45.2%	0.47%	0.00%	51	-1.50	-1.40	7.70%	18.7	23.80%	N/A	1	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	231.1%	85.5%	155.7%	128.1%	7.41%	3.30%	196	-2.70	-1.50	6.00%	5.8	22.60%	0	0	3
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	110.3%	99.6%	99.6%	103.2%	5.86%	1.88%	164	-0.30	0.80	4.10%	4.7	24.40%	0	0	1
										93.50%	85.59%	93.80%	111.98%	9.66%	2.10%	4042	-104.47	-29.13	5.67%		24.14%	*Trust standard is 20%*		
										AVG	AVG	AVG	AVG	AVG	AVG	TOTAL	TOTAL	TOTAL	AVG		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		1264.58		We are unable to collect this information this month		To be confirmed if can measure	-1.80	0.00	4.97%	No equivalent tool for community nurses	58	10	3	1
Community	Bury Rural	Community Heath Team		11.20	10.71%	89.29%				719.45					0.00	-0.50	0.41%		33	4	0	0
Community	Mildenhall & Brandon	Community Heath Team		14.50	20.07%	79.93%				898.87					-0.60	0.00	2.48%		35	3	1	0
Community	Newmarket	Community Heath Team		11.25	28.00%	72.00%				654.87					0.00	0.00	6.88%		20	2	0	1
Community	Sudbury	Community Heath Team		25.92	32.25%	67.75%				1110.52					-4.20	-0.87	9.18%		45	3	1	2
Community	Haverhill	Community Heath Team		13.20	32.05%	67.95%				855.42					-1.84	0.00	0.88%		22	0	0	0
Community	Admission Prevention Service	Specialist Services		13.73	25.13%	74.87%				43.22					-1.42	0.00	3.90%		1	0	0	0
Community	Children	Community Paediatrics		32.89	47.07%	52.93%				1401.83					-0.86	-2.00	12.12%		1	N/A	1	0
										6948.76		#DIV/0!	#DIV/0!		-10.72	-3.37	5.10%		215			
										TOTAL		AVG	AVG		TOTAL	TOTAL	AVG		TOTAL			
																	Target - 3.5%					

Explanations	
	WSFT have some significant environmental layout challenges and additional activity that are not reflected in the SNCT(F14/G1/G8/F12/CCU/NCH)
	Fill Rate is an indication of patient safety - national target 80% (less than = red), Trust internal target 85% (equal and greater than = green)
	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.
	Roster effectiveness is a sum of Sickness (<3.5%), Annual leave (12% - 16%) and Study Leave (2.5% - 3.5%)
	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

12. Learning from deaths

To ACCEPT the report

For Report

Presented by Nick Jenkins

Trust Board – 28 September 2018

Agenda item:	12			
Presented by:	Dr Nick Jenkins, Medical Director			
Prepared by:	Dr Helena Jopling, Consultant in Healthcare Public Health			
Date prepared:	18th September 2018			
Subject:	Learning from Deaths			
Purpose:	X	For information		For approval

Executive summary:

The trust has achieved recognition for its approach to implementing the national Learning from Deaths guidance. The medical reviewers continue to review all deaths which occur in the trust and the work of the Learning from Deaths group is maturing into assurance of the learning which comes out of serious case investigations and incidents of poor care.

Notable items since the last board report in May:

The team is taking an approach of continuous improvement to the way it communicates with families. This includes improving the letter which families receive with review results in response to feedback, and establishing a closer working relationship with the patient advice and liaison service. The medical reviewers speak to a family member in at least half of all cases. The group's family representative now chairs the monthly agenda item on Learning into Action, holding the trust to account on completing learning actions and, in due course, looking back to check those actions have had the impact they were intended to. Peer feedback from other trusts has indicated that family engagement to this extent is something that most trusts haven't tackled at all yet, so although the team are acutely aware there is more to be done to get communication right for this sensitive purpose, WSFT remains ahead of the curve.

We are delighted that two senior matrons will be joining the five doctors on the reviewing team in the coming month. This will bring a very welcome multidisciplinary perspective to the review process. The head of quality improvement will also start receiving the reports on all the cases of excellent care, in order that learning can be maximised from what regularly goes well, as well as where there have been problems.

The next steps will be to embed the learning from deaths programme into business-as-usual, and prepare for the introduction of medical examiners from April 2019, as announced by the Department of Health and Social Care in June[1].

The Board will remember that the trust is required to publish a summary of its mortality statistics and learning from deaths every quarter.

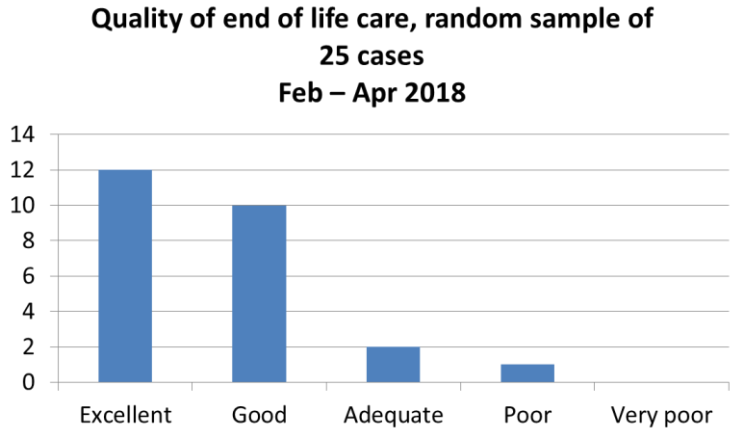
[1] Statement at https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2018-06-11/HCWS755/
Consultation response at http://qna.files.parliament.uk/ws-attachments/921300/original/180611%20Govt%20response%20to%20ME%20and%20death%20certification%20consultation.pdf Please see paragraph 1.5

Outcomes of reviews of deaths, quarter 1, 2018/19

Please see the accompanying dashboard. In summary:

- In quarter 1 there were 214 inpatient deaths, 203 have been reviewed by a medical reviewer
- Seventy-two cases of excellent care were identified
- Six cases of poor care have been identified and one of very poor care. Two of these cases have been referred to the clinical governance team for formal investigation.

A key theme which was synthesised in quarter 1, from both good and poor cases of care, was the timeliness of starting palliative care at the end of life. The learning from deaths programme is providing a richness of data on the quality of end of life care which hasn't been available before. Overall, the standard of care is very high, in line with the CQC's assessment in our most recent inspection.



Family feedback demonstrates this too. An example of the many cases of excellent care was summarised by a medical reviewer as follows:

> "[Patient] was acknowledged to be at the end of life approximately one week before he died. [...] Appropriate efforts were made to consider full-time nursing home placement or hospice placement […].
>
> The family were involved at every stage and their opinions were taken into account. Whilst [patient] remained in WSH, the palliative processes were correct and the care was outstanding. […]
>
> I especially note the excellent integration of ward and palliative care teams when considering palliative medications and syringe drivers and consider this to be excellent."

While a case of poor end-of-life care, particularly from the relatives' perspective, was as follows:

> "Frequent and appropriate medical review with good documentation, particularly by palliative care [but the patient's] daughter felt that […] nurses were 'not on the same page' as the medical teams (despite being 'very caring'). […]
>
> Nurses seemed 'unempowered to do anything' without the doctors' say-so, despite (for example) 'in case' medication being written up, but not given."

In a number of cases, the medical reviewers have felt that the diagnosis of 'nearing death' could have been made sooner with multidisciplinary input, and if it had, the patient's and family's experience of the final admission would have been improved.

For example, in a patient with end-stage lung disease and a number of comorbidities, active treatment was pursued for 13 days until a review by a specialist colleague established that the patient

was in multi-organ failure and nearing death. Palliative care began on day 15 and the patient died 11 hours later.

> "There was only a relatively short period between the recognition of end-of-life [approaching] and [patient] passing away. […]
>
> I do wonder whether a recognition of dying could have been made sooner had the diagnostic benefit of [specialist] input been available sooner. This could have allowed palliative care input"

The medical reviewers are aware, of course, of the benefit of being able to make these judgments through the "retrospectoscope". The professional challenge of making a decision to stop active treatment is well recognised. Nevertheless, with outstanding palliative care available in the trust, and most patients and families being able to receive it, there may be more we can do to make sure that the diagnosis of nearing death is made as early as possible and futile treatment is avoided.

The Learning from Deaths group has referred the theme to the End-of-life steering group, who will receive the data in more detail and discuss the possible improvement opportunities in October. End-of-life care has been recognised as a system priority for some time, with the My Care Wishes yellow folders project encouraging better and earlier conversations about advance care planning for the end of life. The Director of Public Health's 2018 annual report Lasting Legacies: Conversations about end of life in Suffolk has raised the profile of this priority again, and the Suffolk Health and Wellbeing Board held its annual conference on 19th September 2018 on the topic.

Progress will be reported in future board reports.

Preventable deaths in 2017/18

The Board is also asked to note that the number of deaths in 2017/18 judged to have been preventable has risen from 1 in the last quarterly report to 3 this time (line chart in bottom left quadrant of the dashboard). Two cases, one from December and one from March, which had been referred for investigation under the Serious Incident Framework, have concluded and come back to the learning from deaths group for discussion in the round and a judgment on whether, on the balance of likelihood, the patients' deaths could have been prevented.

In both cases, the group took the clinical circumstances and the learning which has emerged into consideration and concluded that, regretfully, the patients' deaths probably could have been prevented. In both cases there has been learning for the clinical teams directly involved in the care, but also learning of value to share.

The case from December has already been presented at a shared learning event held in the trust in June, which was very well attended, and coincided with the visit of Sir David Behan, recently retired chief executive of the Care Quality Commission. Sir David complimented the clinical team and the trust for holding this event in an interview on BBC Radio 4's World at One the following day.

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

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

	X	X	X				
Previously considered by:	Learning from Deaths group						
Risk and assurance:	Safety risk if the trust fails to identify problems in care which lead to patient harm and preventable death, and fails to act to reduce them. Reputational risk if the trust fails to report preventable deaths and fails to demonstrate action to reduce them.						
Legislation, regulatory, equality, diversity and dignity implications	The report describes the trust's approach to meeting the National Quality Board's guidance on Learning from Deaths, which must be reported in the annual report from 2017/18 onwards.						
Recommendation: To note the information on the Learning from Deaths dashboard and the narrative in this summary.							

Learning from Deaths dashboard – Q1 2018/19

Accurate 13 September 2018

West Suffolk NHS
NHS Foundation Trust

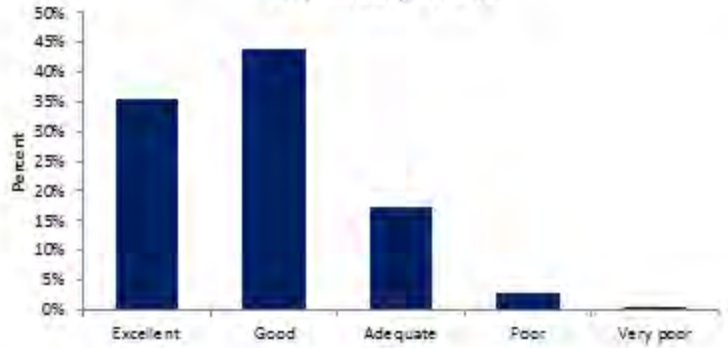
Inpatient deaths	Total	Reviews completed
Q1	214	203
YTD	214	203

Deaths in people in groups under special focus – Q1 (YTD)

Group	Total	> 50% likely preventable
People with learning disabilities	1 (1)	0 (0)
People with severe mental illness	2 (2)	0 (0)
Maternal deaths	0 (0)	0 (0)
Stillbirths	1 (1)	0 (0)
Child deaths	0 (0)	N/A

Overall quality of care

Q1 (dark blue), 2018/19

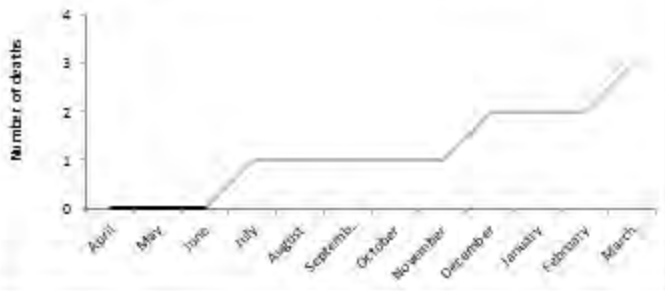


Learning themes identified

Contributing to preventable deaths	N/a
Not contributing to death	End of life care: the standard of care is very high. Unfortunately 'nearing death' is not always diagnosed as early as it could be, so starting end of life care can be delayed.

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

2018/19 (black) compared to 2017/18 (grey)



Preventability benchmarks

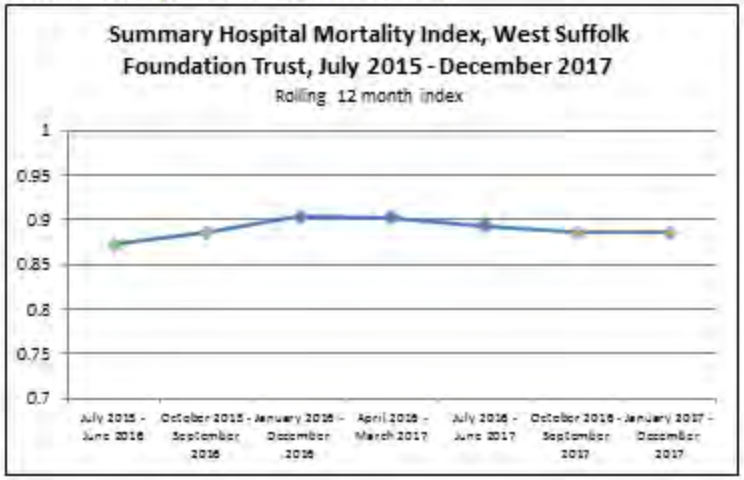
3.0 – 4.3%
Research

0.50%
Real world

0%
WSFT 2018/19 YTD

0.3%
WSFT 2017/18

Summary Hospital Mortality Index (SHMI)



13. Quality and learning report

To ACCEPT a report

For Report

Presented by Rowan Procter

Trust Open Board – 28 September 2018

Agenda item:	13			
Presented by:	Rowan Procter – Executive Chief Nurse			
Prepared by:	Governance Department			
Date prepared:	August 2018			
Subject:	Quality and Learning report			
Purpose:	X	For information		For approval

Executive summary:

This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from in the quarter ending 30/06/18.

Information has been obtained from the following data sources:

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

Key highlights in this report are as follows:

- Two serious incidents with a theme of anaphylaxis.
- NHS Improvement changes to pressure ulcer SI reporting
- Walkabout action plan
- Development of GREATix proposals

Please note:

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

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

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

Activity within the quarter

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

Learning themes from investigations in the quarter

SI RCA reports submitted in Q1

Incident details	Learning
Intrauterine death and Maternal cardiac arrest (with full recovery)	Root causes: The stillbirth was likely due to a cord prolapse causing hypoxia and ischaemia. Maternal cardiac arrest likely caused by rapid and major loss of blood and liquor. Following a thorough and detailed investigation the team felt that there was nothing which could have been done to prevent the events leading up to the loss of the baby. During the investigation and acknowledging the very sad outcome the team could find no omissions of care throughout the care pathway. There were many areas of good practice which were highlighted, such as good team work; this was seen throughout the emergency situations, as well as compassionate support for the family during this difficult time. The investigation also found that good support for the team of staff involved in the incident was evident, in particular the hot debrief shortly after the event and offer of follow up support for those who needed it. The patient and her husband have met with the consultant obstetrician and bereavement midwife to discuss the events which occurred they also touched upon management of any future pregnancies. The patient and her husband will receive the investigation report and will be offered a further appointment with the consultant obstetrician if they wish.

Incident details	Learning
Intrauterine death	Root causes: The cause of the stillbirth could not be explained. After a thorough investigation the team could not identify any cause for the loss of the patient's baby. The care she received throughout the pregnancy was felt to be of a very good standard. In relation to concerns around her anxieties and mental health during the second trimester, the records show particularly good communication and collaborative working between various agencies and maternity services. Referrals to the Fetal Medicine Unit and the Maternity Day Assessment Unit had been appropriate and timely and followed the recommendations of local and national guidelines. In view of the reason for the patient's admission with reduced fetal movements and diagnosis of the loss of her baby, the awareness of fetal movement element was scrutinised very carefully. The investigation identified that patient information regarding fetal movements had been discussed and given to the patient at booking and discussions about fetal movements continued throughout the pregnancy, including emphasising when to contact the Hospital if concerned. The investigation team whilst acknowledging the very sad and unexpected outcome it was considered that all care given had been appropriate and of the expected high standard.
Information Governance	Member of staff has had car broken into at home. Work bag containing ID badge, smartcard, bleep and ward lists was stolen. Following investigation, it was identified that this doctor was not aware how to create the necessary report each day that was needed. As a result, it had become common place for a list to be created and taken home each day. Actions agreed were for an e-Care coach to work with the doctor and ward area to ensure reporting requirements are adequately met and to reinforce message to staff not to remove paper from the Trust site without authorisation.
Failure to diagnose an sub-arachnoid haemorrhage (SAH)	A patient with a past medical history including SAH underwent a CT scan which was undertaken by 4ways healthcare. The CT scan came back as clear with no apparent bleed. However an audit review by the commissioned radiology service highlighted the discrepancy to the hospital a number of days later. This incident illustrated that human error in radiology reporting is unavoidable however there are audit processes in place that monitor this. There was missed opportunity to follow the WSFT guidelines Protocol Management for SAH where it states that when there is clinical suspicion and patient is at high risk of a SAH, the patient should be offered a lumbar puncture even if the CT scan is clear. The investigation noted that a discrepancy such as this incident is a rare event and knowledge of the incident should be communicated to appropriate clinical staff so that lessons can be learnt and staff are aware of the pathway of auditing radiology discrepancies as well as offering the lumbar puncture procedure when a SAH is suspected.
Unexpected death	Patient admitted with a 2 week history of increasing shortness of breath. Cardiac arrest after intravenous administration of amoxicillin. Anaphylaxis confirmed as cause of death at Post Mortem. Paramedics had documented *no known drug allergies* and *"?rash with amoxicillin*". Root causes were identified that patient had co-morbidities including Congestive Cardiac Failure that were making them feel unwell, when they were administered the IV antibiotics they experienced anaphylaxis that had a lack of normal signs and symptoms. This resulted in death. Lessons learned noted that staff should ▪ Have awareness that anaphylaxis does not always present itself clearly when somebody has other co-morbidities that may affect the natural immune response. ▪ Ensure there is clear handover of the patient between the Ambulance and the Emergency Department and all relevant information is transferred through the patient's record. ▪ If ED is in black escalation to respond in a timely appropriate manner (according to the Trust Escalation Guidelines)

Incident details	Learning
Unexpected death	Patient admitted to the hospital with query supraglottitis, and treated with intravenous antibiotics. Later in the evening developed difficulty in breathing, collapsed and suffered a respiratory arrest leading into a cardiac arrest. After a prolonged period of resuscitation, patient did not survive. Care and service delivery problems / Contributory factors were identified: ▪ Late administration of IV antibiotic and hydrocortisone. ▪ Initial airway during respiratory arrest difficult to obtain due to oedema of the pharynx, which continued into the cardiac arrest – front of neck access not attempted sooner. ▪ Failure to follow the ALS guidelines with regard to tachyarrhythmias. Actions arising from this investigation have included the introduction of a 'Plan D (front of neck access) grab bag kit' on the resuscitation trollies  This case has been the subject of a Trust learning event with the permission of the patient's family.
Deteriorating patient (child)	Child admitted for an exacerbation of asthma. During the night the child appeared to deteriorate and was not picked up despite concerns from the mother. Child went into respiratory arrest and required intubation and transfer to ITU. Child stabilised and transferred to PICU at Addenbrookes and has since made a full recovery. Root Causes were highlighted as follows: Three patients on ward with increased acuity, Lack of recognition of deteriorating child and requirement to escalate sooner and Human factors impact with regard to poor communication An action plan has been agreed: ▪ For all ward staff to be involved in checking the emergency equipment ▪ To ensure that the basic airway equipment is easy to find, with the more bulky I-Gels stored together ▪ For all staff to ensure that documentation is a priority ▪ Ensure that guidelines (I.e. asthma are followed; hourly observations) ▪ Switchboard to ensure that all staff are familiar with emergency team activation ▪ Develop an on-going educational programme in order to ensure staff are able to recognise and escalate deteriorating patients (I.e. Revisit training modules, ward based scenarios) ▪ Develop a guideline to support the use of PEWS and recognition and escalation for the deteriorating patient for paediatrics.

Incident details	Learning
Delay in Diagnosis and treatment of carcinoma of prostate	The investigation concluded that it is difficult to quantify the impact of the delay in the treatment of the patient's metastatic cancer, the patient is now receiving the same treatment and pathway of care as they would have done had the patient's diagnosis been identified earlier. The patient is now being managed as a long term metastatic prostate cancer patient. However the investigation found there were a number of the processes within Urology that didn't happen as they should have done for this patient therefore the findings from this report need to be taken on jointly by the clinical and service management of the Urology Team to ensure that each of the elements that the investigation have found and their recommendations are implemented and monitored to prevent them from happening again. ▪ Ensure all GPs know to use the updated Urology Suspected Cancer Referral Form ▪ Change the refer for advice process no second letter required ▪ Implement a system across surgery to ensure that the locums and new consultants are kept up to date on e-Care ▪ Histologist should put patients directly onto the MDT list to avoid Gaps in the process/ names to go directly to the MDT Coordinator ▪ Review process with urology ward clerks to ensure patients are booked for review ▪ Post investigation meeting with urology team and service manager to ensure implementation of the recommendations ▪ Ensure that the Urologists if they are discharging patient review the patient records to ascertain if there is a need for review. ▪ Ensure appropriate level of review and escalation and decision making for a patient when requested.
Pressure ulcers	Following directive issued by NHS Improvement in June 2018 it was confirmed that pressure ulcers are not reportable as an SI unless they meet the criteria of a 'Serious incident' (i.e. a red incident / grade 4 pressure ulcer). There have been no grade 4 pressure ulcers reported since September 2017
Falls	Reports were submitted for two patients who fell and sustained a neck of femur fracture
Infection Prevention	Reports were submitted for two ward closures due to Norovirus

There were no reports submitted on behalf of other organisations in Q1.

Quality Walk About from Q1

During quarter 1 of 2018 we have visited the following areas , F9, F7, F1, DSU, CCU, MTU, Fracture Clinic, Clinical skills labs and F5. In total 9 areas were visited. These have been facilitated by the clinical governance team and have had attendance from the Chief Executive, Chair, Executive Chief Nurse, Medical Director and several non-executive directors and governors who have supported these walkabouts. These have been able to further develop and facilitate a real opportunity to observe, review and interact with both staff and patients. These have been able to review previous walkabouts and often see the units' response to the challenge or the extra support offered as a result of the walkabout.

A great example of this was on F5 where there was a real need for the conversion of a bathroom into a shower room. The unit manager was desperate to have this converted. With her drive and support of the estates team the quality walkabout was able to support the timely commencement of the works between the visit in October and May this year.

Daily checks need to generally to improve. This has been down to reduced staffing; increased acuity however does not detract from the importance for these daily checks. There is an electronic app being designed by the trust to have live monitoring of the daily checks and this will incorporate monitoring features within. This will help to have live information about the completed checks and ensure these are completed due to the incorporated escalation with in the tool. Next meeting planned for end of month to review the app.

Patient experiences have been good and many complimenting on the quality of the care they have received. At times noise at night has been raised, but when discussing this further this has been due to other patients with all except one occasion where it was felt the staff was the result of the noise. All of our interactions have praised the hard working and dedication of the staff and many describe the compassion, caring and dedication of the staff that have treated them. The quarter has seen the appearance of lack of staff and increase workload become more of a common theme with the comment "there just isn't enough of them" often being used.

In total 24 actions were developed following the walkabouts of which 20 have been completed. 10 of these actions were within the paediatric area and are picked up within the task and finish group and have a med term – long term completion timeframe. These included recruitment of further staff and equipment development within the HDU areas. The actions that have been raised as a result following walkabouts have involved escalation to the following teams, Estates and Facilities, Housekeeping, Senior Nursing and Medical teams and others have been able to be managed at the ward level. I would like to acknowledge the support of all of these teams as without them we would not have been able to achieve often a very timely resolve to the issues identified.

We have now established an access database which we are ensuring is working well and will then be embedded into Datix via an in-house build. This is going to be used to report, monitor and update and give assurance of any actions raised and then both picked up and monitored as per actions from incidents.

The quality walkabouts have enabled staff to raise concerns or frustrations directly to senior leaders and also governors directly. This has received much positive feedback and we continue to plan our next quarter's walkabout plan. Moving forward we are exploring the feedback process and this we are hoping to incorporate into our Datix system to ensure oversight of both the issues and actions and timely completion.

We have also listened regarding staffs keenness regarding GREatix and we are in the process of establishing this with the Comms team.

Other learning themes

1. **Subject / Theme** AKI
Source Trust Quality Priority - Reduce the incidence of acute kidney injury
Risk register entry None
Trust owner[1] Deteriorating Patient Group
Summary of learning and areas for improvement in this topic

A secondment for an AKI project nurse has been supported from within the patient safety team to focus time on AKI and improving the standards around AKI for both our patients and staff treating them. This work will be with both existing teams and focussing on new areas for development. They will work across all professions. The first meeting has had to be delayed due to illness.

There will be an update on this subject in the February 2019 report.

2. **Subject / Theme** Triage
Source Theme from Red / Amber incidents
Risk register entry **RR2422**
Trust owner Emergency Department- Failure to recognise, manage and identify deteriorating patients within the emergency department
Summary of learning and areas for improvement in this topic

A triage review was conducted using an observational audit style approach from within the emergency department. Generally the standard was good and the current process appears to be working well. However the time it takes for triage and documentation and coding elements was too long. The team have worked with both information and e-care to both redesign and stream line the pathway with a view that this will be reviewed once changes have been embedded.

3. **Subject / Theme** The unwell Obstetric patient
Source Serious incident
Risk register entry N/A
Trust owner Clinical Directors group
Summary of learning and areas for improvement in this topic

There are two elements of this topic: acute medical care (1) and care within maternity (2).

(1) A statement has been added to the internal professional standards, agreed between the Quality group and clinical directors, that in all cases of pregnant or post-natal women being medically or surgically unwell, the best location for their care to be provided will be decided in a consultant-to-consultant discussion informed by the head of midwifery and the relevant head of nursing.

(2) Following a survey of midwives to identify if they had interest in increasing knowledge and skills for these patients; the anaesthetic team has developed a training programme including:

- Recognition of the unwell pregnant patient
- CVS emergencies Respiratory emergencies
- Neuro problems
- Small workshops:
- Arterial lines- set up and trouble-shooting Oxygen delivery and management
- Pain relief workshop
- ABCDE assessments and management of the unwell woman

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

Updates from themes reported in previous quarters

1. Radiology Reporting Delays

Radiology reporting delays have been a long term issue but more recently have been identified as an increased and current risk in the organisation. This has been a theme that has been identified as a contributory factor to more than one Serious Incident regarding a delay in a patient's diagnosis. The cause of the delays in reporting has been attributed to the number of vacancies for Radiologists we currently have in the organisation. There are two current vacancies and a member of staff on maternity leave which has left the department below establishment by three posts. These posts have been out to advert for which they have been unable to recruit for.

Currently there is a shortage of Radiologists available to recruit to the posts. This is a National acknowledged issue that has been highlighted by the recent national news. The issue has been raised at the Regional Radiology Network and the Radiology Managers Conference in May 2018.

One of the factors for this national shortage is the increase in the number of offsite radiology reporting companies that trusts are out sourcing their reporting to. They are recruiting high numbers of Radiologists with benefits such as flexible working and working from home that reduce the number available of Radiologists to recruit for trust based jobs. Most trusts in the country use some form of outsourced radiology reporting like ourselves for out of hours overnight reporting and waiting list management.

A second factor is the increase in the number of radiology procedures requested, there has been a significant increase in the number of Inpatient and Emergency cases requests over recent years that has put pressure on the current reporting capacity. Outpatient reporting performance suffers the most as that is of a lower clinical priority to the inpatient and emergency imaging undertaken. The increase in requests is demonstrated in figure 1 (number of MRIs carried out in the past 5 years) and figure 2 (number of CT scans carried out in the past 5 years).

Fig 1

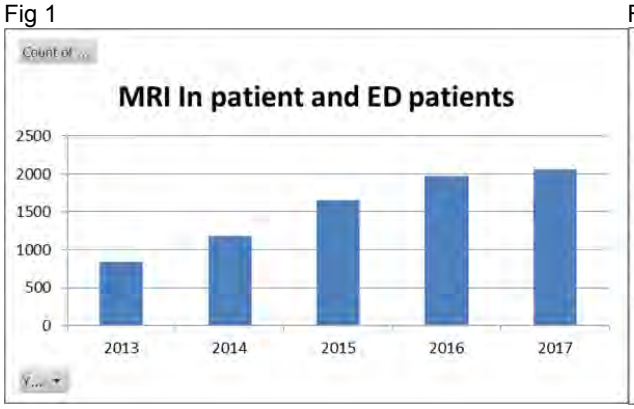
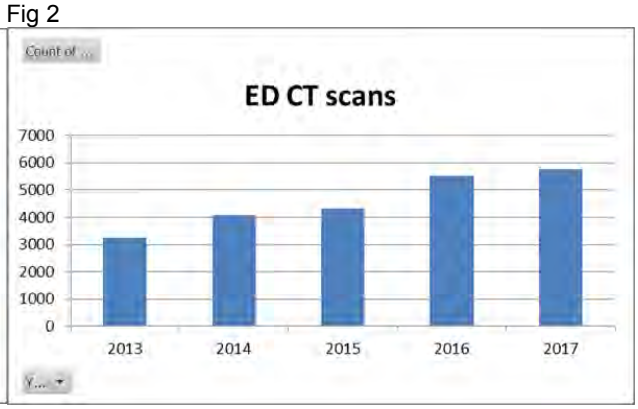


Fig 2



There have been several controls put in place to try and manage this issue.

- Radiology currently has a red risk assessment in place that is reviewed regularly.
- There has been a recent TEG paper escalating the delays in radiology reporting
- Radiology has recruited an extra Radiographer to support the radiologists and screen the MRI cases for urgent reporting.
- Continued triage of the outstanding reporting based on the referral content.

Developments

- Targeted trust recruitment has achieved a recruitment plan that will see the current vacancies filled by Sept 2019. One locum starting in September 18 another in February 19 and a third in September 2019 which will bring the department up to establishment.

- Suggested development of board reporting for radiology reporting KPI data to keep the board aware of the issue and any current risk to patients, it is currently discussed at the divisional performance meeting.
- Development of a government target coming on line in the form of a CQUIN measure nationally.

https://www.cqc.org.uk/sites/default/files/20180718-radiology-reporting-review-report-final-for-web.pdf

2. Paediatrics care of the deteriorating child

This is planned for November for the first one day course with three further dates planned for 2019. We have also extended the invite to our USAF colleagues to attend / assist in teaching. Faculty meeting is planned for October.

Mitigated red risks

During Q1 action to mitigate and downgrade one red risks was taken. This related to the Inability to transfer urgent echocardiograms via PACS. This risk was downgraded to amber after further mitigation to address the concerns was put in place.

Learning from RIDDOR incidents

During Q1 the number of incidents reported to the HSE under RIDDOR has slightly increased from the previous quarter by 3, from 5 to 8. Learning and mitigation included:

- Targeted staff training in moving and handling techniques
- Moving and handling risk assessment being reviewed and updated
- Scorpion security put in place on Ward
- Inspection completed on pavement and walkways

Learning from patient and public feedback:

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

- Midwives undertaking newborn physical examinations are due to receive training from consultant ophthalmologist to ensure site examinations are thorough and appropriate.
- On Ward F3 additional staff have now been trained on Powergate to enable ordering to occur when the ward manager is on leave. This will ensure equipment can be ordered in a timely manner. They are also now stocking a range of neck collars on the ward to ensure these are immediately available when required.
- Patients with neck injuries will now be followed up whether they have a hard or soft collar insitu. Previously this was only for hard collars.
- All patients who have undergone a hysteroscopy will be offered a six week post-procedure follow-up appointment.

14. Safe staffing guardian report

To ACCEPT a report

For Report

Presented by Nick Jenkins

Trust Open Board Report – 28 September 2018

Agenda item:	14			
Presented by:	Nick Jenkins, Executive Medical Director			
Prepared by:	Helen Kroon, HR			
Date prepared:	September 2018			
Subject:	Guardian of safe working report			
Purpose:	X	For information		For approval

Executive summary:

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

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

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

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

Previously considered by:	-
Risk and assurance:	-
Legislation, regulatory, equality, diversity and dignity implications	-
Recommendation: *To accept report*	

QUARTERLY REPORT ON SAFE WORKING HOURS
DOCTORS AND DENTISTS IN TRAINING

1st April 2018 – 30th June 2018

Executive Summary

Introduction

This report would usually have been submitted in July, however the Guardian of Safe Working was not available. As there was no meeting in August, September is the earliest this report could be submitted.

On this occasion the report has been compiled by the Medical Staffing Manager, whilst the Trust is recruiting a new Guardian of Safe Working.

The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A system of Exception Reporting is in place, which replaces monitoring of working hours. This is done using Allocate software, a system already in place at West Suffolk, but extended for this purpose. This report covers the three month period (1st April 2018 – 30th June 2018 inclusive).

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

All trainees taking up appointments are on the New Contract. Trust grade positions are on contracts that mirror the new Contract.

Summary data

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

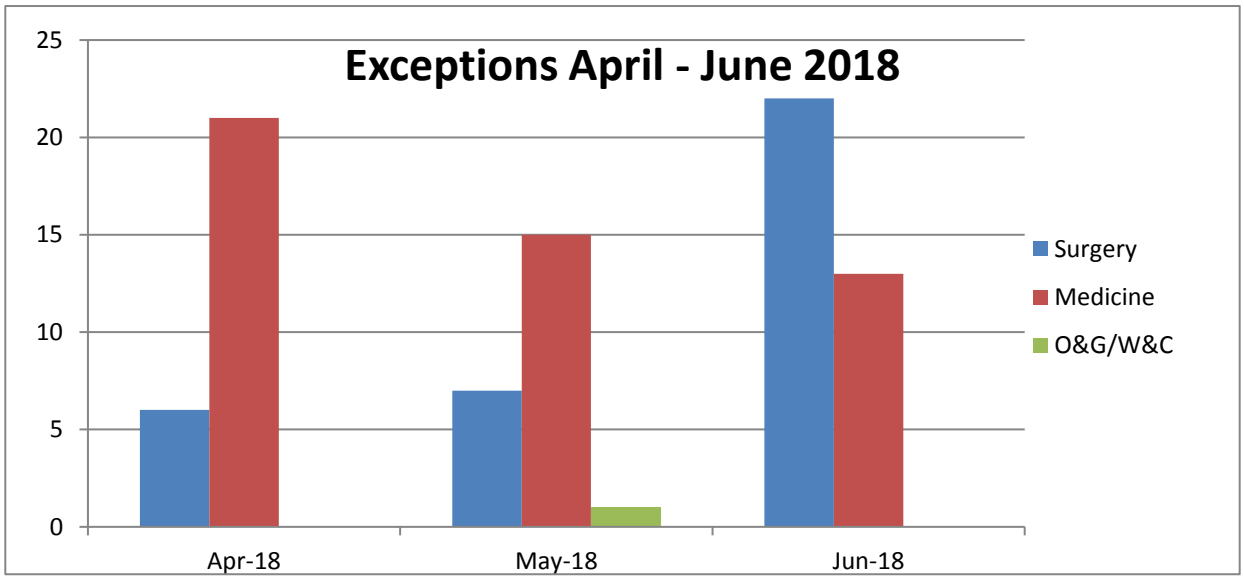
a) Exception reports (with regard to working hours)

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

Exception Reports by DEPARTMENT				
Specialty	No. exceptions carried over from before 31 March 18	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Surgery	2	35	34	1
Medicine	4	49	41	8
Woman & Child/Paeds	2	1	1	0
Clinical Support	0	0	0	0
Total	8	85	76	9

Exception reports by SPECIALTY & GRADE					
Specialty	Grade	Exceptions carried over from before 31 March 18	Exceptions raised	Exceptions closed	Exceptions outstanding
Surgery	F1	0	1	1	0
	F2	2	3	3	0
	T Dr/CT/ST3	0	31	30	1 UNRESOLVED
Medicine	F1	1	16	10	6
	F2	2	31	30	1
	CMT/ACCS	1	2	1	1
Woman & Child	F2	0	1	1	0
	ST3	2	0	0	0
Total		8	85	76	9

Exception reports – RESPONSE TIME			
Specialty	Addressed within 48 hrs	Addressed within 7 days	Addressed in longer than 7 days
Surgery	16	19	0
Medicine	9	27	13
Woman & Child	0	1	0
Total	25	47	13



b) Work schedule reviews for period 1st April 2018 – 30 June 2018

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

Locum Bookings : 1st April – 30th June 2018

TABLE 1 : Shifts requested between 1st April – 30th June 2018 by 'reason requested'

Department	Extra/Rota Compliance/ Induction Cover	Leave (ie Annual/Study/ Interview)	Maternity Leave	Sickness/ Reduced Duties	Vacancy	Grand Total
A&E	8	35	3	8	228	282
Anaesthetics					16	16
Clinical Support				6	56	62
Dermatology					15	15
ENT	3			3		6
General Surgery / Urology	3		6	4	33	46
ITU						0
Medicine	117	16	1	19	76	229
O&G					61	61
Ophthalmology					12	12
Paediatrics				29	12	41
T&O	1	2			16	19
Grand Total	**132**	**53**	**10**	**69**	**525**	**789**

TABLE 2 : Shifts requested between 1st April – 30th June 2018 by 'Agency / In house fill'

Department	A&E Agency	Athona	Holt	IDM	Interact Medical	Locum People	National Locums	NC Healthcare	NHS	Pertemps	Pro-medical	RM Medics	Surgi-call	Unfilled shift	Grand Total
A&E	1				3	32			169	1				76	282
Anaesthetics									16						16
Clinical Support		10							52						62
Dermatology									15						15
ENT									6						6
General Surgery									24	11				11	46
ITU															0
Medicine	1	1	4	12	1			8	154	2		8		38	229
O&G	1								50				9	1	61
Ophthal'									12						12
Paediatrics	12								28		1				41
T&O							1		14					4	19
Grand Total	**15**	**11**	**4**	**12**	**4**	**32**	**1**	**8**	**540**	**14**	**1**	**8**	**9**	**130**	**789**

TABLE 3 : Shifts requested between 1st April – 30th June 2018 filled 'In house only by grade'

Department	Cons	F1	F2/ST	SAS	ST3/4+	Grand Total
A&E	15		30		237	282
Anaesthetics					16	16
Clinical Support	62					62
Dermatology				15		15
ENT					6	6
General Surgery / Urology	11		11		24	46
ITU						0
Medicine	95	6	111		17	229
O&G	17				44	61
Ophthalmology					12	12
Paediatrics	17				24	41
T&O			19			19
Grand Total	**217**	**6**	**171**	**15**	**380**	**789**

Vacancies - HR have provided details of current junior doctor vacancies:

Department	Grade	Apr 18	May 18	Jun 18
A&E	CF (ST3+)	3	3	3
	GP	1	1	1
Anaesthetics	ST3+	3	3	3
	ACCS/CT	1	1	1
Medicine	ST3+	2	2	2
Obs & Gynae	ST3+	2	3	3
T&O	GP	0.5	0.5	0.5
Pediatrics	ST4+	1	1	1
Total		**13.50**	**14.50**	**14.50**

c) Fines

There is a system of financial penalty now in place where exception reporting demonstrates the following:

- a breach of the 48-hour average working week across the reference period agreed for that placement in the work schedule
- a breach in the maximum 72-hour limit in any seven days
- the mimimum 11 hours rest requirement between shifts has been reduced to fewer than 8 hours.

This quarter there were one instance where a fine has been made, all in the department of medicine. This information has been fed back to the Medical Directorate.

Between 1 April 2018 and 30 June 2018, the following breaches occurred:

Doctors	Ward	Date Range (Occurrence)	Breach details	Notes	Total hourly (x4) figure (cost to the Trust)	Hrly Penalty rate paid to doctor	Amount already paid	Amount remaining to Dr	Amount to Guardian fund
Doctor E	G1	03/05/18-22/06/18	48 hrs	average 48.07 over this period (21.00 hrs)	1240.89	568.05	310.17	257.88	672.84

Total breach fines paid by the Trust from August 2017 to date are £8,234.89, and the Guardian Fund currently stands at £4,474.86.

This fine was caused by a breach in the 48 EWTD rule over the length of the reference period.