NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday, 29 Jun 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, 29 June 2018 at 9.15 in the Northgate Room, 2nd Floor, Quince House at West Suffolk Hospital
Organiser	Karen McHugh

Agenda

AGENDA

Agenda Open Board 29 Jun 2018.docx

9:15 GENERAL BUSINESS

1. Introductions and apologies for absence
   To NOTE any apologies for the meeting and request that mobile phones are set to silent
   Apologies: Angus Eaton, Jan Bloomfield
   Presented by Sheila Childerhouse

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

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

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

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

   Item 5 - Open Board Minutes 2018 05 25 May Draft.docx

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

   Item 6 - Action sheet report.doc

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

   Item 7 - Chief Exec Report Jun 18.doc

9:35 DELIVER FOR TODAY

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

   Item 8 - WSFT Board Community and alliance cover sheet June 2018.doc

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

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

   Item 9 - Integrated Quality Performance Report_May_2018_Final.pdf

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10. Discharge summary report
    To RECEIVE an update
    Presented by Nick Jenkins

    Item 10 - WSFT Trust Board Discharge Summary update - June 2018.doc

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

    Item 11 - Finance and workforce cover sheet.docx

    Item 11 - Finance Report May 2018 FINAL.docx

10:35 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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

    Item 12 - Nurse Staffing Dashboard Report - May 2018 data.doc

    Item 12 - WSFT Dashboard - May 2018.xls

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13. Nursing staffing strategy
    To ACCEPT the annual review
    Presented by Rowan Procter

    Item 13 - Nursing Midwifery Strategy 2016-2021 Update 2018 v2.doc

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14. Leadership programme – metrics for success
    To ACCEPT the report
    Presented by Denise Pora

    Item 14 - Trust Board Leadership Update June 2018.doc

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15. Medical revalidation annual report
    To ACCEPT a report
    Presented by Nick Jenkins

    Item 15 - Medical Validation Annual Report 17-18.doc

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16. Putting you first award
    To NOTE a verbal report of this month's winner
    Presented by Rowan Procter

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17. Consultant appointment report
To RECEIVE the report
Presented by Stephen Dunn

Item 17 - Consultant Appointments report - June 2018.doc

11:00 BUILD A JOINED-UP FUTURE

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

Item 18 - eCare WSFT Trust Board June 18.doc

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19. Annual licence certification report - general condition 6 and Continuity of Services condition 7
To APPROVE report
Presented by Richard Jones

Item 19 - NHSI Certification Jun 18.doc

11:10 GOVERNANCE

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

Item 20 - TEG report.doc

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21. Council of Governors report
To RECEIVE the report
Presented by Sheila Childerhouse

Item 21 - CoG Report to Board June 2018.doc

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22. Audit Committee report
To RECEIVE the report
Presented by Sheila Childerhouse

Item 22 - Audit Committee Report Coversheet 29th June 2018.doc

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23. Remuneration Committee report
To RECEIVE the report
Presented by Sheila Childerhouse

Item 23 - Remuneration Committee report.doc

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24. Annual governance review
To APPROVE report
Presented by Richard Jones

Item 24 - Annual governance review 2018-19.doc

Item 24 - Annex A Annual Governance Review questionnaire 2018-19.doc

Item 24 - Annex B KLOE prompts and characteristics.docx

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

Item 25 - Items for next meeting.doc

11:25 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
Presented by Sheila Childerhouse

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27. Date of next meeting
To NOTE that the next meeting will be held on Friday 27 July 2018 at 9:15 am in the Northgate Room.
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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MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 25 MAY 2018

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

Action

GENERAL BUSINESS

18/107 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

Apologies for absence were received from Dawn Godbold.

The Chair welcomed everyone to the meeting and explained that community services had been moved up the agenda to allow for more focus on this. In order to allow more time, there would be exception reporting only in the quality and performance report.

She congratulated Helen Beck on her appointment as the Trust's new Chief Operating Officer. She thanked her for everything she had done for the Trust over the past year in her role as interim Chief Operating Officer.

Helen Beck thanked everyone for all their support during the past year, particularly over the last few weeks leading up to her substantive appointment. She looked forward to continuing to work with board members and her team.

18/108 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

- June Carpenter referred to the fact that this was Steve Turpie's last meeting and thanked him for all the support he had given the governors during his time as a NED.

- She referred to nurse recruitment in the Philippines and that the Trust has not been able to recruit the number of nurses that it had hoped to. She understood that the cost per nurse was fairly high and asked if it was an effective way of recruiting nurses.

Rowan Procter explained that although it could appear that this was not necessarily a cost effective way of recruiting nurses, it was also necessary to look at alternatives and if there were more cost effective ways of recruiting nurses. The Philippines produced some excellent nurses with a high standard of nursing skills. However, one of the key issues was the English language test (IELTS) that nurses recruited from outside the EU were required to take. WSFT only interviewed nurses who had already achieved a certain standard of English, which limited numbers available.

A few nurses from the Philippines would be joining the Trust over the next few months and it was hoped that more would be joining in the near future, as this was still considered a cost effective way of recruiting a good standard of nurses.

Jan Bloomfield explained the process for recruiting and interviewing nurses in the Philippines and that the trajectory was for there to be 44 by September. The Trust was constantly monitoring how these nurses were progressing.

- Liz Steele referred to obesity which had recently been discussed at the STP event and was also mentioned in the Chief Executive's report as being a major issue for the NHS both now and in the future, both in terms of finance and beds. She asked for assurance that the Trust was addressing this and looking at being proactive in its actions, rather than being reactive in its approach.

  Helen Beck explained that WSFT's appointment of Helena Jopling, Public Health Consultant, showed that the Trust was taking this issue very seriously. She and her team were looking at environmental factors that not only affected obesity, but other health related issues as well. Liz Steele acknowledged this but also noted the need for links with education and ongoing monitoring of children and ensuring parents became more aware of the issues relating to obesity.

  It was confirmed that this and one of the ambitions of Helena Jopling's work. The Chair said that this was where the links within the Alliance were so important.

- Joe Pajak referred to the Chief Executive's report and building a joined up future; the 1st joint report of the education, health and social care committee. He felt that the title, 'failing a generation' was very apt and asked what the Trust was doing to ensure that it really had the impact it should with integrating health, education and social care, in order that the prevention of factors such as obesity were addressed in younger people, so that there were not the same problems as people got older.

  The Chief Executive referred to the Trust's Health and Wellbeing Together strategy and area Health & Wellbeing board which meant that the Trust's partners were able to see how this was progressing. WSFT was now working closely with a number of organisations and also promoting healthy living and activity through MyWish; however he felt that there was still more it could do in terms of linking with education. He referred to the work being done by dermatology with West Suffolk College's beautician's students on skin cancer which was a great way of linking with education.

  The 100 day challenge showcase event had taken place yesterday where consultants had spoken about prevention, education and support for diagnosis in the community, which had been very inspiring and an excellent focus on integration.

- Joe Pajak also referred to mental health in education and the number of incidents of self-harm or suicides amongst students who were under pressure due to exams. The Chief Executive explained that there was an ongoing review of the regional mental health strategy and areas where this required particular focus.

Rowan Procter reported that she would be attending a workshop/development day on this particular issue.

- Martin Wood referred to the RTT report and asked for assurance that those patients who were noted by consultants as being clinically urgent were not being disadvantaged.

  Helen Beck confirmed that this was the case but this was not reported anywhere and there was not a measure for this. If Martin Woods had concerns about this she suggested having a discussion with him outside the meeting. The Chair proposed that this should be reflected in one of the reports that went to the board so that it would provide assurance to both the public and clinicians that clinically urgent patients were appropriately prioritised. **H Beck**

18/109 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

18/110 DECLARATION OF INTERESTS

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

18/111 MINUTES OF THE MEETING HELD ON 27 APRIL 2018

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

Page 6, item 18/09, para 3 – it was noted that the Buurtzorg trial would continue until the year end, not month end.

18/112 MATTERS ARISING ACTION SHEET

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

Item 1555 – the issue of an independent STP chair to be raised at the chairs' meeting and programme board by Sheila Childerhouse and Stephen Dunn respectively. To be covered under agenda item 7.

The completed actions were reviewed and there were no issues.

Nick Jenkins referred to the ongoing action of the planned introduction of new epidural infusion sets, which should be showing as 'red' and was outside the Trust's control. He confirmed that the situation remained as before. It was noted that this had previously been an action in the closed meeting and the Chair asked him to explain the situation for the benefit of governors at today's meeting.

Nick Jenkins explained that there was a national mandate in order to prevent a repeat of the never event that had occurred at the WSFT last year. This involved the purchase of new equipment but this was only available from one provider who had not manufactured this. Therefore the risk remained to patients.

18/113 CHIEF EXECUTIVE'S REPORT

The Chief Executive explained that there was now an acknowledgement from both NHS Improvement (NHSI) and NHS England (NHSE) that the system was fragmented and the finance system 'broken'.

Providers being in deficit and commissioners in surplus was the wrong balance and it was proposed that NHSI and NHSE needed to come together with a shared national executive team, reporting to both Chief Executives. It was proposed that NHSI should move from a regulatory to improvement role and there should be seven regions with the appointment of seven NHS leaders. These were most likely to come from the provider side and would report to the Chief Executives of NHSI and NHSE. The national executive team would provide support to these regions.

It was announced yesterday that the STP would be one of four other STPs in the next wave of those areas that were making significant progress on integration and moving towards closer financial alignment. This would, in the future, raise issues around system control totals for the STP. The Chief Executive had raised both locally and nationally the fact that WSFT had not received the capital investment it had hoped for.

It was also anticipated over the next few months that there would be the announcement of a significant financial settlement/investment for the NHS over a long period of time (ten years) but it was not yet clear what this would be.

The Chief Executive echoed the Chair's congratulations to Helen Beck on her appointment as Chief Operating Officer following a demanding appointment process.

He also thanked Steve Turpie for all his work and support as a NED, including the achievement of Foundation Trust status and transforming the focus of the audit committee, as well being instrumental in the Trust's CQC outstanding rating. He commended him for his work within the community and 'Brightstars', and the support he had given Craig Black, and wished him well in the future.

The Chair referred to the proposal that there should be an independent chair of the STP and explained that there had been no progress to date. However, there would be a discussion in the near future on the lay input to the STP. She would be taking a proposal to the chairs' group as she considered there were issues about leadership which needed to be addressed; both in the need for an independent chair and greater lay input. The Chief Executive agreed and said that it was important to be consistent in this approach.

Alan Rose referred to the recent announcement on the progress of the STP and if this meant that it would be granted more freedom from a financial perspective. The Chief Executive considered that this was likely to move towards an overall finance system with a single oversight of commissioner and provider money; however the model was not yet clear and other STPs were having problems in establishing this.

Gary Norgate referred to the mental health "game changer" and the reduction in the number of hospital admissions and asked what the plans in west Suffolk were to influence this. The Chief Executive said that this would be part of the review of the commissioning model and how this service was best provided and integrated. Gary Norgate asked about the 'whole person assessment' for people with long-term health issues and if this was something that WSFT was looking at. The Chief Executive explained that this was not something that was currently being looked but agreed that it should be considered for the future and how it linked to the changing model.

DELIVER FOR TODAY

18/114 ALLIANCE AND COMMUNITY SERVICES REPORT

Nick Jenkins highlighted the first draft of the West Suffolk Alliance Strategy which had been to the STP board.

Steve Turpie considered this to be a very good report but asked what the exact purpose of this was and who else would read it apart from the STP. Nick Jenkins explained that it was about the philosophy by which the alliance was working together and this was as much about its creation and people working together, than who would read it.

The Chief Executive explained that once this document was finalised he was proposing to take it out into the community when he talked to various staff groups. Tara Rose explained that there was a communications strategy for the alliance and a plan for how this would be shared collectively.

Alan Rose referred to pages 24 and 25 of this document where it had tried to quantify outcomes; he considered this to be really helpful. He asked how WSFT was picking up some of these outcomes in its own measures ie within board papers or the community report.

The Chair agreed that this was very important. Identifying some of these outcomes was not always easy as they could be complex, but this was something that the board would definitely want to have sight of. **D Godbold**

The Chair said that she was pleased to see engagement of the hospice and Healthwatch and the wider network. This was really important as part of long term engagement with the population and the alliance and was not always easy, particularly in the initial stages.

Gary Norgate commented on the good progress that had been made with IT which had previously been an area of frustration. He asked about the Buurtzorg initiative and recruitment to this team. Rowan Procter reported that more nurses had been recruited following a recruitment drive and they were also looking at different ways of moving the local team to areas that the Buurtzorg team were covering and getting them to work the Buurtzorg way. This was something that other organisations were doing.

Richard Davies considered this to be an excellent report with examples of some excellent things that were being done and the freedom to integrate. He was delighted with the emphasis on patient care which should make a major difference to the way that patients were being looked after. However his concern was around the assumption that this would ultimately save money. He felt that this would work really well to improve patient care and save money in some areas but could end being more costly and asked if this was something that had been taken into account.

Craig Black explained that there were no assumptions in the short term that this would save money. Nick Jenkins agreed but explained that this was felt to be the best use of financial resources by working together and could save expenditure and avoid costs in the long term.

The Chair referred to the fact that this was a different way of working and asked if the Trust had underlying workforce plans for both recruitment and progression of staff within the community. Rowan Procter explained it was proposed to undertake a review of staff within community services to understand their development and training needs and funding had been made available for this.

Jan Bloomfield suggested there needed to be a group within the west Suffolk system to look at a strategic workforce plan. She was very pleased that the borough council had the same ambition and if WSFT wanted to be considered a great place to work, west Suffolk also needed to be considered a great place to live.

A strategic alliance with the borough was also required to make sure that there was affordable housing for health workers.

Helen Beck explained that organisations across the alliance were also starting to consider how they could work together on recruitment so that they were not competing for the same staff, or staff were not just moving around within these organisations, which was not helpful.

Angus Eaton asked about projects/changes that needed to be implemented/ coordinated across the region and how these would be achieved. Helen Beck explained that the internal PMO had a very specific CIP delivery focus, however the joint transformation team was working together to achieve this. She felt that there was more to be done but the basic structure was in place.

Jan Bloomfield said one of the biggest challenges was to get people to feel that they were working for the alliance, not just individual organisations. Therefore the HR directors across the East of England were working on a model that would allow staff to transfer between organisations without the usual bureaucracy.

18/115 INTEGRATED QUALITY & PERFORMANCE REPORT

Helen Beck reported that despite all their best efforts 52 week waits remained a challenge. There was still an element of patient choice at the end of the pathway rather than the early stages. The number of cancellations during the winter had been the main factor and this was a key area of focus for next winter.

The other key area of focus was the work being undertaken around the emergency department. Rowan Procter, Nick Jenkins and Helen Beck were working together with their deputies and implementing an intensive support regime to assist with the challenges in this area.

Gary Norgate referred to maternity performance where he had concerns around a number of areas; he asked for assurance that these were being addressed. In addition he felt that there were too many areas where performance had been allowed to deteriorate before issues were identified and addressed, eg appraisals, discharge summaries and asked for a comment on how this could be rectified.

Rowan Procter explained that on the whole when an issue was identified with a quality indicator the actions put in place were not reflected in the quality report until two to three months later. With regard to maternity there did not appear to be an obvious trend with any of the issues, although these were being kept under review. She explained that the numbers were relatively small and one incident could result in an indicator moving to red.

Nick Jenkins explained that shoulder dystocia was an area that was carefully monitored, particularly the management of patients who experienced this in the last stages of labour, and he did not consider that there was an issue; again these were relatively small numbers.

Discharge summaries which were taking a long time to fully resolve as this was such a complex problem.

The WHO checklist and recently been updated and required two signatures, which people had not always remembered. However he assured the board that there had not been a single case this month where a check had not been undertaken.

Craig Black agreed that there did not appear to be an issue and explained that a trend had to be over a period of time. In the case of caesarean sections, all the cases had been reviewed and considered to be appropriate.

Gary Norgate confirmed that he was now assured that there was the appropriate level of transparency and issues were followed up to ensure that a trend was not occurring.

Helen Beck referred to Gary Norgate's comment about the need to identify performance issues before they became a major problem, eg discharge summaries. She agreed that there was work to be done on this and explained that the new head of performance and information team were looking at this.

Jan Bloomfield said that she was a disappointed with appraisal performance as it was an area of constant focus. The way of reporting had been changed a few months ago and this had caused a problem. The staff survey did not reflect the poor performance and in quarter four of the friends and family test 90% of staff said that they had had an appraisal. Therefore this indicated that there was a problem with the reporting.

The Chair asked if there was still an issue in the community with people having the time to be released for appraisals. Jan Bloomfield said that this was a similar level to other staff and appraisals were discussed at every performance meeting.

Rowan Procter explained that a different approach was to undertake team appraisals and she would be attending a training session with senior managers and matrons next week on this. A&E was one of the poorest performers in this area due to the pressure that they were under. Therefore in the next week it was planned that team appraisals would be undertaken with 50% of staff in this area. She proposed that this should also be taken out to the community, as appraisals were not about what people were doing wrong but about how they were performing as part of a team.

The Chief Executive referred to Gary Norgate's concerns about recurring issues and that these were not being appropriately addressed. He explained that the executive team were working hard to triangulate information and address issues. He asked if there was further information that was required to provide greater assurance, whilst recognising the nature of the business and the focus that was being given to a number of areas, eg discharge summaries, appraisals, WHO checklists etc.

Alan Rose said that he felt that assurance was provided every month but there was a frustration that this did not always translate into results. The Chief Executive said that there were a variety of mechanisms that could be used to investigate certain areas further if it was felt that this was required.

Steve Turpie suggested that staff sickness was an obvious area which was regularly discussed. Jan Bloomfield agreed and explained the actions that had now been put in place, including return to work interviews which were undertaken for 76% of staff who had been off sick; she considered this to be a good number. Overall WSFT's sickness performance (3.7%) was good compared to most organisations, particularly taking into account the pressure staff had been under. Steve Turpie acknowledged this but suggested that there was a need to look at what actions could be taken to alleviate this pressure.

The Chair proposed having a more detailed discussion about those performance issues that were discussed at every meeting. However, she said there was a need to discriminate between areas where one number could affect an indicator and areas that had a real impact on performance and patient care. There was also a need to look at tracking trends and seeing a difference over time and progress was being made.

Angus Eaton noted that everyone tended to focus on red indicators but he was also concerned about those that were amber or green where perhaps the executive team might have some concerns. He suggested that there should be more transparency about what could be a potential issue, even if it was not currently showing as red. The Chair agreed that this was a very important point and asked that the executive team consider this as well.

Executive team

Review of hospital acquired pressure ulcers

Rowan Procter referred to the report on pressure ulcers and explained the definition of an unavoidable pressure ulcer. She referred to the performance of avoidable pressure ulcers over the last six months and although these were not acceptable she was proud of the Trust's performance on this considering the pressure it had been under.

She referred to performance by ward and noted that this was not as expected. For example G8 had had the worst staffing issues but did not have the highest number of pressure ulcers. This showed that it was not about the number of staff but the quality of nursing. Areas where there had previously been concerns about staffing had received greater focus and training and therefore pressure ulcer performance was better than other areas. The tissue viability team were therefore focussing their attention on wards where pressure areas were occurring to help improve performance. It was proposed to establish an integrated tissue viability team with the community which would also go into nursing home and extend training to help prevent pressure ulcers in these patients.

Richard Davies considered this to be a very useful report. He referred to the definition of avoidable and unavoidable pressure ulcers and asked for clarity around this, particularly in terminally ill or end of life patients. Rowan Procter explained the assessments and checks that were carried out for every patient, irrelevant of their illness; if a check had not been completed this then becomes an avoidable pressure ulcer.

Richard Davies agreed that quality of nursing and doing the simple things well was key in managing pressure ulcer. He asked for assurance as to what was being put in place in wards where pressure ulcer performance was poor to assist staff who were not currently doing the simple things well. Rowan Procter explained that the lessons learned in educating staff on G8 would be repeated in those areas that were performing poorly. She would expect performance to improve in these areas and if it did not she would be looking at whether there was a cultural issue or human factor elements.

The Chair asked if the tissue viability team had the resource for this work. It was explained that ideally more resource in this team was required, particularly to work within the community and nursing homes. Rowan Procter explained that as part of the restructure she and Dawn Godbold were looking at recruiting a senior matron for integrated services as well as there being a head of nursing for integrated services. She also proposed looking at if there was an income opportunity to sell these services to care homes and perhaps looking at training carers under the local authority, which would also help the alliance.

Amanda Keighley reported on the pressure ulcer collaborative which she attended on Monday with two other staff members from WSFT. This was a 120 day collaborative and she explained the work that they were now doing on this and how they would be taking this out into the community, including residential and nursing homes.

Catherine Waller suggested looking at hospital acquired pressure ulcer performance by ward in six months' time and how this had progressed and also thinking about doing something similar in the community. Rowan Procter agreed that this was a good idea. This also needed to be focussed on in the community as if a patient received any care from a WSFT member of staff the pressure ulcer would be attributed to WSFT. **R Procter**

18/116 RTT RECOVERY PLAN

Helen Beck referred to the recovery trajectory for delivery of 92% by October and explained that this meant sustained delivery. Indications were that 91.5% would be achieved in May, but she did not consider this to be sustainable.

The Trust continued to work on the IST assessment tool and a policy was now in place. However applying this whilst doing the right thing for the patient was often a challenge.

The graph at the top of page 2 showed patients at various stages of their pathway, and that the situation was improving. The Trust was now in a much better position of understanding what was happening and taking action where necessary. She said that the team's hard work, determination and effort had been incredible over the past year.

Trauma and orthopaedics (T&O) was an area that was always a challenge in most organisations and was hit hardest by cancellation programmes. Due to the hard work and flexibility of the orthopaedic team performance had improved and was expected to continue with this improvement.

Vascular performance was a concern; however she assured the board that this was being addressed and the Trust was working with the CCG on this. This was a challenge as the workforce came to WSFT from Addenbrooke's on a daily basis and there was a resource issue across the region.

She explained the planned PTL, which were often patients who had received one surgical procedure and were waiting for a second procedure. The Trust was now able to monitor these patients.

18/117 FINANCE AND WORKFORCE REPORT

Craig Black reminded the board that this was the report for month one and contained more estimates than in other months.

The key issue was that the plan for the year would not achieve the control total, which the board had agreed it should not sign up to. NHSI had submitted a revised offer which made the achievement of the control total easier but with less incentive. This would be discussed at the closed board.

There were a large number of estimates in the assessment of CIP performance and more work was required on the this.

The tables on page 9 reflected the work that had been undertaken around productivity and showed activity versus planned staffing levels.
The plan was for the Trust to be 2% more productive this year than last year and this would be monitored throughout the year.

Cash remained an issue but it was expected that the transformation funding for achieving the 2017/18 year-end figures would be received in July.

Steve Turpie referred to borrowing and asked for an update on the submission to NHSI for further funds. Craig Black explained that the outcome of this could well be dependent on the outcome of discussions about the revised control total in the closed board meeting. This meant that the achievement of the capital plan was also dependent on this. Craig Black explained that the Trust was continuing to work on the capacity plans for winter, ie the cath lab and AAU, but currently this meant that almost everything else was at risk.

Gary Norgate referred to page 5 and asked if the assumption that A&E attendances would be less this year was correct. Craig Black confirmed that this was not the case and that this figure was incorrect; he would look into this further. **C Black**

Gary Norgate also referred to additional sessions and noted that the cost of these in March and April was considerably more than the previous year and asked if there was a reason for this. Craig Black explained that some of this was the elective work that had been cancelled in January and February; therefore there was focus in catching up during the following months. There had been a greater level of cancellations in 2017/18 than the previous year but the cost of these was being managed within the budget and that it was not expected that these would continue throughout the year.

Nick Jenkins referred to cash and asked what would happen if the transformation money was not received. Craig Black explained that the Trust would bring forward some of the agreed borrowing in order to maintain the balance. This would only become a major issue if the money was not received towards the end of the financial year.

Alan Rose referred to the rebalancing of provider/commissioner finances as an aspiration within the system and asked if this was something that should be taken note of in this year's finances. Craig Black explained that the mechanism of a system control total had not been agreed by the early ICSs (integrated care systems) and the principals were somewhat flawed at the moment and required further work. However this was the way that the alliance was already working as partners, rather than individual organisations.

The Chair agreed that a lot of discussion would be required as this progressed.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

18/118 NURSE STAFFING REPORT

Rowan Procter highlighted the admission prevention service which had significant vacancies. These were very difficult to recruit to as staff with significant experience and qualifications were required. This was having an impact on admission prevention and a piece of work was being undertaken to support this and different ways of working were also being considered.

The Chair proposed that the board should be kept updated on this as it was key to the winter plan. **R Procter**

Angus Eaton noted the high number of pressure ulcers in patients under the Bury team and asked if this was a cause for concern.
Rowan Procter explained that this was being looked into to understand the reason for this and if there was an issue.

18/119 LEARNING FROM DEATHS – Q4 REPORT

Nick Jenkins explained that this was a quarterly report and was the period in which a new way of learning from deaths was introduced. The reviewers had been in post since 26 February and were reviewing every death. The Trust continued to receive appropriate recognition for this work.

Every bereaved family now had the opportunity for a telephone conversation with the reviewer, and most were taking this up. Once the review was complete a letter was also sent to the family with the outcomes. The dashboard in this report summarised the outcome of the review for the quarter and year to date.
The learning from deaths group was extremely lucky to have a very committed family representative. He was very keen to hold the group to account with regard to the learning from the deaths that had occurred rather than what went wrong or why it happened, which was very helpful.

WSFT was also aspiring to set up a network of family members drawn from learning from deaths groups across the region, but to date there were not enough organisations which had lay members.

Alan Rose asked if the medical reviewers were paid for this work and if it was part of their job plan and they had the time to do this. Nick Jenkins explained that one PA per week was allocated for this and on the whole reviewers were managing to fit this in. However one had not been able to start as she had not had the time and another was fitting it in when he could, which meant that he averaged approximately 0.75 PA per week. This meant that more reviewers would need to be recruited to cover for this.

Gary Norgate commented on the good transparency of this report. He asked if the case which was judged to have resulted in major or catastrophic harm would be discussed at a closed board meeting in the future. It was confirmed that this was the case and that it related to the patient story that Nick Jenkins had read out at a recent meeting.

Catherine Waller agreed that this was an excellent report and commended the reviewers and the team for their work. She referred to a number of high profile deaths that had been reported nationally and asked how the learning from these was fed back into the learning from deaths group. Nick Jenkins explained that currently this was not being done very well and there was work to be done with partners, eg primary care, mental health trusts etc to improve this process.

18/120 QUALITY & LEARNING REPORT

Rowan Procter noted that pressure ulcers had already been discussed.

She highlighted the fact that it was becoming very clear that human factors were a very important part of the healthcare profession and this needed to be focussed on more widely across the Trust. **R Procter**

Gary Norgate agreed that human factors were a very important element of patient care.

This report also included feedback from the quality walkabouts during the last quarter and some of the themes that had been identified.

18/121 NHSBSP SCREENING INCIDENT BRIEFING

Nick Jenkins explained that as this was a national issue it was felt that a paper should come to the board summarising this from the Trust's perspective.

The board received and noted the content of this report.

18/122 FREEDOM TO SPEAK UP GUARDIAN

The Chair welcomed and introduced Nick Finch, Freedom to Speak Up Guardian for WSFT.

Nick Finch explained that this report outlined the work that been going on over the last couple of months.
There had been a very successful visit from Dr Henrietta Hughes, the national Freedom to Speak Up Guardian who had been impressed with how the Trust was led and how motivated the staff were. He explained other areas of work he had been undertaking within this role and his future plans, including linking with the community which was very important.

The Chair thanked him for all his work and asked how much he felt staff knew who he was and what his role was. Nick Finch explained that staff were now recognising him and were aware of his role and that he was receiving more feedback and phone calls etc. His workload was increasing, with May having been the busiest month to date.

The Chief Executive asked what the nature was of issues that were raised and if these could have been discussed with the line manager. Nick Finch explained that in some cases he suggested that people referred back to their line manager and then come back to him if this could not be resolved.

Rowan Procter considered this role to be very important and thanked him for the work that he was doing in resolving or escalating issues quickly, therefore avoiding angst for staff involved.

The Chief Executive agreed and said it was really good that Nick Finch was so accessible and available to staff and was able to resolve things quickly.

The Chair thanked Nick Finch very much for this report and said that it would be interesting to see how this role developed over the next few months.

18/123 NHS RESOLUTION – MATERNITY IMPROVEMENT STANDARDS

Craig Black reminded the board that the NHSLA had tried to implement a scheme to reduce the number of claims in obstetrics. Initially they had increased the premium by 10% which meant an increase of £370k for WSFT. Organisations then had the ability to earn back the 10% by delivering on the ten safety strategy initiatives. This was a self-assessment submission which the board were required to approve and sign off, or change if considered appropriate.

The report showed that the Trust was compliant against nine of these initiatives but only partially complaint against standard 6 which included an element about increasing the frequency at which 'at risk' women were scanned. These women should be scanned at 28 weeks and then at three weekly intervals. WSFT did not have the capacity to achieve this therefore the approach had been to look at those who were most at risk, ie smokers, and then scan at 29 weeks and at four weekly intervals until capacity had been increased. Women with diabetes were already scanned more frequently.

Lynne Saunders, Acting Head of Midwifery, had compiled a great deal of evidence to support WSFT's submission, which was available to board members on Convene.

Steve Turpie asked if not being compliant against all ten initiatives meant that the Trust would not receive the 10% incentive payment. Craig Black explained that this was discretionary and was dependent upon the actions taken to partially achieve the initiative.

Steve Turpie asked if the Trust had looked into sending at risk patients to other local Trusts for their additional ultrasounds; he was concerned that this was a patient safety issue. Craig Black explained that this option had not been considered, however he had enquired as to whether other organisations were experiencing the same issue with capacity for additional scans and it had been confirmed almost universally that this was the case. Therefore it was unlikely that local hospitals would be able to take patients from WSFT. Nick Jenkins confirmed that there was very unlikely to be capacity in the NHS but there could be in the private sector. This would be followed up.

The board approved this submission, subject to investigation as to whether there was the option to send at risk patients elsewhere for additional ultrasounds. The Chair requested that the outcome of this should come back to the next board meeting. **C Black**

18/124 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that the award for this month had been received by Joanne Diaz, Nurse and Robert Howorth, IT manager.

At the start of this year there was a really sick patient who needed one to one nursing and to be transferred to Addenbrookes Hospital with an escort. Joanna stayed on at the end of her shift to provide the one to one care needed for the patient. She then agreed to escort the patient to Addenbrookes and didn't get back to WSH until 1.30am.

Rob Howarth helped enable a patient and his wife to gain access to WIFI in order for them to be part of a family wedding ceremony taking place overseas. He set up the connectivity and offered his assistance to come in over the weekend if the connection failed.

The Chair considered these to be excellent nominations and commended both Joanne and Rob for going the extra mile.

18/125 CONSULTANT APPOINTMENT REPORT

The board noted the following appointments:-

Dr Ryan Butel and Dr Pawel Wawruch, Consultants in Histopathology

Jan Bloomfield noted that histopathology was extremely hard to recruit to and this was an excellent result.

BUILD A JOINED UP FUTURE

18/126 e-CARE REPORT

Craig Back reported that the plan to implement Launchpoint in the emergency department had been delayed as the Trust was not satisfied that it had been able to test this sufficiently.

Milton Keynes University Hospitals NHS FT, which was WSFT's fast follower, had implemented their e-Care system in the last few weeks. This has been supported by staff from WSFT and had gone well.

Alan Rose asked about the patient portal and if it was possible for any of the Trust's patients to be registered on this. Nick Jenkins explained that currently patients had to be within a specific group, eg staff member, governor, rheumatology or diabetics. Feedback from all users to date had been very positive.

The Chair suggested that there needed to be some communication around this so people understood the criteria.

It was reported that the e-Care board had discussed widening this to other groups but it had been agreed to wait until it could be made available to everyone. The timescale for this would be confirmed. **C Black**

18/127 IM&T STRATEGY

Craig Black explained that a great deal of work had gone into this strategy and it had been through the organisation and TEG prior to coming to the board.

There was a strong emphasis on information as this was an area that it was considered required more work and was key to delivering the benefits associated with the infrastructure that had been put in place around e-Care.

Alan Rose asked about the future and if this strategy and the systems that WSFT were developing would be easy to adapt or link with other organisations if the situation changed. Craig Black explained that when developing this strategy the Trust had been mindful of its position within the STP and this had been shared with STP partners. The interoperability standards had also been a critical part of the strategy and there was an idea of extending Cerner to Ipswich and Colchester. This also linked with Addenbrooke's system.

The Chief Executive stressed that the Trust had a clear strategy about working with partners.

Gary Norgate considered this to be a very good report with a lot of recommendations but requested that some sort of prioritisation was shown for these. Craig Black confirmed that this was currently being worked on. **C Black**

The Chair agreed that this was a very impressive document and asked board members to feed any other comments back to Craig Black.

18/128 EXPERIENCE OF CARE STRATEGY

Rowan Procter referred to the three points that Alan Rose had fed back to her prior to the meeting which would be incorporated into the strategy. The first was that the action plans should show what 'good' looked like and include hard metrics. He also requested that there should be clarity on which measure/outcomes the board should be kept updated on. Also recognition that there were best practices and learning from other organisations.

The board approved the strategy subject to the incorporation of the above comments. **R Procter**

18/129 EMERGENCY PREPARATION, RESILIANCE AND RESPONSE (EPRR)

Helen Beck apologised and explained that the annual return was made last September and it had since been recognised that it should have been seen by the board prior to its submission.

There were 104 criteria and on the whole the Trust was now fully compliant. Last September there were nine areas where it was not compliant. As a result a significant amount of work had been undertaken in these areas and there were now only five, which were shown on page 2 of the report. The work that had been undertaken culminated in a full majax exercise across the organisation which was considered to have gone well. The final report on this would provide a significant amount of learning and further work was also required within the community.

Helen Beck had recently attended a regional meeting on this and the team had said that they were extremely well assured of WSFT's progress and action plan.

Richard Davies noted his interest in this and volunteered go through the report with Helen Beck.

The Chair thanked all those involved in putting together this detailed report. The board noted and endorsed the statements in this report.

GOVERNANCE

18/130 TRUST EXECUTIVE GROUP REPORT

The Chief Executive reported that no meeting had taken place since the last board meeting however performance meetings had taken place with the divisions.

18/131 REMUNERATION COMMITTEE REPORT

The board received and noted the content of this report.

18/132 CHARITABLE FUNDS COMMITTEE REPORT

The board received and noted the content of this report.

Jan Bloomfield reported that the MyWish team had been one of four teams shortlisted nationally for the NHS 70 public engagement award, which was a fantastic achievement.

18/133 USE OF TRUST SEAL

The board received and noted the content of this report.

18/134 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were noted.

ITEMS FOR INFORMATION

18/135 ANY OTHER BUSINESS

The Chair thanked Steve Turpie for everything he had done for the Trust during his time as a NED, including helping it achieve FT status and its progress to date.

His input had been extremely valuable and she also thanked him for the support he had given her as incoming Chair. On behalf of the board, governors and whole organisation she thanked him for everything and wished him well for the future.

Steve Turpie said that it had been a privilege to have had the opportunity to be a NED and to have been able to put something back into the organisation that had done so much for his family. He recalled the progress that had been made during the past eight years and encouraged the executive team to continue to strive to improve performance even further.

He referred to and apologised for the number of times he had quoted 'in the private sector' and acknowledged that there was a difference. He said that if he could take 1% of the empathy out of this hospital and inject it into the private sector they would see a different UK. He said that the organisation should be proud of this.

18/136 DATE OF NEXT MEETING

The next meeting would take place on Friday 29 June 2018 at 9.15am in the Northgate Room.

RESOLUTION TO MOVE TO CLOSED SESSION

18/137 RESOLUTION

The Trust board agreed to adopt the following resolution:-

"That members of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1(2) Public Bodies (Admission to Meetings) Act 1960.

6. Matters arising action sheet

To ACCEPT updates on actions not covered elsewhere on the agenda

Presented by Sheila Childerhouse

Board of Directors – 29 June 2018

Agenda item:	Item 6			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	21 June 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
1574	Open	27/4/18	Item 16	Undertake a review of the barriers to staff achieving mandatory training compliance (inc. IT and community). Set out options for improvement.	Discussion of options to address barriers to take place at next mandatory training steering group. Update to be provided to the Board.	JB	27/07/18	Green
1583	Open	25/5/18	Item 8	Consider how to publicise the West Suffolk Alliance strategy and how the outcomes can be monitored by the Board	Included stand in medicine for members events. Will for part of discussion of the summary strategy at SEG.	DG	27/07/18	Green
1584	Open	25/5/18	Item 9	Agreed to structure the commentary in the IQPR based on what the executive team are worried about, rather than just the RAG rating. Also identify indicators for 'deep dive' to test improvement actions and provide assurance e.g. return to work interviews	Review of IQPR is currently taking place	CB	27/07/18	Green
1587	Open	25/5/18	Item 14	In the context of the incidents which identified human factors as a contributory factor, develop a proposal to extend the human factors training focused within surgery across the organisation		RP	27/07/18	Green
1588	Open	25/5/18	Item 17	Consider if there is capacity to scan women with high risk pregnancy elsewhere, including private sector	No capacity currently identified still exploring options to the new Digital Programme Board	CB	29/06/18	Green
1589	Open	25/5/18	Item 20	Confirm the timescale for rolling out wider access to the e-Care patient portal	Will be included in the post pilot review report and recommendations	CB	27/07/18	Green
1590	Open	25/5/18	Item 21	Agreed to prioritise the recommendations set out within the IM&T strategy as part of a delivery plan	Will form part of the report to Board from the new Digital Programme Board	CB	27/07/18	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1591	Open	25/5/18	Item 2	The experience care strategy was approved subject to some developments (what good looks like, include external factors)	Reviewed and being finalised, including changes to the delivery plan	RP	27/07/18	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1475	Open	29/9/17	Item 13	Develop a set of metrics which will provide an indication of the success of the leadership programme	Report in progress to be received at June meeting **AGENDA ITEM**	JB	29/06/2018 (revised)	Complete
1529	Open	26/1/18	Item 7	2018-19 winter planning update to be received by the Board (including learning from 2017-18)	Being developed as part of system based learning exercise. Agreed to consider 'big data' and e-Care population health as part of this work indicating a roadmap and timescales. Scheduled for May to include system learning from 2017-18 **AGENDA ITEM**	HB	29/6/18 (revised)	Complete
1555	Open	29/3/18	Item 2	The issue of an independent STP chair to be raised at the chairs meeting and Programme Board by Sheila and Steve respectively	To be addressed through the STP Board and chairs meetings. **Verbal update at Board**	SC / SD	25/05/18	Complete
1566	Open	29/3/18	Item 18	Schedule a wider Board discussion on the e-Care (GDE) programme and future options/plans	Included in the IT strategy received by the Board in May. The delivery plan for the strategy will form part of the discussion at the Digital Board and be reported to Board of Directors	RJ / CB	27/07/18	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1581	Open	25/5/18	Item 2	Consider how to report against clinically urgent activity for RTT	Included in IQPR	HB	29/06/18	Complete
1582	Open	25/5/18	Item 5	Correction to minute re Buurtzorg 'year end' not 'month end'.	Captured in minutes	RJ	29/06/18	Complete
1585	Open	25/5/18	Item 14	Schedule a follow-up report in six months for pressure ulcer work to monitor progress on acute/community improvement and Alliance working (including nursing homes)	Scheduled for November 2018	RJ	29/06/18	Complete
1586	Open	25/5/18	Item 11	Review emergency department activity reported on page 5 of the finance and workforce report	Updated in finance report	CB	29/06/18	Complete

7. Chief Executive’s report

To ACCEPT a report on current issues from the Chief Executive

Presented by Stephen Dunn

Board of Directors – 29 June 2018

Agenda item:	7			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	21 June 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

Last week the Prime Minister Theresa May set out proposals for a **long-term NHS funding** settlement of an extra £20.5bn by 2023 - an average annual rise of 3.4% above inflation for the next five years. This is a major landmark announcement and we should be extremely grateful for this increase in funding given taxes will have to rise and in the context of the uncertainties around Brexit. I have written to Jeremy Hunt, Secretary of State for health to thank him and the government for committing to this much need additional funding for the NHS. It provides a much needed boost for the NHS in its 70th Birthday year. What a birthday present! In return for the extra investment, the NHS will be expected to commit to a ten-year plan outlining the improvements that can be delivered for this extra investment. We need to make sure we spend any new money wisely.

Here at West Suffolk we will continue to do our bit and endeavour to transform our hospital and health and care system to meet the future challenges and make good this investment. We would love to finish the job in becoming a truly Global Digital Exemplar system and we are keen to support the policy process in developing the 10 year NHS plan. In shaping and responding to the NHS 10 year plan we will update our strategy and operational plans accordingly. Critical to this response is transformation and a key part of our strategy is development of an integrated model for service delivery which we are doing across our local area.

Suffolk and north east Essex is seen nationally as leading the way in providing better care for local people after being named as one of four areas to join the development of integrated care across health, social care and the voluntary sector. An integrated care system would make it easier for patients to access services, see more joined up care delivery and staff should find it easier to work with colleagues from other organisations. One of the key aspects of an **integrated care system, (ICS)** is for the local system to provide support or care closer to people's homes. One example of this already happening across Suffolk and north east Essex is social prescribing, which is a range of non-clinical community services such as walking clubs or self-help groups, often provided by local voluntary groups.

We have a real aspiration in the west of Suffolk to work as one system, which we hope will see us overcoming obstacles across organisational boundaries to streamline services. We strongly believe it will bring more efficiencies in how we work but more importantly improve the experience of patients, carers and citizens. In September 2016 health and care partners formed the **West Suffolk Alliance** and we have committed to work together to improve the health and care system in west Suffolk for all people whether they be a child, part of a family or a single adult. Our belief is that by working together in an Alliance we can have an impact on wellbeing, care and physical and mental health outcomes for people. Our focus within the Alliance is on *people and places*.

The strategy for our Alliance is to move from working as individual organisations towards being a fully integrated single system, with a shared vision, clear local priorities, able to both provide an improved service for people in west Suffolk and also to tackle the sustainability issues faced by the system together. Work has commenced on the delivery plan that will accompany the strategy document. The delivery plan will contain key milestones and timescales for each of the ambitions and actins set out in the strategy.

As part of the next wave of sustainability and transformation partnership (STP) capital funding we are also bidding for £15m to support the redevelopment of the emergency department (ED). Suffolk and north east Essex STP's support for this bid as the sole submission in this funding wave is extremely positive and reflects that the bid is consistent with STP ambitions.

More than **250 shining light nominations** were received, and awards were given to those who have shown particularly outstanding dedication and excellence in the care of their patients, or the initiative to drive through service improvements in the hospital or out in the community. There were 17 award categories, including employee of the year, clinical team of the year, non-clinical team of the year, inspirational leadership, community team of the year, My WiSH Charity champion and volunteer of the year.

The employee of the year award of excellence went to Tracey Green, mortuary and bereavement services manager, who works in a challenging environment where care and compassion is so important. Tracey's colleagues described her care towards the deceased and their families as "second to none", and said she demonstrates completely how health services must care for people from the beginning of their life to the very end. Tracey will be accompanying me to West Minter Abbey ceremony to mark the NHS' 70th birthday celebration. The clinical team of the year award of excellence went to the multi-disciplinary hip fracture team who, in March, led the Trust to becoming the top hospital in England, Wales and Northern Ireland for meeting best practice criteria for patients treated for a hip fracture as rated by the National Hip Fracture Database. G8's Mick Mellon received the volunteer of the year award of excellence. His colleagues said he is "a great tonic for patients and staff" and that the contribution he makes is "invaluable." He even came in to the hospital on Christmas Day dressed as Father Christmas to hand out presents and cards to patients on the ward. I want to thank all our staff who, day after day, go the extra mile to ensure that patients and visitors receive the best possible care and services.

As you will no doubt be aware, this year the NHS is celebrating its 70th birthday, and as part of the celebrations NHS England has founded the NHS70 Parliamentary Awards. We were absolutely thrilled to be nominated in the category for **The Patient and Public Involvement Award** for the Midlands and East of England, and last week we found out that we had actually won! Nominated by Jo Churchill, MP, this award has been presented to us for the work we have done within the community as well as in the hospital. It has highlighted how the charity has gone from strength to strength over the past few years, and how we have helped to contribute to reducing surgical procedure times, waiting times, patient recovery times, and provided sensitive support for patients and their families. We were also commended on how we have supported health and wellbeing initiatives for staff, including psychological support and additional training, to allow staff to go above and beyond their duties. We do all this to ensure the Trust can offer enhanced care that makes a real difference at difficult times.

We celebrated the generosity of **our wonderful volunteers** this month at our annual 'thank you' event. As a thank you for the impact the volunteers have on patient care, cream teas were served by the staff team, before the awards were presented. Twenty-nine volunteers received long service awards, clocking up 315 years of service between them. One volunteer, Grant Greetham, was thanked for giving an incredible 40 years of service to West Suffolk Hospital as a volunteer. We are so proud of volunteers, and we are lucky enough to have more than 400 of them here with us at the Trust. Our partnership working with HelpForce, a community interest company helping to develop the roles of NHS volunteers, will help us to work better with partners and really get the most out of our volunteers. We're currently exploring a number of community based roles, and I look forward to seeing how the scope of volunteering develops over the next few years.

We're proud to have been named as one of the **CHKS Top Hospitals for 2018**, a prestigious award made on the basis of an analysis of data from, for the first time, all hospital trusts in England, Wales and Northern Ireland. More than 20 indicators of performance were analysed by CHKS, a healthcare improvement organisation, with data from information that is regularly submitted by hospitals to NHS Digital in a number of areas. The performance indicators cover safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care, and are revised annually to take into account any newly-available performance information. This award shows what we already know - that our staff are providing top quality care in the NHS. Of course there are things we want to improve, but we must be proud of the innovations and changes

we make to the way we work to ensure the quality of care that we provide is outstanding. It can be hard to innovate when the day-to-day pressures are so high and everyone is so busy, but even in challenging times working in a different way is important for long-term success.

I am absolutely delighted that we have officially appointed **Helen Beck as our executive chief operating officer**, after a rigorous recruitment process. Helen was the Trust's deputy chief operating officer for three years before stepping into the role of interim chief operating officer last year. Helen has been helping to steer the Trust through extensive periods of high demand over the years and has a deep knowledge and understanding of how the Trust operates and the challenges we need to overcome. She has also been instrumental in the Trust's efforts to reduce waiting times for elective treatment. I know the rest of the Board, and the wider organisation, is pleased to have made such a positive appointment, and we look forward to working with Helen for many years to come.

For **May's performance** the focus has been maintained around reducing patient falls and pressure ulcers, with 61 falls and nine Trust acquired pressure ulcers reported. There were no C. difficile cases in the month. The year to date performance for all cancer targets is ahead of the national threshold; however, the Trust failed to deliver the target for two week wait from referral to date first seen in May. The 4 hour wait performance for ED has seen a significant improvement to 94% following targeted action. This is despite activity analysis showing that more than 200 attendances per day is becoming the norm. We experienced a 9% year on year increase in attendances at ED in May 2018 compared to May 2017. RTT performance against the 18 week standard has seen a significant improvement to 92% however there is still work to do to ensure this is a sustainable position throughout the year. A weekly focus remains on those patients waiting longer than 52 weeks for treatment, with 14 long waiting patients reported in May.

Since April there have been significant issues with the new contract for the provision on **non-emergency patient transport services**. The contract is held by the CCG and provides services to both WSFT and Ipswich Hospital Trust (IHT). The key issues are timeliness of the service, a small number of failed pickups, ability to access the call centre and overall co-ordination of the service, which are mainly due to activity numbers approximately 30% higher than those contracted for. We are working closely with the new provider, the CCG and IHT to address these concerns and a detailed action plan has been developed, which includes the provision of additional capacity through a targeted recruitment programme. The chief operating office and her deputy are involved in daily escalation calls to mitigate the current risks until such time as the additional capacity comes on line at the end of July. I would like to apologise to patients, relatives, carers and staff who have experienced poor service during this transition period.

Preparations for **winter 2018-19** are already well under way. This includes capacity modelling, building new physical capacity and staff recruitment plans. The recruitment plans included additional nursing assistants to support the implementation of bay based nursing. This is considered in more detail in the finance and workforce report.

Audit of our accounts for last year confirmed that we had delivered our financial plan for 2017-18, which meant we had received bonus sustainability and transformation funding (STF) with a **year-end position of almost break even** (deficit of £0.3m). The **month 2 financial position** reports a deficit of £2.8m which is £0.4m worse than planned. The Trust has now agreed a control total to make a deficit of £13.8m which will provide Provider Sustainability Funding (PSF, formerly STF) of £3.7m should A&E and Financial targets be met. Therefore the Trust is now planning on a net deficit of £10.1m for 2018-19. However, no PSF is yet included in the financial position. In order to achieve the control total the 2018-19 budgets now include a stretch CIP of £2.8m bringing the total CIP plan to £12.2m (5%). The Trust is currently applying for the cash support from DH to support this revenue deficit and also the planned capital programme of £28.1m.

In the UK, less than 1% of all disposable coffee cups are recycled. We throw away seven million of them every day – that's 2.5 billion a year! With this in mind, we are introducing **reusable hot drinks cups** and new WSFT / My WiSH branded cups will be on sale in Time Out and the Courtyard Café at West Suffolk Hospital and at Newmarket Hospital's White Lodge Café.

Chief Executive blog
We really make our money count: https://www.wsh.nhs.uk/News-room/news-posts/We-really-make-our-money-count.aspx

Deliver for today

Doing our bit for diabetes week

We teamed up with Suffolk County Council Public Health and OneLife Suffolk earlier this month for National Diabetes Week, with a focus on raising awareness of how the condition can be prevented or managed. Approximately 38,000 people are living with diabetes in Suffolk, a number which is increasing by 5% each year. There are also a further estimated 7,500 people in the county living with the condition who have not yet been diagnosed. But, around 60% of Type 2 diabetes can be delayed or prevented by making simple lifestyle changes. Our lead diabetes specialist nurse, Mandy Hunt, led some local media discussions and supported the campaign work to help spread awareness. The diabetes department at the West Suffolk Hospital runs on the ethos that diabetes education is the cornerstone of good self-management for patients, and offers many specialist courses that cover things like diet, lifestyle and medication management. It might seem small, but everything we do to promote health education, public health and empowering people to manage (or even prevent) long term conditions is worth the effort. As a system, we must begin to focus more on prevention rather than cure.

Red bag initiative rolled out across west Suffolk

After a successful trial, the red bag initiative - a scheme to reduce the time care home residents spend in hospital - is currently being rolled out to all west Suffolk care homes. Specialist discharge planning nurse, Debbie Clements-Dimmock, has been visiting staff at their board rounds, to remind and reinforce the purpose and benefits of the red bag.

Invest in quality, staff and clinical leadership

Apprentice adult nursing programme

The Trust is delighted to confirm that 16 places have been offered to new and existing staff, who will be undertaking the four-year apprentice adult nurse programme starting in September. This is an exciting opportunity for potential registered nurses to undertake an NMC approved programme whilst also working for the Trust. The programme will be delivered by the University of Suffolk and students will be supported by our nursing directorate education team. Apprentices will be recognised by their student uniform and name badge and will spend 15 hours a week on clinical placement and theory days, whilst undertaking the remaining 22.5 hours within their base sites as part of the rostered numbers.

Lowest caesarean rates in the country

A Daily Mail article published earlier this month has named the West Suffolk NHS Foundation Trust as having the lowest caesarean section rates in the country. Data published by NHS Digital shows that we delivered 19.3% of babies by C-section, compared to rates as high as 37% in other areas of the country. It was really pleasing to have our fantastic maternity unit highlighted on a national scale, and is evidence of the high-quality care they provide to every woman and baby.

High-flying Hannah scoops award

Congratulation to estates and facilities project manager, Hannah Sharland, who was awarded the individual development award at the recent Health Estates and Facilities Management Association (HefmA) awards. The awards recognise and celebrate the outstanding efforts and achievements demonstrated by NHS estates and facilities teams throughout the past year, and Hannah was nominated for the individual development award for achieving excellence in education and in the workplace.

Build a joined-up future

Dieticians' Week
Last week saw Dietitians' Week return to the Trust and the theme this year was 'Dietitians Do Prevention'. Community dietitian, Michelle Oatridge explained that the need to improve prevention and public health has been identified by all four nations of the UK as crucial factor for sustainable health services. Across various professions within healthcare, prevention and public health activities are being considered crucial in reducing pressure on NHS and social care services. As dietitians we are not often associated with preventative care but rather tend to be considered the 'food police', tasked with tackling obesity by giving weight loss advice. However weight management is just a fraction of the work we do. Our stand in Time Out focused on a different aspect of nutrition each day.

National Carers' Week
There are an estimated 6.5 million carers in the UK currently. One in five people aged 50-64 are carers, yet many people never expect they will take on this role. National Carers' Week, highlighted the amazing and valuable work that people do across the country looking after their loved ones who are elderly, disabled or seriously ill. You may know someone who does this, or be one yourself. It's an important job that contributes hugely to the wellbeing of the person being cared for, and helps our whole community by reducing the strain on public services. But it can also be a very difficult role, which is potentially emotionally, physically and financially draining. If you need further help take a look at:
https://suffolkfamilycarers.org/ or
https://www.carersuk.org/

National news

Deliver for today

Under pressure: Safely managing increased demand in emergency departments
It is commonly known that emergency departments face the same problems no matter whether the trust as a whole is performing well or poorly. This winter the CQC inspected emergency services under pressure and the CQC has recognised that their findings support the concerns expressed by staff themselves. The report describes "committed staff working in difficult circumstances, often going above and beyond what could reasonably be expected of them." CQC (May 2018) It acknowledges that the dedication of staff has enabled the service to provide safe care to many patients but this has not always been the case. The report states that the increasing pressure on emergency departments has led to some care that is unsatisfactory, at times unacceptable. It identifies the step required to address: demand, capacity, capability and output.

Health, Ageing and Support: survey of views of people aged 50 and over
This qualitative study by Ipsos MORI, conducted on behalf of for the Department of Health surveyed the perceptions and attitudes of people aged over 50 on the topics of health, wellbeing, ageing and support. While the report covers a range of topics, it identifies 6 key findings.

Tackling Loneliness: A Community Action Plan
"Loneliness and social isolation can be as bad for patients as chronic health conditions. Loneliness puts people at a 50% increased risk of an early death compared to those with good social connections, and it is as bad for health outcomes as obesity." RCGP (May 2018). According to the Royal College of General Practitioners (RCGP), loneliness has become a public health epidemic and a national public campaign is required to raise awareness of loneliness and social isolation. This publication identifies steps that can be taken to address the issue.

Invest in quality, staff and clinical leadership

NHS staff vote for 6.5% pay deal
Last week it was announced that more than one million NHS workers in England will receive a three-year pay deal, worth 6.5%, after staff voted overwhelmingly in favour of the offer.

Managing multimorbidity: putting patients at the heart of their care
During this audio clip from NICE, Professor David Haslam, chair of NICE, and Dr James Larcombe are interviewed on the subject of multimorbidity and an individual with more than one health condition talks about her personal experiences. People with multimorbidities are often excluded from studies. It is suggested that we need to conduct studies that focus on multimorbidities and the issues surrounding them.

Dementia-friendly rural communities guide
In March 2012, the Prime Minister's Challenge on Dementia was launch to make England the first dementia-friendly nation. People with dementia often stop doing the things that they enjoy and this is even more likely if that person lives in a rural area as it is harder to access the services available. This report by the Alzheimer's Society (May 2018) identifies issues that people who live with dementia in rural locations face. It suggests ways that individuals can make a difference and identifies information and training available.

Build a joined-up future

Developing pathways for referring patients from secondary care to specialist alcohol treatment
It is estimated that up to 5% of inpatients in secondary care may be alcohol dependent. As alcohol is a causal factor in more than 60 medical conditions, there is a need to develop pathways for referral and care for those patients whose routine alcohol screening in secondary care suggests that they may be alcohol dependent. This document provides guidance on how these pathways can be structured.

NHS Community Services: Taking Centre Stage
"It is generally accepted that treating people in the community and in their homes is better for patient outcomes and experience, and the financial sustainability of the NHS." NHS Providers (May 2018). This report offers high quality examples of good practice where community service providers have developed new ways of working collaboratively with other services to improve patient care. The report also argues that community services have been marginalised and not given enough priority at local and national level, perhaps due to a lack of understanding about these services, perhaps due to the diversity of services, organisations and commissioning arrangements involved.

Childhood obesity: Time for action (Eight Report of Session 2017-2018)
Current estimates suggest that nearly a third of children are overweight in the UK. Children are becoming obese at a younger age and staying obese for longer. Prior to the release of the updated childhood obesity plan this report has been published. The report identifies several key areas as a matter of urgency. For example, marketing and advertising; price promotions; early years and schools; takeaways; extending the drinks levy to cover milk products; labelling and provision of services for children living with obesity. It also contains a list of recommendations.

Sugar reduction and wider reformulation programme: Report on progress towards the first 5% reduction and next steps
In 2016 the Government challenged all sectors of the food industry to reduce the sugar content in their products by 20% by 2020. This Public Health England report (May 2018) details the progress made toward reducing sugar content in food and drink products by 5% in the initial year. Although

some progress has been made, the statistics show a that companies have not implemented sufficient change across all areas to meet the 5% target.

Measuring wellbeing inequality: Working paper on the selection of a headline indicator
In recent years, there has been an uptrend in the interest in wellbeing inequality. This working paper by the New Economics Foundation explores the strengths and weaknesses of different measures for wellbeing inequality. The intention being to recommend a measure which could be reported by the Office of National Statistics alongside mean wellbeing.

9:35 DELIVER FOR TODAY

8. Alliance and community services report

To RECEIVE update

Presented by Dawn Godbold

WSFT Board Meeting - 29 June 2018

Agenda item:	8			
Presented by:	Dawn Godbold, Director of Integration and Community Services			
Prepared by:	Dawn Godbold, Director of Integration and Community Services			
Date prepared:	19/06/2018			
Subject:	Community Services and West Alliance update			
Purpose:	x	For information		For approval

Executive summary:

Work to progress integration internally between acute and community services, and externally across the system is progressing well. There continues to be a large amount of enthusiasm and good engagement from all parts of the system. There are many examples of excellent joint working happening at a local level.

The West Suffolk Alliance has shared the first edition of its strategy with the STP board. A further edition will be developed based on the feedback received. The Alliance is developing a delivery plan to support the ambitions set out in the strategy that will describe our timelines and key actions for transformation. The STP has been announced as successful in its bid for wave 2 vanguard status.

An executive level discussion has taken place between WSFT, the CCG and SCC on the current service challenges for both the paediatric speech and language therapy and the children in care service with agreed actions.

Main Points:

This paper describes the progress being made on:

- Integration between acute and community services
- Development of the West Suffolk Alliance
- Update on the paediatric speech and language therapy service
- Update on the Children in Care Initial Health Assessments
- Update on Buurtzorg test and learn

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

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

Community Services and Alliance Update

West Suffolk NHS Foundation Trust Board

29 June 2018

1.0 Introduction

1.1 The work on both integration between acute and community services and development of the Alliance for the west of Suffolk continues to progress well. This paper describes the progress being made on:

- Integration between acute and community services
- Development of the West Suffolk Alliance
- Update on paediatric SLT provision
- Update on Children in Care Initial Health Assessment
- Update on Buurtzorg test and learn

2.0 Acute and Community Integration

2.1 Clinicians continue to work together across organisational boundaries and progress has been made in the following areas:

- The three additional beds have been opened at Newmarket community hospital.
- An additional new post of senior matron for the community has been created and advertised.
- An additional new post to be shared between the lymphoedema service and the community health teams' leg ulcer service has been agreed. This post will enhance the opportunity to streamline these existing separate services and also explore further integration opportunities with the dermatology out-patient leg ulcer services.
- Additional community matron posts (2.8 WTE) have been agreed from growth monies so that each locality will have a dedicated matron, so that each locality can better support: management of long terms conditions, admission avoidance and pull based discharge.
- A band 3/4 acute/community coordinator post to be created to assist with discharge planning from base wards, and to improve liaison between discharge planning team and community services.
- The system wide therapy strategy has been converted into a plan and has now been aligned to the Alliance strategy and will be a key feature of the Alliance Delivery plan.
- The first joint health and social care team lead post is now out to advert (Newmarket locality).
- Newmarket hospital has been supporting the community admission prevention service with their staffing shortages.
- Glastonbury Court has supported community staff by offering a supported phased return to work after a long absence.
- A workshop has been facilitated by NHS Elect to develop a plan for joining the hospital and community IV therapy services into one service.

2.2 Discharge to Optimise and Assess Progress

- This nationally mandated scheme focusses on ensuring no decision about an individual's long **term** care is made whilst in the acute hospital and shifts the assessment process to the individuals own home or home environment. It requires not only a change in practice but a change in mind set across the whole acute/community interface. Underpinned by the ethos of' home first' principles the scheme comprises of four separate but interlinked pathways:

- Pathway 0: This supports the majority of discharges from the hospital and people require no new care and support at home. Delivery of this pathway requires a focus on reablement and is supported by the #endpjparalysis work.

- Pathway 1: this is the second largest pathway and is likely to require the most change in practice. Individuals discharged on this pathway can go home but require new or additional support. A working group led by Jenny McCaughan is in place and a workshop to shape the pathway is planned for the 19 July. The aim is to get the pathway operational through the Support to Go Home and Homefirst services in the first instance by October 2018.

- Pathway 2: This has been operational through Glastonbury Court and more recently through Newmarket Hospital. Plans are in place to implement this pathway at Hazel Court ahead of this winter. Plans are being developed to put in place a model of virtual wards to support a cohort of patients who could go home with an enhanced offer of support.

- Pathway 3: This pathway is aimed at patients who may be heading for long term care placement and includes the Continuing Health Care Assessment, 5Qs and development of a pathway to support patients with protracted delirium.

2.3 Falls and Frailty

- The team in the Frailty Assessment Unit and the community frailty co-ordinator are now working closely on pathway re-design; this will assist with quick turnaround in the unit and improved discharges.
- 'Hot clinics' (could be virtual to maximise resources and get greater geographical coverage) utilising interface geriatricians and specialist nurses/community matrons being explored taking referrals from GPs, care co-ordination centre, early intervention team.
- Work has begun to embed the use of the Rockwood frailty tool across all parts of the system; this will replace all the existing different tools used and ensure standardisation and shared care record use across the system.
- A process is being developed in the frailty assessment unit for a hotline for community staff to access specialist advice; this will support admission avoidance decisions.
- Warm handover will be used as a referral form to accept falls referrals into the community healthcare teams from June. This avoids duplicate referrals having to be made saving clinicians' time.
- The ambulance service falls notification process and related IT issues is being scoped and linked with the clinical falls pathway work to reduce duplication of the falls assessments. The project is developing links with the IT transformation system wide to help ensure our IT developments meet clinical need.
- The system wide falls strategy is scheduled for sign off by July. This will ensure standardisation and co-ordination of pathways/processes/response to falls and support ownership of the falls pathway across the system.
- The Fire Service has agreed to undertake Stage 1 falls assessments as part of their Safe & Well Visits.
- A proposal for case finding options has been written to ensure a proactive approach to falls management moving forward.

3.0 IT Progress

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

3.2 A full review of the usage and support of SystmOne across the community is underway. We are conducting this review so we can optimise and configure the SystmOne modules ready for the mobile working pilot where staff can use the SystmOne application loaded on laptops running Microsoft Windows using a 3/4G cellular connection.

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

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

3.5 HSCN Internet Connections
A Suffolk wide project is currently taking place to upgrade all N3 Internet connections to new HSCN enabled (Health Social Care Network) connections. This will enable pan public sector organisations to integrate their IT Systems to work collaboratively. We will also benefit from improved network performance at community sites which are currently restricted by the existing N3 service.

3.6 GovRoam Wi-Fi
WSH has received funding from NHSD to rollout WiFi to community sites and we are working with IHT to implement WiFi at all community sites. A GovRoam WiFi pilot is in currently being developed in conjunction with Suffolk County Council at the Newmarket Hospital site. A rollout plan will be published shortly when an implementation plan has been finalised.

3.7 Hardware Refresh
Funding has been agreed and the Community ICT Team is in discussions with senior managers to agree a priority plan of replacing hardware (desktops/laptops) within clinical service teams. We are currently evaluating a range of laptops and notebooks to trial and obtain feedback on the most suitable equipment for our clinical needs.

3.8 Mobile Phone Review
The WSH procurement team is working with IHT (East Suffolk) to review and analyse mobile phone usage across all the community teams. This information can be used to obtain the best contract tariffs for voice calls and data usage for the future to ensure they are suitable for the mobile working project.

4.0 Buurtzorg Test and Learn Update

4.1 The Buurtzorg Test and Learn went live at the beginning of March 2018. The team now consist of 6 staff (5.2 WTE) comprised of qualified nurses and support workers. The team are continuing to recruit.

4.2 The current caseload is 16 patients; the team are providing an overnight on call service and are exploring if they are now able to expand the catchment area for the service. Referrals have come from GPs, the hospital and one from the local vicar. This referral is highlighted below as it demonstrates perfectly the 'added value and uniqueness' that this service brings:

Message to the Team From the local Reverend:

"I want you to know how impressed I am with your care you are providing for Mr and Mrs X.

"The last year has been very difficult for Mrs X as her husband's condition has worsened. Because she has her own health issues, I was becoming more and more concerned about both of them.

"Since your team is now looking after their total care and helping in so many ways to sort out benefits they are entitled to, Mrs X's anxiety has lessened considerably. I visited both of them on Friday of last week and could see a visible difference in Mrs X's demeanour and emotional state. She was happier and more relaxed. Mr X was still confused but his anxiety had also dropped."

4.3 The test and learn will be used to understand how we develop a 'service blueprint' inspired by the Buurtzorg model to fully assess what impact and outcomes can be realised in the English health and care system.

4.4 A case will need to be built to demonstrate that paying an increased rate for health and care support results in: better care, better outcomes, better satisfaction for staff and is financially viable in the longer term.

5.0 West Suffolk Alliance Development

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

5.2 The group have considered the long term future for the Support to Go Home Service and agreed to permanent funding on a three way split between Suffolk County Council, CCG and WSFT. This is an excellent example of integration and 'systemness' where it has been recognised that such initiatives are not the responsibility of one organisation in isolation but are system challenges that need a collegiate response.

5.2 The group endorsed the latest version of the strategy document. This was also presented to the ICS project board and was well received. The document was submitted to the STP board on 8 June 2018. Feedback included: the need to reflect the STP ambitions more, greater emphasis needed on the role of the voluntary sector and independent sector, greater alignment requested between all three Alliance documents.

5.3 Work has commenced on the delivery plan that will accompany the strategy document. The delivery plan will contain key milestones and timescales for each of the ambitions and actions set out in the strategy. The development of the delivery plan is now becoming a very large piece of work, and therefore a 'plan on a page' will also be developed for ease of reference. It is acknowledged that the timescale for submission of the plan – due its complexity will need to be revised.

5. 4 The first of a series of roadshows/meetings started on 26 June 2018 to engage community staff with the Trust and seek views on integration.

5.5 Discussions have begun in the Haverhill locality to explore options for greater integration of nursing resources between primary and community services. Both teams have recruitment challenges and it is hoped that greater efficiencies can be realised by sharing more activity, with the potential to create a new hybrid role.

5.6 The planning for development of the Newmarket site into a health and wellbeing centre continues under the oversight of the project board. The project board has had two meetings so far and has started to develop a model for the desired health and wellbeing hub as well as planning for the move of Oakfield GP practice onto the site.

5.7 A system wide and cross county work shop to develop the mental health service offer has been held with WSFT executive attendance.

5.8 Support from the Leadership Centre has been sourced via STP OD monies for the Alliance to use to develop our collaborative working techniques, including how we resolve any conflicts and help us to learn to operate and lead as a system.

6.0 Care Homes

6.1 A draft paper outlining a proposed model of support for care homes (both nursing and residential) has been drafted following a system workshop. The model proposes a tiered approach to support utilising the locality teams, GPs and specialist support from the community matrons, specialist nurses and interface geriatricians.

6.2 The new model will support better management of long term conditions, improved management of avoidable admissions from care homes and avoidable conveyances and attendances at ED.

6.3 Part of the core offer would be increased support from community nurses and a rolling training/education programme for nursing staff.

7.0 Paediatric Speech and Language Therapy

7.1 The board has previously considered the challenges facing this service and the actions being taken to improve waiting times, particularly for those children who need more than one session of therapy. An escalation telephone call between the CEOs of WSFT, the CCG, and directors from SCC and those leading the service re-design was held on 11 June 2018.

7.2 Speech, Language and Communication (SLC) has been identified as a priority for the Children's Alliance in light of increasing demands on services and an ambition for clearer pathways for children, parents and their carers to access services when they need them. A review and re-design was commissioned which has been led jointly by Suffolk County Council's Children and Young People Service and the Ipswich and East and West CCG.

The scope of the review and re-design of SLC is broad and has included the following services:

- Suffolk Communications Aids Resource Centre within the Integrated Community Paediatrics Service
- Specialist Education
- Early Years
- Speech and Language Units
- Universal settings – eg schools
- Early Help – including school nurses and health visitors
- Schools Choice

7.3 A task and finish group has been established to undertake the service review and re-design which includes representatives from these services as well as a representative from the Suffolk Parent Carer Network. They agreed the following guiding principles for the new service.

The new service(s) needs to be:

- A child and family needs-led service;
- A fully integrated service - both universal and specialist services;
- Shared responsibility – everybody's business, across the whole system – bringing clarity of roles and accountability;
- Skills and knowledge across the whole system to support CYP with SLC
- A clear, visible, well understood pathway, open and transparent and easy to navigate;
- An equitable, consistent, sustainable and realistic offer;
- Early identification and timely impactful intervention – at every stage;

- Outcomes focused, evidence based and jointly owned;
- 'Train my parents and my teachers, they know me best'.

7.4 The review has mapped current service provision across these services and organisations and has captured information in relation to resources and demand across the current provision. An options appraisal for each element of the pathway has been produced.

7.5 Through co-production a new model and pathway has been scoped. It is intended the task and finish group will agree the new model at its meeting on 19 June 2018. Through the summer, the officer lead and a resource from the knowledge and intelligence hub within Public Health will produce a costed model which will form part of a business case to be considered by the Children's Alliance in September 2018.

8.0 Children in Care Initial Health Assessment

8.1 The Children in Care Initial Health Assessment process and performance was also a subject of the CEO escalation call between SCC, CCG and WSFT. Both the process and the demand were discussed.

8.2 There are a number of actions that will impact on different parts of this pathway that are being collated into one action plan. Initial analysis shows that late paperwork, lack of capacity and missed appointments seem to be the main three issues

8.3 It was recognised and agreed that this is a system wide problem and should be highlighted to, and discussed at, the newly formed system executive group (SEG) to reach a shared solution. All are committed to this.

8.4 In the short term the CCG have agreed to fund an additional post of 0.5 WTE GP to increase capacity and options such as teenagers seeing their own GP, and greater use of nurse practitioners are being explored.

8.5 The challenge of the rising number of children from outside Suffolk being placed in Suffolk, and the very late notifications to the service for these children is to be escalated to the Corporate Parenting Regional Board.

9.0 Conclusion

9.1 The board is asked to note the good progress being made on individual initiatives and collaborative working in general. The system is continuing to mature and strengthen.

9. Integrated quality and performance report

To ACCEPT the report

Presented by Rowan Procter and Helen Beck

Trust Board – 29 June 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:	June 2018			
Subject:	Trust Integrated Quality & Performance Report			
Purpose:	x	For information		For approval

Executive summary:
This report provides an overview of quality and performance across the Trust. During May the focus has been maintained around reducing patient falls and pressure ulcers, with 61 falls and 9 Trust acquired pressure ulcers reported. There were no C. difficile cases in the month. The year to date performance for all cancer targets is ahead of the national threshold; however, the Trust failed to deliver the target for two week wait from referral to date first seen in May. The 4 hour wait performance for ED has seen a significant increase to 94% following targeted actions despite activity modelling identifying that +200 attendances per day is becoming the norm. We experienced a 9% year on year increase in attendances at ED in May 2018 compared to May 2017. RTT performance against the 18 week standard has seen a significant improvement to 92% however there is still work to do to ensure this is a sustainable position throughout the year. A weekly focus remains on those patients waiting longer than 52 weeks for treatment, with 14 long waiting patients reported in May.

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:	Reviewed monthly at Trust Board
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity	

implications	
Recommendation: Trust Board are asked to note the contents of the report.	

NHS
West Suffolk
NHS Foundation Trust

Integrated quality and performance report



Month Two: May 2018

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 May 2018. There were one cases of hospital-attributable Clostridium difficile case for May 2018; The Trust compliance with decolonization Increased in May 2018 to 91%.

NHS Patient Safety Alerts A total of 7 PSAs have been received in 2017/8, with 0 in May 2018. All the alerts have been implemented within timescale to date.

Patient Falls (Inpatients) - 76 patient falls occurred in May 2018. (*Recovery Action Plan (RAP) included in main report*).

Pressure Ulcers- The number of ward-acquired pressure ulcers continues to be above the local Trust plan of 5 per month. In May 2018, 9 cases occurred, with YTD total of 174. *(RAP included in main report).*

ARE WE EFFECTIVE?

Cancelled Operations for non-clinical reasons - The rate of cancelled operations for non-clinical reasons was recorded at 0.8% in May 2018. (*RAP included in the main report*). **Cancel Operations Patients offered date within 28 Days –** The Rate Cancel Operations Patients offered date within 28 Days was recorded at 90.91% in May 2018 compared to 85.71% In April 2018.

Discharge Summaries- Performance to date is below the 95% target to issue discharge summaries (inpatients and ED). A&E has achieved a rate of 82.50% in May 2018 whereas Inpatient services have achieved a rate of 70.99%. (*RAP included in the main report*).

ARE WE CARING?

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

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

ARE WE RESPONSIVE?

A&E 4 hour wait - The quarter 1 performance for A&E is 89.5%. Recently WSH experienced some exceptionally challenging days and the performance was impacted with 93.5% reported for May 2018. *(RAP included in main report).*

Cancer – Cancer performance (provisional figures) of 85.1% is below the national requirement with a significant increase in the number for referrals in 2 Week Wait suspected breast cancer there is a risk to this target going forward in June. *(RAP included in the main report).*

Referral to Treatment (RTT) - The percentage of patients on an incomplete pathway within 18 weeks is above national with performance in May at 92.14%, however this is not considered to be a sustainable position moving forwards. Data quality issues and validation of the list continue. The total waiting list remains at 16481 in May 2018. In May, 14 patients breached 52-week standard. *(RAP included in the main report).*

ARE WE WELL LED?

Appraisal Rates – A rise has been demonstrated in May to 67.33%. Staffing shortages and winter pressures challenged performance earlier in the year however now this is improving and staffing levels have stabilised, appraisal is being prioritised. The policy has been reinforced for staff not being able to access CDP funding if their mandatory training and appraisal is not in date.

Sickness Absence – Whilst this has reduced in May by (0.04%) to 3.75%, this remains worse than this time last year 3.62% Actions remain in place to support managers to manage both short term and long term absence. Further advice and guidance about maintaining personal health & wellbeing will be offered in the coming months. *(RAP included in the main report).*

ARE WE PRODUCTIVE?

The month 2 financial position reports a deficit of £2.8m which is £0.4m worse than planned. The Trust has now agreed a control total to make a deficit of £13.8m which will provide Provider Sustainability Funding (PSF, formerly STF) of £3.7m should A&E and Financial targets be met. Therefore the Trust is now planning on a net deficit of £10.1m for 2018-19. However, no PSF is yet included in the financial position.

In order to achieve the control total the 2018-19 budgets now include a stretch CIP of £2.8m bringing the total CIP plan to £12.2m (5%).

The Trust is currently applying for the cash support from DH to support this revenue deficit and also the planned capital programme of £28.1m.

2. INTEGRATED QUALITY & PERFORMANCE REPORT DASHBOARD

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

Are we..	Ref.	KPI	Type	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
1. Safe	1.01	NHS E / I Patient Safety Alerts - Total		NT	1	0	0	1	2	1	0	1	0	1	0	0	2	0
	1	NHS E / I Patient Safety Alerts outstanding		0	0	0	0	0	0	0	0	0	0	0	0	0	0	2
	1	Emergency C-Section Rate		14%	10%	12%	12%	9%	13%	12%	11%	10%	11%	14%	10%	13%	16%	11%
	1	All relevant inpatients undergoing a VTE Risk assessment		95%	87%	89%	89%	86%	90%	88%	95%	97%	95%	97%	98%	97%	98%	94%
	1.1	Clostridium Difficile infection - Hospital Attributable		16	3	0	0	1	0	2	6	4	0	1	0	2	1	0
	1.1	MRSA Bacteraemias - Hospital Attributable		0	0	0	0	0	0	2	0	0	0	0	1	0	0	0
	1.1	Patient Safety Incidents Reported		NT	392	508	418	506	466	467	520	588	479	627	553	535	486	579
	1.08	Never Events		0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
2.Effective	2	Canc. Ops - Cancellations for non-clinical reasons		1%	1%	1%	1%	1%	1%	1%	1%	2%	1%	1%	1%	1%	1%	1%
3. Caring	3.01	Compliments (Logged by Patient Experience)			41	52	26	56	28	17	33	87	151	64	20	45	21	33
	3	Formal Complaints		20	10	10	10	6	16	16	17	13	8	12	19	9	13	13
	3	Mixed Sex Accommodation Breaches		0	0	0	0	0	0	0	0	0	1	0	0	1	0	0
	3	IP - Extremely likely or Likely to recommend (FFT)		90%	98%	97%	99%	98%	98%	98%	99%	96%	98%	97%	98%	98%	99%	99%
	3.1	OP - Extremely likely or Likely to recommend (FFT)		90%	95%	96%	97%	95%	95%	96%	96%	96%	99%	95%	96%	95%	97%	97%
	3.1	A&E - Extremely likely or Likely to recommend (FFT)		85%	97%	96%	95%	95%	95%	92%	95%	94%	94%	96%	95%	94%	94%	93%
	3.1	Maternity - Extremely likely or likely to recommend (FFT)		90%	100%	100%	100%	100%	ND	ND	99%	100%	97%	100%	93%	100%	100%	100%
	3.1	Community - Extremely likely or likely to recommend		80%	97%	ND	100%	ND	ND	ND	97%	100%	96%	95%	97%	96%	94%	98%
4. Responsive	4.01	A&E under 4 hr. wait		95%	95%	95%	96%	92%	90%	89%	87%	90%	83%	84%	85%	85%	85%	94%
	4	RTT: % incomplete pathways within 18 weeks		92%	82%	80%	83%	84%	86%	86%	87%	89%	89%	90%	90%	90%	90%	92%
	4	52 week waiters		0%	15	14	15	35	26	29	26	21	15	14	13	24	19	14
	4	Diagnostics within 6 weeks		99%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%
	4.1	Cancer: 2w wait for urgent GP Referrals		93%	94%	92%	97%	95%	96%	91%	83%	98%	97%	98%	98%	95%	93%	85%
	4.1	Cancer 2w wait breast symptoms		93%	94%	99%	89%	98%	100%	98%	100%	100%	99%	97%	93%	87%	97%	83%
	4.1	Cancer 31 d First Treatment		96%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	99%	100%
	4.1	Cancer 31 d Drug Treatment		98%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.1	Cancer 31 d Surgery		94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.10	Cancer 62 d GP referral		85%	89%	83%	86%	85%	86%	87%	94%	90%	87%	87%	80%	88%	93%	85%
	4.1	Cancer 62 d Screening		90%	100%	100%	90%	100%	100%	91%	100%	83%	100%	93%	86%	95%	73%	93%
	4.1	Incomplete 104 day waits			ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	3	1.5

5. Well Led	5.01	NHS Staff Survey (Staff Engagement score -Annual)			NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4%	NA	NA	NA
	5	Staff F&F Test % Recommended - care (Qrtly)		75%	NA	NA	95%	NA	NA	95%	NA	NA	ND	NA	NA	ND	NA	NA
	5	Staff F&F Test % Recommended - place to work (Qrtly)		75%	NA	NA	83%	NA	NA	82%	NA	NA	ND	NA	NA	ND	NA	NA
	5	Turnover (Rolling 12 mths)		<10%	10%	10%	10%	10%	10%	10%	9%	9%	9%	9%	9%	9%	8%	8%
	5.1	Sickness Absence		<3.5%	3.71%	3.62%	3.61%	3.58%	3.58%	3.58%	3.55%	3.51%	3.52%	3.57%	3.70%	3.72%	3.80%	3.80%
	5.1	Executive Team Turnover (Trust Management)		<10%	0%	20%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	5.1	Agency Spend			311	216	255	216	126	150	82	213	245	353	306	373	276	188
	5.1	Monitor Use of Resources Rating			3	3	3	3	3	3	3	3	3	3	3	3	3	3
6. Productive	6.01	I&E Margin		Var	ND	-4.90%	-4.30%	-3.90%	0.13%	-3.04%	-2.55%	-2.47%	-2.60%	-2.34%	-2.56%	20.00%	-10.30%	-7.50%
	6	Capital service cover		Var	ND	- 3.19	- 2.50	- 2.18	- 1.04	- 0.88	- 0.32	0.52	0.24	0.38	0.07	0.68	0.48	1.64
	6	Liquidity (days)			ND	- 12.15	- 15.72	- 10.94	- 11.03	- 12.70	- 15.14	3.64	11.39	6.06	6.84	7.86	12.34	16.83
	6.1	Long Term Borrowing (£m)		4%	44.3	45.7	45.7	45.7	45.7	47.6	47.6	56.7	56.7	64.4	64.1	65.4	67.6	69.8
	6.1	CIP (Variance YTD £'000s)CIP (Variance YTD £'000s)		1.3	40	0	-40	10	0	-54	-10	-74	-22	-419	-469	-539	-54	-47
7.Maternity	7.01	Total number of deliveries (births)		210	215	192	213	215	233	236	205	194	180	199	211	206	195	201
	7.02	% of all caesarean sections		<22.7%	15%	21%	16%	16%	22%	18%	17%	17%	18%	22%	17%	30%	28%	22%
	7.03	Midwife to birth ratio		1.3	1.30	1.27	1.29	1.30	1.33	1.33	1.29	1.28	1.26	1.28	1.29	1.29	1.27	1.30
	7.04	Unit Closures		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.05	Completion of WHO checklist		100%	84%	93%	84%	94%	82%	98%	98%	98%	93%	93%	94%	97%	86%	85%
	7.06	Maternity SIs		NT	1	0	0	0	0	1	1	0	1	2	0	1	2	2
	7.07	Maternity Never Events		NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.08	Breastfeeding Initiation Rates		0.8	80%	81%	86%	77%	85%	79%	81%	80%	80%	82%	76%	79%	76%	76%
8. Community	8	No of avoidable serious injuries or deaths from falls - Community	CO	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
	8.02	Community - Extremely likely or likely to recommend	CO	80%	97%	ND	100%	ND	ND	ND	97%	100%	96%	95%	97%	1	94%	98%
	8.03	RTT 18 weeks Non-Consultant led services - Community	CO	90%	97%	96%	99%	99%	95%	99%	94%	94%	98%	99%	100%	99%	99%	98%
	8.04	Urgent Referrals for Early Intervention Team (EIT) - Community	CO														ND	ND
	8.05	Nursing & therapy Red referrals seen within 4hrs - Community	CO			1.00	1.00	1.00	NA	1.00	NA	NA	1.00	1.00	1.00	1.00	1.00	1.00
	8.06	Nursing & therapy Amber referrals seen within 72hrs - Community	CO			0.99	0.99	0.99	0.96	0.99	0.91	0.97	1.00	1.00	0.96	0.98	1.00	0.99
	8.07	Safeguarding Children Mandatory Compliance (Community)	CO	98%	96%	96%	97%	97%	97%	97%	95%	96%	96%	96%	96%	97%	96%	96%
	8.08	Safeguarding Adults Mandatory Training Compliance (Community)	CO	98%	96%	96%	97%	97%	96%	96%	94%	95%	94%	94%	93%	96%	96%	95%

3. IN THIS MONTH – MAY 2018, MONTH 2

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	May-2018	To Month Year	May-2017

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

In this month.... April 2018

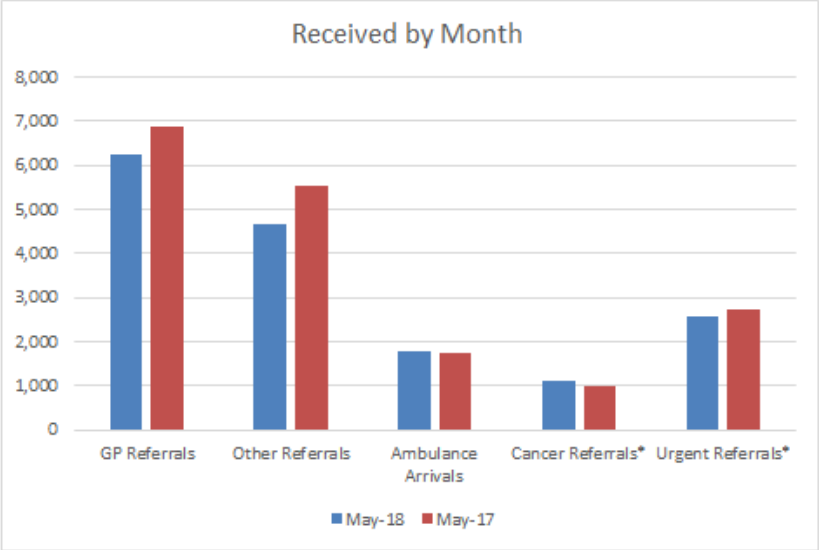
Mth We Received.....	May-18	May-17	Variance	Var. %	Traffic
GP Referrals	6,225	6,889	-664	-10%	↓
Other Referrals	4,664	5,520	-856	-16%	↓
Ambulance Arrivals	1,789	1,755	34	2%	↑
Cancer Referrals*	1,123	1,003	120	12%	↑
Urgent Referrals*	2,576	2,731	-155	-6%	↓

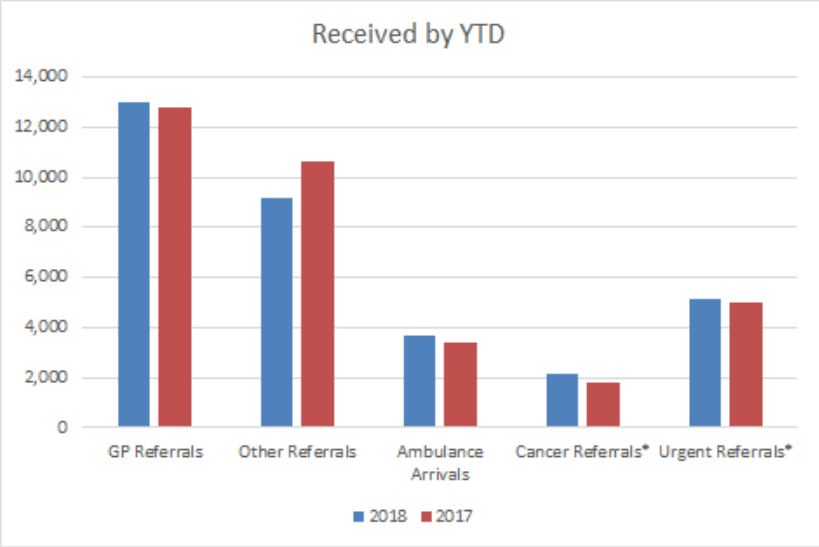
YTD We Received.....	2018	2017	Variance	Var. %	Traffic
GP Referrals	12,980	12,782	198	2%	↑
Other Referrals	9,199	10,608	-1,409	-13%	↓
Ambulance Arrivals	3,676	3,408	268	8%	↑
Cancer Referrals*	2,141	1,828	313	17%	↑
Urgent Referrals*	5,164	5,027	137	3%	↑

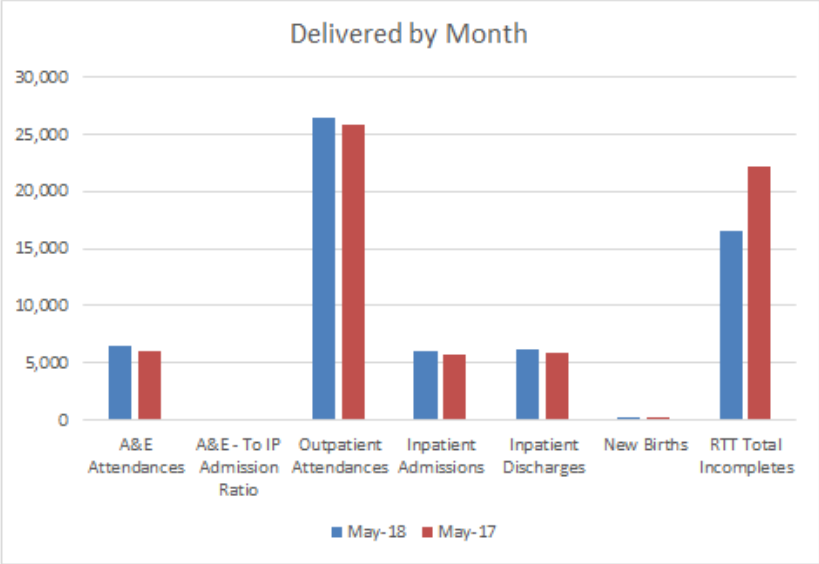
Mth We Delivered.....	May-18	May-17	Variance	Var. %	Traffic
A&E Attendances	6,498	5,971	527	9%	↑
A&E - To IP Admission Ratio	25.8%	29.0%	-3.2%	-3.2%	↓
Outpatient Attendances	26,385	25,754	631	2%	↑
Inpatient Admissions	6,118	5,810	308	5%	↑
Inpatient Discharges	6,126	5,816	310	5%	↑
New Births	201	192	9	5%	↑
RTT Total Incompletes	16,481	22,144	-5,663	-26%	↓

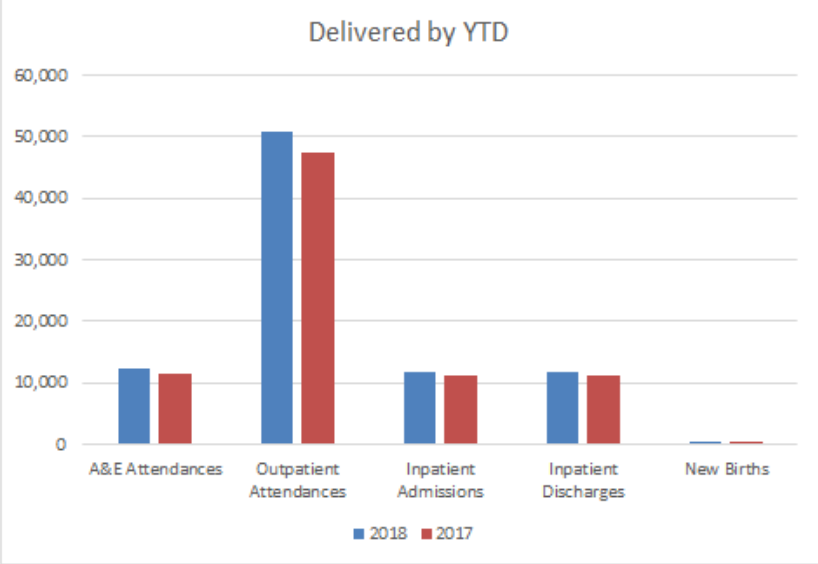
YTD We Delivered.....	2018	2017	Variance	Var. %	Traffic
A&E Attendances	12,465	11,549	916	8%	↑
Outpatient Attendances	50,727	47,541	3,186	7%	↑
Inpatient Admissions	11,684	11,219	465	4%	↑
Inpatient Discharges	11,693	11,257	436	4%	↑
New Births	396	407	-11	-3%	↓

* - Included in Referrals Above


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

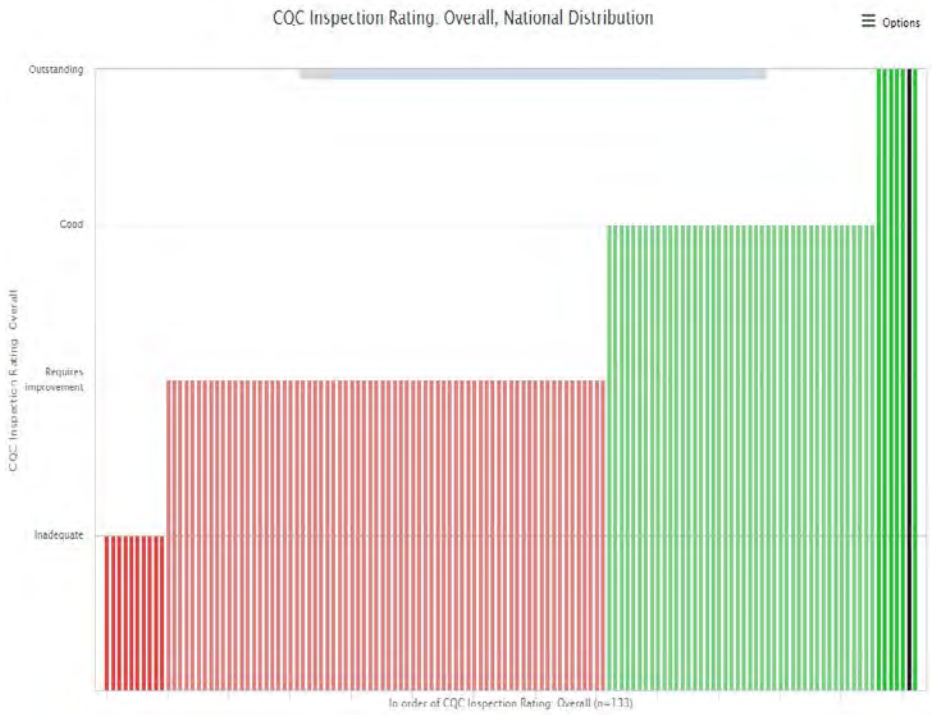

Received by YTD
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
GP Referrals
Other Referrals
Ambulance Arrivals
Cancer Referrals*
Urgent Referrals*
2018
2017

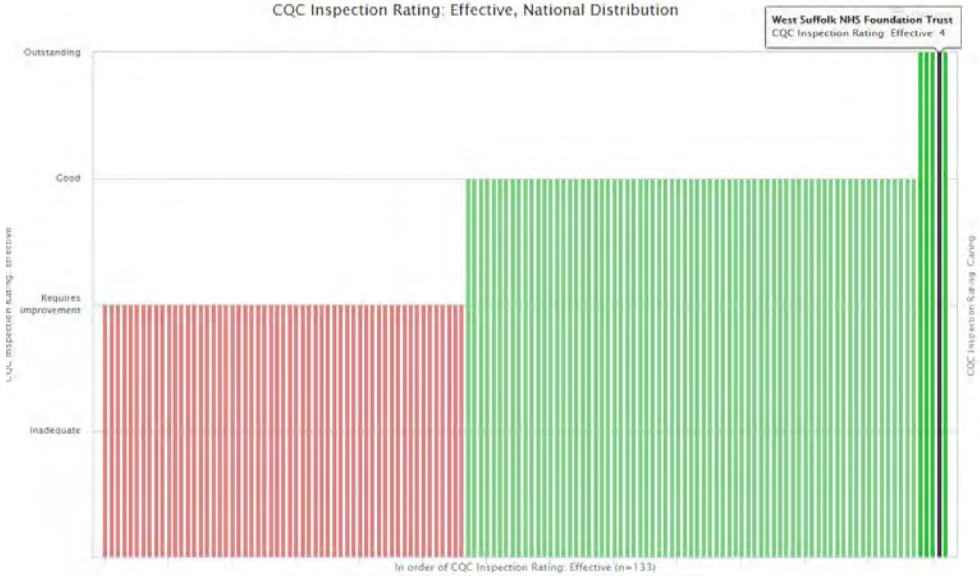

Delivered by Month
30,000
25,000
20,000
15,000
10,000
5,000
0
A&E Attendances
A&E - To IP Admission Ratio
Outpatient Attendances
Inpatient Admissions
Inpatient Discharges
New Births
RTT Total Incompletes
May-18
May-17

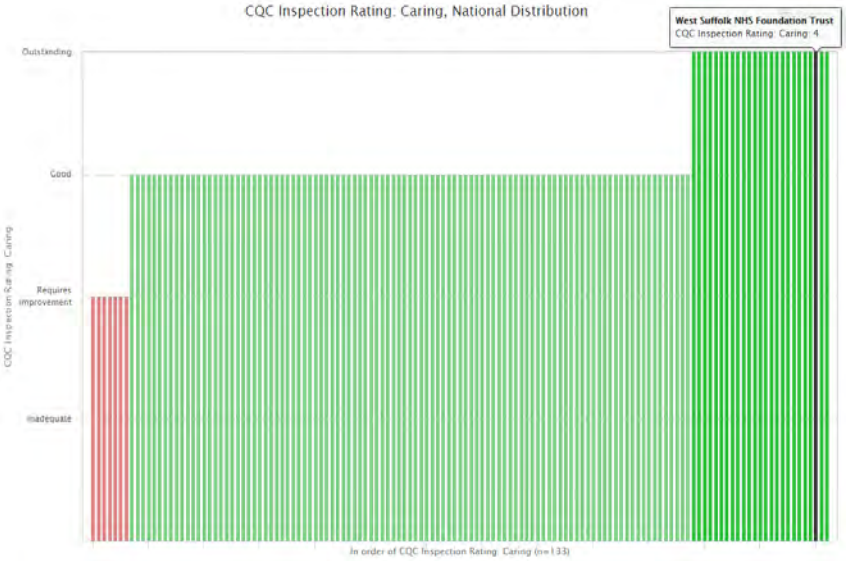

Delivered by YTD
60,000
50,000
40,000
30,000
20,000
10,000
0
A&E Attendances
Outpatient Attendances
Inpatient Admissions
Inpatient Discharges
New Births
2018
2017

4. CQC OVERVIEW

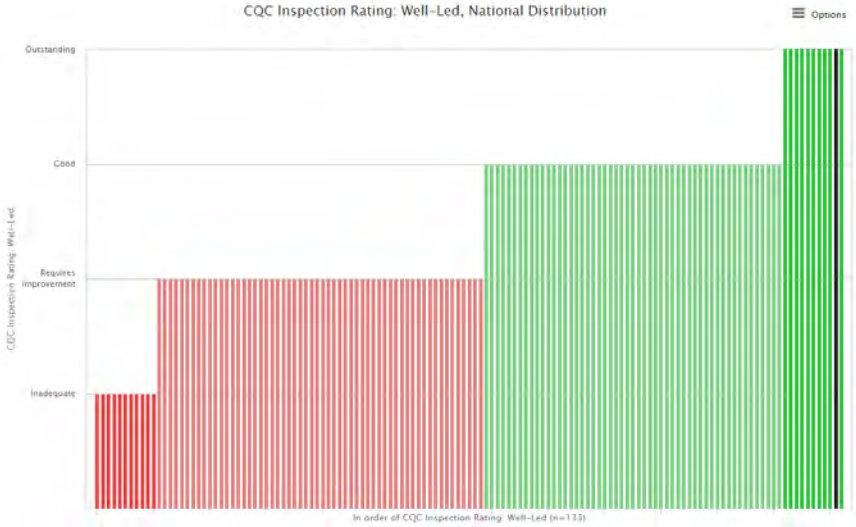
The CQC have launched the Model Hospital website in *alpha* form which highlights comparative indicators in a number of key areas. Quality of Care compartment: CQC ratings as the principal assessment indicators, with additional indicators, including the Friends and Family Test, Ambulance outcomes, &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




CQC Inspection Rating: Effective, National Distribution
West Suffolk NHS Foundation Trust
CQC Inspection Rating: Effective: 4
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Effective
In order of CQC Inspection Rating: Effective (n=133)


CQC Inspection Rating: Caring, National Distribution
West Suffolk NHS Foundation Trust
CQC Inspection Rating: Caring: 4
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Caring
In order of CQC Inspection Rating: Caring (n=133)


CQC Inspection Rating: Responsive, National Distribution
Options
West Suffolk NHS Foundation Trust
CQC Inspection Rating: Responsive: 3
Outstanding
Good
Requires improvement
Inadequate
CQC Inspection Rating: Responsive
In order of CQC Inspection Rating: Responsive (n=133)


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

CQC - QUALITY OF CARE BENCHMARK DASHBOARD

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

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	Apr 2018	94.1%	90.6%	88.0%			
Inpatient Scores from Friends and Family Test - % positive	Apr 2018	99.4%	97.4%	96.3%			
Community Scores from Friends and Family Test - % positive	Apr 2018	94.1%	94.6%	96.5%			
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	9	-	-		No variation available	No trendline available

Caring	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Written Complaints Rate	31/12/2017	11.95	21.24	22.74			

Safe	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Never events	31/03/2018	1	1	1			
Emergency c-section rate	Mar 2018	15.64%	15.36%	15.64%			
VTE Risk Assessment	Q4 2017/18	97.24%	95.79%	95.71%			
Clostridium Difficile - infection rate	To Apr 2018	12.50	9.03	13.08			
MRSA bacteraemias	To Mar 2018	0.74	0.00	0.63			
Potential under-reporting of patient safety incidents	31/01/2018	37.73	43.71	-		No variation available	No trendline available
Escherichia coli (E. coli) bacteraemia bloodstream infection (BSI)	Apr 2018	120	124	128			
Meticillin-sensitive staphylococcus aureus (MSSA) rates to quality indicators	Apr 2018	7	8	9			

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

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

5. DETAILED SECTIONS - SAFE

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

we.		Ref.	KPI	Type	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Safe	Dashboard	1.01	NHS E / I Patient Safety Alerts - Total	TW	0	0	1	2	1	0	1	0	1	0	0	2	0
		1.02	NHS E / I Patient Safety Alerts outstanding		0	0	0	0	0	0	0	0	0	0	0	0	2
		1.03	Emergency C-Section Rate	WS	11.6%	11.5%	8.5%	12.9%	11.9%	11.2%	9.8%	10.6%	14.1%	10.1%	19.4%	16.4%	11.4%
		1.04	All relevant inpatients undergoing a VTE Risk assessment	WS	88.6%	88.8%	85.8%	89.7%	88.0%	94.8%	96.9%	94.7%	96.9%	97.6%	97%	98.2%	94.1%
		1.05	Clostridium Difficile infection - Hospital Attributable	WS	0	0	1	0	2	6	4	0	1	0	2	1	0
		1.06	MRSA Bacteraemias - Hospital Attributable	WS	0	0	0	0	2	0	0	0	0	1	0	0	0
		1.07	Patient Safety Incidents Reported		508	418	506	466	467	520	588	479	627	553	535	486	579
		1.08	Never Events		0	0	0	0	0	0	1	0	0	0	0	0	0
	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	WS	100%	100%	100%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%
		1.10	HII Compliance 1b: Central venous catheter on-going care	WS	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	100%	95%
		1.11	HII Compliance 2a: Peripheral cannula insertion	WS	100%	100%	100%	97%	100%	98%	97%	100%	100%	100%	100%	100%	100%
		1.12	HII Compliance 2b: Peripheral cannula on-going	WS	97%	98%	93%	97%	99%	99%	97%	96%	99%	100%	100%	100%	98%
		1.13	HII Compliance 4a: Preventing surgical site infection preoperative	WS	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.14	HII Compliance 4b: Preventing surgical site infection perioperative	WS	85%	100%	95%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%
		1.15	HII Compliance 5: Ventilator associated pneumonia	WS	100%	100%	100%	100%	100%	100%	78%	100%	100%	100%	100%	100%	100%
		1.16	HII Compliance 6a: Urinary catheter insertion	WS	100%	100%	100%	100%	100%	78%	100%	100%	100%	100%	100%	100%	100%
		1.17	HII Compliance 6b: Urinary catheter on-going care	WS	92%	94%	88%	99%	97%	91%	92%	95%	100%	99%	97%	100%	95%
	Incidents	1.18	Safety Thermometer: % of patients experiencing new harm-free care-Trust	TW	98.26%	98.91%	98.64%	98.18%	97.18%	97.63%	98.38%	98.54%	97.90%	97.71%	98.47%	99.18%	97.78%
		1.19	Safety Thermometer: % of patients experiencing new harm-free care - Community	CO												99.4%	98.1%
		1.20	No of SIRIs	TW	5	7	7	6	5	11	14	10	20	11	6	8	11
		1.21	RIDDOR Reportable Incidents		4	5	0	3	0	2	0	3	0	2	1	2	4
		1.22	Total No of E. Coli (Trust level only)	TW	0	2	2	1	2	1	2	2	2	1	3	1	2
		1.23	No of Inpatient falls - Trust	TW	66	56	75	69	44	56	73	69	76	82	72	68	72
		1.24	No of Inpatient falls - WSH	WS	52	50	66	64	39	47	56	60	68	74	64	55	61
		1.25	No of Inpatient falls - Community Hospitals	CO	14	6	9	5	5	9	17	9	8	8	8	13	19
		1.26	Falls per 1,000 bed days (Locally derived estimate)	WS	4.8	4.6	6.3	5.7	3.7	3.9	5	5.1	5.6	6.52	5.17	6.13	6.76
		1.27	No of Inpatient falls resulting in harm - Trust	TW	20	22	17	18	10	23	18	23	28	26	20	24	24
		1.28	No of Inpatient falls resulting in harm - WSH	WS	17	20	14	18	10	19	15	19	27	25	19	18	19
		1.29	No of Inpatient falls resulting in harm - Community Hospitals	CO	3	2	3	0	0	4	3	4	1	1	1	6	5
		1.30	No of avoidable serious injuries or deaths resulting from falls - Trust	TW	0	0	0	1	0	0	1	0	0	1	0	ND	0
		1.31	No of avoidable serious injuries or deaths resulting from falls - WSH	WS	0	0	0	1	0	0	0	0	0	1	0	ND	0
		1.32	No of avoidable serious injuries or deaths from falls - Community	CO	0	0	0	0	0	0	1	0	0	0	0	0	0
		1.33	Number of medication errors	TW	80	69	78	70	69	70	78	63	72	49	76	60	85
		1.34	No of ward acquired pressure ulcers	WS	9	18	9	13	14	18	17	12	30	15	9	4	9
		1.35	No of Community 'In our Care' pressure ulcers	CO	NA	NA	NA	NA	NA	13	14	6	24	15	14	12	18
		1.36	% of patients with avoidable ward acquired pressure ulcers YTD	WS	37%	30%	30%	34%	33%	32%	28%	28%	29%	28%	ND	29%	ND
		1.37	% of patients with avoidable Community 'In our Care' pressure ulcers	CO	NA	NA	NA	NA	NA	ND	ND	ND	ND	ND	ND	ND	ND

6. DETAILED SECTIONS - SAFE

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

Reporting	1.38	MRSA Quarterly Std (including admission and LOS screens)	TW	NA	NA	92%	NA	NA	93%	NA	NA	90%	NA	NA	92%	92%	NA	NA
	1.39	MRSA Bacteraemias - Community Attributable	CO	0	0	0	0	1	ND	0	0	0	0	0	1		2	0
	1.40	Clostridium Difficile infection - Community Attributable	CO	0	0	0	0	1	1	1	0	0	0	0	2		1	0
	1.41	MRSA - Decolonisation	TW	92%	93%	95%	95%	90%	91%	98%	85%	91%	94%	86%	95%	91%	85%	91%
	1.42	MRSA - RCA Reports	TW	0	0	0	0	0	0	0	0	0	0	0	0	0%	0	0
	1.43	MSSA (Hospital)	WS	ND	1	0	0	1	1	0	1	1	1	0	0	5	0	2
	1.44	SIRI final reports due in month submitted beyond 60 working days	TW	0	1	0	0	0	4	5	4	0	0	1	3	17	3	3
	1.45	SIRIs reported >2 working days from identification as red	TW	0	0	0	0	1	2	3	6	5	7	3	ND	27	0	1
	1.46	Green, Amber & Red Active / Accepted risk assessments not in date		ND	ND	ND	9	0	1	5	0	2	1	4	0	13	1	3
	1.47	Datix Risk Register Red / Amber actions overdue	TW	ND	ND	ND	22	0	0	0	0	0	0	1	3		1	4
	1.48	Rapid access chest pain clinic access within 2 wks.	WS	100%	98%	100%	95%	97%	97%	96%	100%	100%	100%	100%	99%	99%	57%	97%
	1.49	Verbal Duty of Candour outstanding at month-end		3	0	0	0	2	0	1	2	0	2	2	1	10	1	1
	1.50	Hand Hygiene Audits	WS	98%	99%	99%	100%	99%	98%	99%	99%	99%	99%	100%	100%	99%	100%	99%
	1.51	Quarterly antibiotic audit	WS	NA	NA	91%	NA	NA	94%	NA	NA	93%	NA	NA	89%	92%	NA	NA
	1.52	Serious Incident RCA actions beyond deadline for completion		3	1	3	4	1	7	2	9	14	9	8	4	54	9	4
	1.53	% of Green Patient Safety incidents investigated		60%	66%	54%	53%	68%	58%	67%	56%	55%	59%	74%	68%	63%	68%	64%
	1.54	Quarterly Environment/Isolation	WS	NA	NA	91%	NA	NA	92%	NA	NA	92%	NA	NA	91%	92%	NA	NA
	1.55	Quarterly VIP score documentation	WS	NA	NA	84%	NA	NA	80%	NA	NA	87%	NA	NA	80%	82%	NA	NA
	1.56	Isolation data (Trust Level only)	TW	90%	95%	90%	90%	88%	88%	90%	88%	88%	90%	90%	89%	89%	86%	88%
	1.57	Pain Mgt. Quarterly internal report	WS	75%	NA	NA	61%	NA	NA	61%	NA	NA	59%	NA	NA	60%	NA	NA
	1.58	Nutrition Risk Assessment 48hrs	WS	91%	87%	89%	82%	85%	90%	89%	87%	93%	92%	89%	90%	89%	90%	93%
	1.59	Median NRLS (national reporting & Learning system) upload 6 month rolling average (No. of days)		81	87	65	65	58	55	48	61	66	75	65	63	491	46	37

SAFE – WARD ANALYSIS

	Surgery									Medicine														Women & Children					Community	
Indicator	F3	F4	F5	F6	CCS	Theatres	Recovery	ETC	DSU	ED	CCU	G5	F9	F10	G1	G3	G4	G8	MTU	F12	G9	F7	F8	F1	F11	F14	MLBU	NNU	Newmarket	Glastonbury
HII compliance 1a: Central venous catheter insertion					100										100				100										No Data	No Data
HII compliance 1b: Central venous catheter ongoing care	100			100	100								100	100		100	0			100	No Data	No Data								
HII compliance 2a: Peripheral cannula insertion					100	No Data				No Data									100				100	100				No Data	No Data	No Data
HII compliance 2b: Peripheral cannula ongoing	100	100	100	100	100						100	100	100	100		80	100	80		100	No Data	100		100		100		No Data			
HII compliance 4a: Preventing surgical site infection preoperative							100	No Data	100																					
HII compliance 4b: Preventing surgical site infection perioperative							100	No Data	100																					
HII compliance 5: Ventilator associated pneumonia					100																									
HII compliance 6a: Urinary catheter insertion						100				No Data																				
HII compliance 6b: Urinary catheter on-going care	100	100	100	100							100	100	100	100	100	100	80	75		100	No Data	100				100				
Total no of MRSA bacteraemias: Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Quarterly MRSA (including admission and length of stay screens)	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data		
Hand hygiene compliance	100	100	100		100		100	100	100		100		100	100	100	100			100	100		100	100	100	100	100	100	100			
Total no of MSSA bacteraemias: Hospital	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total no of C. diff infections: Hospital	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Quarterly Antibiotic Audit	No Data	No Data	No Data	No Data							No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data				
Quarterly Environment/Isolation	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data
Quarterly VIP score documentation	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data	No Data	No Data	No Data	No Data	No Data	No Data		No Data		
MEWS documentation and escalation compliance																														
No of patient falls	5	0	2	3	0					4	1	8	5	2	1	7	5	8	0	1	0	11	2		0	0			9	2
No of patient falls resulting in harm	1	0	1	2	0					1	0	4	2	0	1	3	3	0	0	0	0	2	1		0	0			4	1
No of avoidable serious injuries or deaths resulting from falls																														
No of ward acquired pressure ulcers	1	0	1	0	0						0	1	2	2	2	0	0	0	0	0	0	0	0		0	0			0	0
Nutrition: Assessment and monitoring	100	100	100	100	100						100	100	100	100	100	100	60	50		100	No Data	100	No Data			90				
No of SIRIs	0	0	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
No of medication errors	5	1	2	1	2	0	1	1	0	10	0	9	4	4	3	1	2	3	0	0	0	6	4	2	5	0	0	2	1	2
Cardiac arrests	0	0	0	0	0	0	0	0	0	2	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Cardiac arrests identified as a SIRI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Pain Management: Quarterly internal report																														
VTE: Completed risk assessment (monthly Unify audit)	97.6	97.1	95.4	90.2	90.0	No Data	No Data	100.0	72.8	No Data	94.1	No Data	100.0	100.0	100.0	100.0	100.0	96.8	No Data	100.0	No Data	95.6	98.9	No Data	No Data	97.5	No Data	No Data	No Data	No Data
Quarterly VTE: Prophylaxis compliance																														
Safety Thermometer: % of patients experiencing new harm-free care	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	100	100

Patient Satisfaction: In-patient overall result	90	100	99	98							99		94	100		93	92			98		90									
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	97	100	100	100							100		100	100		100	100			100		90									
In your opinion, how clean was the hospital room or ward that you were in?	99	100	100	100							100		99	100		94	100			100		94									
Did you feel you were treated with respect and dignity by staff	99	100	100	100							100		96	100		100	100			100		95									
Were staff caring and compassionate in their approach?	99	100	100	100							100		98	100		100	95			100		90									
Did you experience any noise in the night time that you think could have been avoided?	43	100	98	90							89		100	100		86	70			100		67									
Did you find someone in the hospital staff to talk about your worries and fears?	97	100	100	100							100		100	100		87	88			100		100									
Were you involved as much as you wanted to be in decisions about your care and treatment?	99	100	100	100							100		96	100		86	90			93		90									
Did staff talk in front of you as if you were not there?	100	100	100	100							100		98	100		84	90			100		86									
Were you given enough privacy when discussing your condition or treatment?	97	100	100	97							100		100	100		100	100			86		93									
Were you given enough privacy when being examined or treated?	97	100	100	97							100		100	100		100	100			100	100										
Did you get enough help from staff to eat your meals?	96	100	100	100							100		100	100		93	100			100	100										
How many minutes after you used the call button did it usually take before you got the help you needed?	61	98	95	100							100		38	100		91	83			100		79									
Number of Inpatient surveys completed	35	93	75	29							12		32	18		36	13			11		30									
Same sex accommodation: total patients	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Complaints	1	0	0	2	0	0	0	0	0	0	0	0	0	0	0	1	1	1	0	0	0	1	0	0	1	0	0	0	0	0	0
Environment and Cleanliness	91	94	96	93	90	94	97	93	90		88	91	92	90	93	95	97	94	95	96	93		93	98	95	91	94	96				

7. EXCEPTION REPORTS – SAFE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

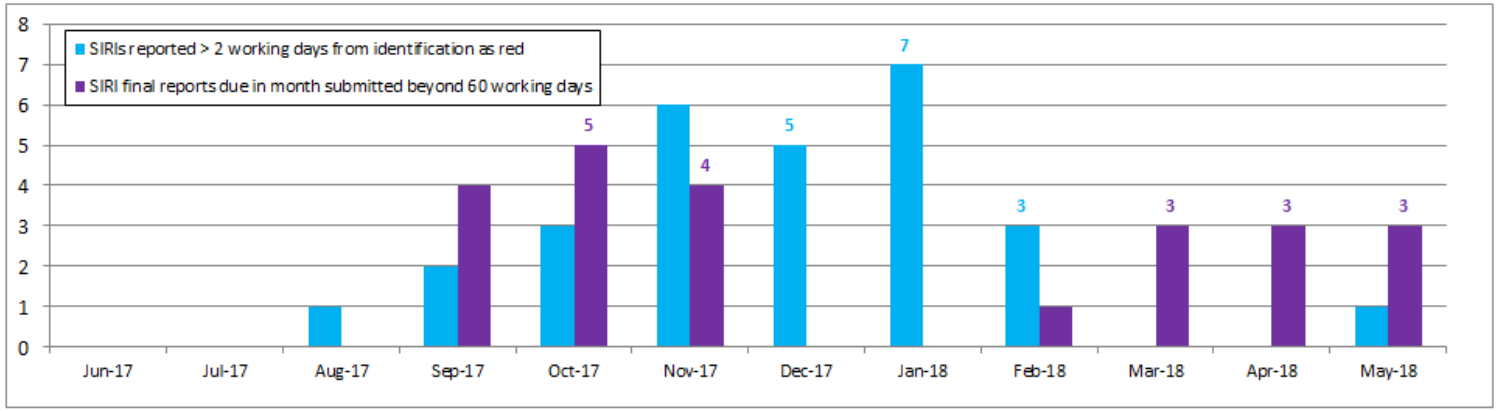
Summary of Current performance & Reasons for under performance

There were three RCA reports which did not meet the 60 working day target in May. All three were hospital acquired pressure ulcers and were sent one day (2 cases) or two days (1 case) days beyond the deadline. One report was reported on STEIs at the conclusion of the investigation as an oversight only and the final report was sent and closed by the CCG without comment.

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

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

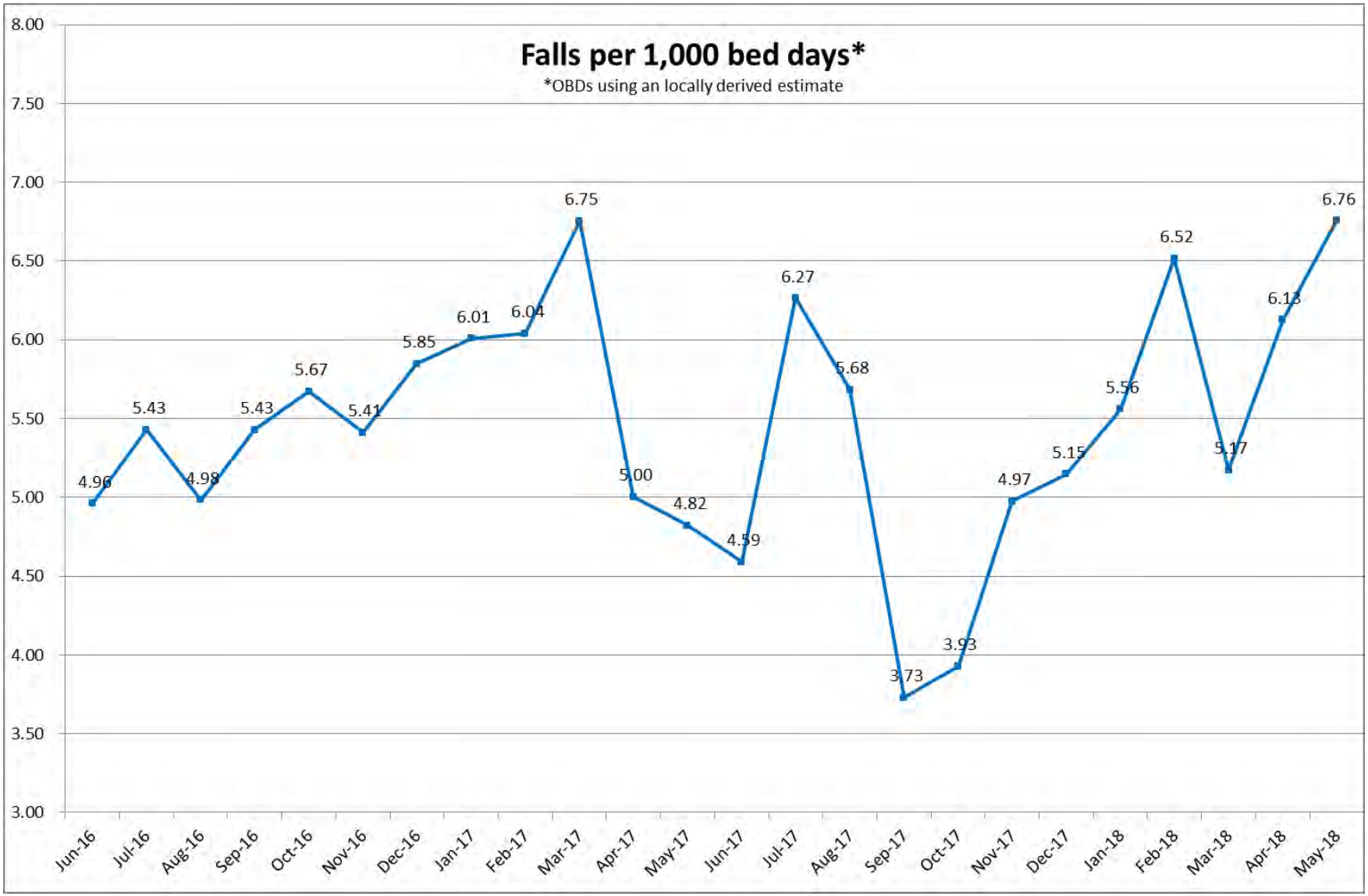
Indicator	Falls
Standard	No of patient falls / falls resulting in harm / No of avoidable serious injuries or deaths resulting from falls / Falls per 1,000 bed days
Name	Rowan Procter
Month	01-May-18
Data Frequency	Monthly
CQC Area	Safe
National Rank	

Summary of Current performance & Reasons for under performance

There were 72 falls in May, a deterioration from 68 in April. There were no moderate (amber) or major (red) harms reported for May. A total of 24 of the 72 falls resulted in minor harm. At Newmarket Hospital there were nine falls recorded in May (4 in April) and at Glastonbury Court there were two falls recorded for May (9 in April), with 62 in WSH. In the month of May five patients were assisted to the floor (4 in April) preventing them from falling. A total of eight patients fell more than twice (one of whom fell six times) during their inpatient stay in May (6 in April). The factors of cognitive and perceptual impairment continue to be reflected in the high numbers of patients falling. This has been exacerbated by the inability to meet core staffing levels, and to provide staff to 'special' patients in relation to the levels of activity and acuity currently faced within the Trust. Cohorting of cognitively impaired patients with observation provided by bay based nursing, along with the use of Wanderguards and Digital Reminiscence Therapy is trying to reduce the total number of falls. The Trust is commencing participation in the NHS Improvement falls collaborative work re implementation of an improvement project within the trust with support from NHSI. RAG rating has been removed from the indicator 'number of falls' with perforance now reported using the indicator 'Falls per 1,000 bed-days'. SPC chart will be used to present the data.

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Total InPatient Falls [WSH]	52	50	66	64	39	47	56	60	68	74	64	55	61
Total InPatient Falls [Community Hospitals]	14	6	9	5	5	9	17	9	8	8	8	13	11
InPatient Falls resulting in harm [WSH]	17	20	14	18	10	19	15	19	27	25	19	18	19
Percentage of falls resulting in harm [WSH]	33%	40%	21%	28%	26%	40%	27%	32%	40%	34%	30%	33%	31%

Actions in place to recover the performance	Expected timeframes for improvements		
The Falls Focus Group meets on a bi-monthly basis, information from this group is then fed back in to the Trust higher level Falls Group led by Dr Suresh.	Falls Group	now complete	
The trust has now provided Falls Pocket Cards (currently being distributed by the Falls Focus Group / Senior Matron Team members).	Falls Group	now complete	
RCP information booklets for patients / relatives on preventing falls are currently being re-produced for the clinical areas to provide to these groups.	Falls Group	now complete	
There are now 3 options in footwear available for in-patients at the WSFT to aid in safe mobility and reduce the number of slips, trips and falls.	Falls Group	now complete	
Initial L&S BP task now set for all in-patient areas at the WSH as per NICE guidance, this is changing to 3 x consecutive days as per NICE guidance from the 30/4/18. This allows for the identification of individuals at risk of falling and the implementation of the appropriate care plans / order sets. The new observation machines have been rolled out to all WSH in-patient areas which supports this process and ensure the timely	Falls Group	now complete	
All 'Amber' classification falls will now be subject to the Level 1 Concise RCA for Falls to ensure appropriate lessons are learnt and information is available to support the duty of candour process.	Falls Group	now complete	
The current falls care plan within eCare is being reviewed and possible amendments will be made to appropriately reflect interventions for consideration and to highlight actions taken. JUNE UPDATE the eCare Design authority have declined this amendment. This action has been replaced by action point below re policy update	Falls Group	Apr-18	closed
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 Focus Group meets on a bi-monthly basis, information from this group is then fed back in to the Trust higher level Falls Group led by Dr Suresh.	Falls Group	now complete	
The Falls Group and the sub Focus Group are currently exploring the option of the 'Catch a Falling Star' falls study day, focusing on the prevention of falls and appropriate treatment post fall. This has successfully been implemented in a London Trust with good results and could be tailored for the specific purposes of the WSFT. The option of a Falls Prevention video for patients to watch (as used in Michigan – Bronson Healthcare Group) is being explored to try and assist in the reduction of falls.	Falls Group	May-18	Jul-18
NHS Improvement falls collaborative work re implementation of an improvement project within the trust	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	Aug-18


Falls per 1,000 bed days*
*OBDs using an locally derived estimate
8.00
7.50
7.00
6.50
6.00
5.50
5.00
4.50
4.00
3.50
3.00
4.96
5.43
4.98
5.43
5.67
5.41
5.85
6.01
6.04
6.75
5.00
4.82
4.59
6.27
5.68
3.73
3.93
4.97
5.15
5.56
6.52
5.17
6.13
6.76
Jun-16
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
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Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Background

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

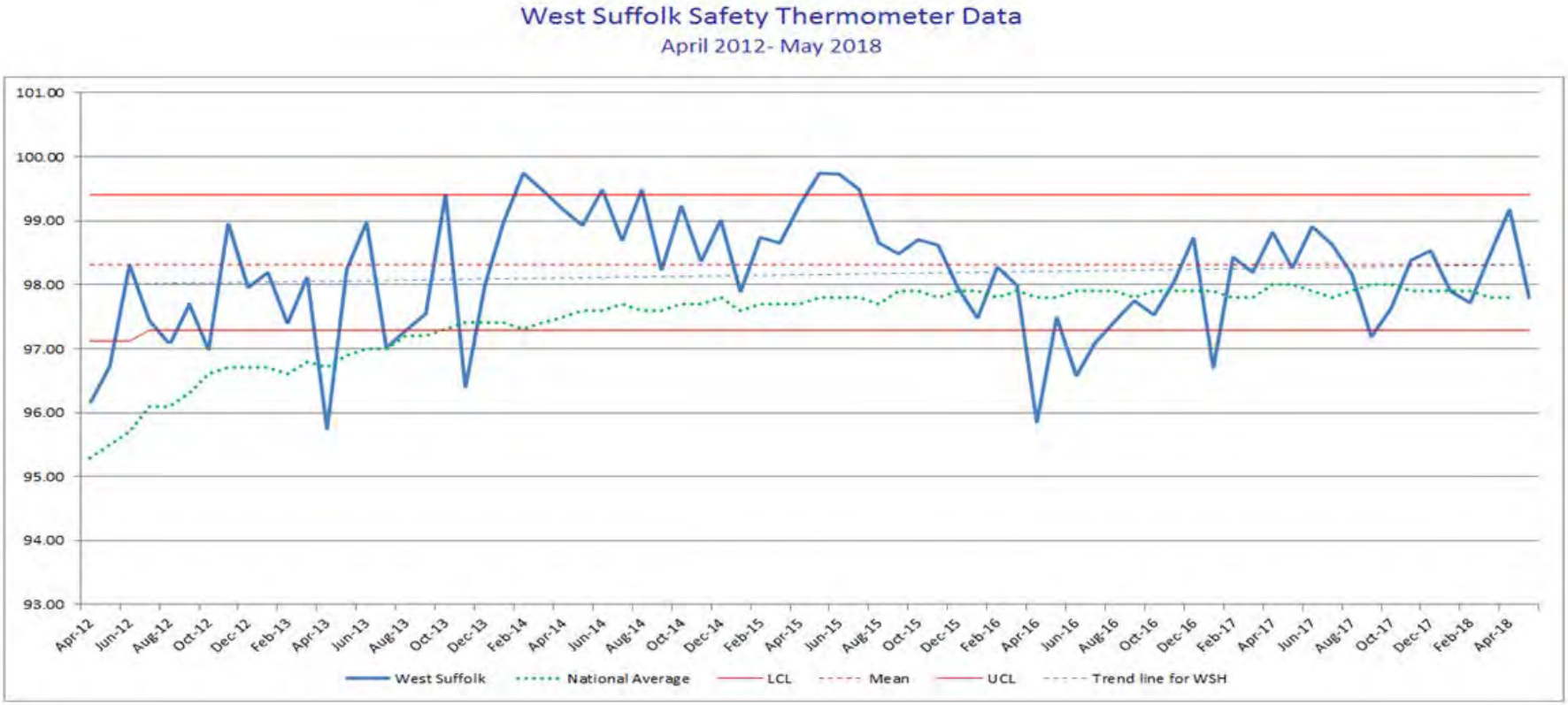
The Trust score for MAY 2018 for new harm free care was 97.78%. It should be noted that the Safety Thermometer is a spot audit and data is collected on a specific day each month. The SPC chart below shows the Trust Harm free care compared to the national benchmark for the period April 2012 to APRIL 2018 and the Trust results for MAY 2018. The National average for APRIL was 97.8%

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

Indicator	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Safety Thermometer - Harm-Free Care	98.43%	98.19%	98.53%	98.26%	98.91%	98.64%	98.18%	97.18%	97.63%	98.38%	98.54%	97.90%	97.71%	98.47%	99.18%	97.78%

Key Recovery Actions

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


West Suffolk Safety Thermometer Data
April 2012- May 2018
101.00
100.00
99.00
98.00
97.00
96.00
95.00
94.00
93.00
Apr-12
Jun-12
Aug-12
Oct-12
Dec-12
Feb-13
Apr-13
Jun-13
Aug-13
Oct-13
Dec-13
Feb-14
Apr-14
Jun-14
Aug-14
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Feb-16
Apr-16
Jun-16
Aug-16
Oct-16
Dec-16
Feb-17
Apr-17
Jun-17
Aug-17
Oct-17
Dec-17
Feb-18
Apr-18
West Suffolk
National Average
LCL
Mean
UCL
Trend line for WSH

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

Compliance with completing risk assessments and weighing patients has remained unchanged overall this month at 93%. This is mainly due to poor results in three ward areas who have experience daily staffing deficits. The majority of wards are achieving 100% compliance. The main reasons for failure were around weighing of patients, re-weighing and "MUST" scoring.

There has been an improvement and sustained compliance on Ward F3, however there has been a deterioation in G4 performance.There has been some focused quality improvement work with the NHSi Nutrition Collaborative. F3 has seen three consecutive months achieving 100% compliance with weights and completing risk assessments.

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

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

Actions in place to recover the performance

Expected timeframes for improven

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

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

The number of hospital acquired pressure ulcers rose to nine in May. There were two grade 3 and seven grade 2. These were spreadh accross multiple wards with no ward having greater than two in the month. Following a variety of preventative initiatives, the target of less than 30% avoidability was achieved at the end of 2017 / 18 despite a backdrop of high acuity, staffing challenges and capacity pressures. Avoidabilty reporting in 2018/19 is changing to a 12 month rolling basis with RAG rating and targets still being considered.

There continues to be an increased focus on early detection of risk, assessment of preventative measures and reporting of damage on admission. There is also a drive to promote timely completion of investigations to ascertain avoidability and promotion of learning from incidents. A recent deep dive of incidents has highlighted a need to improve documentation with regard to preventative care and ongoing management of wounds. Poor documentation is often a key factor in deeming avoidability, as there is a lack of evidence to support an unavoidable status. The trust has been working to develop a tool to ensure consistant classification of avoidable vs non-avoidable. this is due to be trialed over the next few months. There are plans to address this issue by reviewing documentation and developing expected standards of record keeping for nursing staff.

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

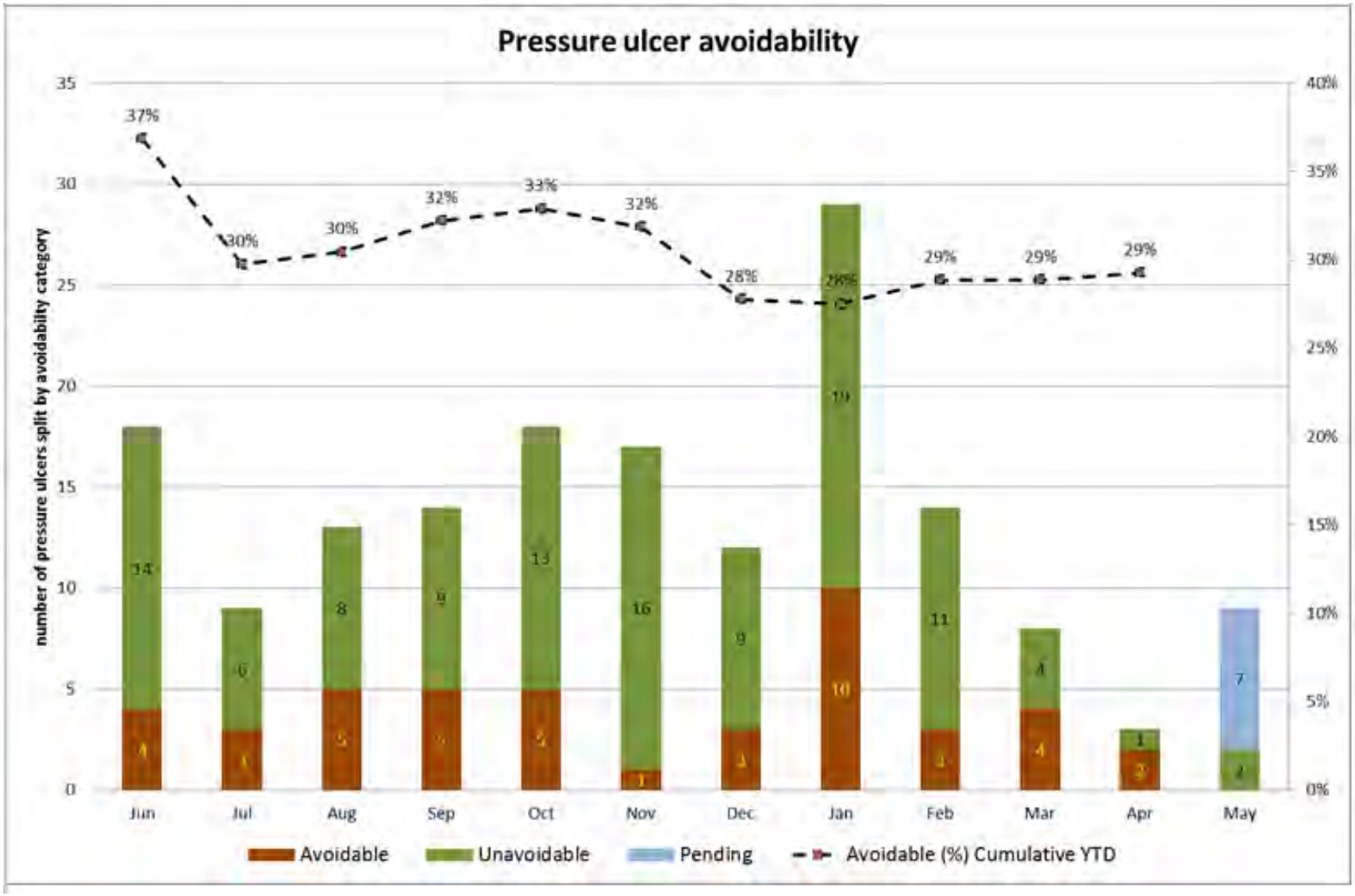
WSFT has applied to join the NHSi pressure ulcer collaborative, with the aim to support some focussed quality improvements in some key priority areas within the acute and community settings.

Indicator	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Target	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	TBC	TBC
Total Pressure Ulcers	10	9	19	10	13	15	19	17	12	30	15	9	4	9
% of patients with avoidable ward acquired pressure ulcers YTD	40%	37%	30%	30%	34%	33%	32%	28%	28%	29%	28%	29%	29%	ND

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Tissue Viability team are exploring the concept of Kennedy grading for end of life patients. This is being discussed with NHE Improvement prior to local pilot on wards G1 and G4	TVN team	Mar-18	Jul-18
The trust has been working to develop a tool to ensure consistant classification of avoidable vs non-avoidable. this is due to be trialed over the next few months	Governanc	Jun-18	Oct-18
To develop standards for record keeping for nursing staff	HoN	May-18	Aug-18


Pressure ulcer avoidability
number of pressure ulcers split by avoidability category
35
30
25
20
15
10
5
0
40%
35%
30%
25%
20%
15%
10%
5%
0%
37%
30%
30%
32%
33%
32%
28%
29%
29%
29%
14
6
8
9
13
16
9
19
11
4
7
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Avoidable
Unavoidable
Pending
Avoidable (%) Cumulative YTD

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

May has seen an increase in the number of pressure ulcers acquired in the community setting for patients in our care; unfortunately one of these was a Grade III pressure sore. The Bury Town Team have again reported a high number of pressure ulcers it has been agreed therefore, that it would be useful to include this team in the Pressure Ulcer Collaborative work, in partnership with acute colleagues. Initially the Collaborative work will focus on supporting patients in one of our Residential Homes, which has experienced an increased number of pressure ulcers, to support staff to understand the importance of repositioning the patient. Further, as we move forwards it has been agreed that acute and community Tissue Viability Link sessions will be run jointly, in order to ensure support and learning across the integrated organisation. It should also be noted that a 0.50 WTE vacancy remains within the Community Tissue Viability service, due to maternity leave, recruitment to this post has been prioritised. Staff have been reminded of the need to ensure that the patient is discharged from the DN caseload following each episode of care, to ensure that they are only held accountable for those patients who develop pressure sores in our care. Similarly to the acute setting, work is also underway in terms of understanding the Kennedy Ulcer and the potential to utilise this grading for patients nearing the end of life.

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

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Active encouragement to achieve timely investigations and learning from incidents by Head of Nursing	HoN	Jan-18	complete

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	MRSA Decolonisation
Standard	90%
ED Name	Anne Howe
Month	01-May-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

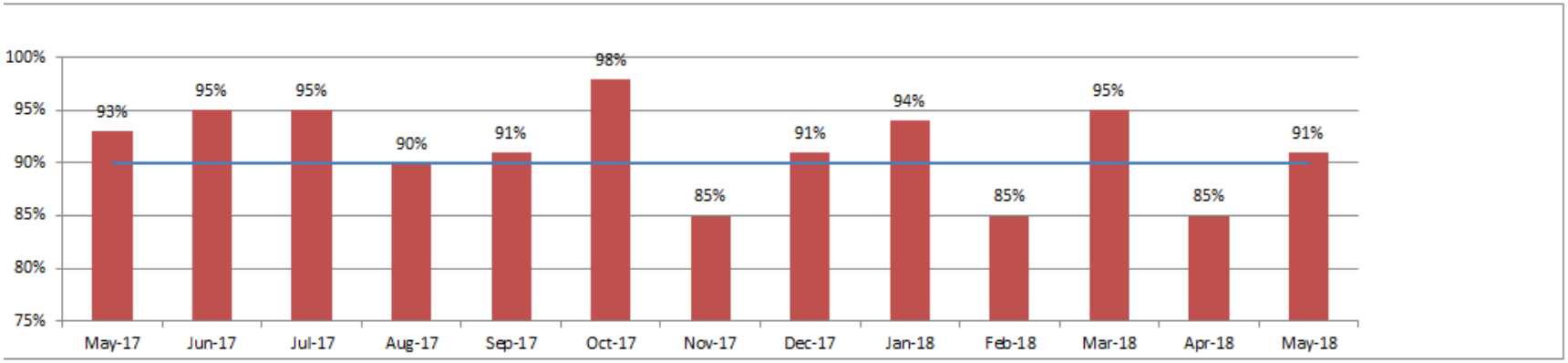
Trust achieved 91% compliance in May 18. The Pharmacy team have a potential solution within eCare to incorporate the decolonization regimen which is being tested and is close to implementation.

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
MRSA Decolonisation	93%	95%	95%	90%	91%	98%	85%	91%	94%	85%	95%	85%	91%

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Pharmacy have devised a solution to incorporate the decolonization prescription (currently a paper document) within the EPR (eCare) which will be tested shortly.	HB	Sep-17	Feb-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

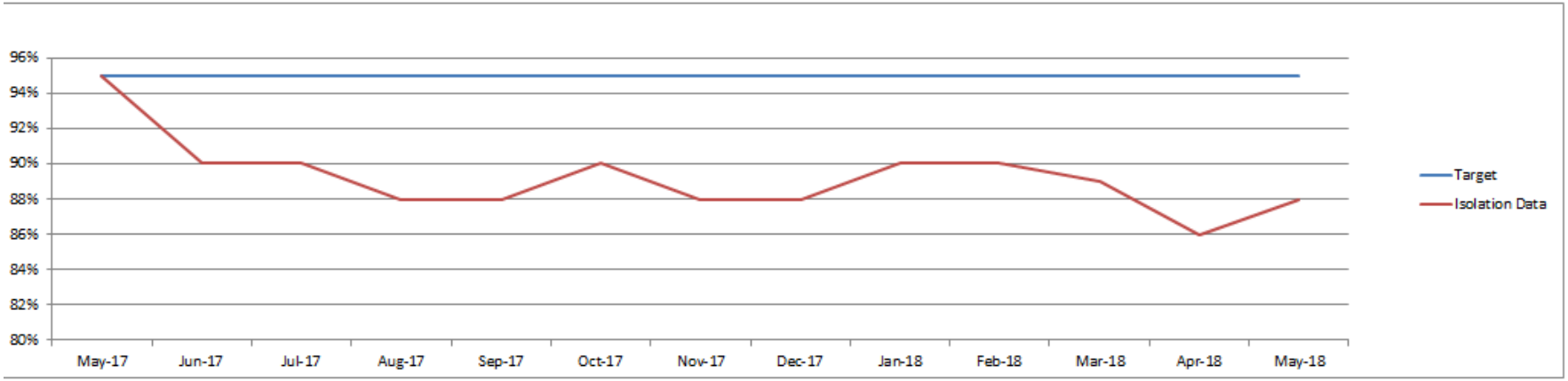
2 patients could not be accomodated in single rooms with symptoms suggestive of infection until 24 hours later due to the capacity on the ward and single room occupancy with confirmed higher risk infections. In addtion patients transferred form other hospitals could not be accomodated in single rooms and were necessarily admitted to a bay and underwent screening there.

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

Actions in place to recover the performance

Expected timeframes for improvements

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



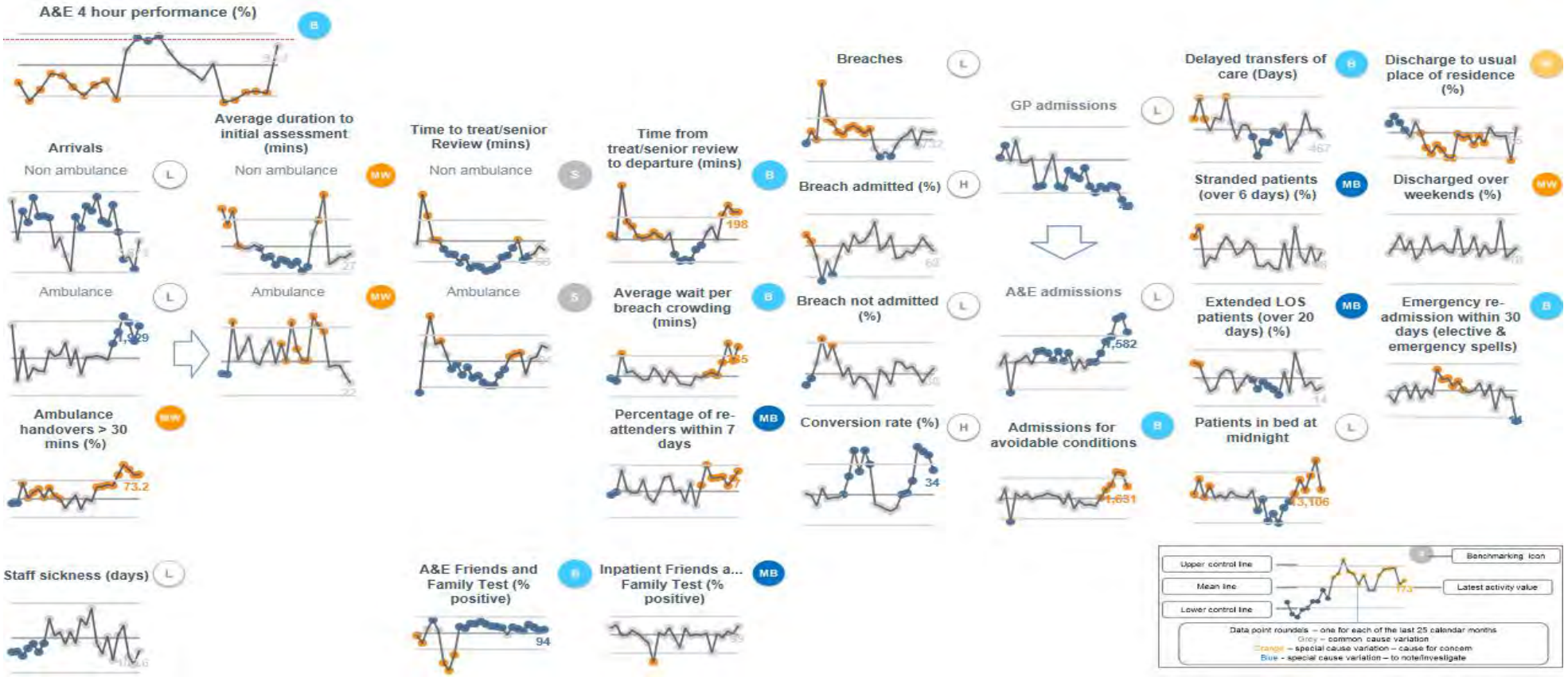
8. DETAILED reports - EFFECTIVE

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

Are we.		Ref.	KPI	Type	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Effective	Dashboard	2.02	Canc. Ops - Cancellations for non-clinical reasons	WS	0.6%	0.6%	1.1%	1.0%	1.2%	1.0%	1.4%	1.9%	1.3%	0.8%	1.2%	0.9%	0.6%	0.8%
	Incidents/Reports	2.05	Cardiac arrests	WS	4	6	4	2	3	6	4	ND	ND	7	ND	ND	3	4
		2.06	Cardiac arrests identified as a SIRI	WS	0	0	1	0	0	0	0	0	0	0	0	0	1	0
		2.07	CAS (central alerts system) alerts overdue		0	0	0	0	0	0	0	0	0	0	0	0	0	0
		2.08	% of relevant patients with Personal Health Plan (PHP)		100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		2.09	NICE guidance baseline and risk assessments not completed within 6 months of publication			ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	56	55
		2.10	WHO Checklist (Qrtly)		NA	NA	99%	NA	NA	99%	NA	NA	99%	NA	NA	98%	NA	NA
		2.11	National clinical audit report baseline & risk assessments not completed within 6 months of publication														22	23
		2.12	Av. Elective LOS (excl. 0 days)		2.75	3.26	2.7	2.54	2.79	2.73	2.93	2.85	2.98	3.06	2.27	3.29	3.34	2.55
		2.13	Av NEL LOS (excl 0 days)		7.59	7.85	7.66	7.47	7.93	7.54	8.23	7.66	7.57	8.40	8.13	8.1	7.96	7.63
		2.14	% of NEL 0 day LOS		19.4%	18.6%	20.3%	18.6%	17.4%	17.5%	18.8%	16.6%	14.7%	13.2%	13.4%	13.51%	14.3%	15.6%
		2.15	NHS number coding		99.7%	99.7%	99.7%	99.4%	99.5%	99.6%	99.6%	99.7%	99.6%	99.7%	99.7%	99.71%	99.7%	99.8%
		2.16	Fractured Neck of Femur : Surgery in 36 hours	WS	97%	96%	96%	85%	97%	97%	96%	84%	100%	100%	96%	93%	89%	79%
		2.17	Discharge Summaries (OP 85% 3d)	WS	65%	62%	57%	57%	57%	55%	58%	58%	58%	60%	58%	56%	62%	57%
		2.18	Discharge Summaries (A&E 95% 1d)	WS	87.9%	88.8%	87.5%	86.7%	85.7%	85.9%	83.6%	84.2%	82.6%	84%	83.4%	82.3%	81.5%	82.5%
		2.19	Non-elective Discharge Summaries (IP 95% 1d)	WS	74.1%	76.8%	76.7%	70.4%	73.0%	73.0%	73.3%	69.2%	74.5%	70.2%	69.8%	70.8%	72.1%	71.0%
		2.20	Elective Discharge Summaries (IP 85% 1d)	WS	74%	72%	74%	74%	72%	69%	73%	68%	69%	73%	71%	73%	72.2%	71%
		2.21	All Cancer 2ww services available on C&B	WS	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		2.22	Canc. Ops - Patients offered date within 28 days	WS	93.33%	93.75%	93.18%	88.46%	75%	92%	84.62%	98.11%	76.67%	94.7%	96.6%	91.67%	85.71%	90.91%
		2.23	Canc. Ops. - No. Cancelled for a 2nd time	WS	0	0	0	0	0	0	0	0	0	0	0	0	0	0

8. EXCEPTION REPORTS – EFFECTIVE

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

The Board reporting for NICE guidance has changed following review at the Clinical Directors meeting after an earlier Internal audit recommendation. Previously compliance against technology appraisals (TAs) was reported however this has been at a green RAG rating for least 3 years of board reporting and therefore assurance can be given that the process no longer requires monthly reporting to Board (the indicator will continue to be reported quarterly to CSEC). The new indicators added are for the completion of NICE guidance and National Clinical Audit report baseline assessments within 6 months of publication as these are consistently not completed to timescale. The CDs meeting receives a list of outstanding items for follow up. In May, targeted follow up in Specialist Medicine provided 4/5 responses for those specialties. The figures below do not reflect totally accurate the progress as it is possible for several to be closed in a month but new reports to be added as they reach their six-month deadline (potentially averaging out the total). In future months this report will include the details of how many have been completed in the period to give a more accurate picture of progress.

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

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

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

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancelled Operations for non-clinical reasons
Standard	Less than 1%
ED Name	Simon Taylor
Month	01-May-18
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission. Current Position - 0.81% against a threshold of 1%.

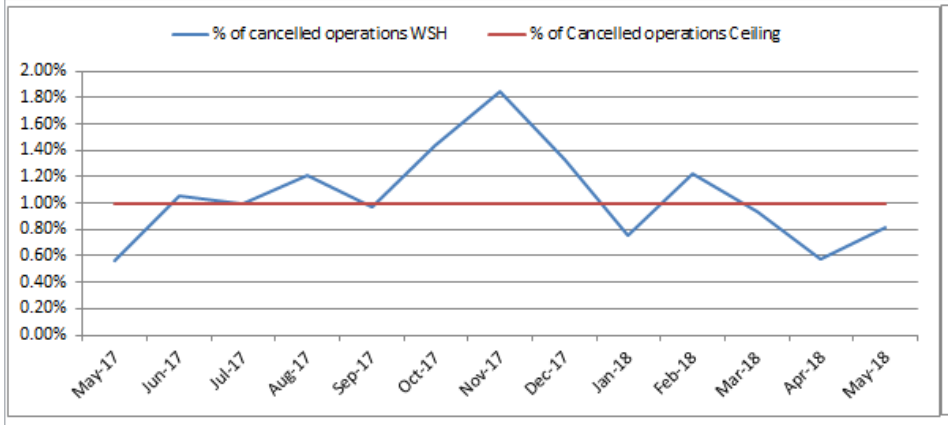
Patients offered date within 28 days of cancelled operation - 90.91% against a ceiling of 100%. This represents two patients who were cancelled and unable to be rebooked within 28 days. The first, a vascular patient was cancelled due to problems with scanned image availability and due to capacity issues within the service was unable to be offered a date within 28 days, they have since had a repeat scan and treatment is being planned based on the results. The second patient was an ophthalmology patient who required a different surgeon on the day of surgery and was cancelled for this reason. They were unable to be rebooked within 28 days due to capacity issues within the service but they have since been rebooked for the 05/07/18.

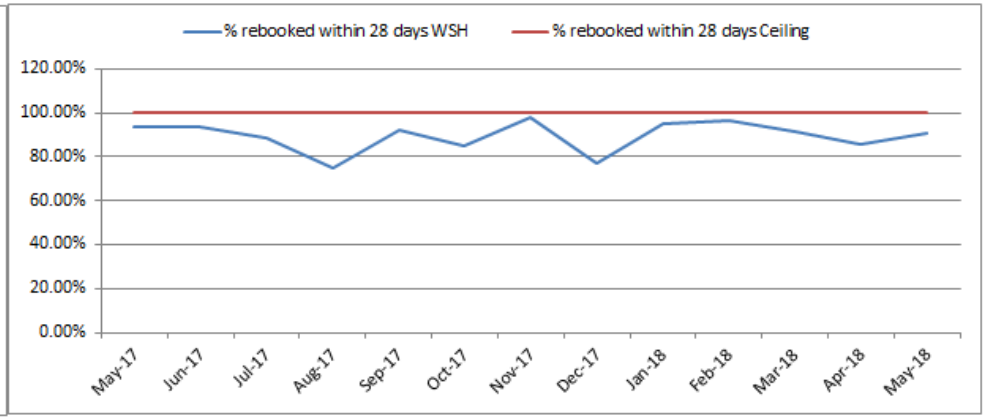
Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
% of cancelled operations WSH	0.56%	1.05%	1.00%	1.21%	0.97%	1.44%	1.85%	1.33%	0.75%	1.22%	0.93%	0.58%	0.81%
% of Cancelled operations Ceiling	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
% of cancelled Ops National Av.	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%
% rebooked within 28 days WSH	93.80%	93.20%	88.50%	75.00%	92.00%	84.60%	98.10%	76.70%	94.70%	96.55%	91.67%	85.70%	90.91%
% rebooked within 28 days Ceiling	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Actions in place to recover the performance

Expected timeframes for improvements

Cancelled Ops (Non-Clinical) This indicator is being closely monitored via the access meeting. Patients Offered within 28 Days – This indicator is not formally agenda'd on each Access meeting for discussion. The intention is to always re-date a patient cancelled for a non-clinical reason within 28 days but this can be restricted by patient choice and capacity constraints in some specialities. Each breach will be recorded on Datix.	HB	Jul-17	





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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

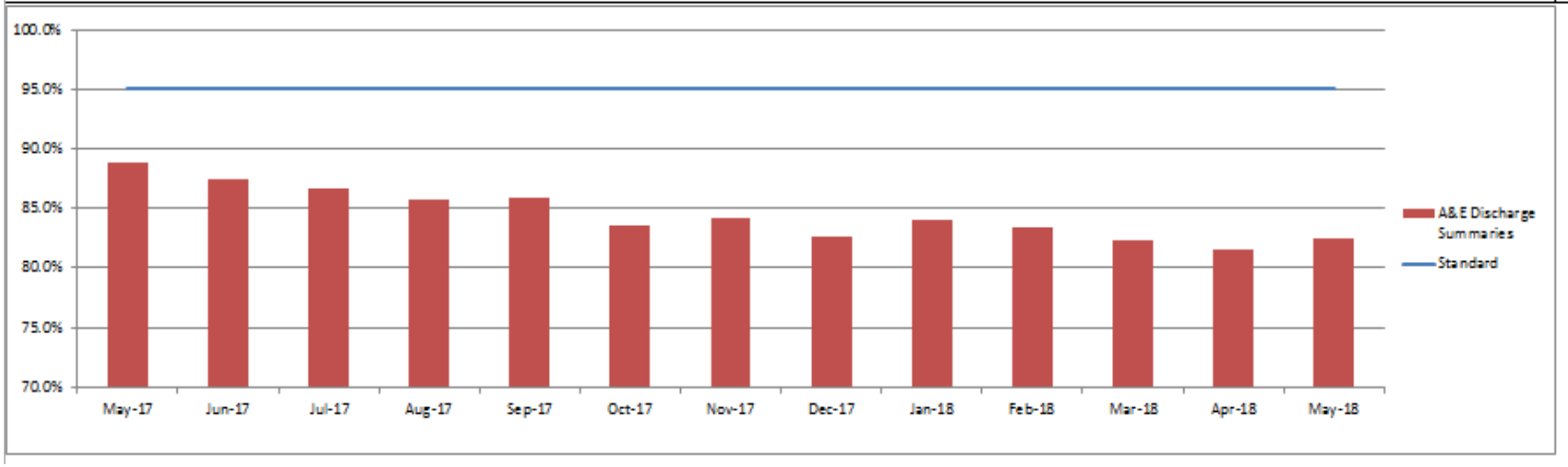
Indicator	Discharge Summaries
Standard	95%
Name	Darin Geary
Month	01-May-18
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

It is disappointing that the data does not reflect the significant work undertaken to improve discharge summaries. The Checkout tab in FirstNet has 98 patients on it (as of 21st June) - 47 of these are from ED with the majority from 15th June onwards. The remaining 51 are speciality patients who are advised weekly about completing these.

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
A&E Discharge Summaries	88.8%	87.5%	86.7%	85.7%	85.9%	83.6%	84.2%	82.6%	84.0%	83.4%	82.3%	81.5%	82.5%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Further enforcement with ED clincians to complete discharge summaries on day of discharge - ED Clinical Director to action. ED Clinician, in conjunction with e-Care Discharge Summary Optimisation Co-ordinator, to review discharge summary completion/process for patients trasnferred to Discharge Waiting Area as process may be different.	NJ	Jun-17	TBC



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

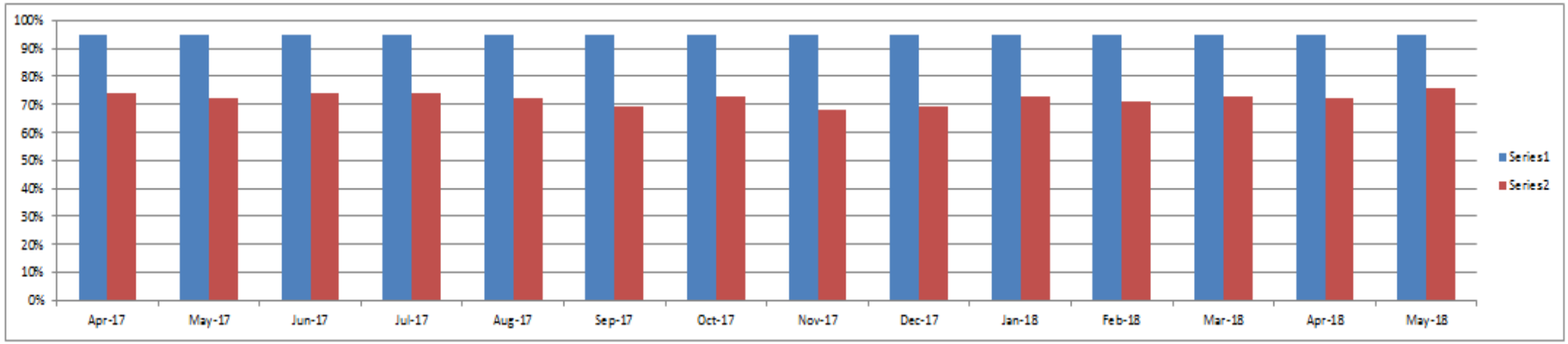
The board have received a separate detailed report outlining the actions we are taking to address our underperformance for distribution of discharge summaries. The report also highlights several examples where significant progress has been made. We are also aware of a disparity between how the hospital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

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

Actions in place to recover the performance

Expected timeframes for improvements

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

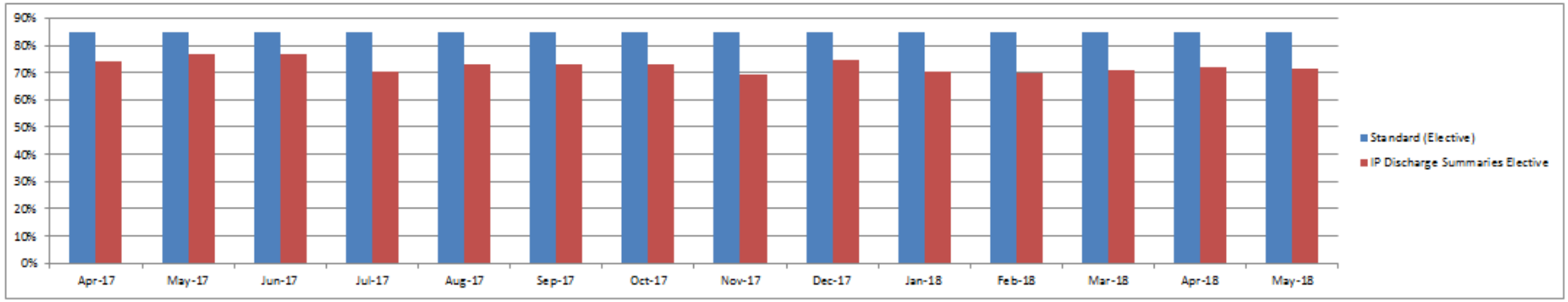
February figure of 70.3%. The trust takes the issue of prompt delivery and quality for discThe board have received a separate detailed report outlining the actions we are taking to address our underperformance for distribution of discharge summaries. The report also highlights several examples where significant progress has been made. We are also aware of a disparity between how the hospital are communicating with GPs and CCG requirements. For example in cardiology day case a letter is sent to the GP rather than a discharge summary. However performance for this area is included within these reports. We therefore need to understand whether these workflows are robust and therefore the reporting needs to change, or whether the workflows need themselves need to amend. When these reviews are concluded this should have a significant impact on the reporting figures shown here. arge summaries very seriously. On this basis we have appointed a dedicated role in the trust to oversee improvements on performance for both speed and quality. The role has only recently been established but early indications are that this will make a significant difference. We will provide data at future boards confirming improvements.

Indicator	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Standard (Elective)	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
IP Discharge Summaries Elective	74.1%	76.8%	76.7%	70.4%	73.0%	73.0%	73.3%	69.2%	74.5%	70.2%	69.8%	70.8%	72.1%	71.2%

Actions in place to recover the performance

Expected timeframes for improvements

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



NHS West Suffolk NHS Foundation Trust

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	Type	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
3. Caring	Dashboard	3.01	Compliments (Logged by Patient Experience)	TW		52	26	56	28	17	33	87	151	64	20	45	21	93
		3.02	Formal Complaints	TW	20	10	10	6	16	16	17	13	8	12	19	9	13	13
		3.03	Mixed Sex Accommodation Breaches	TW	0	0	0	0	0	0	0	0	1	0	0	1	0	0
		3.04	IP - Extremely likely or Likely to recommend (FFT)	WS	90%	97%	99%	98%	98%	98%	99%	96%	98%	97%	98%	98%	99%	99%
		3.05	OP - Extremely likely or Likely to recommend (FFT)	WS	90%	96%	97%	95%	95%	96%	96%	96%	99%	95%	96%	95%	97%	97%
		3.06	A&E - Extremely likely or Likely to recommend (FFT)	WS	85%	96%	95%	95%	95%	92%	95%	94%	94%	96%	95%	94%	94%	93%
		3.07	Maternity - Extremely likely or likely to recommend (FFT)	WS	90%	100%	100%	100%	ND	ND	99%	100%	97%	100%	93%	100%	100%	100%
		3.08	Community - Extremely likely or likely to recommend	CO	80%	ND	100%	ND	ND	ND	97%	100%	96%	95%	97%	96%	94%	
	Other Friends and Family Test Scores	3.09	IP overall experience result	WS	85%	92%	94%	94%	93%	93%	96%	96%	95%	94%	95%	96%	97%	97%
		3.10	OP overall experience result	WS	85%	85%	88%	89%	91%	89%	95%	94%	95%	96%	97%	96%	97%	97%
		3.11	A&E overall experience result	WS	85%	96%	94%	94%	95%	94%	93%	94%	94%	94%	94%	94%	94%	93%
		3.12	Short-stay overall experience result	WS	85%	99%	100%	99%	99%	99%	99%	99%	99%	99%	99%	99%	85%	99%
		3.13	Short-stay Extremely likely or Likely to recommend (FFT)	WS	90%	98.6%	99.7%	99.5%	99%	99%	99%	97%	100%	99.4%	99.7%	99%	100.0%	99%
		3.14	Maternity - overall experience result	WS	85%	100%	100%	100%	100%	100%	100%	98%	95%	100%	93%	100%	99%	95%
		3.15	Maternity postnatal community - extremely likely or likely to recommend (FFT)	WS	90%	100%	100%	ND	ND	100%	100%	ND	ND	ND	ND	ND	100%	97%
		3.16	Maternity birthing unit - extremely likely or likely to recommend (FFT)	WS	90%	100%	100%	ND	ND	100%	100%	100%	ND	100%	100%	ND	100%	ND
		3.17	Maternity antenatal community - extremely likely or likely to recommend (FFT)	WS	90%	98%	100%	ND	ND	100%	96%	ND	ND	ND	ND	ND	100%	100%
		3.18	Children's services overall result	WS	85%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	97%	99%
		3.19	F1 Parent - overall experience result	WS	85%	99%	99%	95%	100%	100%	99%	95%	98%	98%	98%	98%	96%	99%
		3.20	F1 - Extremely likely or likely to recommend (FFT)	WS	90%	100%	100%	92%	100%	100%	100%	94%	97%	100%	100%	100%	92%	100%
		3.21	F1 Children - Overall experience result	WS	85%	100%	94%	ND	ND	ND	ND	ND	ND	ND	ND	ND	85.00%	97%
		3.22	Rosemary ward - extremely likely or likely to recommend (FFT)	WS	90%	ND	ND	ND	ND	ND	100%	100%	100%	78%	85%	100%	79%	100%
		3.23	King suite - extremely likely or likely to recommend	CO	90%	ND	ND	ND	ND	ND	100%	100%	94%	93%	100%	100%	ND	100%
		3.24	Community paediatrics - extremely likely or likely to recommend (FFT)	CO	90%	ND	ND	ND	ND	ND	96%	100%	97%	100%	97%	95%	94.0%	95.00%
		3.25	Community health teams - extremely likely or likely to recommend (FFT)	CO	90%	ND	ND	ND	ND	ND	100%	100%	100%	90%	100%	90%	100%	100.00%
		3.26	Community specialist nursing teams - extremely likely or likely to recommend (FFT)	CO	90%	ND	ND	ND	ND	ND	100%	100%	95%	100%	93%	100%	92.0%	98.00%
		3.27	Stroke Care - Overall Experience Result	WS	85%	ND	98%	99%	ND	99%	100%	85%	ND	98%	95%	100%	95%	92%
		3.28	Stroke Care - extremely likely or likely to recommend	WS	90%	ND	95%	100%	100%	95%	100%	100%	ND	100%	100%	100%	100%	100%
	Complaint Handling	3.29	Complaints acknowledged within 3 working days		90%	90%	100%	100%	93%	94%	100%	100%	87%	92%	100%	100%	92.00%	100%
		3.30	Complaints responded to within agreed timeframe		90%	90%	75%	100%	85%	67%	81%	82%	50%	60%	17%	54%	31%	70%
		3.31	Number of second letters received		1	0	2	1	1	1	2	0	1	0	0	1	2	2
		3.32	Ombudsman referrals accepted for investigation		0	2	0	1	0	0	0	0	1	1	1	0	0	0
		3.33	No. of complaints to Ombudsman upheld		0	ND	ND	ND	ND	ND	ND	0	0	0	0	0	0	0
		3.34	No. of PALS contacts		NT	188	169	176	137	167	190	167	124	161	178	205	183	231
		3.35	No. of PALS contacts becoming formal complaints		<=5	0	0	1	4	2	3	4	1	3	6	1	4	4

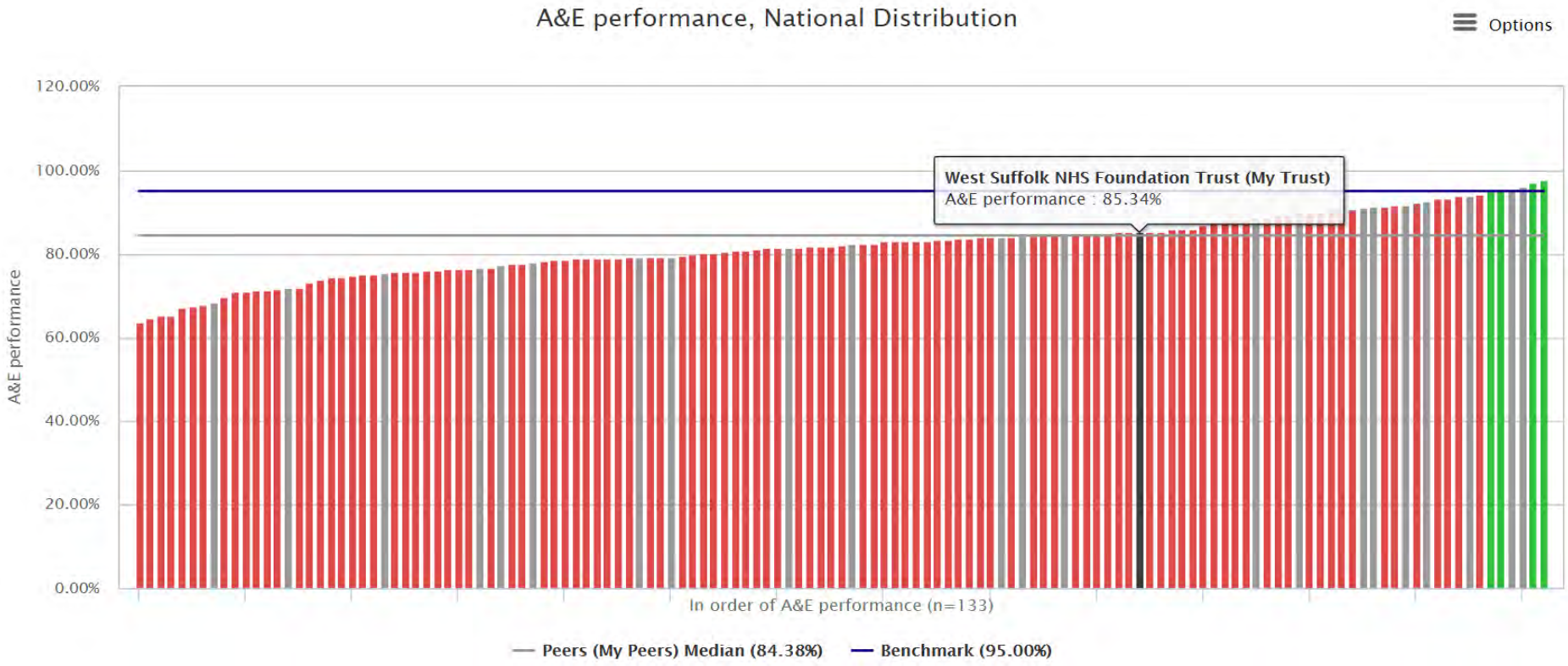
DETAILED REPORTS – RESPONSIVE

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

Area		Ref.	KPI	Type	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
4. Responsive	Dashboard	4.01	A&E under 4 hr. wait	WS	95%	96%	92%	90%	89%	87%	90%	83%	84%	85%	85%	85%	94%
		4.02	RTT: % incomplete pathways within 18 weeks	TW	80%	83%	84%	86%	86%	87%	89%	89%	90%	90%	90%	90%	92%
		4.03	52 week waiters	TW	14	15	35	26	29	26	21	15	14	13	24	19	14
		4.04	Diagnostics within 6 weeks		99.9%	100%	99.5%	100%	100%	100%	100%	100%	100%	99.8%	99.3%	99.7%	99.6%
		4.05	Cancer: 2w wait for urgent GP Referrals	WS	92.3%	96.6%	94.5%	96.0%	91.4%	83.4%	97.9%	97.2%	98.0%	97.5%	94.7%	93.2%	85.1%
		4.06	Cancer 2w wait breast symptoms	WS	99.3%	88.8%	98.1%	100.0%	98.3%	100.0%	100.0%	99.1%	97.1%	92.9%	86.7%	96.7%	82.6%
		4.07	Cancer 31 d First Treatment	WS	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	100%	99%	100%
		4.08	Cancer 31 d Drug Treatment	WS	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		4.09	Cancer 31 d Surgery	WS	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		4.10	Cancer 62 d GP referral	WS	83%	86%	85%	86%	87%	94%	90%	87%	87%	80%	88%	93%	85%
		4.11	Cancer 62 d Screening	WS	100%	90%	100%	100%	91%	100%	83%	100%	93%	86%	95%	73%	93%
		4.12	Incomplete 104 day waits	WS	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	3.0	1.5
	A&E	4.13	Number of Delayed Transfer of Care - (DTOCs)	WS	411	511	481	565	337	250	279	314	326	393	321	208	206
		4.14	A&E time to treatment in department (median) for patients arriving by ambulance - CDM	WS	43	52	52	50	62	59	41	62	57	75	64	70	47
		4.15	A&E - Single longest Wait (Admitted & Non-Admitted)	WS	13.57	10.10	13.53	11.46	12.01	15.44	22.04	16.48	18.11	17.18	19.50	18.14	10.30
		4.16	A&E -Waits over 12 hours from DTA to Admission	WS	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	WS	3	6	5	5	14	10	17	50	122	30	46	17	4
		4.18	A&E - To inpatient Admission Ratio	WS	29.0%	28.3%	27.9%	29.2%	30.5%	30.4%	30.0%	32.8%	31.9%	32.1%	29.6%	27.9%	25.8%
		4.19	A&E Service User Impact (re-attendance in 7 days <5% & time to treat)	WS	1	1	1	1	1	1	1	1	1	1	1	1	1
		4.20	A&E/AMU - Amb. Submit button complete	WS	91.1%	91.7%	91.0%	89.9%	90.3%	87.7%	88.2%	89.4%	85.7%	89.6%	93.5%	92.7%	94.4%
		4.21	A&E - Amb. Handover above 30m	WS	38	31	39	19	15	0	84	110	72	87	74	88	ND
		4.22	A&E - Amb. Handover above 60m	WS	16	9	7	16	30	0	46	54	38	30	17	29	ND
	RTT	4.23	RTT - 18w Admitted (Completed)	TW	67.8%	70.3%	72.9%	69.7%	73.8%	72.0%	70.9%	69.9%	72.6%	73.5%	74.1%	73.4%	71.1%
		4.24	RTT - 18w Non-admitted (Completed)	TW	87.0%	87.3%	87.6%	85.8%	87.3%	84.9%	85.8%	90.6%	88.7%	93.9%	93.42%	92.8%	94.5%
		4.25	RTT waiting List	TW	22144	19931	18676	17346	17236	16694	16641	16195	15363	15804	15396	16223	16481
		4.26	RTT waiting list over 18 weeks	TW	4492	3316	2629	2441	2467	2171	1843	1775	1504	1650	1614	1560	1294
		4.27	RTT 18 weeks Non-Consultant led services - Community	CO	96%	99%	98.8%	94.7%	99.4%	93.7%	94.4%	98.4%	98.7%	100%	99.37%	99%	98%
		4.28	RTT 52 weeks Non-Consultant led services - Community	CO												ND	ND
	Stroke	4.29	Stroke - % Patients scanned within 1 hr.		80%	72%	82%	79%	78%	76%	74%	76%	86.7%	76.7%	70%	74%	64%
		4.30	Stroke - % patients scanned within 12 hrs.		98%	95%	95%	96%	90%	97%	92%	96%	98.3%	100.0%	97.5%	95%	98%
		4.31	Stroke - % Patients admitted directly to stroke unit within 4h		71%	76%	78%	79%	83%	72%	73%	60%	75.4%	79.3%	72.5%	58%	73%
		4.32	Stroke - % greater than 80% of treatment on stroke unit		88%	88%	94%	98%	93%	89%	93%	91%	93.0%	96.6%	87.5%	82%	83%
		4.33	Stroke - % of patients treated by the SESDC		48%	75%	46%	33%	51%	50%	31%	32%	61.5%	50.0%	51.4%	55%	49%
		4.34	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start		86%	95%	92%	88%	85%	83%	82%	89%	93.3%	83.3%	95%	79%	82%
		4.35	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72h		80%	90%	88%	90%	92%	77%	76%	78%	93.0%	86.2%	86.8%	95%	93%
		4.36	Stroke -% of eligible patients given thrombolysis		100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100.0%	100.0%	100%	100%
		4.37	Stroke -% of stroke survivors who have 6mth f/up		58%	ND	ND	ND	58%	ND	ND	ND	61%	ND	ND	ND	ND
		4.38	Stroke -Provider rating to remain within A-C		C	ND	ND	ND	ND	ND	ND	ND	C	ND	C	C	ND
	Other	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	CO												ND	ND
		4.40	Nursing & therapy Red referrals seen within 4hrs - Community	CO	100%	100%	100%	NA	100%	NA	NA	100%	100%	100%	100%	100%	100%
		4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	CO	99%	99%	99%	96%	99%	91%	97%	100%	100%	96%	98%	100%	99%
		4.42	Nursing & therapy Green referrals seen within 18 wks -Community	CO	98%	98%	99%	98%	99%	99%	98%	98%	99%	98%	100%	99%	100%
		4.43	Wheelchair waiting times – Child (Community)	CO												ND	ND
		4.44	Wheelchair waiting times - Adult (Community)	CO												ND	ND
		4.45	Sepsis - 1 hr neutropenic sepsis		47.1%	63.2%	68.8%	82.6%	62.5%	79.0%	73.9%	53.9%	80%	75%	58.3%	63.6%	80.0%

EXCEPTION REPORTS – RESPONSIVE

A&E performance has risen to 93.72% in May From 85.34% in April at West Suffolk. The chart shows performance of West Suffolk against the peers and national. (Latest available data – March 2018)



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

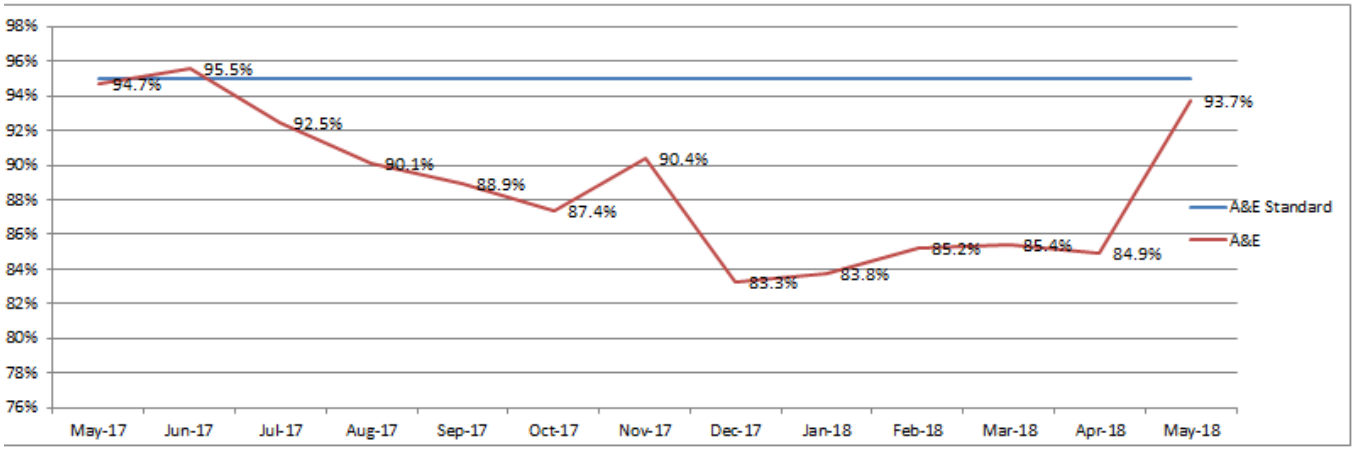
Summary of Current performance & Reasons for under performance

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

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
A&E Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
A&E	94.7%	95.5%	92.5%	90.1%	88.9%	87.4%	90.4%	83.3%	83.8%	85.2%	85.4%	84.9%	93.7%

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

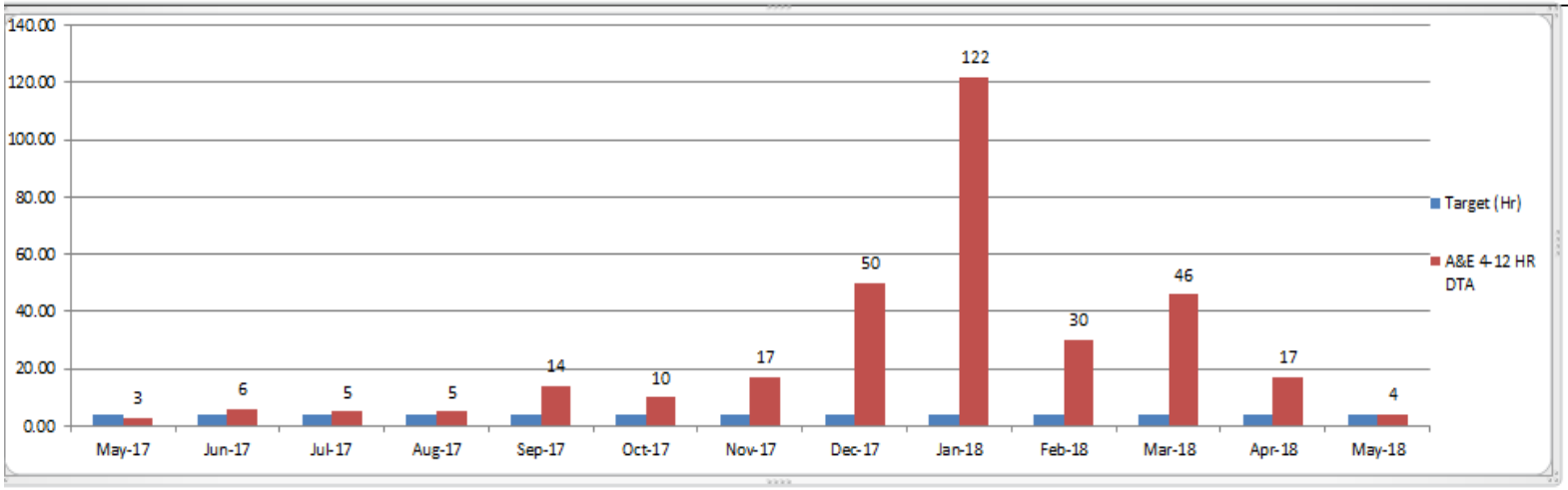
There has been a significant improvement in this area due to the positive impact of medically expected patients going to F8 directly and the overall improved flow within the organisation.

However, there continues to be some challenges around delays in referral to speciality teams or disagreements about appropriateness of referrals to one team versus another. Work is on-going to improve the understanding and adherence to the Internal Professional Standards.

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Target (Hr)	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16	4.16
A&E 4-12 HR DTA	3	6	5	5	14	10	17	50	122	30	46	17	4

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

Description	Owner	Start	End
Development of an ED Escalation policy to ensure consistent escalation of delays from DTA Communication of Internal Professional Standards and adherence to them, particularly specialty referrals.	HB		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

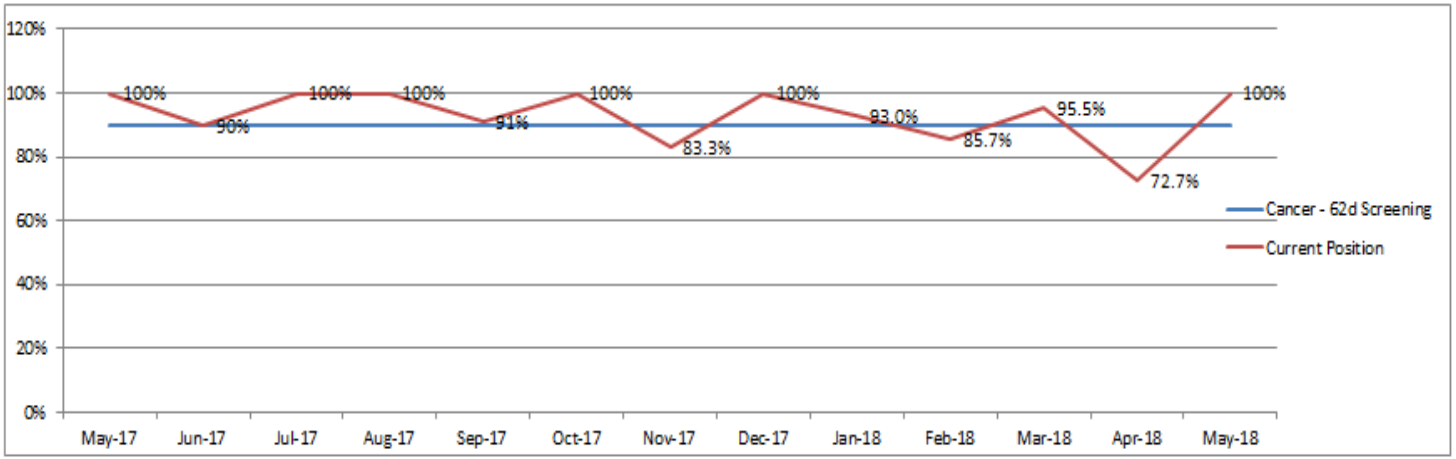
Current Position - 100% against the threshold of 90% and shows good recovery in this performance in May.

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Cancer - 62d Screening	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	100%	90%	100%	100%	91%	100%	83.3%	100%	93.0%	85.7%	95.5%	72.7%	100%

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
The recovery largely relies on timeliness of incoming referrals from the Bowel cancer screening hub and also the flow of patients, as the number of monthly treatment is usually not high.	HB		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

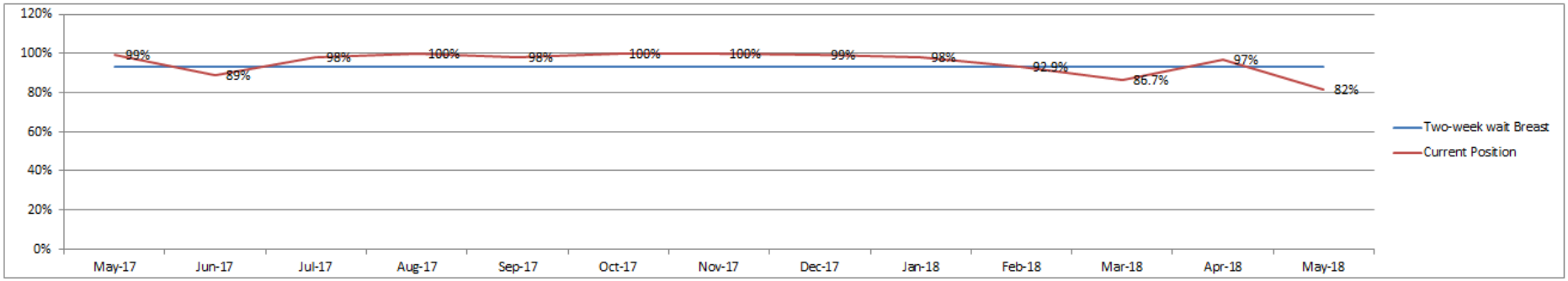
Indicator	Cancer: 2-week wait Breast Referrals
Standard	93%
Name	Sam Dhungana
Month	01-May-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current Performance: 81.6% there were 20 breaches in total of which 6 were due to patient choice or cancellation of 1st offered appointments and 14 due to inadequate clinic capacity to book within 14 days, acknowledging there were 2 days lost due to Bank Holidays.

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Two-week wait Breast	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	99%	89%	98%	100%	98%	100%	100%	99%	98%	92.9%	86.7%	97%	82%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Trust has agreed with the CCG for them to provide a patient reminder card highlighting the importance of accepting first offered appointments. However so far there is no measurable impact on patient compliance. The extra clinics run by the breast services are still proving inadequate to mitigate the increase in demand.	HB		



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

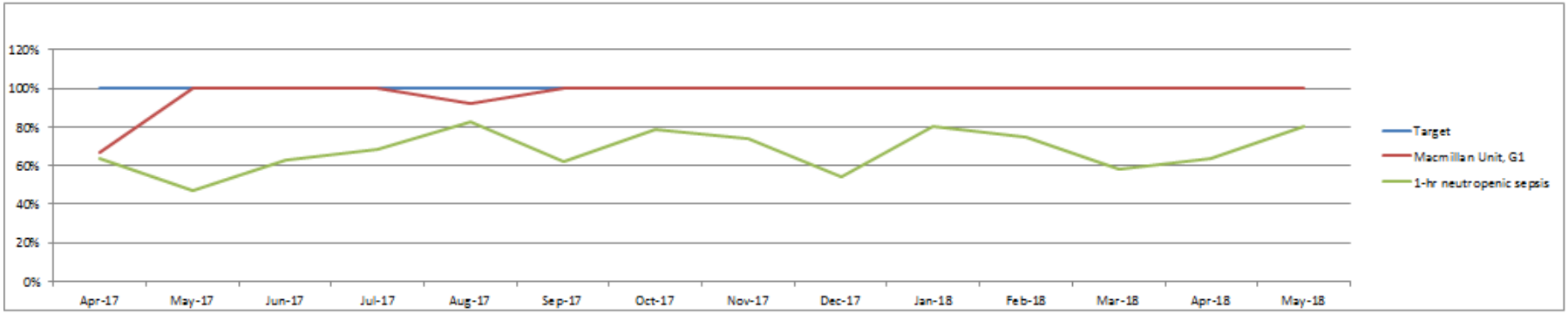
Macmillan – 100%. ED – 71.4%. Overall Trust figure (including AMU) of 80% against a threshold of 100%.

The performance figure for 1 hour door to needle from diagnosis of neutropenic sepsis. May data shows an improvement 16% on the previous months data which was 64% . All breach cases will be undergoing detailed review with a concise investigation completed. These issues will be escalated to the Emergency Department Clinical and Nursing management to address within the departments. The neutropenic pathway is also being reviewed as part of the sepsis group work.

Indicator	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Macmillan Unit, G1	66.7%	100%	100%	100%	92.3%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Emergency Dept, ED	71.4%	40.0%	41.6%	58.3%	70.0%	40.0%	66.7%	62.5%	14.2%	50.0%	44..4%	28.6%	50.0%	71.4%
Acute Medical Unit, AMU	100%	NA	NA	NA	0%	NA	NA	NA	NA	NA	NA	NA	NA	NA
1-hr neutropenic sepsis	63.6%	47.1%	63.2%	68.8%	82.6%	62.5%	79%	73.9%	53.8%	80%	75%	58.3%	64%	80%

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

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

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

Trend

Recovery Trajectory

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

Actions in place to recover the performance

Expected timeframes for improvement

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	LAMS / HoN	May-18	Jun-18

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

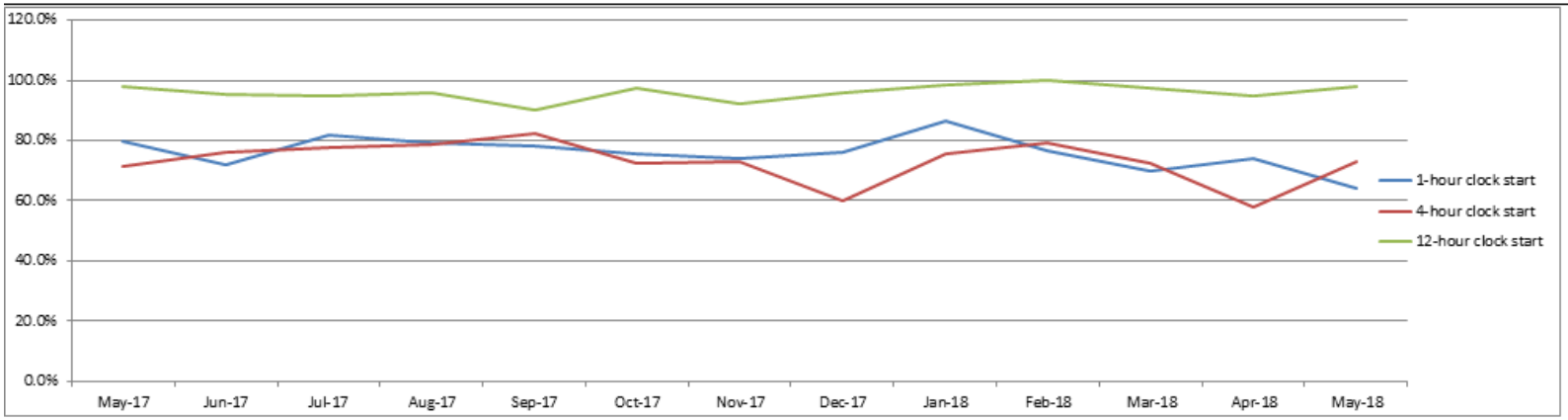
There have been some issues with the triage of our stroke patients, with nine out of fifteen breaches being caused by delays in triage and identification of stroke symptoms. This has therefore caused delays in the referral of patients to the Emergency Stroke Outreach Team. This in turn, for some of our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

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
1-hour clock start	79.6%	72.1%	81.6%	79.2%	78.1%	75.7%	74%	76%	86.7%	76.7%	70%	74%	64%
4-hour clock start	71.4%	76.2%	77.8%	78.7%	82.5%	72.2%	73%	60%	75.4%	79.3%	72.5%	58.0%	73%
12-hour clock start	98.0%	95.4%	94.7%	95.8%	90.2%	97.3%	92.3%	96%	98.3%	100%	97.5%	95.0%	98.0%

Actions in place to recover the performance

Expected timeframes for improvements

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



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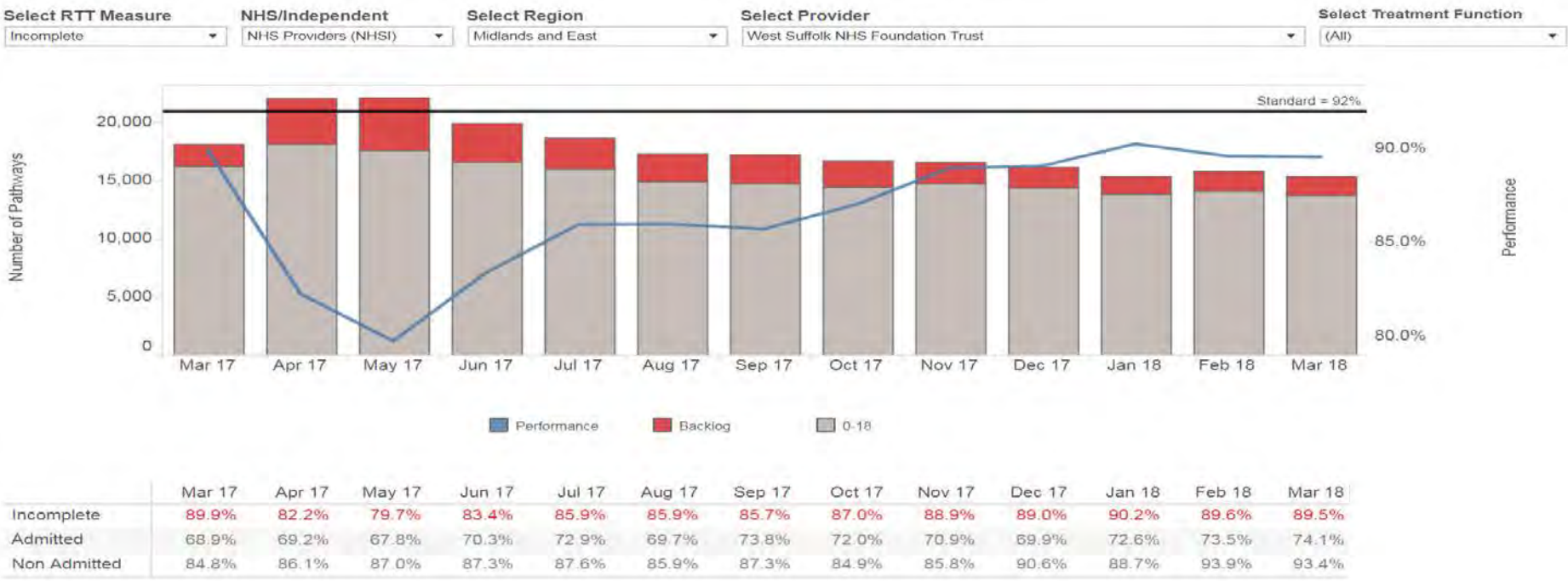
Referral to Treatment

Progress is being made to reduce the number of people on the RTT waiting list and to treat 92% of patients from point of referral to treatment in aggregate – patients on an incomplete pathway. However, the Trust remains a national outlier in term of overall performance as demonstrated in the slides below. The current position for May is a much improved performance which will be reflected in future versions of this graph.

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



	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Incomplete	89.9%	82.2%	79.7%	83.4%	85.9%	85.9%	85.7%	87.0%	88.9%	89.0%	90.2%	89.6%	89.5%
Admitted	68.9%	69.2%	67.8%	70.3%	72.9%	69.7%	73.8%	72.0%	70.9%	69.9%	72.6%	73.5%	74.1%
Non Admitted	84.8%	86.1%	87.0%	87.3%	87.6%	85.9%	87.3%	84.9%	85.8%	90.6%	88.7%	93.9%	93.4%

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

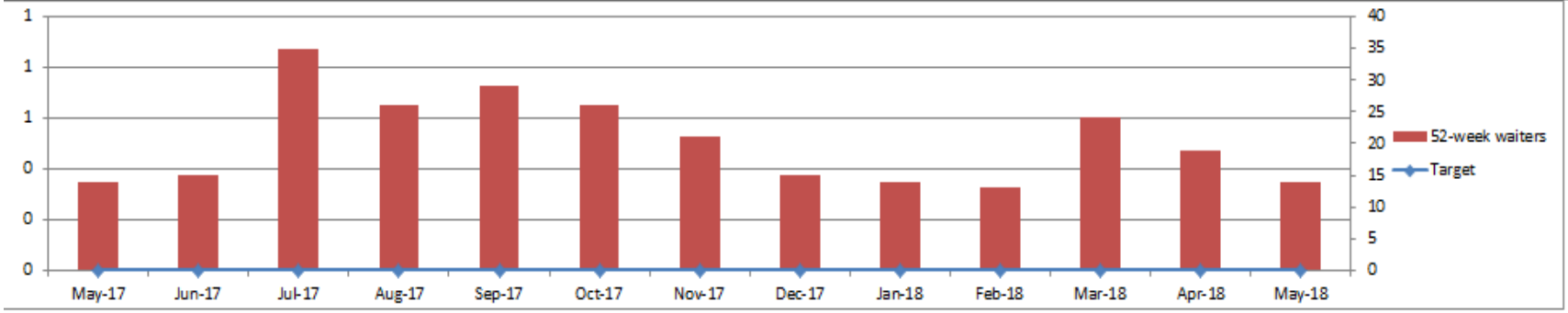
Summary of Current performance & Reasons for under performance

At the end of May, 14 patients had waited over 52 weeks. Five of which have now completed treatment, 6 have a date for treatment or OPA scheduled in June and 2 have dates in July. The remaining 1 has yet to have TCI date allocated. The weekly access meetings are focusing on those at risk of breaching 52 weeks and patient level plans are discussed at this meeting. Patient choice is still a factor towards the end of a number of pathways. We are working with the IST to review the 52 week waiters and a rolling clinical harm review process has been implemented.

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Target	0	0	0	0	0	0	0	0	0	0	0	0	0
52-week waiters	14	15	35	26	29	26	21	15	14	13	24	19	14

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

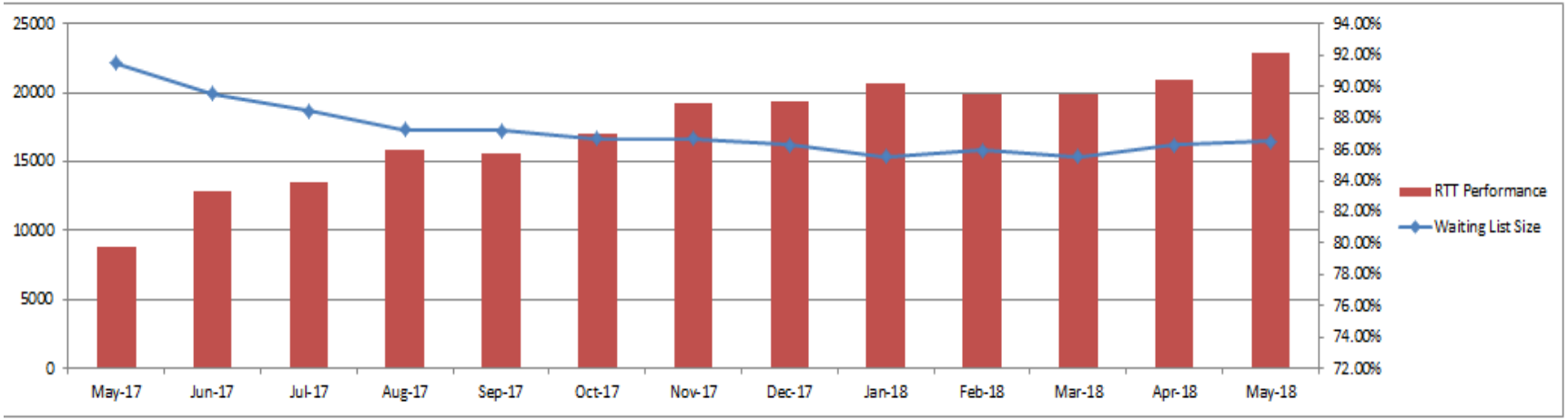
Summary of Current performance & Reasons for under performance

May has seen a continued improvement of the position which has meet the standard of 92% in month. However this is not considered to be a sustainable position as the overall waiting list has grown over recent months to 16,481 and this will need to be monitored going forward . Capacity issues are still present in some specialities including T&O Vascular Surgery and Ophthalmology.

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Waiting List Size	22144	19931	18676	17346	17236	16694	16641	16195	15,363	15,804	15396	16223	16481
RTT Performance	79.71%	83.36%	83.92%	85.93%	85.69%	87.00%	88.92%	89.04%	90.21%	89.56%	89.52%	90.38%	92.15%

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

Description	Owner	Start	End
1. Targeted work is being undertaken to reduce the back log in challenged specialties. 2. There is a specific focus to review the vascular surgery pathway to ensure appropriate referrals to treatment are in place and a meeting with the clinicians in this speciality is planned. 3. Work is underway to look at options to reduce and manage the backlog and capacity constraints within ophthalmology.	HB	Jul-17	TBC

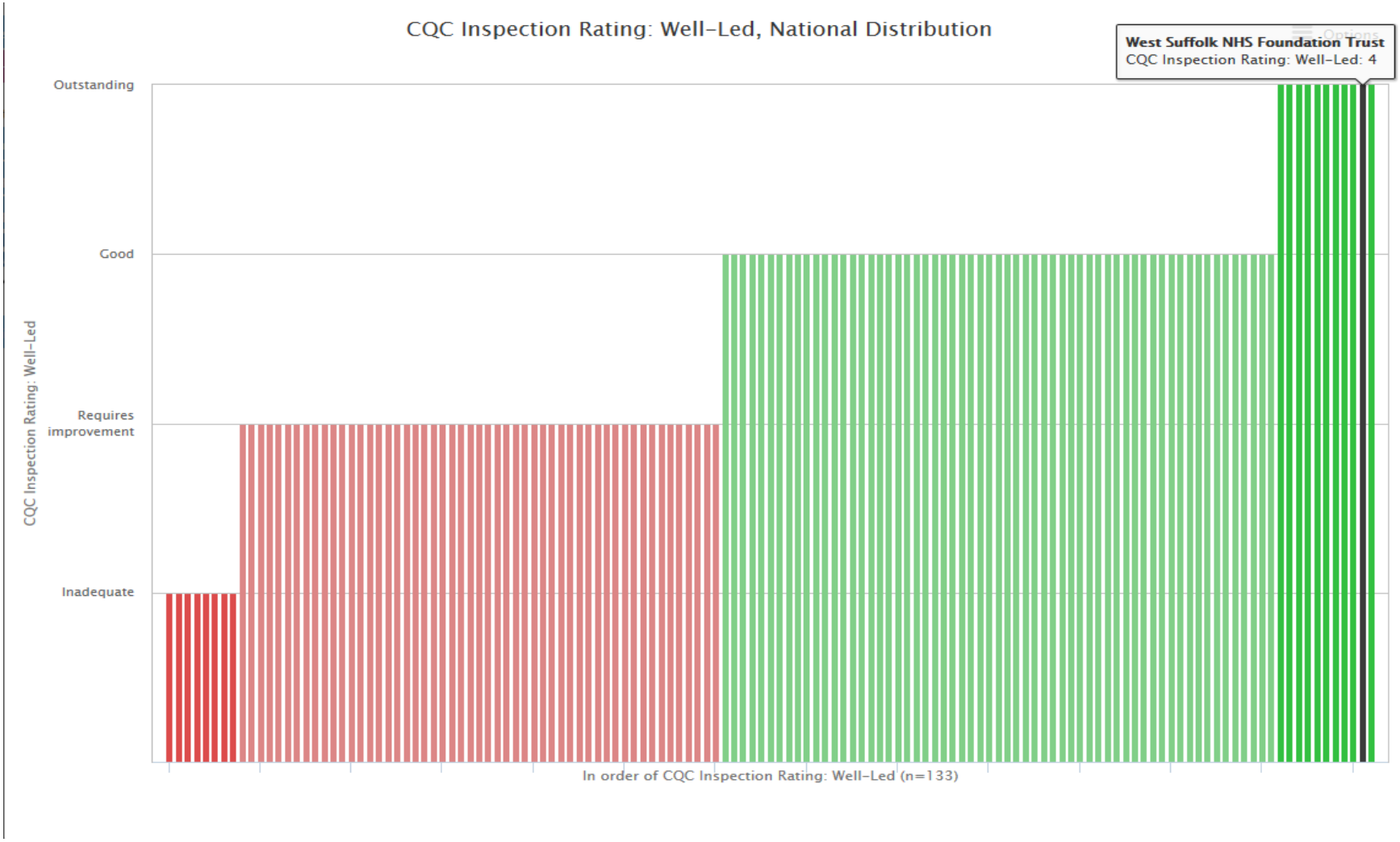


DETAILED REPORTS – WELL-LED

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

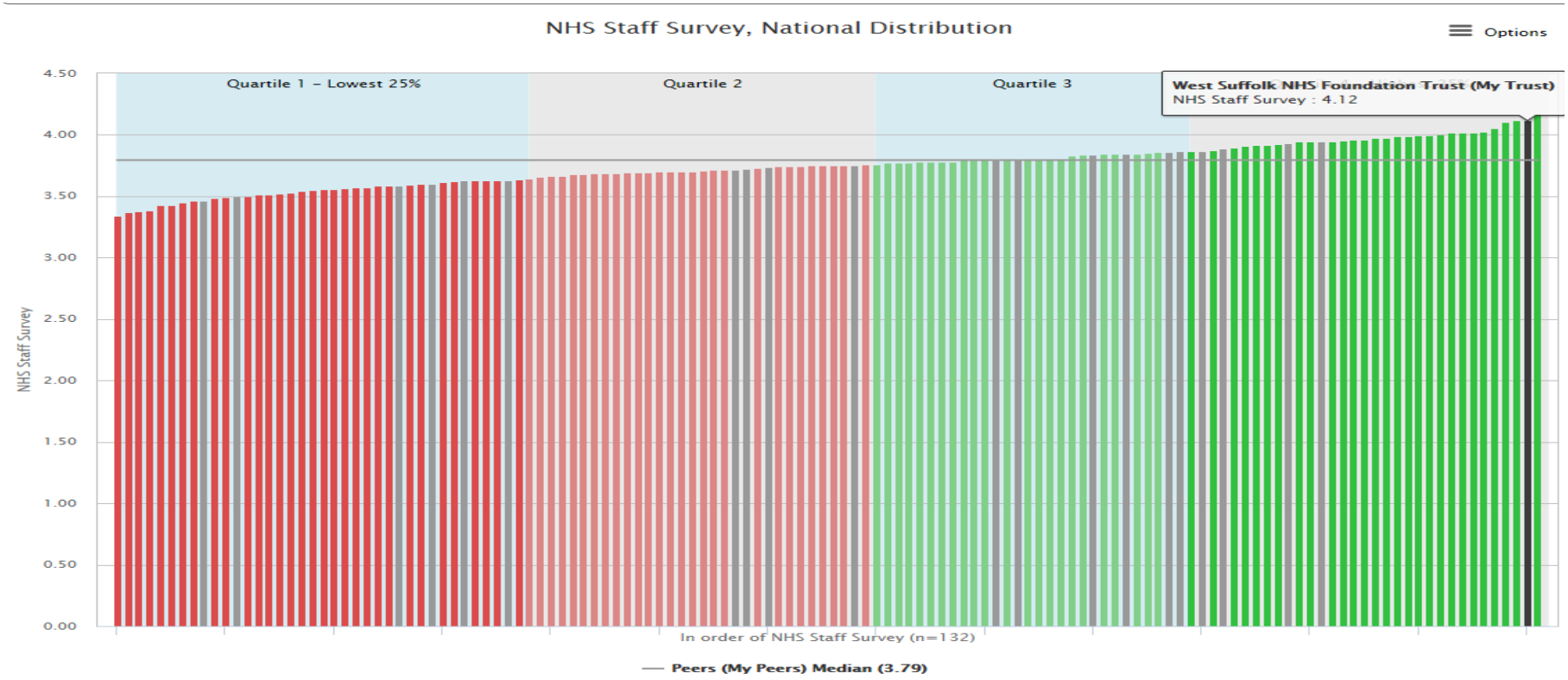
Are we		Ref.	KPI	Type	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
5. Well Led	Dashboard	5.01	NHS Staff Survey (Staff Engagement score -Annual)	WS	NT	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	3.96%	NA	NA	NA
		5.02	Staff F&F Test % Recommended - care (Qrtly)	WS	75%	NA	NA	95%	NA	NA	95%	NA	NA	ND	NA	NA	ND	NA	NA
		5.03	Staff F&F Test % Recommended - place to work (Qrtly)	WS	75%	NA	NA	83%	NA	NA	82%	NA	NA	ND	NA	NA	ND	NA	NA
		5.04	Turnover (Rolling 12 mths)	TW	<10%	10.30%	10.32%	10.30%	9.86%	10.03%	9.80%	9.00%	9.07%	9.28%	9.28%	8.65%	8.78%	8.43%	8.36%
		5.05	Sickness Absence	TW	<3.5%	3.7%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%	3.5%	3.5%	3.6%	3.7%	3.7%	3.8%	3.8%
		5.06	Executive Team Turnover (Trust Management)	WS	<10%	0%	20%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
		5.07	Agency Spend			311	216	255	216	126	150	82	213	245	353	306	373	276	188
		5.08	Monitor Use of Resources Rating			3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Agency, WTE & vacanci	5.09	Agency Spend Cap			378	378	378	378	378	378	378	378	378	378	378	378	ND	ND
		5.10	Bank Spend			957	1054	1512	1197	1234	1112	1195	1179	1326	1078	1093	996	1340	1361
		5.11	Bank/agency Spend percentage			4.6%	3.9%	3.7%	4.9%	3.6%	4.7%	3.8%	4%	5%	5.7%	ND	6%	4.2%	ND
		5.12	Proportion of Temporary Staff			11.0%	11.1%	10.0%	12.2%	11.4%	10.6%	10.1%	10.9%	8.0%	11.1%	11.3%	11.0%	12.5%	11.9%
		5.13	Locum and Medical agency spend			309	368	361	381	347	270	357	381	508	495	487	448%	398	319
		5.14	Total Vacancies			7%	8%	6%	8%	7%	8%	8%	8%	8%	7.1%	7.9%	ND	8%	ND
		5.15	Corporate & Admin Costs as %		<7%	8.48%	8.57%	8.46%	8.47%	8.48%	8.50%	8.60%	8.60%	11.11%	12.21%	10.65%	ND	9.72%	ND
		5.16	% Staff on Maternity/Paternity Leave	TW		2.15%	2.15%	1.98%	1.85%	1.94%	2.00%	2.00%	2.00%	2.00%	1.87%	1.98%	1.93%	1.99%	2.27%
	Other	5.17	Grievance reviews			ND	ND	ND	ND	ND	6	6	6	5	5	5	4	5	4
		5.18	Recruitment Timescales - Av no. of weeks to recruit		7	ND	6	5	5.40	6.40	7	6.90	6.90	6.40	5.40	5.40	5.40	5.40	6
		5.19	DBS checks		95%	92.8%	92.6%	92.6%	98.0%	98.4%	98.5%	97.5%	97.5%	98.5%	98.5%	98.0%	97%	98.0%	97.5%
		5.20	Staff appraisal Rates	TW	90%	ND	92%	92%	ND	ND	53.1%	50.8%	55.8%	62.0%	65.0%	62.3%	63%	67%	67%
		5.21	Trust Participation in on-going National Audits (Qtrly)		90%	NA	NA	94%	NA	NA	96%	NA	NA	96%	NA	NA	96%	NA	NA
	Training	5.22	Infection Control Training (classroom)	TW	85%	95%	96%	95%	95%	96%	94%	95%	95%	95%	94%	94%	95%	94%	95%
		5.23	Infection Control Training (eLearning)	TW	185%	88%	88%	90%	90%	88%	83%	85%	88%	88%	90%	90%	90%	90%	90%
		5.24	Manual Handling Training (Patient)	TW	80%	81%	83%	84%	83%	83%	80%	80%	84%	84%	79%	79%	79%	74%	76%
		5.25	Manual Handling Training (Non Patient)	TW	80%	81%	81%	83%	83%	82%	86%	84%	88%	88%	89%	89%	88%	88%	88%
		5.26	Staff Adult Safeguarding Training	TW	80%	88%	89%	90%	90%	89%	89%	90%	92%	92%	92%	92%	92%	91%	91%
		5.27	Safeguarding Children Level 1	TW	90%	86%	86%	87%	88%	87%	86%	88%	89%	90%	91%	91%	90%	90%	90%
		5.28	Safeguarding Children Level 2	TW	90%	87%	88%	90%	90%	87%	88%	89%	90%	92%	92%	92%	91%	91%	90%
		5.29	Safeguarding Children Level 3	TW	90%	85%	83%	81%	81%	76%	73%	79%	83%	86%	86%	88%	83%	95%	94%
		5.30	Health & Safety Training	TW	80%	88%	89%	89%	89%	89%	89%	90%	91%	91%	92%	92%	91%	90%	90%
		5.31	Security Awareness Training	TW	80%	88%	89%	90%	90%	89%	89%	90%	90%	91%	91%	91%	90%	90%	90%
		5.32	Conflict Resolution Training (eLearning)	TW	80%	81%	83%	85%	86%	80%	80%	81%	82%	95%	76%	85%	84%	86%	87%
		5.33	Conflict Resolution Training	TW	180%	75%	75%	77%	77%	76%	75%	76%	76%	75%	88%	76%	76%	69%	70%
		5.34	Fire Training (eLearning)	TW	280%	85%	86%	87%	87%	85%	85%	85%	85%	84%	84%	84%	82%	80%	82%
		5.35	Fire Training (classroom)	TW	80%	90%	90%	90%	90%	90%	89%	90%	91%	91%	90%	90%	90%	90%	90%
		5.36	IG Training	TW	80%	80%	81%	85%	84%	85%	84%	87%	86%	87%	84%	84%	82%	86%	86%
		5.37	Equality and Diversity	TW	80%	93%	94%	95%	95%	93%	92%	93%	94%	94%	88%	88%	83%	81%	80%
		5.38	Majax Training	TW	80%	86%	86%	88%	88%	87%	86%	88%	88%	89%	90%	90%	88%	88%	88%
		5.39	Medicines Management Training	TW	80%	87%	87%	88%	88%	87%	87%	86%	87%	88%	89%	89%	88%	87%	87%
		5.40	Slips, trips and falls Training	TW	80%	84%	85%	87%	87%	85%	85%	86%	88%	88%	87%	87%	87%	85%	85%
		5.41	Blood-borne Viruses/Inoculation Incidents	TW	80%	84%	84%	86%	86%	84%	84%	85%	86%	87%	86%	86%	86%	85%	86%
		5.42	Basic life support training (adult)	TW	80%	83%	85%	85%	85%	84%	82%	81%	81%	82%	80%	80%	78%	75%	76%
		5.43	Blood Products & Transfusion Processes (Refresher)	TW	80%	80%	82%	83%	82%	79%	79%	80%	78%	80%	75%	75%	72%	73%	72%
		5.44	Mandatory Training Compliance	TW								86%	88%	89%	85%	83%	83%	83%	84%
		5.55	Safeguarding Children Mandatory Compliance (Community)	CO	98%	96.1%	96.4%	96.9%	96.9%	97.1%	96.8%	95.3%	96.1%	96.0%	95.9%	95.7%	96.98%	98.2%	96.0%
		5.56	Safeguarding Adults Mandatory Training Compliance (Community)	CO	98%	96.0%	96.2%	96.8%	96.6%	96.2%	96.1%	94.3%	95.3%	94%	94.1%	93.2%	95.56%	96.0%	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 3 Trusts in England *(Source –Model Hospital-Latest data).*



DETAILED REPORTS – PRODUCTIVE

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

Ref.	KPI	Type	Targe	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
6.01	I&E Margin	TW	Var	ND	-4.9%	-4.3%	-3.9%	0.1%	-3%	-2.6%	-2.5%	-2.6%	-2.3%	-2.6%	0.2	-10.3%	-7.5%
6.02	Distance from Financial Plan	TW	Var								0.2%	0.2%	0.6%	0.1%	2.5%	5.3%	18.5%
6.03	Capital service cover	TW	Var	ND	- 3.19	- 2.50	- 2.18	- 1.04	- 0.88	- 0.32	0.52	0.24	0.38	0.07	0.680	0.48	1.64
6.04	Liquidity (days)	TW		ND	- 12.15	-15.72	-10.94	- 11.03	- 12.70	-15.14	9.64	11.39	6.06	6.84	7.860	12.34	16.83
6.05	Long Term Borrowing (£m)	TW	3.5%	44.3	45.7	45.7	45.7	45.7	47.6	47.6	56.7	58.7	64.4	64.1	65.4	67.6	69.8
6.06	CIP (Variance YTD £'000s)	TW	1.9	40	0	-40	10	0	-54	-10	-74	-22	-419	-469	-539	-54	-47
6.07	A&E Activity	WS		5578	5971	5922	6124	5831	5743	6065	5985	5959	6033	5639	6172	5967	6498
6.08	NEL Activity			2409	2440	2429	2375	2385	2466	2586	2491	2528	2539	2406	2557	ND	ND
6.09	OP - New Appointments	WS		5125	6244	6148	5706	5635	5633	6182	7230	5482	6769	5849	6324	6033	6930
6.10	OP- Follow-Up Appointments	WS		9541	11667	11542	11147	11333	11116	11815	12668	9769	12673	11103	11609	11142	12248
6.11	Electives (Incl Daycase)			2593	3004	2898	2796	2829	2786	2868	3157	2545	2841	2632	2871	ND	ND
6.12	Financial Position (YTD)	TW	Var	-937	-2906	-2758	-3290	-3300	-3953	-4114	-5170	-6600	-6525	-6525	-287	-1760	-2793
6.13	Financial Stability Risk Rating	TW	Var	3	3	3	3	3	3	3	3	3	3	3	3	3	3
6.14	Cash Position (YTD £000s)	TW	Var	7,955	5093	2689	7460	3300	4846	2654	3518	4924	6870	3600	3600	5,322	4550

OPERATIONAL PRODUCTIVITY – TRUST OVERVIEW

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

Data from Accounts	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Operating Expenditure	2016/17	£262.13m	£205.93m	£356.24m			No trendline available
Income	2016/17	£254.48m	£197.16m	£350.09m			No trendline available
Surplus (or) Deficit	2016/17	£-7.65m	£-5.43m	£-3.55m			No trendline available
Surplus (or) Deficit as % of Expenditure	2016/17	-2.9%	-2.9%	-1.1%			No trendline available
Data from Reference Costs	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Expenditure reported in Reference Costs	2016/17	£188.22m	£174.69m	£311.10m			No trendline available
Reference Cost expenditure as % of Operating Expenditure	2016/17	72%	87%	86%			No trendline available
Cost Weighted Output expressed as Weighted Activity Units (WAUs)	2016/17	64,804	52,842	90,210			No trendline available
Cost per WAU (MFF adjusted)	2016/17	£3,023	£3,507	£3,484			No trendline available
Cost per WAU (no MFF adjustment)	2016/17	£2,904	£3,436	£3,436			No trendline available
Market Forces Factor (MFF)	2016/17	0.96	0.96	0.97			No trendline available
Potential Productivity Opportunity (PPO) £	2016/17	£18.89m	£18.89m	£30.34m			No trendline available
Potential Productivity Opportunity (PPO) %	2016/17	10.0%	10.5%	10.0%			No trendline available

EXCEPTION REPORTS – PRODUCTIVE

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

MATERNITY

	Ref.	KPI	Type	Target	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Dashboard	7.01	Total number of deliveries (births)	WS	210	192	213	215	233	236	205	194	180	199	211	206	195	201
	7.02	% of all caesarean sections	WS	<22.7%	21%	16%	16%	22.32%	18.22%	17.10%	17.0%	18.3%	22.1%	17.1%	30.1%	28%	22%
	7.03	Midwife to birth ratio	WS	1.30	1.27	1.29	1.30	1.33	1.33	1.29	1.28	1.26	1.28	1.29	1.29	1.27	1.30
	7.04	Unit Closures	WS	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.05	Completion of WHO checklist	WS	100%	93%	84%	94%	82%	98%	98%	98%	93%	93%	94%	97%	86%	85%
	7.06	Maternity SIs	WS	NT	0	0	0	0	1	1	0	1	2	0	1	2	2
	7.07	Maternity Never Events	WS	NT	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.08	Breastfeeding Initiation Rates	WS	80%	80.5%	87.5%	77.3%	84.8%	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	79%	76.1%	76.3%
Safe	7.09	Elective Caesarean Sections	WS	10%	10%	4.3%	7.0%	9.4%	6.4%	5.9%	7.2%	7.8%	8%	7%	11%	12%	11%
	7.10	Emergency Caesarean Sections	WS	<13%	12%	12%	9%	13%	12%	11%	10%	11%	14%	10%	19%	16%	11%
	7.11	Grade 1 Caesarean Section (Decision to delivery time met)	WS	100%	100%	100%	100%	100%	100%	0%	100%	100%	100%	100%	100%	100%	100%
	7.12	Grade 2 Caesarean Section (Decision to delivery time met)	WS	80%	93%	93%	83%	57%	82%	88%	50%	80%	83%	83%	81%	82%	93%
	7.13	Homebirths	WS	2%	3.7%	2.4%	3.3%	2.6%	2.1%	3.9%	2.6%	3.3%	3.0%	2.4%	0.5%	2.6%	5.0%
	7.14	Midwifery led birthing unit (MLBU) births	WS	>13%	17%	17.3%	18.8%	15.5%	15.3%	17.1%	16%	15%	19.1%	18%	14%	16%	11%
	7.15	Labour Suite births	WS	75%	79%	80.3%	77.9%	82.0%	82.6%	79.0%	81.4%	81.7%	1	79.6%	85.4%	81%	83%
	7.16	Induction of Labour	WS	NT	41%	40.9%	36.6%	38.2%	34.3%	35.1%	43.8%	43.9%	0	41.2%	37.4%	41%	38%
	7.17	Instrument Assisted Deliveries (Forceps & VentoUse)	WS	NT	6.80%	4.9%	4.2%	3.0%	4.7%	4.2%	7.2%	5.9%	0	7.6%	6.8%	13.00%	9.50%
	7.18	Critical Care Obstetric Admissions	WS	0	1	0	1	0	1	0	0	0	2	0	1	1	2
	7.19	Eclampsia	WS	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Effective	7.20	Shoulder Dystocia	WS	2	4	3	5	3	7	6	4	5	4	5	8	5	6
	7.21	Post-partum Hysterectomies	WS	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	WS	0	0	0	0	0	0	0	0	ND	ND	ND	ND	0	0
	7.23	3rd and 4th degree tears (all deliveries)	WS	12	9	6	10	4	4	6	3	8	9	7	2	9	4
Caring	7.24	Maternal death	WS	NT	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.25	Stillbirths	WS	NT	0	0	0	0	1	2	1	0	2	0	0	1	1
	7.26	Complaints	WS		0	1	2	1	0	0	0	1	0	0	1	0	ND
	7.27	No. of babies admitted to Neonatal Unit (>36+6)	WS	NT	9	17	18	13	15	15	11	9	8	16	12	18	10
Responsive	7.28	No. of babies transferred for therapeutic cooling	WS	0	0	0	0	0	0	1	0	1	0	0	0	1	0
	7.29	One to one care in established labour	WS	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	91%	93%
	7.30	Reported Clinical Incidents	WS	60	62	46	64	43	52	61	57	49	63	46	48	46	56
	7.31	Hours of dedicated consultant cover per week	WS	60	110	99	99	96	99	99	108	90	102	93	93	94	90
	7.32	Consultant Anaesthetists sessions on Labour Suite	WS	10	10	10	10	10	10	10	10	10	10	10	10	10	10
	7.33	OPD cover for Theatre 2	WS	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	ND	ND
	7.34	No. of women identified as smoking at booking	WS	NA	35	37	32	30	37	27	28	17	26	21	30	26	31
	7.35	No. of women identified as smoking at delivery	WS	NT	30	26	32	27	25	25	24	26	21	22	24	23	26
	7.36	UNICEF Baby friendly audits	WS	NT	10	10+	10+	10+	10+	10+	10+	10+	10+	ND	10+	ND	ND
	7.37	Proportion of parents receiving Safer Sleeping Suffolk advice	WS	NT	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	62.9	77.8
Other	7.38	No. of bookings (First visit)	WS	NA	262	244	272	245	265	259	245	193	279	253	274	240	251
	7.39	Women booked before 12+6 weeks	WS	95%	95%	98%	95%	100%	93%	99%	97%	97%	96%	96%	ND	95%	3%
	7.40	Female Genital Mutilation (FGM)	WS	NT	0	0	0	0	0	0	0	0	0	1	0	0	0

EXCEPTION REPORTS – MATERNITY

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

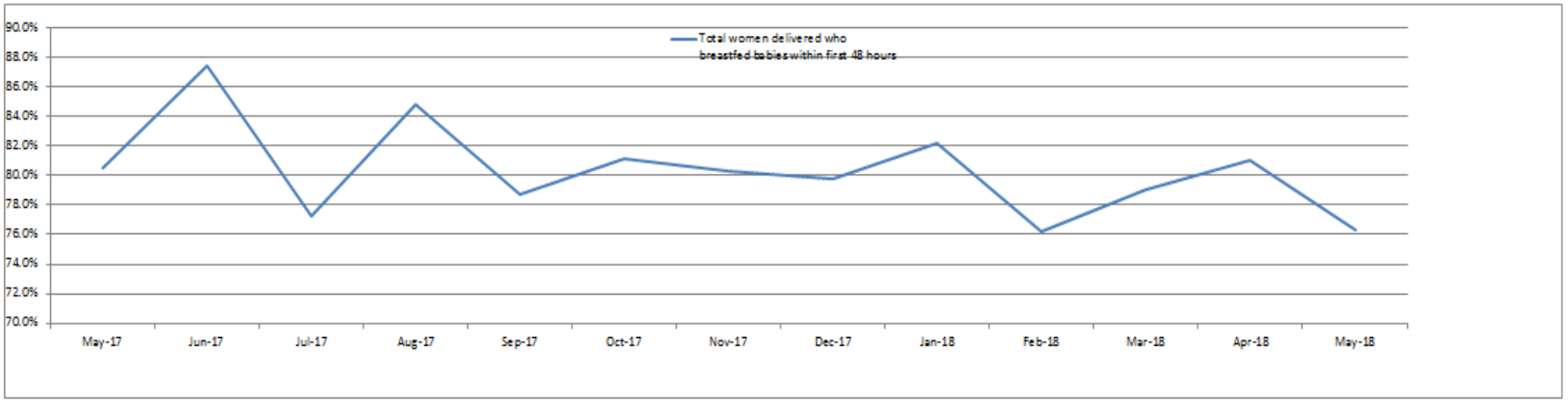
Compliance with the 80% target of babies receiving breastmilk within 48 hours of life was missed at 76% in May 2018. Particularly disappointing when April figures had exceeded the 80% rate. The Maternity service continues to look at ways to improve the breastfeeding initiation rate. Breast feeding audits from May 2018 have highlighted specific areas to improve upon these have been disseminated to staff .

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Total women delivered who breastfed babies within first 48 hours	80.5%	87.5%	77.3%	84.8%	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	79%	81.0%	76%

Actions in place to recover the performance

Expected timeframes for improvements

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

Data for May 2018 reports an emergency CS rate of 11% percentage , with a total CS rate at 22.2 % .This is below our commisioned rate of 22.6. This is pleasingly a significant reduction from the previous 2 months which saw an unusual increase which we unable to fully explain the reason. All emergency CS are monitored weekly and any learning is shared via the Risky Business Publication.The maternity service shall continue to monitor CS a weekly.

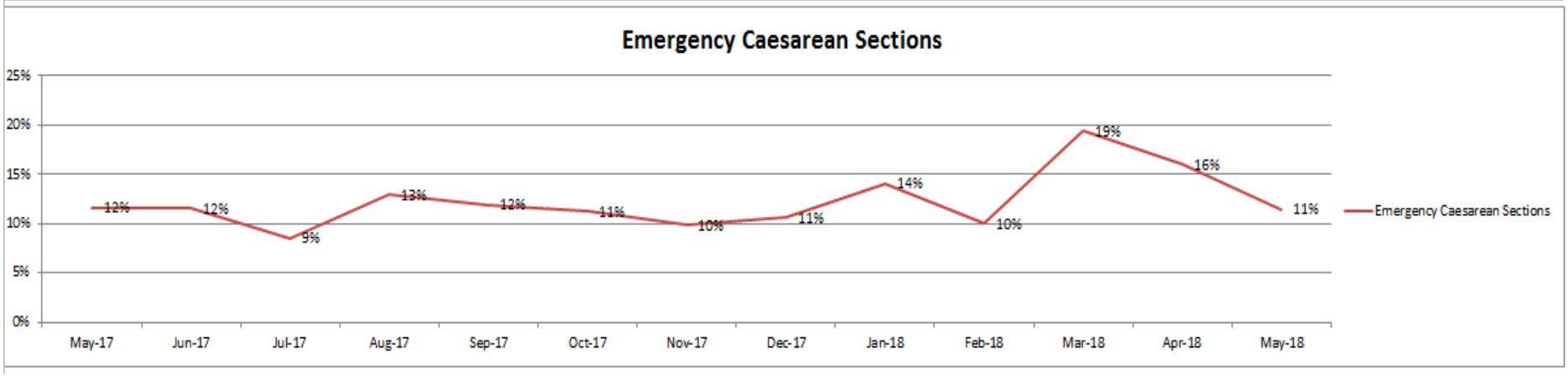
Trend | Recovery Trajectory

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Emergency Caesarean Sections	12%	12%	9%	13%	12%	11%	10%	11%	14%	10%	19%	16%	11%

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Caesarean sections are reviewed weekly at the case management meeting and any learning is shared.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

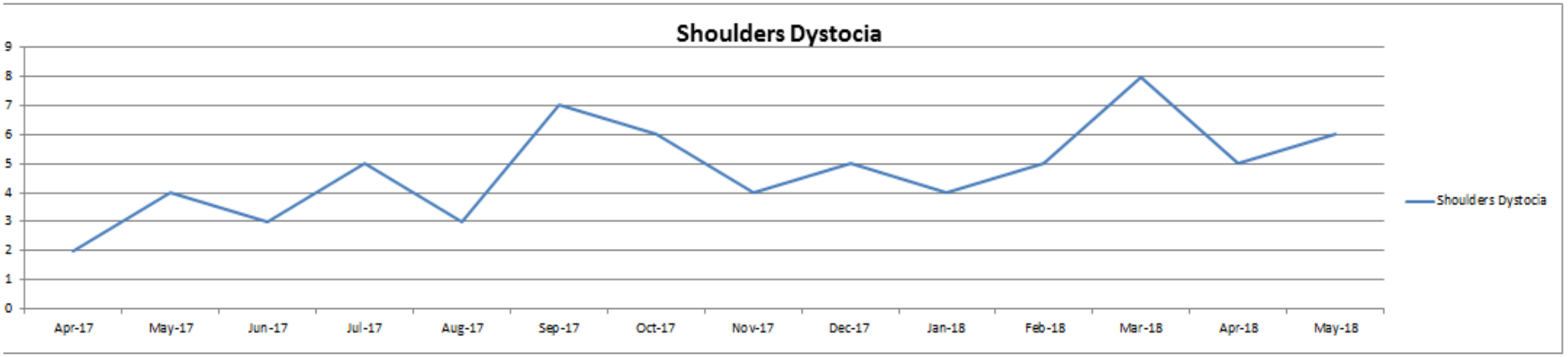
May 2018 had 6 reported shoulder dystocia's, there were no injuries to babies or mothers during the incident. Shoulder dystocia was discussed at the WHG on 18th May. It was suggested the figures should be presented as a percentage therefore more understandable. The RCOG state that risk assessments for the prediction of shoulder dystocia are insufficiently predictive to allow prevention in the large majority of cases. For this reason the service have multiprofessional training in place for the management of this emergency. It has been suggested staff may report shoulder dytocia and begin to implement emergency measures before they have allowed for restitution of the head (The head to align itself with the body) this is captured on E3 as shoulder dystocia. This was also suggested in an audit on shoulder dytocia within the last year and during routine investigations of incidents of shoulder dystocia. It is important that staff recognise and report shoulder dytocia, The service to look at re-auditing cases of shoulder dystocia to identify if there are any training issues identified in its recognition.

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

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Continue to monitor all incidents of shoulder dystocia monthly reported and consider re auditing cases in particular looking at recognition.	RS	Jul-17	Ongoing



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

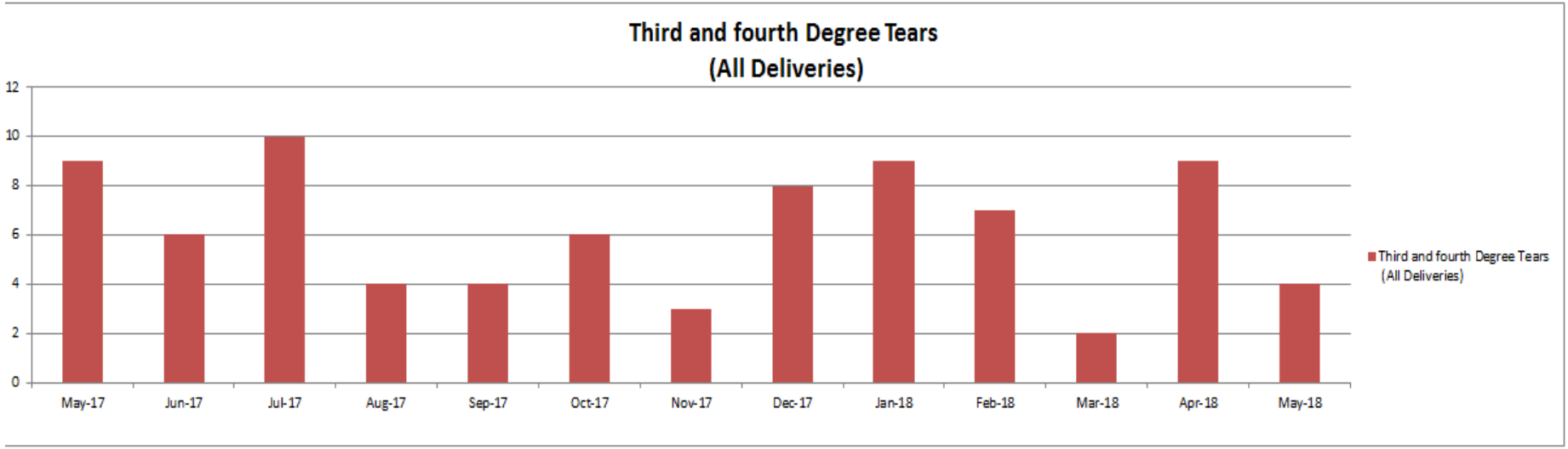
The maternity service continues to maintain the focus on keeping this rate of 3rd and 4th degree tears low. May 2018 showed a significant reduction down to 4. All 3rd and 4th degree tears are on the maternity services trigger list for datix and therefore are indvidually investigated as to the type of delivery appropriate position at delivery. Focus has recently been put on the routine use by some staff of lithotomy for positioning at delivery for normal deliveries. This is not recommeded as a first line of positioning women because of the effects of increased 3rd degree tears and was discussed at the Labour Ward forum on the 22nd May . To be highlighted at Take 5.

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

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Discouraging the use of lithotomy as a first line positioning for women during delivery. Discussed at the LWF and to be highlighted at Take 5 .	RP	Mar-18	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

The total caesarean section rate had seen a marked rise in March and April 2018 at 30.1% and 28% respectively due to a rise in both the elective CS and emergency CS as well as a reduction in the number of births. This is above the current commissioned rate of less than 22.4%. The figures were reviewed at the Womens Health Governance both in April and in May 2018 and although an obvious reason could not be identified and therefore thought to be a unusual anomaly but the service has continued to review this weekly as current practice. However it was noted that our commisioned rate is significantly lower than the national mean of 25.9% of a other hospitals of a similar size (National Maternity and Perinatal Audit 2017)and the lead consultant suggested there needs to be some clarity as to why this figure was commissioned. May 2018 has seen a pleasing and significant fall in the overall rate to 22% in keeping with the maternity services' trend seen over the past year. The maternity service will continue to review all cases of emergency CS weekly at the CS Case Management Meeting.

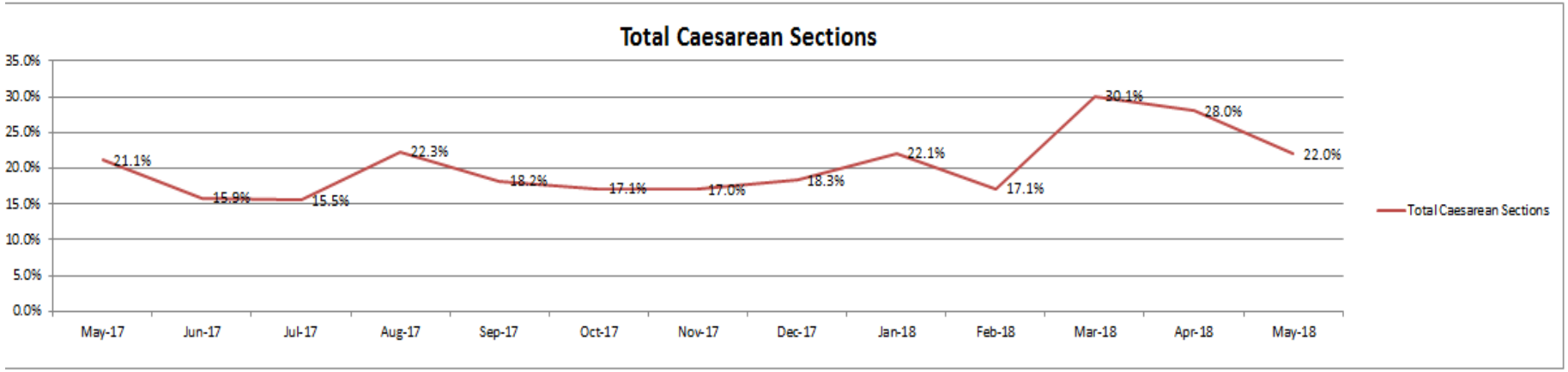
Trend — Recovery Trajectory

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Total Caesarean Sections	21.1%	15.9%	15.5%	22.3%	18.2%	17.1%	17.0%	18.3%	22.1%	17.1%	30.1%	28.0%	22.0%

Actions in place to recover the performance

Expected timeframes for improvements

Description	Owner	Start	End
Continue to discuss at the Divisional Governance meeting. Lead consultant obstetrician would like clarity in the reasoning behind the current commisioned rate as this is much lower than National average (NMPA 2017)			



NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

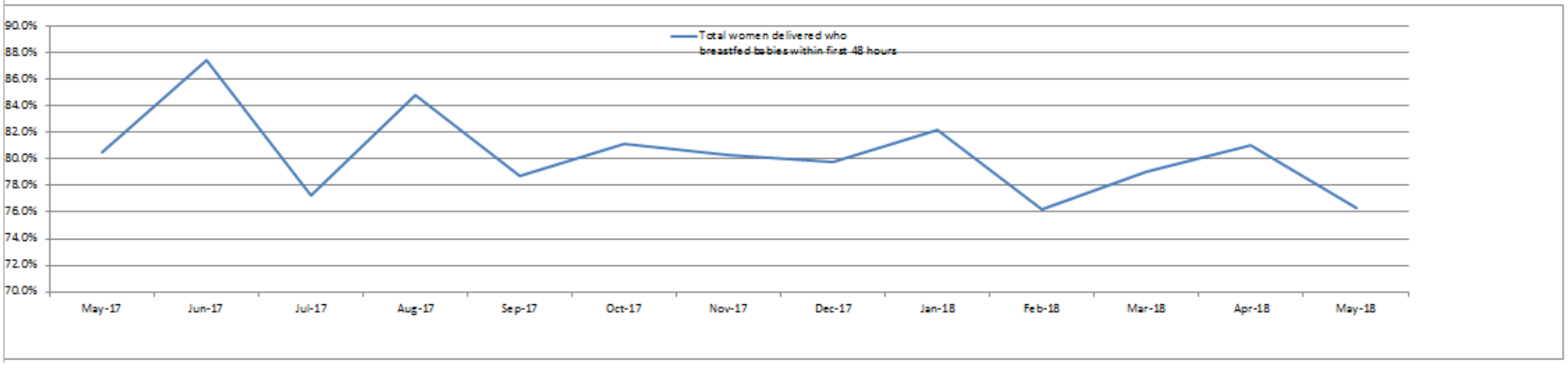
Compliance with the 80% target of babies receiving breastmilk within 48 hours of life was missed at 76% in May 2018. Particularly disappointing when April figures had exceeded the 80% rate. The Maternity service continues to look at ways to improve the breastfeeding initiation rate. Breast feeding audits from May 2018 have highlighted specific areas to improve upon these have been disseminated to staff .

Indicator	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Total women delivered who breastfed babies within first 48 hours	80.5%	87.5%	77.3%	84.8%	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	79%	81.0%	76%

Actions in place to recover the performance

Expected timeframes for improvements

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



NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

Summary of Current performance & Reasons for under performance

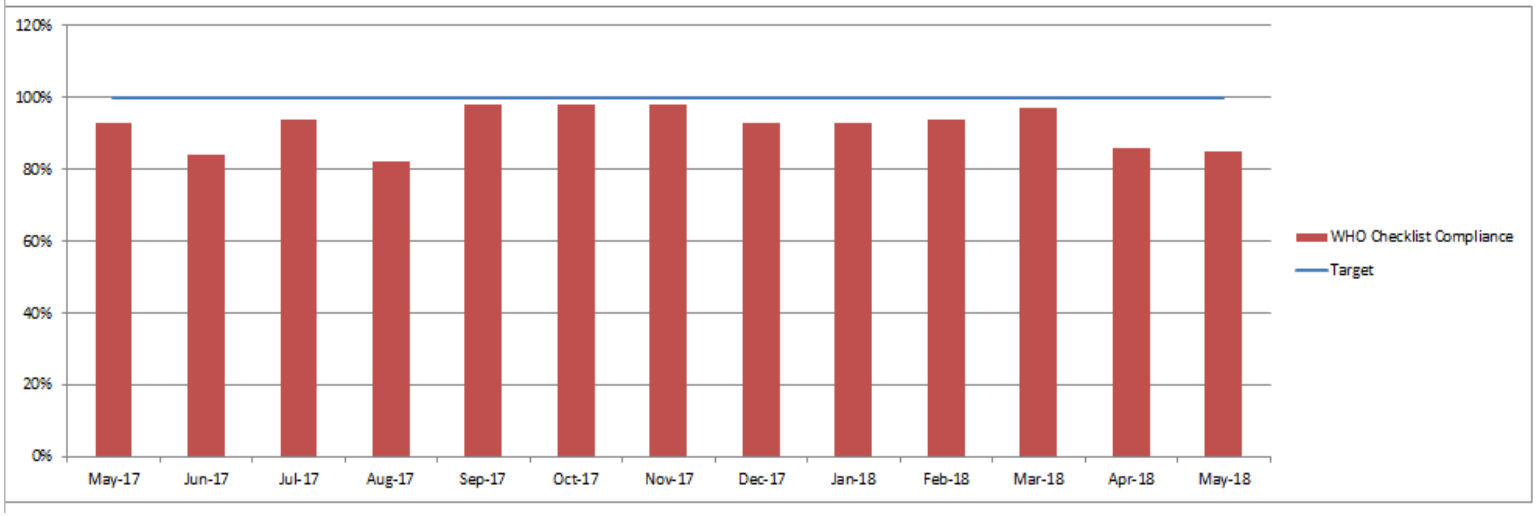
Due to the Maternity services compliance with completion of the WHO safety checklist we have asked to the Trust Governance department to look at our process. It was recognised that maternity is not following the trust process. Following discussion at the Divisional Quality meeting a decison was made to follow the trust process .

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

Actions in place to recover the performance

Expected timeframes for improvement

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



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. Discharge summary report

To RECEIVE an update

Presented by Nick Jenkins

Trust Open Board Meeting – 29th June 2018

Agenda item:	10			
Presented by:	Nick Jenkins, Medical Director			
Prepared by:	Sarah Jane Relf, e-Care/Global Digital Exemplar Operational Lead			
Date prepared:	15 June 2018			
Subject:	To receive update on discharge summary performance			
Purpose:	X	For information		For approval

Executive summary:
This paper provides an update on actions taken to date on improving our performance around distribution and quality of discharge summaries. The report also shows the impact of these interventions. The board is asked to note the report.

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:	*A discharge summary group meets every Wednesday morning and feeds into the trust quality group. The medical director chairs this meeting.*
Risk and assurance:	*The issue is listed on the corporate risk register and monitored through usual internal processes. The board receives an exception report through usual performance reporting.*
Legislation, regulatory, equality, diversity and dignity implications	*Compliance with national standards around discharge summary.*

Recommendation:
The Board is asked to note the report

1. Background

1.1 The clinical commissioning group (CCG) contract provides clear standards for timeliness of correspondence from the trust to primary care. In the current contract these are as shown below:

- Emergency/non elective (inpatient) discharge summaries – 95% sent within 24 hours of discharge
- ED discharge summaries – 95% sent within 24 hours of discharge
- Elective (inpatient / day case) discharge summaries – 85% within 24 hours of discharge
- Clinic letters – 85% sent within three working days.

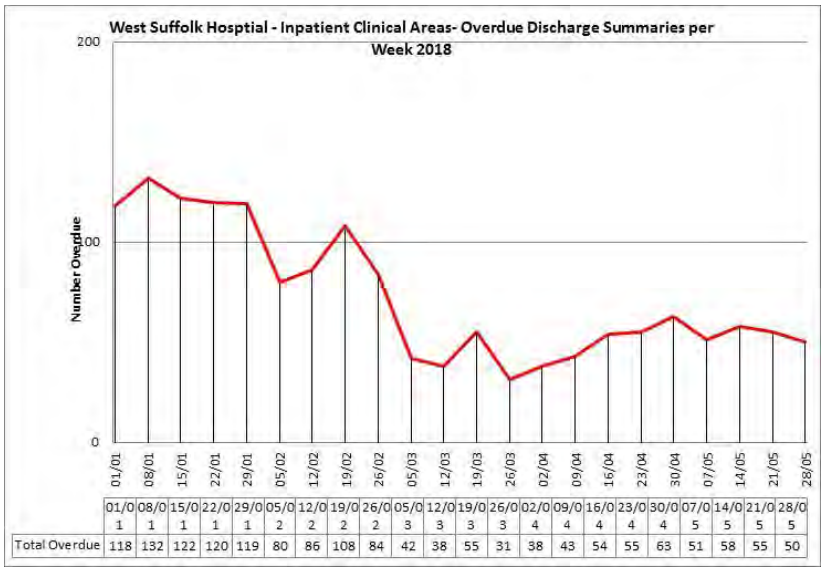
1.2 Currently the trust is underperforming against these targets and has been for some time now. As a result the medical director is leading on a turnaround project that is looking to improve this performance. A new dedicated post has been put in place to drive forward the key actions. Georgia Horobin is working as e-Care discharge summary coach and co-ordinator and reporting directly to the medical director to ensure delivery.

1.3 We are working very closely with the CCG and Local Medical Committee (LMC) to address these issues. All parties recognise that the timeliness targets described in 1.1 may not always be conducive with ensuring that the GP receives high quality information. On that basis we are working collaboratively on our current internal improvement activities and to ultimately agree targets that ensure that we are delivering quality documents in a timely fashion.

2. Timeliness

2.1 We have introduced a number of new reports into the organisation that are enabling managers to monitor how their own areas are performing against the CCG targets. This includes a real time option within e-Care for the wards and emergency department (ED) where they can see clearly which summaries have not been sent. This information is also centrally monitored enabling our discharge summary coach to identify where specific areas or clinicians may need extra support. Appendix A provides an example report.

2.2 The graph below shows the overall improvement in the number of overdue discharge summaries due to improved visibility.

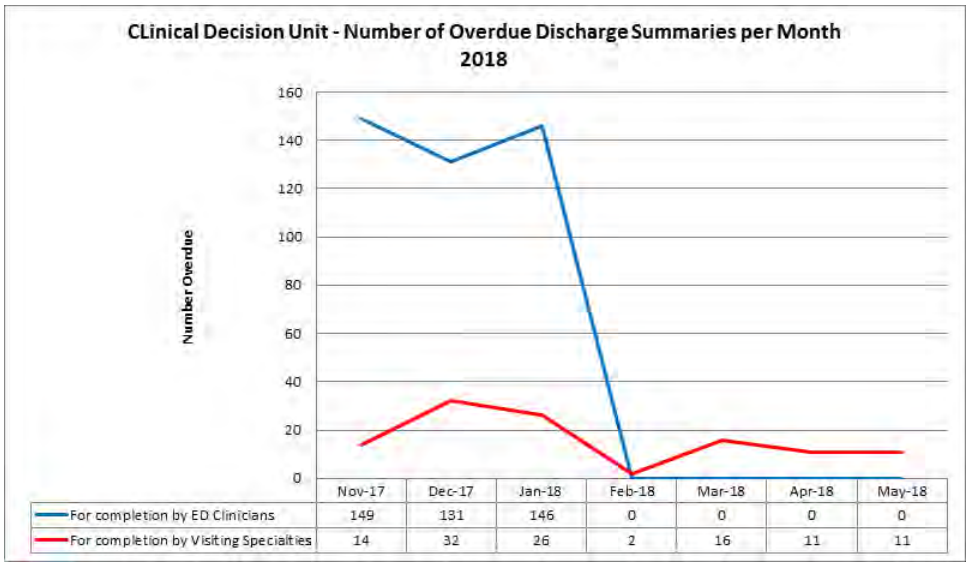


	01/01	08/01	15/01	22/01	29/01	05/02	12/02	19/02	26/02	05/03	12/03	19/03	26/03	02/04	09/04	16/04	23/04	30/04	07/05	14/05	21/05	28/05
Total Overdue	118	132	122	120	119	80	86	108	84	42	38	55	31	38	43	54	55	63	51	58	55	50

2.3 As a case study it is interesting to look at the performance of one of our high turnover inpatient areas (F8). In November 2017 they were taking on average 33.93 hours to complete and issue a discharge summary, which obviously sits outside of CCG targets and compromises optimal patient care. In June 2018 their average time is now 10.27 hours. They have also reduced their average numbers of overdue summaries from 35 per month (in November 2017) to 3 (in June 2018). These show how the new live reporting enables clinical areas to improve their performance significantly. Clearly our challenge is now to ensure that this improved performance can be sustained.

2.4 We are also centrally monitoring which summaries have been produced but not sent on a daily basis in ED (i.e. the clinical team has completed the narrative but not pressed the "send" button within e-Care). These are now being reviewed and sent by the team which provides us with a quick win to improve performance. As an example, an extra 200 summaries were sent in the last month as a result of this monitoring.

2.5 Our monitoring has clearly shown which areas are struggling to achieve the 24 hour target. Not surprisingly these tend to be our high turnover areas such as ED and clinical decision unit (CDU). The discharge summary coach is spending dedicated time with these areas on a daily basis to support them in adhering to agreed processes and workflows in order to improve performance. This includes working with clinicians that visit those areas to treat patients but that do not usually work in that environment. These are known as visiting clinicians. The graph below shows the improvement in performance with CDU from November 2017 to date. It is also shows that we have not seen the same improvements in performance for visiting clinicians and we are working with clinical directors to address this.



2.6 We have also identified specific areas that are not following the usual e-Care workflows and which therefore are impacting on our performance figures. For example when a patient attends the cardiology service within the day surgery unit they are classed as an inpatient for contracting purposes. However the clinician is dictating a clinic letter after the appointment which is then transcribed by the secretary and sent. The information is appropriate however this means we are missing the CCG performance target. We need to work with reporting and contracting to ascertain whether this workflow is correct and therefore inappropriately contained within the figures or whether the workflow needs to change. Either way, when implemented these changes should have an immediate effect on performance.

3. Quality

3.1 It is important that we have a clear understanding of any issues around quality of the information included within the discharge summary. We have established a dedicated inbox for discharge summary queries and issues. All internal and external colleagues are encouraged to use this. This central monitoring enables us to ensure that we are quick to respond and that we can identify any themes or recurrent issues.

3.2 This inbox is receiving on average 50 queries per week which are a combination of requests for missing summaries and/or requests for extra information. We are usually able to turnaround a response to these queries within 24 hours. This has been well received by colleagues within primary care. Since January this year we have dealt with 468 queries through this inbox. In essence we have opened a GP liaison function in the organisation by introducing this inbox and we need to think about how we resource this moving forward.

3.3 This central monitoring has enabled us to identify specific common errors that staff are making and we are then able to intervene and correct these before they are sent. For example in ED it is easy to select the wrong template to complete a discharge summary which means this does not get to the GP. We are now identifying this as it happens and correcting these so that they are sent. In addition we are coaching these staff to avoid them making the mistakes again. This equates to 5 ED summaries each week that were not previously reaching primary care that are now being sent in a timely manner. We are looking to see if there are any similar themes for inpatient wards.

4. Engagement

4.1 It is important that the organisation understands the importance of this issue and the actions we are taking to address this. As such the medical director is actively engaging the clinical leads for each division to support the required change in practice. We are also communicating to wider staff groups through all of the usual trust channels.

4.2 We have been actively engaging with CCG, Local Medical Committee (LMC) and primary care colleagues to ensure that they are aware of our efforts and to outline how they can support us. This has been well received. In addition our discharge summary coach has been visiting practices to ensure that we fully understand the issues from their perspective and to ensure we understand how the process works end to end. We will often partner with CCG colleagues for these visits to ensure consistency in understanding and messaging.

5. Looking forward

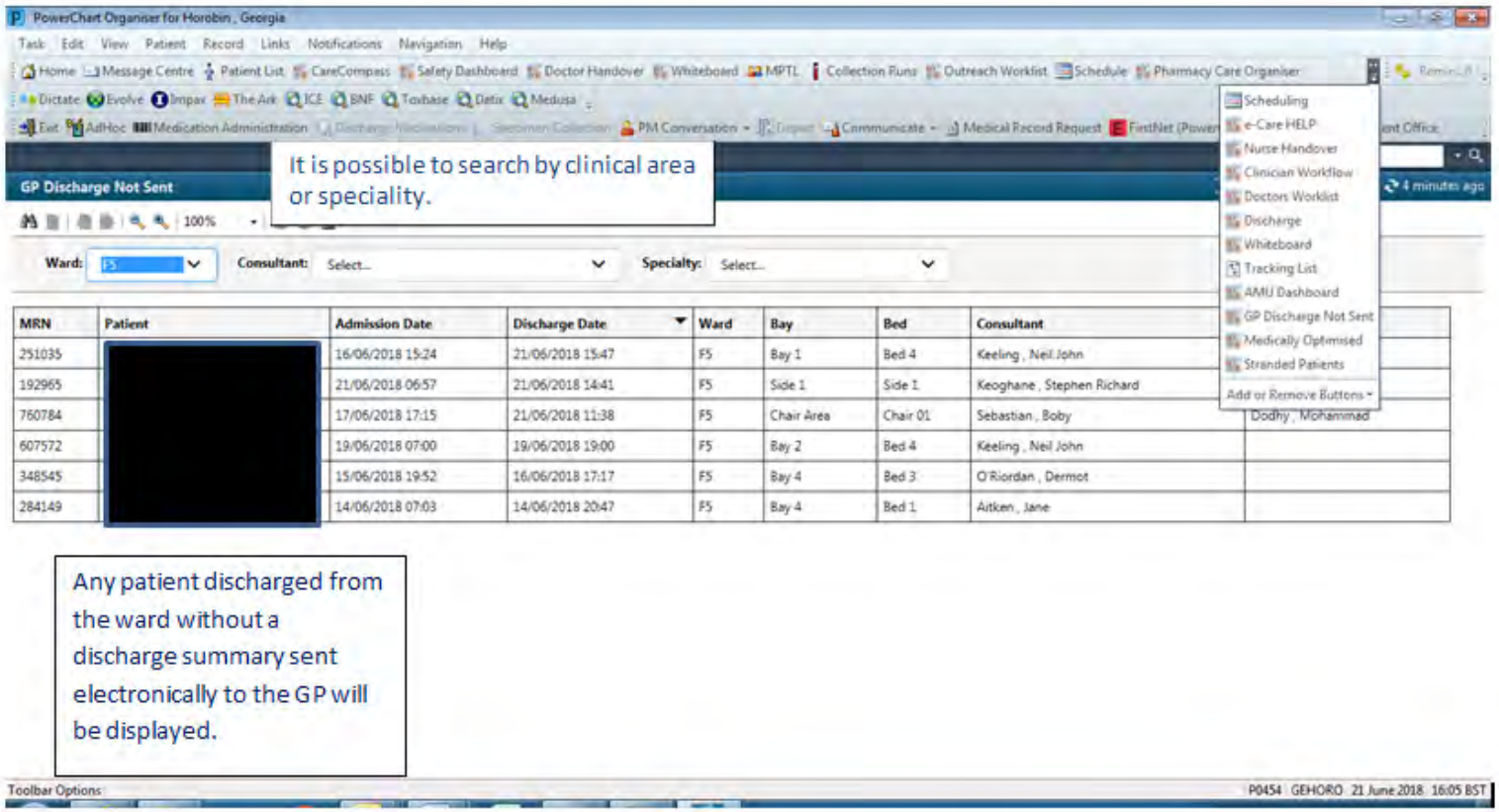
5.1 The improvements described above are around maximising the current discharge processes. However we are also working with Cerner to look at how we might improve the current e-Care workflows to support staff to do the right thing more easily. We hope to introduce a new depart workflow M page later this year which will provide a simpler and more intuitive process for staff to follow.

6. Recommendations

6.1 The board is asked to note the update on discharge summary performance.

Sarah Jane Relf
e-Care/GDE Operational Lead

Appendix A: Example real time report on outstanding discharges



Option can be selected from eCare Toolbar.

11. Finance and workforce report

To ACCEPT the report

Presented by Craig Black

Board of Directors – June 2018

Agenda item:	11			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	25th June 2018			
Subject:	Finance and Workforce Board Report – May 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, formerly STF) of £3.7m should A&E and Financial targets be met. Therefore the Trust is now planning on a net deficit of £10.1m for 2018-19.

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

The reported I&E for May 2018 is a deficit of £953k, against a planned deficit of £861k. This results in an adverse variance of £92k in month (£186k YTD). This overspend predominantly relates to expenditure on agency staff beyond the budget, partly in order to deliver the 92% RTT target.

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

May 2018 (Month 2)

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

Financial Summary

I&E Position YTD	£2.8m	loss
Variance against plan YTD	-£0.2m	adverse
Movement in month against plan	-£0.1m	adverse
EBITDA position YTD	-£1.2m	
EBITDA margin YTD	-69.4%	adverse
Total STF Received	£0.0m	
Cash at bank	£2,097k	

Executive Summary

- The Trust has agreed a control total of a deficit of £13.8m with NHS Improvement for 2018/19. As a result of this the Trust will have access to £3.7m PSF (formerly STF) this year. The planned deficit for the year is therefore £10.1m.
- We therefore have a CIP target of £12.2m (5%)
- The planned deficit for the year to date was £2.6m but the actual deficit was £2.8m, an adverse variance of £0.2m.
- Appendix A outlines the 17-18 reference costs submission

Key Risks

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

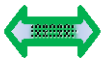
SUMMARY INCOME AND EXPENDITURE ACCOUNT - May 2018	May-18 Budget £m	May-18 Actual £m	May-18 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m	Year end forecast Budget	Year end forecast Actual	Year end forecast Variance F/(A)
NHS Contract Income	16.1	16.2	0.1	31.4	31.6	0.2	190.3	190.3	0.0
Other Income	2.7	2.6	(0.1)	5.4	5.2	(0.2)	33.2	33.2	0.0
Total Income	18.8	18.8	(0.0)	36.8	36.8	(0.0)	223.4	223.4	0.0
Pay Costs	12.6	13.0	(0.3)	25.0	26.0	(0.9)	151.4	151.4	0.0
Non-pay Costs	6.1	6.0	0.1	12.5	12.0	0.5	74.0	74.0	0.0
Operating Expenditure	18.7	19.0	(0.2)	37.5	37.9	(0.4)	225.4	225.4	0.0
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	0.1	(0.2)	(0.2)	(0.6)	(1.2)	(0.4)	(2.0)	(2.0)	0.0
Depreciation	0.7	0.6	0.1	1.4	1.2	0.2	8.2	8.2	0.0
Finance costs	0.3	0.2	0.1	0.6	0.5	0.1	3.6	3.6	0.0
SURPLUS/(DEFICIT) pre PSF	(0.9)	(1.0)	(0.1)	(2.6)	(2.8)	(0.1)	(13.9)	(13.9)	0.0
Provider Sustainability Funding (PSF)									
PSF - Financial Performance	0.0	0.0	0.0	0.0	0.0	0.0	2.6	2.6	0.0
PSF - A&E Performance	0.0	0.0	0.0	0.0	0.0	0.0	1.1	1.1	0.0
SURPLUS/(DEFICIT) incl PSF	(0.9)	(1.0)	(0.1)	(2.6)	(2.8)	(0.1)	(10.2)	(10.2)	0.0

FINANCE AND WORKFORCE REPORT – May 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 – May 2018

Income and Expenditure Summary as at May 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, formerly STF) of £3.7m should A&E and Financial targets be met. Therefore the Trust is now planning on a net deficit of £10.1m for 2018-19.

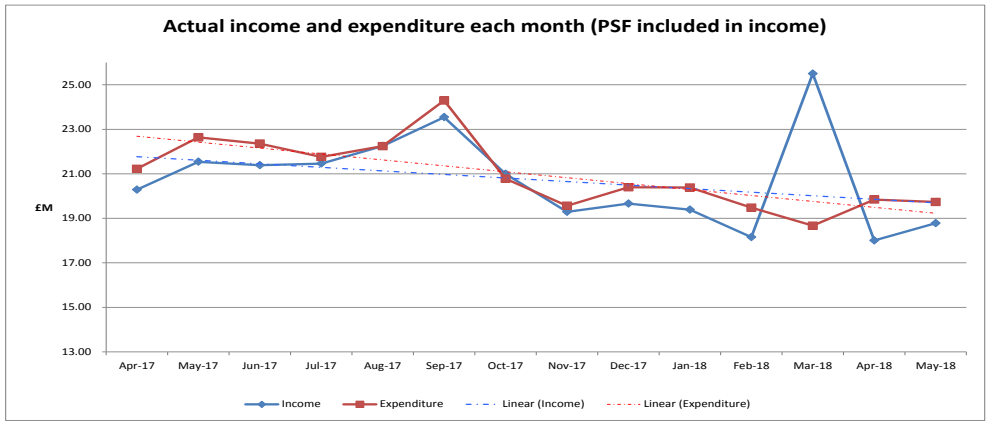
In order to achieve the control total the 2018-19 budgets now include a stretch CIP of £2.8m bringing the total CIP plan to £12.2m (5%). We have utilised the 2018-19 contingency of £1.5m in order to meet this stretch CIP.

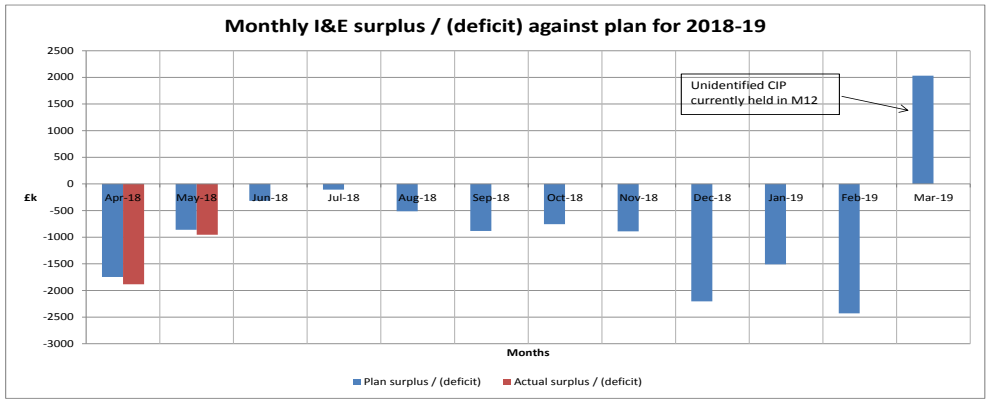
Our revised operating plan has been submitted on this basis. However, no PSF is yet included in the financial position.

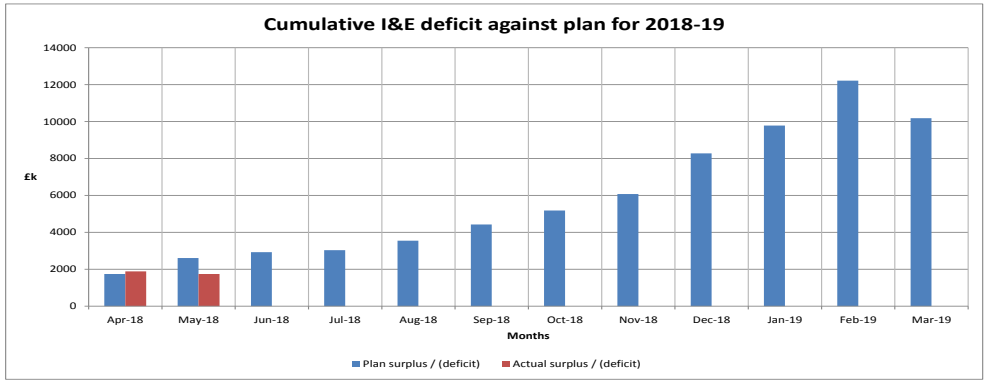
The reported I&E for May 2018 is a deficit of £953k, against a planned deficit of £861k. This results in an adverse variance of £92k in month (£186k YTD). This overspend predominantly relates to expenditure on agency staff above the budget, partly in order to deliver the 92% RTT target

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)	(861)	(953)	(92)	↓	Red
YTD surplus / (deficit)	(2,607)	(2,792)	(186)	↓	Red
Forecast surplus / (deficit)	(10,180)	(10,180)	0	↔	Green
EBITDA (excl STF) YTD	(628)	(1,164)	(536)	↓	Red
EBITDA (%)	(1.7%)	(3.2%)	(1.5%)	↓	Red
Clinical Income YTD	(31,431)	(31,624)	193	↑	Green
Non-Clinical Income YTD	(5,408)	(5,158)	(250)	↓	Red
Pay YTD	25,308	25,965	(657)	↓	Red
Non-Pay YTD	14,137	13,609	528	↑	Amber
CIP target YTD	1,362	1,319	(43)	↓	Red



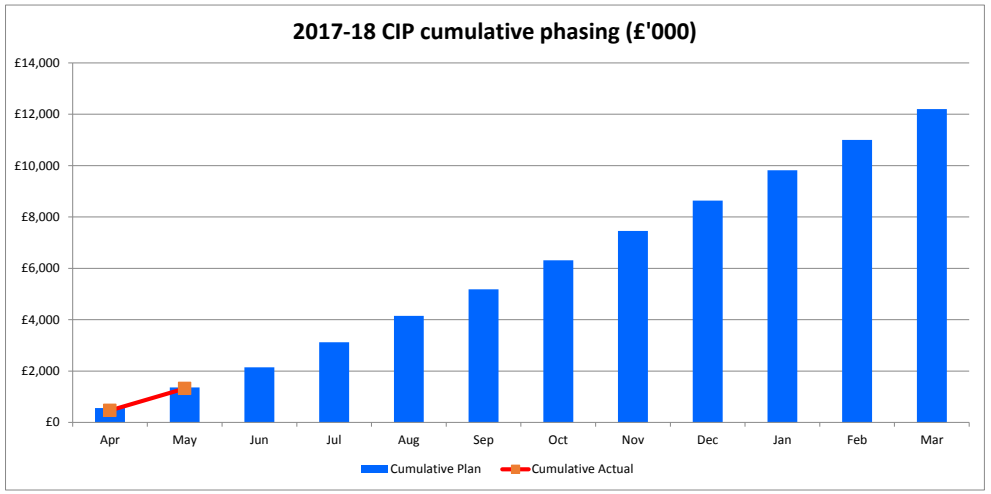


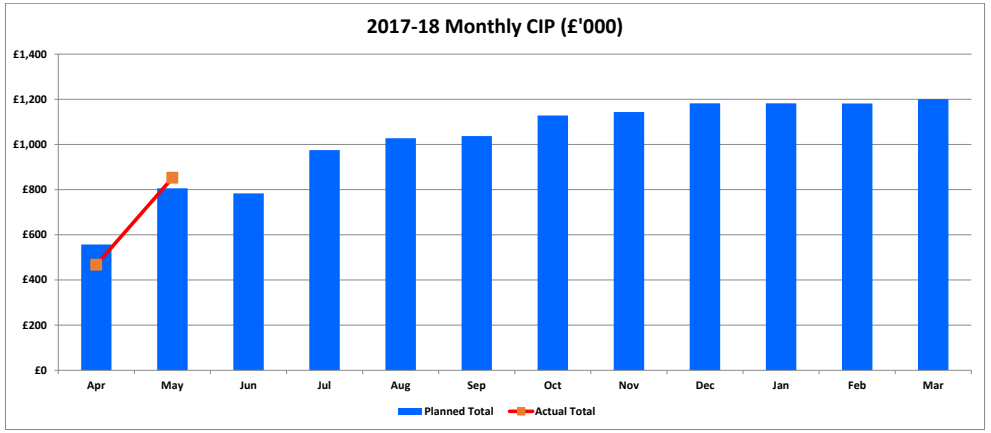


Cost Improvement Programme (CIP) 2018-19

The May position includes a target of £1,362k YTD which represents 11.2% of the 2018-19 plan. There is currently a shortfall of £43k YTD against this plan.

Recurring/Non Recurring	Summary	2018-19 Annual Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Clinical Income	653	78	79
	Activity growth	234	32	32
	Private Patients	78	13	-
	Other Income	890	81	36
	Consultant Staffing	1,076	7	-
	Nursing productivity	111	33	-
	Staffing Review	953	153	85
	Additional sessions	244	16	9
	Temporary Pay	1,028	157	156
	Agency	98	18	24
	Pay controls	20	3	-
	CNST discount	265	44	61
	Community Equipment Service	643	106	71
	Drugs	154	23	42
	Contract renegotiation	69	10	11
	Procurement	768	70	100
	Other	228	10	3
	Service Review	517	27	24
	Patient Flow	810	-	-
	Cancelled CIPs	163	2	-
Recurring Total		**9,000**	**884**	**735**
Non-Recurring	Contingency	1,500	250	250
	Additional sessions	268	7	7
	Contract review	105	-	26
	Other	1,327	221	301
Non-Recurring Total		**3,200**	**478**	**584**
Grand Total		**12,200**	**1,362**	**1,319**



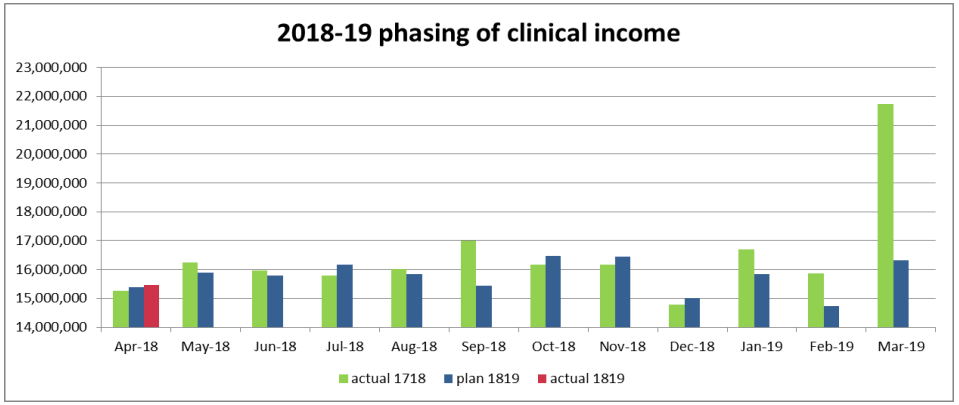


In order to deliver the Trust's control target deficit of planned deficit of £13.8m deficit in 2018-19 we need to deliver a CIP of £12.2m (5%).

FINANCE AND WORKFORCE REPORT – May 2018

Income Analysis

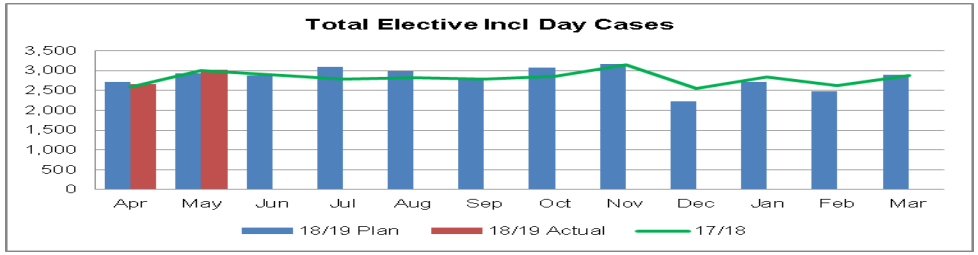
The chart below summarises the phasing of the clinical income plan for 2018-19, including Community Services. This phasing is in line with activity phasing which is how the income is recognised.

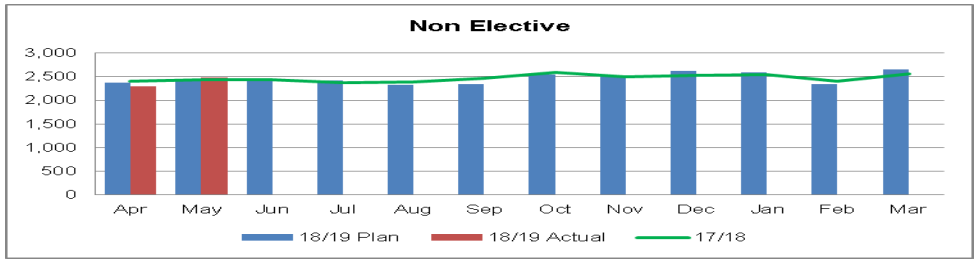


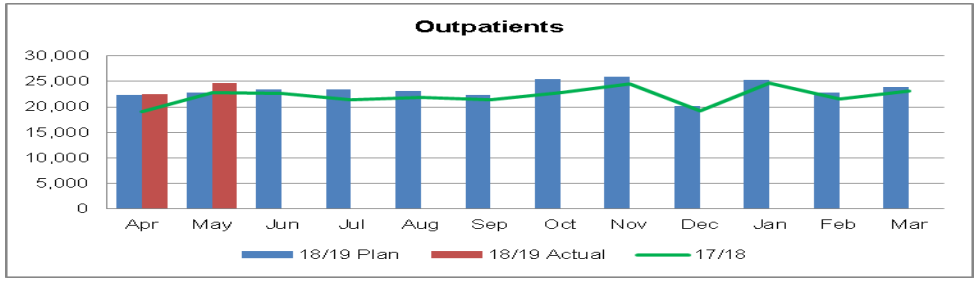
The income position was ahead of plan for May, with over performance being seen within both Outpatient and Non Electives and under performance within the Electives.

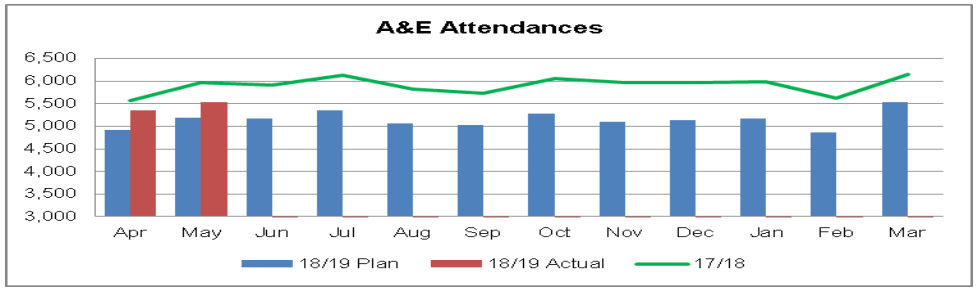
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	712	676	(37)	1,385	1,340	(45)
Other Services	2,505	2,606	101	4,831	5,062	231
CQUIN	319	318	(1)	624	625	1
Elective	3,029	2,821	(208)	5,805	5,452	(354)
Non Elective	5,447	5,482	35	10,756	10,923	167
Emergency Threshold Adjustment	(359)	(362)	(3)	(707)	(732)	(25)
Outpatients	2,765	2,978	213	5,470	5,688	218
Community	1,633	1,633	0	3,266	3,266	0
Total	**16,051**	**16,151**	**100**	**31,431**	**31,624**	**193**

Activity, by point of delivery

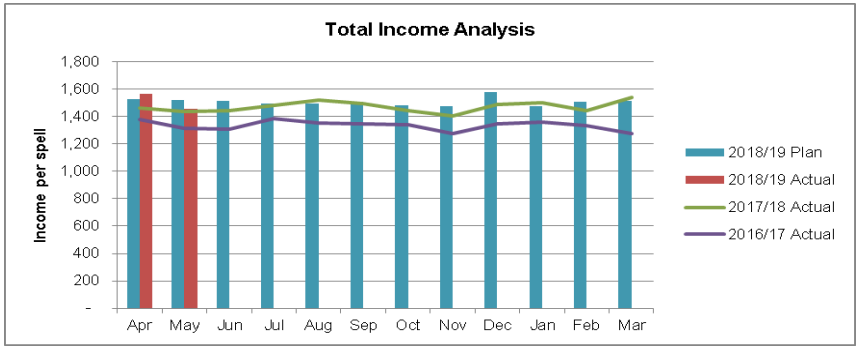


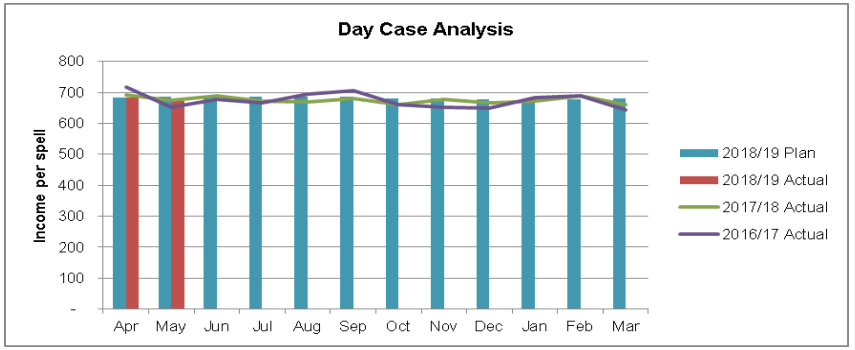


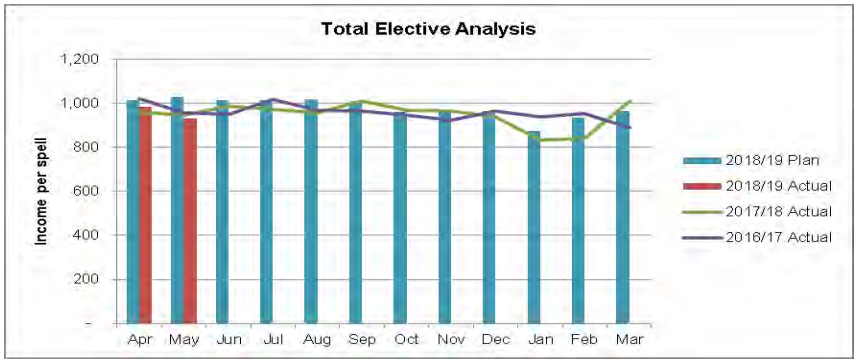


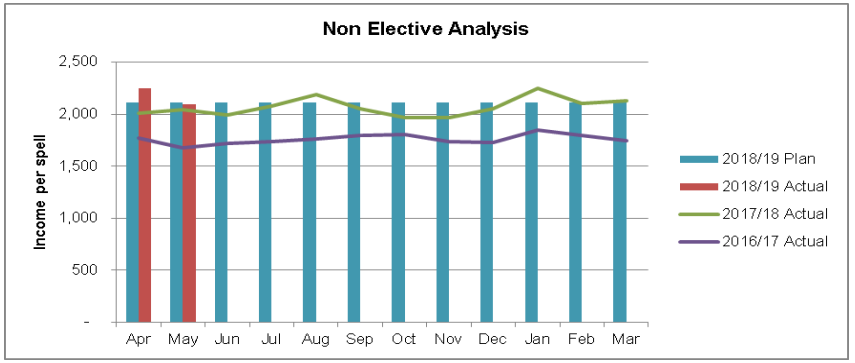


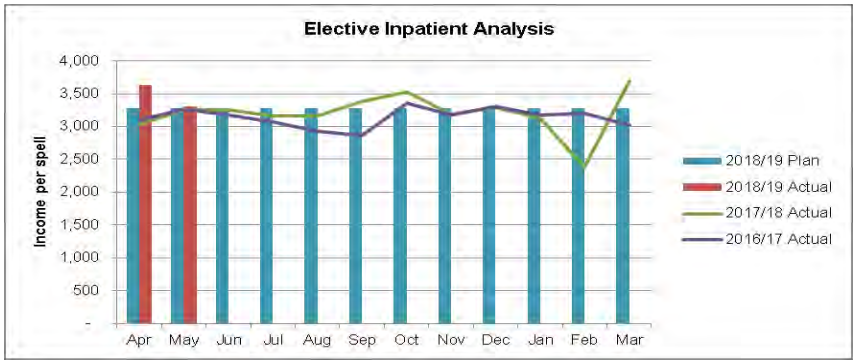
Trends and Analysis

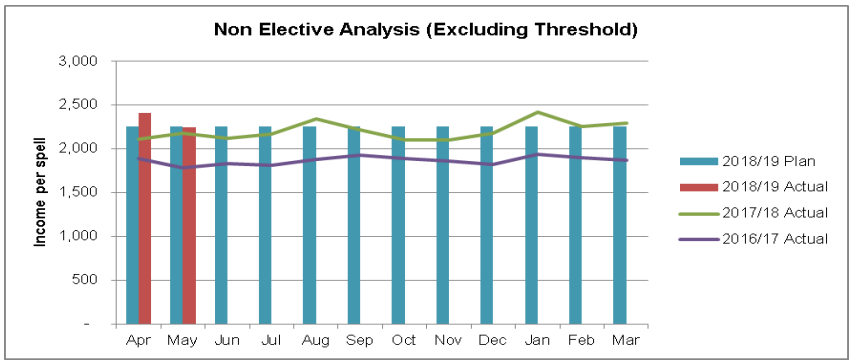












FINANCE AND WORKFORCE REPORT – May 2018

Workforce

Monthly Expenditure (£) Acute services only				
As at May 2018	May-18	Apr-18	May-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**11,109**	**11,167**	**11,163**	**22,275**
Substantive Staff	9,928	9,908	9,695	19,836
Medical Agency Staff (includes 'contracted in' staff)	76	132	136	207
Medical Locum Staff	225	256	231	481
Additional Medical sessions	298	298	263	597
Nursing Agency Staff	88	127	66	215
Nursing Bank Staff	459	347	154	806
Other Agency Staff	(6)	41	76	35
Other Bank Staff	104	145	133	250
Overtime	165	139	89	304
On Call	58	64	59	121
Total temporary expenditure	1,466	1,549	1,208	3,015
Total expenditure on pay	**11,394**	**11,457**	**10,903**	**22,851**
Variance (F/(A))	(285)	(290)	260	(576)
Temp Staff costs % of Total Pay	12.9%	13.5%	11.1%	13.2%
Memo : Total agency spend in month	157	300	278	457

Monthly Whole Time Equivalents (WTE) Acute Services only			
As at May 2018	May-18	Apr-18	May-17
	WTE	WTE	WTE
Budgeted WTE in month	**3,134.7**	**3,121.7**	**3,095.0**
Employed substantive WTE in month	**2765.43**	**2771.75**	**2725.03**
Medical Agency Staff (includes 'contracted in' staff)	9.43	12.67	14.74
Medical Locum	17.4	18.46	18.06
Additional Sessions	24.6	20.82	21.85
Nursing Agency	17.33	25.06	10.26
Nursing Bank	68.2	110.45	50.16
Other Agency	7.4	7.76	20.29
Other Bank	49.2	68.3	60.75
Overtime	56.39	41.67	40.99
On call Worked	7.74	8	11.23
Total equivalent temporary WTE	**257.7**	**313.2**	**248.3**
Total equivalent employed WTE	**3,023.1**	**3,084.9**	**2,973.4**
Variance (F/(A))	111.6	36.7	121.7
Temp Staff WTE % of Total Pay	8.5%	10.2%	8.4%
Memo : Total agency WTE in month	34.2	45.5	45.3

Sickness Rates	3.77%	3.81%	3.62%
Mat Leave	2.13%	2.23%	2.1%

Monthly Expenditure (£) Community Service Only				
As at May 2018	May-18	Apr-18	May-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,516**	**1,517**	**1,129**	**3,033**
Substantive Staff	1,504	1,461	1,049	2,964
Medical Agency Staff (includes 'contracted in' staff)	15	6	14	22
Medical Locum Staff	3	3	3	6
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	9	11	0	20
Nursing Bank Staff	23	14	16	37
Other Agency Staff	17	14	24	31
Other Bank Staff	7	7	7	14
Overtime	8	9	5	17
On Call	3	3	1	6
Total temporary expenditure	85	67	70	152
Total expenditure on pay	**1,589**	**1,528**	**1,120**	**3,117**
Variance (F/(A))	(73)	(11)	9	(84)
Temp Staff costs % of Total Pay	5.4%	4.4%	6.3%	4.9%
Memo : Total agency spend in month	42	31	38	73

Monthly Whole Time Equivalents (WTE) Community Services Only			
As at May 2018	May-18	Apr-18	May-17
	WTE	WTE	WTE
Budgeted WTE in month	**485.56**	**482.69**	**380.57**
Employed substantive WTE in month	**465.73**	**458.75**	**343.1**
Medical Agency Staff (includes 'contracted in' staff)	0.42	0.42	1.5
Medical Locum	0.35	0.35	0.4
Additional Sessions	0.00	0.00	0.0
Nursing Agency	1.96	2.05	0.1
Nursing Bank	3.95	4.86	5.1
Other Agency	3.93	3.62	9.9
Other Bank	2.23	2.30	2.2
Overtime	2.43	2.61	2.5
On call Worked	0.00	0.00	0.0
Total equivalent temporary WTE	**15.27**	**16.21**	**21.5**
Total equivalent employed WTE	**481**	**474.96**	**364.6**
Variance (F/(A))	4.56	7.73	16.0
Temp Staff WTE % of Total Pay	3.2%	3.4%	5.9%
Memo : Total agency WTE in month	6.3	6.1	11.4

Sickness Rates (Feb / Jan)	3.62%	3.61%	3.80%
Mat Leave	1.13%	2.45%	1.1%

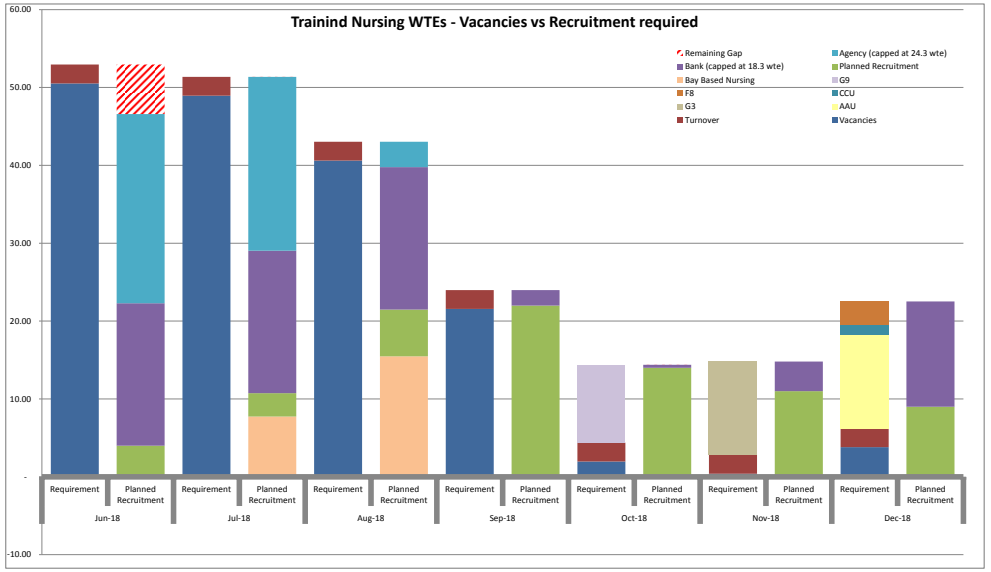
* Note the Acute tables includes Collaborative Procurement Hub staff on WSH Contracts
* Note that pay costs and WTE are gross, ie do not net off income or WTE relating to salary costs recharged to other organisations.

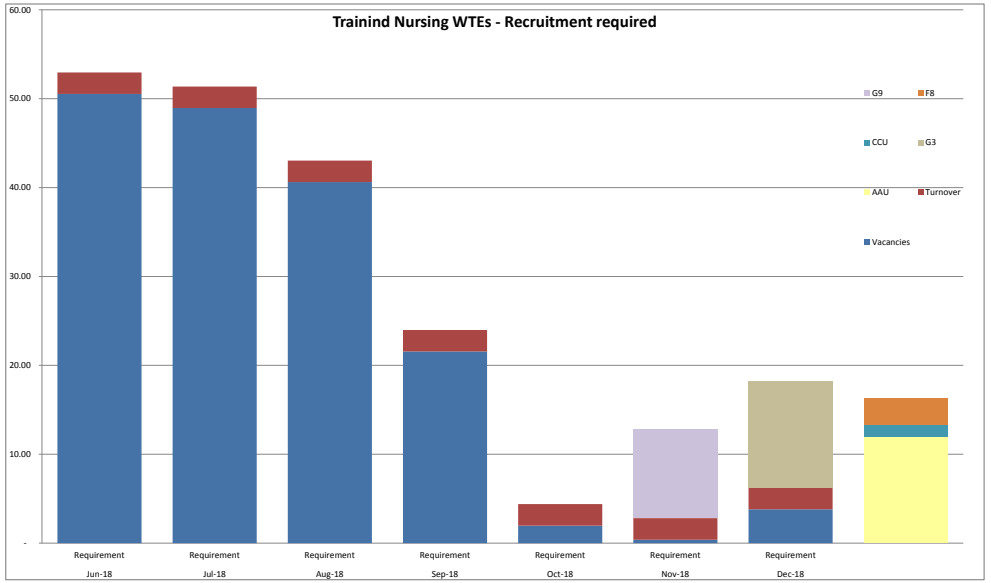
Staffing levels

Staffing for Winter Capacity

The following graphs demonstrate the likely recruitment required, and how these posts will be filled. They are dependent on a number of assumptions that will be monitored over the coming months :

- Turnover is as planned
- Bay based nursing service changes as planned
- New winter capacity opened as planned
- Recruitment is as planned (especially overseas)
  - overseas nurses fill unqualified posts for 12 weeks
  - then able to fill qualified posts
- Maximum bank staff used :
  - Qualified - 18.3 wte and unqualified - 35.3 wte
  - Assume that these staff are available
- Maximum agency staff used :
  - Qualified - 24.3 wte
  - Assume that these staff are available

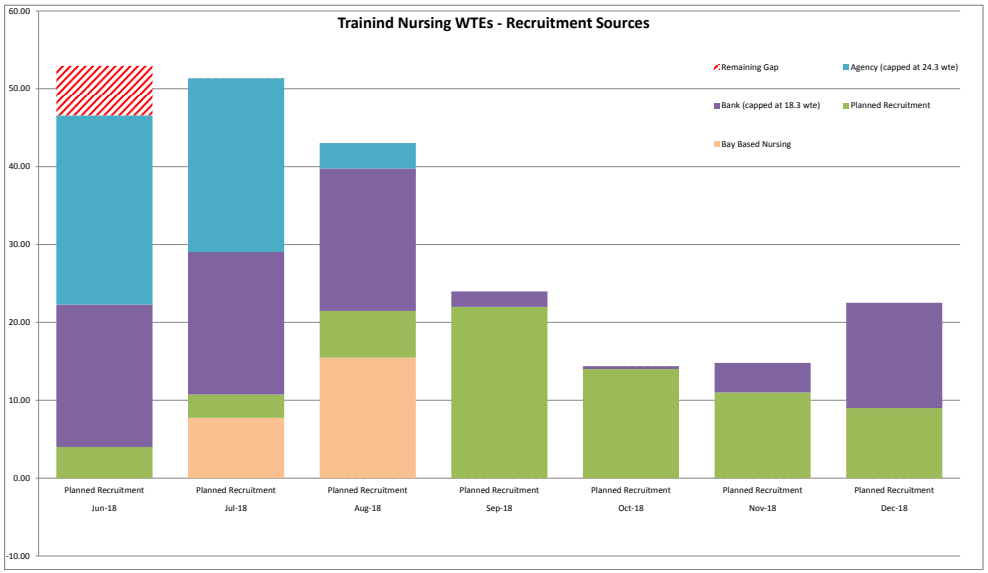


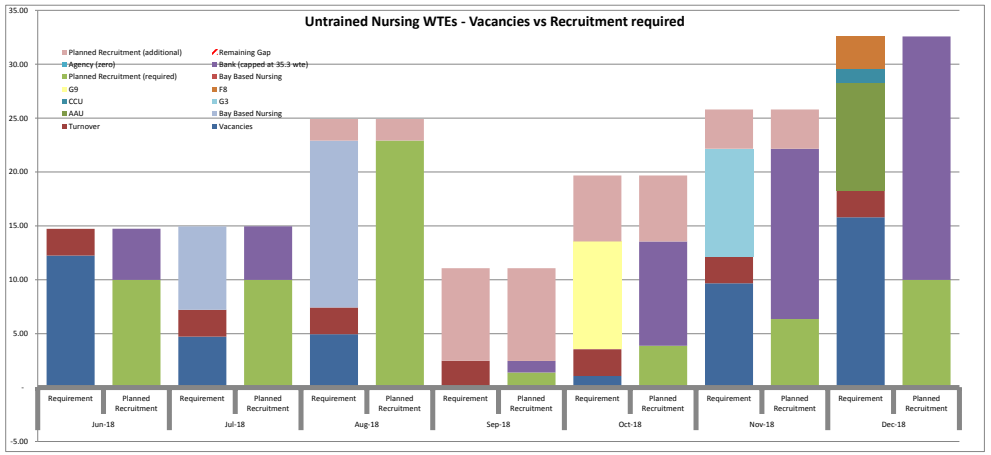


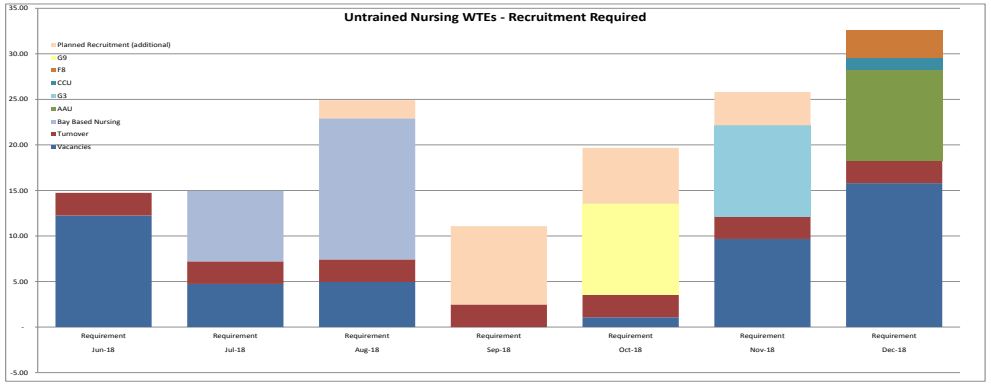
Qualified Nursing

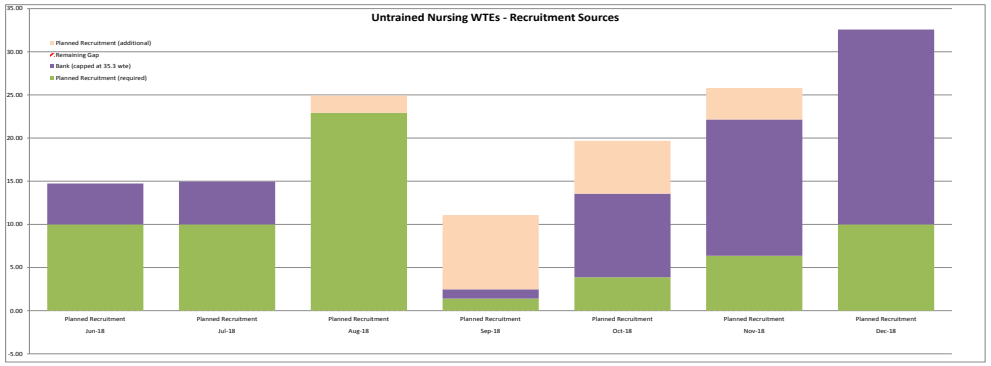
Changes in Qualified Nursing WTEs	Increase in Vacancies	Decrease in Vacancies
Monthly turnover (assumed)	2.4 per month	
Bay Based Nursing - July		7.7
Bay Based Nursing - August		15.5
Recruitment from Graduates - September		5.0
Recruitment from Overseas - September and October		20.0
G9 open - October	12.0	
G3 backfill - November	10.0	
Additional Assessment Capacity - December	10.0	
DOSA on CCU - December	1.3	
Overnight on F8 - Dcember	3.0	
Uisng Bank staff		up to 18.3
Uisng Agency staff		up to 24.3
Other rmonthly recruitment as planned		varies

FINANCE AND WORKFORCE REPORT – May 2018









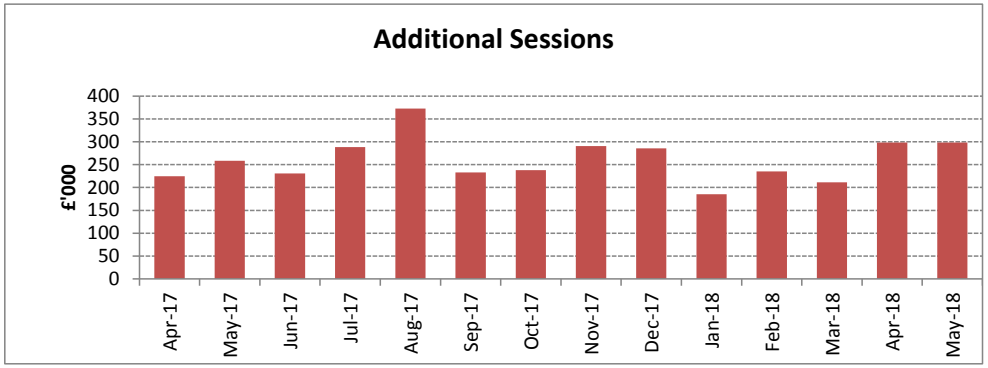
Unqualified Nursing

Changes in Unqualified Nursing WTEs	Increase in Vacancies	Decrease in Vacancies
Monthly turnover (assumed)	2.5 per month	
Bay Based Nursing - July	7.7	
Bay Based Nursing - August	15.5	
Recruitment from overseas - September		15.0
G9 open - October	10.0	
G3 backfill - November	10.0	
Additional Assessment Capacity - December	10.0	
DOSA on CCU - December	1.3	
Overnight on F8 - Dcember	3.0	
Uisng Bank staff		up to 35.3
Other rmonthly recruitment as planned		varies

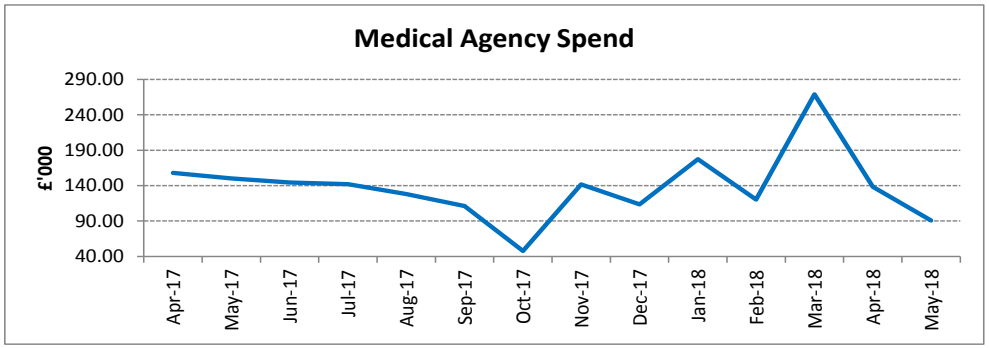
FINANCE AND WORKFORCE REPORT – May 2018

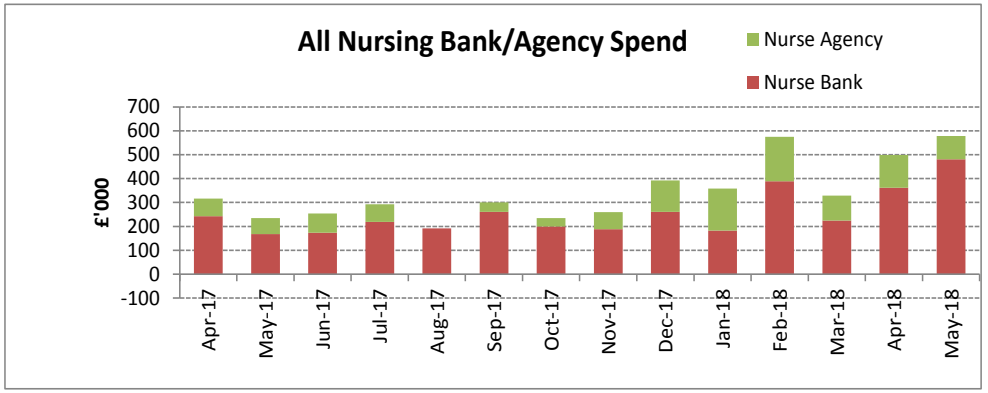
Pay Trends and Analysis

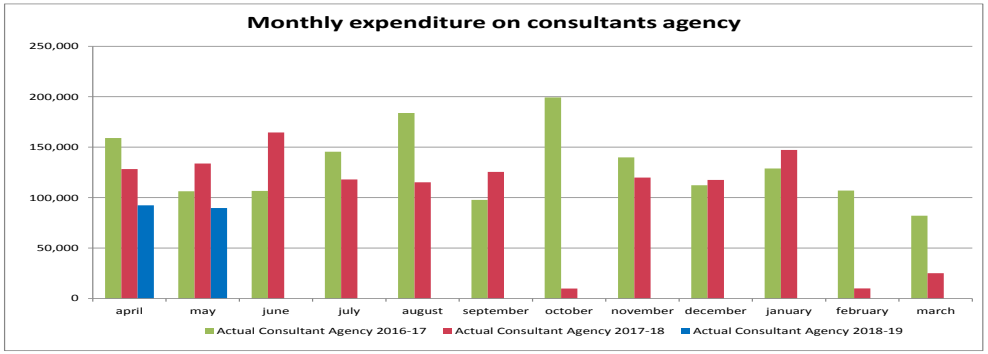
The Trust spent £358k more than budget on pay in May (£657k overspent YTD)

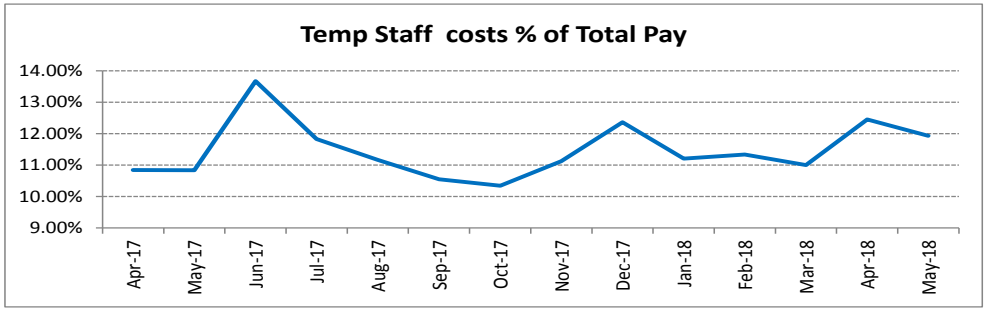


Medical Staff Agency Costs by Speciality	M2 - YTD £'000
Urology	77.4
Anaesthetics	71.9
Cardiology	56.5
Gastroenterology	55.4
Eau Medical Staff	53.2
Medicine - Consultants	50.6
Ophthalmology	44.2
Medicine - Junior Doctors	44.1
Obstetrics	42.2
Trauma & Orthopaedic	31.8
Xray - Wsh	28.8
General Surgery	28.4
Histopathology	23.6
E.N.T.	21.0
Diabetes	15.9
Dermatology	13.5
Plastic Surgery	10.7
Total	**669.1**









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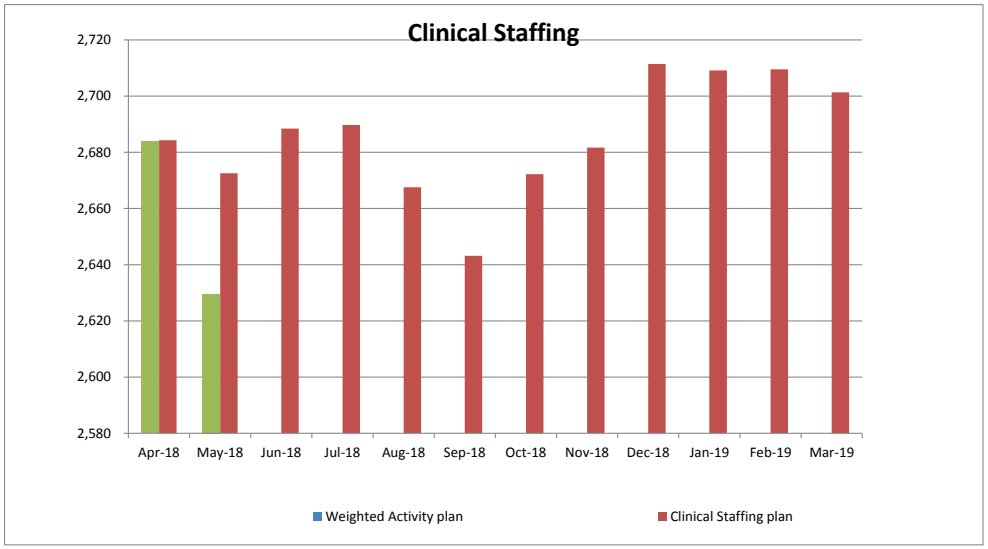
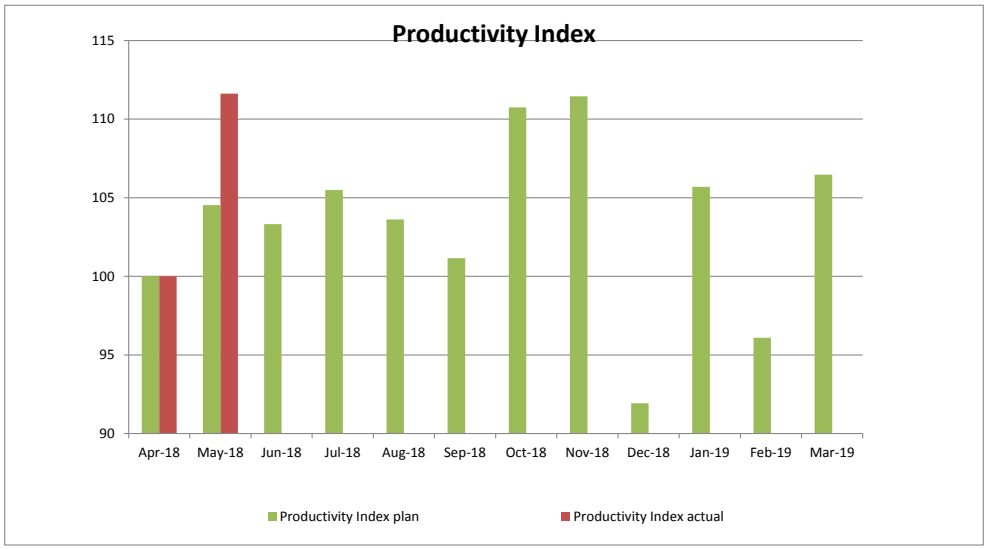
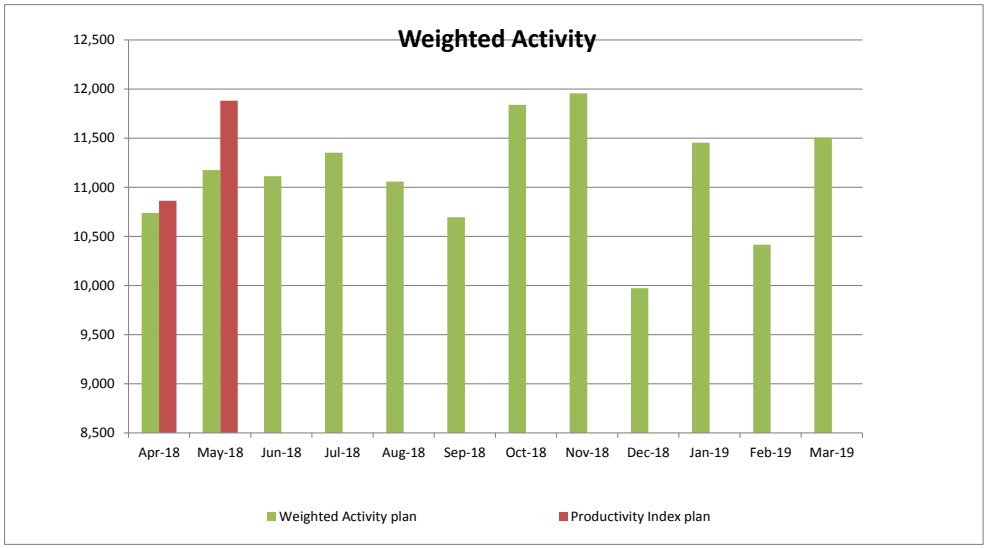
Staffing Productivity







FINANCE AND WORKFORCE REPORT – May 2018

Summary by Directorate

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	May-18 Budget £k	May-18 Actual £k	May-18 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	(5,732)	(5,937)	205	(11,296)	(11,621)	325
Pay Costs	3,461	3,629	(168)	6,957	7,258	(302)
Non-pay Costs	1,328	1,410	(81)	2,765	2,768	(3)
Operating Expenditure	**4,789**	**5,039**	**(249)**	**9,721**	**10,026**	**(305)**
SURPLUS / (DEFICIT)	**942**	**898**	**(44)**	**1,575**	**1,594**	**20**
SURGERY						
Total Income	(5,094)	(4,971)	(123)	(9,931)	(9,913)	(18)
Pay Costs	2,945	3,000	(55)	5,875	6,031	(156)
Non-pay Costs	1,110	1,105	5	2,268	2,264	5
Operating Expenditure	**4,055**	**4,105**	**(50)**	**8,143**	**8,295**	**(151)**
SURPLUS / (DEFICIT)	**1,039**	**866**	**(173)**	**1,788**	**1,619**	**(169)**
WOMENS and CHILDRENS						
Total Income	(2,077)	(2,089)	12	(3,989)	(3,849)	(140)
Pay Costs	1,122	1,158	(36)	2,244	2,314	(70)
Non-pay Costs	183	160	22	320	313	8
Operating Expenditure	**1,304**	**1,318**	**(14)**	**2,565**	**2,627**	**(62)**
SURPLUS / (DEFICIT)	**772**	**770**	**(2)**	**1,424**	**1,222**	**(202)**
CLINICAL SUPPORT						
Total Income	(729)	(754)	26	(1,633)	(1,657)	24
Pay Costs	1,301	1,268	33	2,602	2,583	19
Non-pay Costs	961	984	(23)	1,947	2,019	(72)
Operating Expenditure	**2,261**	**2,252**	**10**	**4,549**	**4,602**	**(53)**
SURPLUS / (DEFICIT)	**(1,533)**	**(1,497)**	**36**	**(2,916)**	**(2,945)**	**(30)**
COMMUNITY SERVICES						
Total Income	(3,995)	(4,043)	48	(7,056)	(7,021)	(36)
Pay Costs	1,987	2,046	(59)	3,981	4,045	(64)
Non-pay Costs	1,008	998	10	1,507	1,546	(39)
Operating Expenditure	**2,995**	**3,044**	**(49)**	**5,488**	**5,591**	**(103)**
SURPLUS / (DEFICIT)	**1,000**	**999**	**(1)**	**1,568**	**1,430**	**(139)**
ESTATES and FACILITIES						
Total Income	(382)	(385)	4	(763)	(722)	(41)
Pay Costs	752	728	23	1,503	1,468	35
Non-pay Costs	579	549	31	1,211	1,038	173
Operating Expenditure	**1,331**	**1,277**	**54**	**2,715**	**2,507**	**208**
SURPLUS / (DEFICIT)	**(949)**	**(892)**	**57**	**(1,951)**	**(1,785)**	**166**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	(1,058)	(601)	(456)	(2,779)	(2,000)	(778)
Pay Costs	1,058	1,153	(95)	2,146	2,265	(119)
Non-pay Costs (net of contingency and reserves)	1,161	768	393	2,750	2,034	716
Finance & Capital	972	778	194	1,978	1,628	350
Operating Expenditure	**3,190**	**2,699**	**492**	**6,874**	**5,927**	**946**
SURPLUS / (DEFICIT)	**(2,133)**	**(2,098)**	**35**	**(4,094)**	**(3,927)**	**167**
TOTAL (including penalties, contingency and reserves)						
Total Income	(19,065)	(18,780)	(285)	(37,448)	(36,782)	(665)
Contract Penalties	0	0	0	0	0	0
Pay Costs	12,624	12,982	(358)	25,308	25,965	(657)
Non-pay Costs	6,329	5,973	356	12,768	11,981	787
Finance & Capital	972	778	194	1,978	1,628	350
Operating Expenditure (incl penalties)	**19,926**	**19,733**	**193**	**40,055**	**39,575**	**480**
SURPLUS / (DEFICIT)	**(861)**	**(953)**	**(92)**	**(2,607)**	**(2,792)**	**(186)**

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

Medicine (Nicola Cottington)

The division was £44k behind plan for the month, £20k ahead YTD.

Contract income was £194k above plan, with all areas except ED exceeding target. ED is being investigated as activity was above plan but income is below. The Department achieved 93.17% against the 4 hour wait target – ranking it 23 out of 137 Type 1 units, and significantly above the national average (85.14%). Performance in April though, will mean that the Trust cannot better 95.12% - the trigger for STF funding for the quarter. Performance was aided by GP ED streaming seeing an improvement in patients per day (12.88) from previous months and GP Expecteds being diverted to AAU.

Elective and outpatient work was £96k above plan. Additional sessions were worked in Gastroenterology, Cardiology and Dermatology, which were not funded. The Division improved by a further 0.4% in the month, averaging 98.1% across all specialties and aiding the Trust to exceed the target in total (92.1%).

Expenditure was overspent by £236k, all due to technical adjustments, rather than performance. The overspend on pay (£168k) was due to back-pay in respect of overtime incentives for the 2017/18 winter period. The non-pay overspend (£81k), related to under accruals in April

CIP performance was £35k behind plan (£107k) in the month, and is forecast to be £423k behind plan (£1,856k) for the full year, before allocation of cross-cutting CIPs. Despite creating a number of new schemes, the Division is unlikely to bridge the gap caused by delays in introducing biosimilars and the Angio/Pacing suite. The phasing of CIPs is split 40/60 between the two halves of the year.

Surgery (Simon Taylor)

The Division has underperformed by £173k (£169k YTD).

Clinical income under achieved against plan by £123k in the month. Outpatients overachieved by £185k across most specialties whilst admitted care underachieved by £180k, with both elective and non-elective underperforming against plan. Most of the admitted care underperformance was in T&O which under achieved against plan by £234k. Critical Care underachieved plan by £50k.

Pay is overspent by £55k. This is due to temporary staffing (£197k) to cover rota gaps caused by vacancies and long term absences, and some additional sessions. The staffing groups which have overspent are Medical staff (£34k) to

support RTT recovery and vacancies, and Nursing staff (£37k), of which £24k relates to the incentive payments offered to cover winter pressures.

Non-pay is underspent by £5k although this would have been over spent if Surgery had been able to fully deliver the Elective plan in May.

CIP is overachieving by £34k. However, this is mainly due to non-recurrent savings. Surgery is still forecasting an underperformance against their CIP target.

Women and Children's (Rose Smith)
In May, the Division reported a deficit of £2k and a deficit of £202k YTD.

Income reported £12k ahead of plan in-month and is £140k behind plan YTD. In month, part pathway maternity income was higher than expected. Year to date, inpatient activity has been behind plan which explains the majority of the year to date variance.

Pay reported a £36k overspend in-month and is £70k overspent YTD. In-month, gaps in the middle grade rota in Obstetrics & Gynaecology were covered with agency and locum registrars. In addition, a vacancy in the Obstetrics and Gynaecology consultant rota was covered by spending on agency and locum consultants. Year to date, the medical staffing issues in Obstetrics & Gynaecology have been a persistent issue and spend in Midwifery has been higher because of the back payment of winter pressures overtime incentives.

Non pay reports a £22k underspend in-month and £8k underspend YTD. These underspends reflect the fact that inpatient activity has been lower than expected in the first two months of the financial year.

Clinical Support (Rose Smith)
In May, the Division reported a surplus of £36k and a deficit of £30k YTD.

Income for Clinical Support reported £26k ahead of plan in-month and is £24k ahead of plan YTD. In month, the radiology department saw a higher number of direct access and breast screening patients. This has also dictated the year to date position.

Pay is £33k underspent in-month and is £19k underspent YTD. In month, the majority of the underspend can be attributed to the Radiology Service as it ceased the agency spend on Sonographers and has vacancies at AHP level. Year to date, the pathology and radiology services have had difficulties in filling the gaps in the senior medical rotas and are currently employing unbudgeted locums. The vacant posts have gone out to advert and, so far, a microbiologist has been recruited.

Non pay reported a £23k overspend in-month and is £72k overspent YTD. This is due to stock adjustments that have been performed to adjust the financial value of the drugs held by the Trust.

Community Services (Dawn Godbold)
The division reported a £1k overspend in month(£139k YTD).

Overall income reported a £48k over recovery in month and £36k under recovery YTD. This is split between contract income for integrated therapies under recovered by £12k and other clinical income over recovery of £60k.

Other clinical income over recovery of £61k includes a one off income adjustment within Paediatrics plus additional income for complex nursing team additional posts, resulting in a £40k over-recovery of income and an EIT income adjustment relating to EIT night service rechargeable to SCC, resulting in a £7k variance.

Pay reported a £59k over spend in month and £64k overspend YTD. Main overspends include staffing overspends in both Glastonbury Court and Rosemary Ward due to additional hours being used to cover staff sickness and phased returns accounting for overspends of £10k and £9k respectively.

Additional recruitment of nursing posts within the paediatric complex nursing team, creating a £9k overspend. This additional recruitment is being funded by CCG via a service variation and is reflected within the income variance.

Non pay reported a £10k underspend in month and £53k overspend YTD. The main in month overspends include additional spend within CES, part underachievement of CIP and part increase in demand.

Use of Resources (UoR) Rating

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

The key features of the UOR ratings are as follows:

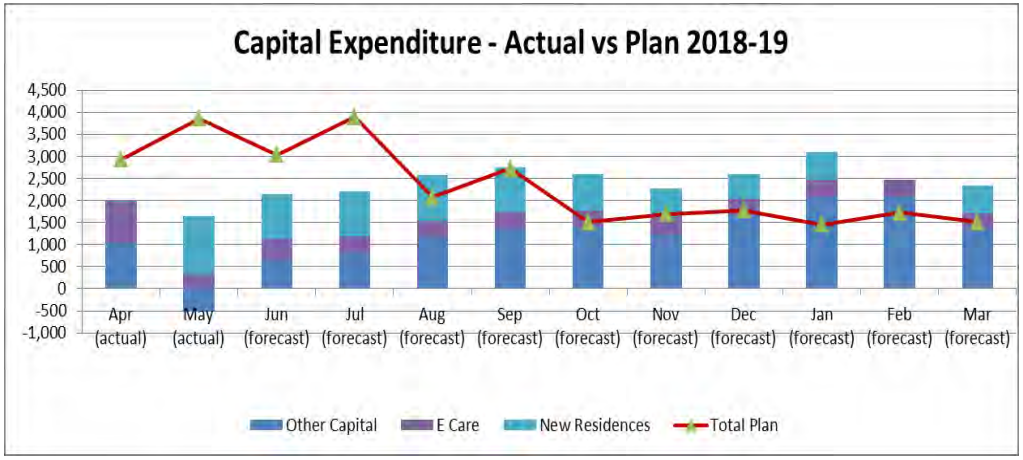
- 1 is the highest score and 4 is the lowest
- The I&E margin ratio is based on a control total basis rather than normalised surplus (deficit).
- The Agency rating measures expenditure on agency staff as a proportion of the ceiling set for agency staff. A positive value indicates an adverse variance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

Metric	Value	Score
Capital Service Capacity rating	-1.635	4
Liquidity rating	-16.832	4
I&E Margin rating	-7.48%	4
I&E Margin Variance rating	3.02%	1
Agency	-45.78%	1
Use of Resources Rating after Overrides		3

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

The I & E margin rating and the Capital Service Capacity rating are closely linked and reflect the Trust is not generating a surplus in revenue to fund capital expenditure. There will be some improvement once the NHSI ratings are adjusted to reflect the Trust has now agreed a control total and will therefore be earning PSF subject to financial and ED performance.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Forecast £'000	Jul Forecast £'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	322	438	380	380	380	380	380	380	380	380	384	5,100
New Residences	37	1,329	1,038	1,030	1,027	1,027	819	663	559	636	0	610	8,774
Other Schemes	1,047	-516	677	804	1,162	1,352	1,396	1,239	1,658	2,079	2,079	1,334	14,312
Total / Forecast	1,999	1,135	2,153	2,214	2,568	2,759	2,595	2,282	2,597	3,095	2,459	2,328	28,186
Total Plan	2,932	3,855	3,031	3,895	2,074	2,721	1,510	1,690	1,784	1,455	1,730	1,509	28,186

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 from April 2019.

At this point in the year the phasing of schemes is subject to change.

Expenditure on e-Care for the year to date is £1,238k with a forecast for the year of £5,100k.

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 forecasts for all projects have been reviewed by the relevant project managers. There are no significant financial risks to the budgets reported. Year to date the overall expenditure of £3,135k is below the plan of £6,787k.

Statement of Financial Position at 31st May 2018

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2018 * £000	Plan 31 March 2019 £000	Plan YTD 31 May 2018 £000	Actual at 31 May 2018 £000	Variance YTD 31 May 2018 £000
Intangible assets	23,852	26,841	23,705	24,738	1,033
Property, plant and equipment	94,170	111,911	97,850	95,342	(2,508)
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**	**142,677**	**125,480**	**124,005**	**(1,475)**
Inventories	2,712	2,600	2,600	2,865	265
Trade and other receivables	21,413	24,961	20,284	21,601	1,317
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	3,601	1,050	4,550	2,097	(2,453)
Total current assets	**27,726**	**28,611**	**27,434**	**26,563**	**(871)**
Trade and other payables	(26,135)	(27,274)	(25,146)	(26,052)	(906)
Borrowing repayable within 1 year	(3,114)	(2,729)	(2,838)	(3,083)	(245)
Current ProvisionsProvisions	(94)	(61)	(61)	(94)	(33)
Other liabilities	(963)	(1,295)	(1,295)	(4,978)	(3,683)
Total current liabilities	**(30,306)**	**(31,359)**	**(29,340)**	**(34,207)**	**(4,867)**
Total assets less current liabilities	**119,367**	**139,929**	**123,574**	**116,361**	**(7,213)**
Borrowings	(65,391)	(101,984)	(73,547)	(65,181)	8,366
Provisions	(124)	(158)	(158)	(124)	34
Total non-current liabilities	**(65,515)**	**(102,142)**	**(73,705)**	**(65,304)**	**8,401**
Total assets employed	**53,852**	**37,787**	**49,869**	**51,056**	**1,187**
Financed by					
Public dividend capital	65,803	66,353	65,803	65,803	(0)
Revaluation reserve	8,021	8,021	8,021	8,021	0
Income and expenditure reserve	(19,974)	(36,587)	(23,955)	(22,767)	1,188
Total taxpayers' and others' equity	**53,850**	**37,787**	**49,869**	**51,056**	**1,187**

Non-Current Assets

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

Trade and Other Receivables

These have increased by £3.2m in May but are still £1.3m below plan. Included within the total is £5.3m for 2017/18 Sustainability and Transformation Fund, £0.3m 2018/19 Provider Sustainability Fund, £6.5m deposits for community equipment and £1.2m prepayments for contracts and leases as well as £5.0m invoices raised.

Cash

Cash is £2.5m lower than plan at the end of May. Loan drawdowns are being delayed as long as possible.

Trade and other payables

This balance has increased by £0.9m in May and is £0.9m more than planned. No payments have been delayed for cash reasons.

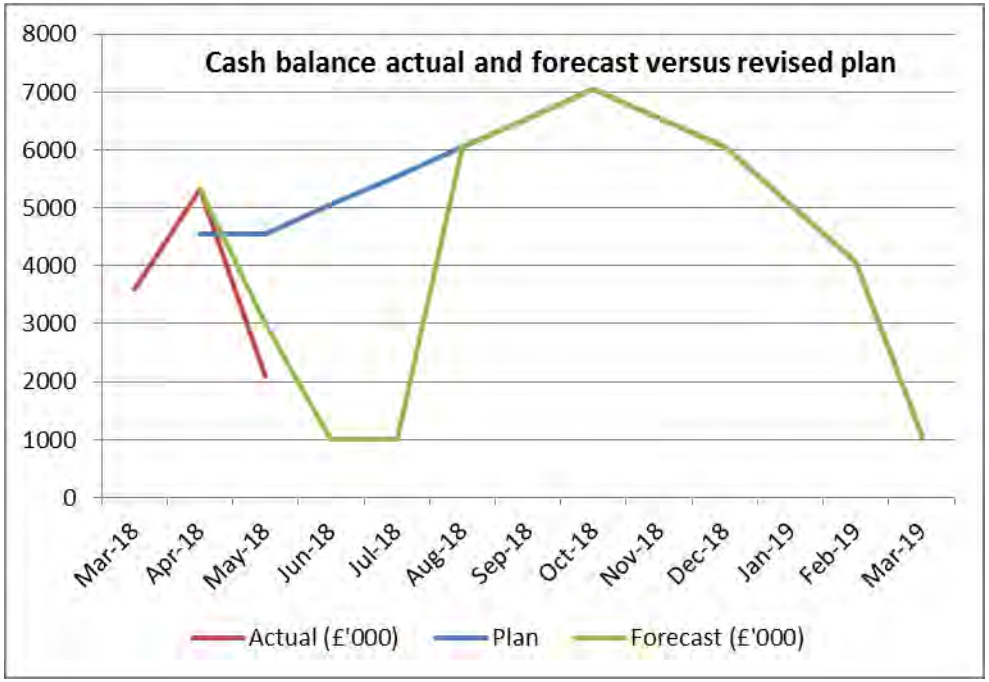
Other liabilities

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

Borrowing

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

Cash Balance Forecast for the year



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

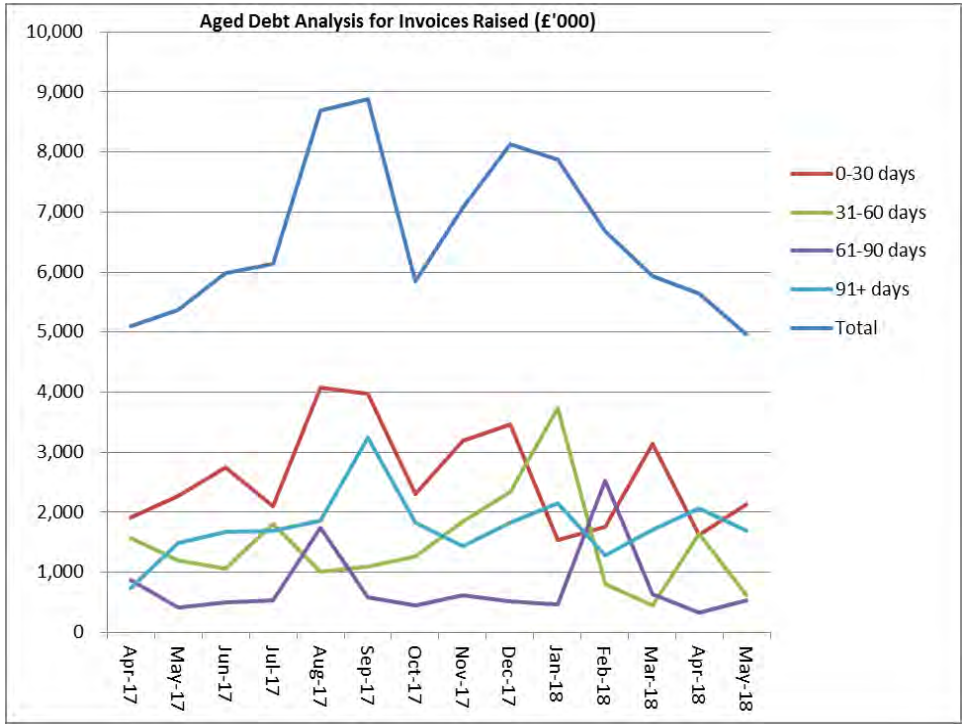
The Trust is required to keep a minimum balance of £1 million.

There is significant uncertainty around the timing of cash receipt for the outstanding 2017/18 STF (£5.3m) and also the timing of securing agreement from DH on the planned borrowing so it is assumed the cash reserves will reduce until both are received. The current forecast assumes receipt of the 2017/18 STF in August 2018.

Debt Management

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

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



The overall level of invoices raised but not paid has decreased by £0.7m in May.

The decrease in debts 31-60 days is mainly because West Suffolk CCG has paid a significant invoice raised at year end.

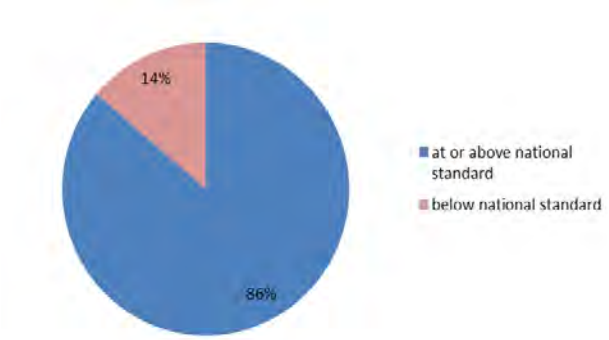
APPENDIX A

Better Costing, Improving Healthcare - PLICS Update June 2018

Reference Cost and Patient Level Costing

The trust is required to submit a Reference Cost return to NHS Improvement each year and, in doing so, is required to explain the methodology used to the trust Board or appropriate subcommittee. This year the Trust is also submitting a patient level return to NHS Improvement as part of the national Costing Transformation Programme. This return is to reconcile with the National Reference Costs submission.

The Trust's costing methodology is in-line with the national costing guidance wherever possible, unless a superior costing method is already applied, or information is not currently available to meet the expected costing methodology. The chart below summarises the current proportion of costs in-line with the guidance:

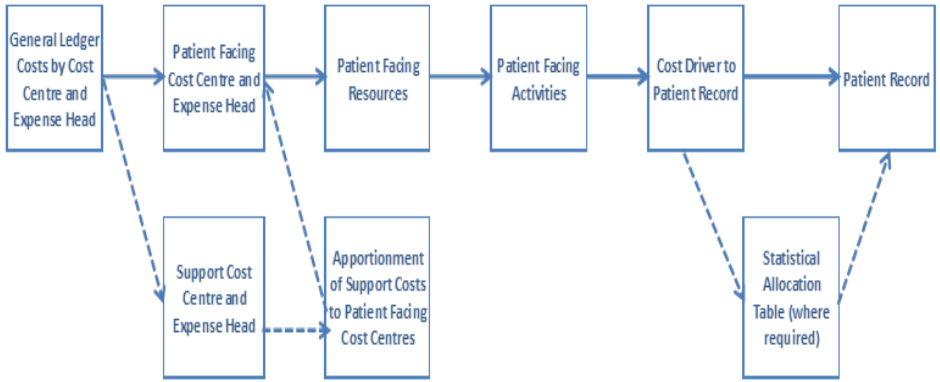


Overhead/ indirect costs are allocated on a basic stepped reapportionment basis rather than the reciprocal basis suggested by the guidance. This will be changed for the 2018/19 submission. The impact of this is not shown in the above chart.

This draft analysis will be updated once the final calculation has been completed. The table below summarises the top 5 areas not yet at the national standards:

Item	Value	Solution
Non consultant medical staff	£13,459,342	New Medical Staff roster system to be used
Specialist nurse	£4,077,123	New Medical Staff roster system to be used, subject to decision to include nursing
Prostheses, implants and devices	£2,484,989	New - e-care phase for theatres to provide the data
Adult critical care - ward care	£2,368,761	Weighting for patient acuity to be developed
Neonatal critical care - ward care	£1,071,630	Weighting for patient acuity to be developed

The flow diagram below summarises the costing process followed, a further example is given in Appendix A.1 :



Further information regarding the national costing guidance and the costing methodology applied can be found here:

https://improvement.nhs.uk/resources/approved-costing-guidance/

https://improvement.nhs.uk/resources/approved-costing-guidance-standards/

The Costing Manager has worked closely with both the Information and Income teams to ensure the information used for costing is reliable and accurate. The collection process has been confirmed with the Information Governance Manager

to ensure due process is followed. A national Data Provision Notice has been issued for this collection, a copy of this can be found on the link below:

Letter to Trusts – PLICS Acute (2018) Data Collection

The Trust is currently reviewing the provision of the costing system to enable full roll-out and use of the information to better analyse performance and inform decision making. The 2017/18 Reference Costs are therefore being calculated using an in-house system. If this is successful the reporting will be developed and made available shortly after the Reference Costs submission, alongside a newly formed Costing working group.

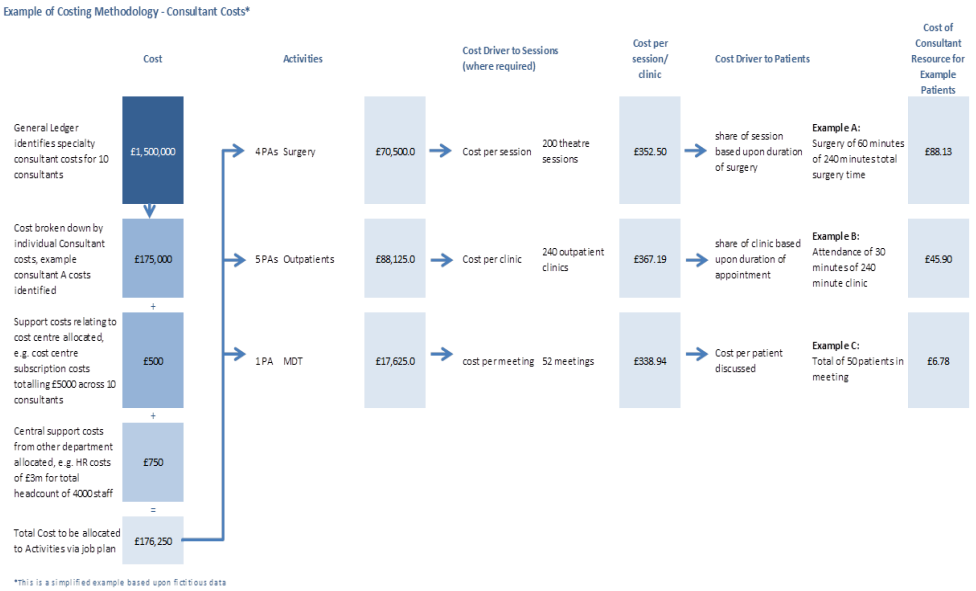
Further external benchmarking will be developed once the 2017/18 national data has been published.

The use of an internal system will also make it easier to integrate new systems to better improve accuracy and achieve the solutions outlined above to further move towards full compliance with the national standards.

A timeline is given below:

	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Produce CTP and submit Reference costs output										
Review and finalise Reference Costs										
Report progress and initial data findings to Board										
Intial costing reports for Steering Group review										
Proposed costing dashboard for Steering Group review										
Publish Reports across organisation										
External/ Internal Audit of revised processes										
Implement further revisions for 18/19 reporting										
Implement patient level costing for the community										

APPENDIX A.1



10:35 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

12. Nurse staffing report

To ACCEPT a report on monthly nurse staffing levels

Presented by Rowan Procter

Trust Board – 29th June 2018

Agenda item:	12			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Sinead Collins, Clinical Business Manager			
Date prepared:	22 June 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 May's and progress of nurse staffing review made below.

Observations

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
A&E	10 medication errors	High agency & bank use. High RN & NA vacancy. High amount of overtime. High sickness
F7	6 medication errors	High agency & bank use. High RN vacancy. High amount of overtime.
F8	4 medication errors	High agency & bank use. High amount of overtime.
Theatres	-	High RN vacancy & sickness. High amount of overtime
DSU	-	High sickness & bank use.
G1	-	High bank use.
G3	3 falls with harm	High bank use & NA vacancy. High amount of overtime
G4	3 falls with harm	High bank use.
G5	9 medication errors & 4 falls with harm	High bank use. High sickness. High RN & NA vacancy. High amount of overtime
G8	-	High bank & agency use. High sickness. High RN & NA vacancy.
F1	-	High bank use & RN vacancy.
F3	5 medication errors	High RN & NA vacancy. High amount of overtime. High bank & agency use. High sickness.
F4	-	High agency & bank use. High RN vacancy.
F5	-	High bank use.
F6	-	High agency & bank use. High RN & NA vacancy. High amount of overtime.
F9	4 medication errors	High agency & bank use. High RN vacancy. High amount of overtime
F10	4 medication errors	High bank use. High RN & NA vacancy. High amount of overtime
Maternity	5 medication errors on F11	High bank use & sickness. High midwife vacancy.
F12	-	High bank use.
F14	-	High amount of overtime
Kings Suite	-	High bank use. High amount of overtime. High sickness.
Rosemary Ward	4 falls with harm	High bank use & amount of overtime.

Vacancies – In West Suffolk Hospital, there are significant vacancies in registered staff, and is 96.30 WTE and there is an unregistered vacancy of 42.11WTE. The registered figure is slightly higher than last month. HR and operations are working on different method to recruit and retain nursing staff. F10 has moved down to G9 and DWA is in Bay D of G9 as well
The Admission Prevention Service has considerable vacancies and has resulted in the service hours being reduced. Action is being taken to improve the situation

Roster effectiveness – Out of 26 areas, 6 are over the Trust standard of 20% (Day surgery unit & ward are counted as one area). This is 15 areas less than April, which is an implies great improvement on roster effectiveness
We are unable to collect this information in the community

Sickness – Out of 27 areas, 10 are over the Trust Standard of 3.5% (six less than last month) (Day surgery unit & ward are counted as one area).
In the community, 5 out of the 9 areas are over the Trust Standard (same as last month).

Updates in March

Community areas some information sources are still to be determined due to transfer over to new computer systems. Community Children's establishment is currently being reviewed. Community Matrons section has been removed out of table.

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	May-18			Establishment for the Financial Year 2017/18						Data for May 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	116.0%	90.1%	124.4%	109.6%	11.72%	6.15%	222	-7.35	-6.20	5.70%	N/A	21.00%	N/A	10	1
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	71.2%	77.6%	111.2%	100.0%	8.62%	6.75%	119	-11.20	-2.45	3.50%	7.17	14.70%	0	6	2
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	99.7%	100.6%	89.7%	130.6%	11.49%	6.12%	148	-2.40	3.20	3.60%	18.43	18.40%	0	4	1
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	103.0%	93.8%	N/A	N/A	0.83%	0.00%	27	-2.38	0.00	3.00%	24.65	15.00%	0	2	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	99.7%	100.0%	N/A	N/A	0.86%	0.00%	153	-7.87	-0.60	6.30%	N/A	16.90%	0	0	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	136.7%	85.8%	59.3%	N/A	0.79%	0.00%	0	-1.30	-0.10	2.90%	N/A	18.50%	0	1	N/A
WSFT	Day Surgery Unit	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC	52.06	78.00%	22.00%	N/A	1 - 1.5	N/A	58.4%	N/A	98.8%	N/A	2.40%	0.00%	12	-0.70	-1.00	5.80%	N/A	17.40%	0	0	0
	Day Surgery Wards													6.65%	0.00%	0	0.10	0.00	4.40%		14.90%			
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	101.1%	92.5%	49.2%	N/A	1.58%	0.00%	93	-0.60	-0.70	0.40%	12.71	14.40%	0	0	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	108.2%	100.0%	121.3%	N/A	6.58%	0.00%	42	0.46	0.40	1.90%	9.32	19.40%	2	3	1
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	96.1%	84.7%	90.5%	94.8%	11.51%	0.70%	134	-0.50	-6.60	2.20%	4.91	10.20%	0	1	3
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	80.6%	89.1%	121.3%	103.9%	15.12%	0.20%	99	-2.44	-2.42	3.40%	5.39	19.00%	0	2	3
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	86.6%	90.5%	99.2%	111.9%	16.19%	1.99%	233	-3.55	-3.34	7.50%	4.91	22.10%	1	9	4
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	63.7%	77.5%	117.3%	95.8%	17.12%	11.43%	25	-10.44	-6.02	9.80%	6.01	20.80%	0	3	0
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	97.0%	119.9%	129.0%	N/A	16.62%	0.00%	35	-5.11	-0.10	2.90%	21.88	15.70%	N/A	2	N/A
WSFT	F3	Trauma and Orthopaedics	34	40.47	59.07%	40.93%	48.48	7	11	89.1%	93.6%	146.4%	108.5%	6.29%	2.50%	412	-4.20	-3.50	6.30%	5.43	17.50%	1	5	1
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	90.1%	93.6%	118.4%	204.5%	11.35%	9.76%	81	-3.94	-1.90	0.60%	9.20	10.10%	0	1	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	98.1%	98.9%	95.5%	131.4%	4.57%	0.36%	12	-0.50	-1.04	1.60%	6.05	15.40%	1	2	1
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	89.1%	92.6%	105.8%	112.3%	4.74%	5.01%	513	-5.03	-3.05	1.70%	5.23	16.70%	0	1	2
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	68.1%	82.7%	86.0%	110.0%	12.71%	3.40%	141	-9.64	-2.80	4.40%	4.42	22.20%	2	4	2
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	88.8%	70.5%	99.4%	96.2%	10.98%	1.01%	115	-5.78	-3.10	2.50%	5.51	14.90%	2	4	0
WSFT	F11	Maternity	29	61.55	72.14%	27.86%	N/A	7.25	14.5	110.0%	93.5%	82.9%	59.5%	11.72%	0.00%	11	-6.05	0.50	5.70%	N/A	16.80%	0	5	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms					1	1													0	0	0
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre					1 - 2	1 - 2													0	0	0
WSFT	F12	Infection Control	8	16.42	68.59%	31.41%	9.61	4	4	77.1%	89.9%	31.0%	101.9%	8.82%	0.60%	12	-2.65	1.00	0.00%	7.98	16.10%	0	0	0
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	98.9%	99.8%	N/A	N/A	1.23%	0.00%	146	-0.90	-0.40	2.20%	14.67	18.80%	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	84.1%	N/A	78.3%	N/A	0.00%	0.00%	0	-0.20	0.00	0.60%	N/A	14.50%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	115.4%	88.3%	14.4%	51.6%	1.34%	0.00%	48	-1.23	-1.40	1.40%	28.99	17.60%	N/A	2	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	123.1%	98.4%	96.9%	77.6%	4.97%	0.00%	169	-0.10	-0.69	2.90%	8.20	22.50%	0	1	4
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	117.0%	99.9%	102.8%	100.8%	6.92%	0.0%	119	-0.80	0.20	6.30%	5.00	20.70%	0	2	1
										95.07% AVG	92.13% AVG	94.54% AVG	105.60% AVG	7.63% AVG	2.00% AVG	3120 TOTAL	-96.30 TOTAL	-42.11 TOTAL	3.55% AVG		17.22% 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		1364.60		We are unable to collect this information this month		To be confirmed if can measure	1.00	0.00	3.49%	No equivalent tool for community nurses	35	11	0	0
Community	Bury Rural	Community Heath Team		11.20	10.71%	89.29%				651.03					1.88	0.00	0.50%		21	3	0	1
Community	Mildenhall & Brandon	Community Heath Team		14.50	20.07%	79.93%				892.00					Not provided in time		0.87%		27	1	0	1
Community	Newmarket	Community Heath Team		11.25	28.00%	72.00%				686.40							2.21%		29	4	0	0
Community	Sudbury	Community Heath Team		25.92	32.25%	67.75%				1246.00							4.58%		39	4	2	3
Community	Haverhill	Community Heath Team		13.20	32.05%	67.95%				909.58							15.16%		18	1	1	1
Community	Admission Prevention Service	Specialist Services		13.73	25.13%	74.87%				60.38					3.92	1.45	4.12%		1	0	0	0
Community	Children	Community Paediatrics		32.89	47.07%	52.93%				1292.48					0.00	0.00	5.06%		1	N/A	0	0
										7102.47 TOTAL		#DIV/0! AVG	#DIV/0! AVG		6.80 TOTAL	1.45 TOTAL	4.50% AVG		171 TOTAL			

Explanations	
	WSFT have some significant environmental layout challenges and additional activity that are not reflected in the SNCT(F14/G1/G8/F12/CCU/NCH)
	Medication errors are not always down to nursing and can be pharmacist or medical staff as well
	In vacancy column: - means vacancy and + means overestablished. This month refer to report however
	Roster effectiveness is a sum of Sickness, Annual leave and Study Leave
	DSU has been split into ward and unit only by HR, that is why only a section has been split in this dashboard
	G9 - Closed during April
	Pressure Ulcer Incidences (In our care) - includes DTI's

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

Target - 3.5%

13. Nursing staffing strategy

To ACCEPT the annual review

Presented by Rowan Procter

West Suffolk NHS
NHS Foundation Trust

Trust Board – 29th June 2018

Agenda item:	13			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Sinead Collins, Clinical Business Manager			
Date prepared:	20th June 2018			
Subject:	Nursing & Midwifery Strategy 2016-2021 : Update			
Purpose:		For information		For approval

Executive summary:

Led by the Executive Chief Nurse, the nursing and midwifery strategy was developed by April 2016 in collaboration with the relevant team members setting out the ambitions and priorities over the coming years, which is now just finished its first year.

It reflects and supports the national framework 'Leading Change, Adding Value: A framework for nursing, midwifery and care staff' was released in May 2016 and it closely aligns with the 'Five Year Forward View' as set out by Simon Stevens, Chief Executive, NHS England.

The strategy aligned with the national nursing/midwifery and wider healthcare strategies to ensure nursing and midwifery continues to forge ahead, delivering the best care to patients, advancing and learning in tandem with national agendas whilst being sufficiently cognisant of local population needs.

This paper outlines the progress to date from April 2017 – March 2018 against the local nursing strategy and provides further detail in relation to the national direction.

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	x	x	x

Previously considered by:	*N/A*
Risk and assurance:	-
Legislation, regulatory, equality, diversity and dignity implications	-

Recommendation:
Description of update in detail given below.

The nursing strategy continues to drive improvements in care delivery and workforce redesign. The nursing & midwifery team will continue to work alongside strategy in 2017 which will ensure steps towards continually improving care, putting patients at the heart of what we do whilst ensuring our workforce are developed and valued for their contribution.

1. Purpose

The Nursing and Midwifery Strategy (2016-2021) was developed by April 2016 in collaboration with the relevant team members setting out the ambitions and priorities over the coming years, which is now just finished its first year. This strategy is under-pinned by our 'Putting you first' values and the ambitions set out in the Trust's vision, 'Our patients, Our hospital, Our future, together'

It reflects and supports the national framework for nursing midwifery and care staff 'Leading Change, Adding Value', which pledges to close the gaps between health and social care by targeting health and wellbeing, care and quality and funding and efficiency. We are committed to delivering the ten commitments of this national framework.

2. Progress

2.1. West and East Community split and move

In October 2017, the community split into east and west hubs that include Ipswich & Colchester and West Suffolk Hospital, respectively, to allow for more integrated work and to help improve patient's experience. Some community services are still pan-Suffolk, e.g. Children and information team; however this is constantly being reviewed. Hospital services are also continuing to develop and integrate their services, e.g. Tissue viability, chaplaincy.

2.2. SAFER Patient Flow Bundle - Red2Green

The Red2Green Board Round has become part of normal practice

2.3. Education

West Suffolk College have developed a close working relationship with WSFT education team, offering apprenticeships and courses to our nursing midwifery and care staff. Due to the nursing bursary being removed WSFT has started offering nursing apprenticeships and first round of selection for this occurred in June 2018. Return-to-work courses and international conversion of nursing to UK standards courses are also being actively advertised

2.4. Staff levels and skills mix

Bay bed nursing is being reviewed due to the high registered nursing vacancies. The method of bay bed nursing will be adapted depending on the ward

2.5. Nursing Current Awareness

Nursing Current Awareness is a list of useful sources of information. This has been organised to reflect the Trust's ambitions and also echoes issues, such as frailty, which feature in the monthly Nursing and Midwifery Council meetings

2.6. Patient experience update

The team have developed a 'Experience of Care' Strategy, that lays out WSFT commitment to regular, high-quality engagement, and our intentions for embedding this into our culture at the Trust. To truly engage with people and improve experience of care, intension is to implement an experience of care cycle, made up of three elements:

- Element one – Feedback: listen and understand
- Element two – Engage: working together
- Element three – Improve: making changes that matter to you

2.7. Nursing – related complaint reduction

There has been an increase in PALs enquires and reduction in complaints due to the issues being dealt with earlier

2.8. Reduction in HCAI

Reducing hospital-associated infections continues to be one of the main priorities for our patients and the public. In addition, it remains a key priority for the NHS as a whole and for our commissioners. Within the Trust we continue to strive for further improvement, with a focus on the timely identification and management of patients with infections and at risk of infection.

2.9. G5 made dementia friendly

During the summer of 2017, a deep cleaning process occurred and G5 was made dementia friendly. New patient's boards were obtained for behind the beds, however they were delivered later than predicted and only 4 wards have them

2.10. Access to a leadership development and competency assessment AND Develop talent management programme to support the future workforce

A leadership development and talent management action plan has been developed for all levels of the Trust and contribute to the development of systems leadership in West Suffolk. This is owned by one of deputy's leads for workforce

This includes: the Key Leaders programme for 20 senior leaders across the organisation; the 2030 Leadership Programme for aspiring future senior leaders; co-ordinated participation in regional and national leadership development programmes; support for the further development of effective developmental coaching and mentoring at all levels of the Trust; and a series of leadership seminars.

2.11. Peer support system of nurses who require extra support

This has been commenced on a bespoke level. This is also being offered to new ward managers due to recent changes and is where experienced ward mangers support and meet with new ward managers

2.12. Professional accountability flow diagram has changed

Please refer to Appendix A for altered flow diagram

2.13. Expert Navy Courses

The Expert Navy four day programme is for ward managers and aspiring B6s. They are looking for one band 6 from each area that feels has the potential and aspiration for a band 7 role in the future. Feedback has been very positive. It is a programme developed and run by the WSFT clinical education team. The sessions are based around managing staff, developing leadership skills and increasing skills to develop their roles.

2.14. Ward Checklist has changed

This has changed to an app method – The Perfect Ward, while working with Pharmacy and Infection Prevention team, a few audits have been combined to reduce duplication but also reduce time writing reports as it the app automatically creates them. Refer to Appendix B for print screens of the app and an example report.

3. Next Steps

A fair amount of progress has been made in this year, but there are still improvements to be made. As well as continuing to develop areas where required, the Nursing Directorate will look to progress:

- Work with operations and estates to get behind bed boards up across trust
- Leads to use CREWS (Caring, Responsive, Effective, Well-Led, Safe) method to share information
- Nurses to lead winter planning and work with other services to implement, e.g. operations, HR etc.
- Recruitment of nursing and midwifery staff – develop innovative methods

4. Embedding the strategy

As previously mentioned, the Nursing & Midwifery Strategy was developed by Nurses and Midwives working at all levels within the Trust .Therefore, all leaders of nursing or midwifery teams are continually finding areas to focus on and issues and/or areas of development and working with the appropriate staff to continue their hard work.

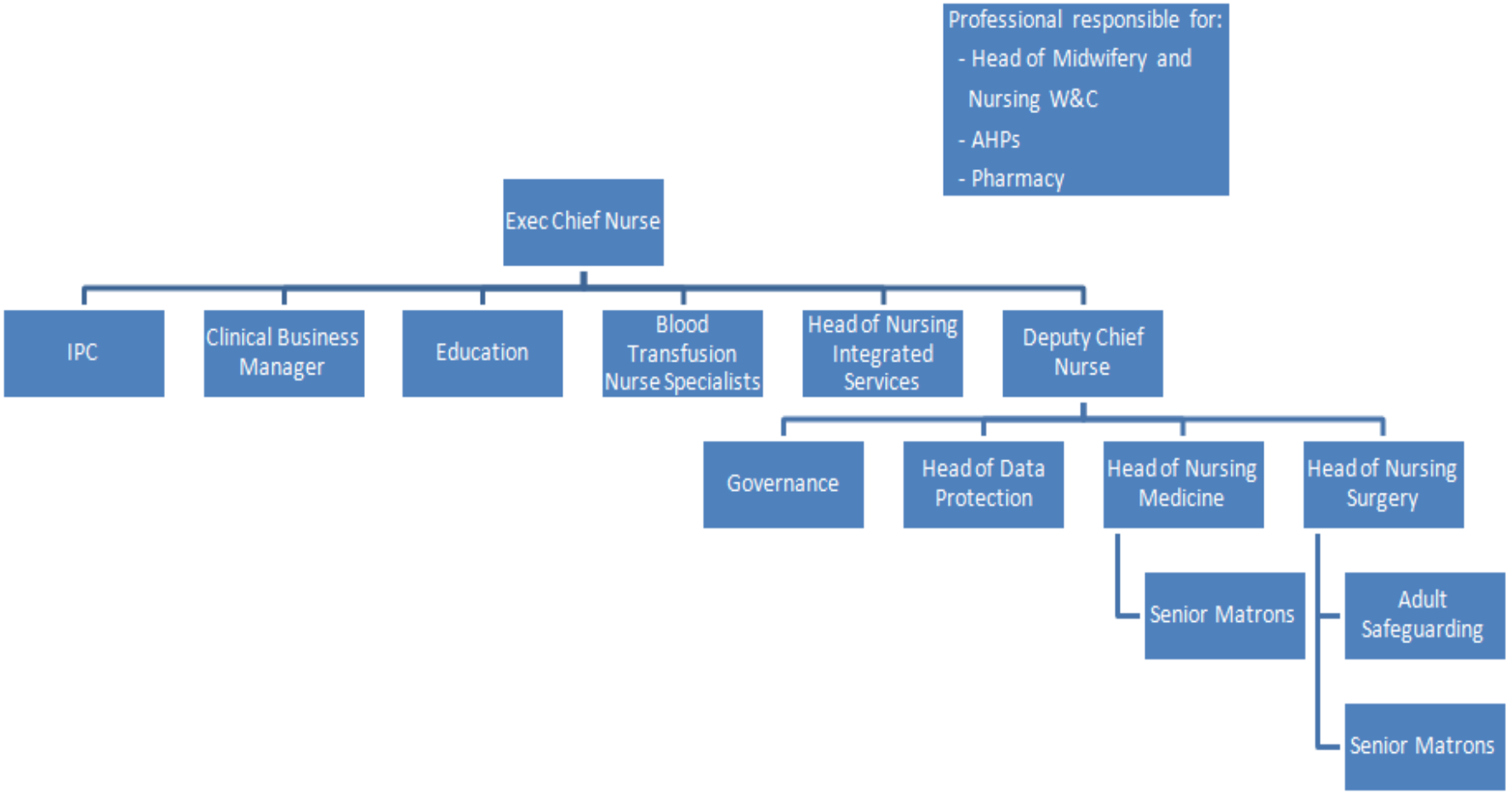
5. Conclusion

The nursing strategy continues to drive improvements in care delivery and workforce redesign. The nursing & midwifery teams will continue to work alongside strategy in 2018 which will ensure steps towards continually improving care, putting patients at the heart of what we do whilst ensuring our workforce are developed and valued for their contribution.

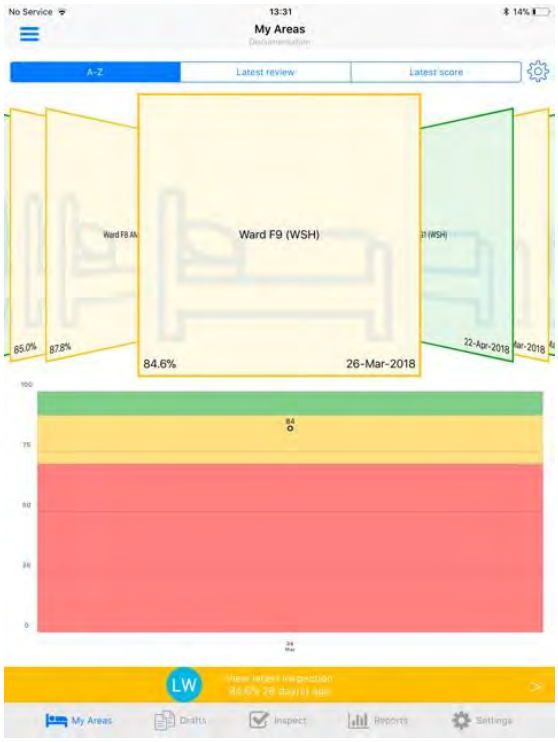
The Board are asked to note:

- The clear commitment amongst Trust staff to progress the principles within the Strategy especially through the difficult winter period. The central focus for this workforce is recruiting, developing and maintaining them so that patients truly central to all care delivery.
- Many of the principles can only be achieved through collaborative working with colleagues working in Higher Education and CCGs, evidenced within the progress made to date.
- The challenge now is to maintain the focus and quality while preparing for the next winter period.
- The Strategy should provide staff with a point of focus and help with decision making for the key priorities that need to be progressed

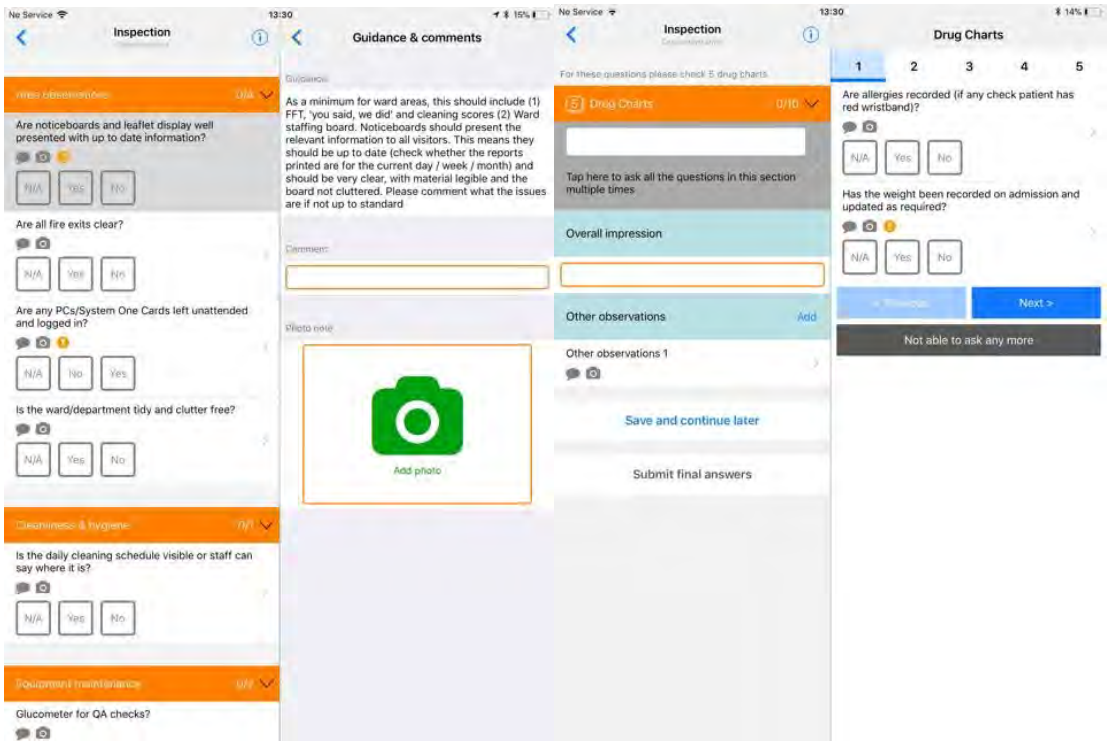
Appendix A – Professional Accountability at WSFT



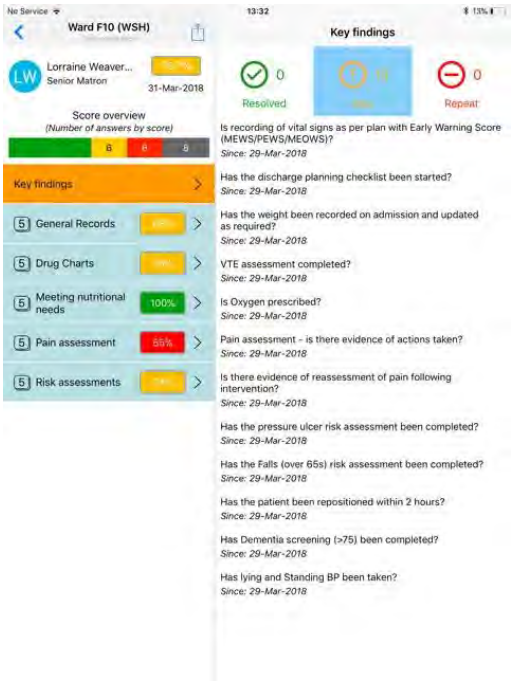
Home page



Inspection page



App report



Print version report

14. Leadership programme – metrics for success

To ACCEPT the report

Presented by Denise Pora

Trust Open Board – 29 June 2018

Agenda item:	14			
Presented by:	Denise Pora, Deputy Director of Workforce (Organisation Development)			
Prepared by:	Denise Pora, Deputy Director of Workforce (Organisation Development)			
Date prepared:	18 June 2018			
Subject:	Leadership Development – Return on Investment 2017/18			
Purpose:	X	For information		For approval

Executive summary:

At the end of 2016/17 the Trust established a central leadership development function to build on existing internal and external provision. In September 2017 the Board requested information to enable it to make a judgement about the quality, value for money and impact of internal, centrally organised leadership development activities in 2017/18.

This report seeks to provide an acceptable level of assurance for Board members to be satisfied about what is being achieved with the investment made. It does this by giving an overview of spending and activities and proposed measures to assess quality and impact. It has been challenging to provide data that is robust, relevant and the time taken to collect it proportionate to the additional financial and workforce investment made by the Trust. The main messages from this report are:

- **Activity:** There was a significant level of activity in 2017/18 with participation from across the hospital and community and all disciplines. There were around 600 attendances at centrally organised leadership development activities during the year.
- **Investment:** our additional spend in new central leadership development was around £47,000 in 2017/18. Whilst calculating a more comprehensive estimate of the true costs of all activities is possible (e.g. the opportunity costs of the time of staff participating in activities) it would be unlikely to add sufficient value to our understanding of the return on the investment made to justify it and would also detract from delivery of the 2018/19 programme.
- **Quality:** We have both internal and external validation of the quality of our leadership development activities, and it is reasonable to judge that they are making a positive contribution to the effectiveness of leadership and management in the organisation.
- **Impact:** The quality of leadership in the Trust has an impact on a number of workforce KPIs. However, since central leadership development activities only started in the summer of 2017 they are unlikely to have had a significant impact on the data in Appendix B of this report and leadership will only ever be one of a number of factors impacting on these KPI. Equally, central leadership activities are only one of a number of factors influencing the quality of leadership in the organisation.

The priority for 2018/19 is to consolidate, build upon and refine the programme established in the last financial year.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		**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:	n/a						
Risk and assurance:	Data supplied by ESR						
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation: The Board are invited to note and accept this report.							

Leadership development return on investment

Background and purpose of this report

This report follows on from the Leadership Development Board Update in September 2017 and addresses the Board's request for information to enable it to make a judgement on the quality, value for money and impact of internal, centrally organised leadership development activities in 2017/18.

The post of Deputy Director of Workforce (Organisation Development) was established in late 2016 and filled substantively in March 2017. The purpose of the role is to set up, maintain and develop central leadership development activities in support of the Trust's service and organisation development agendas. A budget of £100k (excluding staff costs) was agreed by Executive Directors in March 2017 for the three years from 2017/18.

2017/18 Leadership development priorities

The following leadership development priorities were approved by the Board in September 2017:

- Development of leadership and improvement skills at all levels of the trust
- Development of systems leadership in West Suffolk
- Systematic talent management processes that facilitate a clinically led and managerially supported organisation and feed into NHS talent pipelines

Return on investment

Information is provided for the Board on activity, additional spend, quality and impact measures in order to enable members to make a judgement about the return on investment in leadership development.

Activity – see Appendix A

- Details of the activities provided through the central trust leadership development programme April 2017 to March 2018.
- Number and type of trust staff participating.

Activity detailed excludes 1:1 coaching and mentoring.

Additional spending* on central leadership development activities (including staff costs) - £47525 April 2017 to March 2018

- Additional spend* on activities – £19291 (see Appendix A)
- Spend on staff – salary and travel £28234 (0.4 WTE Band 8b including on costs)
- Income generated £3,000 (3 CCG participants on 2030 Leaders Programme)

*In drawing together this information consideration has been given to ensuring the time invested in data collection is proportionate to spending on leadership development. E.g. neither the opportunity costs of staff participating in leadership development activities nor any locum costs incurred by the participation of consultant medical staff have been calculated. The majority of activities have been held in the Education Centre and no costs have been included for this. No apportionment of the annual membership fee for NHS Elect has been made in respect of workshops delivered by NHS Elect nor has a percentage of our contract with our employment lawyers Bevan Brittan been allocated for the workshop provided by them.

Quality measure

- Feedback from participants (see Appendix A)

Participant feedback is a good measure of how well the activity was received and is an indication of how likely participants are to use what they have learnt. The appraisal system allows for measurement of individual behaviour changes but in the absence of a systematic process for collecting and sharing this information we do not have data on any longer term behavioural impact of leadership development activities. Seeking to collect this data centrally would have limited value until/unless a greater proportion of staff have regular appraisals.

The twenty participants on the first 2030 Leaders Programme will be followed up beyond the end of the programme to establish the longer term impact of the process.

Impact measures

- Relevant key performance indicators as follows (see Appendix B)
    - Staff survey
    - Sickness absence rates
    - Staff turnover
    - Appraisal rates
    - Grievances

The chosen KPI are proxy measures for effective leadership within the Trust but it is recognised that many factors other than leadership will be impact on these. However, it is fair to assume there is some correlation between a) engaged, motivated staff, and low sickness absence and turnover and effective leadership and b) central internal leadership development activities and effective leadership within the organisation.

The content and design of leadership development activities also means they are likely to be contributing to the creation of both the organisational and system culture needed for the future i.e. compassionate, inclusive and collaborative leadership.

Despite these caveats this approach gives the Board a basic level of assurance around the impact and value for money of the Trust's investment in centrally managed leadership development activities.

2018/19 Leadership development and talent management priorities

It is important to consolidate and build on the programmes started in 2017/18 to ensure that the culture and behaviours needed for the future become embedded in the organisation. Achievement of the priorities agreed in 2017/18 is an on-going process and they remain relevant for 2018/19 and, probably, beyond. In 2018/19 we will build upon and refine what was started in the last financial year. This will include:

- A second cohort of the 2030 Leaders Programme
- Continuing the Key Leaders programme with the initial cohort with a review of progress in the autumn.
- Continue with regular 5 O'clock Club Meetings
- Continue with our programme of two leadership summits annually
- Further develop the Senior Leaders Management Development Programme
- Continue to implement and develop the senior medical leaders talent management framework
- Further coaching workshops to support the development of a coaching culture

The development of a West Suffolk Alliance organisation development programme and the STP organisation development programme are also expected to impact on the evolution of our leadership and talent management priorities.

Activity *2017/18 priority*	**Participants**	**Feedback***	**Spend**
Leadership Summit 5.7.17 Global Digital Excellence *Systems leadership*	75 senior leaders from WSH and wider West Suffolk system	**1** / **2** / **3** / **4** 0 / 1 / 5 / 10 NB: 'Slido' electronic mechanism for collecting feedback did not work well and only 16 participants completed the evaluation.	Facilitation provided free of charge by NHS Leadership Academy. Venue and refreshment costs not included
Leadership Summit 11.12.17 Leading Self Through Challenging Times *Leadership and improvement skills*	69 band 4 to 6 leaders – clinical and non-clinical from across the Trust	Average rating of 4.7 out of 5 On a scale of 1 – 5 (5 = excellent): • 69.57 = 5 • 30.43 = 4	£3,500 plus refreshments**. No additional venue spend as held in WSH Education Centre
Bringing People and Organisations Together *Systems leadership*	5 band 7+ leaders from across health and social care in Norfolk, Suffolk and NE Essex	Informal feedback from WSH participants positive. HEE commissioned evaluation awaited.	Funded by Health Education England
2030 Leaders Programme *Talent Management* *Systems leadership* *Leadership and improvement skills*	18 WSH staff band 6+ - clinical and non-clinical leaders including 7 consultant medical staff. 3 members staff from West Suffolk CCG Programme comprises 6 x 1 day workshops, 6 x ½ day action learning plus 360 feedback (not all delivered in 2017/18)	Individual elements consistently highly rated by participants. Overall evaluation being prepared following final workshop on 28.6.18 and will inform planning for 2018 2030 Leaders Programme	£14700 (total cost of programme not all spent in 2017/18) plus refreshment costs** included below 1 workshop part of NHS Elect Membership, 1 delivered free of charge by Eastern Academic Health Sciences Network. 360 Feedback assessments provided free of charge by EoE Leadership Academy and feedback facilitator training provided free of charge for 4 staff.
Key Leaders Programme *Talent management* *Leadership and improvement skills*	Ensuring there is systematic support and development for senior clinicians and managers in critical leadership roles. 23 participants selected by Executive Directors	Individual programme of development.	360 feedback funded by EoE NHS Leadership Academy, place on CUFT programme provided for one participant free of charge.

Coaching skills workshops *Leadership and improvement skills*	Open to all in a leadership role in the Trust. 4 workshops held in 2017/18. 45 Staff from all disciplines have attended	**1**	**2**	**3**	**4**	**5**	Workshops delivered as part of NHS Elect Membership
		0	0	1	8	33	
Senior Leaders Management Development Programme: Employee Investigations Workshop *Leadership and improvement skills*	32 band 7+ leaders – clinical and non-clinical including consultant medical staff, from across the Trust	**1**	**2**	**3**	**4**	**5**	Delivered as part of the Trust contract with our employment lawyers. No additional cost.
		0	**0**	**0**	**12**	**13**	
5 O'clock Club Trust Leadership and Quality Improvement Forum *Leadership and improvement skills*	Open to all in trust with an interest in leadership and quality improvement Started in July 2017 – 7 meetings held to end March 2018. Around 350 to 400 attendances over 7 meetings	Attendance generally between 35 and 60+. Positive verbal feedback from participants					Refreshment costs** only. Held in Education Centre.

*overall rating of event on a scale of 1 to 5 (1 = poor and 5 = excellent). July 2017 summit scale was 1 – 4 (Poor, ok, good, excellent)

** refreshment costs included in additional spend of activities £19291

Key Performance Indicators influenced by effective leadership

National NHS Staff Survey 2017			
Key Finding	**WSH NHSFT**	**Acute Trust average**	**Best acute Trust**
Recognition and value of staff by managers and the organisation	3.58	3.45	3.71
Percentage of staff reporting good communication between senior management and staff	42%	33%	48%
Support from immediate managers	3.78	3.74	3.94
Staff recommendation of the organisation as a place to work or receive treatment	4.12	3.75	4.12

Indicator	**2017/18**	**Target**
Sickness absence	**%**	
Medical Directorate	3.63	3.5%
Community Contract	3.56	
Surgical Directorate	3.90	
Women and Child Directorate	3.73	
Corporate Services Directorate	2.79	
Clinical Support Directorate	3.88	
Estates and Facilities Directorate	4.55	
WSH NHSFT	3.72	
Appraisal rates	**%**	
Medical Directorate	52.85	90%
Community Contract	63.71	
Surgical Directorate	58.82	
Women and Child Directorate	66.22	
Corporate Services Directorate	75.46	
Clinical Support Directorate	74.40	
Estates and Facilities Directorate	68.63	
Employee voluntary turnover rate	**%**	
Medical Directorate	10.43	Less than 10%
Community Contract	7.80	
Surgical Directorate	8.97	
Women and Child Directorate	8.70	
Corporate Services Directorate	7.02	
Clinical Support Directorate	7.11	
Estates and Facilities Directorate	12.31	
WSH NHSFT	8.78	
Grievances	**Number**	
WSH NHSFT	6	0

External validation of WSH leadership development

CQC Inspection Report January 2018

Well-led domain rated as 'outstanding'

"There were clear systems in place to ensure that leaders had the skills and experience to complete their role effectively…"

"There was a comprehensive talent identification programme in place and a number of leadership programmes, individually tailored to meet the needs of leaders at different levels of the organisation. Leadership programmes were open to leaders at different levels of the organisation and not just those traditionally seen as senior leaders. There were novel leadership initiatives such as the 5 o'clock club which was open to all staff. Senior leaders were visible and approachable…"

Engagement with the NHS Leadership Academy (NHSLA)
The Trust is regarded as one of the most highly engaged with the NHSLA in the country and as a result was one of 15 trusts nationally invited in April 2018 to participate in research conducted by Ipsos MORI on the impact and future offer of the Academy.

15. Medical revalidation annual report

To ACCEPT a report

Presented by Nick Jenkins

Board of Directors – 29 June, 2018

ITEM NO:	15
PRESENTED BY:	Dr Nick Jenkins, Medical Director
PREPARED BY:	Paul Molyneux, Deputy Medical Director/Nick Jenkins, Responsible Officer and Medical Director
DATE PREPARED:	June 2018
SUBJECT:	Medical Revalidation - Responsible Officer Annual Report 2018
PURPOSE:	To update the Board on the status of Medical Revalidation and Appraisal, and approve the annual Board Statement of Compliance
STRATEGIC OBJECTIVE:	Invest in quality, staff and clinical leadership

EXECUTIVE SUMMARY:

Boards have statutory duties in respect of medical appraisal and revalidation, and are required to receive an Annual Report form the appointed Responsible Officer.

Since the last Annual Report in July 2017, the Trust has implemented the changes proposed by the Revalidation Support Team in their report of January 2016.

This Annual Report outlines the Trust position as of June 2018, updates the Board on recent developments in appraisal and revalidation and asks for confirmation that it is satisfied the West Suffolk is compliant with current regulations.

The report highlights areas where progress has been made, and further work that will be required to ensure both timely and appropriate appraisal of all Senior doctors with a prescribed connection to this Trust.

The number of doctors with whom the Trust has a prescribed connection during this period was 275.

Matters resulting from recommendations made in this report	**Present**	**Considered**
Financial Implications	Yes / ~~No~~	Yes / ~~No~~
Workforce Implications	Yes / ~~No~~	Yes / ~~No~~
Impact on Equality and Diversity impact	~~Yes~~ / No	~~Yes /~~ No
Legislation, Regulations and other external directives	Yes / ~~No~~	Yes / ~~No~~
Internal policy or procedural issues	Yes / ~~No~~	Yes /~~ No~~

Risk Implications for West Suffolk Hospital Appraisal and revalidation are key mechanisms by which assurance is gained regarding high-quality medical care and leadership: without satisfactory processes in place poor performance may go unrecognised and unmanaged.	**Mitigating Actions** (Controls): • Regular monitoring of appraisal compliance, satisfactory revalidations and deferral rates • Escalation process for failure to comply with appraisal requirements • Management of conduct / capability issues using *Maintaining High Professional Standards* process
Level of Assurance that can be given to the Board from the report based on the evidence Sufficient	
Recommendations: • The Board are asked to accept the Annual Report, note the contents and approve it for submission to the higher level Responsible Officer • The Board are asked to approve the statement of compliance confirming that the West Suffolk NHS FT is compliant with relevant legislation and regulations	

Background

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care to patients, improving patient safety and increasing public trust and confidence.

Provider organisations have a statutory duty to support their Responsible Officer in discharging their duties under the Responsible Officer Regulations, and it is expected that provider Boards will oversee compliance by:

- Monitoring the frequency and quality of medical appraisals in their organisation
- Checking there are effective systems in place for monitoring the conduct and performance of their doctors
- Confirming that feedback is sought at suitable intervals from patients so that their views can inform the appraisal and revalidation process for their doctor
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Governance Arrangements

Individual doctors are responsible for ensuring they undertake annual appraisal and have a prescribed connection with a designated body. The Responsible Officer is responsible for evaluating the doctor's performance based on evidence provided through appraisal and other mechanisms, and making a recommendation to the General Medical Council (GMC) every five years about their fitness to practice. Boards have a responsibility to ensure the RO is provided with adequate resources to fulfil their statutory function.

Doctors now have a fixed appraisal month and it has been made clear that they should conduct their appraisal at the latest by the end of the fixed appraisal month. In line with other organisations, failure to complete the appraisal process within three months of the fixed month now counts as a formal 'missed appraisal'. Doctors may agree reasons for delay with the Responsible Officer, but this is only approved if there is a genuine reason such as long term sick leave.

The status of every doctor is continually reviewed and updated and doctors are reminded of upcoming appraisal with sufficient notice to complete their e-portfolio and submit their appraisal documentation to their appraiser in good time for the appraisal interview. Any doctor who is non-compliant with appraisal or revalidation processes is identified early and sent escalating reminders and interventions. The General Medical Counsel has now developed a more formal mechanism for dealing with non-engagement through a non-engagement concern letter. If the Responsible Officer notifies the GMC of non-engagement, as set out in their criteria, the GMC will put the doctor under notice. If sufficient progress is not made by the Doctor to engage in appraisal, the GMC may bring forward the revalidation date to allow the Responsible Officer to submit a recommendation of non-engagement. If a recommendation of non-engagement is made, the GMC will begin the process of removing the doctor's license to practice

Appraisal processes have been well-established for many years. Appraisers are trained and receive top-up training at intervals. An electronic system called 'SARD' is used. In addition to providing a monitoring and reporting function it allows creation of an e-portfolio, generation of an appraisal document equivalent to the GMC 'MAG' form, creation of an appraisal output summary and other tools such as multi-source feedback.

The annual appraisal includes:

- Preparation by the doctor which should include reflection on the full scope of their professional activities, not only their West Suffolk clinical work but private practice, voluntary activities, educational supervisor or appraiser roles and any external professional activities. The doctor

must upload a range of suitable supporting evidence applicable to each role. This is captured in the e-portfolio and transferred to an annual appraisal document prior to the appraisal interview

- An assessment by the Appraiser of the whole of the doctor's professional activities, which should be supported by evidence. The appraiser will review among other things scope of work, activity, patient outcomes, complaints and incidents, colleague and patient feedback, health and probity.

- A review of the personal development plan from the previous year, achievements and challenges, and the development of a new PDP to address the learning needs and career development of the doctor.

- Declarations by the Appraiser and Appraisee that the doctor continues to practice in accordance with the obligations of the General Medical Council *Good Medical Practice* Framework

- An appraisal summary which describes how the appraiser has evaluated the doctor against their professional roles, and what topics were discussed. The summary is an opportunity to describe the doctor's fitness for *purpose* compared to their fitness to *practice*. Although the appraisal process is generally confidential between appraiser and appraise, the summary is often requested by other employers or organisations for whom the doctor provides services and is therefore written so it can be shared by the appraisee.

The West Suffolk Hospital has a system in place which ensures that all doctors have suitable pre-employment checks.

The Trust submits quarterly information to NHS England about appraisal activity including whether the Responsible Officer has sufficient resources to undertake the role, and also submits an Annual Organisational Audit.

Responsible Officer

The RO is appointed by the Board and is normally the Medical Director, as at the West Suffolk. As RO, Dr Nick Jenkins has undertaken all the required training and ongoing training required by NHS England to fulfil this role. His own appraisal includes evaluation against this role and includes provision of supporting evidence to the higher level RO, Dr David Levy. The RO makes recommendations to the GMC regarding revalidation, and can either make a positive recommendation, or recommend deferral or non-engagement.

Medical Appraisal Lead

The Medical Appraisal Lead at the West Suffolk is the Deputy Medical Director, Dr Paul Molyneux, who has undertaken Case Investigator training as well as Responsible Officer Training. The SAS doctors have a Lead appraiser, Dr Balendra Kumar, who ensures this group are suitably advised and supported, even if they only work at the West Suffolk for a short period.

Progress in 2017-18

a) Continue to monitor appraisal uptake/rates of completion Of the 11 doctors showing as 'non-compliant', 4 had an accepted reason for delay, 3 were 2 months overdue. Efforts are ongoing to ensure the remaining Doctors complete their appraisals in the near future. They are sent a formal letter which forms part of their revalidation evidence and must be discussed with their appraiser. If there is no progress, there is now formal process for referral to the General Medical Council to begin the process of non-engagement that ultimately could result in them being removed from the Register

b) Continue to recruit and train new appraisers. A total of 5 new appraisers were recruited and trained. Training was provided by either the Deputy Director of Workforce using a model provided by UEA, or an external trainer with more than a decades experience in appraiser training

c) Provide appraisers with enhanced training through annual Appraiser Training Workshop. The latest workshop took place on 13/6/18

d) Provide appraisers with feedback using SARD evaluation

e) MPIT process embedded - this is the formal transfer of information between Responsible Officers when doctors change designated body. This has been aided by a change to *GMC Connect*, the GMC Revalidation Management system, whereby previous and current Designated Bodies and Responsible Officers are now visible to all ROs.

f) Considerable work has been done on the supporting evidence required for Educational Supervisors to provide as part of their appraisal, including evidence of specific mandatory and other training, and trainee feedback

g) The Revalidation Support Group is now fully established and meets every other month. Membership of the Group comprises the Responsible Officer, Lead Appraiser, a non Executive Director, a senior appraiser and the Executive Director of Workforce and Communications. The Group quality assures previous Appraisals for Doctors approaching revalidation to assist the Responsible Officer in making a recommendation to the GMC. Any issues identified in previous appraisals are also fed back to both appraiser and appraisee

Medical Appraisal Activity

239 doctors were appraised during this period.

Delayed appraisals are detailed in the table below.

3 over 3 months overdue were agreed by the RO – sick, maternity leave, understanding of SARD system or appraiser not available in time (sick or A/L)

		Appraisals Due	Total Completed
Consultants	Completed in due month	75	
	One month overdue	56	
	Two months overdue	15	
	Three months overdue	9	
	Over three months over due	7	
	Not submitted	7	
		169	**162**
Staff Grades	Completed in due month	12	
	One month overdue	4	
	Two months overdue	4	
	Three months overdue	1	
	Over three months over due	0	
	Not submitted	1	
		22	**21**
Fix term & Locum	Completed in due month	10	
	One month overdue	6	
	Two months overdue	3	
	Three months overdue	3	
	Over 3 months overdue	0	
	Not submitted	0	
		22	**22**
Clinical Fellows & Trust Doctors	Completed in due month	13	
	One month overdue	10	
	Two months overdue	5	
	Three months overdue	2	
	Over 3 months overdue	4	
	Not submitted	3	
		37	**34**
	Total		250

The total number of trained appraisers at 31st March 2018 was 51. At present we have a sufficient number of appraisers.

Revalidation Activity

The number of recommendations made between April 2017 and March 2018 was 12

Positive recommendations	11
Deferrals	1
Non-engagements	0
Late recommendations	0

It should be noted that due to the revalidation timetable paid out by the GMC, nearly all doctors have been revalidated in the first three years of the first cycle. This means that revalidation numbers will drop off dramatically in 2016 and 2017 followed by a surge at the start of 2018.

Concerns

There are currently no consultants being managed according to Maintaining High Professional Standards by the Responsible Officer. A small number of doctors with prescribed connections have current or previous GMC undertakings, these are all being managed appropriately and do not give rise to active concerns.

Development Plan / Issues for 17-18

1. As identified last year, appraisers are concerned about the responsibility placed on them in terms of assurance regarding fitness to practice. There is no budget allocated to appraisal for either appraiser training or undertaking appraisals, in comparison to medical educational activities. Appraisers are requesting that their work be formally recognised in their job plans and this is currently under discussion.
2. The Trust has invested in a new Appraisal System, Allocate which will in turn replace the existing System SARD. It is hoped that this transfer between systems will occur seamlessly, but the SARD system will not be decommissioned until the new system has proved fit for purpose and data migration has occurred.
3. Administrative support – there is 0.6 WTE support which was originally set up to provide support for appraisal. Since Revalidation the tasks associated with Appraisal and Revalidation have increased significantly and require assimilation of new requirements, associated tasks, creation and submission of reports to NHS England. The Trust has also increased the number of doctors supported by the administrator over the past few years.

For approval

- The Board are asked to accept the Annual Report, note the contents and approve it for submission to the higher level Responsible Officer
- The Board are asked to approve the statement of compliance confirming that the West Suffolk NHS FT is compliant with relevant legislation and regulations

Attachments:

- Annual Organisational Audit 16-17
- Statement of Compliance

16. Putting you first award

To NOTE a verbal report of this month’s winner

Presented by Rowan Procter

17. Consultant appointment report

To RECEIVE the report

Presented by Stephen Dunn

BOARD OF DIRECTORS – 29th June 2018

Agenda item:	17			
Presented by:	Stephen Dunn, CEO			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	25th June 2018			
Subject:	Consultant Appointments			
Purpose:	X	For information		For approval

Executive summary:

Please find attached confirmation of Consultant appointments

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

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

Previously considered by:	Consultant appointments made by Appointment Advisory Committees
Risk and assurance:	N/A
Legislation, regulatory, equality, diversity and dignity implications	N/A

Recommendation:

For information only

POST:	Consultant – Nephrology
DATE OF INTERVIEW:	Monday, 21st May 2018
REASON FOR VACANCY:	Fast Track Post
CANDIDATE APPOINTED:	[redacted]
START DATE:	Continuous
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	1 1 1

11:00 BUILD A JOINED-UP FUTURE

18. e-Care report

To RECEIVE an update report

Presented by Craig Black

Trust Open Board Meeting – 29th June 2018

Agenda item:	18			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Sarah Jane Relf, e-Care/Global Digital Exemplar Operational Lead			
Date prepared:	15 June 2018			
Subject:	To receive update on e-Care and Global Digital Exemplar Programme			
Purpose:	X	For information		For approval

Executive summary:
This paper provides a summary of the outcomes of work to review the quantifiable benefits achieved as a result of phase 1 and 2 e-Care implementation. The paper clearly demonstrates a return on investment showing improvements for patients and staff alike. In addition we can evidence productivity and efficiency gains.

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

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

Previously considered by:	*e-Care/GDE Programme Board*
Risk and assurance:	*All risks are monitored by the e-Care/GDE Programme Board and Programme Group*
Legislation, regulatory, equality, diversity and dignity implications	*Compliance with General Data Protection Regulation (GDPR)*

Recommendation:
The Board is asked to note the report

To receive update on e-Care and Global Digital Exemplar Programme

1. Background

1.1 The trust recently celebrated the two year anniversary of implementing e-Care. This was an appropriate point to review the benefits that we have achieved to date. The benefits review looked at what we have achieved from our major phase 1 and phase 2 implementations. As a reminder for the board the following functionality was introduced in each phase:

Phase 1 – May 2016	Phase 2 – October 2017 to date
• A new replacement Patient Administration System (PAS) • FirstNet – a dedicated emergency department system • EPMA – medicines management (prescribing and administration) • OrderComms – requesting and reporting for cardiology and radiology • Clinical documentation	• Acute kidney injury (AKI) and sepsis alerts • Full OrderComms functionality including pathology • Paediatrics • Capacity management – new functionality to improve patient flow • New clinical documentation, care plans and care pathways • Medication enhancements including duplicate paracetamol alerting • New diabetic care plan • Integrated observation devices (vital signs) • New emergency care data set

1.2 This paper focusses on those benefits that have shown a quantifiable return. There will be many other qualitative benefits for patients and staff that have not been covered in this report. These 'softer' benefits are equally as important as those shown within this paper. However in order to demonstrate a return on the original investment to the board, we have focussed on the quantifiable benefits within this report.

1.3 It should also be noted that it is impossible to state that e-Care alone has delivered some of the more transactional benefits. As with any trust there will always be multiple initiatives underway at any one time to support improvements in health care. However, e-Care initiatives and improvements will definitely have supported achievement of these.

2. Outcomes of review

2.1 Appendix A shows the full list of benefits that were identified in the original business case and subsequent go live plans. We have also shown which benefits are linked to the GDE programme. Of the 29 original benefits identified the status for each is shown below:

Status	Benefits
Reviewed and showing benefits	13
Reviewed and not showing benefits – requires more understanding	5
Reviewed and shows results but discounted as difficult to prove cause and effect	3
Data quality issue with baseline – requires forward monitoring	4
Work in progress	1
Discounted as no longer relevant	3
TOTALS	**29**

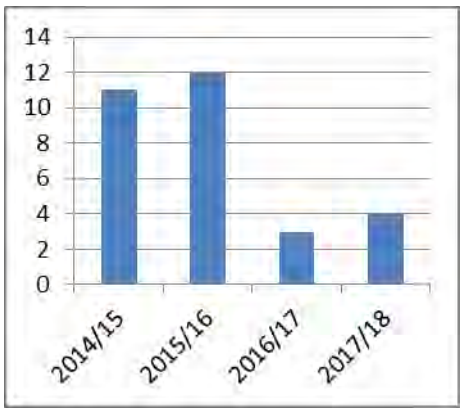
2.2

Integrated devices – covering benefit 1
Benefit(s) achieved: The introduction of integrated devices has reduced the time taken to complete one set of observations by one minute, therefore releasing approximately 8,212 hours of HCA time per annum. This is extra time that can be invested in the care of patients.
What has delivered this: The new vital signs integrated observation machines enable the nurse or health care assistant to take a set of observations and the information is then automatically uploaded into e-Care, therefore removing time taken to transcribe the information into the system. This also removes any potential transcription errors.
Additional commentary: As part of implementation we took a baseline for the average length of time taken to complete a single set of observations. The average was 210 seconds. Assuming the average ward has 3 observations rounds per day and that 450 beds are open this equates to 8,212 hours of saved time for health care assistants over a year.

2.3

OrderComms pathology – covering benefit 2
Benefit(s) achieved: The introduction of ordercomms pathology has reduced the average number of tests taken per encounter from 2.92 to 2.79 tests.
What has delivered this: There are a number of elements of ordercomms pathology that could have contributed to this benefit. There are duplicate prompts for the clinician that show if a test has already been ordered which should have reduced potential duplication. In addition there are ordersets built into system which should avoid over ordering.
Additional commentary: We looked at the total number of tests taken in 2016/17 and compared this against 2017/18. At face value this had increased. However when mapped against the increased activity (across inpatients, outpatients and the emergency department (ED) this showed a reduction in the amount of tests completed per encounter. Whilst the reduction appears small when extrapolated to activity the savings from this could be significant.

2.4

EPMA reduced adverse drug events – covering benefits 3 and 4
Benefit achieved: The introduction of electronic medication prescribing and administration has reduced the number of adverse drug events causing moderate or major harm by 70%. 
What has delivered this: There are a number of prompts and alerts within the system that would fire at the point of prescription and/or administration. In addition we have removed legibility errors from

having handwritten paper charts. All clinical information about the patient is also readily available to the clinician at the point they are prescribing or administering.
Additional commentary: We looked at the total number of adverse drug events causing moderate and major harm for the two years prior to e-Care implementation and two years afterwards. This showed a 70% reduction. Each adverse drug event can result in up to 3 days additional length of stay and therefore this can also translate into a financial benefit. The same analysis on adverse drug events causing minor harm showed an increase. We believe that this is actually due to improved reporting of incidents due to much better visibility within the system. However we need to undertake further work to validate that assumption.

2.5

EPMA savings on paper drug charts – covering benefits 5 and 6
Benefit achieved: The introduction of electronic medication prescribing and administration has reduced costs of printing and scanning by £85k per annum.
What has delivered this: With the EPMA we no longer need to use paper drug charts for the vast majority of prescribing and administration. We can now avoid the costs of printing paper drug charts and from scanning the paper copies when the patient had been discharged.
Additional commentary: There were many more pieces of paper contained within the old paper drug chart and therefore these savings are conservative. However it is difficult to quantify these additional sheets and therefore we have focussed on drug charts specifically.

2.6

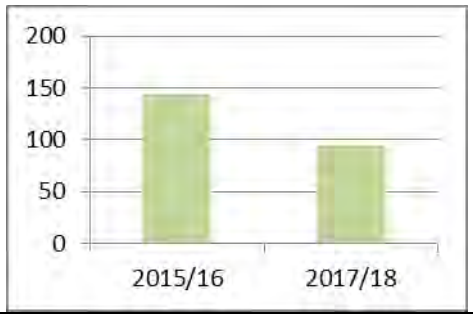
EPMA reduced pharmacy interventions – covering benefit 8
Benefit achieved: The introduction of electronic medication prescribing and administration has reduced the number of pharmacy interventions required by 53%.
What has delivered this: With the EPMA the quality of prescribing information has improved (as described above with prompts and legibility issues removed). This means that the degree of pharmacy intervention required has reduced. In turn, this means that our pharmacists are released to focus on education rather than correction. This will almost certainly have contributed to the other EMPA benefits described here.
Additional commentary: In 2015 we took a baseline from a week's observation audit that showed an average of 806 interventions for that particular week. We multiplied this by 52 weeks to give an approximate annual figure of 41,912. We are now able to report on pharmacy interventions from within the system and for 2017/18 this showed the total of interventions was 19,655.

2.7

EPMA reduced duplicate paracetamol prescribing – covering benefit 9
Benefit achieved: The introduction of paracetamol prescribing alert and 'hard stop' has eliminated the ability to duplicate a paracetamol prescription for adult patients.
What has delivered this: The new paracetamol alert and 'hard stop' which does not allow the inappropriate duplicate prescribing of paracetamol. In the 3 months prior to introduction of the alert, 95 prescriptions of paracetamol were discontinued due to them being duplicated orders. This would equate to 380 episodes per annum.
Additional commentary: The alert is also active for children. However there is the facility to override the alert in paediatrics and therefore we have not included their figures here. Adult doses will tend

to be the same regardless of the route, but paediatrics can have different doses for each route so it may be necessary for them to have multiple prescriptions for different routes on their drug chart at once.

2.8

Sepsis alerts –benefits 10,11,12
Benefit achieved: The introduction of sepsis alerts has reduced the number of patients escalating to ITU from the general wards by 34%. 
What has delivered this: We introduced a new sepsis alert in 2017 and we believe that there is potentially much earlier intervention on the wards as a result of this. This in turn would reduce the number of patients escalated to ITU due to worsening condition. The original business plan outlined ambition of reduction of 33% so this has been achieved.
Additional commentary: In addition to the escalation benefit shown here we had also anticipated seeing a reduction in length of stay on both the wards and in ITU. However our reporting algorithm for this has changed since the introduction of e-Care and therefore it is not possible to identify a comparable baseline against which to measure. On that basis we will measure the improvement from the point of introduction of e-Care which means we cannot demonstrate this benefit at this stage.

2.9

Enterprise level – saved time from no longer 'chasing' paper charts – covering benefit 17
Benefit achieved: The introduction of the electronic patient record has saved on average 15 minutes per shift for each member of clinical staff by having all of the information that they need, at the point they need it and where they need it.
What has delivered this: Prior to introduction of e-Care all staff were sharing a single paper record. This was often being used by other colleagues and/or may be out of the department with the patient or in pharmacy. With e-Care all staff now have the information available whenever they need it and multiple people can use the same record at the same time.
Additional commentary: It is impossible to measure an accurate baseline for this and therefore we have relied on interviewing staff to ask for their view on how much time they have saved. We believe the 15 minutes shown here to be conservative.

2.10

Enterprise level – improved compliance with responding to patient complaints within agree timeline – benefit 17
Benefit achieved: We have seen a 65% improvement on our performance for handling complaints within the agreed timeline.
What has delivered this: A number of staff will usually be involved in reviewing the record and contributing to the

investigation of a complaint. Prior to introduction of e-Care all staff would have used the same paper record and could therefore only complete their part of the investigation when someone else had concluded. Now with e-Care all staff can work concurrently and therefore our timeliness has improved significantly. In addition the quality and completeness of information available to all staff will have improved the quality of our investigation and therefore response.
Additional commentary: We compared Q1 for 2016/17 which showed 46% of complaints were handled within the 25 day deadline and in Q1 2017/18 this had increased to 75%. There has also been considerable operational focus on this area so we cannot claim that e-Care is 100% responsible for this step change however it will definitely have contributed significantly.

2.11

'Tap and go' - covering benefit 23
Benefit achieved: The introduction of 'tap and go' into ED and F8 has reduced the log in times for all clinicians by 26 seconds every time. Clinicians in high throughput areas will log on and off the computers multiple times during a shift and therefore the saving of clinical time is significant.
What has delivered this: Prior to tap and go the clinicians would need to log off and back on again every time they moved from machine to machine. In high throughput areas the clinicians switch machines often during a shift. With 'tap and go' the clinicians have instant no click access and single sign-on to desktops and applications. In addition the screens 'follow' them i.e. they open back up to where they were previously when they switch to a different machine.
Additional commentary: At present this solution is deployed in ED and F8 only.

2.12

License savings - covering benefit 24
Benefit achieved: The introduction of a single integrated electronic patient record has enabled us to discontinue paying for a number of licenses for multiple replaced systems. The most significant reduction relates to the old PAS, ED systems and EPRO. Combined these three equate to a saving of £350k per annum.
What has delivered this: The ability to discontinue previous licenses.
Additional commentary: This figure will grow as more older systems are moved across to e-Care.

2.13 There were three additional benefits that also showed improvements and these were around number of escalation beds open, length of stay and re-admission rates. However it was not felt possible to directly attribute these improvements to e-Care alone as there are many other initiatives that would have supported these achievements. We acknowledge that e-Care will have certainly contributed to these but it was felt impossible to apportion to what degree and therefore these are discounted from our benefits analysis.

2.14 We have highlighted some of the most significant benefits achieved within this paper. In addition to the above there are some benefits that we originally anticipated achieving where analysis has shown this to not be the case at this stage. These are around:

- Adverse drug events causing minor harm.
- The acute kidney injury alert does not seem to have the same impact as the sepsis alert.
- Falls and pressure sores do not seem to have been impacted by the introduction of e-Care.

We now need to work with staff to understand why these have not delivered in the same way and our optimisation team will be focussing on supporting staff to achieve these.

2.15 There were three further benefits that were included in our original business case around avoidance of fines for poor performance. These were removed at this stage as we are on block contract with our main commissioners and therefore these were not relevant at this stage.

2.16 We are still looking at the potential impact on pharmacy costs (from having increased compliance to formulary). Unfortunately the work on this was not complete in time for this board report.

2.17 It is also interesting to look at the impact that introducing e-Care has had on staff satisfaction levels. Evidence from the annual national staff survey would suggest that there has been no negative impact from moving across to an electronic patient record, indeed we have seen a slight improvement on the indicators of care.

National staff survey question	2016	2017
I would recommend my organisation as a place to work	75%	75%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	85%	86%
Staff recommendation as a place to work or receive treatment (*highest score in country for 2017*)	4.10	4.12

2.18 We have significant learning from completing this review and analysis for phase one and two which will support us in ensuring that we identify and achieve anticipated benefits for the forthcoming phase 3.

3. Recommendation

3.1 The board is asked to note this report.

Sarah Jane Relf
e-Care/GDE Operational Lead
16 June 2018

Appendix A: Status for phase 1 and phase 2 benefits

	Worked up for Phase 1 and 2			
	Project/initiative	**Benefit**	**Status**	**GDE?**
1	Integrated devices	Saved nursing assistant time	Reviewed and showing benefits	Yes
2	OrderComms pathology	Reduction in duplicate pathology tests	Reviewed and showing benefits	Yes
3	EPMA	Reduced adverse drug events causing moderate or major harm	Reviewed and showing benefits	No
4	EPMA	Reduced adverse drug events causing minor harm	Reviewed and not showing benefits - requires more work	No
5	EPMA	Reduced spend on scanning of drugs charts	Reviewed and showing benefits	No
6	EPMA	Reduced spend on printing of drugs charts	Reviewed and showing benefits	No
7	EPMA	Reduced pharmacy costs from formulary compliance (high cost and standard)	Work in progress	No
8	EPMA	Reduced pharmacy interventions	Reviewed and showing benefits	Yes
9	EPMA Phase 2	Reduced duplicate paracetamol prescribing	Reviewed and showing benefits	Yes
10	Sepsis alerting	Reduced number of patients escalating to ITU for Sepsis	Reviewed and showing benefits	Yes
11	Sepsis alerting	Reduced length of stay in ITU for Sepsis through earlier identification	Data quality issue therefore no baseline	Yes
12	Sepsis alerting	Reduced length of stay in general wards for Sepsis through earlier identification	Data quality issue therefore no baseline	Yes
13	AKI alerting	Reduced number of patients escalating to ITU for AKI	Reviewed and not showing benefits - requires more work	Yes
14	AKI alerting	Reduced length of stay in ITU for AKI through earlier identification	Data quality issue therefore no baseline	Yes
15	AKI alerting	Reduced length of stay in general wards for AKI through earlier identification	Data quality issue therefore no baseline	Yes
16	Sepsis and AKI alerting	Reduced number of patients escalating to ITU for combined Sepsis and AKI	Reviewed and showing benefits	Yes
17	Enterprise level	Reduced time from chasing results and drug charts etc.	Reviewed and showing benefits	Yes
18	Enterprise level	Increased compliance with responding to complaints within agreed timeline	Reviewed and showing benefits	Yes
19	NoF pathway	Reduction in length of stay for fractured neck of femur pathway	Reviewed - discounted as difficult to show cause/effect	Yes
20	Nursing care compass	Reduction in falls resulting in harm	Reviewed and not showing benefits - requires more work	No
21	Nursing care compass	Reduction in higher grade pressure sores	Reviewed and not showing benefits - requires more work	No
22	Nursing care compass	Reduction in lower grade pressure sores	Reviewed and not showing benefits - requires more work	No
23	Tap and Go	Saved time for clinicians in logging on and off machines	Reviewed and showing benefits	Yes
24	Enterprise level	Reduction in license savings	Reviewed and showing benefits	No
25	Enterprise level	Reduction in re-admission rates	Reviewed - discounted as difficult to show cause/effect	No
26	Enterprise level	Reduction in escalation beds	Reviewed - discounted as difficult to show cause/effect	No
	Phase 1 and 2 benefits not pursued			
	Project/initiative	**Benefit**	**Status**	**GDE?**
27	Enterprise level	NHS litigation costs reduced	Not pursued - releates to maternity which is in phase 3	No
28	Enterprise level	CQUIN compliance	Not pursued - block contract	No
29	Enterprise level	Avoidance of fines for non compliance with discharge letter timescales	Not pursued - black contract	No

19. Annual licence certification report - general condition 6 and Continuity of Services condition 7

To APPROVE report

Presented by Richard Jones

Board of Directors – 29 June 2018

Agenda item:	19			
Presented by:	Steve Dunn, Chief Executive			
Prepared by:	Richard Jones, trust Secretary & Head of Governance			
Date prepared:	21 June 2018			
Subject:	Certificate for NHS Improvement licencing			
Purpose:		For information	X	For approval

Executive summary:

NHS Improvement has issued two self-certification requirements for approval by the Board as part of the annual reporting arrangements. These follow a similar structure and content to previous years and sit alongside the general condition 6 certificate which formed part of the annual report approval on 26 May 2017 (Annex B).

The Board is required to approve the following annual statements and certifications as part of our licencing submissions to NHS Improvement. These are set out below and in greater detail within **Annex A**:

1. **Corporate Governance statement - *Confirmed***
   A range of statements are detailed coving compliance with corporate governance best practice; effective systems and processes; and having the correct personnel in place.

   It is proposed to indicate that the requirement has been met. This is supported by a range of assurances including annual governance assessment; internal and external audit opinions; review by external agencies, including the CQC, performance and management information reported to the Board and its subcommittees.

2. **Training of governors - *Confirmed***
   The Board is asked to confirm that it is satisfied that during 2017/18 it provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure governors are equipped with the skills and knowledge they require.

   It is proposed to indicate that the requirement has been met. This is supported by the working and information received at the Council of Governors, its subcommittees and workshops; training provided during the year; and governor attendance at external events. This compliance position is supported by the Council of Governors commentary in the Annual Quality Report.

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

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X				X
Previously considered by:	General condition 6 and Continuity of Services condition 7 certificate approval as part of Annual Report & Accounts. Governor commentary, including training, approved for inclusion in Annual Quality Report.						
Risk and assurance:	Governance and risk management framework underpinned by policy and procedures. Internal and external audit review of control environment. Annual governance review. Internal and External Audit opinions as part of Annual Report and Accounts.						
Legislation, regulatory, equality, diversity and dignity implications	Set out in NHS Improvement Licence						

Recommendation:

1. The Board approve the six corporate governance statements and certification for training of governors (**Annex A**)
2. The Board receive in public session the general condition 6 and continuity of cervices condition 7 certificates (**Annex B**).

Annex A

Corporate Governance Statement

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	Agreed with NHSI that well-led assessment be undertaken by independent reviewer during 2019/20
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	Confirmed	

(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.		
5 The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	**Confirmed**	
6 The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	**Confirmed**	

Signed on behalf of the board of directors, and having regard to the views of the governors

Signature	**Signature**
Name Sheila Childerhouse	**Name** Dr Stephen Dunn

Certification on governance and training of governors

The Board are required to respond "Confirmed" or "Not confirmed" to the following statement. Explanatory information should be provided where required.

2 Training of Governors

The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

Confirmed

Signed on behalf of the Board of directors, and having regard to the views of the governors

Signature		Signature	
Name	Sheila Childerhouse	**Name**	Dr Stephen Dunn
Capacity	Chairman	**Capacity**	Chief Executive
Date	29 June 2018	**Date**	29 June 2018

Annex B General condition 6 and Continuity of Services condition 7 certificate

A. For Condition G6 – Systems for compliance with licence conditions and related obligations

Question 1

Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	**Confirmed**

Requirements to comply - Guidance on Condition G6 (extract from NHSI Licence)

1. The Licensee shall take all reasonable precautions against the risk of failure to comply with:
   (a) the Conditions of this Licence,
   (b) any requirements imposed on it under the NHS Acts, and
   (c) the requirement to have regard to the NHS Constitution in providing health care services for the purposes of the NHS.

2. Without prejudice to the generality of paragraph 1, the steps that the Licensee must take pursuant to that paragraph shall include:
   (a) the establishment and implementation of processes and systems to identify risks and guard against their occurrence; and
   (b) regular review of whether those processes and systems have been implemented and of their effectiveness.

B. For continuity of service – availability of resources

Question 2

After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	**Confirmed**

OR

After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	

OR

In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.	

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Exceeded the NHSI control total. Achieved an Outstanding CQC comprehensive inspection rating.

11:10 GOVERNANCE

20. Trust Executive Group report

To ACCEPT a report

Presented by Stephen Dunn

Board of Directors – 29 June 2018

Agenda item:	20			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	21 June 2018			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

Executive summary

4 June 2018

Steve Dunn provided an introduction including an update on **external and internal developments**. It was noted that NHSI and NHSE have committed to merge, both in national and locality teams. The Suffolk and north east Essex STP has also been announced as a second wave integrated care system (ICS), which will further boost our integration ambitions. It was recognised that the NHS' 70th birthday is approaching with preparations underway for special events centred on the 5 July.

It was confirmed that, despite the challenge, we exceeded our **financial plan for 2017-18**, which meant we had received bonus sustainability and transformation funding (STF) with a year-end position of almost break even (deficit of £0.3m).

Steve confirmed that as part of the next wave of **STP capital funding** we are bidding for £15m to support the redevelopment of the emergency department (ED). He congratulated the team on delivering 93.7% in May, when the regional average was 90.7%. It was recognised that we continue our focus on ED improvement.

The April **integrated quality and performance report** (IQPR) was reviewed. Improved performance for May in terms of ED and RTT was noted. Capacity and demand reviews are taking place to support the RTT improvement plan and sustainable delivery going forward. Steve emphasised that we are not deprioritising clinically urgent patients to deliver the target.

The **red risk report** was reviewed with discussion and challenge for individual areas. No new red risks were received. Linked to preparation from winter it was agreed that each division review their operational staffing risks.

A review of preparation for **winter 2018-19** was undertaken. This included capacity modelling, physical building and recruitment plans. The recruitment plans included additional nursing assistants to support the implementation of bay based nursing. Areas for development were highlighted as well as the need to prepare for a potential surge in demand during the summer when system staffing can be a challenge.

An update was received on the **health coaching programme** which has been used in the hospital and community services. Extension of the scheme to partner organisations has been supported and funded. Options to provide greater capacity for Trust staff will also be considered.

A fixed term **anaesthetic consultant** post business case was supported.

An update was received on **e-Care and the global digital exemplar** programme. This included final

stages of the safety case for go-live of launchpoint for the ED.

A report on progress with delivery of **7 day services** was considered. Further clarity has been received as to the detail of full implementation regarding standards 2 (time to consultant review) and 8 (on-going review). It is expected that Trusts achieve these two standards in at least 90% of cases seven days per week.

18 June 2018

Steve Dunn provided an introduction to the meeting. This included reflection on the real-term impact of recent announcements on increased **national NHS funding** in the context of the NHS' 70th birthday. These funds will be linked to innovation and improvements, including information technology and operational transformation such as reductions in 'super stranded' patients (patients whose discharge has been delayed for more than 21 days) and modernisation of outpatients. For WSFT the focus of future global digital exemplar (GDE) funding would need to balance investment between the acute and community settings.

It was agreed to schedule a review of the **Trust's strategy and ambitions** in light of anticipated national guidance. This review would include an assessment of progress against the priorities and ambitions.

Steve thanked the **emergency department (ED)** for their response to the additional support offered and the improvements being seen in delivery of the 4 hour wait standard. Operational focus was also given to planning leave for the summer as well as improvement in appraisal rates.

It was noted that the Trust had accepted a **revised control total** offer from NHSI meaning that we need to deliver a £13.8m year-end deficit. Working is ongoing to identify the required additional £2.7m saving.

An update was received on **acute assessment unit (AAU)** developments within the current facilities and plans for the clinical model within the new facility to open by December 2018. A report will be received in August with the proposed operational model reflect final changes to the plans for the physical build which are currently being made. TEG supported the proposals.

A review and challenge for **annual leave** arrangements for the summer took place to ensure appropriate staffing is in place. This review included community services staff and discussions will continue with assistant directors of operations (ADOs) and service managers to ensure effective preparation.

An updated was received on the delivery of **trusted assessment** within the Trust and with local partners. Good progress is being made on implementation which is underpinned by technology and appropriate information sharing between services and across organisational boundaries. It was recognised that we are starting to see reductions in duplication with benefits for patients and staff. The policy for implementation is now in place supported by a single referral form.

The updated **West Suffolk Alliance strategy** was reviewed. The strategy was welcomed and it was recognised that for some patients the boundary of the Alliance will be arbitrary and we would seek to extend the menu of services offered to patients and practices on the periphery of the Alliance such as Thetford and Stowmarket. It was also recognised that WSFT needed to operate as an active member of the STP with a shared strategy and priorities.

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

a) Staff rostering policy – setting out clear expectation for staff and managers regarding leave management
b) Access policy – changes noted and agreed that further clinical engagement is required prior to submission to the Alliance's System Executive Group. A public facing summary of the document will also be produced.

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

21. Council of Governors report

To RECEIVE the report

Presented by Sheila Childerhouse

Board of Directors – 29 June 2018

Agenda item:	21			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Georgina Holmes, Foundation Trust Office Manager			
Date prepared:	21 June 2018			
Subject:	Report from Council of Governors, 17 May 2018			
Purpose:	X	For information		For approval

This report provides a summary of the business considered at the Council of Governors meeting held on 17 May 2018. The report is presented to the board of directors for information to provide insight into these activities. Key points from the meeting were:

- A report was received from the Chair who explained that she had been aiming to get out into the wider organisation more and build links with stakeholders across a wider area, whilst ensuring a balance of internal and external meetings and visits
- The Chief Executive's report provided an update on the challenges facing the Trust and recent achievements
- Response to governors issues raised were received and follow up actions agreed
- The quality and performance and finance reports were reviewed and questions asked on areas of challenge. More information on the community was requested to be included in the performance report
- A presentation was received from Dr Helena Jopling on global excellence in population health and the HealtheIntent platform
- Angus Eaton gave a short presentation on his background, why he wanted to become a NED and what he considered to be important in his role as a NED
- A report was received from governors who attended a recent STP leaders event
- The commentary from the Council of Governors for inclusion in the Annual Quality Report was approved
- A report was received from the nominations committee meeting of 19 April. Seven governors volunteered to act as NED appraisers
- The minutes of the engagement committee meeting of 27 March were received and the terms of reference and engagement strategy were approved
- A report was received from the lead governor and staff governors.

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

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

22. Audit Committee report

To RECEIVE the report

Presented by Sheila Childerhouse

Trust Board Meeting – 29th June 2018

Agenda item:	22			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Louise Wishart, Assistant Director of Finance			
Date prepared:	June 2018			
Subject:	Audit Committee report - meeting held on 24th May 2018			
Purpose:		For information	X	For approval

Executive summary:

The draft minutes of the meetings of the Audit Committee on 24th May 2018 are attached. **Please note these have yet to be approved.** The key issues and actions discussed were:-

- **External Audit Report to Those Charged with Governance**- The Committee considered the issues highlighted by the external auditors including:

    1. The 2017/18 Annual Accounts - a number of amendments had been made, none were material and two unadjusted non-material adjustments remained. The auditors expected to issue an unqualified opinion the following day which did happen.
    2. The audited elements of the Annual Report
    3. The Use of Resources Review - the auditors planned to issue a qualified Value for Money Opinion due to the Trust's deficit position and forecast deficit position going forward. The planned qualified opinion was issued the following day.
    4. The auditors recommended some improvements that could be made to processes and estimates which management and the Committee agreed
    5. The need to review the building insurance arrangements. The Trust is appointing a broker to act on our behalf and obtain quotations for property damage and business interruption insurance.

- **Annual Report** – The Committee asked for some amendments to the 2017/18 draft Annual Report and with those recommended approval to the Trust Board.
- **2017/18 Annual Accounts** – following consideration of the external auditor's report the Committee recommended approval of the accounts to the Trust Board.
- **Quality Report** – the external auditors did not identify any errors in the draft Quality Report but recommended some improvement to processes.
- **Internal Audit** – the final 2017/18 Internal Audit Opinion and Report was considered and accepted.

- **General Condition 6 and Continuity of Service Certification** – This document was approved.
- **New Chair** – the Committee expressed their thanks to Steve Turpie as outgoing Chair for all the work he has done and welcomed Angus Eaton as the new Chair of the Committee.

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

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

Previously considered by:	*This report has been produced for the monthly Trust Board meeting only*
Risk and assurance:	*None*
Legislation, regulatory, equality, diversity and dignity implications	*None*

Recommendation:
The Board is asked to:

- receive and note the Audit Committee report for meeting held on 24th May 2018
- note progress with assessment of property insurance requirements

23. Remuneration Committee report

To RECEIVE the report

Presented by Sheila Childerhouse

Board of Directors – 29 June 2018

Agenda item:	23			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	21 June 2018			
Subject:	Remuneration Committee report – 25 May 2018			
Purpose:	X	For information		For approval

Executive summary

The Committee met on 25 May 2018 to consider and agree the remuneration for the successful candidate from the Chief Operating Officer interviews.

Like other remuneration decisions, the Committee considered a number of factors in deciding the appropriate level of remuneration for the successful candidate for the role. Relativity to benchmarking for executives at medium sized trusts and other Executives in the Trust was referenced although neither were determinants, as all factors were considered in the round.

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

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

Previously considered by:	The Committee meets on a six-monthly basis and provides a report to the Board summarising issues discussed and any issues for escalation.
Risk and assurance:	Failure of the Board to maintain oversight of executive director responsibilities, objectives and performance.
Legislation, regulatory, equality, diversity and dignity implications	NHSI's code of governance NHSI's guidance for very senior managers
Recommendation: The Board notes the report.	

24. Annual governance review

To APPROVE report

Presented by Richard Jones

Board of Directors – 29 June 2018

Agenda item:	24			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	21 June 2018			
Subject:	Annual governance review 2018-19			
Purpose:		For information	X	For approval

Executive summary:

The Board undertakes an annual review of its governance structure in order to ensure that it is adequately discharging its responsibilities. The questions within the self-assessment are based on the CQC and NHSI **well-led assessment framework**.

By well-led, the CQC mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture. The well-led assessment is structured around eight key lines of enquiry (**KLOE**) – see figure 1.

Figure 1: Structure of new well-led assessment framework

A summary of the characteristics for each of these KLOE is provided (**Annex B**). Each KLOE is underpinned by a set of **prompts** which are used by the CQC during their inspections.

Similar to last year it is these prompts that will be used as the basis for the Board members self-assessment of the Trust's well-led rating (**Annex A**). This will allow themes to be identified and ratings to be compared with the previous year.							
Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		X		X		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X				X
Previously considered by:	Previously undertaken self-assessment as part of annual governance review.						
Risk and assurance:	Failure to comply with NHSI single assessment framework or code of governance and quality governance framework						
Legislation, regulatory, equality, diversity and dignity implications	NHSI's code of governance, risk assessment framework and quality governance framework						
Recommendation: The Board is asked to approve the proposed for the annual governance self-assessment approach to be administered through a questionnaire to directors (Annex A)							

Annex A: Annual Governance Review 2018-19

The questions within the self-assessment are based on the CQC and NHSI well-led assessment framework.

By well-led, the CQC mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.

Outstanding	Good	Requires improvement	Inadequate
The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.	The leadership, governance and culture promote the delivery of high-quality person-centred care.	The leadership, governance and culture do not always support the delivery of high-quality person-centred care. Regulations may or may not be met.	The delivery of high-quality care is not assured by the leadership, governance or culture. Normally some regulations are not met.

The assessment is structured around eight key lines of enquiry (KLOE) for leadership and governance:

1. Is there the leadership capacity and capability to deliver high quality, sustainable care?
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
3. Is there a culture of high quality, sustainable care?
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?
5. Are there clear and effective processes for managing risks, issues and performance?
6. Is appropriate and accurate information being effectively processed, challenged and acted on?
7. Are the people who services, the public, staff and external partners engaged and involved to support high quality sustainable services?
8. Are there robust systems and processes for learning, continuous improvement and innovation?

A summary of the characteristics for each of these KLOE is provided separately and **should be read prior to answering these questions.** Please return the completed questionnaire (preferably electronically) by **31 July 2018** to georgina.holmes@wsh.nhs.uk

Please respond to each of the questions based on the ratings set out below:

Risk rating	Definition
Outstanding ☆	The service is performing exceptionally well.
Good ●	The service is performing well and meeting our expectations.
Requires improvement ●	The service isn't performing as well as it should and we have told the service how it must improve.
Inadequate ●	The service is performing badly and we've taken action against the person or organisation that runs it.

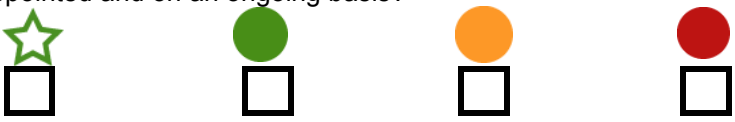
Well-led framework governance review

Completed by:

NED ☐ Exec. ☐

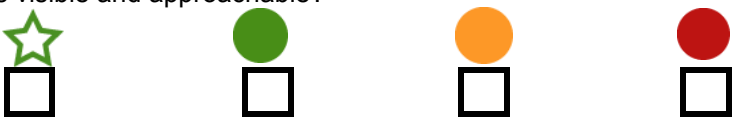
KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?

Q1.1 Do leaders have the skills, knowledge, experience and integrity that they need – both when they are appointed and on an ongoing basis?



Q1.2 Do leaders understand the challenges to quality and sustainability and can they identify the actions needed to address them?

Q1.3 Are leaders visible and approachable?

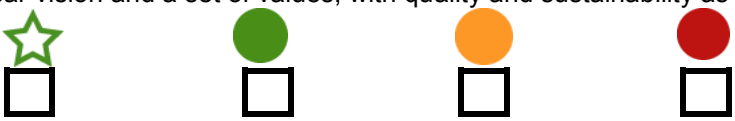


Q1.4 Are there clear priorities for ensuring sustainable, compassionate, inclusive and effective leadership, and is there a leadership strategy or development programme, which includes succession planning?

Comments or suggestions for improvement

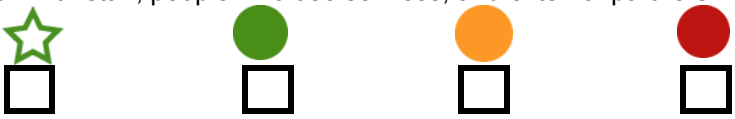
KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people who use services, and robust plans to deliver?

Q2.1 Is there a clear vision and a set of values, with quality and sustainability as the top priorities?



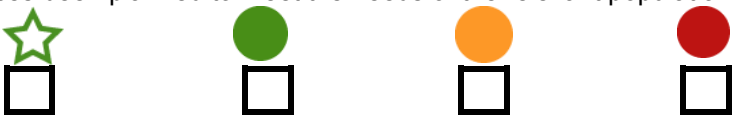
Q2.2 Is there a robust realistic strategy for achieving the priorities and delivering good quality, sustainable care?

Q2.3 Have the vision, values and strategy been developed using a structured planning process in collaboration with staff, people who use services, and external partners?



Q2.4 Do staff know and understand what the vision, values and strategy are, and their role in achieving them?

Q2.5 Is the strategy aligned to local plans in the wider health and social care economy, and how have services been planned to meet the needs of the relevant population?



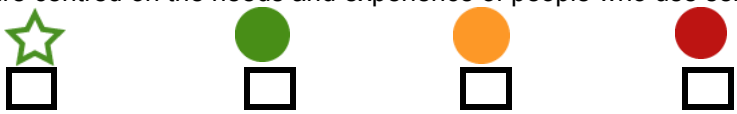
Q2.6 Is progress against delivery of the strategy and local plans monitored and reviewed and is there evidence to show this?

Comments or suggestions for improvement

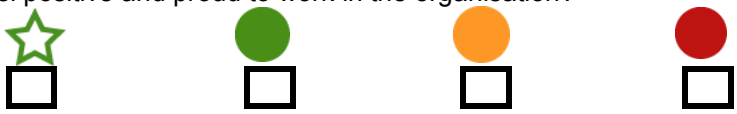
KLOE 3: Is there a culture of high quality, sustainable care?

Q3.1 Do staff feel supported, respected and valued?

Q3.2 Is the culture centred on the needs and experience of people who use services?



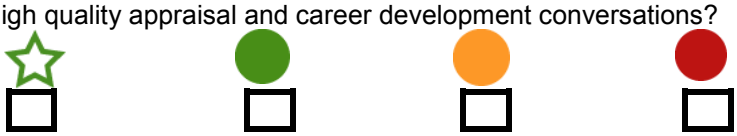
Q3.3 Do staff feel positive and proud to work in the organisation?



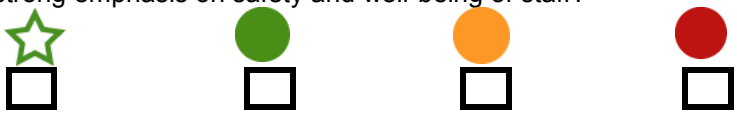
Q3.4 Is action taken to address behaviour and performance that is inconsistent with the vison and values, regardless of seniority?

Q3.5 Does the culture encourage, openness and honesty at all levels within the organisation, including with people who use services, in response to incidents? Do leaders and staff understand the importance of staff being able to raise concerns without fear of retribution, and is appropriate learning and action taken as a result of concerns raised?

Q3.6 Are there mechanisms for providing all staff at every level with the development they need, including high quality appraisal and career development conversations?



Q3.7 Is there a strong emphasis on safety and well-being of staff?



Q3.8 Are equality and diversity promoted within and beyond the organisation? Do all staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably?

Q3.9 Are there co-operative, supportive and appreciative relationships among staff? Do staff and teams work collaboratively, share responsibility and resolve conflict quickly and constructively?

Comments or suggestions for improvement

KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Q4.1 Are there effective structures, processes and systems of accountability to support the delivery of the strategy and good quality, sustainable services? Are these regularly reviewed and improved?

Q4.2 Do all levels of governance and management function effectively and interact with each other appropriately?

Q4.3 Are staff at all levels clear about their roles and do they understand what they are accountable for and to whom?

Q4.4 Are arrangements with partners and third-party providers governed and managed effectively to encourage appropriate interaction and promote coordinated, person-centred care?

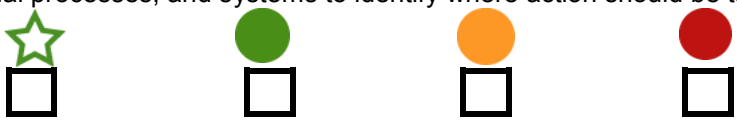
Comments or suggestions for improvement

KLOE 5. Are there clear and effective processes for managing risks, issues and performance?

Q5.1 Are there comprehensive assurance systems, and are performance issues escalated appropriately through clear structures and processes? Are these regularly reviewed and improved?

Q5.2 Are there processes to manage current and future performance? Are these regularly reviewed and improved?

Q5.3 Is there a systematic programme of clinical and internal audit to monitor quality, operational, and financial processes, and systems to identify where action should be taken?



Q5.4 Are there robust arrangements for identifying, recording and managing risks, issues and mitigating actions? Is there alignment between the recorded risks and what staff say is 'on their worry list'?

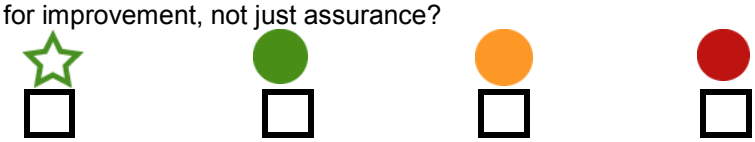
Q5.5 Are potential risks taken into account when planning services, for example seasonal or other expected or unexpected fluctuations in demand, or disruption to staffing or facilities?

Q5.6 When considering developments to services or efficiency changes, how is the impact on quality and sustainability assessed and monitored? Are there examples of where financial pressures have compromised care?

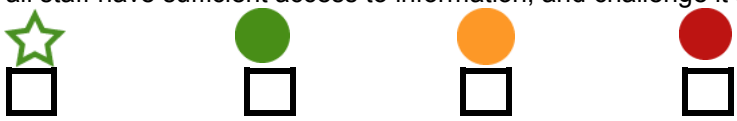
Comments or suggestions for improvement

KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?

Q6.1 Is there a holistic understanding of performance, which sufficiently covers and integrates people's views with information on quality, operations and finances? Is information used to measure for improvement, not just assurance?



Q6.2 Do quality and sustainability both receive sufficient coverage in relevant meetings at all levels? Do all staff have sufficient access to information, and challenge it appropriately?



Q6.3 Are there clear and robust service performance measures, which are reported and monitored?

Q6.4 Are there effective arrangements to ensure that the information used to monitor, manage and report on quality and performance is accurate, valid, reliable, timely and relevant? What action is taken when issues are identified?

Q6.5 Are information technology systems used effectively to monitor and improve the quality of care?

Q6.6 Are there effective arrangements to ensure that data or notifications are submitted to external bodies as required?

Q6.7 Are there robust arrangements (including appropriate internal and external validation), to ensure the availability, integrity and confidentiality of identifiable data, records and data management systems, in line with data security standards? Are lessons learned when there are data security breaches?

Comments or suggestions for improvement

KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

Q7.1 Are people's views and experiences gathered and acted on to shape and improve the services and culture? Does this include people in a range of equality groups?

Q7.2 Are people who use services, those close to them and their representatives actively engaged and involved in decision-making to shape services and culture? Does this include people in a range of equality groups?

Q7.3 Are staff actively engaged so that their views are reflected in the planning and delivery of services and in shaping the culture? Does this include those with a protected equality characteristic?

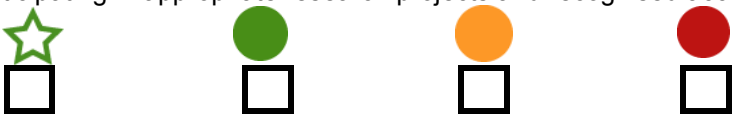
Q7.4 Are there positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs?

Q7.5 Is there transparency and openness with all stakeholders about performance?

Comments or suggestions for improvement

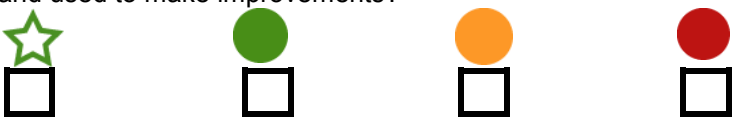
KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

Q8.1 Do leaders and staff strive for continuous learning, improvement and innovation? Does this include participating in appropriate research projects and recognised accreditation schemes?



Q8.2 Are there standardised improvement tools and methods, and do staff have the skills to use them?

Q8.3 How effective is participation in and learning from internal and external reviews, including those related to mortality or the death of a person using the service? Is learning shared effectively and used to make improvements?



Q8.4 Do all staff regularly take time out to work together to resolve problems and to review individual and team objectives, processes and performance? Does this lead to improvements and innovation?

Q8.5 Are there systems in place to support improvement and innovation work including objectives and rewards for staff, data systems, and processes for evaluating and sharing the results of improvement work?

Comments or suggestions for improvement

Please return the completed questionnaire (preferably electronically) by **31 July 2018** to georgina.holmes@wsh.nhs.uk

Annex B CQC rating characteristics

Well-led			
By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality and person-centred care, supports learning and innovation, and promotes an open and fair culture.			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.	The leadership, governance and culture promote the delivery of high-quality person-centred care.	The leadership, governance and culture do not always support the delivery of high-quality person-centred care. Regulations may or may not be met.	The delivery of high-quality care is not assured by the leadership, governance or culture. Normally some regulations are not met.
W1: Is there the leadership capacity and capability to deliver high-quality, sustainable care?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
There is compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care. There is a deeply embedded system of leadership development and succession planning, which aims to ensure that the leadership represents the diversity of the workforce. Comprehensive and successful leadership strategies are in place to ensure and sustain delivery and to develop the desired culture. Leaders have a deep understanding of issues, challenges and priorities in their service, and beyond.	Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed. Leaders at every level are visible and approachable. Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, deployment and support processes and succession planning. The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and acts to address them.	Not all leaders have the necessary experience, knowledge, capacity, capability or integrity to lead effectively. Staff do not consistently know who their leaders are or how to gain access to them. The need to develop leaders is not always identified or action is not always taken. Leaders are not always aware of the risks, issues and challenges in the service. Leaders are not always clear about their roles and their accountability for quality.	Leaders do not have the necessary experience, knowledge, capacity, capability or integrity to lead effectively. There is no stable leadership team, with high unplanned turnover and/or vacancies. Leaders are out of touch with what is happening on the front line, and they cannot identify or do not understand the risks and issues described by staff. There is little or no attention to succession planning and development of leaders. Staff do not know who their leaders are or what they do, or are unable to access them. There are few examples of leaders making a demonstrable impact on the quality or sustainability of services.

W2: Is there a clear vision and credible strategy to deliver high-quality sustainable care to people, and robust plans to deliver?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
The strategy and supporting objectives and plans are stretching, challenging and innovative, while remaining achievable. Strategies and plans are fully aligned with plans in the wider health economy, and there is a demonstrated commitment to system-wide collaboration and leadership. There is a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Plans are consistently implemented, and have a positive impact on quality and sustainability of services.	There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well-defined objectives that are achievable and relevant. The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and, external partners. The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population. Progress against delivery of the strategy and local plans is monitored and reviewed and there is evidence of this. Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place. Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.	The strategy and plans have some significant gaps or weaknesses that undermine their credibility, and do not fully reflect the health economy in which the service works. They may not have been recently created or reviewed. Staff do not always understand how their role contributes to achieving the strategy. The statement of vision and guiding values is incomplete, out of date, or not fully credible. Results of stakeholder consultation are not always taken into account in strategies or plans. Staff are not always aware of, support, or do not understand the vision and values, or have not been fully involved in developing them. Progress against delivery of the strategy and plans is not consistently or effectively monitored or reviewed and there is no evidence of progress. Leaders at all levels are not always held to account for the delivery of the strategy.	There is no current strategy, or the strategy is not underpinned by detailed, realistic objectives and plans for high-quality and sustainable delivery, and it does not reflect the health economy in which the service works. Staff do not understand how their role contributes to achieving the strategy. There is no credible statement of vision and guiding values. Key stakeholders have not been engaged in the creation of the strategy. Staff are not aware of or supportive of, or do not understand, the vision and values, or they were developed without staff and wider engagement. There is no effective approach to monitoring, reviewing or providing evidence of progress against delivery of the strategy or plans. The strategy has not been translated into meaningful and measurable plans at all levels of the service.

W3: Is there a culture of high-quality, sustainable care?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
Leaders have an inspiring shared purpose, and strive to deliver and motivate staff to succeed. There are high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act. There is a strong organisational commitment and effective action towards ensuring that there is equality and inclusion across the workforce. Staff are proud of the organisation as a place to work and speak highly of the culture. Staff at all levels are actively encouraged to speak up and raise concerns, and all policies and procedures positively support this process. There is strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.	Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing. Leaders at every level live the vision and embody shared values, prioritise high-quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services. Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening	Staff satisfaction is mixed. Improving the culture or staff satisfaction is not seen as a high priority. Staff do not always feel actively engaged or empowered. There are teams working in silos or management and clinicians do not always work cohesively. Staff do not always raise concerns or they are not always taken seriously, appropriately supported, or treated with respect when they do. People do not always receive a timely apology when something goes wrong and are not consistently told about any actions taken to improve processes to prevent the same happening again. Staff development is not always given sufficient priority. Appraisals take place inconsistently or are not of high quality. Equality and diversity are not consistently promoted and the causes of workforce inequality are not always identified or adequately addressed. Staff, including those with particular protected characteristics under the Equality Act, do not always feel they are treated equitably.	There is no understanding of the importance of culture. There are low levels of staff satisfaction, high levels of stress and work overload. Staff do not feel respected, valued, supported or appreciated. There is poor collaboration or cooperation between teams and there are high levels of conflict. The culture is top-down and directive. It is not one of fairness, openness, transparency, honesty, challenge and candour. When something goes wrong, people are not always told and do not receive an apology. Staff are defensive and are not compassionate. There are high levels of bullying, harassment, discrimination or violence, and the organisation is not taking adequate action to reduce this. When staff raise concerns they are not treated with respect, or the culture, policies and procedures do not provide adequate support for them to do so. The culture is defensive. There is little attention to staff development and there are low appraisal rates.

	again. Behaviour and performance inconsistent with the vision and values is identified and dealt with swiftly and effectively, regardless of seniority. There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility is shared. There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations. Equality and diversity are actively promoted and the causes of any workforce inequality are identified and action taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.		

W4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
Governance arrangements are proactively reviewed and reflect best practice. A systematic approach is taken to working with other organisations to improve care outcomes.	The board and other levels of governance in the organisation function effectively and interact with each other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective. Staff are clear about their roles and accountabilities.	The arrangements for governance and performance management are not fully clear or do not always operate effectively. There has been no recent review of the governance arrangements, the strategy, or plans. Staff are not always clear about their roles, what they are accountable for, and to whom.	The governance arrangements and their purpose are unclear, and there is a lack of clarity about authority to make decisions and how individuals are held to account. There is no process to review key items such as the strategy, values, objectives, plans or the governance framework. Staff and their managers are not clear on their roles or accountabilities. There is a lack of systematic performance management of individual staff, or appropriate use of incentives or sanctions.

W5: Are there clear and effective processes for managing risks, issues and performance?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
There is a demonstrated commitment to best practice performance and risk management systems and processes. The organisation reviews how they function and ensures that staff at all levels have the skills and knowledge to use those systems and processes effectively. Problems are identified and addressed quickly and openly.	The organisation has the processes to manage current and future performance. There is an effective and comprehensive process to identify, understand, monitor and address current and future risks. Performance issues are escalated to the appropriate committees and the board through clear structures and processes. Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns. Financial pressures are managed so that they do not compromise the quality of care. Service developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood.	Risks, issues and poor performance are not always dealt with appropriately or quickly enough. The risk management approach is applied inconsistently or is not linked effectively into planning processes. The approach to service delivery and improvement is reactive and focused on short-term issues. Clinical and internal audit processes are inconsistent in their implementation and impact. The sustainable delivery of quality care is put at risk by the financial challenge.	There is little understanding or management of risks and issues, and there are significant failures in performance management and audit systems and processes. Risk or issue registers and action plans, if they exist at all, are rarely reviewed or updated. Meeting financial targets is seen as a priority at the expense of quality.

W6: Is appropriate and accurate information being effectively processed, challenged and acted on?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
The service invests in innovative and best practice information systems and processes. The information used in reporting, performance management and delivering quality care is consistently found to be accurate, valid, reliable, timely and relevant. There is a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement.	Integrated reporting supports effective decision making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people with quality, operational and financial information. Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary. Performance information is used to hold management and staff to account. The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses. Data or notifications are consistently submitted to external organisations as required. There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Information technology systems are used effectively to monitor and improve the quality of care.	The information used in reporting, performance management and delivering quality care is not always accurate, valid, reliable, timely or relevant. Leaders and staff do not always receive information to enable them to challenge and improve performance. Information is used mainly for assurance and rarely for improvement. Required data or notifications are inconsistently submitted to external organisations. Arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems are not always robust	The information that is used to monitor performance or to make decisions is inaccurate, invalid, unreliable, out of date or not relevant. Finance and quality management are not integrated to support decision making. There is inadequate access to and challenge of performance by leaders and staff. There are significant failings in systems and processes for the management or sharing of data.

W7: Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
There are consistently high levels of constructive engagement with staff and people who use services, including all equality groups. Rigorous and constructive challenge from people who use services, the public and stakeholders is welcomed and seen as a vital way of holding services to account. Services are developed with the full participation of those who use them, staff and external partners as equal partners. Innovative approaches are used to gather feedback from people who use services and the public, including people in different equality groups, and there is a demonstrated commitment to acting on feedback. The service takes a leadership role in its health system to identify and proactively address challenges and meet the needs of the population.	A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture. The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture. The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.	There is a limited approach to sharing information with and obtaining the views of staff, people who use services, external partners and other stakeholders, or insufficient attention to appropriately engaging those with particular protected equality characteristics. Feedback is not always reported or acted on in a timely way.	There is minimal engagement with people who use services, staff, the public or external partners. The service does not respond to what people who use services or the public say. Staff are unaware or are dismissive of what people who use the service think of their care and treatment. Staff or patient feedback is inappropriately filtered or sanitised before being passed on.

W8: Are there robust systems and processes for learning, continuous improvement and innovation?			
Outstanding	**Good**	**Requires improvement**	**Inadequate**
There is a fully embedded and systematic approach to improvement, which makes consistent use of a recognised improvement methodology. Improvement is seen as the way to deal with performance and for the organisation to learn. Improvement methods and skills are available and used across the organisation, and staff are empowered to lead and deliver change. Safe innovation is celebrated. There is a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There is a strong record of sharing work locally, nationally and internationally.	There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research. There is knowledge of improvement methods and the skills to use them at all levels of the organisation. There are organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems, and ways of sharing improvement work. The service makes effective use of internal and external reviews, and learning is shared effectively and used to make improvements. Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.	There is weak or inconsistent investment in improvement skills and systems among staff and leaders. Improvements are not always identified or action is not always taken. The organisation does not react sufficiently to risks identified through internal processes, but often relies on external parties to identify key risks before they start to be addressed. Where changes are made, the impact on the quality and sustainability of care is not fully understood in advance or it is not monitored.	There is little innovation or service development, no knowledge or appreciation of improvement methodologies, and improvement is not a priority among staff and leaders. There is minimal evidence of learning and reflective practice. The impact of service changes on the quality and sustainability of care is not understood.

25. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

Presented by Richard Jones

Board of Directors – 29 June 2018

Agenda item:				
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	21 June 2018			
Subject:	Items for next meeting			
Purpose:		For information	X	For approval

The attached provides a summary of scheduled items for the next meeting and is drawn from the Board reporting matrix, forward plan and action points.

The final agenda will be drawn-up and approved by the Chair.

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

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

Previously considered by:	The Board receive a monthly report of planned agenda items.
Risk and assurance:	Failure effectively manage the Board agenda or consider matters pertinent to the Board.
Legislation, regulatory, equality, diversity and dignity implications	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.

Recommendation:

To approve the scheduled agenda items for the next meeting

Scheduled draft agenda items for next meeting – 27 July 2018

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient story		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Alliance and community service report	✓		Written	Matrix	DG
Integrated quality & performance report, including staff recommender score, mandatory training (including barriers) and appraisal	✓		Written	Matrix	HB/RP
Finance & workforce performance report	✓		Written	Matrix	CB
Transformation report (Including Category Towers) – Q1	✓		Written	Matrix	HB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Nurse staffing report	✓		Written	Matrix	RP
Safe staffing guardian report	✓		Written	Matrix	NJ
Freedom to speak up guardian	✓		Written	Matrix	JB
National patient survey report	✓		Written	Matrix	RP
Equality annual report	✓		Written	Matrix	JB
Safeguarding children annual report	✓		Written	Matrix	RP
Sustainable Carbon Reduction Strategy annual report, including performance against KPIs (links to Annual Report)	✓		Written	Matrix	JB
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
Strategic update, including Alliance, System Executive Group and System Transformation Partnership (STP)		✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Quality & Risk Committee report, including annual complaint report	✓		Written	Matrix	SC
Scrutiny Committee report		✓	Written	Matrix	GN
Confidential staffing matters		✓	Written	Matrix – by exception	JB
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	RQ

11:25 ITEMS FOR INFORMATION

26. Any other business

To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency

Presented by Sheila Childerhouse

27. Date of next meeting

To NOTE that the next meeting will be held on Friday 27 July 2018 at 9:15 am in the Northgate Room.

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

28. The Trust Board is invited to adopt the following resolution:

“That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1 (2), Public Bodies (Admission to Meetings) Act 1960

Presented by Sheila Childerhouse