Board of Directors (In Public)

Schedule	Friday, 30 Nov 2018 9:15 AM — 12:00 PM GMT
Venue	Northgate Room, Quince House, WSFT
Description	A meeting of the Board of Directors will take place on Friday, 30 November 2018 at 9.15 in the Northgate Room, 2nd Floor Quince House, West Suffolk Hospital, Bury St Edmunds
Organiser	Karen McHugh

Agenda

AGENDA

Agenda Open Board 30 Nov 2018.docx

9:15 GENERAL BUSINESS

1. Introductions and apologies for absence
   To NOTE any apologies for the meeting and request that mobile phones are set to silent
   For Reference - Presented by Sheila Childerhouse

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

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

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

NHS
West Suffolk
NHS Foundation Trust

5. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 28 September 2018
   For Approval - Presented by Sheila Childerhouse

   Item 5 - Open Board Minutes 2018 11 02 Nov Draft.docx

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

   Item 6 - Action sheet report.doc

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

   Item 7 - Chief Exec Report Nov 18.doc

9:45 DELIVER FOR TODAY

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

   Item 8 - Community and alliance board cover sheet - November V1 2018.doc

   Item 8 - WSFT Board paper community and alliance update November 2018 V4.doc

   Item 8 - Appendix 1 Community Services and Alliance Update November WSFT Board.docx

   Item 8 - Appendix 2 Community Services and Alliance Update November WSFT Board.docx

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

   Item 9 - Integrated Quality & Performance Report_November_2018_Draft_v1.docx

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10. Finance and workforce report
    To ACCEPT the report
    For Report - Presented by Craig Black

    Item 10 - Board report Cover sheet - M7.docx

    Item 10 - Finance Report October 2018 Final.docx

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11. EU Exit report
    To ACCEPT the report
    For Report - Presented by Helen Beck

    Item 11 - WSFT Board EU EXIT v 0 2 071118.doc

10:45 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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

    Item 12 - Board Report - Staffing Dashboard - October 2018 data.doc

    Item 12 - WSFT Dashboard - Oct 2018.xls

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13. Freedom to speak up guardian – Q2
    To ACCEPT a report
    For Report - Presented by Jan Bloomfield

    Item 13 - Freedom to speak up guardian report - Nov 2018.docx

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14. Quality and learning report for Q2
    To ACCEPT a report, including progress with quality priorities for 2018-19
    For Report - Presented by Rowan Procter

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

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

    Item 15 - Consultant appointment report - November 2018.doc

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

11:30 BUILD A JOINED-UP FUTURE

17. WSFT Digital Board report
    To ACCEPT the report
    For Report - Presented by Craig Black

    Item 17 - WSFT Digital Board report - November 2018.doc

11:40 GOVERNANCE

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

    Item 18 - TEG report.doc

19. Audit Committee report
    To ACCEPT the report, including agreeing delegated authority for approval of the Charitable funds annual accounts
    For Report - Presented by Angus Eaton

    Item 19 - Audit Committee Report Coversheet November 2018.doc

    Item 19 - Draft Terms of Reference for approval at 30.11.2018 Trust Board.doc

20. Charitable Funds report
    To ACCEPT the report
    For Report - Presented by Gary Norgate

    Item 20 - Charitable Funds Board Report 30th November 2018.doc

21. Council of Governors report
    To ACCEPT the report
    For Report - Presented by Alan Rose

    Item 21 - CoG Report to Board Nov 2018.doc

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

Item 22 - Items for next meeting.doc

12:00 ITEMS FOR INFORMATION

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

24. Date of next meeting
To NOTE that the next meeting will be held on Friday, 25 January 2019 at 9:15 am in Quince House, West Suffolk Hospital.
For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

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

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To APPROVE the minutes of the meeting held on 28 September 2018

For Approval

Presented by Sheila Childerhouse

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 2 NOVEMBER 2018

AT SUDBURY COMMUNITY HEALTH CENTRE

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	•	
Louisa Pepper	Non Executive Director		•
Rowan Procter	Executive Chief Nurse	•	
Alan Rose	Non Executive Director	•	
In attendance			
Georgina Holmes	FT Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Tara Rose	Head of Communications		

Action

GENERAL BUSINESS

18/215 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

Apologies for absence were noted as above.

The Chair welcomed everyone to the meeting and explained that she was keen to hold meetings across the Trust's catchment area where suitable venues were available.

18/216 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

- Liz Steele noted the increase in falls over the last month and if asked anyone looked at vitamin D levels and if there were fewer falls in the summer when vitamin D levels were higher. Rowan Procter thanked Liz Steele for this question and said she would follow this up. **R Procter**

- June Carpenter referred to the minor casualty department which used to be in Sudbury and asked if there was a plan to reinstate this, as had been promised to the residents of Sudbury in the past.

  The Chief Executive explained that what was discussed some years ago was that there would be a new health centre, as had been provided. WSFT's strategic direction was to move services back into localities and although it did not own Sudbury Community Health Centre it provided several services out of this site and also worked with local GPs in the centre of Sudbury. However, due to financial pressures there were no plans to develop minor injuries services in the localities. WSFT was planning to develop its emergency department and was still waiting for funding for this.

Gary Norgate said that there needed to be timely communication if services were to be discontinued and it was important to engage the community in any decisions that were to be made. The Chair agreed that this was important and said the Trust would continue to try to ensure that changes in services were managed in this way.

Dawn Godbold explained that the Trust was currently talking to GPs about the level of enhanced services that could be provided, eg stitching wounds.

- Joe Pajak referred to agenda item 6, ref 1613, and asked if there could be a monthly update on the Trust's preparedness for Brexit. Helen Beck explained that there had not been a great deal of information available; however more information was now coming through. This would be taken to the scrutiny committee first with a plan on how to respond to the advice together with a plan for a no deal Brexit. A summary of this could then be brought to a public board meeting. The two main issues were supplies and staff. Some suppliers were being managed centrally and WSFT was reviewing the risk around some smaller suppliers.

  Jan Bloomfield explained that there had been a significant amount of communication with existing European staff. There was a scheme that they had to register with so that they could keep their residency status after December 2020. The executive team were considering how the Trust could support these employees with their registration as it had a high proportion of European staff, not all of whom were nurses. She hoped to be able to report back next month about the support processes being put in place for these staff.

- Joe Pajak referred to the governance model for pathology services and commented that there may be an opportunity for governor involvement in the governance structure. **R Jones**

- John Ellison (west Suffolk resident) reported that he had been unable to access the papers for this meeting in the normal way, ie from the Trust's website; however a hard copy of the papers had been made available for him today. Tara Rose apologised and explained that the reason for this had been identified as the format of the landscape papers in the document.

18/217 REVIEW OF AGENDA

The Chair noted that the agenda was very full and asked board members to be succinct and to the point.

18/218 DECLARATION OF INTERESTS

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

18/219 MINUTES OF THE MEETING HELD ON 28 SEPTEMBER 2018

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

Page 10, 18/199, 2nd sentence to be amended to read, "Medical reviewers were currently not funded by the government and Trusts were still awaiting clarity as to what the arrangements would be after next spring."

18/220 MATTERS ARISING ACTION SHEET

The ongoing and closed actions were reviewed and no issues were raised.

18/221 CHIEF EXECUTIVE'S REPORT

- The Chief Executive highlighted the following items in his report:-

- WSFT had achieved 95.5% against the A&E four hour wait target in September and had been the second strongest performer for A&E in the country last week. Achieving this had involved a huge amount of whole hospital and system working and he was very grateful for the efforts of the executive team as well as staff. However, winter was now approaching and staffing was a concern and would be a challenge.

- The board would continue to go out into the community and visit the teams.

- Finance continued to be an ongoing challenge, particularly taking into account the staffing pressures over the winter.

- He thanked the Friends' shop for the contribution they had made over the past year and for their ongoing support.

- He considered the creative training set up by the clinical skills team to be an excellent initiative.

Jan Bloomfield reported that to date at least 2012 members of staff (over 50%) had had a flu jab. The campaign was continuing and the board noted its commitment to the Trust's ambition for 100% of healthcare workers to be vaccinated. The Chief Executive highlighted annex A, best practice management for healthcare worker vaccination, self-assessment.

Gary Norgate asked what the worst month was for A&E, in terms of volume. Helen Beck said that January was likely to be the worst time but October had been very busy and the Trust had achieved 93%. Last week it was second in the country with bed occupancy of 97-98%. Nick Jenkins explained that summer was the busiest time for minor injuries, but there were fewer admissions.

Alan Rose referred to bullying and harassment and asked if WSFT had been asked as a Trust to make any changes as a result of national statements. The Chief Executive stressed that the Trust took this very seriously and had a zero tolerance policy. A press release was being sent out today explaining that WSFT was developing and launching its own in house restrictive physical intervention (RPI) security team. There had previously been internal incidents of bullying which had resulted in dismissal of staff and the board and executive team remained committed to ensuring that this type of behaviour was managed and taken very seriously.

Jan Bloomfield explained that staff were encouraged to take forward any issues and there was a very strong support network for staff.

Angus Eaton asked about the availability of flu jabs for board members. Nick Jenkins explained that it had not been possible to bring the vaccine with him to Sudbury today as it needed to be kept cool. The vaccine being given to staff was only suitable for those people under 65, anyone over this age needed to go to their GP. Jan Bloomfield explained that vouchers for flu jabs at Lloyds pharmacies were available for board members and governors who were under 65.

DELIVER FOR TODAY

18/222 ALLIANCE AND COMMUNITY SERVICES REPORT

Dawn Godbold explained that this report provided an update on internal and wider system activity. A new system wide forum for occupational therapists had been launched which was designed to share ideas and good practice.

Item 3 was a good example of how teams were working together to improve quality. Although no poor practice had been identified, the incident had highlighted an opportunity for sharing good practice in the management of sepsis. This had resulted in a team being established to look at the provision of training and education in the community with a number of actions being agreed.

Good progress was now being made with IT and the community services 'pillar 3', digital group had held their first meeting. The aim of this was to manage IT in the community and highlight any issues and also ensure a link with WSFT's digital transformation programme.

The initial feedback from Suffolk Health and Wellbeing on Buurtzorg had been received and it was hoped that the report form the Kings Fund would be available for the end of November.

Following the first year of the alliance, a very successful away day had taken place with representatives from across the system.

Item 8 gave details of the transformation funding/bids that had been awarded and how these would be spent across the system.

Measures and metrics at CCG and STP level were given in item 9. The next piece of work which was currently in progress would include social care measures and more qualitative measures.

The Chair thanked Dawn Godbold for a very positive report. Richard Davies agreed and asked about the challenges and risks such as the Health and Wellbeing report on Buurtzorg as well as other projects for integration and the staffing and sustainability of these. He asked about the risk to the Trust if projects were not sustainable and whether appropriate focus was being given to the challenges.

Dawn Godbold explained that there was real focus on Buurtzorg and recruiting nurses into this model, which was a significant challenge. Buurtzorg was still being seen as 'test and learn' and the Trust needed to reassure staff and look at how to scale this up and incorporate the principles of the model into the healthcare team model. It was hoped that this would help to attract more staff. Richard Davies asked if the Barrow surgery team was being kept informed, Dawn Godbold explained that this was being managed but it was important to find a way of making Buurtzorg sustainable.

Alan Rose reported that at last night's informal meeting between the governors and NEDs Andrew Hassan, partner governor for primary care, was able provide information on some of the system initiatives and governances processes. He considered his appointment to be a very good development for the Council of Governors.

He thanked Dawn Godbold for the radar charts which were very valuable as they provided an enormous amount of data.

Gary Norgate was very pleased to see that the alliance was working and asked if there was a view on Burtzoorg's relative costs compared to the traditional model, ie total cost of ownership. Dawn Godbold explained that it was difficult to give a view as this was currently so small. It was hoped that this information might be provided in the Kings Fund report but it not be possible as it was so small.

Rowan Procter said that it was interesting that although the numbers were small the Barrow team were still very concerned about the continuation this service.

The Chief Executive said that the radar charts would provide the opportunity for gains and working with GP practices to improve performance against indicators. Dawn Godbold agreed and said that this would help inform priorities in the future and look at health issues in more detail by locality, eg cardiac disease in the Brandon area.

Angus Eaton referred to Gary Norgate's question and asked if decisions were being made about costs across both community and secondary care, ie system wide. The Chair agreed that it was very important to look at this system wide. Nick Jenkins said that he hoped that this might also enable decisions to be made about any investment in the community or acute, or whether to invest in primary care for the system's greater good, ie do what was right for patients.

Helen Beck noted that a significant amount of the transformation funding was being put into atrial fibrillation and going into GP practices to manage this and prevent people having strokes. This was a good example of money being put into primary care.

18/223 INTEGRATED QUALITY & PERFORMANCE REPORT

Rowan Procter reported that although the internal target for a 5% reduction in falls had not been achieved, the Trust had achieved the target set by the CCG.

The falls national champion had visited WSFT and was not able to advise on any more that could be done to prevent falls.

There were three patients who had suffered falls resulting in harm (fractured neck of femur). The investigations into all three had concluded that these were unavoidable, which was a positive. Initiatives were being trialled to reduce falls in community hospitals, including putting night lights in bays and coloured blankets on beds, as more patients fell at night. Although performance was disappointing, Rowan Procter was satisfied that the Trust was doing everything it could; she stressed that staffing issues had not contributed to falls.

Pressure ulcers had increased to 14, but this did not actually equate to 14 patients as some patients had more than one pressure ulcer. The tissue viability team were doing significant pieces of work in the community and a pilot was being undertaken in a care home.

There had been a significant dip in MRSA performance compared to last month. The infection control team were trying to understand if there was a trend to this but nothing had come to light so far. This would continue to be monitored.

There were no outstanding duties of candour this month.

Gary Norgate congratulated the team on the good progress that was being made during challenging times. However, he noted a number of areas that required improvement including appraisals and risk assessments.

He also noted a reduction in maternity activity which was 9% behind year to date and 12% for the month. He asked at what point the Trust would look at other options for the provision of this service.

Rowan Procter explained that each division was required to come back next month with a clear action plan to address appraisals. Helen Beck explained that a detailed report on appraisals was produced and that she held a monthly meeting with each assistant director of operations to review performance at an individual employee level.

Craig Black explained that every hospital in the country lost money on maternity services as the tariff was fundamentally wrong. However, it was evident that the more volume there was, the more financially effective this was. Activity had remained fairly consistent for a number of years. Nick Jenkins explained that the decrease in numbers compared to last year was due to the Trust providing maternity services to Lakenheath last year, which meant that the numbers had increased last year. Therefore numbers at WSFT had not significantly decreased.

Craig Black acknowledged that the numbers and performance were an issue as WSFT was a relatively small unit but there was no other capacity in the area, and the issues was the same in Norfolk and Ipswich. The Chair suggested that all the new houses being built in Bury St Edmunds were likely to attract young families and result in an increase in demand for this service. Nick Jenkins explained that the Trust was making changes to how it provided maternity services, including outreach services in Haverhill and Newmarket, to try and attract more women to have their babies delivered at WSFT.

Tara Rose explained that Lynne Saunders, head of maternity services, had asked her not to promote the service until the refurbishment had been completed. There would then be a long term campaign to attract more women to WSFT.

Richard Davies noted that the text relating to the safety thermometer said that it should be red, but it was showing as green. It was confirmed that this was an error.

Richard Davies referred to the neutropenic sepsis data which was reassuring. He asked for more focus and data on sepsis, particularly non-neutropenic sepsis. It was agreed that this information would be provided. **R Procter**

Rowan Procter highlighted the significant improvement in the turnaround time for production of second letters responding to complaints. The Chair acknowledged this and passed on her thanks to Cassia Nice and her team.

Angus Eaton expressed concern that refresher training on blood products and transfusion processes had gone backwards. Rowan Procter explained that a plan was being developed; training was being undertaken on the wards but she needed to understand why this was not improving and whether it was due to staffing issues. She would provide an update at the next meeting. **R Procter**

Helen Beck highlighted an area of particular concern and focus as being 62 day cancer performance, which had dipped significantly in the month. However, she explained that it did not take large numbers to result in a dip. There were two reasons for this, ie issues with diagnostic performance and a change in the way in which breaches were allocated between WSFT and tertiary centres. The head of elective access was focussing specifically on cancer pathway work and an update would be provided as this work progressed.

Angus Eaton noted the significant improvement that had been made on 52 week waits. Helen Beck explained that the breaches were mostly as a result of patient choice at the end of long pathways and patients could have been treated before 52 weeks if they had taken the original date they were offered.

Alan Rose referred to sickness absence and noted inconsistencies in data compared to the health and wellbeing report. He asked Jan Bloomfield if she had any particular concerns. She said that she had no increase in concern but there was a real focus on sickness absence with weekly meetings with the HR team and representatives from each division. WSFT was below the national average of 4.5%, but was not meeting its stretch target of 3.5%. Rowan Procter confirmed that there did not appear to be a trend, eg work related stress. It was hoped that the flu vaccine would have a positive impact over the next few months.

18/224 FINANCE AND WORKFORCE REPORT

Craig Black referred to the national headlines and there being no new announcements in the budget relating to health. An announcement had been made in July around a future allocation for health services equating to 3.6% growth in expenditure next year. This represented a significant increase but was below the long term average growth rate in health services expenditure. There had, however, been an announcement in the budget on targeting the growth in funding towards mental health services which had been disproportionally affected by austerity.

The Trust's financial performance for September was similar to previous months, ie slightly behind plan. This was primarily due to the increase in pay costs that had not been fully funded and costs related to expenditure to try to address the backlog of patients waiting for wheelchairs in the community. A paper would be going to the CCG in November to consider whether they could provide additional support in recognition of the pressures that WSFT was facing

Achieving the A&E performance target for quarter had improved the financial position by £400k.

Proposals for the capital plan for future years would be presented to the board at the end of November. It was considered that it would be prudent to apply for loans earlier rather than later. **C Black**

Craig Black explained that cash continued to be his biggest concern.

Alan Rose noted that although the Trust was currently £0.5m behind plan it was still forecasting that it would achieve its year end plan. Craig Black explained that the plan assumed that a greater proportion of income would be received in the second half of the year.

Gary Norgate noted that the organisation was falling behind in the recruitment of nurses and asked if the financial impact had been modelled for the second half of the year. He also noted that some CIPs were falling behind significantly, ie consultant staffing and nursing productivity, and asked what the result would be if some of the more challenging CIPs were not achieved.

Craig Black explained that nursing productivity was around implementing bay based nursing which was behind in timing but would be implemented. With regard to consultant staffing, additional sessions to manage activity pressures had exceeded what had originally been planned for and there was still a significant backlog in certain specialties for referral to treatment (RTT), ie ophthalmology.

Gary Norgate asked for assurance that divisions were continuing to try to achieve these CIPs. Rowan Procter confirmed that bay based nursing would be implemented within the next month and should result in an improvement to this CIP.

Jan Bloomfield explained that the introduction of 'Allocate' should have a positive impact on consultant productivity/staffing.

Craig Black explained that they were now looking at next year's CIPs and would begin by focussing on schemes that had not be achieved this year.

Gary Norgate asked about the cost of recruitment contingency plans. Craig Black explained that the contingency plans were currently being worked through, both inside and outside the organisation and more clarity on this would be given at the next board meeting. **C Black**

Angus Eaton asked for more clarity on this. He understood that the built in contingency had been used in order to achieve the stretch target and asked if there was anything else that could be done from an operational perspective. Craig Black confirmed that there was no contingency but discussions were being had with the CCG and it was hoped that additional income would come into the organisation that was not currently in the plan.

Workshops were already being held in the community and hospital divisions to look at CIP schemes for next year. The organisation was also looking at pulling forward CIPs planned for next year to help improve the situation this year.

Nick Jenkins confirmed that the plan was to use the contingency to achieve the stretch target and the board had agreed that it would not be able to rely on this. Angus Eaton acknowledged this but said that next year the Trust would need to find additional savings.

He asked when the block contract would come to an end. Craig Black explained that the length of the contract was determined by the Department of Health and that it was currently a two year contract which was in its second year. He did not expect that this would change significantly for the following year.

18/225 TRANSFORMATION REPORT

Helen Beck explained the content of this report. Representatives from NHSI and the emergency care intensive support team (ECIST) had recently visited WSFT during the multi-agency discharge event and had been impressed by the processes in place to manage flow and the care they had witnessed in clinical areas

She highlighted the diagnostic virtual ward which would provide a better experience for patients. She explained Trustmarque and the work being undertaken to understand and manage demand. This included information about regular users so that these patients could be identified and managed in a better way.

Section 2, integrated care programme project highlights, had been written by the CCG transformation lead and gave details of what was happening within the CCG to try to manage demand They had conducted a review of demand management and A&E attendances and a summary of their findings was given in this report. GP streaming had not had the impact that was hoped with only 15-20 people being seen per day. They would look at developing this model early next year.

Details of planned care work, ie RTT and national campaigns were given in section 3.

Section 4 provided an update on the PMO (project management office). Workshops had taken place in September and plans for CIPs for next year would be pulled together by the end of November.

Gary Norgate referred to GP streaming and the CCG's review of A&E attendances and suggested that there might be a need to take a 'blank piece of paper' approach to the whole system care model, ie basis for provision of services and what drives volume. Helen Beck said that it would be useful to analyse and understand this by GP practice and what was driving change at practice level. The new integrated urgent care contract had recently been put on hold due to a number of issues, but this should have an impact when launched.

Richard Davies noted that the medicines division finance report indicated that GP streaming was having an effect on the four hour wait; he asked what the issue with this was. Helen Beck said that she thought that the model was too restrictive and there had also been an issue with fill rates. Out of hours and at weekends there could be 20 to 30 patients through this service, but it had never reached its full capacity of 40 patients per day. Expanding the criteria needed to be looked at, but this would require additional support for the GP and training ANPs (Advanced Nurse Practitioners) in minor illness and minor injuries.

The Chief Executive agreed that GP streaming appeared to be of limited benefit but had had some success and developing this further was the right way to go. It had helped to develop relationships and taken some pressure off the department as well as helping to improve the physical environment.

Alan Rose asked about transformation projects and how these related to the CCG's and STP's projects. Helen Beck explained that WSFT's projects were not separate to the CCG. A member of the CCG's team had produced sections of this report , and the staff worked across both organisations.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

18/226 NURSE STAFFING REPORT

Rowan Procter explained that none of the information in this report was unexpected but she was pleased to see that the nurse sensitive indicators were still being maintained despite the fill rates. The biggest area for concern on staffing was F3, which was reflected in the nurse sensitive indicators, but there had been very high acuity patients on this ward in the last few months.

Nick Jenkins agreed that it was very good that nursing staff continued to provide the quality of care considering the pressure they were under. This was about the professionalism of the team who were looking after and supporting one another. The Chair agreed and said that while on quality walkabouts she had witnessed the excellent quality and warmth of care which was phenomenal. Patients, relatives and friends had also commented on this and it was something to be very proud of.

Gary Norgate asked if the varying performance of wards was due to high acuity in some areas, or the staffing in some areas. Rowan Procter explained that this was multi-factorial and that staff were moved around on a daily basis in order to mitigate risks as far as possible. When she first started in this role there were a number of wards that she was concerned about, however this was now not the case.

Alan Rose referred to sickness rates which were red in 75% of wards, equating to an average of 5.75%. He asked Rowan Procter if she was concerned about this. She said that she was concerned due to the impact on patients and staff teams. There were a number of individuals on long term sickness and in some cases she was trying to bring people back into a different area where their long term condition could be managed more appropriately.

18/227 MANDATORY TRAINING REPORT

Jan Bloomfield explained that there was a difference in mandatory training reported in the quality and performance report and in this report. The target in the quality and performance report was 80%, whereas in this report it was a stretch target of 90%.

In consultation with Helen Beck and Rowan Procter it had been agreed to cancel all mandatory training in January and the HR team was planning how to manage this post January.

Rowan Procter noted the significant improvement in Prevent training.

18/228 ANTENATAL AND NEWBORN SCREENING ANNUAL REPORT 2017-18

Nick Jenkins highlighted the recommendation that the board approve the delegation of future reports to the Clinical Safety and Effectiveness committee (CSEC). He explained that this report was required to be seen by NEDs for compliance but he did not consider this to be a board report. The board agreed that in future this should go to CSEC for more detailed scrutiny and discussion. **R Jones**

Angus Eaton asked about escalation. Nick Jenkins said that these were issues that should be escalated locally and then if necessary escalated by the division to CSEC.

18/229 SAFE STAFFING GUARDIAN REPORT – Q2

Nick Jenkins explained that this report had not been prepared by the Guardian of Safe Working Hours (GOSW) as the Trust was currently in between guardians. It was hoped to appoint to this role within the next two weeks, therefore the next report would be given by the new guardian.

The Chair asked Nick Jenkins if he was concern about the figures relating to medicine. He acknowledged that this should be a concern, but there were a higher number of doctors in medicine. He had discussed this with colleagues around the region and it seemed that different cohorts of doctors engaged more in this process.

The increase was between July and August when new doctors came into the Trust; there was a need to look at whether a trend developed following this period. He explained that when new doctors first came into the organisation it took them longer to do a job and therefore this resulted in the generation of more exception reports.

Jan Bloomfield explained that exception reports were reported by each division. This enabled themes to be looked at and provided an understanding of what junior doctors were doing and if any patterns were developing.

Alan Rose asked if there was a cap for the number of exceptions. Nick Jenkins explained that there was a system for financial penalties and the internal fines currently stood at £4.5k. The junior doctors decided how this money should be spent to enhance their health and wellbeing and reduce the risk of burn out. This would be discussed with the new guardian.

18/230 CONSULTANT APPOINTMENT REPORT

The board noted the appointment of the following:-

Dr Isabel Lentell – Consultant haematology

Mr Robin Youngs – Consultant otolarynologist

It was considered that there was a very good level of candidates, with a good process which provided assurance.

18/231 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that the award for this month had been received by Ian Beck HR, workforce and Laura Tebbut, Community staff nurse, Sudbury Community Health Centre.

Ian always looked at ways to improve services and systems not only to the benefit of himself and his team but to the benefit of the Trust. He used his creative design skills to produce visually engaging information and campaigns. He combined these design skills with analytical information to provide clear and informative work.

One Friday, Laura started work at 9.00am and, whilst triaging, also visited local patients on a very busy day. At 4.30pm she picked up a request for a syringe driver to be commenced on an end-of-life patient. The out-of-hours nurses did not have anyone with the skills needed to attend so she decided she would not allow the patient to receive regular injections to attempt to manage their symptoms, as this was not the optimum care for the patient. She ensured the patient received the care they needed and had taken the out-of-hours nurse with her on the visit to ensure the nurse's development needs were met. As a result she did not finish work until 9.00pm. She also worked additional hours on the Saturday and once again got home later than planned. She managed all of this whilst in pain with a personal ailment that she was awaiting surgery to correct.

The board congratulated Ian and Laura on this award and their commitment to staff, patients and the Trust.

BUILD A JOINED UP FUTURE

18/232 STAFF HEALTH AND WELLBEING PROGRAMME UPDATE

Jan Bloomfield explained that this report had been produced by Molly Thomas-Meyer, together with Helena Jopling and the occupational health team, who were constantly looking at how to improve staff health and wellbeing.

The Chair considered this to be an excellent report that looked at system working. She was pleased to see the work that was being undertaken on 'every contact counts'.

Alan Rose noted that staff were also feeling supported by the Trust. Jan Bloomfield said she hoped that RPI team would have an impact on the health and wellbeing of staff.

GOVERNANCE

18/233 TRUST EXECUTIVE GROUP REPORT

The board noted the content of this report.

18/234 QUALITY & RISK COMMITTEE REPORT

The board noted the content of this report.

18/235 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were noted. Issues arising from today would also be included.

ITEMS FOR INFORMATION

18/236 ANY OTHER BUSINESS

There was no further business.

18/237 DATE OF NEXT MEETING

The next meeting would take place on Friday 30 November 2018 at 9.15am in the Northgate Room, Quince House, West Suffolk NHS Foundation Trust.

RESOLUTION TO MOVE TO CLOSED SESSION

18/238 RESOLUTION

The Trust board agreed to adopt the following resolution:-

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

6. Matters arising action sheet

To ACCEPT updates on actions not covered elsewhere on the agenda

For Report

Presented by Sheila Childerhouse

Board of Directors – 30 November 2018

Agenda item:	6			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	22 November 2018			
Subject:	Matters arising action sheet			
Purpose:		For information	X	For approval

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

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

Actions are RAG rating as follows:

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

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**			**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X			X		X		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*	
	X	X	X	X	X	X	X	

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

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

Ongoing actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1604	Open	29/6/18	Item 24	Report annual governance review findings at the end of September.	Questionnaires issued. Report will be drafted for meeting in November when all responses received. **Scheduled for review at Quality & Risk Committee in order to provide sufficient time for discussion prior to final report and action plan to Board in January '19**	RJ	25/1/19 (revised)	Amber
1636	Open	2/11/18	Item 2	Consider impact of other factors on fall occurrences and trends	Being picked up as part of a project on F3	RP	25/01/19	Green
1641	Open	2/11/18	Item 10	Provide a report on final position and consequences of the winter contingency plans	Being finalised as part of planning for second winter escalation ward on G9. There is still some risk around our ability to staff this final part of the plan and we are therefore exploring residential and nursing home capacity across all of our localities as an alternative in the event of not being able to safely staff G9.	HB / RP	30/11/18	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1613	Open	27/7/18	Item 10	Review Brexit impact as part of the Trust's emergency preparedness arrangements (including review of supplier risk). Update to Audit Committee in 2 November 2018	Building into supplier and business continuity plans. Based on further requests for national reporting it has been agreed that this evolving issue be included in the Scrutiny work plan with monthly reporting as required. **Agreed on 2/1//18 to provide update at the Board meeting on 30 November - AGENDA ITEM**	HB	30/11/18	Complete
1627	Open	28/9/18	Item 8	Schedule the Buurtzorg report be received by the Board at the end of November	2/11/18 recognising the limitation of the pilot size it was request that the review considers system costs and savings are part of the evaluation	DG	30/11/18	Complete
1637	Open	2/11/18	Item 2	Request to consider governor involvement in the NEESPS governance arrangements	This suggestion was subsequently made at the Council of Governors meeting and it was accepted that such an arrangement would undermine the role of the governors in holding the Board to account through the NEDs.	RJ	30/11/18	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1638	Open	2/11/18	Item 9	Provide a focused report on sepsis management and performance at the next meeting	There has been significant work to improve our sepsis management performance, including neutropenic sepsis. Improvement within the Trust and ED have been delivered through a number of changes:Employed a Band 7 educator for ED; Red folder for neutropenic patients attending and work flow through the department; Increased focus on spotting and treatment of sepsis, this included patient group directions (PGD) to improve prescribing practices; and employed a band 6 sepsis nurse also who will start in Jan 2019.ED neutropenic sepsis performance for patients with door to needle time of 1 hour or less has improved to 90.9% for September (an 18% improvement).	RP	30/11/18	Complete
1639	Open	2/11/18	Item 9	Provide a remedial action plan to improve blood product mandatory training compliance	When the deterioration in performance was observed a number of action were introduced to understand the issue and address gaps: • reviewed the distribution list for staff who receive monthly reports of staff compliance - Clinical Directors, General Managers and Matrons • Sent targeted emails to all line managers highlighting the individual staff' that were non-compliant with the training requirement • established regular additional face: face transfusion updates for Theatre registered practitioners, midwives, Paediatric doctors, A&E doctors, general & theatre Porters• Requested assurance from the education	RP	30/11/18	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
					& training team that the registers of face: face sessions are being accurately recorded on OLM as staff mandatory training • The transfusion training for Health Care Assistant (HCA) induction was incorporated into the outreach session • A review of the training matrix was requested to ensure only those staff that participate in transfusion have the requirement attached to their record. Completion of this work is awaiting response from the Community team. We have been advised that until this is received the matrix cannot be updated • Benchmarked frequency & target for training with other trusts in the East of England & Salford hospital indicate WSH has a target of 90% for training (range 75%-100%, mean 80%). 36% of responders require annual completion, 36% biannual & 27% 3 yearly. The targets range from 75%-100% • Confirmed with the education & training team that email alerts are sent to staff to advise them on the need to complete their refresher training• Requested that Drs completion/non completion is link to appraisal/study leave application • Sought information from Lisa Sarson to ascertain how she achieves good compliance stats for her subject. It was concluded that we have tried all the actions she completed when faced with a similar			

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
					problem. • Reported issues that staff encountered completing the on-line assessment to IT dept & OLM (we have been advised these are resolved) • The e-learning modules are updated annually & targeted to individual professional groups to ensure relevance • Escalated concerns to HTC, Quality Group & CSEC It is very difficult to understand why the deterioration in compliance is occurring in transfusion and not in other 'subjects' where it is expected similar staff groups to complete training. It is possible stats may be 'skewed' by frequency of requirement and frequency of face:face training. Continuing to review option of inclusion on junior doctors induction training.			
1640	Open	2/11/18	Item 10	Provide a draft capital programme for 2019/20	**AGENDA ITEM** - closed meeting as contains detailed information which would compromise the tender processes	CB	30/11/18	Complete
1642	Open	2/11/18	Item 14	Include the antenatal screening annual report in the CSEC work programme	Terms of reference and reporting matrix of CSEC updated	RJ	30/11/18	Complete

7. Chief Executive’s report

To ACCEPT a report on current issues from the Chief Executive

For Report

Presented by Stephen Dunn

Board of Directors – 30 November 2018

Agenda item:	7			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	22 November 2018			
Subject:	Chief Executive's Report			
Purpose:		For information	X	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

As the weather starts to take a colder turn the focus that we have had on **preparing for winter** since last January feels so important. We have seen some key milestones in the last few weeks that will allow us to respond to the predicted pressure.

On 10 November we opened the Trust's new Cardiac Centre and accepted our first inpatients. The effort and teamwork that went into this was truly amazing. I'd like to thank everyone involved but the list is so long I wouldn't want to miss anyone out! The unit looks fabulous and it was so exciting to see the first patients in their beds. The cath lab has now seen its first pacemaker implants and angiograms performed and we can now look forward to the journey ahead. I do feel its important that we recognise the contribution that the My WiSH Charity in raising money to fund the move to the diagnostic unit – an amazing achievement and I know the team are already working on the next campaign.

The move to the new Cardiac Centre is an important part of our winter plans as it creates capacity for additional beds on the old cardiac ward (G3). We have currently opened 20 of these beds with plans to open the remaining 12 beds as part of our winter escalation. The space previously occupied by CCU is now being used for the discharge waiting area which will enable us to expand the cohort of patients to include the diagnostic virtual ward. In addition, we are on track to open our new acute assessment unit (AAU) on 30 November. This will mean that patients referred by ED as well as GPs for medical assessment will go straight to this dedicated facility. I was delighted to walk around this facility this week and it is truly amazing providing state of the art facilities for our patients and staff – it makes the difficult decision we made to move staff from this area, including the executive team into Quince House so worthwhile.

The final stage of the plans to create additional capacity is to create a second winter escalation ward on G9. There is still some risk around our ability to staff this final part of the plan and we are therefore exploring residential and nursing home capacity across all of our localities as an alternative in the event of not being able to safely staff G9.

Our main concern remains the same as others across the NHS – **staffing services safely**. This has been part of our on-going focus. We have been trying to offer flexible roles to encourage nurses back to nursing, been overseas to recruit nurses (and have already started to welcome new nursing colleagues from the Philippines). And we're offering lots of opportunities for people to get on the nursing ladder, including as a nursing assistant for which absolutely no prior healthcare experience is needed. Nurses and nursing assistants are not only some of the most caring people I know, but some of the best leaders.

Alongside this focus within the hospital we are working closely with our **community colleagues and Alliance partners** to ensure we are able to respond to winter pressures and do the right thing for all our patients. Examples of some of this work include:

- The Care Homes local enhanced service (LES) primary care team are working with GP practices to map practices to care homes and start to provide proactive care for residents. This includes: an allocated care home lead within the practice; a regular 'ward round' on a fixed day of the week with a GP or alternative healthcare professional; advance care planning and dementia diagnosis case finding; and regular contact including discussion of falls, falls reviews and promotion of i-stumble
- The early intervention team (EIT) continue to develop out of hours assessment of care home residents and support care homes with care management needs e.g. IV therapy, test proactive community input of care within nursing homes. An EIT therapist will support care homes to help manage falls and support manual handling. This will also help promote early reablement and rehabilitation to support residents after illness and falls. Mobilisation plan in progress

- Implementation of discharge to optimise and assess (D2OA) pathway 1 test and learn has gone well with the service now being implemented across five acute base wards. 20 patients have been supported to date and with excellent progress of discharge dates within 1 day of being medically optimised and reduction in care packages post the initial reablment period at home
- The rapid implementation vehicle (RIV) and EIT is operating over winter for a six-month period until March 2019 to provide an urgent response for patients who may need conveying to ED if not seen and assessed by a healthcare professional. The operation times of the service are 1100-1900 Monday – Friday (including Bank Holidays) and the localities currently able to access the RIV are Sudbury, Bury Town and Bury Rural
- The West Suffolk Alliance is working to design an integrated Responsive Service which is likely to bring together the existing reactive services of west Suffolk health and care services across each of the Connect localities. The reactive services that are being considered are the Early Intervention Team (EIT), Support to Go Home (STGH) and Homefirst. This may also include some elements of Adult Social Care (ACS) and Domiciliary Care

I was delighted to join staff and West Suffolk MP and Secretary of State for Health and Social Care, Matthew Hancock, earlier this month to formally open our **new ultrasound service** - which will see Haverhill patients receive ultrasounds in the town for the first time. The service, which will be staffed by our sonographers and has been supported by the NHS West Suffolk Clinical Commissioning Group (WSCCG), is provided in the Christmas Maltings surgery in Camps Road, and means that Haverhill patients will be able to have much-needed scans without leaving the town – no longer having to travel to West Suffolk Hospital, Addenbrooke's, or Newmarket Hospital for the service. This project come to fruition thanks to the unwavering efforts of Betty McLatchy, former Haverhill councillor and mayor, who spearheaded a whopping £20,000 of community fundraising to contribute towards the equipment required.

We continue to support our staff to have flu jabs to protect themselves, their patients and their colleagues. I'm delighted that, at the time of writing, more than 2,325 of our staff have opted to have the **flu vaccination**. That will likely have gone up even further at the time of reading! This is such great news and proves that our staff are dedicated to protecting themselves and those around them. Thank you to each and every one of you!

During October we achieved some exceptional days of ED performance when we have been the best performing trust in the country. Overall for **October's performance** there were 61 falls and 13 Trust acquired pressure ulcers. There was one C. difficile case in the month. The Trust failed to deliver on the target for 2 week wait for urgent GP referrals, with reported performance at 76.1% and Cancer 62 day GP referral with reported performance 77.4% due to significant increases in demand. The 4 hour wait performance for the emergency department for October was 93.3% with attendances continuing at an increased level year-on-year level at 10.3% (adjusted). RTT performance against the 18 week standard has improved in October with performance of 90.2%, with seven long waiting patients reported for the month.

The **month seven financial position** reports a deficit of £7.1m. This is £0.8m worse than planned, partly due to provider sustainability funding (PSF) funding being behind plan as a result of ED performance in Q1 (£0.2m). The Trust has agreed a control total to make a deficit of £13.8m which will provide PSF of £3.7m should ED and financial targets be met. Therefore the Trust is now planning on a net deficit of £10.1m for 2018-19. In order to achieve the control total the 2018-19 budgets now include a stretch cost improvement programme (CIP) of £2.8m bringing the total CIP plan to £12.2m (5%). The Trust is currently applying for the cash support from the Department of Health (DH) to support this revenue deficit, and also the planned capital programme of £28.1m.

During November we held a joint executive meeting with East Suffolk and North Essex Foundation Trust (ESNEFT) to review the provision of **pathology services**. While challenges clearly remain,

there was absolute commitment from ESNEFT, who host North East Essex and Suffolk Pathology Services (NEESPS), to address the deficiencies identified by the MHRA and deliver sustainable, high quality pathology services. We have actively engaged with NHS Improvement as one of our regulators to provide focus and support in this area and will be meeting with them in December to review progress.

I really pleased that a brand new protection team has been introduced at the West Suffolk Hospital to help keep you, our patients, and our buildings safe. Twelve new members of staff make up our brand new **restrictive physical intervention (RPI) security team**, who will help to make sure our hospital environment is one that looks and feels safe and secure. As well as supporting conflict incidents, the specially-trained team will help to keep the hospital protected by conducting regular patrols and sweeps of the site, monitoring access to restricted areas, helping to keep locked areas secure. The 24/7 team is headed up by Darren Cooksey, security manager. Sadly, in last year's NHS Staff Survey (2017) 18% of staff reported that you had been subjected to physical violence from patients, their relatives or members of the public – well above the NHS national average (15%). The new team has received specialist conflict management and mediation training, and, among their other duties, will be on hand to help protect staff if someone is behaving in an aggressive or inappropriate way. The team can be called by any staff member at any time for support, which could be on a ward or on a one-to-one basis.

As part of our digital agenda, we have joined forces with a company called Medic Creations to provide a piece of software, called **Medic Bleep**, to our staff – which will in time replace our old pager and bleep system. In the simplest terms, Medic Bleep is a communication app that allows staff to message and call colleagues, individually or in groups. It works in a similar way to WhatsApp – but it has tailored healthcare functionality that meets General Data Protection Regulation and NHS information governance standards. That means it can be used to share and discuss appropriate patient data with colleagues, safely.

Chief Executive blog
Get ready like us...winter is coming: https://www.wsh.nhs.uk/News-room/news-posts/Get-ready-like-us-winter-is-coming.aspx

Deliver for today

Stop the Pressure day
Prevention of avoidable pressure ulcers is one of the key ways to prevent patient harm in hospital. Thursday 15 November was Stop the Pressure day, and thank you to everyone at the Trust who has taken part. The tissue viability team arranged several events to raise awareness of pressure ulcers in Time Out and across the Trust. Pressure ulcers are commonly encountered in patients admitted to hospital and those in long-term care facilities. Older people, and all patients with limited mobility or impaired sensation, are at particular risk. Pressure ulcers (also known as pressure sores or bedsores) are injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin. They can happen to anyone, but usually affect people confined to bed or who sit in a chair or wheelchair for long periods of time.

Sepsis awareness day
Sepsis (also known as blood poisoning) is the immune system's overreaction to an infection or injury. Normally our immune system fights infection – but sometimes, for reasons we don't yet understand, it attacks our body's own organs and tissues. If not treated immediately, sepsis can result in organ failure and death. Yet with early diagnosis, it can be treated with antibiotics. The Trust's critical care outreach team held hold an awareness day at West Suffolk Hospital on in November linking in the with the seasonal flu campaign and also involving the acute oncology service team in order to promote awareness of neutropenic sepsis (a life-threatening complication of anticancer treatment), staff shared information on wards and there were displays in Time Out and also at Newmarket Community Hospital.

Volunteers inspect local hospitals
Cleanliness, food, and privacy at West Suffolk and Newmarket hospitals have been rated and scored by a team of patient assessors to help improve patient experience. Findings from an annual independent survey of standards of the West Suffolk NHS Foundation Trust's (WSFT) hospital sites have rated the Trust positively across a number of areas – with cleanliness being scored at a standout 99.97% at the West Suffolk and 100% at Newmarket. The Patient-Led Assessment of the Care Environment (PLACE) is the national NHS benchmark for ensuring services are offered in a clean, safe environment. Teams of independent local people volunteered their time to undertake the PLACE inspections at the West Suffolk Hospital and Newmarket Community Hospital earlier this year. The aim is to get the patients' perception of every experience they have at the hospital, from arrival at the site, to the place where they are treated, to leaving. The volunteers scored the hospitals on a wide range of issues, including cleanliness; privacy; dignity and wellbeing; dementia; access for disabled people; general maintenance; and food, which included sampling meals. This is the first time the Newmarket site has been scored as part of WSFT and initiatives to make improvements as a result of the findings are already in place.

Invest in quality, staff and clinical leadership

Catering have retained Eat Out Eat well gold award
Congratulations to the Trust's catering team, which has retained its Eat Out Eat Well gold award! The accolade is awarded to caterers who make it easier for their customers to make healthy choices when eating out.

Domestic abuse awareness morning
On 10 October more than 40 staff attended the domestic abuse awareness morning organised by Julia Dunn and Lisa Sarson. The group heard from the police, Anglia Care Trust, the independent domestic violence advisors (IDVAs) and the Bury St Edmunds' Women's Refuge. They also heard from a 'survivor' of domestic abuse who frankly told the group her story. She spoke of how important it is for staff to 'ask the questions', because even if the victim is not ready to leave or cannot see the situation they are in, the seed that something is not right has been sown. She feels there had been several missed opportunities where health staff could have asked her about her own situation. Feedback about the event has been hugely positive, with staff asking for another session to be organised next year, which will enable those that were on the waiting list to attend too.

Preceptorship health and wellbeing roadshow
Over 30 new members of the Trust attended the recent health wellbeing roadshow as part of their preceptorship programme. They found out what the Trust and its health and wellbeing partners had to offer, including OneLife Suffolk, Care First and Neyber. They also took the opportunity to share their ideas about how to support staff's health and wellbeing.

Build a joined-up future

MADE event success
As part of winter planning and based on predicted peaks in demand, the Trust recently held a multi-agency discharge event (MADE) working with the wider health and social care system to find new ways to both recover and cope with demand. The MADE event took place on 9 and 10 October, with predicted peaks in demand on 7 and 14 October. This was spot on – we saw 241 attendances to the emergency department and 83 admissions to the hospital on Sunday 14 October alone.

In addition to managing demand through West Suffolk Hospital we welcomed system partners in to ensure we had a rounded view of the various patient pathways in the west of Suffolk, and to

showcase how we are working together across health and social care. The aim of the event was to: benefit patients, by ensuring care is delivered in the right place at the right time; benefit acute staff to ensure they gain a greater understanding of services available outside of the acute organisation; benefit wider health and social care system partners to ensure they get a realistic flavour of the demands faced in an acute setting.

On 9 and 10 October teams consisting of Trust staff and system partners attended board rounds where teams paid particular attention to definite discharges, potential discharges and discharges planned over the next couple of days following the "Why not home? Why not today?" ethos. Statistically, the MADE contributed to a decrease in breaches and a slight increase in the number of discharges leading up to 14 October. As a result of findings from the day, recommendations have been made about working practices and if any changes are to be implemented, these will be communicated in due course.

National news

Deliver for today

Promoting healthy weight in children, young people and families
This resource is made up of briefings and practice examples to promote healthy weight for children, young people and families as part of a whole systems approach. The briefings help to make the case for taking action to reduce childhood obesity, give examples of actions that can be taken, and provide key documents that form the evidence base and other useful resources. Practice examples are also given to illustrate what local areas are doing.

Exercise is 'critical' for a healthy pregnancy
Guidance from Canada suggests that keeping active during pregnancy leads to fewer complications, better physical and emotional wellness for the mother and better outcomes for the baby. To achieve the health benefits, the guidance encourages pregnant women who have no medical restrictions to achieve at least 150 minutes of moderate-intensity physical activity each week, and to exercise for a minimum of three days per week. It is suggested that those who follow the guidelines could reduce the risk of pregnancy-related illness such as depression by at least 25%, and reduce the risk of developing gestational diabetes, high blood pressure and preeclampsia by 40%.

Invest in quality, staff and clinical leadership

Tackling loneliness
This review is the first of its kind to establish what we know about loneliness and effective ways to tackle it. It is a first step to develop the evidence, revealing big gaps in the current evidence base. It is important to remember that these findings only cover the interventions included in the studies looked at by the review.

Managing malnutrition to improve lives and save money
This report explains why malnutrition costs so much and highlights the importance of identifying and appropriately managing malnutrition and the cost savings that can be achieved by better management of the condition.

Preventing stress at work
The Health and Safety Executive (HSE) has launched a new Talking Toolkit to help employers prevent work related stress. Developed to mark National Stress Awareness Day the toolkit encourages conversations between managers and employees about the causes of work related stress. Six conversation templates have been designed to support managers and

employees to talk about issues which may be causing work related stress or which could have potential to become future causes if not managed properly.

Build a joined-up future

Prevention is better than cure: our vision to help you live well for longer
The document sets out the government's vision for stopping health problems from arising in the first place and supporting people to manage their health problems when they do occur. The goal is to improve healthy life expectancy by at least five extra years, by 2035, and to close the gap between the richest and poorest in society.

Taking our health for granted: plugging the public health grant funding gap
This briefing paper states that an additional £3.2 billion a year is required to reverse the impact of government cuts to the public health grant and ensure that it is re-allocated according to need. The grant enables local authorities to deliver vital public health services, such as obesity programmes, drug and alcohol services and sexual health services, but this paper finds that it has seen a £700 million real terms reduction in funding between 2014/15 and 2019/20 – a fall of almost a quarter (23.5 per cent) per person.

A fair, supportive society: summary report
This report, commissioned by NHS England, highlights that some of the most vulnerable people in society – those with learning disabilities – will die 15-20 years sooner on average than the general population. Much of the government action needed to improve life expectancy for people with disabilities is likely to reduce health inequalities for everyone. The report recommends that action should focus on the 'social determinants of health', particularly addressing poverty, poor housing, discrimination and bullying.

9:45 DELIVER FOR TODAY

8. Alliance and community services report

To ACCEPT the report

For Report

Presented by Dawn Godbold

Trust Board Meeting - 30 November 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:	21/11/2018			
Subject:	Community Services and West Alliance update			
Purpose:	x	For information		For approval

Executive summary:

The Trust continues to drive forward the integration agenda both at a local and system level. There are a range of work programmes underway that demonstrate the pace and scale at which the system is evolving and maturing.

Main Points:

This paper outlines:

- Integration of the operational management of community services into the Trust structure
- Ongoing work to support the development of the integrated neighbourhood teams, with dedicated named dietetic leads and a named SaLT lead to support with complex cases.
- Development of alliance and system working, exploring options how WSFT and primary care could align more closely and continuing to evolve roles from single organisation responsibilities to be more system focussed.
- Early learning from the Rapid Intervention Vehicle initiative
- An update on the Buurtzorg / Neighbourhood Nursing Test and Learn
- Details on the Integrated Pain Management service

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

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

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

Community Services and Alliance Update

West Suffolk NHS Foundation Trust Board

30 November 2018

1.0 Introduction

This paper updates the Board of the work underway on integration between acute and community services and progress on alliance working for the west of Suffolk.

2.0 Acute and Community Integration

2.1 The community services transferred on 1st October 2017 and it was agreed that, in order to ensure continuity and provide assurance to community staff, the operational management of the services would temporarily sit under the Director of Integration and Community Services rather than the COO.

2.2 Since October 2017 community services have integrated well into the Trust and system integration and development of the alliance model has developed well.

2.3 As planned, pre-transfer, it is now time to fully integrate the operational management of the community services into the Trust structure by moving operational responsibilities from the Director of Integration to the COO from the 1st January 2019. This will ensure that the Community and Integrated Services Division services are fully embedded into the same structures as the other divisions within the Trust.

2.4 In line with our strategy we will build an integrated operational management structure and the community and integrated services division will, in time, have joint management posts/roles and responsibilities with social care and mental health partners.

2.5 The discussions with partners are at an early stage and will take time to refine, agree and implement. Therefore arrangements for a fixed term (12 months) Associate Director of Operations (like the other divisions) is being made.

2.6 We have held our first community nursing strategy workshop with nurses from all areas of the community (mental health and primary care) invited. The discussions at this and future sessions will inform our plans for nursing development and workforce requirements.

2.7 In keeping with acute areas to evidence the good practice that our staff provides and to prepare them for a possible CQC visit, we are re-introducing Quality Assurance Visits (QAV) across the community areas.

2.8 The format of these visits, are based around the CQC's Key Lines of Enquiries: Safe, Effective, Caring, Responsive and Well Led.

2.9 There will be staff observing practice, asking quick questions about process and meetings will be organised with appropriate people. On these visits, at the end there will be a debrief session for the leads of the area and any member of staff who would like to join. The team involved in these visits will be clinical and governance based and the aim is also to have a Non–Executive Director present as well.

2.10 The OT and PT professional leads are working with the community managers to map out a more robust career structure for community therapists. The resulting business case will aim to rebalance the existing structure in line with the acute-based therapists, to ensure fair opportunity, improve access to CPD and improve patient access to specialist expertise in community services. Clinicians will be involved in the process to ensure a realistic and attractive outcome.'

2.11 The benefits of therapists working across both acute and community is illustrated in Appendix 1 which is feedback from an acute physio who has recently been on rotation to one of the community teams: Anwen Rees, Band 6 rotational physio – medicine.

3.0 Integrated Neighbourhood Team Development

3.1 Following the successful event held in Brandon to commence development of the locality plan, further events are planned for Haverhill, Mildenhall and Sudbury.

3.2 To strengthen and support the development of the integrated neighbourhood teams, each team now has a named dietetic lead and a named SaLT lead that will support the INT with complex cases and provide support and advice to all members of the team.

3.3 The SaLT and dietetic teams have made excellent progress with the nationally mandated work with care homes aimed at ensuring patients are receiving the correct texture softened and liquidised food. This is an important patient safety and quality initiative which will ensure good nutrition and avoid admissions due to choking or pneumonia.

3.4 So far 23 care homes have completed the training with a further 13 care homes having training sessions booked.

3.5 Feedback has all been very positive. 'Clear, concise and very informative.' Uptake has been about 8-12 staff from each home which equates to roughly 10% of staff.

3.6 SaLT staff have 'dropped in' to training sessions to monitor quality/content and provide additional support if required in larger settings. After each home has completed training, care homes receive a courtesy call from Speech and Language Therapy. Further training will be offered especially for some of the larger homes.

3.7 There is a 'Chef Day' for care homes planned for February 2019 and the community SaLT team will support on an on-going individual basis when doing care home visits – trying to visit at lunchtimes to support with texture modification.

3.8 There is a support package being developed for people who are no longer under the care of the SaLT team and information is being prepared for GP's to assist with on-going management.

3.9 A second meeting of the Pillar Three Community Digital Group has been held. Good progress has been made with the distribution of new I.T equipment, with the wheelchair service and paediatric SaLT service in particular benefitting. Please see Appendix 2 for the second edition of the community I.T newsletter.

4.0 Alliance and System Working

4.1 The Countywide Children's and Young Peoples (CYP) steering group continues to meet monthly and progress the 6 priority areas for transformation. In response, the West CYP Alliance group has continued to develop its own localised strategy and actions. The second draft of this document will be shared in December.

4.2 We expect to receive the business case associated with the paediatric SaLT service re-design during December. Once received, we will be able to analyse the impact this will have on waiting times for new referrals and subsequent therapy packages.

4.3 Following the visit made to Wolverhampton in November, we continue to explore how WSFT and primary care could align more closely.

4.4 We are continuing our work to evolve roles from single organisation responsibilities to have more of a system focus and responsibility. We are creating a system integration and partnership team. The team will be formed from existing roles in the CCG and WSFT and are not additional posts to the system. This will be led by the current COO of the CCG whose remit will change to assist the integration agenda.

4.5 The team, which will include the current Director of Integration and the joint transformation team, will have shared responsibility for strengthening the development of the Alliance way of working and will include the primary care team at the CCG as well as some aspects of the CCG COO role.

4.6 The team will continuously evolve to include, in time, other functions such as medicines management as the future remit of the CCG continues to change in line with devolvement of responsibilities to the Alliance and strategic commissioning becoming the responsibility of the STP level ICS.

4.7 Successful appointments have been made to four of the six locality link workers. These posts will be instrumental in supporting each locality to become a cohesive team at neighbourhood level, to identify their local priorities, to support the locality lead role and make neighbourhood connections.

4.8 Following the initial visioning event held on the 11th October with partners and the community event held on the 18th October in Brandon we have received a positive response from those that attended.

4.9 A meeting has been held with the architects to draw initial plans based on the requirements that have been fed in so far. A meeting regarding the covenant on the land and the benefits of health and leisure co-locating is to be held late November.

4.10 Discussions are underway with the school, the highways department and the planning department. We are still working towards March 2019 to commence work.

5.0 Rapid Intervention Vehicle Initiative

5.1 In order to support the winter plan for west Suffolk in 18/19 a Rapid Intervention Vehicle (RIV) has been established for a five month period (October – March) to provide an urgent response for patients in the Bury Town, Bury Rural and Sudbury localities; who otherwise may have been conveyed to A&E if not seen and assessed by a healthcare professional.

5.2 The operation times of the service are 1100-1900 Monday – Friday (including Bank Holidays). The service commenced as a trial phase in the Bury Town and Sudbury Localities on the 1st October and has now extended to include Bury Rural Locality. This has been funded by the CCG at £18,250 for the pilot period.

5.3 The RIV complements the existing Early Intervention Team service by adding a specialist paramedic from EEAST, who is able to administer a suite of medicines (i.e. analgesia, antibiotics, working within pre-determined Patient Group Directives) working alongside a therapist from the Early Intervention Team to provide equipment, transfer/ mobility reviews and additional support to keep people safe in their usual place of residence (e.g. following a fall).

5.4 The RIV receives referrals from GP surgeries or local healthcare teams (from the designated localities) via the Care Co-ordination Centre for patients requiring an urgent admission prevention response in their usual place of residence. The service also responds to EEAST triaged C5 calls for non-injured fallers (that require lifting or a clinical intervention) and low acuity sick persons calls.

5.5 From the 1st October to the 16th November, 59 patients have been assessed by the RIV with only 4 needing conveyance to ED avoided. Referrals started slowly but have started to pick up pace since the specialist paramedic and therapists have started to visit the GP surgeries to further explain the service.

5.6 We will be exploring the role of the paramedic and nurse further to determine what additional skills could be utilised in to increase the number and range of interventions the service could provide.

6.0 Buurtzorg Test and Learn Update

6.1 The aim of the early test and learn was identified as "establishing a stable operational blueprint inspired by the Buurtzorg Model, through a process of adaptation and review".

6.2 The actions for establishing the operational framework can be broken down into four key areas:

a) A holistic care model linked to local networks
A model which enables a team of nurses and nurse assistance to deliver services currently spilt between social care and health, covering re-ablement, wellbeing and nursing. The model should include: a defined geographic area in which the team operates; an established referred process; and, functional links to the informal and professional networks; and,

b) A functional self-directing team
A team with the right skills, behaviours and knowledge to function as a self-directing team. Clearly established processes and procedures for supporting nursing and non-nursing tasks.

c) A functional 'back office'
A clearly defined functional 'back office' to support the team including, a coach, accountable clinical lead and heatshield. The back-office will support the development of protocols and processes and the information flows between the team and the wider system.

d) Infrastructure support
Establishing the necessary infrastructure to support the team, including I.T hardware, office and an appropriate I.T system to support care assessment, planning and monitoring.

6.3 Once established the aim is to deliver a pilot (second phase) where the aim will be to assess what impacts and outcomes can be realised in the English health and care system from this way of working.

6.4 Priority has been given to the integration of personal care into the model, and additional support has been placed within the team to develop this way of working. A social worker has also been allocated to the team to provide mentoring and support to the team by attending every team meeting (where possible) and carrying out joint visits.

6.5 Staffing the team has been one of the greatest challenges facing the Test and Learn. An early approach of offering permanent contracts and secondment opportunities was put in place to try to mitigate some of the risks associated with recruiting to the Test and Learn. However, recruitment exercises have attracted limited applications, despite interest in the model from nurses seen in engagement activities.

6.6 There have also been a number of staff changes in the team over the course of the Test and Learn (the maximum size of the team has been 5.2fte), and recently a number of members of the team have resigned leaving only 1.6fte remaining in the team.

6.7 The establishment of a fully functioning care model is predicated on a fully resourced team (the Buurtzorg model is based on 8fte), and the ability to recruit the 'right people' with the skills, values and enthusiasm for developing this way of working. Further recruitment is now a priority and needs to be progressed at pace.

6.8 The table below shows the data for the team so far:

Suffolk Neighbourhood Nursing & Care Team (WEST)

Measure		2018								Total
		Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	
Number of Referrals	**Total**	**4**	**6**	**11**	**19**	**28**	**25**	**20**	**33**	**146**
Referral Source	GP (National code: 3)	2	3	5	6	7	4	2	9	**38**
	24hr care setting - NH	0	0	0	2	7	7	12	7	**35**
	Self - Referral	0	1	1	4	7	4	1	4	**22**
	West Suffolk hospital	0	1	3	4	3	1	1	3	**16**
	CHT Community Staff	2	1	1	2	0	5	1	2	**14**
	GP - discharge letter not required	0	0	0	0	2	0	0	2	**4**
	Other (National code: 97)	0	0	0	0	1	2	1	0	**4**
	Addenbrookes hospital	0	0	0	0	1	0	1	1	**3**
	Carers	0	0	0	0	0	0	0	3	**3**
	Ambulance Service	0	0	0	1	0	0	0	1	**2**
	APS	0	0	0	0	0	0	0	1	**1**
	Bed Based Unit	0	0	0	0	0	1	0	0	**1**
	Hospice/specialist palliative care te	0	0	0	0	0	0	1	0	**1**
	Papworth Hospital	0	0	1	0	0	0	0	0	**1**
	Practice Nurse	0	0	0	0	0	1	0	0	**1**
Discharges	**Total**	**1**	**0**	**4**	**15**	**30**	**25**	**15**	**34**	**124**
Average Length of time on caseload (By month of discharge)	Days	31.00	n/a	33.50	20.67	34.43	32.68	78.27	64.65	**45.94**
Contacts	**Total**	**51**	**82**	**159**	**230**	**232**	**275**	**264**	**337**	**1630**
	Face to face	50	80	147	216	206	260	244	322	**1525**
	Telephone	1	2	12	14	26	15	20	15	**105**
Average Length of Visit (mins)	**Total**	**23.57**	**40.27**	**56.16**	**60.80**	**53.97**	**40.81**	**41.72**	**40.02**	**46.42**
	Face to face	24.00	41.15	59.15	64.00	58.67	41.86	44.17	41.22	**48.55**
	Telephone	2.00	5.00	19.50	11.36	16.69	22.67	11.75	14.33	**15.51**
Average Number of Visits per Day (Number of contacts divided by number of days in month)	**Total**	**1.65**	**2.73**	**5.13**	**7.67**	**7.48**	**8.87**	**8.80**	**10.87**	**6.65**
	Face to face	1.61	2.67	4.74	7.20	6.65	8.39	8.13	10.39	**6.22**
	Telephone	0.03	0.07	0.39	0.47	0.84	0.48	0.67	0.48	**0.43**

6.9 £200,000 has been secured to support the next phase of the project. A further £140,000 is also available from the iBCF but this is predicated on the team delivering the holistic care approach of integrated nursing and personal care. Due to the staffing issues, there is also likely to be an underspend on this year's budget. This will be fully assessed once the start dates of new members of staff and end dates for staff leaving has been agreed.

6.10 The Kings Fund and Healthwatch Suffolk have both been commissioned to undertake an evaluation of the test and learn. The Kings Fund report will focus on the lessons learned from a cultural/system perspective, due to the small size of the test and learn it will be difficult to draw any quantitative conclusions from the study. Due to the difficulty in getting

interviews in place the report is not likely to be available until January. Healthwatch Suffolk are completing patient interviews to offer a qualitative perspective on the test and learn.

6.11 The Nuffield Trust has been secured to provide quantitative evaluation for the next phase of delivery. The Nuffield Trust has been funded by NIHR to carry out rapid evaluations (together with our partners at UCL). Further information on the project can be found here: https://www.nuffieldtrust.org.uk/project/rset-the-rapid-service- evaluation-team. This support is fully funded and there would therefore be no direct cost to the project.

6.12 The Nuffield Trust are currently developing a scoping document to outline the recommended evaluation approach, this would be based on assessing the impact on patients, staff and the wider system. The Nuffield team have a number of specialists in economic modelling and it has been requested that this is included within the scope of the evaluation

7.0 Integrated Pain Management Service

7.1 The Integrated Pain Management Service (IPMS) was previously held as 2 separate contracts. Both WSFT and the Suffolk GP Federation held a contract with the CCG for separate elements of the pathway.

7.2 As part of our integration plans we are now combining these contracts into one, with an integrated approach to service delivery and management.

7.3 Jointly with the GP Federation we are undergoing a 'most capable provider' dialogue with the CCG to bring the service into the Alliance contract alongside the other community based services.

7.4 We have developed a memorandum of understanding and a truly integrated model that has WSFT as the lead contractor and Suffolk GP Federation as the management lead.

7.5 Combining the shared expertise and knowledge across the whole pathway will mean that we can offer a true 'end-to-end' service.

7.6 The vision of the IPMS is to deliver a single pain management service across West Suffolk by integrating existing services provided for inpatients, outpatients (including procedures) and the community.

7.7 The team has agreed the following values:

- We will work together as Alliance partners to create one multi-disciplinary team to deliver holistic pain management services for patients.
- We will use a bio-psychosocial approach for pain management with a range of treatments to ensure patients receive the right treatment by the appropriate clinician in the most suitable location for them.
- We will not allow organisational boundaries to prevent us from making changes to improve quality of care for patients.
- We will continue to invest in our workforce to ensure the staff are highly trained and are happy and motivated.
- We will use our resources better by reducing duplication and waste.

7.8 WSFT and SGPF Executive Teams will have overall joint accountability for the IPMS and oversee the work of the IPMS via the IPMS Board, which will in turn report to the West Alliance Steering Group.

8.0 Conclusion

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

Community Services and Alliance Update

West Suffolk NHS Foundation Trust Board

30 November 2018

Appendix One

Reflections from Anwen Rees, Band 6 rotational physio – medicine on time spent on rotation with the Bury rural community team.

Following my recent 8 month rotation with the Bury rural community team, I wanted to take the opportunity to improve the link between acute and community therapy.

From being a physio in the community, I have witnessed first- hand just how 'in the dark' we can be with poor referrals and finding out information can be very challenging and time consuming.

Overall, I felt WSH referrals were among / are the best / most detailed referrals which is great! But improvements could be made on accuracy of referral time scale recommendations.

For this reason, I have printed out copies of the triage criteria, which is used by community therapists to assess the urgency of referrals. I will put these up in each office for you all to refer to when sending SPOAs. I hope you find them useful to help you categorize your referral and its relevant time scale.

I will also be adding community office numbers to the list of contact details we have for each community team (the current COD number is not always the best number to use, as these mobile phones can be out in the community with therapists, so they would not have access to a computer).

I would really encourage anyone sending an SPOA to contact the relevant community team (this depends on your patients GP surgery) to discuss the referral. If the patient is known to them they will be able to offer insight on previous therapy input, patient compliance and progress.

Equally, they will be able to discuss what therapy they can offer in the community, which may help direct you when writing the referral.

I found we would get many referrals in the community for patients who were already "open" to us, or for patients who simply had a large amount of previous community interventions and had made very little progress.

In these cases, a referral may not be needed, just a simple handover on the phone, which would save the acute and community teams a lot of precious time.

IT Update

For community staff

NHS West Suffolk NHS Foundation Trust

November 2018

Dear colleagues,
This is my second update, letting you know how we are investing in and improving IT for West Suffolk NHS Foundation Trust (WSFT) community colleagues.

NEL remains the community IT service provider, but I and the Trust IT team are working with them to tackle day to day issues and drive improvements long-term. The Trust continues to look to the future, investing in equipment and software that will support you in your work and improve patient experience.

Please ensure you continue to log any IT issues with the NEL service desk, and use the communityict@wsh.nhs.uk address to escalate any problems.

NEL service improvement – progress

We know the service we receive from NEL needs to improve. The WSFT community ICT team is working with NEL managers on a turnaround plan to achieve better results for you, from the service desk and field engineers. An escalation process is in place; team leads are encouraged to use this via the community email address if you have any urgent IT issues which are impacting on delivering clinical services.

I am working with the NEL procurement team to reduce the time it takes for a replacement desktop or laptops to be procured and delivered. WSFT is funding the provision of local buffer stock to be given to community colleagues when machines fail, reducing the time staff are without access to a working computer.

SystmOne support and optimisation – progress

The SystmOne support team at 86 Sandy Hill Lane has agreed to run troubleshooting clinics for WSFT clinical teams across the county, exploring and dealing with specific issues. They will also look at how S1 templates and units can be reconfigured to make them more efficient; and enabling the use of S1 mobile. Chris Barlow will be contacting team leads and managers to arrange dates and everyone is asked to support maximum staff attendance.

- We have worked in partnership with the SystmOne support team at 86 Sandy Hill Lane to provide a dedicated telephone number for community staff to contact for S1 support and queries. The new number is 01473 278997.

WiFi and GovRoam implementation – progress

The team is surveying the first 10 sites to have WiFi installed, which will allow colleagues to use laptops without connecting to a docking station/port replicator. This should be especially useful during handover.

Nigel is on the asset trail – please help

Nigel Peed is contacting all managers and team leads to verify and update the information we have on our asset database – such as laptops, desktops, data SIM cards and mobile phones held by team members. Please do all you can to support him in this, as this information will be imported into the electronic staff record records in the future. Nigel is prioritising the collection of SIM card information, currently administered by East Suffolk and North Essex NHS Foundation Trust.

The action plan

The following tasks are under way:

- Working with the HR team to ensure returning staff (e.g. after parental/sick leave) have access to the systems they need
- Exploring with NEL ways to speed up internet browsers and connection times
- In preparation for community staff using the ESR system for data, payslips etc., looking at the software updates required to give everyone access
- Progressing the introduction of 3D wound care software, being piloted with Bury Town and Bury Rural community health teams
- Working with the county council to enable community staff that use Care First to have access to the new Liquid Logic system.

Key contacts – keep in touch

West Suffolk Community IT email
communityict@wsh.nhs.uk

NEL service desk phone number and email address
0808 168 5168 ITServicedesk.Anglia@nelcsu.nhs.uk

SystmOne support team email
Systmonesupport@suffolkch.nhs.uk

Best wishes
Andrew Smith
IT implementation manager, WSFT

9. Integrated quality and performance report

To ACCEPT the report

For Report

Presented by Rowan Procter and Helen Beck

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

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

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

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

NHS
West Suffolk
NHS Foundation Trust

Integrated quality and performance report



Month Seven: October 2018

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Putting you first

CONTENTS

EXECUTIVE SUMMARY

DETAILED SECTIONS

1 EXECUTIVE SUMMARY

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

ARE WE SAFE?

Healthcare associated infections (HCAIs) – There were no MRSA bacteraemia cases in October 2018 and 1 case of hospital attributable clostridium difficile. The trust compliance with decolonization increased in October 2018 to 95.0%. (Exception report, pg.21).

CAS (Central Alerting System) Open (PSAs) – A total of 23 PSAs have been received in 2018/9, with 4 in October 2018. All the alerts have been implemented within timescale to date.

Patient Falls (All patients) - 61 patient falls occurred in October 2018 which was a decrease from last month.

Pressure Ulcers - The number of ward acquired pressure ulcers continues to be above the local trust plan of 5 per month. In October 2018, 13 cases occurred with a year to date total of 65.

ARE WE EFFECTIVE?

Cancelled Operations for non-clinical reasons - The rate of cancelled operations for non-clinical reasons was recorded at 1.5% in September 2018. (*Exception report pg 25*).

Cancelled Operations Patients offered date within 28 Days – The rate of cancelled operations where patients were offered a date within 28 days was recorded at 80% in October 2018 compared to 90% in September 2018. (*Exception report main report pg. 28*).

Discharge Summaries- Performance to date, whilst below the 95% target to issue discharge summaries, is showing improvement (inpatients and ED). A&E has achieved a rate of 85.8% in October 2018 whereas inpatient services have achieved a rate of 77.9% (Non-Elective) and 80.8% (Elective.) (Exception report, pg.27).

ARE WE CARING?

Mixed Sex Accommodation breaches (MSA) – No Mixed Sex Accommodation breaches occurred in October 2018.

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.

Complaints responded to in time – October 2018 reported performance at 83.0% compared to 100% in September. (Exception report pg. 30).

ARE WE RESPONSIVE?

A&E 4 hour waits – October 2018 reported performance at 93.3% with a 10.3% year on year (Adjusted) increase in attendances. (*Exception report pg.34*).

Cancer – Cancer has experienced significant increases in demand in the last few months. The challenge of demand and capacity continues with three areas failing the target for October. These areas were 2 week wait for urgent GP referrals, with reported performance at 76.1%, Cancer 62 day GP referral with reported performance 77.4% and Cancer 62 d Screening with reported performance 72.7%. (*All figures are provisional and exception reports pgs. 37-39)*

Referral to Treatment (RTT) – The percentage of patients on an incomplete pathway within 18 weeks for October was 90.2%. The total waiting list is at 18075 in October. In October 7 patients breached the 52 week standard. (*Exception report, pgs.35-36, 44-46)*.

ARE WE WELL LED?

Appraisal - The appraisal rate for October 2018 is 76.0%. (*Exception report, pg.54*).

Sickness Absence – The sickness absence rate has decreased this month to 3.8% (*Exception report, pg.53*).

Staff FFT figures - The online survey is open to all staff in the Trust and regularly reaches up to 20% response rate.

Performance has consistently been above the national average score on both core questions and we regularly place within in the top ten nationally on both core questions;

- As a place to work - our average total score being a positive 82% which is on average 19% higher than the national average for England,
- As a place to receive care, our average total score being a positive 94% which is on average 14% higher than the national average for England,

Since Q1 2017/18 we have been asking two additional questions; whether staff regularly have an annual appraisal and whether they have a return to work discussion after periods of sickness:

- On average, 78% of respondents say they have a return to work discussion after periods of sickness
- On average, 89% of respondents say they have an annual appraisal and this quarter, appraisal response is 92%.

These figures have maintained a reasonable upward trend since we started asking the two additional questions - rising by 3% for return to work discussions and rising by 6% for appraisal reviews.

2. INTEGRATED QUALITY & PERFORMANCE REPORT DASHBOARD

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

INTEGRATED QUALITY & PERFORMANCE REPORT														
Are we..	Ref.	KPI	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Av/YTD
1. Safe	1.01	CAS (Central Alerting System) Open	1	0	1	0	0	0	2	5	3	4	5	4	23
	1.02	CAS (Central Alerting System) Overdue	0	0	0	0	0	0	0	0	0	0	0	0	0
	1.04	All relevant inpatients undergoing a VTE Risk assessment	96.9%	94.7%	96.9%	97.6%	97.3%	98.2%	94.1%	95.1%	93.0%	93.7%	94.0%	96.0%	94.9%
	1.05	Clostridium Difficile infection - Hospital Attributable	4	0	1	0	2	1	0	0	1	1	1	1	5
	1.06	MRSA Bacteraemias - Hospital Attributable	0	0	0	1	0	0	0	0	0	1	0	0	1
	1.07	Patient Safety Incidents Reported	588	479	627	553	535	486	579	465	469	521	488	511	3519
	1.08	Never Events	1	0	0	0	0	0	0	0	0	0	0	0	0
2.Effective	2.02	Canc. Ops - Cancellations for non-clinical reasons	1.9%	1.3%	0.8%	1.2%	0.9%	0.6%	0.8%	1.5%	1.8%	1.5%	1.2%	1.5%	1.3%
3. Caring	3.01	Compliments (Logged by Patient Experience)	87	151	64	20	45	21	93	44	49	33	35	73	348
	3.02	Formal Complaints	13	8	12	19	9	13	13	11	20	9	10	8	84
	3.03	Mixed Sex Accommodation Breaches	0	1	0	0	1	0	0	1	0	0	0	0	1
	3.04	IP - Extremely likely or Likely to recommend (FFT)	96.0%	97.7%	97.1%	98.1%	98.0%	99.0%	99.0%	98.0%	99.0%	99.0%	99.0%	96.0%	98.4%
	3.05	OP - Extremely likely or Likely to recommend (FFT)	96.0%	98.6%	95.1%	96.2%	95.0%	97.0%	97.0%	97.0%	97.0%	98.0%	96.0%	96.0%	96.9%
	3.06	A&E - Extremely likely or Likely to recommend (FFT)	94.0%	94.0%	96.4%	94.9%	94.0%	94.0%	93.0%	94.0%	96.0%	95.0%	97.0%	96.0%	95.0%
	3.07	Maternity - Extremely likely or likely to recommend (FFT)	100%	97.3%	100%	93.0%	100%	98.0%	99.4%	96.7%	100%	95.0%	92.0%	100%	97.3%
	3.08	Community - Extremely likely or likely to recommend	100%	95.7%	95.2%	97.4%	96.0%	94.0%	98.0%	97.0%	90.0%	98.0%	95.0%	100%	96.0%
4. Responsive	4.01	A&E under 4 hr. wait	90.4%	83.3%	83.8%	85.2%	85.4%	84.9%	93.7%	93.9%	89.0%	87.6%	95.9%	93.3%	91.2%
	4.02	RTT: % incomplete pathways within 18 weeks	88.9%	89.04%	90.2%	89.6%	89.5%	90.4%	92.2%	91.4%	91.4%	89.3%	89.9%	90.2%	90.7%
	4.03	52 week waiters	21	15	14	13	24	19	14	10	9	10	2	7	71
	4.04	Diagnostics within 6 weeks	100%	100%	100%	100%	99.3%	99.7%	99.6%	99.8%	99.9%	97.6%	99.5%	99.0%	99.3%
	4.05	Cancer: 2w wait for urgent GP Referrals	97.9%	97.2%	98.0%	97.5%	94.7%	95.9%	94.9%	91.6%	97.6%	89.5%	80.9%	76.1%	89.5%
	4.06	Cancer 2w wait breast symptoms	100%	99.1%	97.1%	92.9%	86.7%	96.7%	82.6%	84.9%	92.8%	95.9%	93.9%	96.4%	91.9%
	4.07	Cancer 31 d First Treatment	99.3%	100%	100%	100%	100%	99.1%	100%	100%	100%	100%	100%	99.2%	99.7%
	4.08	Cancer 31 d Drug Treatment	100%	100%	100%	100%	100%	100%	100%	100%	100%	98.7%	98.5%	100%	100%
	4.09	Cancer 31 d Surgery	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.10	Cancer 62 d GP referral	89.5%	87.1%	86.6%	79.8%	87.8%	93.3%	85.1%	86.5%	84.8%	89.9%	78.0%	77.4%	85.0%
	4.11	Cancer 62 d Screening	83.3%	100%	93.3%	85.7%	95.5%	72.7%	100%	100%	88.2%	100%	90.5%	72.7%	89.2%
	4.12	Incomplete 104 day waits	ND	ND	ND	ND	ND	3.0	1.5	0	1.0	3.0	2.0	0	10.5

INTEGRATED QUALITY & PERFORMANCE REPORT														
Are we..	Ref.	KPI	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Av/YTD
5. Well Led	5.01	NHS Staff Survey (Staff Engagement score -Annual)	NA	NA	NA	4.0%	NA	NA	NA	NA	NA	NA	NA	NA	NA
	5.02	Staff F&F Test % Recommended - care (Qrtly)	NA	ND	NA	NA	ND	NA	NA	95.0%	NA	95.0%	NA	93.0%	94.3%
	5.03	Staff F&F Test % Recommended - place to work (Qrtly)	NA	ND	NA	NA	ND	NA	NA	83.0%	NA	82.0%	NA	82.0%	94.3%
	5.04	Turnover (Rolling 12 mths)	9.1%	9.3%	9.3%	8.7%	8.8%	8.4%	8.4%	8.5%	8.6%	8.6%	8.7%	8.0%	8.5%
	5.05	Sickness Absence	3.5%	3.5%	3.6%	3.7%	3.7%	3.8%	3.8%	3.7%	3.8%	3.8%	3.9%	3.8%	3.8%
	5.06	Executive Team Turnover (Trust Management)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	5.07	Agency Spend	213	245	353	306	373	276	188	330	433	507	393	381	2508
	5.08	Monitor Use of Resources Rating	3	3	3	3	3	3	3	3	3	3	3	3	3
6. Productive	6.01	I&E Margin	-2.5%	-2.6%	-2.3%	-2.6%	20.0%	-10.3%	-7.5%	-6.3%	-7.30%	-6.80%	-7.20%	-6.40%	-7.4%
	6.03	Capital service cover	0.52	0.24	0.38	0.07	0.68	0.48	1.64	-0.80	-0.93	0.87	-0.92	0.63	0.97
	6.04	Liquidity (days)	9.64	11.39	6.06	6.84	7.86	12.34	16.83	15.36	16.67	14.36	19.19	17.56	16.04
	6.05	Long Term Borrowing (£m)	56.7	58.7	64.4	64.1	65.4	67.6	69.8	69.0	70.7	74.2	75.3	75.5	71.7
	6.06	CIP (Variance YTD £'000s)	-74	-22	-419	-469	-539	-54	-47	-75	-100	-120	-38	-28	-66.0
7. Maternity	7.01	Total number of deliveries (births)	194	180	199	211	206	198	203	201	172	208	208	224	1414
	7.02	% of all caesarean sections	17.0%	18.3%	22.1%	17.1%	30.1%	28.2%	22.4%	18.2%	17.1%	17.0%	22.8%	22.7%	21.2%
	7.03	Midwife to birth ratio	1.28	1.26	1.28	1.29	1.29	1.30	1.30	1.30	1.30	1.30	1.30	1.31	1.30
	7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.05	Completion of WHO checklist	98.0%	93.0%	93.0%	94.0%	97.0%	86.0%	85.0%	88.0%	94.0%	95.0%	93.0%	93.0%	90.2%
	7.06	Maternity SIs	0	1	2	0	1	2	2	0	1	0	0	1	6
	7.07	Maternity Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.08	Breastfeeding Initiation Rates	80.3%	79.8%	82.2%	76.2%	79.0%	76.1%	76.3%	80.7%	85.1%	76.2%	80.2%	83.0%	79.7%
8. Community	1.32	No of avoidable serious injuries or deaths from falls - Community	1	0	0	0	0	0	0	0	0	0	0	0	0
	4.27	RTT 18 weeks Non-Consultant led services - Community	94.4%	98.4%	98.7%	100%	99.4%	99.2%	97.6%	100%	98.7%	99.0%	99.0%	99.0%	98.9%
	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	NA	NA	NA	NA	NA	100%	100%	100%	100%	100%	ND	100%	100.0%
	4.40	Nursing & therapy Red referrals seen within 4hrs - Community	NA	100%	100%	96.4%	100%	96.4%	100%	100%	98.2%	100%	100%	100%	99.2%
	4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	96.9%	100%	99.3%	98.0%	97.6%	98.8%	99.4%	99.5%	97.4%	99.4%	99.5%	99.0%	99.0%
	5.55	Safeguarding Children Mandatory Compliance (Community)	96.1%	96.0%	95.9%	95.7%	97.0%	98.2%	95.8%	95.3%	94.7%	95.1%	96.2%	95.9%	95.9%
	5.56	Safeguarding Adults Mandatory Training Compliance (Community)	95.3%	94.0%	94.1%	93.2%	95.6%	96.0%	95.0%	94.9%	94.3%	94.9%	97.0%	97.1%	95.6%

3. IN THIS MONTH – OCTOBER 2018, MONTH 7

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	Oct-2018

To Month Year	Oct-2017

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

In this month.... October 2018

Mth We Received.....	Oct-18	Oct-17	Variance	Var. %	Traffic
GP Referrals	6,787	5,950	837	14.1%	⇧
Other Referrals	5,406	5,638	-232	-4.1%	⇩
Ambulance Arrivals	1,815	1,809	6	0.3%	⇧
Cancer Referrals*	1,090	998	92	9.2%	⇧
Urgent Referrals*	2,870	2,540	330	13.0%	⇧

YTD We Received.....	2018	2017	Variance	Var. %	Traffic
GP Referrals	45,342	42,162	3,180	7.5%	⇧
Other Referrals	36,912	36,079	833	2.3%	⇧
Ambulance Arrivals	12,375	12,235	140	1.1%	⇧
Cancer Referrals*	7,414	6,690	724	10.8%	⇧
Urgent Referrals*	18,980	17,453	1,527	8.7%	⇧

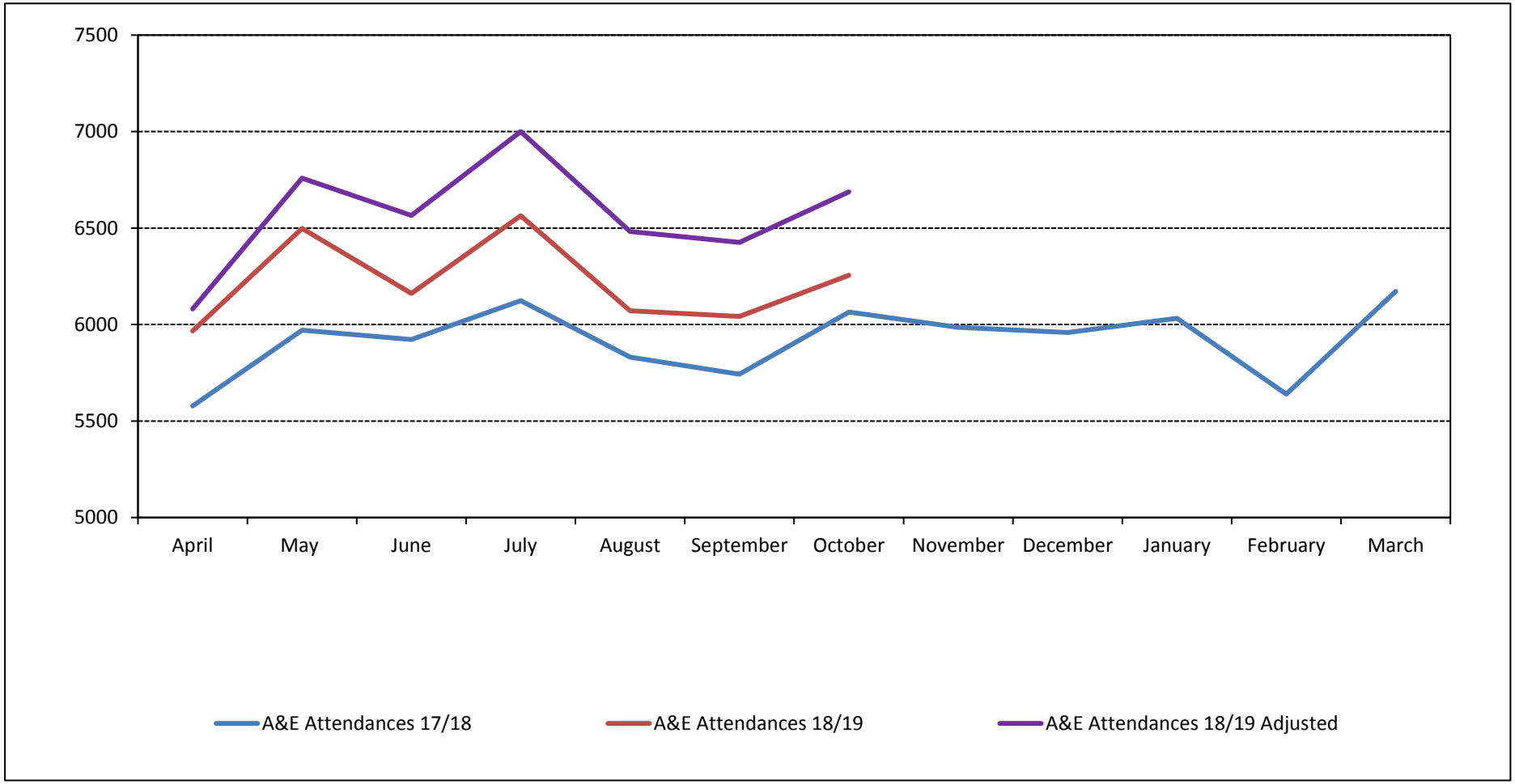
Mth We Delivered.....	Oct-18	Oct-17	Variance	Var. %	Traffic
A&E Attendances	6,256	6,065	191	3.1%	⇧
GP Expected	431	0	431		
**ED Attendances(Adjusted)	6,687	6,065	622	10.3%	⇧
A&E - To IP Admission Ratio	28.6%	30.4%	-1.8%	-1.8%	⇩
Outpatient Attendances	27,959	25,723	2,236	8.7%	⇧
Inpatient Admissions	6,365	5,894	471	8.0%	⇧
Inpatient Discharges	6,343	5,908	435	7.4%	⇧
New Births	224	205	19	9.3%	⇧
RTT Total Incompletes	18,075	16,694	1,381	8.3%	⇧

YTD We Delivered.....	2018	2017	Variance	Var. %	Traffic
A&E Attendances	43,560	41,234	2,326	5.6%	⇧
A&E Adjusted Attendances	46,001	41,234	4,767	11.6%	⇧
Outpatient Attendances	169,320	171,775	-2,455	-1.4%	⇩
Inpatient Admissions	41,350	39,895	1,455	3.6%	⇧
Inpatient Discharges	41,348	39,922	1,426	3.6%	⇧
New Births	1,190	1,509	-319	-21.1%	⇩

* - Included in Referrals Above

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

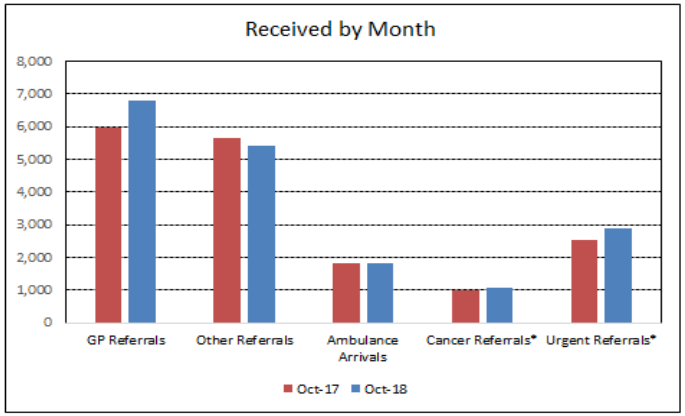
A&E Attendances Year chart (Adjusted)

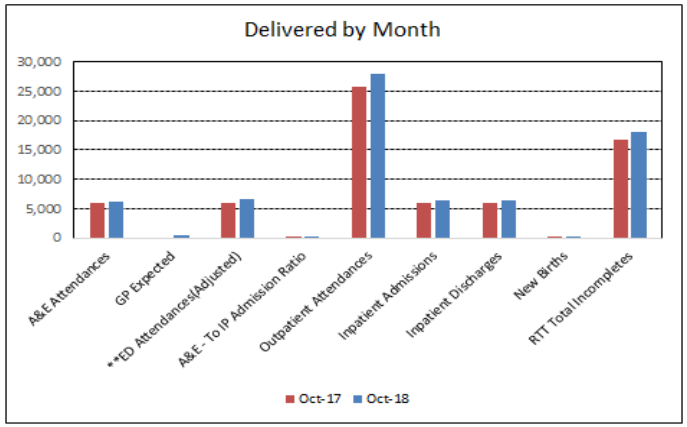


11

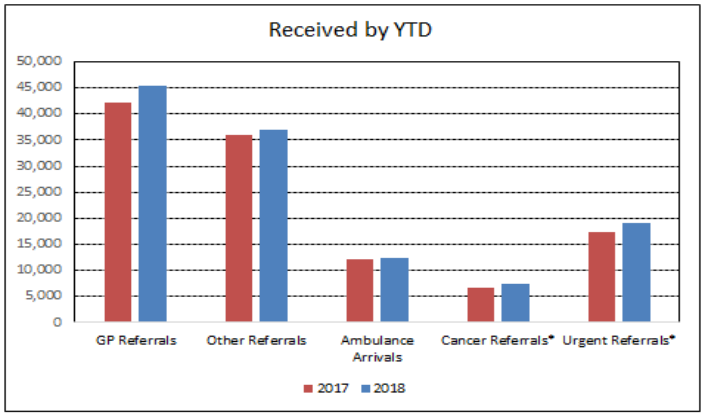
GP and other referrals show a significant increase year on year of 7.5% and other referrals by 2.3%. However cancer referrals has increased year on year of 10.8%. A&E attendances continue to show an increase and incomplete RTT pathways are higher than last year. Ambulance arrivals have remained at a similar level.

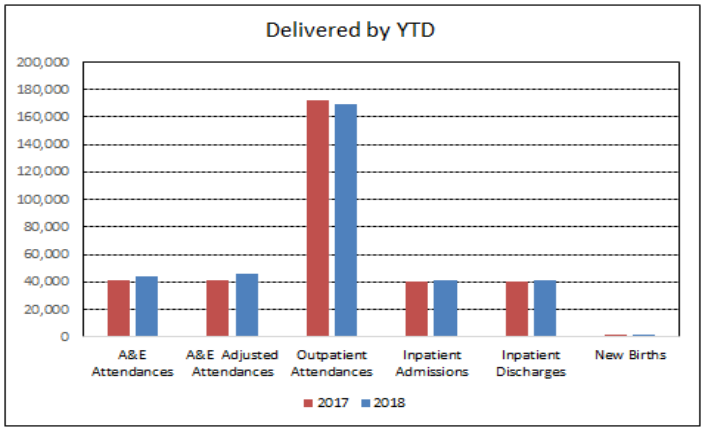
MONTHLY





YEAR TO DATE





DETAILED REPORTS

4. DETAILED SECTIONS – SAFE

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

Are we.		Ref.	KPI	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	YTD(Apr18-Mar19
1.Safe	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.10	HII Compliance 1b: Central venous catheter on-going care	100%	100%	100%	100%	100%	100%	100%	100%	95.0%	100%	91.0%	97.0%	95.0%	100%	96.9%
		1.11	HII Compliance 2a: Peripheral cannula insertion	100%	98.0%	97.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96.0%	99.4%
		1.12	HII Compliance 2b: Peripheral cannula on-going	100%	99.0%	97.0%	96.0%	99.0%	100%	100%	100%	98.0%	97.0%	98.0%	96.0%	88.0%	100%	96.7%
		1.13	HII Compliance 4a: Preventing surgical site infection preoperative	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.14	HII Compliance 4b: Preventing surgical site infection perioperative	100%	100%	100%	100%	100%	95.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.15	HII Compliance 5: Ventilator associated pneumonia	100%	100%	78.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.16	HII Compliance 6a: Urinary catheter insertion	100%	78.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.17	HII Compliance 6b: Urinary catheter on-going care	100%	91.0%	92.0%	95.0%	100%	99.0%	97.0%	100%	95.0%	92.0%	97.0%	97.7%	89.0%	94.0%	95.0%
	Incidents	1.18	Safety Thermometer: % of patients experiencing new harm-free care-Trust	100%	97.6%	98.4%	98.5%	97.9%	97.7%	98.5%	99.2%	97.8%	98.7%	99.2%	88.0%	97.8%	98.7%	97.1%
		1.19	Safety Thermometer: % of patients experiencing new harm-free care - Community	100%	NA	NA	NA	NA	NA	NA	99.4%	98.1%	99.0%	99.3%	99.1%	97.7%	98.9%	98.8%
		1.20	No of SIRIs	NT	11	14	10	20	11	6	8	11	0	5	6	2	4	36
		1.21	RIDDOR Reportable Incidents	NT	2	0	3	0	2	1	2	4	1	1	1	0	3	12
		1.22	Total No of E. Coli (Trust level only)	NT	1	2	2	2	1	3	1	2	0	1	0	0	0	4
		1.23	No of Inpatient falls - Trust	NT	56	73	69	76	82	72	68	72	62	42	75	64	61	444
		1.24	No of Inpatient falls - WSH	<48	47	56	60	68	74	64	55	61	50	31	63	55	47	362
		1.25	No of Inpatient falls - Community Hospitals	NT	9	17	9	8	8	8	13	11	12	11	12	9	14	82
		1.26	Falls per 1,000 bed days	NT	3.93	4.97	5.15	5.56	6.52	5.17	6.13	6.76	4.84	2.82	5.70	5.27	4.29	5.12
		1.27	No of Inpatient falls resulting in harm - Trust	NT	23	18	23	28	26	20	24	24	22	13	24	12	12	131
		1.28	No of Inpatient falls resulting in harm - WSH	NT	19	15	19	27	25	19	18	19	22	11	20	12	11	113
		1.29	No of Inpatient falls resulting in harm - Community Hospitals	NT	4	3	4	1	1	1	6	5	0	2	4	0	1	18
		1.30	No of avoidable serious injuries or deaths resulting from falls - Trust	0	0	1	0	0	1	0	ND	0	0	0	0	0	0	0
		1.31	No of avoidable serious injuries or deaths resulting from falls - WSH	0	0	0	0	0	1	0	ND	0	0	0	0	0	0	0
		1.32	No of avoidable serious injuries or deaths from falls - Community	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
		1.33	Number of medication errors	NT	70	78	63	72	49	76	60	85	43	56	61	63	71	439
		1.34	No of ward acquired pressure ulcers	NT	18	17	12	30	15	9	4	9	9	6	10	14	13	65
		1.35	No of Community 'In our Care' pressure ulcers	NT	13	14	6	24	15	14	12	19	16	13	20	10	23	113
		1.36	% of patients with avoidable ward acquired pressure ulcers YTD	<30%	32.0%	28.0%	28.0%	29.0%	28.0%	29.0%	29.3%	28.0%	28.0%	29.0%	30.0%	ND	ND	28.9%
		1.37	% of patients with avoidable Community 'In our Care' pressure ulcers	NT	54.0%	56.0%	55.0%	50.0%	47.0%	46.0%	43.0%	ND	ND	ND	ND	ND	ND	43.0%
		1.60	% of patients at risk of falls (with a Falls assessment)	NT	73.2%	71.7%	74.3%	73.8%	71.1%	71.7%	71.1%	71.6%	72.2%	74.6%	72.8%	72.0%	73.3%	72.5%

Are we.		Ref.	KPI	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	YTD(Apr18-Mar19
1. Safe	Reporting	1.38	MRSA Quarterly Std (including admission and LOS screens)	90%	NA	NA	90.0%	NA	NA	92.0%	NA	NA	88.0%	NA	NA	87.0%	NA	87.5%
		1.39	MRSA Bacteraemias - Community Attributable	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
		1.40	Clostridium Difficile infection - Community Attributable	NT	1	0	0	0	0	2	4	1	1	4	5	4	3	22
		1.41	MRSA - Decolonisation	95%	98.0%	85.0%	91.0%	94.0%	86.0%	95.0%	85.0%	91.0%	90.0%	81.0%	97.0%	86.0%	95.0%	89.3%
		1.42	MRSA - RCA Reports	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		1.43	MSSA (Hospital)	NT	0	1	1	1	0	0	0	2	2	0	0	0	1	5
		1.44	SIRI final reports due in month submitted beyond 60 working days	0	5	4	0	0	1	3	3	3	0	1	0	0	0	7
		1.45	SIRIs reported >2 working days from identification as red	0	3	6	5	7	3	ND	0	1	0	0	0	0	0	1
		1.46	Green, Amber & Red Active / Accepted risk assessments not in date	0	5	0	2	1	4	0	1	3	2	0	3	0	4	13
		1.47	Datix Risk Register Red / Amber actions overdue	0	0	0	0	0	1	3	1	4	3	0	0	0	1	9
		1.48	Rapid access chest pain clinic access within 2 wks.	100%	96.3%	100%	100%	100%	100%	99.1%	57.5%	97.3%	97.3%	96.2%	96.7%	98.6%	99.2%	91.8%
		1.49	Verbal Duty of Candour outstanding at month-end	0	1	2	0	2	2	1	1	1	2	2	0	0	0	6
		1.50	Hand Hygiene Audits	95%	99.0%	99.0%	99.0%	99.0%	100%	100%	100%	99.0%	99.0%	99.0%	100%	100%	100%	99.6%
		1.51	Quarterly antibiotic audit	98%	NA	NA	93.0%	NA	NA	89.0%	NA	NA	92.2%	NA	NA	89.0%	NA	90.6%
		1.52	Serious Incident RCA actions beyond deadline for completion	0	2	9	14	9	8	4	9	4	4	7	4	2	5	35
		1.53	% of Green Patient Safety incidents investigated	NT	67.0%	56.0%	55.0%	59.0%	74.0%	68.0%	68.0%	64.0%	61.0%	68.0%	59.0%	63.0%	64.0%	65.3%
		1.54	Quarterly Environment/Isolation	90%	NA	NA	92.0%	NA	NA	91.0%	NA	NA	92.0%	NA	NA	93.0%	NA	92.5%
		1.55	Quarterly VIP score documentation	90%	NA	NA	87.0%	NA	NA	80.0%	NA	NA	86.0%	NA	NA	83.0%	NA	84.5%
		1.56	Isolation data (Trust Level only)	95%	90.0%	88.0%	88.0%	90.0%	90.0%	89.0%	86.0%	88.0%	87.0%	88.0%	91.0%	91.0%	91.0%	88.9%
		1.57	Pain Mgt. Quarterly internal report	80%	61.3%	NA	NA	58.8%	NA	NA	NA	NA	NA	86.0%	NA	NA	85.5%	85.8%
		1.58	Nutrition Risk Assessment	95%	89.0%	87.0%	93.0%	92.0%	89.0%	90.0%	90.0%	93.0%	88.0%	91.0%	88.0%	96.0%	95.0%	91.6%
		1.59	Median NRLS (national reporting & Learning system) upload 6 month rolling average (No. of days)	41	48	61	66	75	65	63	26	31	60	59	51	40	37	43
		1.61	E coli - Hospital Attributable	NT	1	2	2	2	1	3	1	2	2	1	1	1	2	7
		1.62	E coli - Community Attributable	NT	12	17	14	7	10	7	14	19	14	13	15	13	14	75
		1.63	Klebsiella spp. - Hospital Attributable	NT	0	1	0	0	0	0	1	0	0	2	0	0	0	3
		1.64	Klebsiella spp. - Community Attributable	NT	1	3	2	2	0	3	4	1	0	3	2	3	1	23
		1.65	Pseudomonas - Hospital Attributable	NT	0	0	0	0	1	0	0	0	0	0	1	0	0	0
		1.66	Pseudomonas - Community Attributable	NT	1	0	0	5	0	1	1	1	0	0	0	1	1	2

SAFE – DIVISIONAL LEVEL ANALYSIS

	August			September			October		
Indicator	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
HII compliance 1a: Central venous catheter insertion	100	100		100	100		100	100	
HII compliance 1b: Central venous catheter ongoing care	100	92		100	92		100	100	
HII compliance 2a: Peripheral cannula insertion	100	100	100	100	100	100	100	96	90
HII compliance 2b: Peripheral cannula ongoing	100	94	100	100	81	100	100	100	100
HII compliance 4a: Preventing surgical site infection preoperative	100			100			100		
HII compliance 4b: Preventing surgical site infection perioperative	100			100			100		
HII compliance 5: Ventilator associated pneumonia	100			100			100		
HII compliance 6a: Urinary catheter insertion	100	100		100	100		100	100	
HII compliance 6b: Urinary catheter on-going care	100	95		100	85		100	91	
HII compliance 7: Clostridium Difficile- prevention of spread									
Total no of MRSA bacteraemias: Hospital	0	0	0	0	0	0	0	0	0
Quarterly MRSA (including admission and length of stay screens)				97	76	89			
Hand hygiene compliance	100	100	100	100	100	100	100	100	100
Total no of MSSA bacteraemias: Hospital	0	0	0	0	0	0	1	0	0
Total no of C. diff infections: Hospital	0	1	0	0	1	0	0	1	0
Quarterly Antibiotic Audit				86	90	100			
Quarterly Environment/Isolation				94	92	94			
Quarterly VIP score documentation				81	84	89			

Indicator	August			September			October		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
No of Inpatient falls	10	53	0	8	48	0	6	41	0
No of Inpatient falls resulting in harm	3	18	0	2	17	0	1	11	0
No of avoidable serious injuries or deaths resulting from falls	0	0	0						
No of ward acquired pressure ulcers	3	7	0	4	10	0	1	12	0
Nutrition: Assessment and monitoring	100.0	82.0	90.0	97.0	96.0	93.0	95.6	94.7	85.3
No of SIRIs	1	4	1	0	2	0	1	1	1
No of medication errors	8	34	8	18	30	8	14	30	4
Cardiac arrests	0	5	0	1	5	0	0	3	0
Cardiac arrests identified as a SIRI	0	0	0	0	0	0	0	0	0
Pain Management: Quarterly internal report							86.1	88.3	40
VTE: Completed risk assessment (monthly Unify audit)	93.4	93.6	100.0	94.6	93.3	97.7	95.7	96.0	97.5
Quarterly VTE: Prophylaxis compliance									
Safety Thermometer: % of patients experiencing new harm-free care	99.4	99.4	100.0	98.0	97.6	100.0	100.0	97.9	100.0

Indicator	August			September			October		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
Patient Satisfaction: In-patient overall result	96.0	94.0	96.0	98.0	96.0	99.0	95.0	94.0	92.0
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	99.0	99.0	100.0	99.0	98.0	100.0	96.0	97.0	93.0
In your opinion, how clean was the hospital room or ward that you were in?	97.0	95.0	97.0	99.0	96.0	100.0	97.0	94.0	98.0
Did you feel you were treated with respect and dignity by staff	100.0	99.0	100.0	100.0	99.0	100.0	99.0	98.0	96.0
Were staff caring and compassionate in their approach?	99.0	98.0	100.0	100.0	100.0	100.0	99.0	97.0	93.0
Did you experience any noise in the night time that you think could have been avoided?	87.0	89.0	87.0	90.0	84.0	100.0	80.0	88.0	100.0
Did you find someone in the hospital staff to talk about your worries and fears?	98.0	99.0	94.0	99.0	97.0	100.0	97.0	95.0	90.0
Were you involved as much as you wanted to be in decisions about your care and treatment?	96.0	93.0	93.0	99.0	94.0	94.0	96.0	92.0	82.0
Did staff talk in front of you as if you were not there?	100.0	95.0	98.0	99.0	97.0	94.0	99.0	96.0	96.0
Were you given enough privacy when discussing your condition or treatment?	100.0	99.0	100.0	100.0	99.0	100.0	100.0	98.0	93.0
Were you given enough privacy when being examined or treated?	100.0	99.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Did you get enough help from staff to eat your meals?	97.0	94.0	83.0	98.0	95.0	100.0	97.0	94.0	80.0
How many minutes after you used the call button did it usually take before you got the help you needed?	83.0	74.0	95.0	86.0	87.0	100.0	86.0	81.0	76.0
Number of Inpatient surveys completed	252	177	23	236	198	9	236	175	14
Same sex accommodation: total patients	0	0	0	0	0	0	0	0	0
Complaints	2	5	2	3	4	1	2	3	2
Environment and Cleanliness	93.3	92.8	95.6	93.2	93.2	94.6	94.0	92.9	93.4

5. Exception reports – Safe

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	HII Compliance
Standard	100%
Name	Rowan Procter
Month	Oct-18
Data Frequency	Monthly
CQC Area	Safe

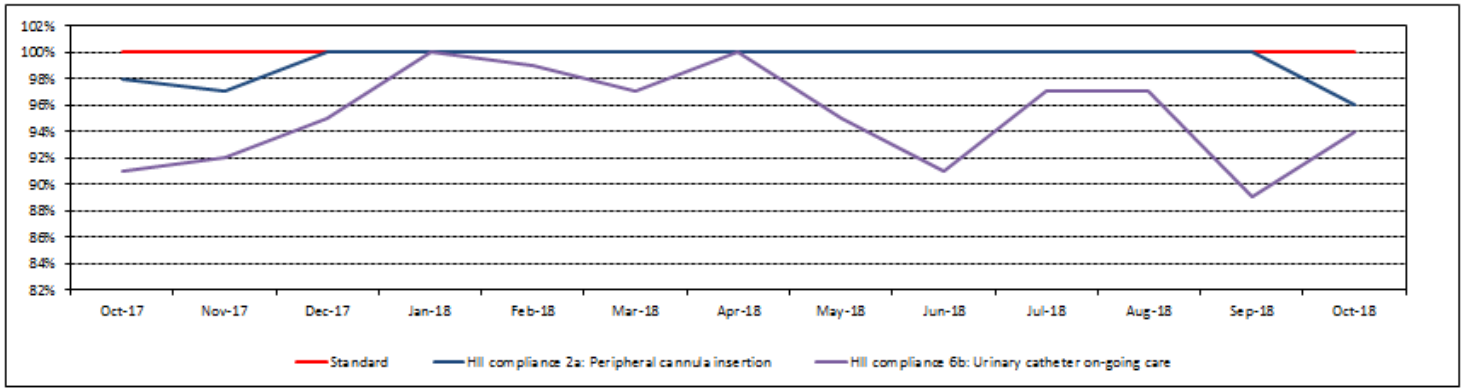
Summary of Current performance & Reasons for under performance

2a: There was a single failing with documentation on Ward F1. This is being explored and will be rectified by the team

6b: There have been improvements in performance in many wards with focussed education from the Ward Managers and Senior Matrons. Poor compliance with documentation is the main reason for non-compliance, but there has been significant improvement with this on Ward G5 which was previously failing in this element

Month		Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
HII compliance 2a: Peripheral cannula insertion	Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Current Position	98.0%	97.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96.0%
HII compliance 6b: Urinary catheter on-going care	Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Current Position	91.0%	92.0%	95.0%	100%	99.0%	97.0%	100%	95.0%	91.0%	97.0%	97.0%	89.0%	94.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Pilot on ward to improve the care and documentation of urinary catheters	Infection Prevention	Aug-18	Nov-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

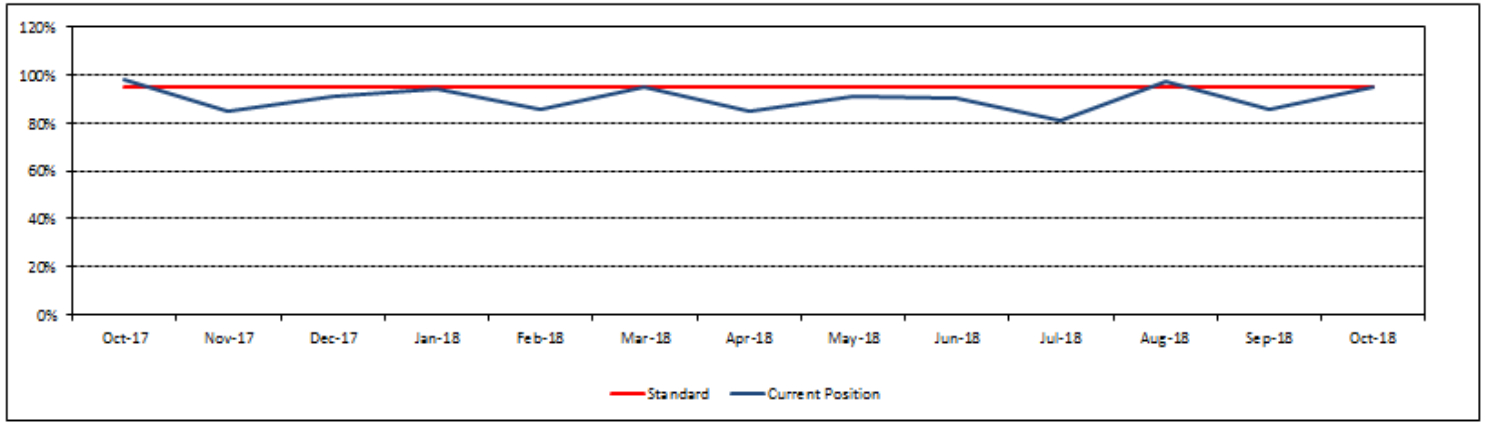
Indicator	MRSA - Decolonisation
Standard	95%
Name	Anne Howe
Month	Oct-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

From October 2018 the regimen is now an order set on eCare which should address the documentation issues going forward. Briefly discussed with CCG colleagues how they would like this data to be captured. The Trust will monitor the timeliness of the initiation of the decolonization order set and check the compliance.
In October there were 6 patients who required decolonization all had the regimen prescribed in a timely manner (within 12h which met our criteria) however 1 had the old style paper document so has been marked as non compliant hence 95% score. We have addressed this with the ward in question and will remove old paperwork. In addition this is discussed as part of Mandatory training weekly.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	98.0%	85.0%	91.0%	94.0%	86.0%	95.0%	85.0%	91.0%	90.0%	81.0%	97.0%	86.0%	95.0%

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

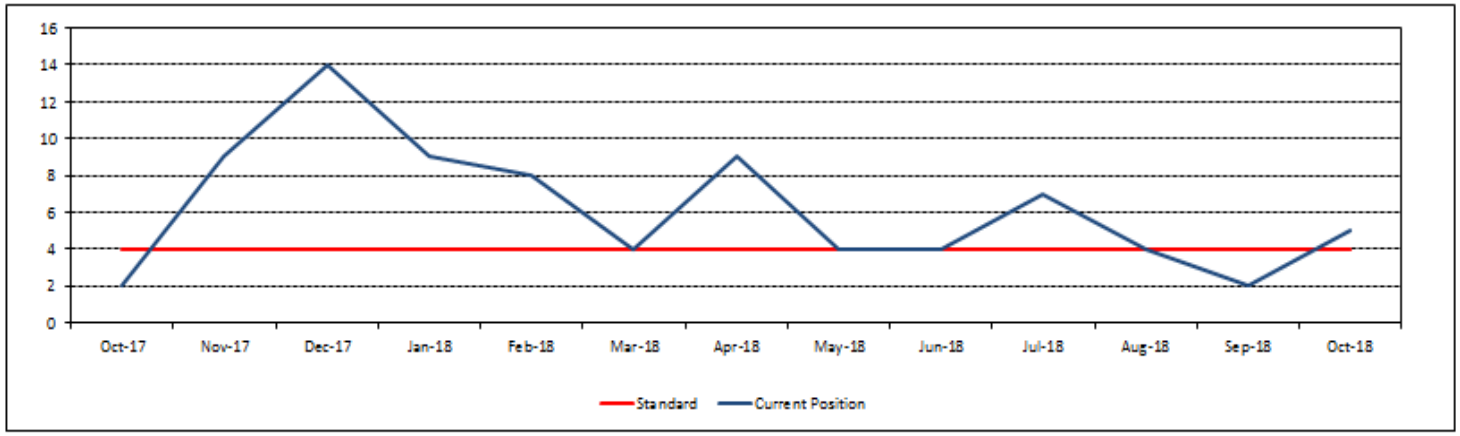
Indicator	Timeliness of RCA action completion
Standard	4
Name	Rowan Procter
Month	Oct-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Five actions remain overdue:
- Three relate to review of guidelines within Maternity. There has been good progress in this work and it is envisaged that these will be completed in the near future once the relevant review, consultation and approval pathways are completed.
- One relates to the provision of onsite testing of respiratory viral swabs for Influenza. Equipment has been sources and staff trained however contractual negations are still in progress with Pathology partners (PHE/NEESPS)
- One relates to the ordering of repeat or 'add on' tests on e-Care is still in discussion to achieve resolution.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	4	4	4	4	4	4	4	4	4	4	4	4	4
Current Position	2	9	14	9	8	4	9	4	4	7	4	2	5

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Clinical Directors meeting have agreed to take greater oversight of RCA action completion	Clinical Directors	2018	Ongoing
Discussion with Senior matrons and Ward Managers at Nursing & Midwifery and Clinical Council (NMCC)	NMCC	2018	Ongoing



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

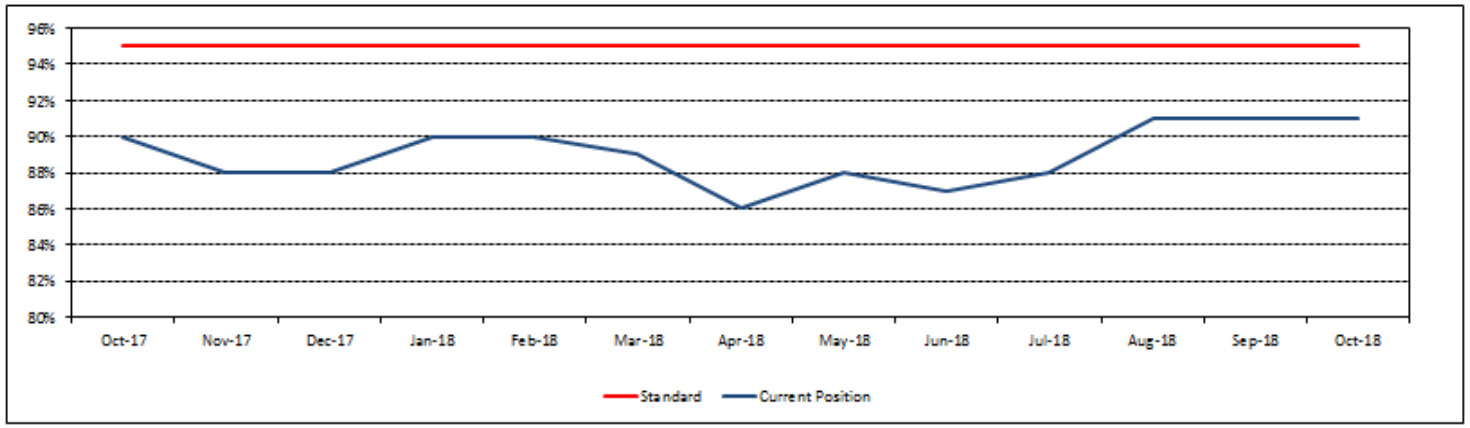
Indicator	Isolation data (Trust Level only)
Standard	95%
Name	Anne Howe
Month	Oct-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Compliance with Isolation is at 91%. The side room capacity is monitored daily (Mon to Fri) by the Infection Prevention Nurses(IPN) and occupancy is risk assessed throughout the day, including a daily review of patients on the Intervention Prevention Nurses ward visits and this information is provided to the site capacity/bed flow meetings. Wards were advised on the measures required to mitigate onward transmission. F12 Adult isolation ward has been utilized for optimum use throughout October to ensure that patients with the highest infection risk are managed there if at all possible including patients with Tuberculosis following the temporary relocation of F10 to G9.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	90.0%	88.0%	88.0%	90.0%	90.0%	89.0%	86.0%	88.0%	87.0%	88.0%	91.0%	91.0%	91.0%

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



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5. DETAILED REPORTS - EFFECTIVE

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

Are we.		Ref.	KPI	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	YTD(Apr18-Mar19)
2.Effective	Incidents/Reports	2.05	Cardiac arrests	NT	4	ND	ND	7	ND	ND	3	4	2	7	3	6	ND	25
		2.06	Cardiac arrests identified as a SIRI	NT	0	0	0	0	0	0	1	0	0	0	0	0	0	1
		2.07	CAS (central alerts system) alerts overdue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		2.09	NICE guidance baseline and risk assessments not completed within 6 months of publication	10	ND	ND	ND	ND	ND	ND	56	55	48	47	41	49	48	344
		2.10	WHO Checklist (Qrtly)	100%	NA	NA	99.0%	NA	NA	98.0%	NA	NA	99.0%	NA	NA	98.0%	NA	98.5%
		2.11	National clinical audit report baseline & risk assessments not completed within 6 months of publication	5	ND	ND	ND	ND	ND	ND	22	23	17	18	18	18	18	134
		2.12	Av. Elective LOS (excl. 0 days)	NT	2.93	2.85	2.98	3.06	2.27	3.29	3.39	2.8	2.66	2.85	3.29	2.6	3.24	2.98
		2.13	Av NEL LOS (excl 0 days)	NT	8.23	7.66	7.57	8.40	8.13	8.1	8.53	7.93	7.24	7.82	8.00	7.15	7.18	7.69
		2.14	% of NEL 0 day LOS	NT	18.8%	16.6%	14.7%	13.3%	13.3%	13.7%	13.6%	15.0%	15.7%	15.0%	13.3%	14.7%	14.7%	14.6%
		2.15	NHS number coding	99%	99.6%	99.7%	99.6%	99.7%	99.7%	99.7%	99.7%	99.8%	99.8%	99.8%	99.3%	99.5%	99.7%	99.7%
		2.16	Fractured Neck of Femur : Surgery in 36 hours	85%	96.0%	84.0%	100%	100%	96.0%	93.0%	89.0%	79.0%	100%	94.4%	100%	90.3%	96.9%	92.8%
		2.17	Discharge Summaries (OP 85% 3d)	85%	58.0%	58.0%	58.0%	60.0%	58.0%	56.0%	62.0%	57.0%	63.0%	54.0%	ND	ND	ND	59.0%
		2.18	Discharge Summaries (A&E 95% 1d)	95%	83.6%	84.2%	82.6%	84.0%	83.4%	82.3%	81.5%	82.5%	86.1%	86.4%	88.4%	88.9%	85.8%	85.7%
		2.19	Non-elective Discharge Summaries (IP 95% 1d)	95%	73.3%	69.2%	68.9%	70.2%	69.8%	70.8%	73.5%	75.7%	78.1%	76.6%	76.9%	75.3%	77.9%	76.3%
		2.20	Elective Discharge Summaries (IP 85% 1d)	85%	73.3%	68.0%	74.5%	72.8%	71.2%	72.9%	72.1%	71.2%	72.1%	69.5%	70.8%	79.8%	80.8%	73.8%
		2.21	All Cancer 2ww services available on C&B	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		2.22	Canc. Ops - Patients offered date within 28 days	100%	84.6%	98.1%	76.7%	94.7%	96.6%	91.7%	85.7%	90.9%	100%	90.0%	91.9%	90.0%	80.0%	89.8%
		2.23	Canc. Ops. - No. Cancelled for a 2nd time	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0

EXCEPTION REPORTS – EFFECTIVE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

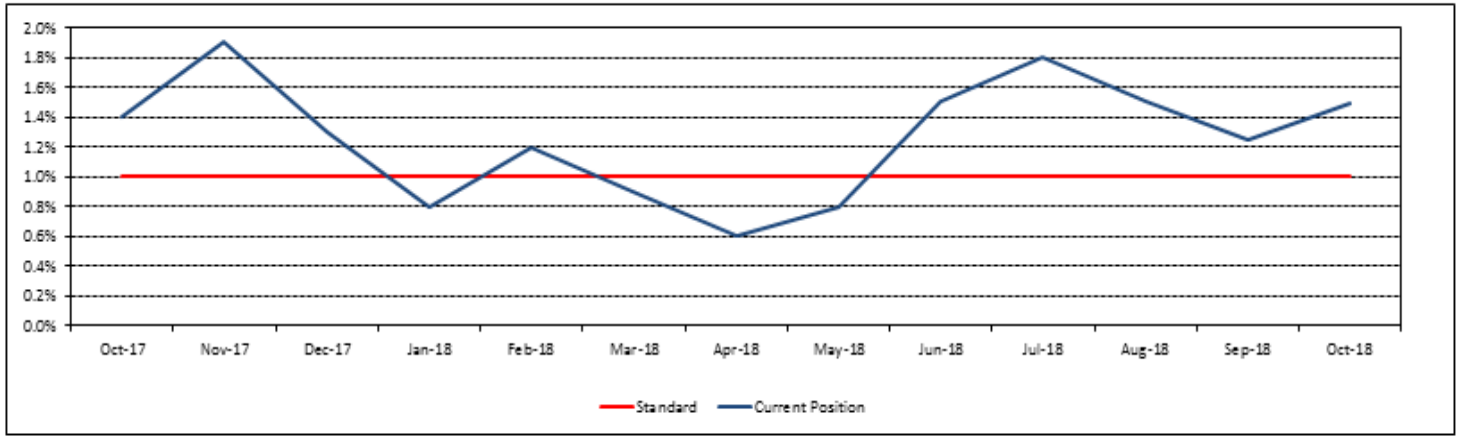
Indicator	Canc. Ops - Cancellations for non-clinical reasons
Standard	1%
Name	Hannah Knights
Month	Oct-18
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

Increase in amount of operations cancelled on the day. This was mostly due to consultant/anaesthetic staff sickness and some cancellations due to bed capacity.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1%
Current Position	1.4%	1.9%	1.3%	0.8%	1.2%	0.9%	0.6%	0.8%	1.5%	1.8%	1.5%	1.2%	1.5%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to follow escalation & cancellation protocols.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

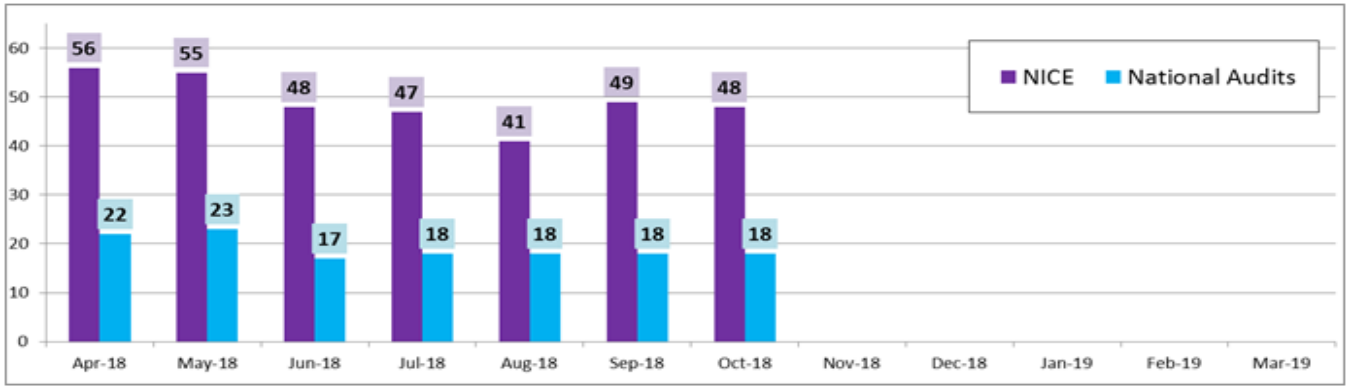
Indicator	NICE and AUDIT Baseline assessment submitted within six
Standard	0
Name	Nick Jenkins
Month	Oct-18
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

NICE baseline assessments
Seven baseline assessments were completed in October 2018 and six guidelines were published (six months ago) in April 2018 that require a completed baseline assessment, resulting in a reduction from 49 to 48 baseline assessments not completed within 6 months of publication. This indicator remains AMBER
National clinical audit baseline assessments
Two baseline assessments were completed in October 2018 and two reports were published (six months ago) in April 2018 that require a completed baseline assessment, resulting in a maintenance of 18 baseline assessments not completed within 6 months of publication. This indicator remains RED

Month		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
NICE	Standard	0	0	0	0	0	0	0
	Current Position	56	55	48	47	41	49	48
National Audits	Standard	0	0	0	0	0	0	0
	Current Position	22	23	17	18	18	18	18

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

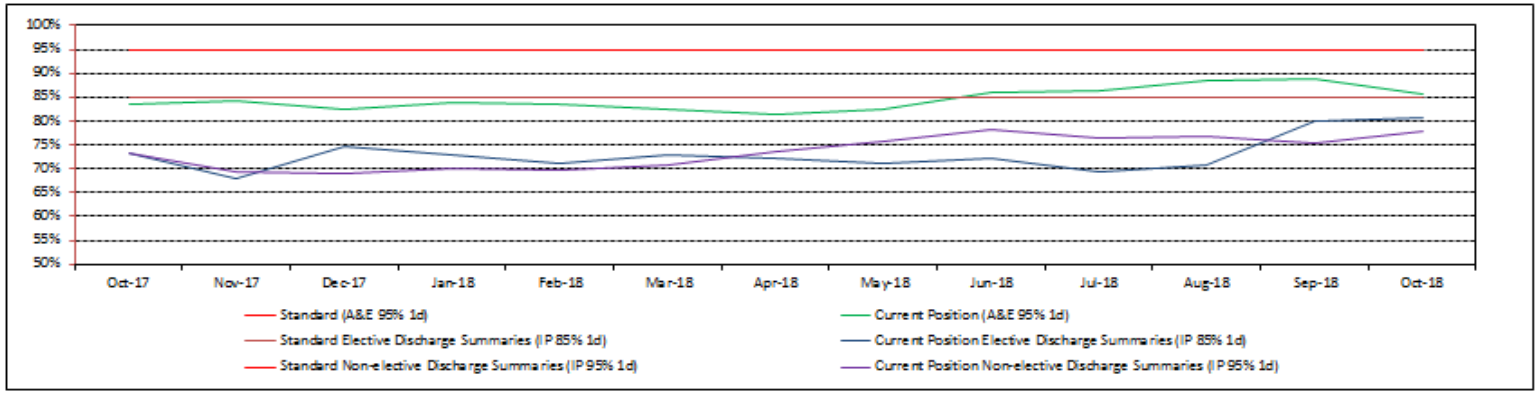
Indicator	Discharge Summaries (A&E 95% 1d)
Standard	95%
Name	Georgia Horobin
Month	Oct-18
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

We continue to work closely with all departments to improve performance on timeliness of discharge summaries. Within ED we are working to embed the new standard operating procedures that will provide clear guidance to all clinicians. In addition we are introducing new reporting functionality that will clearly show them where they have outstanding summaries to complete. Our main focus over the last month has been to move the new cardiology unit onto producing discharge summaries within e-Care which had previously been created on paper. This will be a significant improvement for primary care colleagues. Dr Christopher Browning from the CCG is now working with us to support junior doctor education on the information that is most helpful to GPs.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard (A&E 95% 1d)	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position (A&E 95% 1d)	83.6%	84.2%	82.6%	84.0%	83.4%	82.3%	81.5%	82.5%	86.1%	86.4%	88.4%	88.9%	85.8%
Standard Elective Discharge Summaries (IP 85% 1d)	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Current Position Elective Discharge Summaries (IP 85% 1d)	73.3%	68.0%	74.5%	72.8%	71.2%	72.9%	72.1%	71.2%	72.1%	69.5%	70.8%	79.8%	80.8%
Standard Non-elective Discharge Summaries (IP 95% 1d)	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position Non-elective Discharge Summaries (IP 95% 1d)	73.3%	69.2%	68.9%	70.2%	69.8%	70.8%	73.5%	75.7%	78.1%	76.6%	76.9%	75.3%	77.9%

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Canc. Ops - Patients offered date within 28 days
Standard	100%
Name	Hannah Knights
Month	Oct-18
Data Frequency	Monthly
CQC Area	Effective

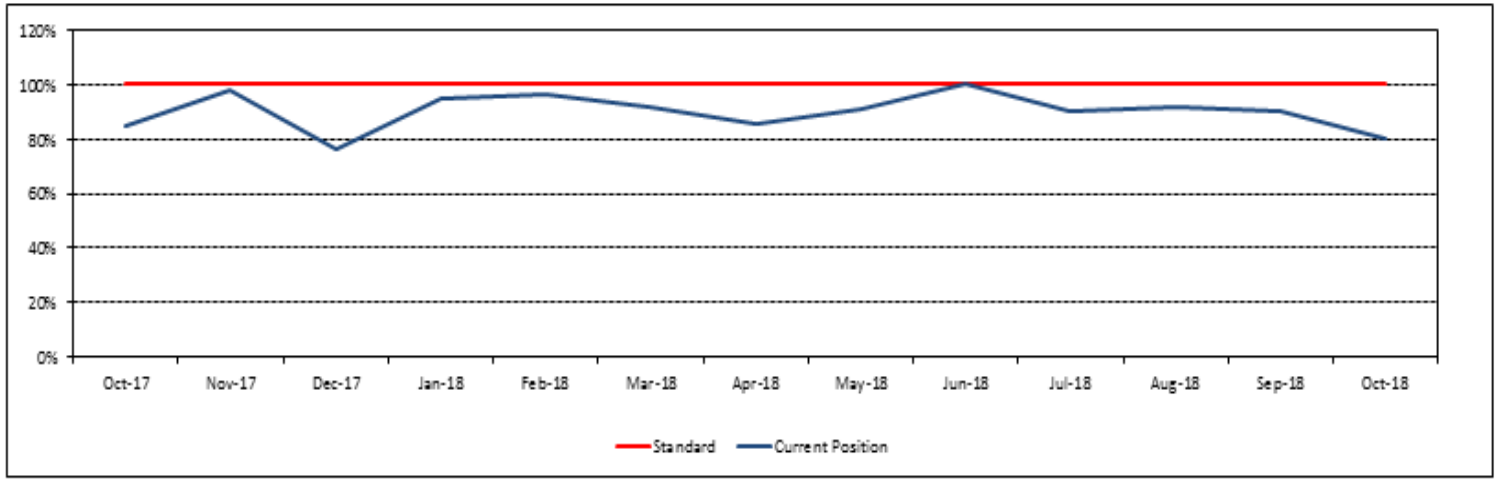
Summary of Current performance & Reasons for under performance

9 patients were unable to be booked back within 28 days of their cancellation. 2 x gynaecology patients due to sickness, 4 x Orthopaedic patients due to consultant availability, 2 x Vascular due to overall capacity and 1 x General Surgery patient who is very complex and needed build up to bring back in. 40 Cancelled with 8 Breaches.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	84.6%	98.1%	76.7%	94.7%	96.6%	91.7%	85.7%	90.9%	100%	90.0%	91.9%	90.0%	80.0%

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

Description	Owner	Start	End
Continue to monitor 28 day breach report and discuss at weekly access meeting.	HK	Oct-18	



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6. DETAILED REPORTS - CARING

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

Are we..		Ref.	KPI	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	YTD(Apr 18-Mar19)
3. Caring	Other Friends and Family Test Scores	3.09	IP overall experience result	85%	96.0%	96.0%	95.0%	94.0%	95.0%	96.0%	97.0%	97.0%	97.0%	97.0%	95.0%	97.0%	95.0%	96.4%
		3.10	OP overall experience result	85%	95.0%	94.0%	95.0%	96.0%	97.0%	96.0%	97.0%	97.0%	97.0%	97.0%	96.0%	96.0%	97.0%	96.7%
		3.11	A&E overall experience result	85%	93.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	93.0%	94.0%	95.0%	97.0%	94.0%	95.0%	94.6%
		3.12	Short-stay overall experience result	85%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	100%	99.0%	99.0%	98.0%	99.0%	100%	99.0%	99.1%
		3.13	Short-stay Extremely likely or Likely to recommend (FFT)	90%	99.0%	97.0%	100.0%	99.4%	99.7%	99.0%	100%	99.0%	98.0%	98.0%	99.0%	99.0%	100%	99.0%
		3.14	Maternity - overall experience result	85%	100%	98.0%	95.0%	100%	93.0%	100%	99.0%	95.0%	96.0%	100%	97.0%	94.0%	97.0%	96.9%
		3.15	Maternity postnatal community - extremely likely or likely to recommend (FFT)	90%	100%	ND	ND	ND	ND	ND	100%	97.0%	96.0%	100%	100%	98.0%	98.0%	98.4%
		3.16	Maternity birthing unit - extremely likely or likely to recommend (FFT)	90%	100%	100%	ND	100%	100%	ND	100%	ND	ND	100%	100%	100%	100%	100%
		3.17	Maternity antenatal community - extremely likely or likely to recommend (FFT)	90%	96.4%	ND	ND	ND	ND	ND	100%	100%	94.0%	97.0%	100%	100%	100%	98.7%
		3.18	Children's services overall result	85%	ND	ND	ND	ND	ND	ND	97.0%	99.0%	96.0%	95.0%	98.0%	95.0%	85.0%	95.0%
		3.19	F1 Parent - overall experience result	85%	99.0%	95.0%	98.0%	98.0%	98.0%	98.0%	96.0%	99.0%	96.0%	95.0%	98.0%	95.0%	95.0%	96.3%
		3.20	F1 - Extremely likely or likely to recommend (FFT)	90%	100%	94.0%	97.0%	100%	100%	100%	92.0%	100%	96.0%	95.0%	94.0%	91.0%	93.0%	94.4%
		3.21	F1 Children - Overall experience result	85%	ND	ND	ND	ND	ND	ND	85.0%	97.0%	96.0%	99.0%	91.0%	95.0%	93.0%	93.7%
		3.22	Rosemary ward - extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	78.0%	85.0%	100%	78.0%	100%	88.0%	76.0%	100%	90.0%	100%	90.4%
		3.23	King suite - extremely likely or likely to recommend	90%	100%	100%	94.0%	93.0%	100%	100%	ND	100%	100%	75.0%	100%	100%	100%	95.8%
		3.24	Community paediatrics - extremely likely or likely to recommend (FFT)	90%	96.0%	100%	97.0%	100%	97.0%	95.0%	94.0%	95.0%	100%	100%	100%	94.0%	100%	97.6%
		3.25	Community health teams - extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	90.0%	100%	90.0%	100%	100%	100%	66.0%	89.0%	100%	100%	93.6%
		3.26	Community specialist nursing teams - extremely likely or likely to recommend (FFT)	90%	100%	100%	95.0%	100%	93.0%	100%	92.0%	98.0%	100%	77.0%	90.0%	94.0%	100%	93.0%
		3.27	Stroke Care - Overall Experience Result	85%	100%	85.0%	ND	98.0%	95.0%	100%	95.0%	92.0%	100%	100%	100%	90.0%	100%	96.7%
		3.28	Stroke Care - extremely likely or likely to recommend	90%	100%	100%	ND	100%	100%	100%	100%	100%	100%	95.0%	97.0%	97.0%	100%	98.4%
	Complaint Handling	3.29	Complaints acknowledged within 3 working days	90%	100%	100%	87.0%	92.0%	100%	100%	92.0%	100%	100%	100%	88.0%	66.0%	100%	92.3%
		3.30	Complaints responded to within agreed timeframe	90%	81.0%	82.0%	50.0%	60.0%	17.0%	54.0%	31.0%	70.0%	50.0%	40.0%	83.0%	100%	83.0%	65.3%
		3.31	Number of second letters received	1	2	0	1	0	0	1	2	2	6	2	1	0	2	15
		3.32	Ombudsman referrals accepted for investigation	1	0	0	1	1	1	0	0	0	0	0	0	1	0	1
		3.33	No. of complaints to Ombudsman upheld	0	ND	0	0	0	0	0	0	0	0	0	0	0	0	0
		3.34	No. of PALS contacts	NT	190	167	124	161	178	205	183	231	214	275	233	198	224	1558
		3.35	No. of PALS contacts becoming formal complaints	<=5	3	4	1	3	6	1	4	4	4	4	2	2	1	21

EXCEPTION REPORTS –CARING

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	Complaints responded to within agreed timeframe
Standard	90%
Name	Cassia Nice
Month	Oct-18
Data Frequency	Monthly
CQC Area	Caring

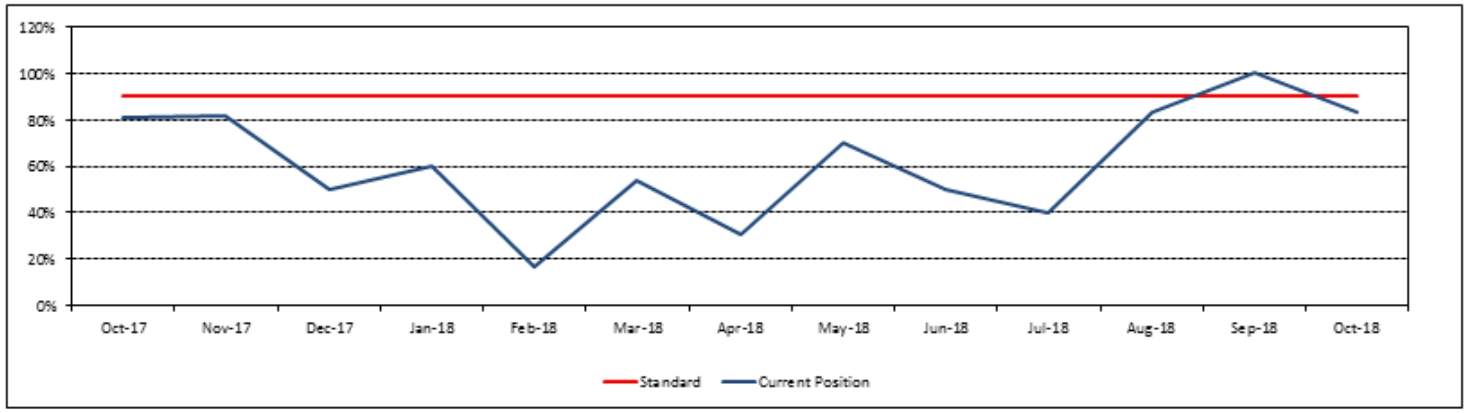
Summary of Current performance & Reasons for under performance

10 out of 12 complaints were responded to within their timeframe in October. One of these was a multi-organisational response in which we were waiting for information from another hospital.

We will continue to allocate complaint responses accordingly to ensure response rates do not deteriorate.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	81.0%	82.0%	50.0%	60.0%	17.0%	54.0%	31.0%	70.0%	50.0%	40.0%	83.0%	100%	83.0%

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

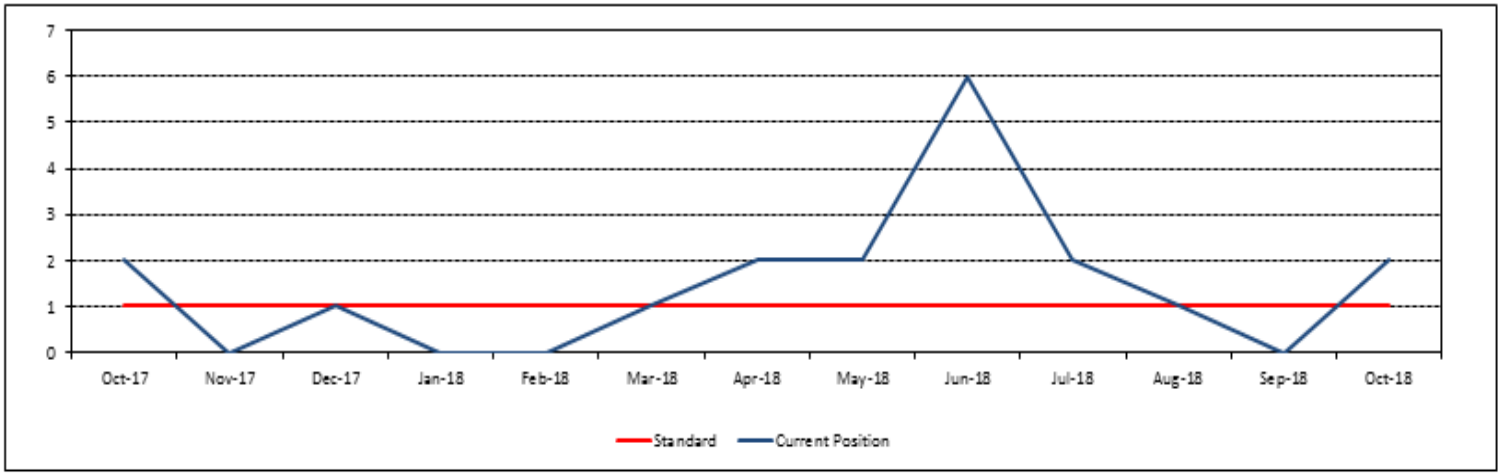
Indicator	Number of second letters received
Standard	1
Name	Cassia Nice
Month	Oct-18
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Two second letters were received in October. These were unrelated in subject and area. They also related to complaints that were responded to within different months and cannot be attributed to one another therefore no theme detected.

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

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



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7. DETAILED REPORTS - RESPONSIVE

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

Are we..		Ref.	KPI	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	YTD(Apr18-Mar19)
4. Responsive	A&E	4.13	Number of Delayed Transfer of Care - (DTOCs)	NT	250	279	314	326	393	321	208	206	203	130	242	176	191	194
		4.14	A&E time to treatment in department (median) for patients arriving by ambulance - CDM	120	59	41	62	57	75	64	62	48	49	49	46	39	46	48
		4.15	A&E - Single longest Wait (Admitted & Non-Admitted)	6 hrs.	15.44	22.04	16.48	18.11	17.18	19.50	18.14	10.30	12.22	14.49	15.54	12.23	16.17	14.16
		4.16	A&E -Waits over 12 hours from DTA to Admission	12 Hrs.	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		4.17	A&E - Admission waiting 4-12 hours from dec. to admit	4	10	17	50	122	30	46	17	4	8	15	31	10	31	116
		4.18	A&E - To inpatient Admission Ratio	27%	30.4%	30.0%	32.8%	31.9%	32.1%	29.6%	27.9%	25.8%	25.0%	23.9%	25.7%	28.3%	28.6%	26.5%
		4.19	A&E Service User Impact (re-attendance in 7 days <5% & time to treat)	1 met	1	1	1	1	1	1	1	1	1	1	1	1	1	1
		4.20	A&E/AMU - Amb. Submit button complete	80%	87.7%	88.2%	89.4%	85.7%	89.6%	93.5%	92.7%	94.4%	92.8%	91.3%	90.1%	91.0%	93.1%	92.2%
		4.21	A&E - Amb. Handover above 30m	0	40	84	110	72	87	74	88	84	13	21	24	6	21	257
		4.22	A&E - Amb. Handover above 60m	0	21	46	54	38	30	17	29	3	5	31	16	2	30	116
	RTT	4.23	RTT - 18w Admitted (Completed)	90%	72.0%	70.9%	69.9%	72.6%	73.5%	74.1%	73.4%	71.1%	76.9%	74.7%	74.0%	75.5%	74.6%	74.3%
		4.24	RTT - 18w Non-admitted (Completed)	95%	84.9%	85.8%	90.6%	88.7%	93.9%	93.4%	92.8%	94.5%	93.3%	93.9%	91.0%	88.5%	89.8%	92.0%
		4.25	RTT waiting List	<15396	16694	16641	16195	15363	15804	15396	16223	16481	16739	16715	16601	18105	18075	16991
		4.26	RTT waiting list over 18 weeks	NT	2171	1843	1775	1504	1650	1614	1560	1294	1443	1433	1775	1830	1772	1587
		4.27	RTT 18 weeks Non-Consultant led services - Community	90%	93.7%	94.4%	98.4%	98.7%	100%	99.4%	99.2%	97.6%	100%	98.7%	99.0%	99.0%	99.0%	98.9%
		4.28	RTT 52 weeks Non-Consultant led services - Community	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Stroke	4.29	Stroke - % Patients scanned within 1 hr.	77%	75.7%	74.4%	75.6%	86.7%	76.7%	70.0%	73.7%	63.6%	77.7%	76.3%	84.4%	93.3%	64.0%	76.1%
		4.30	Stroke - % patients scanned within 12 hrs.	96%	97.3%	92.3%	95.6%	98.3%	100%	97.5%	94.7%	97.7%	100%	89.5%	100%	100%	100%	97.4%
		4.31	Stroke - % Patients admitted directly to stroke unit within 4h	75%	72.2%	72.5%	60.0%	75.4%	79.3%	72.5%	57.9%	73.2%	84.1%	75.0%	79.6%	82.8%	73.3%	75.1%
		4.32	Stroke - % greater than 80% of treatment on stroke unit	90%	88.9%	92.5%	91.1%	93.0%	96.6%	87.5%	81.6%	82.9%	100%	88.9%	88.6%	96.6%	88.9%	89.6%
		4.33	Stroke - % of patients treated by the SESDC	48%	50.0%	30.8%	32.4%	61.5%	50.0%	51.4%	54.8%	48.7%	58.5%	50.0%	53.9%	69.2%	52.4%	55.4%
		4.34	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start	80%	83.3%	82.1%	88.9%	93.3%	83.3%	95.0%	79.0%	81.8%	97.8%	92.1%	97.8%	96.7%	94.0%	91.3%
		4.35	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72h	75%	77.1%	76.3%	77.5%	93.0%	86.2%	86.8%	94.6%	92.5%	88.6%	89.2%	79.6%	86.2%	73.5%	86.3%
		4.36	Stroke -% of eligible patients given thrombolysis	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		4.37	Stroke -% of stroke survivors who have 6mth f/up	50%	ND	ND	ND	61.0%	ND	ND	ND	57.0%	ND	ND	ND	ND	ND	57.0%
		4.38	Stroke -Provider rating to remain within A-C	C	ND	ND	ND	C	ND	C	C	ND	ND	ND	ND	ND	ND	C

Are we..		Ref.	KPI	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	YTD(Apr18-Mar19)
4. Responsive	Other	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	95%	ND	ND	ND	ND	ND	ND	100%	100%	100%	100%	100%	ND	100%	100%
		4.40	Nursing & therapy Red referrals seen within 4hrs - Community	95%	NA	NA	100%	100%	96.4%	100%	96.4%	100%	100%	98.2%	100%	100%	100%	99.2%
		4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	95%	90.9%	96.9%	100%	99.3%	98.0%	97.6%	98.8%	99.4%	99.5%	97.4%	99.4%	99.5%	99.0%	99.0%
		4.42	Nursing & therapy Green referrals seen within 18 wks -Community	95%	99.3%	97.8%	98.0%	99.8%	99.9%	99.9%	99.3%	99.9%	100%	100%	100.0%	99.6%	99.7%	99.8%
		4.43	Wheelchair waiting times – Child (Community)	100%	43.8%	75.0%	72.7%	55.6%	61.9%	42.2%	90.9%	100%	95.2%	90.9%	100%	100%	ND	96.2%
		4.44	Wheelchair waiting times - Adult (Community)	NT	69.8%	83.5%	70.5%	71.4%	73.6%	72.5%	75.6%	78%	80.0%	54.9%	100%	73.1%	ND	77.0%
		4.45	Sepsis - 1 hr neutropenic sepsis	100%	79.0%	73.9%	53.9%	80.0%	75.0%	58.3%	63.6%	80.0%	57.9%	80.0%	72.2%	90.9%	90.0%	76.4%
		4.46	Percentage of Children in Care initial health assessments completed within 28 calendar days of becoming a child in care	100%	ND	ND	ND	ND	ND	ND	0.0%	4.8%	8.0%	23.1%	31.6%	11.8%	33.3%	16.1%
		4.47	Percentage of Service Users (children) assessed to be eligible for NHS Continuing Healthcare whose review health assessment is completed annually	80%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	86.7%	86.2%	86.4%

EXCEPTION REPORTS – RESPONSIVE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

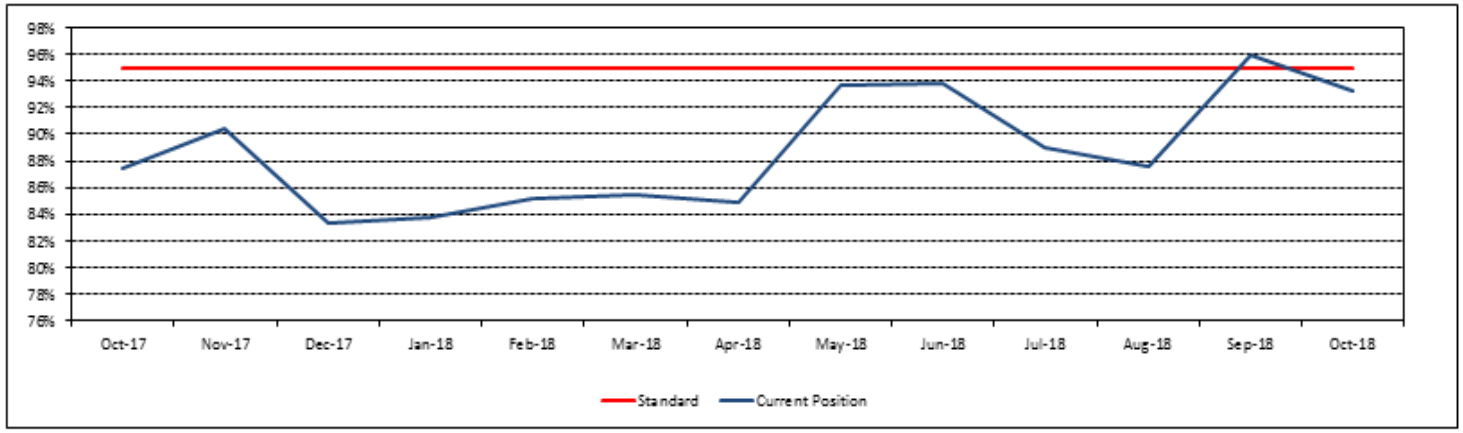
Indicator	A&E under 4 hr. wait
Standard	95%
Name	Nicola Cottington
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

In October, the Trust experienced two periods of peak demand. This led to increased waits in the Emergency Department, particularly for patients awaiting admission to a bed accounting for 32% of the breaches and wait to CDM accounting for 36% of breaches for the month.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	87.4%	90.4%	83.3%	83.8%	85.2%	85.4%	84.9%	93.7%	93.9%	89.0%	87.6%	95.9%	93.3%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Additional capacity planned for winter in line with bed modelling predictions. ED recovery action plan in place.	NC	Nov-18	Mar-18



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

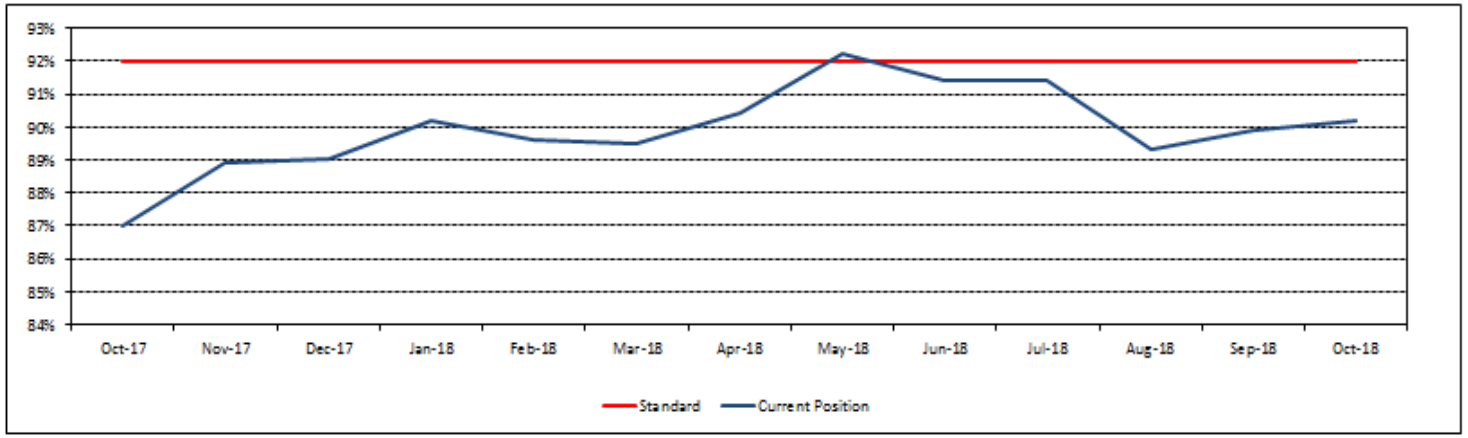
Indicator	RTT: % incomplete pathways within 18 weeks
Standard	92%
Name	Hannah Knights
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Improved performance to 90.2%. Specialities who failed to meet the target include Ophthalmology, Gynaecology, Pain Management, and Vascular. Ophthalmology has capacity issues for cataract surgery, Gynaecology has had issues with capacity for urogynaecology patients and consultant availability, Pain Management has had several cancelled lists and Vascular Surgery has long standing capacity issues in both outpatients and for surgery.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Current Position	87.0%	88.9%	89.0%	90.2%	89.6%	89.5%	90.4%	92.2%	91.4%	91.4%	89.3%	89.9%	90.2%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Outsourcing of Ophthalmology cataracts & additional lists for WSH consultants.	ST	Dec-18	
Full review of Gynaecology service	RS	Dec-18	
Review of all options for Vascular surgery, including alternative providers	ST	Nov-18	
Explore option of using DSU for Pain Management to avoid list cancellations	NC	Nov-18	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

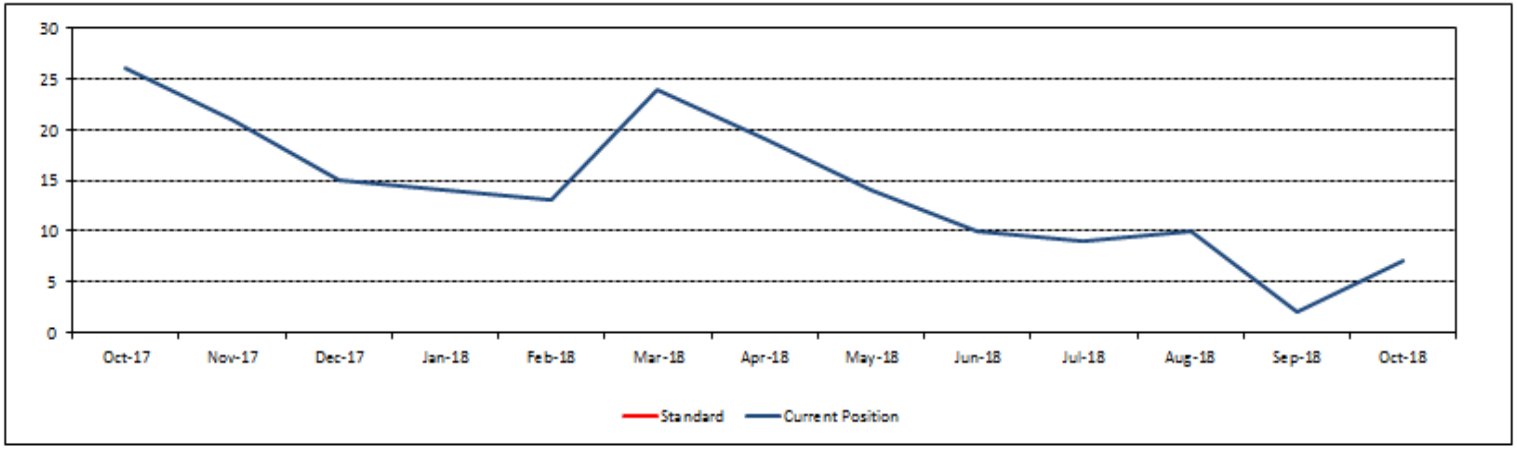
Indicator	52 week waiters
Standard	0
Name	Hannah Knights
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

The 7 patients consist of 3 x Vascular patients, 1 x Colorectal, 1 x Plastic Surgery, 1 x Ophthalmology and 1 x Orthopaedics. 2 of the Vascular patients have chosen to wait until January for their surgery, the other 5 patients have now all been treated. Three of the breaches in Plastic, Ophthalmology and Orthopaedic were identified through the validation process at month end as having been closed incorrectly.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	26	21	15	14	13	24	19	14	10	9	10	2	7

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor long waiting patients via the Access Meeting	HK	Sep-18	TBC
Continue focus on validating pathways to ensure accuracy of PTL document	HK	Oct-18	TBC
Focus on roll out of RTT training	HK	Jan-19	TBC



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancer: 2w wait for urgent GP Referrals
Standard	93%
Name	Hannah Knights
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

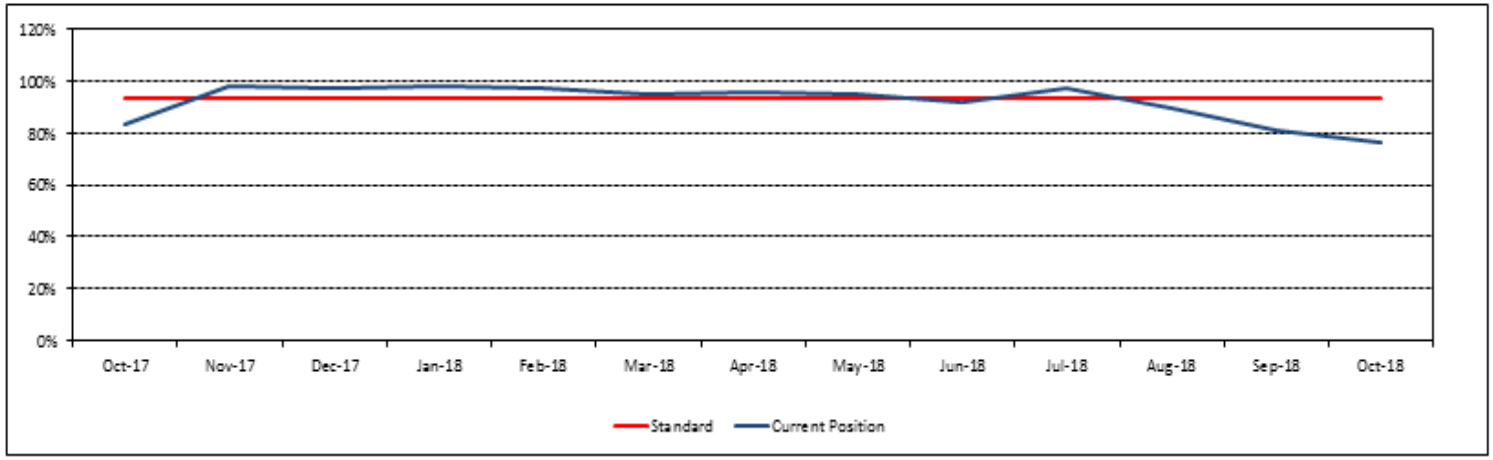
Summary of Current performance & Reasons for under performance

Current performance: 76.1% this is down from 80.9% last month and is largely owing to limited capacity in dermatology services in particular with some difficulties noted in Urology, Upper GI and Lung to date first seen appointments within 14 days. All other specialities performed well above 93% in September.
The dermatology services were not successful in finding locum cover. The situation will be reversed following the return of both Consultants, and the performance of this service is likely to feature recovery from November. As many of the dermatology 2 WW referrals received in July, August are booked over 14 days and are counted against September and October breach, there will be ongoing impact on 2 WW performance in the first place with added risk to the 62 days performance for the trust.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	83.4%	97.9%	97.2%	98.0%	97.5%	94.7%	95.9%	94.9%	91.6%	97.6%	89.5%	80.9%	76.1%

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

Description	Owner	Start	End
Ensure appropriate escalation in place	HK	01.10.18	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancer 62 d GP referral
Standard	85%
Name	Hannah Knights
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current Performance: 78.5% - There have been ongoing challenges since September in terms of 62 days cancer waits performance due to high numbers of breaches: Colorectal-5, Breast, Gynaecology and Urology -1 each and Skin and Upper GI 2 on a local pathway and H/N (ENT)-2, Urology-2, Lung 1 and 2 Gynaecology on a pathway shared with other providers. There are combination of capacity and complex pathway issues.

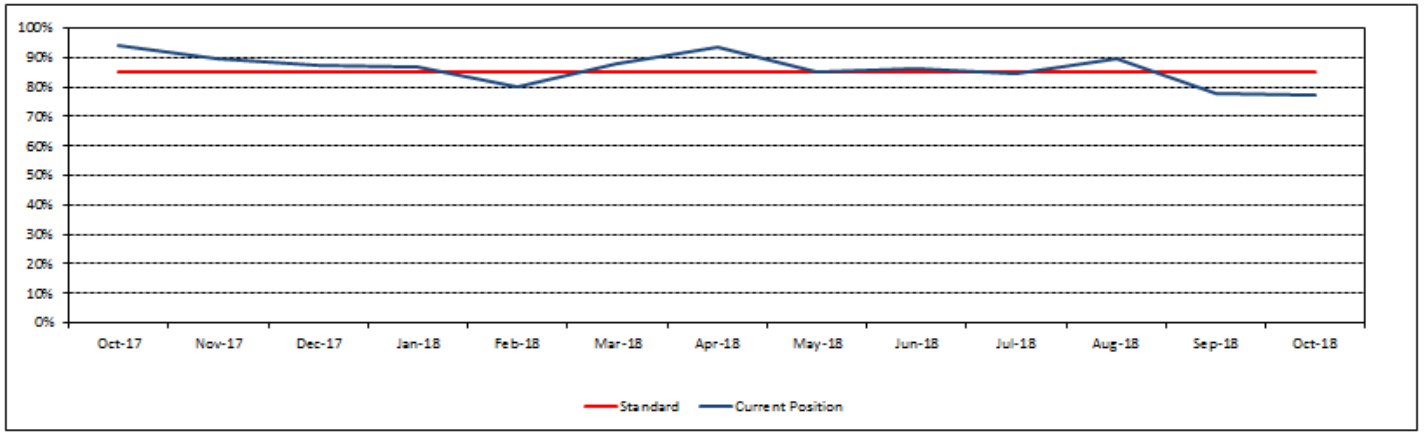
Since good recovery back in August, the performance has dipped and a separate recovery plan is being prepared incorporating various actions in particular to improve Urology, Colorectal and ENT diagnostic pathways. Whilst it's in progress, relevant ADOs have received the copies of all recent 62 days RCAs with a view to agree and introduce any improvement measures.

The Cancer transformation funding to procure Saturation Biopsy Kit to improve Urology diagnostics and Colonoscopies to improve Endoscopy diagnostic for colorectal pathways are both progressing.

All 62 days breach RCAs been sent over to the relevant clinicians in the MDT and the services for review and for learning opportunities to prevent future recurrences. There was no clinical harm reported on any of the reviewed pathways.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Current Position	93.9%	89.5%	87.1%	86.6%	79.8%	87.8%	93.3%	85.1%	86.5%	84.8%	89.9%	78.0%	77.4%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Full review of current cancer PTL meeting and ensure relevant divisional attendance	HK	22.10.18	
Formal Escalation process for patients to be created	HK	01.11.18	
Review of current pathways within Colorectal, Urology & ENT	HK	01.12.18	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

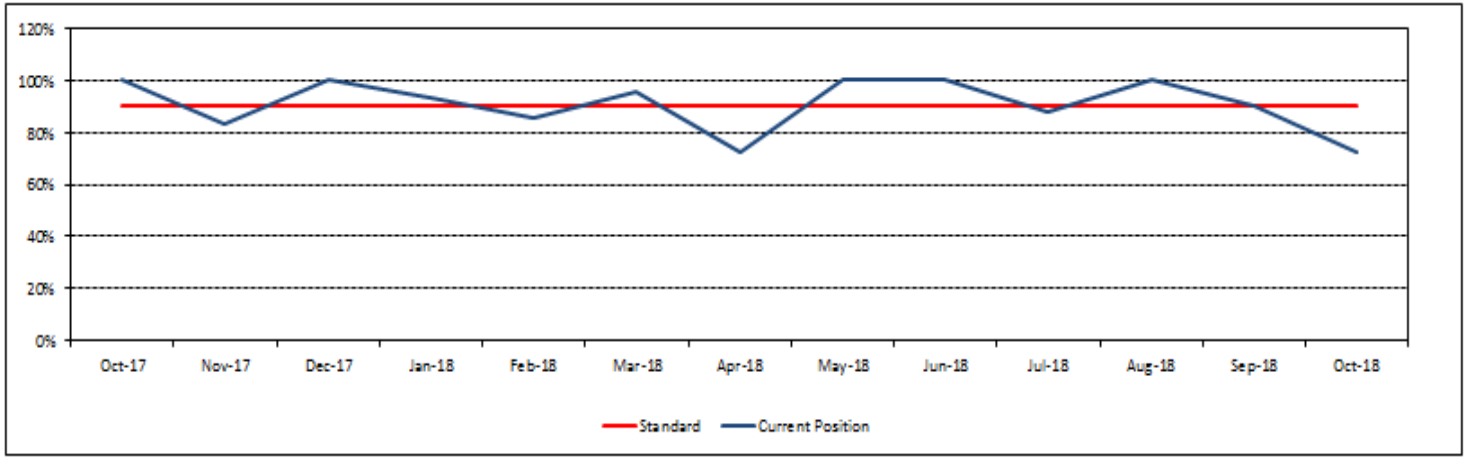
Indicator	Cancer 62 d Screening
Standard	90%
Name	Hannah Knights
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current Performance: 72.7%, this was primarily due to one patient taking time to agree to progress with the investigations and a complex pathway and a very low volume of activity of only 5 and half patients to account.
Owing to small number of patients to report within this standard, any factors contributing to the delay in a single pathway risks underperformance on this standard. Cancer services keep both the Breast and Colorectal teams well informed of the treatment target date as soon as a screening referral pathway starts and escalate likely delays with diagnostic/staging tests and or start of treatment to the relevant services to help offer an earlier appointment/TCI dates to these patients, where possible.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	100%	83.3%	100%	93.3%	85.7%	95.5%	72.7%	100%	100%	88.2%	100%	90.5%	72.7%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Ensure appropriate escalation in place	HK	01.10.2018	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

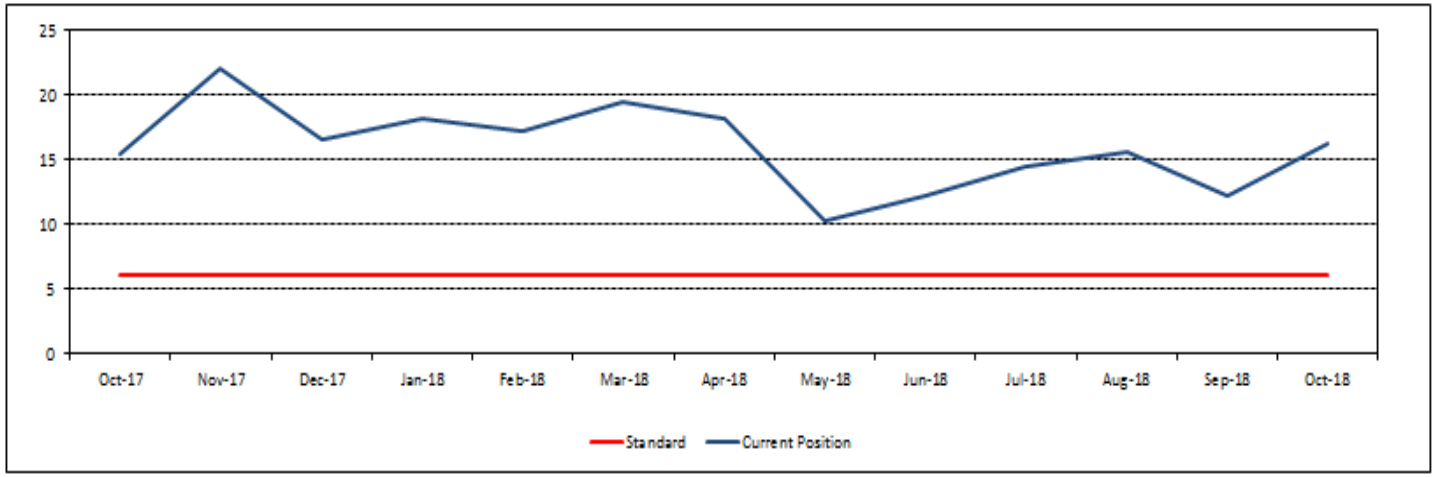
Indicator	A&E - Single longest Wait (Admitted & Non-Admitted)
Standard	6 Hours
Name	Nicola Cottington
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

This patient unfortunately required further imaging as CT was unclear, then also required repeated bloods when assessed by surgical team. It was identified following investigations that a surgical bed was required and there was then a delay in a bed being available due to high demand on the Trust during this period.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	6	6	6	6	6	6	6	6	6	6	6	6	6
Current Position	15.44	22.04	16.48	18.11	17.18	19.50	18.14	10.30	12.22	14.49	15.54	12.23	16.17

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
ED recovery plan in place	NC	Nov-18	Mar-19



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	A&E - Admission waiting 4-12 hours from dec. to admit
Standard	4
Name	Nicola Cottington
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

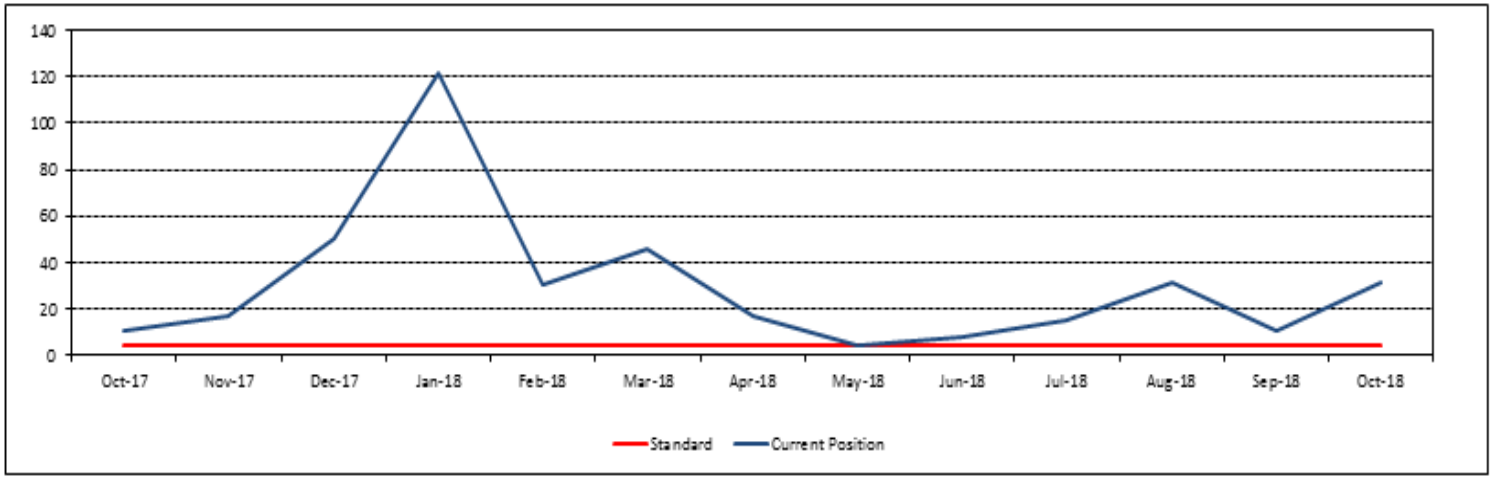
Summary of Current performance & Reasons for under performance

In October the Trust experienced two periods of increased demand and admissions, which unfortunately led to delays for patients requiring beds.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	4	4	4	4	4	4	4	4	4	4	4	4	4
Current Position	10	17	50	122	30	46	17	4	8	15	31	10	31

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

Description	Owner	Start	End
Additional capacity planned for winter in line with bed modelling predictions	NC	Nov-18	Mar-18



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	A&E - Amb. Handover above 30m
Standard	0
Name	Nicola Cottington
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

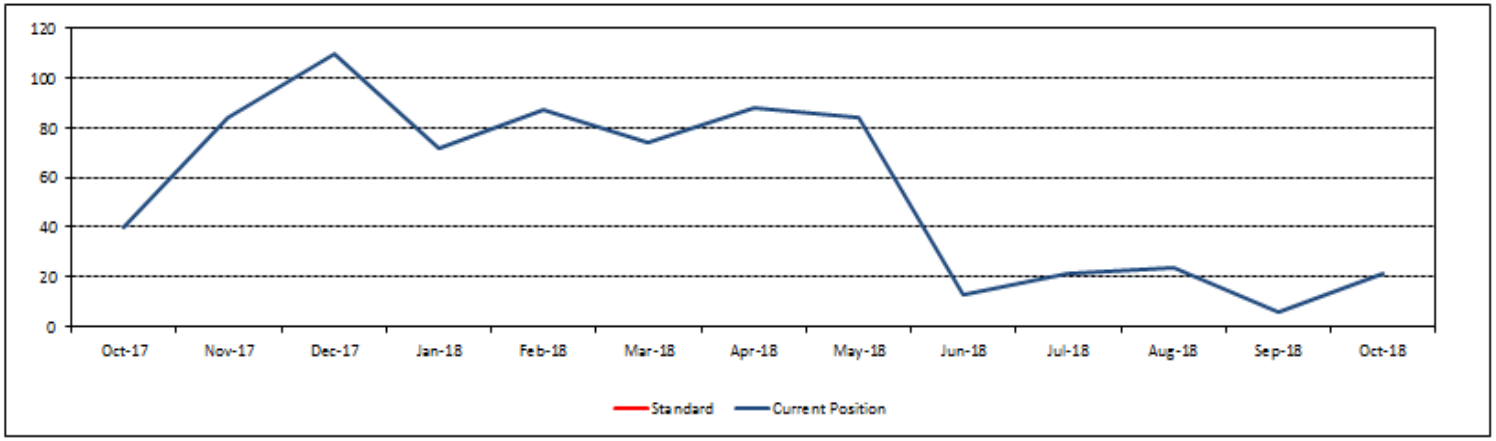
Summary of Current performance & Reasons for under performance

There was an increase in October to 21 ambulance handovers recorded over 30 minutes compared to 6 in September. During October there were two peaks in attendances and admissions, leading to an exacerbation of the space constraints in the Emergency Department. The main factor in ambulance delays is this lack of space to accommodate patients when the department is full.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	40	84	110	72	87	74	88	84	13	21	24	6	21

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

Description	Owner	Start	End
Internal winter ambulance escalation plan being finalised Increased focus on ambulance delays- communicated through staff meetings, morning ED huddle and performance being monitored by key staff Increased HALO cover during winter period	NC	Oct-18	Mar-18



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

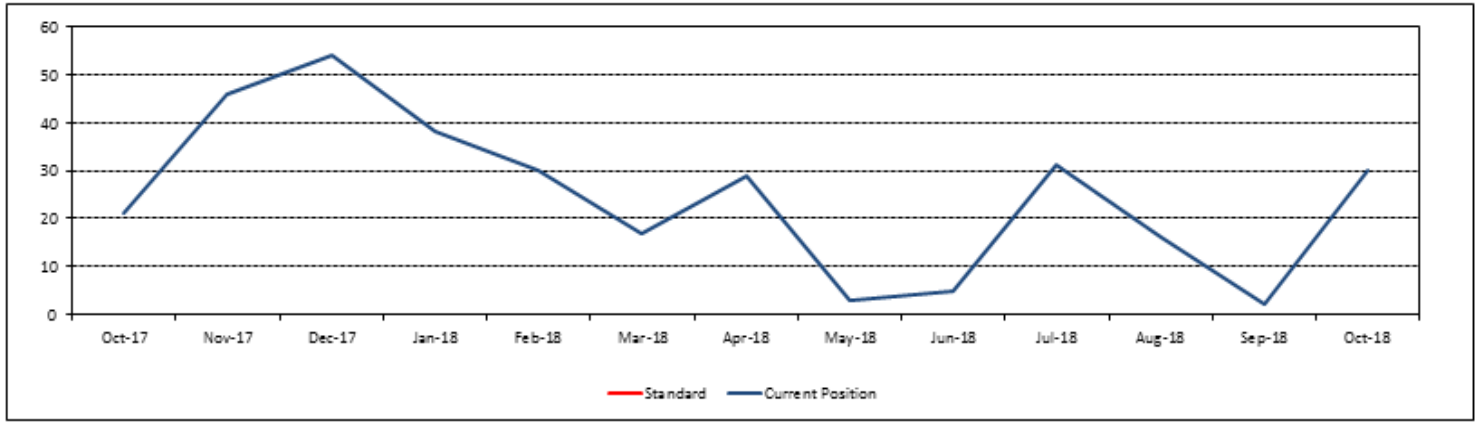
Indicator	A&E - Amb. Handover above 60m
Standard	0
Name	Nicola Cottington
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

There was an increase in ambulance handover delays recorded over 60 minutes in October, to 30, compared to 2 in September. There were two peaks in attendances and admissions in October, leading to an exacerbation of the existing space constraints within the ED.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	21	46	54	38	30	17	29	3	5	31	16	2	30

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Internal winter ambulance escalation plan being finalised Increased focus on ambulance delays- communicated through staff meetings, morning ED huddle and performance being monitored by key staff Increased HALO cover during winter period Agreed escalation process for ambulance delays between EEAST and WSFT	NC	Oct-18	Mar-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

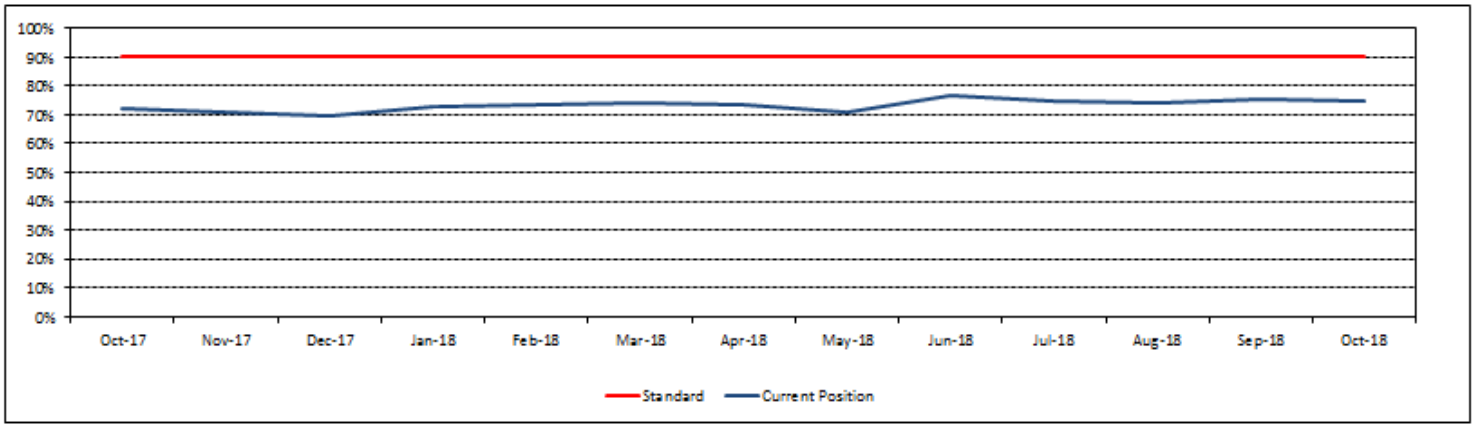
Indicator	RTT - 18w Admitted (Completed)
Standard	90%
Name	Hannah Knights
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Continued focus on booking longest waiting patients for their surgery, which has a negative impact on the admitted performance.
Ophthalmology, Vascular and Gynaecology predominantly are booking patients for surgery in excess of 18 weeks.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	72.0%	70.9%	69.9%	72.6%	73.5%	74.1%	73.4%	71.1%	76.9%	74.7%	74.0%	75.5%	74.6%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Outsourcing of Ophthalmology cataracts & additional lists for WSH consultants.	ST	Dec-18	
Full review of Gynaecology service	RS	Dec-18	
Review of all options for Vascular surgery, including alternative providers	ST	Nov-18	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	RTT - 18w Non-admitted (Completed)
Standard	95%
Name	Hannah Knights
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

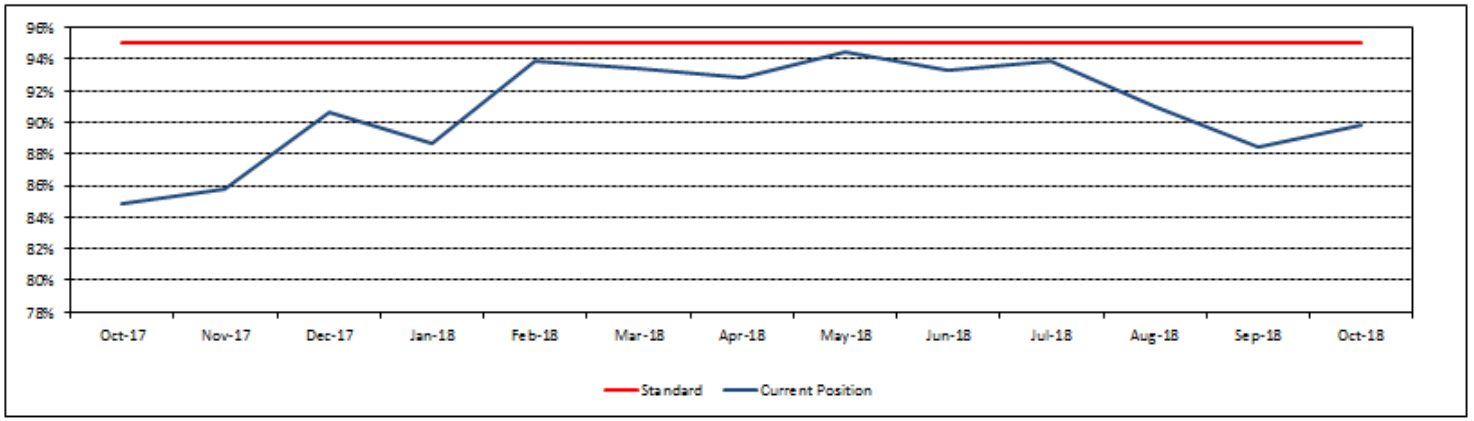
Summary of Current performance & Reasons for under performance

Slight improved performance in October compared to September. Specialities with long pathway delays for 1st appointment or diagnostics including Ophthalmology, Vascular and Gynaecology. Gastroenterology cleared a large number of long waiting patients, which would have an impact on the non admitted performance.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	84.9%	85.8%	90.6%	88.7%	93.9%	93.4%	92.8%	94.5%	93.3%	93.9%	91.0%	88.5%	89.8%

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

Description	Owner	Start	End
Outsourcing of Ophthalmology cataracts & additional lists for WSH consultants.	ST	Dec-18	
Full review of Gynaecology service	RS	Dec-18	
Review of all options for Vascular surgery, including alternative providers	ST	Nov-18	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

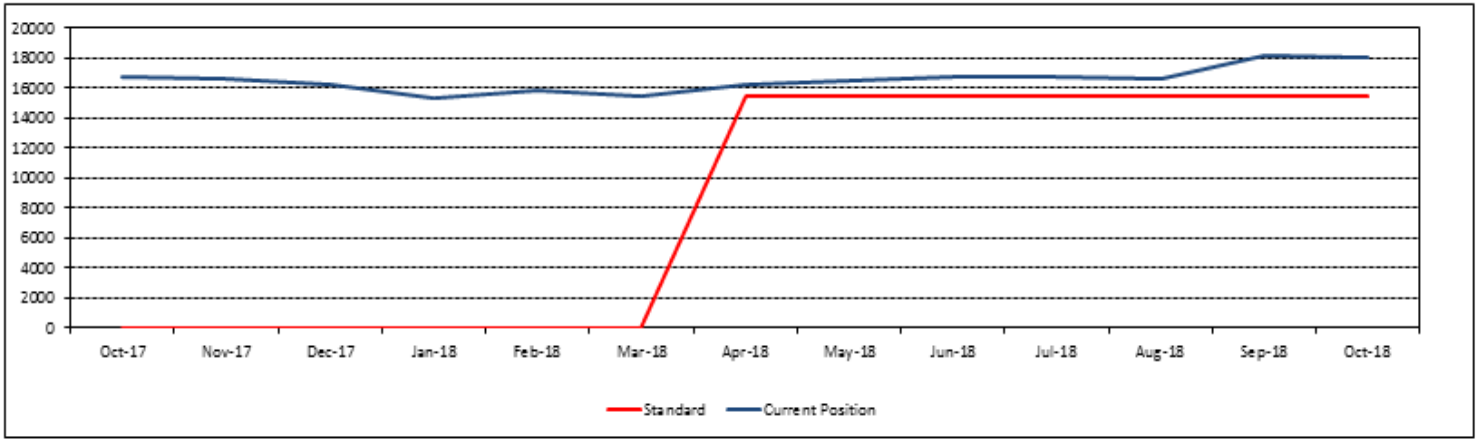
Indicator	RTT waiting List
Standard	15396
Name	Hannah Knights
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Pot size increased when appointment slot issues added to the PTL in September 2018.In addition significant backlogs in Ophthalmology and Vascular particularly have driven an increase in the overall number.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	NA	NA	NA	NA	NA	NA	15396	15396	15396	15396	15396	15396	15396
Current Position	16694	16641	16195	15363	15804	15396	16223	16481	16739	16715	16601	18105	18075

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Outsourcing of Ophthalmology patients to ensure the number is manageable	ST	Dec-18	TBC
Exploring options for managing Vascular waiting list	ST	Dec-18	TBC
Continued focus on booking clinics and theatres fully	ST	Dec-18	TBC



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Stroke - % Patients scanned within 1 hr.
Standard	77%
Name	Jane Allen
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

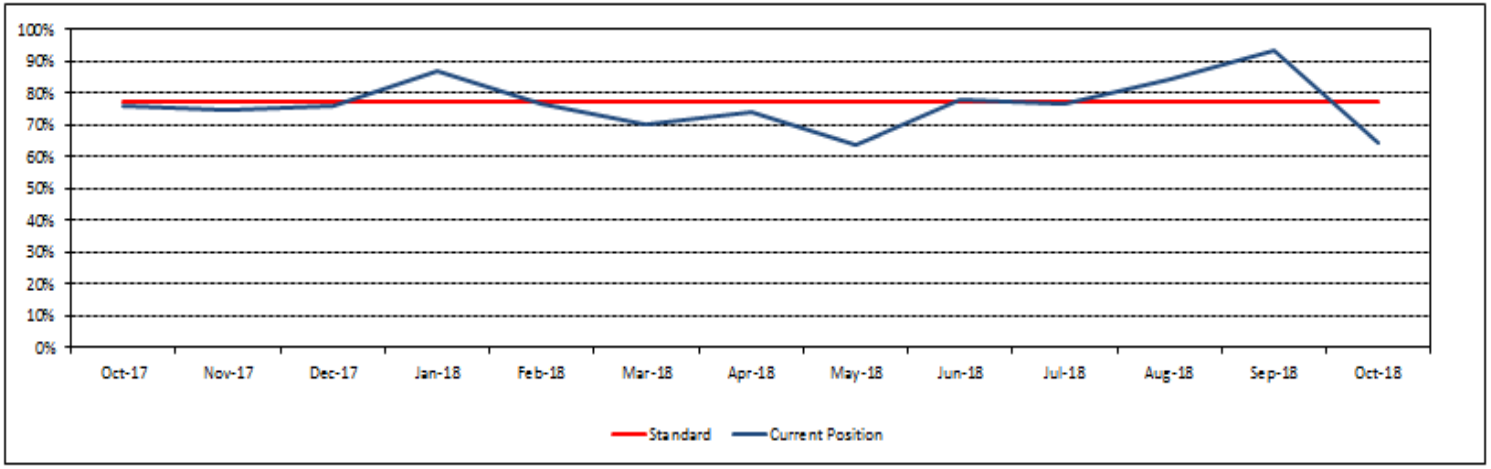
Summary of Current performance & Reasons for under performance

5 breaches occurred with patients arriving with atypical/unusual presentation and with stroke not initially identified on arrival. 3 were inpatient strokes, with 1 of these patients delayed telling staff for 4.5hrs about onset of new symptoms, there was also some delay in notifying Early Stroke Outreach Team. 1 patient a clinical decision was made to MRI the patient but this was not available within the one hour time frame. 1 patient chose to have an MRI instead of scan to avoid radiation again this was not available within the hour.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%
Current Position	75.7%	74.4%	75.6%	86.7%	76.7%	70.0%	73.7%	63.6%	77.7%	76.3%	84.4%	93.3%	64.0%

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

Description	Owner	Start	End
Meetings to continue with ED management team, ESOT and stroke audit coordinator to review all ED breaches and identify areas for further training to be implemented.	JA	Nov-18	Dec-18



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

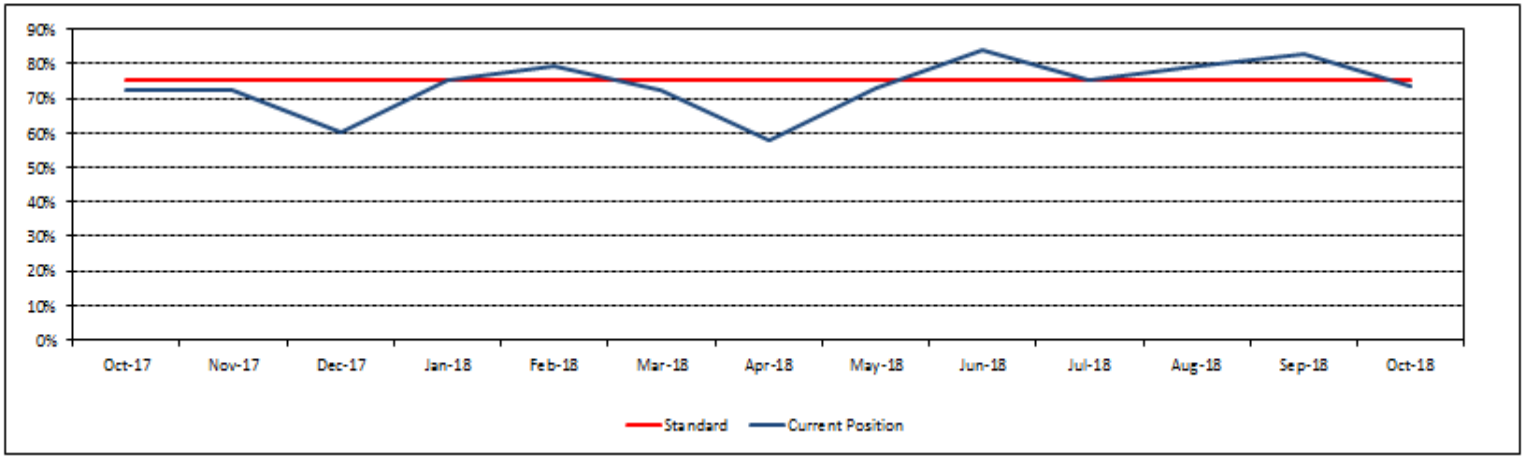
Indicator	Stroke - % Patients admitted directly to stroke unit within 4h
Standard	75%
Name	Jane Allen
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

The causes of many of the breaches are multifactorial, with delays in triage, stroke alert, referral to the stroke team and availability of beds, affecting the patients arriving on the stroke unit within 4 hours. There has been a lack of ring-fenced beds over this period due to escalation which has contributed to patients breaching this target.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
Current Position	72.2%	72.5%	60.0%	75.4%	79.3%	72.5%	57.9%	73.2%	84.1%	75.0%	79.6%	82.8%	73.3%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
We are monitoring when ring-fenced beds are available or not on a daily basis. When there are no beds, the service manager is contacted directly to assist in resolving the problem. Ongoing training for ED staff to promote early identification of stroke patients thus facilitating them to reach the stroke unit sooner.	JA	Jan-18	Dec-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

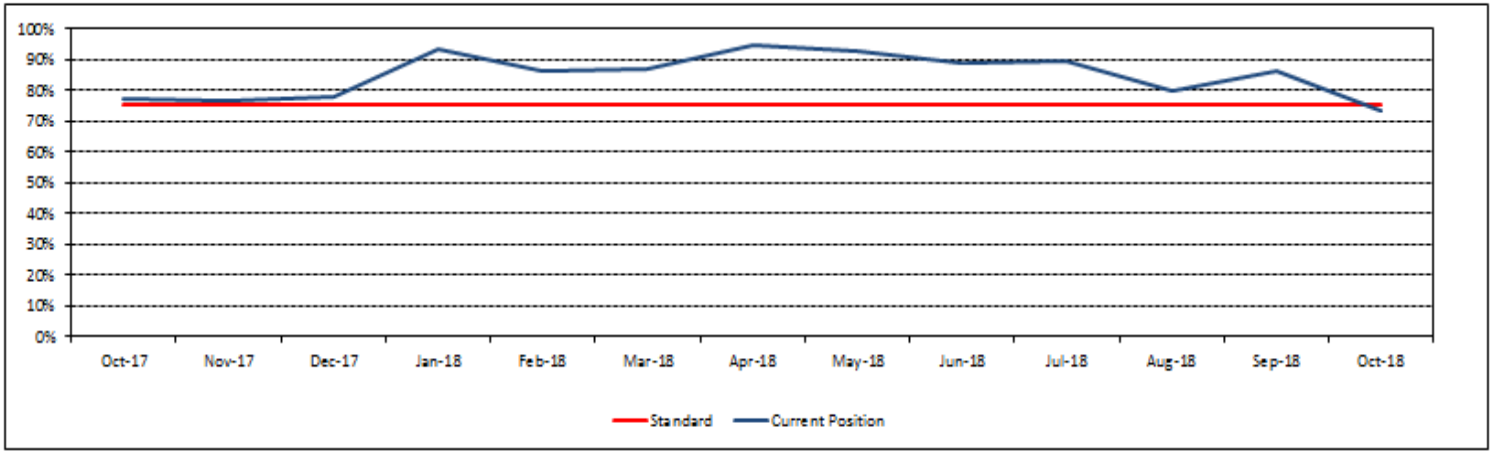
Indicator	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72h
Standard	75%
Name	Jane Allen
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

It is extremely rare for stroke therapists not to meet this target. The numbers of stroke patients discharged in this period was extremely high so possibly this high workload could have contributed to the failing of the target. More work will be done to establish the cause for this.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
Current Position	77.1%	76.3%	77.5%	93.0%	86.2%	86.8%	94.6%	92.5%	88.6%	89.2%	79.6%	86.2%	73.5%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Service Manger to discuss with therapies lead and ask if stroke therapists could meet stroke audit coordinator to determine cause for this deterioration.	JA	Nov-18	Dec-18



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

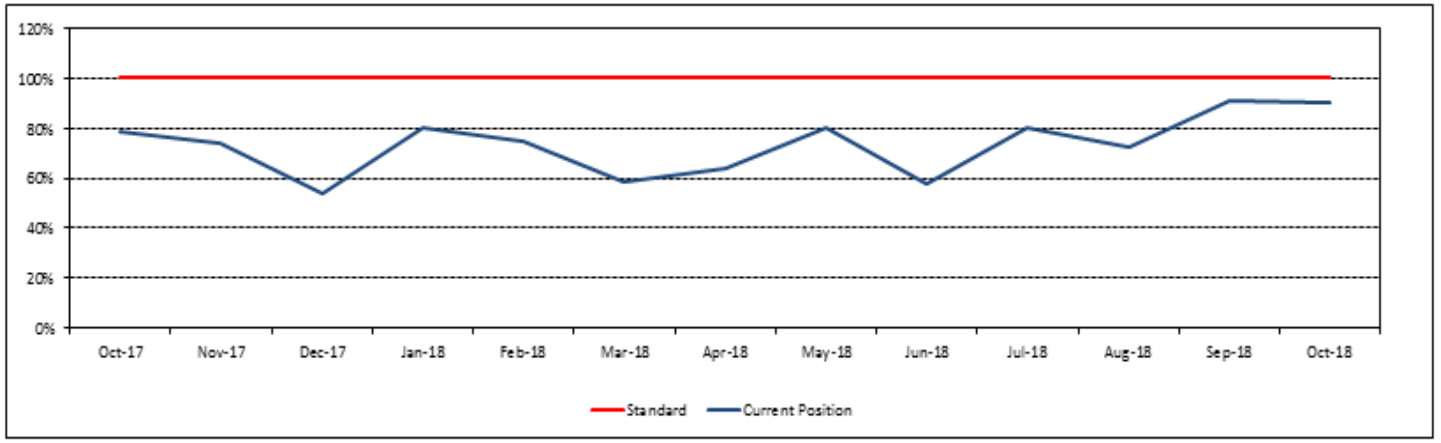
Indicator	Sepsis - 1 hr neutropenic sepsis
Standard	100%
Name	Abby Ormes
Month	Oct-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Introduction of the Emergency Department Neutropenic Sepsis FastTrack Pathway NSFP (Red Folder) copy displayed on info board in ED staff room. Separate teaching and sign-off for Neutropenic Sepsis anti-biotic PGD by ED PDN. High level of new starters in ED, ED PDN currently working through teaching and sign-off. Detailed learning and sign-off within the newly introduced Emergency Department Adult and Paediatric Competency Workbooks. NSFP communicated to the ED Team through 'hot topics' at the start of the shift. Monthly Neutropenic Sepsis Targets to be displayed on info board in ED staff room for continued shared learning

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	79.0%	73.9%	53.9%	80.0%	75.0%	58.3%	63.6%	80.0%	57.9%	80.0%	72.2%	90.9%	90.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Electronic register of neutropenic sepsis anti-biotic PGD sign-off (will be within the new ED training database which is currently being developed)			
Addition to the Band 7 Floor Coordinator individual competencies, responsible for allocating the NSFP to a ED Nurse(with anti-biotic PGD sign-off) within 15 minutes of registration.			



8. DETAILED REPORTS – WELL-LED

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

Are we.		Ref.	KPI	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	YTD(Apr18 Mar19)
5. Well Led	Agency, WTE & vacancies	5.09	Agency Spend Cap	486	378	378	378	378	378	378	322	196	329	433	507	393	381	366
		5.12	Proportion of Temporary Staff	12%	10.1%	10.9%	8.0%	11.1%	11.3%	11.0%	12.5%	11.9%	9.7%	11.3%	12.7%	12.0%	11.8%	11.7%
		5.13	Locum and Medical agency spend	NT	357	381	508	495	487	468	398	319	468	624	524	434	524	470
		5.57	Additional sessions	NT	198	233	238	136	186	167	253	238	207	161	270	250	338	245
		5.16	% Staff on Maternity/Paternity Leave	NT	2.0%	2.0%	2.0%	1.9%	2.0%	1.9%	2.0%	2.3%	2.38%	2.43%	2.60%	2.64%	2.65%	2.43%
	Other	5.17	Grievance reviews	NT	6	6	5	5	5	4	5	4	4	3	3	4	4	27
		5.18	Recruitment Timescales - Av no. of weeks to recruit	7	6.9	6.9	6.4	5.4	5.4	5.4	5.4	5.6	5.4	5.4	5.0	6.1	6.4	5.6
		5.19	DBS checks	95%	97.5%	97.5%	98.5%	98.5%	98.0%	97.0%	98.0%	97.5%	98.0%	98.0%	98.0%	98.0%	98.5%	98.0%
		5.20	Staff appraisal Rates	90%	50.8%	55.8%	62.0%	65.0%	62.3%	63.0%	67.0%	67.3%	69.3%	75.8%	75.2%	76.9%	76.0%	72.5%
		5.21	Trust Participation in on-going National Audits (Qtrly)	90%	NA	NA	96.0%	NA	NA	96.0%	NA	NA	ND	ND	NA	ND	NA	NA

Are we.		Ref.	KPI	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	YTD(Apr18 Mar19)
5. Well Led	Training	5.22	Infection Control Training (classroom)	85%	94.7%	95.0%	95.0%	94.0%	94.0%	95.0%	94.0%	95.0%	94.0%	95.0%	95.0%	95.0%	94.0%	94.6%
		5.23	Infection Control Training (eLearning)	85%	85.1%	88.0%	88.0%	90.0%	90.0%	90.0%	90.0%	90.0%	91.0%	90.0%	87.0%	90.0%	89.0%	89.6%
		5.24	Manual Handling Training (Patient)	80%	80.4%	84.0%	84.0%	79.0%	79.0%	79.0%	74.0%	76.0%	77.0%	75.0%	79.0%	76.0%	77.0%	76.3%
		5.25	Manual Handling Training (Non Patient)	80%	84.4%	88.0%	88.0%	89.0%	89.0%	88.0%	88.0%	88.0%	83.0%	83.0%	81.0%	85.0%	82.0%	84.3%
		5.26	Staff Adult Safeguarding Training	80%	90.2%	92.0%	92.0%	92.0%	92.0%	92.0%	91.0%	91.0%	92.0%	90.0%	89.0%	91.0%	91.0%	90.7%
		5.27	Safeguarding Children Level 1	90%	88.0%	89.0%	90.0%	91.0%	91.0%	90.0%	90.0%	90.0%	89.0%	89.0%	88.0%	89.0%	89.0%	89.1%
		5.28	Safeguarding Children Level 2	90%	88.6%	90.0%	92.0%	92.0%	92.0%	91.0%	91.0%	90.0%	91.0%	91.0%	89.0%	90.0%	90.0%	90.3%
		5.29	Safeguarding Children Level 3	90%	78.6%	83.0%	86.0%	86.0%	88.0%	83.0%	95.0%	94.0%	94.0%	94.0%	89.0%	91.0%	91.0%	92.6%
		5.30	Health & Safety Training	80%	89.8%	91.0%	91.0%	92.0%	92.0%	91.0%	90.0%	90.0%	91.0%	91.0%	89.0%	90.0%	89.0%	90.0%
		5.31	Security Awareness Training	80%	89.6%	90.0%	91.0%	91.0%	91.0%	90.0%	90.0%	90.0%	91.0%	90.0%	89.0%	89.0%	88.0%	89.6%
		5.32	Conflict Resolution Training (eLearning)	80%	81.4%	82.0%	95.0%	76.0%	85.0%	84.0%	86.0%	87.0%	87.0%	88.0%	82.0%	83.0%	83.0%	85.1%
		5.33	Conflict Resolution Training	80%	76.5%	76.0%	75.0%	88.0%	76.0%	76.0%	69.0%	70.0%	70.0%	71.0%	73.0%	71.0%	69.0%	70.4%
		5.34	Fire Training (eLearning)	80%	85.0%	85.0%	84.0%	84.0%	84.0%	82.0%	80.0%	82.0%	81.0%	81.0%	84.0%	91.0%	83.0%	83.1%
		5.35	Fire Training (classroom)	80%	90.0%	91.0%	91.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	89.0%	90.0%	84.0%	89.0%	88.9%
		5.36	IG Training	80%	87.0%	86.0%	87.0%	84.0%	84.0%	82.0%	86.0%	86.0%	83.0%	84.0%	82.0%	82.0%	80.0%	83.3%
		5.37	Equality and Diversity	80%	93.0%	94.0%	94.0%	88.0%	88.0%	83.0%	81.0%	80.0%	79.0%	79.0%	79.0%	80.0%	81.0%	79.9%
		5.38	Majax Training	80%	88.0%	88.0%	89.0%	90.0%	90.0%	88.0%	88.0%	88.0%	89.0%	88.0%	88.0%	88.0%	89.0%	88.3%
		5.39	Medicines Management Training	80%	86.0%	87.0%	88.0%	89.0%	89.0%	88.0%	87.0%	87.0%	88.0%	89.0%	87.0%	86.0%	87.0%	87.3%
		5.40	Slips, trips and falls Training	80%	86.0%	88.0%	88.0%	87.0%	87.0%	87.0%	85.0%	85.0%	86.0%	86.0%	86.0%	85.0%	86.0%	85.6%
		5.41	Blood-borne Viruses/Inoculation Incidents	80%	85.0%	86.0%	87.0%	86.0%	86.0%	86.0%	85.0%	86.0%	87.0%	88.0%	85.0%	86.0%	87.0%	86.3%
		5.42	Basic life support training (adult)	80%	81.0%	81.0%	82.0%	80.0%	80.0%	78.0%	75.0%	76.0%	76.0%	75.0%	79.0%	79.0%	79.0%	77.0%
		5.43	Blood Products & Transfusion Processes (Refresher)	80%	80.0%	78.0%	80.0%	75.0%	75.0%	72.0%	73.0%	72.0%	73.0%	74.0%	74.0%	73.0%	74.0%	73.3%
		5.44	Mandatory Training Compliance	90%	86.3%	88.1%	88.7%	84.6%	83.2%	82.8%	83.3%	84.0%	85.0%	84.0%	84.0%	85.0%	85.0%	84.3%
		5.55	Safeguarding Children Mandatory Compliance (Community)	90%	95.3%	96.1%	96.0%	95.9%	95.7%	97.0%	98.2%	95.8%	95.3%	94.7%	95.1%	96.2%	95.9%	95.9%
		5.56	Safeguarding Adults Mandatory Training Compliance (Community)	90%	94.3%	95.3%	94.0%	94.1%	93.2%	95.6%	96.0%	95.0%	94.9%	94.3%	94.9%	97.0%	97.1%	95.6%

EXCEPTION REPORTS – WELL LED

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

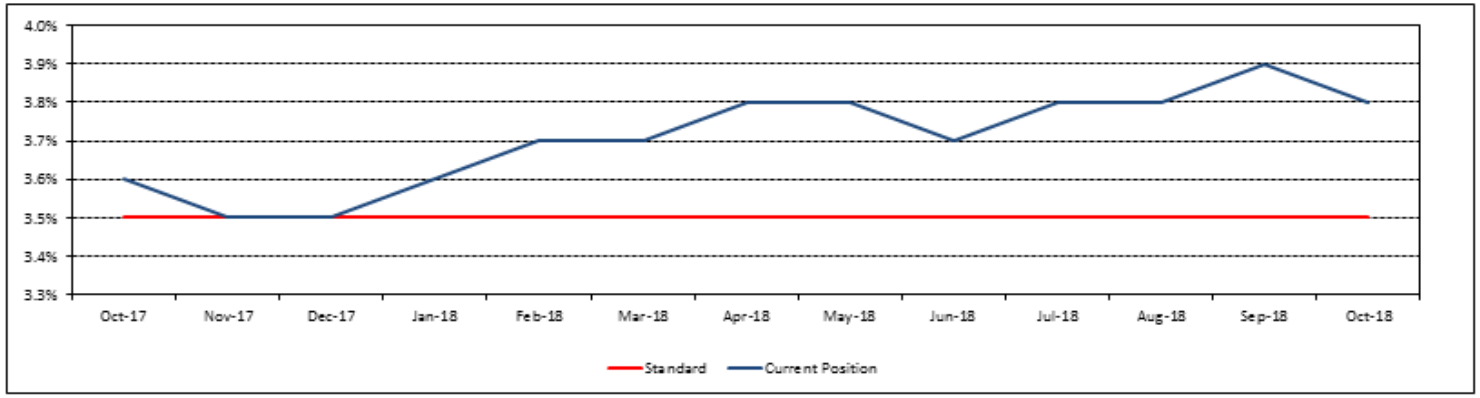
Indicator	Sickness Absence
Standard	3.5%
Name	Denise Needle
Month	Oct-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

The sickness absence rate has reduced this month to 3.8 %, a reduction of 0.06%.
The Trust continues to actively encourage all staff to have the flu jab in order to try and minimise any dramatic increases over the winter period. Other actions remain in place to support managers to manage both short term and long term absence.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
Current Position	3.6%	3.5%	3.5%	3.6%	3.7%	3.7%	3.8%	3.8%	3.7%	3.8%	3.8%	3.9%	3.8%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Flu vaccine promotion, active management of both long and short term absence			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

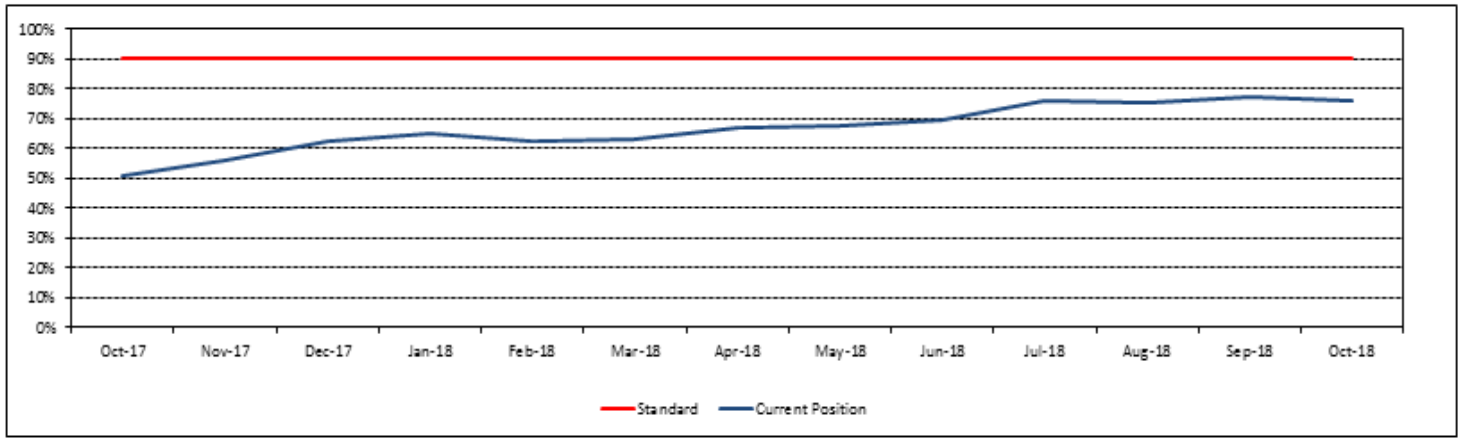
Indicator	Staff appraisal Rates
Standard	90%
Name	Denise Needle
Month	Oct-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Performance has seen a reduction of 0.9%. Many routine meetings, which may include appraisals, are postponed when the hospital experiences high demand, so this is likely to impact upon compliance. Senior managers continue to monitor and review those areas with little or no appraisal history,.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	50.8%	55.8%	62.0%	65.0%	62.3%	63.0%	67.0%	67.3%	69.3%	75.8%	75.2%	76.9%	76.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Senior management scrutiny of the process to encourage appraisal compliance. We have also increased the number of training sessions available for those staff needing to be trained.	DN	Oct-18	Jul-05



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

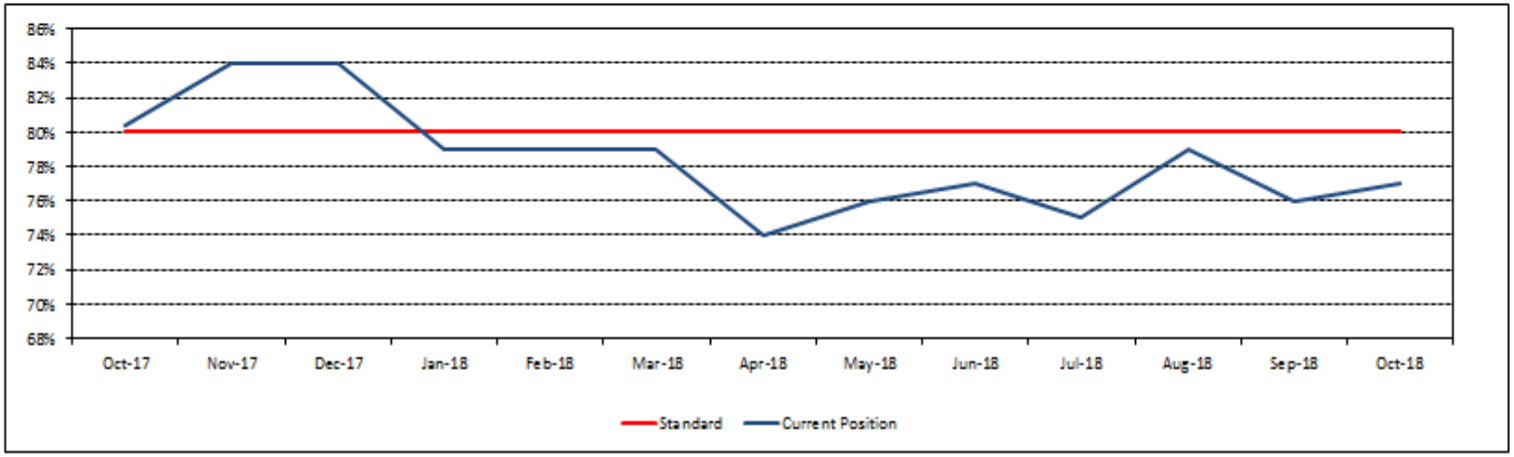
Indicator	Manual Handling Training (Patient)
Standard	80%
Name	Neil Herbert
Month	Oct-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

The Manual Handling team have currently trained more staff in 2018 than many of the previous 5 years. More training sessions have been provided than in previous years and in a team that only consists of 2 people and the nature of our training it wouldn't be feasible to conduct anymore. The reasons why we are currently 3% off our target of 80% is down to what I believe is the increase enthuse on Induction to ensure wards are well stocked with staff for winter escalation. Also mandatory updates for nursing staff were poorly attended in the first 4 months of 2018 for example out of 36 spaces only 10 were taken up on the 15th February 2018. To conclude training sessions have been provided throughout the year but if attendance is low maintaining compliance at 80% will always be difficult.

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

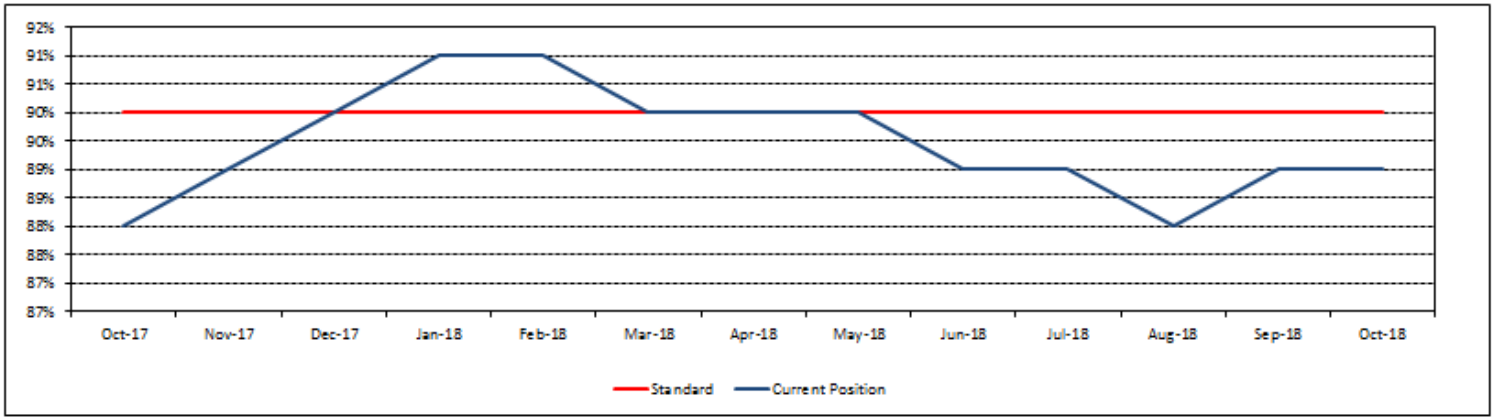
Indicator	Safeguarding Children Level 1
Standard	90%
Name	Lisa Sarson
Month	Oct-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Level 1 and level 2 safeguarding children training is provided as an e-learning package and required to be completed every 3 years. Monthly reports are sent to budget holders and it has also been requested as a standing agenda item for directorate meetings to address staff non-compliance. Managerial staff can access the training reports and identify who is not compliant. It should be a shared responsibility of the manager and individual to ensure level 1 is achieved and address any compliance issues. The current position for November 2018 is 90%

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	88.0%	89.0%	90.0%	91.0%	91.0%	90.0%	90.0%	90.0%	89.0%	89.0%	88.0%	89.0%	89.0%

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

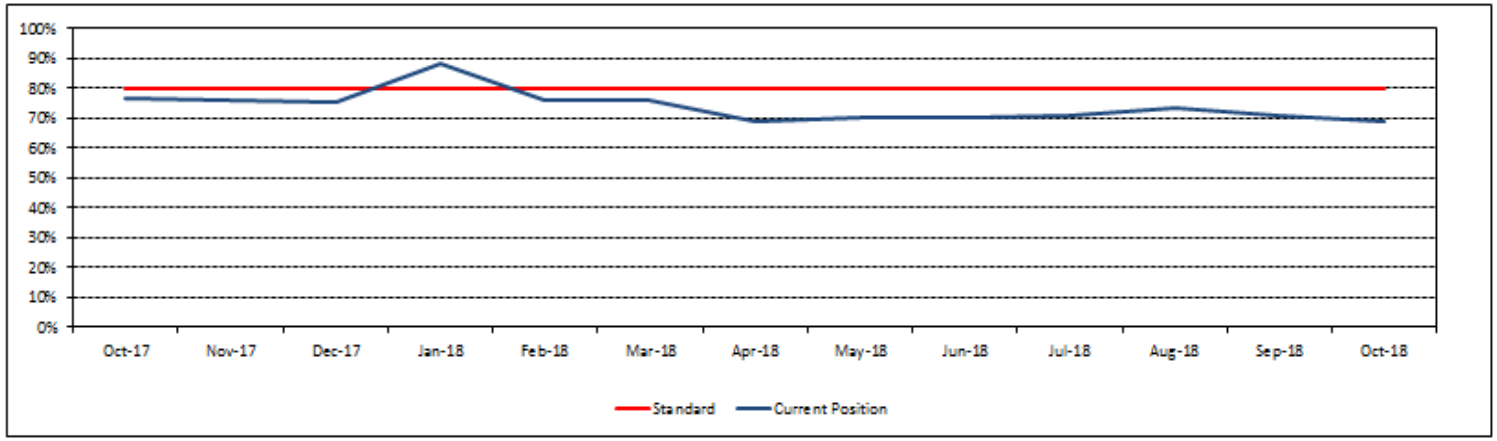
Indicator	Conflict Resolution Training
Standard	80%
Name	Darren Cooksey
Month	Oct-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

The following wards have been targeted in September and the managers and associated Matrons being sent an e-mail by the Area Security Management Specialist which identifying their staffs that are out of date. It is hoped this will prompt the wards to send their staff on the training sessions.
Ward and non-compliant staff ED-15, F1-9, F3-23, F4-11, F5-19, F6-7, F7-22, F8-8, F9-14 , F10-7, F11-16, G3-5, G4-24, G5-20, G8-14, DSU-19 Patient flow-9, Total 242.
Additional training sessions have also been arranged by the training department to help and encourage more staff to attend. The Area Security Management Specialist has requested that the training department issue another report for staff showing non-compliance of conflict resolution training in November at which point the Area Security Management Specialist will send another e-mail to those ward with non-compliant staff .

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Current Position	76.5%	76.0%	75.0%	88.0%	76.0%	76.0%	69.0%	70.0%	70.0%	71.0%	73.0%	71.0%	69.0%

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

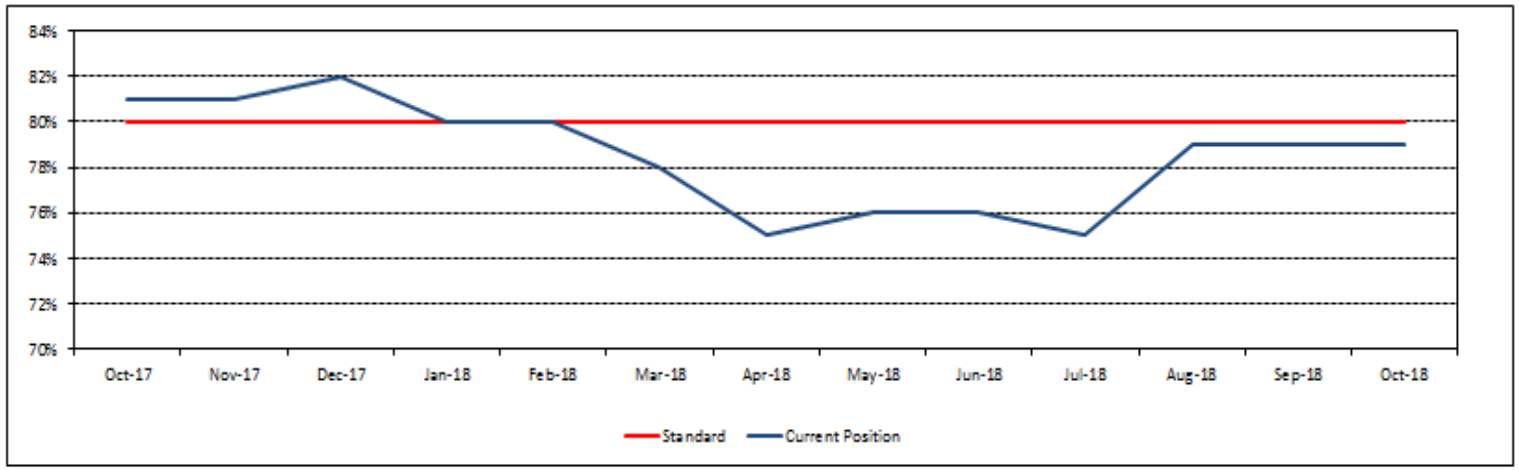
Indicator	Basic life support training (adult)
Standard	80%
Name	Julie Head
Month	Oct-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

We have appointed further educational hours for resuscitation services to deliver training. We are currently awaiting VAF approval for a further 0.4 WTE in training hours. With the addition of community in 2019, these extra hours are crucial to ensure an increase in compliance.

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

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

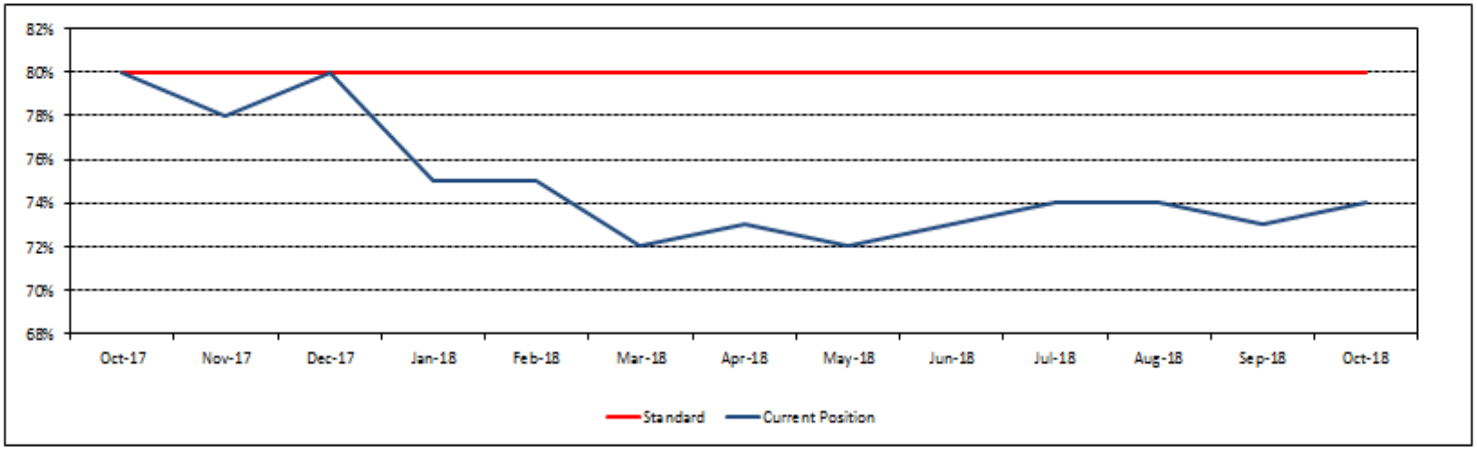
Indicator	Blood Products & Transfusion Processes (Refresher)
Standard	80%
Name	Gilda Bass
Month	Oct-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

November compliance has increased to 75% however the Transfusion team are awaiting feedback from the Education & Training team regarding the stats used to calculate compliance. No single reason has been identified for staff not complying with training requirements or why monthly reports are not being acted upon. It is anticipated that compliance will further deteriorate as winter pressures impact & training is deferred.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
A summary of all actions taken to date, by the Hospital Transfusion Team, has been forwarded to the Executive Chief Nurse.	GB	Nov-18	Nov-18
Issue referred to Head of Quality Improvement with request to assist the HTT in identifying root cause & corrective actions	GB/VT	Nov-18	Jan-19
Request made to Workforce Development Manager to review how statistics are generated & to consider how staff are alerted to complete the training	GB	Nov-18	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

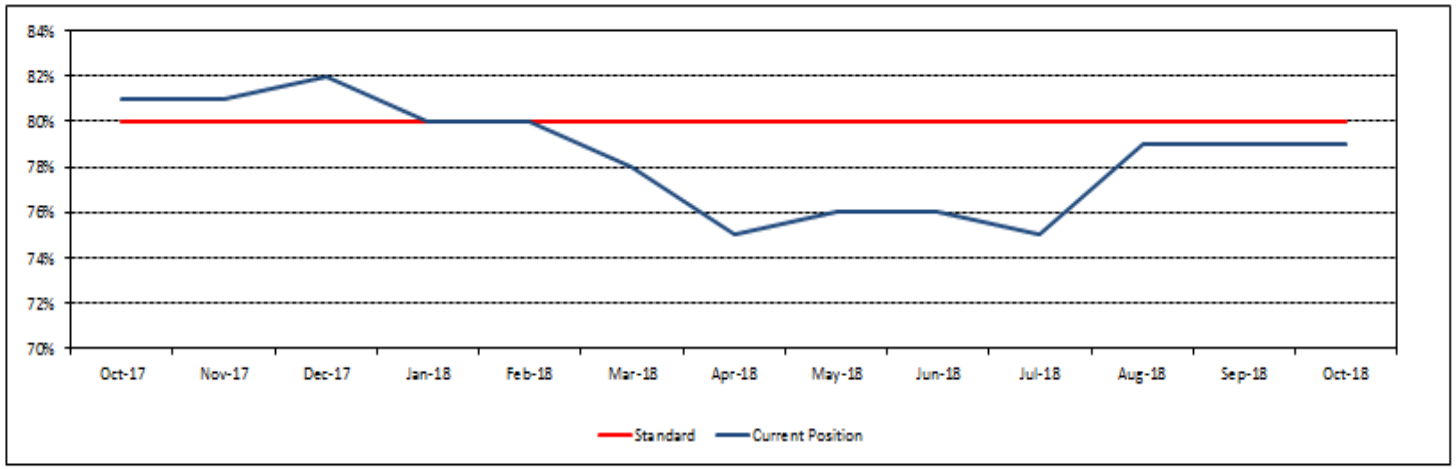
Indicator	Basic life support training (adult)
Standard	80%
Name	Julie Head
Month	Oct-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

We have appointed further educational hours for resuscitation services to deliver training. We are currently awaiting VAF approval for a further 0.4 WTE in training hours. With the addition of community in 2019, these extra hours are crucial to ensure an increase in compliance.

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

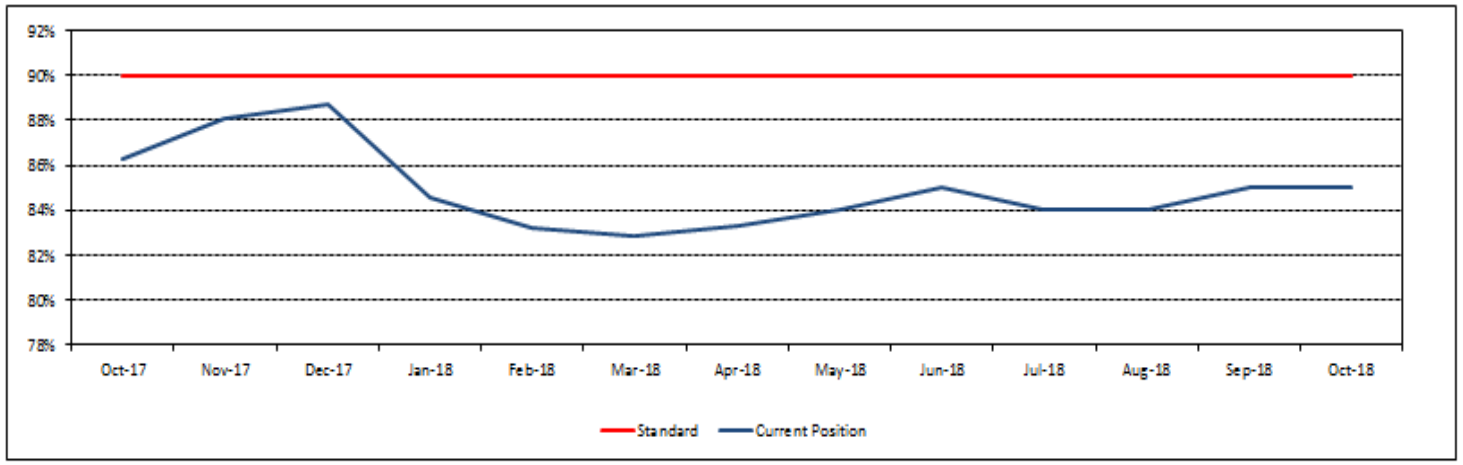
Indicator	Mandatory Training Compliance
Standard	90%
Name	Rebecca Rutterford
Month	Oct-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Emails targeting those who are less than 60% compliant have been sent to the heads of departments to try and encourage uptake before Winter.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	86.3%	88.1%	88.7%	84.6%	83.2%	82.8%	83.3%	84.0%	85.0%	84.0%	84.0%	85.0%	85.0%

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



9. DETAILED REPORTS – PRODUCTIVE

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

Are we..		Ref.	KPI	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	YTD(Apr18-Mar19)
6. Productive	Activity	6.07	A&E Activity	NT	6065	5985	5959	6033	5639	6172	5967	6498	6161	6564	6072	6042	6256	43560
		6.08	NEL Activity	NT	2586	2491	2528	2539	2406	2557	2273	2474	2471	2475	2370	2378	2615	17056
		6.09	OP - New Appointments	NT	6182	7230	5482	6769	5849	6324	6033	6930	6379	6598	6007	6113	7381	45441
		6.10	OP- Follow-Up Appointments	NT	11815	12668	9769	12673	11103	11609	11142	12248	11520	11750	10929	10879	12773	81241
		6.11	Electives (Incl Daycase)	NT	2868	3157	2545	2841	2632	2871	2665	3019	2799	2871	2786	2737	3030	19907
	Finance	6.12	Financial Position (YTD)	Var	-4114	-5170	-6600	-6525	-6525	-287	-1760	-2793	-3159	-4420	-5641	-7119	-7122	-32014
		6.13	Financial Stability Risk Rating	Var	3	3	3	3	3	3	3	3	3	3	3	3	3	21
		6.14	Cash Position (YTD £000s)	Var	2654	3518	4924	6870	3600	3600	5322	4550	2239	6852	7231	3934	1338	31466
	Ratios	6.15	% Consultant to Consultant Referrals	NT	10.6%	10.0%	10.9%	12.7%	13.7%	13.0%	14%	12.2%	13.3%	12.8%	11.7%	10.5%	11.2%	12.2%
		6.16	New to FU Ratios	1.9	1.91	1.78	1.79	1.87	1.90	1.84	1.85	1.77	1.81	1.78	1.82	1.78	1.73	1.79

EXCEPTION REPORTS – PRODUCTIVE

The finance report within the Board papers contains full details.

10. DETAILED REPORTS- MATERNITY

Are we..		Ref.	KPI	Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	YTD(Apr18-Mar19)
7.Maternity	Safe	7.09	Elective Caesarean Sections	10%	5.9%	7.2%	7.8%	8.0%	7.1%	10.7%	11.8%	10.9%	7.6%	4.7%	7.8%	9.6%	8.6%	8.7%
		7.10	Emergency Caesarean Sections	12%	11.2%	9.8%	10.6%	14.1%	10.1%	19.4%	16.4%	11.4%	10.6%	12.4%	9.2%	13.0%	14.1%	12.4%
		7.11	Grade 1 Caesarean Section (Decision to delivery time met)	100%	0.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	40.0%	100%
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)	80%	88.0%	50.0%	80.0%	83.0%	83.0%	81.0%	82.0%	93.0%	90.0%	58.0%	64.0%	82.0%	71.0%	77.1%
		7.13	Homebirths	2%	3.9%	2.6%	3.3%	3.0%	2.4%	0.5%	2.6%	5.0%	1.5%	2.4%	1.5%	3.8%	1.8%	2.7%
		7.14	Midwifery led birthing unit (MLBU) births	>13%	17.1%	16.0%	15.0%	19.1%	18.0%	14.1%	16.4%	11.4%	11.4%	18.8%	17.0%	11.5%	14.4%	14.4%
		7.15	Labour Suite births	77.5%	79.0%	81.4%	81.7%	77.9%	79.6%	85.4%	81.0%	83.0%	86.9%	78.2%	80.6%	83.7%	82.7%	82.3%
		7.16	Induction of Labour	29.3%	35.1%	43.8%	43.9%	37.2%	41.2%	37.4%	41.0%	37.8%	40.9%	37.6%	36.4%	34.1%	35.5%	37.6%
		7.17	Instrument Assisted Deliveries (Forceps & VentoUse)	>14%	4.2%	7.2%	5.9%	7.0%	7.6%	6.8%	13.0%	9.5%	10.1%	10.0%	12.6%	11.5%	11.8%	11.2%
		7.18	Critical Care Obstetric Admissions	0	0	0	0	2	0	1	1	2	1	0	1	1	0	6
		7.19	Eclampsia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Effective	7.20	Shoulder Dystocia	2	6	4	5	4	5	8	5	6	8	5	6	9	9	48
		7.21	Post-partum Hysterectomies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		7.22	Women requiring a blood transfusion of 4 units or more	0	0	0	ND	ND	ND	ND	0	0	1	2	0	0	1	4
		7.23	3rd and 4th degree tears (all deliveries)	12	6	3	8	9	7	2	9	4	6	4	7	7	3	40
	Caring	7.24	Maternal death	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
		7.25	Stillbirths	NT	2	1	0	2	0	0	1	1	0	1	0	0	0	3
		7.26	Complaints	NT	0	0	1	0	0	1	0	ND	0	3	1	0	1	5
		7.27	No. of babies admitted to Neonatal Unit (>36+6)	NT	15	11	9	8	16	12	18	10	9	7	13	8	9	74
	Responsive	7.28	No. of babies transferred for therapeutic cooling	0	1	0	1	0	0	0	1	0	0	0	0	0	0	1
		7.29	One to one care in established labour	100%	100%	100%	100%	100%	100%	100%	91.0%	93.0%	92.3%	97.0%	97.0%	100%	100%	95.8%
		7.30	Reported Clinical Incidents	50	61	57	49	63	46	48	46	56	48	27	39	44	34	294
		7.31	Hours of dedicated consultant cover per week	60	99	108	90	102	93	93	94	90	93	93	90	87	87	634
		7.32	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	10	70
		7.34	No. of women identified as smoking at booking	NT	27	28	17	26	21	30	26	31	22	19	21	23	22	164
		7.35	No. of women identified as smoking at delivery	NT	25	24	26	21	22	24	23	26	14	15	27	21	22	148
		7.36	UNICEF Baby friendly audits	10	10	10	10	10	ND	10	ND	ND	10	ND	ND	ND	ND	10
		7.37	Proportion of parents receiving Safer Sleeping Suffolk advice	80%	ND	ND	ND	ND	ND	ND	62.9%	77.8%	81.8%	88.0%	80.0%	96.0%	97.0%	83.4%
	Other	7.38	No. of bookings (First visit)	NT	259	245	193	279	253	274	240	251	237	252	236	231	234	1681
		7.39	Women booked before 12+6 weeks	95%	99.0%	97.0%	97.0%	96.0%	96.0%	ND	95.4%	96.0%	96.6%	94.4%	96.0%	92.0%	92.0%	94.6%
		7.40	Female Genital Mutilation (FGM)	NT	0	0	0	0	1	0	0	0	0	0	0	0	0	0

EXCEPTION REPORTS – MATERNITY

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

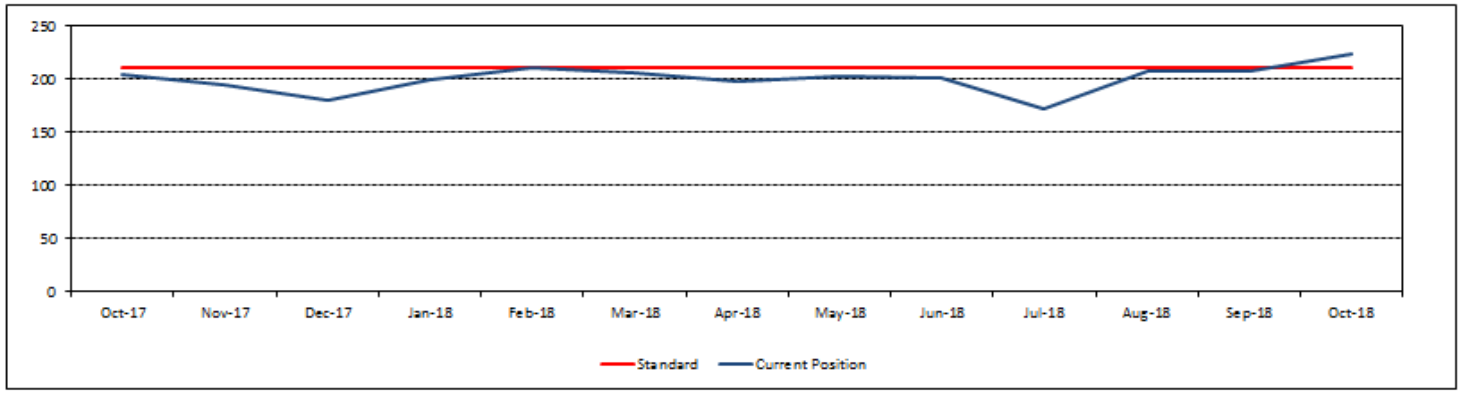
Indicator	Total number of deliveries (births)
Standard	210
Name	Jane Lovedale
Month	Oct-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

This month saw a significant rise in the number of births at 224. RAG rated as red as above our ratio of midwives to births. There were occasions during the month were in order to achieve one to one care in labour the escalation policy was activated. Whilst the service achieved 100% one to one care in labour, escalation and relocation of staff and the pulling in of the community teams has a significant effect on the community workload particularly when called in during the night. This together with staff sickness this month and reduced space on the labour suite due to the refurbishment means that staff have worked hard to ensure safe practice and good patient experience. Positive appreciation has been expressed to staff for their hard work. It is not possible to say whether this is an isolated increase however the service will monitors this closely to ensure safe practice continues.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	210	210	210	210	210	210	210	210	210	210	210	210	210
Current Position	205	194	180	199	211	206	198	203	201	172	208	208	224

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
As the service Continue to monitor this increased activity.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

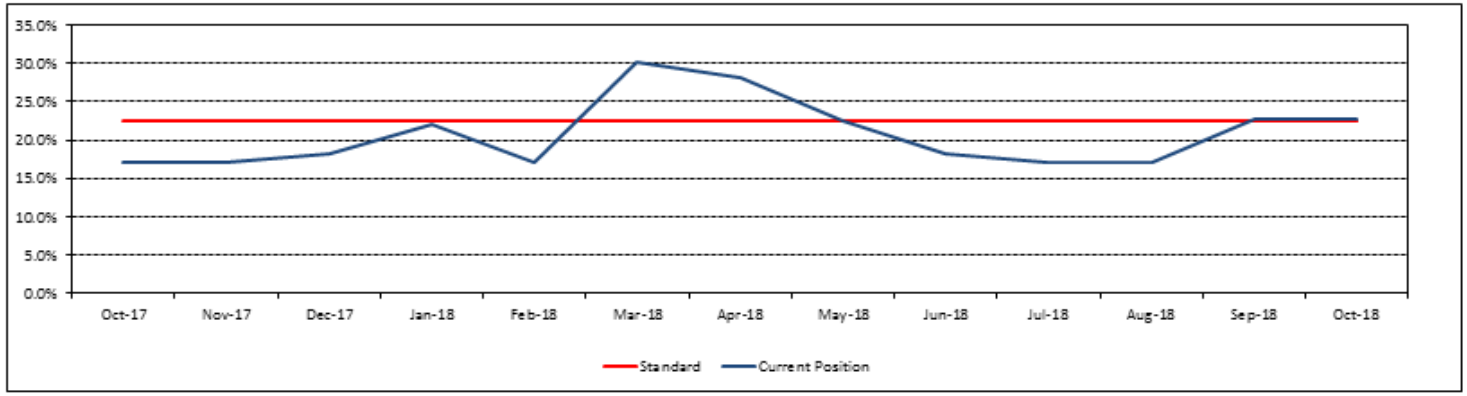
Indicator	% of all caesarean sections
Standard	22.6%
Name	Jane Lovedale
Month	Oct-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The overall caesarean section rate which includes both emergency and elective caesarean sections showed a slight increase this month of 22.7% (0.1% above our commissioned rate of 22.6%) The rise is reflected in the emergency caesarean sections rate whilst the elective rate remains low. This was very slightly down from last month of 22.8%. The rate of caesarean sections should be considered together with the rates for both instrumental and normal births which both show a reduction. Overall the rate over the last 8 months is still lower than the commissioned rate at around 22.3%. The Maternity Service continues to monitor this closely.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	22.6%	22.6%	22.6%	22.6%	22.6%	22.6%	22.6%	22.6%	22.6%	22.6%	22.6%	22.6%	22.6%
Current Position	17.1%	17.0%	18.3%	22.1%	17.1%	30.1%	28.2%	22.4%	18.2%	17.1%	17.0%	22.8%	22.7%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor closely by reviewing emergency CS at the weekly case management meeting.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

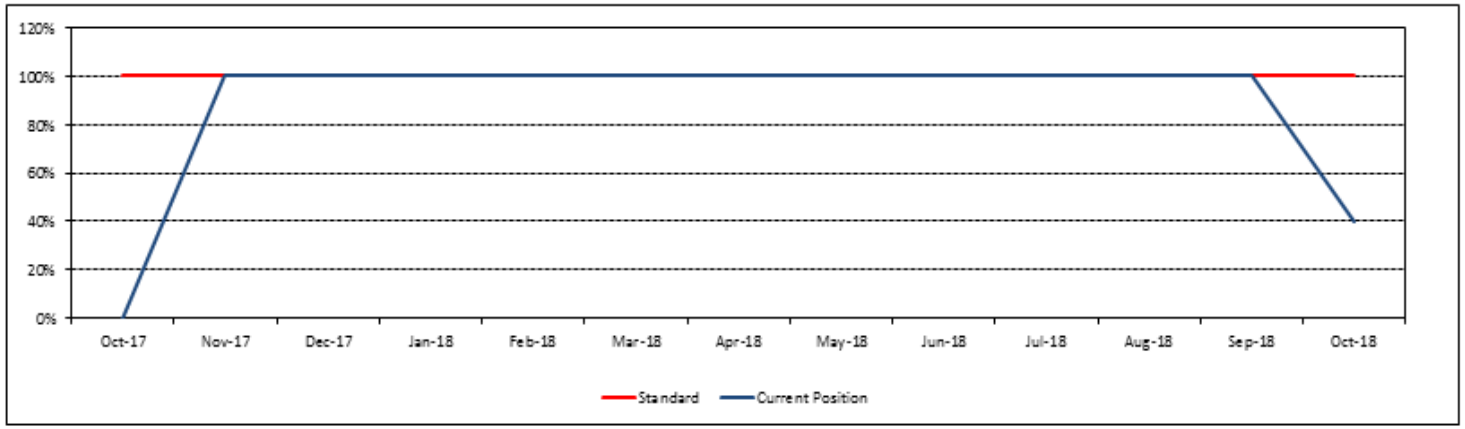
Indicator	Grade 1 Caesarean Section (Decision to delivery time met)
Standard	100%
Name	Jane Lovedale
Month	Oct-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

October has shown a significant fall in achieving the Decision to Delivery time for Grade one Caesarean Section. Grade 1 Caesarean Section is expected to achieve delivery within 30 minutes. This is the first time this has been less than 100% this year. Each of the three case has been reviewed at the case management meeting. The delays were between 2-12 minutes. All were felt appropriate delays in avoiding a general anaesthetic. The Labour Suite is undergoing a refurbishment and the transfer to theatre takes slightly longer. Although one case occured after the refurbishment had started it was not though to be the reason for the delay. Decision to delivery time was discussed at the Womens Health Governance and as agreed last month one of the consultants will be presenting the data over a 3 month period in February 2019.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	0.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	40.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To continue to monitor the D to D rates weekly identify any learning outcomes.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

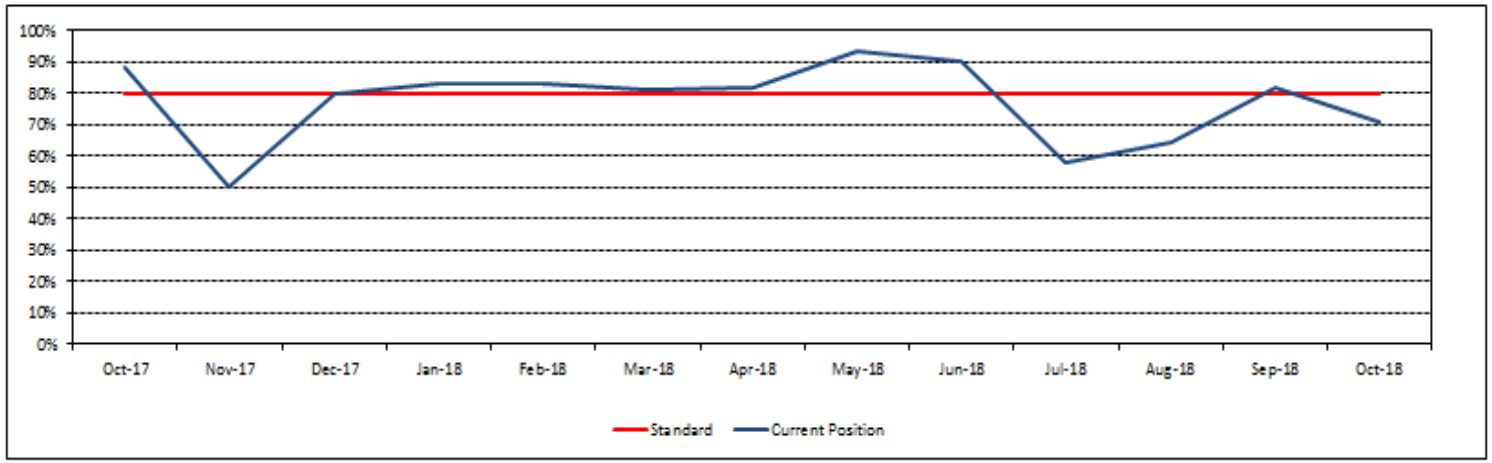
Indicator	Grade 2 Caesarean Section (Decision to delivery time met)
Standard	80%
Name	Jane Lovedale
Month	Oct-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

This month there was 4 of 14 cases where a grade 2 Caesarean Section was out of the 75 minute timeframe calculated at 71%. The expected standard for compliance is 80% for Grade 2 Caesarean Section. All cases were discussed at the weekly case management meetings. All cases had clear documentation for the delay and thought to be appropriate in view of ensuring safety for mother and baby. The maternity service plans to present the decision to delivery data at the Clinical Governance Steering group in February 2019 and identify any themes evident.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Current Position	88.0%	50.0%	80.0%	83.0%	83.0%	81.0%	82.0%	93.0%	90.0%	58.0%	64.0%	82.0%	71.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To continue to monitor weekly at the case management meeting and feedback any learning to the individual and on Risky Business monthly publication.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

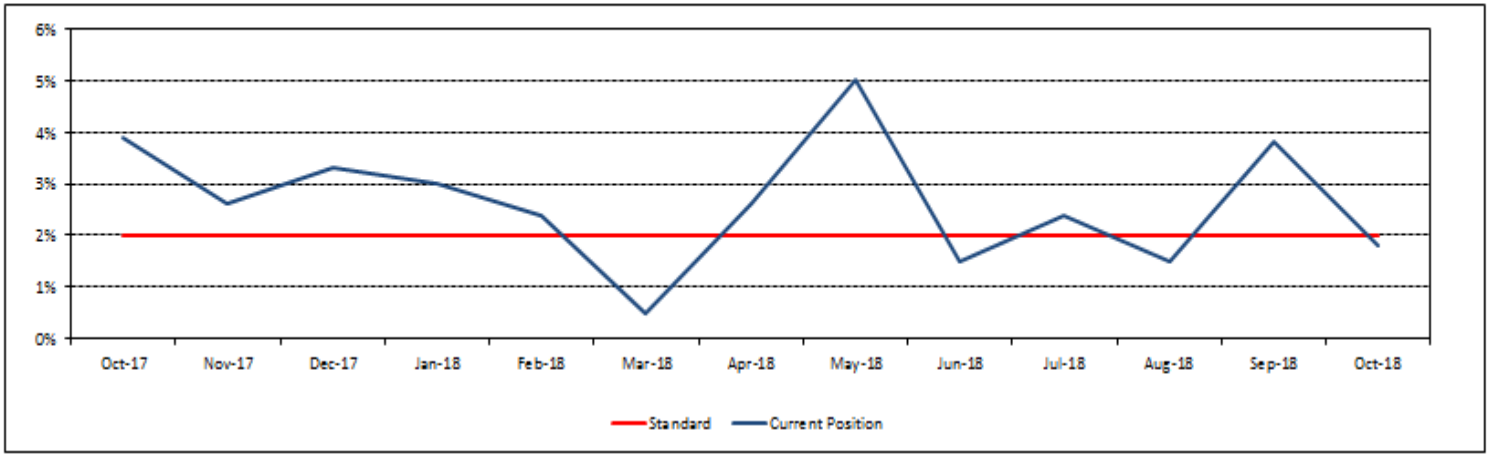
Indicator	Homebirths
Standard	2%
Name	Jane Love dale
Month	Oct-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Since June the Home birth rate has decreased (With the exception of September). Although the Trust standard is 2% the expectation of the maternity service is to achieve 2.5%. The maternity service aspires to achieve 10%. There is currently work being undertaken in the maternity service to develop continuity of carers as part of the implementation of 'Better Births. By improving the care pathway for women wanting a home birth is thought to be the starting point to increase the rate of homebirths. The outpatient service manager is putting together a Task and Finish group to look at providing a homebirth team.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Current Position	3.9%	2.6%	3.3%	3.0%	2.4%	0.5%	2.6%	5.0%	1.5%	2.4%	1.5%	3.8%	1.8%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Task and Finish Group proposed to look at the home birth pathway and to provide a home birth team for the future.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

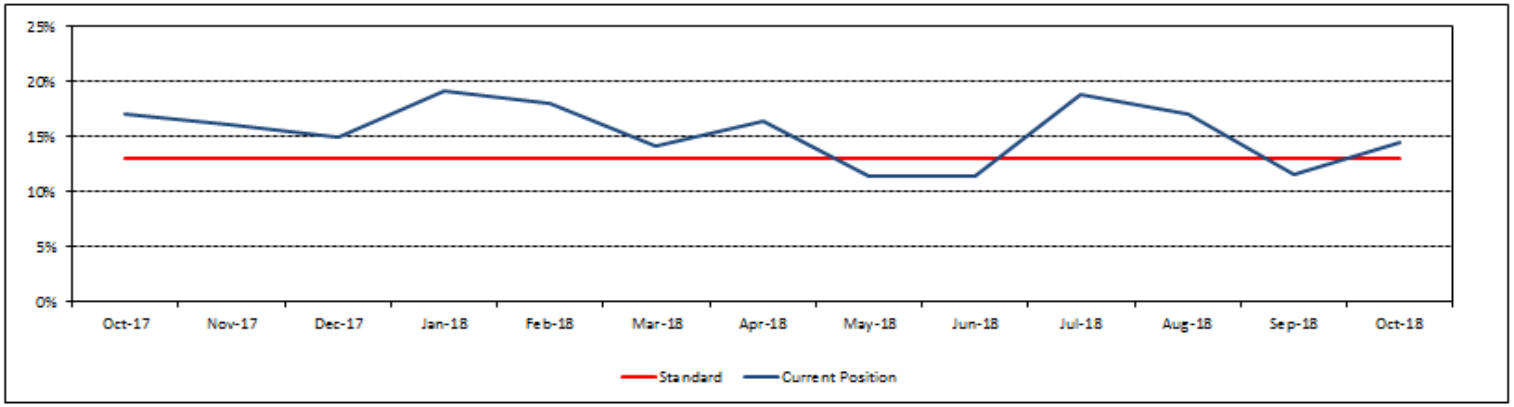
Indicator	Midwifery led birthing unit (MLBU) births
Standard	13%
Name	Jane Lovedale
Month	Oct-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The Maternity Service's standard for women delivering in the Birthing Unit is 20% this year we have unfortunately not achieved this. October the percentage was 14.4 %. This has thought to have occurred for a number of reasons. The change in surveillance and identification of small babies has led to an increase of Inductions, in addition staffing has had an impact. It has been agreed at the WHG that during the refurbishment of the labour suite and the move to all women delivering on the Midwifery led birthing unit and reduced labour suite rooms data would be difficult to collect accurately and we would therefore not be including Midwifery led birthing unit deliveries on the dashboard until the refurbishment has been completed. In the meantime the new Midwifery led birthing unit manager will be reviewing the risk assessment for delivery on Midwifery led birthing unit care and will have an action plan in place to increase the numbers owhen refurbishment is completed.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%
Current Position	17.1%	16.0%	15.0%	19.1%	18.0%	14.1%	16.4%	11.4%	11.4%	18.8%	17.0%	11.5%	14.4%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
MLBU manager to review the risk assessment and criteria for MLBU to fully implement when LS refurbishment completed.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

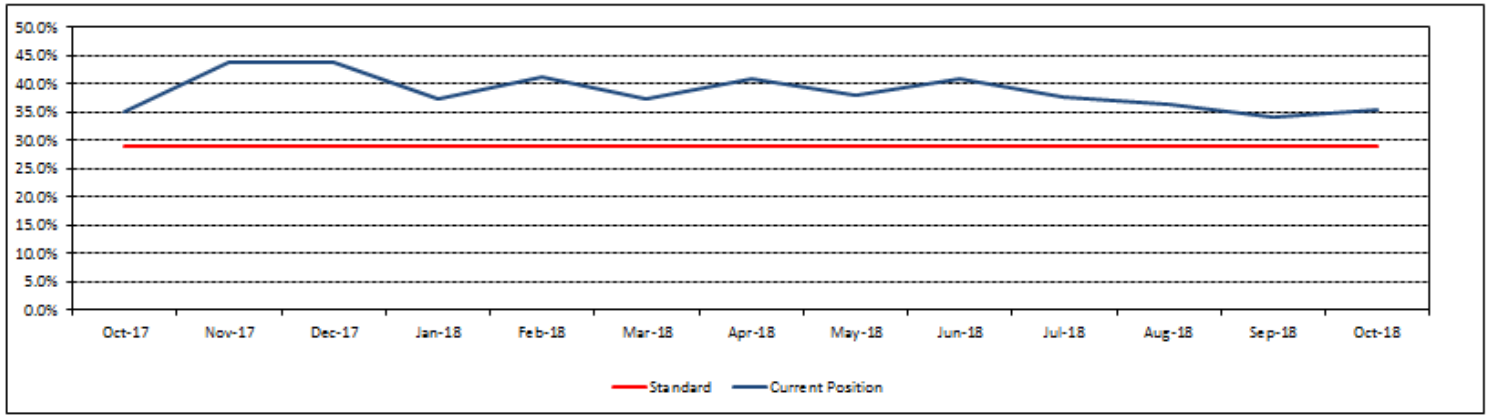
Indicator	Induction of Labour
Standard	29.3%
Name	Jane Lovedale
Month	Oct-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Induction of Labour is increasingly common in Britain and the trend is likely to continue to rise as women's age increases and more women enter pregnancy with pre existing medical conditions. The purpose of Induction of Labour is commonly to prevent stillbirth or illness in babies or illness exacerbated by pregnancy such as pre eclampsia. In many circumstances the alternative to Induction of Labour is caesarean section and should be considered in the context of Elective caesarean section. Other reasons for the increase are the introduction of fetal surveillance using Gestation Related Optimal Weight. Increase is detection of gestational diabetes mellitus which NICE recommends induction of labour at 38 weeks. Next year the National Maternity and Perinatal Audit Audit report will be published the expectation is that the standard for Induction of Labour will change, however we continue to monitor and an audit of Induction of Labour is ongoing.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	29.0%	29.0%	29.0%	29.0%	29.0%	29.0%	29.0%	29.0%	29.0%	29.0%	29.0%	29.0%	29.0%
Current Position	35.1%	43.8%	43.9%	37.2%	41.2%	37.4%	41.0%	37.8%	40.9%	37.6%	36.4%	34.1%	35.5%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
ongoing Audit of IOL for presentation at CGSG in the new year.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Shoulder Dystocia
Standard	2
Name	Jane Lovedale
Month	Oct-18
Data Frequency	Monthly
CQC Area	Maternity

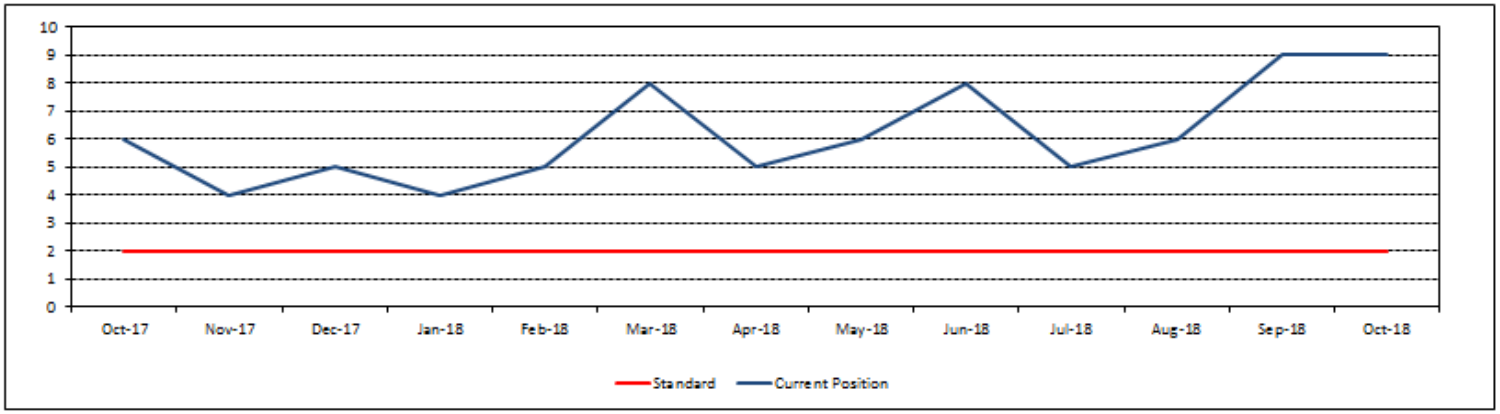
Summary of Current performance & Reasons for under performance

Shoulder dystocia remains above the standard of consistently. Shoulder dystocia is defined as a vaginal cephalic delivery that requires additional obstetric manoeuvres to deliver the fetus after the head has delivered and gentle traction has failed. There can be significant perinatal morbidity and mortality associated with the condition, even when it is managed appropriately. Our standard is 2 per month however maternity consistently remains high. Previous audits have demonstrated that the majority were not true shoulder dystocia although we do report them as shoulder dystocia because we include moving the woman into McRoberts position a manoevre although no internal or other external manoeures have been attempted. The lead consultant is focusing on this issue at PROMPT training with midwives. Whilst Shoulder dystocia cannot generally be predicted we continue to ensure all midwives and medical staff are trained annually. There has been no injuries to mother or babies in those reported this month.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	2	2	2	2	2	2	2	2	2	2	2	2	2
Current Position	6	4	5	4	5	8	5	6	8	5	6	9	9

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

Description	Owner	Start	End
Awaiting ongoing audit to be presented at CGSG early 2019			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

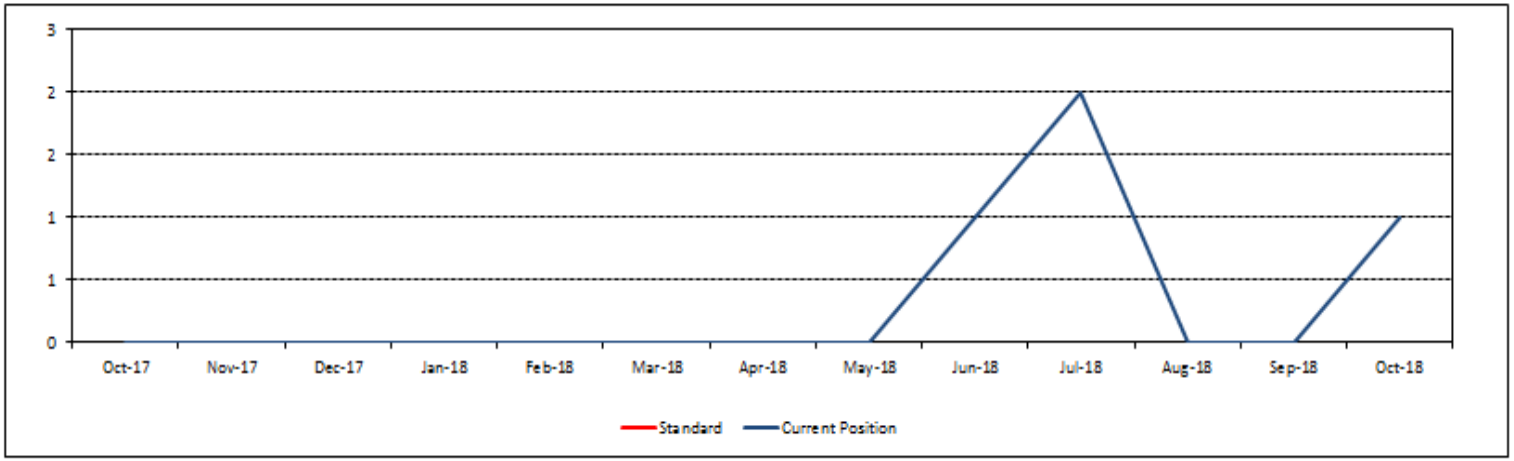
Indicator	Women requiring a blood transfusion of 4 units or more
Standard	0
Name	Jane Lovedale
Month	Oct-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

One woman this month required 5 units of blood transfused following a Caesarean section for a Twin delivery. Post partum haemorrhage is a risk at delivery for all women however some are at a higher risk than others. In this case twins presented an increase risk due to the increased stretching of the uterus and the large surface area of two placenta. The management of this case has been reviewed by the Multiprofessional team and was considered to be very well managed.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to risk assess all women for the possibility of PPH and ensure systems are in place to reduced / mitigate the impact.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

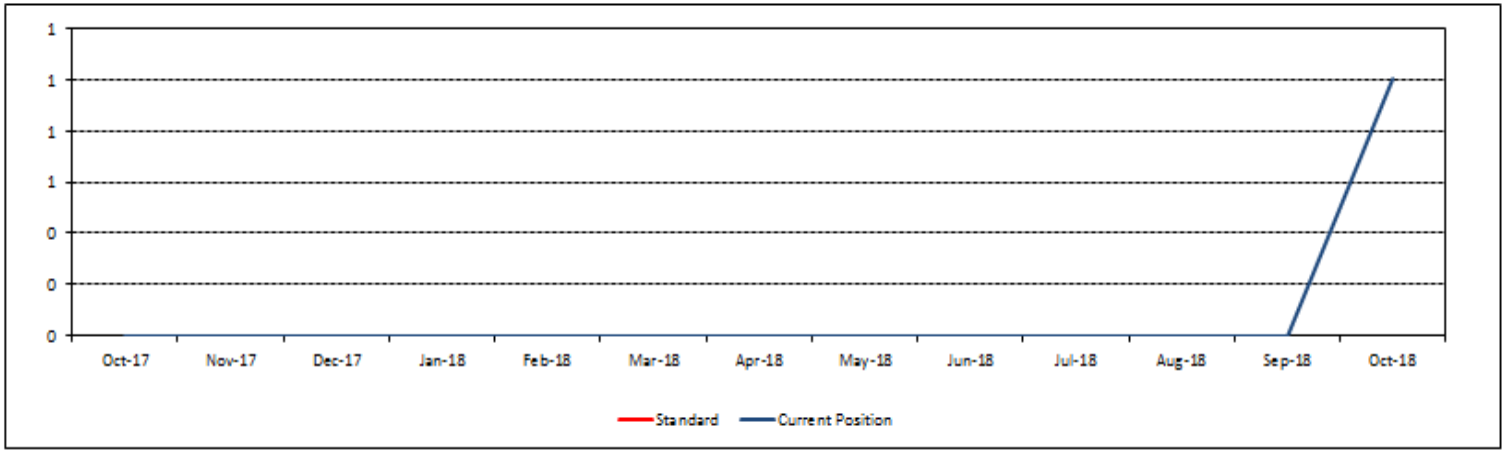
Indicator	Maternal death
Standard	0
Name	Jane Lovedale
Month	Oct-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries - UK reports that 8.8 women per 100.000 died during pregnancy and up to 6 weeks after giving birth or the end of pregnancy. The maternity service reported a maternal death in October 2018. In this case the woman was low risk antenatally but developed a condition of perinatal cardiomyopathy. The death is currently being investigated. The healthcare safety Investigation branch team have been supporting the family. Mechanisms have been put in place to support the staff involved.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To ensure any learning identified following the investigation is cascaded to all staff			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

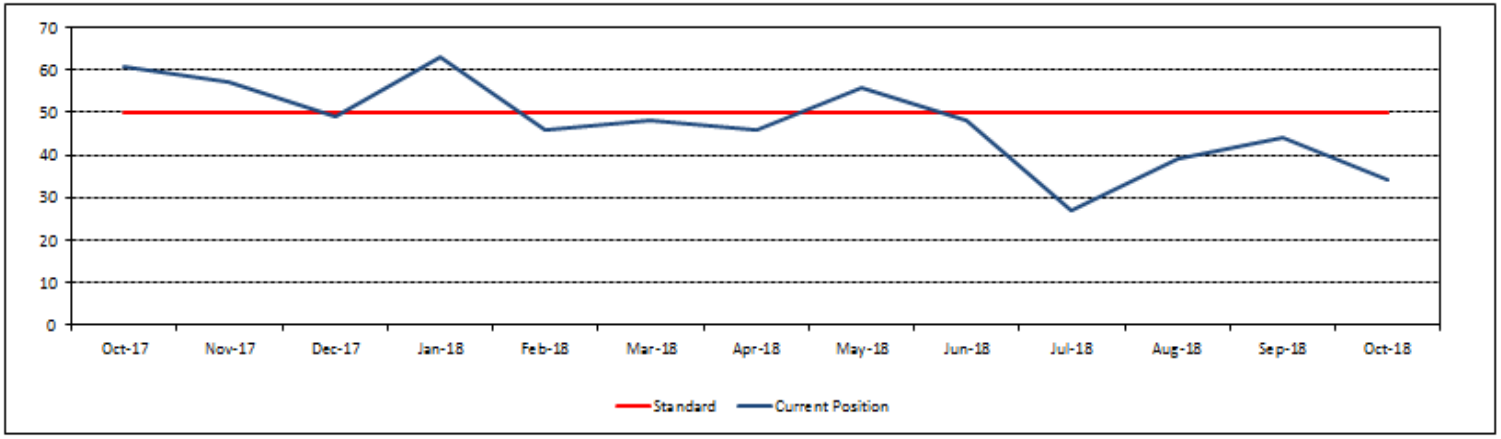
Indicator	Reported Clinical Incidents
Standard	50
Name	Jane Lovedale
Month	Oct-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

There has been a decrease in incident reporting over the last few months with October at 34,with an average of 42 in 2018-19 to date. Maternity has a trigger list of Obstetric incidents where a Datix is expected to be generated. Cross referencing with E3 maternity system demonstrated that staff were not completing a Datix as expected. The issue of under reporting has been highlighted in Octobers issue of Risky Business included the Trigger list. The service has had a number of new midwives starting over the last few months which may have contributed to this reduction as well as increase clinical activity. Further communication to staff via Take 5 also highlighted this issue over the week of 22nd October. The service will continue to monitor.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	50	50	50	50	50	50	50	50	50	50	50	50	50
Current Position	61	57	49	63	46	48	46	56	48	27	39	44	34

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor and cross reference on E3 via the maternity risk office where a Datix has not been completed and highlight to staff.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

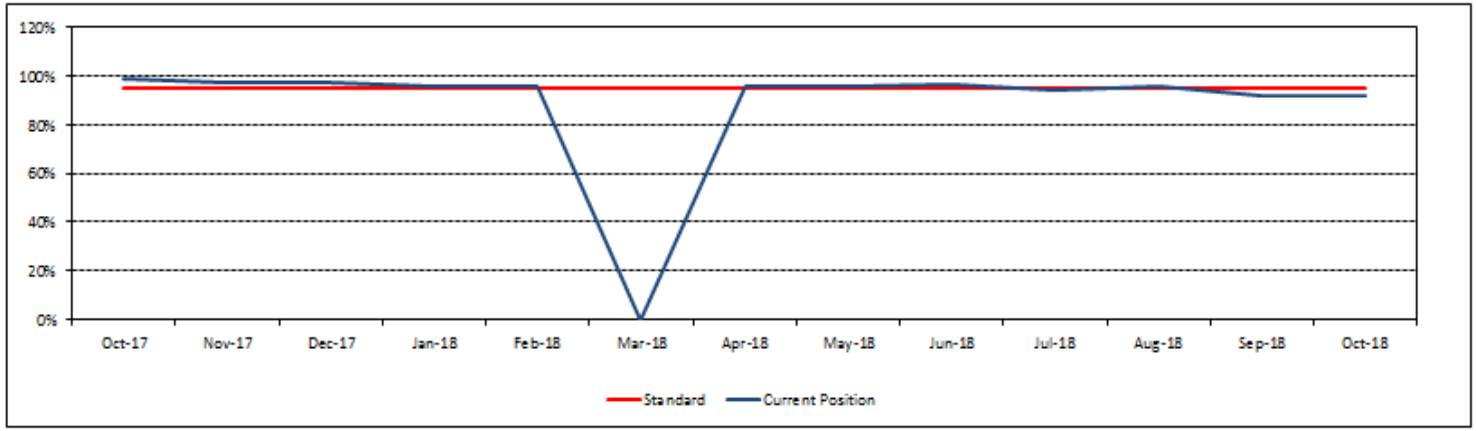
Indicator	Women booked before 12+6 weeks
Standard	95%
Name	Jane Lovedale
Month	Oct-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

NICE guidance recommends that booking should take place before 10 weeks for all women. The main rationale behind this is to allow women to participate in Antenatal screening programmes for haemaglobinopathies and and Down's Syndrome in a timely fashion and accurate date the pregnancy. This month has shown a decrease in women booked by 12+6. Whilst the service is very robust in collecting this data and includes women who themselves did not access services before 12+6 there has been a change. This issue was discussed at the Women's Health Governance meeting on the 19/11/18 an a decision to look more closely at the reasons why there has been a significant change. The outpatient services manager to look audit those women over the last two months identify any themes and present to the CGSG.

Month	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	99.0%	97.0%	97.0%	96.0%	96.0%	ND	95.4%	96.0%	96.6%	94.4%	96.0%	92.0%	92.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Audit of 2 months data of women who were not booked by the recommended gestation 12+6 .			



10. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – November 2018

Agenda item:	10			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	23rd November 2018			
Subject:	Finance and Workforce Board Report – October 2018			
Purpose:	x	For information		For approval

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

The reported I&E for October 2018 is a deficit of £16k, against a planned surplus of £60k. This results in an adverse variance of £76k in month (£783k YTD). This YTD overspend predominantly relates to

- underperformance against the A&E performance (£165k adverse variance against PSF)
- pay award underfunded (£400k)
- community equipment backlog of wheelchairs (£200k)

We are optimistic additional funding may be approved by WS CCG to recognise increased activity in relation to RTT and repatriated patients

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	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
October 2018 (Month 7)

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

Financial Summary

I&E Position YTD	£7.1m	loss
Variance against plan YTD	-£0.8m	adverse
Movement in month against plan	-£0.1m	adverse
EBITDA position YTD	-£3.5m	
EBITDA margin YTD	-41.2%	adverse
Total PSF Received	£1.481m	accrued
Cash at bank	£1.338m	

Executive Summary

- The Trust has agreed a control total of a deficit of £13.8m with NHS Improvement for 2018/19. (£10.2m after PSF).
- The planned deficit for the year to date was £6.3m but the actual deficit was £7.1m, an adverse variance of £0.8m.
- We are optimistic additional funding may be approved by WS CCG to recognise increased activity in relation to RTT and repatriated patients

Key Risks

- Securing cash PDC support from DH for the 2018-19 revenue and capital plans.
- Delivering the £12.2m cost improvement programme.
- Containing the increase in demand to that included in the plan (3.2%)
- Cost pressures associated with pay award
- Recruitment of Registered Nurses to ensure the Trust is fully staffed for the additional capacity required for winter

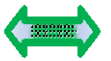
SUMMARY INCOME AND EXPENDITURE ACCOUNT - October 2018	Oct-18 Budget £m	Oct-18 Actual £m	Oct-18 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m	Year end forecast Budget	Year end forecast Actual	Year end forecast Variance F/(A)
NHS Contract Income	16.5	16.4	(0.1)	111.5	111.4	(0.1)	190.2	192.1	1.8
Other Income	3.9	4.0	0.2	22.4	22.7	0.2	39.3	39.2	(0.2)
Total Income	20.4	20.4	0.0	133.9	134.1	0.2	229.6	231.2	1.7
Pay Costs	13.4	13.5	(0.1)	92.2	93.2	(1.1)	158.4	160.5	(2.2)
Non-pay Costs	6.8	6.8	(0.0)	44.2	44.3	(0.2)	76.0	75.5	0.5
Operating Expenditure	20.2	20.4	(0.1)	136.4	137.6	(1.2)	234.4	236.0	(1.7)
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	0.2	0.1	(0.1)	(2.4)	(3.5)	(1.0)	(4.8)	(4.8)	0.0
Depreciation	0.5	0.5	0.0	4.0	3.6	0.4	6.5	6.5	0.0
Finance costs	(0.0)	0.2	(0.2)	1.5	1.5	0.0	2.6	2.6	0.0
SURPLUS/(DEFICIT) pre PSF	(0.3)	(0.6)	(0.3)	(8.0)	(8.6)	(0.6)	(13.9)	(13.9)	0.0
Provider Sustainability Funding (PSF)									
PSF - Financial Performance	0.3	0.3	0.0	1.2	1.2	0.0	2.6	2.6	0.0
PSF - A&E Performance	0.1	0.4	0.3	0.5	0.3	(0.2)	1.1	0.9	(0.2)
SURPLUS/(DEFICIT) incl PSF	0.1	(0.0)	(0.1)	(6.3)	(7.1)	(0.8)	(10.2)	(10.3)	(0.2)

FINANCE AND WORKFORCE REPORT – October 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 – October 2018

Income and Expenditure Summary as at October 2018

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

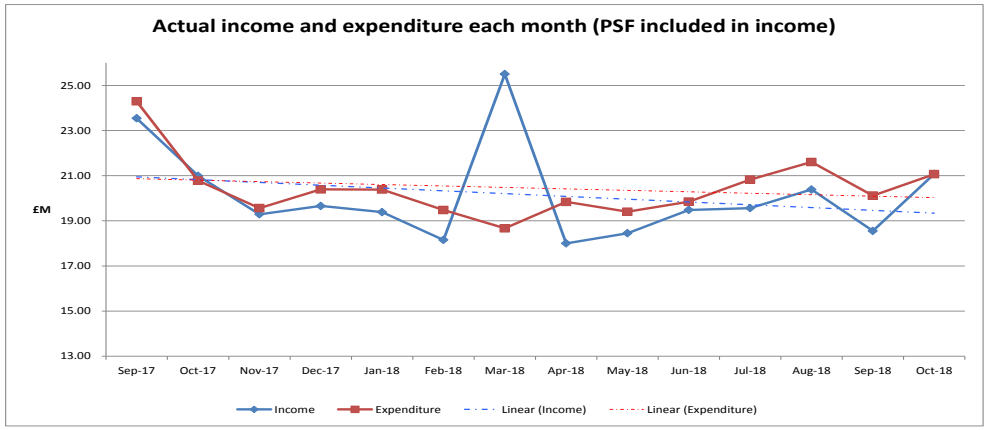
In order to achieve the control total the 2018-19 budgets include a stretch CIP of £2.8m bringing the total CIP plan to £12.2m (5%). We have utilised the 2018-19 contingency of £1.5m in order to meet this stretch CIP.

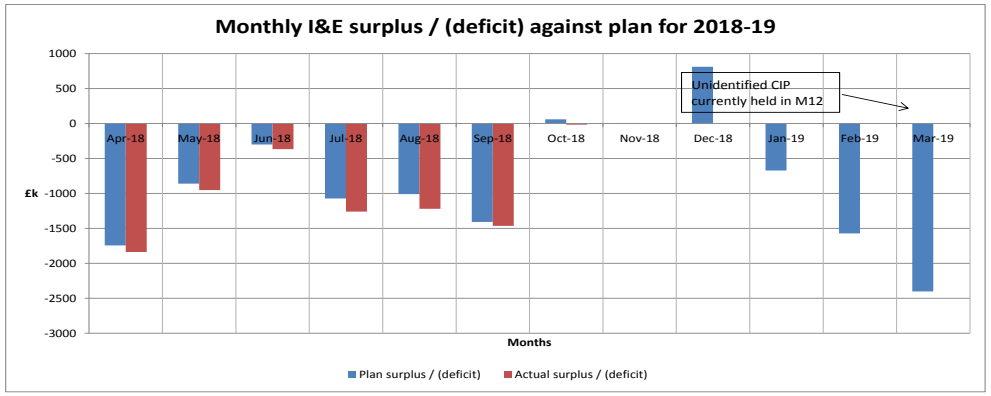
The reported I&E for October 2018 is a deficit of £16k, against a planned surplus of £60k. This results in an adverse variance of £76k in month (£783k YTD). This YTD overspend predominantly relates to

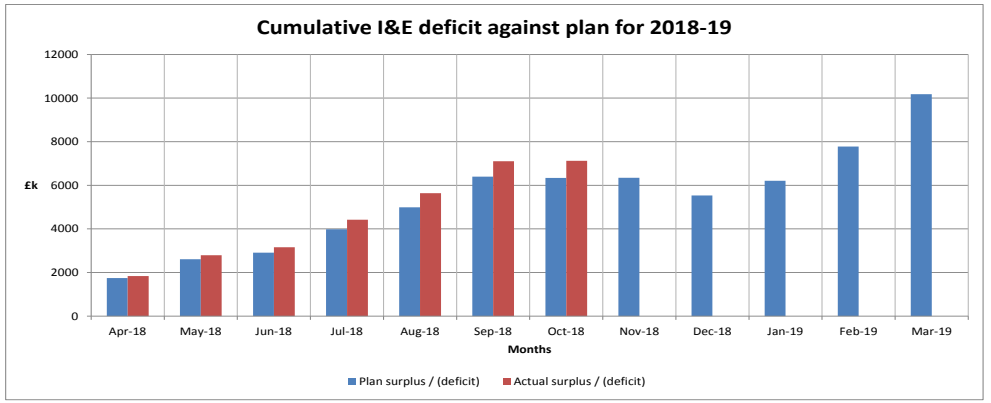
- underperformance against the A&E performance (£165k adverse variance against PSF)
- pay award underfunded (£400k)
- community equipment backlog of wheelchairs (£200k)

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)	60	(16)	(76)	↓	Amber
YTD surplus / (deficit)	(6,339)	(7,122)	(783)	↑	Amber
Forecast surplus / (deficit)	(10,180)	(10,180)	0	↔	Green
EBITDA (excl STF) YTD	(2,432)	(3,483)	(1,051)	↑	Red
EBITDA (%)	(1.8%)	(2.6%)	(0.8%)	↔	Red
Clinical Income YTD	(111,493)	(111,434)	(60)	↓	Green
Non-Clinical Income YTD	(24,071)	(24,151)	81	↑	Red
Pay YTD	92,193	93,250	(1,056)	↑	Red
Non-Pay YTD	49,710	49,457	253	↑	Green
CIP target YTD	6,537	6,509	(28)	↓	Amber





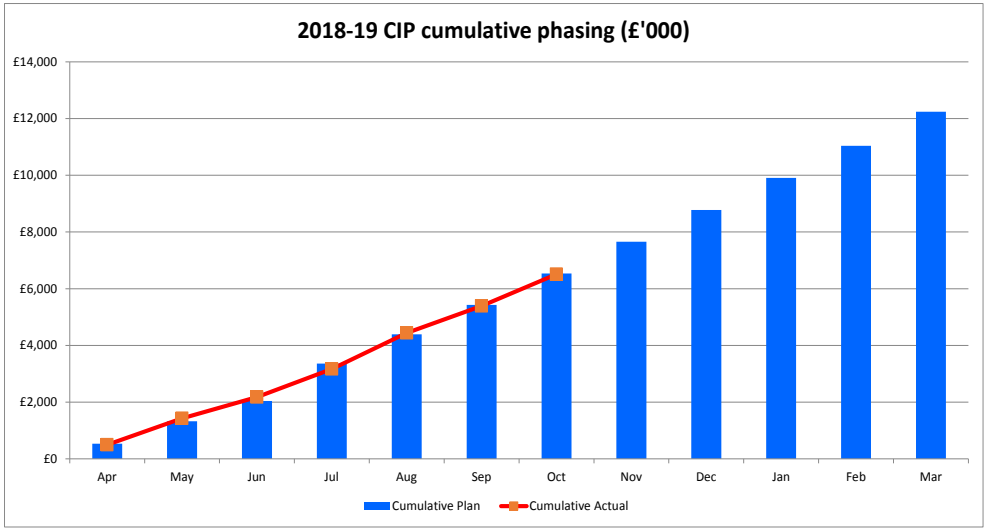


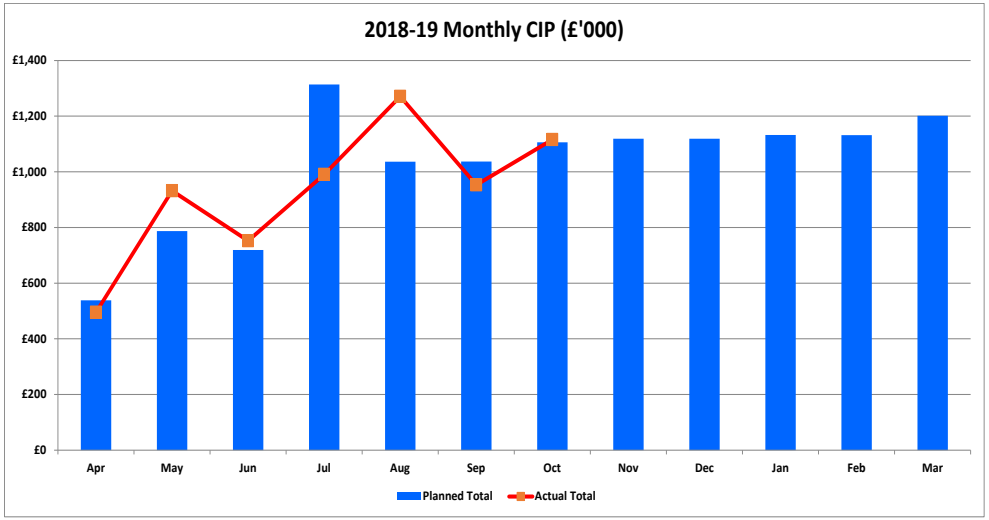
Cost Improvement Programme (CIP) 2018-19

The October position includes a target of £6.54m YTD which represents 53.4% of the 2018-19 plan. There is a shortfall of £28k YTD against this plan.

Recurring/Non Recurring	Summary	2018-19 Annual Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Clinical Income	529	300	237
	Activity growth	234	133	-
	Private Patients	78	46	14
	Other Income	890	355	347
	Consultant Staffing	885	37	15
	Nursing productivity	71	15	19
	Staffing Review	80	513	686
	Additional sessions	58	15	7
	Temporary Pay	712	428	541
	Agency	98	63	88
	Pay controls	-	-	-
	CNST discount	265	155	27
	Community Equipment Service	643	375	373
	Drugs	167	96	151
	Contract renegotiation	69	39	37
	Procurement	840	437	286
	Other	178	65	119
	Service Review	366	157	107
	Patient Flow	629	489	490
	Divisional Cross Cutting allocations (T	1,880	906	276
	Cancelled CIPs	324	155	-
Recurring Total		**8,994**	**4,776**	**3,821**
Non-Recurring	Capitalisation	1,550	875	875
	Other Income	0	-	-
	Additional sessions	268	61	-
	Contract review	100	50	97
	Non-Specific Divisional savings	0	-	662
	Other	1,327	774	1,055
Non-Recurring Total		**3,245**	**1,761**	**2,688**
Grand Total		**12,239**	**6,537**	**6,509**

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%).





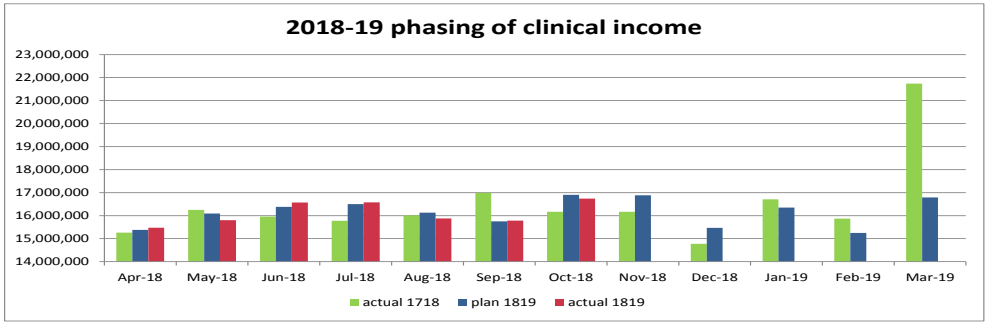
Cost Improvement Programme (CIP) 2019-20

The Trust is planning on a CIP of 4% in 2019-20, being £8.9m. The PMO is leading workshops with each Division to formulate plans which will be shared through the Transformation Steering Group (TSG)

FINANCE AND WORKFORCE REPORT – October 2018

Income Analysis

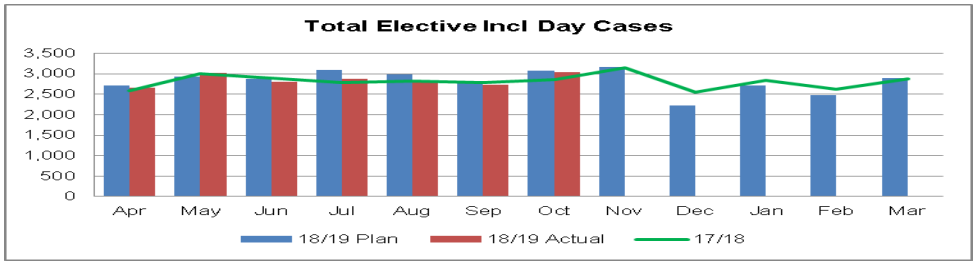
The chart below summarises the phasing of the clinical income plan for 2018-19, including Community Services. This phasing is in line with activity phasing which is how the income is recognised.

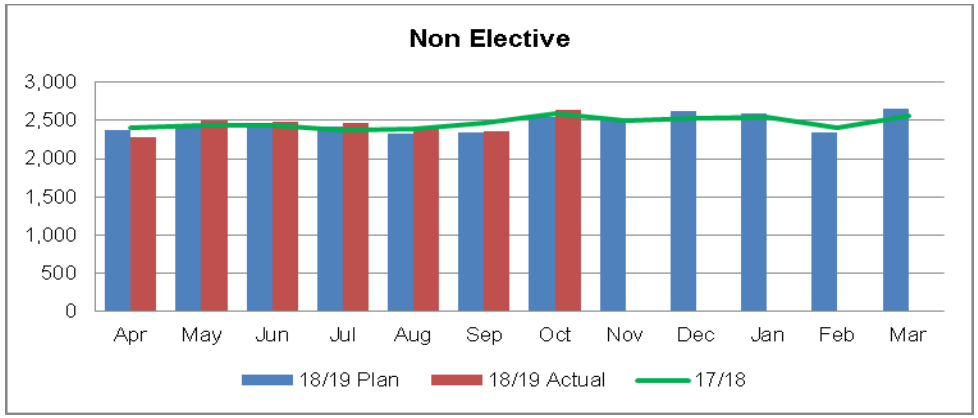


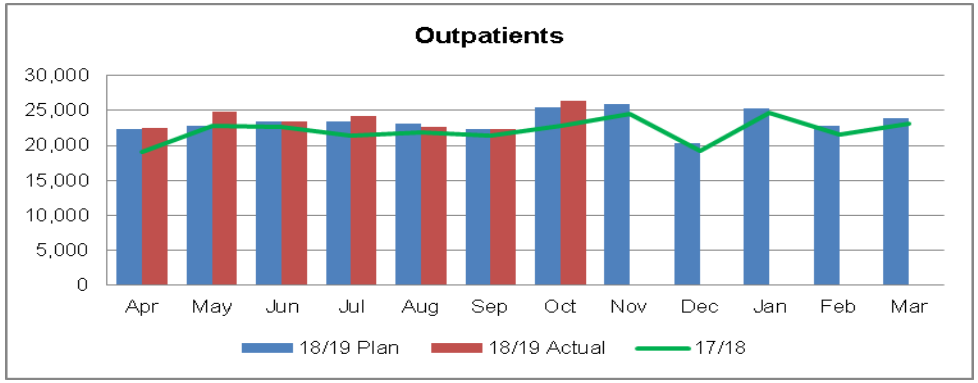
The income position was behind of plan for October. The main area of underperformance against the plan was seen within Other Services and Elective.

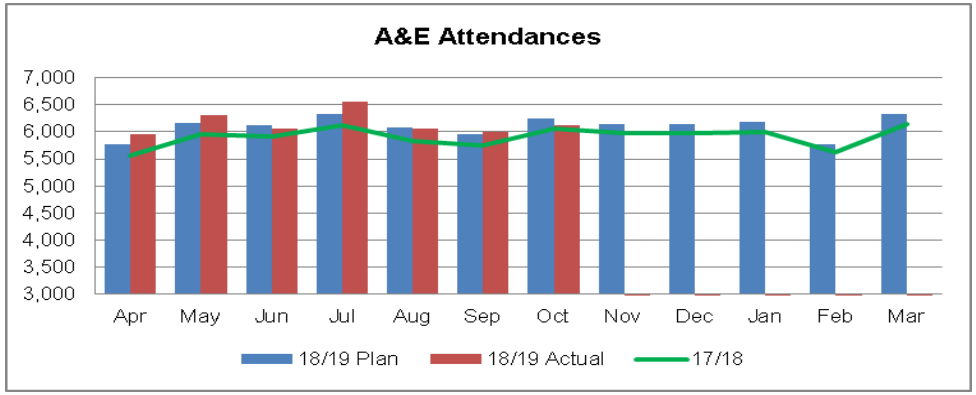
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	723	749	26	4,932	5,248	317
Other Services	2,003	1,362	(641)	13,769	13,718	(51)
CQUIN	332	345	12	2,218	2,223	4
Elective	2,978	2,918	(60)	20,784	19,056	(1,727)
Non Elective	5,675	5,961	286	37,686	38,156	470
Emergency Threshold Adjustment	(373)	(435)	(61)	(2,477)	(2,609)	(132)
Outpatients	3,081	3,371	290	19,745	20,805	1,059
Community	2,119	2,119	0	14,837	14,837	0
Total	**16,538**	**16,390**	**(148)**	**111,493**	**111,434**	**(60)**

Activity, by point of delivery

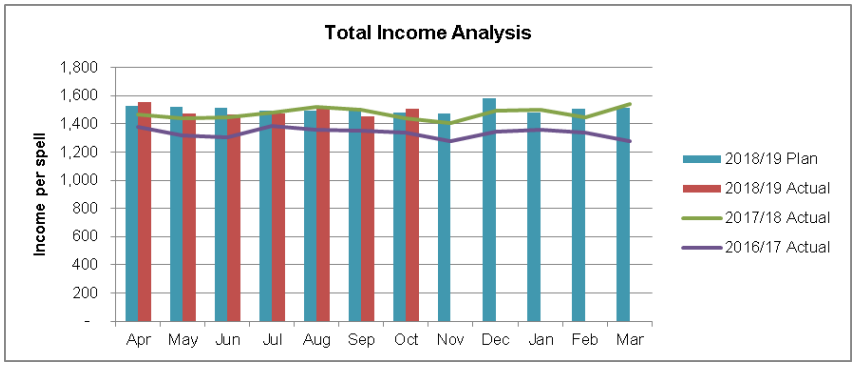


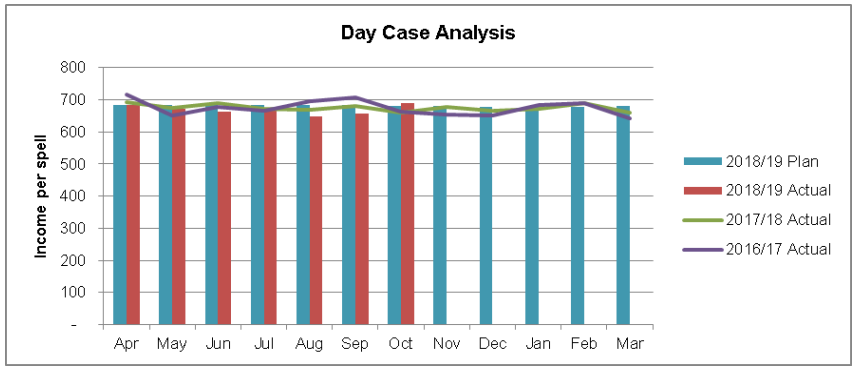


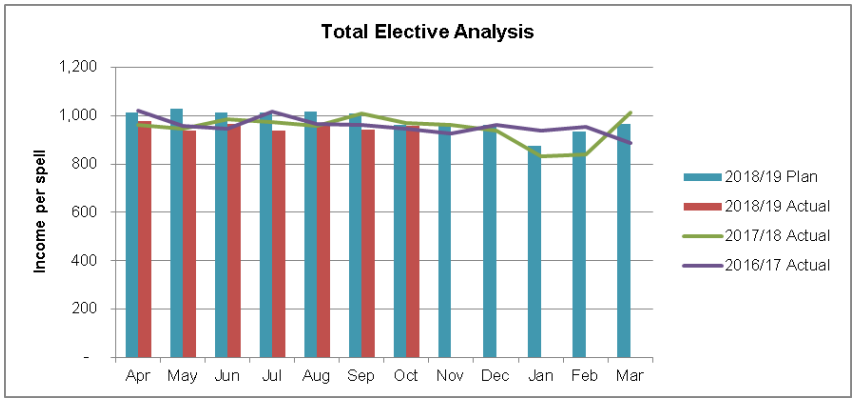


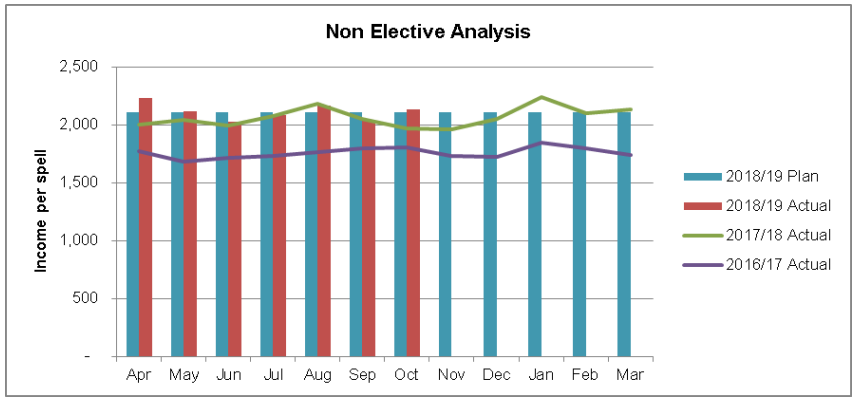


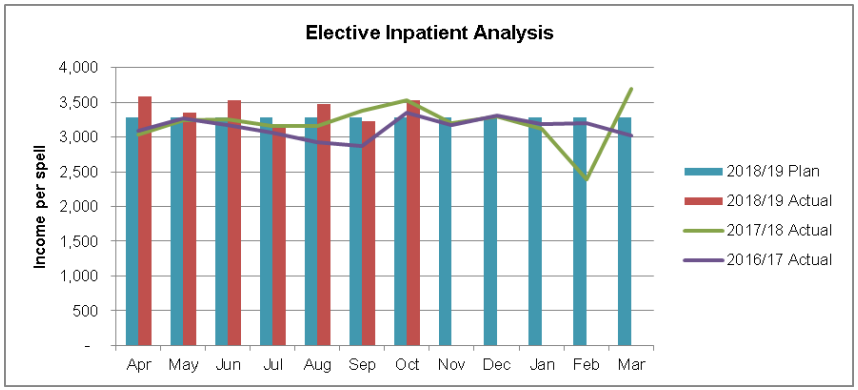
Trends and Analysis

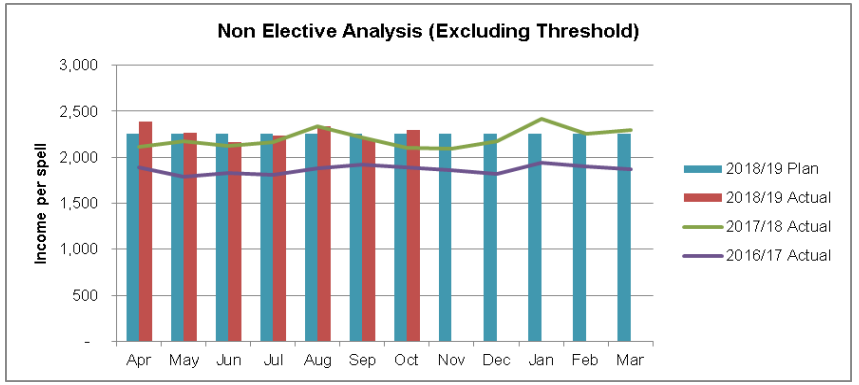












FINANCE AND WORKFORCE REPORT – October 2018

Workforce

Monthly Expenditure (£) Acute services only				
As at October 2018	Oct-18	Sep-18	Oct-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**11,843**	**11,691**	**10,810**	**81,280**
Substantive Staff	10,513	10,452	9,711	71,958
Medical Agency Staff (includes 'contracted in' staff)	247	185	41	1,436
Medical Locum Staff	260	210	306	1,685
Additional Medical sessions	338	248	238	1,860
Nursing Agency Staff	78	87	45	654
Nursing Bank Staff	265	372	182	2,295
Other Agency Staff	13	99	87	208
Other Bank Staff	144	150	121	993
Overtime	110	111	126	798
On Call	60	56	56	417
Total temporary expenditure	1,514	1,518	1,202	10,346
Total expenditure on pay	**12,027**	**11,970**	**10,913**	**82,304**
Variance (F/(A))	(185)	(279)	(103)	(1,024)
Temp Staff costs % of Total Pay	12.6%	12.7%	11.0%	12.6%
Memo : Total agency spend in month	338	371	173	2,298

Monthly Whole Time Equivalents (WTE) Acute Services only			
As at October 2018	Oct-18	Sep-18	Oct-17
	WTE	WTE	WTE
Budgeted WTE in month	**3,160.9**	**3,142.7**	**3,017.8**
Employed substantive WTE in month	2865.44	2789.32	2747.72
Medical Agency Staff (includes 'contracted in' staff)	18.42	16.78	7.28
Medical Locum	19.36	19.15	16.96
Additional Sessions	25.06	21.5	19.06
Nursing Agency	16.21	16.95	9.15
Nursing Bank	77.73	86.1	60.5
Other Agency	3.57	10.9	18.39
Other Bank	64.19	74.58	59.27
Overtime	32.5	31.39	35.16
On call Worked	6.96	6.65	8.01
Total equivalent temporary WTE	**264.0**	**284.0**	**298.7**
Total equivalent employed WTE	**3,129.4**	**3,073.3**	**3,037.0**
Variance (F/(A))	31.5	69.3	3.6
Temp Staff WTE % of Total Pay	8.4%	9.2%	9.8%
Memo : Total agency WTE in month	38.2	44.6	71.5
Sickness Rates	3.86%	3.86%	3.87%
Mat Leave	2.58%	2.89%	2.2%

Monthly Expenditure (£) Community Service Only				
As at October 2018	Oct-18	Sep-18	Oct-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,557**	**1,633**	**1,539**	**10,914**
Substantive Staff	1,463	1,499	1,384	10,476
Medical Agency Staff (includes 'contracted in' staff)	14	14	7	84
Medical Locum Staff	3	3	3	21
Additional Medical sessions	0	1	0	3
Nursing Agency Staff	7	3	(10)	50
Nursing Bank Staff	19	23	17	132
Other Agency Staff	(12)	(18)	17	45
Other Bank Staff	7	10	7	60
Overtime	8	7	6	54
On Call	3	3	1	21
Total temporary expenditure	51	47	48	470
Total expenditure on pay	**1,514**	**1,545**	**1,432**	**10,946**
Variance (F/(A))	43	88	107	(33)
Temp Staff costs % of Total Pay	3.3%	3.0%	3.4%	4.3%
Memo : Total agency spend in month	9	0	14	179

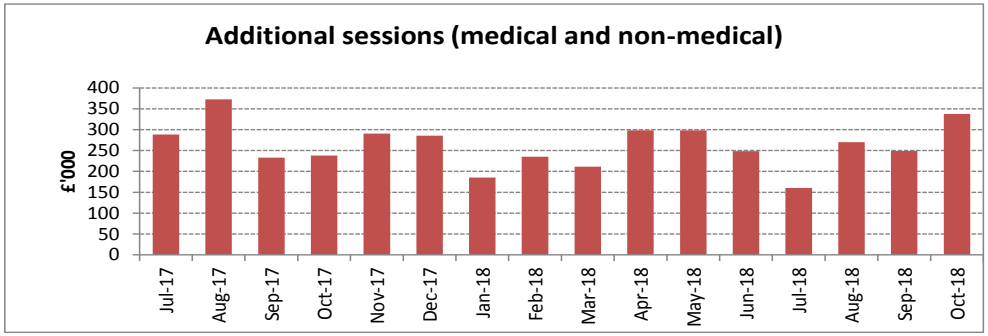
Monthly Whole Time Equivalents (WTE) Community Services Only			
As at October 2018	Oct-18	Sep-18	Oct-17
	WTE	WTE	WTE
Budgeted WTE in month	**485.78**	**486.93**	**501.92**
Employed substantive WTE in month	462.94	463.71	453.5
Medical Agency Staff (includes 'contracted in' staff)	0.92	0.92	0.5
Medical Locum	0.35	0.35	0.4
Additional Sessions	0.00	0.00	0.0
Nursing Agency	1.23	1.30	0.1
Nursing Bank	6.80	5.56	5.4
Other Agency	1.27	2.67	5.6
Other Bank	2.70	3.90	2.1
Overtime	2.54	1.94	2.2
On call Worked	0.00	0.00	0.0
Total equivalent temporary WTE	**15.81**	**16.64**	**16.1**
Total equivalent employed WTE	**478.75**	**480.35**	**469.6**
Variance (F/(A))	7.03	6.58	32.40
Temp Staff WTE % of Total Pay	3.3%	3.5%	3.4%
Memo : Total agency WTE in month	3.4	4.9	6.1
Sickness Rates (Sep / Aug)	3.85%	3.85%	3.51%
Mat Leave	3.36%	3.38%	1.4%

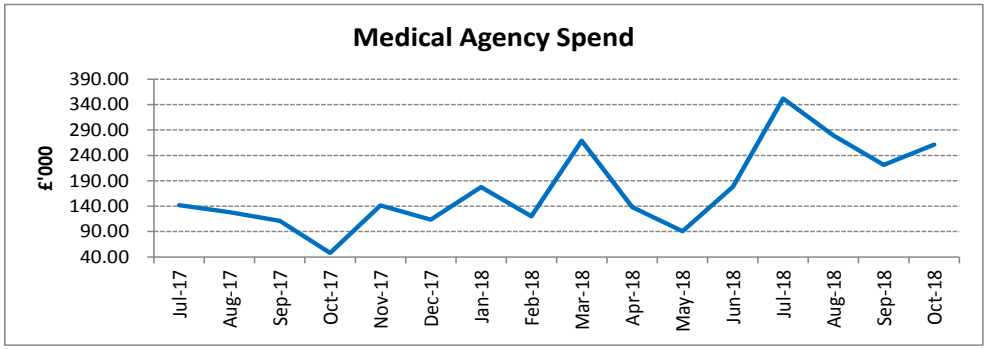
FINANCE AND WORKFORCE REPORT – October 2018

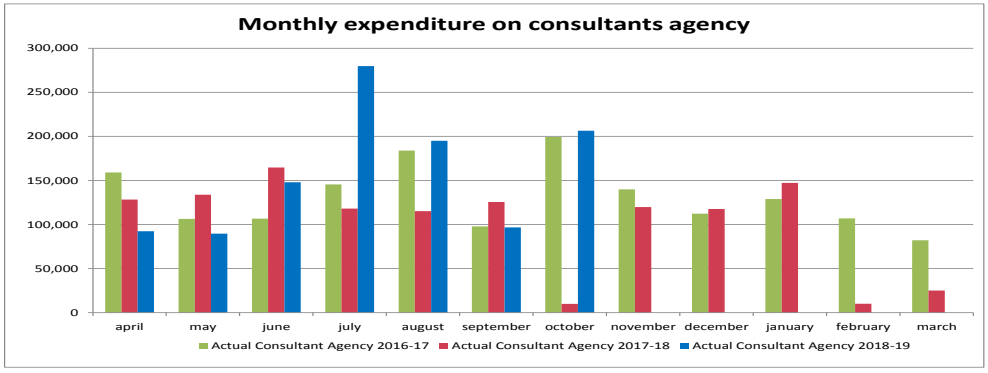
Pay Trends and Analysis

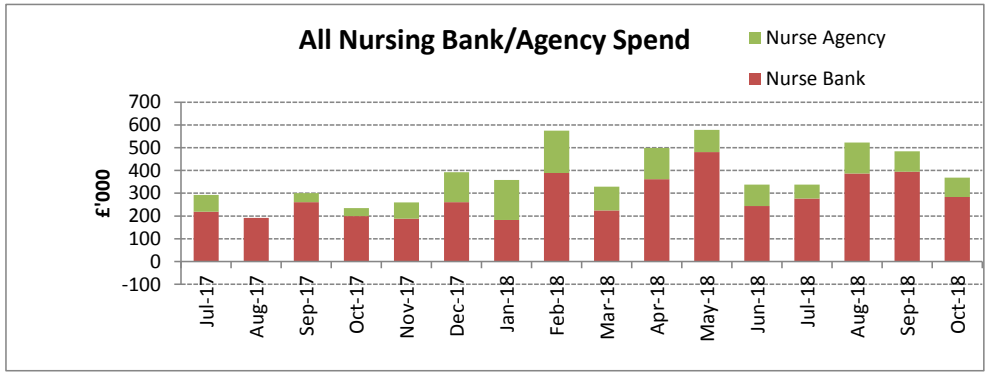
The Trust spent £142k more than budget on pay in October (£1,056k overspent YTD). This partly reflects the unfunded pay award which is estimated to be a cost pressure of £485k in 2018-19

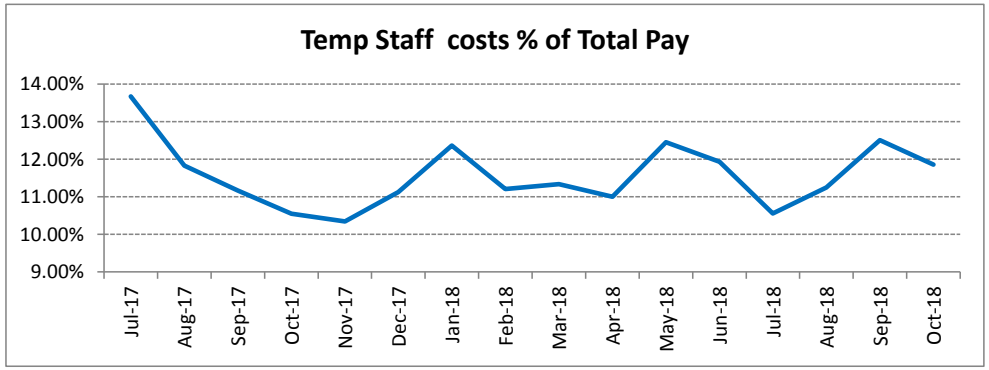
Medical Staff Agency Costs by Speciality	M7 - YTD £'000	M7 £'000
Anaesthetics	280.6	54.8
Urology	271.7	58.1
Gastroenterology	263.8	78.4
Xray - Wsh	237.8	39.7
Medicine - Junior Doctors	195.6	43.5
Eau Medical Staff	169.6	58.7
General Surgery	142.7	41.5
Clinical Haematology	133.8	(1.2)
Cardiology	133.6	7.3
Diabetes	123.4	39.6
Medicine - Consultants	103.7	(9.1)
Ophthalmology	89.6	18.0
Obstetrics	71.3	0.6
E.N.T.	70.8	15.1
Histopathology	65.2	2.1
Chest Medicine	63.7	0.8
Dermatology	61.7	7.0
Plastic Surgery	51.7	8.6
Total	**2,530.3**	**463.8**

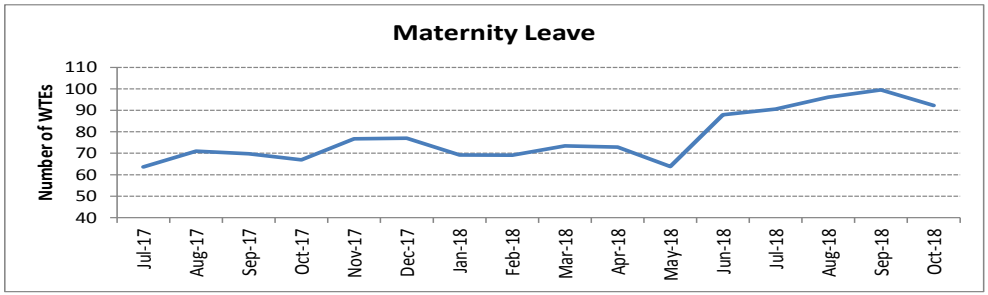












Staffing and recruitment

We have registered nursing vacancy rates significantly below other hospitals in the East of England (with some other hospitals reporting 25% RN vacancies)

In October the Trust had 81 vacancies for registered nursing posts on wards and A&E, as below. These were broadly covered through

- 26 WTE bank and overtime,
- 16 WTE agency staff and
- over-establishing unregistered staff by 33 WTE.

The net shortfall on registered nurses was therefore 38.8 WTEs. This is a significant improvement on September (59.4 WTE) with an over establishment of 43.8 WTE unregistered nurses

Registered Nursing - Ward	October - Vacancies (incl maternity leave)	October - Bank and overtime	October - Agency	October - Unfilled / (overstaffed)
Accident & Emergency	6.05	2.24	8.09	(4.28)
C.C.U.	2.12	0.78	0.00	1.34
Ward F9	7.38	2.07	0.43	4.88
Ward F10	4.88	0.43	0.34	4.11
Ward F12	2.61	0.56	0.12	1.93
Ward G1 Hardwick Unit	5.96	1.19	0.00	4.77
Cardiac Ward	2.51	0.50	0.32	1.69
Ward G4	3.76	1.07	0.12	2.57
Ward G5	5.87	0.65	0.12	5.10
Ward G8	10.43	0.58	4.09	5.76
Ward F1 Paediatrics	6.13	4.53	0.00	1.60
Ward F3	4.08	1.95	0.01	2.12
Ward F4	1.95	0.63	0.00	1.32
Ward F5	(2.84)	0.47	0.00	(3.31)
Ward F6	5.35	2.41	0.83	2.11
Gynae Ward (On F14)	(0.61)	0.36	0.00	(0.97)
Neonatal Unit	1.88	0.51	0.00	1.37
Ward F8 Ambulatory Core	(1.72)	2.38	1.11	(5.21)
Ward F7 Short Stay	11.73	1.44	0.13	10.16
Ward G9 Escalation Ward	0.00	0.00	0.50	(0.50)
Community - Glastonbury Court	(0.42)	0.32	0.00	(0.74)
Newmarket Hosp-Rosemary ward	4.24	1.31	0.00	2.93
Total	**81.34**	**26.38**	**16.21**	**38.75**

Unregistered Nursing - Ward	October - Vacancies (incl maternity leave)	October - Bank and overtime	October - Unfilled / (overstaffed)
Accident & Emergency	3.61	1.41	2.20
C.C.U.	0.94	0.44	0.50
Ward F9	3.13	4.72	(1.59)
Ward F10	0.67	1.58	(0.91)
Ward F12	(1.53)	1.25	(2.78)
Ward G1 Hardwick Unit	(1.15)	0.54	(1.69)
Cardiac Ward	0.94	4.11	(3.17)
Ward G4	4.26	4.91	(0.65)
Ward G5	4.49	4.23	0.26
Ward G8	0.61	3.91	(3.30)
Ward F1 Paediatrics	0.25	0.52	(0.27)
Ward F3	2.73	0.83	1.90
Ward F4	1.91	1.15	0.76
Ward F5	2.47	1.84	0.63
Ward F6	2.40	2.01	0.39
Gynae Ward (On F14)	1.00	0.05	0.95
Neonatal Unit	(0.15)	0.20	(0.35)
Ward F8 Ambulatory Core	(13.80)	3.20	(17.00)
Ward F7 Short Stay	(2.96)	2.65	(5.61)
Ward G9 Escalation Ward	(4.22)	0.00	(4.22)
Community - Glastonbury Court	(0.05)	0.50	(0.55)
Newmarket Hosp-Rosemary ward	2.26	0.64	1.62
Total	**7.81**	**40.69**	**(32.88)**

Recruitment of Registered Nurses

The additional capacity required for winter requires around 16 additional registered nurses and 16 additional unregistered nurses.

- 3 overseas nurses passed their OSCE on 12th November 2018
- 4 overseas Nurses are booked for their OSCE on 11th December 2018
- 4 overseas nurses are booked for their OSCE on 17th December 2018.
- 3 overseas nurses are booked for their OSCE on 19th December 2018.
- 5 overseas nurses are due to arrive on 29th November 2018.
- 34 agency nurses are currently going through Ecare and have offered to work 3 long day shifts
- We have offered enhanced shift payments to RNs which is resulting in staff offering to work additional shifts, specifically on wards G4, G8 and F6. This results in staff being released to staff the additional winter capacity required.

There are a further 8 registered nurses confirmed as starting during November, December and January. These nurses are effectively filling our usual turnover, (which is around 2.5 WTEs per month).

Summary by Division

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Oct-18 Budget £k	Oct-18 Actual £k	Oct-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	(6,087)	(6,372)	285	(40,188)	(41,070)	882
Pay Costs	3,507	3,682	(175)	24,784	25,758	(974)
Non-pay Costs	1,338	1,541	(202)	9,575	9,720	(146)
Operating Expenditure	**4,845**	**5,223**	**(378)**	**34,358**	**35,478**	**(1,120)**
SURPLUS / (DEFICIT)	**1,242**	**1,149**	**(93)**	**5,829**	**5,592**	**(237)**
SURGERY						
Total Income	(5,249)	(5,441)	193	(35,663)	(35,034)	(628)
Pay Costs	3,030	3,157	(127)	21,053	21,260	(207)
Non-pay Costs	1,196	1,251	(55)	8,192	8,244	(52)
Operating Expenditure	**4,225**	**4,407**	**(182)**	**29,244**	**29,504**	**(259)**
SURPLUS / (DEFICIT)	**1,023**	**1,034**	**10**	**6,418**	**5,531**	**(887)**
WOMENS and CHILDRENS						
Total Income	(2,328)	(2,384)	56	(14,391)	(13,957)	(434)
Pay Costs	1,141	1,207	(66)	7,957	8,282	(324)
Non-pay Costs	155	173	(18)	1,090	1,128	(38)
Operating Expenditure	**1,296**	**1,380**	**(85)**	**9,047**	**9,409**	**(362)**
SURPLUS / (DEFICIT)	**1,033**	**1,004**	**(29)**	**5,344**	**4,548**	**(796)**
CLINICAL SUPPORT						
Total Income	(874)	(880)	7	(5,851)	(5,926)	74
Pay Costs	1,394	1,418	(24)	9,703	9,624	78
Non-pay Costs	1,037	1,041	(3)	7,276	7,429	(153)
Operating Expenditure	**2,431**	**2,459**	**(28)**	**16,978**	**17,053**	**(75)**
SURPLUS / (DEFICIT)	**(1,558)**	**(1,579)**	**(21)**	**(11,127)**	**(11,127)**	**(1)**
COMMUNITY SERVICES						
Total Income	(3,290)	(3,235)	(55)	(22,115)	(22,124)	8
Pay Costs	2,051	2,017	34	14,312	14,323	(10)
Non-pay Costs	1,205	997	208	6,810	6,839	(29)
Operating Expenditure	**3,256**	**3,014**	**242**	**21,123**	**21,162**	**(39)**
SURPLUS / (DEFICIT)	**34**	**221**	**187**	**993**	**962**	**(31)**
ESTATES and FACILITIES						
Total Income	(332)	(376)	44	(2,625)	(2,494)	(131)
Pay Costs	787	782	5	5,530	5,465	65
Non-pay Costs	586	715	(129)	4,038	4,135	(97)
Operating Expenditure	**1,374**	**1,498**	**(124)**	**9,568**	**9,600**	**(32)**
SURPLUS / (DEFICIT)	**(1,042)**	**(1,122)**	**(80)**	**(6,943)**	**(7,106)**	**(164)**
CORPORATE (excl reserves)						
Total Income	(2,697)	(2,362)	(335)	(15,169)	(14,980)	(188)
Pay Costs	1,489	1,278	211	8,855	8,538	317
Non-pay Costs (net of contingency and reserves)	1,343	1,097	247	7,614	6,842	772
Finance & Capital	536	710	(174)	5,553	5,120	433
Operating Expenditure	**3,368**	**3,084**	**284**	**22,022**	**20,500**	**1,522**
SURPLUS / (DEFICIT)	**(672)**	**(722)**	**(51)**	**(6,853)**	**(5,520)**	**1,333**
TOTAL (including reserves)						
Total Income	(20,855)	(21,049)	194	(136,003)	(135,585)	(417)
Pay Costs	13,399	13,541	(142)	92,193	93,250	(1,056)
Non-pay Costs	6,861	6,815	46	44,595	44,337	258
Finance & Capital	536	710	(174)	5,553	5,120	433
Operating Expenditure (incl penalties)	**20,796**	**21,065**	**(270)**	**142,341**	**142,707**	**(365)**
SURPLUS / (DEFICIT)	**60**	**(16)**	**(76)**	**(6,339)**	**(7,122)**	**(783)**

Note the clinical income figures are as earned within each Division as opposed to the contractual value (the adjustment to the block value is posted to Corporate, alongside other non-division specific income such as CQUIN and Excluded Drugs).

Medicine (Nicola Cottington)

The division was £111k ahead of plan for the month, (£171k adverse YTD).

Pressures from meeting National Targets (ED 4 hour, RTT 18 weeks and diagnostic 6 weeks) influenced contract income (£301k above plan), but this over performance was negated by the expenditure required to support this activity.

In October the Trust saw 92.75% of patients within 4 hours. Whilst below the national target (95%), experience in November shows this continuing, so that the Trust is on track to secure additional funding for the quarter by exceeding 90%. GP streaming reversed its improved performance from the previous two months and saw just 12.1 patients per day against a capacity of approximately 40 per day. ED attendances were 4.56% above plan (not including GP expected and Streaming) resulting in income being £26k above plan.

In terms of patient flow, the middle of the month was anticipated to be one of the most challenging periods of the year, and additional staff were commissioned to mitigate the impact. ED and AMU Medical staffing were overspent by £61k and £55k respectively, covering middle grade vacancies and the expected pressures. The former may be alleviated with two new Registrars starting in January. Nursing costs across these two areas was overspent by £65k (£47k spent on agency and £20k on overtime), helping to support flow.

The Division achieved 94.9% (95.5% in September) seen within 18 weeks, and 99.8% of echos and 97.9% of endoscopies (targets 92% and 99% respectively). Trust wide the RTT (18 week target) was not met, but the Diagnostic waits target was achieved. To secure this performance, resources were especially concentrated on Gastroenterology – the only specialty in the Division failing RTT, and involved in endoscopies. Additional sessions, and cover for a vacancy resulted in a £66k overspend. Other areas affected were Diabetes, Dermatology (both demand and vacancy) and Cardiology. Demand for these areas within Suffolk appear to be increasing, but are potentially exacerbated by issues in surrounding trusts, most notably Papworth (Cardiology), N&N (Dermatology) and Colchester (Respiratory). The issues at King's Lynn are well publicised, but due to distances should not have a significant impact on WSFT.

Activity pressures meant that CIP performance was well below target (£171k versus £333k), with schemes on Drugs, additional sessions and patient transport most significantly affected.

FINANCE AND WORKFORCE REPORT – October 2018

Surgery (Simon Taylor)
The division has overperformed by £10k in month (£887k overspent YTD).

Clinical income over achieved by £214k. Outpatient activity over achieved by £158k and admitted elective care by £41k. General Surgery significantly over achieved plan on admitted care (£113k), and Ophthalmology and Urology were the top performing specialities for Outpatients (£47k & £41k respectively).

Pay is over spent by £127k. The main driver for this is additional sessions, relating to long-term sickness and vacancy cover, as well as support for RTT. There is also a cost pressure relating to temporary cover for junior doctors, broadly due to vacancies and sickness. These pressures are offset somewhat by under spends relating to Nursing and Admin posts.

Non-pay is over spent by £55k. This mainly relates to prosthesis, which mirrors the increase in activity reported in month.

Women and Children's (Rose Smith)
In October the division is behind plan by £29k (£796k YTD).

Income reported £56k ahead of plan in-month and is £434k behind plan YTD. In month, neonatal activity was higher than planned. Year to date, both elective and non-elective inpatient activity has been behind plan which explains the majority of the year to date variance.

Pay reported a £66k overspend in-month and is £324k overspent YTD. In-month, a locum consultant was employed to cover long term sickness in Paediatrics and additional consultant cover was arranged to address some of the RTT pressures in Obstetrics & Gynaecology. Year to date, the medical staffing issues in Obstetrics & Gynaecology have been an issue and the long term consultant sickness has put pressure on the Paediatric budget.

Non pay reported an £18k overspend in-month and is £38k overspent YTD. The in-month overspend was driven by increased expenditure on drugs and MSE. The YTD overspend has been driven by part-pathway charges for West Suffolk patients who have given birth at other trusts.

Clinical Support (Rose Smith)
In October, the division overspent by £21k (£1k YTD).

Income for Clinical Support reported £7k ahead of plan in-month and is £74k ahead of plan YTD. In month, the Radiology Department saw a higher number of direct access and breast screening patients. This has also driven the year to date position which has been supplemented by higher volumes of radiology outpatient activity.

Pay is £24k overspent in-month and is £78k underspent YTD. In month, the majority of the overspend has been driven by consultant medical staffing pressures in Radiology. Year to date, the Radiology and Pharmacy departments have not been able to fully backfill their vacancies with bank, agency and overtime.

Non pay reported a £3k overspend in-month and is £153k overspent YTD. Year to date, the underlying pressures from the HODS element of the Pathology contract continue to put pressure on the division's budget.

Community Services (Dawn Godbold)
The division reported a £187k underspend in month (£31k overspent YTD).

Overall income reported £55k under plan in month (£8k over plan YTD). This is mainly due to an under-recovery of contract income (£42k), of which £35k relates to an accrual in respect of underactivity relating to Central Equipment Services for the quarter July – September 18.

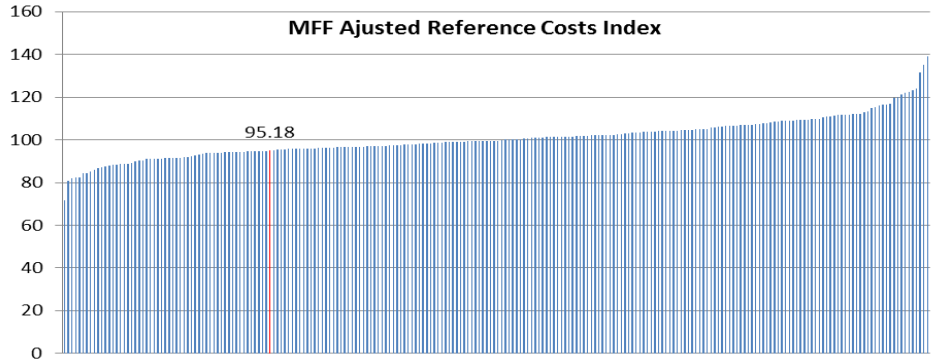
Pay reported a £34k underspent in month and £10k overspend YTD. In-month underspend is due to a number of vacancies across the division mainly in Community Health Teams.

Non pay reported a £208k underspend in month (£29k overspend YTD). The in-month underspend is primarily due to the Community Equipment Service, which is a combination of new contract savings and a stock adjustment following the change in contract relating to Peripheral Stores stock ownership.

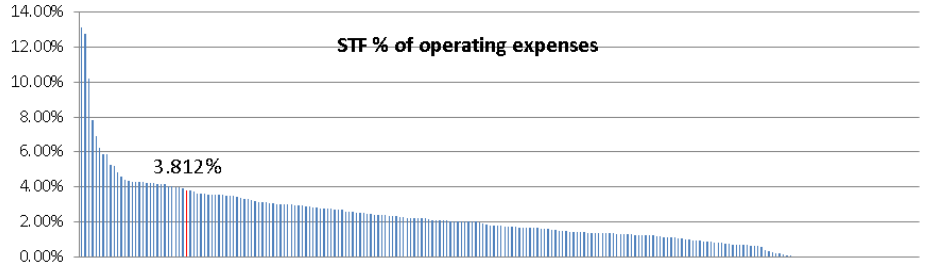
WSFT Reference Costs Analysis 2017-18

The **Organisation-Wide** Reference Costs Index (RCI) is a measure of efficiency against all providers of NHS care in England. The average score is 100 and those scoring greater than 100 have spent more than average to deliver similar care whilst those scoring under 100 cost less than average.

The RCI is available as both adjusted and unadjusted for the Market Forces Factor (MFF). The MFF is an adjustment for unavoidable differences in costs across different regions of the country, for example the cost of land. WSFT scores an MFF adjusted RCI of 95 and is within best performing quartile of provider Trusts in England, as shown on the chart opposite, where each line represents an organisation's RCI score.

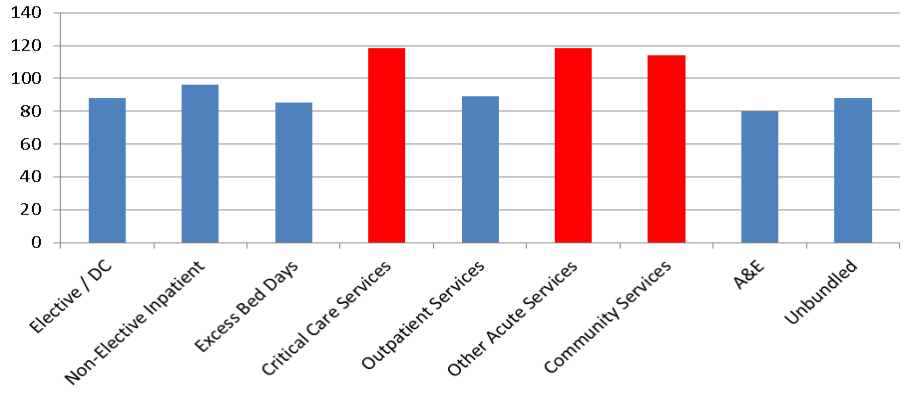


Although this shows the Trust is efficient, it is a decline from the prior year's score of 86. There has been a change in the collection guidance in 2017/18. The Sustainability and Transformation Fund (STF) is now excluded from the collection whereas in previous years it reduced the costs reported. The second graph demonstrates that, as a percentage of total operating expenses, the Trust was in the top 25% for the amount of STF received and therefore this change in treatment in-part explains the movement in RCI score



The effect of Community Services has also worsened our overall index. Due to data collection difficulties Community Services tend to score highly against Acute Services skewing our overall RCI score upwards). Without community services our acute services only would place WSFT in the top 10 acute trusts.

By Department, the Trust scores better than average in most areas with the exception of Other Acute, Critical Care and Community Services, as shown on the chart opposite where the average at WSFT is represented by the red bars.



Critical Care is a low volume/ high cost service where unit cost can vary with relatively low volume fluctuations. This also makes it sensitive to changes in cost allocations and further review of the costing methodology is required.

The 'Other Acute Services' category relates to Direct Access Services and this variation is likely to relate to an allocation issue.

Community Services include the contract change in October 2017. Further work is required to improve cost allocations going forward for the new contract structure and to ensure accurate collection of activity data.

Use of Resources (UoR) Rating

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

The key features of the UOR ratings are as follows:

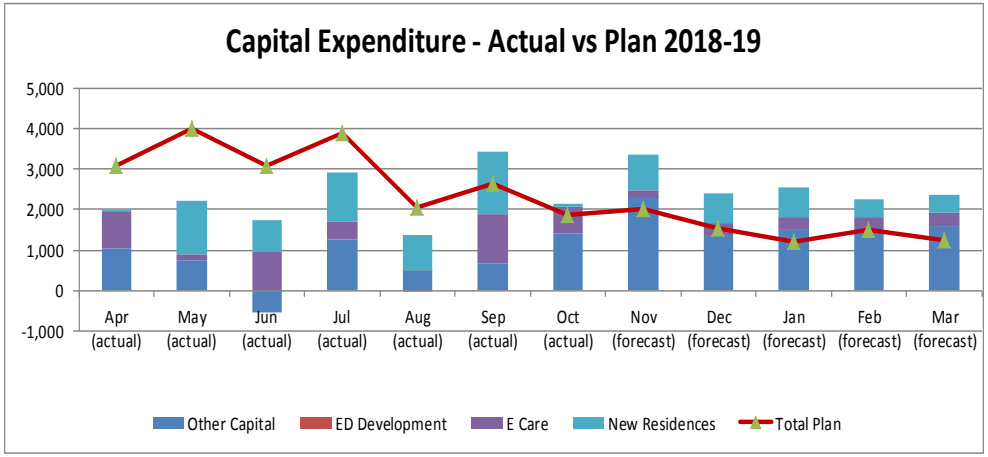
- 1 is the highest score and 4 is the lowest
- The I&E margin ratio is based on a control total basis rather than normalised surplus (deficit).
- The Agency rating measures expenditure on agency staff as a proportion of the ceiling set for agency staff. A positive value indicates an adverse variance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

Metric	Value	Score
Capital Service Capacity rating	-0.626	4
Liquidity rating	-17.553	4
I&E Margin rating	-5.20%	4
I&E Margin Variance rating	0.50%	1
Agency	-24.43%	1
Use of Resources Rating after Overrides		3

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

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

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2018-19 £'000
E Care	916	131	975	457	-11	1,217	670	188	290	290	290	324	5,737
ED Development	0	0	0	0	9	0	0	20	0	0	20	0	50
New Residences	37	1,329	773	1,210	903	1,557	57	878	728	728	478	435	9,112
Other Schemes	1,047	760	-555	1,259	471	658	1,401	2,281	1,369	1,516	1,484	1,597	13,287
Total / Forecast	1,999	2,220	1,193	2,926	1,372	3,432	2,128	3,367	2,387	2,534	2,272	2,356	28,186
Total Plan	3,098	4,022	3,098	3,911	2,041	2,638	1,876	2,007	1,551	1,221	1,497	1,226	28,186

The capital programme for the year is shown in the graph above. The reconfiguration of ED has largely been removed from the 2018/19 plan because a bid is being submitted for Wave 4 capital funding which, if successful, will be available during 2019/20. The expenditure represents design and feasibility costs already committed.

Expenditure on e-Care for the year to date is £4,186k with a forecast for the year of £5,737k.

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 plus there is slippage on Residences compared to plan. The next phase of the roof replacement programme commenced slightly later than the original plan forecast.

As part of the capital plan the estates projects are committed to slippage totalling £1,217k currently there is only £287k slippage to find.

Statement of Financial Position at 31st October 2018

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2018 * £000	Plan 31 March 2019 £000	Plan YTD 31 Oct 2018 £000	Actual at 31 Oct 2018 £000	Variance YTD 31 Oct 2018 £000
Intangible assets	23,852	27,909	26,462	26,991	529
Property, plant and equipment	94,170	111,399	106,692	102,650	(4,042)
Trade and other receivables	3,925	3,925	3,925	3,925	0
Other financial assets	0	0	0	0	0
Total non-current assets	**121,947**	**143,233**	**137,079**	**133,566**	**(3,513)**
Inventories	2,712	2,700	2,700	2,577	(123)
Trade and other receivables	21,413	19,500	18,500	22,648	4,148
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	3,601	1,050	3,050	1,338	(1,712)
Total current assets	**27,726**	**23,250**	**24,250**	**26,563**	**2,313**
Trade and other payables	(26,135)	(27,499)	(26,433)	(23,910)	2,523
Borrowing repayable within 1 year	(3,114)	(3,357)	(3,373)	(3,083)	290
Current ProvisionsProvisions	(94)	(26)	(26)	(94)	(68)
Other liabilities	(963)	(1,000)	(6,500)	(8,188)	(1,688)
Total current liabilities	**(30,306)**	**(31,882)**	**(36,332)**	**(35,274)**	**1,058**
Total assets less current liabilities	**119,367**	**134,601**	**124,997**	**124,855**	**(142)**
Borrowings	(65,391)	(90,471)	(78,590)	(75,499)	3,091
Provisions	(124)	(158)	(158)	(124)	34
Total non-current liabilities	**(65,515)**	**(90,629)**	**(78,748)**	**(75,622)**	**3,126**
Total assets employed	**53,852**	**43,972**	**46,249**	**49,232**	**2,983**
Financed by					
Public dividend capital	65,803	66,103	65,803	68,308	2,505
Revaluation reserve	8,021	8,021	8,021	8,021	0
Income and expenditure reserve	(19,974)	(30,152)	(27,575)	(27,096)	479
Total taxpayers' and others' equity	**53,850**	**43,972**	**46,249**	**49,232**	**2,983**

Non-Current Assets

There is some slippage on the capital programme, mainly on Residences and implicit finance leases, although GDE is ahead of plan.

Trade and Other Receivables

These have increased by £3.0m in October and are £4.1m higher than planned. This is mainly due to amounts outstanding from ESNEFT, Chrystal and Health Education England which have now been received. In additions PSF for Q2 is outstanding and GDE income has been recognised but not received.

Cash

Managing the cash position was a challenge towards the end of October. Receivables outstanding as referred to previously, combined with the capital PDC application for £8.1m being outstanding still presented a significant difficulties. The position towards the end of November will again become critical and this situation will happen every month until the outcome of the capital PDC application is known and GDE revenue is received following final sign off of the milestones achieved.

Trade and Other Payables

This is money owed to other organisations. Payables have increased by £0.4m since September but are £2.5m less than estimated in the plan for October. This is mainly due to slippage on capital.

Other liabilities

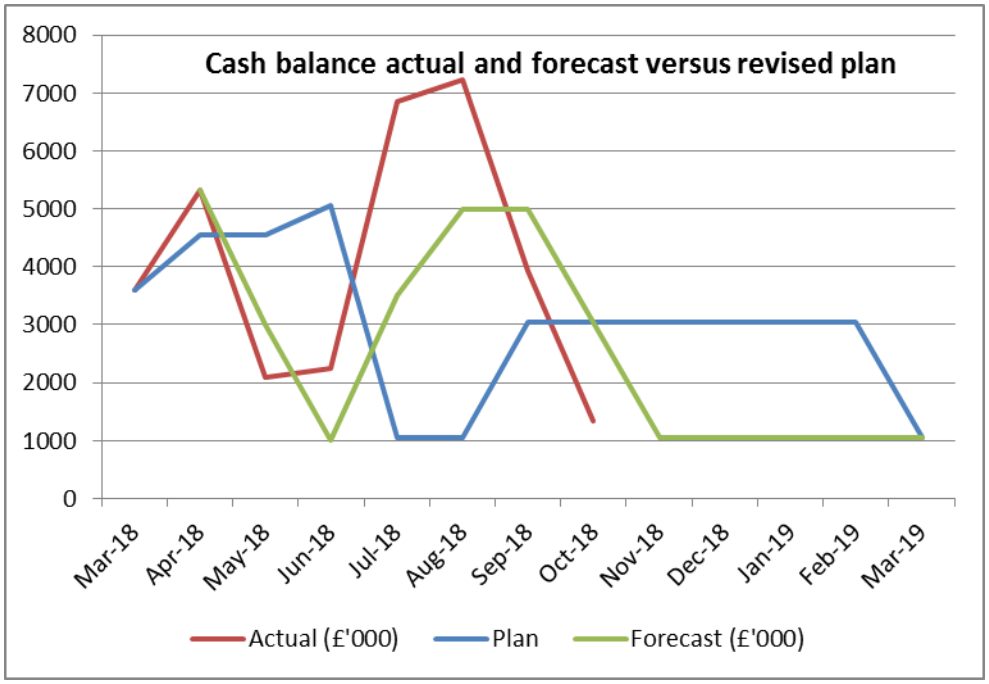
This balance reflects the difference between the income received, mainly for patient care, and the amount that we are able to recognise following the delivery of service. This balance has now started to decrease as the payments from the CCG have reduced in line with plan. The variance relates to a deliberate acceleration of the cash received in August which is not recognised as income until it has been earned.

Borrowing

The small increase in borrowing for October related to revenue deficit borrowing in line with our revenue deficit control total plan. However borrowing is less than plan because it was assumed that we would have drawn down more capital borrowing at this point in the year than we have. This is partly due to slippage on the capital programme but also because the assumed capital loan has been replaced by a £8.1m PDC application and the decision on this is now critical.

PDC is higher than planned because the Trust has been awarded £2.3 million capital PDC for the first phase of the Acute Assessment Unit expected to open by the end of November 2018. PDC does not have to be repaid but does attract a cash charge of 3.5% per annum. This cash has now been received.

Cash Balance Forecast for the year



The graph illustrates the cash trajectory since March, plan and revised forecast. The Trust is required to keep a minimum balance of £1 million.

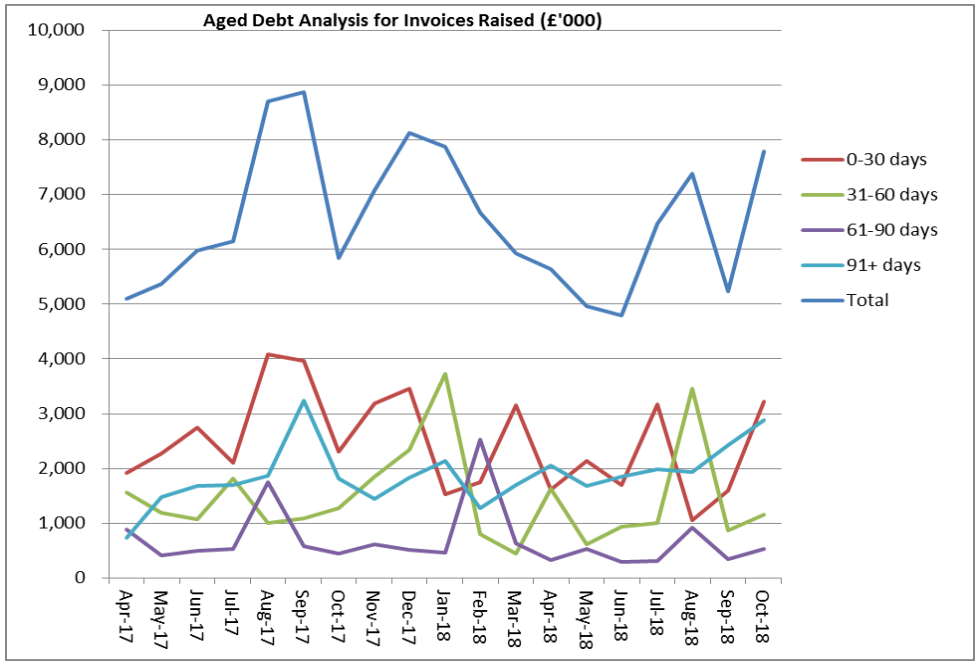
The 2017/18 STF (£5.3m) was paid earlier than expected in July with no notice.

The timing of agreement from DH on the required £8.1m PDC funding or borrowing for the 2018/9 capital programme is still uncertain and is now critical. It is assumed the cash balance will now be at the minimum level required until the year end although some receipts are difficult to predict e.g. PSF and PDC so there may still be some unexpected increases temporarily.
The profiling of the CCG contract payments reduces significantly from October onwards following accelerated payments in the first half of the year.
The Trust is borrowing cash from DH equivalent to its control total deficit of £10.2m in 2018/19 in addition to capital borrowing. Payments to suppliers may have to be delayed if a positive decision on the PDC application is not received soon.

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 increased by £2.6m in October. This is mainly due to outstanding invoices to ESNEFT for pathology recharges, HEE for an adjustment (increase) to the Learning and Development agreement and invoices to Chrystal relating to the Cath Lab Managed Service. Most of these balances have cleared since the month end.

Old balances remain with Cambridge University Hospital NHS Foundation Trust (Addenbrookes), mainly relating to Newmarket, and Ipswich Hospital NHS Trust prior to their merger with Colchester for charges relating to Community Services.

11. EU Exit report

To ACCEPT the report

For Report

Presented by Helen Beck

Trust Board Meeting– 30 November 2018

Agenda item:	11			
Presented by:	Helen Beck			
Prepared by:	Alex Baldwin, Barry Moss			
Date prepared:	07 November 2018			
Subject:	EU Exit Impact Assessment and Contingency Planning			
Purpose:		For information	x	For approval

Executive summary:

Scrutiny committee has requested a briefing on the impact of the EU Exit as part of the Trust's emergency preparedness arrangements (including a review of supplier risk).

The Trust has contributed to cross-organisation consultation as part of our response to a Suffolk Resilience Forum request for our pre-EU Exit preparatory plans and a letter from Secretary of State, Department of Health and Social Care regarding preparatory arrangements relating to purchasing.

This paper sets out preparatory work underway as well as identifying plans for future resilience initiatives. Due to the current uncertainty regarding any future deal it is expected that these plans will be revised following national, regional, sector or local impact analysis which is anticipated in the coming months.

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:	Scrutiny committee
Risk and assurance:	A lack of sufficient planning time given by national, regional and local organisations within our chain of authority. Competing and greater operational priorities at the time of announcement concerning winter pressures, flu etc
Legislation, regulatory, equality, diversity and dignity implications	

Recommendation: The Board are asked to note the current position and support the proposed development plan.

Background

The EU Exit deal is expected to be announced around 13-14th December 2018. It is also anticipated that advance notifications of the impact / consequences of the deal will emerge from DHSC before then, thereby allowing additional planning to be undertaken.

To date, the Secretary of State has written (letter dated 12/10/18) to all trust chief executives to advise of the requirements to ensure continuity of supply of goods and services in the event of a no deal EU Exit. A pack of materials has been received by each trust's head of procurement, including a self-assessment methodology to use to identify contracts that may be impacted by the EU Exit. The letter asks for the appointment of a board-linked Senior Responsible Officer to oversee this work and a summary of contracts deemed highly impacted, with mitigating activities, by 30 November. The pack also includes a list of categories and suppliers that are being managed by DHSC, such as the supply of medicines. Trusts have been asked to ignore considering those suppliers to date, and concentrate on their own suppliers not on the centralised list to determine what the EU exit may mean to them.

Furthermore, the Suffolk Resilience Forum (SRF) has asked for the Trust to analyse the Technical Notes issued thus far by central government and provide feedback. NHS England have informed the SRF that we will not be responding to them as yet and directed that we ignore this request until further notice.

Current Position

We can anticipate that the immediate areas of concerns can be grouped in two categories, procurement and staffing.

These can be further grouped as follows:

Procurement:

- Procurement contracts
- Supplier dependency (1st, 2nd and 3rd order suppliers)
- Access to materiel stocks and their sustainability post-deal.
- Raised costs of products in short-supply, in competition with other organisations, or artificially elevated by the supplier due to the circumstances.
- Delays in supply, in processing staff applications (see attached email for assurances/process)

Staffing:

- Ability to retain existing EU workforce.
- Ability to attract additional workforce from EU member states.
- The recruitment, retention, training and qualifying of staff, thereby impacting on current sustainability and staff morale.

Forward Planning

<u>Procurement:</u>

In response to the Secretary of State request the procurement team have reviewed the Trusts Top 500 suppliers. Of these 89 have been identified as being "in scope" for local review [suppliers of the following items are being reviewed nationally so are "out of scope" at this time: food, pharmacy, utilities, medicines supply, NHS supply chain suppliers].

In line with the Department of Health and Social Care guidance the Trust has undertaken an initial review of these suppliers and will facilitate an internal workshop with key departments; estates and facilities, EBME, IT and purchasing. This workshop is scheduled to take place on 23 November. Risk assessments will be undertaken with each department and will form the basis of further action planning as required. In support of this work all "in scope" suppliers will be asked to provide plans for a no EU Exit deal in advance of the workshop.

In addition divisions, via the Associate Directors of Operations, have been asked to identify supplies, which whilst small in monetary value, would have a significant impact on business operation should they become unavailable for any reason.

The procurement team is leading this work and is in weekly teleconference dialogue with the Department of Health and Social Care.

Staffing:

The impact on existing European Economic Area (EEA) workers is emerging. As at 02 November 2018 the Trust has 240 identified EEA staff members with a further 406 of unknown origin.

The Home Office has announced plans to afford health workers rights to gain status to remain in the UK via a new settlement scheme. The scheme opens to employees of the health and social care sector on 1st November 2018 and provides employees with settled status unrestricted rights to remain once they have been living in the UK continuously for 5 years.

In support of staff from EEA areas the Trust proposes to fund the application fee (a cost of c.30k is anticipated) and the HR team will develop a package of support for staff members considering the option of seeking settled status.

The Trust has also received guidance on the recognition of professional qualifications. Notice, received on 12 October, states that, in the event of no deal, the Mutual Recognition of Professional Qualifications (MRPQ) Directive will no longer apply to the UK. The government will develop a new recognition procedure for EEA professionals which will differ from existing arrangements (for example, automatic recognition and temporary access to regulated activities on the basis of a declaration will no longer be applicable). The government will work with the devolved nations and the regulatory bodies to ensure a UK-wide system of recognition.

The notice sets out that:

- EEA professionals (including UK nationals holding EEA qualifications) who are already established and have received a recognition decision in the UK, will not be affected and their existing recognition decision will remain valid.
- EEA professionals (including UK nationals holding EEA qualifications) who have not started an application for a recognition decision in the UK before exit will be subject to future arrangements, which will be published before exit day.
- EEA professionals (including UK nationals holding EEA qualifications) who have applied for a recognition decision and are awaiting a decision on exit day will, as far as possible, be able to conclude their applications in line with the provisions of the MRPQ Directive.

Business continuity planning:

The revised command, control and co-ordination (C3) plan provides a framework for the operational, tactical and strategic management of evolving threats and risks the organisation faces. This model builds on processes we use day-to-day as business as usual and provides a clear framework for use in an escalated scenario (such as a major incident). It is therefore appropriate to use the same tools for the preparation of our EU Exit plans.

Therefore in preparation the Trust will, via the Head of Emergency Planning, Resilience and Response, review emergency preparedness capability. This will primarily focus on a priority review of business continuity plans stratified for clinical risk. It will include but is not limited to:

- Accident and Emergency
- Theatres
- Critical care
- Pharmacy
- Pathology

It is expected that this task will require a re-prioritisation of existing work plans but will be undertaken in collaboration with clinical and operational teams.

Summary

In summary the Trust will undertake 3 key initial actions:

1. To continue to review its supply chain in line with DHSC guidance.
2. To provide support to existing EEA staff members considering seeking settled status and those whose professional registration will be affected in the event of a no-deal scenario.
3. Undertake a rapid review of business continuity plans for high risk areas.

It is anticipated further actions will be identified by these initial tasks in addition to updates and request provided by the government and NHS governing bodies. The Trust will form a specific EU Exit planning team under the designated Senior Responsible Officer (COO). It will be led by the Head of EPRR and Deputy Chief Operating Officer and supported by specialists as required. The planning team will co-ordinate the above identified tasks and work to develop a Trust plan which will be integrated with local, regional and national planning and implementation guidelines. It is noted that this plan is emergent and will be developed as and when guidance is issued.

Scrutiny committee will be advised of developments on a regular basis.

10:45 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

12. Nurse staffing report

To ACCEPT a report on monthly nurse staffing levels

For Report

Presented by Rowan Procter

Trust Board – 30th Nov 2018

Agenda item:	12			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Sinead Collins, Clinical Business Manager			
Date prepared:	21 November 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 October's and progress of nurse staffing review made below.

Observations

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
ED	6 medication errors	High agency & bank use. High RN & NA vacancy. High amount of overtime. High sickness
F7	4 medication errors	High agency & bank use. High RN vacancy and over established in NA. High sickness. High amount of overtime.
F8	5 medication errors	High bank use. High amount of overtime. Over established in staff in prep for move in December. High sickness
CCS	-	High RN vacancy
Theatres	-	High RN/ODP vacancy. High amount of overtime
Recovery	-	High sickness
DSU	-	High sickness & bank use.
CCU	-	High amount of overtime & bank use.
G1	-	High bank use. High RN vacancy and over established in NA
G3	-	High bank use & NA vacancy. High amount of overtime. High sickness
G4	5 pressure ulcers & 3 falls (with harm)	High bank use. High amount of overtime & sickness. High RN vacancy
G5	3 falls (with harm)	High bank use. High RN vacancy. High amount of overtime.
G8	-	High bank & agency use. High sickness. High RN vacancy. High amount of overtime.
F1	-	High bank use & RN vacancy. High amount of overtime
F3	7 medication errors	High RN vacancy. High amount of overtime.
F4	-	High agency & bank use.
F6	-	High agency & bank use. High RN vacancy. High amount of overtime.
F9	-	High bank use. High RN vacancy. High amount of overtime. High sickness.
F10	-	High bank use. High RN vacancy and over established in NA. High sickness. High amount of overtime.

Maternity	-	High bank use & sickness.
F12	-	High bank use.
F14	-	High amount of overtime & sickness.
NNU	-	High sickness. High bank use
Kings Suite	-	High bank use. High amount of overtime. High sickness.
Rosemary Ward	-	High agency & bank use. High amount of overtime. High sickness. High RN vacancy.
Bury Town CHT	14 pressure ulcers (in our care)	High sickness.
Bury Rural CHT	6 pressure ulcers (in our care)	-
Newmarket CHT	-	High sickness.
Sudbury CHT	4 missed visits	High sickness.
Children CHT	-	High Band 4 vacancy. High sickness.

Vacancies – **This part of the dashboard is inaccurate due to Healthroster not being adapted for bay based nursing in the acute hospital and finance department not sharing their vacancy figures. The community teams (except children) have not shared their vacancy figures and been informed by the LAMs to assume its zero in these cases.**

In West Suffolk Hospital, there are significant vacancies in registered staff, and is -100.79WTE and there is an unregistered over establishment of 13.43WTE. The registered and unregistered figures are better than last month. HR, nursing directorate, comms and operations are developing different methods to recruit and retain nursing staff. Bay base nursing establishment is being implemented by adjusting the rosters in October – this will adjust vacancies. The recruitment of nursing assistants is in progress

Band 4 specialist nursery nurses have 3.0 WTE vacancies to cover package agreed by CCG in the Complex Care Team. High vacancy in Rosemary Ward due to change to long-shift initiation

Roster effectiveness – Out of 27 areas, 21 are over the Trust standard of 20% (Day surgery unit & ward are counted as one area). This is the better than September.

Roster effectiveness is a sum of Sickness (Trust standard <3.5%), Annual leave (Trust Standard 12% - 16%) and Study Leave (Trust Standard 2.5% - 3.5%) – It is not a sum of the maximum % but on average. Roster effectiveness has not been 'drilled' down any further than sickness due to annual & study leave % are based on appropriate management of staff.

We don't collect this information in the community

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

In the community, 5 out of the 8 areas are over the Trust Standard (same as last month).

Community Workforce
The workload of the teams has seen an increase in regards to Patient Facing Contact hrs except Children's Services as seen a decrease. Three community teams have seen a slight decrease in unplanned requests (Bury Town, Sudbury, Newmarket), while another three saw a slight increase (Bury Rural, Haverhill). Mildenhall & Brandon's missed visits have doubled since September

Updates in November

Within the overseas recruitment over 180 conditional offers.

We've had the following arrive/due to arrive:

Month	*Number of arrivals*
Jul-18	*3*
Aug-18	*4*
Sep-18	*6*
Oct-18	*9*
Nov-18	*5*
Total	*27*

From the above figure (not including November):

- 10 overseas nurses have passed their OSCE and are now working as Band 5 Nurses (this includes the 3 nurses who had to re-sit the OCSE - we found out on 16/11 that they have passed).
- 4 OSCE booked for 17 December 2018
- 3 OSCES are booked for 19 December 2018
- 4 OSCES are currently being arranged - Date to be confirmed
- 1 Nurse awaiting their decision letter

Welcome Payments:

Since June 2018 we have welcomed 15 Band 5 nurses into the organisation (not including newly qualified).

Nursing Assistants:

Interviews on 22nd October 2018 = 3 offers accepted.
Interviews on 23rd October 2018 = 5 offers accepted.
Interviews on 16th November 2018 = 7 offers to be made.

NA advert closed 15th November, we've received 26 applications which I'm currently shortlisting – interviews will be held on 27th November.

N.B. Newmarket Hospitals fill rate is 200% due to current roster on Healthroster being in transition phase and has currently a few flexible shifts producing this percentage

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Oct-18			Establishment for the Financial Year 2017/18						Data for October 2018																
										Workforce															Nursing Sensitive Indicators		
Trust	Ward Name	Speciality	Current Funded Beds/Chairs Trolleys	Current Funded Establishment (WTE)	Current Funded Total Establishment Registered to Unregistered (%)		SCNT Establishment (WTE) (Feb 2017)	Number of patients per RN/Midwife (not including unit manager)		Fill rate Registered %		Fill rate Unregistered %		Bank staff use %	Agency staff use %	Overtime (Hrs)	Vacancies (WTE)		Sickness (%)	Overall Care Hours Per Patient Day	Roster Effectiveness - Total Non Productive Time (% excl maternity)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)
					Registered	Unregistered		Day	Night	Day	Night	Day	Night				Registered	Unregistered						
WSFT	ED	Emergency Department	21 trollies and 30 chairs	81.79	70.47%	29.53%	N/A	1 - 4	1 - 5	80.8%	94.1%	103.0%	110.5%	5.62%	11.28%	563	-7.79	-4.20	7.40%	N/A	20.60%	N/A	6	0
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	56.4%	68.7%	108.3%	105.5%	6.53%	5.10%	187	-12.10	5.00	6.40%	6.0	24.40%	0	4	2
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	110.2%	109.8%	143.7%	167.8%	16.07%	0.66%	284	1.60	13.45	8.50%	7.0	30.20%	0	5	2
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	89.7%	86.2%	N/A	N/A	0.92%	0.00%	45	-5.54	0.00	4.70%	30.5	17.90%	1	2	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	107.0%	99.9%	N/A	N/A	0.07%	0.00%	240	-4.60	-0.30	3.80%	N/A	20.30%	0	0	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	142.4%	92.0%	83.2%	N/A	4.07%	0.00%	61	0.40	-0.10	7.00%	N/A	24.90%	0	0	N/A
WSFT	Day Surgery Unit	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC	52.06	78.00%	22.00%	N/A	1 - 1.5	N/A	65.8%	N/A	124.3%	N/A	1.41%	0.00%	0	-1.30	-0.20	3.10%	N/A	1.41%	0	0	0
	Day Surgery Wards													11.20%	0.00%	0	0.20	-0.10	12.80%		11.20%			
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	92.4%	78.5%	46.1%	N/A	8.78%	0.00%	169	-0.80	-1.00	0.80%	11.5	27.60%	0	2	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	91.3%	101.2%	106.9%	N/A	8.56%	0.25%	62	-5.58	3.00	3.50%	8.2	21.20%	1	3	0
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	81.9%	86.7%	78.3%	100.0%	16.36%	1.27%	153	-0.14	-3.92	7.10%	5.0	24.20%	0	0	1
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	79.9%	74.0%	105.7%	116.1%	17.86%	0.42%	567	-5.94	-2.92	5.70%	5.8	26.30%	5	1	3
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	86.7%	81.2%	97.3%	116.2%	21.01%	1.39%	243	-6.94	-1.22	4.80%	5.1	15.30%	1	3	3
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	74.2%	78.9%	100.7%	106.8%	15.97%	13.71%	134	-11.12	0.31	10.10%	6.1	27.50%	2	1	1
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	144.3%	104.6%	70.0%	N/A	27.39%	0.00%	119	-4.54	2.80	3.60%	10.0	20.40%	N/A	2	N/A
WSFT	F3	Trauma and Orthopaedics	34	40.47	59.07%	40.93%	48.48	7	11	84.5%	85.0%	136.8%	112.7%	3.37%	0.71%	446	-3.03	-0.10	4.40%	5.2	20.40%	0	7	0
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	81.1%	89.0%	88.2%	181.5%	8.61%	2.34%	12	0.30	0.10	2.90%	9.2	20.20%	0	0	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	94.1%	96.6%	98.2%	121.8%	4.42%	0.00%	80	0.22	1.07	2.80%	6.8	19.40%	0	1	1
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	70.3%	74.6%	121.4%	133.1%	12.84%	3.20%	425	-5.38	-0.42	4.70%	4.7	21.50%	0	2	0
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	69.4%	73.1%	87.1%	131.9%	20.08%	0.49%	252	-9.69	0.40	6.90%	4.9	24.20%	1	0	1
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	79.2%	78.4%	102.1%	106.2%	9.12%	1.25%	248	-7.90	4.40	6.80%	5.9	22.80%	1	3	1
WSFT	F11	Maternity	29					7.25	14.5													0	1	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms	61.55	72.14%	27.86%	N/A	1	1	104.7%	90.1%	80.3%	60.2%	10.54%	0.00%	79	-1.56	-0.30	6.40%	N/A	21.70%	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	82.2%	70.2%	40.6%	156.4%	8.66%	0.56%	12	-2.60	1.48	3.20%	9.6	14.80%	0	0	0
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	102.2%	97.9%	N/A	N/A	1.91%	0.00%	132	-0.30	-0.40	10.20%	12.4	25.50%	0	1	0
WSFT	MTU	Medical Treatment Unit	9 trollies and 8 chairs	9.00	80.00%	20.00%	N/A	5 - 8	N/A	93.1%	N/A	80.1%	N/A	0.00%	0.00%	0	-0.20	0.00	0.00%	N/A	12.20%	1	1	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	92.7%	94.6%	25.1%	19.4%	6.14%	0.00%	83	-2.26	-1.40	15.20%	17.9	29.10%	N/A	0	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	259.2%	85.9%	171.7%	117.9%	11.75%	6.78%	151	-4.30	-2.10	5.80%	5.6	25.00%	0	1	0
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	115.9%	94.1%	97.3%	106.9%	5.38%	0.00%	210	0.10	0.10	12.50%	4.7	26.20%	0	0	1
										97.47% AVG	87.41% AVG	95.69% AVG	115.04% AVG	9.45% AVG	1.76% AVG	4957 TOTAL	-100.79 TOTAL	13.43 TOTAL	6.11% AVG		21.30% AVG	*Trust standard is 20%*		

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		1313.17		We are unable to collect this information this month		To be confirmed if can measure	0.00	0.00	9.98%	No equivalent tool for community nurses	54	14	0	2
Community	Bury Rural	Community Heath Team		11.20	10.71%	89.29%				675.82					0.00	0.00	0.00%		26	6	2	0
Community	Mildenhall & Brandon	Community Heath Team		14.50	20.07%	79.93%				945.37					0.00	0.00	1.30%		63	2	2	2
Community	Newmarket	Community Heath Team		11.25	28.00%	72.00%				553.05					0.00	0.00	10.37%		21	0	1	0
Community	Sudbury	Community Heath Team		25.92	32.25%	67.75%				1142.73					0.00	0.00	5.35%		37	0	2	4
Community	Haverhill	Community Heath Team		13.20	32.05%	67.95%				880.82					0.00	0.00	0.19%		26	1	0	0
Community	Admission Prevention Service	Specialist Services		13.73	25.13%	74.87%				126.67					0.00	0.00	3.90%		0	0	0	0
Community	Children	Community Paediatrics		32.89	47.07%	52.93%				919.90					-0.86	-3.00	7.90%		0	N/A	0	0
										6557.53 TOTAL		#DIV/0! AVG	#DIV/0! AVG		-0.86 TOTAL	-3.00 TOTAL	4.87% AVG Target - 3.5%		227 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)
	Fill Rate is an indication of patient safety - national target 80% (less than = red), Trust internal target 85% (equal and greater than = green)
	Medication errors are not always down to nursing and can be pharmacist or medical staff as well
	In vacancy column: - means vacancy and + means overestablished.
	Roster effectiveness is a sum of Sickness (<3.5%), Annual leave (12% - 16%) and Study Leave (2.5% - 3.5%)
	DSU has been split into ward and unit only by HR, that is why only a section has been split in this dashboard
	G9 - Closed during April
	Pressure Ulcer Incidences (In our care) - includes DTI's

Key	
N/A	Not applicable
ETC	Eye Treatment Centre
I/D	Inappropriate data
TBC	To be confirmed

13. Freedom to speak up guardian – Q2

To ACCEPT a report

For Report

Presented by Jan Bloomfield

Trust Open Board Report – 30 November 2018

Agenda item:	13			
Presented by:	Jan Bloomfield, Executive Director for Workforce and Communications			
Prepared by:	Nick Finch, Freedom to speak up guardian			
Date prepared:	November 2018			
Subject:	Freedom to speak up guardian report			
Purpose:	X	For information		For approval

Executive summary:

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

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

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

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

Recommendation:

The Board is asked to note this report

Background

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

Role of the Guardian

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

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

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

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

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

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

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

Credible with experience that resonates with frontline staff.

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

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

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

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

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

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

Updates

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

- Attending Preceptorship days for newly qualified Nurse and Midwifes and Clinicians.
- Attending the Marketplace and helpfulness staff event and given a presentation about my role.
- Attending and met with the new overseas Nurses at their induction giving them a good insight into my role.
- A working link with the new Senior Independent Non – Executive Director.
- Working with the National Guardians Office.
- Working with the Eastern Region Guardians Office, attending meetings and telephone conferences.
- Continue to attend Trust Inductions.
- Building a link with other Freedom to Speak Up Guardians from outside of the East Anglian Region following a very well received presentation by Helen Beck to Health Professionals on the subject of the journey to outstanding CQC status.

Concerns Raised

Concern	Numbers	Status
Behaviour/ attitude	2	1 Resolved 1 Outstanding
Trust procedure/practice	1	Outstanding
Capacity/workload	0	
Miscellaneous	5	Resolved

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

Behaviour/attitude These are two cases working with staff and HR or have been asked to support staff. To date one has been resolved and the other is outstanding with the member of staff awaiting closure.

Trust procedure/practice This case was raised by a member of staff on behalf of a staff group and relates to their departments practices and procedures. The case was forwarded to the director responsible. Assurance has been given to the member of staff that the situation had been discussed by the Executives Directors and plans were being put in place to resolve the matter as soon as possible.

Capacity/workload No cases to date.

Miscellaneous Have been approached by five members of staff who raised issues but had not yet communicated with their line manager about their issue. All were advised about the role of the Freedom to Speak Up Guardian and what it entails.

Future plans

- To continue meeting with all staff groups to advertise of the role and support where necessary.
- Continue to raise the profile to staff so that they are fully aware who the FTSUG is and how can be approached.
- To continue to work with the Executive Directors, Non –Executive Directors, Senior managers and governors.
- To host an Eastern Counties Freedom to Speak Up Network meeting at West Suffolk Hospital.

Conclusion

Over the last 6 months the FTSUG has been approached in their role as the Freedom to Speak up Guardian. This has been made apparent by the number of staff who have raised concerns or in some cases contacted me to ask advice about how to report an issue.

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

14. Quality and learning report for Q2

To ACCEPT a report, including progress with quality priorities for 2018-19

For Report

Presented by Rowan Procter

Trust Open Board – 30 November 2018

Agenda item:	14			
Presented by:	Rowan Procter – Executive Chief Nurse			
Prepared by:	Governance Department			
Date prepared:	November 2018			
Subject:	Quality and Learning report incorporating a review of hospital acquired pressure ulcers			
Purpose:	X	For information		For approval

Executive summary:

This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from in the quarter ending 30/09/18.

Information has been obtained from the following data sources:

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

Key highlights in this report are as follows:

- Falls collaborative
- Acute Kidney Injury (AKI)
- Maternity Hub supporting pregnant women and their families
- CQC preparedness visit in Emergency Department
- Review of hospital acquired pressure ulcers (HAPU) over a six month period **(Appendix 1)**

Please note:

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

Trust priorities	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	X	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	X				X
Previously considered by:							
Risk and assurance:							
Legislation, regulatory, equality, diversity and dignity implications							
Recommendation: The Board to note this report.							

Activity within the quarter

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

A review of hospital acquired pressure ulcers (HAPUs) at the West Suffolk NHS Foundation Trust within the period of the past 6 months, from May 2018 and up to, and including October 2018 is provided as an appendix to this report.

Learning themes from investigations in the quarter

NB: NHS Improvement have issued a document stating that pressure ulcer cases should not be considered as a reportable SI unless they meet the criteria of a serious incident. As a result of this there are no pressure ulcers listed below.

NNB: In Q2 there were four incidents investigated internally within Obstetrics that in future will fall under the remit of the Healthcare Safety Investigation Branch (HSIB) with external investigations undertaken and fed back to the Trust.

SI RCA reports submitted in Q2

Incident details	Learning
WSH-IR-30513 Failed administration of agreed Urology treatment	The investigation found that in this case there was evidence that the plan of care agreed for the patient at the Urology Multidisciplinary team meeting (MDT) was communicated but was not achieved due to human error. There was a breakdown in the treatment pathway of the actions to be achieved, which in turn caused the patient to have a significant delay in the treatment of his condition. The investigation agreed there is no way of knowing if the prognosis of the patient would have been different but that treatment could have well have stopped disease progression over these twelve months. Root cause(s) identified as: Failure to enact the Urology MDT meeting outcomes in contrary to the operational policies of the MDT and no fail safe mechanism in place to monitor whether MDT meeting outcomes are acted upon or not and report it back to the MDT. Actions agreed were as follows: ▪ Ensure that the outcome of the Urology MDT and all cancer MDTs are communicated via message centre in the patient records. ▪ Implementation of an eCare pool mail box for the Urology Specialist Nurses

Incident details	Learning
	▪ Work with IT to ensure message centre training for clinicians is available ▪ Each Urology MDT meeting action log should be followed up by the MDT coordinator prior to the next meeting to ensure actions have been achieved (via update in urology MDT terms of reference). ▪ Agree a system within cancer services that follows up each patient until planned pathway of care is complete.
WSH-IR-34373 Delay in the diagnosis and treatment pathway for pancreatic cancer	The investigation reported a delay in the patient receiving a definitive pancreatic cancer diagnosis due to the patient's symptoms not triggering a timelier CT scan and results. The GP did not speak to the duty radiologist when requesting the CT scan but completed a routine request. At that time there had been no formal communication to all GPs of the process for GPs to talk directly to the duty Radiologist to book an outpatient CT scan. This has now been robustly communicated. The patient's symptoms and his pathway did not fit the standard/ established pathway for fast track referral. The GP tried to adapt the referral pathway in place for the best outcome for the patient but at the time there was more than one commissioned referral pathway available which did not aid communication and documentation across secondary care and may have contributed to the delay in the patient's pathway to diagnosis. When the patient's case received Upper Gastroenterology MDT consideration the potential diagnosis was then identified and then subsequently confirmed. The timescale from the patient's referral to MDT review was not optimal in timescale. The Investigation of the patient's CT scan results suffered a significant reporting delay due to the build-up of a back log of CT scan reporting caused by a lack of Radiologist reporting resource. This had been acknowledged by the Trust and was being managed by the process of triaging the requests for scans but as the CT scan had been a routine request it was not prioritised for reporting. Actions agreed were as follows: ▪ Review radiology X-ray pathway to ensure primary care are able direct referral for appropriate CT scans as per the NICE *Suspected Cancer: Recognition and Referral* and communicate this update to primary care ▪ Include in Medical Directors bulletin article about consideration of correct trigger phraseology to be used to ensure an appropriate radiology reporting timeframe. ▪ Develop a Task and Finish group to review the referral pathway for the weight loss clinic based on the most recent NICE guidance available and invite the CCG to participate. ▪ Carry out an Audit into faecal elastase testing which is hoped will inform and embed the use of this test in people with chronic diarrhoea ▪ Consultant Gastroenterologist to contact the Senior Gastroenterologist in the Eastern Region requesting a meeting to discuss these issues and formulate an action plan.
WSH-IR-34662 Unexpected Death / Delay in administering steroid medication	The investigation noted that the patient had a complex medical presentation of a very rare genetic disease (Triple A Syndrome) resulting in many co-morbidities. This included Addison's disease a disorder of adrenal cortisol hormone insufficiency requiring regular steroid dose to prevent 'Addisonial crisis'. The patient was prescribed hydrocortisone for his Addison's disease throughout his inpatient stay however it was noted that one dose was not given due to "Equipment/supplies unavailable". It was unknown whether this contributed to the patient's death but the investigation considered it as a possibility. Root cause(s) identified as: a complex medical presentation of a very rare genetic disease and aspiration pneumonia with a background of a poor immune response and long-term steroid use that masked the usual clinical signs of sepsis together with the staff unawareness that steroids should not be withdrawn suddenly in Addison's disease. Actions agreed were as follows: ▪ A daily eCare report of patients with Addison's shared with the endocrine Consultants alerting them that one of their outpatients has attended for an acute episode of care. ▪ Consideration of an emergency admission file note to be added to patient's record who have a rare chronic condition ▪ Implementation of quality improvement project to review the current method of how steroids are prescribed, administered and whether there are more effective ways of doing this.

Incident details	Learning
	▪ Review of doses not given on e-Care to assess themes and refer to the Drugs & Therapeutic committee and e-Care optimisation group.
WSH-IR-36094 Delay in diagnosis and treatment of carcinoma of prostate	Root cause(s) identified as: Existing Prostate-specific antigen (PSA) test result not acknowledged at referral stage or undertaken subsequently, possibly inadequate first procedure requiring redo, MDT review not undertaken following first procedure, histology results not reviewed following first procedure. The investigation also acknowledged that when a Urology review was requested on the ward it should have been a more senior member of staff than a junior doctor that reviewed the patient to ensure senior decision-making and that there were conversations where the patient was discussed between medical colleagues but didn't document their discussion. Actions agreed were as follows: ▪ The findings from this report need to be taken on by the clinical and service management of the Urology Team to ensure that each of the elements that the investigation have found and their recommendation are implemented and monitored to stop them from happening again. ▪ Ensure all GPs know to use the updated Urology Suspected Cancer Referral Form ▪ Change the refer for advice process no second letter required ▪ Implement a system across surgery to ensure that the locums and new consultants are kept up to date on eCare ▪ Histologist to put patients directly onto the MDT list to avoid gaps in the process ▪ Review process with urology ward clerks to ensure patients are booked for review ▪ Ensure that the Urologists if they are discharging patient review the patient records to ascertain if there is a need for review. ▪ Ensure appropriate level of review and escalation and decision making for a patient when requested.
WSH-IR-39173 Patient suffered cardiac arrest following probable aspiration	The patient developed respiratory compromise following ingestion of medication and water leading to a cardiac arrest requiring resuscitation. A subsequent CT scan showed a sigmoid volvulus. The investigation noted that failure to diagnose this sigmoid volvulus resulted in failure to escalate to a surgical consultant and therefore deliver appropriate treatment. The patient suffered a cardiac arrest (presumably post respiratory arrest) resulting in admission and a stay in the Intensive Care Unit with subsequent cognitive impairment, blindness and paralysis requiring extensive rehabilitation and 24 hour a day care, which will be life-long. As well as the root causes highlighted above, the investigation also noted the following points of learning: ▪ The importance of ensuring that patients are reviewed following implementation of treatment plans, including the need for further imaging (particularly if the patient is not responding to treatment), and the requirement for a consultant review. ▪ The importance of listening to and recording concerns or escalation from relatives. ▪ Junior doctors should use the existing escalation pathway to raise concerns to seniors if a patient is clinically deteriorating. ▪ Need to improve awareness of the specific needs of patients with complex or multiple co-morbidity ▪ Nursing staff need to ensure that they are all aware of the policy regarding patients' own medication and administration ▪ The report resulting from the radiology discrepancy meeting where the patient's X-ray was reviewed did not give a clear narrative of the findings for this particular X-ray. ▪ Ward staff must ensure that their behaviour is befitting of the organisation's values; they should behave respectfully and professionally Actions agreed were as follows: ▪ Clinical Directors to set expectations during every induction for new doctors to ensure that junior staff inform the Consultant when a patient presents with complex needs (potential of differing diagnosis). ▪ All newly admitted surgical patients should be reviewed daily by the senior clinician on call – including out of hours. This could occur via an evening discussion of those patients between the Registrar and the Consultant; thus ensuring that patients

Incident details	Learning
	receive a senor review, treatment plans are reviewed with the potential for the identification of further imaging and / or alternative treatment. ▪ Patient with acute abdominal pain including those with possible bowel obstruction should have senior clinical review where appropriate imaging (including CT scan) should be considered. ▪ Confusion regarding patients own medication to be disseminate to staff to ensure that ward nursing staff are aware of Medication policy regarding patient's own medication and that if a ward does not have certain medication, this can be obtained out of hours from the emergency drug cupboard by the Site Manager. ▪ Initial abdominal X-ray to be included again in the next discrepancy meeting for discussion. The incident was also the subject of a complaint from the family of the patient and a list of questions posed by the family were considered within the investigation report. On conclusion the final report was sent to the family and, during a meeting to discuss the investigation findings, it became apparent that full verbal and written Duty of candour (DoC) had not taken place despite being reported as complete in previous Board papers. This has been addressed and the family are aware that the original incorrect recording of DoC has been corrected. Additional actions agreed to address this failure of the DoC process were as follows: ▪ ICU senior clinicians to be reminded of the current DoC policy ▪ Review of the Metavison prompt regarding correct DoC process to ensure that clinicians follow it correctly.
WSH-IR-38808 Timely identification and management of a case of necrotising fasciitis.	This was a case identified for review through the Trust's 'Learning from deaths' pathway. The investigation noted that the patient presented with severe sepsis and severely ulcerated /infected areas demonstrating many risk factors for necrotising fasciitis, however the clinicians initially treated for diabetic ketoacidosis and sepsis with no consideration for an alternative diagnosis and necrotising fasciitis was not considered at point of admission. This resulted in a late escalation to the Surgical Consultant following admission and therefore a delay in surgical intervention. The investigation also noted that whilst Intravenous fluid and antibiotic medication was administered in the Emergency Department (ED) it was not recorded in e-Care (misleading with regards to treatment already provided) Contributory unavoidable factors of the impact of staffing deficits and of other patient acuities were highlighted with the ICU Sister helping in the ED Resuscitation area, the on-call ICU Consultant dealing with another sick patient requiring transfer to Papworth Hospital and emergency surgery already being carried out resulting in delay with surgical intervention once identified as necessary. Actions agreed were as follows: ▪ Seek guidance from the e-Care team regarding the use of a visual prompt for sepsis source / causative actor of infection when patient red flags for sepsis ▪ Include necrotising fasciitis within the FY1 Sepsis scenario during the 'Management of Deteriorating Patient study day. ▪ Add the necrotising fasciitis guideline to the Sepsis trolleys Emergency Department to be reminded that fluid charts are commenced for all patients receiving IV fluid. ▪ Ensure that ICU Nurses are able to record medication and fluid on the e-Care system ▪ Update fluid balance charts and add ability to prescribe fluid on e-Care, launching this during the 'Deteriorating Patient Awareness week' ▪ Potential necrotising fasciitis / source of infection red flags to be included within tissue viability education ▪ Review of pathway and process for opening second theatre for emergencies when required
WSH-IR-38334 Transfer of new-born baby to tertiary hospital for therapeutic	The Trust undertakes case reviews on all transfer for therapeutic cooling .This was a baby born in poor condition following a category 1 caesarean section for a fetal bradycardia requiring resuscitation and transfer to a tertiary hospital for therapeutic cooling with a diagnosis of hypoxic ischaemic encephalopathy (HIE) with suspected sepsis. The baby's weight at birth was calculated to be on the 4th centile smaller than the estimated fetal weight on ultrasound scan (60th centile at 37 weeks gestation).

Incident details	Learning
cooling	The investigation was unable to confirm with certainty the root cause of this incident. There were risk factors identified of Gestational Diabetes Mellitus and the possibility of sepsis secondary to maternal infection reported on the placental histology although neonatal microbiological cultures taken at the WSH were reported to be negative. It was not possible to confirm whether or not increased surveillance of baby during the induction process would have changed the outcome in this case however it was noted that staff did not follow the minimum expected standard of 4 hourly maternal and fetal observations. Actions agreed were as follows: ▪ The consultant body to review the feasibility of introducing pulsatility Index as a method of assessing fetal wellbeing at the Clinical Governance Steering Group. ▪ Development of a guideline outlining the minimum expected maternal and fetal observations for inpatient antenatal women. ▪ Include on the antenatal white board the expected maternal and fetal observations for each individual antenatal woman. ▪ The ultrasound team to undertake a quality assessment of ultrasound scanning in this case and to discuss with the maternity service as a learning opportunity. ▪ 'Induction of labour' and 'Management of diabetes' guidelines to be reviewed and updated.
WSH-IR-38913 Intrauterine death	The Trust undertakes case reviews on all Intrauterine deaths. This was an Intrauterine death at 39 weeks & 5 days. The mother was initially assessed as high risk at booking due to a low BMI of 17.7 was therefore booked for Consultant-led care with serial ultrasound growth scans at 32 and 36 weeks gestation. A subsequent risk assessment by the consultant obstetrician after a fetal growth scan at 36 weeks reported that she was appropriate for transfer to midwife led care. The 38th week antenatal appointment recorded normal fetal movements however sadly at an attendance one week later no fetal heart was audible and an intrauterine death was confirmed on a departmental ultrasound scan. After a thorough investigation it was agreed that there were no care service delivery problems identified which had contributed to the sad outcome in this case. However the investigation did identify areas for improvement relating to documentation of patient information giving and results of carbon monoxide testing and questions around smoking (although this lady was not a smoker), these were identified as lessons learnt and actions identified to feedback to the staff involved. No other actions were identified as being required.
WSH-IR-39545 Intrauterine death	The Trust undertakes case reviews on all Intrauterine deaths. This was an Intrauterine death at 40 weeks & 4 days. The mother was assessed as low risk at booking and was therefore booked for Midwife-led care. The mother attended the Maternity Day Assessment Unit on four occasions reporting reduced fetal movements however they were assessed to be normal on each occasion At 40 weeks and 4 days gestation. The mother attended the Labour suite and the midwife could not auscultate the fetal heart and an ultrasound scan confirmed an intrauterine death. The investigation concluded that there were no issues with care identified and that Trust guidance had been followed throughout. Post Mortem findings noted that the underlying cause of the fetal death was uncertain. The review did note that the Maternity Service should undertake a robust review of the interpretation of the Royal College of Obstetrics and Gynaecology 'Green Top' guideline in relation to recurrent perceived reduced fetal movements and review the current Trust guideline. However in this case this would not have changed the outcome on this occasion. No other actions were identified as being required.
WSH-IR-39274 Neonatal death	The Trust undertakes case reviews on all Neonatal deaths. This was a death of a baby born at 23 weeks and 4 days. The baby was born with very poor apgars of 2-2-2 and resuscitation was undertaken but unsuccessful. The mother and her partner were both recorded as smokers and the mother was referred to smoking cessation services at booking and again at 16 weeks when she was still reported to be smoking 25 cigarettes a day. The health records do not record whether the

Incident details	Learning
	partner was referred to smoking cessation services or advised of the risks. Root cause was identified as extreme prematurity at birth. No definitive underlying cause was identified however the placental findings of possible chronic placental abruption correlate with the history of bleeding. There is a known increased risk of premature labour and placental abruption in women who smoke during pregnancy. The investigation concluded that there were no issues with care identified and notable practice was highlighted that the paediatric team continued the ventilation breaths after the decision to stop the resuscitation, whilst the mother was made comfortable and was able to hold the baby wrapped in a blanket.
WSH-IR-38722 Patient fall resulting in neck of femur fracture	A concise RCA investigation was undertaken for this fall which deemed it unavoidable. It was acknowledged that some assessments had not been completed during the admission but the falls risk had been assessed prior to the fall, and appropriate measures to avoid falls were in place. There were several recorded instances to show that the patient was independently mobile with frame around the ward. As such there was nothing to suggest that the patient should have been attached to a wander-guard. Contributory factors were noted of intermittent confusion levels and the independence of patient who often refused offers of assistance/help. The report highlighted that all post fall care was provided but that this care was slightly delayed due to miss-communication between on-call Doctors at handover, however the patient received good nursing care, and it appears that the effects of this delay on the patient were minimal. The fall happened on Ward G9 when it was in operation as a winter escalation ward. An action was agreed to implement an induction process on opening of winter escalation ward which captures requirements of safety assessments for nursing staff as the review had noted that safety assessments for this patient were not completed on weekly basis, or when there was a change in the patient's condition.

There were no reports submitted on behalf of other organisations in Q2.

Quality Walk About from Q2

During quarter 2 we visited a total of 11 areas including wards, clinic areas and laboratories and these were attended by the Chief Executive, Chair, Executive Chief Nurse, Medical Director, Director of Finance and Director of workforce and several non-executive directors and governors. The walkabouts have further served to observe and review real time care and service delivery in a multitude of settings whilst providing staff, patients and visitors the opportunity to escalate issues, concerns or indeed compliments of the area.

This quarter has also incorporated a larger style CQC preparedness visit of the Emergency Department which has provided assurance for both the walkabout team and the ED staff that the department had worked hard to prepare for such a visit. This was an opportunity for staff to highlight any outstanding issues which needed to be escalated and addressed in terms of care and service delivery prior to another inspection and raised issues for example such as the need for clearer signage to the department.

The development of an electronic app to support live monitoring of daily checks is in progress and has been prioritised as we move into winter. The ability to escalate non-compliance to the Senior Nursing team will ensure safety and quality for all wards and departments.

From all the areas visited the actions which have been raised have been captured on an access database with a view to moving this to Datix to centralise the monitoring of the actions. The actions have been varied and are reflective of the issues raised as a result of these visits covering for example HR and an introduction of a 10% retainer for nursing staff, reviewing transport issues on Datix for patients waiting in the discharge waiting area, preparation of suction canisters in the clinical area and exploring a better process for updating ward boards/information. These actions are now monitored through the Trust's quality group for assurance of completion

Other learning themes

Subject / Theme Falls
Source Incidents / Trust Quality Priority
Risk register entry Trust generic risk assessment 'Patients at risk of slips, trips and falls'
Trust owner Falls group
Summary of learning and areas for improvement in this topic

The 2017/18 Trust annual report identified Falls as a quality priority and the Trust is currently participating in the NHSI Falls Collaborative Project. The clinical lead for Falls is Dr Mohanraj Suresh with Sarah Watson, Head of Nursing for Medicine providing the nursing / management lead.

Initial focus of the collaborative has been on prevention of frequent fallers, "*To reduce the frequent faller cycle of harm with a 10% reduction in falls of patients who have fallen more than twice during admission on Ward G8 (acute stroke) and Rosemary Ward (Newmarket community hospital)*"

The team felt there was a cohort of patients who were at high risk of falling due to previous falls and were not highlighted to receive specialist care. A series of engagement activities were undertaken and with an initial focus to review the use of the 'leaf' symbol currently used to alert staff and patient/visitors/carers to patients who are at risk or have fallen.

The leaf is used in different colours for patients at risk of falling and having already fallen. Staff were asked:

- Have you seen these signs?'
- Do you know what the different colours mean?'
- Do you have another suggestion for highlighting a patient at risk of falling?

Feedback on this exercise suggested a new sign of a falling person. Patients and relatives were asked their opinion as it was recognised that this is less confidential than the generic leaf design and were supportive of a change if it will help prevent falls.

Changes that have been implemented during the collaborative exercise include relaunch of the Falls link groups to a three time a year link study days, introduction of falls ward champions and review of the Trust falls group terms of reference. The impact of bay-based nursing will be studied to assess the impact on falls reduction and Trust is also looking into the introduction of a 'Carers Contract' ensuring early collaborative with patients and carers.

Subject / Theme Implementation of a Central Communication Hub to support pregnant women and their families under the care of the West Suffolk Hospital
Source Service Quality development
Risk register entry N/A
Trust owner[1] Women and Children's Health
Summary of learning and areas for improvement in this topic

The aim of the central community hub is intended to meet the current and future demands of the service, as it is currently a challenge for women to access a midwife on an ad hoc basis to provide them advice and support and to meet the initial booking targets of 12 weeks and 6 days (antenatal screening KPI by 10+0 weeks, which will be the recommendation in the near future).

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

Four community teams cover the West Suffolk area and supporting approximately 2800 pregnant women with advice, appointments, test results and completion of forms until the pregnancy ceases or discharged to the health visitor team. This can result on average 241 calls per month, however a message is often left as the team midwife may not available at that point to which the midwife would then respond when possible. 'Better Births' 2016 reported that women wanted a more 'digital service' and to information accessible to them when they need it, and to be able to discuss concerns with health care professionals. (p33)

Since May 2018 the community hub has provided 9am until 3pm central point for women to have direct and timely access to a midwife, either by telephone or by email. This has significantly reduced the number of missed calls due to either party being unavailable. Midwives are also able to contact women by email answering routine enquiries when necessary. As a result of the service women can now complete a referral for pregnancy directly to the midwife via the hub.

Updates from themes reported in previous quarters

Subject / Theme Acute Kidney Injury (AKI)
Source Incidents / Trust Quality Priority
Risk register entry No
Trust owner Deteriorating Patient Committee
Summary of learning and areas for improvement in this topic

The 2017/18 Trust annual report identified AKI and the management of fluid balance as a quality priority with specific indicators chosen to aim for a reduction in incidence of AKI and improvement in fluid management in inpatients (acute and community). Dr Vivian Yui, Consultant Nephrologist is the clinical lead for this quality improvement project overseen by the Deteriorating Patient Lead Nurse and supported by the patient safety team in Governance.

An aggregated analysis of incidents relating to the late recognition and escalation of patients with AKI staging was undertaken and the findings from the report are as follows:

All three cases demonstrate a lack of recognition of the urgency of AKI treatment from junior medical staff and nursing staff looking after these patients, therefore a late administration of the AKI-7 bundle

1	2	3	4	5	6	7
Daily bloods	Measure urine output	Stop nephrotoxic drugs	Appropriate fluid challenge	Maintain normal blood pressure	Consider imaging & exclude obstruction	Senior review & consideration of specialist review

Clinicians are not acting on grossly deranged blood results including AKI staging quickly enough. There appears to be a lack of understanding of the urgency of escalation and AKI treatment (I.e. Rapid fluids, repeat blood tests etc.). This could potentially lead to worsening renal failure and permanent renal damage due to late treatment.

Recommendations from the report are currently being considered to agree an action plan. These include actions to promote improvements in practice as well as opportunities to feedback the lessons learned the relevant staff groups across the Trust:

- AKI stage 2 and 3 to alert on e-Care when flags occur to Nursing staff which directs them to inform the clinician
- AKI stage 2 and 3 alerting to appear for those patients for medical staff. This will navigate them to the correct treatment

- Medical and Nursing staff need to ensure that they are aware of the importance of AKI and fluid balance – especially as often, these patients vital signs may not be initially compromised. Include this in as an update to all mandatory / deteriorating patient educational packages.
- Fluid balance charting to be revised within e-Care to ensure a more user friendly approach
- Renal Physician to use this aggregated report during Grand Round presentation to junior medical staff (26/9/2018)
- AKI scenario embedded within the PfPP week 'Management of the deteriorating patient study day' for FY1 Doctors
- Updated fluid balance and AKI alerting (e-Care) to be disseminated during 'Deteriorating patient week'

Mitigated red risks

During Q2 action to mitigate and downgrade one red risk was taken. This related to inadequate community nurses staffing levels. This risk was downgraded to amber after further mitigation to address the concerns was put in place.

Learning from RIDDOR incidents

During Q2 the number of incidents reported to the HSE under RIDDOR has decreased from the previous quarter by 4, from 8 to 4. Learning and mitigation included:

- Targeted staff training in moving and handling techniques
- Staff reminded of the importance of timely incident reporting
- Risk assessments reviewed

Learning from patient and public feedback:

12 complaints received in quarter two were deemed to be upheld at the time of producing this report. Actions from these were as follows:

Ref.	Issues identified	Actions and learning
WSH-COM-1396	• Avoidable inpatient fall • Admitting ward unaware of patient's dementia	Patient placed in a side room inappropriately due to staff being unaware of dementia diagnosis, therefore fall was avoidable. The complaint has been discussed at both ward governance meetings to ensure handover between wards is full and staff have been made aware of the impact of this lack of communication.
WSH-COM-1390	• Failure to identify the need for a stroke alert • Long wait to be reviewed by a doctor in the emergency department • Staff failed to provide patient with pressure relief when requested	Training has been provided to the emergency department by the stroke team in early detection and training materials have also been displayed. Recruitment of an auxiliary nurse has been undertaken to oversee the waiting room, including regular observations of patients waiting. Additional advanced clinical practitioners have been recruited to assist with examining and treating patients. The complaint has been discussed with the department at their governance meeting to allow further reflection and learning.
WSH-COM-1388	• Lack of staff awareness about newly formed perinatal mental health service resulting in miscommunication with patient • Lack of confidentiality when discussing patient's care	Full explanation of the perinatal service and process for accessing given to the patient. All midwives have now received training on how to access the perinatal mental health service to ensure this does not happen again. As it was a very new service at the time it is understandable that there was some initial misunderstanding. Student midwife has been spoken to about the appropriateness of confidential discussions and understands why this was wrong. She has refreshed her information governance training.
WSH-COM-1387	• Red reflex falsely identified resulting in newborn blindness being missed during newborn and infant physical examination	Training session around sight examination for all midwives undertaking newborn examinations has been arranged with a consultant ophthalmologist.
WSH-COM-1385	• Pain not appropriately managed	Whilst nursing staff did attempt to repeatedly contact medical team for stronger pain relief, unfortunately they were caught up with an emergency. This complaint was discussed at the governance meeting and staff were encouraged to escalate in person if struggling to get response and patient in significant pain.
WSH-COM-1382	• Subtle fractures missed • Inadequate pain relief due to the above	Misinterpretation of CT scan discussed at radiology discrepancy meeting on 23 August 2018, finding subtle fractures of T5 and T6 were missed. Consultant radiologist has acknowledged this and apologies given for the impact this had on pain management. It was noted that management of the injury would not have differed; conservative management most appropriate however appropriate pain relief was not provided due to the diagnosis of soft tissue injury only.

Ref.	Issues identified	Actions and learning
WSH-COM-1380	• Patient entitled to free handrail installation at her home. Not appropriately communicated with patient resulting in her paying for this herself.	Patient has been reimbursed £240 for the handrail. The community team have been reminded of the importance of clear communication and documentation.
WSH-COM-1375	• Junior doctor failed to check patient's troponin levels resulting in failure to diagnose heart attack	Individual junior has been spoken to about this complaint. Benefits of checking troponin levels is now included in consultant lectures to emergency juniors, and this specific complaint is described.
WSH-COM-1371	• Husband of a deceased patient was contacted to inform that his wife's lost wedding ring had been found without checking her condition; she had passed away several months before	Voluntary services, who manage lost property, are now required to check every patient record prior to making contact. This is prompted and evidenced on their property spread sheet to ensure this occurs.
WSH-COM-1370	• Failure to diagnose a melanoma	Patient reimbursed for her private consultation and histology in which she was diagnosed. Unfortunately the patient did not have the typical characteristics of a melanoma however the dermatology team have reflected on this and will remain vigilant.
WSH-COM-1367	• Found consultant rude	Any complaints about attitude are upheld as that is personal perception. The consultant has reflected on this and the complaint has been included for discussion at appraisal.
WSH-COM-1364	• Incorrect boot fitted for ruptured Achilles	Training has been organised with less experienced members of the nursing team to ensure knowledge of correct appliances. Educational material has also been developed by the practice development nurse for all nursing staff to refer to.

The following action plan has been generated as a result of the CQC Inpatient Survey 2017:

Issues identified	Actions and learning
Q 14. Were you ever bothered by noise at night from other patients?	To conduct a targeted survey around preventable noise at night to understand how this can be improved Gentle reminder in welcome packs for patients to be mindful of others
Q15. Were you ever bothered by noise at night from hospital staff?	Reintroduce a question around noise at night from staff in the inpatient satisfaction survey Raise profile of earplugs and ensure staff are offering them to all patients Consider communication around promotion of earplugs
Q16. In your opinion, how clean was the hospital or ward that you were in?	Arrange for focused local survey around cleanliness to be carried out for 1 week per quarter
Q19. How would you rate the hospital food?	Alternative juice is being looked into A local survey is being conducted on the quality of the hospital food A trial is being undertaken on housekeeping staff distributing patient meals A question about hospital food is being added to the inpatient survey
Q30. Did you know which nurse was in charge of looking after you? (this would have been a different person after each shift change)	Explore the roll out of digital boards Ensure boards are clearly visible displaying which nurse is in charge
Q38. Do you feel you got enough emotional support from hospital staff during your stay?	Work with Chaplaincy Services and volunteers to ensure more volunteers are placed in wards to talk to patients Provide clear information about support available and links to PALS QI testing of patient profiles on G4
Q47. Afterwards, did a member of staff explain how the operation or procedure had gone in a way you could understand?	Inclusion of a paragraph in welcome packs to encourage patients to ask questions if they don't understand
Q58. Did a member of staff tell you about medication side effects to watch for when you went home? Q61. Did a member of staff tell you about any danger signals you should watch for after you went home?	Promote medications information line and include contact details in welcome pack. Question about medications has been included in the discharge waiting area patient survey.
Q62. Did hospital staff take your family or home situation into account when planning your discharge?	Promotion of discharge to assess to improve staff and patient understanding

The patient and carer experience group identified several actions to improve experience of care in quarter two:

Issues identified	Actions and learning
Relatives reported a poor pick-up rate for ward telephones	Head of nursing to request switchboard call data to be shared with ward managers, as was happening previously. This has not occurred for some time so this will be picked up again to monitor.
Patients and visitors would appreciate information detailing what parking income is spent on	This has been shared with the communications team to see if information can be published on the trust website for assurance.
Lack of understanding about what to expect during the discharge planning process	Literature is being developed to be shared with patients and families during the discharge process. This will be included in the welcome packs once in place.
Volunteers receive a lot of 'soft intelligence' around patient experience that is not being gathered	Voluntary services manager has informed all volunteers of the feedback email address and asked them to provide feedback and suggestions, of their own and of patients, to this email address.
E-zec medical staff unable to access patient location prior to pick up from the ward, resulting in delays if patients have moved wards since the transport request was made	Explore options for the E-zec medical office staff, based in the hospital, accessing patient location on e-Care.
Community patients are unable to give feedback so easily from their homes	Trial the introduction of a volunteering position, whereby patients will be telephoned at home to collect their feedback about the services but also to combat loneliness and provide conversation and support.
Lack of clarity on trust policy around dogs being allowed on wards when patients are nearing end of life	A guidance sheet is being produced so ward staff feel confident in decisions they make around this.

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

Report from Helen Beard – Head of Nursing for Surgery

Executive summary:

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

During this period, there have been 63 reported HAPUs, 51 grade 2 and 12 grade 3. There have been no incidents of grade 4 HAPUs.

The report demonstrates that there has been a significant reduction in HAPUs over the past year and describes some of the initiatives and integrated working, which has helped to achieve this.

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

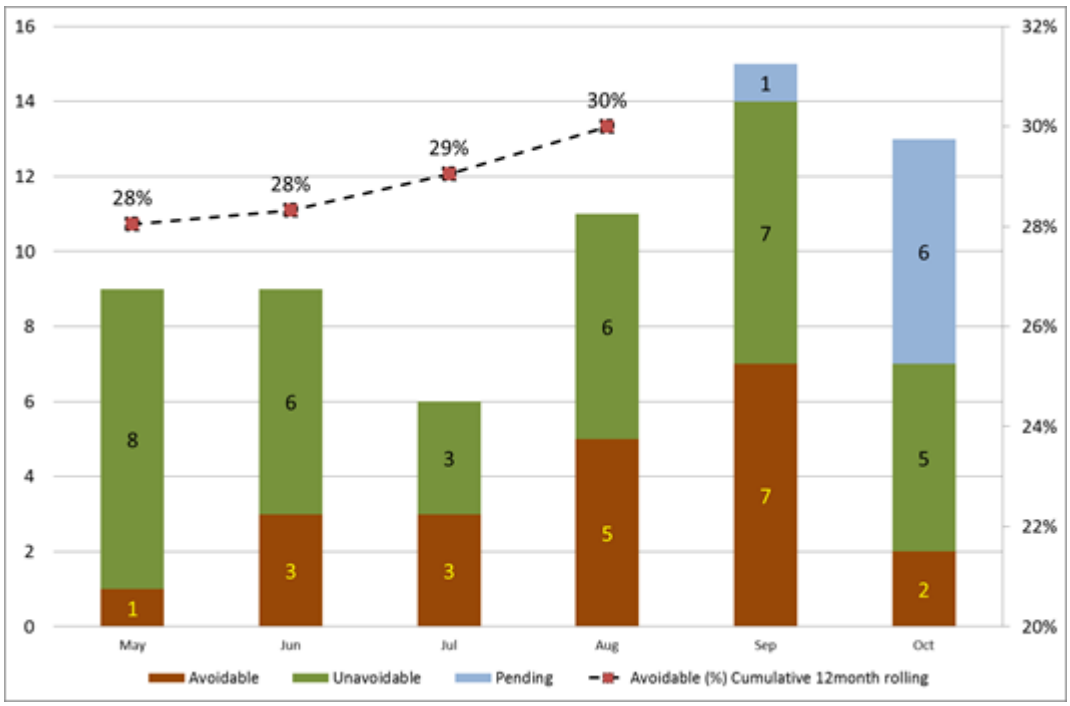
Purpose

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

Incidence

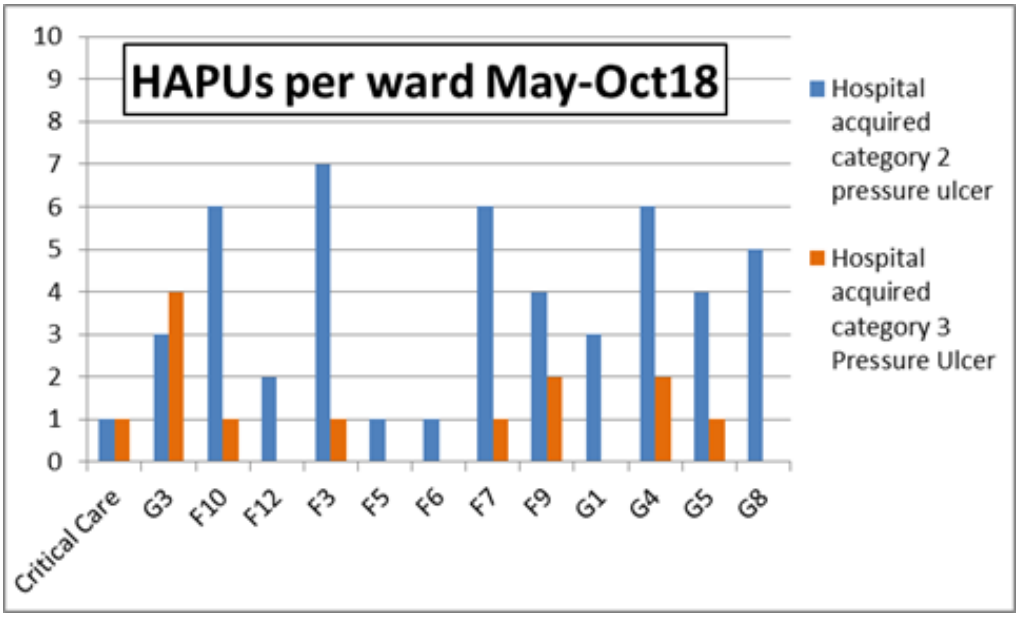
During this period, there have been 63 reported HAPUs, a reduction of 20 HAPUs compared to the previous six months, where there were 83 reported HAPUs, a 16.6% reduction over this period. The breakdown of grades in this period is, 51 grade 2 and 12 grade 3. There have been no incidents of grade 4 HAPUs. The definitions of the HAPU grading can be found in Annex 1.

Of these 63 HAPUs, 19 have been deemed avoidable at the time of this report, with 12 incidents still to be determined as to whether the pressure ulcer could have been avoided. This is detailed in the chart below:



Despite high temperatures and difficult working conditions during the summer months, the number of HAPUs remained low, however, there has been an increase in the numbers from August onwards. This trend may be indicative of staffing deficits across the organisation which have impacted during these months. This issue is currently being mitigated by an increase in recruiting nursing assistants in an attempt to ease the pressure created by high Registered Nurse vacancy.

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



The wards with consistently higher incidence of HAPUs; F3, F9, F10, G4 and G5, all continue to experience high acuity, staffing deficits and have substantial numbers of frail, vulnerable, elderly patients, many with complex comorbidities, placing them at greater risk. However, it should be acknowledged that the majority of these wards, have seen a reduction of reported incidents despite the complex challenges they encounter. Most significantly, these wards have seen a

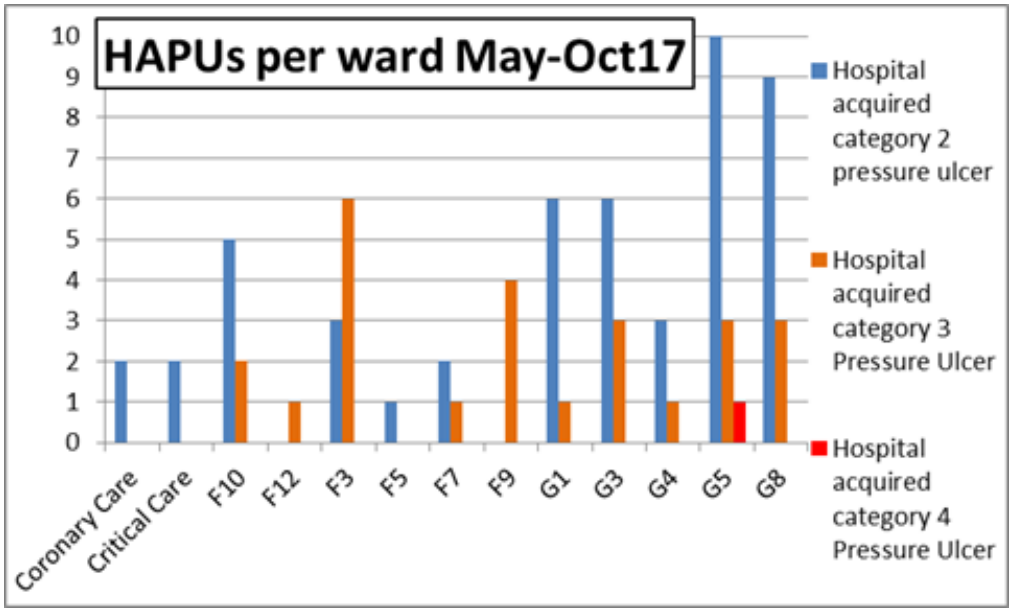
reduction in the number of grade 3 HAPUs, which is indicative of earlier recognition of risk and instigation of preventative measures.

In contrast, Wards F7 and G3 have seen an increase in reported HAPUs during this period and this is likely indicative of higher than average acuity, staffing deficits due to chronic vacancy and most pertinent, an increased length of stay on wards which are normally short stay with a high turnover of patients.

Ward F4 does not feature on the chart as there have been no HAPUs reported in the past 12 months. This is an elective ward, who has embraced the learning from previous incidences to ensure pressure ulcer prevention is in the forefront of care provision. This is despite seeing an ever increasing cohort of patients with more complex comorbidities who are at greater risk of pressure damage than in the past.

In comparison, the following chart indicates data from the same six month period in 2017. During that period, there were 76 reported HAPUs, 51 grade 2s, 24 grade 3s and 1 grade 4. This indicates that there has been a reduction in HAPUs from the equivalent reportable period of last year to this year, from 76 to 63 HAPUs. Most significantly, there has been a reduction in grade 3 HAPUs from 24 to 12, a 50% reduction.

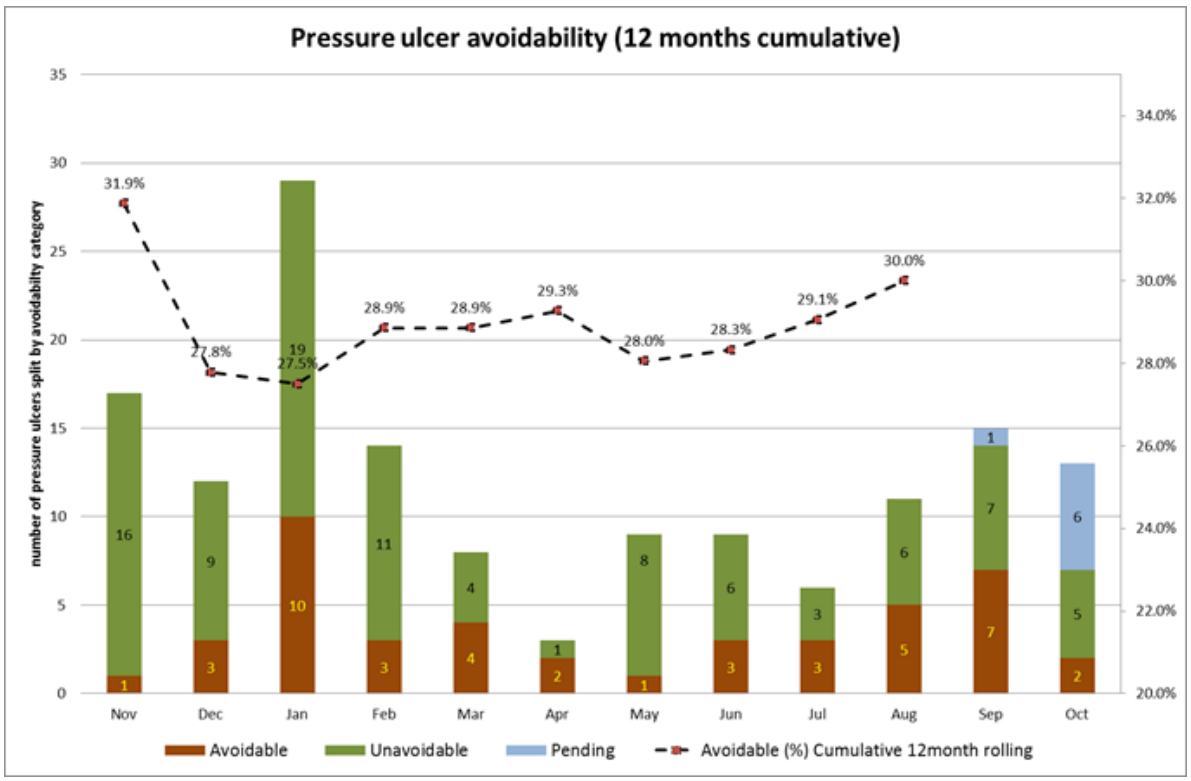
There have been improvements demonstrated by Wards F9, G1, G4 and G5 in pressure ulcer prevention. This has been achieved by focussed education and support from the Tissue Viability team and Senior Matrons. The teams in these areas have engaged with assessing risk factors, promoting preventative measures and endorsing the SSKIN principles. There is a significant decline on Wards F7 and G3, these are current areas of focus for the Tissue Viability Team with support from the Senior Matrons.



Reducing avoidable HAPUs

With the reduction of number of HAPUs reported, there has been a slight increase in the percentage of avoidable pressure ulcers over the past 12 months, however the Trust continues to achieve the target of less than, or equivalent to, 30% consistently for several months within the past two quarters. This is demonstrated in the chart below:

There has been a slight increase in avoidability in latter months and reasons for this increase are being explored as there are no obvious themes. There is close monitoring of the effect of bay based nursing and the reduction of registered nurse to patient ratio. This initiative has been driven by challenges in Registered Nurse recruitment and increasing vacancies. The scheme has been mitigated against by increasing the number of non-registered staff to ward areas and it is envisaged that this initiative will reduce the number of HAPUs.



Learning from incidents

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

Following a deep dive review of the avoidable HAPUs in April 2018, it was identified that a lack of repositioning of patients featured heavily as an indication of non-compliance with the pressure ulcer prevention principles.

In April 2018, West Suffolk Foundation Trust joined the NHS Improvement (NHSi) pressure ulcer collaborative. This is a national collaborative designed to ensure quality improvement measures are adopted to ultimately prevent and reduce incidence of pressure ulcers.

It was decided that repositioning was a fundamental principle of pressure ulcer avoidance and by using technology; a training package has been developed to raise awareness of the effect of regular position changes. This practice has been promoted on the inpatient areas and in a local residential home. These initiatives have been positively received by NHSi collaborative leads, who have provided excellent feedback on the plans and actions so far.

A ‘M.A.P’ system has been purchased, which allows monitoring of pressure areas through a LCD screen and demonstrate the impact of repositioning and bed movements in a very visual and engaging way. This training is currently being rolled out across the wards and departments in the acute and community settings through ‘Repositioning Roadshows’, and was launched during ‘Stop the Pressure’ week earlier in November. This portable device can be taken to the various departments and appropriate residential homes in the community to develop an enhanced understanding of pressure area prevention across all disciplines.

Participating in the collaborative has provided the organisation with the opportunity to share ideas nationally and showcase the initiatives and successes and lessons learnt, as well as engage in joined working across the acute and community services locally.

Other initiatives

Student Nurse Placements: The Tissue viability team have initiated a programme of bespoke short placements for pre-registration student nurses. This is an excellent opportunity to encourage students going through their training to adopt the principles of pressure area prevention and management and make an impact on the newly qualified nurses on the wards.

The Heel Heroes**:** This initiative continues with further training events to keep the allocated 'Heel Heroes' up to date and maintain momentum. Heel ulcers are nationally the second highest location for pressure ulcers and there continues to be a reduction in heel pressure ulcers since this and other projects are carried out.

Ongoing training**:** The Tissue Viability team continues its commitment to training and development across the hospital, being involved in staff inductions and close working with the Practice Development team to provide targeted training to various disciplines and bands across the hospital. This has recently been extended to groups of Allied Health Professionals, therapy assistants and college students potentially taking up further careers in healthcare.

'Bitesize' training sessions continue, are well attended and appear to be having a positive impact on reducing the incidence of pressure ulcers and promoting quality in wound care in general.

Enhanced Photography methods through Trust IPAD: A further development in the care and management of HAPUs is the introduction of a photography app on a dedicated iPad to upload images of wounds directly to e care. This initiative provides the ability to accurately record all hospital acquired pressure ulcers, to monitor progress and deterioration with wounds in our care and provides a bench mark.

New NHSI pressure ulcer reporting and grading guidelines

In recent years, there has been considerable effort to reduce the number of pressure ulcers and related harm, but this effort has been offset by disparities between trusts in the way they define, measure and report pressure ulcers. As part of the Stop the Pressure programme, new guidance on pressure ulcer definition and measurement in England was issued in June 2018 by NHS Improvement after a consensus-seeking exercise involving a large range of stakeholders. "*We anticipate that full implementation of the recommendations from April 2019 will improve understanding of the level of pressure damage harm in England. This will in turn support an organisation's ability to learn from reported incidents, and inform the quality improvement programmes that are required to help reduce reported pressure damage and improve the quality of care*" [NHSI June 2018].

The guidance will be rolled out nationally from April 2019 and encompasses 30 recommendations (See Annex 2) including an agreed definition of pressure ulcers National roll-out is preceded by the following steps:

- Quarter 1: finalisation of governance and approval of recommendations in practice across all national stakeholders [**National**]
- Quarter 2: communication to all key stakeholders about revised approach [**National**]
- Quarter 3: trusts complete preparations for implementing revised framework in relation to their local measurement approaches [**Local**]
- Quarter 4: shadow reporting using revised framework by all trusts [**Local**]

A plan to achieve the deadline of April 2019 has been formulated (see Annex 2). A communication plan for staff is also being developed to be led by the Tissue Viability team, Heads of Nursing and Matrons for Hospital and Community.

Summary

Over the past six months, there has been a significant reduction in the number of HAPUs, despite the challenges of increasing patient numbers, staffing deficits and high acuity. This reduction is evident when compared to the previous six months and the equivalent time period in 2017. However, it has to be acknowledged that this number may increase in the coming months with the changes in reporting and inclusion of moisture damage to the reporting structure.

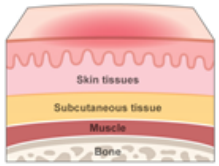
Overall, positive strides have been achieved over the past six months with integrated working across the divisions, both in the acute services and community setting, all with the same goal, to reduce the risk of pressure damage occurring and effectively manage those in our care.

PRESSURE ULCER PREVENTION ACTION PLAN 2018 /19					
Issue	**Action**	**Lead**	**RAG rating**	**Deadline**	**Comments**
Incidence of avoidable pressure ulcers	To reduce number of HAPUs overall and number of avoidable HAPUs by 10%	HoN Surgery / TVNs / Matrons	Achieved	August 2018	
There are inconsistencies with record keeping; specifically risk assessments not completed on admission and every 7 day, plans of care not initiated, documenting visual skin checks and position changes.	Development of a group to review documentation	HoN	Complete	May 2018	Group commenced and work is ongoing
	Development of standards for record keeping for the nursing staff	HoN		April 2019	Group commenced and work is ongoing
	Development of quality improvement measures to monitor compliance	HoN		September 2018	
	Support staff to attend TVN bitesize teaching sessions.	Matrons	Complete	May 2018	
	TVN to deliver ward based training on completing skin and wound assessments.	TVNs	Complete	May 2018	This training is ongoing
	Assurance of completion of safety assessments via Perfect Ward audits	Matrons	Complete	May 2018	Ongoing reviews
	Monthly review of compliance of patient safety reports	Matrons	Complete	May 2018	Ongoing reviews
Improve consistency with determining avoidability status	Development of criteria to determine avoidability / unavoidability	TVN / Governance team	Closed	July 2018	This action has been closed in line with new NHSi guidance
Incidence of pressure ulcer onset in last days of life	Initiate process of Kennedy ulcer reporting for patients in the last days of life	TVNs	Closed	July 2018	This action has been closed in line with new NHSi guidance
Repositioning of patients is inconsistent	Promote regular repositioning via teaching sessions and education	TVNs	Complete	June 2018	This action is ongoing
	Review documentation as part of standards for record keeping	HoN		April 2019	Date extended due to scope of project
	Roll out training using the MAP system	TVN		December 2018	
Lack of assessment of skin integrity within Emergency Department	Review benefits of introducing risk assessment scoring to Emergency Department	ED manager / TVN		May 2018	To gain an update on progress

PRESSURE ULCER PREVENTION ACTION PLAN 2018 /19					
Issue	**Action**	**Lead**	**RAG rating**	**Deadline**	**Comments**
Review of Governance process	Matrons and Ward Managers to continue to share specific concerns at Governance meetings and via harm free action plans	Matrons	Complete	May 2018	
	Tissue Viability to continue to oversee the pressure ulcer prevention group (PUPG) plan and report quarterly to CSEC	TVNs	Complete	May 2018	This action is ongoing
To embed the NHSi reporting guidelines	Update DATIX reporting system	Governance / TVNs		Jan 2019	
	Communicate changes to ward and department teams	HoN / TVN / Communication team		March 2019	

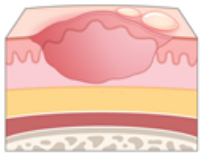
Annex 1 - Pressure ulcer staging

Stage 1



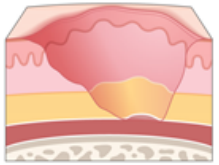
Non-blanching erythema of intact skin.

Stage 2



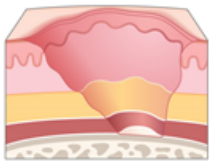
Partial thickness skin loss involving epidermis, dermis or both. Superficial and presents as blister or abrasion.

Stage 3



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

Stage 4



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

Annex 2 - Summary of NHSI Recommendations and High level action plan

Issue	Action	Recommendations	Update	Status
Terminology	Incorporate updated terminology into all PU documentation (policy, guidelines, training material, website content, etc.)	1-9, 11-14	CG10176 Pressure ulcer prevention guideline has been updated for terminology and is awaiting publication once all the monitoring pathways have been finalised.	In progress
Monitoring	Agree new classification structure and amend: a. Datix data capture b. Local investigation templates c. CCG and WSFT committee reporting templates	13, 15-26	a. Datix will be updated in December to allow shadow reporting in Q4. b. An updated concise investigation template is being designed by the Tissue Viability team. c. Proposed new reporting templates have been developed for IQPR, CSEC and CCG	In progress
Clinical Practice	Document does not highlight any change to clinical practice except to make explicit the requirement for weekly review of all unstageable and DTI ulcers	27	Already in place in: ▪ e-Care documented wound assessment ▪ SystemOne Care plan	Complete
Investigation	Serious Incident (SI) reporting should only incorporate 'serious' incidents	10, 28-29	Prior to this the Trust reported all Category 2 (moderate harm) incidents as an SI. This has stopped following confirmation from the CCG.	Complete

Recommendation
1. We should use the term 'pressure ulcer'
2. A pressure ulcer should be defined as: "Localised damage to the skin and/or underlying tissue, usually over a bony prominence (or related to a device), resulting from sustained pressure (including pressure associated with shear). The damage can present as intact skin or an open ulcer and may be painful"
3. A pressure ulcer that has developed due to the presence of a device should be referred to as a 'device-related pressure ulcer'
4. The 2015 NPUAP definition of device-related pressure ulcers should be used: "Pressure ulcers that result from the use of devices designed and applied for diagnostic or therapeutic purposes"
5. A pressure ulcer that has developed at the end of life due to 'skin failure' should not be referred to as a 'Kennedy ulcer'
6. Organisations should follow the current classification system recommended in international guidelines, incorporating categories I, II, III and IV
7. Organisations should follow the current classification system recommended in international guidelines, incorporating DTI
8. Organisations should follow the current classification system recommended in international guidelines, incorporating unstageable ulcers
9. The definition of a POA should be that it is observed during the skin assessment undertaken on admission to a service

Recommendation
10. The Department of Health and Social Care's definition of avoidable/unavoidable should not be used
11. The definition of a new pressure ulcer within a setting is that it is first observed within the current episode of care
12. The term 'category' should be used from October 2018 at a national level (in national reporting/policy documents)
13. Local organisations should, from October 2018, work towards using the term 'category' in clinical practice and local reporting/policy documents, with full implementation by the end of October 2018
14. The '72-hour rule' should be abandoned
15. Reporting of all pressure ulcers grade 2 and above on admission (POA) (observed in the skin assessment on admission to that service) should be incorporated into local monitoring systems.
16. Device-related pressure ulcers should be reported and identified by the notation of (d) after the report – for example, 'category II pressure ulcer (d)' – to allow their accurate measurement
17. Kennedy ulcers should not be measured separately
18. All reports should identify patients using their NHS number, not the hospital number, to help reduce duplication of reporting
19. Reporting pressure ulcers of category II and above should be incorporated into local monitoring systems
20. Reporting unstageable pressure ulcers should be incorporated into local monitoring systems
21. Reporting DTIs should be incorporated into local monitoring systems
22. Reporting of new POAs should be incorporated into local monitoring systems
23. The number of patients with a pressure ulcer should be incorporated into local monitoring systems
24. All pressure ulcers, including those that are considered avoidable or unavoidable, should be incorporated into local monitoring
25. MASD should be counted and reported in addition to pressure ulcers
26. Where skin damage is caused by a combination of MASD and pressure, it will be reported based on the category of pressure damage
27. Unstageable and DTI ulcers should be reviewed by a clinician with appropriate skills on a weekly basis to help identify a definitive PU category and change the category as required
28. Only pressure ulcers that meet the criteria for a serious incident should be reported to commissioners
29. We recommend no change to the definition of an incident and no amendment to the Serious Incident Framework: Supporting Learning to Prevent Reoccurrence (NHS England, 2015), which remains the overarching policy
30. NHS Safety Thermometer data collection should continue as a monthly point prevalence tool in all trusts to aid understanding of pressure ulcers and other harms in a local clinical setting. All trusts should undertake the NHS Safety Thermometer measurement each month to support quality improvement at individual department level. Data generated should be cross-referenced with other local data sources (e.g. NRLS) to understand the harm profile in any clinical area

15. Consultant appointment report

To RECEIVE the report

For Report

Presented by Jan Bloomfield

Trust Board Meeting– 30 November 2018

Agenda item:	15			
Presented by:	Jan Bloomfield, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	21st November 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:	Acute Consultant Paediatrics
DATE OF INTERVIEW:	Monday, 12th November 2018
REASON FOR VACANCY:	Fast Track Post
CANDIDATE APPOINTED:	[redacted]
START DATE:	Permanent Start Date: 14th November 2018
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	1 1 1

POST:	Hybrid Consultant in Paediatrics
DATE OF INTERVIEW:	Monday, 12th November 2018
REASON FOR VACANCY:	Fast Track Post
CANDIDATE APPOINTED:	[redacted]
START DATE:	Pending receipt of CCT
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted] aji University, India stitute of Medical Sciences, ember 1998 (D.N.B.) Paediatrics, Delhi cember 2004
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	1 1 1

16. Putting you first award

To NOTE a verbal report of this month’s winner

For Report

Presented by Jan Bloomfield

11:30 BUILD A JOINED-UP FUTURE

17. WSFT Digital Board report

To ACCEPT the report

For Report

Presented by Craig Black

Trust Board Meeting – 30 November 2018

Agenda item:	17			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Sarah Jane Relf, e-Care/GDE Operational Lead			
Date prepared:	23 November 2018			
Subject:	To receive update from Digital Board			
Purpose:	X	For information		For approval

Executive summary:
This paper confirms key points of interest raised and discussed at the Digital Board on 29 October 2018. Of particular note are updates on MMODAL, MedicBleep projects and the delay to implementation of ophthalmology.

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:	*Separate pillar group meetings and Digital Board.*
Risk and assurance:	*Full risks are reviewed at each meeting with any high level risks reported through to board assurance framework as appropriate.*
Legislation, regulatory, equality, diversity and dignity implications	*GDPR consideration is applied to all projects.*

Recommendation:
The Board is asked to note the update.

1. Background

1.1 In May 2016, the trust embarked on a major change programme to introduce a new electronic patient record (EPR). The programme was branded e-Care. In this initial phase, the programme introduced the following functionality:

- A new replacement Patient Administration System (PAS)
- FirstNet – a dedicated emergency department system
- EPMA – medicines management (prescribing and administration)
- OrderComms – requesting and reporting for cardiology and radiology
- Clinical documentation

1.2 Further enhancements have been made over the last 18 months including:

- 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
- VitalLinks
- Deteriorating patient workflows

1.3 The West Suffolk Hospital NHS Foundation Trust (WSFT) is one of 16 hospitals chosen to become a flagship Global Digital Exemplar (GDE). As part of the GDE programme funding was awarded to those hospitals considered to be the most advanced digitally with the hospital receiving £10million.

1.4 Our GDE programme comprises of four pillars:

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

The remainder of this paper provides an update on implementation of the GDE programme.

2. Pillar one

2.1 It was noted that the go live for OpenEyes (new ophthalmology system) has been moved from November to January 2019. This was to take advantage of the most recent version of the software which includes many enhancements.

2.2 The trust continues to work with national leads to agree a suitable approach for closed loop medication. This is a key requirement of achieving HIMMS level 6 and 7 which is a delivery requirement of GDE funding. We are also closely following the approach of Cambridge University Hospitals NHS Trust who have implemented a model of closed loop whereby the box of medication is scanned.

2.3 The board agreed a two phased approach to implementation of MedicBleep whereby staff would be “onboarded” onto the new system over a period of weeks and we would then consider removal of bleeps at a point when the significant bleep holders were all registered and actively using MedicBleep. This will be in the new year.

2.4 The board received the safety case and readiness assessment for cardiology upgrade and approved the go live.

2.5 We have been piloting roll out of new voice recognitation software called MMODAL with pain clinics. Overall the pilot was successful however it was noted that we need to complete a backload of patients into MMODAL to ensure that the system runs at maximum effectiveness. This will be completed by middle of January. Whilst awaiting this backload we will focus on bringing on board a number of smaller specialities that do not have transcription backlogs.

3. Pillar two

3.1 Helena Jopling reported that patient portal expansion was on hold until key project resource was available at the end of November. At this stage we have 712 people registered on the system with the expectation that this will increase significantly when we can actively recruit again.

3.2 It was also agreed that we needed to develop an application strategy that would guide our future FIHR application programme. This will be completed by the end of the financial year.

4. Pillar three

4.1 All GDE sites are required to produce four blueprints each year. The board noted the draft first blueprint for the organisation which describes how we implemented our therapy workflows. This has to be submitted to NHS Digital by end of this month for formal review prior to publication in the new year. This will then be publically available.

5. Pillar four

5.1 Mike Bone reported that there would need to be a full network shutdown prior to the end of the year and that he was working with operational and emergency planning leads to ensure that this was safely implemented.

6. Recommendation

6.1 The board is asked to note the report.

11:40 GOVERNANCE

18. Trust Executive Group report

To ACCEPT a report

For Report

Presented by Stephen Dunn

Board of Directors – 30 November 2018

Agenda item:	18			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	23 November 2018			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

Executive summary

19 November 2018

Steve Dunn provided an introduction to the meeting recognising the huge amount of work and staff effort to open the **new cath lab** – which he described as looking amazing. He thanked all involved. A discussion took place on performance across the Trust against **quality and operational targets**. It was reported to the committee that ESNEFT have indicated a significant variance from the planned forecast year-end position. Discussion took place on the potential impact of this from an operational and strategic transformation partnership (STP) perspective.

An update was given on **winter planning** including progress to open and staff additional capacity to provide resilience. It was recognised that resilience could only be achieved by working across the acute and community services and with system partners. A leadership development day is taking place in December to support and promote system working.

The **red risk report** was reviewed with discussion and challenge for individual areas. Three new red risks were received relating to: management of children in ED; methotrexate prescribing; and upgrade of the chemotherapy information system. The key strategic risks identified were:

- **System financial and operational sustainability** will impact of the quality of patient services (linked to operational performance and CIP planning and transformation)
- **Winter planning** (new) to ensure safe staffing and capacity for winter 2018-19.
- **Pathology services** – delivery of pathology services, including MHRA inspection, TPP reconfiguration and implementation of the new Clinisys System. These all have an impact on service delivery and patients services directly impacting of quality and sustainability of services.

The risk regarding failure to recognise, manage and identify deteriorating patients within the emergency department was downgraded to amber as a result of the mitigating action put in place. This will be kept under review.

The draft **capital programme for 2019-20** was review and with some amendments approved for submission to the Board. It was recognised that the 2018-19 capital funding has not yet been received and mitigation would need to be taken towards the end of the year to maintain the Trust's cash position if the funding is not received.

The revised **business plan templates** were approved and the timescale for completion reviewed and approved (January 2019). An update was received on **implementation of Allocate**. Implementation remains on track to deliver benefits across a range of activities: e-job planning; e-appraisal; medical rostering; and Allocate cloud. It was noted by the clinical lead that implementation had improved and a

good working relationship existed with the supplier.

A report was received from the **Digital Programme Board**. Key elements of the programme were reviewed including 'go live' with MModal with a revised scope in the early stages of implementation and ambitious plans for population health management.

The **Staff Health and well-being report** was received which described how occupational health services are embedded within operations, including community staff, and draws on best practice. There is a clear focus on mental health and working to provide advice and support on menopause.

A report was received which described the work of the **West Suffolk Alliance**. Changes to roles and accountability within the Alliance were set out, including closer integration between Trust and CCG staff to support the work plan. It was noted that as Dawn Godbold is retiring in January 2019 and operational responsibility for community services will, as part of the planned transition, move to sit under the Chief Operating Officer. Dawn was thank for the huge amount of work she has led and it was noted that she will continue to work on a part-time basis on the Alliance transformation agenda. Discussion took place on the focus of mental health service deliver and the role the Trust could play in supporting this work.

A part of the Alliance working the new **frailty clinical model** was reviewed. The service will now see the patients in the area of best care which may be ED, CDU, AAU, short stay or base ward, with an aim to ensure that length of stay is minimised and that re-admission is avoided. The significant amount of time and effort to get to this position was recognised.

5 November 2018

Steve Dunn provided an introduction to the meeting including a review of the key **Board papers** from the previous week - cancer and diagnostic performance was reviewed, It was noted that the executives have been invited to participate in CQC visits across the country as subject matter experts for well-led and specialist areas.

As part of the regular dialogue that takes place with the **CQC** a planned visit has been scheduled to meet with staff from maternity and nursing staff from across the Trust [*post meeting note: at the end of the successful visit it was suggested that the CQC return in March to speak with allied health professional and junior doctors*]. In addition, it was reported that the CQC had received an anonymous whistleblowing concern regarding action in response to safety concerns and the response when concerns are escalated. The Trust is responding to these and while the issues raised were not familiar to those in the room it was agreed that divisions engage with staff to test perceptions of patient safety and raising concerns.

The **red risk report** was reviewed and it was noted that the risk for managing deteriorating patient in ED had been downgraded to amber as a result of mitigation actions being put in place. It was agreed that TEG members be invited to a planned Board session on risk appetite.

A full discussion took place on the latest position regarding **pathology services** and the joint executive meeting with ESNEFT. It was accepted that while challenging the correct approach is being followed.

The result of the **CQC inpatient survey** were reviewed and the planned action to be taken by the divisions. The **education and library annual report** were received. The report was recognised as providing a good summary that gives visibility and highlights what a great resource we have in the library.

Relevant **policy documents**:

a) the **Trust travel plan** was approved – this recognised the pressure on site and encouraged car sharing. It was also noted that work to improve the changing facilities is almost complete but the facilities within Quince House are available for use by all staff
b) the **fee paying service policy** was approved with some minor amendments. The policy has been produced to: provide clear guidelines for staff for the management of private practice; outline an open and auditable process; clarify the boundaries between NHS and Private

healthcare; and ensure that all staff members are aware of their responsibility in identifying and recording fee paying services

c) the **Direction of choice policy** was approved. The policy provides: fair and equitable policy application to any person (18 years and over); guidance with regard to the rights of carers; clear process in relation to patient flow and discharge from hospital; reinforcement of consistent good discharge planning; and detailed clear escalation process.

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

19. Audit Committee report

To ACCEPT the report, including agreeing delegated authority for approval of the Charitable funds annual accounts

For Report

Presented by Angus Eaton

Trust Board Meeting – 30 November 2018

Agenda item:	19			
Presented by:	Angus Eaton, Non-Executive Director			
Prepared by:	Louise Wishart, Assistant Director of Finance			
Date prepared:	November2018			
Subject:	Audit Committee report - meeting held on 2nd November 2018			
Purpose:		For information	X	For approval

Executive summary:

The draft minutes of the meetings of the Audit Committee on 2nd November 2018 are not yet approved. The key issues and actions discussed were:-

- **Deep Dive**- **Risk Appetite.** BDO attended to present a session on risk appetite. The Committee found the presentation very useful and agreed that BDO should be invited back for a Board Development Session. The next development session is 28 February 2019.

- **Quality and Risk Subcommittee Report including Clinical Audit**- It was confirmed that the business case for the point of care testing would be available shortly as that was a significant concern for CSEC. This has subsequently been considered by EDs. Going forward the Committee will receive the summary Quality and Risk Subcommittee report only rather than receiving the detailed Clinical Audit Report too. The review and challenge of that report will continue to take place at CSEC.

- **Internal Audit and Counter Fraud**- The Internal Audit Progress Report confirmed that 5 reports had been issued since the last report to the Committee. Of the 5 reports, 1 was rated as partial assurance relating to Annual Leave Management

  The Executive Chief Nurse provided the Committee with assurance that actions were in place to address the issues raised including a ward annual leave process. This would require a set amount of annual leave to be taken per quarter.

  The Committee has made it clear that it expects performance to improve on actions implemented in accordance with the timescales agreed when Internal Audit Reports are issued.

  The Trust Local Counter Fraud Specialist (LCFS) highlighted the activities going on across the Trust in November which is Fraud Awareness month.

- **External Audit**- The Committee received an update on progress against external audit recommendations. One of the recommendations related to buildings insurance. The auditors highlighted the current cover is limited and that further cover should be considered. Progress has been made on this but the issue is still outstanding.

- **Revised Terms of Reference**- The Committee recommended changes to the Terms of Reference in July which were approved by the Board but following further discussion additional

changes were proposed and agreed subject to Board approval. These are enclosed and Board approval is requested.

- **Delegation of authority to approve the Charitable Fund Accounts**- The Committee requests that the Board delegates authority to approve the 2017/18 Charitable Fund Annual Report and Accounts to the Audit Committee. The outcome of the audit was not available for the November meeting and it needs to be considered before the Annual Report and Accounts are approved. The Charity Commission deadline for approval is 31 January 2019.

- **Appointment of Internal Audit and Counter Fraud Provider**- Following a competitive tender the Committee recommends to the Board the appointment of RSM for both Internal Audit and Counter Fraud Services for 3 years with the potential to extend for a further year. RSM is the current service provider.

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 2nd November 2018
- approve the revised Audit Committee Terms of Reference
- delegate authority to approve the 2017/18 MyWish Annual Report and Accounts to the Audit Committee
- approve the appointment of RSM to provide Internal Audit and Counter Fraud Services for 3 years with the potential to extend for a further year

Audit Committee – 2 November 2018

Agenda item:	9.1			
Presented by:	Louise Wishart, Assistant Director of Finance			
Prepared by:	Louise Wishart, Assistant Director of Finance Richard Jones, Trust Secretary			
Date prepared:	19 October 2018			
Subject:	Review of Terms of Reference			
Purpose:		For information	✓	For approval

Executive summary:

The Committee reviewed its Terms of Reference in July following the required annual cycle and informed by the outcome of Committee members completing a self-assessment.

Following a meeting between the Chair of the Committee, the Director of Resources, the Trust Secretary and Head of Governance and the Assistant Director of Finance, further changes are proposed to the Terms of Reference highlighted in this document.

In addition to the changes highlighted by amendments to the Terms of Reference it is proposed that:

- *Executive Directors are not required to attend all meetings unless there is an issue on the agenda particularly relevant to their area of responsibilities; and*
- *SFI waivers and Losses and Compensation will continue to be reported to the Committee but annually rather than quarterly. The reports would then be considered by Trust Executive Group quarterly to highlight the issues more regularly to those with the ability to improve controls.*

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

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

Previously considered by:	*The Terms of Reference were last reviewed in July 2018.*
Risk and assurance:	*The HFMA Audit Committee checklist has been used to inform the annual review of the Terms of Reference.*

Legislation, regulatory, equality, diversity and dignity implications	
Recommendation: The Committee is asked to review and request Board approval for the suggested amendments to the Committee's Terms of Reference and for the Committee to approve the further changes proposed which do not require an amendment to the Terms of Reference	

AUDIT COMMITTEE TERMS OF REFERENCE

1 Constitution

1.1 The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

2 Aim

2.1 The Committee will provide an independent and objective view of the Trust's internal control environment and the systems and processes by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations".

3 Scope

3.1 The Committee has overarching responsibility for monitoring specific elements of the systems and processes relating to governance, including financial systems, records and controls; financial information; compliance with law, guidance and codes of conduct; independence of internal and external audit; and the control environment (including measures to prevent and detect fraud). The Committee is responsible for providing an opinion as the adequacy of the integrated governance arrangements and Board Assurance Framework.

3.2 The Committee has a statutory role in respect of assurance, controls, compliance, data and probity, and on behalf of the Board it will review the work of its Sub-Committees, requesting explanations where required. The aim is to ensure complete coverage while avoiding duplication by close liaison and cross-representation between these committees. The coverage required includes assurance for Trust owned and part owned organisations, as well as key partners.

4 Membership

4.1 The Committee shall be appointed by the Board of Directors from amongst the Non-executive Directors of the Trust and shall consist of no fewer than three members, one of whom has recent and relevant finance experience. One of the members will be appointed Chair of the Committee by the Board of Directors.

4.2 The Trust Chair will ensure that there is cross-representation by Non-executive directors on the Audit Committee and the Quality & Risk Committee and its Sub-Committees.

4.3 A quorum will be two members.

4.4 The Chair of the Trust shall not be a member of the Committee.

5 Attendance at Meetings

5.1 The Director of Resources, Assistant Director of Finance and the Trust Secretary will normally attend all Committee meetings.

5.2 The Head of Internal Audit and a representative of the Trust's External Auditors will attend as necessary.

5.3 Other members of the Board of Directors have the right of attendance at their own discretion.

5.4 All other attendances will be at the specific invitation of the Committee.

5.5 The Committee will have the over-riding authority to restrict attendance under specific circumstances.

5.6 The Committee will meet with the External and Internal Auditors, without any other Board Director present at least once a year.

5.7 Attendance at meetings will be recorded as part of the normal process of the meeting. A record of attendance will be reported as part of the Committee's Annual Report.

6 Frequency of Meetings

6.1 Meetings will normally be held at least three times a year.

6.2 Special meetings may be convened by the Board of Directors or the Chair of the Committee.

6.3 The External Auditors or Internal Auditors may request a meeting if they consider that one is necessary.

7 Authority

7.1 The Board of Directors authorises the Committee to investigate any activity within its duties (as detailed below) and grants to the Committee complete freedom of access to the Trust's records, documentation and employees. This authority does not extend, other than in exceptional circumstances, to confidential patient information.

7.2 The Committee may seek any information (excluding confidential patient information, other than in exceptional circumstances) or explanation it requires from the Trust's employees who are directed to co-operate with any request made by the Committee.

7.3 The Trust Board authorises the Committee to obtain external professional advice or expertise if the Committee considers this necessary.

8 Duties and Responsibilities

The duties and responsibilities of the Committee are as follows:

8.1 Governance and Assurance

8.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

8.1.2 In addition the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will include the Quality & Risk Committee, its subcommittees, which consider clinical quality and corporate risk, including: clinical audit, health & safety, research and information governance.. The conclusion of this review should be referred to specifically in the Committee's Annual Report to the Board of Directors.

8.1.3 In particular, the Committee shall independently monitor and review:

8.1.3.1 the Annual Governance Statement (AGS) and the assurance system for all other external disclosure statements such as declarations of compliance with the Care Quality Commission registration, and any formal announcements relating to the Trust's financial performance, together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors. Under normal circumstances this would be through review of the annual report and accounts. Other significant external disclosure statements shall also be open to monitoring and review by the Committee.

8.1.3.2 the effectiveness of systems of internal financial and budgetary control and the integrity of reporting statements.

8.1.3.3 the effectiveness of systems for ensuring the optimum collection of income.

8.1.3.4 the effectiveness of risk management systems.

8.1.3.5 the effectiveness of the Board Assurance Framework (BAF).

8.1.3.6 the Committee will use a programme of 'deep dive' reviews to test the BAF and its priority areas as part of an assurance programme. The Committee's assessment of the effectiveness of the BAF should be included in the Committee's Annual Report to the Board of Directors.

8.1.3.7 the Quality Report assurance and review alongside the annual report and accounts.

8.1.3.8 the systems for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements, including the NHS Constitution, as set out in relevant guidance.

8.1.3.9 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.

8.1.3.10 arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

8.1.4 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

8.1.5 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

8.1.6 The Committee will receive the minutes of the Quality & Risk Committee for the purpose of ensuring: that there is no duplication of effort between the two

Committees; that no area of assurance is missed and; as part of its responsibility for reviewing the Annual Governance Statement prior to submission to the Board of Directors.

8.1.7 The Audit Committee shall ensure that there is a system for reviewing the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation. These will include, but will not be limited to, NHS Improvement, any reviews by DH Arms length bodies or regulators/inspectors (CQC, NHS Resolution etc) and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies etc.)

8.1.8 The Committee will consider how its work integrates with wider performance management and standards compliance and include this within the Annual Report to the Board of Directors.

8.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Board of Directors. An Internal Audit Charter will be agreed annually which will include objectives, responsibilities and reporting lines. An Internal Audit Charter will be agreed annually which will include objectives, responsibilities and reporting lines. This will be achieved by:

8.2.1 considering the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal.

8.2.2 the review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework.

8.2.3 consideration of the major findings of internal audit investigations, the effectiveness of the management's response and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

8.2.4 this will include exception reports of management action beyond deadline and consideration of the findings of Internal Audit "testing" of completed actions.

8.2.5 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.

8.2.6 assessing the quality of internal audit work on an annual basis.

8.2.7 ensuring any material objection to the completion of an assignment which has not been resolved through negotiation is brought to the Committee by the Chief Executive Officer or Director of Resources with a proposed solution for a decision.

8.3 Counter Fraud

The Committee shall ensure that there is an effective counter fraud function established by management that meets the Standards set out by the NHS Counter Fraud Authority and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

8.3.1 consideration of the provision of the Counter Fraud service, the cost of the audit and any questions of resignation and dismissal.

8.3.2 consideration of the major findings of counter fraud work (and management's response).

8.3.3 ensuring that the Counter Fraud function is adequately resourced and has appropriate standing within the organisation.

8.3.4 receiving an annual review of the work undertaken by the counter fraud function.

8.4 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work.

8.4.1 Consideration of the appointment, performance and cost effectiveness of the External Auditor, making a recommendation to the Council of Governors on appointment of External Audit.

8.4.2 To ensure that the External Auditor remains independent in its relationship and dealings with the Trust and to review the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;

8.4.3 To review the annual audit plan and to discuss with the External Auditor, before the audit commences, the nature and scope of the audit.

8.4.4 As part of the audit plan, discuss with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

8.4.5 To review External Audit reports, including value for money reports and management letters, together with the management response.

8.4.6 To consider where the external auditors might profitably undertake investigative and advisory work, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm..

8.4.7 To develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and

8.4.8 To assess the quality of external audit work on an annual basis.

8.5 Financial Reporting

8.5.1 The Audit Committee shall review the Annual Report and Financial Statements of the Trust and its Charitable funds before submission to the Board, to determine their completeness, objectivity integrity and accuracy. This review will cover but is not limited to:

- the wording in the Annual Governance Statement (AGS) and other disclosures relevant to the Terms of Reference of the Committee;
- changes in, and compliance with, accounting policies and practices;
- explanation of estimates and provisions having material effect;
- unadjusted mis-statements in the financial statements;
- major judgemental areas;

- the schedule of losses and special payments; and
- significant adjustments resulting from the audit.

8.6 Key Trust Documents

8.6.1 Review proposed changes to Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board for approval by the Board of Directors.

8.6.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

8.6.3 To review the Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board on a two yearly basis for approval by the Board of Directors.

8.7 Audit findings of key partners

8.7.1 To receive and consider relevant internal and external audit findings of significant partnership operations or operations for which we are full or part owners. For 2019-20 these were identified as:

8.7.1.1 North East Essex and Suffolk Pathology Services (NEESPS) audits commissioned by East Suffolk and North East Essex NHS FT

8.7.1.2 Category Towers audits undertaken by their appointed internal and external auditors

8.7.2 To receive and consider relevant assessments of key supplier risks.

8.8 Other

8.8.1 Review compliance with Standing Orders and Standing Financial Instructions through a schedule of waivers

8.8.2 Review schedules of losses and compensations

8.8.3 Seek assurance that the process to ensure supply chain risk is identified and appropriate actions have been taken is operating effectively.

8.8.4 Entries recorded in the gifts and hospitality register would be considered on an exception basis as reported by the panel considering the entries made.

9 Reporting, Accountability, Monitoring and Review of Effectiveness

9.1 The minutes of Audit Committee meetings shall be formally recorded and submitted to the Board of Directors along with a report of its activities no less often than three times a year; The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

9.2 The Audit Committee shall review its terms of reference annually.

9.3 The Audit Committee shall carry out a self-assessment in relation to its own performance no less than once every two years, reporting the results to the Board of Directors.

9.4 An annual report of the activities of the Audit Committee shall be presented to the Board of Directors and the Council of Governors, identifying any matters in respect of which it

considers that action or improvement is needed and making recommendations as to the steps to be taken.

9.5 A separate section of the Trust's annual report will describe the work of the Committee in discharging its responsibilities.

9.6 The Committee will report to the Board planned future workload and priorities for approval.

9.7 The Committee will agree on an annual basis a reporting framework for all areas of it terms of reference (Annex A). This determines standing items for the agenda and items for regular reporting.

9.8 Maintain and monitor performance against the agreed reporting framework.

9.9 Follow-up agreed actions to ensure these are implemented in a timely and effective manner.

Draft submitted to Audit Committee on 2 November 2018

20. Charitable Funds report

To ACCEPT the report

For Report

Presented by Gary Norgate

Trust Open Board Meeting – 30th November 2018

Agenda item:	20			
Presented by:	Gary Norgate, Non-Executive Director			
Prepared by:	David Swales, Technical Accountant			
Date prepared:	22 November 2018			
Subject:	Charitable Funds Board Report			
Purpose:	X	For information		For approval

Executive summary:

The Charitable Funds Committee met on 19th October 2018. The key issues and actions discussed were:-

- The Every Heart Matters appeal stands at a total of £436k following the transfer of £150k from a legacy supporting "the cardiac centre".
- There has been a lot of fund raising activity in progress and being planned and the Committee were pleased with the progress being made.
- The committee considered the next appeal following the completion of Every Heart Matters. The Butterfly garden project providing a less clinical area for Macmillan patients was discussed. It was supported by the Committee. It would require a full business case and approval by the Board.
- A paper requesting a part time legacy officer was discussed. The principle was supported but it was requested that a more formal proposal highlighting how fundraising would be focussed to help all charitable funds across the Trust.
- The Committee approved the proposal for the Clinical School Camera System.
- The first draft of the Annual Report and Accounts were discussed. A number of suggestions were made. It was agreed that a report on the strategic aims of the Charity and the reserves policy need to be prepared and considered by the Committee.
- It was noted that the Report and Accounts would be approved by the Audit Committee following delegated responsibility from the Trust Board.
- The Committee were updated on the performance on the investments. There had been an initial drop in value but it was noted that investments must be considered over the medium / long term.
- A new fund had been established following the receipt of a specific legacy for the West Suffolk Dialysis Unit

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

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	**X**	**X**	**X**	**X**	**X**	**X**
Previously considered by:	Charitable Funds Committee						
Risk and assurance:	None						
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation: The Trust Board is asked to consider the report of the Charitable Funds Committee							

21. Council of Governors report

To ACCEPT the report

For Report

Presented by Alan Rose

Board of Directors – 30 November 2018

Agenda item:	21			
Presented by:	Alan Rose, Deputy Chair			
Prepared by:	Georgina Holmes, Foundation Trust Office Manager			
Date prepared:	23 November 2018			
Subject:	Report from Council of Governors, 14 November 2018			
Purpose:	X	For information		For approval

This report provides a summary of the business considered at the Council of Governors meeting held on 14 November 2018. The report is presented to the board of directors for information to provide insight into these activities. Key points from the meeting were:

- Alan Rose chaired the meeting as Sheila Childerhouse had given her apologies. He welcomed and introduced Louisa Pepper to her first meeting of the Council of Governors.
- A written report was received from the Chair highlighting meetings and visits she had attended since the last meeting.
- The Chief Executive's report provided an update on the challenges facing the Trust and recent achievements.
- Responses to governors' issues were received.
- The quality and performance and finance reports were reviewed and questions asked on areas of challenge.
- A presentation was received from Rowan Procter on patient safety assurance and how quality was measured. Information on complaints received over the last quarter and key areas and trends were also presented.
- Louisa Pepper gave a presentation on her background and experience, why she wanted to be a NED and what she could bring to the role.
- A report was received on the West Suffolk Alliance, including plans for the next 12 months and benefits being seen as a result of partnership working.
- Liz Steele was elected as lead governor and Florence Bevan as deputy lead governor. Alan Rose thanked June Carpenter for all her work as lead governor.
- Reports were received from the Nominations committee and the Engagement committee.
- Reports were received from the lead governor and staff governors.
- Dates for Council of Governors meetings for 2019 were noted.

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

22. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Richard Jones

Board of Directors – 30 November 2018

Agenda item:	22			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	22 November 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 – 25 January 2019

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 services report	✓		Written	Matrix	DG / HB
Integrated quality & performance report: appraisal & mandatory training	✓		Written	Matrix	HB/RP
Transformation report (Including Category Towers)	✓		Written	Matrix	HB
Finance & workforce performance report	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Nurse staffing report	✓		Written	Matrix	RP
Learning from death report – Q2	✓		Written	Matrix	NJ
"Putting you first award"	✓		Verbal	Matrix	JB
Safe staffing guardian report – Q3	✓		Written	Matrix	NJ
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
Communication strategy	✓		Written	Matrix	JB
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Remuneration Committee report	✓		Written	Matrix	AE
Quality & Risk Committee report	✓		Written	Matrix	SC
Scrutiny Committee report		✓	Written	Matrix	GN
Annual governance review report and improvement plan	✓		Written	Matrix	RJ
Risk management strategy and policy	✓		Written	Matrix	RJ
Non-executive director responsibilities review	✓		Written	Action	SC
Register of interests	✓		Written	Matrix	RJ
Confidential staffing matters		✓	Written	Matrix – by exception	JB
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

12:00 ITEMS FOR INFORMATION

23. Any other business

To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency

For Reference

Presented by Sheila Childerhouse

24. Date of next meeting

To NOTE that the next meeting will be held on Friday, 25 January 2019 at 9:15 am in Quince House, West Suffolk Hospital.

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

25. 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