Board of Directors (In Public)

Schedule	Friday 1 November 2019, 9:00 AM — 11:30 AM GMT
Venue	Northgate Room, Quince House, WSFT
Description	A meeting of the Board of Directors will take place on Friday, 1 November 2019 at 9.00am in the Northgate Room, 2nd Floor Quince House, West Suffolk Hospital, Bury St Edmunds
Organiser	Karen McHugh

Agenda

9:00 'How your power silences truth' TED talk by Megan Reitz

AGENDA
Presented by Sheila Childerhouse

Agenda Open Board 1 Nov 2019.docx

9:15 GENERAL BUSINESS
Presented by Sheila Childerhouse

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

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

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

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

5. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 27 September 2019
   For Approval - Presented by Sheila Childerhouse

   Item 5 - Open Board Minutes 2019 09 27 September Draft.docx

---

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

---

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 Oct '19.doc

9:40 DELIVER FOR TODAY

---

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

   Item 8 - Master IQPR SPC September19v2.docx

   Item 8 - Integrated Quality & Performance Report_September19_v1.docx

---

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

   Item 9 - Board report Cover sheet - M06.docx

   Item 9 - Finance Report September 2019 Final.docx

---

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

---

11. Non-urgent patient transport update
    To ACCEPT the report
    For Approval - Presented by Helen Beck

    Item 11 - WSFT Trust Board NEPTS report 241019.doc

---

12. Winter planning - tracking report
To ACCEPT the report
For Report - Presented by Helen Beck

Item 12 - WSFT Trust Board winter plan tracking report 251019.doc

---

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

---

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

Item 13 - Board Report - Staffing Dashboard - September 2019 data.docx

Item 13 - WSFT Dashboard - September 2019.xls

---

14. Mandatory training report
To approve the report recommendations
For Report - Presented by Kate Read

Item 14 - Mandatory Training Trust Board 19 10.docx

---

15. Safe staffing guardian report – Q2
To receive the report
For Report - Presented by Nick Jenkins

Item 15 - Safe Staffing Guardian cover sheet - 1 nov 2019.doc

Item 15 - Safe staffing Guardian Quarterly Report July - Sep 19.docx

---

16. Freedom to speak up guardian report
For Report - Presented by Kate Read

16.1. To receive the report from the FTSU guardian
For Approval - Presented by Nick Finch

Item 16.1 - Freedom to Speak Report - trust board 1 November 2019.doc

---

16.2. To receive response to national FTSU guidance
For Approval - Presented by Kate Read

Item 16.2 - Response to national FTSU guidance.doc

---

17. Consultant appointment
To NOTE the report
For Report - Presented by Kate Read

Item 17 - Consultant appointment report -October 2019.doc

---

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

11:10 BUILD A JOINED-UP FUTURE

---

19. Integration Report
To ACCEPT the report
For Report - Presented by Kate Vaughton

Item 19 - WSFT Board - Integration Update Paper Nov 19 - 2019-10-24kv.docx

Item 19 - Appendix 1 - DRAFT Locality delivery plan Mildenhall and Brandon.docx

Item 19 - Appendix 2 - Frailty Test and Learn.docx

11:20 GOVERNANCE

---

20. Trust Executive Group report
To ACCEPT the report and the patient safety and learning strategy
For Report - Presented by Stephen Dunn

Item 20 - TEG report.doc

Item 20 Annex B - Patient safety and learning strategy - Oct 19 - facing pages.pdf

---

21. Quality & Risk Committee report
To approve the report recommendations
For Approval - Presented by Sheila Childerhouse

Item 21 - Quality and Risk Committee cover sheet.docx

---

22. Charitable funds report
To APPROVE the report
For Approval - Presented by Gary Norgate

Item 22 - Charitable Funds Board Report.doc

---

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

Item 23 - Items for next meeting.doc

11:30 ITEMS FOR INFORMATION

---

24. 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

24.1. To NOTE that the next meeting will be held on Friday, 29 November 2019 at 9:15 am in Newmarket 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

9:00 ‘How your power silences truth’ TED talk by Megan Reitz

9:15 GENERAL BUSINESS

Presented by Sheila Childerhouse

1. Introductions and apologies for absence

To NOTE any apologies for the meeting and request that mobile phones are set to silent

For Reference

Presented by Sheila Childerhouse

2. Questions from the public relating to matters on the agenda

To RECEIVE questions from members of the public of information or clarification relating only to matters on the agenda

Presented by Sheila Childerhouse

3. Review of agenda

To AGREE any alterations to the timing of the agenda

For Reference

Presented by Sheila Childerhouse

4. Declaration of interests for items on the agenda

To NOTE any declarations of interest for items on the agenda

For Reference

Presented by Sheila Childerhouse

5. Minutes of the previous meeting

To APPROVE the minutes of the meeting held on 27 September 2019

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 27 SEPTEMBER 2019

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Sheila Childerhouse	Chair	•	
Helen Beck	Chief Operating Officer	•	
Craig Black	Executive Director of Resources	•	
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	Trust Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Kate Read	Interim Deputy Director of Workforce		
Tara Rose	Head of Communications		
Kate Vaughton	Director of Integration and Partnerships		
Governors in attendance (observation only)			
Peter Alder, June Carpenter, Judy Cory, Amanda Keighley, Jo Pajak, Jane Skinner, Liz Steele			

Action

GENERAL BUSINESS

19/170 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

Apologies were noted from Rowan Procter.

The Chair welcomed everyone to the meeting.

19/171 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Joe Pajak thanked Helen Beck for her report on Brexit preparations. He referred to the National Audit Office's report on exiting the EU and supplying the health and social care sectors and asked if there was anything more that WSFT could reasonably do as a Trust to prepare and try to reassure the public. It was agreed that this would addressed under item 11, 'EU Exit Report'.

Amanda Keighley referred to the item in the Chief Executive's report on palliative care and unrelieved pain. She asked for assurance that this was not an issue locally. The Chief Executive said there had been a specific focus by the system on end of life care and it had been agreed that a piece of work on this should be undertaken; the issue of unrelieved pain would be incorporated into this work. **R Procter**

Liz Steele, on behalf of the governors, commended staff on all the work they had put into the visit by the CQC. She also congratulated Nick Jenkins on his feedback on WSFT's use of IT at the recent event which she had attended.

She said that she understood that there was a pharmacist on every ward. Therefore she was surprised at the dip in performance on the number of patients being told what their medication was for and asked for assurance that this was being addressed. Nick Jenkins noted that this referred to the results of the national patient survey report. He confirmed that there was a pharmacist attached to every ward and said that this had come as a surprise to the executive team and would be reviewed. **N Jenkins**

June Carpenter reported that she had undertaken an area observation yesterday in the pharmacy outpatient area and the pharmacist had asked patients if they understood what their medication was for, when to take it and possible side effects. Nick Jenkins explained that there was also a scheme in the community to ensure that patients were aware of what their medication was for etc.

The Chair echoed Liz Steele's thanks to all staff, particularly the executive team, for all their hard work in preparation for the CQC visit. She was very pleased with their feedback on staff engagement.

19/172 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

19/173 DECLARATION OF INTERESTS

None to report.

19/174 MINUTES OF THE MEETING HELD ON 28 JUNE 2019

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

19/175 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following update given:

Item 1740; include Filipino staff short story on the quality and risk committee agenda for September. It was noted that this would be part of the agenda for the quality and risk committee meeting this afternoon.

The completed actions were reviewed and there were no issues.

19/176 CHIEF EXECUTIVE'S REPORT

The Chief Executive reported that the hospital had continued to be very busy during the summer which had resulted in a considerable amount of additional spend on agency staff and locums. A further cohort of overseas nurses would be joining the Trust which should assist the financial position as well as helping to relieve the pressure on other staff. A very good recruitment campaign was also being undertaken but he stressed that as well as additional nurses the organisation also needed more space/capacity. The second phase of the acute assessment unit (AAU) would be officially opened next week and this would help to provide additional capacity.

He thanked governors, the board and executive team for their input and attendance at the annual members meeting which went extremely well. The soap box challenge had also been a very good event and had raised a considerable amount of money.

The feedback from the CQC had been very positive about staff engagement and he thanked the teams and staff for their preparation and work on this. However, there were a number of areas that the CQC wanted to follow up on and it was hoped that these could be addressed and clarified.

The Chief Executive's report also contained reference or links to a number of other reports, including Freedom to Speak Up guidance. Richard Jones explained that a response to this would come to the next board meeting. **K Read**

Alan Rose referred to the outcome of the CQC inspection and suggested that the board needed to be realistic and accept that there was small chance that the Trust could lose its outstanding rating which would require significant a communication plan. He hoped that this would not happen but the organisation needed to be aware that this was a possibility and be prepared as to how this would be communicated to the public. The Chief Executive acknowledged that this was a risk and stressed that no one was being complacent.

Tara Rose agreed and said that whatever CQC rating was received would require a comprehensive communications plan. She assured the board that this would be in place for whatever rating the Trust was given.

DELIVER FOR TODAY

19/177 INTEGRATED QUALITY AND PERFORMANCE REPORT

Helen Beck explained that she would highlight issues in her area and then where possible respond to questions for Rowan Procter in her absence.

There had been a slight deterioration in referral to treatment times (RTT) which was not a surprise as the numbers had been reduced through validation rather than activity. Work continued with the operational teams to try to spend the additional funding that had been provided by the CCG to deliver additional activity. However, it was very difficult to identify opportunities to safely outsource patients to other providers within the vicinity.

The issues around diagnostics in cardiology had been resolved and the remaining issues in other areas continued to be addressed. The issues in endoscopy had been partly due to resources and also capacity and replacing the washers; it was anticipated that performance in this areas would recover by the end of October.

The two week cancer wait target was being achieved apart from patients with breast cancer symptoms where there were breaches. However, Helen Beck stressed that this was due to patient choice not capacity, therefore the Trust was working with primary care about the message being given to patients on how important it was that they attended appointments.

The 62 day cancer performance was very volatile due to the small number of patients. As diagnostic performance in endoscopy improved this had increased to 81% which at the required figure of 85%.

At the request of WSFT the Intensive Support Team had visited the Trust and undertaken a review of its cancer performance. The report had just been received and would be reviewed and discussed by the Trust Executive Group and other relevant groups/areas.

Richard Davies noted that discharge summary performance had deteriorated rather than improved. He also referred to the patient experience survey and poor performance relating to the discharge process and communicating with patients. He asked if the management of discharges and communication needed to be focussed on within the organisation and as a system. Helen Beck agreed that this was an issue across the system and that there were actions that could be taken to improve this, particularly relating to communication.

Where possible the acute and community teams and assistant directors of operations (ADOs) were looking at aligning discharging planning teams etc within the community rather than within the acute setting. Work was also being undertaken around patient information and discharge leaflets. Staffing challenges also had some impact on this.

Nick Jenkins agreed that there were actions that could be taken to improve this. A successful joint session last year run by Dermot O'Riordan and Christopher Browning about the importance of accurate and relevant discharge information had appeared to have an impact and resulted in an improvement in performance. It was planned that a further session would take place at the start of the academic year. He agreed that this was also related to staffing issues. **N Jenkins**

Gary Norgate asked if the use of temporary staff should decrease in September. It was confirmed that this was the case. He referred to pressure ulcers and the narrative on when an improvement could be expected to be seen and asked if narratives for other indicators could also include this information. **C Black**

Angus Eaton agreed that this information would be helpful. He referred to the SPCs and said it would be useful to understand if these were proving useful in the management of the areas they related to. Also if they were beginning to identify early indicators that there could be issues in certain areas. Helen Beck explained that currently the production of these was very much at strategic level. However, Joanna Rayner and Alex Baldwin were undertaking further work with greater detail and how to produce data in different ways. To date it was difficult to say what impact this was having.

Craig Black explained that within the next few months staff would be able to access this information within their area which should help to identify issues sooner. The next stage was to get more into predictive analytics.

The Chair asked if there were any lessons that could be learned from other Trusts which used these as a tool. Craig Black explained that a lot of work had been undertaken previously looking at information and systems used by other Trusts but it had not been possible to identify the best system. Therefore WSFT was working with Cerner to produce a better version/product.

Alan Rose noted that over the last few months the patient experience team had struggled with responding to complaints and performance was now at 40%; he had been working with the patient experience manager to try to understand the reason for this. One of the reasons appeared to be that complaints were becoming more complex which was creating a demand on staff to respond to these. It was confirmed that an additional member of staff for this team had been approved. It was noted that the number of complaints had reduced.

Gary Norgate noted that performance appeared to be very low for nutrition assessments and initial health assessments for children in care. He suggested that there should be a different set of metrics for children in care which enabled the board to understand if WSFT was meeting its requirements. Helen Beck explained that she reviewed a very detailed report for this each month and this indicated that WSFT was not really offering people much choice for appointments. The 18 week performance for paediatrics in the community was very good, ie 98-99%; therefore she had been having discussions about how to prioritise certain groups of patients. The plan was to hold three appointment slots a week for children in care that could be released to other people at short notice. This would continue to be monitored and she hoped that there would be an improvement in performance from October onwards. **H Beck**

Louisa Pepper referred to nutrition assessments and said that when she had taken part in a quality walkabout an issue had been identified with e-care and these assessments; she asked if this was being addressed. Nick Jenkins confirmed that Rowan Procter was following this up. It was requested that there should be an update at the next meeting. **R Procter**

Angus Eaton asked about duty of candour and noted that there were still challenges in this area but there would be a review in September with recommendations. He asked for assurance that this was taking place. Nick Jenkins said that he would follow this up with Rowan Procter and a report would come back to the next meeting. **N Jenkins**

Louisa Pepper noted the improvement in risk assessment performance. Nick Jenkins acknowledged this but said it was hoped that performance in this area should significantly improve over the next few months.

Richard Davies referred to patients scanned within one hour for a possible stroke. He noted that patients who breached were often patients who were missed in the emergency department because they were not considered to have had a stroke. He acknowledged that diagnosis could be very difficult but asked if there was something that could be done about the pathways in the emergency department. Nick Jenkins agreed that this was an issue but it was challenging and difficult to diagnose a stroke in some instances which meant that a senior review would not be asked for. He confirmed that all missed diagnoses were reviewed.

Helen Beck explained that stroke was one of the new emergency department performance indicators. This would help raise awareness in the emergency department and help drive change.

19/178 QUALITY AND LEARNING REPORT – Q1

Nick Jenkins highlighted the learning from deaths work, summary of quality walkabouts and 'Greatix', ie learning from excellence, which was also very important.

Alan Rose considered this to be the most important report of all as it showed how the organisation triangulated and learned from information. The Chair agreed that it was important to learn from the positives as well as the negatives.

Gary Norgate also agreed that this was a very good report and said that it provided reassuring information on nutrition. He referred to learning from serious incidents and never events and asked for assurance that actions were being taken in the form of written warnings or documented lessons followed up by discussions in appraisals. Nick Jenkins explained that all doctors were required to mention any serious incidents that they had been involved in in their appraisals and there was a feedback check with the governance team that these had been reported. Gary Norgate asked if this was also the case with nurses. Craig Black confirmed that where an individual was mentioned in more than one complaint this would be reported to Rowan Procter. Nick Jenkins explained that he also received information if doctors were mentioned in more than one complaint.

The Chief Executive explained that Greatix allowed staff to report what they saw and provided the opportunity to feedback formally to those staff who might not otherwise receive this feedback. He said that Paul Morris should be credited for this.

19/179 FINANCE AND WORKFORCE REPORT

Craig Black reported that the financial position after month five was very poor, with a deficit of £4.1m, against a planned deficit of £1.5m, which meant that the Trust was now £2.6m behind budget. However, he explained that some of this related to delays in information around temporary staffing costs.

The report provided a lot of detail but the main issues were the same as every other month, ie the use of temporary nurses and medical staff which was linked to additional capacity. Although there was a variance of £2.5m the Trust had delivered £2.5m of activity in excess of plan. However, nurse staffing levels showed an increase in the ratio of staff to beds, particularly unregistered staff. Some of this was planned, particularly around bay based nursing. The additional nurses from the Philippines would help the situation but temporary nurses were still being used within the organisation.

The provision of additional capacity within the organisation as part of winter planning would also come with an additional cost and the system could not afford the additional activity that was being delivered. The attempt to meet RTT times had resulted in additional costs with additional sessions and the use of locum staff. He stressed that all this activity was unaffordable within the control total.

In response to the deterioration of the financial position each division be asked to put together a recovery plan. As a result, a number of actions had already been implemented in order to address the over spend but these would not be sufficient to achieve the target.

Discussions were being had with the CCG about the additional activity and the Chief Executive and Craig Black were meeting with Ed Garratt, the CCG's accountable officer, next week to discuss this. Craig Black stressed that this was a system issue and there needed to be a system solution. Relationships with the CCG were better than they had ever been and it was hoped that there would be system response to this. However, something different needed to be done because WSFT and the rest of the country could not afford to keep providing additional capacity to treat patients.

The Chair asked Craig Black to comment on a move to a collective control total for the STP. Craig Black said that every other acute hospital within the region was reporting similar pressures in terms of an increase in capacity which was resulting in them being overspent, with the exception of Cambridge and Peterborough who were being supported by all the other systems to the effect of £25m.

Within the local STP ESNEFT was reporting similar pressures although the CCGs' financial position in the east was better than in the west. However, it did not appear that there was the flexibility within the rest of the STP to balance out the position in WSFT or ESNEFT.

Kate Vaughan referred to the CCG's financial position and explained that it had £1m of cost pressure around prescribing and continuing health care and primary network development funding.

Gary Norgate thanked Craig Black for a very transparent report and for explaining how the position had deteriorated so quickly. He referred to the additional demand and resources and asked if one was in line with the other, ie £1m overspend in the corporate division which did not reflect additional capacity. Craig Black explained that the over spend in the corporate division was where some CIPs were based. He said that the increase in staff against an increase in capacity was an interesting question.

There had been a 5% increase in nursing staff and 4%-4.5% increase in capacity which suggested that the organisation was becoming less productive. However, this was not reflected on the wards which raised the question about how comparable a unit of activity was between years, ie acuity of patients etc. Therefore it was difficult to compare volume of activity and staff numbers year on year.

Angus Eaton agreed that this was a good, clear report which provided a good explanation of the situation. He asked if the board was doing everything within its power to react to the situation that the organisation was in and if there was sufficient support etc to address this.

Craig Black explained the consequence that the over spend had on the cash position, ie not hitting the control total meant not receiving sustainability funding, therefore the ability to invest in the estate in the future. A report would be going to the closed board meeting with more detail about the actions being taken to recover the position and also actions for further debate. The outcome of these discussions would then be detailed in the report to the open board meeting next month.

The Chief Executive said that it would not be possible to do everything planned due to the financial position that the organisation was in. Safety would be the priority and ensuring that there were the staffing levels to respond to demand, but it was also important to ensure that the organisation was not over staffed. However, he stressed that there would be trade-offs to enable this to happen.

Angus Eaton noted that the cash position had decreased significantly and asked what was being done to address this. Craig Black explained that a loan application for capital had been submitted in advance of this financial year. However the approval process had been somewhat protracted and this had not yet been approved; the Trust had been asked to resubmit its application a number of times. The capital programme had continued without the loan, therefore the cash position was worse than it otherwise would have been. As the capital funding had not been received when it was expected the cash position had deteriorated accordingly.

The Chair thanked Craig Black and explained that this would be discussed further in the closed board meeting. There would be the opportunity for governors to ask questions about finances in the quality and risk committee meeting this afternoon.

19/180 EU EXIT REPORT

Helen Beck explained that this report gave details of the preparations that were being made in line with everything that the Trust was being asked to do by the emergency planning teams both nationally and regionally. The issue around the gap in social care provision had been picked up locally and had been assessed as low risk, as only 6% of the workforce were EU nationals.

Over the next days and weeks the local and national implications of the Audit Commission's report that Joe Pajak had referred would be looked at. The difficulty would be if everyone started to purchase and stockpile drugs, medical supplies etc, as this would create a problem. Therefore, the advice was that this would be done at national level. However, the Trust would be watching what the Audit Commission was saying carefully and if there was any action it needed to take. WSFT had excellent and well developed command and control structures in place which would help in managing any unexpected consequences.

Joe Pajak asked how it could be communicated to people who had concerns about supplies of life saving drugs that this was being addressed. Kate Vaughton explained that a communications plan to reassure people had been discussed with

the CCG and this would continue. The Chair suggested that WSFT and the CCG needed to consider a communications plan for this. It was confirmed that Tara Rose was involved in the communication streams around all of this. **H Beck / T Rose**

The Chief Executive reported that he recently been to NHS Expo where he attended a couple of presentations on the Brexit programme and a national meeting of NHS England. It had been stressed that this was one of the priorities for NHS leadership and everyone should be proceeding with the expectation that 31 October would happen. In terms of planning, the NHS had been well prepared for 31 March and had since had more time to plan further.

However, there was a concern that as 31 October was approaching winter this would create a further degree of pressure. WSFT's preparation had been very good but there was also a national concern about winter and social care staff who were EU nationals on zero hours contracts. This could result in potential discharge issues during the winter. The other national concern was the problem that panic stock piling could create and this was why communication was so important.

He said that he was very reassured by the planning that had been done but there could be issues outside WSFT's control.

It was proposed that Tara Rose should send governors details about the communication plans for Brexit. **T Rose**

Richard Davies asked for absolute assurance about flu vaccine supplies. Nick Jenkins said could not give specific assurance around this but the flu vaccine had started to arrive. The Chief Executive understood that the majority of the flu vaccine should be in the country by 31 October, apart from the vaccine for a specific group of young people with chronic conditions. Nick Jenkins explained that staff who had direct patient contact would take priority.

19/181 NON-URGENT PATIENT TRANSPORT UPDATE

Helen Beck reported that earlier this week, at the request of E-Zec, there had been a meeting between their commercial director, operational director and Ed Garratt to talk about the contract. She explained that E-Zec had contracts in other areas of the country which they delivered successfully and she felt that it was good to see them making this overture. They recognised that this contract was not working which could therefore impact on other contracts in the future; therefore they had proposed an alternative option as to how this could be addressed. At no additional cost to the CCG they proposed putting in additional resources and differentiating between the crews that dealt with outpatient activity and discharge activity. They also proposed giving the acute Trusts greater control over managing discharge activity.

This proposal would need further scrutiny but provided another option. An update would be given at the next meeting. **H Beck**

The Chair said that this was positive news; however she would like to receive more positive feedback from patients.

Gary Norgate said that he was shocked by the waiting times for transport experienced by patients and asked if the longest waiting times were monitored. Helen Beck assured the board that a number of individuals were spending a great deal of time every day trying to manage this process and mitigate some of these issues. The control room at the hospital monitored and managed picking up times and waiting times. Some of the issues were around the way in which E-Zec had been capturing and reporting this data.

The transport office had also been moved from the front of the hospital to the discharge lounge.

19/182 WINTER PLANNING – TRACKING REPORT

Helen Beck explained that this was an iteration of the paper that had previously been to the board. The bed model showed what it would look like at different percentage increases in demand and could be changed if the actual numbers changed as the organisation moved into winter. Currently this was predictive modelling and subject to a lot of variations.

The operational plan had been amended as a result of feedback from the senior nursing team. F10 would be used as the planned medical escalation ward and G9 as medical surge capacity.

Demand management initiatives were outlined in the report and modelling work was being undertaken to enable numbers to be put against these initiatives so that the impact of these can be understood.

She explained that this paper was a plan as to how to manage patients coming through the front door. However, she stressed that there were financial constraints and resources needed to be managed effectively.

The Chair asked if the escalation areas would be ready when required as this had not been the case last year. Helen Beck confirmed that this had been addressed and staff to manage these areas had been identified.

Alan Rose noted that a 4% increase in demand had been used as the best case scenario. Therefore he asked why there was a need to incur additional costs as the Trust had been able to plan for this. Helen Beck explained that some of this was due to not being able to close the escalation capacity during the summer, which related to the current overspend issues. She said that this reflected what it cost, not what was budgeted and allowed for. It was explained that these figures were included in the forecast and that figures in this report reflected the figures within the budget.

Nick Jenkins reported that doctors had been recruited and were ready to staff the escalation areas in the winter, ie G3 and F10. However, there were no dedicated staff for the surge capacity. He stressed that the increase in beds also impacted on the diagnostic capacity etc.

Helen Beck confirmed that pharmacy and therapy resources had also been identified for the escalation areas. However, if the surge capacity was opened staff would need to be moved from other areas and bank staff would also need to be used.

The Chair asked if any increase in support in the community had been included in the winter plan. Helen Beck confirmed that this was the case and additional band sixes and therapists had been put into each team. There were also integrated teams within the community to assist in patient experience etc.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

19/183 NURSE STAFFING REPORT

Kate Read reported that there were 19 nursing assistant vacancies, but there were 16 in the pipeline to fill these and more were to be recruited from the USAF base, which was very positive. 77 of the 79 registered nurse vacancies had been filled.

A large number of overseas and newly qualified nurses would be starting shortly and additional training had been arranged for these individuals.

The Chief Executive considered this to be very positive and said that the amount of work that had been undertaken to recruit these staff should not be under estimated. Gary Norgate agreed and said that the Trust now needed to ensure that it stopped using bank and agency staff, or if it did this should be reflected by an increase in performance/activity.

19/184 NATIONAL PATIENT SURVEY REPORT

Richard Jones explained that this would be reviewed by the Patient Voice Group and the divisions and a further report would go back to the Patient Experience Committee. **R Procter**

19/185 EDUCATION REPORT

Kate Read highlighted the benefits of the graduate course in medicine. WSFT had been top in the East of England in the General Medical Council survey for post graduate medical education with a 3% increase on the previous year.

The nursing and midwifery student placement capacity would increase by 34 over the next few months. Adult nursing placements and ODP placements had both increased to six.

Details of the apprenticeship training which WSFT was now able to provide as a result of the government apprenticeship levy were given in the report. It was also looking at gifting some of its levy to its Alliance partners who were not part of this scheme.

She highlighted the various initiatives under the leadership and talent management programme and thanked Denise Pora and her team for all their work on this, as did the board. She also highlighted the work being undertaken to promote healthcare as a career.

Richard Davies considered this to be an excellent report and said that it was very good to see the range and quality of the educational work being undertaken.

19/186 INTERIM PEOPLE PLAN

Kate Read explained that this report provided a high level summary of the six workstreams to support this plan. WSFT had also submitted five areas of excellent practice to the Academy for inclusion in its guide.

Angus Eaton considered this to be a very comprehensive report and asked how the outcomes of the activity described would be measured. Kate Read explained that this was part of the workforce strategy group which reported to TEG on a quarterly basis.

19/187 ANNUAL REPORTS FOR:

The Chair considered these to be a very good collection of annual reports with a lot of positive information but also with key challenges within them.

187.1 Equality

Denise Pora explained that this report demonstrated to the board that the action plan from the previous year had been completed. She highlighted the work being undertaken by Nicola Cottington on the LGBT+ network; Jen Bacon to support staff and patients with visual impairment and Cassia Nice to collect information about patients' protected characteristics on a form included with outpatient appointment letters.

The Chair thanked Denise Pora and everyone else who was delivering these changes.

The board approved this report, the Trust's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports, prior to publication.

187.2 Infection prevention

Angus Eaton asked if community services were part of this report. It was confirmed that this was the case.

The board received and approved this report.

187.3 Safeguarding children and adults

The board received and approved this report.

19/188 CONSULTANT APPOINTMENT REPORT

The board noted the appointment of the following:

Dr Drew Welch – Consultant in Anaesthetics
Dr Daniel Gavin – Consultant in Gastroenterology

19/189 PUTTING YOU FIRST AWARD

Kate Read reported that Putting You First Awards had been received by Esther Rawlinson, critical care follow-up sister and Joanna Rayner, Head of Performance & Efficiency in August and Rose Dennis in September.

Esther Rawlinson had worked in critical care for many years and last year was appointed as follow-up sister. Since then she had supported patients on the ward, and at clinics and support groups, and had worked with an ex-patient to facilitate the provision of access to a local leisure centre to enable patients to improve their rehabilitation journey. In July she organised a very successful critical care open evening where the compassion she extended to patients and their families was apparent. Her professionalism and compassion went beyond what was expected and she had the respect of both the critical care team and of patients and their families.

Joanna Rayner originally volunteered to do a few shifts on the Medic Bleep help desk prior to go live. She quickly immersed herself in the project and became someone everyone relied on, eventually becoming a part of the go-live leadership team. She was always the first to step up to help and kept everyone on the straight and narrow with her organisational skills, offering many extra ideas that were snapped up by the project team.

Rose Dennis had been very supportive of all her colleagues in the transfer of IT systems and e-Care. She had been positive, encouraging and helping with log-ins, explaining to colleagues how to use e-Care and Trust IT systems. This has all been done with a smile, and very willingly. She had done this with no fuss or bother and without being asked and deserved recognition for this approach and attitude.

The board congratulated Esther, Joanna and Rose and agreed that they were all a great example of staff going the extra mile.

BUILD A JOINED-UP FUTURE

19/190 WEST SUFFOLK ALLIANCE REPORT

Kate Vaughton referred to the place based needs assessments (PBNA) which were being developed by public health for each locality. It had also been agreed that the alliance should sign up to the social prescribing model across the whole of its area, which was a significant achievement.

The alliance had received twice as many applications for realising ambitions funding than was expected. Further information on the successful bidders would come back to the next meeting.

Ian Galin, Chief Executive of West Suffolk Council, had attended the recent system executive group (SEG) meeting and presented plans and opportunities for engagement and integrated working with the alliance. The SEG agreed that this was an important area of work and would help move towards a more structured planning of health provision. An update would be given to a future meeting.

Richard Davies was pleased to see potential for outcomes of this work and asked what data was being collected on social prescribing and if data was being collected for all the practices. Kate Vaughton explained that a trajectory for this would have to be submitted and that this would be 15%, rather than the suggested 25%.

GOVERNANCE

19/192 TRUST EXECUTIVE GROUP REPORT

The Chief Executive highlighted the Freedom to Improve document that was attached. This summarised the work that had been done and would be done in the future across the organisation and system and provided a clear narrative of the quality improvement approach. Nick Jenkins considered this to be very positive and credited Helena Jopling and Tara Rose for all their work on this.

The board noted the content of this report and approved the quality improvement framework - Freedom to improve: Delivering high quality safe care, together

19/193 AUDIT COMMITTEE REPORT

The board received this report and approved the revised terms of reference.

19/194 DIGITAL BOARD REPORT

Gary Norgate noted the significant progress that had been made, including Medic Bleep; HIMSS 6 and HIMMS 7; work on the atrial fibrillation (AF) dashboard and go-live with e-Care at Newmarket hospital.

Helen Beck reported that Sara Judge had been appointed as chief clinical information officer for community services and had undertaken a full governance review of the community.

19/195 COUNCIL OF GOVERNORS REPORT

The board received and noted the content of this report.

19/196 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were noted and approved.

19/197 USE OF TRUST SEAL

The board noted the use of the Trust's seal.

ITEMS FOR INFORMATION

19/198 ANY OTHER BUSINESS

There was no further business.

19/199 DATE OF NEXT MEETING

Friday 1 November at 9.15am in the Northgate Room, Quince House, West Suffolk NHS Foundation Trust.

RESOLUTION TO MOVE TO CLOSED SESSION

19/200 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 – 1 November 2019

Agenda item:	6			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	25 October 2019			
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
1736	Open	26/7/19	Item 8	Provide quarterly reporting on locality baseline reviews (within IQPR or Alliance report)	Scheduled to complete first round of reviews in October, so report to Board at end of November.	KV	29/11/19	Green
1748	Open	27/9/19	Item 2	Provide local perspective in response to national report regarding unrelieved pain in palliative care in England		RP	29/11/19	Green
1749	Open	27/9/19	Item 2	In respond to national patient survey finding relating to discharge issues and communication it was confirmed that a repeat training session will be scheduled for the trainees (including primary care perspective)		NJ	29/11/19	Green
1751	Open	27/9/19	Item 8	Continue to improve the narrative in the IQPR to ensure consistency and clarity in terms of 'When' field for timing of improvements e.g. pressure ulcers. Also agreed as art of next phase of IQPR development to review the SPC metrics which are indicators as future performance	This continues to be reviewed with relevant subject leads leads	CB	31/01/20	Green
1752	Open	27/9/19	Item 8	Noted overview of nutrition performance in the IQPR and quarterly learning reports. However agreed that need a clear plan, including timescales, to deliver improvement (including feedback from the F9 pilot).		RP	29/11/19	Green
1753	Open	27/9/19	Item 8	Continue to monitor effectiveness of action to improve appointment access and uptake for children in care initial assessments	Expect improvement from October - reported to Board at the end of November 2019	HB	29/11/19	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1754	Open	27/9/19	Item 8	Provide an update on action to improve access/use of care plans in e-Care		RP	29/11/19	Green
1755	Open	27/9/19	Item 8	Report the conclusion of the duty of candour review		NJ	29/11/19	Green
1759	Open	27/9/19	Item 15	Following co-production process the Patient Experience Committee to receive plan in response to the national patient survey results		RP	31/01/20	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1740	Open	26/7/19	Item 16	Include Filipino staff story on the quality and risk committee agenda for September	Agenda for Q&RC meeting on 27 September	RP	27/09/19	Complete
1750	Open	27/9/19	Item 7	Provide a response to the new national FTSU guidance	**AGENDA ITEM**	KR	01/11/19	Complete
1756	Open	27/9/19	Item 10	Ensure that remedial action plans (including those reviewed in closed Board) are reflected in next month's open Board finance report	**AGENDA ITEM**	CB	01/11/19	Complete
1757	Open	27/9/19	Item 11	Communication to be prepared for governors to update on EU Exit preparation. This will be based on further discussion between the operational and comms teams	Briefing circulated to Governors on 17/10/19	HB / TR	01/11/19	Complete
1758	Open	27/9/19	Item 12	Provide update on the non-urgent transport proposal received from E-Zec	**AGENDA ITEM**	HB	01/11/19	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 – 1 November 2019

Agenda item:	7			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	24 October 2019			
Subject:	Chief Executive's Report			
Purpose:	X	For information		For approval

Executive summary:

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

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

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

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

Recommendation:

To receive the report for information

Chief Executive's Report

Despite the financial challenge we face I can't start this month's Board report any other way can I? We have had some much-welcomed and fantastic news for the people of West Suffolk. A few weeks ago the Prime Minister set out his plan that "in the next ten years we will build 40 new hospitals in the biggest **investment in hospital infrastructure** for a generation." And we are one of the 40.

West Suffolk Hospital is one of the projects that has been 'green-lighted' to proceed to the next level of development plans. We know that we need a new hospital; it was built in 1974 and given a predicted lifespan of 30 years, and although we've managed our estate well and invested in new developments on the site (like the acute assessment unit, labour suite, emergency department, new staff accommodation and cardiac suite), the remaining areas of the hospital visually look tired and old, and we have some very real challenges with our buildings and general estate maintenance.

That this has been acknowledged at a national level is welcome news. A total pot of £100m of seed money is being made available to help kick start the next stage of developing these plans, and we expect to receive a portion of that which is a real indication of both the intent for and need of a new hospital. It may take 5-10 years for any new hospital plans, whether on the current or a different site, to come to fruition, but the Trust is delighted to be included in this announcement. Engagement with the local community and care partners will be essential to progress, but this is welcome news for the future of healthcare in West Suffolk, and indeed the integrated care system. We will now start the exciting work with our system partners to develop options and these plans.

But our investment in our current site hasn't stopped, and local MP Jo Churchill formally opened our acute assessment unit earlier this month. This dynamic unit has been helping us to transform how emergency patients are assessed and treated. It is designed to support emergency patients and GP referrals that need observation, diagnosis and treatment, but who don't need major emergency department care – for example, patients with chest pain who may need a heart monitor and clinical observation.

Built behind the West Suffolk Hospital's emergency department, phase one of the AAU opened to the public in December 2018; phase two opened to the public in September 2019. The latest, exciting developments include the expansion of the ambulatory emergency care (AEC) space, and the monitored bay. It also has its own dedicated ambulance entrance, so if you drive into the hospital site you'll be able to spot it! Since it first opened the unit has received 9,710 AAU patient admissions and 3,275 AEC patient attendances (Dec '18 to Aug '19).

One of the ways in which we deliver the services in AAU is the innovative use of physicians associates (PAs). We've been celebrating our **PAs and allied health professionals (AHPs)** for PA Week and AHP Day respectively to highlight their importance to patient care. We're so lucky to have colleagues with a variety of skills here at WSFT, who all come together to provide well-rounded, holistic care to our patients. If you haven't had chance to catch up with some of the content and videos, take a look back at our Twitter feed (@WestSuffolkNHS).

I'm delighted that our staff here have once again rated our hospital and community services as one of the **best places to receive treatment and best places to work**. In the most recent NHS Staff Friends and Family Test (FFT), for January to March (one of the busiest periods we've ever had), 92% of WSFT staff surveyed said they would recommend the Trust as a place to receive treatment, the seventh highest percentage recorded in England. In addition, 79% said they would recommend it as a place to work, which is the tenth highest percentage recorded in England. There's no greater testament to a health organisation than to be entrusted with the care of staff themselves and their loved ones, as they are often part of the local community. My own family use our services, and I'm in agreement with my colleagues – it's a great place to receive care.

And if that wasn't enough, our emergency department is performing better than most trusts in the country in several areas of urgent and emergency care, according to the Care Quality Commission's latest urgent and emergency care survey. We matched the **highest score in England for the availability of help from members of staff** while patients were waiting in the emergency department, and the overall score for waiting times. We're really proud of these scores, which show that patients are having a positive, high-quality experience in our emergency department. We have significantly improved from the 2016 survey, and this is a real credit to the quality care our staff provide. They continue to go the extra mile, despite seeing around a 10% increase in attendances to our emergency department year on year. But there is always room for improvement – outstanding doesn't mean perfect.

Overall in terms of September's **quality and performance** we continue to be challenged against a range of metrics. There were 55 falls, 49 Trust acquired pressure ulcers and three C. difficile infections. The challenge of demand and capacity continues with four areas failing the target for September 2019 - cancer 2 week wait breast symptoms with performance at 91.8%, cancer 62 day GP referral with performance at 77.2%, cancer 62 day screening with performance at 85.7% and incomplete 104 day wait with three breaches reported in September 2019. Referral to treatment performance for September was 82.0%, with six patients waiting longer than 52 weeks. The Trust is part of a pilot scheme trialling a number of new metrics for emergency department (ED) performance. These new metrics have replaced the longstanding 4-hour wait performance metric, so this has therefore been removed from the report. When the new metrics have been agreed nationally they will be included for monitoring.

Our **financial position** remains very much on our minds and we remain extremely concerned with the deterioration in our financial performance with the month six position reporting a deficit of £5.4m YTD which is £3.9m worse than plan. We agreed a control total to breakeven which means we need to deliver a cost improvement programme of £8.9m. We continue to forecast to meet our plan to break even in 2019-20. However, this requires a recovery plan to reduce the current rate of expenditure by around £10m. We do have recovery plans in place but it's clearly going to take a huge effort from all colleagues to get us to where we were aiming to be, which was to break even at the end of this financial year. The Board will consider this position and options at the meeting on 1 November.

I'm really proud of the work in the community to **join-up care to meet individual need**. A community service that wraps individual care around people with complex needs has been recently been expanded. There are now six community matrons looking after patients in west Suffolk who have chronic, long-term conditions, helping them to achieve the best quality of life they can, and preventing unnecessary admission to hospital. Expanding the service is part of our Trust's drive to support alliance working, a partnership approach that brings together public, private and voluntary health and care providers to improve the lives of local people.

Flu season is here and we are urging all frontline and patient-facing staff to have the **flu vaccination** as soon as possible, to protect themselves, their family and their patients. The campaign began on 1 October, when vaccinations were offered in Time Out, the occupational health department and peer vaccinators out and about in the hospital and in the community. This year supply of the vaccine will be staggered, as the World Health Organisation delayed releasing the formula by four weeks to take in the data from the Australian flu season (there, the flu season peaked in the early weeks). This was to ensure the vaccine is as effective as possible against this year's flu strain. The vaccine is being delivered to us in three batches in October and November, so the decision has been taken to prioritise vaccination in the first weeks of the campaign to frontline clinical staff and staff who are patient-facing, such as receptionists.

A part of our **Freedom to Speak Up** arrangements we have launched a new anonymous reporting phone line and intranet form to give staff another way to share concerns. We know that, across the

NHS, one of the main reasons colleagues don't speak up when they see something is because they fear they might be victimised or punished for it. Here at WSFT, we work really hard to create a culture of compassion, honesty and learning. We want everyone to feel they have a voice, control and influence. But we know that we don't always get that right – in last year's NHS Staff Survey:

- Of those staff that had experienced harassment, bullying or abuse at work, only 37.9% reported it
- Of those staff that had experienced physical violence at work, only 49.7% reported it
- Of those staff that saw an error, near miss or incident that you thought could hurt staff, patients, or service used, only 91.4% of you reported it.

So we're taking steps to try and make reporting feel safer and easier. We'd always encourage colleagues to formally report issues where they feel able to do so rather than use anonymous tools, but we'd rather hear this way than not at all!

As I write this report we approach the second part of our **Care Quality Commission (CQC) inspections** for the year, with the well-led set to take place between 28 and 30 October. The service line inspections are now almost complete and we look forward to working with the inspection team to continue to make improvements to our services - we have always said that outstanding does not mean perfect, and we know we have areas where we need to improve. But we have much to celebrate, and most of all I have enjoyed letting the inspectors see first-hand how outstanding our staff are at caring.

There is much to celebrate despite the pressures and staff working exceptionally hard

Chief Executive blog - A look back at my summer reading
https://www.wsh.nhs.uk/News-room/news-posts/A-look-back-at-my-summer-reading.aspx

Deliver for today

Newmarket hosts event focusing on dysphagia
The integrated speech and language therapy team hosted a Dysphagia Awareness Day at Newmarket Community Hospital on Thursday, 3 October. The aim was to improve knowledge and awareness of swallowing difficulties for colleagues working at the hospital, in the community and local care homes, as well as the general public. It was also an opportunity to share information about IDDSI – the International Dysphagia Diet Standardisation Initiative – which should now be followed across Suffolk, ensuring everyone adheres to the guidelines for modified food and drink.

Invest in quality, staff and clinical leadership

Video link technology set to improve care home support
Care home staff and nurses are working on a project which will allow them to jointly assess residents whose health has deteriorated unexpectedly – even if they are not in the same place. The idea will see staff working in care homes video-call nurses when they are concerned about a resident. Special technology will then be used to take vital health metrics, such as heart rate and blood pressure, so that the nurse can advise on the best care for that individual. The aim is to reduce the number of people who are taken into hospital unnecessarily, while making sure they receive the most appropriate care in the right place to meet their needs.

Patient safety a priority for expanded teams:

- Six nurses have joined the new **integrated tissue viability service** (TVS), working across WSFT community and acute hospital services to support care for patients with skin health needs. Based at the West Suffolk Hospital site, team members can be found working on the wards, at the six leg ulcer clinics in our community services, and in patients' homes with community colleagues. Team lead Anna Taylor said: "This is an investment in supporting our staff to provide safer and better patient care to people with conditions such as leg ulcers, surgical site infections and pressure ulcers.

- A team dedicated to improving the quality and safety of patient care we provide through timely and accurate pathology results has recently been expanded, and now has four colleagues working across WSFT services. The **point of care testing (POCT) team** is led by Emma Scrivener, a registered biomedical scientist who moved from the pathology laboratory to get the innovative work under way last year.

Build a joined-up future

Showcasing success - trusted assessment case study
Housebound Mrs Smith is referred by her GP to the Care Coordination Centre (CCC) for a community occupational therapy (OT) assessment. One of her carers has also referred her separately for a social care OT assessment through Customer First. Both referrals are visible to the CCC and Customer First, so the duplication is quickly identified. The health and social care OTs discuss Mrs Smith's case and agree the health OT will lead on her care. During a visit to Mrs Smith's home, the OT uses shared records to view her previous assessments so they can talk about what has helped in the past and what wasn't as successful. They make a plan, the OT orders all equipment Mrs Smith needs and is able to return a few days later to see how she is getting on.

Using trusted assessment means that Mrs Smith was contacted by, assessed, treated and followed up by the same clinician, building trust while making sure she doesn't need to keep

repeating her story to different professionals. It also improves efficiency for health and care services by working across organisational boundaries to prevent duplication. Trusted assessment is now in place across Support to Go Home, Early Intervention Team and Home First services and is currently being rolled out through all six integrated neighbourhood teams.

Sharing data to improve services
A partnership which is helping Suffolk's public services to make better use of data to help plan the way services are designed and delivered is celebrating its first anniversary. The Suffolk Office of Data and Analytics (SODA) is a partnership of the Ipswich and East Suffolk and West Suffolk CCGs, local councils and Suffolk Constabulary. In its first year it has used data to support decision -making around issues such as race disparity, housing need and the economic cost of mental health problems. It has also been used to build evidence around domestic abuse and forecast the income which councils can expect from business rates up until 2026. Anyone who thinks they could benefit from combining data, or who has any questions about SODA, should email michaela.breilmann@suffolk.gov.uk.

National news

Deliver for today

The winter 2019/20 flu vaccination: Who should have it and why
A booklet by Public Health England which includes information for children and pregnant women.

Diagnosis of delirium in hospitals can be improved by the 4As test
A new shorter test for delirium appears helpful in assessing older people in hospital who may have the condition. A normal score on the 4 As (Alertness (or Arousal), Attention, Abbreviated Mental Test -4 item version, and Acute change) test effectively rules out delirium while an abnormal score is reasonably useful for detecting the condition. People detected by the test would still need a full assessment to confirm the diagnosis.

For high-risk patients and those with sudden-onset confusion, these early results show that the 4 As test is a practical tool for initial assessment in time-pressured environments. It will need further testing in other settings.

NHS hospitals go back to the future for dementia care (NHS England)
NHS hospitals are going back to the future to help patients with dementia by decorating their wards, rooms and corridors in 1940s and 1950s style – creating a calming, familiar environment which can help jog memories, reduce anxiety and distress.

With ageing well and caring for people with dementia both key priorities in the NHS Long Term Plan, hospitals across the country have revamped their dementia ward décor. With innovations ranging from a 'memories pub' to 1950s style 'reminiscence rooms' and even a cinema booth where patients can watch old films.

Invest in quality, staff and clinical leadership

There and back – what people tell us about their experiences of travelling to and from NHS services (Healthwatch Report)
This briefing by Healthwatch documents the findings of a survey undertaken between March and May this year asking communities how they want the NHS to improve locally. Healthwatch found that travel was a key issue, with nine out of every ten people confirming that convenient ways of getting to and from health services were either important or very important. In two thirds of the country, communities told Healthwatch they wanted more focus in local plans on improving the links between transport and health and care services.

Delivering same-sex accommodation
This guidance has been updated to reflect current patient pathways, including further definition of what is and is not a mixed-sex accommodation breach and circumstances in which mixing may be justified and therefore not constitute a breach.

Life after loss: an economic evaluation of specialist counselling after baby loss
This report is an economic evaluation of the baby loss charity Petals, which provides counselling to women and their partners who have experienced the death of a baby. The evaluation calculates that the national provision of counselling to 4,822 mothers would cost £3.17 million per annum, which would create a national safety net of support to help parents at this immensely difficult time. No such service currently operates across England and Wales. The report highlights that specialist baby loss counselling is inexpensive, effective and reduces government expenditure.

Build a joined-up future

Going Dutch in West Suffolk: learning from the Buurtzog model of care

This article discusses five things that have been learned from trying to implement the Buurtzog model in England, and is informed by the observations of the model as it has been initiated in West Suffolk. The Buurtzorg model of care, developed by a social enterprise in the Netherlands in 2006, involves small teams of nursing staff providing a range of personal, social and clinical care to people in their own homes in a particular neighbourhood. There's an emphasis on one or two staff working with each individual and their informal carers to access all the resources available in their social networks and neighbourhood to support them to be more independent.

The nursing teams have a flat management structure, working in 'non-hierarchical self-managed' teams. This means they make all the clinical and operational decisions themselves. They can access support from a coach, whose focus is on enabling the team to learn to work constructively together, and a central back office. In 2017 a group of NHS and local government organisations in West Suffolk, who had joined forces in a project to support older people to live independently at home, initiated a test-and-learn of the Buurtzorg model.

NHS Digital launches staff campaign to boost cyber security in the workplace
The Keep I.T. Confidential campaign aims to educate staff across the NHS on the direct impact of data and cyber security on patient safety and care. It improves knowledge of data and cyber security practices which can be adopted in their everyday work, to embed a culture of cyber security throughout the NHS. Keep I.T. Confidential reinforces the message that data security is an extension of patient confidentiality and good patient care. It highlights key cyber security threats and the actions that staff can take to mitigate risk in these areas.

Stoptober 2018: campaign evaluation
Stoptober is a major annual event to encourage smokers to quit for 28 days in October - with the aim of stopping smoking permanently. This report measures the impact of Stoptober in 2018. It aims to assess the scale of the campaign (reach and visibility), the degree to which people engage with different elements of Stoptober, and actions and behaviours generated by Stoptober.

9:40 DELIVER FOR TODAY

8. Integrated quality and performance report

To ACCEPT the report

For Report

Presented by Rowan Procter and Helen Beck

Trust Board – 1st November 2019

Agenda item:	8			
Presented by:	Craig Black			
Prepared by:	Joanna Rayner, Head of Performance and Efficiency			
Date prepared:	21st October 2019			
Subject:	SPC Integrated Quality & Performance Report			
Purpose:	x	For information		For approval
Executive summary:	The attached report contains a new style of performance reporting using statistical process control charts.			

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: That the report is noted.							

NHS
West Suffolk
NHS Foundation Trust

Understanding how performance data are presented in our Board papers

The charts in our Board report can tell you a lot about how our Trust is performing over time, but if you're not used to seeing data in this way it can take a little time to get used to. This short guide will help you to understand the charts and interpret the data we're showing you.

What is it?

The main type of chart is known as a statistical process control (SPC) chart. This plots data like a run chart, and allows you to see:

- if something is improving, deteriorating or staying the same over time
- if changes are expected, or very unusual
- whether it's likely the Trust will be able to meet the standard that's been set.

The SPC chart is an analytical technique – underpinned by science and statistics – that plots data over time. It helps us understand variation; this then guides us on what the most statistically significant changes are, and therefore what we need to focus our attention on. It's widely used across the NHS and is considered best practice for presenting data.

What will it show me?

The beauty of SPC charts is that they allow you to identify the most significant performance changes. That means each month you might see a slightly different suite of indicators shown in this report - depending on which have flagged as having seen significant changes or trends that need discussion by the Board.

That can look like there are more negative than positive trends, but rest assured that doesn't mean everything is bad! If indicators are ticking along or doing well they may not be presented in the report every month, as the Board needs to focus on those areas where we can do better. This helps to make sure we're focusing on, and fixing, the most important things first.

What does it look like?

When we use SPC charts, we largely use the same terminology and colours as the rest of the NHS.

Generally speaking:

- Things written in grey show no significant change or trend
- Things written in blue show a positive change or trend
- Things written in orange show a negative change or trend

Putting you first

You might see these terms and colours used, particularly in the summary table that gives an overview of what indicators are included in that month's report.

Assurance (how we're doing)

No target:

This means that for this particular indicator, there's no national or local standard/target to benchmark ourselves against. It's usually written in grey.

Hit and miss against target:

This means that the standard likely won't be either achieved or missed consistently – that it will vary, but not significantly so. It's usually written in grey.

Consistently below target:

This means that we're not meeting the standard, and are unlikely to under the current conditions. It's usually written in orange.

Consistently above target:

This means that we're meeting the standard, and are likely to continue doing so under the current conditions. It's usually written in blue.

Variations (the trends)

Common cause variation:

Common cause variation means there has been no statistically significant change to the trend. It's usually written in grey.

Special cause variation (blue or orange):

This will either be written in blue, to show a statistically significant positive change or trend, or in orange to show a statistically significant negative change or trend. It usually happens because we've started to do something differently.

These are points to look out for, because if there's special cause variation it means something has changed over a period of time (six data points). It's useful because it makes sure we don't react to 'one-off' changes or blips, but focus on trends that show a long term, consistent shift (either positively or negatively).

We might already know what caused the change, but if we don't it allows us to investigate and find out. Eventually if the change is sustained (positive or negative), it will become common cause variation as it'll be classed as our new norm.

Charts

For each of the indicators we show in the report, you'll be able to find a corresponding statistical process control (SPC) chart.

The chart is a graph used to study how something changes over time, and data is plotted in time order.

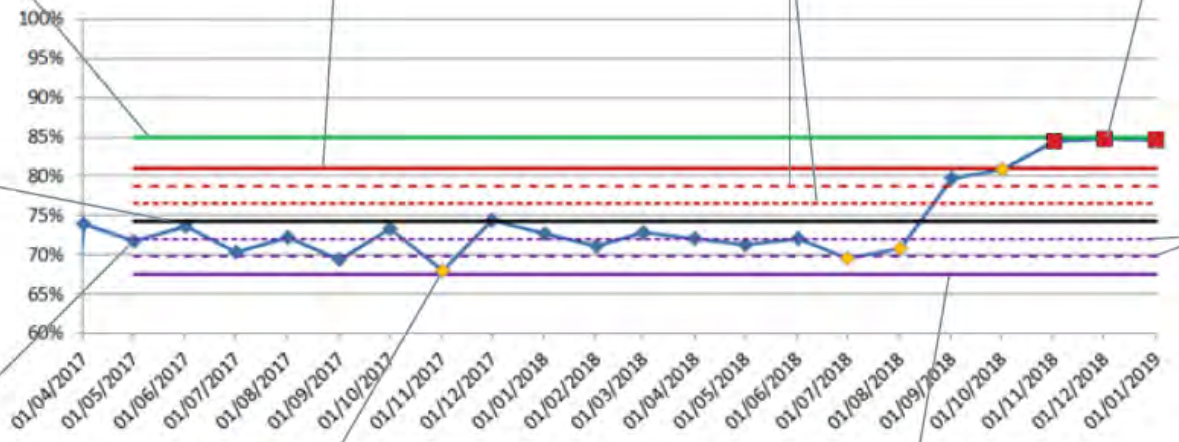
A control chart always has:

- a central line for the average or mean (shown in black on our graphs)
- an upper line for the upper process limit (shown in red on our graphs)
- a lower line for the lower process limit (shown in purple on our graphs).

These lines are determined from historical data.

On the next page you can see an example graph to help you.

SPC chart: example graph



Green line: shows the Trust or national standard (if there is one)

Solid red line: shows the upper process limit, i.e. the upper limit of what the Trust should statistically be capable to produce. It's plotted at a distance of +3 standard deviations from the average

Dotted red lines: Show +1 and +2 standard deviations from the average, to show movement towards the upper process limit

Red data points: these plot the performance against the date on the bottom axis, and show special cause variation (statistically significant either positively or negatively) outside the expected limits

Black line: shows the average, or mean, performance

Dotted purple lines: Show -1 and -2 standard deviations from the average, to show movement towards the lower process limit

Blue data points: these plot the performance against the date on the bottom axis, and show common cause variation (no statistical significance)

Yellow data points: these plot the performance against the date on the bottom axis, and show special cause variation (statistically significant either positively or negatively) within the expected trend

Solid purple line: shows the lower process limit, i.e. the lower limit of what Trust should statistically be capable to produce. It's plotted at a distance of -3 standard deviations from the average

Putting you first

Summary Table

The tables below provide a summary of the indicators that are contained within the report. It is intended to provide an 'at a glance' view of the metrics to act as a guide on which KPIs to focus attention on.

Date	Sep-19

Safe domain	Standard	Actual	Trend	Assurance	Notes
New Pressure Ulcers - Trust	0	49	Common Cause Variation	Consistently above target	
Falls per 1,000 bed days	No target	4.94	Common Cause Variation	No target	

Effective domain	Standard	Actual	Trend	Assurance	Notes
Discharge Summaries: Outpatients	85%	ND	ND	Consistently below target	No data since August 2018
Discharge Summaries: A&E	95%	86%	Special Cause Variation - Low	Consistently below target	
Discharge Summaries: Non Elective Admissions	95%	90%	Special Cause Note/Investigation - High	Consistently below target	
Discharge Summaries: Elective Admissions	85%	90%	Special Cause Note/Investigation - High	Consistently below target	

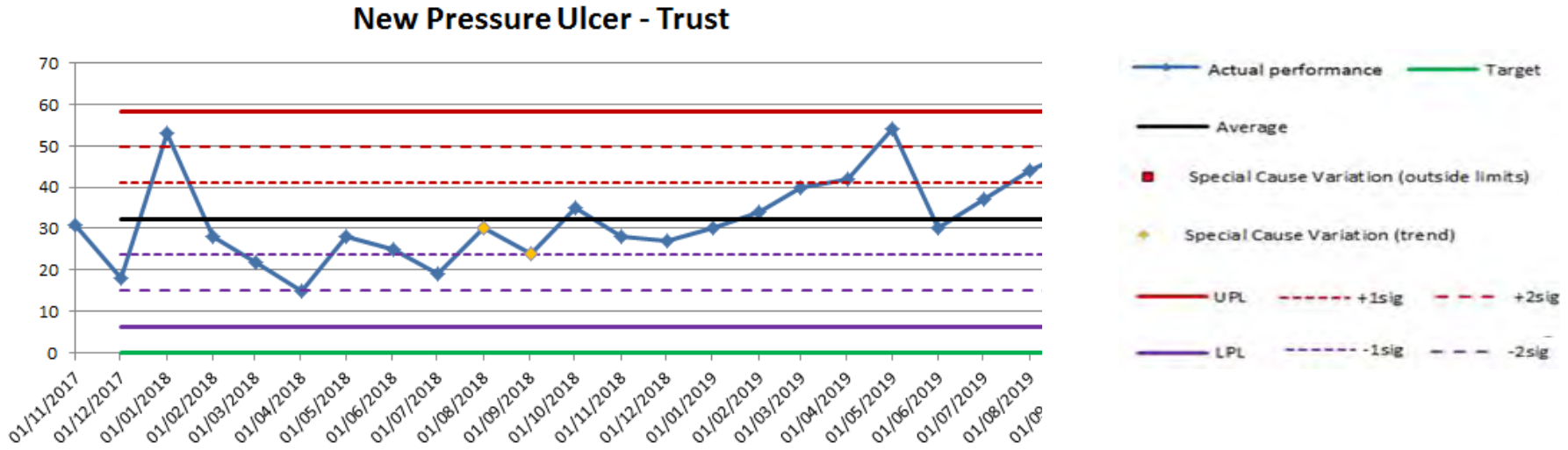
Caring domain	Standard	Actual	Trend	Assurance	Notes
Compliments	No target	78	Common Cause Variation	No target	
Complaints	20	17	Common Cause Variation	Hit and miss against target	

Responsive domain	Standard	Actual	Trend	Assurance	Notes
Referral to Treatment 18 week standard	92%	82%	Special Cause Variation - Low	Hit and miss against target	
Diagnostics 6 week standard	99%	95%	Special Cause Variation - Low	Hit and miss against target	
Sepsis	100%	88%	Special Cause Note/Investigation -	Hit and miss against target	
Cancer 2 week GP referral to assessment standard	93%	93%	Common Cause Variation	Hit and miss against target	
Cancer 2 week breast referral to assessment standard	93%	92%	Special Cause Variation - Low	Hit and miss against target	
Cancer 62 day referral to treatment standard	85%	77%	Special Cause Variation - Low	Hit and miss against target	
Community referral to treatment within 18 weeks	90%	95%	Common Cause Variation	Hit and miss against target	
Wheelchair waiting times – Child (Community)	92%	100%	Special Cause Note/Investigation - High	Hit and miss against target	

Well-led domain	Standard	Actual	Trend	Assurance	Notes
Sickness Absence	3.5%	4%	Special Cause Note/Investigation - Low	Hit and miss against target	
Proportion of Temporary Staff	12%	8%	Common Cause Variation	Hit and miss against target	

Maternity	Standard	Actual	Trend	Assurance	Notes
Number of deliveries (births)	210	201	Common Cause Variation	Hit and miss against target	
Caesarean Section rate	22.6%	29%	Special Cause Variation - High	Hit and miss against target	
Breast Feeding Initiation	80%	83%	Common Cause Variation	Hit and miss against target	

Pressure Ulcers - Trust

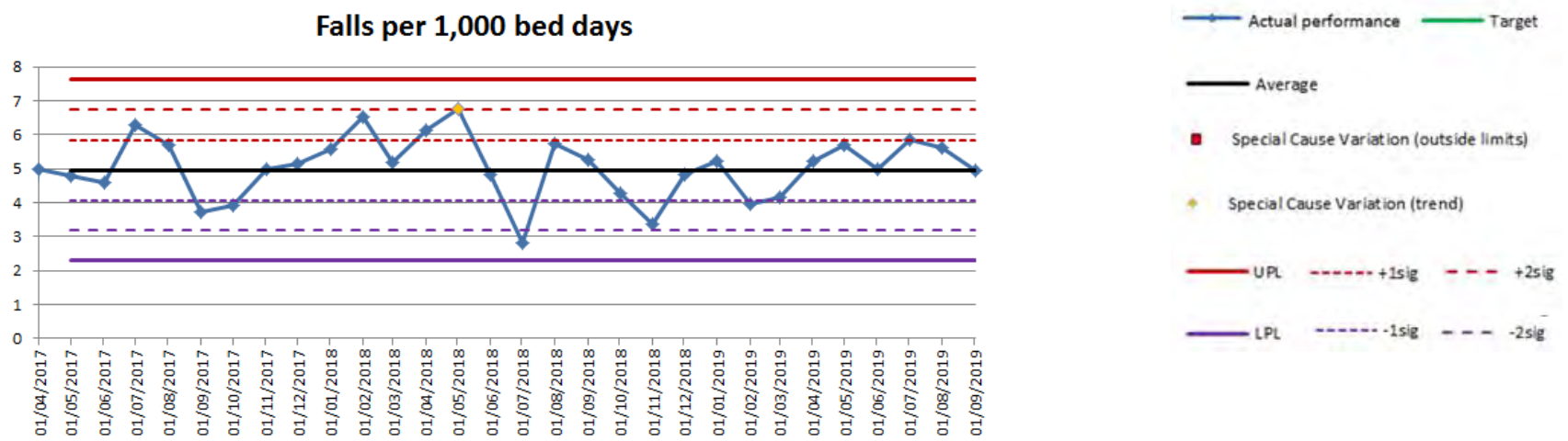


Narrative

What	Common cause variation
Why	The patients in our care continue to demonstrate increasing complexity and co-morbidity, however this is difficult to quantify without a dependency/acuity tool, which is currently being investigated within the Community and Integrated Service Division. Some concerns have been raised by Tissue Viability colleagues in terms of ensuring smooth patient pathways receiving wound care in their own homes with potentially deteriorating wounds and the ability of the team to refer for diagnostics.
How	We continue to develop the new internal monitoring processes reported on last month. As a Trust, the Community and Integrated Services Division report a larger number of new Pressure ulcers; patients in the care of community teams in their own homes are not subject to 24 hour care/support and our focus will be around providing preventative advice, equipment and support to patients, families and carers. Our Senior Matron for this Division is working closely with those community teams who report an increasing incidence in Pressure ulcers.
When	Our focus continues towards a 5% reduction in new Pressure ulcers by the end of this financial year; this is an enormous challenge however this is supported by ongoing and increasing learning opportunities for staff in all settings.

Safe

Inpatient Falls - Trust

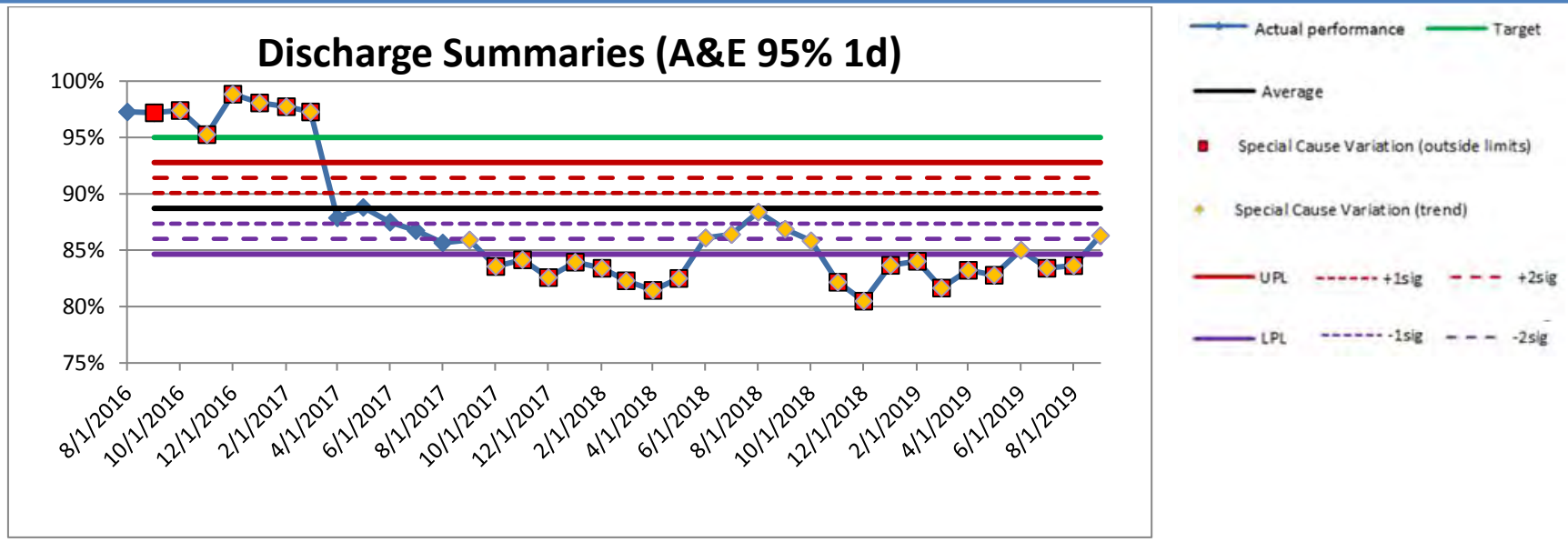


Narrative

What	Common cause variation
Why	There was one fall resulting in serious harm in September, a neck of femur on F7. A full investigation is ongoing into these incidents. YTD we have had 10 falls with serious harm.
How	In 2019/20 the new CQUIN Preventing Hospital Falls - Admitted patients aged over 65 years, with LOS at least 48 hours will drive further improvements. We have commenced trialling new falls prevention technology on F3 and then trialling in other clinical areas including the community.
When	This is an ongoing work plan and quality improvement initiatives will continue to be progressed via the Falls Group including ongoing liaison with the contacts gained through the previous work in the regional NHSI collaborative. We now have some dedicated Matron hours focused on falls training and quality improvements within the Trust.

Safe

Discharge Summaries ED

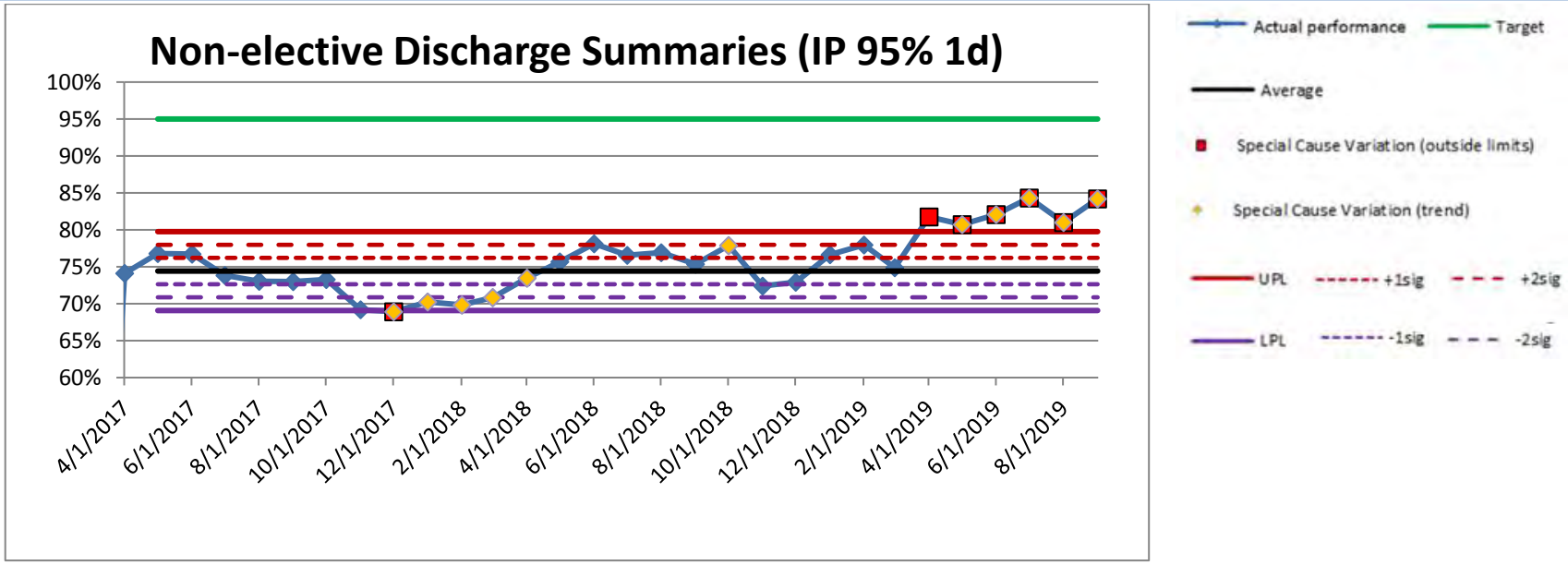


Narrative

What	Special Cause Variation - Low but we have seen a slight improvement this month.
Why	We continue to work with departments to try and improve timeliness of discharge summaries.
How	Reports identify which specific areas may need support and this is targeted through the operation divisions. We will be repeating the training that we delivered to Juniors.
When	-

Effective

Discharge Summaries Non elective admissions

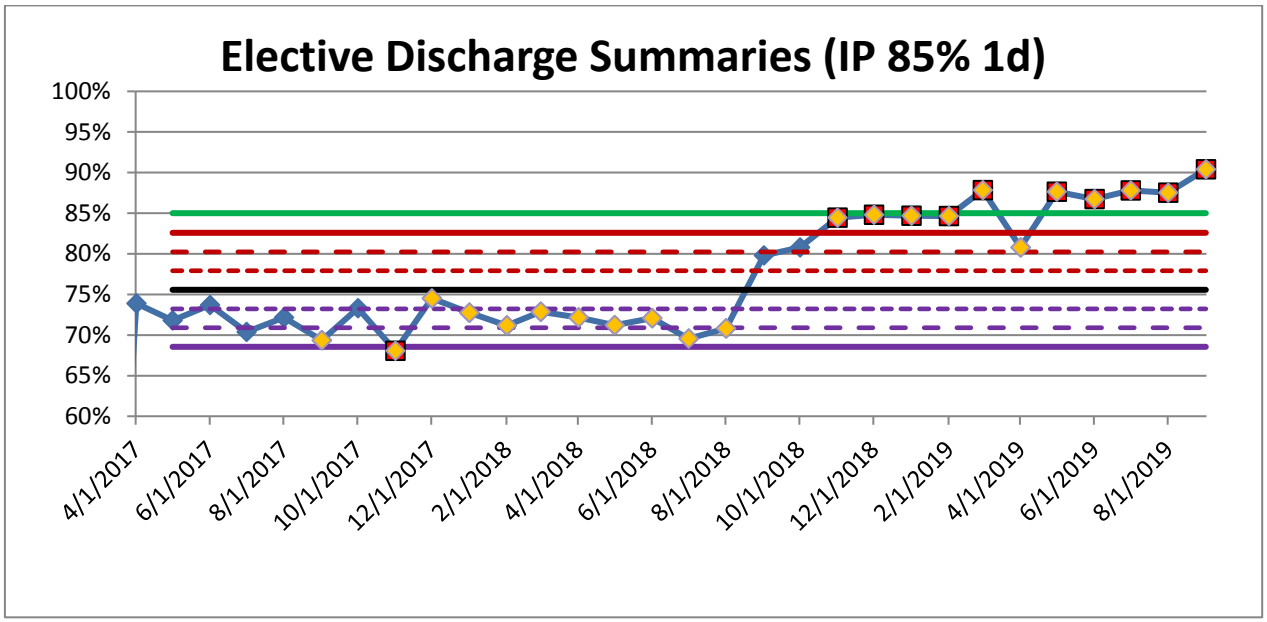


Narrative

What	Special Cause Note/Investigation – High, we have seen an increase this month.
Why	We continue to work with departments to try and improve timeliness of discharge summaries.
How	Reports identify which specific areas may need support and this is targeted through the operation divisions.
When	-

Effective

Discharge Summaries Elective admissions

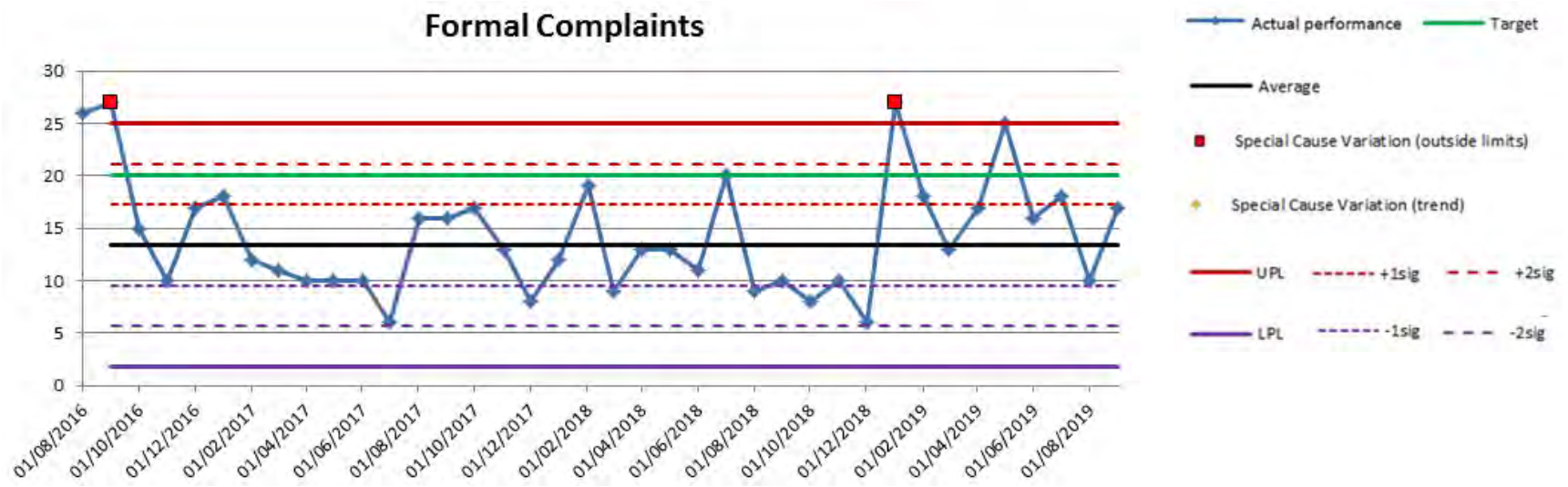


Narrative

What	Special Cause Note/Investigation - High we have seen an increase this month.
Why	We continue to work with departments to try and improve timeliness of discharge summaries.
How	Reports identify which specific areas may need support and this is targeted through the operational divisions
When	-

Effective

Complaints

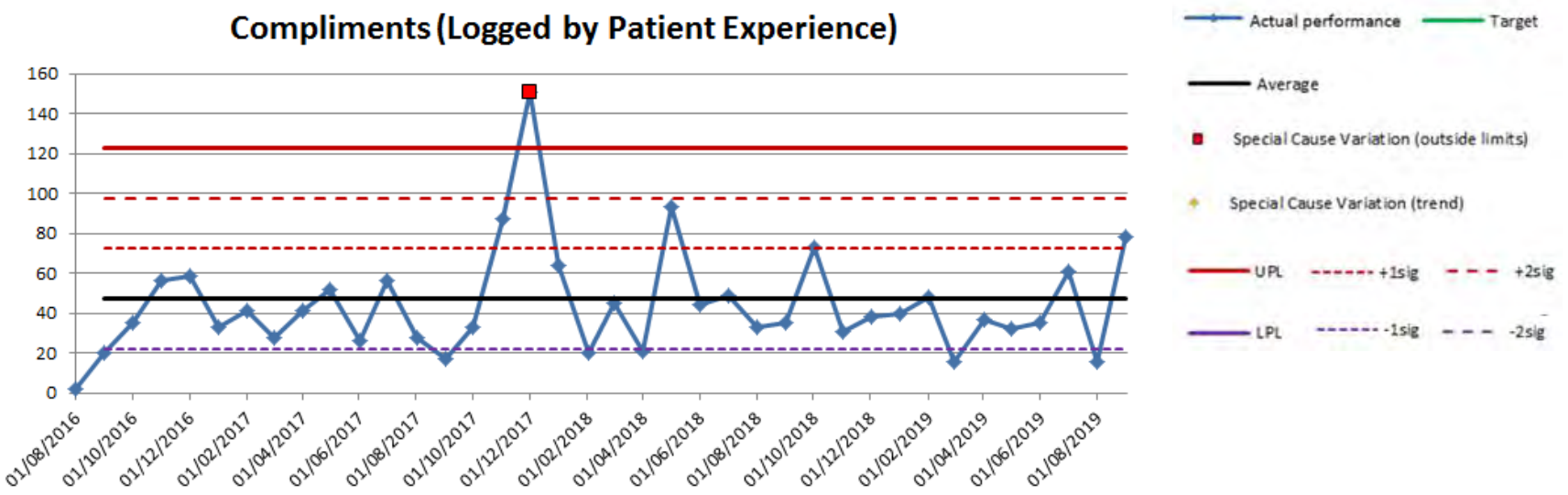


Narrative

What	Total formal complaints above normal limits
Why	Formal complaints have increased over the past calendar year and continue to remain at a higher level than previous years.
How	The PALS team continue to deal with concerns and enquiries proactively to offer support to patients and relatives and try and offer quick resolutions. Resources within the patient experience team are being reviewed to manage increasing demands.
When	The total number of complaints is expected to remain at this higher level despite the utilisation of PALS. To ensure we are delivering a good service to patients and relatives, resources within the team are being reviewed.

Caring

Compliments

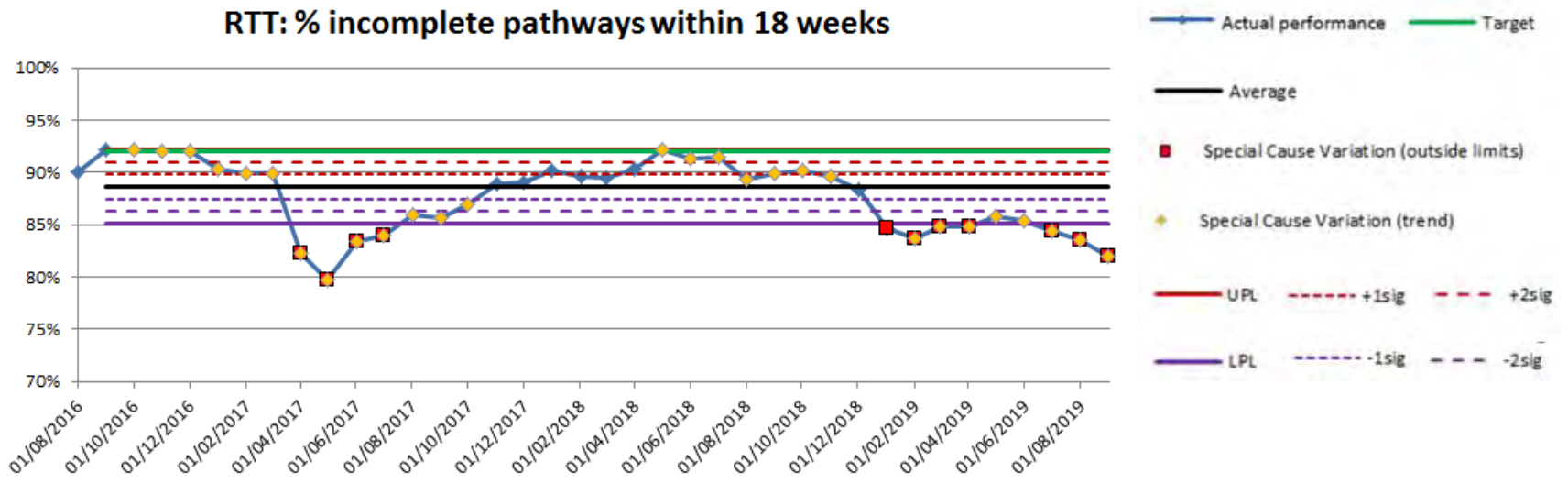


Narrative

What	Increase in compliments logged
Why	Wards & Departments provided more compliments with the patient experience team for central logging.
How	Our aim is for all compliments to be shared with the patient experience team.
When	On-going message across Trust highlighting this.

Caring

RTT

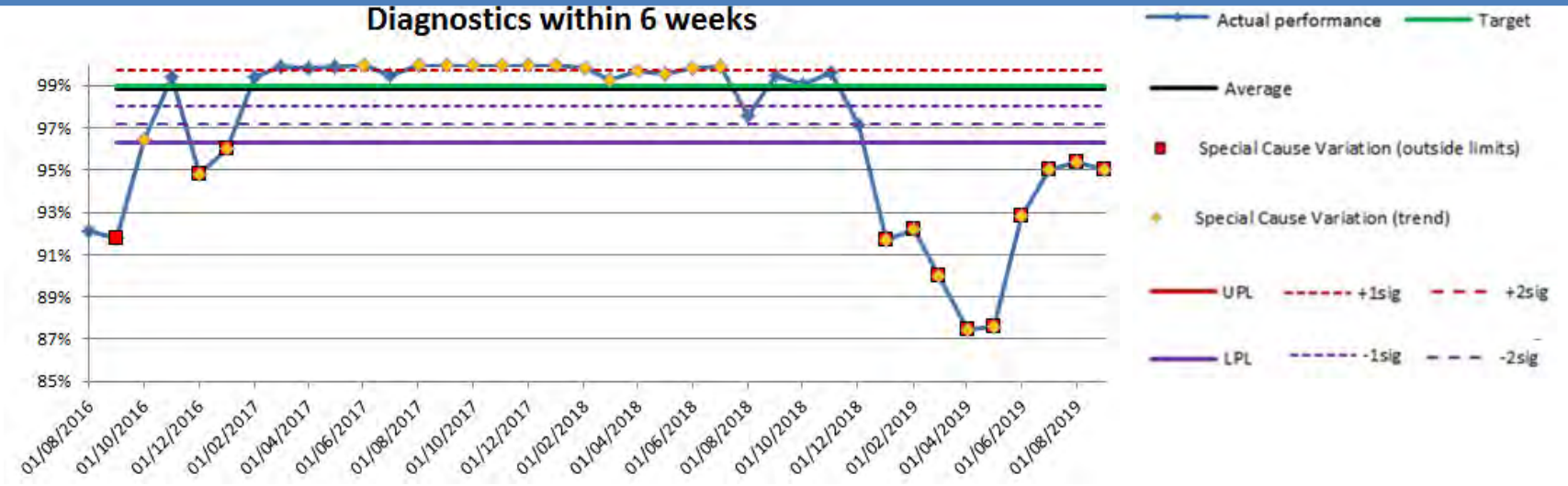


Narrative

What	Special cause variation - low
Why	There is underachievement of the standard within General Surgery, Urology, Trauma and Orthopaedics, ENT, Ophthalmology, Gastroenterology, Cardiology, Thoracic medicine and Gynaecology. Whilst some of these areas have shown minor improvement from July to August, Trauma and Orthopaedics, Ophthalmology and General Surgery have shown a considerable increase in patients over 18 weeks.
How	Action plan for recovery in place for all specialities not meeting performance, Continue to monitor long waits at weekly access meeting.
When	ongoing

Responsive

Diagnostics within 6 weeks

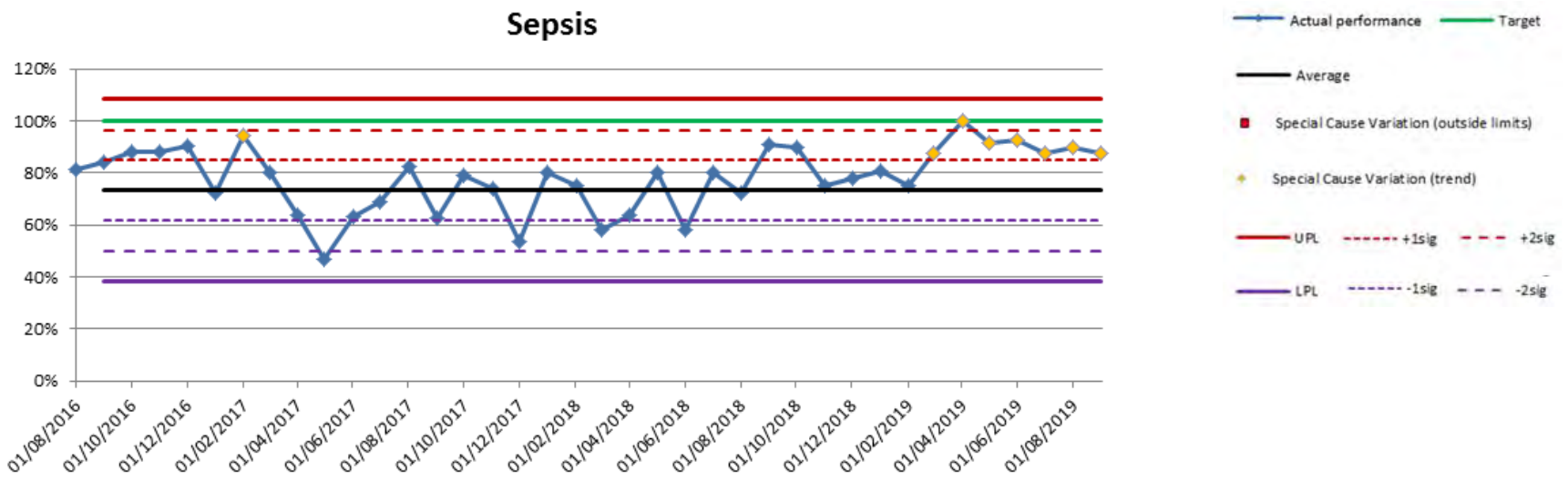


Narrative

What	Special cause variation - low
Why	Diagnostic performance has deteriorated marginally this month and capacity issues to impact on waiting times for endoscopy related diagnostic procedures.
How	Work continues on the colorectal and urology (cystoscopy & urodynamics) pathways in particular to provide long term sustainability. In the short term the urology service is challenged by consultant absence but locum support for the service is being sourced.
When	Unknown

Responsive

Sepsis

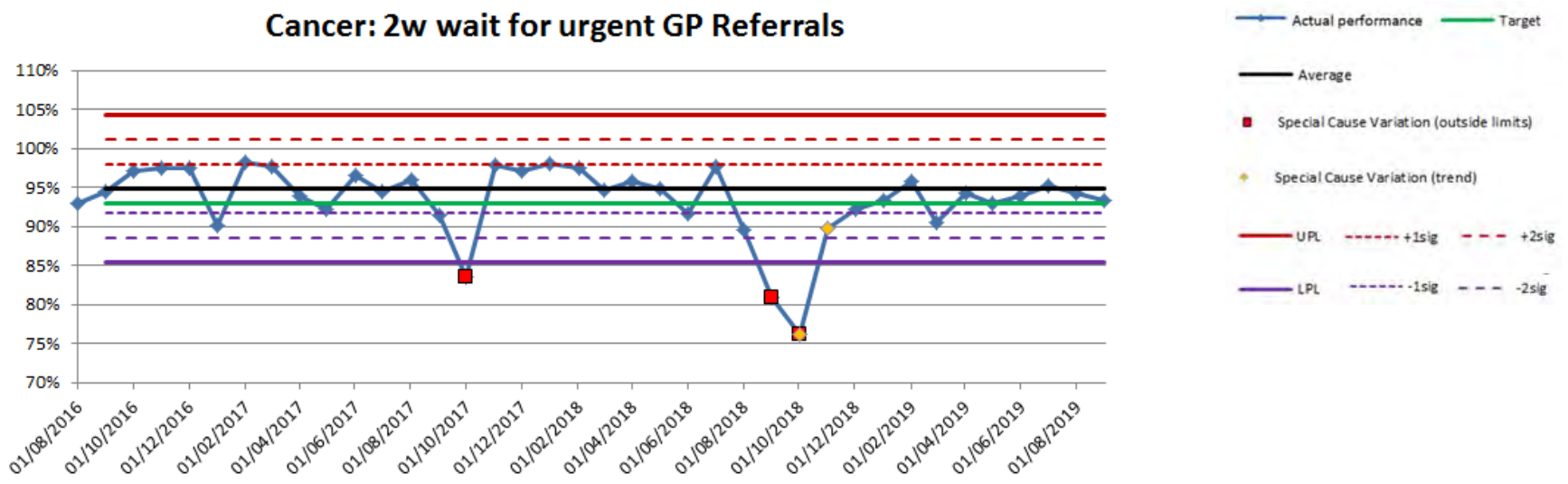


Responsive

Narrative

What	Special cause variation –high
Why	Performance against national standards for door to needle time for Neutropenic was 87.5% for the month of September. Of the 8 patients who were admitted to G1, 7 patients received the required treatment within the 1 hour time scale and 1 patient breached the national standard. Of the 8 patients who were admitted through ED, 7 patients were treated within the hour and 1 patient breached the national standard.
How	Introduction of the Emergency Department Neutropenic Sepsis FastTrack Pathway NSFP (Red Folder) copy displayed on info board in ED staff room.
When	Ongoing

Cancer 2 week referral

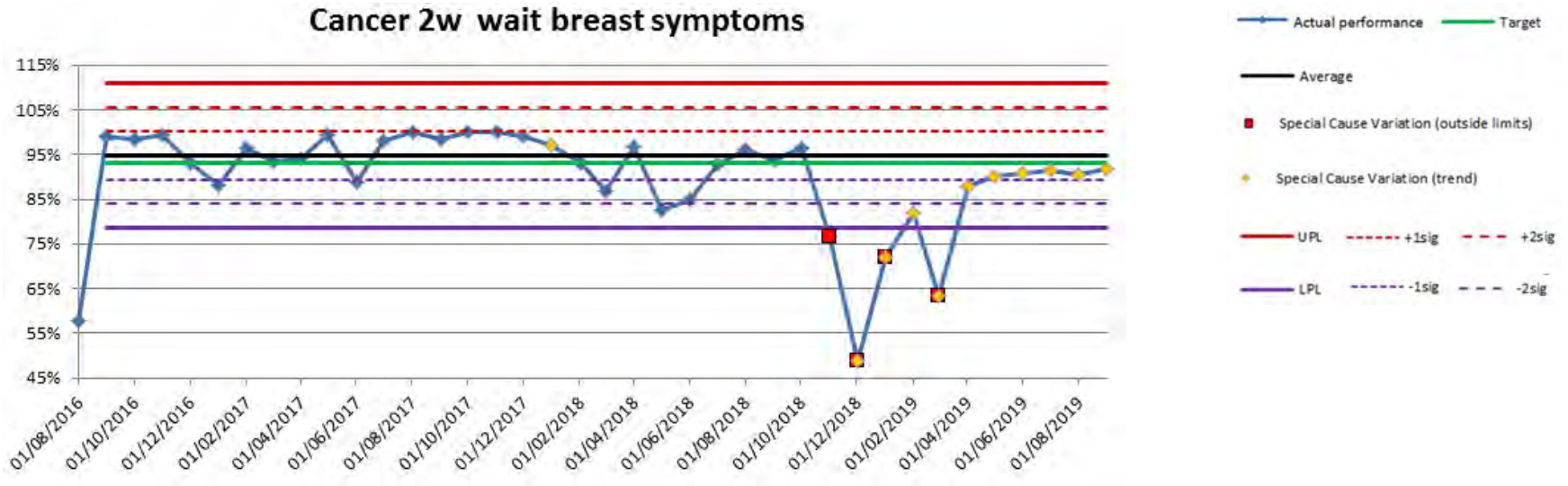


Narrative

What	Common cause variation with the assurance this measure will hit and miss the target.
Why	Generally increased referrals and capacity constraints for diagnostics.
How	Focus on capacity within diagnostics.
When	Unknown

Responsive

Cancer 2 week referral Breast

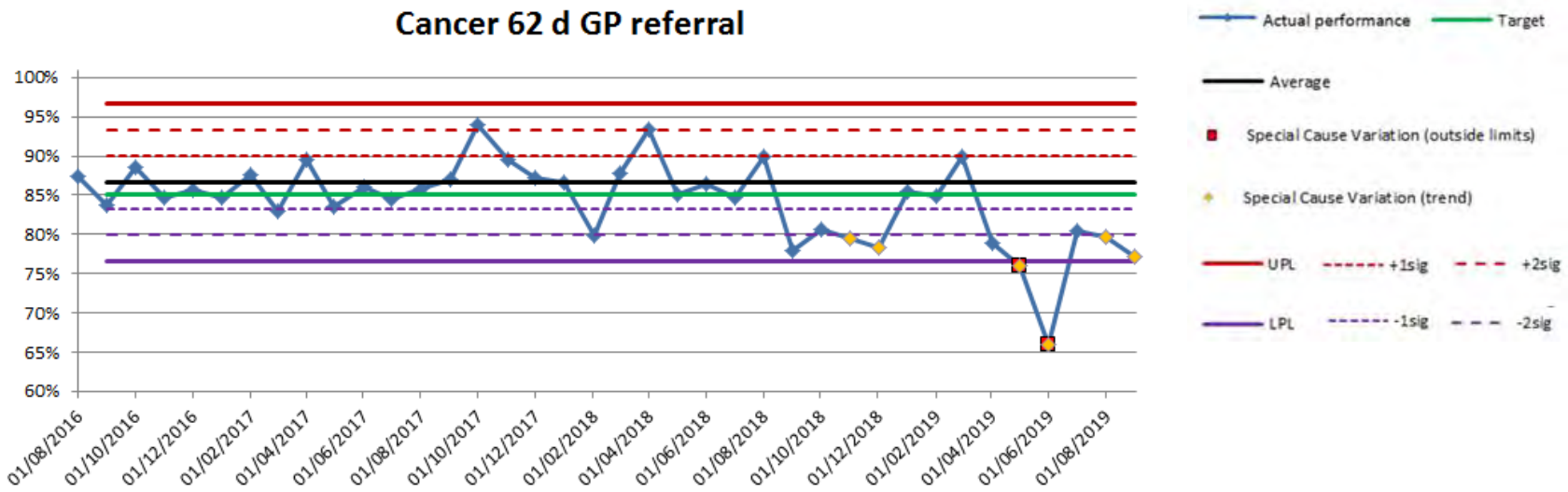


Narrative

What	Special cause variation - low
Why	This is primarily due to patient unavailability during holidays in the 14 days window. .
How	Capacity has been increased by an additional clinic on Friday PM for breast pain symptom patients. In addition to converting one of the screening clinics to enhance the capacity to book 1st appointments for 2 WW patients, the breast unit also runs additional clinics during when relevant clinicians are available during the evenings and weekends
When	unknown

Responsive

Cancer 62 Day

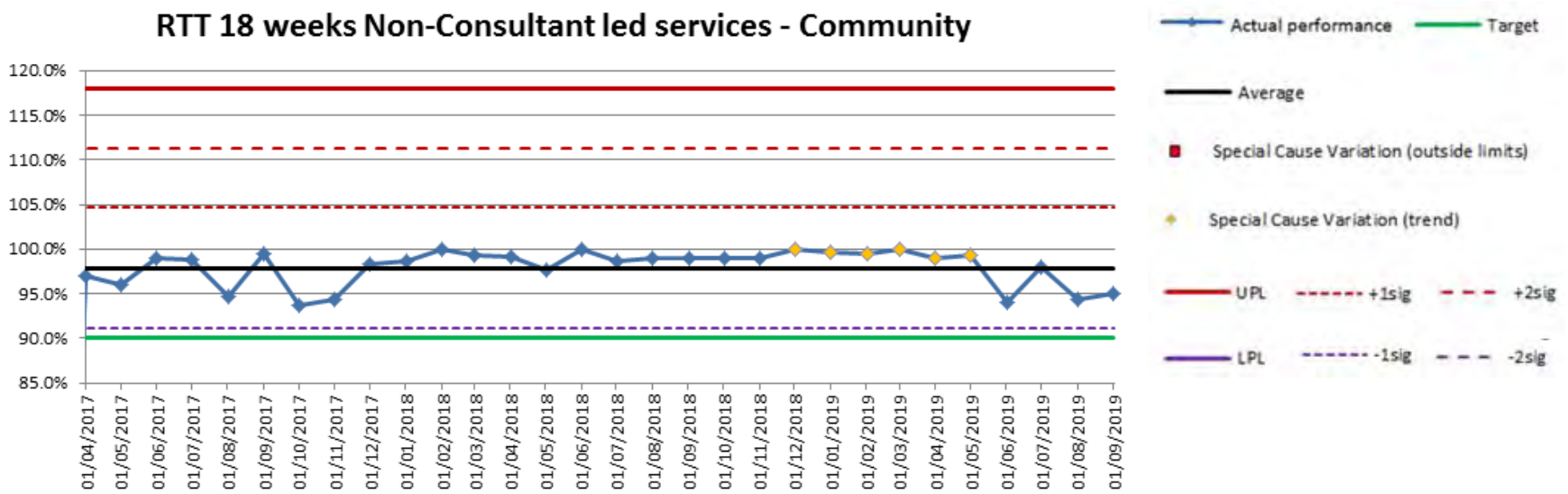


Narrative

What	Special cause variation - low
Why	10 breaches locally in the Trust and 4 shared pathway breaches, some involving cases of late referrals.
How	Colorectal, Prostate and Lung teams are currently involved in implementation of the best practice pathways with a view to improve on early diagnostics and timely treatment. Several work streams are currently in progress to tie in with the recovery action plan in place with service leads for specific pathways; regular meetings are held to ensure this is on track.
When	unknown

Responsive

RTT non consultant led

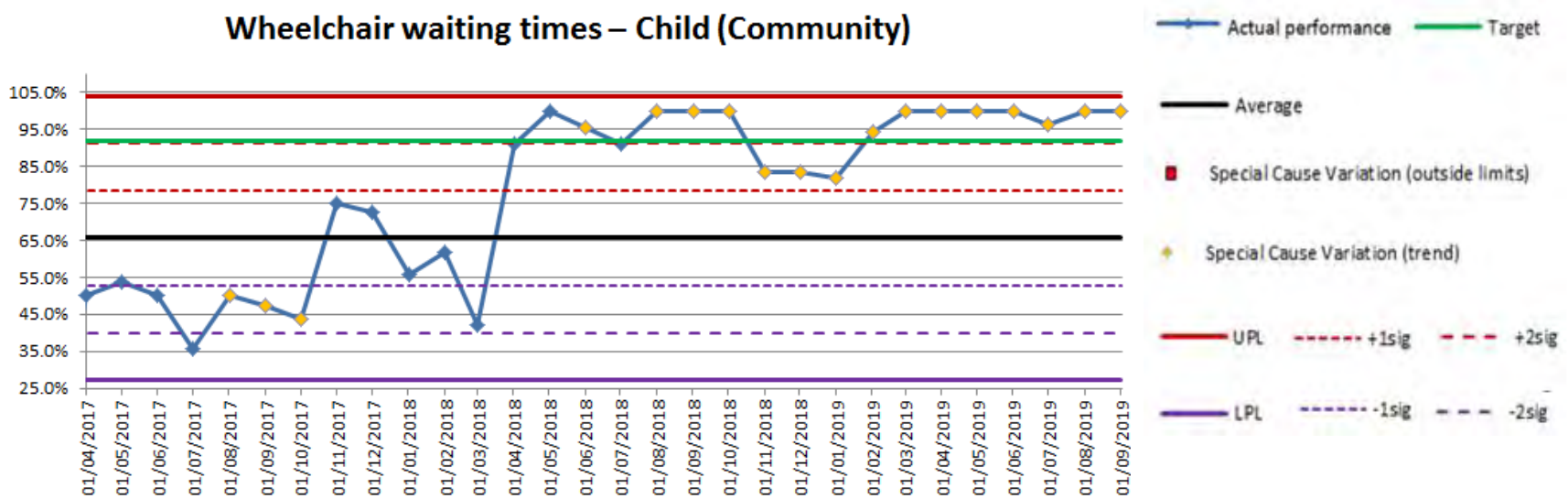


Narrative

What	Common cause variation
Why	-
How	-
When	-

Community

Wheelchair waiting times – Child (Community)

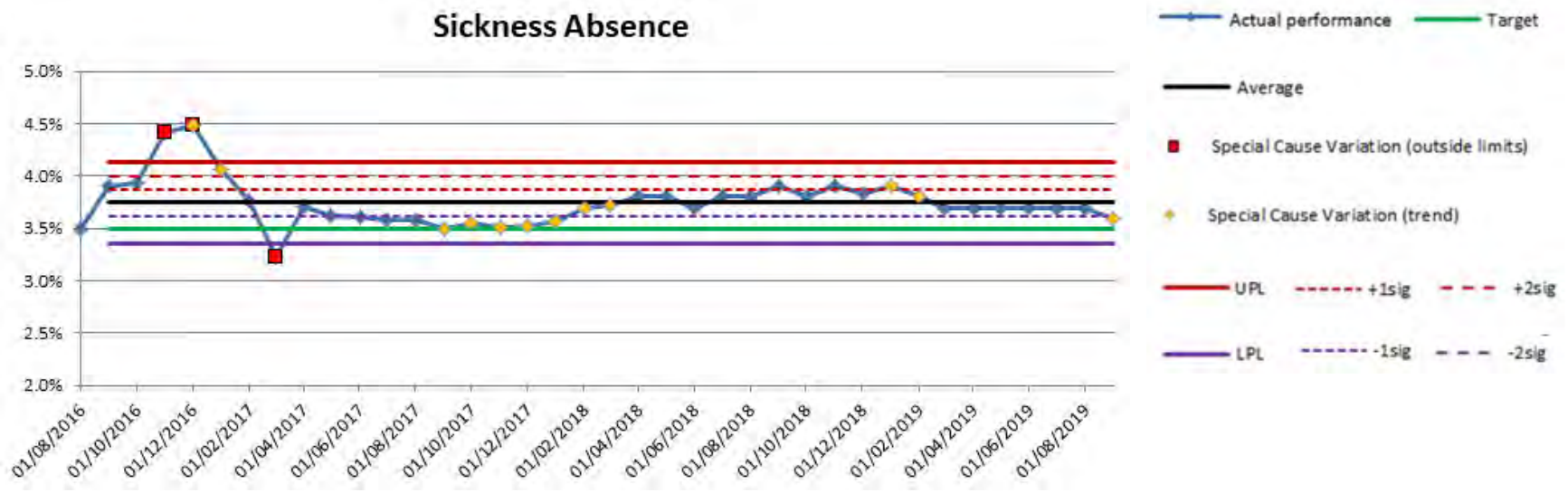


Narrative

What	Special cause variation – high
Why	-
How	-
When	-

Community

Sickness absence

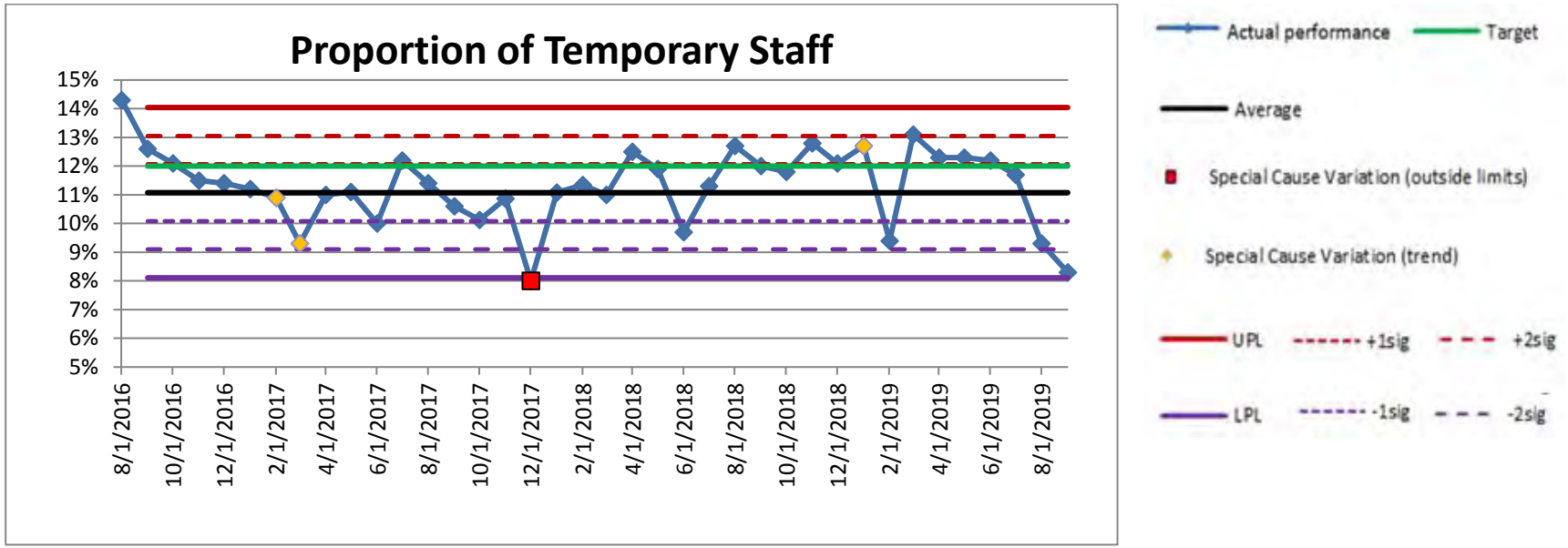


Narrative

What	Special cause variation – low with 7 points below the average.
Why	Community is currently running at 8.8%.
How	We are significantly lower than other NHS Trusts, with the national average running around 4%, and will continue to support return to work, OH referrals etc. Community managers are sent monthly sickness reports, which highlights anyone who has reached a Bradford factor score of 100+ in a six-month period. Report also shows anyone who is close to reaching 100 points.
When	unknown

Well Led

Proportion of temporary staff

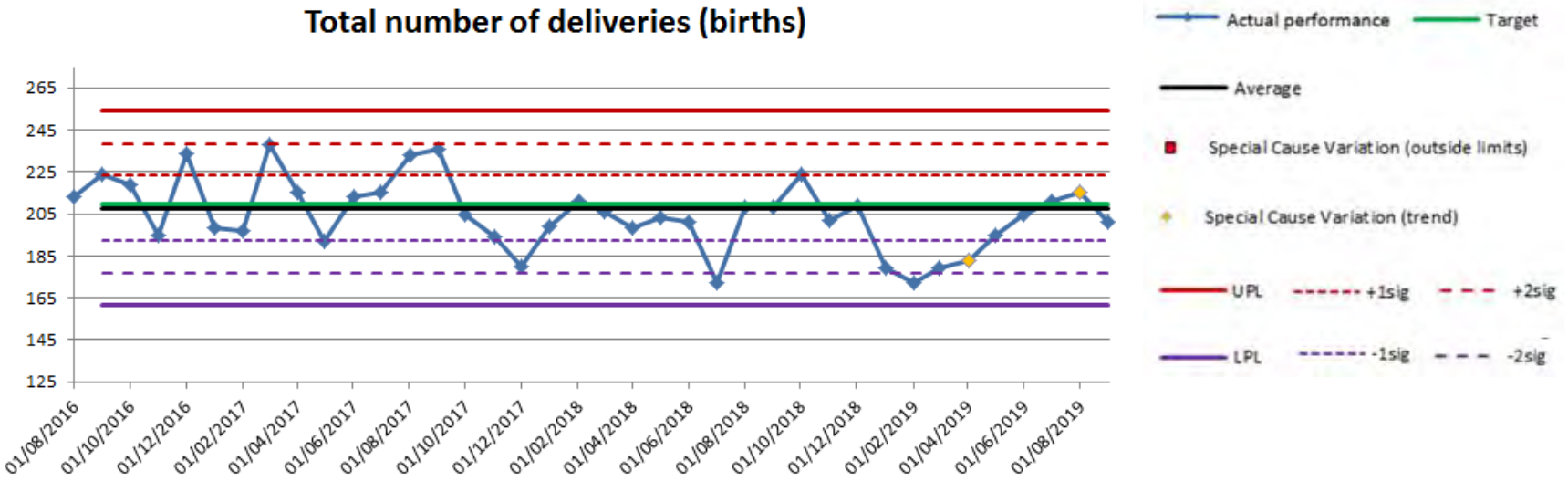


Narrative

What	Common Cause Variation
Why	-
How	-
When	-

Well Led

Total number of deliveries

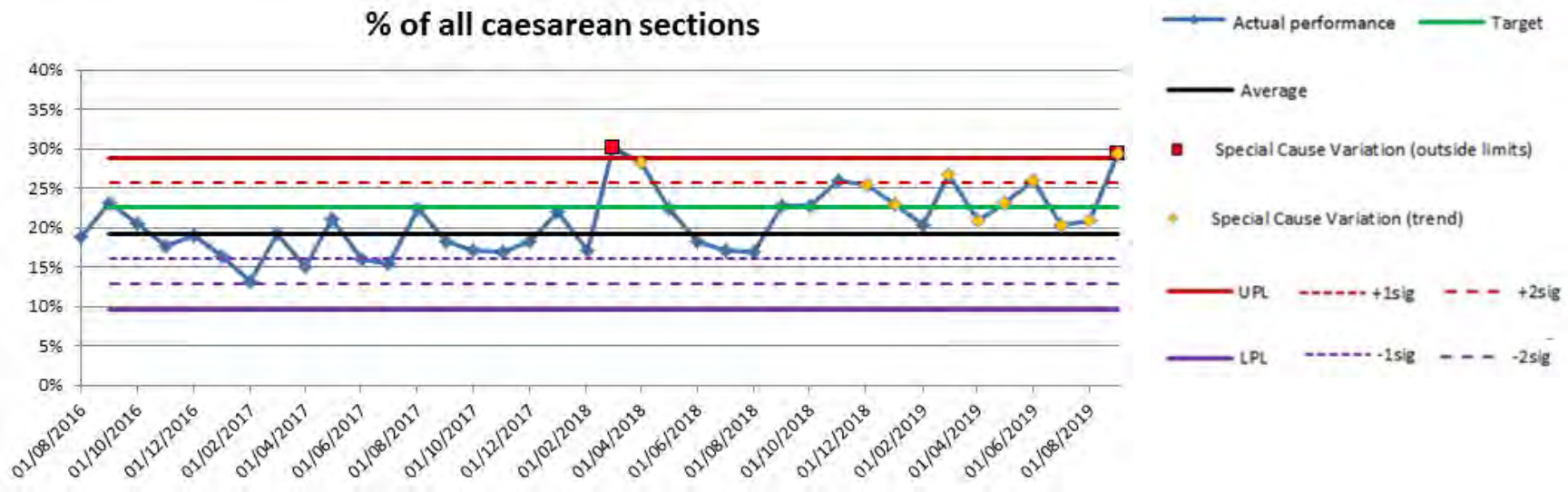


Narrative

What	Common cause variation
Why	-
How	-
When	-

Maternity

Caesarean section rate

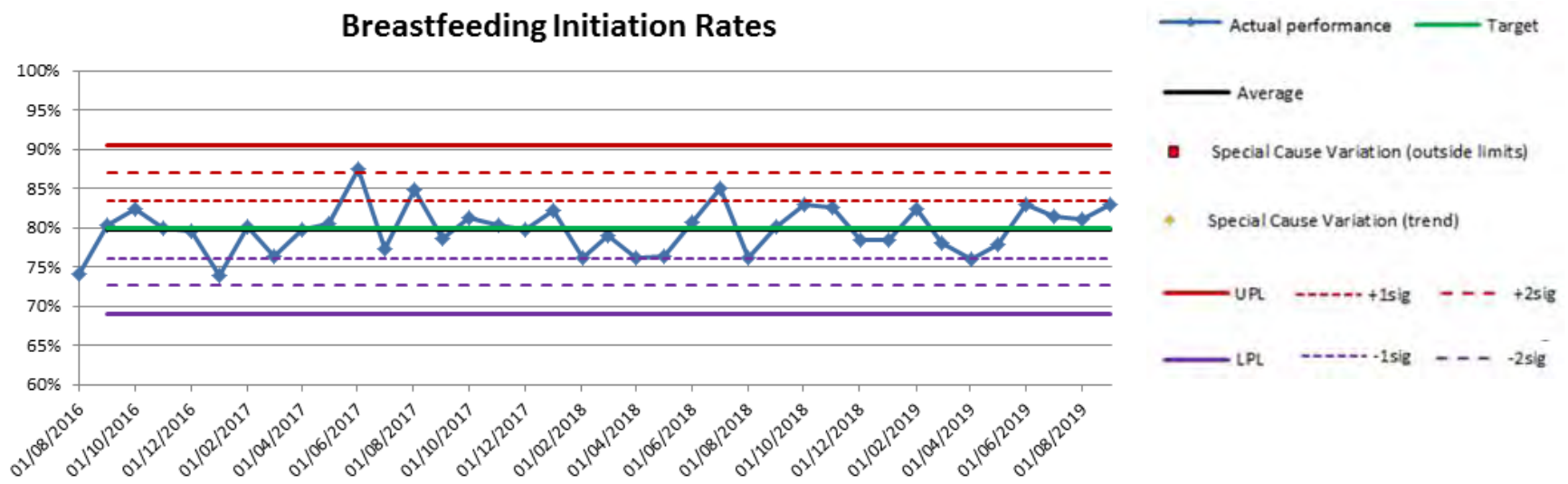


Narrative

What	Special Cause Variance - High
Why	September figures for overall percentage of Caesarean sections was above the standard of 26%. This is because the emergency Caesarean sections was increased this month. However for the last 12 month period the average rate was 23% below the agreed standard of 26%.
How	The service continues to monitor via the Women's Health Governance monthly and weekly at the case management meeting.
When	Ongoing

Maternity

Breast feeding initiation



Narrative

What	Common cause variation.
Why	-
How	-
When	-

Maternity

Trust Board – October 2019

Agenda item:	8			
Presented by:	Rowan Procter, Executive Chief Nurse Helen Beck, Chief Operating Officer			
Prepared by:	Rowan Procter, Executive Chief Nurse Helen Beck, Chief Operating Officer Joanna Rayner, Head of Performance and Efficiency			
Date prepared:	October 2019			
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 15 onwards.			

<table>
<tr><td rowspan="2">Trust priorities</td><td colspan="2">Deliver for today</td><td colspan="2">Invest in quality, staff and clinical leadership</td><td colspan="2">Build a joined-up future</td></tr>
<tr><td colspan="2">X</td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td rowspan="2">Trust ambitions</td><td>Deliver personal care</td><td>Deliver safe care</td><td>Deliver joined-up care</td><td>Support a healthy start</td><td>Support a healthy life</td><td>Support ageing well</td><td>Support all our staff</td></tr>
<tr><td></td><td>x</td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Previously considered by:</td><td colspan="7">Monthly at Trust Board</td></tr>
<tr><td>Risk and assurance:</td><td colspan="7">To provide oversight and assurance to the Board of the Trusts performance.</td></tr>
<tr><td>Legislation, regulatory, equality, diversity and dignity implications:</td><td colspan="7">Performance against national standards is reported.</td></tr>
<tr><td colspan="8">Recommendation:
The Trust Board notes the monthly performance report.</td></tr>
</table>

NHS
West Suffolk
NHS Foundation Trust

Integrated quality and performance report



Month Six: September 2019

Putting you first

CONTENTS

EXECUTIVE SUMMARY

1	EXECUTIVE SUMMARY NARRATIVE	05
2	INTEGRATED PERFORMANCE REPORT DASHBOARD	08
3	IN THIS MONTH – A SUMMARY OF ACTIVITY INFORMATION	10

DETAILED SECTIONS

1	ARE WE SAFE?	13
2	ARE WE EFFECTIVE?	34
3	ARE WE CARING?	38
4	ARE WE RESPONSIVE?	41
5	ARE WE WELL-LED?	61
6	ARE WE PRODUCTIVE?	66
7	MATERNITY	68

Putting you first

ARE WE SAFE?

Healthcare associated infections (HCAIs) – There were no MRSA Bacteraemia - hospital attributable cases and there were 3 hospital attributable clostridium difficile cases within the month (Exception report at page 18). The trust compliance with decolonisation increased in September to 100%.

CAS (Central Alerting System) Open (PSAs) – 4 Patient Safety Alerts have been received in September 2019. All of the alerts have been implemented within timescale this year to date.

Patient Falls (All patients) – 55 patient falls occurred in September 2019, which is a decrease from 62 in August 2019. (Exception report at pages 22-24).

Pressure Ulcers – 49 cases occurred in September 2019, which is an increase from 44 in August 2019. (Exception report at page 25).

ARE WE EFFECTIVE?

Cancelled Operations for non-clinical reasons – The rate of cancelled operations for non-clinical reasons was recorded at 1.3% in September 2019. (Exception report at page 35).

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 82.9% in September 2019 compared to 94.9% in August 2019. (Exception report at page 37).

Discharge Summaries - A&E has achieved a rate of 84.9% in September 2019, whereas inpatient services have achieved a rate of 86.3% (Non-elective) and 90.4% (Elective). (Exception report at page 36)

ARE WE CARING?

Mixed Sex Accommodation breaches (MSA) – No Mixed Sex Accommodation breaches occurred in September 2019.

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 – September 2019 reported performance at 40.0% compared to 44.0% in August 2019. (Exception report at page 39).

ARE WE RESPONSIVE?

Cancer – The challenge of demand and capacity continues with four areas failing the target for September 2019. These areas were Cancer 2 week wait breast symptoms with performance at 91.8%, Cancer 62 d GP referral with performance at 77.2%, Cancer 62 d Screening with performance at 85.7% and Incomplete 104 day wait with 3 breaches reported in September 2019. (Exception report at pages 47-50).

Referral to Treatment (RTT) – The percentage of patients on an incomplete pathway within 18 weeks for September 2019 was 82.0%. The total waiting list was 20831 as at the end of September 2019, with 6 patients who breached the 52-week standard. (Exception report at pages 43-45).

ARE WE WELL LED?

Appraisal - The appraisal rate for September 2019 is 82.3%.(Exception report at page 64).

Sickness Absence – The Sickness Absence rate for September 2019 is 3.6%.(Exception report at page 63).

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	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Av/YTD
1. Safe	1.01	CAS (Central Alerting System) Open	NT	5	4	7	8	8	13	11	10	6	6	1	1	4	28
	1.02	CAS (Central Alerting System) Overdue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	1.04	All relevant inpatients undergoing a VTE Risk assessment	95%	94.0%	96.0%	96.1%	94.4%	94.6%	95.2%	95.4%	95.0%	95.4%	95.1%	95.2%	94.1%	95.6%	95.1%
	1.05	Clostridium Difficile infection - Hospital Attributable	20	1	1	2	0	0	4	1	1	2	1	1	2	3	10
	1.06	MRSA Bacteraemias - Hospital Attributable	0	0	0	0	0	0	0	0	0	1	0	0	1	0	2
	1.07	Patient Safety Incidents Reported	NT	488	511	478	546	766	625	646	670	651	587	617	622	632	3779
	1.08	Never Events	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0
2.Effective	2.02	Canc. Ops - Cancellations for non-clinical reasons	1%	1.2%	1.5%	1.3%	0.5%	1.0%	1.0%	0.6%	1.9%	1.2%	1.9%	0.8%	1.6%	1.3%	1.4%
3. Caring	3.01	Compliments (Logged by Patient Experience)	NT	35	73	31	38	40	48	16	37	32	35	61	16	78	259
	3.02	Formal Complaints	20	10	8	10	6	27	18	13	17	25	16	18	10	17	103
	3.03	Mixed Sex Accommodation Breaches	0	0	0	0	0	28	0	0	0	0	20	2	0	0	22
	3.04	IP - Extremely likely or Likely to recommend (FFT)	90%	99.0%	96.0%	98.0%	98.0%	98.0%	97.0%	97.0%	95.0%	95.0%	98.0%	97.0%	97.0%	96.0%	96.3%
	3.05	OP - Extremely likely or Likely to recommend (FFT)	90%	96.0%	96.0%	96.0%	97.0%	97.0%	97.0%	97.0%	97.0%	96.0%	97.0%	96.0%	96.0%	96.0%	96.3%
	3.06	A&E - Extremely likely or Likely to recommend (FFT)	90%	97.0%	96.0%	96.0%	97.0%	96.0%	97.0%	99.0%	94.0%	88.0%	95.0%	87.0%	89.0%	92.0%	90.8%
	3.08	Community - Extremely likely or likely to recommend	80%	95.0%	100%	100%	97.0%	98.0%	95.0%	100%	95.0%	97.0%	95.0%	94.3%	95.2%	97.0%	95.6%
4. Responsive	4.02	RTT: % incomplete pathways within 18 weeks	92%	89.9%	90.2%	89.7%	88.3%	84.7%	83.6%	84.8%	84.8%	85.8%	85.4%	84.4%	83.3%	82.0%	84.3%
	4.03	52 week waiters	0	2	7	6	10	7	7	2	1	4	4	2	2	6	19
	4.04	Diagnostics within 6 weeks	99%	99.5%	99.0%	99.6%	97.1%	91.7%	92.2%	90.0%	87.5%	87.6%	92.8%	95.0%	95.4%	95.1%	92.2%
	4.05	Cancer: 2w wait for urgent GP Referrals	93%	80.9%	76.1%	89.8%	92.2%	93.4%	95.8%	90.5%	94.3%	93.1%	93.8%	95.3%	94.2%	93.4%	94.0%
	4.06	Cancer 2w wait breast symptoms	93%	93.9%	96.4%	76.7%	48.8%	72.1%	82.0%	63.5%	87.8%	90.6%	90.8%	91.3%	90.3%	91.8%	90.4%
	4.07	Cancer 31 d First Treatment	96%	100%	99.3%	100%	100%	99.2%	100%	100%	100%	98.0%	99.0%	99.0%	100%	100%	99.3%
	4.08	Cancer 31 d Drug Treatment	98%	98.5%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.09	Cancer 31 d Surgery	94%	100%	100%	100%	100%	94.4%	100%	100%	100%	95.0%	100%	100%	100%	100%	99.2%
	4.10	Cancer 62 d GP referral	85%	78.0%	80.6%	79.5%	78.3%	85.5%	84.8%	90.0%	78.4%	76.9%	65.9%	83.0%	80.6%	77.2%	77.0%
	4.11	Cancer 62 d Screening	90%	90.5%	80.0%	93.8%	87.9%	100%	100%	95.2%	92.9%	90.5%	86.7%	100%	100%	85.7%	92.6%
	4.12	Incomplete 104 day waits	0	2.0	0	3.0	0	0	1.0	1.0	2.0	4.0	5.0	6.0	3.0	3.0	23.0

NHS
West Suffolk
NHS Foundation Trust

INTEGRATED QUALITY & PERFORMANCE REPORT																
Are we..	Ref.	KPI	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Av/YTD
5. Well Led	5.01	NHS Staff Survey (Staff Engagement score -Annual)	NT	NA	NA	NA	NA	NA	7.4%	NA	NA	NA	NA	NA	NA	NA	NA
	5.02	Staff F&F Test % Recommended - care (Qrtly)	75%	NA	93.0%	NA	NA	NA	91.0%	NA	NA	NA	92.0%	NA	NA	93.0%	92.5%
	5.03	Staff F&F Test % Recommended - place to work (Qrtly)	75%	NA	82.0%	NA	NA	NA	78.0%	NA	NA	NA	79.0%	NA	NA	75.0%	77.0%
	5.04	Turnover (Rolling 12 mths)	<10%	8.7%	8.0%	8.0%	8.0%	8.0%	7.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%
	5.05	Sickness Absence	<3.5%	3.9%	3.8%	3.9%	3.8%	3.9%	3.8%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.6%	3.7%
	5.06	Executive Team Turnover (Trust Management)	<20%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	17.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.8%
	5.07	Agency Spend	550	393	381	620	500	637	330	524	426	366	482	364	530	452	437
	5.08	Monitor Use of Resources Rating	NT	3	3	3	3	3	3	3	3	3	3	3	3	3	3
6. Productive	6.01	I&E Margin	Var	-7.20%	-6.40%	-6.00%	ND	-6.10%	-5.80%	-5.50%	-5.80%	-6.70%	-7.60%	-6.90%	-7.60%	-8.00%	-7.10%
	6.03	Capital service cover	Var	-0.92	-0.63	-0.50	ND	-0.42	-0.25	-0.27	0.34	0.23	0.12	0.17	-0.22	-0.35	0.29
	6.04	Liquidity (days)	NT	19.19	17.56	21.57	ND	15.86	15.18	26.80	24.13	24.98	22.90	32.70	37.91	41.60	30.7
	6.05	Long Term Borrowing (£m)	4	75.3	75.5	76.5	ND	85.5	64.1	65.4	95.7	85.0	88.2	82.2	83.4	81.7	86.0
	6.06	CIP (Variance YTD £'000s)	1.9	-38	-28	-46	-53	-45	-48	0	-32	-75	-46	-70	-199	-127	-91.5
7. Maternity	7.01	Total number of deliveries (births)	210	208	224	202	209	179	172	179	183	195	205	211	215	201	1210
	7.02	% of all caesarean sections	26%	22.8%	22.7%	25.9%	25.4%	22.9%	20.3%	26.8%	20.8%	23.1%	25.9%	20.4%	20.9%	29.4%	23.4%
	7.03	Midwife to birth ratio	1.32	1.30	1.31	1.29	1.30	1.28	1.26	1.27	1.27	1.28	1.29	1.30	1.31	1.29	1.29
	7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.05	Completion of WHO checklist	95%	93.0%	93.0%	94.4%	95.0%	96.0%	95.0%	93.0%	94.0%	93.0%	97.0%	97.0%	93.0%	95.0%	94.8%
	7.06	Maternity SIs	NT	0	1	0	0	0	1	0	1	1	2	0	0	1	5
	7.07	Maternity Never Events	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.08	Breastfeeding Initiation Rates	80%	80.2%	83.0%	82.6%	78.5%	78.5%	82.4%	78.1%	76.0%	77.8%	83.0%	81.5%	81.0%	83.0%	80.4%
8. Community	1.32	No of avoidable serious injuries or deaths from falls - Community	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	4.27	RTT 18 weeks Non-Consultant led services - Community	90%	99.0%	99.0%	99.0%	100%	99.7%	99.6%	100%	99.0%	99.4%	94.0%	98.0%	94.4%	95.0%	96.6%
	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	95%	ND	100%	100%	100%	NA	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.40	Nursing & therapy Red referrals seen within 4hrs - Community	95%	100%	100%	99.9%	100%	96.6%	100%	100%	100%	100%	100%	93.8%	97.3%	97.1%	98.0%
	4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	95%	99.5%	99.0%	99.2%	98.4%	99.0%	98.8%	99.3%	100%	99.5%	99.3%	98.8%	99.5%	99.9%	99.5%

9

Putting you first

3. IN THIS MONTH – SEPTEMBER 2019, MONTH 6

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	Sep-2019					To Month Year	Sep-2018				

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

In this month.... Sep-2019

Mth We Received.....	Sep-19	Sep-18	Variance	Var. %	Traffic	YTD We Received.....	2019	2018	Variance	Var. %	Traffic
GP Referrals	5,068	6,538	-1,470	-22.5%	↓	GP Referrals	36,027	39,430	-3,403	-8.6%	↓
Other Referrals	4,434	5,137	-703	-13.7%	↓	Other Referrals	30,351	32,419	-2,068	-6.4%	↓
Ambulance Arrivals	1,771	1,678	93	5.5%	↑	Ambulance Arrivals	11,377	10,560	817	7.7%	↑
Cancer Referrals*	1,076	996	80	8.0%	↑	Cancer Referrals*	6,437	6,329	108	1.7%	↑
Urgent Referrals*	2,351	2,605	-254	-9.8%	↓	Urgent Referrals*	15,901	16,294	-393	-2.4%	↓

Mth We Delivered.....	Sep-19	Sep-18	Variance	Var. %	Traffic	YTD We Delivered.....	2019	2018	Variance	Var. %	Traffic
ED Attendances (excluding GP Expected/Streamed)	6,023	4,967	1,056	21.3%	↑	ED Attendances (excluding GP Expected/Streamed)	35,633	31,374	4,259	13.6%	↑
**ED Attendances(Adjusted)	7,247	6,429	818	12.7%	↑	**ED Attendances(Adjusted)	43,402	39,325	4,077	10.4%	↑
GP Expected via ED	587	500	87	17.4%	↑	GP Expected via ED	3,462	3,293	169	5.1%	↑
GP Streamed	289	578	-289	-50.0%	↓	GP Streamed	2,092	2,640	-548	-20.8%	↓
GP Expected direct to AAU/AEC	348	384	-36	-9.4%	↓	GP Expected direct to AAU/AEC	2,215	2,018	197	9.8%	↑
A&E - To IP Admission Ratio	27.1%	28.3%	-1.2%	-1.2%	↓	A&E - To IP Admission Ratio	27.3%	26.1%	1.2%	4.5%	↑
Outpatient Attendances	26,145	23,811	2,334	9.8%	↑	Outpatient Attendances	156,440	150,769	5,671	3.8%	↑
Inpatient Admissions	5,990	5,746	244	4.2%	↑	Inpatient Admissions	36,041	34,997	1,044	3.0%	↑
Elective Admissions	2,913	2,631	282	10.7%	↑	Elective Admissions	17,210	16,271	939	5.8%	↑
Non Elective Admission	3,077	3,115	-38	-1.2%	↓	Non Elective Admission	18,983	18,726	257	1.4%	↑
Inpatient Discharges	5,995	5,721	274	4.8%	↑	Inpatient Discharges	36,065	35,017	1,048	3.0%	↑
Elective Discharges	2,905	2,646	259	9.8%	↑	Elective Discharges	17,442	16,279	1,163	7.1%	↑
Non Elective Discharges	3,090	3,075	15	0.5%	↑	Non Elective Discharges	18,648	18,738	-90	-0.5%	↓
New Births	201	208	-7	-3%	↓	New Births	1,210	1,190	20	2%	↑

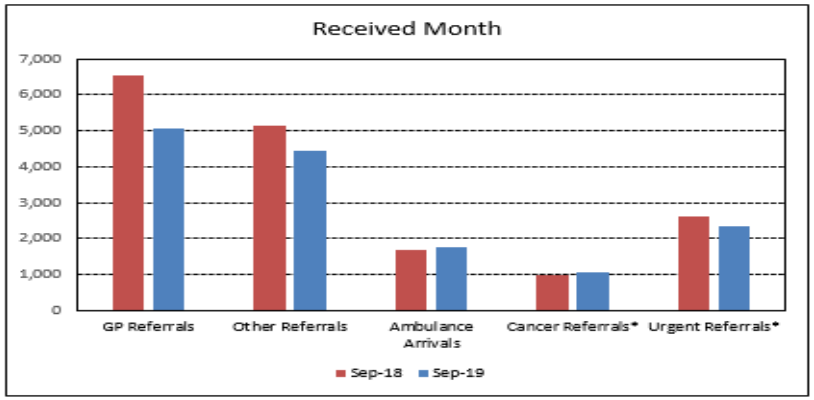
* - Included in Referrals Above

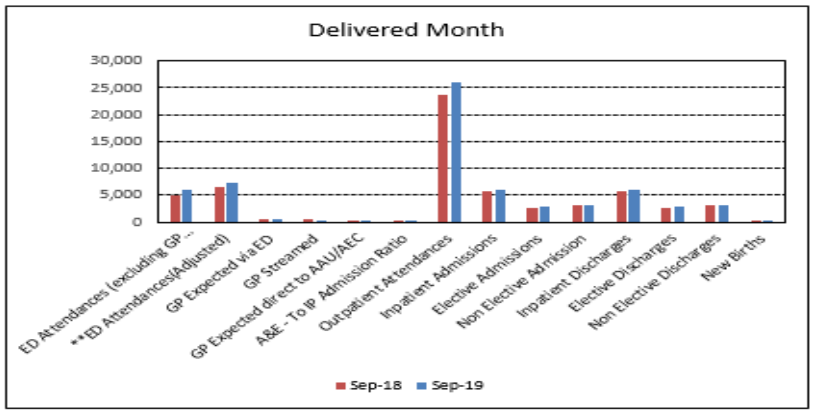
** - The ED adjusted figure adds ED attendances, GP Streamed and all GP expected (Including direct to AAU/AEC) together to reflect the position in 2017 when these were reported together.

A&E Attendances Year chart (Adjusted)

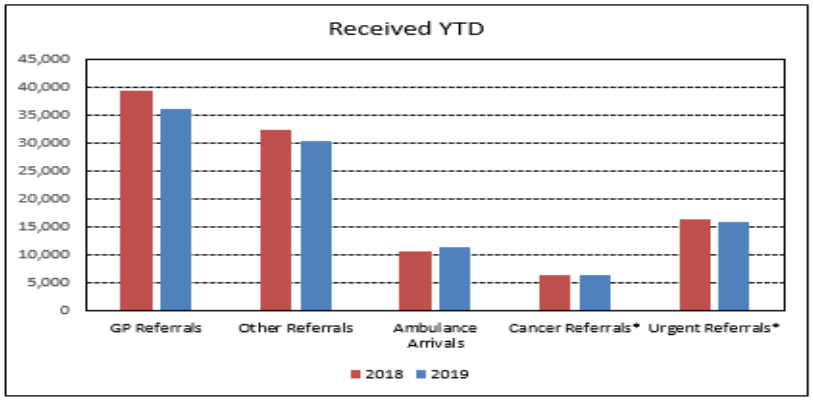
GP, cancer referrals and other referrals demonstrate a reduction year on year. A&E attendances continue to show an increase and incomplete RTT pathways are higher than last year.

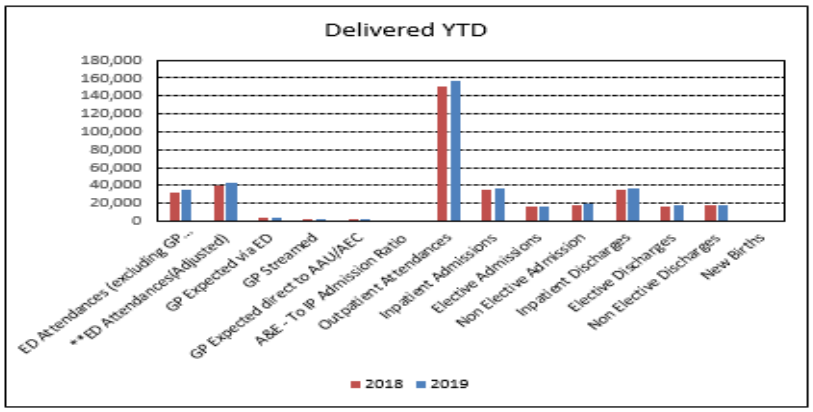
Monthly





Yearly





11

Putting you first

NHS
West Suffolk
NHS Foundation Trust

DETAILED REPORTS

Putting you first

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	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	YTD(Apr19-Sep19)
1.Safe	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	100%	100%	100%	100%	100%	100%	94.4%	100%	100%	100%	100%	100%	83.0%	88.9%	95.3%
		1.10	HII Compliance 1b: Central venous catheter on-going care	100%	95.0%	100%	96.0%	100%	96.2%	96.4%	87.1%	89.0%	100%	100%	100%	100%	100%	98.2%
		1.11	HII Compliance 2a: Peripheral cannula insertion	100%	100%	96.0%	96.0%	100%	97.9%	100%	96.4%	100%	98.0%	100%	100%	91.0%	90.0%	96.5%
		1.12	HII Compliance 2b: Peripheral cannula on-going	100%	88.0%	100%	100%	100%	97.0%	99.3%	99.2%	100%	98.4%	100%	99.2%	100%	100%	99.8%
		1.13	HII Compliance 4a: Preventing surgical site infection preoperative	100%	100%	100%	95.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.14	HII Compliance 4b: Preventing surgical site infection perioperative	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.15	HII Compliance 5: Ventilator associated pneumonia	100%	100%	100%	100%	100%	100%	100%	90.0%	ND	90.0%	100%	100%	100%	100%	98.0%
		1.16	HII Compliance 6a: Urinary catheter insertion	100%	100%	100%	100%	100%	90.9%	100%	100%	ND	100%	100%	100%	100%	100%	100%
		1.17	HII Compliance 6b: Urinary catheter on-going care	100%	89.0%	94.0%	97.0%	98.0%	92.2%	88.8%	95.2%	96.0%	94.2%	96.1%	100%	100%	98.8%	97.5%
	Incidents	1.18	Safety Thermometer: % of patients experiencing new harm-free care-Trust	100%	97.8%	98.7%	98.7%	96.2%	98.3%	97.0%	97.9%	96.6%	97.8%	97.0%	99.1%	98.3%	95.6%	97.4%
		1.19	Safety Thermometer: % of patients experiencing new harm-free care - Community	100%	97.7%	98.9%	99.0%	96.4%	98.4%	97.0%	99.0%	96.1%	99.7%	98.6%	99.7%	99.3%	99.0%	98.7%
		1.20	No of SIRIs	NT	2	4	3	5	6	2	2	5	6	1	3	2	6	23
		1.21	RIDDOR Reportable Incidents	NT	0	3	2	3	1	3	3	2	2	2	0	1	2	9
		1.22	Total No of E. Coli (Trust level only)	NT	0	0	0	1	2	0	1	1	3	2	4	3	1	14
		1.23	No of Inpatient falls - Trust	NT	64	61	48	61	81	54	56	74	75	61	73	62	55	400
		1.24	No of Inpatient falls - WSH	<48	55	47	35	53	61	42	47	60	66	53	65	58	50	352
		1.25	No of Inpatient falls - Community Hospitals	NT	9	14	13	8	20	12	9	14	11	8	8	4	5	50
		1.26	Falls per 1,000 bed days	NT	5.27	4.29	3.35	4.82	5.21	3.95	4.17	5.21	5.71	4.98	5.87	5.60	4.94	5.39
		1.27	No of Inpatient falls resulting in harm - Trust	NT	12	12	17	15	25	14	15	21	15	18	22	15	17	108
		1.28	No of Inpatient falls resulting in harm - WSH	NT	12	11	13	12	22	10	13	16	14	14	20	14	17	95
		1.29	No of Inpatient falls resulting in harm - Community Hospitals	NT	0	1	4	3	3	4	2	5	1	4	2	1	0	13
		1.30	No of avoidable serious injuries or deaths resulting from falls - Trust	0	0	0	0	2	1	0	0	4	2	1	2	1	1	11
		1.31	No of avoidable serious injuries or deaths resulting from falls - WSH	0	0	0	0	2	1	0	0	4	2	1	2	1	1	11
		1.32	No of avoidable serious injuries or deaths from falls - Community	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		1.69	PU present on admission to service - Trust	NT	73	77	71	78	99	69	87	89	90	88	62	89	80	498
		1.70	PU present on admission to service – Inpatients	NT	58	60	57	61	77	49	58	60	62	64	35	72	69	362
		1.71	PU present on admission to service – Community teams	NT	17	17	14	17	22	20	29	29	28	31	27	17	11	143
		1.33	Number of medication errors	NT	63	71	54	61	79	78	72	89	76	65	89	56	83	458
		1.72	New PU - Trust	0	24	35	28	27	30	34	40	42	54	31	37	44	49	257
		1.67	New PU – Inpatients	0	14	13	19	17	11	16	21	20	25	11	17	18	19	110
		1.68	New PU – Community teams	0	10	22	9	10	19	18	19	22	29	20	20	26	30	147
		1.73	Moisture associated skin damage	0	NA	NA	NA	NA	17	18	22	18	14	14	26	21	29	122
		1.74	Device related (% of total)	NT	NA	NA	NA	NA	2.0%	6.0%	5.0%	4.0%	5.0%	3.0%	2.0%	4.0%	0.0%	3.0%
		1.60	% of patients at risk of falls (with a Falls assessment)	NT	72.0%	73.3%	72.7%	71.6%	73.0%	71.9%	73.9%	73.2%	73.7%	73.1%	73.2%	74.7%	72.4%	73.4%

Putting you first

Are we..		Ref.	KPI	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	YTD(Apr19-Sep19)
1. Safe	Reporting	1.38	MRSA Quarterly Std (including admission and LOS screens)	90%	87.0%	NA	NA	89.0%	NA	NA	88.0%	NA	NA	87.0%	NA	NA	91.0%	89.0%
		1.39	MRSA Bacteraemias - Community Attributable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		1.40	Clostridium Difficile infection - Community Attributable	NT	4	3	2	2	4	1	6	3	4	3	5	1	2	18
		1.41	MRSA - Decolonisation	95%	86.0%	95.0%	97.0%	94.0%	94.0%	100%	92.0%	100%	100%	94.0%	100%	95.0%	100%	98.2%
		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	0	0	0	2	0	0	1	1	2	0	4
		1.44	SIRI final reports due in month submitted beyond 60 working days	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
		1.45	SIRIs reported >2 working days from identification as red	0	0	0	0	0	0	0	1	0	0	0	1	0	1	2
		1.46	Green, Amber & Red Active / Accepted risk assessments not in date	0	0	4	2	3	79	55	55	55	53	56	53	19	0	236
		1.47	Datix Risk Register Red / Amber actions overdue	0	0	1	4	1	65	65	65	65	64	65	41	30	1	266
		1.48	Rapid access chest pain clinic access within 2 wks.	95%	98.6%	99.2%	99.2%	100%	100%	100%	100%	100%	100%	100%	100%	97.5%	99.0%	99.4%
		1.75	Verbal DoC undertaken within 10 working days of incident report	NT	NA	NA	NA	NA	NA	NA	NA	47.0%	60.0%	69.0%	63.0%	55.0%	30.0%	54.0%
		1.76	Total written (initial notification letter) Duty of Candour still outstanding at month-end NB: Only includes cases where verbal has already been completed	3	NA	NA	NA	NA	NA	NA	NA	4	3	5	8	5	3	28
		1.49	Verbal Duty of Candour outstanding at month-end	0	0	0	0	6	0	4	5	4	4	2	5	2	3	20
		1.50	Hand Hygiene Audits	100%	100%	100%	99.6%	98.8%	100%	100%	99.7%	100%	100%	99.5%	100%	97.0%	99.0%	99.3%
		1.51	Quarterly antibiotic audit	98%	89.0%	NA	NA	90.0%	NA	NA	87.0%	NA	NA	89.0%	NA	NA	90.0%	89.5%
		1.52	Serious Incident RCA actions beyond deadline for completion	0	2	5	11	5	14	8	13	25	21	26	19	14	16	121
		1.53	% of Green Patient Safety incidents investigated	NT	63.0%	64.0%	60.0%	59.0%	71.0%	72.0%	71.0%	63.0%	74.0%	63.0%	68.0%	67.0%	68.0%	67.2%
		1.54	Quarterly Environment/Isolation	90%	93.0%	NA	NA	93.0%	NA	NA	92.0%	NA	NA	92.0%	NA	NA	93.0%	92.5%
		1.55	Quarterly Visual Infusion Phlebitis score documentation	90%	83.0%	NA	NA	84.0%	NA	NA	85.0%	NA	NA	86.0%	NA	NA	87.0%	86.5%
		1.56	Isolation data (Trust Level only)	90%	91.0%	91.0%	91.0%	90.0%	80.0%	75.0%	85.0%	85.0%	85.0%	89.0%	85.0%	87.0%	87.0%	86.3%
		1.57	Pain Mgt. internal report	80%	NA	85.5%	NA	NA	84.5%	NA	NA	85.2%	84.1%	84.3%	83.2%	84.3%	83.5%	84.1%
		1.58	Nutrition % of patients with a MUST/PYMS assessment completed for within 24hrs	95%	82.0%	83.0%	83.0%	84.0%	83.0%	81.0%	79.0%	81.0%	81.0%	82.0%	83.0%	84.0%	85.7%	82.8%
		1.59	Median NRLS (national reporting & Learning system) upload 6 month rolling average (No. of days)	41	40	75	84	98	78	82	38	57	70	84	ND	ND	ND	70
		1.61	E coli - Hospital Attributable	NT	1	2	0	1	2	0	1	1	3	2	4	3	1	14
		1.62	E coli - Community Attributable	NT	13	14	13	11	8	9	16	12	18	17	24	24	15	110
		1.63	Klebsiella spp. - Hospital Attributable	NT	0	0	0	1	0	1	0	1	0	0	1	1	0	3
		1.64	Klebsiella spp. - Community Attributable	NT	3	1	3	2	1	1	1	2	3	4	6	1	6	22
		1.65	Pseudomonas - Hospital Attributable	NT	0	0	0	0	0	1	0	2	0	0	0	0	0	2
		1.66	Pseudomonas - Community Attributable	NT	1	1	0	1	1	2	0	0	1	3	4	1	1	10

NHS West Suffolk NHS Foundation Trust

SAFE – DIVISIONAL LEVEL ANALYSIS

	July			August			September		
Indicator	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
HII compliance 1a: Central venous catheter insertion	100	100		78.0	100		85.7	100	
HII compliance 1b: Central venous catheter ongoing care	100	100		100	100		100	100	
HII compliance 2a: Peripheral cannula insertion	100	100	100	90.0	85.0	100	100	78.6	100
HII compliance 2b: Peripheral cannula ongoing	100	98.5	100	100	100	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	
HII compliance 6b: Urinary catheter on-going care	100	100		100	100		100	98.2	
HII compliance: Antibiotic Prescribing - All care setting		88.0		100	76.0		90.0	96.0	100
HII compliance: Antibiotic Prescribing - Secondary Care		76.0		63.0	83.0		65.0	74.0	100
HII compliance: Chronic Wounds									
Total no of MRSA bacteraemias: Hospital	0	0	0	1	1	0	0	0	0
Quarterly MRSA (including admission and length of stay screens)							98.0	81.0	94.0
Hand hygiene compliance	100	100	100	91.0	98.0	100	98.5	100	80.0
Total no of MSSA bacteraemias: Hospital	0	1	0	1	1	0	0	0	0
Quarterly Environment & Standard Principles Compliance							93.0	91.0	94.0
Total no of C. diff infections: Hospital	0	0	0	0	2	0	1	2	0
Quarterly Antibiotic Audit							90.3	89.2	94.4
Quarterly VIP score documentation							89.0	87.0	84.0

15

Putting you first

Indicator	July			August			September		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
No of patient falls	16	45	4	9	47	2	6	44	0
No of patient falls resulting in harm	5	16	0	2	12	0	2	15	0
No of avoidable serious injuries or deaths resulting from falls	0	0	0	0	0	0	0	0	0
No of ward acquired pressure ulcers	3	14	0	9	7	0	5	14	0
No of avoidable ward acquired pressure ulcers									
Nutrition: Assessment and monitoring	80.8	88.2	62.0	77.6	90.9	51.1	84.5	90.7	56.6
No of SIRIs	0	2	1	1	0	0	1	4	1
No of medication errors	18	44	10	11	30	6	23	39	7
Cardiac arrests	2	5	0	0	5	0	1	2	0
Cardiac arrests identified as a SIRI	0	0	0	0	0	0	0	0	0
Pain Management	84.6	86.4	55.5	86.3	86.2	54	84.9	86.7	48.1
VTE: Completed risk assessment (monthly Unify audit)	95.9	94.9	91.2	97.1	95.1	64.8	96.2	95.2	96.1
Quarterly VTE: Prophylaxis compliance									
Safety Thermometer: % of patients experiencing new harm-free care	100	97.9	100	93.9	97.2	90.0	97.6	96.9	100

Indicator	July			August			September		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
Patient Satisfaction: In-patient overall result	92.0	88.0		95.0	85.0	83.0	93.0	86.0	85.0
How likely are you to recommend our services to friends and family if they need similar care or treatment	98.0	95.0		99.0	95.0	100.0	99.0	94.0	100.0
In your opinion, how clean was the hospital room or ward you were in?	97.0	95.0		97.0	96.0	97.0	96.0	97.0	98.0
How was the food choice during your hospital stay?	87.0	89.0		92.0	86.0	81.0	86.0	87.0	79.0
How was the food taste and quality during your hospital stay?	86.0	89.0		93.0	86.0	81.0	86.0	86.0	82.0
Did you feel you were treated with respect and dignity by staff?	98.0	97.0		99.0	97.0	97.0	100.0	97.0	96.0
Were staff caring and compassionate in their approach?	98.0	97.0		99.0	97.0	100.0	100.0	96.0	96.0
Did you find a member of staff to talk to about your worries and fears?	99.0	96.0		99.0	92.0	92.0	98.0	96.0	100.0
Were you involved as much as you wanted to be in decisions about your care and treatment?	94.0	90.0		97.0	88.0	92.0	97.0	90.0	89.0
Did you experience any noise in the night time?	88.0	82.0		91.0	82.0	95.0	84.0	75.0	78.0
Did you get enough help from staff to eat your meals?	98.0	100.0		98.0	98.0	100.0	99.0	94.0	100.0
Minutes after you used the call button did it take to get help?	89.0	70.0		86.0	71.0	85.0	80.0	71.0	79.0
Did someone from pharmacy discuss your medications with you at any time during your hospital stay?	84.0	78.0		88.0	63.0	17.0	86.0	67.0	38.0
Were you given clear written or printed information about your take-home medications?	96.0	87.0		97.0	75.0	53.0	98.0	84.0	83.0
Were the purposes of your take-home medications explained to you in a way you could understand?	89.0	78.0		96.0	71.0	68.0	96.0	82.0	89.0
Number of Inpatient surveys completed	293	245		233	177	39	237	162	56
Same sex accommodation: total patients	0	2	0	0	0	0	0	0	0
Complaints	3	10	3	1	5	2	5	9	2
Environment and Cleanliness	94.3	92.0	94.5	94.6	92.3	94.8	94.1	92.5	92.8

5. Exception reports – Safe

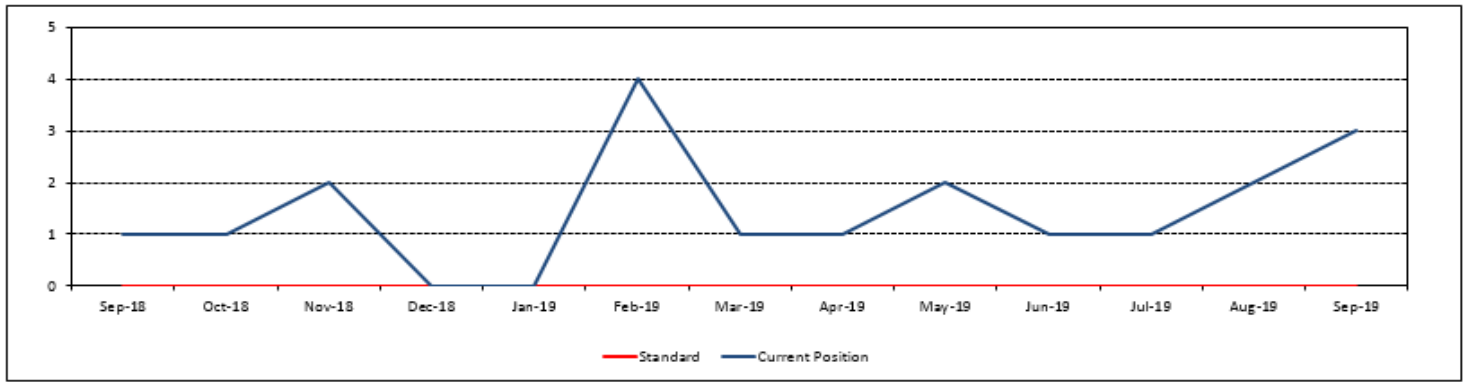
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	Clostridium Difficile infection - Hospital Attributable
Standard	0
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

There have been 3 Hospital Onset cases recorded in September 2019 and 2 Community Onset but Hospital/Health (COHA) care associated cases.
This is the highest monthly total this year to date (2019-2020). The Hospital onset cases have been investigated and two are confirmed as non trajectory 1 is awaited. The cases occurred on: G3 1 case, F12 1 case & F6 1 case. There are no links to the cases and ribotyping is distinct.
However a possible theme is the use of Tazocin . Accordingly the risk register has been updated to reflect this.
Of the Community Onset but Hospital/Health cases 1 is non trajectory and 1 has been escalated for full post infection review .

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	1	1	2	0	0	4	1	1	2	1	1	2	3

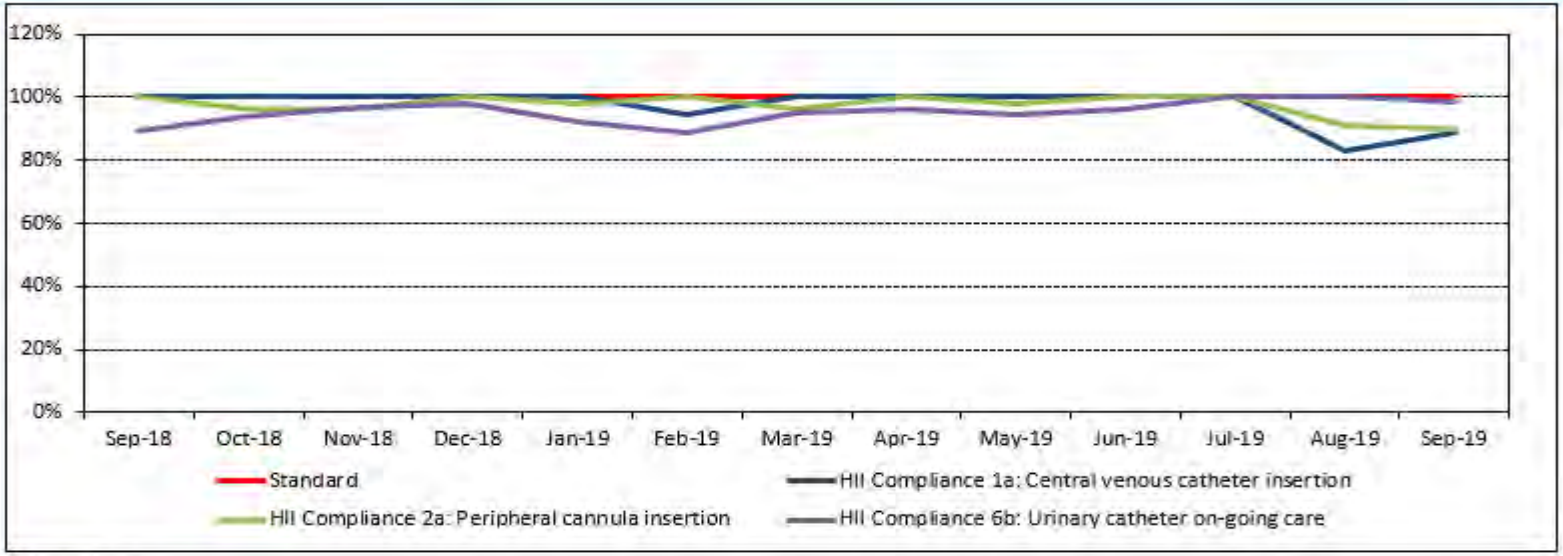
Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
An action to update the Trust risk register has been completed, in conjunction with pharmacy, that availability of Tazocin in 2019 for treating sepsis of unknown origin may increase the risk of higher numbers of C difficile being identified at the Trust. (Tazocin was extremely limited in availability last year).			



18

Putting you first

High Impact Interventions (HIIs)



Narrative

What	Performance is measured against a target of 100% for each High impact intervention (HII). In September, all of the HIIs achieved 100% except HII 1a: Central venous cannula insertion, 2a: Peripheral cannula insertion and 6b - Urinary catheter on going care.
Why	Failure in 1a (in Critical Care), 2a (on Ward G1) and 6b (on Ward G4) brought performance down.
How	Critical Care has failed to achieve 100% for 1a. For two months running and the area is being asked to highlight themes and how to address these. The new Matron for Critical care will be integral in overseeing this. On the wards the Matrons work closely with the teams to ensure performance is maintained and (where necessary) improves.
When	An HII annual review was due to take place in September looking at reporting pathways with particular focus on 6b as the element most likely to fail the 100% target (although it did achieve 100% in July and August). This review has been rescheduled to November and will form part of the wider IQPR review being led by the Head of Performance.

Safe

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

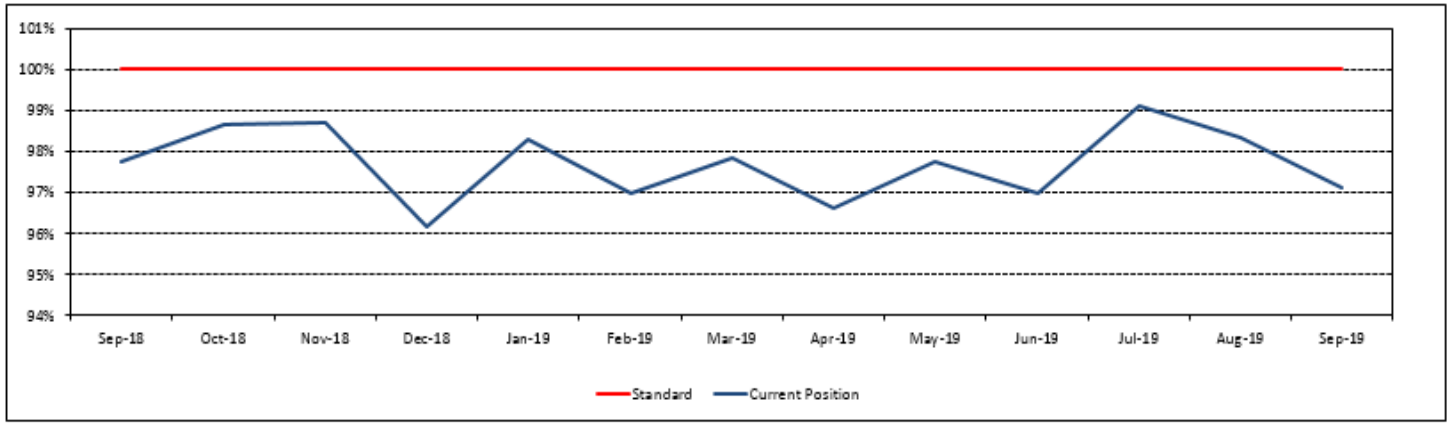
Indicator	Safety Thermometer - Harm-Free Care (New Harms)
Standard	100%
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

The National 'Harm Free' care composite measure is defined as the proportion of patients without a pressure ulcer (ANY origin, category II - IV), harm from a fall in the last 72 hours, a urinary tract infection (in patients with a urethral urinary catheter) or new VTE treatment. It should be noted that the Safety Thermometer is a spot audit and data is collected on a specific day each month. The SPC chart below shows the Trust Harm Free care compared to the National benchmark for the period Oct17 to Sep19.

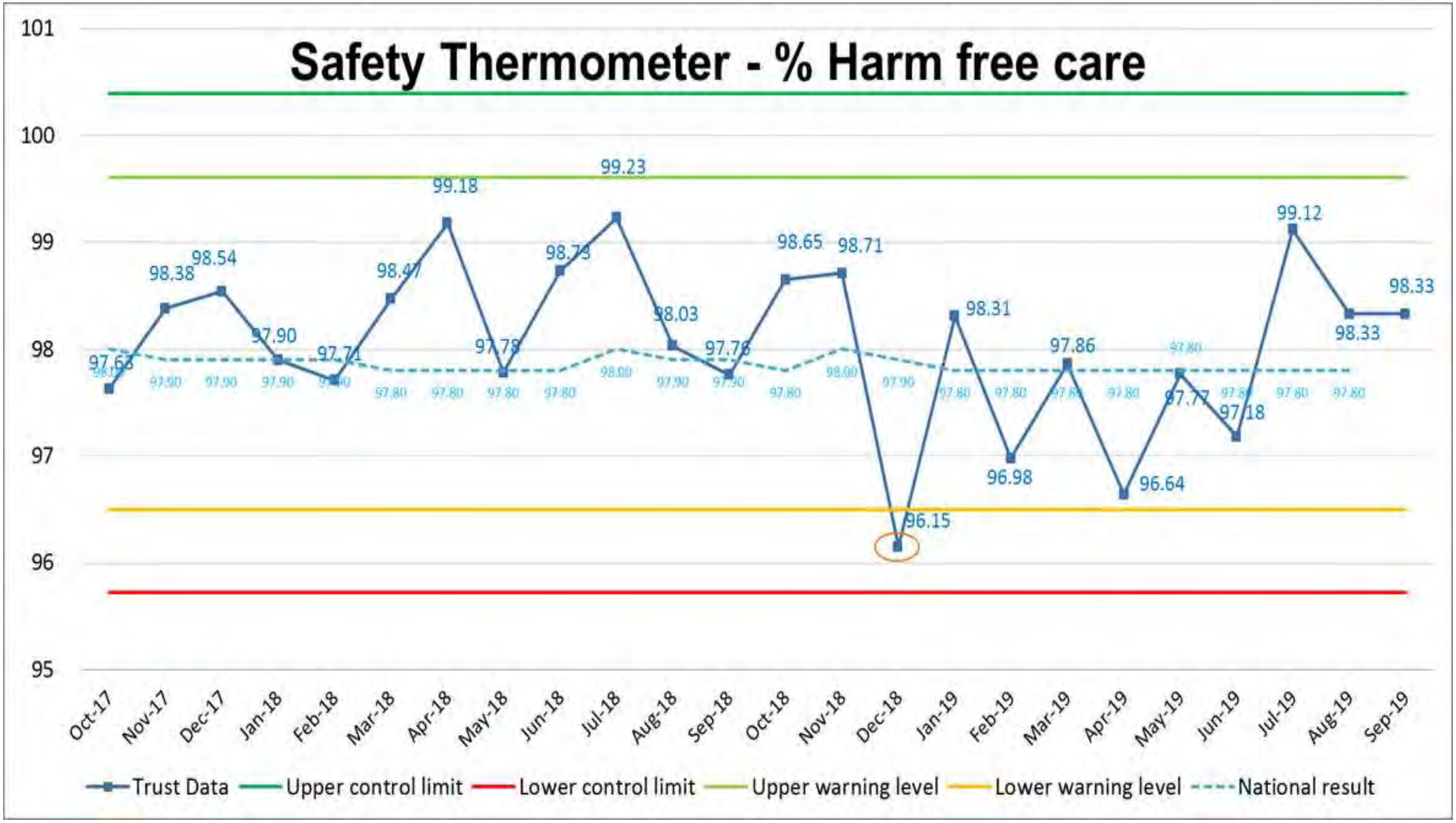
Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	97.8%	98.7%	98.7%	96.2%	98.3%	97.0%	97.9%	96.6%	97.8%	97.0%	99.1%	98.3%	97.1%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Regular review of our quality data being carried out with in the month. Review of audits such as perfect ward, incidents and staffing issues to allow for early identification and escalation via the patient safety huddle or directly with the nursing team. Projects around Falls, Pressure Ulcers and Sepsis continue. The way in which we review the data is also now under review to ensure this is the most efficient and effective method, allowing us to be responsive to our quality indicators	HONs	October	December



20

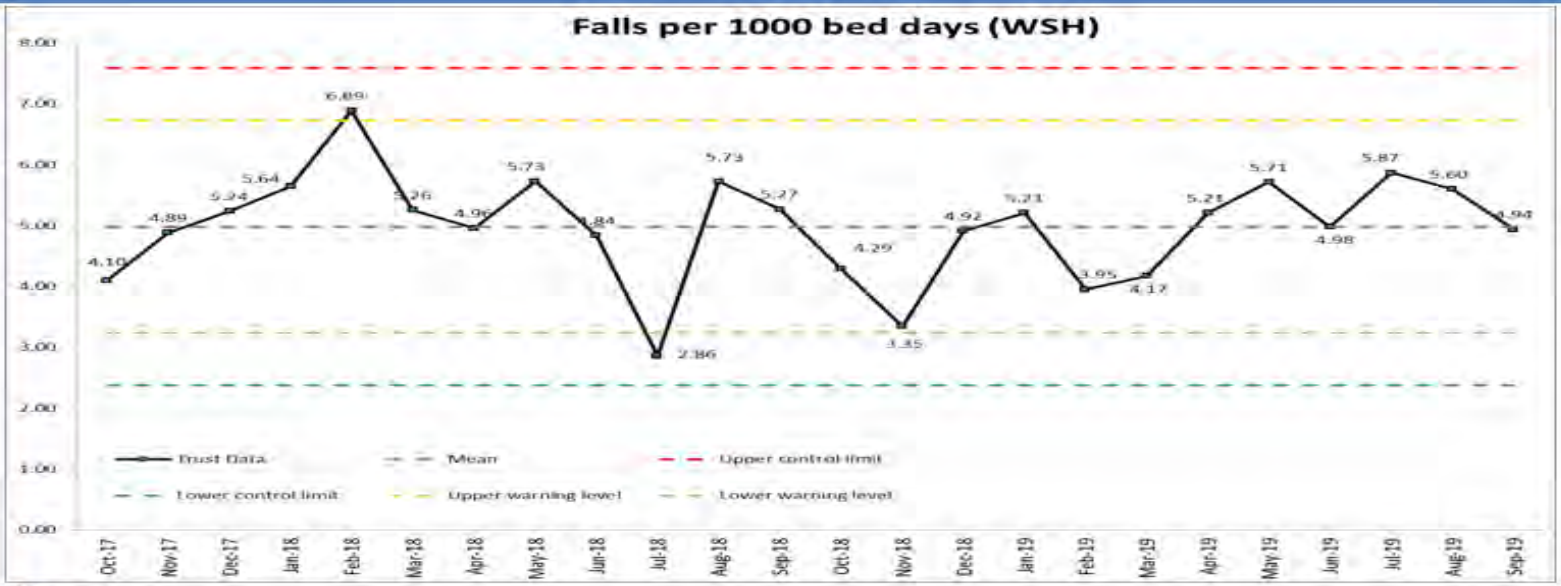
Putting you first



21

Putting you first

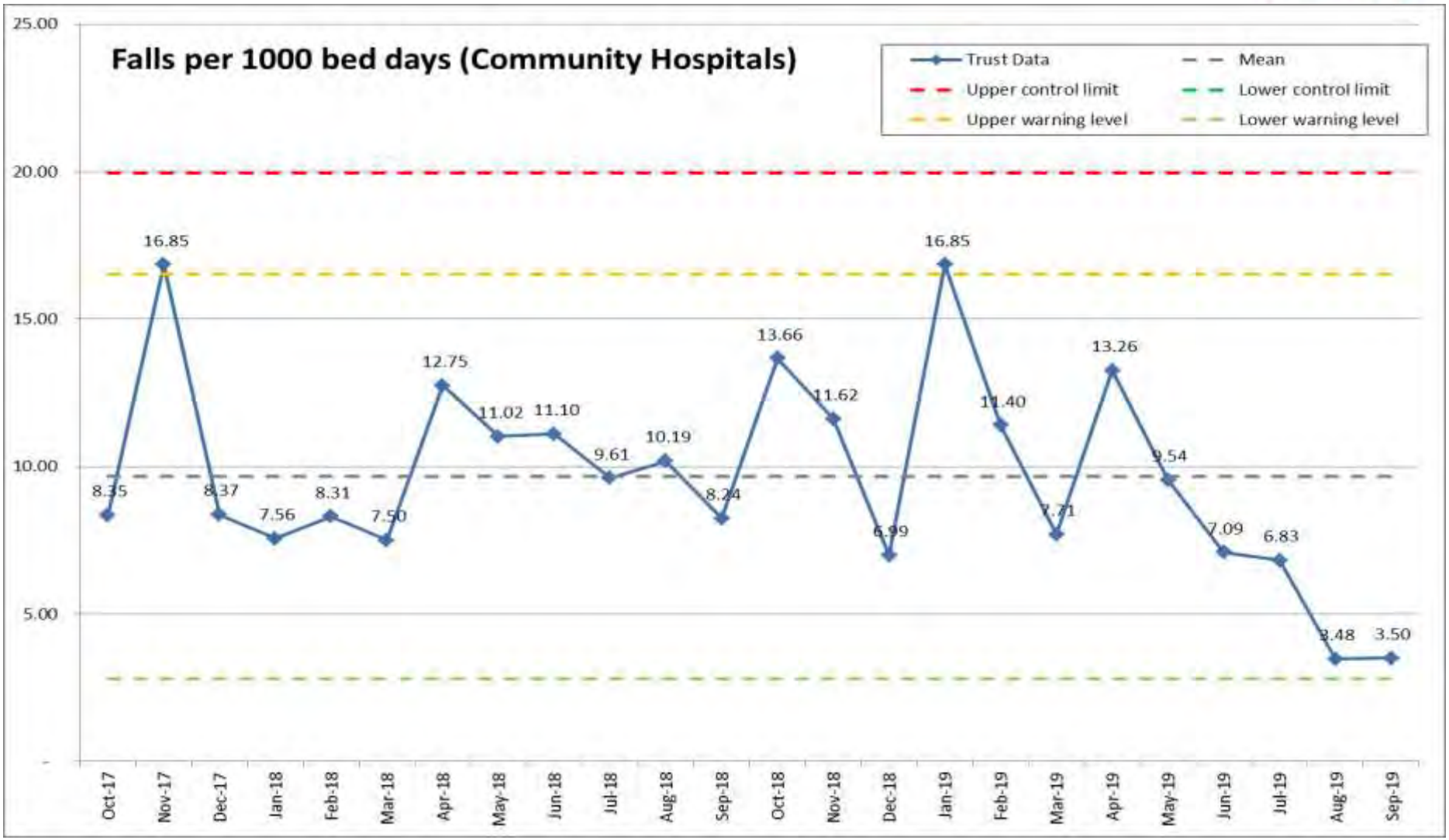
Falls



Narrative

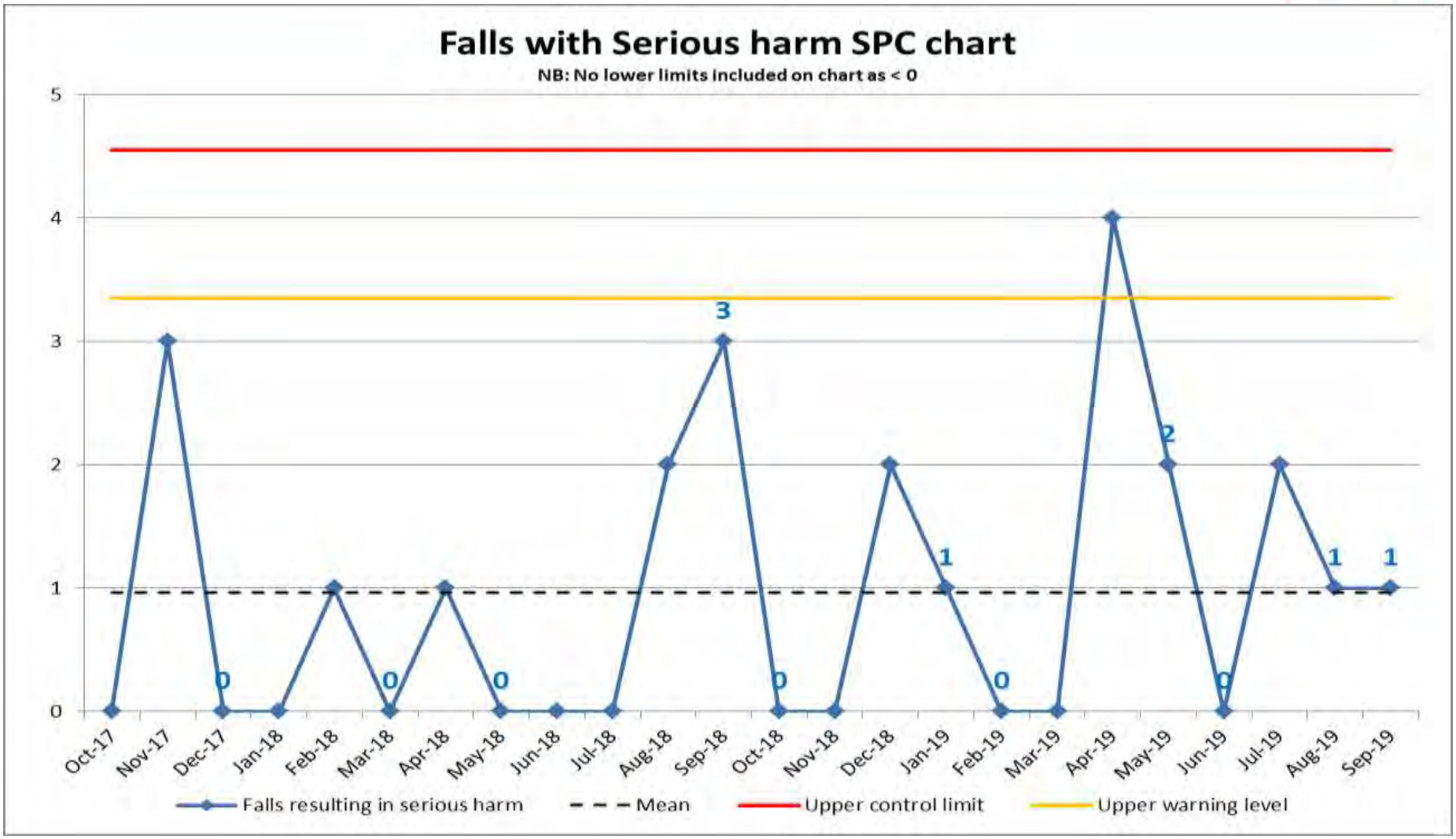
What	The total number of Trust inpatient falls fell in September to a total of 55 (50 in WSH & 5 in Community beds), the falls per 1,000 bed days is 4.94 maintaining a value within the expected range.
Why	The Trust monitor trends in patient falls on a monthly basis including the impact of higher levels of bed occupancy and/or patient acuity. There was one fall resulting in serious harm in September, a neck of femur on F7. A full investigation is ongoing into these incidents. YTD we have had 10 falls with serious harm (see SPC chart below)
How	In 2019/20 the new CQUIN Preventing Hospital Falls - Admitted patients aged over 65 years, with LOS at least 48 hours will drive further improvements. We have commenced trialling new falls prevention technology on F3 and then trialling in other clinical areas including the community. Our training package is being reviewed and updated by the falls Matron.
When	This is an ongoing work plan and quality improvement initiatives will continue to be progressed via the Falls Group including ongoing liaison with the contacts gained through the previous work in the regional NHSI collaborative. We now have some dedicated Matron hours focused on falls training and quality improvements within the Trust.

Safe



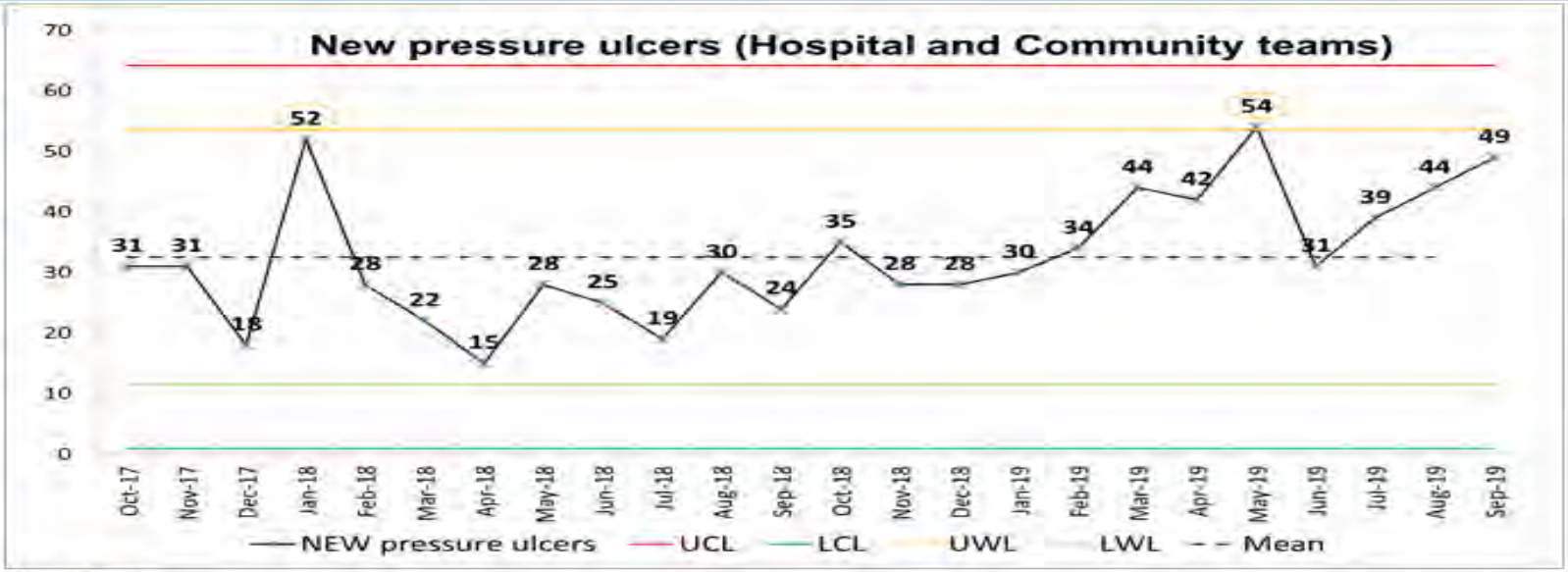
23

Putting you first



Putting you first

Pressure ulcers

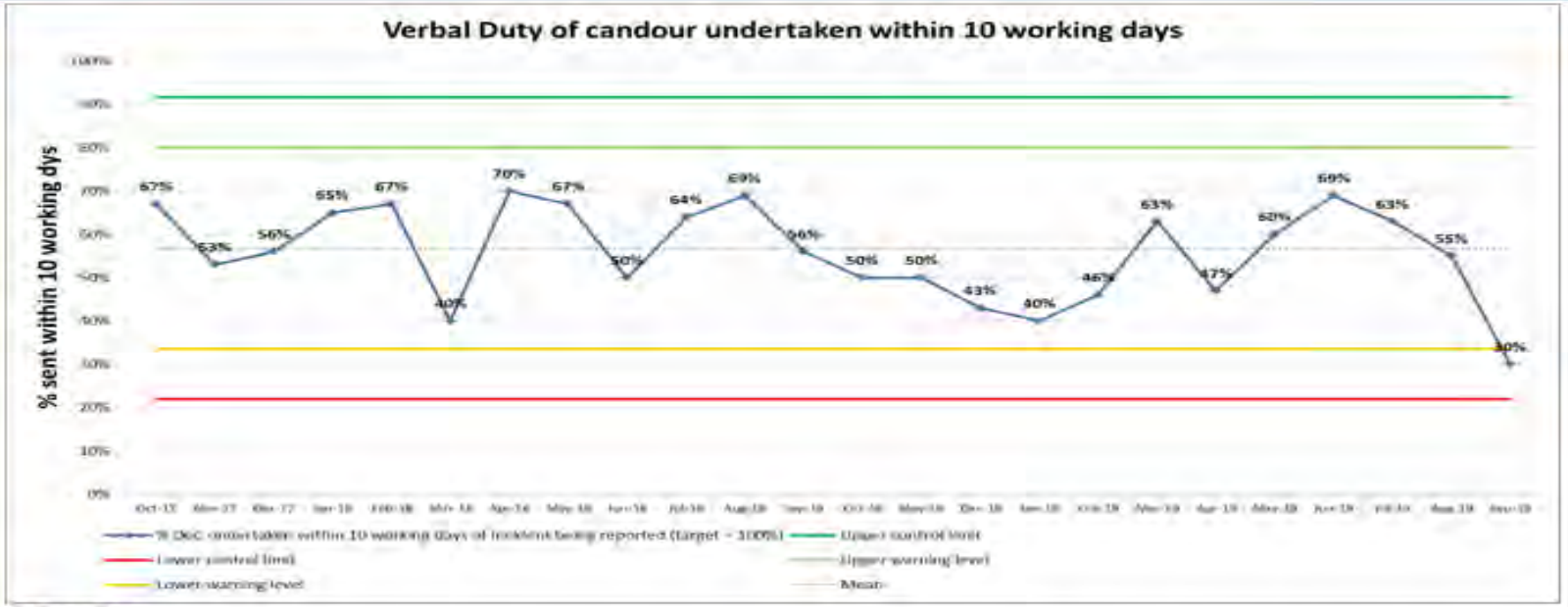


Narrative

What	An overall increase in new Pressure ulcers has been seen during September. An additional Cat 2 Pressure ulcer was reported during the month, however the largest increase was around Cat 3 Pressure ulcers (↑from 3 to 9). It is pleasing that no Cat 4 Pressure ulcers were reported during September.
Why	The patients in our care continue to demonstrate increasing complexity and co-morbidity, concerns have been raised by Tissue Viability colleagues in terms of ensuring smooth patient pathways receiving wound care in their own homes with potentially deteriorating wounds and the ability of the team to refer for diagnostics. We are working on finding a solution to this which will ensure that earlier treatment of deteriorating wounds can take place; this will not only enhance wound care but will improve the patient experience.
How	We continue to develop the new internal monitoring processes reported on last month to provide a structured framework from which to secure learning, that can be shared with clinical teams. As a Trust, a large number of new Pressure ulcers are reported by the Community and Integrated Services Division; patients in the care of community teams in their own homes are not subject to 24 hour care/support and our focus will be around providing preventative advice, equipment and support to patients, families and carers. Our Senior Matron for this Division is working closely with those community teams who report an increasing incidence in Pressure ulcers.
When	Our focus continues towards a 5% reduction in new Pressure ulcers by the end of this financial year. This is an enormous challenge however is supported by ongoing and increasing learning opportunities for staff in all settings. Benchmarking ourselves with other integrated organisations is also considered useful and data is being sought. We will present a report on the outcome and learning from Pressure ulcers RCAs in November's Board Learning Report.

Safe

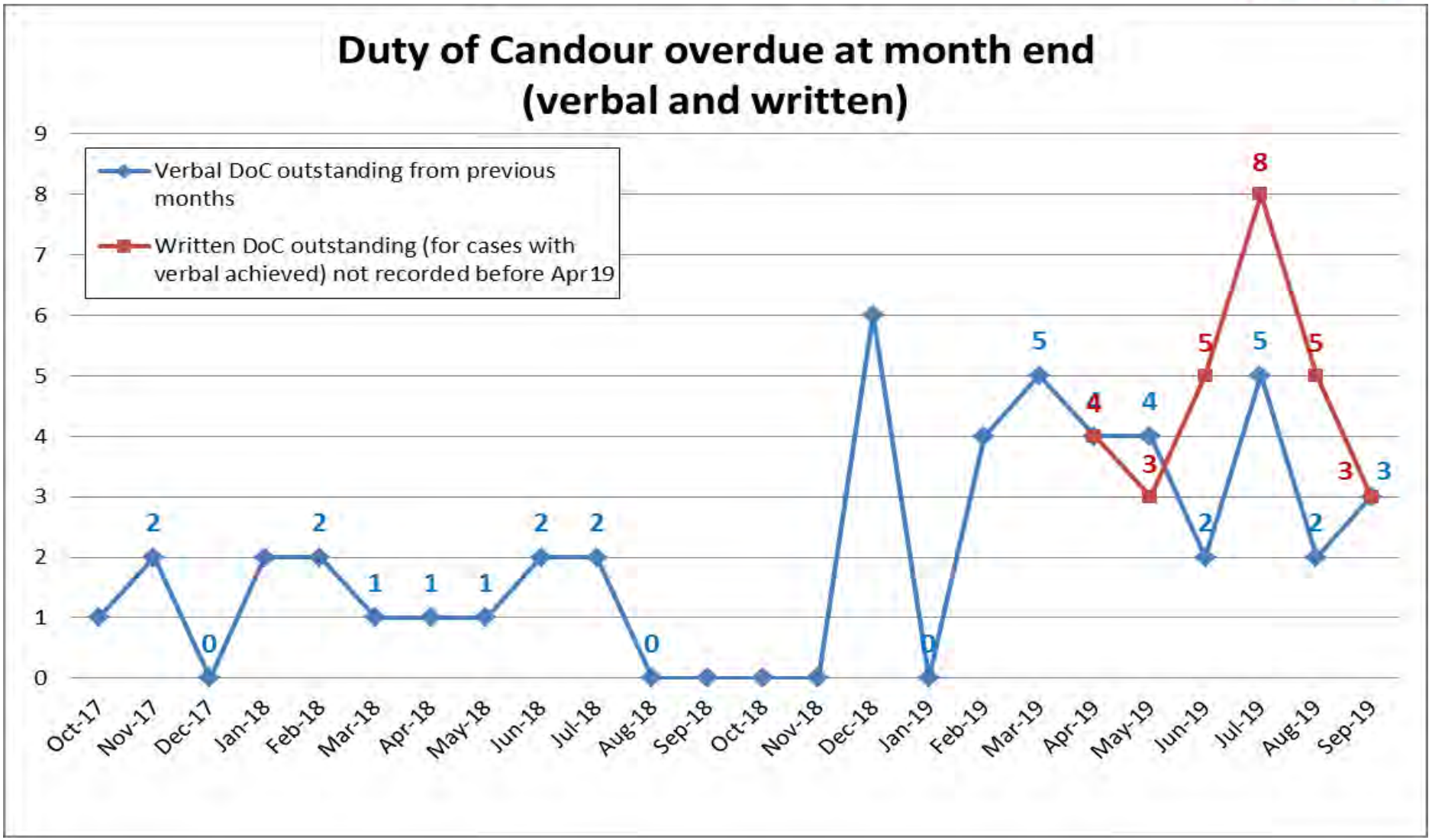
Duty of Candour



Narrative

What	An SPC chart is provided which measures timely verbal Duty of Candour against the national requirement of 10 working days. In addition, indicators counting how many cases are still overdue both verbal and written are provided in a run-chart, below.
Why	Compliance with the 10-day target fell to its lowest rate in September. The performance varies month on month however it not usually adversely affected by total number of cases. There is targeted follow up of the individuals responsible for undertaking Duty of Candour by the Patient Safety team with escalation to the Divisional steering groups and Clinical Directors meeting.
How	In September, options to improve all three Duty of Candour indicators were discussed. This is a multi-faceted issue with separate issues relating to different professions, different divisions and even record keeping and it has been suggested that it might benefit from a QI-style improvement plan.
When	The new Patient Safety Incident Response Framework pilot will also impact on Duty of Candour (not on the overarching need to do Duty of Candour but more in terms of what patients are told about investigation pathways) and so the Duty of Candour improvement plan needs to run side-by-side with that. To that end, a timeframe of Q4 19/20 has been set.

Safe



27

Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

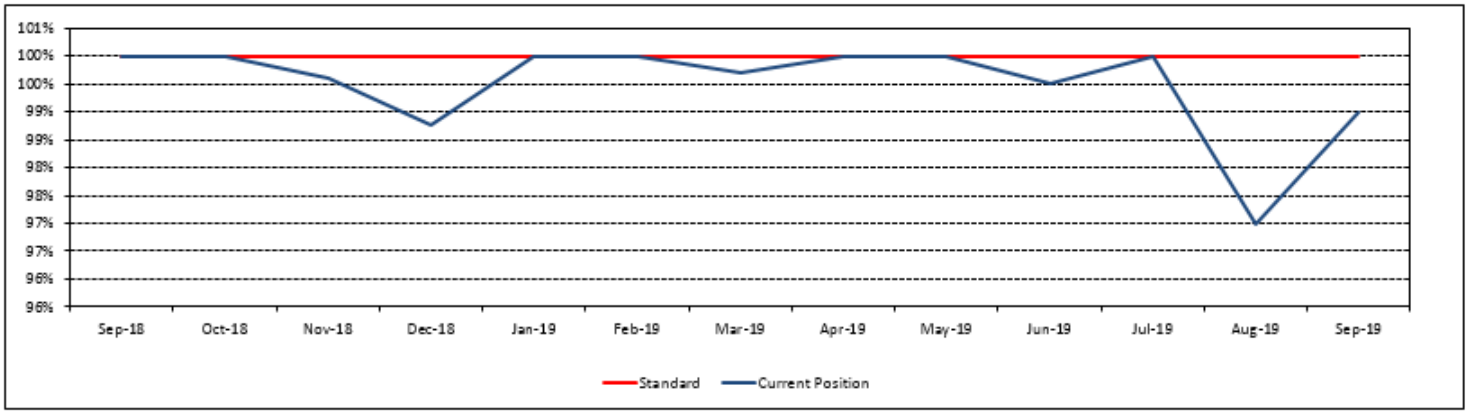
Indicator	Hand Hygiene Audits
Standard	100%
Executive Lead	Paul Morris
Month	Sep-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

One failure evident within the Surgical Division, during which a member of staff failed to wash their hands following patient intervention. This is noted as the only failure recorded across the Trust during the month, no themes therefore evident.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	100%	100%	99.6%	98.8%	100%	100%	99.7%	100%	100%	99.5%	100%	97.0%	99.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Ward Manager to be asked to remind staff to ensure that handwashing is undertaken following the delivery of patient care.		Sep-19	Oct-19



28

Putting you first

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

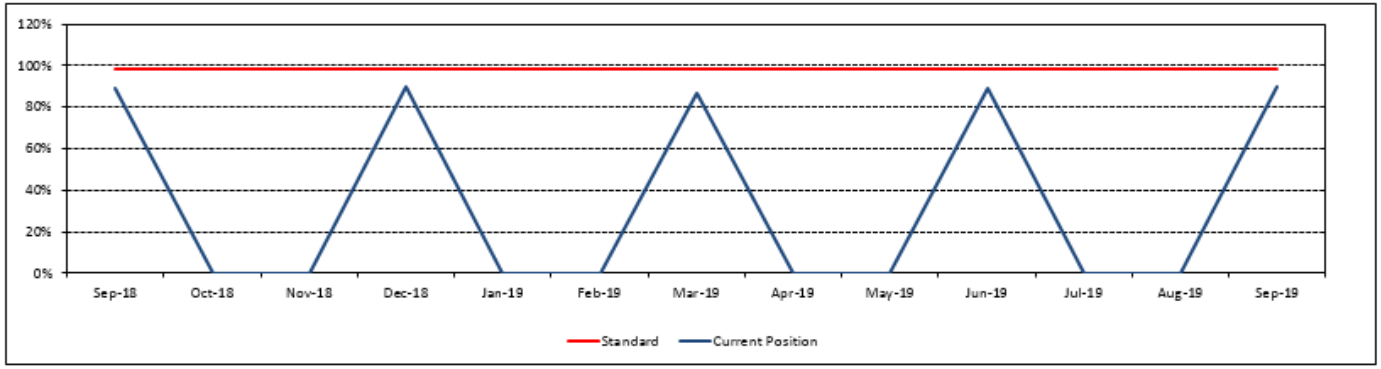
Indicator	Quarterly antibiotic audit
Standard	98%
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Quarterly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

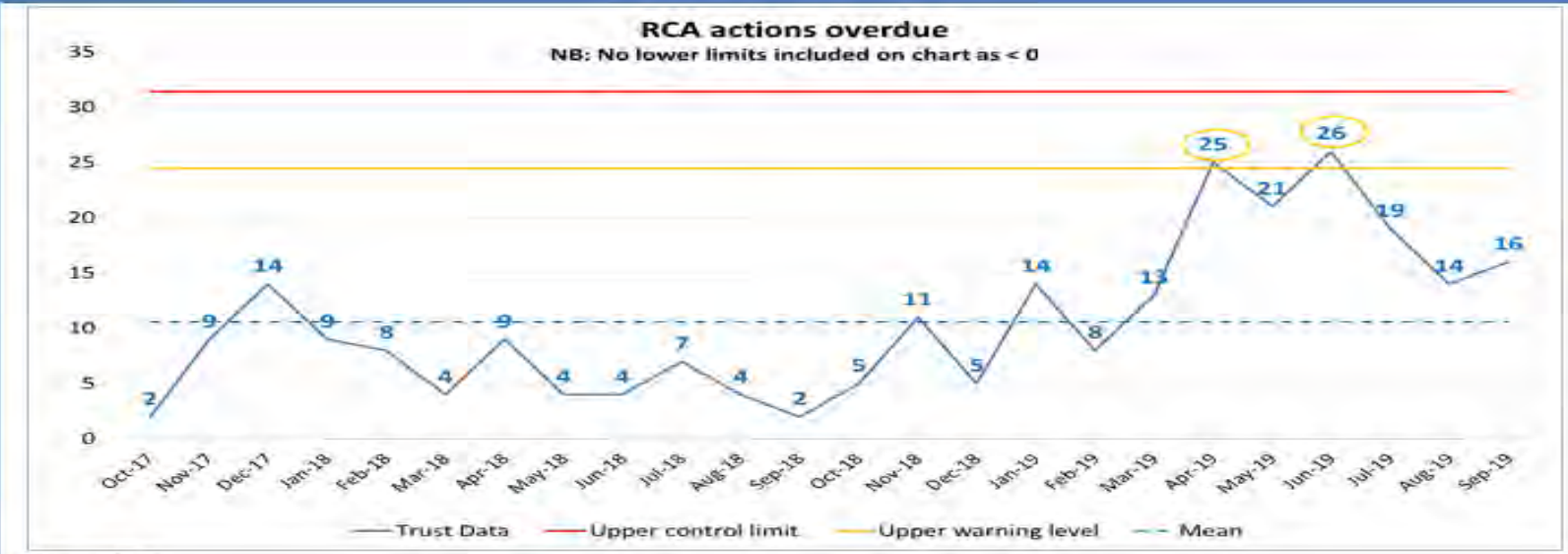
The main issues for concern this quarter continue be with the documentation of a review of antibiotic treatment within 72 hours both in the notes and on the e-Care drug chart. In the absence of the review alert only 37 out of 64 patients had the review date updated on the e-Care drug chart, alongside a documented review in the e-Care notes which is in line with best practice guidance.
The audits continue to identify non-compliance with the use of restricted antibiotics, for example Meropenem and Tigecycline, that were not discussed with a Consultant Microbiologist where the course exceeded 72 hours, as per Trust guidance. This applies even if the restricted antibiotic is 1st line treatment as stated in the Trust Antibiotic Guideline.
The Antibiotic Audit Nurses and Antibiotic Pharmacist are available to attend individual Ward Governance meetings to discuss with the Doctors, Ward Pharmacists and Ward staff to discuss non-compliances with a view to promoting best practice prescribing alongside Antimicrobial Stewardship.
Pharmacists incorporate antibiotic prescribing practice within the medical and surgical induction training sessions and Pharmacy alongside the Antibiotic Audit Nurses provide annual training on Antibiotic Stewardship to the Registered Nurses via the Mandatory Training platform.
Ward Pharmacists are regularly updated on any changes to antibiotic supply, that may affect prescribing practice by the Antimicrobial Pharmacist.
Various electronic training packages that aid training inAcute Medication Service are available within the Trust.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Current Position	89.0%	NA	NA	90.0%	NA	NA	87.0%	NA	NA	89.0%	NA	NA	90.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Antibiotic audits and attendance at clinical governance groups (Consultant engagement is key)			
Junior Doctor, Nurse and Pharmacist training provided by myself and the Antibiotic audit Nurses			
Restricted antibiotic ward rounds a. This can be remote in the microbiologist's office (Dr Kerr and myself, although due to A/L, sick leave etc this has not occurred for a while unfortunately) b. This can be a referral from a ward Pharmacist to me if they are concerned (regarding duration, choice or optimisation of treatment). This also provides an opportunity for training Junior staff. I can then refer to the Microbiologists if there is not a clear action to take or there is a lack of culture results to determine an appropriate response.			



RCA actions



Narrative

What	Negative upward trend which crossed the Upper Control Limit in April and June
Why	The target of <5 overdue has not been achieved since September 2018 despite targeted follow up of the Action owners by the Patient Safety team with escalation to the Divisional steering groups and Clinical Directors meeting.
How	Already in place are monthly 'RCA actions review meeting' in the Patient Safety team, Clinical Directors meeting report on overdue actions for which a Consultant is owner and 3-month post-report follow up ('wash-up meeting') for key Serious Incidents (such as those which are also the subject of an Inquest or have a complex action plan). More structured 'actions due' reports will be provided to the divisions to enable pro-active completion rather than waiting until they are overdue. The Trust is also participating in the national pilot of the new Patient safety incident response framework (PSIRF) which had its first introductory meeting on the 11th October. This is likely to impact on this indicator in the future although this will be in the longer term.
When	The wash-up meetings are now taking place initially just for SIs which relate to inquests as this has the additional benefit of providing reassurance to the Coroner that the trust is acting upon its findings. The 'actions due' reports will be provided to the divisions from November and the trend will be monitored to see is this has a measurable impact.

Safe

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

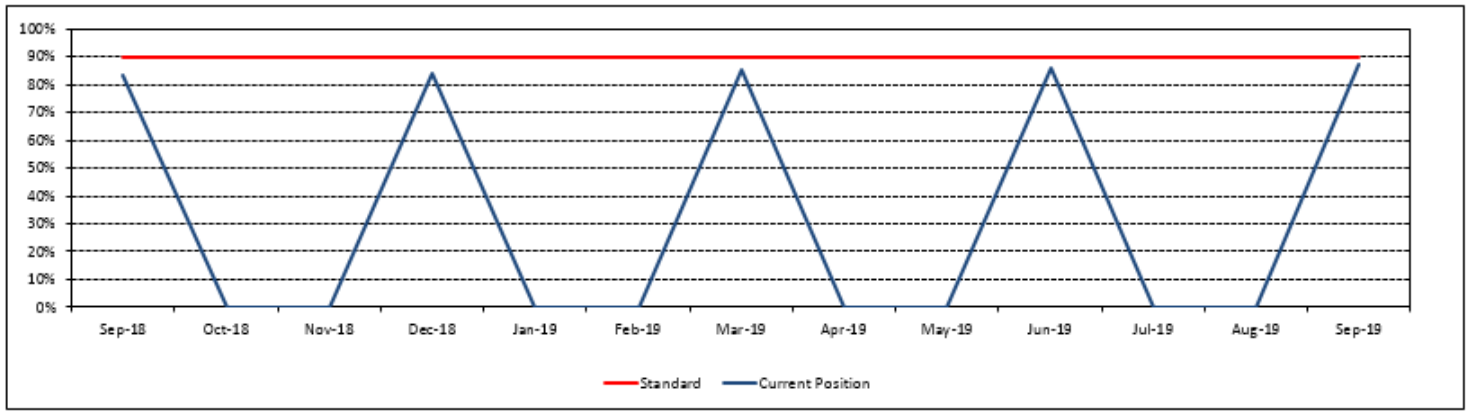
Indicator	Quarterly Visual Infusion Phlebitis score documentation
Standard	90%
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Quarterly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Visual Infusion Phlebitis score compliance rates have continued to steadily increase again from 86% to 87% this quarter. The timely removal of the intravenous peripheral cannula continues to be audited this quarter; the aim is to reduce the amount of invasive devices in situ which in turn reduces the risk of patients acquiring Healthcare Associated Infections. National Guidance states that care of the intravenous peripheral cannula is documented at least once every shift. In Quarter Two this data was collected, however was not included in the compliance figures. Each ward was fed back to individually as part of their audit report. Cannula insertions and removal of, should also be documented on e-Care in 'lines, drains & tubes' at the time of occurrence with a Visual Infusion Phlebitis score being documented at the time of removal. Work continues to improve documentation of cannula insertions in particular.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	83.0%	NA	NA	84.0%	NA	NA	85.0%	NA	NA	86.0%	NA	NA	87.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Visual Infusion Phlebitis score compliance is increasing albeit slowly and this is to be commended all of the actions that we are able to put in place are in place. The team are currently working with the eCare team in respect of the Cerner Infection Control module if this is successful it is anticipated that next year the clinical teams will have a format which makes the management of lines tubes and drains more accessible.			



Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

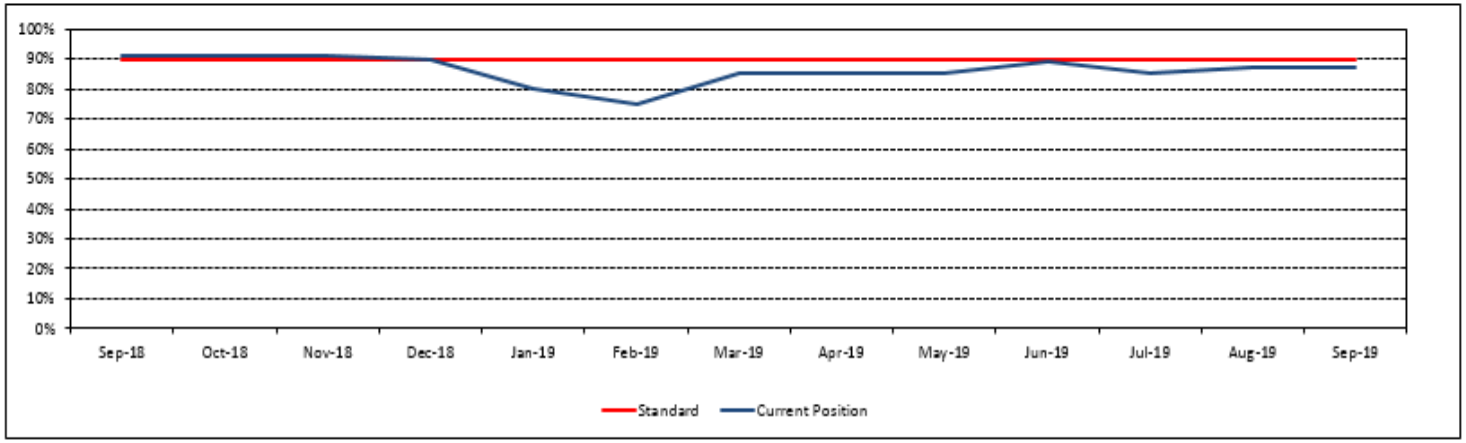
Indicator	Isolation data (Trust Level only)
Standard	90%
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

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 Infection 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 to ensure that patients with the highest infection risk are managed there if at all possible. The first Influenza case was recorded this quarter patient appropriately admitted to F12.

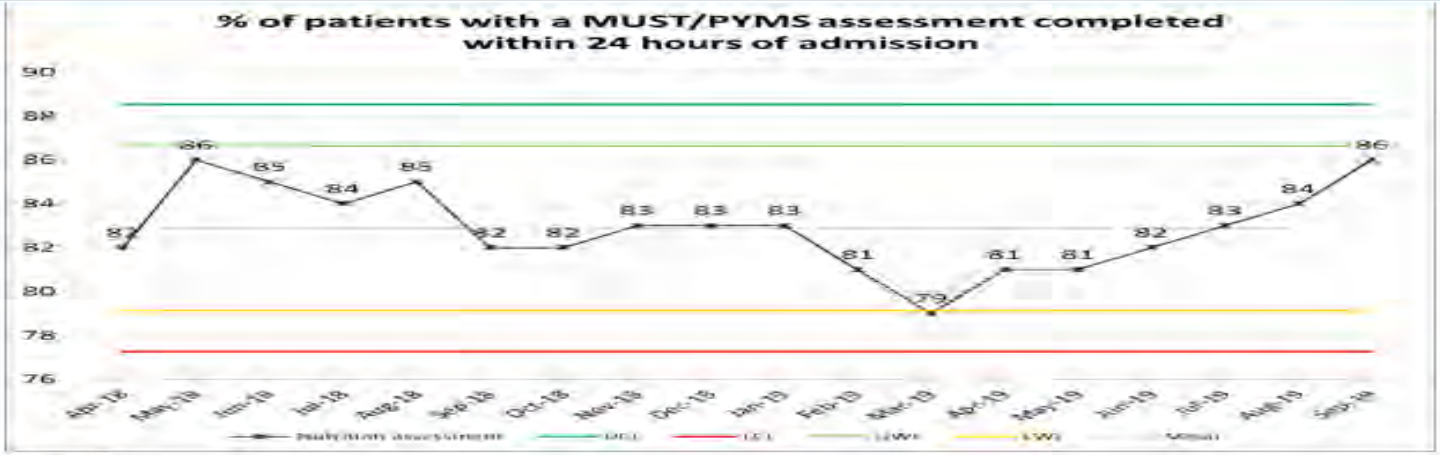
Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	91.0%	91.0%	91.0%	90.0%	80.0%	75.0%	85.0%	85.0%	85.0%	89.0%	85.0%	87.0%	87.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
The Trust is aware of this and it is recognised on the risk register, with agreement to increase capacity as new developments (such as the Cardiac centre) are designed. A new build would have to be designed on a percentage breakdown of at least 50% single rooms. For example the new Royal Papworth has far more than that.			



Putting you first

Nutrition



Narrative

What	The chart continues to show an upward trend but still within the SPC parameters.
Why	Head of Nursing has been in conversation with Paediatrics where performance continues to be poor and varies considerably between months (although this does not materially affect the trust overall percentage). There has been some improvement in this area and it continues to be an area of focus for the team. There is continued promotion by the Senior Matrons within the Surgical Division to improve and maintain compliance. This is being achieved with engagement of the Ward Managers and Band 6 team leads by daily review of the Ward Patient Safety Dashboard. It has been identified that some areas have deteriorated in their performance and this is being actioned by the Senior Matrons aligned to the areas.
How	Following the completion of the NHS Improvement nutrition collaborative the work continues on progressing activity to improve nutritional assessments, referrals and care planning in addition, reviewing and enhancing the implementation of protected meal times. Work has also been undertaken on reviewing the multiple data and measurement sets that existed for food, fluid and nutrition and these have been streamlined, these will form part of the patient safety report. We have been working with the communication team to improve this process and are aiming to have a process of 3 measures to feedback to teams: • Information on compliance from Patient safety dashboard monthly. • A quarterly audit to review accuracy and Monthly assurance via 'Perfect Ward'. • In addition there will be a quarterly protected mealtime audit. Nutritional care is also monitored via the Perfect Ward App. There is also specific work commencing with focus on the Stroke patients following the publication of the 2018 Sentinel Stroke National Audit Programme
When	This is an ongoing work plan and quality improvement initiatives will continue to be progressed via the Nutrition Group and by the Matrons / Ward Managers through the use of the Nutrition dashboard and Perfect Ward audit data. There is also now a Nutrition Quality improvement sub-group set up with a structured action plan, which was updated for the last Nutrition group meeting and included in the report to CSEC and the Trust Board learning reports in September.

Safe

5. DETAILED REPORTS - EFFECTIVE

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

we.		Ref.	KPI	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	YTD(Apr19-Sep19)
2.Effective	Incidents/Reports	2.05	Cardiac arrests	NT	6	9	ND	3	5	5	3	4	5	0	7	5	3	24
		2.06	Cardiac arrests identified as a SIRI	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		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	49	48	43	42	35	33	28	19	15	17	16	16	16	99
		2.10	WHO Checklist (Qrtly)	100%	98.0%	NA	NA	99.0%	NA	NA	99.0%	NA	NA	99.0%	NA	NA	ND	99.0%
		2.11	National clinical audit report baseline & risk assessments not completed within 6 months of publication	5	18	18	19	21	26	28	29	19	16	13	13	14	14	89
		2.12	Av. Elective LOS (excl. 0 days)	NT	2.60	3.25	3.50	3.35	2.81	3.92	2.91	2.75	3.26	2.7	2.53	2.79	2.73	2.79
		2.13	Av NEL LOS (excl 0 days)	NT	7.98	7.66	7.61	7.56	7.43	8.69	8.05	8.46	8.70	8.93	8.17	7.89	7.68	8.30
		2.14	% of NEL 0 day LOS	NT	14.0%	14.4%	15.9%	15.4%	14.6%	13.8%	14.9%	14.2%	13.7%	13.3%	11.6%	14.5%	13.8%	13.5%
		2.15	NHS number coding	99%	99.7%	99.8%	99.8%	99.8%	99.7%	99.7%	99.8%	99.8%	99.8%	99.7%	99.5%	99.8%	99.8%	99.7%
		2.16	Fractured Neck of Femur : Surgery in 36 hours	85%	90.3%	96.9%	100%	100%	97.0%	100%	92.8%	96.2%	92.9%	96.9%	100%	96.0%	100%	97.0%
		2.18	Discharge Summaries (A&E 95% 1d)	95%	86.9%	85.8%	82.2%	80.5%	83.7%	84.0%	81.7%	83.2%	82.8%	85.0%	83.4%	83.7%	84.9%	83.8%
		2.19	Non-elective Discharge Summaries (IP 95% 1d)	95%	75.3%	77.9%	72.4%	72.9%	76.6%	78.0%	74.9%	81.8%	80.7%	82.1%	84.3%	81.0%	86.3%	82.7%
		2.20	Elective Discharge Summaries (IP 85% 1d)	85%	79.8%	80.8%	84.5%	84.8%	84.7%	84.6%	87.9%	80.8%	87.7%	86.7%	87.8%	87.5%	90.4%	86.8%
		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%	86.7%	77.5%	100%	91.7%	82.8%	100%	73.3%	79.2%	93.3%	100%	90.0%	94.9%	82.9%	90.0%
		2.23	Canc. Ops. - No. Cancelled for a 2nd time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Putting you first

EXCEPTION REPORTS – EFFECTIVE

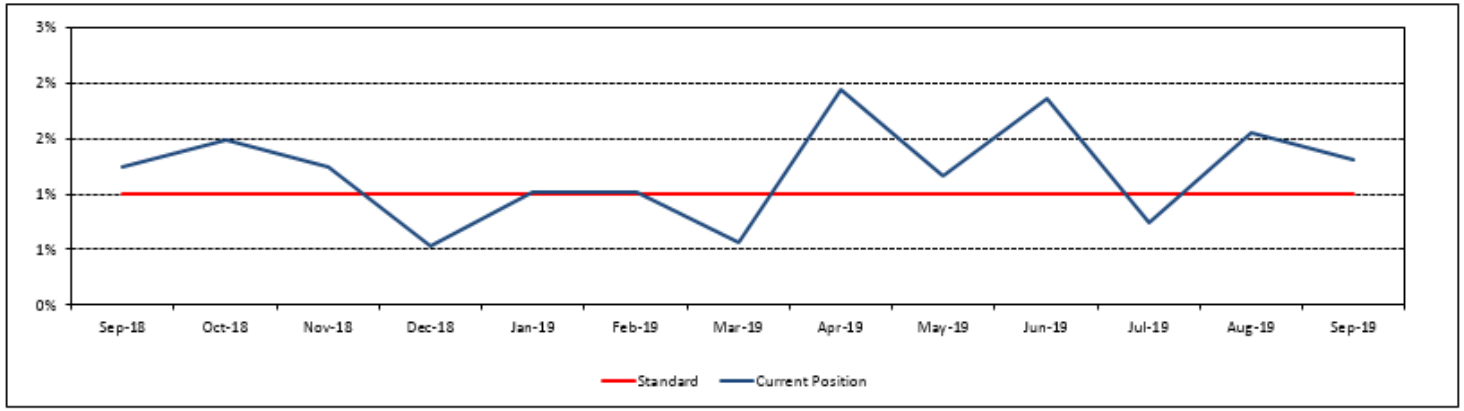
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	Canc. Ops - Cancellations for non-clinical reasons
Standard	1%
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

Slight reduction in cancelled admissions, however theatre staff shortages and some equipment issues in Urology have impacted this performance.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
Current Position	1.2%	1.5%	1.3%	0.5%	1.0%	1.0%	0.6%	1.9%	1.2%	1.9%	0.8%	1.6%	1.3%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to ensure that escalation process for elective cases is followed.	AP	Sep-18	TBC



Putting you first

NHS
West Suffolk
NHS Foundation Trust

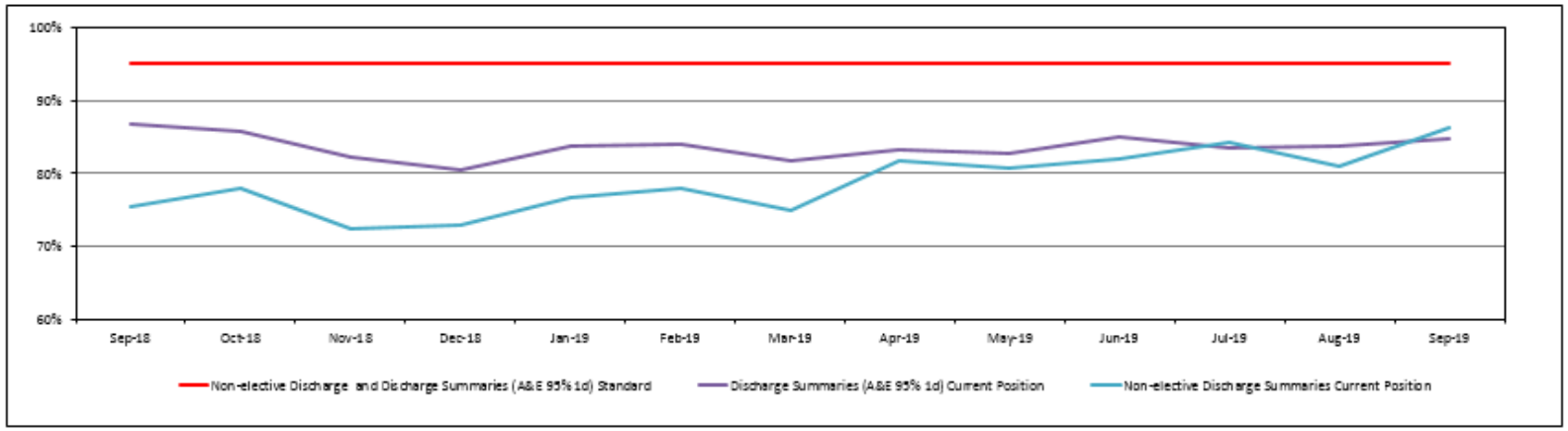
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	Discharge Summaries
Standard	95%
Executive Lead	Nick Jenkins
Month	Sep-19
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

The position has improved from August for both areas. We continue to work with departments to try and improve timeliness of discharge summaries. Reports identify which specific areas may need support and this is targeted through the operational divisions. We will be repeating the training that we delivered to juniors in September. This showed a demonstrable improvement for the last intake when completed.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Non-elective Discharge and Discharge Summaries (A&E 95% 1d) Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Discharge Summaries (A&E 95% 1d) Current Position	86.9%	85.8%	82.2%	80.5%	83.7%	84.0%	81.7%	83.2%	82.8%	85.0%	83.4%	83.7%	84.9%
Non-elective Discharge Summaries Current Position	75.3%	77.9%	72.4%	72.9%	76.6%	78.0%	74.9%	81.8%	80.7%	82.1%	84.3%	81.0%	86.3%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Targeted work with departments that do not comply with standard.	SJ	ongoing	



Putting you first

NHS West Suffolk NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

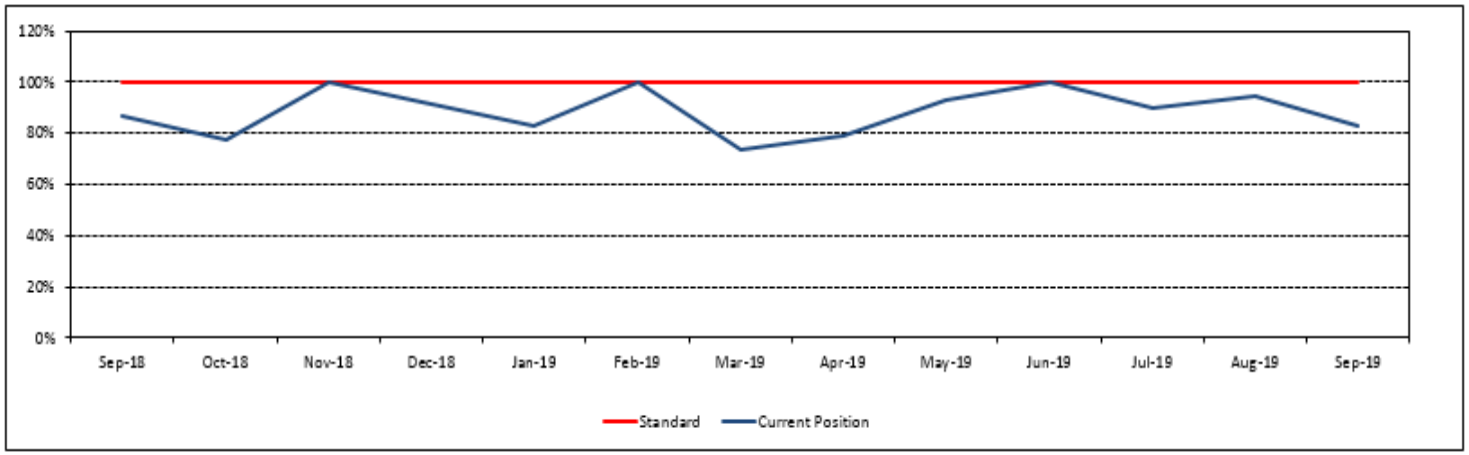
Indicator	Canc. Ops - Patients offered date within 28 days
Standard	100%
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

6 patients waited longer than 28 days for their TCI to be re-booked. For 3 patients this is due to an equipment issue and there was a lead in time for this equipment to come back in. For 2 other patients, there was no capacity to bring them forward any further due to the current lists being full with long waiting for cancer patients. The last patient needed to have an MRI prior to surgery. 5 of the patients have new dates to come in, with one still needing further investigation prior to proceeding.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	86.7%	77.5%	100%	91.7%	82.8%	100%	73.3%	79.2%	93.3%	100%	90.0%	94.9%	82.9%

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



Putting you first

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	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	YTD(Apr19-Sep19)
3. Caring	Other Friends and Family Test Scores	3.09	IP overall experience result	90%	97.0%	95.0%	95.0%	98.0%	95.0%	94.0%	95.0%	94.0%	90.0%	92.0%	91.0%	90.0%	90.0%	91.2%
		3.10	OP overall experience result	90%	96.0%	97.0%	97.0%	97.0%	97.0%	98.0%	98.0%	98.0%	97.0%	98.0%	96.0%	96.0%	98.0%	97.2%
		3.11	A&E overall experience result	90%	94.0%	95.0%	95.0%	95.0%	95.0%	95.0%	96.0%	93.0%	85.0%	93.0%	86.0%	87.0%	92.0%	89.3%
		3.12	Short-stay overall experience result	90%	100%	99.0%	96.0%	98.0%	98.0%	99.0%	98.0%	98.0%	99.0%	99.0%	98.0%	99.0%	98.0%	98.5%
		3.13	Short-stay Extremely likely or Likely to recommend (FFT)	90%	99.0%	100%	99.0%	99.0%	97.0%	97.0%	97.0%	99.0%	99.0%	99.0%	98.0%	99.0%	99.0%	98.8%
		3.15	Maternity postnatal community - extremely likely or likely to recommend (FFT)	90%	98.0%	98.0%	100%	100%	100%	100%	100%	100%	100%	96.0%	100%	98.0%	98.0%	98.7%
		3.18	Children's services overall result	90%	95.0%	85.0%	95.0%	93.0%	100%	100%	98.0%	96.0%	98.0%	98.0%	100%	100%	95.0%	97.8%
		3.19	F1 Parent - overall experience result	90%	95.0%	95.0%	98.0%	94.0%	97.0%	97.0%	95.0%	99.0%	98.0%	99.0%	98.0%	99.0%	97.0%	98.3%
		3.20	F1 - Extremely likely or likely to recommend (FFT)	90%	91.0%	100%	96.0%	87.0%	100%	100%	100%	96.0%	98.0%	100%	100%	100%	100%	99.0%
		3.21	F1 Children - Overall experience result	90%	95.0%	93.0%	95.0%	93.0%	100%	100%	98.0%	86.0%	89.0%	98.0%	100%	100%	95.0%	94.7%
		3.22	Rosemary ward - extremely likely or likely to recommend (FFT)	90%	90.0%	100%	100%	100%	100%	80.0%	100%	80.0%	95.0%	100%	86.0%	100%	100%	93.5%
		3.23	King suite - extremely likely or likely to recommend	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95.0%	100%	99.2%
		3.24	Community paediatrics - extremely likely or likely to recommend (FFT)	90%	94.0%	100%	100%	100%	100%	96.0%	100%	100%	100%	94.0%	97.0%	98.0%	96.0%	97.5%
		3.25	Community health teams - extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	100%	93.0%	93.0%	100%	100%	97.0%	90.0%	95.0%	92.0%	98.0%	95.3%
		3.27	Stroke Care - Overall Experience Result	90%	90.0%	100%	93.0%	ND	ND	89.0%	97.0%	96.0%	95.0%	97.0%	98.0%	89.0%	94.0%	94.8%
		3.28	Stroke Care - extremely likely or likely to recommend	90%	97.0%	100%	100%	100%	ND	93.0%	89.0%	100%	100%	100%	100%	100%	100%	100%
	Complaint Handling	3.29	Complaints acknowledged within 3 working days	90%	66.0%	100%	100%	100%	100%	88.0%	84.0%	94.0%	83.0%	81.0%	94.0%	80.0%	94.0%	87.7%
		3.30	Complaints responded to within agreed timeframe	90%	100%	83.0%	88.0%	83.0%	75.0%	100%	94.0%	86.0%	77.0%	71.0%	60.0%	44.0%	40.0%	63.0%
		3.31	Number of second letters received	1	0	2	1	1	3	2	0	2	2	4	1	1	3	13
		3.32	Ombudsman referrals accepted for investigation	1	1	0	0	0	0	0	0	0	0	0	1	1	0	2
		3.33	No. of complaints to Ombudsman upheld	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		3.34	No. of PALS contacts	NT	198	224	219	143	231	211	228	184	190	191	252	207	223	1247
		3.35	No. of PALS contacts becoming formal complaints	<=5	2	1	3	0	2	5	4	2	5	6	4	2	0	19

Putting you first

EXCEPTION REPORTS –CARING

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

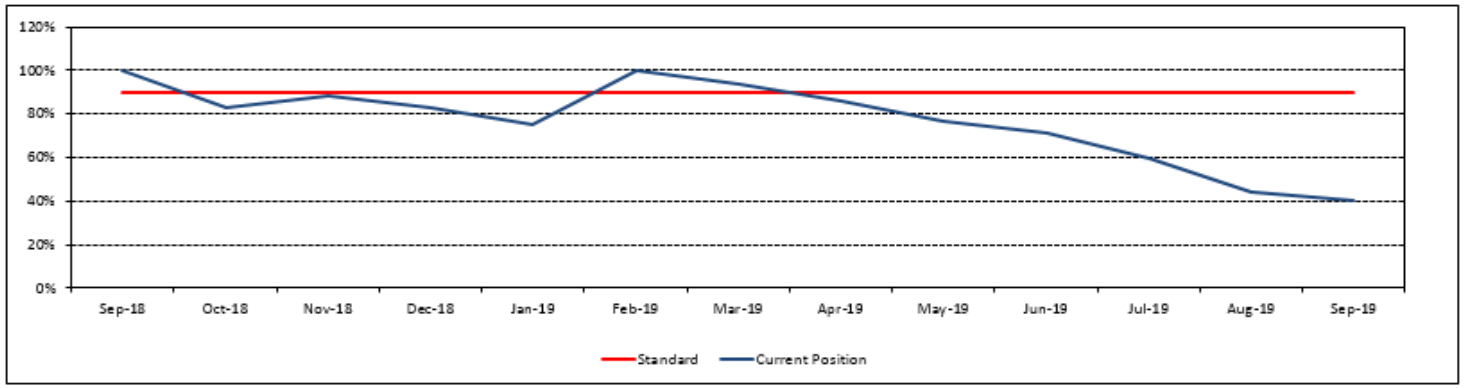
Indicator	Complaints responded to within agreed timeframe
Standard	90%
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Increased demand from previous months has continued to impact response timeframes. We are continuing to receive bank assistance to improve overall performance.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	100%	83.0%	88.0%	83.0%	75.0%	100%	94.0%	86.0%	77.0%	71.0%	60.0%	44.0%	40.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Bank assistance is in place to manage a caseload of complaint responses which will support the team in managing workload, however, there will be a vacancy in the team in the near future which will decrease resource for response writing. Performance is therefore not expected to improve greatly in Q3. The Head of Patient Experience is conducting a budget transfer in order to recruit additional staffing with a focus on formal complaints; this job will need to be evaluated and approved by VAF panel so a realistic timeframe for improvement will be Q4. Once this newly established post is in place performance is expected to be consistently 'green'.			



Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

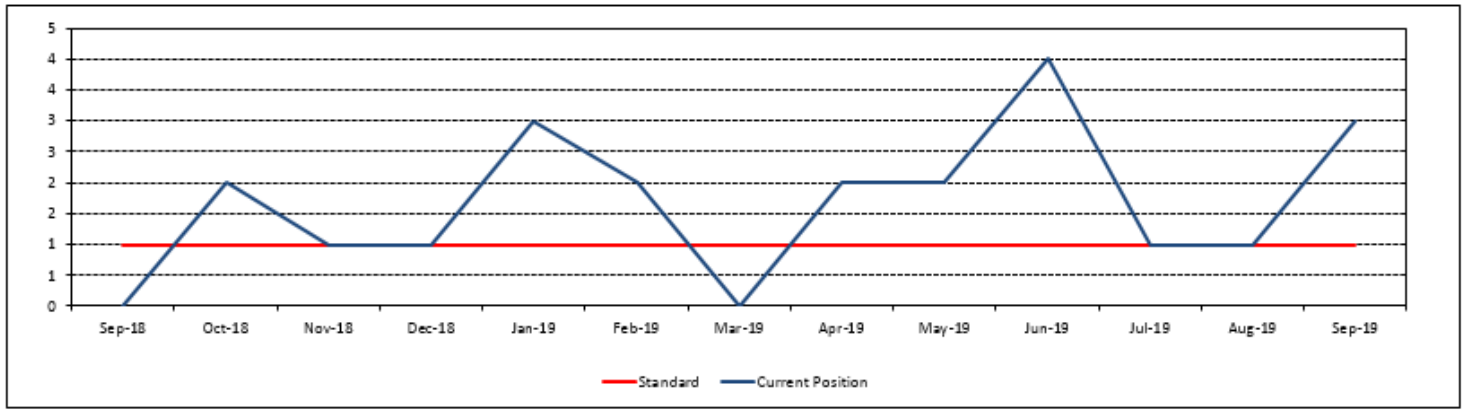
Indicator	Number of second letters received
Standard	1
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Three second letters were received in September. These did not have any themes in common and related to different concerns. The original investigation for these complaints were complex, therefore did not provide the desired outcome to complainants.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	1	1	1	1	1	1	1	1	1	1	1	1	1
Current Position	0	2	1	1	3	2	0	2	2	4	1	1	3

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Bank assistance is in place to manage a caseload of complaint responses which will support the team in managing workload, however, there will be a vacancy in the team in the near future which will decrease resource for response writing. Performance is therefore not expected to improve greatly in Q3. The Head of Patient Experience is conducting a budget transfer in order to recruit additional staffing with a focus on formal complaints; this job will need to be evaluated and approved by VAF panel so a realistic timeframe for improvement will be Q4. Once this newly established post is in place performance is expected to be consistently 'green'.			



Putting you first

7. DETAILED REPORTS - RESPONSIVE

Putting you first

Are we..		Ref.	KPI	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	YTD(Apr19-Sep19)
4. Responsive	A&E	4.13	Number of Delayed Transfer of Care - (DTOCs)	NT	224	270	268	320	287	389	460	447	404	425	432	406	488	434
		4.14	A&E time to treatment in department (median) for patients arriving by ambulance - CDM	120	39	46	45	46	47	43	43	46	46	43	55	33	26	42
		4.15	A&E - Single longest Wait (Admitted & Non-Admitted)	6 hrs.	12.23	16.17	13.05	15.35	20.32	14.35	13.55	14.35	13.23	20.01	17.18	20.35	11.48	16.10
		4.16	A&E -Waits over 12 hours from DTA to Admission	0	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	31	24	54	125	113	65	155	105	119	133	33	30	575
		4.18	A&E - To inpatient Admission Ratio	32%	28.3%	28.6%	30.3%	31.2%	31.3%	31.6%	29.7%	29.0%	28.8%	27.2%	25.5%	26.1%	27.1%	27.3%
		4.19	A&E Service User Impact (re-attendance in 7 days <5% & time to treat)	1 met	1	1	1	1	1	1	1	1	1	1	1	1	1	1
		4.20	A&E/AMU - Amb. Submit button complete	80%	91.0%	93.1%	94.7%	95.0%	94.9%	96.5%	95.4%	95.3%	95.6%	96.4%	94.7%	96.0%	ND	95.6%
		4.21	A&E - Amb. Handover above 30m	0	6	21	15	40	61	33	41	46	41	41	129	31	ND	288
		4.22	A&E - Amb. Handover above 60m	0	2	30	8	14	59	10	15	13	36	28	74	3	ND	154
	RTT	4.25	RTT waiting List	<15396	18105	18071	17915	18426	19601	18341	19730	20427	21061	21253	20937	20942	20831	20909
		4.26	RTT waiting list over 18 weeks	NT	1830	1766	1855	2149	2999	3005	3006	3111	2985	3101	3270	3495	3746	3285
		4.27	RTT 18 weeks Non-Consultant led services - Community	90%	99.0%	99.0%	99.0%	100%	99.7%	99.6%	100%	99.0%	99.4%	94.0%	98.0%	94.4%	95.0%	96.6%
		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%	93.3%	64.0%	84.0%	80.0%	83.0%	75.5%	84.4%	75.8%	75.0%	80.0%	69.6%	70.6%	63.0%	72.3%
		4.30	Stroke - % patients scanned within 12 hrs.	96%	100%	100%	100%	97.5%	94.3%	98.1%	95.6%	97.0%	97.2%	95.0%	95.7%	94.1%	93.5%	95.4%
		4.31	Stroke - % Patients admitted directly to stroke unit within 4h	75%	82.8%	73.3%	83.7%	78.4%	78.4%	61.5%	78.6%	75.0%	71.4%	81.6%	77.5%	63.6%	74.4%	73.9%
		4.32	Stroke - Greater than 80% of treatment on stroke unit	90%	96.6%	88.9%	93.9%	91.9%	94.1%	84.3%	81.0%	96.9%	88.6%	86.8%	90.0%	97.0%	88.4%	91.3%
		4.33	Stroke - % of patients treated by the SESDC	48%	69.2%	52.4%	63.6%	48.0%	63.2%	49.1%	66.7%	54.2%	73.3%	55.0%	40.0%	71.4%	39.4%	55.6%
		4.34	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start	80%	96.7%	94.0%	88.0%	90.0%	96.2%	86.8%	91.1%	90.6%	88.9%	90.0%	84.8%	85.3%	82.6%	87.0%
		4.35	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72h	75%	86.2%	73.5%	89.6%	78.4%	87.5%	89.6%	80.0%	76.2%	75.0%	77.1%	92.9%	80.0%	83.3%	80.8%
		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%	65.0%	NA	NA	56.0%	NA	NA	57.0%	NA	NA	68.0%	NA	NA	ND	68.0%
		4.38	Stroke -Provider rating to remain within A-C	C	C	NA	NA	C	NA	NA	C	NA	NA	C	NA	NA	ND	C

NHS
West Suffolk
NHS Foundation Trust

Are we..		Ref.	KPI	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	YTD(Apr19-Sep19)
4. Responsive	Other	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	95%	ND	100%	100%	100%	ND	100%	100%	100%	100%	100%	100%	100%	100%	100%
		4.40	Nursing & therapy Red referrals seen within 4hrs - Community	95%	100%	100%	100%	100%	96.6%	100%	100%	100%	100%	100%	93.8%	100%	97.1%	98.5%
		4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	95%	99.5%	99.0%	99.9%	100%	99.0%	98.8%	99.3%	99.2%	99.5%	99.3%	98.8%	97.3%	99.9%	99.0%
		4.42	Nursing & therapy Green referrals seen within 18 wks -Community	95%	99.6%	99.7%	99.2%	98.0%	99.5%	99.5%	99.5%	99.4%	99.5%	100%	99.6%	99.5%	99.4%	99.5%
		4.43	Wheelchair waiting times – Child (Community)	92%	100%	100%	83.3%	83.3%	81.8%	94.1%	100%	100%	100%	100%	96.3%	100%	100%	99.4%
		4.45	Sepsis - 1 hr neutropenic sepsis	100%	90.9%	90.0%	75.0%	77.8%	81.0%	75.0%	87.5%	100%	91.7%	92.9%	87.5%	90.0%	87.5%	91.6%
		4.48	% of initial health assessments completed within 15 working days of receiving all relevant paperwork.	95%	NA	NA	NA	NA	NA	NA	NA	93.3%	40.0%	46.2%	50.0%	20.0%	21.1%	45.1%
		4.46	Percentage of Children in Care initial health assessments completed within 28 calendar days of becoming a child in care	100%	11.8%	33.3%	21.4%	15.4%	0.0%	20.0%	14.3%	33.3%	40.0%	38.5%	50.0%	20.0%	6.7%	31.4%
		4.47	Percentage of Service Users (children) assessed to be eligible for NHS Continuing Healthcare whose review health assessment is completed annually	80%	86.7%	86.2%	90.0%	97.0%	100%	100%	ND	99.0%	96.2%	100%	100%	100%	100.0%	99.2%

Putting you first

EXCEPTION REPORTS – RESPONSIVE

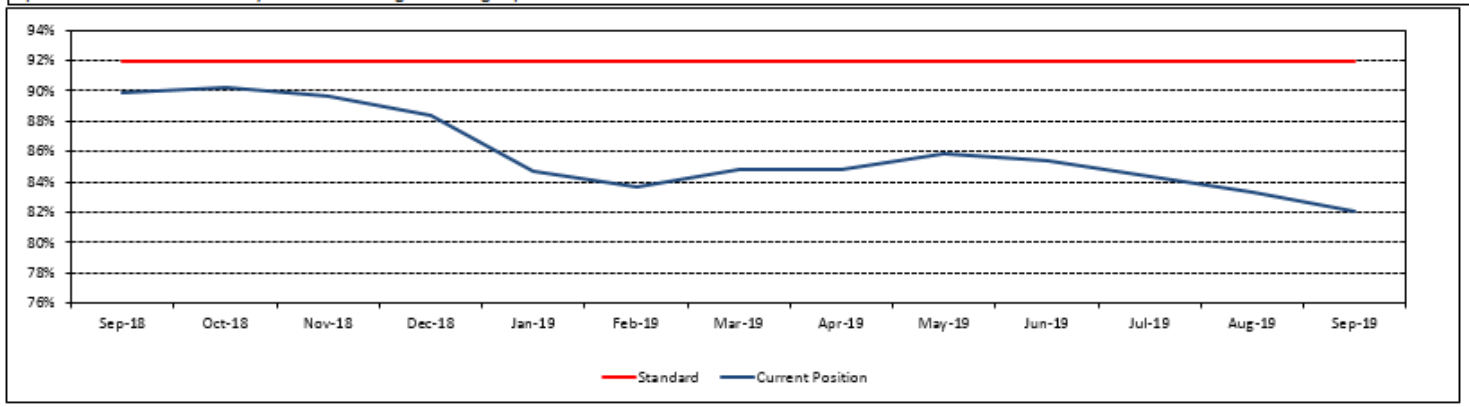
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	RTT: % incomplete pathways within 18 weeks
Standard	92%
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

The overall position has deteriorated from August to September t in this standard. There is underachievement of the standard within General Surgery, Urology, Trauma and Orthopaedics, ENT, Ophthalmology, Gastroenterology, Cardiology, Thoracic medicine and Gynaecology. Whilst some of these areas have shown minor improvement from July to August, Trauma and Orthopaedics, Ophthalmology and General Surgery have shown a considerable increase in patients over 18 weeks. The Trust is currently still working through validation and the possibility of any additional capacity is still being explored, which makes providing a recovery trajectory

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Current Position	89.9%	90.2%	89.7%	88.3%	84.7%	83.6%	84.8%	84.8%	85.8%	85.4%	84.4%	83.3%	82.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Action plan for recovery in place for all specialities not meeting performance	HK	Dec-18	
Continue to monitor long waits at weekly access meeting	HK	Aug-18	
Validation of the PTL continues with internal and external validation teams and roll out of RTT training for staff	HK	Jun-19	
Options for additional activity and outsourcing still being explored	AB	Jun-19	



Putting you first

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

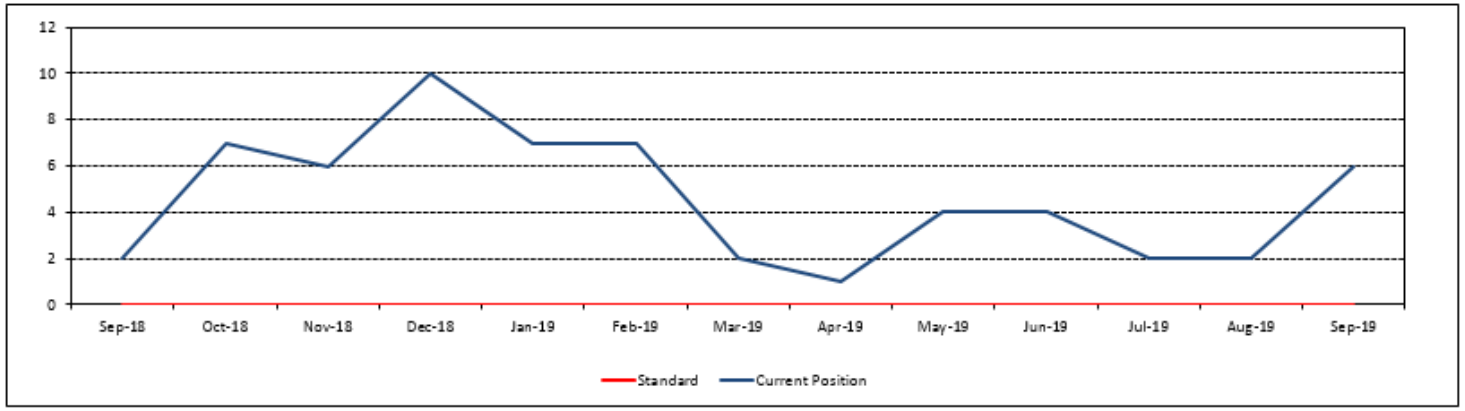
Indicator	52 week waiters
Standard	0
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Significant increase in 52 week breaches for September. The breakdown is as follows; 1. General Surgery patient, has had to have multiple diagnostics prior to surgery and consultations, complex surgery which needs careful consideration. Patient has an Outpatient appointment on the 22nd October to discuss next steps. 2. Vascular surgery patient who was cancelled on the 21/8 as needed to have General Anaesthetic procedure, patient then cancelled date for the 23/09, currently booked for the 23/10. 3. Gynaecology patient - cancelled 18/9 due to holiday, surgery was completed on the 1/10. 4. Colorectal Surgery patient - pathway was re-validated to merge with gynae pathway, patient was completed 08/10. 5 & 6 - both colorectal - patients were not on the PTL report, due to an issue with Cerner, which has now been escalated in severity. One patient has a date for November currently, the other is awaiting a date but this will be in October.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	2	7	6	10	7	7	2	1	4	4	2	2	6

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Monitor of long waiting patients at weekly access meeting	HB		
RCA's completed for all patients who breach 52 weeks, with clinical harm review	HK	Jun-18	TBC
Issue with Cerner escalated in severity	NY	Oct-19	Oct-19



Putting you first

NHS West Suffolk NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

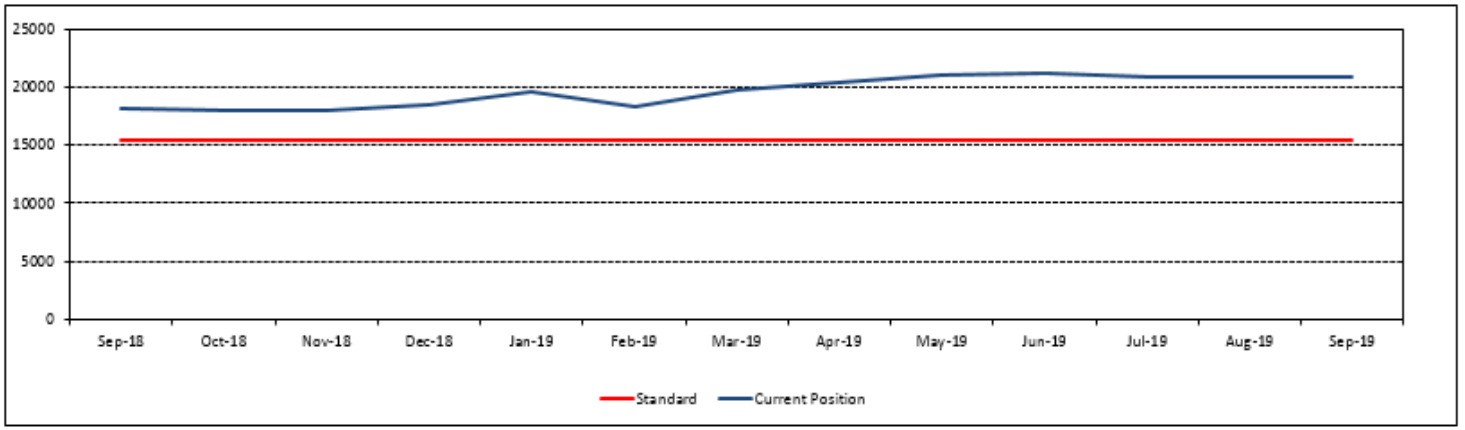
Indicator	RTT waiting List
Standard	15396
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Overall waiting list size has reduced slightly, with the amount of completed clock stops increasing over the past few weeks. There has been an increase in overall waiting list for General Surgery, Plastics and Gastro however a slight reduction has been seen in Trauma and Orthopaedics, Ophthalmology and Cardiology.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396
Current Position	18105	18071	17915	18426	19601	18341	19730	20427	21061	21253	20937	20942	20831

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Action plan for recovery in place for all specialities not meeting performance	HK	Dec-18	
Continue to monitor long waits at weekly access meeting	HK	Aug-18	
Options for in/out sourcing being explored using CCG funding - Ophthalmology has been out to interest for Cataracts, Locum consultants in place for Respiratory and Trauma and Orthopaedics, with options being explored in ENT and Gastro.	AB	Jul-19	Apr-20



Putting you first

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Diagnostics within 6 weeks
Standard	99%
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

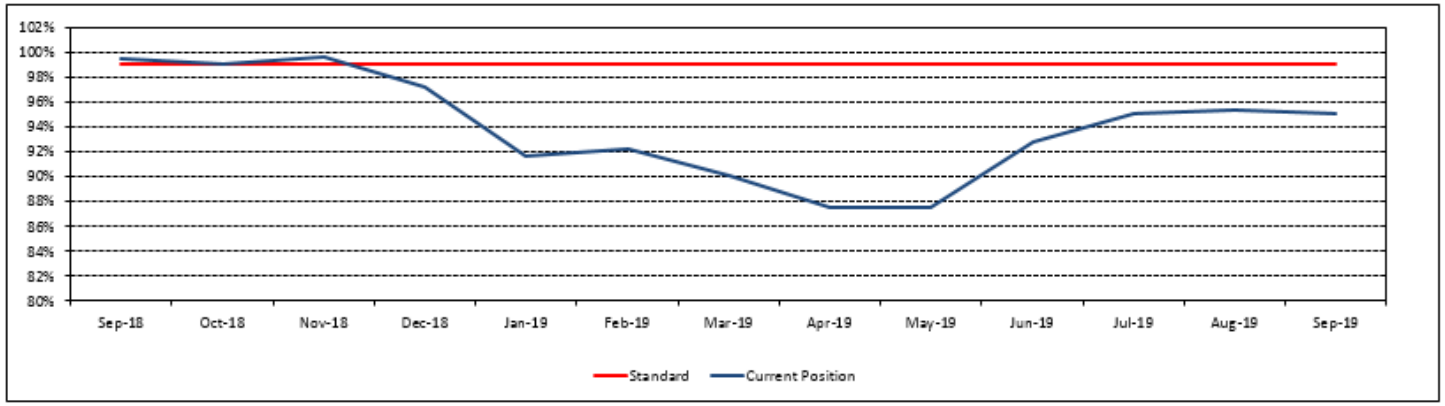
Summary of Current performance & Reasons for under performance

Diagnostic performance has deteriorated marginally this month with failure of the standard in Audiology, colonoscopy, Flexi signmoidoscopy, Cystoscopy and Gastroscopy. Work continues on the colorectal and urology (cystoscopy & urodynamics) pathways in particular to provide long term sustainability. The IST is supporting a review of demand and capacity within the Endoscopy services at the end of October. New consultants have been appointed in Gastroenterology which will support their recovery in 2020. In the short term the urology service is challenged by consultant absence but locum support for the service is being sourced. The performance is expected to improve in October 2019.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Current Position	99.5%	99.0%	99.6%	97.1%	91.7%	92.2%	90.0%	87.5%	87.6%	92.8%	95.0%	95.4%	95.1%

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

Description	Owner	Start	End
Review of cystoscopy capacity and clinician timetables to establish sustainable cystoscopy capacity	S Taylor	Oct-19	Dec-19
Review of CNS Clinics to establish sustainable capacity for urdoynamics	S Taylor	Oct-19	Dec-19
IST to support Demand and Capacity within Endoscopy	H Knights	Oct-19	Dec-19



Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancer 2w wait breast symptoms
Standard	93%
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

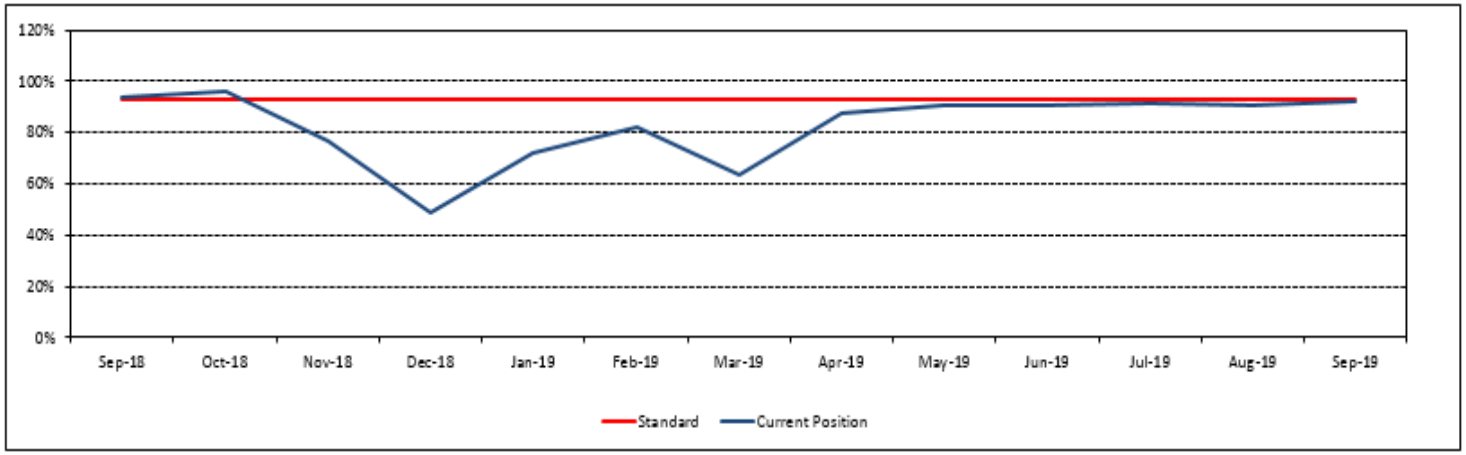
Summary of Current performance & Reasons for under performance

This is primarily due to patient controlled factors including 4/9 away on holidays in the 14 days window.
In addition to converting one of the screening clinics to enhance the capacity to book 1st appointments for 2 WW patients, the breast unit also runs additional clinics during when relevant clinicians are available during the evenings and weekends.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	93.9%	96.4%	76.7%	48.8%	72.1%	82.0%	63.5%	87.8%	90.6%	90.8%	91.3%	90.3%	91.8%

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

Description	Owner	Start	End
Capacity has been increased by an additional clinic on Friday PM for breast pain symptom patients. Patient if required further radiological investigation are booked in to the earliest			
New referral forms are with the CCG in the final stage of publication - these should separate the breast pain referrals, for which there is a dedicated clinic	CCG	Apr-19	



Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

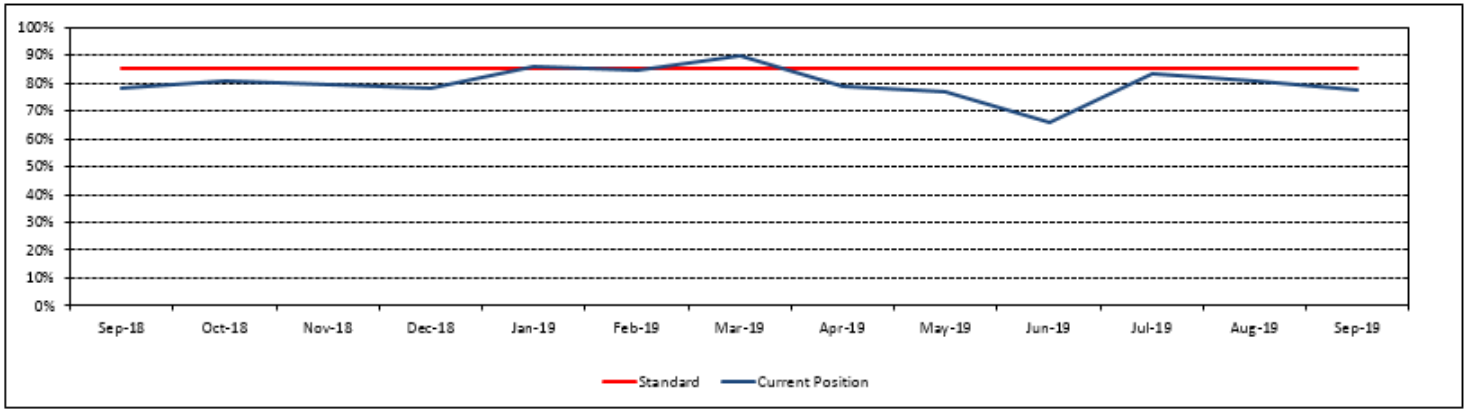
Indicator	Cancer 62 d GP referral
Standard	85%
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current performance 77%: Owing to 3/13 Colorectal, 2/13 H/N, 2/13 Skin, 2/13 Urology and 1/13 each in Breast and haem breaches locally in the Trust and 4 shared pathway breaches: Gynaecology -3, and 1 urology, some involving cases of late referrals.
Colorectal, Prostate and Lung teams are currently involved in implementation of the best practice pathways with a view to improve on early diagnostics and timely treatment. Several work streams are currently in progress to tie in with the recovery action plan in place with service leads for specific pathways, regular meetings are held to ensure this is on track. The Trust has currently committed to a recovery date for 62 days of March 2020.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Current Position	78.0%	80.6%	79.5%	78.3%	85.5%	84.8%	90.0%	78.4%	76.9%	65.9%	83.0%	80.6%	77.2%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
All patients over 62 days are discussed in detail at the weekly Cancer PTL Meeting.	HK	Dec-18	
Colorectal, Prostate and Lung teams are currently involved in implementation of the best practice pathways with a view to improve on early diagnostics and timely treatment	HK	Jan-19	Mar-20
IST currently working with the Trust on Capacity and Demand, Pathway analysis and PTL management	HK	Sep-19	Mar-20



49

Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

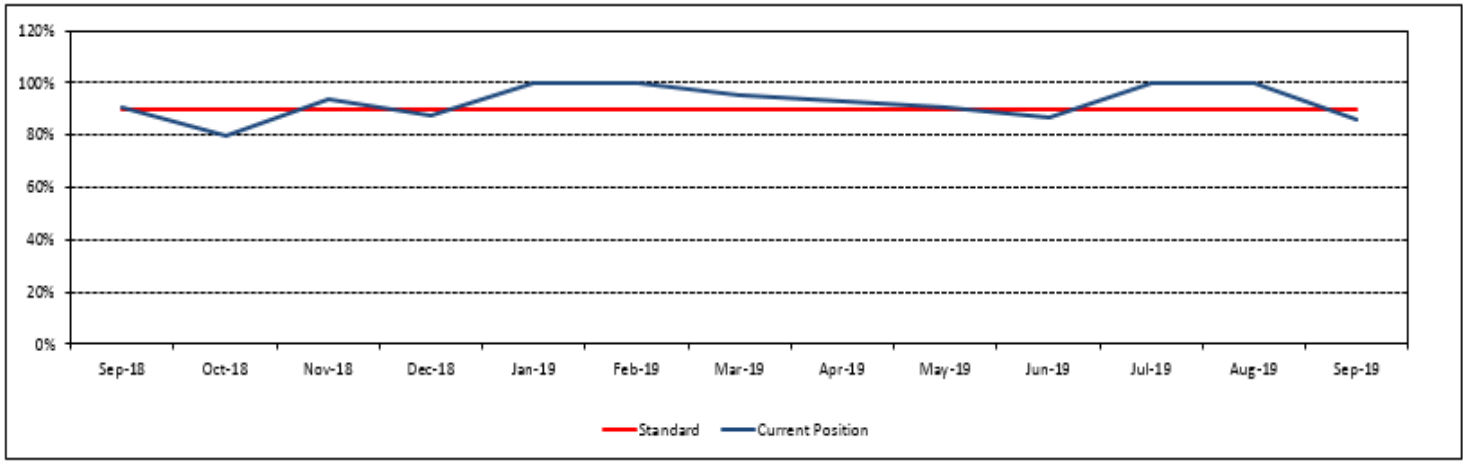
Indicator	Cancer 62 d Screening
Standard	90%
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

This is due to unexpected delays due to further tests required to stage 2 patients before treatment plan and also capacity issues during August holidays and late referral from the centre as patient was on holidays during diagnostic pathway. Complex presentations requiring more tests and patient choice are some of the difficult situation to avoid and due to small denominator, there is high risk of underperformance. The quarter end position is above 90%, though.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	90.5%	80.0%	93.8%	87.9%	100%	100%	95.2%	92.9%	90.5%	86.7%	100%	100%	85.7%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Team reviewing the RCAs with a view to see opportunities for improvement.			



Putting you first

NHS West Suffolk NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Incomplete 104 day waits
Standard	0
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

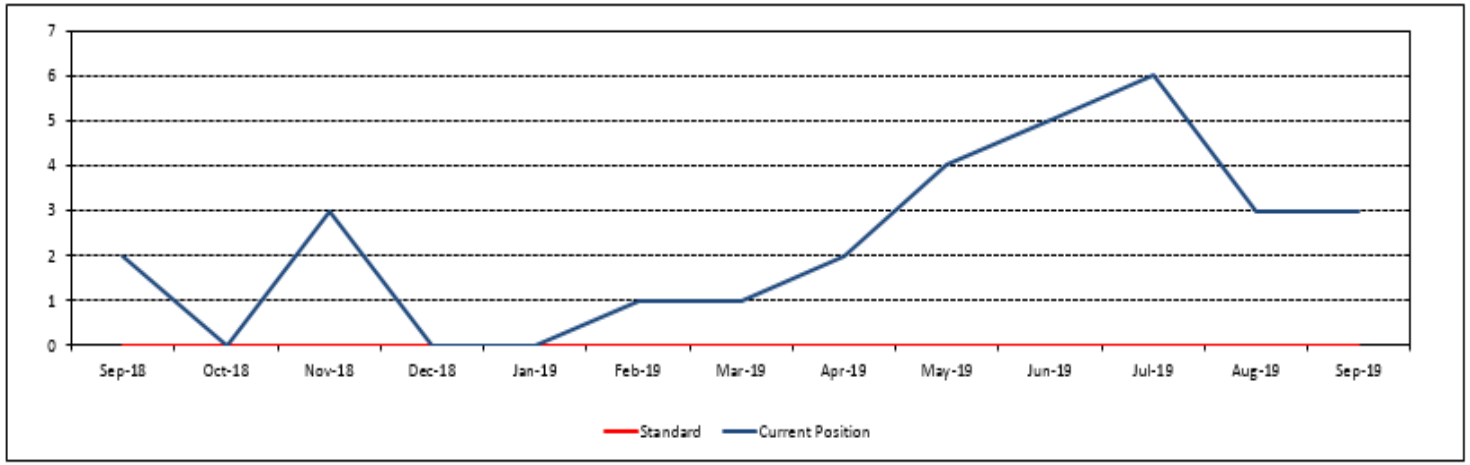
Summary of Current performance & Reasons for under performance

2 Colorectal pathway breach owing to delay in diagnosis/ staging due to capacity issues within Endoscopy and Radiology, including one patient requiring change in initial diagnostic due to medical reason

1 Lung complex pathway incidental finding from initial referral to other speciality, required invasive investigations at the centre and late return for treatment locally.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	2.0	0	3.0	0	0	1.0	1.0	2.0	4.0	5.0	6.0	3.0	3.0

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
All patients over 62 days discussed in detail at weekly cancer PTL meeting for escalation	HK	Mar-19	
104 day breaches to be submitted via DATIX and full investigation to be carried out with clinical engagement and opportunities for learning	SD	Dec-18	



51

Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

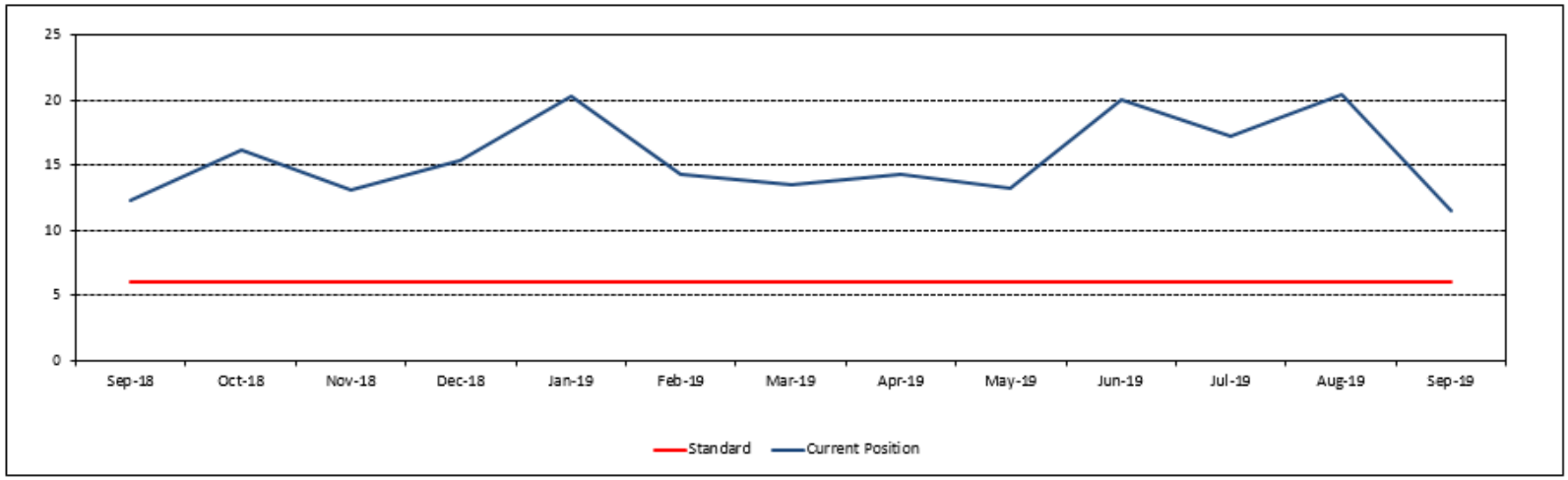
Indicator	A&E - Single longest Wait (Admitted & Non-Admitted)
Standard	6
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

The single longest wait in September was 11 hours and 48 minutes. This was a patient who arrived in department during escalation and had a long wait for a medical bed. This is the first month this year that we have had no patients with a length of stay of over 12 hours

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	6	6	6	6	6	6	6	6	6	6	6	6	6
Current Position	12.23	16.17	13.05	15.35	20.32	14.35	13.55	14.35	13.23	20.01	17.18	20.35	11.48

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Implementation of escalation process for long stay to avoid 12 Length of Stay Breaches - ensure patients are escalated to ED Management team and Site Management at 8 hours to ensure a clear plan is in place to transfer or discharge patient, eradicating 12 hour length of stays. Successful in September (0 12 hour waits in month)	Ian Pridding	Jul-19	Ongoing
Focused work on Mental Health Pathways - improved working with mental health colleagues to ensure appropriate escalations of mental health patients with long stays in the department.	Ian Pridding	Oct-19	Jan-20



52

Putting you first

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	A&E - Admission waiting 4-12 hours from dec. to admit
Standard	4
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

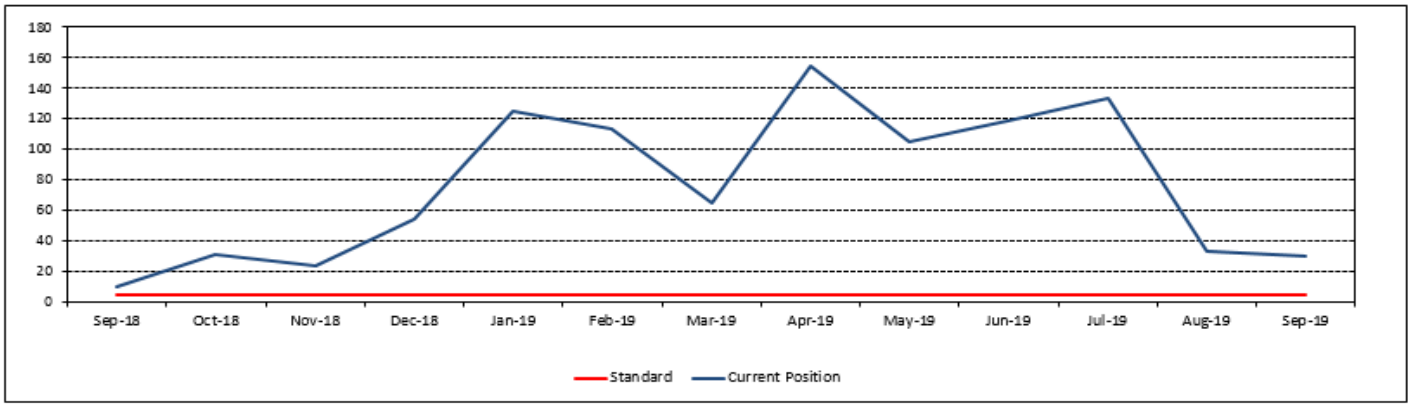
Summary of Current performance & Reasons for under performance

30 patients waited between 4-12 hours for a bed following a decision to admit. This has decreased slightly since August.
There is a comprehensive improvement plan of ED, hospital and system wide actions to address the delays in getting patients to the appropriate ward once the decision to admit has been made.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	4	4	4	4	4	4	4	4	4	4	4	4	4
Current Position	10	31	24	54	125	113	65	155	105	119	133	33	30

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

Description	Owner	Start	End
ED Senior Ops Manager to take on managerial responsibility of Acute Asessment Unit, Ambulatory Emergency Care, F7 (Short Stay Emergency) and G3 to support more joint up working between emergency village (including establishment of Surgical Ambulatory Care Unit.) Aim to improve utilisation of UEC to imporve Same Day Emergency Care metrics and avoid admissions.	Ian Pridding	Oct-19	Ongoing
Increased focus on Getting it Right First Time metrics in support of the next phase of the urgent care standards trial Dedicated support funded by NHS England to drive improvements	Nicola Cottington/Ian Pridding	Nov-19	Ongoing
Introduction of new areas within patient journey to improve patient flow: - Frailty Assessment Unit - November 2019, Rapid Assessment and Treatment Area - December 2019, Surgical Ambulatory Care area - December 2019	Ian Pridding	Oct-19	Jan-20
Implementation of escalation process for long stay to avoid 12 hour Length of Stay Breaches - ensure patients are escalated to ED Management team and Site Management at 8 hours to ensure a clear plan is in place to transfer or discharge patient, eradicating 12 hour length of stays. Successful in September (0 12 hour waits in month) Focused work on Mental Health Pathways.	Ian Pridding	Oct-19	Jan-20



Putting you first

NHS West Suffolk NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

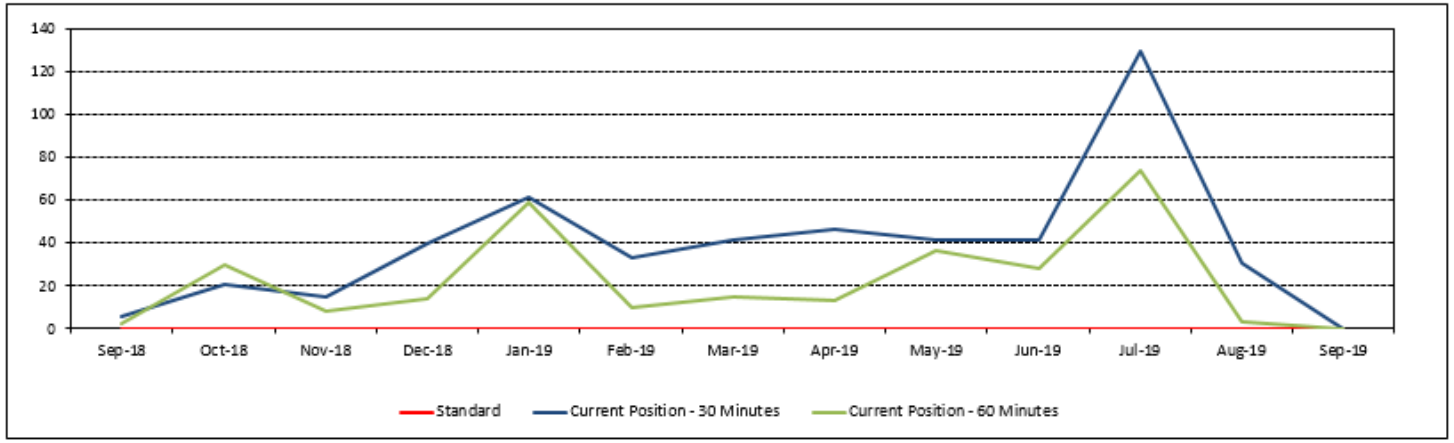
Indicator	A&E - Ambulance Handovers
Standard	0
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Data for Ambulance Handovers is a month behind due to the comprehensive validation process carried out on the data.
The number of patients waiting for over 30 minutes reduced from 129 in July to 31 in August. August also saw a reduction in the number of patients waiting over 60 minutes for Handover, from 74 in July to 3 in August

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position - 30 Minutes	6	21	15	40	61	33	41	46	41	41	129	31	ND
Current Position - 60 Minutes	2	30	8	14	59	10	15	13	36	28	74	3	ND

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Establishment of a dedicated Rapid Assessment and Treatment area to facilitate timely ambulance handover, rapid review and decision making and allow space for escalation of ambulance arrivals	ED Team	Oct-19	Dec-19
Development of escalation action cards for HALO, ED Floor Coordinator and Bed and Site teams for required actions at 15 minutes, 30 minutes and 45 minutes offload delays to ensure consistent cross hospital focus and improved understanding of required action to offload ambulances.	Ian Pridding	Oct-19	Nov-19



Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

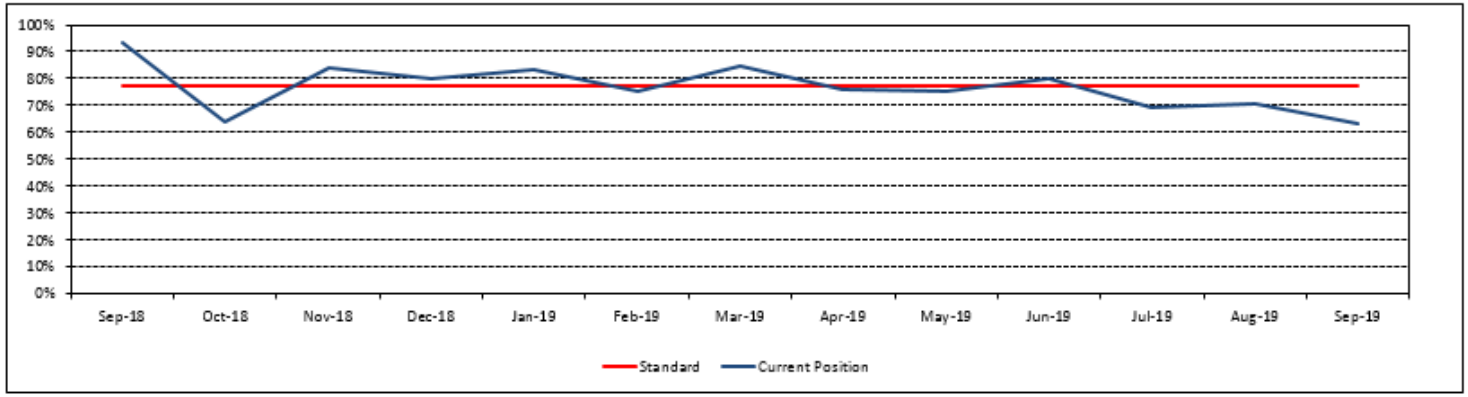
Indicator	Stroke - % Patients scanned within 1 hr.
Standard	77%
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Unfortunately this was a very difficult month with a high number of patients breaching. Unusually there were 6 inpatient strokes within the month who often take longer for their symptoms to be recognised and for Early Stroke outreach team to be alerted. Of the remaining breaches the majority occurred in ED.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%
Current Position	93.3%	64.0%	84.0%	80.0%	83.0%	75.5%	84.4%	75.8%	75.0%	80.0%	69.6%	70.6%	63.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Monthly reviews between Early Stroke outreach team and Ward manger in ED. This has now been more formalised with feedback of actions being requested from ED. A meeting has been scheduled with Lead clinicians and Senior management team of Stroke and ED to look at the potential of ED doctors requesting scans instead or in addition to the medical reg to try and prevent out of hour breaches. Teaching sessions continue for all nursing staff within the Trust.	JA	Sep-19	Dec-19



Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

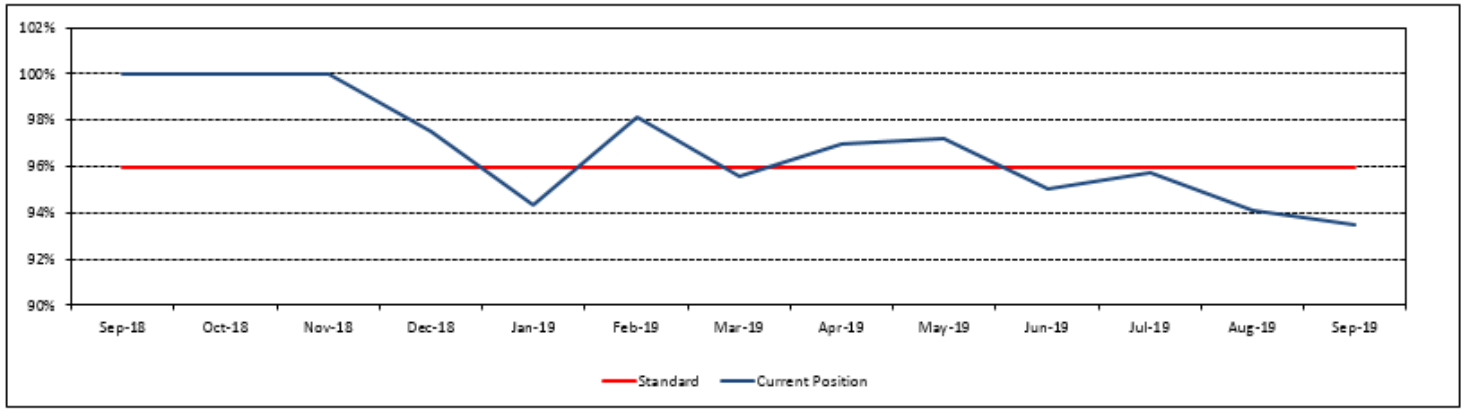
Indicator	Stroke - % patients scanned within 12 hrs.
Standard	96%
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

There were four breaches. 3 of these were again inpatient strokes with a delay to inform Early Stroke outreach team and 1 was a patient who was intubated on ITU and later found to have had a stroke.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
Current Position	100%	100%	100%	97.5%	94.3%	98.1%	95.6%	97.0%	97.2%	95.0%	95.7%	94.1%	93.5%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To continue with Trust study days to improve early recognition of stroke and to also put some brief reminder bullet points in the Green Sheet. This is done periodically and the next one is due in the green sheet week beginning 28th October 2019.	JA	May-19	Jan-20



Putting you first

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

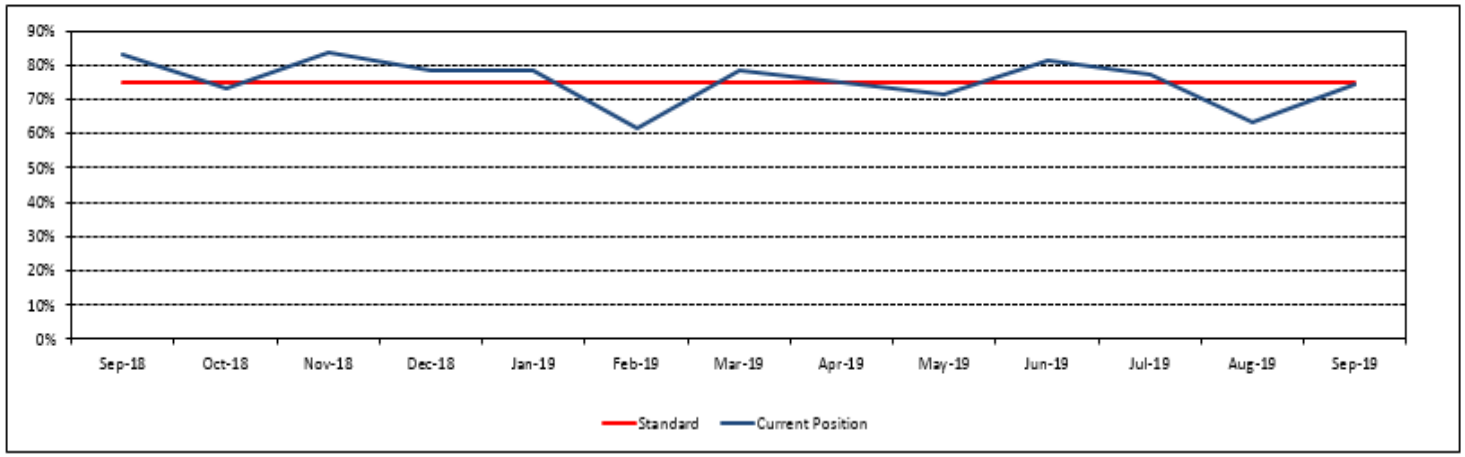
Indicator	Stroke - % Patients admitted directly to stroke unit within 4h
Standard	75%
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Narrowly missed target. The high number of inpatient strokes - 6 in all was one of the main reasions for not meeting the target, along with some delays in informing Early Stroke Outreach team, leaving not enough time to get the patient to G8. There were however no issues with bed availability, owing to the opening of Hyper-acute Stroke Unit.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
Current Position	82.8%	73.3%	83.7%	78.4%	78.4%	61.5%	78.6%	75.0%	71.4%	81.6%	77.5%	63.6%	74.4%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To continue with the established study days for nursing staff throughout the organisation.	JA	May-19	Jan-20



Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

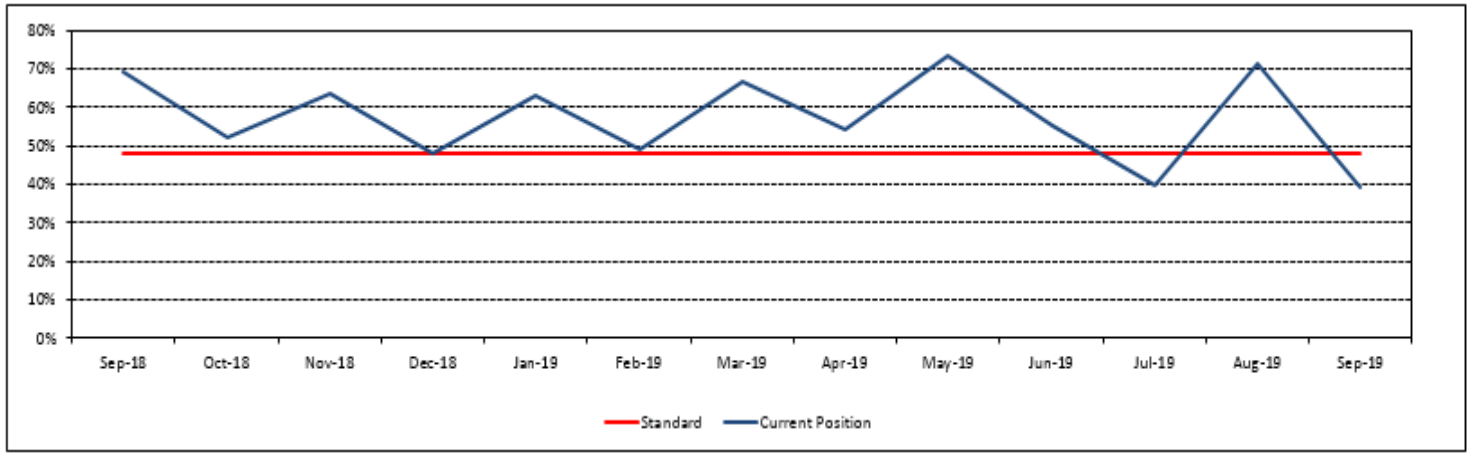
Indicator	Stroke - % of patients treated by the SESDC
Standard	48%
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

All those suitable for Early Stroke Discharge team were referred. The target was not met because there were a high number of deaths - 12 in all and 5 patients were transferred to level 2 care so therefore not meeting the criteria for Early Stroke Discharge.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%	48%
Current Position	69.2%	52.4%	63.6%	48.0%	63.2%	49.1%	66.7%	54.2%	73.3%	55.0%	40.0%	71.4%	39.4%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
None - this was unavoidable			



Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

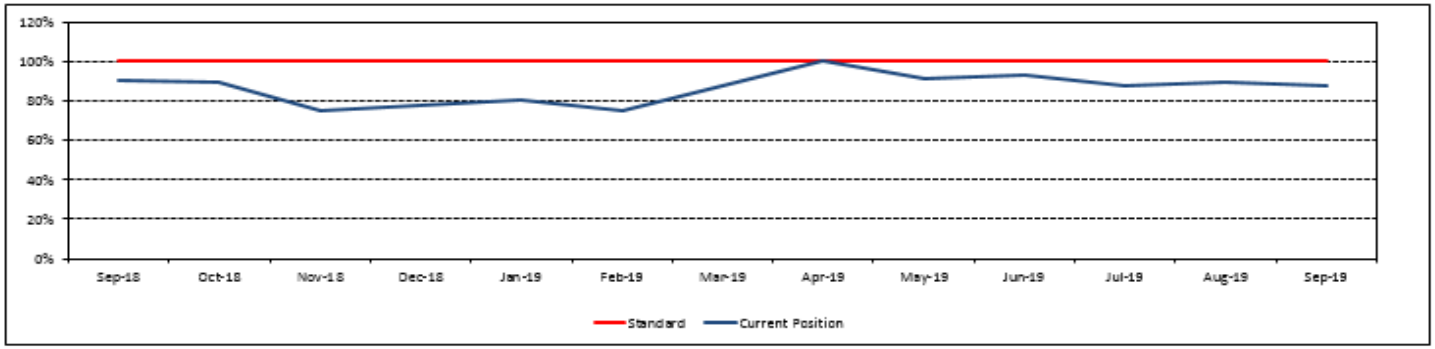
Indicator	Sepsis - 1 hr neutropenic sepsis
Standard	100%
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Performance against national standards for Door to Needle time for Neutropenic was 87.5% for the month of September. Of the 8 patient's who were admitted to G1, 7 patient's received the required treatment within the 1 hour time scale and 1 patient breached the national standard. Of the 8 patients who were admitted through ED, 7 patient's were treated within the hour and 1 patient breached the national standard. Please see below action plan to address the issues and improve performance against this standard.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	90.9%	90.0%	75.0%	77.8%	81.0%	75.0%	87.5%	100%	91.7%	92.9%	87.5%	90.0%	87.5%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Introduction of the Emergency Department Neutropenic Sepsis FastTrack Pathway NSFP (Red Folder) copy displayed on info board in ED staff room	DB/AO	Dec-18	Ongoing
Separate teaching and sign-off for neutropenic sepsis anti-biotic PGD by ED PDN	GB	Dec-18	Ongoing
High level of new starters in ED, ED PDN currently working through teaching and sign-off	GB	Dec-18	Ongoing
Detailed learning and sign-off within the newly introduced Emergency Department Adult and Paediatric Competency Workbooks.	DB/AO	Dec-18	Ongoing
NSFP communicated to the ED Team through 'hot topics' at the start of the shift	IP/DB	Dec-18	Ongoing
Monthly Neutropenic Sepsis Targets to be displayed on info board in ED staff room for continued shared learning	AO/IP	Dec-18	Ongoing
Electronic register of neutropenic sepsis anti-biotic PGD sign-off (will be within the new ED training database which is currently being developed)	AO/IP	Dec-18	Ongoing
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	IP/DB	Dec-18	Ongoing
Neutropenic Sepsis Criteria (used in RCA template) now added to NSFP (red folder) checklist, for clearer guidance	AO	Dec-18	Ongoing
To involve Floor Coordinator with answering neutropenic RCA document around explanation for individual shifts	AO	Dec-18	Ongoing
Regular ED agency nurses to complete competencies and PGD's for neutropenic sepsis antibiotics	GB	Jan-19	Ongoing
ED Administration staff to print Oncology triage from evolve at point of registration and to be included within the NSFP folder	DR/AO	Jan-19	Ongoing
Intense focus on Neutropenic Sepsis/Sepsis by Sepsis Nurse teaching sessions and utilising the ED 'topic of the week' board to share learning	BF/AO	May-19	Ongoing



Putting you first

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

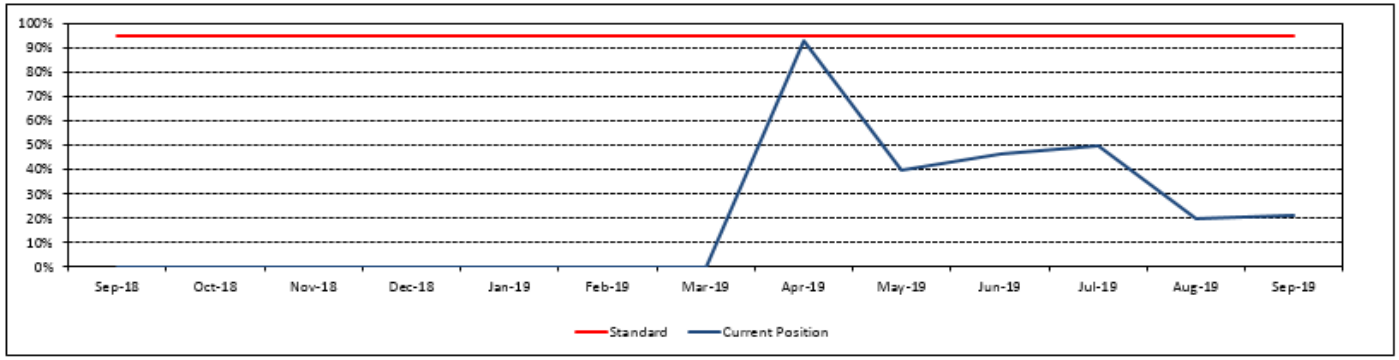
Indicator	% of initial health assessments completed within 15 working days of receiving all relevant paperwork.
Standard	95%
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

There were 19 Initial Health Assessments in September, 4 of which were completed within 15 working days of the service being made aware and receiving all the relevant paperwork.
Of the 15 who breached the 15working days target:
10 of the 14 Initial Health Assessments had the first Appointment offered after the 15 working day target.
1 of the referrals was unavailable to the service for 47 days due to being seriously ill.
Capacity challenges:
• 1 Consultant Paediatrician on Sick leave post surgery
• 1 Consultant Paediatrician on compassionate leave, family crisis – cancellation of some booked appointments.
The above impacted on the east locality – unable to replace capacity from within team as needing to cover general paediatric clinical activity and maintain adoption activity in the absence of the Adoption Medical Advisor, above.
One of the General Practitioner with Special Interest's in the west offering additional appointment slots with the view to catch up capacity lost due to holidays in August

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	NA	NA	NA	NA	NA	NA	NA	93.3%	40.0%	46.2%	50.0%	20.0%	21.1%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Plan for improving capacity moving forward: • Paediatricians reviewing job plan/clinic schedules to make appointments available each week (within current allocated Initial Health Assessment slots) rather than spread unevenly in the month • Proposal to be presented at the CCG Contract meeting on 17 October, for funding to increase one General Practitioner with Special Interest hours on a salaried basis in the west to increase capacity and responsiveness (releasing Paediatrics to routine community paediatric work). • Notice given by one General Practitioner with Special Interest in the west that Initial Health Assessment work will end with effect from October. Contact to be made with another GP who has expressed an interest in this work (also mitigate by proposal above).	Nic Smith-Howell		



Putting you first

NHS West Suffolk NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

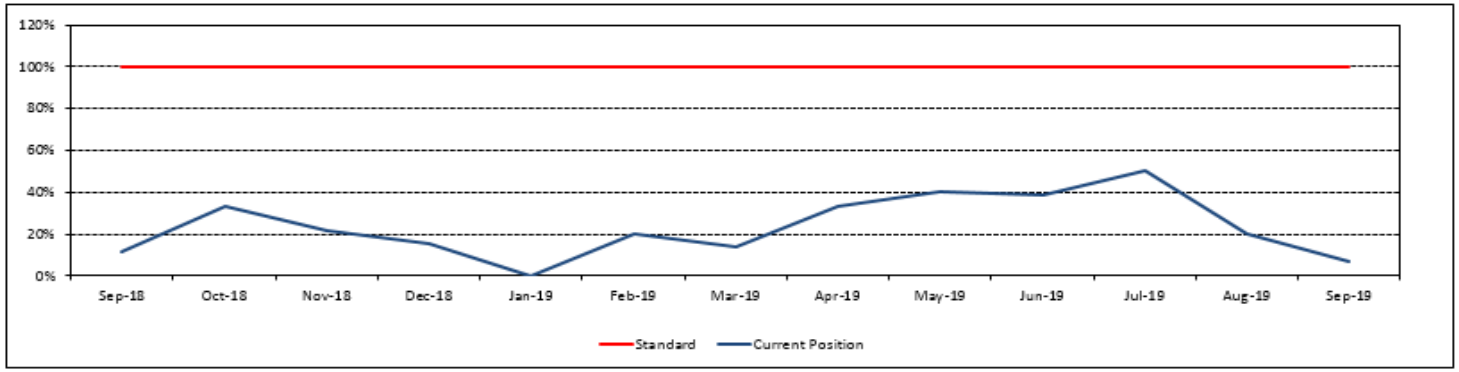
Indicator	Percentage of Children in Care initial health assessments completed within 28 calendar days of becoming a child in care
Standard	100%
Executive Lead	Helen Beck
Month	Sep-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

1 out of 19 Initial Health Assessments in September were completed within 28 days of the child being placed in care.
Of the remaining 18 Initial Health Assessments, 7 was a delay of over a week from the child being placed in care and the service receiving all the relevant information.
Capacity challenges:
• 1 Consultant Paediatrician on Sick leave post surgery
• 1 Consultant Paediatrician on compassionate leave, family crisis – cancellation of some booked appointments.
The above impacted on the east locality – unable to replace capacity from within team as needing to cover general paediatric clinical activity and maintain adoption activity in the absence of the Adoption Medical Advisor, above.
One of the General Practitioner with Special Interest's in the west offering additional appointment slots with the view to catch up capacity lost due to holidays in August

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	11.8%	33.3%	21.4%	15.4%	0.0%	20.0%	14.3%	33.3%	40.0%	38.5%	50.0%	20.0%	6.7%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Plan for improving capacity moving forward: • Paediatricians reviewing job plan/clinic schedules to make appointments available each week (within current allocated Initial Health Assessment slots) rather than spread unevenly in the month • Proposal to be presented at the CCG Contract meeting on 17 October, for funding to increase one General Practitioner with Special Interest hours on a salaried basis in the west to increase capacity and responsiveness (releasing Paediatrics to routine community paediatric work). • Notice given by one General Practitioner with Special Interest in the west that Initial Health Assessment work will end with effect from October. Contact to be made with another GP who has expressed an interest in this work (also mitigate by proposal above).	Nic Smith-Howell		



Putting you first

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	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	YTD(Apr19 Sep19)
5. Well Led	Agency, WTE & vacancies	5.09	Agency Spend Cap	486	393	381	620	500	486	486	486	461	461	461	461	461	461	461
		5.10	Bank Spend		1212	1222	1140	1167	1114	971	1277	992	777	1000	868	1222	1031	982
		5.12	Proportion of Temporary Staff	12%	12.0%	11.8%	12.8%	12.1%	12.7%	9.4%	13.1%	12.3%	12.3%	12.2%	11.7%	9.3%	8.3%	11.0%
		5.13	Locum and Medical agency spend	NT	434	524	570	555	522	389	448	487	238	408	389	615	487	437
		5.57	Additional sessions	NT	250	338	288	266	216	274	283	272	272	273	221	286	175	250
		5.16	% Staff on Maternity/Paternity Leave	NT	2.64%	2.65%	2.73%	2.83%	2.80%	2.64%	2.58%	2.82%	2.67%	2.49%	2.40%	2.23%	2.01%	2.44%
	Other	5.58	New grievance or employment tribunals in the month	NT	0	1	4	0	2	0	1	1	0	0	1	0	0	2
		5.18	Recruitment Timescales - Av no. of weeks to recruit	7	6.1	6.4	6.4	6.4	5.3	4.8	5.2	6.0	6.1	5.0	8.0	5.4	5.4	6.0
		5.19	DBS checks	95%	98.0%	98.5%	97.5%	97.5%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
		5.20	Staff appraisal Rates	90%	76.9%	76.0%	79.0%	76.4%	77.0%	76.0%	79.0%	77.0%	80.0%	81.0%	81.0%	81.0%	82.3%	80.4%

Putting you first

NHS
West Suffolk
NHS Foundation Trust

Are we.		Ref.	KPI	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	YTD(Apr19 Sep19)
5. Well Led	Training	5.22	Infection Control Training (classroom)	90%	95.0%	94.0%	95.0%	94.0%	96.0%	96.0%	93.0%	94.0%	95.0%	95.0%	95.0%	96.0%	96.0%	95.2%
		5.23	Infection Control Training (eLearning)	90%	90.0%	89.0%	90.0%	91.0%	91.0%	91.0%	81.0%	82.0%	82.0%	89.0%	90.0%	91.0%	91.0%	87.5%
		5.24	Manual Handling Training (Patient)	90%	76.0%	77.0%	76.0%	76.0%	80.0%	77.0%	78.0%	69.0%	80.0%	78.0%	80.0%	81.0%	83.0%	78.5%
		5.25	Manual Handling Training (Non Patient)	90%	85.0%	82.0%	86.0%	84.0%	87.0%	88.0%	67.0%	56.0%	76.0%	62.0%	67.0%	70.0%	73.0%	67.3%
		5.26	Staff Adult Safeguarding Training	90%	91.0%	91.0%	90.0%	90.0%	91.0%	91.0%	85.0%	85.0%	87.0%	89.0%	88.0%	89.0%	90.0%	88.0%
		5.27	Safeguarding Children Level 1	90%	89.0%	89.0%	90.0%	91.0%	91.0%	90.0%	91.0%	91.0%	92.0%	92.0%	92.0%	93.0%	93.0%	92.2%
		5.28	Safeguarding Children Level 2	90%	90.0%	90.0%	90.0%	91.0%	91.0%	91.0%	86.0%	86.0%	90.0%	90.0%	89.0%	92.0%	92.0%	89.8%
		5.29	Safeguarding Children Level 3	90%	91.0%	91.0%	90.0%	90.0%	91.0%	91.0%	57.0%	51.0%	71.0%	61.0%	58.0%	84.0%	83.0%	68.0%
		5.30	Health & Safety Training	90%	90.0%	89.0%	89.0%	90.0%	89.0%	89.0%	87.0%	87.0%	88.0%	90.0%	90.0%	92.0%	91.0%	89.7%
		5.31	Security Awareness Training	90%	89.0%	88.0%	89.0%	89.0%	89.0%	88.0%	81.0%	83.0%	87.0%	88.0%	88.0%	91.0%	92.0%	88.2%
		5.32	Conflict Resolution Training (eLearning)	90%	83.0%	83.0%	85.0%	86.0%	86.0%	86.0%	68.0%	70.0%	74.0%	81.0%	82.0%	85.0%	88.0%	80.0%
		5.33	Conflict Resolution Training	90%	71.0%	69.0%	74.0%	75.0%	72.0%	72.0%	77.0%	74.0%	78.0%	76.0%	76.0%	75.0%	76.0%	75.8%
		5.34	Fire Training (eLearning)	90%	91.0%	83.0%	85.0%	88.0%	85.0%	83.0%	83.0%	78.0%	83.0%	83.0%	83.0%	87.0%	87.0%	83.5%
		5.35	Fire Training (classroom)	90%	84.0%	89.0%	88.0%	86.0%	89.0%	87.0%	89.0%	88.0%	89.0%	89.0%	89.0%	91.0%	90.0%	89.3%
		5.36	IG Training	95%	82.0%	80.0%	83.0%	82.0%	81.0%	83.0%	78.0%	79.0%	81.0%	94.0%	86.0%	91.0%	90.0%	86.8%
		5.37	Equality and Diversity	90%	80.0%	81.0%	82.0%	84.0%	85.0%	85.0%	87.0%	86.0%	88.0%	90.0%	90.0%	93.0%	92.0%	89.8%
		5.38	Majax Training	90%	88.0%	89.0%	89.0%	90.0%	90.0%	89.0%	78.0%	80.0%	82.0%	84.0%	84.0%	88.0%	87.0%	84.2%
		5.39	Medicines Management Training	90%	86.0%	87.0%	87.0%	87.0%	87.0%	86.0%	80.0%	81.0%	83.0%	86.0%	86.0%	86.0%	86.0%	84.7%
		5.40	Slips, trips and falls Training	90%	85.0%	86.0%	85.0%	87.0%	86.0%	86.0%	74.0%	76.0%	79.0%	82.0%	81.0%	85.0%	86.0%	81.5%
		5.41	Blood-borne Viruses/Inoculation Incidents	90%	86.0%	87.0%	88.0%	89.0%	89.0%	87.0%	78.0%	80.0%	83.0%	85.0%	85.0%	89.0%	88.0%	85.0%
		5.42	Basic life support training (adult)	90%	79.0%	79.0%	80.0%	80.0%	81.0%	80.0%	79.0%	73.0%	81.0%	81.0%	81.0%	81.0%	82.0%	79.8%
		5.43	Blood Products & Transfusion Processes (Refresher)	90%	73.0%	74.0%	75.0%	76.0%	77.0%	76.0%	65.0%	62.0%	68.0%	77.0%	75.0%	77.0%	75.0%	72.3%
		5.44	Mandatory Training Compliance	90%	85.0%	85.0%	86.0%	86.0%	85.0%	86.0%	82.0%	82.0%	85.0%	86.0%	86.0%	87.0%	88.0%	85.7%

Putting you first

EXCEPTION REPORTS – WELL LED

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Sickness Absence
Standard	3.5%
Executive Lead	Jan Bloomfield
Month	Sep-19
Data Frequency	Monthly
CQC Area	Well Led

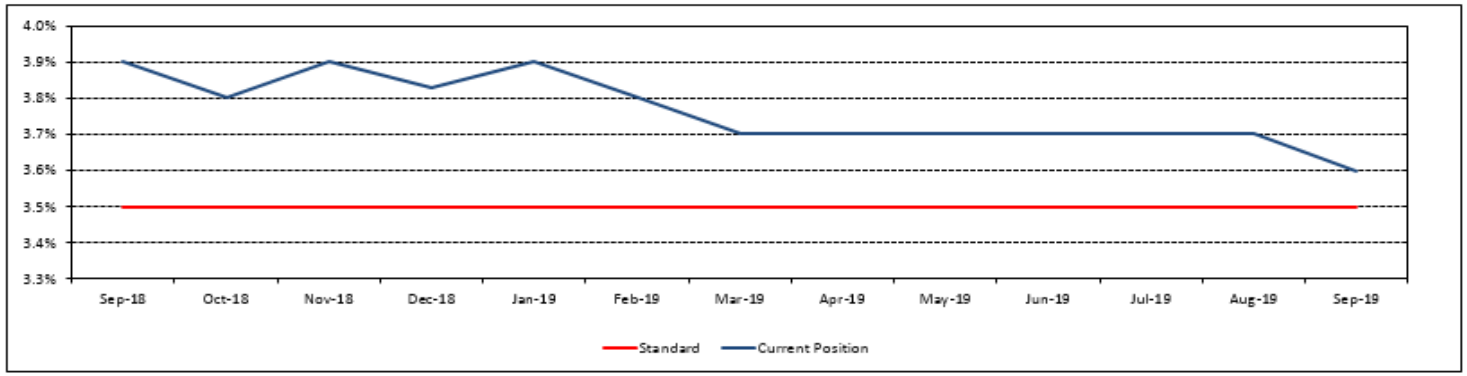
Summary of Current performance & Reasons for under performance

current performance has gone down to 3.6%. Community is currently running at 8.8%. other parts of the trust are higher than this. Community managers are sent monthly sickness reports which highlights anyone who has reached a Bradford factor score of 100+ in a six month period. Report also shows anyone who is close to reaching 100 points

- At the start of 2019, Community staff were harmonised onto the WSFT policy for Improving Employee Health, Wellbeing and Attendance. This has provided a consistent approach in the management of sickness absence
- HR supporting managers with Sickness Absence meetings as they do for other staff.
- Sickness percentages/information reported to the monthly Community Management meetings
- Occupational Health attended management meetings to advise managers of the services they offer.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
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	3.9%	3.8%	3.9%	3.8%	3.9%	3.8%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.6%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
We are significantly lower than other NHS Trusts, with the national average running around 4%, and will continue to support return to work, OH referrals etc.			



64

Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

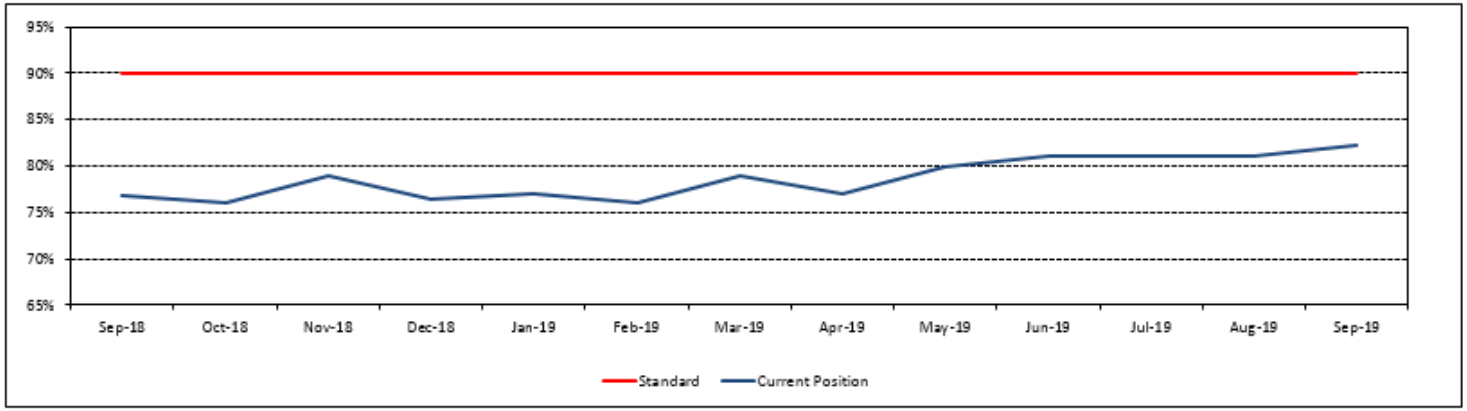
Indicator	Staff appraisal Rates
Standard	90%
Executive Lead	Jan Bloomfield
Month	Sep-19
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Appraisal performance increased to 82.3%

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	76.9%	76.0%	79.0%	76.4%	77.0%	76.0%	79.0%	77.0%	80.0%	81.0%	81.0%	81.0%	82.3%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
HR managers are currently targeting those managers with the most out of date appraisals, meeting with them to support them to improve compliance levels.			



Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

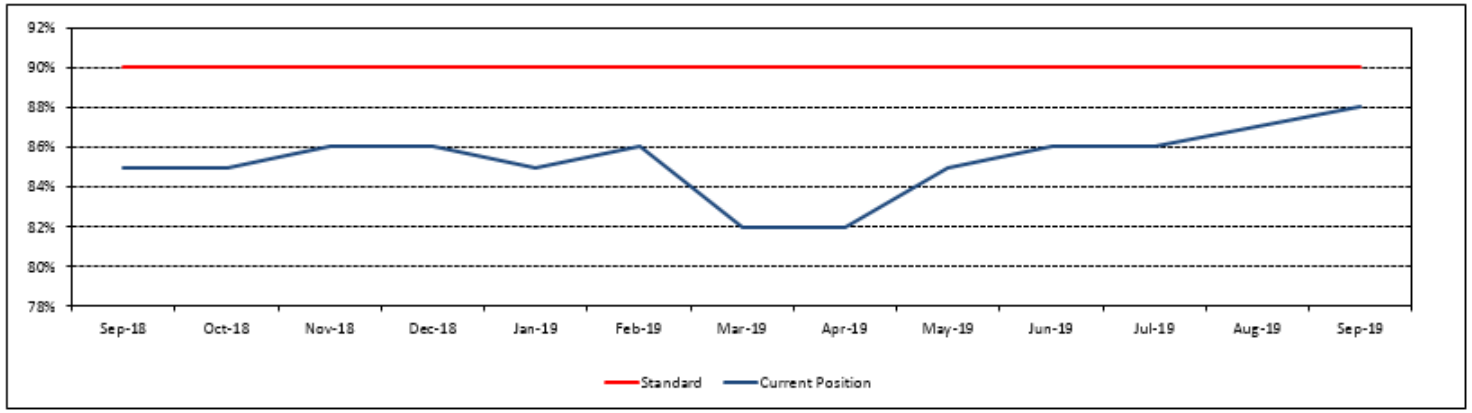
Indicator	Mandatory Training Compliance
Standard	90%
Executive Lead	Jan Bloomfield
Month	Sep-19
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Compliance has improved by 1%

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	85.0%	85.0%	86.0%	86.0%	85.0%	86.0%	82.0%	82.0%	85.0%	86.0%	86.0%	87.0%	88.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
We have recently reviewed all mandatory training subjects, as reported to the board this month. Changes will take a while to implement but we are hopeful it will result in increased compliance in some areas.			



Putting you first

NHS West Suffolk NHS Foundation Trust

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	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	YTD(Apr19-Sep19)
6. Productive	Activity	6.07	A&E Activity	NT	6042	6256	6114	6155	6371	5741	6695	6729	6946	6692	7300	6661	6829	41157
		6.08	NEL Activity	NT	2356	2638	2770	2520	2750	2467	2604	2464	2695	2379	2496	2465	2468	14967
		6.09	OP - New Appointments	NT	6113	7381	7255	5995	7059	6419	7086	8369	8947	8536	9365	7660	9115	51992
		6.10	OP- Follow-Up Appointments	NT	10879	12773	12289	9834	12610	11107	11536	22314	19866	19733	21458	19079	19942	122392
		6.11	Electives (Incl Daycase)	NT	2379	3033	3047	2519	3202	2957	2971	2806	2974	2755	3095	2892	3036	17558
	Finance	6.12	Financial Position (YTD)	Var	-7119	-7122	-7494	-6534	-8691	-7955	-287	529	-481	-1681	-2106	-4239	-5712	-13690
		6.13	Financial Stability Risk Rating	Var	3	3	3	3	3	3	3	3	3	3	3	3	3	18
		6.14	Cash Position (YTD £000s)	Var	3934	1338	5162	3518	4924	6870	3600	11140	5825	1467	2119	1787	2061	24399
	Ratios	6.15	% Consultant to Consultant Referrals	NT	15.0%	14.0%	15.0%	17.0%	16.0%	17.0%	15.0%	17.0%	16.0%	16.0%	16.0%	15.0%	15.0%	15.8%
		6.16	New to FU Ratios	NT	2.34	2.27	2.16	2.16	2.31	2.37	2.20	2.66	2.22	2.31	2.29	2.48	2.19	2.36

EXCEPTION REPORTS – PRODUCTIVE

The finance report contains full details.

10. DETAILED REPORTS- MATERNITY

Are we..		Ref.	KPI	Target	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	YTD(Apr19-Sep19)
7.Maternity	Safe	7.09	Elective Caesarean Sections	12%	9.6%	8.6%	10.4%	9.1%	6.7%	9.3%	11.2%	9.3%	11.3%	7.8%	9.5%	9.8%	10.0%	9.6%
		7.10	Emergency Caesarean Sections	14%	13.0%	14.1%	15.4%	16.3%	16.2%	11.0%	15.6%	11.5%	11.8%	18.0%	10.9%	11.2%	19.4%	13.8%
		7.11	Grade 1 Caesarean Section (Decision to delivery time met)	100%	100%	40.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)	80%	82.0%	71.0%	57.0%	79.0%	76.1%	92.3%	87.0%	100%	85.0%	81.0%	82.0%	64.0%	82.0%	82.3%
		7.13	Homebirths	2%	3.8%	1.8%	2.0%	1.0%	2.2%	2.9%	2.8%	3.8%	3.1%	1.5%	2.4%	2.3%	3.0%	2.7%
		7.14	Midwifery led birthing unit (MLBU) births	20%	11.5%	14.4%	NA	NA	NA	NA	NA	24.0%	14.4%	16.1%	19.4%	12.9%	14.4%	16.9%
		7.15	Labour Suite births	77.5%	83.7%	82.7%	82.6%	83.0%	78.8%	77.9%	82.1%	71.0%	82.1%	82.0%	77.3%	85.1%	82.1%	79.9%
		7.16	Induction of Labour	29.3%	34.1%	35.5%	38.3%	42.1%	40.8%	39.0%	42.2%	35.0%	39.5%	39.0%	38.9%	35.8%	38.8%	37.8%
		7.17	Instrument Assisted Deliveries (Forceps & VentoUse)	>14%	11.5%	11.8%	13.9%	8.1%	8.9%	12.2%	11.7%	8.2%	8.2%	12.2%	8.5%	10.7%	11.5%	9.9%
		7.18	Critical Care Obstetric Admissions	0	1	0	0	3	1	0	0	0	0	0	0	0	0	0
		7.19	Eclampsia	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0
	Effective	7.20	Shoulder Dystocia	2	9	9	4	4	6	4	4	9	2	7	5	0	3	26
		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	1	0	1	1	0	1	1	0	0	0	0	0	1
		7.23	3rd and 4th degree tears (all deliveries)	12	7	3	8	2	6	2	0	7	2	4	6	4	3	26
	Caring	7.24	Maternal death	0	0	1	0	0	0	0	0	0	1	0	0	0	0	1
		7.25	Stillbirths	NT	0	0	0	0	0	0	0	1	1	2	0	0	0	4
		7.26	Complaints	NT	0	1	1	0	3	3	1	0	3	0	0	0	1	4
		7.27	No. of babies admitted to Neonatal Unit (>36+6)	NT	8	9	10	15	7	7	9	8	8	16	4	12	12	60
	Responsive	7.28	No. of babies transferred for therapeutic cooling	0	0	0	0	0	0	1	0	0	0	0	0	0	1	1
		7.29	One to one care in established labour	100%	100%	100%	100%	99.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		7.30	Reported Clinical Incidents	50	44	34	42	38	50	40	59	56	47	43	61	78	44	329
		7.31	Hours of dedicated consultant cover per week	60	87	87	99	93	105	87	98	96	105	90	102	90	96	579
		7.32	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	10	60
		7.34	No. of women identified as smoking at booking	NT	23	22	20	34	20	18	28	23	25	22	23	27	22	142
		7.35	No. of women identified as smoking at delivery	NT	21	22	18	31	18	16	27	20	20	21	22	28	19	130
		7.36	UNICEF Baby friendly audits	10	NA	NA	NA	NA	NA	NA	NA	NA	24	NA	NA	NA	NA	24
		7.37	Proportion of parents receiving Safer Sleeping Suffolk advice	80%	96.0%	97.0%	95.0%	97.5%	96.1%	97.0%	94.5%	95.0%	85.6%	80.0%	93.0%	81.0%	89.0%	87.3%
	Other	7.38	No. of bookings (First visit)	NT	231	234	222	206	278	226	242	231	251	241	257	232	230	1442
		7.39	Women booked before 12+6 weeks	95%	92.0%	92.0%	98.0%	95.1%	96.0%	96.4%	92.0%	95.0%	95.0%	94.0%	98.0%	97.0%	93.0%	95.3%
		7.40	Female Genital Mutilation (FGM)	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0

EXCEPTION REPORTS – MATERNITY

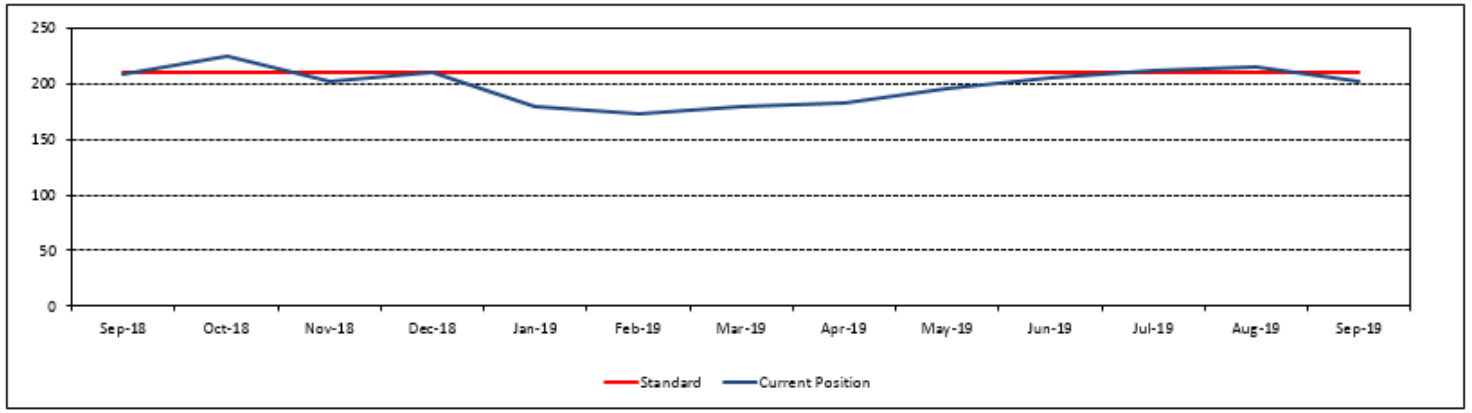
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	Total number of deliveries (births)
Standard	210
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Following the refurbishment the Labour Suite is working hard to recover the reduced number of births during this period and has seen a slow increase since February. Further work is being done to encourage more women to book at the WSH particularly those on the geographical boundaries. It is hoped that the work in communications around the opening of the Labour Suite will have an impact in increasing the numbers of women who choose to give birth at the WSH.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	210	210	210	210	210	210	210	210	210	210	210	210	210
Current Position	208	224	202	209	179	172	179	183	195	205	211	215	201

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Communications involved in grand opening of the Labour Suite			



NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

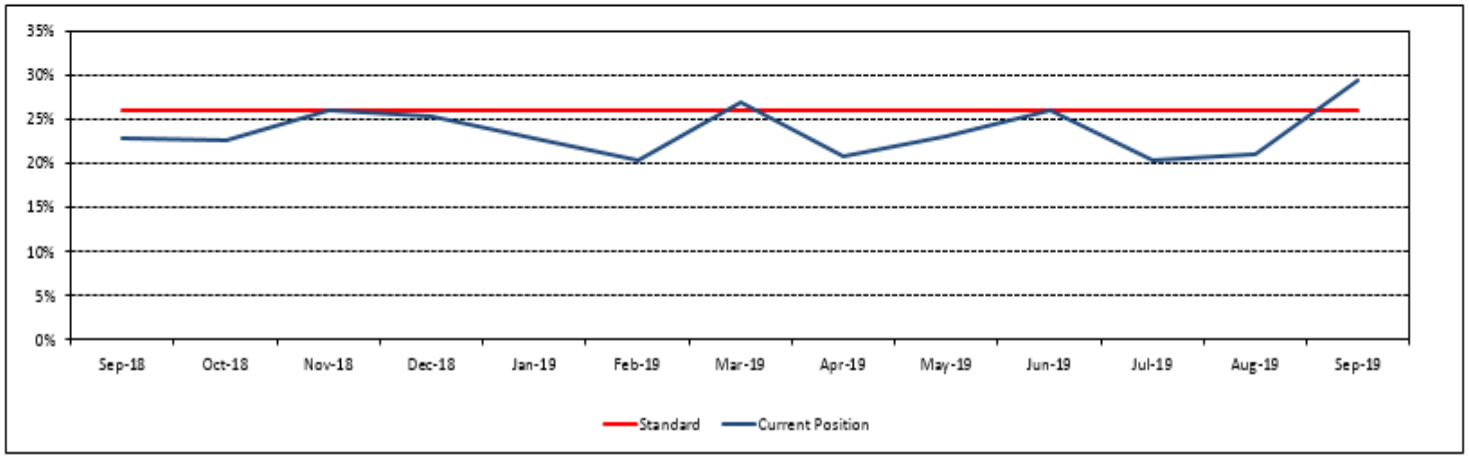
Indicator	% of all caesarean sections
Standard	26%
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

September figures for overall percentage of Caesarean sections was above the standard of 26%. This is because the emergency Caesarean sections was increased this month. However for the last 12 month period the average rate was 23% below the agreed standard of 26%. The service continues to monitor via the Women's Health Governance monthly and weekly at the case management meeting.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	26%	26%	26%	26%	26%	26%	26%	26%	26%	26%	26%	26%	26%
Current Position	22.8%	22.7%	25.9%	25.4%	22.9%	20.3%	26.8%	20.8%	23.1%	25.9%	20.4%	20.9%	29.4%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
The service continues to monitor via the womens health Governance monthly and weekly at the case management meeting.			



71

Putting you first

NHS West Suffolk NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

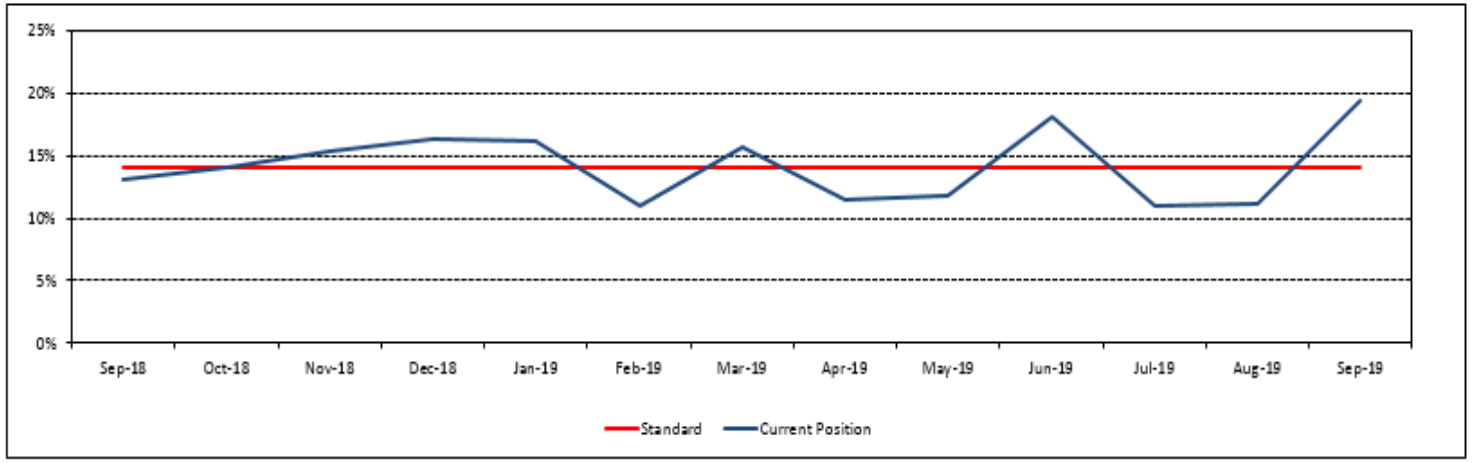
Indicator	Emergency Caesarean Sections
Standard	14%
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The service saw a significant increase in the number of emergency caeasarean sections in September to 19.4%. Despite the last 12 months recording occasional peaks in the emergency rate overall for a 12 month period the percentage was 13.7% below the current expected standard. The service will continue to observe and if any trend upwards and continue to review emergency caeasarean sections in the weekly MDT meeting.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%
Current Position	13.0%	14.1%	15.4%	16.3%	16.2%	11.0%	15.6%	11.5%	11.8%	18.0%	10.9%	11.2%	19.4%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor both dashboard figures monthly and Emergency caeasarean sections weekly.			



Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

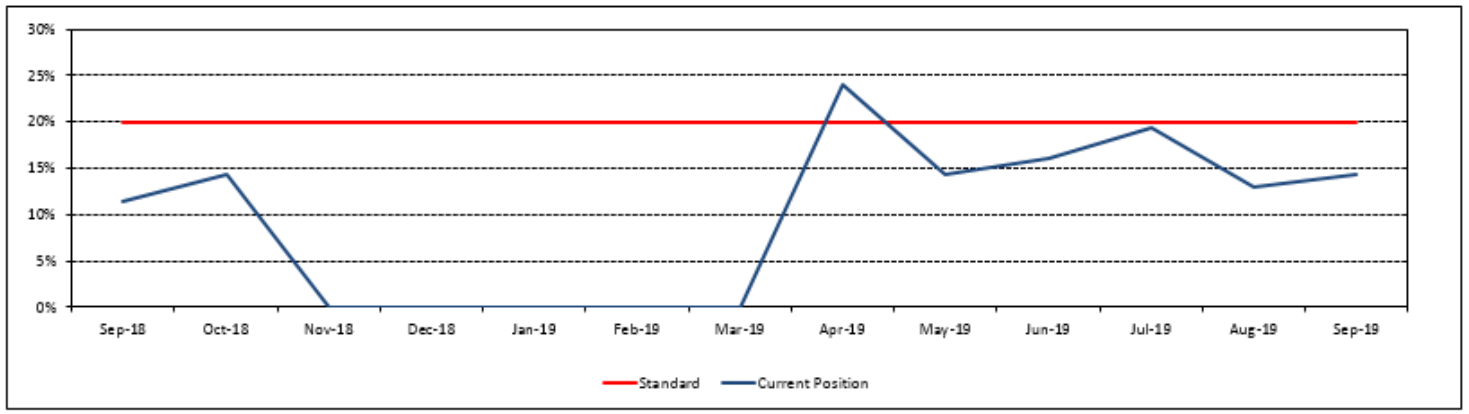
Indicator	Midwifery led birthing unit (MLBU) births
Standard	20%
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Midwifery led birthing unit has been below the standard set of 20% for the last few months, however this appears to be in line with other birthing units who find it difficult to achieve. September showed the first month since the Labour suite refurbishment that women transferred to the Labour suite in labour were for clinical reasons only and not due to reduced staffing . The Midwifery led birthing unit is fully staffed and this should have a positive impact.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
Current Position	11.5%	14.4%	NA	NA	NA	NA	NA	24.0%	14.4%	16.1%	19.4%	12.9%	14.4%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
In January there are plans to introduce continuity of carer for low risk women. The service will continue to monitor the numbers, but expects to see these improve over the coming months.			



Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

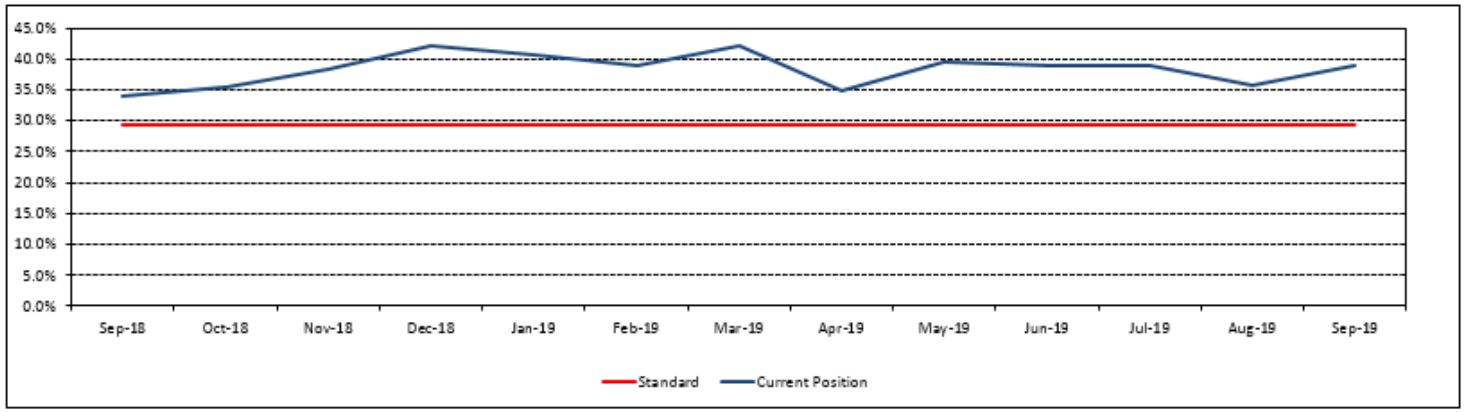
Indicator	Induction of Labour
Standard	29.3%
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The Induction of Labour rate is consistently above the standard of 29.3 % Recent audits have shown appropriate management of cases and reflect that we follow NICE guidelines in conditions such as Gestational diabetes, growth restriction and reduced fetal movements. We have a higher than average successful delivery of women who have had a previous caesarean sections which may increase the rate above other trusts of a similar size who may undertake Elective caesarean sections on these women.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%
Current Position	34.1%	35.5%	38.3%	42.1%	40.8%	39.0%	42.2%	35.0%	39.5%	39.0%	38.9%	35.8%	38.8%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To discuss the consistent high percentage at the Women's Health Governance meeting.			



Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

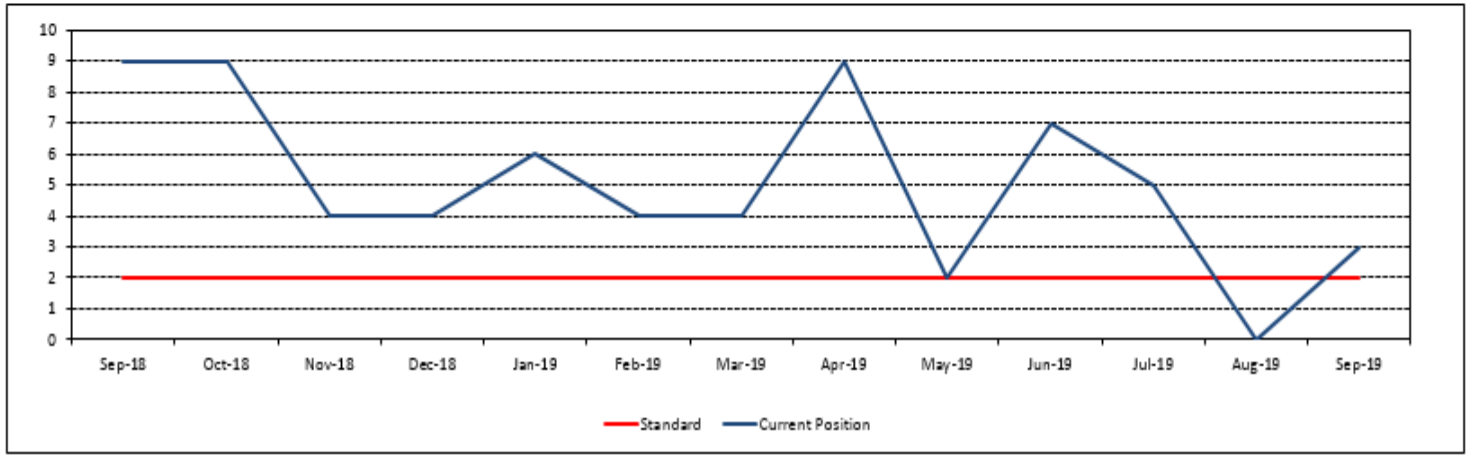
Indicator	Shoulder Dystocia
Standard	2
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

In most instances, shoulder dystocia cannot be prevented because it cannot be predicted. The maternity service is aware that this emergency appears to be over reported by staff and managed with a change of maternal position, this is discussed at the Mandatory training. As an obstetric emergency an important aspect of Shoulder Dystocia is ensuring staff are trained in its management. All staff undergo multi professional training annually. Of the three cases of reported Shoulder Dystocia no injuries were reported to mother or baby.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	2	2	2	2	2	2	2	2	2	2	2	2	2
Current Position	9	9	4	4	6	4	4	9	2	7	5	0	3

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



Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

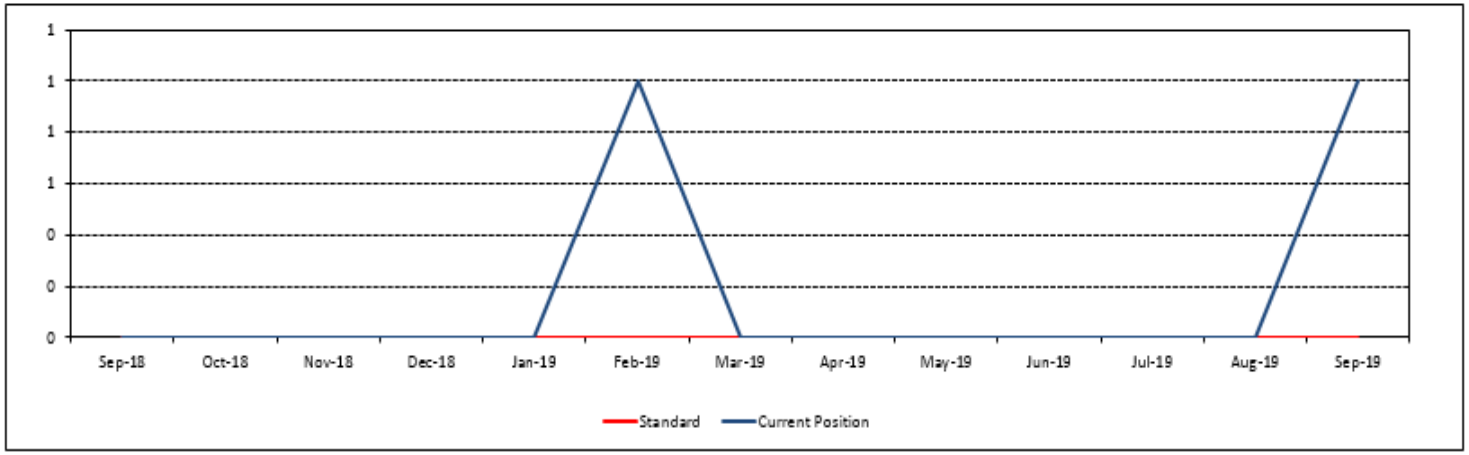
Indicator	No. of babies transferred for therapeutic cooling
Standard	0
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Whilst babies transferred for therapeutic cooling for suspected brain injury at birth is not common the impact can be devastating for the family. In this case the woman was undergoing a combined spinal /epidural prior to artificial rupture of membranes in theatre. In this case the mother had a profound hypotension following the spinal and the baby a fetal bradycardia. Whilst the fetal heart normally recovers once mother is stabilised this did not occur . Grade 1 caesarean sections was performed with baby in poor condition however baby made good progress following cooling and was discharge soon after.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	0	0	0	0	0	1	0	0	0	0	0	0	1

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Day 5 to be undertaken and any immediate actions identified . The case then handed over to the Health Safety Investigation Branch HSIB for investigation.			



Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

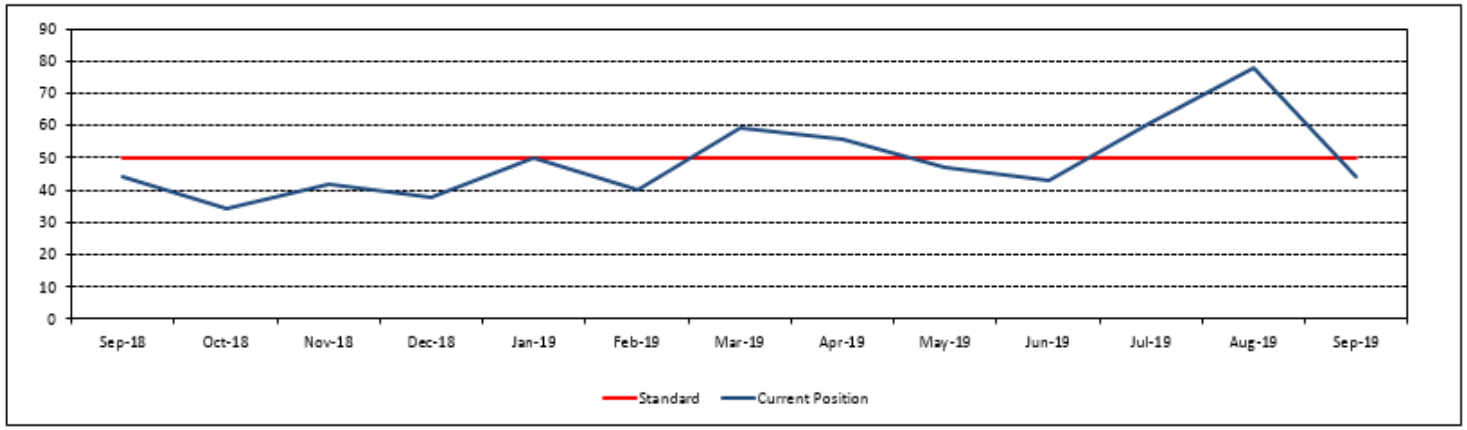
Indicator	Reported Clinical Incidents
Standard	50
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Reported incidents this month was slightly below the standard of 50 expected. The rate generally reflect the activity in the unit deliveries were slightly down on last month. Quarterly statistics presented this month for Quarter 2 showed a marked increase in overall reporting of 183 incidents compared to the same quarter last year which reported 117 incidents. Overall there appears to be a normal variation.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	50	50	50	50	50	50	50	50	50	50	50	50	50
Current Position	44	34	42	38	50	40	59	56	47	43	61	78	44

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Staff are encouraged to report incidents with the trigger list as an aid memoir.			



77

Putting you first

NHS
West Suffolk
NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

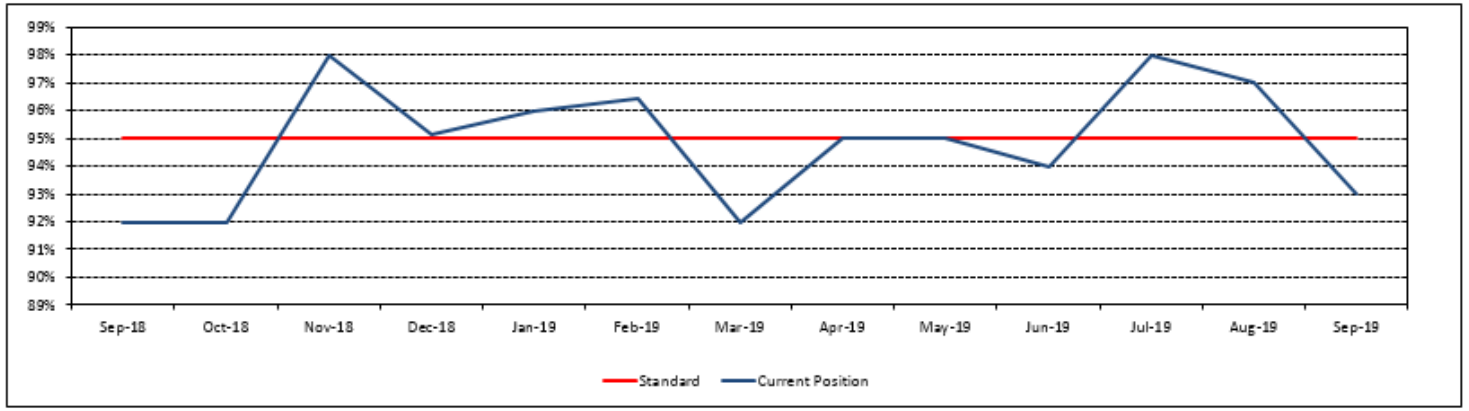
Indicator	Women booked before 12+6 weeks
Standard	95%
Executive Lead	Rowan Procter
Month	Sep-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

It is important that women book early in pregnancy to allow for early screening programmes to be undertaken. This month there was a reduction in women who were booked by the midwife after 12+6 days. The majority of these cases are due to women presenting later in pregnancy and there are various reasons why they do this. The data has gone back to the outpatient service manager for review and discussion with the community teams. Despite patient information around surgeries and children's centres there are still women who do not understand the importance of early referral to maternity services. Whilst our rates are better than most in the region the service continues to review how to engage vulnerable women to present earlier.

Month	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	92.0%	92.0%	98.0%	95.1%	96.0%	96.4%	92.0%	95.0%	95.0%	94.0%	98.0%	97.0%	93.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Discussion of the data with the Outpatient service manager			



Putting you first

9. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – October 2019

Agenda item:	9			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	25th October 2019			
Subject:	Finance and Workforce Board Report – September 2019			
Purpose:	x	For information		For approval

Executive summary:
The reported I&E for September 2019 is a deficit of £1.3m, against a plan to break even. This results in an adverse variance of £1.3m in September (£3.9m YTD). The YTD loss is now £5.4m which, after delivering a recovery plan of £1.8m would still suggest a loss (before PSF/FRF) of £10.0m by year end once seasonal factors are included. This is £10.0m worse than our control total.

We propose that we submit a formal re-forecast to NHSI/E of £10.0m deficit (before PSF/FRF). This requires Board approval.

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 and agree to the re-forecast as proposed

FINANCE AND WORKFORCE REPORT
SEPTEMBER 2019 (Month 6)

Executive Sponsor : Craig Black, Director of Resources
Author : Nick Macdonald, Deputy Director of Finance

Financial Summary

I&E Position YTD	£5.4m	loss
Variance against plan YTD	-£3.9m	adverse
Movement in month against plan	-£1.3m	adverse
EBITDA position YTD	-£4.3m	adverse
EBITDA margin YTD	-3.4%	adverse
Total PSF Received	£4.443m	accrued
Cash at bank	£2.1m	

Executive Summary

- The planned deficit for the year to date was £1.5m but the actual deficit was £5.4m, an adverse variance of £3.9m.
- The reported position includes accruing for all FRF/PSF.
- We believe we should re-forecast to a loss of £10.0m (before PSF/FRF) which requires board approval. This would mean losing PSF/FRF relating to 19-20 of £6.0m.
- This forecast requires a recovery plan of £1.8m which includes prioritising the financial position against quality and performance targets.

Key Risks

- Delivery of £8.9m CIP programme
- Delivery of £1.8m recovery plan
- Containing demand within budgeted capacity
- Lost PSF of £6.0m should we fail to meet our control total

SUMMARY INCOME AND EXPENDITURE ACCOUNT - September 2019	Sep-19			Year to date			Year end forecast		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	17.3	17.2	(0.1)	108.3	108.4	0.1	217.8	216.4	(1.4)
Other Income	2.6	2.5	(0.1)	14.5	13.9	(0.6)	28.9	28.0	(0.9)
Total Income	**19.8**	**19.7**	**(0.1)**	**122.8**	**122.3**	**(0.5)**	**246.7**	**244.4**	**(2.2)**
Pay Costs	14.2	14.8	(0.6)	84.4	86.5	(2.1)	170.0	172.6	2.6
Non-pay Costs	5.5	6.1	(0.7)	38.2	40.1	(1.9)	75.1	80.4	5.3
Operating Expenditure	**19.6**	**20.9**	**(1.3)**	**122.6**	**126.6**	**(4.0)**	**245.1**	**253.0**	**7.9**
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**	**(1.2)**	**(1.4)**	**0.2**	**(4.3)**	**(4.5)**	**1.6**	**(8.6)**	**(10.2)**
Depreciation	0.7	0.6	0.1	3.9	3.6	0.3	7.8	7.2	(0.6)
Finance costs	0.3	0.3	0.0	1.9	2.0	(0.1)	3.9	4.3	0.4
SURPLUS/(DEFICIT)	**(0.8)**	**(2.1)**	**(1.3)**	**(5.6)**	**(9.8)**	**(4.2)**	**(10.1)**	**(20.1)**	**(10.0)**
Provider Sustainability Funding (PSF)									
MRET, FRF/PSF - Financial Performance	0.7	0.7	0.0	4.1	4.4	0.3	10.1	4.4	(5.7)
SURPLUS/(DEFICIT) incl PSF	**(0.0)**	**(1.3)**	**(1.3)**	**(1.5)**	**(5.4)**	**(3.9)**	**0.0**	**(15.7)**	**(15.7)**

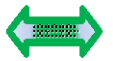
FINANCE AND WORKFORCE REPORT - SEPTEMBER 2019

Contents:

- Income and Expenditure Summary Page 3
- 2019-20 CIP Page 4
- Recovery Plan and Forecast Page 5
- Income Analysis Page 6
- Workforce Planning and Analysis Page 8
- Divisional Positions Page 12
- Use of Resources (UoR) Page 14
- Capital Page 15
- Balance Sheet Page 16
- Cash and Debt Management Page 17

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 - SEPTEMBER 2019

Income and Expenditure Summary as at September 2019

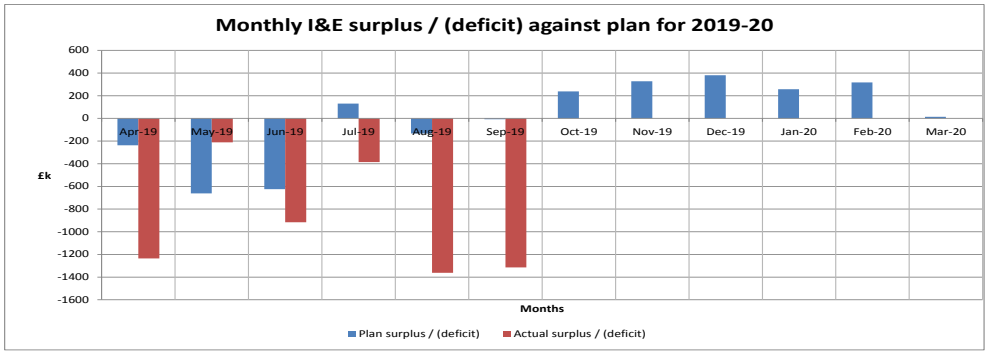
The reported I&E for September 2019 is a deficit of £1.3m, against a plan to break even. This results in an adverse variance of £1.3m in September (£3.9m YTD). During September the medical staffing pay awards were paid, backdated to April, which added around £0.5m to the variance.

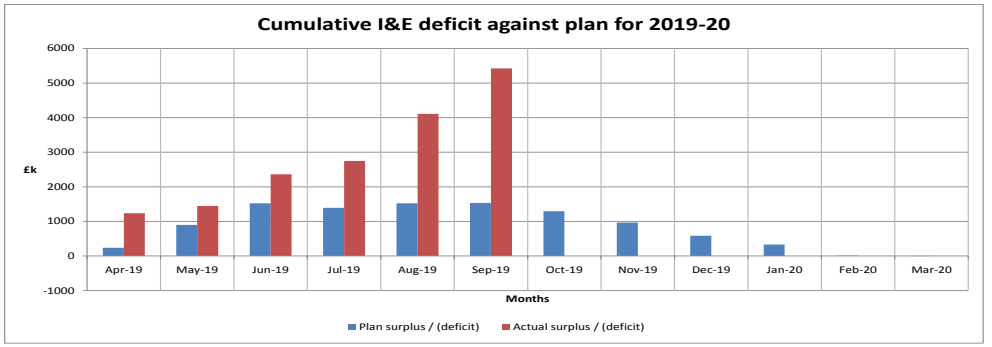
The YTD variance of £3.9m includes activity of £3.4m that is not chargeable under the GIC. Therefore the adverse position can be seen to be almost entirely driven by demand.

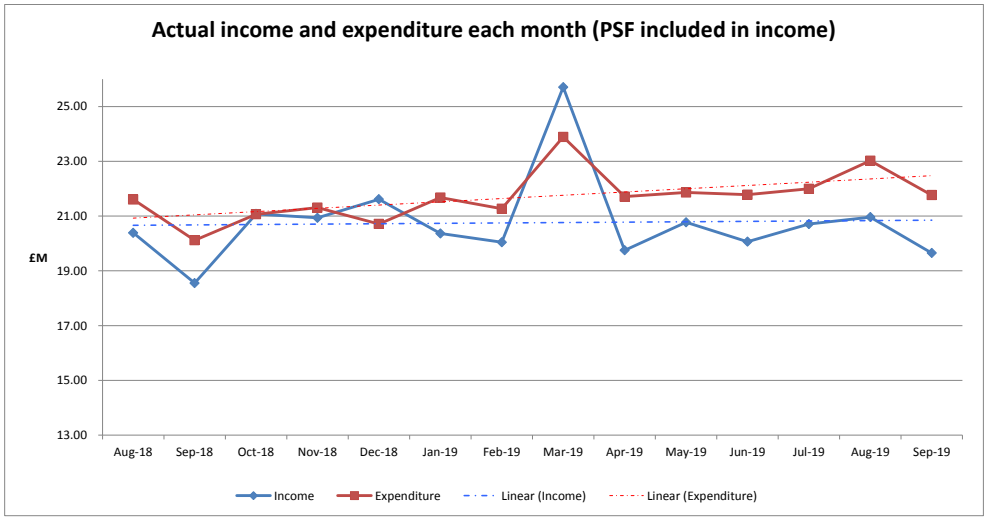
Our control total and plan is to break even in 2019-20, but the current position indicates a deficit of £10m after delivering a recovery plan of £1.8m. We therefore propose that we re-forecast to a deficit of £10.0m in 19-20.

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)	(7)	(1,312)	(1,305)	↑	Red
YTD surplus / (deficit)	(1,529)	(5,416)	(3,887)	↑	Red
Forecast surplus / (deficit)	9	9	0	↔	Red
EBITDA (excl STF) YTD	190	(4,279)	(4,469)	↑	Red
EBITDA (%)	0.1%	(3.4%)	(3.5%)	↑	Red
Clinical Income YTD	(103,681)	(103,828)	148	↓	Green
Non-Clinical Income YTD	(23,288)	(22,894)	(393)	↑	Amber
Pay YTD	84,410	86,494	(2,085)	↑	Red
Non-Pay YTD	44,087	45,644	(1,557)	↑	Red
CIP target YTD	4,755	4,628	(127)	↓	Amber



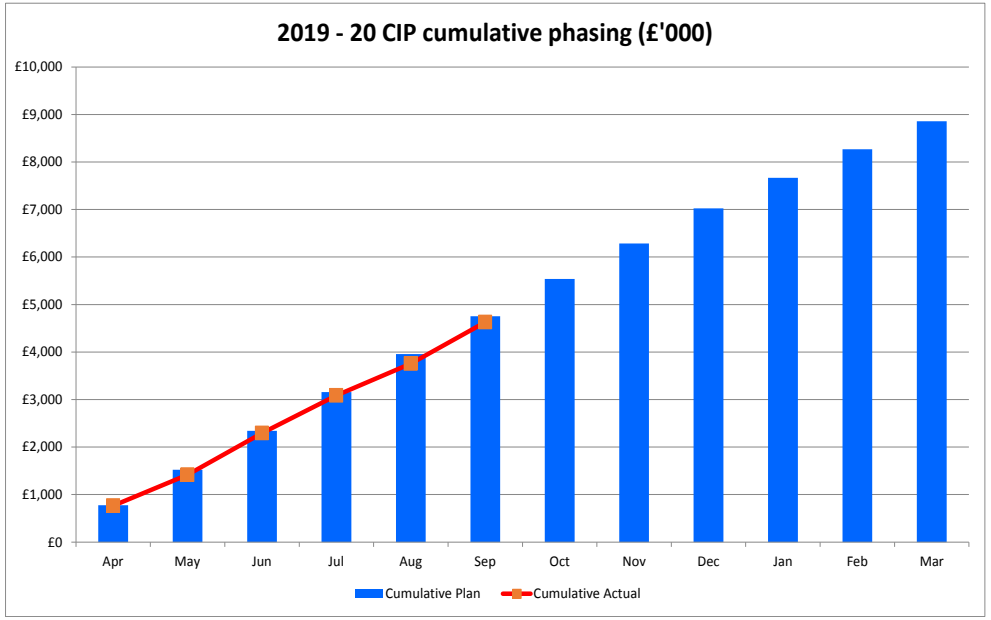


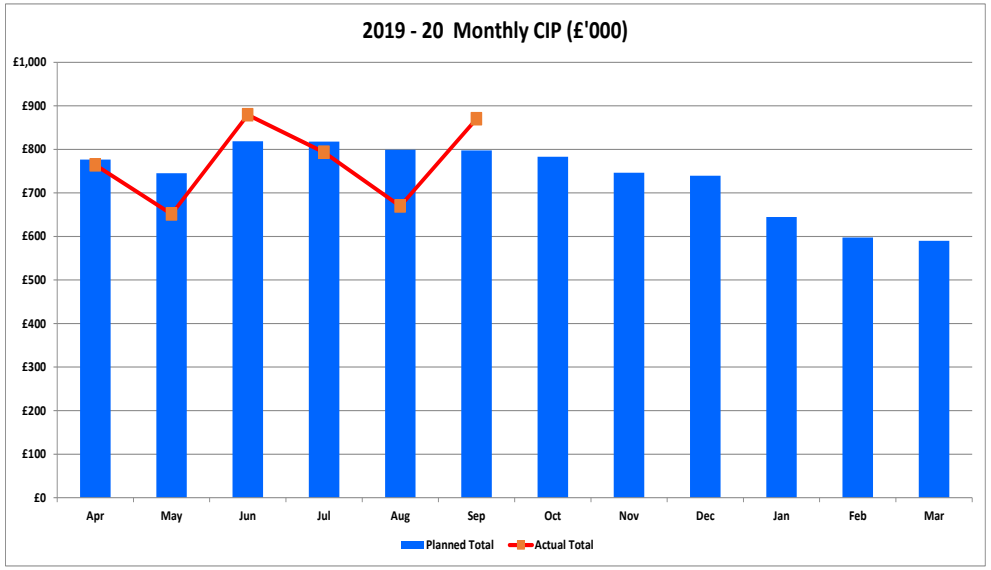


Cost Improvement Programme (CIP) 2019-20

In order to deliver the Trust's control target in 2019-20 we needed to deliver a CIP of £8.9m (4%). By September we planned to achieve £4,755k (53.7% of the annual plan) but achieved £4,628k (£127k behind plan, being 52.3%).

Recurring/Non Recurring	2019-20 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	100	50	44
Procurement	731	360	471
Activity growth	-	-	-
Additional sessions	15	8	0
Community Equipment Service	575	507	448
Drugs	1,840	1,124	1,131
Estates and Facilities	60	29	29
Other	1,344	402	569
Other Income	1,743	1,013	870
Pay controls	361	177	142
Service Review	20	7	-
Staffing Review	1,076	573	448
Theatre Efficiency	178	73	61
Recurring Total	**8,044**	**4,321**	**4,213**
Non-Recurring			
Estates and Facilities	87	51	-
Other	350	177	12
Pay controls	376	207	402
Non-Recurring Total	**812**	**434**	**415**
Grand Total	**8,856**	**4,755**	**4,628**





FINANCE AND WORKFORCE REPORT - SEPTEMBER 2019

2019-20 recovery plan

Each Clinical Division has presented recovery plans as summarised below. After risk adjusting, this recovery plan is anticipated to improve the position by around £1.8m. However, all these schemes are subject to the same governance that is in place for all other Cost Improvement Programmes, including Quality Impact Assessment and Project Management.

2019-20 Recovery Plan, by Division		£'000	£'000
Medicine	In place		
	Drug spend review	252	
	Review of neurophysiology charges	146	398
	To be implemented (risk adjusted)		
	ED and wards- reduce use of agency/bank nursing	126	
	Angio pacing stock take	100	
	Reduce medical locums and additional sessions	548	
	Reduce cardiac physiologist additional sessions	32	290
			688
Surgery	In place		
	Improve delivery of CIP	116	
	SAU limited to agreed facility	99	
	Vascular reduction	78	
	Urology Fibres	89	
	Stop plastic surgery locum	58	
	Reduce additional sessions to agreed budgets	134	575
	To be implemented (risk adjusted)		
	Vacancy freeze	25	
	Increase income Resus	25	
	Critical Care Drugs Review	25	
	Non pay controls	50	
	Travel costs reduction	25	54
			629
Womens and Childrens	In place		
	Addressing the backfill of Clinical Fellows	62	
	Control establishment/sickness on F1	108	170
	To be implemented (risk adjusted)		
	Change NNU staff mix	17	
	Change midwife to birth ratio to 1:31.5	181	
	Rationalise Community Midwifery visits	8	74
			244
Clinical Support Services	In place		
	Improvement in Diagnostic income	51	
	Obtain rebate for POCT Co-ordinator	21	
	Pharmacy turnover to mitigate pay overspends	84	
	Rationalise Chemical Pathology outpatients	20	
	Scanning Team to work within establishment	34	210
Total			1,771

A further £1.8m of proposals have been suggested and discussed at Scrutiny Committee but not included in the forecast since they require further discussion and may have a detrimental impact on quality and possibly safety.

- RTT - worsening by 1.5% would improve the forecast by £0.5m. These savings would be from temporary medical staff (locums and additional sessions).
- ED - reduce temporary medical staffing by 3 WTEs would improve the forecast by £0.35m. An assessment needs to be made for the impact on safety.
- Temporary Nursing - removing all agency and overtime expenditure would improve the forecast by £1m.

2019-20 forecast

2019-20 Forecast using year to M6 as a trend	£'000	£'000
September 2019 YTD loss (excl 1819 PSF of £280k)		5,696
Straight line forecast based on M1-6 (adjusted for income phasing)		10,107
Additional costs anticipated M7-12 (Newmarket and Winter)		1,650
Do nothing forecast		11,757
Recovery Plan (see table)		(1,771)
Forecast loss (before MRET, PSF/FRF funding)		9,986

Since our forecast includes £6m relating to over performance we are in discussion with WSCCG to pay towards this activity. Any funding received would improve the position.

Whilst we have outlined our recovery plan above, these savings are broadly the same as non-recurring costs that will be incurred in the second part of the year (specifically around the acquisition of Newmarket Hospital and Winter Pressures).

Therefore the forecast loss is £10.0m (without including MRET or 19-20 PSF/FRF).

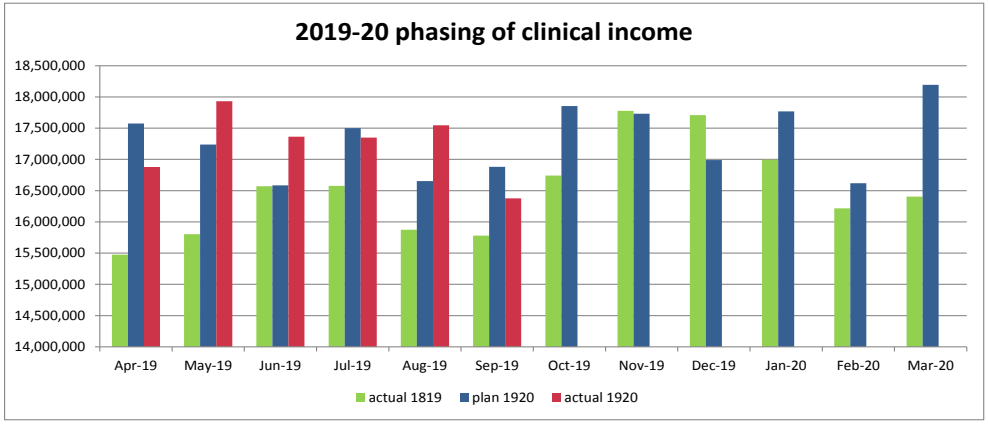
If we assume our failure to meet the control total will mean we will no longer receive the 19-20 PSF/FRF this loss becomes £7.5m YTD and we would forecast a total loss of £15.7m, (includes 18-19 PSF of £280k) with a trajectory as below :

	Adjusted financial performance surplus/(deficit) including MRET, excl PSF and FRF (incl 1819 PSF)			
Month	Initial Planned loss	Revised plan / forecast	Actual (incl MRET)	Cumulative Actuals
Apr-19	(1,331)		(803)	(803)
May-19	(203)		(934)	(1,737)
Jun-19	(890)		(1,197)	(2,934)
Jul-19	(104)		(1,053)	(3,986)
Aug-19	(928)		(1,809)	(5,795)
Sep-19	(617)		(1,709)	(7,504)
Oct-19	62	(1,068)		(8,572)
Nov-19	184	(914)		(9,486)
Dec-19	(753)	(1,789)		(11,275)
Jan-20	(101)	(1,097)		(12,372)
Feb-20	(1,314)	(2,297)		(14,669)
Mar-20	40	(997)		(15,665)
	(5,954)	(15,665)		

FINANCE AND WORKFORCE REPORT - SEPTEMBER 2019

Income Analysis

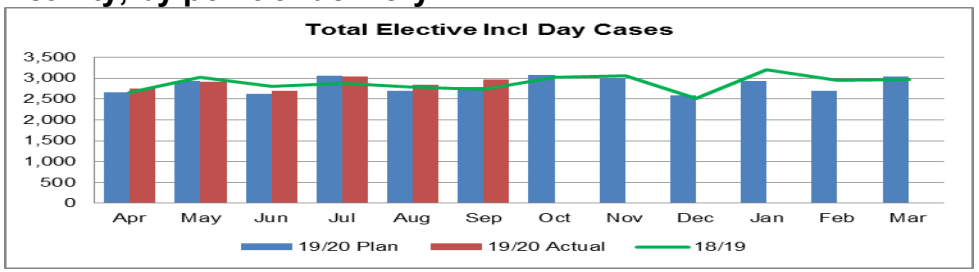
The chart below demonstrates the phasing of all clinical income plan for 2019-20, including Community Services. This phasing is in line with phasing of activity.

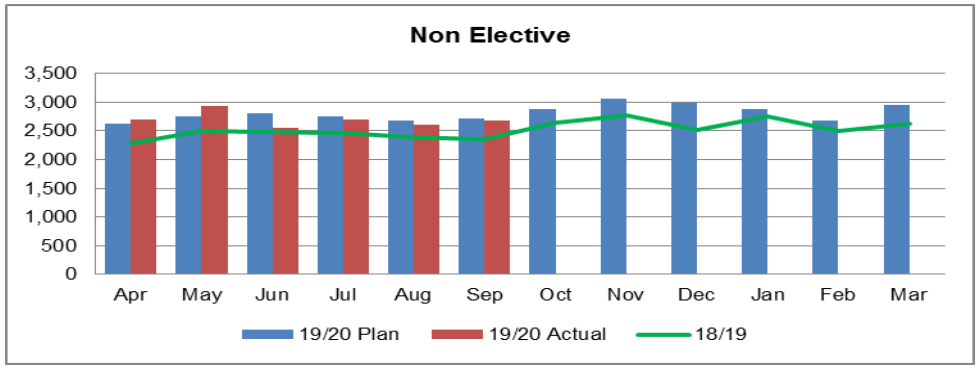


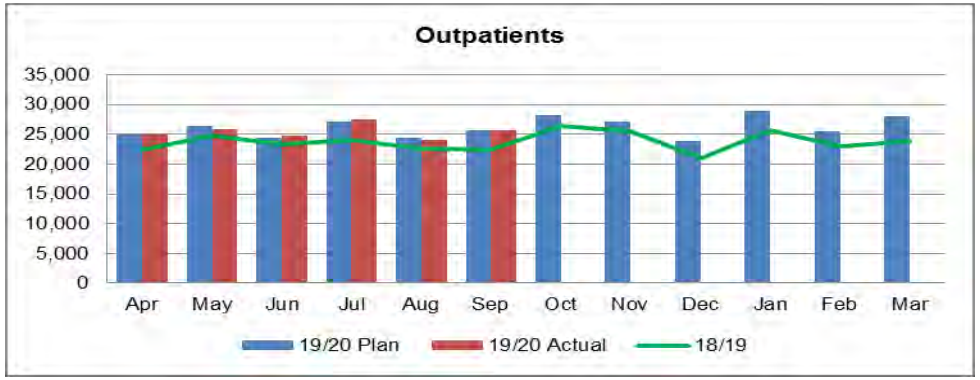
The income position was slightly behind plan for September. The main area of underperformance was within Other Service.

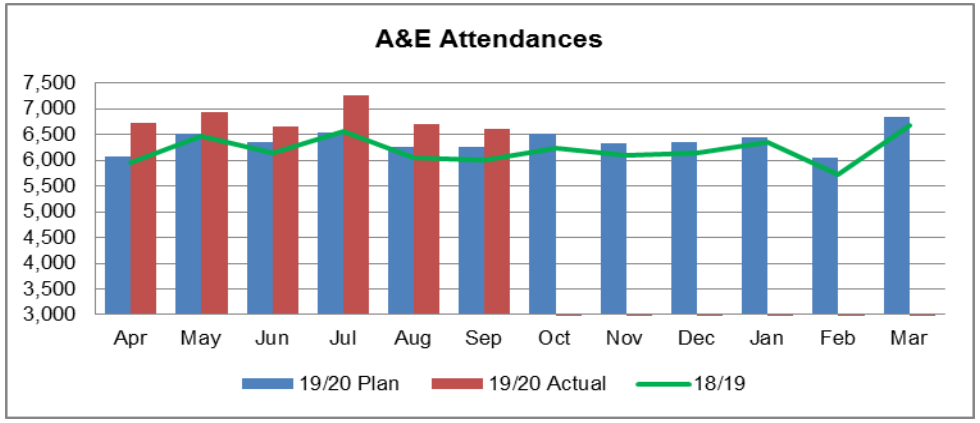
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	890	962	72	5,404	5,882	478
Other Services	631	311	(319)	8,637	8,706	68
CQUIN	169	173	4	1,015	1,015	(0)
Elective	2,773	2,806	33	16,574	16,124	(450)
Non Elective	6,051	6,169	117	36,356	36,424	68
Emergency Threshold Adjustment	(332)	(332)	0	(2,014)	(2,014)	0
Outpatients	3,086	3,137	50	18,382	18,402	20
Community	3,221	3,215	(6)	19,326	19,290	(36)
Total	**16,490**	**16,440**	**(50)**	**103,681**	**103,828**	**148**

Activity, by point of delivery

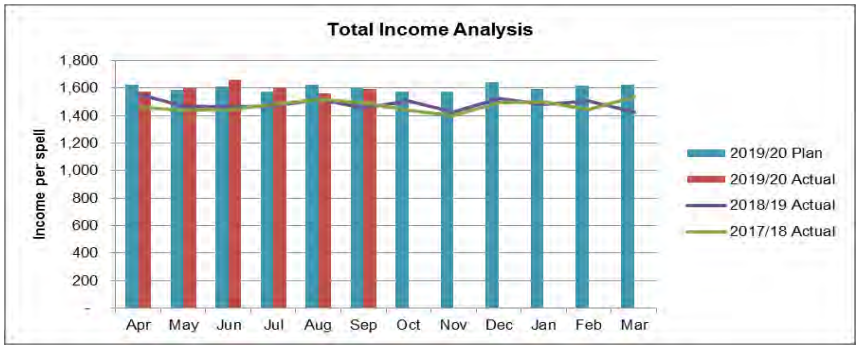


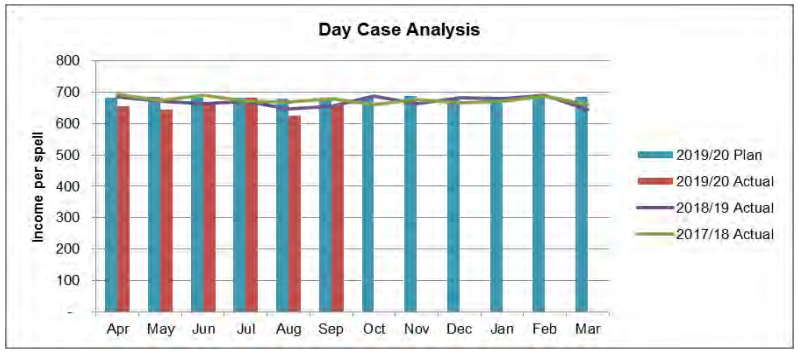


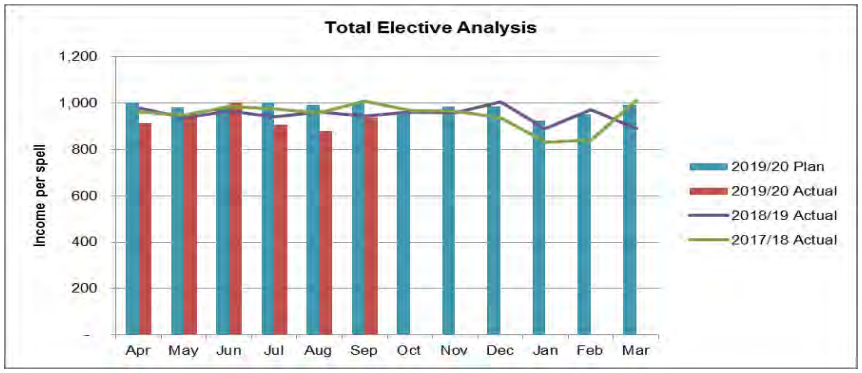


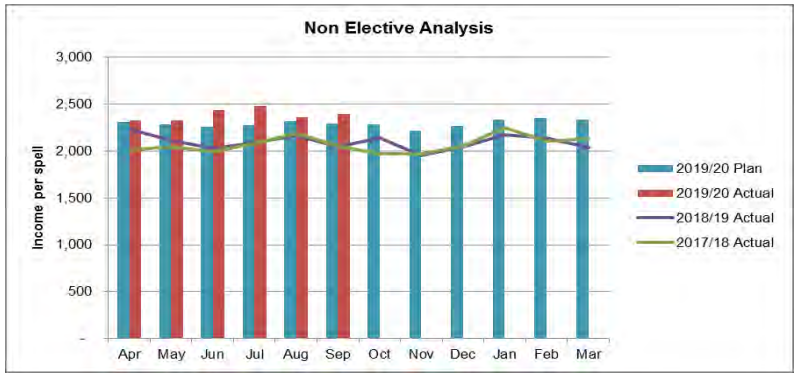


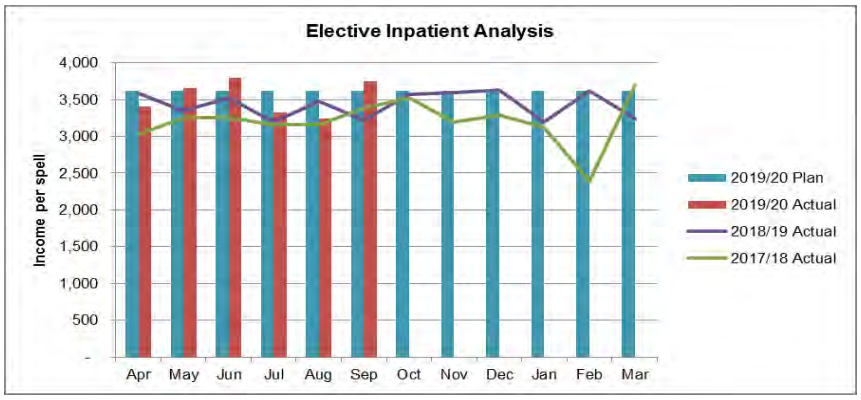
Trends and Analysis

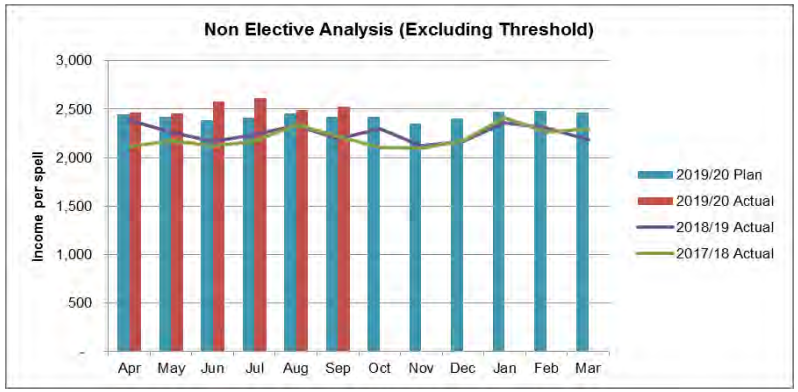












FINANCE AND WORKFORCE REPORT - SEPTEMBER 2019

Workforce

Monthly Expenditure (£) Acute services only				
As at September 2019	Sep-19	Aug-19	Sep-18	YTD 2019/20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**12,459**	**12,415**	**11,691**	**74,194**
Substantive Staff	11,497	11,186	10,452	66,908
Medical Agency Staff (includes 'contracted in' staff)	187	201	185	901
Medical Locum Staff	288	399	210	1,632
Additional Medical sessions	231	331	248	1,654
Nursing Agency Staff	147	180	87	944
Nursing Bank Staff	269	242	372	1,625
Other Agency Staff	70	79	99	432
Other Bank Staff	134	162	150	863
Overtime	103	144	111	966
On Call	77	69	56	419
Total temporary expenditure	1,505	1,807	1,518	9,436
Total expenditure on pay	**13,002**	**12,993**	**11,970**	**76,344**
Variance (F/(A))	(543)	(578)	(279)	(2,151)
Temp Staff costs % of Total Pay	11.6%	13.9%	12.7%	12.4%
Memo : Total agency spend in month	404	460	371	2,278

Monthly Whole Time Equivalents (WTE) Acute Services only			
As at September 2019	Sep-19	Aug-19	Sep-18
	WTE	WTE	WTE
Budgeted WTE in month	**3,342.4**	**3,323.4**	**3,142.7**
Employed substantive WTE in month	3053.57	3023.43	2789.32
Medical Agency Staff (includes 'contracted in' staff)	11.32	11.97	16.78
Medical Locum	28.91	35.02	19.15
Additional Sessions	20.86	24.57	21.5
Nursing Agency	86.48	25.28	16.95
Nursing Bank	15.01	77.42	86.1
Other Agency	60.99	19.47	10.9
Other Bank	16.71	72.73	74.58
Overtime	29.89	38.36	31.39
On call Worked	7.35	6.69	6.65
Total equivalent temporary WTE	**277.5**	**311.5**	**284.0**
Total equivalent employed WTE	**3,331.1**	**3,334.9**	**3,073.3**
Variance (F/(A))	11.3	(11.5)	69.3
Temp Staff WTE % of Total Pay	8.3%	9.3%	9.2%
Memo : Total agency WTE in month	158.8	56.7	44.6
Sickness Rates (August/July)	3.37%	3.62%	3.86%
Mat Leave	2.17%	2.54%	2.89%

Monthly Expenditure (£) Community Service Only				
As at September 2019	Sep-19	Aug-19	Sep-18	YTD 2019-20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,703**	**1,703**	**1,633**	**10,216**
Substantive Staff	1,677	1,607	1,499	9,647
Medical Agency Staff (includes 'contracted in' staff)	8	12	14	63
Medical Locum Staff	3	3	3	27
Additional Medical sessions	0	2	1	7
Nursing Agency Staff	11	23	3	107
Nursing Bank Staff	25	21	23	169
Other Agency Staff	9	12	(18)	28
Other Bank Staff	9	9	10	41
Overtime	5	7	7	40
On Call	5	3	3	22
Total temporary expenditure	76	93	47	503
Total expenditure on pay	**1,754**	**1,700**	**1,545**	**10,150**
Variance (F/(A))	(51)	2	88	66
Temp Staff costs % of Total Pay	4.4%	5.5%	3.0%	5.0%
Memo : Total agency spend in month	29	47	0	198

Monthly Whole Time Equivalents (WTE) Community Services Only			
As at September 2019	Sep-19	Aug-19	Sep-18
	WTE	WTE	WTE
Budgeted WTE in month	**528.75**	**528.7**	**486.93**
Employed substantive WTE in month	497.31	489.72	463.71
Medical Agency Staff (includes 'contracted in' staff)	0.54	0.74	0.92
Medical Locum	0.35	0.35	0.35
Additional Sessions	0.00	0.00	0.00
Nursing Agency	1.55	3.29	1.30
Nursing Bank	7.83	6.90	5.56
Other Agency	3.85	4.97	2.67
Other Bank	2.09	2.41	3.90
Overtime	1.40	2.20	1.94
On call Worked	0.06	0.02	0.00
Total equivalent temporary WTE	**17.7**	**20.9**	**16.6**
Total equivalent employed WTE	**515.0**	**510.6**	**480.4**
Variance (F/(A))	13.77	18.10	6.58
Temp Staff WTE % of Total Pay	3.4%	4.1%	3.5%
Memo : Total agency WTE in month	5.9	9.0	4.9
Sickness Rates (August/July)	3.22%	3.69%	3.85%
Mat Leave	2.46%	2.49%	3.38%

Pay Trends and Analysis

Nursing – Staffing levels

The tables below compare actual registered and unregistered nursing within ward based and non-ward based services between April 2018 and September 2019.

It should be noted that during 2018 bay based nursing was introduced which created around 45 unregistered posts and reduced the establishment for registered nursing. Whilst the mix of staff will have changed the total numbers should remain much the same (if there has been no increase in beds). However, over the last 18 months there has been a total increase in nursing of 59.15 WTEs in ward based areas.

	Sept 18 to Sept 19			April 18 to September 19		
Nursing WTE Actual Increase / (Decrease)	**Ward Based**	**Non Ward Based**	**Total**	**Ward Based**	**Non Ward Based**	**Total**
Registered	40.11	43.30	**83.41**	1.97	39.66	**41.63**
Unregistered	50.73	11.49	**62.22**	57.18	16.00	**73.18**
Total	90.84	54.79	**145.63**	59.15	55.66	**114.81**

	Sept 18 to Sept 19		
Nursing WTE % Increase / (Decrease)	**Ward Based**	**Non Ward Based**	**Total**
Registered	11.0%	6.6%	**8.2%**
Unregistered	15.2%	6.3%	**12.1%**
Total	13.0%	6.5%	**9.5%**

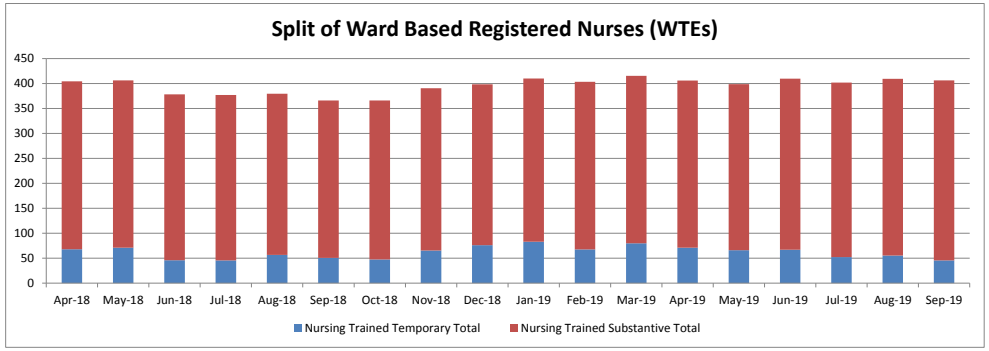
Due to increasing bed capacity the next table compares ward based nursing WTEs with average beds open in each month to demonstrate whether the increase in staffing is in line with growth in capacity. Looking at the total increase in nursing negates changes associated with the implementation of bay based nursing. It can be seen that the ratio of total nurses to beds has increased from 1.61 WTE per bed to 1.77 WTE, an increase of 5.4%.

WTEs incl A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19	Jul-18	Jul-19	Aug-18	Aug-19	Sep-18	Sep-19	
Average Beds (midnight count)	445	462	432	458	430	467	438	473	419	450	416	446	incl GC
Registered WTEs	404	406	406	399	378	410	377	402	380	409	366	406	
Unregistered WTEs	313	354	286	363	297	368	302	372	310	370	333	384	
Total	717	760	692	762	675	778	679	774	690	779	699	790	

All wards incl A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19	Jul-18	Jul-19	Aug-18	Aug-19	Sep-18	Sep-19	yr on yr
Registered per bed (incl Agency)	0.91	0.88	0.94	0.87	0.88	0.88	0.86	0.85	0.91	0.91	0.88	0.91	103.5%
Unregistered per bed	0.70	0.77	0.66	0.79	0.69	0.79	0.69	0.79	0.74	0.82	0.80	0.86	107.5%
Total Nursing per bed	1.61	1.64	1.60	1.66	1.57	1.67	1.55	1.64	1.65	1.73	1.68	1.77	105.4%

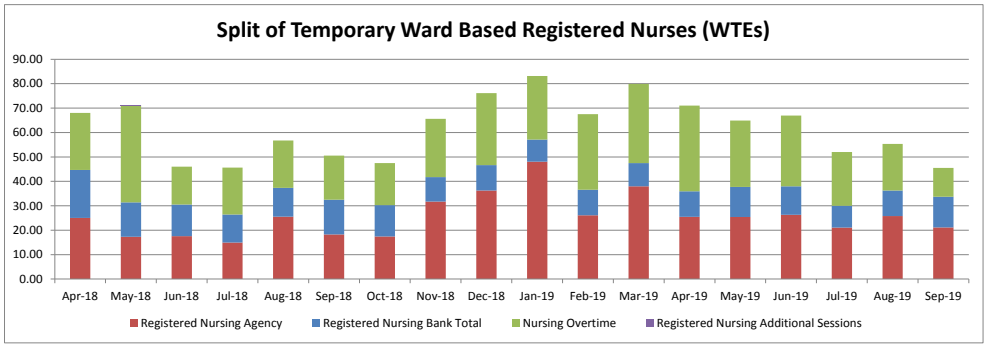
Excluding A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19	Jul-18	Jul-19	Aug-18	Aug-19	Sep-18	Sep-19	yr on yr
Registered per bed (incl Agency)	0.76	0.73	0.79	0.74	0.75	0.73	0.72	0.71	0.76	0.76	0.74	0.76	102.4%
Unregistered per bed	0.65	0.72	0.61	0.74	0.64	0.73	0.64	0.73	0.69	0.77	0.75	0.81	107.7%
Total Nursing per bed	1.42	1.46	1.43	1.49	1.37	1.49	1.35	1.45	1.46	1.53	1.48	1.57	105.6%

Excluding escalation areas there were 72.3 WTE vacancies at the end of September 2019. The tables below demonstrate the split between substantive and non-substantive nurses in ward based areas and how these were filled, as well as a table demonstrating the net vacancies after filling vacancies with temporary staff.

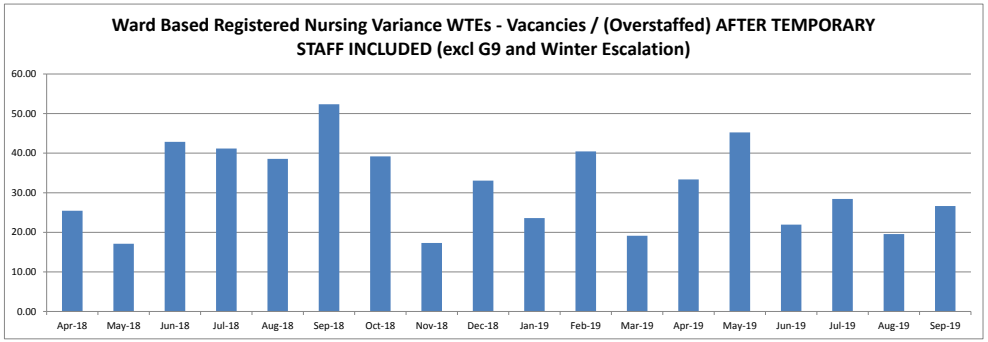


We used 45.6 temporary WTEs to fill the majority of vacant posts during September (55.5 in August).

FINANCE AND WORKFORCE REPORT - SEPTEMBER 2019



However, after using temporary nursing staff there remained 26.6 WTE uncovered Ward Based Registered Nursing Vacancies during September 2019 (19.6 WTE as at August 2019)



Ward Based Registered Nurses were under established by 26.6 WTE during September after utilising temporary registered nurses, broken down as below :

Division	Ward Area	Sum of plan august 19	Sum of Actual august 19	NET vacancies (over / (under)) August 19	Sum of plan september 19	Sum of Actual september 19	NET vacancies (over / (under)) September 19
Medical Services	A&E Medical Staff	6.12	7.01	0.89	6.12	7.27	1.15
	Accident & Emergency	64.46	62.46	(2.00)	64.46	60.44	(4.02)
	C.C.U.	0	0	0.00	0	0	0.00
	Ward F9	20.85	19.32	(1.53)	20.85	18.38	(2.47)
	Ward F12	11.27	10.23	(1.04)	11.27	9.88	(1.39)
	Ward G1 Hardwick Unit	23.74	20.7	(3.04)	23.74	21.02	(2.72)
	Cardiac Ward	16.9	18.07	1.17	16.9	21.32	4.42
	Ward G4	19.78	16.66	(3.12)	19.78	17.28	(2.50)
	Ward G5	18.93	18.31	(0.62)	18.93	17.86	(1.07)
	Ward G8	24.62	21.45	(3.17)	24.62	20.33	(4.29)
	Medical Treatment Unit	7.04	7.13	0.09	7.04	7.62	0.58
	Respiratory Ward	20.69	21.77	1.08	20.69	20.19	(0.50)
	Cardiac Centre	40.14	34.65	(5.49)	40.14	35.33	(4.81)
	AAU	20.96	19.28	(1.68)	27.3	21.36	(5.94)
	Ward F7 Short Stay	22.66	23.61	0.95	22.66	24.23	1.57
Medical Services Total		318.16	300.65	(17.51)	324.5	302.51	(21.99)
Surgical Services	Ward F3	19.57	17.99	(1.58)	19.57	17.41	(2.16)
	Ward F4	13.78	11.51	(2.27)	13.78	11.88	(1.90)
	Ward F5	19.59	20.5	0.91	19.59	20.28	0.69
	Ward F6	19.57	19.04	(0.53)	19.57	21.53	1.96
Surgical Services Total		72.51	69.04	(3.47)	72.51	71.1	(1.41)
Woman & Children S	Gynae Ward (On F14)	11.18	12.79	1.61	11.18	10	(1.18)
Woman & Children Services Total		11.18	12.79	1.61	11.18	10	(1.18)
Community	Newmarket Hosp-Rosemary ward	12.43	12.62	0.19	12.43	11.19	(1.24)
	Community - Glastonbury Court	11.69	11.3	(0.39)	11.69	10.88	(0.81)
Community Total		24.12	23.92	(0.20)	24.12	22.07	(2.05)
Grand Total		**425.97**	**406.4**	**(19.57)**	**432.31**	**405.68**	**(26.63)**

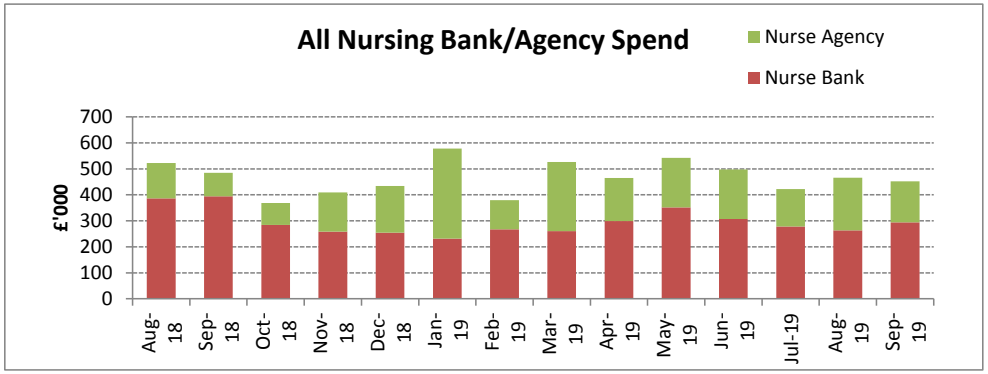
Ward Based Unregistered Nurses were over established by 41.83 WTE during September after utilising temporary unregistered nurses, broken down as below :

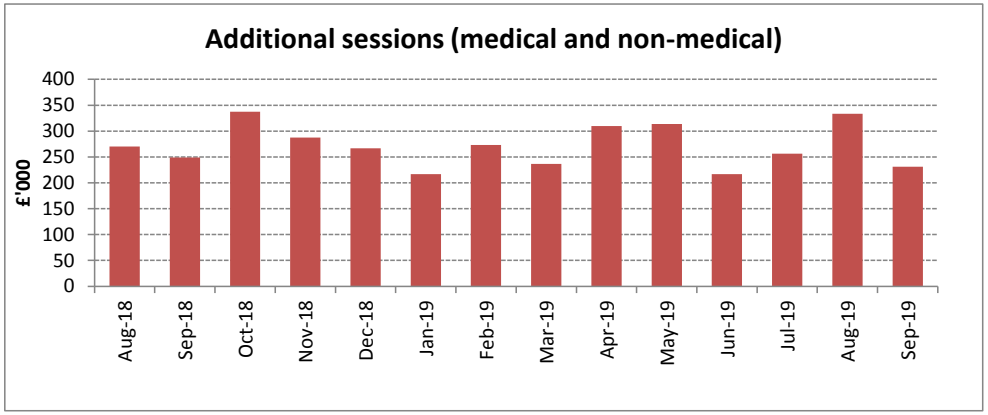
Division	Ward Area	Sum of plan august 19	Sum of Actual august 19	NET vacancies (over / (under)) August 19	Sum of plan september 19	Sum of Actual september 19	NET vacancies (over / (under)) September 19
Medical Services	Accident & Emergency	26.51	24.2	(2.31)	26.51	24.47	(2.04)
	C.C.U.	0	0	0.00	0	0	0.00
	Ward F9	23.18	24.71	1.53	23.18	26.2	3.02
	Ward F12	5.15	6.71	1.56	5.15	6.6	1.45
	Ward G1 Hardwick Unit	9.01	9.64	0.63	9.01	12.41	3.40
	Cardiac Ward	18.6	23.05	4.45	18.6	21.85	3.25
	Ward G4	25.03	28.72	3.69	25.03	29.38	4.35
	Ward G5	23.18	24.69	1.51	23.18	27.4	4.22
	Ward G8	25.13	26.6	1.47	25.13	29.77	4.64
	Ward G9 Escalation Ward	0	4.79	4.79	0	4.75	4.75
	Respiratory Ward	21.13	19.85	(1.28)	21.13	22.86	1.73
	Cardiac Centre	15.2	18.42	3.22	15.2	19.14	3.94
	AAU	25.51	29.98	4.47	29.8	29.91	0.11
	Ward F7 Short Stay	31.94	28.81	(3.13)	31.94	29.27	(2.67)
Medical Services Total		249.57	270.17	20.60	253.86	284.01	30.15
Surgical Services	Ward F3	22.26	25.02	2.76	22.26	25.97	3.71
	Ward F4	9.61	9.59	(0.02)	9.61	9.09	(0.52)
	Ward F5	14.51	15.65	1.14	14.51	14.71	0.20
	Ward F6	14.51	17.56	3.05	14.51	16.73	2.22
Surgical Services Total		60.89	67.82	6.93	60.89	66.5	5.61
Woman & Children Ser	Gynae Ward (On F14)	1	4.41	3.41	1	4.78	3.78
Woman & Children Services Total		1	4.41	3.41	1	4.78	3.78
Community	Newmarket Hosp-Rosemary ward	13.47	13.49	0.02	13.47	15.11	1.64
	Community - Glastonbury Court	12.64	14.04	1.40	12.64	13.29	0.65
Community Total		26.11	27.53	1.42	26.11	28.4	2.29
Grand Total		**337.57**	**369.93**	**32.36**	**341.86**	**383.69**	**41.83**

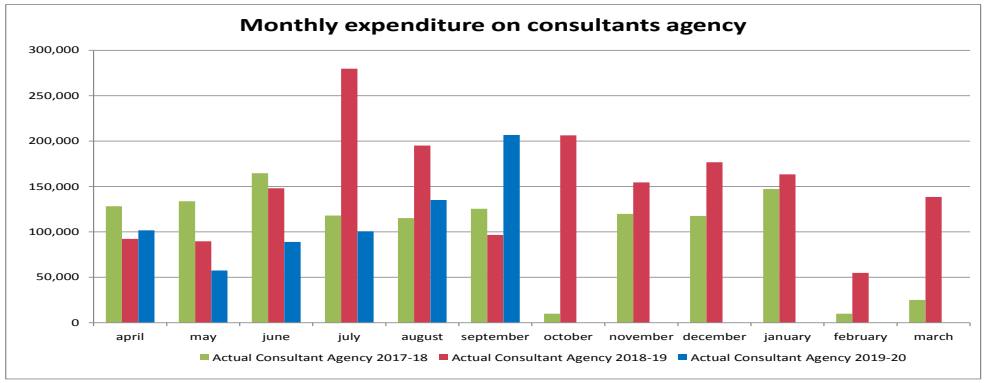
FINANCE AND WORKFORCE REPORT - SEPTEMBER 2019

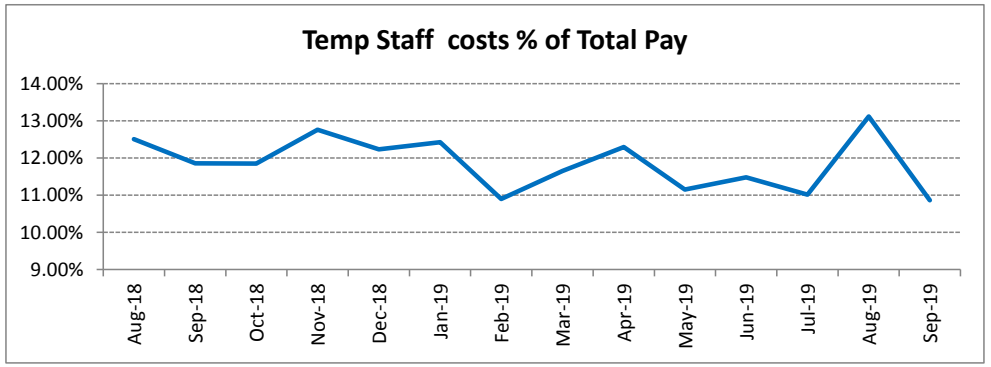
Pay Costs and Analysis

The Trust has overspent £594k on pay during September (£2.1m YTD).

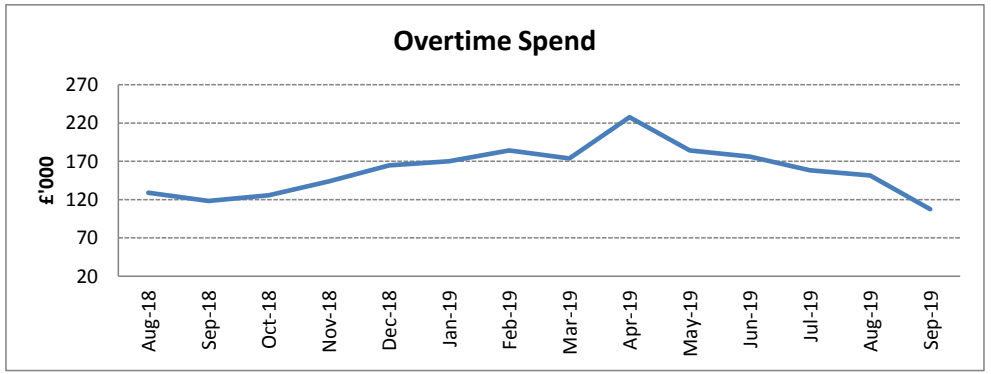








Overtime costs are falling as a result of an initiative to replace planned overtime with bank shifts (that do not attract the overtime premium).



FINANCE AND WORKFORCE REPORT - SEPTEMBER 2019

Summary by Division

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS (NET CONTRIBUTION) - September 2019

DIVISIONAL INCOME AND EXPENDITURE ACCOUNTS	Current Month Budget £k	Current Month Actual £k	Current Month Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	(6,879)	(6,981)	102	(42,594)	(43,044)	450
Pay Costs	3,976	4,281	(305)	23,653	24,573	(920)
Non-pay Costs	1,637	1,529	109	9,313	9,240	73
Operating Expenditure	**5,613**	**5,810**	**(197)**	**32,966**	**33,813**	**(847)**
SURPLUS / (DEFICIT)	**1,266**	**1,171**	**(94)**	**9,628**	**9,231**	**(397)**
SURGERY						
Total Income	(4,589)	(4,496)	(93)	(30,623)	(30,500)	(123)
Pay Costs	3,041	3,306	(264)	18,304	18,767	(463)
Non-pay Costs	1,200	1,143	57	6,946	6,703	243
Operating Expenditure	**4,241**	**4,449**	**(208)**	**25,250**	**25,469**	**(219)**
SURPLUS / (DEFICIT)	**348**	**47**	**(301)**	**5,373**	**5,031**	**(342)**
WOMENS and CHILDRENS						
Total Income	(1,918)	(2,000)	81	(11,721)	(11,727)	6
Pay Costs	1,203	1,330	(127)	7,181	7,579	(397)
Non-pay Costs	147	154	(7)	907	834	73
Operating Expenditure	**1,350**	**1,484**	**(134)**	**8,088**	**8,412**	**(324)**
SURPLUS / (DEFICIT)	**568**	**515**	**(53)**	**3,633**	**3,315**	**(319)**
CLINICAL SUPPORT						
Total Income	(841)	(770)	(71)	(5,008)	(5,039)	31
Pay Costs	1,526	1,543	(17)	9,074	8,999	75
Non-pay Costs	1,021	1,271	(250)	6,104	6,735	(631)
Operating Expenditure	**2,547**	**2,814**	**(267)**	**15,178**	**15,734**	**(556)**
SURPLUS / (DEFICIT)	**(1,706)**	**(2,044)**	**(338)**	**(10,170)**	**(10,695)**	**(525)**
COMMUNITY SERVICES						
Total Income	(2,550)	(2,571)	21	(16,402)	(16,434)	32
Pay Costs	2,307	2,351	(45)	13,736	13,722	14
Non-pay Costs	987	1,202	(216)	5,868	6,603	(735)
Operating Expenditure	**3,294**	**3,554**	**(260)**	**19,604**	**20,325**	**(721)**
SURPLUS / (DEFICIT)	**(744)**	**(983)**	**(239)**	**(3,202)**	**(3,891)**	**(689)**
ESTATES and FACILITIES						
Total Income	(404)	(386)	(18)	(2,423)	(2,303)	(120)
Pay Costs	874	885	(11)	5,244	5,236	7
Non-pay Costs	585	538	46	3,508	3,654	(146)
Operating Expenditure	**1,459**	**1,423**	**36**	**8,752**	**8,890**	**(139)**
SURPLUS / (DEFICIT)	**(1,055)**	**(1,037)**	**18**	**(6,328)**	**(6,587)**	**(259)**
CORPORATE (excl Reserves)						
Total Income	(3,412)	(3,249)	(163)	(18,347)	(17,676)	(671)
Pay Costs	1,235	1,060	175	7,218	7,620	(402)
Non-pay Costs (net of Contingency and Reserves)	(120)	298	(417)	5,710	6,295	(585)
Finance & Capital	980	873	107	5,882	5,581	302
Operating Expenditure	**2,096**	**2,231**	**(135)**	**18,810**	**19,495**	**(685)**
SURPLUS / (DEFICIT)	**1,316**	**1,018**	**(298)**	**(462)**	**(1,819)**	**(1,356)**
TOTAL						
Total Income	(20,593)	(20,452)	(141)	(127,118)	(126,723)	(395)
Pay Costs	14,162	14,756	(594)	84,410	86,494	(2,085)
Non-pay Costs	5,458	6,136	(678)	38,355	40,064	(1,709)
Finance & Capital	980	873	107	5,882	5,581	302
Operating Expenditure	**20,600**	**21,765**	**(1,165)**	**128,647**	**132,139**	**(3,492)**
SURPLUS / (DEFICIT)	**(7)**	**(1,312)**	**(1,305)**	**(1,529)**	**(5,416)**	**(3,887)**

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).

Page 12

Medicine (Nicola Cottington)

The division reported an adverse variance of £94k in September (£397k YTD).

Pay overspent by £305k in month. A large part of this was the in-month payment of £113k in respect of M1-6 back pay for the medical staffing pay increase.

Temporary recruitment and the need to improve and/or maintain RTT positions affected both Dermatology and Gastroenterology in month. Gastro saw a marginal improvement in RTT (from 85.97% to 86.36% in month) whilst Dermatology maintained their position above 92%. Both departments have been successful in recruiting to substantive positions so it is anticipated that the expenditure on locums will reduce in the coming months.

It should be noted that although ED recorded £78k variance above plan in month, this represents a significant reduction in temporary medical staffing hours by 33% in September compared to August whilst still coping with increased activity against both prior year and plan (10% and 14% respectively).

The non-pay budget is £109k underspent in month. This is driven by the continued underspend on Drugs (£103k in month, £219k YTD).

Medicine Division is forecasting a £2.0m overspend for this financial year. The division is focusing on delivering its financial recovery plan and is working through schemes with reference to non-financial risks to ensure that patient safety and quality is not compromised.

Surgery (Simon Taylor)

The division reported an adverse variance of £301k in September (£342k YTD).

Income underachieved by £93k in month (£14k YTD). Critical Care continues to be above plan and we are working to understand this sustained increase in activity. Private patient income continues to be significantly below last year.

Pay reported a £264k overspend in the month and £463k YTD. £154k of the over spend relates to medical pay awards that has been back dated until the 1st April. Temporary Nursing and Medical locums continue to cause a significant cost pressure across surgery.

Non pay reported a £57k underspend in month (£243k YTD). However, this underspend is not anticipated to continue due to a planned increase in Orthopaedic procedures.

Surgery's forecast is for an adverse variance of £1.8m. This includes significant forecasted increase in anaesthetics costs and the division is working with the service to limit this unavoidable cost pressure.

The division has set up robust monitoring of additional sessions and is also changing non pay ordering to require more scrutiny.

Women and Children's (Rose Smith)
The division reports an adverse variance of £53k in September (£319k YTD).

Income reported £81k ahead of plan in-month, (£6k YTD). In-month inpatient and outpatient activity was above plan which more than offset the lower activity seen in the neonatal unit. Year to date, non-elective and neonatal activity have consistently been behind plan.

Pay reported a £127k overspend in-month, (£397k YTD) and it is forecast to overspend by £704k. In-month, £72k of the overspend relates to the medical pay award, £28k relates to medical staffing gaps in Paediatrics and £20k relates to RTT and tier two rota gaps in Obstetrics and Gynaecology. The paediatric department have successfully recruited a tier two doctor which will help to reduce the gaps requiring cover on the rota.

Non-pay reported a £7k overspend in-month, (£73k underspend YTD). Year to date, the underspend in this area reflects the low non-elective activity.

Clinical Support (Rose Smith)
The division reported an adverse variance of £338k in September (£525k YTD).

Income for Clinical Support reported £71k behind plan in-month, (£31k ahead of plan YTD) and forecast to be £58k behind plan.

Pay reported a £17k overspend in-month, (£75k underspend YTD) and is forecast to underspend by £25k. The cost pressure from the medical pay award was offset by vacancy gaps in Outpatients. YTD the vacancy gaps in Outpatients and Pharmacy staffing have more than offset the pay pressures experienced from the high levels of demand experienced by Radiology. The Outpatient service is holding vacancies as part of the Division's financial recovery plan.

Non-pay reported a £250k overspend in-month, (£631k overspent YTD) and is forecast to overspend by £1,366k. In month averse variances were :

- £64k of cost pressures in Radiology from Sunday endoscopy sessions, out of hours reporting and consumables.
- Pathology experienced £70k of in month cost pressures from the 2019/20 NEESPS contract, Point of Care Testing and blood products.
- Pharmacy quarterly adjustment for un-invoiced stock of £69k and
- the Trust continues to send a high volume of patient letters that was reflected in a £31k overspend against the budget.

Year to date, the demand related pressures in Radiology and the 2019-20 pathology contract have put pressure on the Division's non-pay budget. The Division is holding a CIP workshop in November to help mitigate these.

Community Services and Integrated Therapies (Michelle Glass)
The division reported an adverse variance of £239k in September (£689k YTD).

Income reported a £21k over recovery in month. The year to date income position has improved to a favourable variance of £32k.

In-month over spend on pay of £45k, following the payment of non-recurrent pay arrears of £50k. Whilst the Division continue to use agency staff to cover vacancies across Integrated Therapy Services in order to meet demand, ensure service resilience and to support patient flow, these costs continue to be managed within the Division's pay budget.

Non-pay reported an adverse variance of £216k in September, (£721k YTD). The cost of providing wheelchair equipment has continued to increase due to additional activity, as well as costs to enable improvements in IT infrastructure to support mobile working for clinicians. The year to date position also reflects increased expenditure on Community Equipment required to support patients at home, in the community and to support timely discharge from the hospital. For example, to support Pathway One, equipment is allocated early on, and there has been a marked increase in the number of requests for same day delivery to support this. The budget is profiled to anticipate higher spend on CES in the second half of the financial year, so we do not anticipate significant further escalation of cost pressures due to additional demand through the winter.

Due to the ongoing demand and cost pressures faced by the Division, a Budget Recovery Plan has been prepared which aims to improve the outturn position for the Division in 2019/20 , without adversely impacting patient care. The Recovery Plan includes further schemes that would enable opportunity for recovery, cost avoidance and additional income collection.

Use of resources 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.

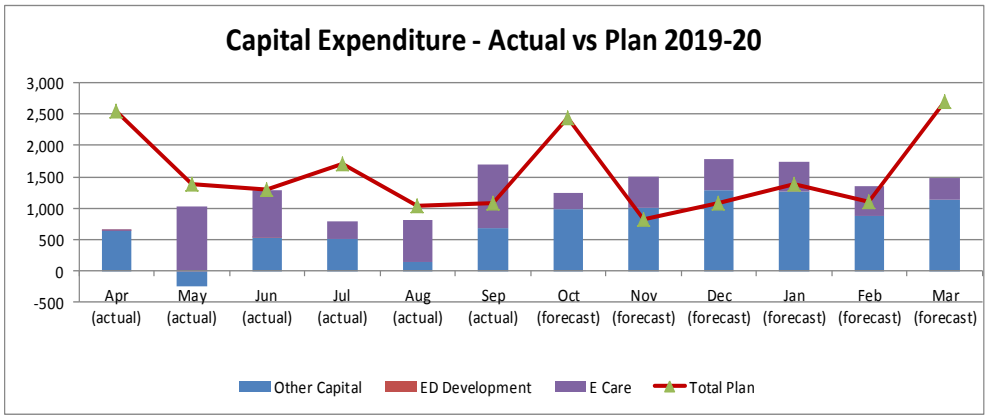
Metric	Value	Score	Plan
Capital Service Capacity rating	0.3	4	4
Liquidity rating	-41.6	4	4
I&E Margin rating	-6.2%	4	2
I&E Margin Variance rating	-4.6%	4	1
Agency	-5.0%	1	1
Use of Resources Rating after Overrides		3	3

The Trust is scoring an overall UoR of 3 this month, which is consistent with previous months.

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.

The Trust's revenue position for 2019/20 will need to improve to a significant surplus in order to be able to repay borrowing due and fund the planned capital programme without further borrowing.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2019-20 £'000
E Care	34	1,019	743	290	679	1,018	261	481	493	472	470	353	6,310
ED Development	0	0	0	0	0	0	0	0	0	0	0	0	1
Other Schemes	636	-242	534	512	138	682	992	1,017	1,284	1,273	886	1,132	8,844
Total / Forecast	**670**	**777**	**1,277**	**802**	**817**	**1,700**	**1,253**	**1,497**	**1,777**	**1,745**	**1,356**	**1,485**	**15,155**
Total Plan	**2,560**	**1,385**	**1,305**	**1,710**	**1,050**	**1,075**	**2,434**	**815**	**1,075**	**1,380**	**1,101**	**2,702**	**18,592**

The initial capital budget for the year was approved at the Trust Board Meeting on 26 April as part of the operational plan approval.

The capital programme for the year is shown in the graph above. The ED transformation scheme has now been approved subject to Full Business Case approval for £14.9m less £1.5m for an anticipated asset sale. This scheme is shown separately in the table above. It is now due to commence in 2020/21.

The Trust is awaiting final confirmation of a capital loan to support the capital programme. For this reason many of the estates projects are held awaiting this approval. The forecast assumes the position without the loan. Until this loan is approved the minimum level of estates capital to support ongoing projects is being undertaken.

As the larger estate schemes have not started there are no material variances on the schemes. E-care expenditure continues to be spent. This is still within forecast but this position is getting tighter.

As reported previously the NHS Capital Budget is insufficient to fund all capital programmes and across our STP we have been asked to reduce our Capital programme by 20%. This has resulted in a reduction to our programme of £3.7m (to £14.9m). Although this decision has been partly reversed it still applies to those organisations that are supporting their capital programme with loan funding. Therefore the reduction still applies to WSFT. The difference between £14.9m and the forecast relates to donated assets and the energy efficient lighting scheme as these are funded though different funding streams (ie MyWish Charity and Salix)

This means that the current capital programme is quite tight with no slack for any significant urgent capital requirements.

FINANCE AND WORKFORCE REPORT - SEPTEMBER 2019

Statement of Financial Position at 30th September 2019

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2019	Plan 31 March 2020	Plan YTD 30 September 2019	Actual at 30 September 2019	Variance YTD 30 September 2019
	£000	£000	£000	£000	£000
Intangible assets	33,970	35,940	34,936	34,911	(25)
Property, plant and equipment	103,223	115,395	112,563	113,261	698
Trade and other receivables	5,054	4,425	4,425	5,054	629
Other financial assets	0	0	0	0	0
Total non-current assets	**142,247**	**155,760**	**151,924**	**153,226**	**1,302**
Inventories	2,698	2,700	2,700	2,715	15
Trade and other receivables	22,119	20,000	20,000	19,503	(497)
Other financial assets	0	0	0	0	0
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	4,507	1,050	2,246	2,061	(185)
Total current assets	**29,324**	**23,750**	**24,946**	**24,279**	**(667)**
Trade and other payables	(28,341)	(32,042)	(30,082)	(29,045)	1,037
Borrowing repayable within 1 year	(12,153)	(3,134)	(3,134)	(12,860)	(9,726)
Current Provisions	(47)	(20)	(20)	(47)	(27)
Other liabilities	(1,207)	(992)	(5,917)	(8,384)	(2,467)
Total current liabilities	**(41,748)**	**(36,188)**	**(39,153)**	**(50,336)**	**(11,183)**
Total assets less current liabilities	**129,823**	**143,322**	**137,717**	**127,169**	**(10,548)**
Borrowings	(84,956)	(99,186)	(96,529)	(81,729)	14,800
Provisions	(111)	(150)	(150)	(111)	39
Total non-current liabilities	**(85,067)**	**(99,336)**	**(96,679)**	**(81,840)**	**14,839**
Total assets employed	**44,756**	**43,986**	**41,038**	**45,329**	**4,291**
Financed by					
Public dividend capital	69,113	70,430	69,221	69,112	(109)
Revaluation reserve	6,931	9,832	8,021	9,855	1,834
Income and expenditure reserve	(31,288)	(36,276)	(36,204)	(33,638)	2,566
Total taxpayers' and others' equity	**44,756**	**43,986**	**41,038**	**45,329**	**4,291**

Non-Current Assets

The net capital investment in intangible assets and property, plant and equipment (PPE) is lower than originally planned due to the phasing of the capital programme starting later than planned during 2019/20. In addition, we acquired Newmarket Hospital on 30 September for £8.5m, which is now reflected within property, plant and equipment. This was not included in the plan.

Cash

The cash position continues to deteriorate and this is in line with the reported position. The cash position is being monitored on a daily basis to ensure that the minimum level requirement of £1m is maintained. We achieved a cash balance of £2m at the end of September, however this was largely due to the CCG paying some income in advance. This balance is reflected within other liabilities as deferred income.

Trade and Other Payables

These have increased by £1.5m since August. This is due to the Trust continuing to hold back payments at the end of the month to ensure that our minimum cash balance of £1m was maintained. The trade payables balance is in line with the plan.

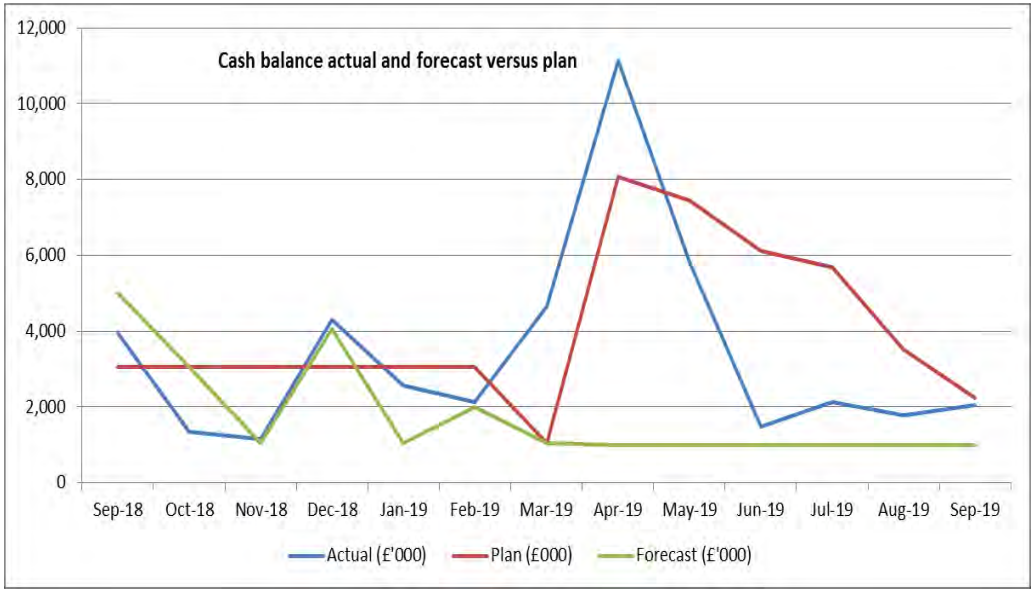
Borrowing

Our borrowing requirements continue to be kept under close review. A further loan of £1.8m has been received in October. Further borrowing is expected to be required in November. The Trust is required to repay £4.2m of loans by 31 March 2020.

FINANCE AND WORKFORCE REPORT - SEPTEMBER 2019

Cash Balance Forecast for the year

The graph illustrates the cash trajectory since September 2018. The Trust is required to keep a minimum balance of £1m.

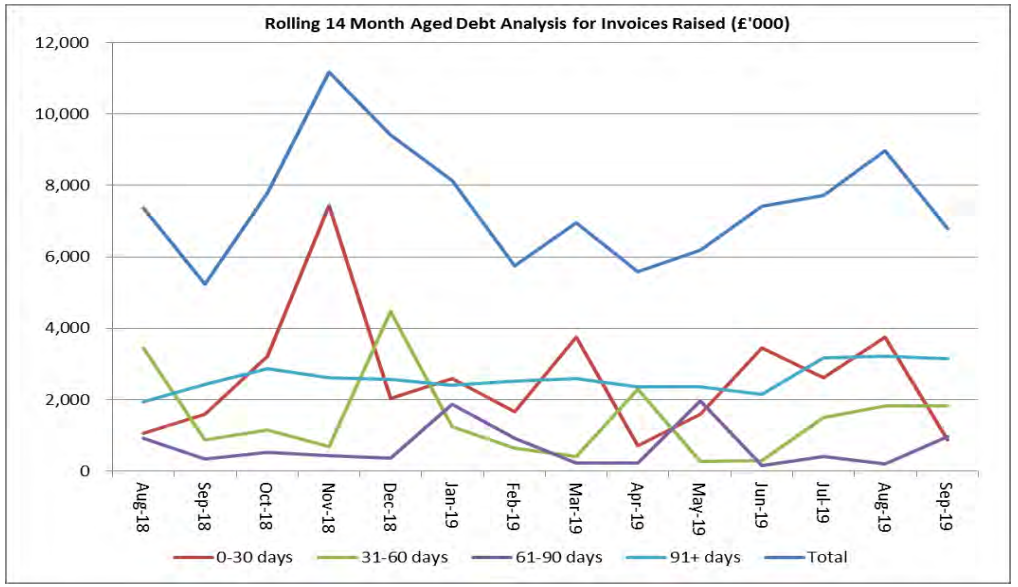


The September 2019 cash position is slightly lower than planned and is linked to the current financial position. The Trust secured some cash in advance from the CCG to assist with maintaining the £1m minimum cash balance. We continue to use our cash reserves on capital spend, which we can recover once we receive our capital funding.

The cash position is being rigorously monitored on a daily basis to ensure that the minimum level requirement of £1m is maintained. We have received a revenue support loan of £1.8m for October and are expecting to make a further application for revenue support in November. We anticipate the approval of our capital loan to be imminent.

Debt Management

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



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 overall level of invoices raised but not paid has decreased by £2.1m since September. Over 83% of these outstanding debts relate to NHS Organisations, with over 43% of these relating to old debts over 90 days. We are actively trying to agree a position with the corresponding NHS Organisations for these debtor balances.

10. EU Exit report

To ACCEPT the report

For Report

Presented by Helen Beck

11. Non-urgent patient transport update

To ACCEPT the report

For Approval

Presented by Helen Beck

Trust Board – 1 November 2019

Agenda item:	11			
Presented by:	Helen Beck, chief operating officer			
Prepared by:	Alex Baldwin, deputy chief operating officer			
Date prepared:	24th October 2019			
Subject:	Non-emergency patient transport (NEPTS)			
Purpose:	x	For information		For approval

Executive summary:

The paper provides a brief update on proposals to enhance the provision of NEPTS at West Suffolk along with a recommended course of action.

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

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

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

Recommendation:
The Board is asked to note the contents of this report.

Update

E-Zec Medical Transport Ltd (E-Zec) are three months into the current recovery plan but performance is not improving at the rate expected by the joint service commissioners. We know that poor performance is causing poor patient experience, delayed discharges, missed appointments and generating a significant amount of coordination work that the Trust is undertaking. Whilst all issues are being monitored and investigated, learning is not being embedded.

In mid-September E-Zec approached the CCG to discuss recent performance. It was acknowledged by E-Zec that more dramatic improvement was required and that a fundamental change to the service model would provide better experience for commissioners and patients. It was agreed collectively that current level of performance is not acceptable.

E-Zec has proposed to change the mechanism for managing discharge activity by dedicating vehicles for sole use by the Trusts for this purpose. This would increase the level of control for each Trust as we would be responsible for the allocation and logistical management of these vehicles. This model is being used successfully in other acute settings and we have engaged with commissioners and providers in Swindon who manage the NEPTS in this way. It is anticipated that adopting this model will deliver improvements to the contract as a whole.

This proposal includes an overall uplift in additional road based staff (crew) of 25 across the contract (25% increase in personnel) and an additional 14 vehicles (30% increase) to the Suffolk fleet. Vehicles will be allocated to the Trust on a daily basis to manage discharges accordingly. Whilst the detail is being worked through it is anticipated that this will equate to three vehicles dedicated daily at West Suffolk Monday to Friday, and two vehicles at the weekend.

Initial conversation with the joint commissioners has been positive although all are in agreement that this must be a system change and equally supported at each acute site. It has been recognised as a positive step which has the potential to significantly improve the performance of NEPTS.

The revised model will allow for increased focus and capacity for outpatient appointments, managed and controlled by E-Zec. They will review operations as a whole to allow for potential efficiencies and to support capacity management across the contract outside core hours and when discharge demand is high.

Detailed planning is currently underway and whilst the final operating model has not been agreed it is expect that any administrative resource increase is met by E-Zec.

At the time of writing it is anticipated that this model will be adopted from 2 December 2019 for an initial period of three months with ongoing review.

12. Winter planning - tracking report

To ACCEPT the report

For Report

Presented by Helen Beck

Trust Board – October 2019

Agenda item:	12			
Presented by:	Helen Beck, chief operating officer			
Prepared by:	Alex Baldwin, deputy chief operating officer Sarah Watson, head of nursing – medicine division Darin Geary, senior operations manager – women's and children's division			
Date prepared:	25 October 2019			
Subject:	Winter Plan			
Purpose:	x	For information		For approval

Executive summary:

This paper provides a brief summary update on winter plans inclusive of current bed utilisation, recruitment and staffing and initial post-Christmas plans. Details of paediatric winter plans have been included in this paper for the first time.

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

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

Previously considered by:	N/A
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	*To be assured that the Trust has robust plans in place to deal with increased demand during the winter season.*

Recommendation:
The Board is asked to note the contents of this report.

Introduction

The board has previously received a summary of proposed plans to manage anticipated increase in demand during the winter season. It is expected that the Trust will increase its adult acute bed base as follows:

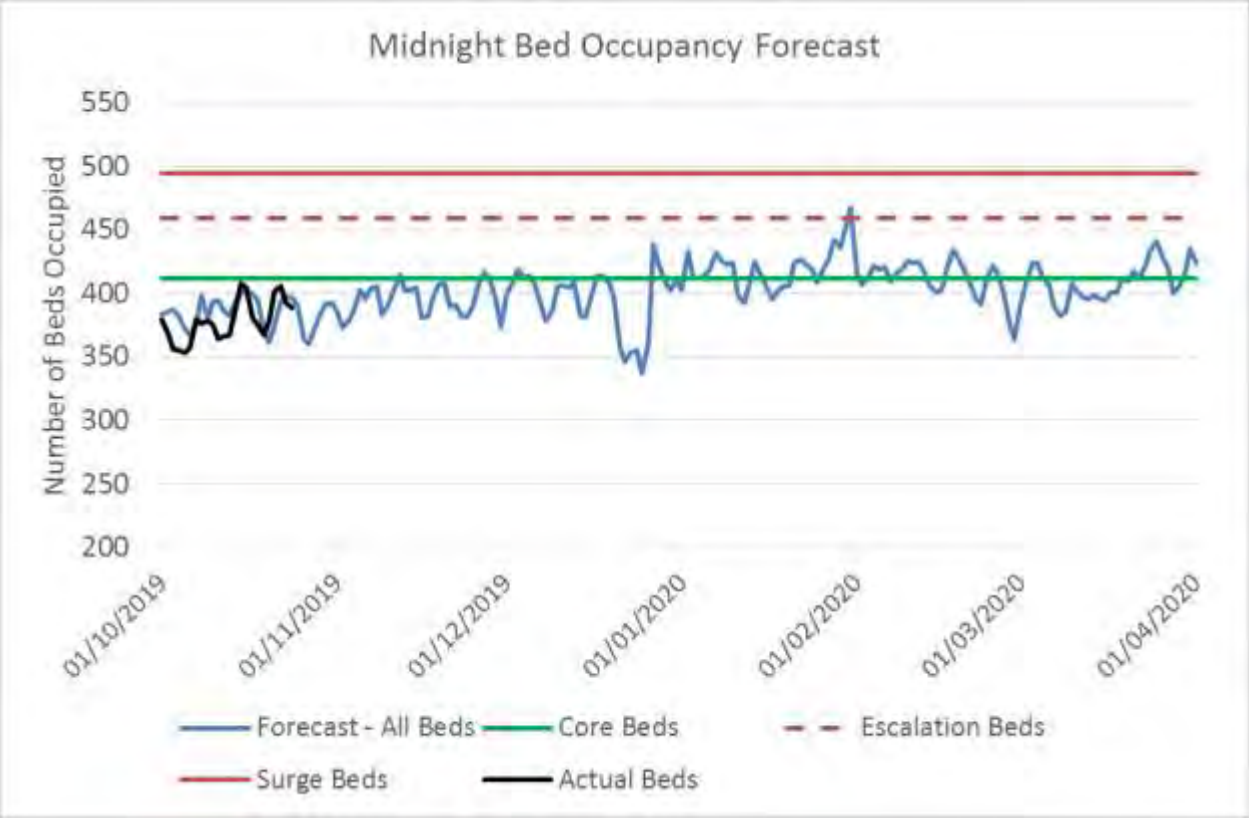
- 21 October 2019 – Gynae and Early Pregnancy Assessment Unit EPAU to have moved from F10 back to F14. **This is complete.**
- 16 December 2019 – F10 to open as a medical escalation ward in preparation for significant increase in demand expected from 27 December.
- 1 January 2020 – 10 additional community beds available for admission avoidance and reablement support. This will be available until 31 March 2020.
- 27 January 2020 – G9 is opened as medical surge capacity in preparation for significant increase in demand expected from 29 January.

The paediatric bed base will remain unchanged with flexibility between CAU and inpatient beds in line with the BAU approach throughout the year.

Bed utilisation

As previously reported the Trust has developed a comprehensive adult bed occupancy forecast for winter 2019/20. Table 1 provides a summary of peaks in demand expected at the end of December and again at the end of January (assuming 4.1% demand increase). The model also tracks current bed occupancy which, reassuringly, is at or slightly below expected demand. This will be reviewed weekly as we head in to the winter season.

Table 1: forecast bed occupancy



By way of comparison, bed days (based on midnight occupancy) between April and September 2019 has increased by 9.4% compared with the same period last year. However it should be noted that the increase is significantly distorted by occupancy between April and June which increased between 10% and 16.8% compared with the same period the previous year.

Capacity increase

The medicine division continues to plan to open F10 on 16th December. It is anticipated that the majority of staff will be in place from 1st December to allow for a period of acclimatisation.

At the time of writing the division has recruited **14.82** WTE registered nurses to staff the ward. This includes two overseas nurses who have not yet arrived and WTE redeployed from other ward areas across the Trust. There remain **3.38** WTE registered nurses vacancies to be filled.
The division have also identified **18.17** WTE nurse assistants to work on the ward. This includes **5.62** WTE bank staff rostered via fixed term contracts. There are **2.63** WTE nurse assistant vacancies to be filled. Recruitment for these vacancies is ongoing.
Finally the division has been successful in recruiting a Band 7 ward manager who commences in post at the beginning of December. It is expected that the ward roster will be completed at the beginning of November.

There are a number of issues which are being worked through, not least staffing for G9 which is not currently allocated. All clinical areas will be approached again to support with staff for G9 which is expected to be open at the end of January.

Equipment for both F10 and G9 is currently being procured and we have full support in place from IT and facilities.

General Nursing Recruitment

The following summary of current staff vacancies for registered and unregistered nurses is provided for the purpose of assurance of the Trust's ability to staff its ward areas appropriately during the winter season.

Registered nurses

The position has significantly improved and while we plan to take those in the current overseas pipeline we will suspend further overseas recruitment until at least January 2020. RN gap is currently 65 which is covered by 45 temporary staff giving a net position of 20. Over the coming months as the 50 overseas nurses gain their PIN and are able to work as RNs this will reduce to 15 vacancies.

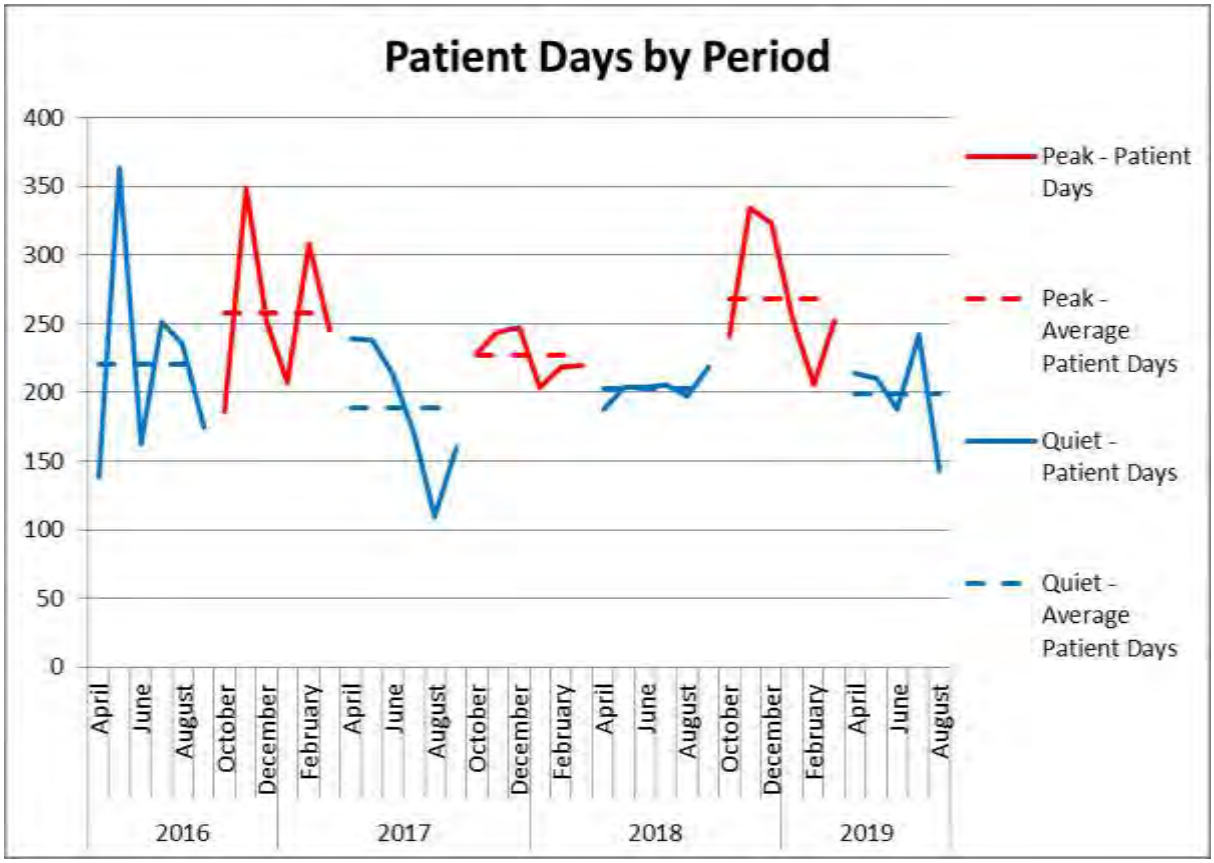
Nursing assistants

The Trust has 59 NA gaps but 50 of these are currently filled by overseas nurses acting in NA roles until they have the UK PIN (at which point they will move from NA to RN roles). The Trust is utilising 54 temporary staff from bank to cover gaps. We will have greater reliance on these staff as the overseas nurses move into RN roles.

Paediatrics

It was acknowledged by NHSI in 2018/19 that nationally winter planning for paediatrics is poor in comparison to winter planning undertaken for adult services. Therefore, the winter planning group is reviewing planning for paediatrics that is being undertaken by the Department. These considerations include staffing numbers (medical and nursing), enhancing nursing skills, and patient pathways.

Analysis of the activity profile demonstrates a clear increase in demand during the winter season (for paediatrics this often starts in October and remains high through to March).



In response, the women & children's division presented a business case for two Acute Paediatricians to support the Tier 2 rota and an additional Paediatrician to cover remaining gaps (currently identified as outpatient clinics). TEG have approved the advertisement for Paediatricians, with the number to be appointed dependent on further financial analysis to be presented back to TEG.

In addition to recruitment of Paediatrians, the department has requested to run a model of a second consultant on call on a standby basis for weekends during the paediatric winter period. This will provide additional on site consultant support if required by the paediatrician of the week (POW). This is planned for 2019/20 and will be reviewed for efficiency at the end of the winter season.

Equally it is evidenced that uplift in nursing establishment is required due to the peak in inpatient activity. Analysis demonstrates that three RNs are required at these peak periods, reflecting both demand and increased acuity, notably Level 2 patients requiring HDU care. The current staffing of two registered nurses per shift is only sufficient during periods of reduced acuity as in during the summer months. The department have proactively commenced allocating one additional nurse for every shift.
The addition of an extra registered nurse on every shift is equivalent to an increase of **5.8** WTE with a cost impact of **£175k** (assuming cover between October and March).

In addition the service has implemented an enhanced skills development programme that covers venepuncture, cannulation, capillary blood sampling and ECG's, with plans to expand to include catheterisation and tracheostomy care in the future.

Finally the service has reviewed its escalation procedure which is up to date and fit for purpose. When implemented, revised job planning will release additional consultant led cover for CAU which will increase support for the POW. Discussions are underway with the ITU team to ensure safe and effective care is in place for level 2 children to ensure their needs are met regardless of their location in the hospital. These plans are contingent on the additional paediatric nurse required for each shift to ensure safe nursing ratios for the level 2 children.

Initial post-Christmas plans

Planning for the immediate post-Christmas period is underway. The ask of the senior management team will be to provide additional cover for the weekend of 28/29 December and 4/5 January which mirrors the support in place last year. It is also expected that there will be additional support provided by on-site presence from tactical on call as required across the Christmas period.

The Trust has decided not to run a Perfect Week or MADE (multi agency discharge event) this year as the activity is largely embedded as business as usual and learning from previous events demonstrates greater benefit for system partners than patients.

Instead the Trust will focus on enhanced review of super stranded patients (patients with a length of stay greater than 21 days).

It is proposed that the Trust enhances its MDT approach to super stranded patients via the creation of a team who visit ward areas and review all patients who have been in hospital for 21 days or more with the ward team. This approach reflects the ECIST "long stay Wednesday" approach.

The team consists of the following:

- Senior clinical decision maker – consultant or registrar
- Head of nursing
- Head of therapies
- Social care senior operational lead
- Discharge planning lead
- scribe

The team will meet the ward manager, doctor and senior matron at an allotted time and discuss every patient who has been in hospital for 21 days or more (5 minutes per patient). A series of questions will be asked:

- Does this person need to be in an acute hospital bed?
- What is this person waiting for/ what specific action needs to happen next? Why not home today?
- What needs to happen to make this day a green day for this person?
- What can the ward visiting team do to help?

Evidence from organisations that have adopted this approach (Kettering, Cambridge University Hospital) demonstrates benefit through reducing the longest length of stays and supporting the wards to raise issues which may delay other patients discharge. There is also tangible evidence that these reviews increase ward engagement and support the ward to board approach.

Board will be kept informed of any developments with this plan.

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

13. Nurse staffing report

To ACCEPT a report on monthly nurse staffing levels

For Report

Presented by Rowan Procter

Trust Board – 1st November 2019

Agenda item:	X			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Rowan Procter, Executive Chief Nurse, and Sinead Collins, Clinical Business Manager			
Date prepared:	25th October 2019			
Subject:	Quality and Workforce Report & Dashboard – Nursing			
Purpose:	X	For information		For approval

Executive summary:
The aim of the Quality and Workforce Report and Dashboard is to enhance the understanding ward and theatre staff have on the service they deliver, identify variation in practice, investigate and correct unwarranted variation and lead change to demonstrate value. This dashboard has been altered as of July 2019 report to give the Trust Board a quick overview staff levels and patient safety. It also complies with national expectation to show staffing levels within Open Trust Board Papers.

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:
This paper is to provide overview of September's position about nursing staff and actions taken to mitigate, future plans and update on national requirements.
The dashboard provides summary of nursing staffing levels and effect on nurse sensitive indicators

NHSI Safer Staffing - National Quality Board Recommendations

'Developing workforce safeguards – October 2018' document released by NHS follow-up meeting required with HR leads is occurring on the 30th October 2019 before next meeting Task and Finish Group occurs to agree workforce plan next steps.

Nursing vacancy accuracy position – September figures are still not accurate and continued work with HR, Finance and Operations to occur.

Healthroster implementation into community – Allocate/Healthroster Community to be included in NHSi Bid

Overview of July and August nurse staffing position

Are we safe?
Matrons continue to have daily safety huddles and now on 7 day shift pattern to help provide safe staffing assurance

Assurance for community staffing has interim measures of daily calls with area leads and the local area managers and nursing leads, however for a more visual and accurate measure they will have to wait till later in year before HealthRoster can start to be implemented. Senior team members are actively working with team leads to implement safer staffing measures, as identified in WSFT rostering policy.

Steps are being made to ensure the wards are appropriately staffed for winter escalation wards with the correct skill mix, as well has having appropriate oversight and governance

Are we efficient?
The sickness has got worse this month

The Heads of Nursing for Medicine, Surgery and Community meet with senior operational managers, West Suffolk Professionals Manager and the HealthRoster Lead on a weekly basis, to review forthcoming rosters with the aim to identify staffing deficits in a timely way. This ensures early identification of vacant shifts to WSP staff and provides an opportunity for proactive planning and mitigation of risk.

CHPPD figures similar to comparable wards in other hospitals.

Future planning – Nursing staff

Overseas Nurses/Nursing Assistants

Month	Number of arrivals	
Jul-18	3	
Aug-18	4	
Sep-18	6	
Oct-18	9	
Nov-18	5	
Dec-18	0	
Jan-19	4	
Feb-19	7	
Mar-19	6	
Apr-19	0	
May-19	16	
Jun-19	14	
Jul-19	13	
Aug-19	0	
Sep-19	12	
Oct-19	12	Due to arrive on 31 October 2019
Total	110	

Information as at 20 September 2019:
65 overseas nurses have passed their OSCE and are now working as Band 5 Nurses
22 OSCE exams are booked for October 2019
12 OSCE exams are booked for December 2019

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Sep-19		Establishment for the Financial Year 2019/20		Data for September 2019																	
					Workforce													Nursing Sensitive Indicators					
Trust	Ward/Area Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Fill rate Registered %		Fill rate Unregistered %		Bank Use %	Agency use %	Overall Care Hours Per Patient Day	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)	Red Incidents	Complaints	Compliments
			Registered	Unregistered	Day	Night	Day	Night				Registered	Unregistered									
WSFT	ED	Emergency Department	54.91	23.43	93.1%	105.9%	82.0%	170.8%	8.1%	13.0%	N/A	-8.40	-4.30	6.30%	14.20%	0.90%	N/A	5	0	1	2	10
WSFT	AAU	Acute Admission Unit	27.30	29.59	93.2%	78.0%	74.7%	118.4%	4.9%	4.6%	14.6	0.00	4.60	4.00%	12.00%	5.00%	0	3	0	0	0	0
WSFT	F7	Short Stay Ward	22.84	30.94	73.6%	93.7%	95.4%	112.8%	11.7%	2.7%	6.2	-1.90	-2.80	8.20%	12.50%	8.20%	1	5	5	1	0	0
WSFT	CCS	Critical Care Services	41.07	1.88	95.4%	88.4%	N/A	N/A	2.2%	6.0%	32.0	0.60	2.00	3.60%	11.90%	4.20%	2	3	0	0	0	1
WSFT	Theatres	Theatres	61.68	22.27	96.1%	98.9%	N/A	N/A	3.6%	0.0%	N/A	-3.40	0.20	5.00%	13.60%	1.30%	N/A	1	1	0	0	0
WSFT	Recovery	Theatres	21.23	0.96	152.1%	100.2%	67.5%	N/A	4.1%	0.0%	N/A	-1.03	0.00	1.90%	16.10%	4.30%	0	1	N/A	0	0	0
WSFT	Day Surgery Unit	Theatres	28.43	8.59	52.8%	N/A	152.3%	N/A	0.4%	0.0%	N/A	-3.90	2.50	12.50%	9.60%	0.00%	0	1	0	0	0	1
	Day Surgery Wards		11.76	1.79					11.5%	0.0%		-0.60	0.10	10.00%	13.50%	4.50%						
WSFT	ETC	Opthalmology	TBC	TBC	73.0%	N/A	97.1%	N/A	1.0%	0.0%	N/A	2.20	2.80	0.70%	9.40%	4.70%	N/A	0	0	0	0	4
WSFT	PAU	Pre-assessment	TBC	TBC	76.3%	N/A	82.0%	N/A	1.1%	0.0%	N/A	0.00	1.30	4.50%	15.70%	0.00%	N/A	0	0	0	1	0
WSFT	Endoscopy	Endoscopy	TBC	TBC	151.0%	N/A	143.1%	N/A	0.0%	0.0%	N/A	-3.00	1.00	5.40%	16.50%	2.00%	N/A	3	0	0	0	2
WSFT	Cardiac Centre	Cardiology	38.14	15.20	88.0%	94.7%	101.0%	100.0%	2.5%	0.0%	10.0	-3.20	1.30	3.30%	12.30%	2.80%	1	1	0	0	0	13
WSFT	G1	Palliative Care	23.96	8.31	93.7%	98.7%	67.0%	N/A	13.7%	1.1%	11.2	-2.30	3.50	8.20%	14.90%	4.50%	1	9	1	0	0	0
WSFT	G3	Endocrine & Medicine	TBC	TBC	123.1%	158.1%	150.9%	139.8%	8.5%	3.3%	6.4	-0.20	5.40	1.90%	6.40%	0.00%	3	2	2	1	3	2
WSFT	G4	Elderly Medicine	19.16	24.36	80.2%	92.0%	96.3%	100.2%	16.3%	7.7%	5.6	-3.90	-1.60	7.10%	13.10%	4.20%	1	4	1	0	0	2
WSFT	G5	Elderly Medicine	18.41	22.66	94.6%	94.5%	92.0%	122.8%	20.8%	4.0%	5.5	-1.00	-3.80	7.00%	14.90%	2.50%	3	3	2	0	1	6
WSFT	G8	Stroke	23.15	28.87	83.9%	96.1%	107.4%	117.2%	14.8%	4.8%	7.6	-1.90	-0.30	5.70%	12.80%	7.30%	2	1	1	0	0	0
WSFT	F1	Paediatrics	18.13	7.16	105.0%	99.0%	96.2%	N/A	19.4%	0.0%	16.4	-2.10	2.30	5.00%	20.10%	0.00%	N/A	1	N/A	0	0	0
WSFT	F3	Trauma and Orthopaedics	19.58	22.27	92.8%	99.0%	95.1%	106.2%	16.8%	8.3%	5.7	-5.00	0.00	5.10%	13.60%	1.90%	3	7	0	0	0	0
WSFT	F4	Trauma and Orthopaedics	12.78	10.59	85.5%	90.3%	70.0%	99.7%	13.5%	2.0%	8.0	-3.10	-2.90	4.90%	15.40%	4.50%	0	3	0	0	1	2
WSFT	F5	General Surgery & ENT	19.58	14.51	99.2%	93.5%	91.6%	110.9%	7.7%	0.0%	5.6	0.60	-1.40	5.40%	16.00%	0.00%	0	0	0	0	0	11
WSFT	F6	General Surgery	19.57	14.51	95.3%	100.0%	93.9%	104.9%	8.9%	2.9%	5.0	-1.80	0.80	8.00%	15.80%	1.90%	0	7	2	1	2	15
WSFT	F8	Respiratory	19.90	20.13	102.1%	98.4%	97.4%	101.6%	4.9%	10.6%	6.9	-1.20	-1.40	3.80%	16.40%	0.00%	2	3	1	0	0	0
WSFT	F9	Gastroenterology	20.32	22.56	100.3%	96.6%	87.8%	141.7%	21.6%	2.0%	4.0	-1.50	-2.20	8.60%	13.80%	3.90%	0	2	2	0	0	0
WSFT	F11	Maternity	49.58	13.89	90.8%	91.6%	84.5%	69.1%	10.5%	0.0%	N/A	2.90	0.20	4.20%	15.70%	3.00%	0	3	0	0	0	2
WSFT	MLBU	Midwifery Led Birthing Unit															0	0	0	0	0	0
WSFT	Labour Suite	Maternity															0	0	0	1	0	0
WSFT	Antenatal Clinic	Maternity	TBC	TBC	89.6%	N/A	73.4%	N/A	2.0%	0.0%	N/A	1.50	-0.40	1.10%	15.40%	0.00%	N/A	0	0	0	0	0
Community	Community Midwifery	Maternity	TBC	TBC	59.3%	N/A	57.2%	N/A	5.0%	0.0%	N/A	-3.50	0.00	4.60%	11.90%	7.10%	0	0	0	0	0	0
WSFT	F12	Infection Control	11.02	5.00	81.3%	93.0%	79.1%	105.2%	8.5%	1.2%	8.1	-1.90	0.90	4.60%	15.50%	0.00%	0	0	0	0	0	2
WSFT	F10	Gynaecology	11.18	1.00	120.6%	116.5%	N/A	N/A	41.7%	1.4%	9.2	-1.90	0.00	3.30%	9.40%	0.00%	0	1	0	0	1	1
WSFT	MTU	Medical Treatment Unit	7.04	1.80	83.6%	N/A	95.7%	N/A	6.9%	0.0%	N/A	0.80	-0.20	9.70%	16.80%	4.40%	0	1	0	0	0	0
WSFT	NNU	Neonatal	20.85	3.64	99.0%	87.7%	36.9%	57.2%	3.2%	0.0%	20.9	-1.50	-1.00	0.00%	18.80%	2.20%	N/A	2	N/A	0	0	2
WSFT	Outpatients	Outpatients	TBC	TBC	61.4%	N/A	82.6%	N/A	4.5%	0.0%	N/A	-0.30	-2.40	7.10%	16.10%	3.20%	N/A	0	0	0	0	0
WSFT	Radiology Nursing	Radiology	TBC	TBC	97.1%	N/A	122.0%	N/A	10.8%	0.0%	N/A	-0.40	-1.40	0.80%	12.20%	4.20%	N/A	0	0	0	0	0
WSFT	DWA	Discharge Waiting area	TBC	TBC	14.4%	N/A	32.5%	N/A	57.8%	12.4%	N/A	-1.20	-1.00	0.00%	30.00%	0.00%	0	1	0	0	0	0
Newmarket	Rosemary Ward	Step - down	12.34	13.47	145.2%	101.4%	100.6%	105.7%	7.2%	8.5%	5.7	-1.50	1.30	4.20%	16.20%	0.00%	1	0	0	0	0	1
Glastonbury Court	Kings Suite	Medically Fit	11.50	12.64	115.3%	99.0%	103.5%	103.4%	9.8%	0.4%	5.1	-1.20	-0.60	6.50%	18.30%	0.00%	0	2	0	0	0	0
					93.07% AVG	98.62% AVG	94.07% AVG	110.39% AVG				-54.23 TOTAL	2.50 TOTAL	5.06% AVG	14.63% AVG	2.58% AVG	20 TOTAL	75 TOTAL	18 TOTAL	5 TOTAL	11 TOTAL	77 TOTAL

Trust	Team Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Patient facing contact (hrs)	Unplanned requests	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (New)	Nursing/Midwifery Administrative Medication Errors	Red Incidents	Missed Visits	Complaints	Compliments
			Registered	Unregistered			Registered	Unregistered									
Community	Bury Town	Community Heath Team	17.59	5.60	1406.43	96	-2.97	-0.20	1.94%	Not available comprehensively till Healthroster implemented	Not available this month	5	1	0	0	0	0
Community	Bury Rural	Community Heath Team	10.00	1.20	776.98	39	-2.00	-1.20	1.11%			10	0	0	1	0	0
Community	Mildenhall & Brandon	Community Heath Team	12.59	3.91	799.55	56	-0.60	-0.11	2.60%			1	2	0	1	0	0
Community	Newmarket	Community Heath Team	8.10	2.75	571.68	23	0.00	0.00	1.61%			5	0	0	0	0	0
Community	Sudbury	Community Heath Team	18.03	8.36	1200.57	88	-3.58	-1.20	2.10%			7	0	0	0	0	0
Community	Haverhill	Community Heath Team	8.97	4.23	916.37	64	-2.60	0.00	6.22%			1	0	0	0	0	0
Community	Admission Prevention Service	Specialist Services	11.28	3.45	193.38	1	0.00	0.00	8.80%			0	0	0	0	0	0
Community	Specialist Services	Cardiac Rehab and Heart Failure	TBC	TBC	506.90	6	0.00	0.00	0.00%			0	0	0	0	0	0
Community	Children	Community Paediatrics	16.37	15.01	1144.83	2	0.00	-0.24	3.11%			N/A	0	0	0	0	0
					7516.69 TOTAL	375.00 TOTAL	-11.75 TOTAL	-2.95 TOTAL	3.05% AVG	#DIV/0! AVG	#DIV/0! AVG	29 TOTAL	3 TOTAL	0 TOTAL	2 TOTAL	0 TOTAL	0 TOTAL

Explanations	
	Fill Rate: an indication of patient safety - national target 80% (less than = red), Trust internal target 85% (equal and greater than = green)
	In vacancy column: - means vacancy and + means over established. Excludes maternity leave as separate column
	Sickness Trust target: <3.5%
	Annual Leave target: (12% - 16%)
	Maternity Leave: no target
	Medication errors are not always down to nursing and can be pharmacist or medical staff as well
	DSU has been split into ward and unit only by HR, that is why only a section has been split in this dashboard
	F10 (F14) gynae inpatients ward no of beds 16 and 2 SR - and have a ward attender section

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

14. Mandatory training report

To approve the report recommendations

For Report

Presented by Kate Read

Board of Directors – 1 November 2019

Agenda item:	14			
Presented by:	Kate Read, Deputy Director of Workforce			
Prepared by:	Rebecca Rutterford, Workforce Development Manager			
Date prepared:	15th October 2019			
Subject:	Mandatory Training			
Purpose:		For information	☑	For approval

Executive summary:
The following recovery plan sets out a clear set of actions to deliver a real and sustained improvement to mandatory training compliance figures.
Whilst the expectation is that all staff are up to date in all domains of mandatory training, the Trust target is set at 90% (95% for Information Governance) compliance in order to take in to account staff who fall in to the reporting period, but who are unable to undertake their training due to sick or parental leave.

Compliance
Since the June 2019 Trust Board report there has been an overall increase in compliance of 4% (breakdown see appendix A) with further improvements expected once the mandatory training review changes have been inputted into our training system, Oracle Learning Management (OLM).

Applicant Portal
The applicant Portal which allows applicants to access their ESR (Electronic Staff Record) has been launched. The portal allows applicants to access and complete their mandatory e-learning training prior to their start date and confirm and track their recruitment status. Any training which has been completed at a neighbouring Trust which is part of the Streamlining project will show on the applicant's portal as already compliant.

Appendix A is the October 2019 Mandatory Training Report, this represents data taken from the system on 10th October 2019.
Appendix B The Recovery Plan outlines the actions currently in place to improve take up of mandatory training across the Trust.
Appendix C Details changes made to mandatory training requirements following an internal review.
Appendix D Provides performance impact assessments for those areas below 80%, compiled by the subject matter experts for each area.
Appendix E Community compliance information following CQC feedback

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*
		☑					☑

Putting you first

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

Subject Matter - High Level Mandatory Training Analysis October 2019

Competency	Trust Target	Match	No Match	Grand Total	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	% Difference between June 19 and Oct 19
179|LOCAL|Infection Control - Classroom|	90%	1887	87	1974	95%	94%	96%	96%	95%	95%	95%	96%	95%	95%	96%	96%	0%
NHS|MAND|Safeguarding Children Level 1 - 3 Years|	90%	3835	308	4143	90%	91%	91%	90%	91%	92%	92%	92%	93%	95%	93%	93%	1%
179|LOCAL|Safeguarding Children Level 2|	90%	1815	165	1980	90%	91%	91%	91%	91%	88%	90%	89%	90%	89%	91%	92%	3%
179|LOCAL|Security Awareness|	90%	3797	346	4143	89%	89%	89%	88%	88%	83%	87%	86%	89%	88%	91%	92%	5%
179|LOCAL|Equality and Diversity|	90%	3791	352	4143	82%	84%	85%	85%	85%	87%	88%	90%	90%	90%	93%	92%	2%
179|LOCAL|Health & Safety / Risk Management|	90%	3776	367	4143	89%	90%	89%	89%	89%	87%	88%	90%	91%	90%	92%	91%	1%
179|LOCAL|Infection Control - eLearning|	90%	2055	213	2268	90%	91%	91%	91%	90%	83%	82%	87%	90%	88%	91%	91%	3%
179|LOCAL|Information Governance|	95%	3745	398	4143	83%	82%	81%	83%	81%	80%	81%	85%	86%	87%	91%	90%	5%
NHS|CSTF|Preventing Radicalisation - Basic Prevent Awareness - 3 Years|	90%	3744	399	4143	90%	91%	92%	91%	91%	90%	91%	91%	92%	90%	91%	90%	-1%
179|LOCAL|Fire Safety Training - Classroom|	90%	3741	402	4143	88%	88%	89%	87%	85%	90%	89%	90%	90%	88%	91%	90%	0%
179|LOCAL|Safeguarding Adults|	90%	3711	432	4143	90%	90%	91%	91%	91%	86%	87%	88%	89%	88%	89%	90%	2%
179|LOCAL|Blood Bourn Viruses/Inoculation Incidents|	90%	2074	277	2351	88%	89%	89%	87%	88%	80%	83%	83%	85%	85%	88%	88%	5%
179|LOCAL|Conflict Resolution - elearning|	90%	909	126	1035	85%	86%	86%	86%	86%	70%	74%	76%	81%	81%	85%	88%	12%
179|LOCAL|Major Incident|	90%	3623	520	4143	89%	90%	90%	89%	89%	80%	82%	82%	85%	85%	88%	87%	5%
179|LOCAL|Fire Safety Training - eLearning|	90%	3609	534	4143	85%	86%	85%	83%	83%	84%	83%	84%	84%	83%	87%	87%	3%
179|LOCAL|Medicine Management (Refresher)|	90%	1501	239	1740	87%	87%	87%	86%	86%	81%	83%	84%	86%	85%	86%	86%	2%
179|LOCAL|Slips Trips Falls|	90%	2336	387	2723	85%	87%	86%	86%	87%	76%	79%	80%	82%	81%	84%	86%	6%
179|LOCAL|Moving and Handling - Clinical|	90%	1887	382	2269	76%	76%	80%	77%	79%	80%	80%	80%	79%	82%	82%	83%	3%
NHS|MAND|Safeguarding Children Level 3 - 1 Year|	90%	428	90	518	90%	90%	91%	91%	91%	70%	71%	82%	80%	79%	84%	83%	1%
NHS|CSTF|Preventing Radicalisation - Prevent Awareness - No Specified Renewal|	90%	2358	497	2855	66%	68%	70%	70%	70%	78%	81%	81%	82%	82%	83%	83%	1%
179|LOCAL|Basic Life Support - Adult|	90%	2207	471	2678	80%	80%	81%	80%	81%	82%	81%	80%	81%	81%	81%	82%	2%
179|LOCAL|Moving & Handling - elearning|	90%	920	220	1140	76%	78%	76%	75%	77%	74%	76%	78%	80%	79%	82%	81%	2%
179|LOCAL|Conflict Resolution|	90%	1335	417	1752	74%	75%	72%	72%	71%	77%	78%	77%	76%	75%	75%	76%	-1%
179|LOCAL|Blood Products & Transfusion Processes (Refresher)|	90%	1176	383	1559	75%	76%	77%	76%	77%	67%	68%	76%	78%	76%	77%	75%	0%
179|LOCAL|Moving and Handling Non Clinical Load Handler|	90%	355	130	485	86%	84%	87%	88%	86%	65%	64%	57%	61%	65%	70%	73%	16%

Appendix B

Item	Requirement	Action	Update	Completion date	Responsibility	% Predicted improvement
1	Review of Mandatory Training Subjects	Address increase of mandatory training. (Trust has seen 30% increase in courses provided during previous 12 months)	A full review of all mandatory training courses has taken place to ensure appropriateness, renewal period and relevance to staff group(s). All changes were managed in a safe, auditable way, placing patient and employee safety as the top priority. All changes to Mandatory Training have been outlined in appendix C	Complete	Mandatory Training Steering Committee	4% projected improvement to be seen once changes inputted into ESR
2	Update OLM following Mandatory Training Review	Update ESR and staff records to reflect requirements	Education & Training Team are currently inputting the amendments made following the full mandatory training review (see item above).	31/12/19	Mandatory Training Team	
3	Improve access to e-learning modules	Implement necessary changes to server to improve access and usability of e-learning system.	IT completed all relevant sever updates. The mandatory training team have transferred all e-learning packages onto the Articulate software. This has resulted in all employees both on site and off being able to access and complete e-Learning from any device which has access to the internet. It has also made the system easier to use with significantly less work arounds and intervention required from IT.	19/07/19	Rob Smith Rob Howorth	2%
4	Support streamlining for junior doctors	Continue to engage with streamlining projects Provide opportunities for mitigation where streamlining is not currently in place	Revision of induction timetables to include West-Suffolk specific mandatory training courses Work with Trusts across region to achieve best possible data transfer through ESR system. The Streamlining project for the East of England kick-off date is end Oct 2019. The Mandatory Training Team has provided over 10 additional e-learning sessions to support the August intake of Jr Drs to be compliant with their training at the point of Induction.	05/08/19 05/08/20	Lorna Lambert, Rota co-ordinators	0.5%
5	Managers to have direct access to staffs performance information including mandatory training	To implement ESR (Electronic Staff Record) Supervisor Self Service	Implementation plan agreed with full roll out by March 2020.	31/03/20	Workforce Team HR	

Item	Requirement	Action	Update	Completion date	Responsibility	% Predicted improvement
6	Community training data to be reviewed	It has been raised that some community data does not seem to be accurate within the ESR system and does not match local records, specifically from Paediatrics	Community Leads to provide the Education & Training Team with details of those records/individuals which do not match or are inaccurate in OLM. The Education & training Team to investigate and then update as appropriate.	31/12/2019	Michelle Glass, Nick Smith-Howell	

Appendix C

Mandatory Training Review Outcome

Subject	Outcome
Equality & Diversity	**No Change**
Health & Safety	**Changed from 3 yearly to 2 yearly**
Safeguarding Adults	**No Change**
Prevent Awareness	**No change**
Moving & Handling	**Clinical** To remain at an annual update for all staff who move patients. Agreed that Porters would move to an annual clinical training requirement. **Non Clinical** – To move from annual to 2 yearly **E-learning** – To move from 2 yearly to 3 yearly
Medicines Management	**No change** Look at changing the face to face session at the Mandatory Training Refresher day to an e-learning package.
Infection Prevention	**No Change**
Fire	**No Change**
Blood Transfusion	**No Change**
Safeguarding Children Level 1-3	**No Change**
Information Governance	**No Change**
Slips, Trips & Falls	Juliet Bevan to review whether this package can be included within the Health & Safety e-learning
Security Awareness	**Once only at Induction**
Conflict Resolution	**No Change (currently)** Darren Cooksey to push forward with Managing Challenging Behaviour review. Job description will be evaluated ASAP for the internal trainer. This will enable more responsive and relevant training for each Dept; this would then count towards mandatory training. In addition, shorter training sessions could be provided more regularly.
Major Incident (formally known as Majax)	**Once only at Induction –** Name to change to Major Incident
Blood Borne Viruses	**To be included in Infection Control Training**– Sue Pollett to liaise with Anne How
Basic Life Support	**No Change**

Performance impact assessments

Appendix D

Subject	Issues	Performance Concerns	Lead
179|LOCAL| Conflict Resolution|	• Staffing levels and the Ward/ Departments ability to backfill will affect the numbers attending • Release of staff on clinical areas.	• Failure to recognise body language indications of possible aggression. • Failure to recognise warning signs when an aggressor is agitated or distressed. • Failure to recognise danger signs which may indicate imminent attack. • Failure to employ applicable communication skills • Litigation consequences • Potential staff injuries resulting in RIDDOR absenteeism. • Poor staff morale	Portering and Security manager
179|LOCAL| Blood Products & Transfusion Processes (Refresher)|	• Failure of staff to use on line training package provided • Not clear of process within Trust to ensure mandatory training is complied with and consequences	• Staff unaware of updated national/local guidelines to minimise the risks of transfusion. • Potential "never event" of ABO incompatible transfusion resulting in patient harm • Potential Litigation • Non-compliance with DoH circular 'Better Blood Transfusion'.	Blood Transfusion Committee
179|LOCAL|Moving and Handling Non Clinical Load Handler|	• Areas which organise own training not putting on sessions • Poor uptake	• MSK injury to staff • Increase in staff RIDDOR'S • Financial implications to the trust	Moving and handling Advisor

Community Update

Since January 2019 our community colleagues training requirements and records transferred over to the core WSFT programmes and systems. A number of challenges have been identified in ensuring their compliance is achieved and their training needs are being met.

Challenges

New subjects
There have been differences identified between historical community requirements and requirements set by WSFT. This includes new subjects which the community have not previously had to complete. These subjects include: Slips, trips and falls, Security Awareness and Major Incident. Where possible community specific training has been created and inputted into OLM to ensure relevance (security awareness and major incident). Slips, trips and falls needs to be removed from a number of community staff in paediatrics as it was felt it was not appropriate. As part of the main mandatory training review Slips, trips and falls is being reviewed as a subject for all WSFT staff and alternative options are being investigated. As such until this has been resolved the removal of records has been suspended.

New system
Community colleagues and managers have had to learn to use a new system to monitor and complete their training. IT server issues meant that access and usability was affected with various IT issues being identified. These issues have now been addressed and access and usability is resolved. Communication of training compliance for all staff is sent to managers monthly and staff can access their own training compliance via the system.

As staff become more familiar with the new system and utilise the improved accessibility it is expected that compliance will increase. Also staff are also utilising the ability to book onto a full days training to cover them for all their training but this can result in an initial delay in becoming compliant. It is thought that once the new structure has run for a year that this will also see an improvement in compliance.

Amendments
Feedback from community leads is that some of the data in OLM does not match the data they hold locally. We have requested these details be sent to the Education & Training Team so they can be investigated and updated as appropriate.

Actions taken

A full review of Induction programmes to ensure they are appropriate for both acute and community colleagues.
This has meant some significant changes to both the content of training and to the delivery. Changes have been made throughout the year based on feedback from staff. There is a significant change to the layout, which is hoped will balance between staff being trained appropriately and safety without sacrificing unnecessary delays in starting in the workplace. The new programme starts in January 2020.

Additional Community update days, with a specific paediatric stream.
Additional community specific mandatory training days have been organised, seeing a 30% increase in the amount of sessions being offered each year. These have been well received by community colleagues who feel they are a better use of time than trying to book onto ad hoc courses attended previously.

Transfer of all training records
All relevant training records downloaded from Staff Pathways, the original community training system, have been migrated over into Oracle Learning Management (OLM), WSFT's training system. There were over 22,000 records sent over.

Mapping of existing training and reviewing requirements
A review of all community training requirements have been completed by either the subject leads or department leads. This has then been inputted into OLM by the mandatory training team.

15. Safe staffing guardian report – Q2

To receive the report

For Report

Presented by Nick Jenkins

Trust Board – 1 November 2019

Agenda item:	15			
Presented by:	Nick Jenkins, Executive Medical Director			
Prepared by:	Francesca Crawley, Gardian of Safe Working			
Date prepared:	14th October 2019			
Subject:	Safe Staffing Guardian Report – Quarterly Report July 2019 – September 2019			
Purpose:	x	For information		For approval

Executive summary:

The report is compiled by the Guardian of Safe Working Hours (GOSW), a role appointed as part of the new contract. The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed.

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

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

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

Recommendation: For the board to endorse the quarterly report.

NHS
West Suffolk
NHS Foundation Trust

QUARTERLY REPORT ON SAFE WORKING HOURS

DOCTORS AND DENTISTS IN TRAINING

31st July 2019 – 30th September 2019 Executive Summary

Introduction

The purpose of the report is to provide evidence of safe rostering and compliance with the TCS; to highlight any difficulties which have arisen and to explain how they are being addressed. A system of Exception Reporting is in place and uses Allocate software.

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

All trainees taking up appointments are on the New Contract. Locally employed doctors are on contracts that mirror the new contract.

Summary data

Number of doctors in **training on 2016** TCS (total):	148 (includes p/t trainees)
Amount of time available in job plan for guardian to do the role: per week	1 PAs / 4 hours
Admin support provided to the guardian (if any):	0.5WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee[1]
Amount of job-planned time for Clinical Supervisors:	0, included in 1.5 SPA time[1]

Putting you first

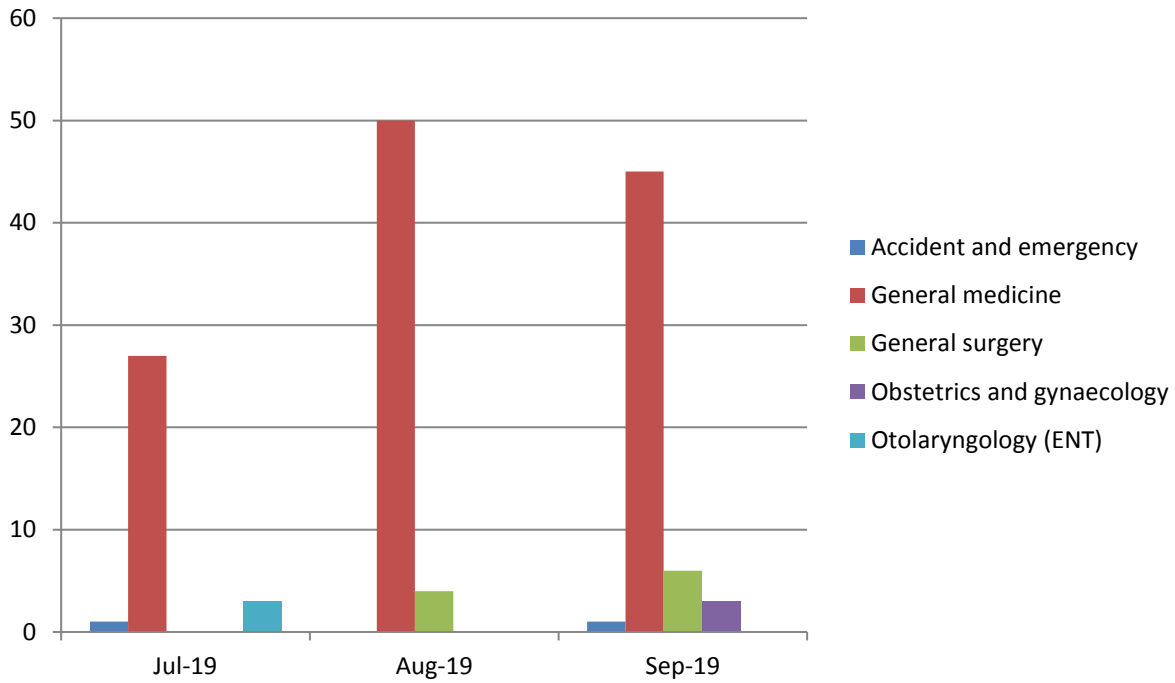
1. Exception reporting: 31st July – 30th September 2019

a) Exception reports (with regard to working hours)

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

Exception Reports by EXCEPTION TYPE						
Department	Grade	Pattern of Hours worked	Educational Opportunities or available Support	Support available during Service Commitments	Hours of Work	Total overtime hours claimed
Surgery	F1	0	0	0	8	6.75
	F2	0	0	0	5	4.25
	GP/ST/CT	0	0	0	0	0
	ST3+	0	0	0	0	0
Medicine	F1	1	0	4	60	114.
	F2	0	0	0	24	40.25
	GP/ST/CT	0	0	0	35	65.50
	ST3+	0	0	0	0	0
Woman & Child	FY2	0	2	1	0	0
	GP/ST/CT	0	0	0	0	0
	ST3+	0	0	0	0	0
Psychiatry/ off site	F1	0	0	0	19	10.25
Total		**1**	**2**	**5**	**151**	**241.00**

Exceptions reports by month and department



Please note that as psychiatry claims are not logged by the West Suffolk Hospital's Exception Reporting system, these do not show in the bar graph, but have been resolved as outlined in 1b below.

b) Work schedule reviews for period 31st July – 30th September 2019

Work schedule reviews for individuals may be requested by either the doctor, or the education/clinical supervisor, service manager or guardian in writing.

One work schedule review has been completed for the F1 trainee in Psychiatry due to their shift duty start time being inaccurate.

2) Immediate Safety Concerns: 31st July – 30th September 2019

As outlined in the Terms and Conditions, immediate safety concerns (ICS) should be reported (orally) as an ISC to the consultant in charge on the day of the incident, a Datix to be completed and then an exception report submitted within 24 hours.

One immediate safety concern was submitted for 19th July 2019 by a doctor working on Ward F8 (Respiratory Ward). The immediate safety concern was regarding some very sick patients, lack of doctors being available to help and support available.

The doctors on the ward that day were met with by the Service Manager to discuss the details and reported these back to the consultants to highlight what measure could be put in place to support doctors regarding prioritisation. The Service Manager would also speak to the nursing staff regarding how to deal with non urgent task referrals to doctors during such occasions.

3) Locum Bookings: 31st July – 30th September 2019

TABLE 1: Shifts requested between 31st July – 30th September 2019 by 'reason requested'

Locum Bookings by REASON REQUESTED							
Department	Extra/Rota Compliance/ Induction Cover	Leave (ie Annual/Study)	Maternity Leave	Sickness/Reduced Duties	Specialist Project Work	Vacancy	Grand Total
Aneasthetics	8	0	0	6	0	0	**14**
Emergancy Medicine	133	156	3	15	0	194	**501**
Cardiology	71	0	0	0	0	0	**71**
Community Paediatrics	0	0	0	0	0	48	**48**
Dermatology	50	0	0	0	0	36	**86**
ENT	8	0	0	3	0	0	**11**
General Surgery	28	14	0	39	0	22	**103**
Haematology	6	0	0	16	0	0	**22**
Medicine	327	84	125	19	0	344	**899**
Microbiology	0	0	0	0	2	0	**2**
Obstetrics and Gynecology	15	0	0	9	0	5	**29**
Paediatrics	0	0	0	17	0	64	**81**
Radiology	2	0	0	0	0	60	**62**
Trauma and Orthopaedics	7	4	0	8	0	9	**28**
Urology	7	19	0	20	0	0	**46**
Grand Total	**662**	**277**	**128**	**152**	**2**	**782**	**2003**

TABLE 2: Shifts requested between 31st July 2019 – 30th September 2019 by 'Agency / In house fill'

Filled by Agency / NHS		
Department	NHS	Agency
Aneasthetics	387	0
Emergancy Medicine	14	114
Cardiology	71	0
Community Paediatrics	0	48
Dermatology	86	0
ENT	11	0
General Surgery	101	2
Haematology	2	20
Medicine	490	409
Microbiology	2	0
Obstetrics and Gynecology	26	3
Paediatrics	57	24
Radiology	62	0
Trauma and Orthopaedics	28	0
Urology	46	0
Grand Total	**1383**	**620**

4) Vacancies - 31st July – 30th September 2019

HR has provided details of current junior doctor vacancies:

Department	Grade	Jul	Aug	Sept
A&E	ST3+	3	5	5
Anaesthetics	ST3+	2	1	1
Medicine	ST3+	0	0.6	0.6
Medicine	F2/ST1-2	3	1	0
T&O	ST3+	0	1	0
Pediatrics	ST4+	1	1	0
Pediatrics	F2/ST1-2	0	0	0.7
Total		**9**	**9.6**	**7.3**

5) Fines - 31st July – 30th September 2019

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

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

This quarter there was no instance where a fine has been made.

Total breach fines paid by the Trust from August 2017 to date are £8,439.09 and the Guardian Fund currently stands at £4,484.63.

£100.96 was used from the Guardian Fund for Junior Doctors change over refreshment pack.

Matters Arising

1. There has been a safety concern raised about the weekend cover for medicine at F1 level. This has been discussed with the service manager, clinical director and the F1 and the juniors' responsibilities over the weekend have been adjusted to resolve this by changing a clerking shift to an on-call shift to support the other doctors.

2. The terms and conditions of the junior doctors' contract state that from December 2019 no doctor can work more than one in three weekends. This can be overridden and implemented by August 2020 if agreed by the clinical director, juniors and GOSW. HR has established that ITU, palliative care and ED are not currently compliant. It is not possible to recruit sufficient doctors to these specialties by December 2019.

Following discussion with the relevant individuals, we will not be able to make these changes for December 2019 without affecting patient and trainee safety. The increased numbers will definitely be in place for August 2020 with a plan to do this sooner if possible. These are very specialised areas and recruiting safe middle grade doctors in ED is a particular challenge.

3. There have been multiple ER's from one of the medical wards. I have met with the lead consultant and service manager once and there have been several subsequent meetings also involving the clinical director. It has been decided to try to recruit a locum to provide additional cover on this ward, whilst a part time trainee is in one of the full time positions. This has gone to advert.

4. The F1 post in psychiatry is a WSFT post, but based at Wedgewood. It starts at 09.00. The trainee was asked to come in for 08.30 handover and to ER for 30 minutes every day. Following 4 weeks discussion with NSFT the work schedule has now been altered to reflect the hours worked.

16. Freedom to speak up guardian report

For Report

Presented by Kate Read

16.1. To receive the report from the FTSU guardian

For Approval

Presented by Nick Finch

Trust Board – 1 November 2019

Agenda item:	16.1			
Presented by:	Nick Finch, Freedom to Speak Up Guardian			
Prepared by:	Nick Finch, Freedom to Speak Up Guardian			
Date prepared:	October 2019			
Subject:	Freedom to Speak up Guardian			
Purpose:		For information	x	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					x

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

Recommendation:
To accept the report

Report from the Freedom to Speak Up Guardian

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:

- I have attended the Marketplace and Helpfulness staff event and given a presentation about my role.
- I attended a number of overseas nurse's inductions giving them a good insight into my role.
- I continue to work with the new Senior Independent Non – Executive Director.
- Working with the National Guardians Office, providing statistics, learning and telephone conferences.
- Continue to attend Trust Inductions.
- Along with the East of England Lead Freedom to Speak Up Guardian I facilitated a very successful meeting at West Suffolk Foundation Trust where Guardians from across the region either attended or used a tele-conference facility.
- I have attended a junior doctor's forum with a further dates booked.

Concerns Raised

Concern	Numbers	Status
Behaviour/ attitude	4	3 Resolved 1 Outstanding
Trust procedure/practice	0	
Capacity/workload	0	
Miscellaneous	2	2 Resolved

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

Behaviour/attitude There are four cases where I have either worked with staff and HR and where I have been asked to support staff. To date three have been resolved and one is outstanding.

Trust procedure/practice no cases to date.

Capacity/workload no cases to date.

Miscellaneous I was approached by two members of staff who raised issues and were advised to discuss with their line manager first. 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 so that staff are fully aware who I am and how I can be approached.

- To continue to work with the Executive Directors, Non –Executive Directors, senior managers trusted partners and staff governors.

- To find a way of improving community staff awareness.

- To meet the CQC as part of their inspection (well led).

Conclusion

Over the last 5 months I have continued to fulfill my 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.
I feel that being visible and the role being well advertised gives staff confidence to come forward with issues and know they will be listened to and given the support and any suitable they need.

I recommend the Trust board note this report.

16.2. To receive response to national FTSU guidance

For Approval

Presented by Kate Read

Trust Board – 1 November 2019

Agenda item:	16.2			
Presented by:	Kate Read, Interim Deputy Director of Workforce			
Prepared by:	Jan Bloomfield, Executive Director of Workforce and Communications			
Date prepared:	October 2019			
Subject:	Response to national Freedom to Speak Up guidance in NHS trusts and NHS foundation trusts			
Purpose:		For information	x	For approval

Executive summary:

A Freedom to Speak Up guide has been produced by NHS Improvement and the National Guardian's Office, setting out their expectations which are available to the Trust. The Executive Director of Workforce will use this guide to help the board reflect on its current position and the improvement needed to meet the expectations nationally set.

The below report, details the guidance and how the Trust will repond to the expectations.

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

Recommendation:

For the board to approve this response from the Trust

Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts

1. Introduction

This guide has been produced jointly by NHS Improvement and the National Guardian's Office.

The guide sets out their expectations, details individual responsibilities and includes supplementary resources which are available to the Trust.

It is expected that the executive lead for FTSU, Executive Director of Workforce and Communications (EDWC) to use this guide to help the board reflect on its current position and the improvement needed to meet the expectations nationally set. Ideally the board should repeat this self-reflection exercise at least every two years.

It is not appropriate for the FTSU Guardian to lead this work as the focus is on the behaviour of executives and the board as a whole. But obtaining the FTSU Guardian's views would be a useful way of testing the board's perception of itself.

The improvement work the board does as a result of its reflections is best placed within a wider programme of work to improve culture. This programme should include a focus on creating a culture of compassionate and inclusive leadership; the creation of meaningful values that all workers buy into; tackling bullying and harassment; improving staff retention; reducing excessive workloads; ensuring people feel in control and autonomous, and building powerful and effective teams.

The good practice highlighted in the guidance is not a checklist: a mechanical 'tick box' approach to each item is not likely to lead to better culture. Equally, focusing on process and procedure at the expense of honestly reflecting on how you respond when someone speaks up will not improve the way the board leads the cultural improvement agenda. The attitude of the board to the review process and the connections it makes between speaking up and improved patient safety and staff experience are much more important.

2. Their expectations

2.1 Behave in a way that encourages workers to speak up

All executive directors have a responsibility for creating a safe culture and an environment in which workers are able to highlight problems and make suggestions for improvement. FTSU is a fundamental part of that. They also understand that an organisational or

department culture of bullying and harassment or one that is not welcoming of new ideas or different perspectives may prevent workers from speaking up which could put patients at risk, affect many aspects of their staff's working lives, and reduce the likelihood that improvements of all kinds can be made.

Executive directors understand the impact their behaviour can have on a trust's culture and therefore how important it is that they reflect on whether their behaviour may inhibit or encourage someone speaking up. To this end executive directors;

- are able to articulate both the importance of workers feeling able to speak up and the trust's own vision to achieve this
- speak up, listen and constructively challenge one another during board meetings
- are visible and approachable and welcome approaches from workers
- have insight into how *Their power could silence the truth*
- thank workers who speak up
- demonstrate that they have heard when workers speak up by providing feedback
- seek feedback from peers and workers and reflect on how effectively they demonstrate the trust's values and behaviours
- accept challenging feedback constructively, publicly acknowledge mistakes and make improvements

Trust response:

The Trust has a set of leadership behaviours set out below and these will be reviewed in light of the responsibilities set out above.

Executive Directors to consider how they could test how their behaviours are perceived such as feedback incidental feedback from staff surveys and 360% feedback

2.2 Demonstrate commitment

The board is required to demonstrate its commitment to creating an open and honest culture where workers feel safe to speak up by:

- having named executive and non-executive leads responsible for speaking up, who can demonstrate that they are clear about their role and responsibility and can evidence the contribution they have made to leading the improvement of the trust's speaking up culture. The guidance sets out the responsibilities of the executive and non-executive lead

Trust response:

The trust has a named executive and non-executive leads responsible for speaking up and they are clear on their responsibilities. The trust will consider ways of ensuring there is a link between the work of these individuals which has led to improvements of the trust's speaking up culture

- including speaking up and other related cultural issues in its board development programme

Trust response:

The Board secretary will ensure that that speaking up and other related cultural issues are featured in the annual board development programme. Action taken already includes unconscious bias training, a board briefing on current Freedom to speak up structures and actions and **the *their power could silence truth video* shown at the Board in October 2019**

- having a sustained and ongoing focus on the reduction of bullying, harassment and incivility

Trust response:

The Trust has an action plan in place and devoted its Summer Leadership (2019) Summit to tackling bullying and harassment and improving quality through compassionate, inclusive leadership. The action plan from this summit was sent by the Chairman and CEO to all our corporate leaders to demonstrate commitment from the Board.

- sending out clear and repeated messages that it will not tolerate the victimisation of workers who have spoken up and taking action should this occur with these messages echoed in relevant policies and training. The executive lead for FTSU is responsible for gaining assurance that the experience of workers who speak up is a positive one

Trust response:

Regular communication is disseminated across the Trust – Executive leads meets regularly with FTSU Guardian to receive feedback on speaking up experience

- investing in sustained and continuous leadership development

Trust response:

The Trust has a fully resourced Leadership framework which is regularly reviewed and reported upon

- having a well-resourced FTSU Guardian and champion model. This guide sets out suggestions of how to assess your FTSU Guardian's capability and capacity

Trust response:

FTSU Executive Lead has discussed this with FTSU Guardian and assessed role against the guidance and satisfied that the Trust has appropriately supported the Guardian.

The executive lead and the non-executive lead, along with the chief executive and chair meet regularly with the FTSU Guardian and provide appropriate advice and support. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate urgent matters rapidly (preserving confidence as appropriate).

For the future relevant executive directors will ensure the FTSU Guardian has ready access to applicable sources of data and other information to enable them to triangulate speaking up issues and proactively identify patterns, trends, and potential areas of concerns.

Finally, executive directors encourage and to enable our FTSU Guardian to develop bilateral relationships with regulators, inspectors, and other FTSU Guardians, and attend regional network meetings, National Guardian conferences, training and other related events.

- supporting the creation of an effective communication and engagement strategy that encourages and enables workers to speak up and promotes changes made as a result of speaking up. This guide sets out suggestions of how to evaluate the effectiveness of your communication strategy

Trust response:

The Trust intends to produce a FTSU Strategy which will include the communication and engagement plan. **This will be presented to the Board in January 2020**

The guide sets out that the Board should have a clear vision for the speaking up culture in their trust that links the importance of encouraging workers to speak up with patient safety, staff experience and continuous improvement. The vision is supported by a strategy that has been developed by the executive lead for FTSU; this sits under the trust's overarching strategy and supports the delivery of other relevant strategies.

The board will discuss and agree the strategy and is provided with regular updates. The executive lead for FTSU will review the FTSU strategy annually, including how it fits with the overall trust strategy, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they will be overcome; and whether the right indicators are being used to measure success.

- inviting workers who speak up to present their experiences in person to the board

Trust response:

The Board to discuss and plan as this has been previously agreed. **This will be in place by December 2019**

2.3 Board assurance - FTSU culture is healthy and effective

The board needs to be assured that workers will speak up about things that get in the way of providing safe and effective care and that will improve the experience of workers.

We may need further assurance when there have been significant changes, where changes are planned, or there have been negative experiences such as:

- before a significant change such as a merger or service change
- when an investigation has identified a team or department has been poorly led or a culture of bullying has developed
- when there has been a service failing
- following a Care Quality Commission (CQC) inspection where there has been a change in rating

It is the executive lead's responsibility to ensure that the board receives a range of assurance and regular updates in relation to the FTSU strategy.

An important piece of assurance is the report provided in person by the FTSU Guardian, at least every six months and the guide sets out the kind of information the board should expect to be in the FTSU Guardian's report. To be clear this should not be the only assurance the board receives.

Trust response:

The Trust will review the FTSU Guardian report to ensure the Board receives assurance through this reporting mechanism

Another important piece of assurance is an audit report of the trust's speaking up policy. The trust's speaking up arrangements must be based on an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement and should be audited at least every two years. The audit report should not focus solely on FTSU Guardian activity but on the effectiveness of all the speaking up channels as well as the whole speaking up culture.

Trust response:

The Trust speaking up policy meets the national standards and framework and will plan to audit in **Summer 2020.**

2.4 Be open and transparent with external stakeholders

A healthy speaking up culture is created by boards that are open and transparent and see speaking up as an opportunity to learn.

The board regularly discusses progress against the FTSU strategy and (respecting the confidentiality of individuals) themes and issues arising from speaking up (across all the trust's speaking up channels) at the public board. The trust's annual report contains high level, anonymised data relating to speaking up, as well as information on actions the trust is taking to support a positive speaking up culture.

To enable learning and improvement, executive directors discuss learning from speaking up reviews, audits and complex cases among their peer networks. To support this learning, ideally, reviews and audits are shared on the trust's website.

The executive lead for FTSU requests external improvement support when required.

Trust response:

Executives routinely discuss challenges and opportunities presented by the matters raised via speaking up with commissioners, CQC, NHS Improvement and their local quality surveillance groups.

The Trusts FTSU Strategy will ensure it meets the standards set out above and ensures the Public Board meeting will receive an annual report – the first report being presented in **October 2020**

3. Conclusion

Meeting the expectations in this guide will help our board to send the message that any ideas, concerns, feedback, whistleblowing and complaints are all seen as opportunities to stop and reflect on whether something could be done differently.

Valuing workers' opinions and acting on them, publicising the good that comes from speaking up, and making clear and unequivocal statements that you will not tolerate staff being victimised for speaking up, will all encourage workers to use their voice for the benefit of patients and their colleagues.

17. Consultant appointment

To NOTE the report

For Report

Presented by Kate Read

BOARD OF DIRECTORS – 1 November 2019

Agenda item:	17			
Presented by:	Jan Bloomfield, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	Thursday 24th October 2019			
Subject:	Consultant Appointments			
Purpose:	X	For information		For approval

Executive summary:
Please find attached confirmation of Consultant appointments

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

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

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

Recommendation:

For information only

POST:	Consultant in Rheumatology
DATE OF INTERVIEW:	Thursday 26th September 2019
REASON FOR VACANCY:	Replacement Post
CANDIDATE APPOINTED:	[redacted]
START DATE:	Monday 4th November 2019
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	1 1 1

POST:	Consultant in Nephrology & AMU
DATE OF INTERVIEW:	Thursday 3rd October 2019
REASON FOR VACANCY:	Replacement Post
CANDIDATE APPOINTED:	[redacted]
START DATE:	Thursday 3rd October 2019
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	3 1 1

18. Putting you first award

To NOTE a verbal report of this month’s winner

For Report

Presented by Kate Read

11:10 BUILD A JOINED-UP FUTURE

19. Integration Report

To ACCEPT the report

For Report

Presented by Kate Vaughton

West Suffolk NHS Foundation Trust Board Meeting
1 November 2019

Agenda item:	19			
Presented by:	Kate Vaughton, Director of Integration and Partnerships, WSFT/WSCCG Helen Beck, Chief Operating Officer, WSFT			
Prepared by:	Jo Cowley, Senior Alliance Development Lead, WSCCG Dawn Godbold, Associate Director, Integration and Partnership, WSFT Sandie Robinson, Associate Director of Transformation, WSCCG Lesley Standring, Head of Operational Improvement, WSFT			
Date prepared:	24th October 2019			
Subject:	Integration Update			
Purpose:	x	For information		For approval

Executive summary:
This paper provides an update on the progress being made with integration in the West Suffolk system including specific transformation projects. This replaces the separate papers received at previous boards on Alliance development and transformation. It is proposed that this report is brought to the Board on a quarterly basis in line with the previous transformation report timetable.

Main Points:

This paper provides an update on:

- Alliance governance and meetings update
- Locality development and Place Based Needs Assessments
- Primary Care Networks
- Organisational Development and training programmes
- Transformation projects
- Realising Ambitions funding update

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

Putting you first

Previously considered by:	Monthly update to board
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	
Recommendation: The Board is asked to note the progress being made and agree that they will receive this Integration Report quarterly.	

Integration Update

West Suffolk NHS Foundation Trust Board

1 November 2019

1.0 Introduction

1.1 This paper is a combined report updating the board on the development of the West Suffolk Alliance ***and*** the transformation activity taking place internally to the trust and across the wider system. It is proposed that this report is brought to the Board on a quarterly basis in line with the previous transformation report timetable.

1.2 This move, from separate papers to one combined paper, reflects the much closer working now taking place in the system, and the avoidance of duplication that was identified as an ambition in the Alliance strategy. It demonstrates that roles and projects are no longer 'organisationally constrained', and shared responsibility for reporting exists.

2.0 Alliance governance and meetings update

2.1 **Lay member event** – This event will bring together the NHS lay community plus local councillors to discuss and agree how the role can add value into the alliance. The date for the event has been confirmed as the afternoon of the 22nd January 2020. The event builds on discussions happening in each locality about how we can best utilise the existing patient participation forums and primary care patient groups to ensure we have user voice, challenge and knowledge built into our plans.

2.2 **System Executive Group** – The next meeting of the SEG is on the 6th November 2019 and will be held as a workshop, using facilities at Haverhill Leisure Centre. The aims of the session are to set the future agenda for alliance working, acknowledging what we have achieved to date, looking at opportunities and challenges and how we can make sure the alliance delivers more than the sum of its parts.

2.3 **Alliance Steering Group –** The Steering Group met on the 24th October. Following on from a workshop in August the group reviewed the purpose of the meeting and confirmed membership across Alliance partners. The group agreed that they would:

- Prioritise a core range of issues that are of prime importance to the alliance. This would provide a focus of the group's work.
- Develop a delivery plan with milestones. Some of the content of this will be aligned to the ICS 5 year plan, and also will incorporate the locality plans as well as plans from enabling functions such as workforce development and estates.
- Unblock issues and help partner organisations make change. This was considered one of the added value roles of the steering group and the alliance ways of working
- Act as a trusted adviser to the System Executive Group, making proposals and following up on SEG decisions, as well as horizon scanning and acting as a first filer for new initiatives and ideas.

2.4 The importance of the Steering Group modelling alliance behaviours and values was stressed.

2.5 The next steps agreed included:

- The development of the alliance delivery plan. As well as the ICS "must dos" and a link back to the ICS Higher Ambitions, the plan would focus on:
    - Locality development including the integrated neighbourhood teams and the primary care networks
    - Community based prevention, including the responsive approach
    - Demand management
    - Co-ordinating the work of the enabling work streams

- How we target inequalities
- Creating a forward plan for the steering group based on monitoring the delivery priorities
- Improving our internal and external communications.

2.6 The bulk of the meeting was turned over to a discussion about workforce development Graham Seward from Health Education England and Denise Needle who leads on Workforce for the Alliance managed the session. The output from the meeting will be turned into the workforce programme for the alliance and will feed into both the alliance delivery plan and into the Integrated Care System plan. Some of the ideas coming forward included joint training and training passports, more flexible recruitment, the sharing of induction materials and having standard information in job descriptions. The Local Workforce Action Group is responsible for taking these ideas forward.

2.7 **System finance group** – The System Resources Group is meeting regularly with partners from the NHS, the County Council and the District Councils. The most recent meeting focused on financial challenges. The next meeting is scheduled for 30th October 2019.

2.8 **Quality Group –** The Alliance Quality Group is due to meet on the 29th January 2020. This new group will identify opportunities for quality improvement and areas where we are experiencing barriers in terms of system change. Additionally it will provide the Board function for the system wide Quality Improvement programme, for which WSFT is the lead partner.

2.9 **Alliance input into the Integrated Care System (ICS) 5 year plan** – The next stage for the ICS five year plan is to develop a delivery plan which will be an amalgam of plans from the alliances and plans from overarching programmes. The first draft is due to be complete in November 2019. The opportunity for the alliance is a closer linkage between the programmes going on at ICS level, those going on at West Suffolk level and those going on within each of our six localities.

3.0 Locality plan update

3.1. Activity within the Alliance continues to focus on the development of the localities as a core building block for the delivery of the alliance strategy. Helen Beck has now taken the role of locality lead for the Bury Town locality. This means we now have a spread of knowledge and experience in the leads from all parts of the system. Each locality is working on its own delivery plan. Each of these locality delivery plans will be a live document and contains actions and priorities that the locality has identified, as well as reflecting some West Suffolk-wide and ICS priorities. An example of one of these plans is attached as Appendix 1. This is an evolving document and will continue to get more populated as it is worked through each item. For example the items relating to the Place Based Needs Assessments (PBNA) will be more fully populated once we have discussed these with the locality group.

3.2 To support the localities to mature and enable integrated working, a maturity matrix is being developed for the Integrated Neighbourhood Team (INT) and for the locality by team leaders and senior clinicians and managers. The matrix will set out:

- the component parts (building blocks) that identify a well-functioning team/locality
- the signs/measures of maturity of the component parts (levels 1, 2 and 3)
- the actions that need to be taken in each team/locality to move through the levels
- how teams to self-assess their level of maturity and progress against each component part

3.3 **Place Based Needs Assessments (PBNAs)** – Public health are developing PBNA for each locality. These are available on the Healthy Suffolk website - https://www.healthysuffolk.org.uk/jsna/pbna.

3.4 We currently have PBNAs for Mildenhall/Brandon, Newmarket, Haverhill and Sudbury. The PBNA's will be distilled down by each locality into the main priorities (which will show where

the locality has a particular poor performance) and actions set against each. These actions will form part of the locality delivery plan and the locality group will monitor progress. The Alliance Steering Group have commissioned a West Suffolk overview from the Public Health Team that brings together all of the local PBNAs into a West Suffolk view, with a particular focus on inequalities.

3.5 The Alliance communication leads will be using the information from the PBNAs to establish a rolling programme of events in each locality, led by Locality Leads. The objectives for each event will be to share knowledge gathered in the PBNAs, help set local priorities, working with communities to get their ideas on how to improve health and wellbeing in their area, recognising that NHS and public sector organisations are not the only answer to people's own health and wellbeing. The information from these events will be collated so that we start to gather engagement intelligence to inform wider alliance plans.

4.0 Primary Care Networks (PCNs)

4.1 PCNs are measuring their maturity against the NHSE maturity matrix which will help identify what support the PCN or Clinical Director needs to mature their PCN. There is funding available for support through national programmes. Some of the Clinical Directors have begun a 'One Clinical Community' learning set and course where they meet and train with other leaders from the West Suffolk Alliance providers.

4.2 One of the features of the PCNs is an increase in social prescribing. In West Suffolk there has been agreement that this will be managed through Life Link – building on the success of that project. Adverts are currently out for additional staff, with the aim of covering the whole of the West Suffolk Alliance area.

5.0 Organisational development for the Integrated Neighbourhood Teams – update

5.1 **One Clinical Community** - So far, the programme has been well received by participants who are meeting new people, learning from each other and establishing relationships. One Social Care professional said *'I was very nervous about being with hospital consultants and GP's… but you know what? They are just people like me, trying to do their best'.*

5.2 The programme also offers the opportunity for participants to meet and get to know key people from across the system that they would not usually engage with, and to develop new shared approaches to system challenges. The programme will encourage teams to think collaboratively and work together differently, using the Alliance ambitions and principles.

5.3 An Acute Consultant participant said *'It's made me think about the way in which we do consultant appointments, we concentrate on the academic skills and qualifications, but their values and behaviours in terms of system and team working are just as important'.*

5.4 As we develop our PCNs across West Suffolk, the relationships and skills learnt will form a great foundation to move projects at pace for the benefit of our patients.

5.5 **Integrated Neighbourhood Teams (INTs)** training – The first cohort to attend this two-day programme was Bury Rural – both social care and community health staff. The trainer commented that the group was really well engaged and committed. The remaining five cohorts have been identified and are programmed in between now and the end of January 2020. The training is a critical part of supporting the roll out of the trusted assessment approach.

6.0 Transformation Projects Update

6.1 **Changes to Integrated Care and Planned Care Programmes** – The two existing integrated and planned care transformation teams have now come together under single

leadership to deliver a joint approach to support delivery of the West Suffolk Alliance Strategy and Delivery plan. The new team will be an integral part of the delivery resource working alongside Alliance partners as well as colleagues in:

- Ipswich and East
- Mental Health and CYP transformation teams
- The proposed new strategic programme team at ICS level leading on agreed ICS wide programmes of work including Cancer, Maternity, Diabetes, Cardiology, Respiratory and Neurology (including Stroke)

6.2 The new focus of delivery will be through the West Suffolk localities as part of the Locality based Delivery Teams ensuring that most of the design and implementation will be around place and person rather than organisation and specialty. An example of this is the work we are doing to support care homes which is being transferred and managed through the locality delivery plans.

6.3 The priorities for the team will be the Alliance Delivery Plan, in particular the Integrated Neighbourhood Teams, the ICS strategic programmes and the key areas identified from the Place Based Needs Assessments and locality mapping. Some aspects of the programme of work will retain a pan locality approach BUT will be delivered within the Locality by the LDT. This means that each transformation team member will hold responsibility for a locality as part of the LDT AND a pan locality area.

6.4 **Turbo Projects and Service Reviews –** The elective pathway service reviews have now been handed over to the Operational Leads to progress. Transformation support will be provided to demand management areas.

6.5 **Outpatients and Diagnostics –** Transformation and operational leads will work together to deliver a system review that aligns the development of the place and person approach in the localities.

6.6 **Integrated Urgent Care & GP Streaming –** This remains a challenged service with an increase in call volume by 10%. Care UK presented to the October A&E Delivery Board and highlighted a number of key challenges:

- Recruitment to call handling staff
- Capacity to undertake ED revalidation
- Lack of ED alternatives via Directory of Services
- Profiling of services on Directory of Services
- Direct appointment booking into services

6.7 The clinical model for the new integrated front door minors streaming service was approved at the October A&E Delivery Board.

6.8 **Alliance Transformation Funding –** The last Board paper included a list of areas that have been funded via the alliance transformation funding. A final scheme for an additional 10 winter beds has been approved and procurement has commenced.

6.9 ***Red to Green (R2G)/SAFER –*** Following on from the successful rapid improvement events across F3 and G5 the team have now moved on to F8, F4, F5, F6, G1 and G3. The matrons and service managers have played an active role in making the changes required to ensure all wards are working towards the red to green and SAFER principles.

6.10 The team will continue to work with the remaining wards with a plan to complete by end November 2019.

6.11 **High Intensity Users (HIU) –** Two HIU MDTs have taken place, with good engagement from system partners. The next step is discussion with GPs to determine how we all use the information gleaned to jointly manage patients. This work will complement the work already being undertaken in primary/community/social care MDT's. The HIU coordinator

will attend a selection of primary care MDTs so that joint approach and care management plan can be agreed.

6.12 We have trialled an NHS secure skype called 'visionable' at one MDT. 'Visionable' allows the GP to dial into a hospital based MDT and participate in the discussion about the patient with hospital colleagues. We will work with Guildhall and Barrow Surgery, which is part of the Bury Town locality, to test this further.

6.13 **Frailty - Frailty Collaborative –** The trust has participated in the national NHS Frailty Collaborative. A particular project we have been involved with is the 'Frailty Test and Learn'.

The work will help us to:

- ensure the frailty score is accurately recorded within 30 minutes of presentation to the emergency department.
- ensure the patients are appropriately picked up by the frailty team.

6.14 The test and learn ran from 12th August for 2 weeks. The work was led by Dr Junco-Russeau, Clinical Lead for Frailty and supported by two frailty nurses and a member of staff from the Early Intervention Team.

6.15 Junior doctors and nursing staff from F7 were also part of the wider team involved in the delivery of the new pathway of care. At the start and end of each day a 'huddle' was held with the team, management representation, the medically optimised team and a transformation team member. At the morning meeting a decision was made on the focus for the day. The late afternoon meeting concentrated on what had gone well and what not so well.

6.16 The exercise produced a number of learning points that are summarised in Appendix 2.

6.17 The national team visited the hospital in September and were impressed by the work we had done.

6.18 The final session was held in London where the trust submitted a video showing the journey for the collaborative work

6.19 **IV antibiotics in the community** – A bid to the CCG was successful in gaining a year's funding to test the use of Baxter pumps in the community for patients who need multiple doses of intravenous antibiotics. Currently these patients either have to stay in hospital or have to attend clinic multiple times a day as community teams are unable to provide the frequency of timed visits required.

6.20 If successful this will create bed capacity, community team capacity and improve the patient experience. There is also a training programme underway to teach the nurses at Glastonbury Court, Newmarket hospital and a local care home to administer this treatment, which will free up acute unit beds for those patients who are too sick to receive their treatment at home.

6.21 Community Teams Productivity – The hospital transformation team are planning to start work with the Bury Town community health team in November exploring productivity and using red to green principles to manage caseloads, with the aim of releasing capacity to further support admission prevention and earlier hospital discharge via pathway 1.

7.0 Realising Ambitions funding update

7.1 Bids to the value of over £750,000 were made into the West Suffolk Realising Ambitions fund. A panel of alliance stakeholders met on the 10TH October and agreed funding of £437,000 for 24 organisations working within the West Suffolk alliance area. The panel included a lay member from the Community Engagement Group, as well as professionals with expertise in the three priority areas for funding: obesity, loneliness and mental health.

The winners of the grants will be made public at the Suffolk Community Foundation Annual Celebration event on the 25th November.

8.0 Conclusion

The Trust is asked to note the progress being made through the West Suffolk Alliance and the Trust's wider partnership working.

Appendix 1

Mildenhall and Brandon Locality "Plan on a Page" 2019 – 2022

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

West Suffolk Alliance Ambitions		*Programme*	*Locality Specific Actions*	*Locality Owner/Lead*	*Partners*
To strengthen support for people to stay well and manage their wellbeing and health in their communities	• Introducing different ways of working that help people to manage health and care problems earlier • Developing local integrated teams • Delivering short-term care to people in a crisis • Bringing all of our system elements together and transform services so the meet local needs • Working with the private, voluntary and wider public sector to ensure our communities can thrive.	**1.Rapid Intervention Vehicle-** Admission avoidance scheme, multi-professional	• Ensure communication to referrers • Analyse usage/outcomes • Target non referring practices	Hannah	EEAT (East of England Anglian Ambulance Trust)/WSFT/WSCCG
		2. End of Life Equipping communities to be prepared, and to help and support those experiencing dying, caring and grief.	• Support development of compassionate communities in Mildenhall, including; • Linking and connecting with individuals and community groups through GPs and other community assets, and supporting people to realise networks of support. • Work with care homes to support them to become part of the community (an asset) as a place of expertise for death, dying and grief. Support care homes with hospice specialist advice and expertise.	St Nicholas Hospice Care representative	St Nicholas Hospice Care Communities/Independent Care Homes/WSCCG/CHT/WSC
		3. Developing Integrated Working Strengthening collaborative working around people and places	• Training/Education 2-day programme for the team leads • Shared Managers forum • Co-location where possible • Implement trusted assessment • Shared IT access • Joint triage of referrals • Robust MDT	Heather, Julie & Lesley-Ann	WSFT/SCC/WSCCG/NSFT/PCN
		4. Care Homes- keeping our care home residents well	• Mabbs Hall – participating in – Medicines Optimisation in Care homes (MOCH), Interface Geriatrician project, End of Life Support and training with hospice. • Mildenhall Lodge participating in Early Intervention Team (EIT) Care Homes support project (phase 2) • Brandon Lodge – participating in MOCH/ EIT Care Homes support project (phase 1) • Longer term sustainability of Care homes managing demand plan with closer working between INTs and Care Homes in their locality as well as engagement with the ambulance service and shared workforce across health, social care and Care Homes. By continuing to develop system relationships, this will support managing demand.	Hannah?	Independent Care homes
To focus with individuals on their needs and goals.	• Testing new ways of delivering health and care services that break down traditional organisational barriers • Creating person centred plans so that people will have one plan that explains how services will meet their wellbeing and health needs	**5. High Intensity Users-** supporting and assisting individuals who frequently use services	• Once established the HIU meetings will be moved to M&B with more influence from primary care services.	Sandra & Godfrey	WSFT/WSCCG/PCN
		6. Responsive Support Service – a joined up response to a short term need	• Where practicable possible service within the Responsive specifications will be delivered in the locality. M&B due to it collocated and integrated INT will be proposed as 'test and learn' sites for future improvements.	Hannah, Heather & Julie	SCC/WSFT/WSCCG/
		7. Mildenhall Hub	• Ensure there is locality representation to the steering group • Develop the clinical strategy for the locality to influence design	Heather, Julie, ?	SCC/WSC/WSFT/WSCCG/NSFT/Abbeycroft/

	• Coordinating help for people and checking we can share their records across relevant professionals • Supporting self-care and self-management • Using feedback from people to inform our redesign options and how we spend the West Suffolk pound	Health and wellbeing hub embedded in the community.	• Ensure design maximises integrated working and is future proof • Working with locality VCSE and community groups to coproduce final design. • Building work commenced – aimed completion late summer 2020 Complex Patient meetings run by Community Matron, attended by Health & Social care staff. Discussing High Intensity users & other individuals care needs		
		8. Brandon Hub/Leisure Centre – exploring options for co-location and greater partnership working between health and leisure.	• Ensure representation to the steering group • Develop the clinical strategy for the locality to influence design • Ensure design maximises integrated working and is future proof • Test new workforce roles between health and Abbeycroft • Commence Social Prescribing office. .	Heather, Hannah,	SCC/WSC/WSFT/WSCCG/NSFT/Abbeycroft/Forest Surgery
To change both the way we work together and how services are configured	• Developing a Five Year Delivery Plan showing how we will deliver the outcomes agreed as a system, delivering what works best for people in West Suffolk • Health and care leaders will be meeting regularly with partners to plan how we deliver our vision and track actions against our Delivery Plan • Moving towards an Integrated Care System where we can truly use our resources flexibly to meet local need • Expanding our collaboration with the voluntary and community sector organisations, and district and borough councils, working closer together to improve people's wellbeing and health	**9. Primary Care Network –** Groups of GP practices working together across a defined geographical area. (Shared with Newmarket)	• Establish working rhythm between PCN and locality • Understand the duplication areas in PCN guidance and localities • Identify key themes that span primary care and the community and address through a coordinated approach • Ensure that relevant information is fed from PCN to locality and vice versa via the Clinical Director	Lee, Emma & Nick	PCN/WSCCG/WSFT/NSFT
		10. Social Prescribing A way for local agencies to refer people to a LifeLink coordinator, who give people time, focusing on 'what matters to me' and taking a holistic approach to people's health and wellbeing. They connect people to community groups and statutory services for practical and emotional support.	• A candidate has been offered and accepted LifeLink Coordinator role. Starting 1 day a week August 2019 and full time from October 2019. Tis member of staff will work half the week in Brandon and Half in Mildenhall • Soft launch from 7th August when referrals started to be accepted. Rob Jones transferred from Haverhill 2 days a week in August, increasing to full time in September. Rob will also work half week in Brandon and half week in Mildenhall. • Planning an official launch event for each project apx mid-late September. • New email account has been set up brandon-lifelink@westsuffolk.gov.uk • mildenhall-lifelink@westsuffolk.gov.uk All stakeholders, GPs and mental health teams have been informed of referral route. Referral via DSX is also available to GPs. • Final discussions on additional provision from LifeLink for PCNs underway (to provide social prescribing for each PCN using the government funding they have been allocated). Awaiting final confirmation on funding with PCN/CCG and agreement of service level agreement.	Suzanne + Life link coordinator	WSC/WSCCG/NSFT/SCC/VS/
		11. Frailty Project- improve the way we support our frailest residents	• Project commenced 1st April with Market Cross • Evaluate once 25 patients reached	Hannah, Sandra & Godfrey	WSFT/WSCCG/Market Cross
		12 Care Co-ordination Centre/ independent wellbeing service review of referral pathways to support local joint triage and assessment	• Establish working group/ scope of project • Define ideal processes • Agree desired changes and assess impact • Implement change	Heather & Julie	WSFT/SCC/ESNEFT/CCG's/
To make effective use of resources	• Increasing the proportion of our health and care spend that is spent in the community, whilst achieving value of money • Working to get a whole system understanding of health and care resources and how best to use them to support an Integrated Care System • Working together to address the financial pressures within each of our Alliance organisations • Developing and implementing plans for IT & digital solutions, estates, communication & engagement,	**13. Developing the Locality –** creating a strong community that is resilient, informed and easy to work and live in	• Establish locality delivery group • Agree priorities • Develop profile • Take action!	Lesley – Ann, Dawn, Leiat	WSFT/SCC/WSCCG/NSFT/GP FED/PCN/ VCSE/
		14. Community Pharmacy The LPC (local Pharmaceutical committee) are being to work with PCN's about increasing community pharmacies and their impact.	• Healthy living pharmacy 2 – Engaging with customers to understand their needs and self-care through knowledge and signposting • Trained staff in Market Hill to provide health checks • Giving information to all pharmacies to provide services such as stop smoking, EHC –Emergency hormonal contraceptive service, Chlamydia screening and treatment, needle exchange, Supervised consumption – (coming off drugs), • CPCS– NHS urgent medicines services advanced service – which is linked to 111 for the supply of urgently needed medication out of hours. • Need support with new Patient Group Direction services to get commissioning moving workload from GP surgeries.	Myra Battle	WSCCG/LPC/

	workforce, and organisational development • Taking every opportunity to use our assets together to reduce duplication and drive out in efficiency, through sharing public sector buildings as we aim to develop community 'hubs' in each of our localities and consolidate corporate functions		• Palliative care services to be launched through pharmacy supporting end of life care, • PDG for management of lower acuity conditions which will support the community by being able to treat minor aliments directly through pharmacy i.e conjunctivitis. • Being engaged with Mildenhall hub building knowledge to signpost to local services. • Social prescribing need to link with pharmacy enabling and supporting referrals. • Pharmacy to be more involved in locality campaign provision.		
		15 Elective Care – • **Diabetes** • **My COPD** • **Atrial Fibrillation** • **Telemedicine/health**	• AF- Paul Wood has been appointed as the Stroke Prevention community volunteer who will be testing patients in the Health clinic in Mildenhall. • Diabetes - Increased referrals to diabetes prevention programme for pre-diabetics (includes digital diabetes prevention app when available) • ECLIPSE diabetes dashboard – roll out to remaining practices (Lakenheath & Reynard); promote planned interventions upon findings from 9 care processes at annual diabetes checks • Implement digital diabetes app for T2 diabetes education and personal lifestyle coach. • Implement Gestational Diabetes Mellitus (GDM) Pilot – diabetes prevention pilot for ladies post-pregnancy, with GDM pathway for primary care annual checks	Juliet	WSFT/WSCCG/PCN/
		17. Rural Transport for people who are housebound			
		18. Children to adult services transition			
		19. PBNA	• Wider Determinants of Health • Primary care Children & Young People • Hospital Admissions • Older Peoples Health • USAF		

Appendix 2 – Learning from the Frailty Test and Learn Exercise

What was positive?

- Use of medic bleep as a team to communicate.
- Being flexible by using a daily PDSA approach to the change.
- Making much better use of the community teams in managing patients for a Community Assessment Bed
- Inclusion exclusion criteria agreed by the end of the 2 weeks.

What further work is required to move forward?

- Further education for staff outside of the frailty team including F7 staff and the patient flow team to understand the role of the FAU.
- Clearer communication with the ED team about the changes we made each day.
- Review the frailty nurses capacity now that they are concentrating on FAU.
- Community Matrons felt they didn't have the same access to the frailty nurses to ask about inpatients - ? They could utilise discharge planning team
- Referrals previously seen by the frailty nurses now picked up by the geriatricians - ? Is that sustainable.

What could make a significant and sustainable difference moving forward?

- A protected assessment area to pull patients from ED and assess for SDEC or short stay admission would be beneficial. This should not be part of the bed base of the hospital and be closed at 20:00hrs.
- The frailty team having control over their short stay bed base. This allows the team to pull slightly sicker patients who may need admission. This avoids having to join the ED queue for a bed and reducing flow in the assessment area.
- covering 8am to 8pm with a single consultant is not sustainable.
- Medicine team to discuss how to collaborate and reconfigure the front end teams and identify the gaps and include in the divisional business plan.
- Building the MDT together under one leadership making it easier to communicate and make quicker decisions.

11:20 GOVERNANCE

20. Trust Executive Group report

To ACCEPT the report and the patient safety and learning strategy

For Report

Presented by Stephen Dunn

Board of Directors – 1 November 2019

Agenda item:	20			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	25 October 2019			
Subject:	Trust Executive Group (TEG) report			
Purpose:		For information	X	For approval

Executive summary

7 October 2019

Steve Dunn provided an **introduction** to the meeting. A challenging discussion took place on the financial position and the recovery plan requirement. A summary of the CQC feedback was received which recognised the positive attitude of our staff. Areas for improvement were noted ahead of further unannounced visits as part of the inspection. The transfer of Newmarket Hospital to WSFT ownership was welcomed along with the national recognition and support for a new hospital locally. Discussion recognised the need for clinical engagement to develop models of integrated care as part of a system based solution. Nick Jenkins fed back discussion from the recent reconstituted medical staff committee, including plans for future scheduling of the agenda.

Quality, operational and financial performance was reviewed from the recent Board papers. Discussion took place on the two MRSA bacteraemia cases for which an appeal is being supported by the CCG. Review focused on pressure ulcer and duty of candour compliance. The high levels of activity in August were reviewed in the context of the ongoing pilot of the new emergency department standards. Diagnostic, cancer and referral to treatment (RTT) performance were subject to review and discussion along with preparation for winter. This included discussion on preparation for predicted peaks in demand.

Detailed discussion took place on the current **financial position and forecast** for 2019-20. The recovery plans from divisions were noted but recognised that this leaves £10m gap. Further discussion took place on options regarding temporary nurse spend, emergency department spend and RTT additional session spend. It was recognised that any scheme to mitigate spend in these areas must be underpinned by quality impact assessments (QIAs), as with other recovery schemes. The challenging position was recognised.

An update report received on the **human factors** with focus on the new strategy group, work of the faculty and key focus of the work plan. It was agreed to consider whether this programme can be extended to be system based through locality groups

TEG approved the extension of **staff survey** to include all staff in the latest national round, rather than the previous sampling approach. It was noted that having opened last week we have already received 600 responses.

Noted that continue to engage in external and internal planning for **EU exit** at end of October based on no deal scenario. Assurance received from government on health preparedness nationally, including delivery of goods and services. Emergency planning table top exercises continue, including staff prioritisation for key services. Recognised that additional risk with exit at this time of year with proximity

to winter and reliance on key services and staffing. Assurances have been received from social care on preparedness, including staffing.

The **winter planning** report was discussed and reflected on the assumptions for the bed modelling and the spikes of activity to require surge capacity. It was noted that there are no plans to reduce elective orthopaedic activity or use F4 at this stage. The operational plan to deliver winter preparation was reviewed and approved. Further work continues to review staffing plans for escalation and surge capacity and a further review of the paediatric winter plan will be reported to a future meeting.

The **paediatric consultant** business case was reviewed and the position agreed that recognising the service challenge that need to progress the advert while undertake further analytical review to inform the number of consultant posts required.

The outcome of the **MHRA inspection visit** was noted and it was welcomed that the findings were consistent with what expected based on NEESPS self-assessment. TEG welcomed the feedback which demonstrated progress, even if limited.

An update was received from the **digital board**. Noted that, informed by the junior doctors engagement, we are finalising the programme for next year. The plans for HIMMS 6 compliance have been impacted by national developments – expected to by July 2020.

Received the **education and training report** and noted the staffing changes that have taken place that support the comprehensive programmes of work. This included a significant focus on support and supervisor roles across professional groups. The underpinning leadership development and talent management programme were highlighted as part of Priority 2: Invest in quality, staff and clinical leadership (Annex A).

Discussion took place on a piece of **organisational development work** to be undertaken by NHS Elect. The review is the first stage of a wider process that will go on to consider leadership, responsibilities and accountabilities at the business unit levels.

21 October 2019

Steve Dunn provided an **introduction** to the meeting and confirmed that he had received further communication from Matt Hancock regarding the positive commitment to the new hospital development. It was recognised that system based plans need to be developed, including the commitment to existing programmes of work. It was noted that our ICS's response to the NHS long term plan had been commended as one of the best in the country.

The **red risk report** was received. There was one new red risk relating to compliance with version two of the Saving Babies' Lives Care Bundle guidance. Mitigating actions to control the risks were reviewed. No red risks were downgraded and one draft red risk was noted. As a result of mitigations put in place five red risks, which had been subject to executive review, were noted and approved as downgraded. The corporate and operation risks were also reviewed which are subject to executive review and discussion at divisional performance review meetings. As part of the agenda the meeting also received an update on the work to assess and mitigate the estates risk for the WSH site. 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** to ensure safe staffing and capacity for winter.
- **Pathology services** – delivery of pathology services, including MHRA inspection and NEESPS accountability and control. These all have an impact on service delivery and patients services directly impacting of quality and sustainability of services.

Discussion took place on the feedback received from the **CQC inspection team** following their site visits related to the service level inspection. This will be used to support preparation for the well-led

inspection at the end of October.

The **Quality Group report** was received. The final patient safety and learning strategy (Annex B) was welcomed by TEG as providing an informative summary. It was noted that the group would include a focus on the improvement work as a result of the CQC feedback.

A report was received on Q1 activities as part of the **patient flow quality priority** for 2019/20. The aim of the quality priority is to ensure Red2Green and SAFER are fully embedded across the organisation. This will ensure we have the best possible patient flow which will ensure patients do not stay longer in an acute bed than they need to and lead to a reduction in delays in the emergency department.

It was recognised that **promoting the health and wellbeing** of all our staff is important to support them in delivering excellent care for our community as well as being a marker of a good employer. An update report was received which set out how this support is being provided and indicators of its impact. The focus on supporting staff mental and emotional health wellbeing and understanding and addressing the needs of medical staff were welcomed.

The **emergency preparedness, resilience and response (EPRR) report** was received and discussed. This focussed on updates to the Trust's emergency preparedness capability, including strategic commander training for scenario based events.

An update report on the implementation of **Allocate** was received cutting across a number of activities: e-appraisal; medical rostering; activity manager; and locum on duty. The financial impact of delays early in the project were recognised and it was emphasised that job planning must be completed as a priority to support business as usual transition of the project.

The last quarters **waivers** were reviewed, while this remains an important focus it was noted these had reduced since the last report.

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

1. The Board note the report
2. Approve the patient safety and learning strategy

Annex A: Leadership development and talent management programme (from education report)

- The 2030 Leaders Programme provides leadership development for aspiring senior leaders and is an important element in our talent management strategy. 21 clinical and non-clinical leaders from WSFT and West Suffolk CCG are participating in the 2019/20 programme; this includes five members of consultant medical staff. The 2030 Leaders Programme was launched in 2017 and this current programme runs until March 2020. We are exploring options with Alliance partners through the Local Workforce Advisory Group (LWAG) to run a similar programme within the West Suffolk system.

- Twenty-two of our most senior clinical and non-clinical leaders have participated in the WSFT key leaders programme to date. This programme is another part of our talent management strategy aimed at developing the capabilities needed to support leaders in some of our most crucial posts. Development activities include 360 feedback, one-to-one coaching and participation in a range internal and external leadership development programmes.

- The very successful Expert Navy programme for new band 7 ward managers and band 6 nurses aspiring to a ward leadership role is running again in 2019 and a programme has also been developed for Allied Health Professionals at band 6. These programmes are run by the Clinical Education Team in the Nursing Directorate and support succession management to middle level leadership positions.

- Fourteen WSFT staff, including six members of consultant medical staff, community matrons and local managers are participating in the One Clinical Community Leadership Development Programme which started in September 2019. The programme is aimed at those in a clinical or other senior leadership and who value the opportunity to develop their own skills with others in the local health economy in a collaborative and practical way. Dr Nick Jenkins is one of the programme sponsors along with senior colleagues from the West Suffolk Alliance.

- The Trust Summer Leadership Summit in June focussed on “Improving quality through compassionate, inclusive leadership”. It was attended by over 70 senior trust leaders. The morning session focused on how we create a more inclusive culture and improve everyone’s experience at work. In the afternoon participants reflected on and developed a shared understanding of what outstanding means for staff and the people we serve. They also learnt about new enablers of outstanding care from patient safety and quality improvement. An action plan to improve everyone’s experience at work through addressing poor behaviour, including bullying and harassment, has been drawn from Summit participants’ experience and suggestions. This is now being implemented.

- Trust Board members have undertaken the Trust’s unconscious bias e-learning in support of the Trust’s Inclusion Strategy objective to promote and support inclusive leadership at all levels of the trust. Feedback on the training has been excellent.

- A clinical leadership event for 30 junior doctors, organised by Dr Jane Sturgess, Consultant Anaesthetist, was held in April. The day introduced participants to basic leadership concepts and to gain knowledge of the importance of clinical leadership. Feedback on the day was excellent and a further day will be held in October.

- A workshop, including leadership development for SAS and locally employed doctors, organised by Dr Zuleikha D’Souza, SAS doctors’ tutor, will be held in November.

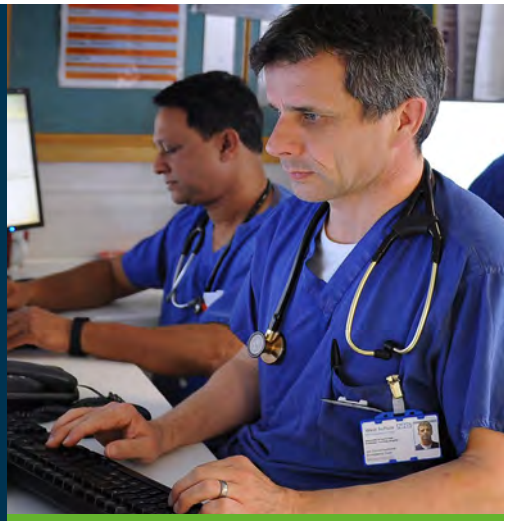
- A number of staff are participating on Management Apprenticeships at levels 3 and 5 using the national apprentice levy – both through external educational providers and an in-house programme.

- As part of our on-going Staff, Management and Leadership Development Programme over 200 staff will participate in mental health awareness training in 2019. This includes over 100 leaders who are participating on the Suffolk MIND two-day programme 'Mental Health for Managers' which provides participants with the tools to recognise when staff are experiencing mental health difficulties and provide appropriate support. A further 100+ staff have attended mental health awareness and emotional first aid training.

- The 5 O'clock club continues with regular bi-monthly meetings in 2019 providing speakers on either a leadership or quality improvement theme. In the summer the Dean of St Edmundsbury Cathedral, the Very Reverend Joe Hawes spoke about leadership and in September members heard from Ben Tipney, a former international athlete rowing for Great Britain, on human factors. Deputy Chief Constable of the Sussex Police Force, Joanne Shiner will be speaking in November.

NHS
West Suffolk
NHS Foundation Trust

Patient safety and learning strategy



Contents

Foreword from Paul Morris, head of patient safety and effectiveness	4
Patient safety and learning in the NHS	5
1. Putting safety first	8
2. Being open and honest	9
3. Embedding ‘just culture’	11
4. Continually learning and improving	12
5. Supporting patients and staff	14
6. Promoting collaborative working	16
7. Incorporating human factors	18
Appendix A: Three-year plan	22
Appendix B: Quality assurance framework	24

Hello, my name is Paul Morris. I am the deputy chief nurse and head of patient safety and effectiveness at the West Suffolk NHS Foundation Trust (WSFT).

We pride ourselves on delivering safe care to all our patients. On the occasions when there is unintended or unexpected harm to people during the provision of healthcare we endeavour to learn from these situations, putting the patient, their families and our staff at the core of everything we do. We aspire to be an open and honest organisation which is candid and provides open channels of communication.

For this reason, patient safety forms the principle ambition of our Trust; to deliver the best quality and safest care for our community. All patients should be treated in a safe environment and protected from harm so we strive to continuously improve and innovate through effective and collaborative teamwork.

With the publication in July 2019 of the national NHS patient safety strategy, ***Safer culture, safer systems, safer patients***, now is the right time to launch our own blueprint for action.

As a Trust we recognise the benefits that can be had from sharing and cascading learning from incidents and near misses or great catches, learning from deaths, and the patient experience. We know that implementing quality improvement initiatives based on this learning are a great way to improve safe care .We know that if this is done effectively it can help to minimise future risks and strengthen the quality of the services we provide. We aim to share and cascade learning from 'board' to ward and 'ward to board', recognising every member of our organisation has a part to play in delivering safe care.

As a global digital exemplar (GDE) organisation we seek to learn from the opportunities provided through our electronic patient record system (e-Care), which acts as a repository for huge amounts of data relevant to patient safety.

This is why I am passionate to ensure we have high standards of investigation, incorporating human factors and situational awareness so as to learn from these incidents and implement change. Achieving this using a 'just culture' method across the organisation, ensuring staff are supported to celebrate success and learn from incidents. We confident that we get it right most of the time but when we don't it is important to learn with each and every opportunity, and that's what makes us a great and safety conscious organisation.

Paul

Patient safety and learning in the NHS

Patient safety is the avoidance of unintended or unexpected harm to people during the provision of healthcare.

Where are we now?

The patient safety movement is now more than 20 years old and has made much progress in that time. In 2003, the NHS launched the National reporting and learning service (NRLS), a world-leading incident reporting, review and response system.

As a direct result of this, the NHS has removed or reduced significant risks from across the system, for example; introducing new devices that prevent the accidental administration of drugs by the wrong route and improving the detection of acute kidney injury. In 2019/20 the new patient safety incident management system (PSIMS) is due to be completed once pilot processes have concluded. The trust is one of a select number of organisations involved in the public beta phase testing of this system.

The NHS has an increasing awareness of important approaches to improving patient safety. These include: the role of human factors and ergonomics in improving systems and processes; and the impact of quality improvement methods through initiatives and work of organisations like the Health Foundation and the patient safety collaborative.

The Trust's web-based electronic incident reporting system (Datix) supports multidisciplinary incident reporting, which includes a high level of reporting near misses, no harm incidents, and minor harm incidents.

Reporting of these 'green' incidents is seen as a key driver for identification and management of risks to prevent more serious harm occurring.

Our challenges

Patient safety and learning is of primary importance to us as an acute and community services trust and is reflected in our overarching Trust value - 'putting you first'.

The Trust works hard to ensure that the care it provides continually strives to achieve this in all services it provides, every day. Most of the time we get this right and do this well, but we know we are not perfect and want to address the challenges we face to make improvements.

We know we can improve for example, in the way we investigate incidents and how we share learning from them. We engage with staff regularly about the serious incident framework and process, and they have told us that:

- some staff still fear blame
- some staff believe incident reporting is a punitive process whilst others believe it is ineffective
- staff can struggle to prioritise and implement patient safety alerts designed to reduce risks because the governance systems can be bureaucratic rather than responsive
- some processes have a focus on completing an action rather than supporting reduction of risk.

Where do we want to go?

Don Berwick's 2013 report 'A promise to learn, a commitment to act' continues to inform our approach to improving patient safety and the quality of care provided.

The NHS is not learning as well as it could do when things go wrong, meaning that mistakes are repeated and opportunities to put in place effective systemic barriers to error are missed. Also, more needs to be done to develop the kind of leadership and culture across the whole of the NHS where everyone feels empowered to speak out about safety concerns and where patients and families are always included as full partners in care.

The Trust has committed to 'deliver safe care' as one its ambitions, with another being 'support all our staff, and we will deliver this through our patient safety and learning annual plans.

The aim of the strategy is to:

- reduce the instances of harm to our patients
- improve engagement with patients and staff when things don't go to plan
- support patients and staff through the investigation process to ensure learning is implemented

These aims translate into seven principles:

1. Putting safety first
2. Being open and honest
3. Supporting patients and staff
4. Continually learning from incidents and excellence and supporting quality improvement
5. Collaborative working across the health economy
6. Embedding a 'just culture' throughout the organisation
7. Integrating human factors and ergonomics into our work flows

1. Putting safety first

We have identified a number of initiatives to support work across the organisation to monitor, maintain and improve patient safety.

Implementation of guidance

We will ensure that we are working to latest national best practice standards across the organisation.

We will identify and inform the Trust of the latest NICE guidance for each area of specialty for implementation into its practice.

Monitoring of practice

Through our programmes of clinical audit, quality priorities, quality improvement projects and integrated quality and performance reporting (IQPR) to support, monitor and report clinical best practice across the organisation to make ongoing improvements.

Daily patient safety brief

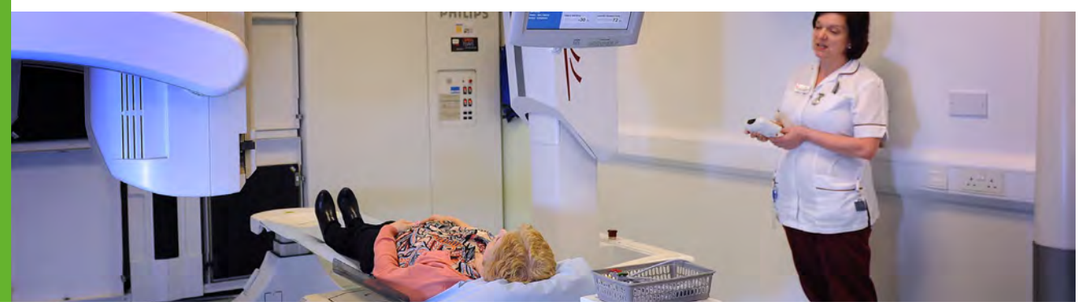
We will carry out a daily multidisciplinary patient safety briefing each morning, led by the senior matrons and patient safety and quality team. This is a forum to communicate and capture any patient safety issues overnight and for that day.

There is attendance by the multidisciplinary teams supporting the areas of safeguarding, learning disabilities, staffing, dementia, tissue viability, palliative care, information technology, end of life, security and infection prevention to ensure safety issues are paramount and the focus of the day.

All these initiatives, combined with a 'board to ward' focus on safety, underpin our one vision 'to deliver the best quality and safest care for our community'.

With a Trust commitment to:

- Focus on key indicators of harm; including pressure ulcers, falls, hospital acquired infections, venous thromboembolism (VTE) and medical errors.
- Measure the outcome of quality improvement projects through our quality improvement framework.
- Participation in regional and national collaborative and adoption of best practice.
- Maintain our position in the top 10% of hospitals with the lowest mortality.
- Ensure early identification of patients at risk of deterioration.
- Train, educate and support staff to deliver safe and effective care.



2. Being open and honest

To support a culture of being open and honest with our patients we need to work to earn their trust, by engaging effectively both when things go well and when things don't go as planned.

Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care that causes, or has the potential to cause, harm or distress – this includes saying sorry. This should be in the form of an apology on behalf of the trust to the patient or, where appropriate, the patient's carer, family or advocate.

Talking about incidents where people were harmed can be uncomfortable. Not talking about them is dangerous. Ensuring a conversation is carried out promptly, sensitively and sympathetically with patients and their relatives is one of the ways we can ensure we are being open and honest. This is called duty of candour.

Openness is a prerequisite for sharing insight about safety: being open supports the kind of positive accountability needed for change, as well as being the right thing to do.

The opportunity for staff to be open and honest with the organisation is also a key driver for improvement. Whether through our local Freedom to Speak Up guardian and trusted partners or the planned raising concerns helpline, patient safety can be enhanced by staff who are willing to share their experiences for the greater good and are supported to do this.

With a Trust commitment to:

- Continue to carry out duty of candour for patients ensuring it is carried out promptly, sensitively and sympathetically.
- Continue to support the 'freedom to speak up, freedom to improve' campaign by promoting our own staff trusted partners, freedom to speak up guardian, and Datix reporting options
- Reviewing the content of the whistleblowing policy (PP056) to ensure it is reflective of current practice and supports staff.
- Implementing a 'raising concerns' phone line which will support staff to raise concerns anonymously on a secure answer machine monitored by the patient safety team. The phone will be answerphone only and allows the member of staff to report a concern they have direct to the organisation.

3. Embedding a 'just culture'

In his 2013 report A promise to learn, a commitment to act, Don Berwick advised the NHS to "abandon blame as a tool".

Evidence from across other industries and countries tells us that punishing people when they make mistakes will not mean they make fewer mistakes. It is wrong to believe that if people simply try hard enough, they will not make any errors. Blaming people for error does not improve safety; we should instead focus on changing systems and processes to make it easier for people to do their jobs safely.

In a just culture, inadvertent human error, freely admitted, is not normally subject to sanction to encourage reporting of safety issues. In a just culture, investigators principally attempt to understand why failings occurred and how the system led to sub-optimal behaviours. However a just culture also holds people appropriately to account where there is evidence of gross negligence or deliberate acts.

With a Trust commitment to:

- Reviewing the staff survey findings annually to find out how staff feel about safety and learning and act upon the findings.
- Develop a support network for staff during and following serious incident investigation.

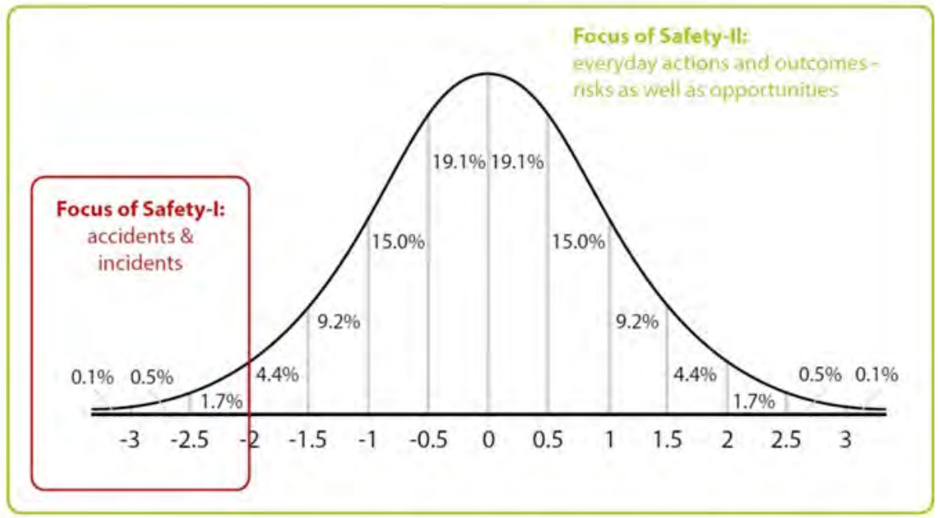
4. Continually learning and improving

The NHS has committed to continuous improvement of safety; essentially this means that improving patient safety is not a problem to be 'solved' once and for all.

Instead, working to enhance the reliability of how we provide healthcare should be a constant aim for us all.

As a Trust we have identified that the most important approach to improving patient safety and preventing adverse incidents from reoccurring is learning from our own or others' practice across healthcare. Patient safety in the NHS is moving from ensuring that 'as few things as possible go wrong' to ensuring that 'as many things as possible go right'.

This matches the concept of moving from Safety–I to Safety-II learning from things that go well in the trust, everyday practice and not just from things that don't go to plan and cause harm.

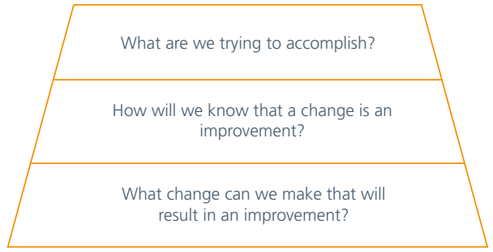


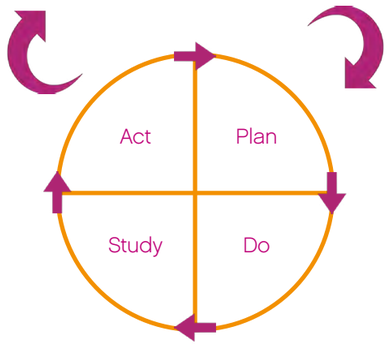
With a Trust commitment to:

- Increase our focus on learning around why things go wrong, looking deeper than the non-compliance issues and incorporating human factors.
- Put systems in place to learn from what goes well and commit to increase focus on reviewing good practice so they can be built upon and replicate in other areas. The trust plans to implement a new 'GREATix' excellence reporting portal to enable staff to feedback good practice that can then be shared.
- Encouraging our staff to identify and then act on those areas where we can improve through our Trust Freedom to speak up, freedom to improve' initiative and monitoring the impact of this.
- To use multiple engagement tools to share learning from incidents and good practice.

Current learning initiatives include:

- Weekly executive led quality walkabouts across all areas of the Trust
- Patient safety led table top exercises to review live practice
- Trust-wide shared learning events and bulletin which shares learning from incidents, clinical reviews and quality improvement projects
- Review our local and national clinical audit and national best practice findings and recommendations
- Trust quality priorities: quality improvement, patient flow and human factors
- 'Learning from deaths'
- Community quality assurance visits and monthly quality bulletin
- Divisional patient safety and quality meetings
- 'Risky business' maternity newsletter
- Safety huddle communication boards in clinical areas





5. Supporting patients and staff

Compelling evidence from patients, families, carers and staff has revealed weaknesses in the way NHS organisations investigate, communicate and learn from when things go wrong.

Nationally, those who have had a poor experience of NHS patient safety investigations tell us this can have a lasting social and physiological impact for patients, families, carers and staff alike. This has fuelled recent efforts to improve investigation practice to better support those affected by incidents and to prevent repetition of harm.

It is a priority to appropriately involve and support patients, families, carers, staff; as well as other stakeholders in incident investigation.

Continued collaborative working is required with the support of the patient experience team and clinicians to improve patient and staff experience of incident investigation. Good quality, early and consistent engagement is key.

The Trust commits to providing patients, their families or carers involved with:

- Timely notice of their care or a patient in their care being subject to a patient safety investigation through the duty of candour pathway.
- Good quality information about the investigation process and the timescales that are involved, including updates if the timescale has been changed.
- An opportunity to contribute their experience of what happened to enhance the incident investigation.
- An individual point of contact for patients and their families to provide support or answer any questions.
- Sharing the findings of the investigation and inviting patients, their families and carers to meet with us to answer any questions they have regarding the outcome of the investigation and the report findings.
- Investigation reports are not sent before a weekend, to ensure there is an available informed contact to answer questions quickly.
- An opportunity to talk to a senior member of the learning from deaths team to discuss any areas of concern, or to feedback praise for excellent care during their relative's admission and last days.

The Trust commits to providing staff involved with:

- An incident debrief process for staff or teams.
- Supportive mentoring from peers
- Opportunities for professional support and occupational health (if required)
- Assistance from patient safety experts in the completion of investigation reports
- An objective review of the entirety of care delivered when a patient dies that focuses on learning rather than blame

6. Promoting collaborative working

It is acknowledged that barriers which exist to implementing learning across organisations can be removed through collaborative working.

Incident investigations can result in recommendations being made that cannot be achieved by one clinician or team alone, but require collaborative working across a number of different divisions, specialties, professional identities and the wider local health economy.

A collaborative approach can improve communication, save time, reduce duplication of effort, improve working

relationships and provide a better experience for people who use health services.

We are active members of a health and care partnership, which makes up the West Suffolk Alliance. Through this Alliance began to deliver community services within our geographical footprint in October 2017 and has been more broadly working together to improve the service offer to the population of West Suffolk since this point.

Our focus within the West Suffolk Alliance is on people and places, and the strategy sets out the commitment of all partners to move from working as individual organisations towards being a fully integrated, single system based around the individual.

To achieve this shared vision, clear local priorities have been agreed to provide an improved service for people in West Suffolk and to tackle the sustainability issues faced by the system together.

The West Suffolk Alliance has agreed four interrelated ambitions, which underpin the strategy; these demonstrate how as Alliance partners we will make progress together. They do not displace the individual organisational priorities, but rather show the benefit from Alliance working.

The Alliance strategy builds on the six Connect localities, which are arranged around natural communities, with the aim of building resilience and strengthening local services offered wherever possible. For the west of Suffolk the localities are: Newmarket, Haverhill, Sudbury, Brandon and Mildenhall, Bury Town and Bury Rural.

These groupings can be thought of as a 'hub and spoke' with the system leadership as the 'hub' and the six locality areas as the 'spokes'.

The patient safety and quality team will promote collaborative working to achieve:

- A greater sense of shared values, vision and purpose
- A plan on how to work together more effectively
- Improved clinical engagement
- Improved relationships between team members
- Develop a better understanding of each other's roles and challenges

It is hoped that all these initiatives will improve clinical engagement and visibility of patient safety and quality across the trust.

With a Trust commitment to:

- Implementing a new post of a deputy medical director for quality with protected time for quality improvement and clinical effectiveness.
- The Trust commits to continue to work with the United States Air Force and the British Army in a mutually beneficial exchange of skills and workforce.
- Working with the ambulance service to share our learning and support them in setting up a 'learning from deaths' process

7. Incorporating human factors

The objective of a Trust-wide wide approach to human factors and ergonomics is to support the reduction in the likelihood of catastrophic harm to patients.

Human factors science is not just about optimising individual and team behaviours to improve patient safety culture.

It is also about designing the workplace and the equipment in it to accommodate the limitations of human performance.

Healthcare professionals are human and are fallible. We all make mistakes. Such errors can cause patients catastrophic harm. Although up to 70% of safety incidents involve human error it is rarely in isolation. It is also rare that serious safety incidents are as a result of lack of clinical knowledge.

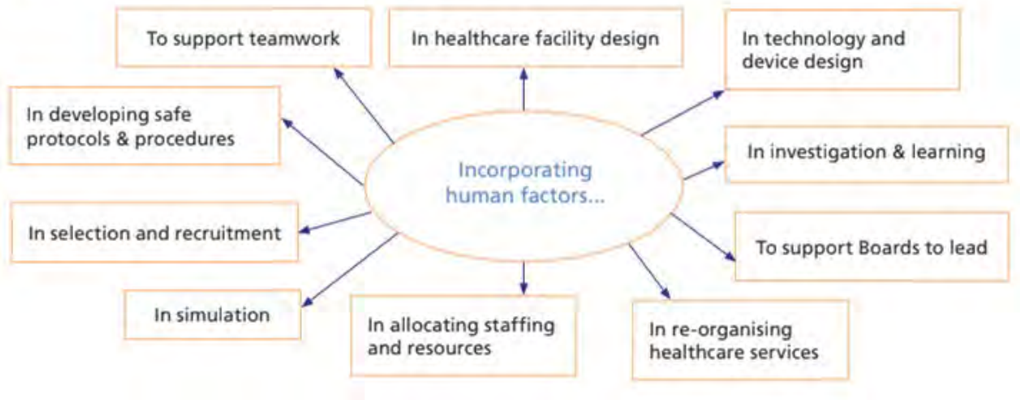
They are usually a combination of human performance and system factors.

Very rarely is lack of technical skill to blame when analysing incidents, rather the research literature and major incident reports are replete with examples of leadership, situational awareness, communication, coordination and team work failures (McCulloch et al, 2009).

Staff human factors training aims to recognise human fallibility, the physical environment, physical demands, service/ product design, teamwork, process design, cognition and mental workload and their impact upon events.

Attention also needs to be paid to systems factors such as those outlined below in Figure 1:

Figure 1: Human factors methods and applications



The Trust has chosen Human Factors as one of three quality priorities for 2019/20 with an aim to support the continued development of a positive safety culture where learning from error is the norm.

- To encourage/improve the incident reporting of minor incidents and near misses (an improved reporting culture).
- Increase awareness of individual behaviours and enhance team working to reduce the severity of harm to patients (if anything we want to increase the number of green incident reporting so that the learning from them reduces the number of severe (red) incidents)
- Explore/demonstrate strategies for improving/structuring communication whilst also addressing hierarchies which hinder effective safe transfer of information.
- Demonstrate the risks to patient safety associated with staff fatigue/stress, cognitive workload/human performance and limitations and how to identify and manage these risks in self and the wider team.
- Improve staff awareness of limitations of device/product design and the risks they pose to both individuals and patients. Promote good reporting strategies whilst encouraging dialogue with device/ equipment manufacturers.

With a Trust commitment to:

- To expand the Trust human factors training faculty first developed in 2017 to represent the multidisciplinary staff group clinical and non-clinical working across all areas of the Trust.
- To continue to offer human factors training to all staff groups across the Trust.
- To develop further workstreams to incorporate human factors consideration into areas such as; medical devices and equipment, design of healthcare systems, incident Investigation and areas of non-compliance.
- To run human factors network events to bring together staff from all areas of the organisation to share their experience and learning around human factors.
- To run simulations of scenarios training in all areas of the Trust with human factors feedback.

Relevant Trust policies and procedures

- Safer surgery pathway, PP299
- Consent to examination or treatment, PP113
- Strategy for risk management, PP093
- Being open - the duty of candour, PP197
- Clinical audit, PP214
- Diagnostic and therapeutic equipment training, PP206
- Learning from deaths, PP350
- Incident reporting and management, PP105
- Responding to nationally issued best clinical practice incorporating NICE guidance, PP205
- Supporting staff during an investigation of an adverse incident complaint or claim, PP198

References

NHS Patient Safety Strategy: Safer culture, safer systems, safer patients

NHSI / NHSE - The future of NHS patient safety investigation

NHSI / NHSE - National safety standards for invasive procedures (NatSIPPS)

NHSI / NHSE - Revised Never Events policy and framework

A promise to learn – a commitment to act, improving the Safety of Patients in England, National Advisory Group on the Safety of Patients in England (Aug 2013)

NICE (The National Institute for Health and Care Excellence)

Clinical human factors group - implementing a human factors approach in healthcare

Appendix A: three year plan

Objectives	2019/2020 Year 1	2020/2021 Year 2	2021/2022 Year 3
Ensure that key indicators of harm; (such as pressure ulcers, falls, hospital acquired infections and VTE) are reported upon through the trust's integrated quality and performance reporting framework (the IQPR) and via the relevant assurance committees e.g., medication errors through the Drugs & therapeutics committee report to the Clinical safety & effectiveness committee.	√		
Measure the outcome of quality improvement projects through our Quality Improvement framework	√	√	
Participation in regional and national collaborative and adoption of best practice	√	√	
Maintain our position in the top 10% of hospitals with the lowest mortality	√	√	√
Use the trigger tools within our electronic patient record to ensure patients at risk of deterioration are identified at the earliest opportunity' and undertake audits to provide assurance that these tools are being used effectively.	√	√	√
Train, educate and support staff to deliver safe and effective care through a wide ranging programme including mandatory training, link practitioner forums and 'bite size' teaching sessions	√	√	√
Carry out duty of candour for patients ensuring it is carried out promptly, sensitively and sympathetically. This to be reported via the IQPR and clinical directors group meetings.	√	√	√
We commit to continue to support the 'freedom to speak up' campaign by promoting our own staff guardians	√		
Implementing a 'raising concerns' phone-line	√		
Review and update of the trust whistleblowing policy	√		
Using a maturity matrix to measure our organisation's position with reference to a 'Just culture'	√	√	
Reviewing the staff survey findings annually to find out how staff feel about safety and learning and act upon the findings	√	√	√
Develop a support network for staff during and following serious incident investigation		√	√
Incorporating human factors into investigation and learning pathways through the wider human factors quality priority action plan	√	√	
Implementation web based GREATix excellence reporting system	√		
To use multiple lines of engagement including regular communications and learning events to increase our dissemination of learning from incidents and good practice.	√	√	
Give the opportunity for patients, families and their carers to participate in serious incident investigations and ensure open channels of communication throughout the process.	√	√	
Implementing a new post of a deputy medical director for quality		√	
Participation in the new patient safety incident management system (PSIMS) public beta phase testing	√		
Pilot the new NHS patient safety implementation framework	√	√	

Appendix B: quality assurance framework

West Suffolk NHS Foundation Trust

Hardwick Lane

Bury St Edmunds

Suffolk IP33 2QZ

www.wsh.nhs.uk

@WestSuffolkNHS

/WestSuffolkNHS

Putting you first

21. Quality & Risk Committee report

To approve the report recommendations

For Approval

Presented by Sheila Childerhouse

Board of Directors – Friday 1 November, 2019

Agenda item:	21			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Ruth Williamson, PA			
Date prepared:	28 October, 2019			
Subject:	Quality and Risk Subcommittee Reports			
Purpose:		For information	X	For approval

Executive summary:

A presentation was received from two of the Filipino nursing contingent, Hazel Banada and Napoleon Manaog on their personal journeys as part of the overseas nursing recruitment experience.

A further presentation was received from various members of the integrated care system on the work being undertaken on implementation of the mental health strategy.

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

(a) **Corporate Risk Committee (19/08/2019)**
Noted completion of the fire safety risks and implementation of short-term fix in respect of CL3 work in pathology.

(b) **Clinical Safety & Effectiveness Committee (09/09/2019)**
Issue of attendance levels remains a concern and is being kept under review. Award of extra funding to Point of Care Testing also noted.

(c) **Patient Experience Committee**
June meeting cancelled. Next meeting of Committee due on 6 December, 2019.

Quality Group Report
Report accepted.

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

Recommendation:

To receive the report for information and assurance.

22. Charitable funds report

To APPROVE the report

For Approval

Presented by Gary Norgate

Trust Open Board Meeting – 1st November 2019

Agenda item:	22			
Presented by:	Gary Norgate, Non-Executive Director			
Prepared by:	Liana Nicholson, Assistant Director of Finance			
Date prepared:	28 October 2019			
Subject:	Charitable Funds Board Report			
Purpose:	X	For information		For approval

Executive summary:

The Charitable Funds Committee met on 20th September 2019. The key issues and actions discussed were:-

- The Committee were pleased with the success of the event of the Soap Box Challenge, raising nearly £19k. The hard work of the Trust, the community engagement and the corporate business engagement was commended.
- The Committee noted a piece of land given the Trust, which can't be developed on. The land has been offered to the neighbours for purchase.
- The Committee were updated on the Butterfly Garden project. KLH Architects have offered to do the plans for zero fee. The Committee is looking into the use of lottery funds. This project will be taken to the Trust Board for final approval once it has been finalised.
- The Committee were updated on the latest position with regards to a property that was proving difficult to sell. A cash buyer has been found and the property should sell for slightly more than expected. The executors are moving quickly as the buyer has expressed a quick move.
- The Committee were updated on the performance on the investments. The investment is continuing to perform well and was showing an overall gain of £107k at the date of the meeting.
- It was brought to the attention of the Committee that the Investment Fund Manager's policy on fossil fuels has changed, as part of their ethical investment strategy.
- The draft un-audited Annual Report and Accounts were presented to the Committee. The audited Accounts will be presented to the Charitable Funds Committee on 1st November with recommendation for approval by the Audit Committee on the same day.
- The Committee approved the setting up of a fund for the Mortuary.
- The Macmillan unit received a significant legacy of £100k. Although this Fund will be underwriting the Butterfly Garden project, a significant fund balance will remain. Discussions will be held with the Fund Manager to ensure that the funds are spent.

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							

23. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Richard Jones

Board of Directors – 1 November 2019

Agenda item:	23			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	25 October 2019			
Subject:	Items for next meeting			
Purpose:		For information	X	For approval

The attached provides a summary of scheduled items for the next meeting and is drawn from the Board reporting matrix, forward plan and action points.

The final agenda will be drawn-up and approved by the Chair.

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

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

Previously considered by:	The Board receive a monthly report of planned agenda items.
Risk and assurance:	Failure effectively manage the Board agenda or consider matters pertinent to the Board.
Legislation, regulatory, equality, diversity and dignity implications	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.

Recommendation:

To approve the scheduled agenda items for the next meeting

Scheduled draft agenda items for next meeting – 29 November 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
Integrated quality & performance report	✓		Written	Matrix	HB/RP
Finance & workforce performance report, staff recommender scores	✓		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
Quality and learning report, including learning from deaths and quality priorities	✓		Written	Matrix	RP / NJ
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Antenatal and newborn screening	✓		Written	Matrix	HB
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
7 day service report	✓		Written	Matrix	NJ
Digital board report	✓		Written	Matrix	CB
Primary care vertical integration – decision point		✓	Written	Action point	KV
Emergency department business case		✓	Written	Action point	CB
Strategic update, including Alliance, System Executive Group and Integrated Care System (ICS)		✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Audit Committee report	✓		Written	Matrix	SC
Digital board report, including community IT update	✓		Written	Matrix	CB
Scrutiny Committee report, including networked pathology strategy		✓	Written	Matrix	GN
Confidential staffing matters		✓	Written	Matrix – by exception	JB
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Annual review of governance		✓	Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

11:30 ITEMS FOR INFORMATION

24. 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

24.1. To NOTE that the next meeting will be held on Friday, 29 November 2019 at 9:15 am in Newmarket 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