NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday, 26 Jul 2019 9:15 AM — 11:30 PM BST
Venue	Northgate Room, Quince House, WSFT
Description	A meeting of the Board of Directors will take place on Friday, 26 July 2019 at 9.15 in the Northgate Room, 2nd Floor Quince House, West Suffolk Hospital, Bury St Edmunds
Organiser	Karen McHugh

Agenda

AGENDA
Presented by Alan Rose

Agenda Open Board 26 Jul 2019 .docx

9:15 GENERAL BUSINESS
Presented by Alan Rose

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

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 Alan Rose

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

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

NHS
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NHS Foundation Trust

5. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 28 June 2019
   For Approval - Presented by Alan Rose

   Item 5 - Open Board Minutes 2019 06 28 June Draft.docx

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

   Item 6 - Action sheet report.doc

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

   Item 7 - Chief Exec Report Jul '19.doc

9:40 DELIVER FOR TODAY

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

   Item 8 - Master IQPR SPC June19.pdf

   Item 8 - Integrated Quality & Performance Report_June 19.docx

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9. Winter learning and planning report
   To APPROVE the report recommendations
   For Approval - Presented by Helen Beck

   Item 9 - Winter capacity plan draft 201920 v4.doc

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

    Item 10 - Board report Cover sheet - M03.docx

    Item 10 - Finance Report June 2019 FINAL.docx

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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11. Transformation report Q1
    To APPROVE the report recommendations
    For Approval - Presented by Helen Beck

    Item 11 - Transformation Board Report July 2019.doc

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

    Item 12 - Board Report - Staffing Dashboard - June 2019 data.docx

    Item 12 - WSFT Dashboard - June 2019.xls

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13. Safe staffing guardian report
    To APPROVE the report recommendations
    For Approval - Presented by Nick Jenkins

    Item 13 - Safe staffing guardian cover sheet.doc

    Item 13 - Safe staffing Guardian Quarterly Report April - June 19 final.docx

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14. CNST Incentive Scheme
    To approve the report
    For Approval - Presented by Craig Black

    Item 14 - CNST Incentive Scheme cover paper July 2019.doc

    Item 14 - Compliance with CNST Incentive Scheme 2019 for Trust Board July 2019 wi....docx

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

    Item 15 - Consultant Appointment.doc

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

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17. Annual clinical excellence awards report
To NOTE report
For Report - Presented by Nick Jenkins

- Item 17 - Annual clinical excellence awards report.doc
- Item 17 - Appendix 1a.docx
- Item 17 - Appendix 1.docx

11:10 BUILD A JOINED-UP FUTURE

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18. West Suffolk Alliance Report update
To ACCEPT the report
For Report - Presented by Kate Vaughton

- Item 18 - WSFT Alliance Update July 2019 Cover Sheet.doc
- Item 18 - WSFT Alliance Update July 2019.doc
- Item 18 - App 1 Governance Info.pdf
- Item 18 - App 2 Locality Timeline.pdf

11:20 GOVERNANCE

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19. Trust Executive Group report
To ACCEPT the report
For Report - Presented by Craig Black

- Item 19 - TEG report.doc
- Item 19 - Annex PP(19)093 Risk Management Policy and Strategy DRAFT.docx

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20. Quality & Risk Committee report
To approve the report recommendations
For Approval - Presented by Alan Rose

- Item 20 - Q&R report cover sheet.doc
- Item 20 - Q&R Minutes - 2019 06 28 June DRAFT v2.docx
- Item 20 - Q&RC Annex CQC prep.pptx

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21. Annual report and accounts
To receive the report
For Report - Presented by Richard Jones

Item 21 - Annual report cover sheet.doc

Item 21 - WESTSUFFOLK Annual report and accounts 2018_19 FINAL.pdf

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

Item 22 - Items for next meeting.doc

11:30 ITEMS FOR INFORMATION

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

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24. Date of next meeting
To NOTE that the next meeting will be held on Friday, 27th September 2019 at 9:15 am in Quince House, West Suffolk Hospital
For Reference - Presented by Alan Rose

RESOLUTION TO MOVE TO CLOSED SESSION

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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 Alan Rose

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DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 26 JUNE 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			
Alex Baldwin	Deputy Chief Operating Officer		
Richard Jones	Trust Secretary		
Karen McHugh	PA to CEO *(minutes)*		
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, Florence Bevan, Judy Cory, Amanda Keighley, Jo Pajak, Liz Steele, Peta Cook, Barry Moult, Jane Skinner			

Action

GENERAL BUSINESS

19/121 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

The Chair welcomed everyone to the meeting.

Apologies were noted from Angus Eaton and Helen Beck. The Chair welcomed Alex Baldwin, Deputy Chief Operating Officer, who was deputising for Helen.

19/122 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

- Liz Steele referred to the upcoming CQC inspection and asked if the executive team was concerned about how the issues that consistently caused the board concern, eg pressure ulcers and falls, may affect the outcome. If so, what was being put into place to manage this and if there was anything that the governors could do to support and assist with this. The Chair explained that the focus was for the whole board and not just the executive team. Rowan Procter reported that a presentation would be given at the next Quality and Risk committee and a paper would be going to the next board meeting on what actions were being taken. She explained that CQC preparedness was 'business as usual' as the organisation was always striving to deliver high standards of care; however there were some areas where there was additional focus following previous CQC feedback. Pressure ulcers and falls were part of 'business as usual'.

The Chief Executive echoed Rowan's comments. He reported that the Trust had been coping better than many Trusts during the busy winter and spring period and the CQC would take this into account. The board reports, which were open and transparent, demonstrated how the organisation was responding to the challenges it faced. It was not known which areas the CQC would visit but it was anticipated that it was likely to be few key areas such as the emergency department, maternity and critical care. He explained that he would be briefing the board and governors on the process and that the strength of support from the board and governors during the CQC's previous visit contributed to the 'well-led' assessment. Liz Steele said that the governors were very keen to assist with this. The Chair thanked her and said that the board would consider if there were other ways that governors could be engaged.

- Jo Pajak thanked the non-executive directors for meeting with the governors last night and for the insight they gave on the pathology strategy, in particular to action 1712 and 1667. He asked for assurance that as the strategy was developed patients would not suffer or be at risk. The Chair acknowledged that this was a major concern which had occupied a great deal of the board's time. Nick Jenkins said that he would address this question under agenda item 6, matters arising action sheet.

19/123 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

19/124 DECLARATION OF INTERESTS

None to report.

19/125 MINUTES OF THE MEETING HELD ON 24 MAY 2019

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

19/126 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following updates given:

Item 1667; agreed to work with ESNEFT to develop a shared briefing for governors at both ESNEFT and WSFT. Richard Jones explained that this action was still showing as red as the briefing was only sent to governors last night. Nick Jenkins explained that this was still not a joint briefing to both sets of governors. The briefing has been prepared on the basis that it would be a joint briefing and the draft had been sent to him for comment and he had made one minor amendment. However, ESNEFT had then come back and said that this was fine for WSFT governors but they would be doing something different for their governors. Therefore the intended joint briefing for governors had still not been achieved. The Chair would be meeting with the new interim Chair of ESNEFT and this would be a priority for discussion; she would also email her in the meantime.

The Chief Executive proposed that WSFT should follow up with ESNEFT their rationale for not wishing to send a joint briefing; and whether they had a different approach to communicating with their governors on this subject. The Chair agreed that this could be the case but said that the more that shared briefings could be produced; the more the two Trusts would be working in harmony with each other. There was also a plan to meet as a joint board to encourage more joint working, not only in pathology. She suggested that it would also be a good idea if links between governors from both organisations could be created.

Nick Jenkins explained that the positive aspect was that the briefing that had been sent out to governors had been prepared by NEESPS, ESNEFT and WSFT; which was a good example of joint working. He stressed that the draft strategy was the key issue and had great potential for linking pathology services across Suffolk and North East Essex better. It was extremely important that this document was produced in conjunction with primary care and this would be the focus over the next couple of weeks.

The Chair asked Jo Pajak if this had addressed his question. He said that the briefing had been extremely helpful but suggested that a joint presentation to governors from both organisations on the pathology strategy should be organised. Nick Jenkins said that once the strategy had been finalised he would be happy to present this to governors. The Chair agreed that this would be a good idea and she would follow this up with the new Chair of ESNEFT.

N Jenkins / R Jones

Gary Norgate referred to Jo Pajak's question as to how the board/governors could be assured that patients were not being harmed or receiving poor service. Nick Jenkins said that there was no evidence that patients were being harmed. There were a number of systems in place to identify, report and investigate harm and there had been no occurrences, therefore he was confident that no harm had occurred. However he said that there was a risk as there were labs which were not currently accredited to the standard that the Trust would like them to be. This did not mean that highest quality standards were not being provided in the labs but it meant that there was no absolute assurance that this was the case, which was why it was red risk on the register and the focus of attention. He stressed that just because it was a risk it did not mean that harm was occurring.

Item 1707: Drill down into community sickness absence performance to consider themes and improvement strategies. The progress on this was noted with an update scheduled for the board meeting on 1 November. The action would therefore be closed.

Item 1712; 1. Send the draft pathology strategy to Governors after it has been shared with staff. 2. Consider how to make public the performance against the new getting it right first time (GIRFT) pathology dashboard. Nick Jenkins considered that this could now be closed, with the agreement of the board.

The completed actions were reviewed and the following comments made:

Item 1705; provide an update on the trajectory to improve mandatory training and appraisal compliance, and specifically the low reported compliance with information governance mandatory training. This information was provided as an annex which the board received and noted.

19/127 CHIEF EXECUTIVE'S REPORT

The Chief Executive referred to the interim NHS People Plan which he encouraged the board to read. This focussed on making the NHS a good place to work and improving leadership culture with a focus on being positive and compassionate. It also encouraged a focus on the shortage of nurses and development of a modern workforce to deliver 21st century care with integrated working. The current issues with pensions was also referred to.

He said that this reflected a number of things that were happening within WSFT, such as the new accommodation block which was officially opened yesterday and should help with the recruitment and retention of staff. This was providing accommodation for the new Filipino nurses who had been arriving at a rate of

approximately ten per month and were starting to make a massive difference in alleviating the pressures on nursing staff that had been experienced through the winter. A further 40 newly qualified Filipino nurses would be joining the Trust over the next couple of months and this would continue to be a focus.

A range of events had recently been held to thank staff, volunteers and charity supporters; this again was about creating a positive and supportive culture.

The Trust's bi-annual leadership summit took place last week and he particularly thanked Denise Pora for all the work she had put into arranging this. This had been a very good event which had focussed on the feedback from the most recent staff survey, where WSFT came out as the fourth best in terms of staff engagement. However there were issues around ensuring that there was an inclusive focus and that any occurrences of bullying and harassment continued to be addressed. The Trust had also been promoting its LGBT network and was setting up other networks to focus on inclusion. WSFT had a more diverse workforce than the community it served and a lot was being done to promote and value diversity and the contribution made by individuals.

WSFT was promoting park runs and this was particularly being focussed on in Haverhill. The Chief Executive would be taking part in a number of running events in support of MyWish over the next year and would be asking for individuals for support in the future.

A new digital body, NHSX, had been set up and the Trust had written to its Chief Executive inviting them to visit and see the work that it had been undertaking on e-Care etc.

This week WSFT launched MedicBleep (a secure WhatsApp), it was the first hospital in the country to move away from pagers which had been in use for the last 60 years. Over the first few days approximately four times the amount of bleep 'traffic' had been seen and this should help improve communication across the hospital and community and would provide considerable time saving to front line staff. The response to this had been very good, although there had been a few teething issues. He thanked all those involved in the successful go-live of this initiative.

The Chief Executive referred to the national emergency care performance pilot and explained that Trusts taking part had been asked not to report on this. He said that there were good reasons for this but assured everyone that the Trust remained very focussed on quality and safety. The Chair explained that the organisation continued to track its performance but was not allowed to share the detail; she stressed that the Trust always shared everything that it possibly could.

Gary Norgate referred to the report on mandatory training and appraisal performance recovery, which suggested that agenda for change pay progression would be linked to individuals having an appraisal. He considered this to be a great step forward. He asked if this meant that if an individual did not have an appraisal they would not receive their agenda for change pay progression. Kate Read explained that this would be implemented over a three year period starting from April 2020. She confirmed that this would be the case and a policy had been written which would be going to various groups for approval over the next couple of months. There had been good evidence from Trusts that had implemented this early that this had made a difference.

Gary Norgate asked about the CQC inspection and recalled that there had been a huge amount of effort from staff in preparation for the previous inspection. He asked if the executive team was confident that the organisation was as prepared for this

inspection as it was for the last one. Rowan Procter confirmed that this was absolutely the case and explained that over the next month she and the Chief Executive would be running a variety of presentations and events for staff to remind them what this would involve, eg a stand in Time Out, focussed walkabouts etc.

The Chief Executive explained that since the CQC last inspection the Trust had been responding to the feedback, including changes around the emergency department, new labour suite etc. However it was important to reinforce the need for people to focus on the basics on a daily basis, as well continuing to provide high quality care. The Chair agreed and said that she was sure that the NEDS and governors would continue to support and challenge staff in this, which was a very important part. She stressed that this was a whole team effort.

Alan Rose referred to the leadership summit and discussions around bullying and harassment, where WSFT was an outlier, and asked if any actions had come out to address this within the Trust. The Chief Executive stressed that WSFT was not an outlier; however there were instances where this was occurring and there were things that could be done to address this. He explained how the session worked with the 70 people who attended being divided into groups to identify actions that could be undertaken. These would be collated and would go back to the Trust Executive Group for further action. He considered that the key action for the Trust was to set up more networks similar to the LGBT network, which had been very positive and provided support to more vulnerable groups of staff. He said that it was very positive that the Trust was not being complacent about this and was embracing and discussing this.

DELIVER FOR TODAY

19/128 INTEGRATED QUALITY AND PERFORMANCE REPORT

Rowan Procter explained there were six areas which she would like to highlight to the board.

She assured the board that the four outstanding duty of candour cases were different to the four from last month. Since this report had been produced these had been completed and there were currently no outstanding duty of candours.

The number of pressure ulcers had increased, although this remained within the thresholds on the SPC charts. As a result the tissue viability team in this area had been increased, for both the hospital and community. A very focussed piece of work was also being undertaken, part of which was to reduce pressure ulcers in the community and identify these early before a patient came into hospital.

NICE baseline assessments continued to reduce and were now at 15. The Trust was removing its internal target of 10 but needed to ensure that the downward trend continued. Overdue national audit reports baseline assessments also continued to decrease which was another positive.

The number of complaints had increased to 25 this month which was a concern. She had discussed this with Nick Jenkins and a deep dive would be undertaken with a report on the outcome of this coming back to the board next month.

There had been a significant reduction in the recommender score for emergency department experience. She had discussed this with the head of patient experience who suggested that this could be due to the change in the way this information was collected. This was previously a paper survey which patients completed whilst in the department; it was now through an SMS message following their visit which gave

them time to reflect on their experience. The team would be focussing on improving this score.

Gary Norgate thanked Rowan Procter for addressing the areas of concern that he had also identified. However, this showed the pressure the organisation was under despite the fact that it was no longer in the challenging winter period. He asked if this was also a pressure period and if this was causing increased risk. She said that there no longer appeared to be seasonal variations and pressure was continuing with an increase in demand which the Trust was not environmentally built for, particularly the emergency department. Staffing also continued to be significantly stretched. Alex Baldwin agreed and said that the organisation was continuing to see increased demand across all of its services, including RTT and cancer services. Some of this related to the way in which capacity was being managed through the hospital, eg escalation capacity had recently been reduced which had resulted in additional challenges.

Gary Norgate considered the narrative in this report to be good However he requested that rather than saying "ongoing" in the 'when' section, this should indicate when an improvement could expect to be seen, eg milestone, which would provide assurance that there would be an outcome. **C Black**

Richard Davies referred to use of the SPC charts, eg duty of candour, which although well below target appeared to be okay, without looking at the data provided in the original report. The Chair agreed and said that it was a matter of getting used to using these new charts and one set of data, as discussed at the previous board.

Alan Rose agreed with Gary Norgate's concerns about the high demand within the organisation which appeared to manifesting itself in a higher number of complaints, missing a few targets, staffing fatigue and possibly sickness. He was concerned that this could become accepted as the norm ie the challenges of the higher demand and increased activity resulting in a higher number of pressure ulcers etc.

The Chief Executive reminded the board that for the last financial year there was an increase of approximately 9% in attendances and admissions which was double what the Trust planned for and triple what it was told to plan for as part of national planning assumptions. The plans and the additional capacity that the Trust put in place for last winter had enabled it to manage and deliver improved performance in the emergency department. However staff were under a huge amount of pressure and the quality of the service that was delivered was not always to the standard that the organisation aspired to.

This was a focus of the west Suffolk system and were number of things that were being put in place to help to address this, including additional nursing recruitment, improving the infrastructure of the emergency department, opening of the second phase of the acute assessment unit. The core element of the Trust's strategy was alliance working and discussions were taking place with the CCG about how the increase in demand could be addressed, working with partners across the system. He assured the board that managing demand was a key focus of the organisation and west Suffolk system. The Chair agreed and said that preparation for next winter would be an ongoing focus of the board.

The Chief Executive explained that the East of England had seen a different level of demand/pressure to that which the whole of the NHS was experiencing. As a result the regional team had held a regional workshop to try to understand the reasons for this and develop a more collaborative NHS response to some of these pressures.

Kate Vaughton reported that conversations that the alliance was having around demand management was having a ripple effect and other services were experiencing similar challenges, eg schools were facing an increase in demand from parents and children, as well as an increase in sickness and stress of staff. The effect of this across the wider system would therefore become a focus of the system executive team.

Alex Baldwin referred to the 62 day cancer standard which had not been achieved and was currently at 75.9%. This was due to demand pressures in cancer services with underperformance particularly in colorectal and urology which was mainly a result of a lack of capacity for diagnostics. A rapid improvement plan was being developed, but this would only be for the medium team. As a result he had commissioned the NHS intensive support team to undertake a governance review of the Trust's cancer services to provide assurance that the appropriate processes were in place to address the challenges it was facing. This review would be undertaken in July. He expected the outputs to be very similar to the review that had previously been undertaken for referral to treatment times (RTT).

RTT performance had improved to 85.8% against the 92% standard, however there continued to be challenges around the overall waiting list which was increasing. A very comprehensive plan was currently being developed jointly by WSFT and the CCG to address RTT performance. A core part of this was capacity and demand analysis which would be reported next week and the board would be updated with more detail once this had been concluded. **H Beck**

Alex Baldwin referred to the pilot for the new emergency department performance standards which WSFT was taking part in. It was very early to draw any definitive conclusions from this but he assured the board that there had been no demonstrable change in behaviours in the way in which any of the teams were treating patients in the emergency department. He stressed the importance of this as and this would be kept an eye on.

Gary Norgate asked for a comment on the disappointing numbers for completion of the WHO checklist, particularly as this was so important, and whether the Trust should move to a zero tolerance policy on this. Nick Jenkins said that he did not know the reason for the numbers but he would like this to be better than it was. **N Jenkins**
However, he explained that when a checklist was recorded as not having been completed it was because it had not been fully completed, not because one had not been completed at all. There always seemed to be a reason or excuse for a checklist not being fully completed but this did not go unchallenged. He would follow this up with the relevant clinical directors and provide an update to the board. **N Jenkins**

The Chair said that it would be helpful to know if other Trusts were achieving the standard of 100%, or if not what they were achieving; this would provide a benchmark which would be helpful.

Richard Davies was pleased to see an improvement in the two week wait breast cancer performance. He noted that the reasons given for the 62 day waits performance was the high number of referrals; however the data in the report suggested that referrals for cancer were actually decreasing. Alex Baldwin explained that Trust was seeing a difference in cancer referrals in different specialties which was impacting disproportionally across the board; the increases in referrals to some specialties was contributing to some of the performance issues. This was an aggregate versus speciality level difference.

19/129 NON-EMERGENCY PATIENT TRANSPORT

Alex Baldwin explained that the paper provided details of the discussions that had taken place between WSFT, the CGG and Ezec who were the provider of non-emergency patient transport for Suffolk.

A formal contract performance notice had now been issued to Ezec and a comprehensive rapid improvement plan had been produced as a result of this. A significant number of actions were required to be delivered to improve performance and this would be reviewed on a weekly basis by WSFT, the CCG and ESNEFT. The actions mainly consisted of two areas; the first being recruitment of staff to deliver the capacity that the contract required and had been a challenge to Ezec since the beginning of the contract in April 2018. The other area was around how effective Ezec were operationally deploying this resource on a day to day basis to meet the needs of both acute providers.

There was a high level of frustration at the speed to which Ezec had responded to the needs of both organisations and the challenges that they faced and WSFT had been very clear with them about this. Some improvement was starting to be seen but there was still a long way to go to deliver the performance that was required. Considerable improvement was expected during July and this was the timeframe that they were being held to account for delivery. Ezec had provided assurance that this would be the case; however challenges were still being seen on a day to day basis at an operational level. There continued to be a high degree of scrutiny and support for Ezec within the hospital, mainly from the discharge waiting area team and outpatient flow team. The CCG escalation team were also providing additional support to Ezec.

Louisa Pepper said that there had obviously been concerns from governors and patients had also raised issues during quality walkabouts. She was pleased to see the level of detail and the timescale for improvement of July and was keen that Ezec should be held to account for this. Alex Baldwin assured her that this would be the case. She asked what the alternative, ie plan B was for this service. Alex Baldwin said that at present there was no alternative plan but conversations were beginning with partners in the system to scope a plan B in case the level of improvement that was expected from Ezec was not delivered.

The CCG was very clear that this process would come to a conclusion, either through an improvement being seen and a return to the normal level of performance which would enable the contract to continue. Or the logical end point would be that notice would be served to terminate the contract.

The Chair asked if part of the issue was that there was no obvious alternative provider. Alex Baldwin agreed that this was part of the issue. Kate Vaughton suggested confirming that Ezec provided this service in other parts of the country to a level of quality over and above the previous provider. Alex Baldwin confirmed that this was the case. She said that if they had a track record of being able to provide a satisfactory service they should not have any excuses for not being able to meet the requirements of the action plan. She understood that both Ezec and the CCG were relatively hopeful that this would be the case and that conversations about possible alternative providers were not necessarily giving any confidence that the service would much better.

Gary Norgate said that the information Kate Vaughton had provided gave him more confidence that Ezec was a capable provider if they could get their act together. He asked if their recruitment would include a number of genuine logistics experts or was it just drivers.

Alex Baldwin explained that this would be both logistics expertise and drivers and crews to man the vehicles; there had also been an increase in seniority of people to manage the contract.

The Chair noted that a further report would come back to the board meeting in July. She asked if in the meantime conversations would take place about a plan B as there would need to be a planning and implementation period if this was required. Alex Baldwin confirmed that conversations would be ongoing during July and an update would be provided at the next board meeting. **H Beck**

19/130 FINANCE AND WORKFORCE REPORT

Craig Black explained that the pressure that was being experienced within the organisation was reflected in the financial position and as at the end of month two the Trust was £0.5m behind the financial plan.

He confirmed that the sustainability funding which was currently amalgamated with the income figure would be shown separately in the future. This was much more complex this year but he would try to present this in a way which would be more helpful to the board. **C Black**

The pressure on the Trust was reflected in both pay and non-pay performance, with the additional beds that were open and the extra temporary staff that were being employed putting pressure on the pay budgets. Pressure on non-pay was particularly due to an increase in the issuing of equipment to patients in the community.

The report gave a lot of detail on pay with a focus on nursing staff which was directly related to the number of beds that were open. Discussions were taking place with the CCG as in the first two months of the year the value of the additional work that the Trust had delivered was just over £1m above the contract, which had resulted in additional expenditure of £0.5m to deliver this. He said that this was the level of expenditure that would be expected to achieve this; therefore he was confident that the control environment was still appropriate, which was an important factor.

WSFT operated within the STP and the financial position of the STP was important in setting the context of discussions that the Trust would be having with the CCG around this extra activity. The STP was providing £5m support to Cambridge and Peterborough STP this year and there was also pressure on CCG funding, with funding that had previously come through additional streams of income now being included in the baseline. Therefore the financial pressure on all parts of the system was reasonably significant this year.

As part of the integrated care system (ICS) process the Trust had committed to a system wide control total, therefore the performance it was reporting was being seen within the whole STP financial performance and the pressure within this organisation was being mirrored in other parts of the STP.

As in previous years, at the end of the first quarter the forecast position would be included in the finance report.

Alan Rose asked as the Trust was already behind plan due to the increase in demand if there was a requirement for new cost improvement programmes (CIPs) to be identified to mitigate this, eg an additional £1m. Craig Black explained that the Trust was having discussions with the CCG around securing additional income and the message had also been put out into the organisation that there was a requirement for every division to meet their budgets, including their CIPs.

Gary Norgate noted that one of the biggest items in the CIP was the staffing review. He asked what exactly this was and if the Trust was confident that it could be delivered as CIPs relating to staffing were always the hardest to achieve. Craig Black explained that this pulled together all of the initiatives within the divisions related to staffing. He said that this had to be delivered and the divisions were all held to account to meet their budgets and it was not possible for the organisation to deliver a sizeable CIP without focussing on staffing. He agreed that this was the hardest CIP to deliver, particularly against a background of increasing demand where the pressure was to increase not reduce staff numbers.

Gary Norgate referred to ward based registered nursing vacancies where the report appeared to suggest that this would get worse before it got better; he asked if this was a concern. Craig Black said that this would be discussed under the next agenda item, nurse staffing report, but he confirmed that this was a concern both from a financial and quality perspective. From a financial perspective employing temporary staff who were required to fill the vacancies was more expensive than employing substantive staff. He assured the board that this was a focus of the executive team.

Gary Norgate referred to the £4.2m loan to be paid back by 31 March 2020 and asked if the Trust would be able to do this. Craig Black said that this would not be possible and he had made it clear to the Department of Health that the organisation would not be in a position to pay this back. They had therefore asked WSFT to compile the plan in the way that it had been and assume that it would not be paid back. As he had said a number of times at previous board meetings the Trust was borrowing money that it had no realistic prospect of ever being able to repay. However, WSFT was in a much better financial position than the vast majority of organisations.

The Chief Executive said that the financial position of the NHS was being reviewed as part of the long term plan, but this was work in progress.

Alan Rose asked about the 44 uncovered nurse vacancies on the wards, after temporary and bank staff, and how great a problem this number was and if it should be tracked. Craig Black explained that this number had consistently been around 40 for a long time and broadly the organisation was able to manage with this number of vacancies, although it was not easy to do so and was reflected in the pressure the organisation was under. The establishment was set based on the professional judgement of the clinical staff in the organisation, balanced with financial priorities. Alan Rose recalled that previously it had been said that these vacancies would be filled. Craig Black confirmed that this was the intention and a plan as to how these vacancies would be managed for the rest of the year would be provided to the board, and this would also be reflected in the finance report. **K Read**

The Chief Executive said that there was always a set of metrics related nurse staffing which were tracked to achieve a clear narrative on the staffing pressures of the Trust. He explained that although the vacancies could be filled, often people were not starting for several months. Sickness and maternity cover also needed to be taken into account when looking at rota gaps and there was not necessarily one element that gave a clear picture of the reason for rota gaps.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

19/131 NURSE STAFFING REPORT

Rowan Procter explained that even though the percentage had stabilised there had been an increase in staff sickness in the inpatient areas. However community sickness had reduced which was very positive.

The fill rate was being achieved in the majority of areas. There was a 'safety huddle' every morning and staff were moved around the organisation, which although could be demoralising for staff it ensured patient safety.

She explained that where no figures were shown under vacancies this was because the whole of health roster was being completely updated. However, she assured the board that vacancies were reducing and the trajectory was that these would be in a positive figure by September and the recruitment strategy was planned to continue.

Gary Norgate noted that the suggestion was that the number of registered nurse ward based vacancies was going to go up between now and September and the Trust was entering the holiday period. There was also an increase in sickness in some areas. He was concerned that this would lead to a really difficult summer and asked for assurance that there was a robust plan to manage this, particularly as staff were already under considerable pressure and many were due for and were entitled to a holiday. Rowan Procter explained that senior matrons and service managers were currently having one to one conversation with some members of staff and asking them to move their annual leave because of these concerns. However this was difficult, due to school holidays etc.

19/132 MEDICAL REVALIDATION ANNUAL REPORT

Nick Jenkins explained that he was the responsible officer for 262 doctors and this report summarised the appraisal situation for all of these. There were six doctors who should have had an appraisal and had not and had no logical reason not to have done so. These were being managed through the appropriate process which at its conclusion could result in a warning from the GMC about their engagement in the revalidation process. However, no one from WSFT had yet been in this situation.

Doctors were required to have an appraisal in order to get their validation and the trajectory was that this level of performance would continue.

19/133 SEVEN DAY SERVICES ASSURANCE REPORT

Alex Baldwin explained that this was the annual audit of the Trust's four key service standards as set out by NHS England.

There were two standards relating to consultant review, the first being first consultant review within 14 hours (clinical standard 2). Performance against this was 78%, which was a slight reduction on the last audit which took place in April 2018. However, this was the equivalent of three patients and the point at which 90% of patients had received a review within 17 hours had not deteriorated compared to the last audit.

Clinical standard 8, ongoing once/twice daily consultant review as required. No patients in the audit required a twice daily review, therefore this was not reported in this period. However there had been a slight reduction in the audit for patients requiring a once daily review. He explained the importance of documentation in the clinical record and that unlike a patient having to be seen by a consultant within 14 hours this could be delegated to another member of the clinical team, but this had to be documented and recorded in the clinical record. If this was not recorded and there was no clear documentation that a consultant was part of the conversation or had directed a practitioner to undertake the review it could not be recorded as compliant with the standard. He also thought that the results for the previous audit were probably higher than expected therefore the deterioration was not as much a cause for concern as it otherwise might be.

The other two service standards related to availability to access to diagnostic procedures 24/7 and the Trust remained 100% compliant with both of these, which was in line with the previous audit.

Nick Jenkins agreed with Alex Baldwin's comments and said that the challenge for a hospital of WSFT's size was what services it could and could not provide seven days a week and during the night. This used to be a nationally reported and published set of standards and this was the first time that Trusts had been mandated to look at these themselves. He explained that the sample sizes were quite small therefore the percentage variations were a matter of two or three patients; therefore it was hard to be sure that the difference was real and in fact the position was relatively consistent. The Trust did not deliberately have a patient reviewed by a consultant on arrival just to meet the standard as this was a waste of the consultant's time and of no benefit to the patient until the test results were available. This meant that if a patient arrived early evening by the time their test results were available they would not be reviewed by a consultant until the ward round the next morning and if they were not first on the list they were likely to breach the 14 hour standard. It was this group of patients who tended to be the 20% who were not seen within the standard 14 hours.

One of the ambitions for the surgical assessment unit that was currently being set up was that there would be evening reviews of admitted patients by a consultant, which was not currently the case. This was an example of actions that the Trust was taking to mitigate this although it would never be possible to review all patients within 14 hours.

The Chair acknowledged that there were limitations on a Trust this size and the important thing was to be able to monitor whether there was any adverse impact on patients and this did not appear to be case. Nick Jenkins explained that it was known that the outcomes for surgical patients were better when they had an early consultant review. There was less risk of harm and a shorter length of stay and it would be good to be able to deliver this service as far as possible.

Alan Rose asked if there were any other areas beyond the availability of doctors which would help the Trust to provide as safe as possible service, eg diagnostics, porters, pharmacy etc. Nick Jenkins said that the Trust was meeting the diagnostics standards 100% of the time so he was confident that patients had access to diagnostics. However, if the Trust increased consultant presence it would need to increase the presence of other services as they did not work in isolation.

19/134 CONSULTANT APPOINTMENT REPORT

None to report.

19/135 PUTTING YOU FIRST

Kate Read reported that there had been three nominations for a Putting You First award this month and one for a Shining Light:

Craig Wickstead, head of x-ray, Newmarket Community Hospital
For several years Craig has been the lead on a tenant's forum at the hospital which was extremely valuable to tenants and helped to ensure shared working in the interests of patients and staff at Newmarket.

He was also a valued lead in x-ray to liaise with over clinical queries and concerns and had delivered training to senior physiotherapists. He was a great example of somebody leading on alliance working.

Sophie Banham, HR team
Sophie has worked tirelessly to support all the honorary contracts for the Trust. In addition she did all the behind-the-scenes work for the USAF and Army often at short notice. She had really helped the partnership flourish and also supported the placement project, often resulting in life-changing events for young servicemen. These placements gave invaluable clinical exposure, from clinical skills and knowledge to experiencing the emotional highs and lows of healthcare.

Sophie was a real 'unsung hero' who always went the extra mile.

Will Leeper, therapy assistant
Will was providing cover at Newmarket Community Hospital when a patient fell. He responded very quickly to the fall alarm, and when he arrived in the room he found the patient has sustained a cut to his face. He very quickly applied pressure to the wound, reassured the patient, made him comfortable and took control of the situation. Ward colleagues were present, but it was Will who really kept the patient feeling calm and reassured.

His nomination read "I feel he went above and beyond on this occasion. The patient was at the heart of what he did, and his care and compassion was lovely to see."

Rowan Procter, executive chief nurse – nominated for a Shining Light
Rowan was nominated by a patient who said that she had assisted her, her family and so many other vulnerable people when passing through the hospital, to do everything in her power to ensure they were supported in every way. She was caring, hardworking, and efficient, and went the extra mile at every opportunity she had. She should be applauded for her resilience to deal with such hard decisions and situations daily.

"'Rowan not only helped people in the good, she also dealt with the bad and the ugly, being the face of complaints, tears, anger and the way she holds herself is beyond admirable. I believe this is recognition that she deserves."

The board congratulated all the above. The Chair particularly congratulated Rowan who had been unable to officially receive a Shining Light as she was director but it was felt that she should be recognised for this nomination.

BUILD A JOINED-UP FUTURE

19/136 WEST SUFFOLK ALLIANCE REPORT

Kate Vaughton said that she would include a map of the primary care networks in a future alliance report. On the whole these fitted in with the current localities, although they were not a perfect fit. Conversations had been had with the clinical directors as to how they would work across the localities and in some areas they would also provide support to more than one team, eg Newmarket and Forest Heath. Due to the size of some of the networks they would take some time to get established in the next six to twelve months; therefore it would be premature to change locality borders at this stage. One benefit was that this had already created some clinical leadership at locality level with a greater level of direction and a more cohesive team. **K Vaughton**

A significant amount of activity was now taking place in the four key work streams for mental health. She had facilitated a large workshop last Friday where there had been good attendance from alliance partners, NSFT and NSFT commissioners. There was now a significant amount of energy around how to take this forward and at the same time mitigate some of the risk that was in the system.

This planning work should be completed towards the end of September and she would bring back the outcomes of this to the board meeting October.

Social prescribing was an example of wider engagement and providing people with a connection back into the community and to something in their immediate surrounding was starting to have a benefit in terms of reducing their reliance on statutory services. This was over and above trying to reduce GP appointments. The impact this could have on end of life patients and frailty patients was also being looked at.

The mental health pilot in Haverhill pilot showed that the use of social prescribing rather than medication had a material impact on how individuals moved on in their own journey. It was early days to know the figures for this but the initial outcomes looked very positive. There would be a presentation at the System Executive Group (SEG) next week and there was support to roll it out to another three localities.

Gary Norgate asked for an update on the contract for community IT which continued to be a key issue. Craig Black explained that plans were being drawn up as to how the organisation could take the service on. However it was important to ensure that the Ipswich part of ESNEFT shared the same approach as this was a countywide contract, therefore there needed to be plans across the whole country to withdraw from the contract. The plans had been shared with Ipswich and a response was awaited but this lack of response may need to be escalated.

Gary Norgate asked if the most competent provider process for mental health was still being considered. Kate Vaughton confirmed that this was the case and work was being undertaken to look at the model that would inform this process as well as assurance work gathering data around activity, staffing, risk etc. The team doing this work were also supporting other areas of work therefore this process would be from October onwards.

Gary Norgate asked what the key findings were that came out of the Kings Fund Study on Buurtzorg and how these had informed phase two. Kate Vaughton said that this was a very ambitious pilot/piece of work and the key learning, which was also reinforced by the feedback from Healthwatch, was that this was an absolute gold standard service to offer a patient and there had been fantastic feedback. The system now needed to identify the key components which could be rolled out more broadly to the localities. She considered this was around how to create an environment with a team that could work across boundaries and spend a greater degree of time focussing on the whole individual rather than just their condition. This had also had the biggest impact in terms of staff reward, patient feedback and outcomes.

The plan was that the Bury Town locality team would be the next area to test this. There was a very enthusiastic GP who would lead on this and had some theories on what could be done to impact on the demand in the hospital. Recruitment for this team would be taking place over the next six to twelve months.

The Chief Executive reported that West Suffolk Council had presented figures at a recent event, which showed a circa 25% drop in GP attendances for those people who had access to social prescribing. However, for patients who had not had access to this service no change in attendances had been seen. He considered this to be very significant and encouraging, although it was still early days.

He also referred to the fact that there were a couple of clinical directors job sharing in some of the primary care networks and asked Kate Vaughton whether this would affect the effectiveness of these networks by diluting responsibility for these.

She said that one of the key challenges was around resource and this was a way of mitigating this. In terms of engagement and the way the individuals had approached this this should also be more beneficial than one individual. She highlighted the Blackbourne network where Dr West had a considerable amount of NHS experience whereas this was Dr Chapman's first leadership role, therefore this would in effect be a mentor/mentee role. She said it was very positive that a number of these individuals were keen to be involved and although they were not interested in the politics or sitting on the CCG board they were interested in what happened in their teams at a local level.

GOVERNANCE

19/137 TRUST EXECUTIVE GROUP REPORT

The board received and noted the content of this report.

19/138 CHARITABLE FUNDS COMMITTEE REPORT

The board received and noted the content of this report.

Gary Norgate said that there were some good, positive investments and ways in which the money was being spent and excellent work by the charitable funds team.

19/139 AUDIT COMMITTEE REPORT

The board received and noted the content of this report.

19/140 GENERAL CONDITION 6 AND CONTINUITYU OF SERVICES CERTIFICATE

Richard Jones explained that there were two parts for approval by the board:

The first part (annex A) was the Corporate Governance Statement which set out a number of requirements and the Training For Governors which was part of the annual review process. This was supported by the commentary from governors which was included in the annual quality report.

The second part of the document (annex B) was to receive in public the General condition 6 and Continuity of Services condition 7 certificate which was part of the annual report and assurance statement.

The board approved the six corporate governance statements and certification for training of governors (Annex A).

The board received in public session the general condition 6 and continuity of cervices condition 7 certificates (Annex B).

19/141 AGENDA ITEMS FOR NEXT MEETING

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

CQC to be included as a standing item for the next few months **R Jones**

ITEMS FOR INFORMATION

19/142 ANY OTHER BUSINESS

There was no further business.

19/143 DATE OF NEXT MEETING

The next meeting would take place on Friday 26 July at 9.15am in the Northgate Room, Quince House, West Suffolk NHS Foundation Trust.

RESOLUTION TO MOVE TO CLOSED SESSION

19/144 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 Alan Rose

Board of Directors – 26 July 2019

Agenda item:	6			
Presented by:	Alan Rose, Deputy Chair & Non-Executive Director			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	19 July 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
1704	Open	26/4/19	Item 8	Provide a trajectory for improvement of nutrition compliance as a result of the work with e-Care	Action plan provided as appendix to board actions - Agenda item 6 - Appendix 2. **Improvement trajectory to be received by Board following pilot on F9 (available August).**	RP	27/9/19 (revised)	Green
1720	Open	28/6/19	Item 6	Governor pathology briefing issued for WSFT but ESNEFT have indicated that they will not use this for their Governors - this is being following-up to understand the rationale. Also consider establishing a link between WSFT and ESNEFT governors through the lead governor role.	**A presentation on the pathology strategy has been scheduled for the Council of Governors meeting on 6 August.**	NJ/RJ	27/09/19	Green
1722	Open	28/6/19	Item 8	Review the performance regarding WHO checklist with clinical directors, and look at this in the context of performance / intervention at other trusts	**Scheduled for review of remedial action at CDs meeting**	NJ	27/09/19	Green
1723	Open	28/6/19	Item 9	Provide an update progress/developments with non-urgent patient transport	**Receive verbal update at meeting**	HB	26/07/19	Green
1726	Open	28/6/19	Item 17	Include a map for primary care networks (PCNs) in the Alliance report	**A draft representation has been prepared and is being used as the basis for a graphic designed map for the PCNs. This should be available for the next meeting.**	KV	27/09/2019 (revised)	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1671	Open	25/1/19	Item 8	Schedule a report which sets out learning from winter, including input across the system and Alliance partners	Preliminary assessment of Trust learning as part of the closed. This will be expanded to provide a system-view and planning for 2019-20 which will conclude after the end of May. The outcome of this joint working will be reported to the Board by July and verbal updates provided. **AGENDA ITEM**	HB	26/7/19 (revised)	Complete
1721	Open	28/6/19	Item 8	Requested that the narrative in the 'When' box be developed to focus on the outcome to be achieved and the timescale for delivery (stating "Ongoing monthly" is insufficient)	**Updated in IQPR**	CB	26/07/19	Complete
1724	Open	28/6/19	Item 10	Separate the sustainability funding within the finance report to help with presentation	**Updated in finance report**	CB	26/07/19	Complete
1725	Open	28/6/19	Item 10	Track the plan for reducing nurse vacancies against the plan for the year within the finance and workforce report	**Included in report**	KR	26/07/19	Complete

7. Chief Executive’s report

To ACCEPT a report on current issues from the Chief Executive

For Report

Presented by Craig Black

Board of Directors – 26 July 2019

Agenda item:	7			
Presented by:	Craig Black, Deputy Chief Executive Officer & Executive Director of Resources			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	19 July 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

July has seen us wish another very **happy birthday to the NHS**, as it turned the ripe old age of 71. We were delighted to see the RT Hon Matt Hancock MP, who dropped by the West Suffolk Hospital and attended an afternoon tea hosted by local NHS Retirement Fellowship branches to celebrate with staff past and present. The NHS's first ever patient was 13-year-old Sylvia Diggory, who I believe had a very serious liver condition called acute nephritis; I'm pleased to say the NHS started as it meant to go on, and Sylvia led a very long life and went on to have children and grandchildren thanks to the care of the NHS – literally from day-one. How far we have all come since the birth of the NHS; Sylvia Diggory may have been the first NHS patient, but I very much hope we won't ever see a last. To the next 71 years!

In the meantime, we plough on with **our developments**; not just the new emergency department, but a new acute assessment unit and new labour delivery suite are also under build. Those of you who have visited West Suffolk Hospital recently might have spotted our new staff and student accommodation blocks at the back of the site. Rt Hon Jo Churchill MP kindly joined us to formally open those a few weeks ago, and they're already being well used!

One crucial development to add to the list is that the Department of Health and Social Care has provided approval in principle for the ownership of **Newmarket's community hospital** to be transferred to us from NHS Property Services. We are already doing so much on site to integrate primary, community, outpatient, social work and mental health teams; I look forward to working in partnership with our staff, other tenants, alliance members, patients and our communities to develop and expand services in the future. A newly developed policy has enabled NHS trusts to apply for ownership of buildings on their estate, which are currently owned by NHS Property Services and Community Health Partnerships. Transfer will be finalised on the completion of a series of conditions applied to the business case, so watch this space.

We often talk about the '**West Suffolk way'** here, which is just as much about doing the little things as the big things to improve what we do for patients. If you have visited the West Suffolk Hospital in Bury St Edmunds recently, you may have noticed that there are flowers blooming and bees buzzing! This is down to the hard work of some of our Trust's estates team and volunteers who have made it their mission to ensure the hospital supports the town with its Bury in Bloom credentials. We always try to ensure the hospital is clean, tidy and attractive for patients, visitors and staff, but I'm particularly proud of our hardworking team and volunteers this year for providing such a calming and pleasant environment for our patients and staff. These small things really do make a difference.

For any organisation, but especially one that cares for its community, ensuring the wellbeing of its staff is vitally important. Our Trust is an **inclusive employer** that values its people above all else, wants to ensure equal access and opportunities and for no one to experience discrimination or intolerance. The new Workforce Disability Equality Standard (WDES) aims to help NHS organisations improve the working lives of disabled people. At WSFT, we are encouraging disabled people amongst our staff, and any colleagues who want to get involved, to help develop the ways we support everyone who works with us. We know this is an area where we need to improve. There is evidence both nationally and locally that disabled people may have a poorer experience at work than those who do not have a disability. For example, they are more likely to experience bullying and harassment and less likely to believe they have equal opportunities for career progression or promotion.

The **Trusted Partners initiative** is one of the ways WSFT shows its commitment to supporting its most valued asset - our staff. Colleagues from across the Trust offer a variety of life experience, and a willingness to share a safe, non-judgemental, confidential and supportive response to anyone who needs it. They are there to listen, talk through issues and problems, and where appropriate, signpost people to more formal sources of support. While staff can approach the

Partners for anything where you feel a listening ear would help, if they believe they are being bullied or discriminated against because of your gender, orientation, race or culture, we really want to hear from them.

I would like to say a huge thank you for everyone's support following our go-live with **Medic Bleep** in July. We know that any system change takes some getting used to, and the patience, understanding and willingness to support we have seen from staff has been so appreciated. Medic Bleep is the new communication tool to replace non-emergency bleeps. This is another huge step on our digital agenda and, most importantly, it will give our staff more time back to do what they do best – care for patients. Because after all, our patients are what it's all about!

We continue to develop our **West Suffolk Alliance** and I was delighted when earlier this month when the Alliance agreed to support a system-based approach to delivery of quality improvement methods. This programme will be supported by the renowned Institute for Healthcare Improvement (IHI).

Overall in terms of June's **quality and performance** there were 61 falls and 31 Trust acquired pressure ulcers, both show a reduction from May. There was one case of C. difficile. We failed to deliver on the cancer targets for three areas: 2 week wait breast symptoms (90.9%), Cancer 62 day GP referral (67.2%) and incomplete 104 days wait with five breaches reported in June 2019. Referral to treatment performance for June was 85.4%, with four patients waiting longer than 52 weeks for treatment. The Trust is part of a pilot scheme trialling a number of new metrics for ED performance. These new metrics have replaced the longstanding 4-hour waits performance metric, so this has therefore been removed from this month's report. When the new metrics have been agreed nationally they will be included for monitoring.

The month three **financial position** reports a deficit of £2.4m which is £0.8m 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 £4m, as well as escalation costs to fund winter pressures of around £1m. Across the STP we have also been asked to reduce our capital programme by 20% - a reduction in the Trust's capital programme of £3.7m.

As you may already be aware, the **Care Quality Commission (CQC)** will be inspecting us sometime between 26 August and 28 October. The inspection is run 'unannounced', meaning that the inspectors could arrive on site anytime between these dates. It doesn't feel like a long time since the CQC was last here. But this isn't unusual; the CQC has changed how it inspects services and the majority of trusts will have an inspection every year. So, we need to be ready and all on the 'front foot', in both our acute and community services. To showcase the things we're really proud of, we need to make sure that we all get the basics right.

The results of the **General Medical Council's latest doctors in training survey** have been issued and I am delighted to say that we are once again ranked as the number one acute trust in the east of England in terms of overall satisfaction – moving up three percentage points to 82%. The survey asks doctors in training, from foundation doctors to specialists, questions based on a number of criteria, including clinical supervision, educational supervision, induction, teamwork and supportive environment.

In the **National Institute for Health Research** 2018/19 league tables, our research team have come top of the Eastern region for the largest increase in people participating in NHS research, with a 126% increase compared to the previous year! That comes to more than 1,500 participants. We're very proud of our amazing research team who are supporting research to improve patient treatment and care in the future. Keep up the good work, guys!

I was truly humbled earlier this month when alongside the **Guide Dog Association** and Jen Bacon Trust eye clinic liaison officer, I was guided with Trust chair Sheila Childerhouse around the hospital. We were wearing simulation-specs and using canes and really got to feel what it might be like to be visually impaired and have to navigate a hospital independently, but it also helped to raise awareness with staff about sight loss within our healthcare setting. Helen Sismore, community engagement for guide dogs East Anglia, and Geraldine McKeag and her guide dog Quinter, wanted to join the group too, to review how easy our NHS facilities are to access independently for people with sight impairment and to look at both clinic and corridor accessibility.

Chief Executive blog
Help us help you: https://www.wsh.nhs.uk/News-room/news-posts/Help-us-help-you.aspx

Deliver for today

Diabetes is focus for community study day
Our community diabetes team recently organised a successful West Suffolk diabetes study day for 50 GPs and practice nurses at the British Racing School in Newmarket. The team worked with Astra Zeneca to secure excellent speakers for the event. Most were home-grown, including Jessie Wright, one of the diabetes specialist dietitians at WSH, who talked about diabetes, liver disease and diet.

Invest in quality, staff and clinical leadership

What does the EBME team do?
Absolutely vital to the running of the Trust, some of you may never have heard of this brilliant team, comprising of two managers and seven technicians. The electro-biomedical engineering (EBME) department and medical equipment library services team manage, maintain, loan and purchase the majority of medical devices in the Trust

Chief resident programme prize-winners
Specialist registrars Dr Adam Devany (trauma and orthopaedics) and Dr Chrishan Gunasekera (ophthalmology), were hailed as joint first prize-winners at this year's Chief Resident Clinical Leadership and Management Development Programme. Run jointly by The Judge Business School, Cambridge University, and Cambridge University Hospital's post-graduate medical centre, and sponsored by the East of England Deanery, the one-year programme is aimed at doctors in their final training years prior to taking up consultant roles, and general practitioners seeking leadership roles within commissioning.

Royal College of Physicians' Eastern Update in Medicine conference
Congratulations to Dr Chris Paisey, foundation year two (FY2) trainee doctor, on winning first prize at the Royal College of Physicians' Eastern Update in Medicine conference for his poster presentation, 'Large scale retrospective mortality analysis in patients who develop acute kidney injury in a district general hospital'. The poster detailed a quality improvement project that Dr Paisey, Dr David Chapman (FY1) and consultant nephrologist Vivian Yiu undertook using e-Care. Due to the availability of electronic medical records, they were able to run a report looking at more than 4,000 patients who were admitted over a two-year period with acute kidney injury.

Build a joined-up future

Car park improvements
Please be aware that from July the Trust will be making improvements to car park A at the front of the site. The improvements include resurfacing and new lighting, following feedback from our

patients. This will mean there will temporarily be slightly fewer spaces available for patients and visitors to park (30% reduction in car park A). Car park C at the top of St Nicholas Way, which is usually staff only, will be signposted as also available for patients while works are ongoing. The Trust is also providing information for patients about the works through appointment letters and on our Trust website. Thank you for your patience.

Video consultations
In line with our digital ambitions to utilise technology for our patients, we've been running a pilot in paediatrics where we've been using video consultations for follow up appointments. The pilot has been a great success, and we are now exploring what other areas of the Trust might benefit from video consultations.

National news

Deliver for today

RCPCH prevention vision for child health (Royal College of Paediatrics and Child Health)
In advance of the Department of Health and Social Care's Prevention Green Paper, this strategy paper from the Royal College of Paediatric and Child Health sets out its proposals for how to transform the health and wellbeing of children and young people in the UK. It states that the amount of free sugar in baby food should be reduced and the government should place a 'moratorium' on public health funding cuts.

What a difference a place makes: the growing impact of health and wellbeing boards
This report highlights how health and wellbeing boards (HWBs) are making a real difference through a wide range of initiatives, including reducing hospital admissions and time spent in hospital, reducing demand for GP appointments, helping thousands of smokers to quit, imposing restrictions on fast food outlets near schools, and reducing unemployment, poverty and poor housing.

Invest in quality, staff and clinical leadership

The NHS patient safety strategy: safer culture, safer systems, safer patients (NHS Improvement)
Patient safety is about maximising the things that go right and minimising the things that go wrong. It is integral to the NHS's definition of quality in health care, alongside effectiveness and patient experience. This strategy sets out what the NHS will do to achieve its vision to continuously improve patient safety.

Being fair: supporting a just and learning culture for staff and patients following incidents in the NHS
This guidance highlights the need for the NHS to involve users of care services and staff in safety investigations. It aims to help the NHS to create an environment to better support staff when things go wrong and to encourage learning from incidents. Key challenges include fear, equity and fairness, and bullying and harassment.

The role of the GP in caring for gender-questioning and transgender patients
This paper provides an overview of the key issues facing gender-questioning and transgender patients, general practice and the broader health system. It establishes the RCGP's position on the role of a GP in providing care to patients experiencing gender dysphoria, the policy principles underpinning this position and recommendations for ensuring these patients receive equal access to the highest standard of care.

Build a joined-up future

NHS long term plan implementation framework (NHS England)
Following the publication of the NHS long-term plan, NHS England and NHS Improvement committed to publishing an implementation framework, setting out further detail on how it would be delivered. Local systems are developing their five-year strategic plans, which will describe the population needs and case for change in each area, then propose practical actions that the system will take to deliver the commitments set out in the NHS long-term plan. The framework summarises these commitments alongside further information to help local system leaders refine their planning and prioritisation. This includes detail about where additional funding will be made available to support specific commitments and where activity will be paid for or commissioned nationally.

Hierarchy disruptors: bringing specialist knowledge from hospital to community care
This commentary describes Project ECHO (extension for community healthcare outcomes) which is a new approach to healthcare being piloted around the world. If successful, its supporters claim it could provide a new model of care for the NHS.

A citizen-led approach to health and care: Lessons from the Wigan Deal
In 2011, Wigan Council had to make unprecedented savings after significant cuts in funding from central government. Drastic measures were needed, including a radical reshaping of the relationship between the council and residents. This became known as the Wigan Deal. This report provides an independent critique of the Wigan Deal, drawing on in-depth research, including interviews with key stakeholders, focus groups with members of the public and evidence from data analysis. It explores what local authorities, NHS organisations and others can learn from Wigan's journey of transformation.

Watch the film – see how the Deal transformed communities by seeing people as assets, working with residents and communities across a range of organisations and agencies. Film is 12.57 minutes long and well worth a watch. (YouTube)

Designing integrated care systems (ICSs) in England (NHS England)
This guide sets out the different levels of management that make up an integrated care system, describing their core functions, the rationale behind them and how they will work together.

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 – 26th July 2019

Agenda item:	8			
Presented by:	Craig Black			
Prepared by:	Joanna Rayner, Head of Performance and Efficiency			
Date prepared:	19th July 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.

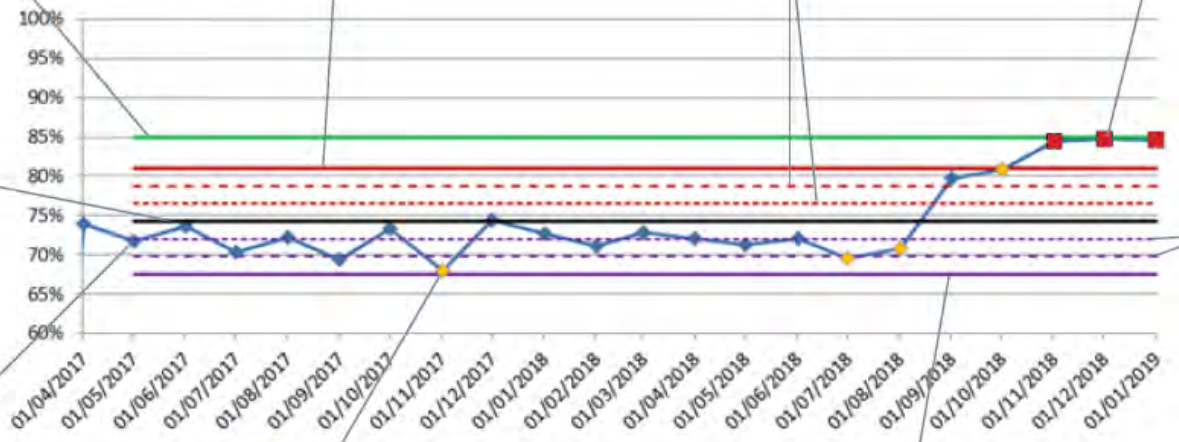
A control chart always has:

- 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	Jun-19

Safe domain	Standard	Actual	Trend	Assurance	Notes
New Pressure Ulcers - Trust	0	30	Common Cause Variation	Consistently above target	
Falls per 1,000 bed days	No target	4.98	Common Cause Variation	No target	

Effective domain	Standard	Actual	Trend	Assurance	Notes
Discharge Summaries: Outpatients	85%	FALSE	ND	Consistently below target	No data since August 2018
Discharge Summaries: A&E	95%	85%	Special Cause Variation - Low	Consistently below target	
Discharge Summaries: Non Elective Admissions	95%	82%	Special Cause Note/Investigation - High	Consistently below target	
Discharge Summaries: Elective Admissions	85%	87%	Special Cause Note/Investigation - High	Consistently below target	

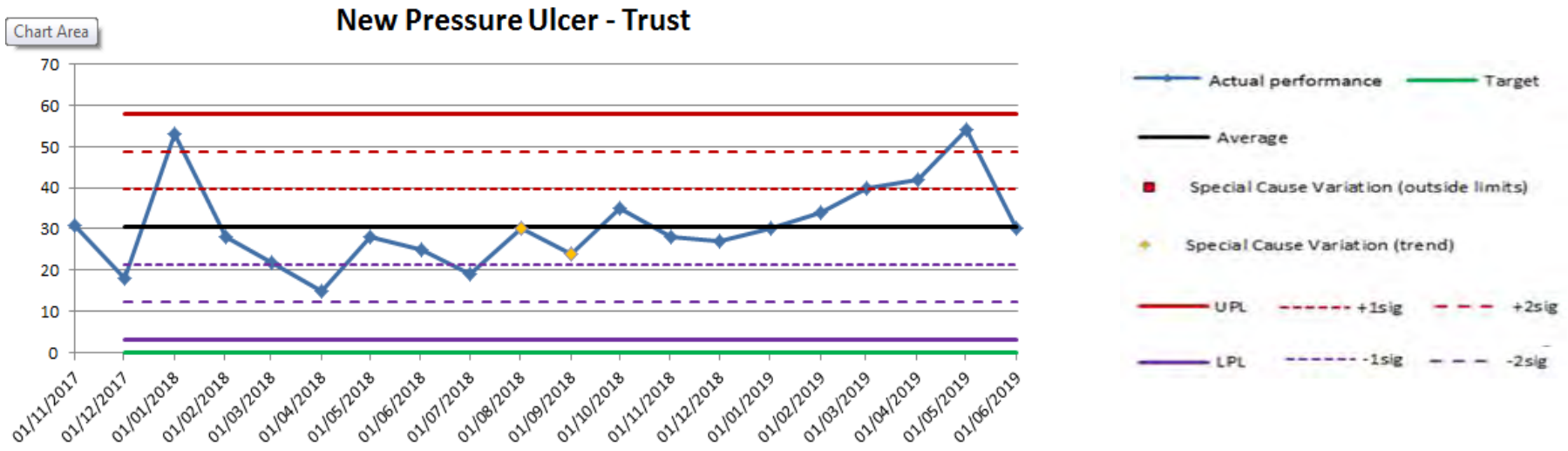
Caring domain	Standard	Actual	Trend	Assurance	Notes
Compliments	No target	35	Common Cause Variation	No target	
Complaints	20	16	Common Cause Variation	Hit and miss against target	

Responsive domain	Standard	Actual	Trend	Assurance	Notes
Referral to Treatment 18 week standard	92%	85%	Special Cause Variation - Low	Hit and miss against target	
Diagnostics 6 week standard	99%	93%	Special Cause Variation - Low	Hit and miss against target	
Sepsis	100%	93%	Special Cause Note/Investigation - High	Hit and miss against target	
Cancer 2 week GP referral to assessment standard	93%	94%	Common Cause Variation	Hit and miss against target	
Cancer 2 week breast referral to assessment standard	93%	91%	Special Cause Variation - Low	Hit and miss against target	
Cancer 62 day referral to treatment standard	85%	67%	Special Cause Variation - Low	Hit and miss against target	
Community referral to treatment within 18 weeks	90%	94%	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%	Common Cause Variation	Hit and miss against target	
Proportion of Temporary Staff	12%	12%	Common Cause Variation	Hit and miss against target	

Maternity	Standard	Actual	Trend	Assurance	Notes
Number of deliveries (births)	210	205	Common Cause Variation	Hit and miss against target	
Caesarean Section rate	22.6%	26%	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

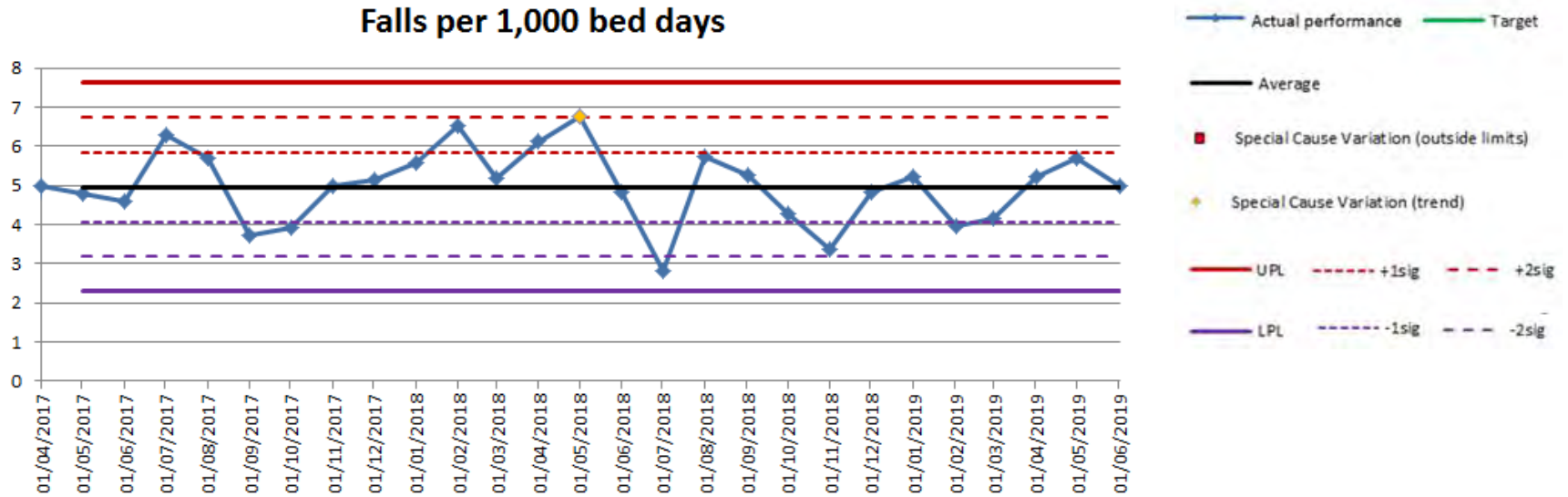


Narrative

What	It is pleasing to note the reduction this month in the number of new pressure ulcers reported as an organisation. The total number of Cat 2 pressure ulcers reduced to 21 during May (from 45 last month), Unstageable pressure ulcers also saw a small decrease to 5 (from 6 during May 2019), however Cat 3 pressure ulcers increased to 5 (from 3 during May 2019).
Why	A number of the initiatives detailed last month continue, but it is always important to note our aspirational target of zero new pressure ulcers, balanced with the potential for skin damage occurrence when caring for sick and often frail patients. All teams (both acute and community) continue to work to capacity; it is pleasing to have seen the closure of some escalation areas, allowing clinical staff to return to base wards. Within the community setting, where caseload/acuity is more difficult to quantify, communication continues on a daily basis to match clinical capacity to demand in terms of patients cared for in their own homes. It is interesting to note that despite a significant reduction in the number of new pressure ulcers reported last month, the number of pressure ulcers present on admission to the organisation has remained at very similar levels
How	Almost all new team members recruited to the Integrated Tissue Viability Team are now in post. Bite-size teaching sessions have recommenced with the TVS visiting areas on an ad-hoc basis to support staff in the clinical area.
When	This proactive approach to reducing the incidence of new pressure ulcers continues; during the PUPG meeting on 18.07.19 an Action Plan will be developed to first identify the current position in terms of good nutritional assessment and appropriate interventions in place to reduce the risk and promote wound healing and to set goals to improve this position. It is anticipated that an improvement in nutritional assessments for this group of patients will be evidenced within reporting for September 2019. The team continue to respond to trends in a responsive way by reviewing new PU's for each month at the Monthly Pressure Ulcer Review Meetings.

Safe

Inpatient Falls - Trust

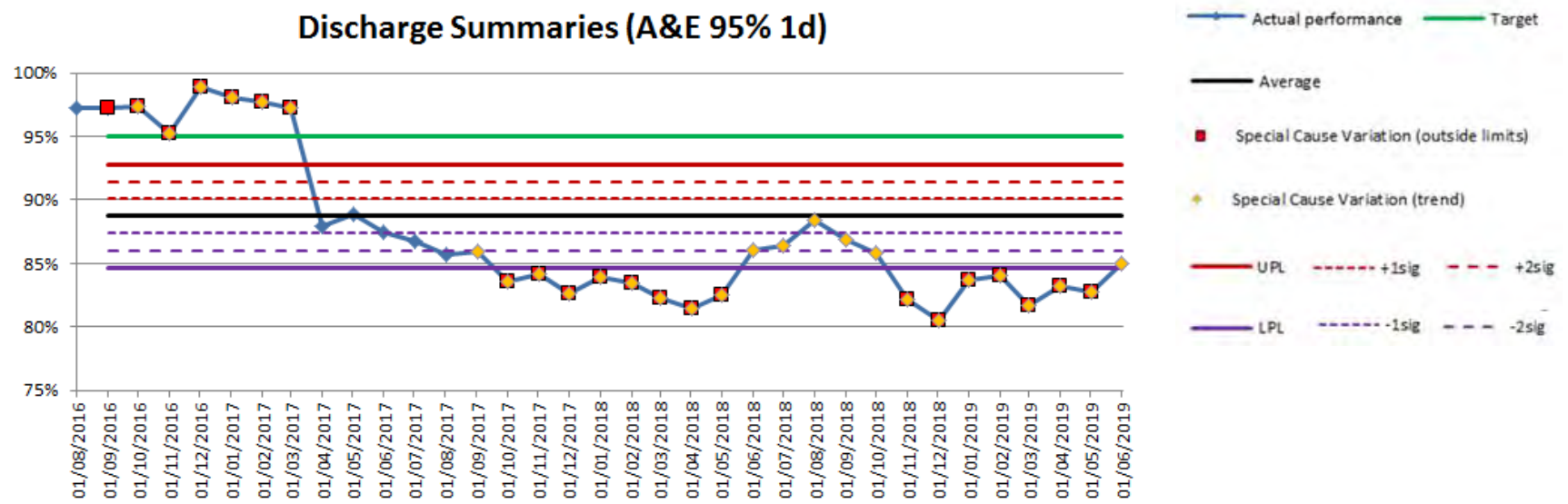


Narrative

What	The total number of Trust inpatient fell in June to total of 61 (53 in WSH & 8 in Community beds) and the falls per 1,000 bed days also fell to 4.98 maintaining a value within the expected range. In the Community Hospitals we continue to promote a positive risk taking environment where patients are encourage to maintain and regain independence prior to discharge.
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. In June, there were ten individuals who fell twice or more, including three who each fell three times contributing to the overall number. There were no falls resulting in serious harm in June (although there have been two so far in July). One patient in CDU fell and sustained a # NoF, and one patient fell on F6 resulting in # right NoF. Full investigations are ongoing into these incidents. Following the four falls with serious harm in April, an SPC chart has been included in the IQPR (see 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 are attending a National conference in September focusing on falls prevention and the CQUIN and NICE quality standards. We are planning on trailing new technology during August on three 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. From August, we will have some dedicated Matron hours focused on falls training and quality improvements within the Trust.

Safe

Discharge Summaries ED

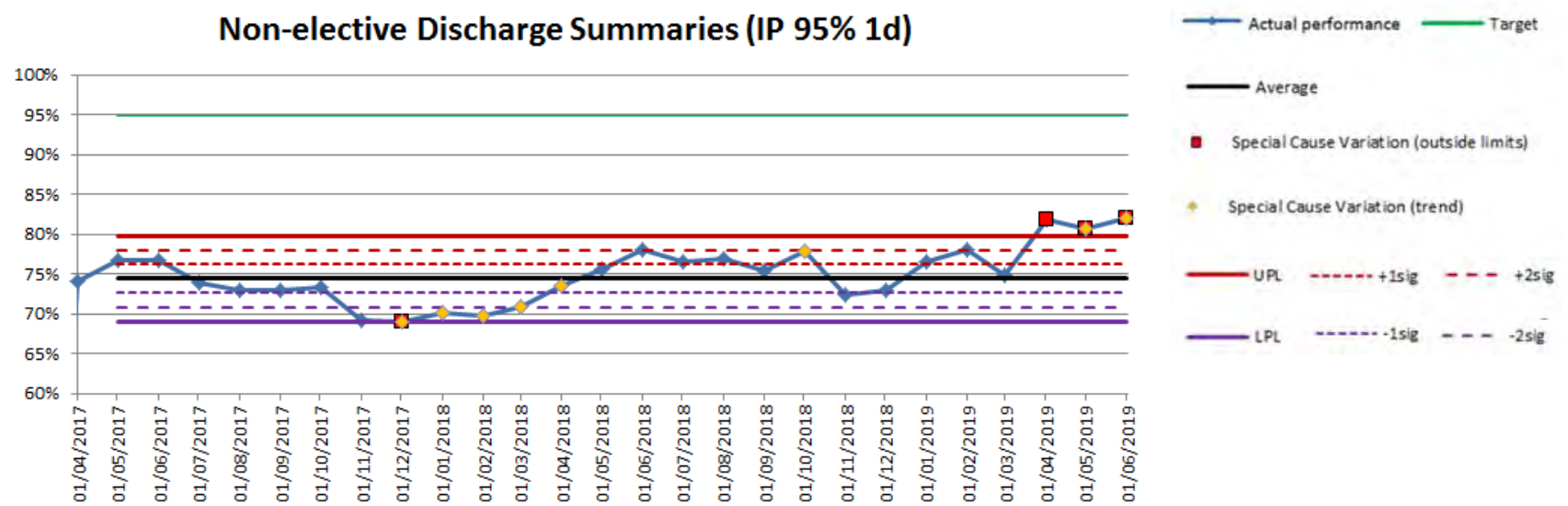


Narrative

What	The chart shows a slight improvement with performance back inside of the control limits. The target is unlikely to be achieved under the current trajectory.
Why	The Chief Operating Officer is now taking personal responsibility for overseeing performance for each area. Weekly reports are distributed to each area and most areas have less than ten outstanding discharge summaries each week. Any areas with greater numbers than this are required to take immediate action.
How	We continue to work with the ED team and the visiting clinicians to try and address this.
When	-

Effective

Discharge Summaries Non elective admissions

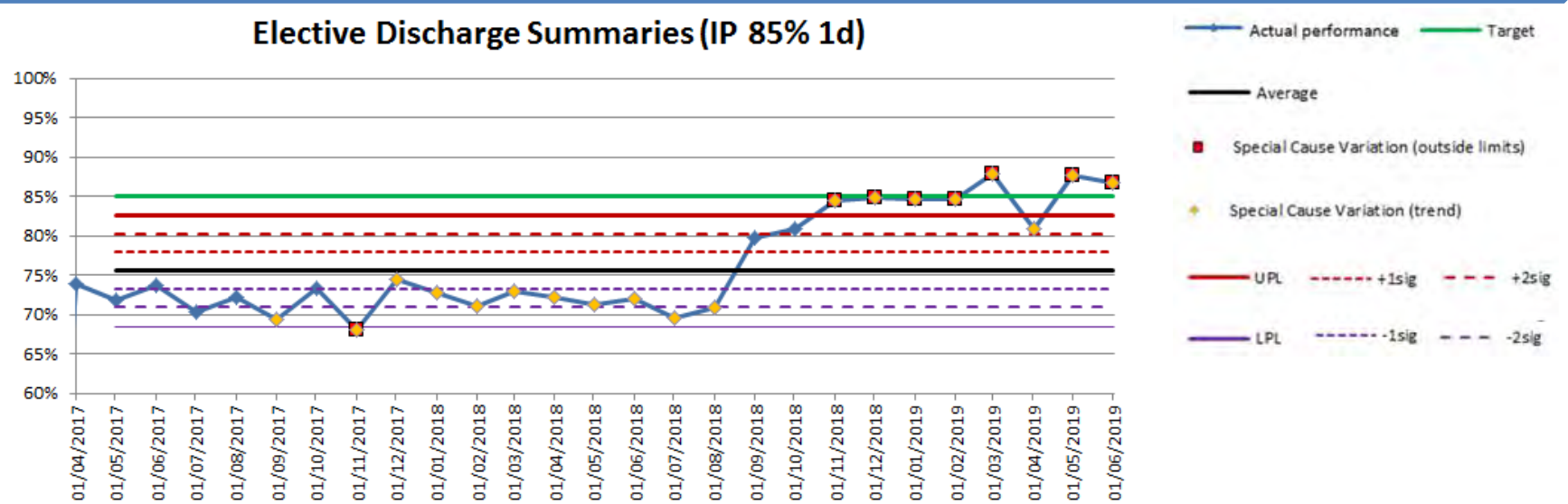


Narrative

What	The chart shows no trend but there is a Special Cause Variation- High with the last 3 months data point's performing above the upper control limit.
Why	The Chief Operating Officer is now taking personal responsibility for overseeing performance for each area. Weekly reports are distributed to each area and most areas have less than ten outstanding discharge summaries each week. Any areas with greater numbers than this are required to take immediate action.
How	We continue to work with the team and the visiting clinicians.
When	-

Effective

Discharge Summaries Elective admissions

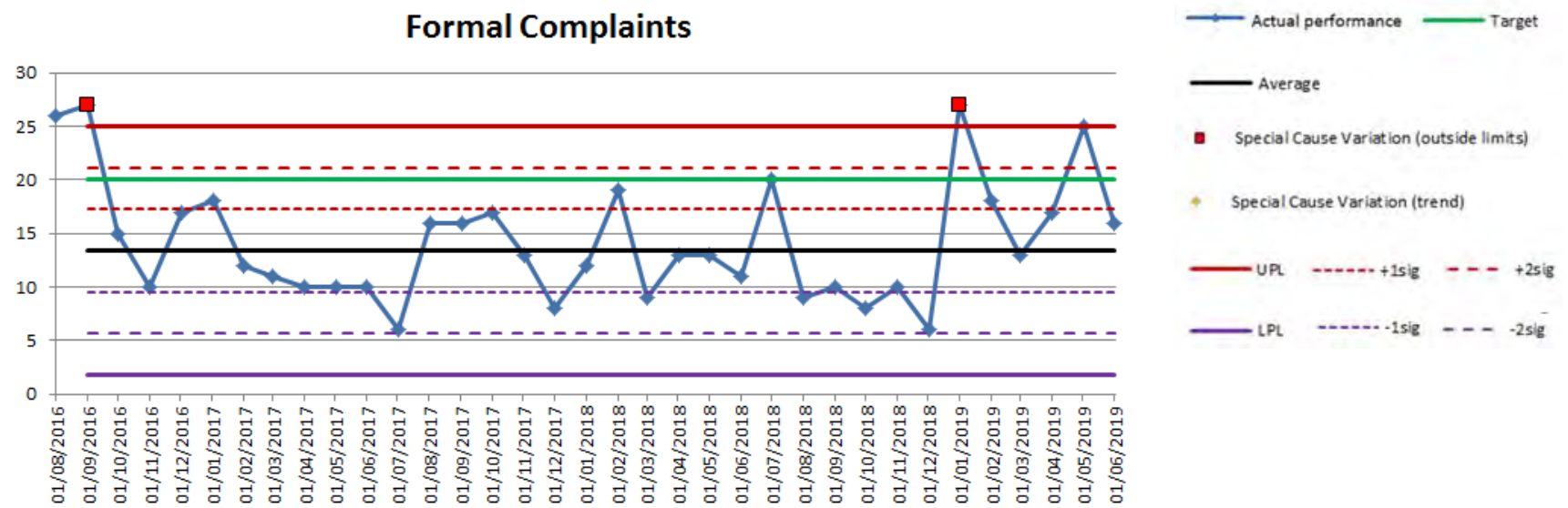


Narrative

What	The chart showed a slight dip compared to last month but still above target.
Why	The Chief Operating Officer is now taking personal responsibility for overseeing performance for each area. Weekly reports are distributed to each area and most areas have less than ten outstanding discharge summaries each week. Any areas with greater numbers than this are required to take immediate action.
How	We continue to work with the team and the visiting clinicians.
When	-

Effective

Complaints

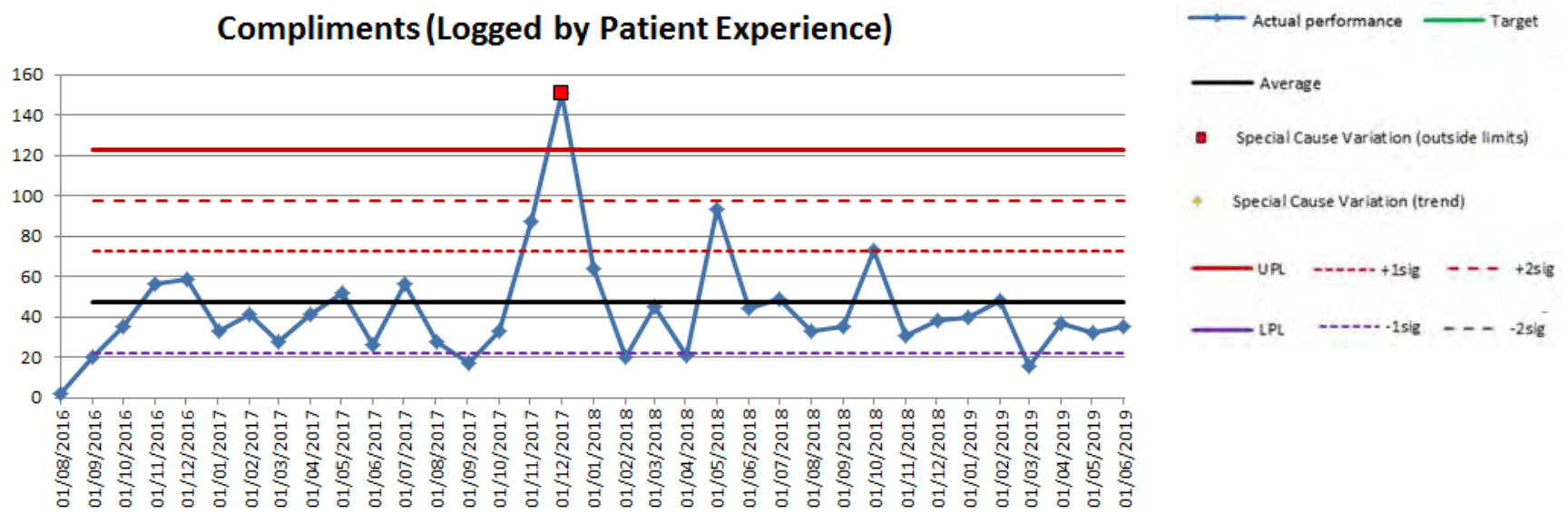


Narrative

What	This month's decrease now puts us back under the target.
Why	-
How	-
When	-

Caring

Compliments



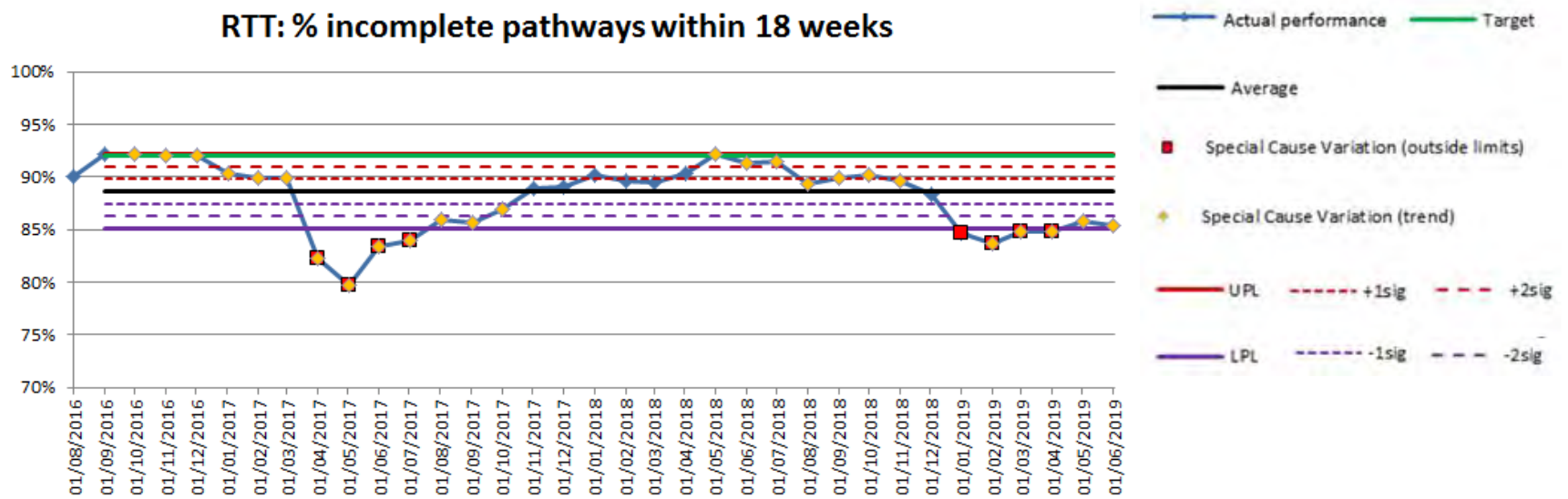
Narrative

What	Slight increase this month compared to last month, no trend showing.
Why	-
How	-
When	-

Caring

RTT

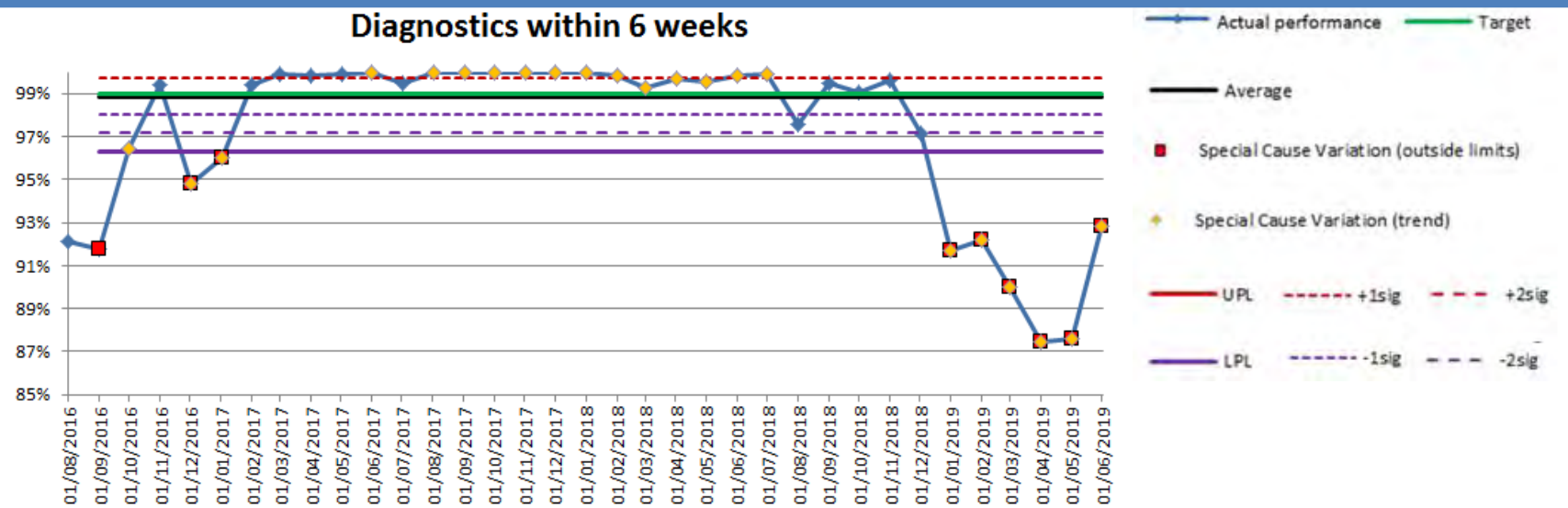
Responsive



Narrative

What	Special Cause Variation – Low, slight drop this month.
Why	Patients are exceeding their waiting times in multiple specialities, with significant impact in Vascular, Ophthalmology, General Surgery, T&O, Urology and Gynaecology.
How	Waiting times for first appointment in Vascular, Cataract surgery in Ophthalmology, Joint surgery in T&O and first appointment and Urogynae in Gynaecology are the main focus.
When	-

Diagnostics within 6 weeks

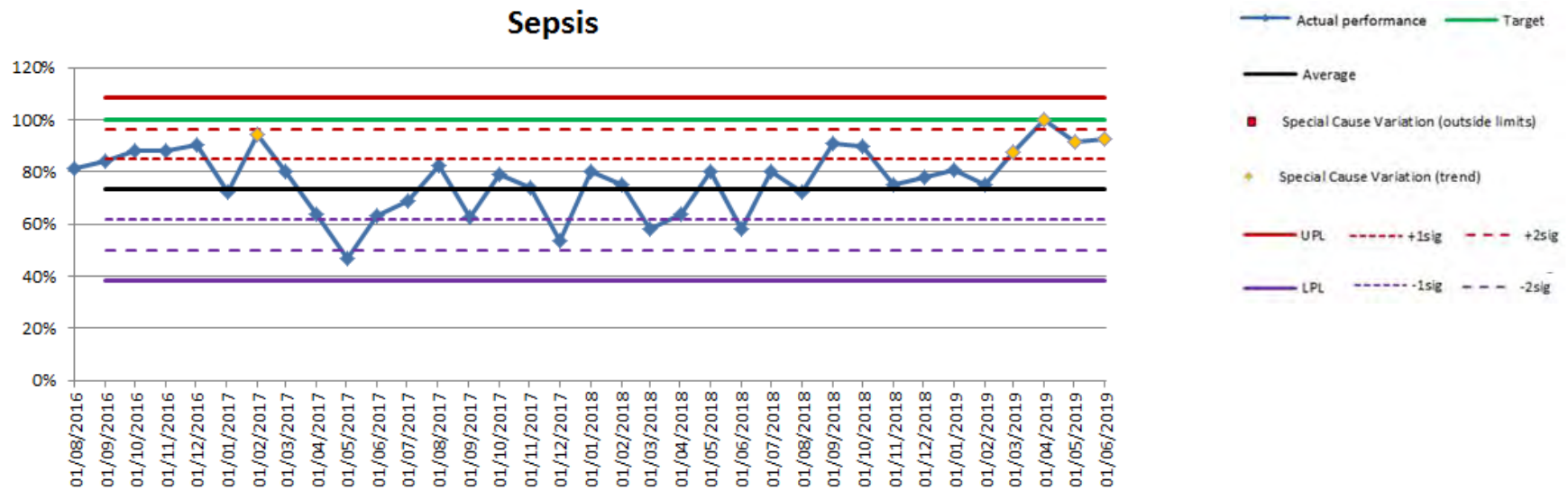


Narrative

What	Special Cause Variation – Low, this month has seen a large improvement compared to the last 4 months.
Why	-
How	Cystoscopy - on going capacity issues are impacting this element of the service, compounded by clinician absence. An improvement is anticipated in July with longer term service developments being worked on to stabilise this for the future. Cardiology - There is a recovery plan for cardiology diagnostics in place with anticipated compliance by the end of July.
When	-

Responsive

Sepsis

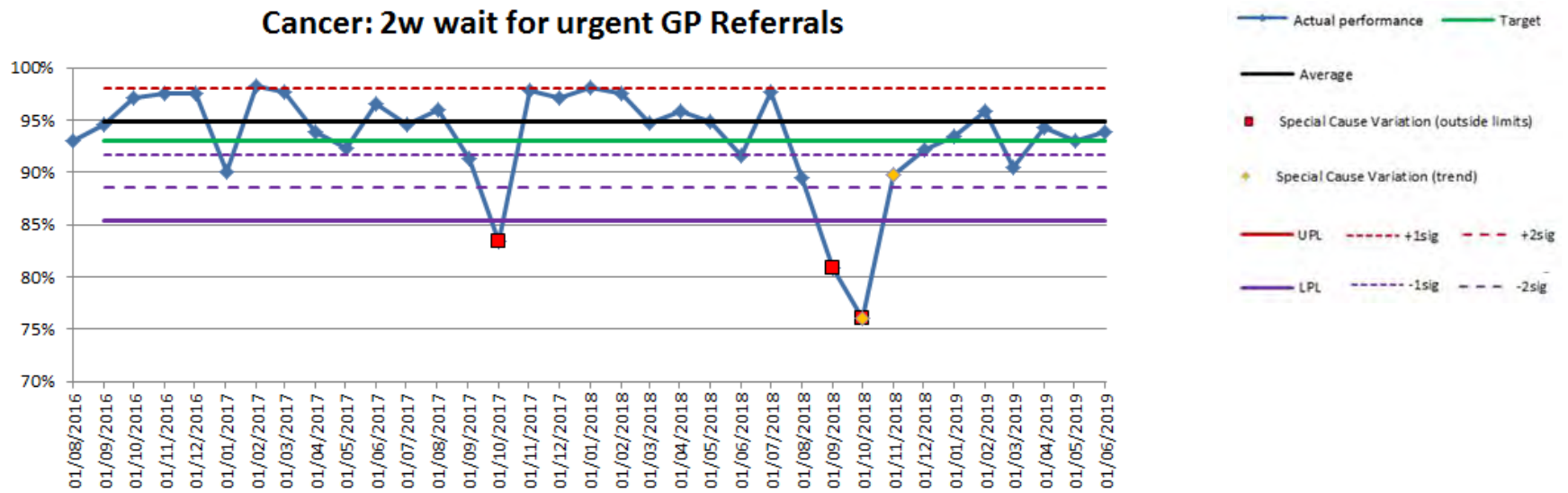


Narrative

What	Special Cause variation – High, we have been seeing a slight increase this month compared to last month however a performance trend has not yet been demonstrated.
Why	-
How	-
When	-

Responsive

Cancer 2 week referral

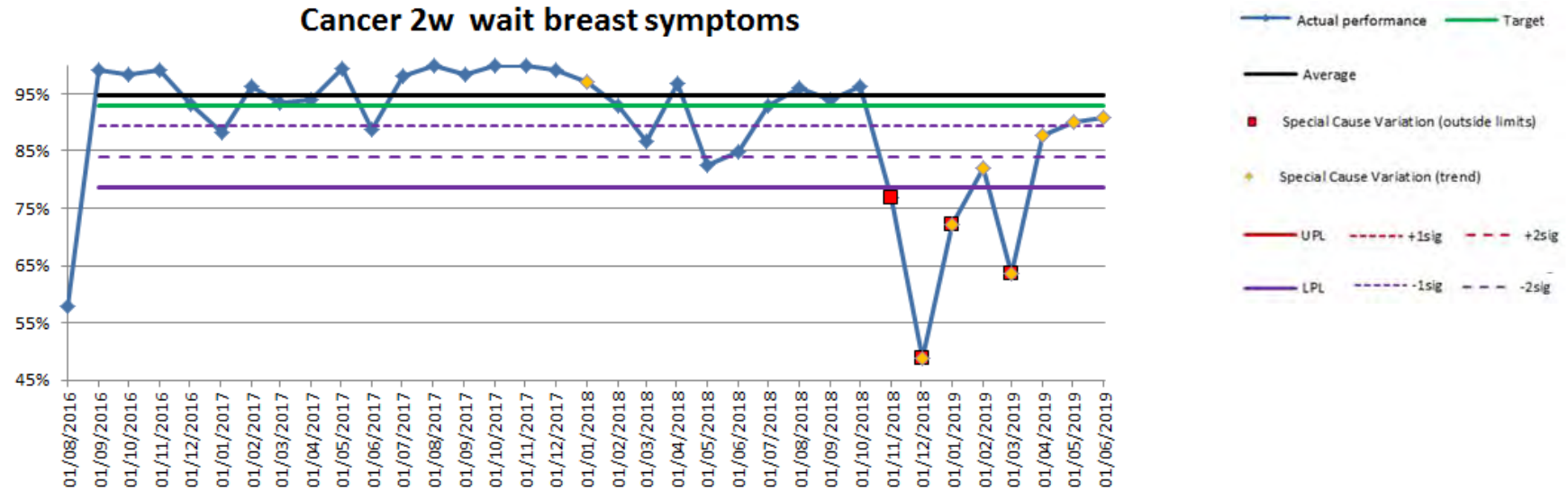


Narrative

What	Common cause variation in the performance 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	-

Responsive

Cancer 2 week referral Breast

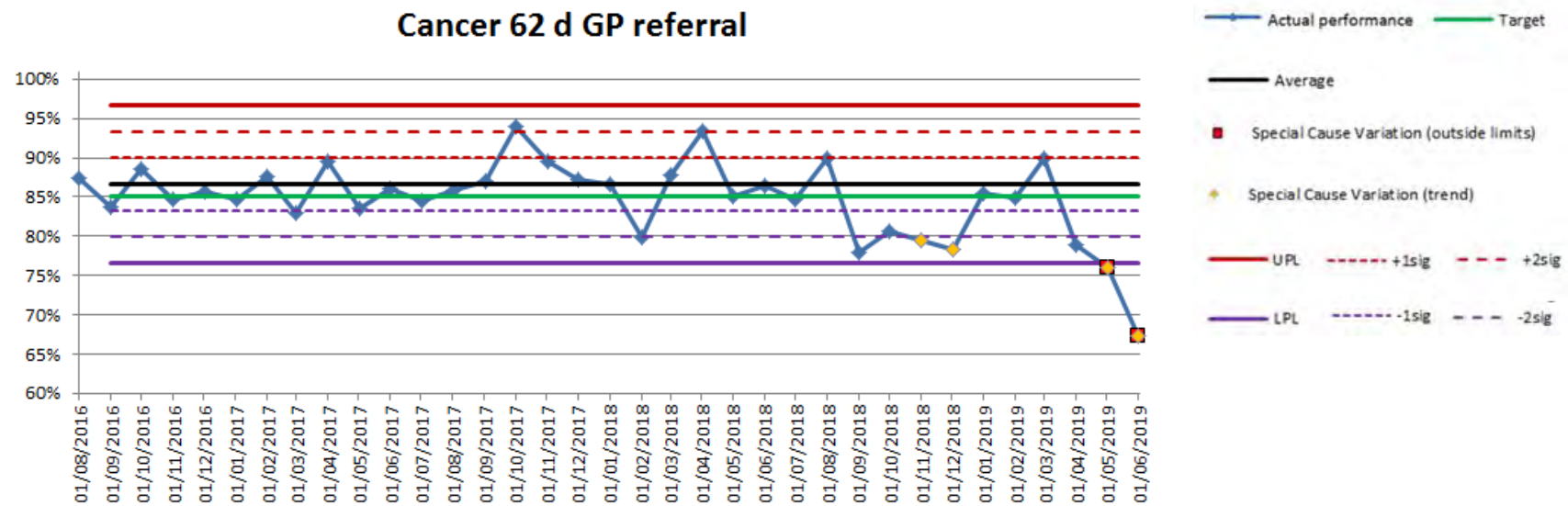


Narrative

What	Special Cause Variation – Low, we have seen another improvement this month.
Why	This is primarily due to patient choice factors on 12/14 breaches and the referral numbers are also sustained.
How	-
When	-

Responsive

Cancer 62 Day

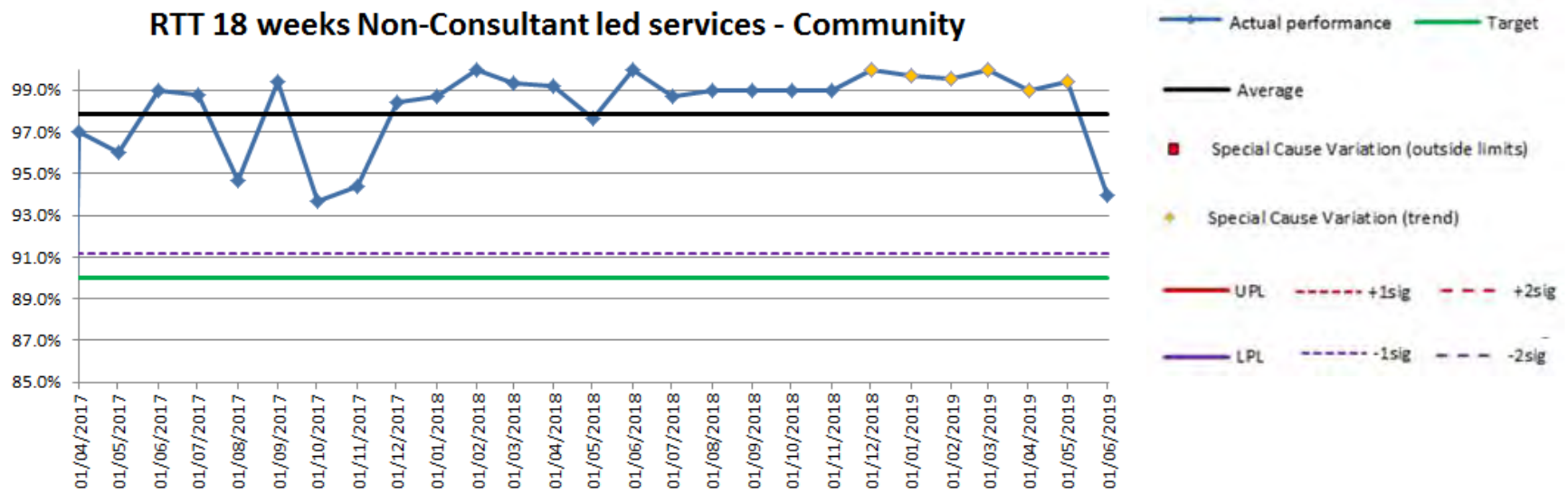


Narrative

What	Special Cause Variation – Low, we are seeing a downward progression appearing.
Why	Owing to high number of referrals and delay in diagnostics/ staging in colorectal pathways in particular with 10 colorectal breaches. In addition there were 2 Lung, 2 Skin, 2 Upper GI and 2 Urology breaches locally in the Trust and 4 shared pathway breaches: Breast-1, Gynae -2, Head/Neck -1, some involving cases of late referrals. Both skin patients contributed to the breach by declining to attend an earlier appointment with plastic surgeons to agree for excision.
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.
When	-

Responsive

RTT non consultant led

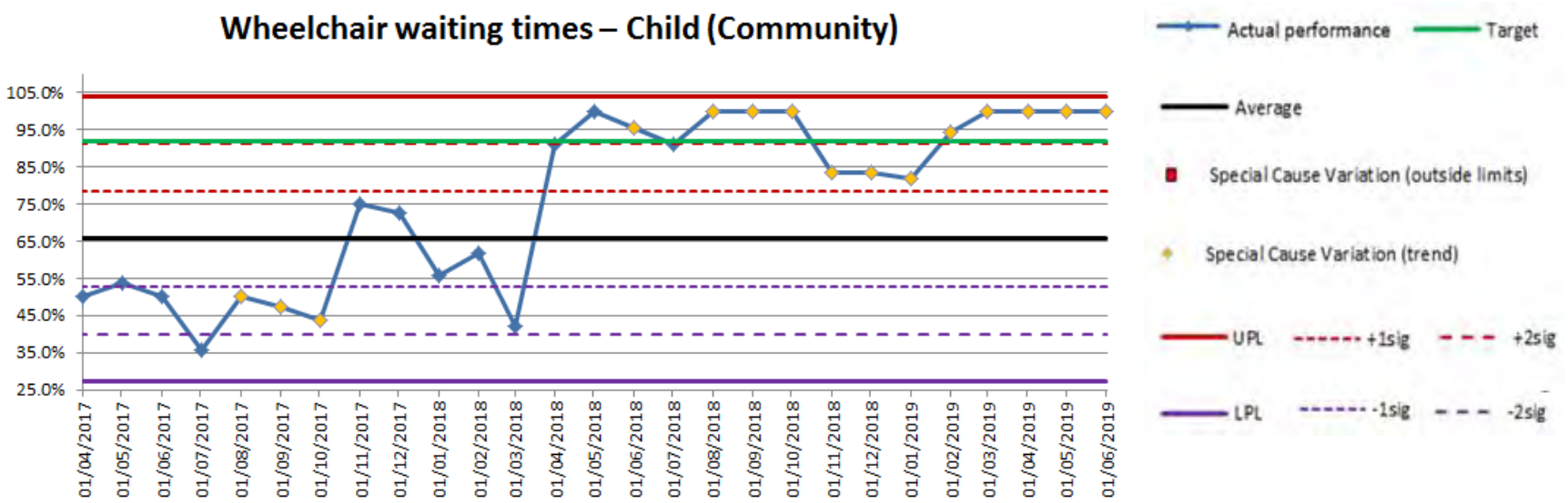


Narrative

What	The performance as fallen this month but is still above the target.
Why	-
How	-
When	-

Community

Wheelchair waiting times – Child (Community)

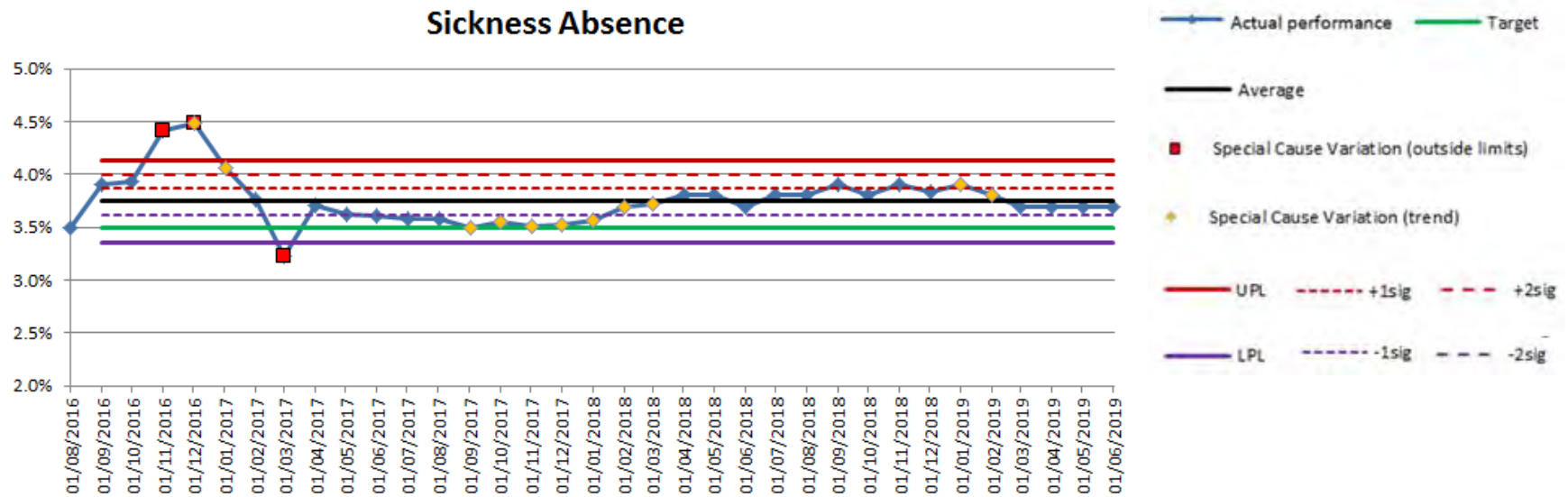


Narrative

What	Special Cause – High, we are seeing a positive trend appearing, hitting 100% for the last 4months.
Why	-
How	-
When	-

Community

Sickness absence

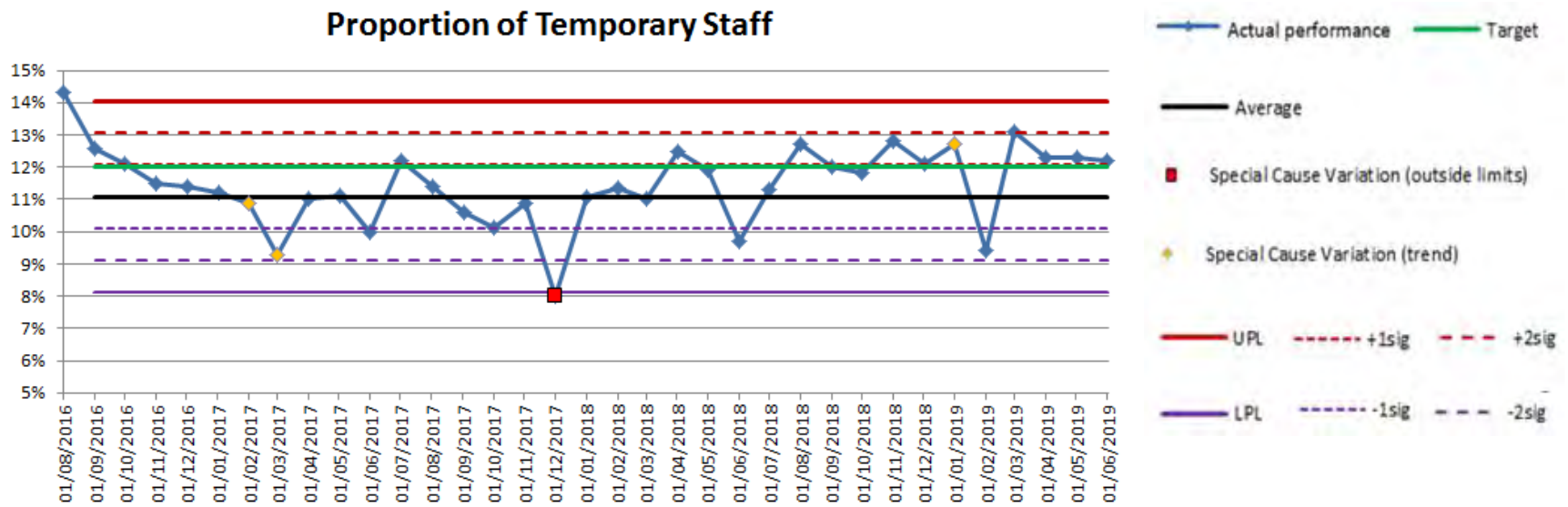


Narrative

What	The chart is showing a common cause variation with no significant trend.
Why	Stable performance is maintained.
How	-
When	-

Well Led

Proportion of temporary staff

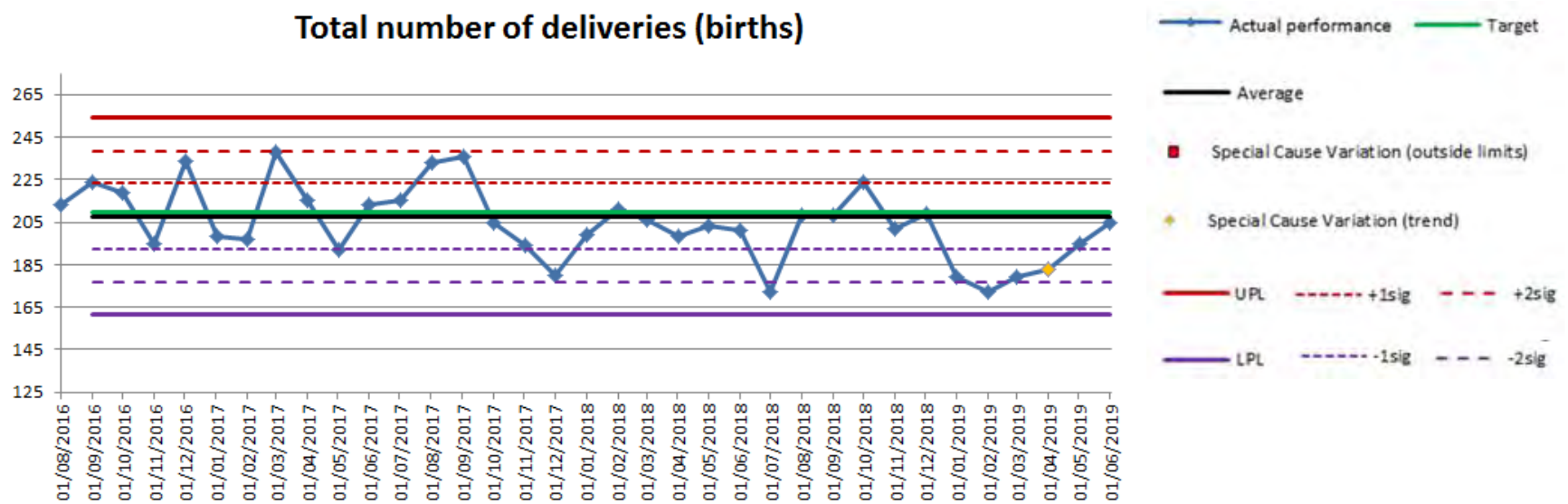


Narrative

What	Common Cause, we are slightly above target again this month.
Why	-
How	-
When	-

Well Led

Total number of deliveries

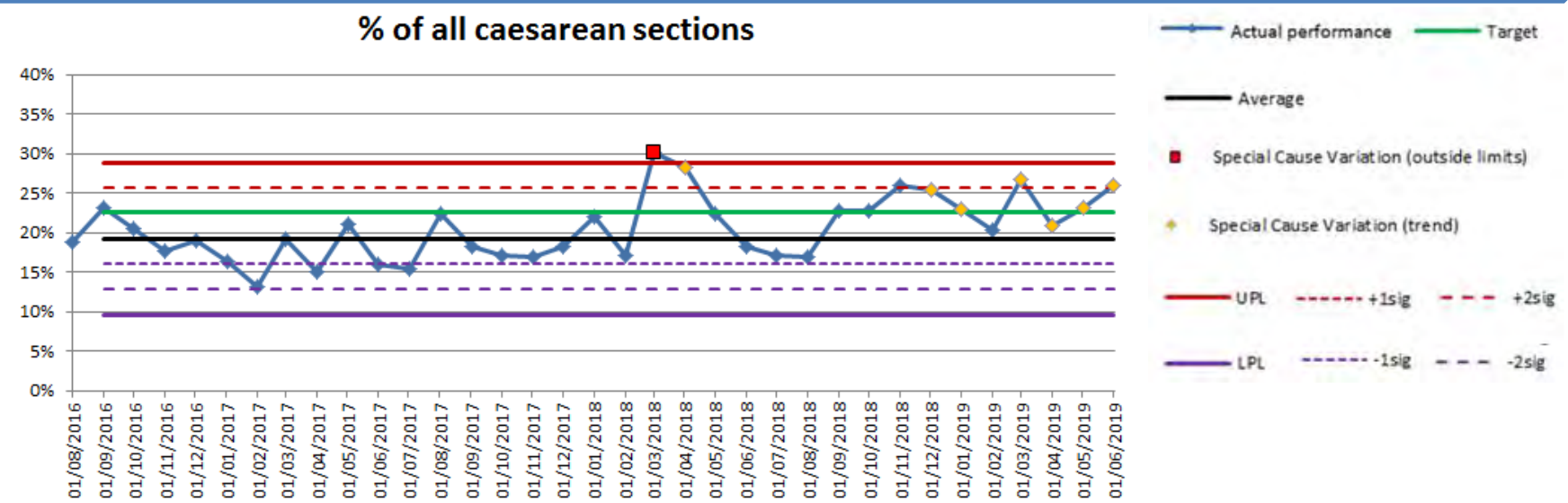


Narrative

What	Common Cause, we are seeing an improvement back towards our target.
Why	-
How	-
When	-

Maternity

Caesarean section rate

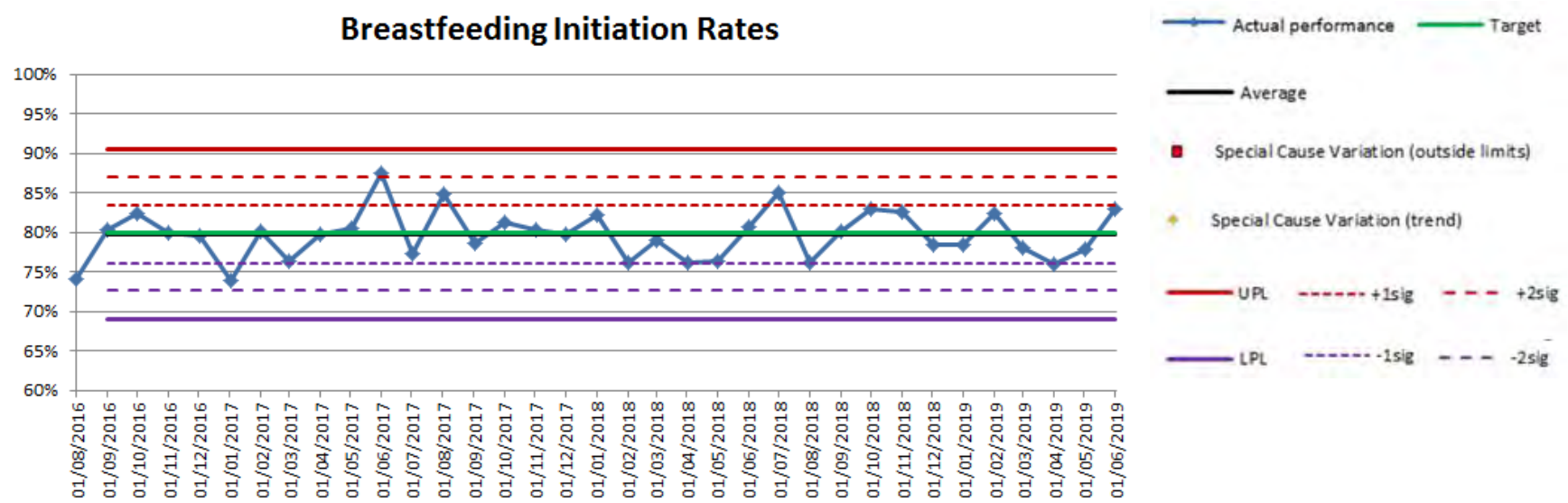


Narrative

What	The chart suggests that this is an area that should be reviewed. Previous performance outside of control limits however no trend identified.
Why	Clinical lead is conducting a review to identify any cause for this deterioration in performance.
How	To be identified if applicable.
When	-

Maternity

Breast feeding initiation



Narrative

What	Common cause variation, No trend but now back above target.
Why	-
How	-
When	-

Maternity

Trust Board – 26 July 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:	July 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 17 onwards.			

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

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

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

Recommendation:

The Trust Board notes the monthly performance report.

NHS
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Integrated quality and performance report



Month Three: June 2019

3

Putting you first

CONTENTS

EXECUTIVE SUMMARY

DETAILED SECTIONS

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

ARE WE SAFE?

Healthcare associated infections (HCAIs) – There were no MRSA Bacteraemia - hospital attributable cases in June 2019 and there was one hospital attributable clostridium difficile cases within the month. The trust compliance with decolonisation decreased in June to 94.0%. (Exception report at page 25)

CAS (Central Alerting System) Open (PSAs) – A total of 6 Patient Safety Alerts have been received in June 2019. All of the alerts have been implemented within timescale to date.

Patient Falls (All patients) – 61 patient falls occurred in June 2019, which is a decrease from 75 the previous month. (Exception report at page 20,21,22)

Pressure Ulcers – 31 cases occurred in June 2019, which is a decrease from 51 in May 2019. (Exception report at page 23)

ARE WE EFFECTIVE?

Cancelled Operations for non-clinical reasons – The rate of cancelled operations for non-clinical reasons was recorded at 1.9% in June 2019. (Exception report at page 34)

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 100% in June 2019 compared to 93.3% in May 2019.

Discharge Summaries - A&E has achieved a rate of 85.0% in June 2019, whereas inpatient services have achieved a rate of 82.1% (Non-elective) and 86.7% (Elective). (Exception report at page 37)

ARE WE CARING?

Mixed Sex Accommodation breaches (MSA) – 20 Mixed Sex Accommodation breaches occurred in June 2019. (Exception report at page 39)

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 – June 2019 reported performance at 71.0% compared to 77.0% in May 2019. (Exception report at page 41)

ARE WE RESPONSIVE?

Cancer – Cancer has experienced significant increases in demand in the last few months. The challenge of demand and capacity continues with three areas failing the target for June 2019. These areas were Cancer 2 week wait breast symptoms with performance at 90.9%, Cancer 62 d GP referral with performance at 67.2% and Incomplete 104 day wait with 5 breaches reported in June 2019. (Exception reports at page 50-52)

Referral to Treatment (RTT) – The percentage of patients on an incomplete pathway within 18 weeks for June was 85.4%. The total waiting list was 21253 as at the end of June 2019, with 4 patients who breached the 52-week standard. (Exception reports at page 46-48)

ARE WE WELL LED?

Appraisal - The appraisal rate for June 2019 is 81.0%. (Exception report at page 64)

Sickness Absence – The Sickness Absence rate for June 2019 is 3.7%. (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	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Av/YTD
1. Safe	1.01	CAS (Central Alerting System) Open	NT	5	3	4	5	4	7	8	8	13	11	10	6	6	22
	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%	95.1%	93.0%	93.7%	94.0%	96.0%	96.1%	94.4%	94.6%	95.2%	95.4%	95.0%	95.4%	95.1%	95.2%
	1.05	Clostridium Difficile infection - Hospital Attributable	20	0	1	1	1	1	2	0	0	4	1	1	2	1	4
	1.06	MRSA Bacteraemias - Hospital Attributable	0	0	0	1	0	0	0	0	0	0	0	0	1	0	1
	1.07	Patient Safety Incidents Reported	NT	465	469	521	488	511	478	546	766	625	646	670	651	577	1898
	1.08	Never Events	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0
2.Effective	2.02	Canc. Ops - Cancellations for non-clinical reasons	1%	1.5%	1.8%	1.5%	1.2%	1.5%	1.3%	0.5%	1.0%	1.0%	0.6%	1.9%	1.2%	1.9%	1.7%
3. Caring	3.01	Compliments (Logged by Patient Experience)	NT	44	49	33	35	73	31	38	40	48	16	37	32	35	104
	3.02	Formal Complaints	20	11	20	9	10	8	10	6	27	18	13	17	25	16	58
	3.03	Mixed Sex Accommodation Breaches	0	1	0	0	0	0	0	0	28	0	0	0	0	20	20
	3.04	IP - Extremely likely or Likely to recommend (FFT)	90%	98.0%	99.0%	99.0%	99.0%	96.0%	98.0%	98.0%	98.0%	97.0%	97.0%	95.0%	95.0%	98.0%	96.0%
	3.05	OP - Extremely likely or Likely to recommend (FFT)	90%	97.0%	97.0%	98.0%	96.0%	96.0%	96.0%	97.0%	97.0%	97.0%	97.0%	97.0%	96.0%	97.0%	96.7%
	3.06	A&E - Extremely likely or Likely to recommend (FFT)	90%	94.0%	96.0%	95.0%	97.0%	96.0%	96.0%	97.0%	96.0%	97.0%	99.0%	94.0%	88.0%	95.0%	92.3%
	3.07	Maternity - Extremely likely or likely to recommend (FFT)	90%	96.7%	100%	95.0%	92.0%	100%	93.0%	100%	100%	100%	ND	ND	ND	ND	ND
	3.08	Community - Extremely likely or likely to recommend	80%	97.0%	90.0%	98.0%	95.0%	100%	100%	97.0%	98.0%	95.0%	100%	95.0%	97.0%	95.0%	95.7%
4. Responsive	4.02	RTT: % incomplete pathways within 18 weeks	92%	91.4%	91.4%	89.3%	89.9%	90.2%	89.7%	88.3%	84.7%	83.6%	84.8%	84.8%	85.8%	85.4%	85.3%
	4.03	52 week waiters	0	10	9	10	2	7	6	10	7	7	2	1	4	4	9
	4.04	Diagnostics within 6 weeks	99%	99.8%	99.9%	97.6%	99.5%	99.0%	99.6%	97.1%	91.7%	92.2%	90.0%	87.5%	87.6%	92.8%	89.3%
	4.05	Cancer: 2w wait for urgent GP Referrals	93%	91.6%	97.6%	89.5%	80.9%	76.1%	89.8%	92.2%	93.4%	95.8%	90.5%	94.3%	93.1%	93.8%	93.8%
	4.06	Cancer 2w wait breast symptoms	93%	84.9%	92.8%	95.9%	93.9%	96.4%	76.7%	48.8%	72.1%	82.0%	63.5%	87.8%	90.2%	90.9%	89.6%
	4.07	Cancer 31 d First Treatment	96%	100%	100%	100%	100%	99.3%	100%	100%	99.2%	100%	100%	100%	98.0%	99.0%	99.0%
	4.08	Cancer 31 d Drug Treatment	98%	100%	100%	98.7%	98.5%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.09	Cancer 31 d Surgery	94%	100%	100%	100%	100%	100%	100%	100%	94.4%	100%	100%	100%	100%	100%	100%
	4.10	Cancer 62 d GP referral	85%	86.5%	84.8%	89.9%	78.0%	80.6%	79.5%	78.3%	85.5%	84.8%	90.0%	79.8%	77.7%	67.2%	74.9%
	4.11	Cancer 62 d Screening	90%	100%	88.2%	100%	90.5%	80.0%	93.8%	87.9%	100%	100%	95.2%	92.3%	90.5%	92.9%	91.9%
	4.12	Incomplete 104 day waits	0	0	1.0	3.0	2.0	0	3.0	0	0	1.0	1.0	2.0	4.0	5.0	11.0

Putting you first

INTEGRATED QUALITY & PERFORMANCE REPORT																
Are we..	Ref.	KPI	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Av/YTD
5. Well Led	5.01	NHS Staff Survey (Staff Engagement score -Annual)	NT	NA	NA	NA	NA	NA	NA	NA	NA	7.4%	NA	NA	NA	NA	NA
	5.02	Staff F&F Test % Recommended - care (Qrtly)	75%	95.0%	NA	95.0%	NA	93.0%	NA	NA	NA	91.0%	NA	NA	NA	92.0%	92.0%
	5.03	Staff F&F Test % Recommended - place to work (Qrtly)	75%	83.0%	NA	82.0%	NA	82.0%	NA	NA	NA	78.0%	NA	NA	NA	79.0%	79.0%
	5.04	Turnover (Rolling 12 mths)	<10%	8.5%	8.6%	8.6%	8.7%	8.0%	8.0%	8.0%	8.0%	7.0%	8.0%	8.0%	8.0%	8.0%	8.0%
	5.05	Sickness Absence	<3.5%	3.7%	3.8%	3.8%	3.9%	3.8%	3.9%	3.8%	3.9%	3.8%	3.7%	3.7%	3.7%	3.7%	3.7%
	5.06	Executive Team Turnover (Trust Management)	<20%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	17.0%	0.0%	0.0%	5.7%
	5.07	Agency Spend	550	330	433	507	393	381	620	500	637	330	524	426	366	482	425
	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	-6.3%	-7.30%	-6.80%	-7.20%	-6.40%	-6.00%	ND	-6.10%	-5.80%	-5.50%	-5.80%	-6.70%	-7.60%	-6.70%
	6.03	Capital service cover	Var	-0.80	-0.93	0.87	-0.92	-0.63	-0.50	ND	-0.42	-0.25	-0.27	0.34	0.23	0.12	0.69
	6.04	Liquidity (days)	NT	15.36	16.67	14.36	19.19	17.56	21.57	ND	15.86	15.18	26.80	24.13	24.98	22.90	24.00
	6.05	Long Term Borrowing (£m)	4	69.0	70.7	74.2	75.3	75.5	76.5	ND	85.5	64.1	65.4	95.7	85.0	88.2	95.7
	6.06	CIP (Variance YTD £'000s)	1.9	-75	-100	-120	-38	-28	-46	-53	-45	-48	0	-32	-75	-46	-32
7. Maternity	7.01	Total number of deliveries (births)	210	201	172	208	208	224	202	209	179	172	179	183	195	205	583
	7.02	% of all caesarean sections	26%	18.2%	17.1%	17.0%	22.8%	22.7%	25.9%	25.4%	22.9%	20.3%	26.8%	20.8%	23.1%	25.9%	23.3%
	7.03	Midwife to birth ratio	1.3	1.30	1.30	1.30	1.30	1.31	1.29	1.30	1.28	1.26	1.27	1.27	1.28	1.29	1.28
	7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.05	Completion of WHO checklist	100%	88.0%	94.0%	95.0%	93.0%	93.0%	94.4%	95.0%	96.0%	95.0%	93.0%	94.0%	93.0%	97.0%	94.7%
	7.06	Maternity SIs	NT	0	1	0	0	1	0	0	0	1	0	1	1	2	4
	7.07	Maternity Never Events	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.08	Breastfeeding Initiation Rates	80%	80.7%	85.1%	76.2%	80.2%	83.0%	82.6%	78.5%	78.5%	82.4%	78.1%	76.0%	77.8%	83.0%	78.9%
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%	100%	98.7%	99.0%	99.0%	99.0%	99.0%	100%	99.7%	99.6%	100%	99.0%	99.4%	94.0%	97.4%
	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	95%	100%	100%	100%	ND	100%	100%	100%	NA	100%	100%	100%	100%	100%	100%
	4.40	Nursing & therapy Red referrals seen within 4hrs - Community	95%	100%	98.2%	100%	100%	100%	99.9%	100%	96.6%	100%	100%	100%	100%	100%	100%
	4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	95%	99.5%	97.4%	99.4%	99.5%	99.0%	99.2%	98.4%	99.0%	98.8%	99.3%	100%	99.5%	99.3%	99.6%

3. IN THIS MONTH –JUNE 2019, MONTH 3

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

From Month Year	Jun-2019

To Month Year	Jun-2018

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

In this month.... Jun-2019

Mth We Received.....	Jun-19	Jun-18	Variance	Var. %	Traffic
GP Referrals	5,214	6,502	-1,288	-19.8%	↓
Other Referrals	4,888	5,383	-495	-9.2%	↓
Ambulance Arrivals	1,869	1,711	158	9.2%	↑
Cancer Referrals*	979	1,038	-59	-5.7%	↓
Urgent Referrals*	2,558	2,623	-65	-2.5%	↓

YTD We Received.....	2019	2018	Variance	Var. %	Traffic
GP Referrals	17,629	19,840	-2,211	-11.1%	↓
Other Referrals	14,921	16,251	-1,330	-8.2%	↓
Ambulance Arrivals	5,671	5,387	284	5.3%	↑
Cancer Referrals*	3,143	3,209	-66	-2.1%	↓
Urgent Referrals*	7,670	8,088	-418	-5.2%	↓

Mth We Delivered.....	Jun-19	Jun-18	Variance	Var. %	Traffic
ED Attendances (excluding GP Expected/Streamed)	5,689	5,259	430	8.2%	↑
**ED Attendances(Adjusted)	7,043	6,568	475	7.2%	↑
GP Expected via ED	558	518	40	7.7%	↑
GP Streamed	440	384	56	14.6%	↑
GP Expected direct to AAU/AEC	356	407	-51	-12.5%	↓

YTD We Delivered.....	2019	2018	Variance	Var. %	Traffic
ED Attendances (excluding GP Expected/Streamed)	17,242	15,539	1,703	11.0%	↑
**ED Attendances(Adjusted)	21,479	19,408	2,071	10.7%	↑
GP Expected via ED	1,761	1,810	-49	-2.7%	↓
GP Streamed	1,356	1,276	80	6.3%	↑
GP Expected direct to AAU/AEC	1,120	783	337	43.0%	↑

A&E - To IP Admission Ratio	27.2%	25.0%	2.2%	2.2%	↑
Outpatient Attendances	25,116	25,101	15	0.1%	↑
Inpatient Admissions	5,759	5,844	-85	-1.5%	↓
Elective Admissions	440	384	56	14.6%	↑
Non Elective Admission	2,686	2,684	2	0.1%	↑
Inpatient Discharges	5,717	5,880	-163	-2.8%	↓
Elective Discharges	3,031	3,160	-129	-4.1%	↓
Non Elective Discharges	2,675	2,691	-16	-0.6%	↓
New Births	205	201	4	2%	↑

A&E - To IP Admission Ratio	28.3%	26.2%	2.1%	7.9%	↑
Outpatient Attendances	77,275	76,231	1,044	1.4%	↑
Inpatient Admissions	17,978	17,527	451	2.6%	↑
Elective Admissions	8,343	8,195	148	1.8%	↑
Non Elective Admission	9,590	9,332	258	2.8%	↑
Inpatient Discharges	17,967	17,572	395	2.2%	↑
Elective Discharges	8,741	8,195	546	6.7%	↑
Non Elective Discharges	9,267	9,377	-110	-1.2%	↓
New Births	583	602	-19	-3%	↓

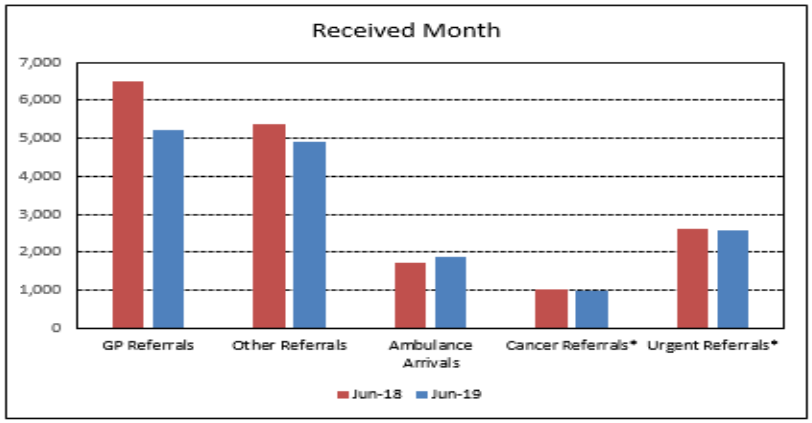
* - Included in Referrals Above

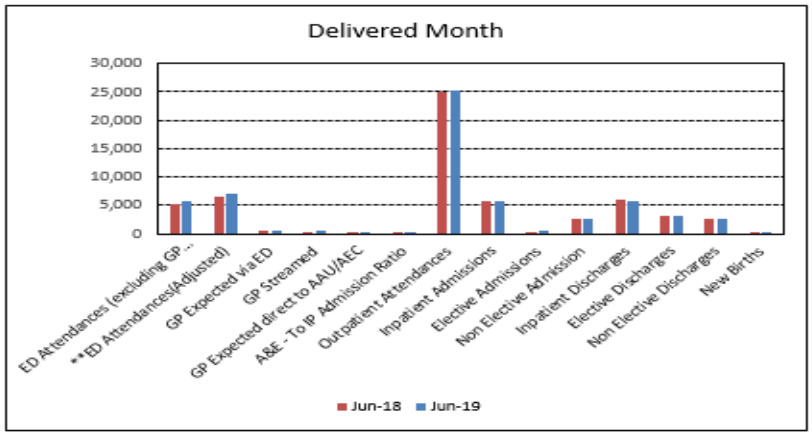
** - The ED adjusted figure adds ED attendances, GP Streamed and all GP expected (Including direct to AAU/AEC) together to reflect the position in 2017 when these were reported together.

A&E Attendances Year chart (Adjusted)

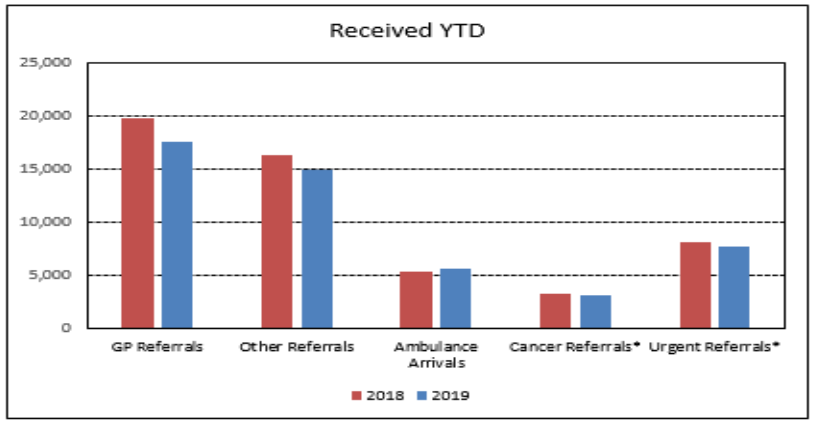
GP, cancer referrals and other referrals demonstrate a reduction year on year. A&E attendances continue to show an increase and incomplete RTT pathways are higher than last year.

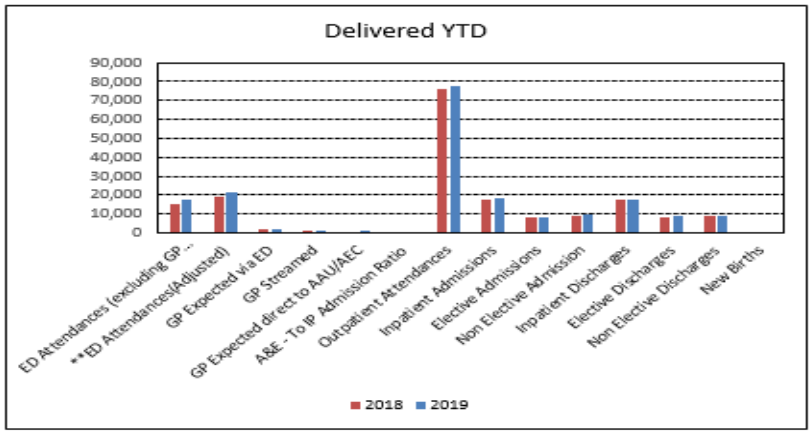
Monthly





Yearly





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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	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	YTD(Apr19-Jun19)
1.Safe	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	100%	100%	100%	100%	100%	100%	100%	100%	100%	94.4%	100%	100%	100%	100%	100%
		1.10	HII Compliance 1b: Central venous catheter on-going care	100%	100%	91.0%	97.0%	95.0%	100%	96.0%	100%	96.2%	96.4%	87.1%	89.0%	100%	100%	96.3%
		1.11	HII Compliance 2a: Peripheral cannula insertion	100%	100%	100%	100%	100%	96.0%	96.0%	100%	97.9%	100%	96.4%	100%	98.0%	100%	99.3%
		1.12	HII Compliance 2b: Peripheral cannula on-going	100%	97.0%	98.0%	96.0%	88.0%	100%	100%	100%	97.0%	99.3%	99.2%	100%	99.4%	100%	99.8%
		1.13	HII Compliance 4a: Preventing surgical site infection preoperative	100%	100%	100%	100%	100%	100%	95.0%	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%	100%	100%	100%	90.0%	ND	90.0%	100%	95.0%
		1.16	HII Compliance 6a: Urinary catheter insertion	100%	100%	100%	100%	100%	100%	100%	100%	90.9%	100%	100%	ND	100%	100%	100%
		1.17	HII Compliance 6b: Urinary catheter on-going care	100%	92.0%	97.0%	97.7%	89.0%	94.0%	97.0%	98.0%	92.2%	88.8%	95.2%	96.0%	94.2%	96.1%	95.4%
	Incidents	1.18	Safety Thermometer: % of patients experiencing new harm-free care-Trust	100%	98.7%	99.2%	88.0%	97.8%	98.7%	98.7%	96.2%	98.3%	97.0%	97.9%	96.6%	97.8%	97.0%	97.1%
		1.19	Safety Thermometer: % of patients experiencing new harm-free care - Community	100%	99.0%	99.3%	99.1%	97.7%	98.9%	99.0%	96.4%	98.4%	97.0%	99.0%	96.1%	99.7%	98.6%	98.1%
		1.20	No of SIRIs	NT	0	5	6	2	4	3	5	6	2	2	5	6	1	12
		1.21	RIDDOR Reportable Incidents	NT	1	1	1	0	3	2	3	1	3	3	2	2	2	6
		1.22	Total No of E. Coli (Trust level only)	NT	0	1	0	0	0	0	1	2	0	1	1	3	2	6
		1.23	No of Inpatient falls - Trust	NT	62	42	75	64	61	48	61	81	54	56	74	75	61	210
		1.24	No of Inpatient falls - WSH	<48	50	31	63	55	47	35	53	61	42	47	60	66	53	179
		1.25	No of Inpatient falls - Community Hospitals	NT	12	11	12	9	14	13	8	20	12	9	14	11	8	33
		1.26	Falls per 1,000 bed days	NT	4.84	2.83	5.73	5.27	4.29	3.35	4.82	5.21	3.95	4.17	5.21	5.71	4.98	5.30
		1.27	No of Inpatient falls resulting in harm - Trust	NT	22	13	24	12	12	17	15	25	14	15	21	15	18	54
		1.28	No of Inpatient falls resulting in harm - WSH	NT	22	11	20	12	11	13	12	22	10	13	16	14	14	44
		1.29	No of Inpatient falls resulting in harm - Community Hospitals	NT	0	2	4	0	1	4	3	3	4	2	5	1	4	10
		1.30	No of avoidable serious injuries or deaths resulting from falls - Trust	0	0	0	0	0	0	0	2	1	0	0	4	2	1	7
		1.31	No of avoidable serious injuries or deaths resulting from falls - WSH	0	0	0	0	0	0	0	2	1	0	0	4	2	1	7
		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	67	74	68	73	77	71	78	99	69	87	89	90	88	267
		1.70	PU present on admission to service – Inpatients	NT	57	61	53	58	60	57	61	77	49	58	60	62	64	186
		1.71	PU present on admission to service – Community teams	NT	13	15	15	17	17	14	17	22	20	29	29	28	31	88
		1.33	Number of medication errors	NT	43	56	61	63	71	54	61	79	78	72	89	76	65	230
		1.72	New PU - Trust	0	25	19	30	24	35	28	27	30	34	40	42	54	31	127
		1.67	New PU – Inpatients	0	9	6	10	14	13	19	17	11	16	21	20	25	11	56
		1.68	New PU – Community teams	0	16	13	20	10	22	9	10	19	18	19	22	29	20	71
		1.73	Moisture associated skin damage	0	NA	NA	NA	NA	NA	NA	NA	17	18	22	18	14	14	46
		1.74	Device related (% of total)	NT	NA	NA	NA	NA	NA	NA	NA	2.0%	6.0%	5.0%	4.0%	5.0%	3.0%	4.0%
		1.60	% of patients at risk of falls (with a Falls assessment)	NT	72.2%	74.6%	72.8%	72.0%	73.3%	72.7%	71.6%	73.0%	71.9%	73.9%	73.2%	74.0%	71.9%	73.0%

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Are we..		Ref.	KPI	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	YTD(Apr19-Jun19)
1. Safe	Reporting	1.38	MRSA Quarterly Std (including admission and LOS screens)	90%	88.0%	NA	NA	87.0%	NA	NA	89.0%	NA	NA	88.0%	NA	NA	87.0%	87.0%
		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	1	4	5	4	3	2	2	4	1	6	3	4	3	10
		1.41	MRSA - Decolonisation	95%	90.0%	81.0%	97.0%	86.0%	95.0%	97.0%	94.0%	94.0%	100%	92.0%	100%	100%	94.0%	98.0%
		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	2	0	0	0	1	1	0	0	0	2	0	0	1	1
		1.44	SIRI final reports due in month submitted beyond 60 working days	0	0	1	0	0	0	1	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	0	0	0	1	0	0	0	0
		1.46	Green, Amber & Red Active / Accepted risk assessments not in date	0	2	0	3	0	4	2	3	79	55	55	55	53	56	164
		1.47	Datix Risk Register Red / Amber actions overdue	0	3	0	0	0	1	4	1	65	65	65	65	64	65	194
		1.48	Rapid access chest pain clinic access within 2 wks.	95%	97.3%	96.2%	96.7%	98.6%	99.2%	99.2%	100%	100%	100%	100%	100%	100%	100%	100%
		1.75	Verbal DoC undertaken within 10 working days of incident report	NT	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	47.0%	60.0%	69.0%	58.7%
		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	NA	NA	NA	4	3	5	4
		1.49	Verbal Duty of Candour outstanding at month-end	0	2	2	0	0	0	0	6	0	4	5	4	4	2	10
		1.50	Hand Hygiene Audits	100%	99.0%	99.0%	100%	100%	100%	99.6%	98.8%	100%	100%	99.7%	100%	100%	99.5%	99.8%
		1.51	Quarterly antibiotic audit	98%	92.2%	NA	NA	89.0%	NA	NA	90.0%	NA	NA	87.0%	NA	NA	89.0%	89.0%
		1.52	Serious Incident RCA actions beyond deadline for completion	0	4	7	4	2	5	11	5	14	8	13	25	21	26	72
		1.53	% of Green Patient Safety incidents investigated	NT	61.0%	68.0%	59.0%	63.0%	64.0%	60.0%	59.0%	71.0%	72.0%	71.0%	63.0%	74.0%	63.0%	66.7%
		1.54	Quarterly Environment/Isolation	90%	92.0%	NA	NA	93.0%	NA	NA	93.0%	NA	NA	92.0%	NA	NA	92.0%	92.0%
		1.55	Quarterly VIP score documentation	90%	86.0%	NA	NA	83.0%	NA	NA	84.0%	NA	NA	85.0%	NA	NA	86.0%	86.0%
		1.56	Isolation data (Trust Level only)	90%	87.0%	88.0%	91.0%	91.0%	91.0%	91.0%	90.0%	80.0%	75.0%	85.0%	85.0%	85.0%	89.0%	86.3%
		1.57	Pain Mgt. internal report	80%	NA	86.0%	NA	NA	85.5%	NA	NA	84.5%	NA	NA	85.2%	84.1%	84.3%	84.5%
		1.58	Nutrition % of patients with a MUST/PYMS assessment completed for within 24hrs	95%	88.0%	91.0%	88.0%	82.0%	83.0%	83.0%	84.0%	83.0%	81.0%	79.0%	80.7%	80.6%	83.7%	81.7%
		1.59	Median NRLS (national reporting & Learning system) upload 6 month rolling average (No. of days)	41	60	59	51	40	75	84	98	78	82	38	ND	ND	ND	ND
		1.61	E coli - Hospital Attributable	NT	2	1	1	1	2	0	1	2	0	1	1	3	2	6
		1.62	E coli - Community Attributable	NT	14	13	15	13	14	13	11	8	9	16	12	18	17	47
		1.63	Klebsiella spp. - Hospital Attributable	NT	0	2	0	0	0	0	1	0	1	0	1	0	0	1
		1.64	Klebsiella spp. - Community Attributable	NT	0	3	2	3	1	3	2	1	1	1	2	3	4	9
		1.65	Pseudomonas - Hospital Attributable	NT	0	0	1	0	0	0	0	0	1	0	2	0	0	2
		1.66	Pseudomonas - Community Attributable	NT	0	0	0	1	1	0	1	1	2	0	0	1	3	4

SAFE – DIVISIONAL LEVEL ANALYSIS

	April			May			June		
Indicator	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
HII compliance 1a: Central venous catheter insertion		100		100	100		100	100	
HII compliance 1b: Central venous catheter ongoing care	100	83		100	100		100	100	
HII compliance 2a: Peripheral cannula insertion		100	100	100	96.15	100	100	100	
HII compliance 2b: Peripheral cannula ongoing	100	100	100	98.21	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				90			100		
HII compliance 6a: Urinary catheter insertion					100			100	
HII compliance 6b: Urinary catheter on-going care	100	94		100	90		100	94.6	
HII compliance: Antibiotic Prescribing - All care setting		93		89	88		100	70	100
HII compliance: Antibiotic Prescribing - Secondary Care		76			84		90	60	
HII compliance: Chronic Wounds									
Total no of MRSA bacteraemias: Hospital	0	0	0	0	1	0	0	0	0
Quarterly MRSA (including admission and length of stay screens)							96	79	87
Hand hygiene compliance	100	100	100	100	100	100	100	98.3	
Total no of MSSA bacteraemias: Hospital	0	0	0	0	0	0	0	1	0
Quarterly Environment & Standard Principles Compliance							93	92	91
Total no of C. diff infections: Hospital	0	1	0	2	0	0	0	1	0
Quarterly Antibiotic Audit							90	89	97

Indicator	April			May			June		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
Quarterly VIP score documentation							81	89	84
No of patient falls	11	49	0	17	46	1	5	48	0
No of patient falls resulting in harm	3	13	0	4	10	0	2	12	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	6	14	0	5	18	0	3	8	0
No of avoidable ward acquired pressure ulcers									
Nutrition: Assessment and monitoring	74	89	54	78	87	61	82	89	65
No of SIRIs	2	0	0	1	3	1	0	0	0
No of medication errors	18	43	9	12	39	8	22	29	5
Cardiac arrests	0	4	0	0	5	0	0	0	0
Cardiac arrests identified as a SIRI	0	0	0	0	0	0	0	0	0
Pain Management	85.8	88.7	57	85.5	87.4	51.3	84.9	88.3	52.8
VTE: Completed risk assessment (monthly Unify audit)	95.9	94.3	95.7	96.3	94.7	94.9	97.2	93.8	91.9
Quarterly VTE: Prophylaxis compliance									
Safety Thermometer: % of patients experiencing new harm-free care	97.6	96.2	100.0	96.8	96.4		98.8	93.5	100.0

Indicator	April			May			June		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
Patient Satisfaction: In-patient overall result	95.0	93.0		92.0	86.0	87.0	93.0	89.0	
How likely are you to recommend our services to friends and family if they need similar care or treatment	96.0	94.0		97.0	91.0	100.0	98.0	98.0	
In your opinion, how clean was the hospital room or ward you were in?	98.0	94.0		97.0	94.0	94.0	98.0	96.0	
How was the food choice during your hospital stay?				89.0	88.0	86.0	89.0	90.0	
How was the food taste and quality during your hospital stay?				88.0	88.0	79.0	89.0	89.0	
Did you feel you were treated with respect and dignity by staff?	99.0	97.0		99.0	96.0	91.0	99.0	100.0	
Were staff caring and compassionate in their approach?	98.0	97.0		99.0	97.0	88.0	98.0	100.0	
Did you find a member of staff to talk to about your worries and fears?	99.0	94.0		99.0	94.0	88.0	97.0	97.0	
Were you involved as much as you wanted to be in decisions about your care and treatment?	96.0	93.0		96.0	89.0	90.0	96.0	92.0	
Did you experience any noise in the night time?	84.0	81.0		80.0	78.0	83.0	87.0	82.0	
Did you get enough help from staff to eat your meals?	98.0	92.0		100.0	98.0	100.0	100.0	98.0	
Minutes after you used the call button did it take to get help?	77.0	78.0		82.0	72.0	89.0	81.0	81.0	
Did someone from pharmacy discuss your medications with you at any time during your hospital stay?				84.0	72.0	0.0	88.0	78.0	
Were you given clear written or printed information about your take-home medications?				94.0	77.0	90.0	95.0	77.0	
Were the purposes of your take-home medications explained to you in a way you could understand?				95.0	76.0	82.0	95.0	77.0	
Number of Inpatient surveys completed	181	117		226	161	12	225	145	
Same sex accommodation: total patients	0	0	0	0	0	0	0	20	0
Complaints	6	4	1	9	7	5	6	7	3
Environment and Cleanliness	91.7	86.7	93.8	94.7	91.8	93.6	93.9	92.7	94.6

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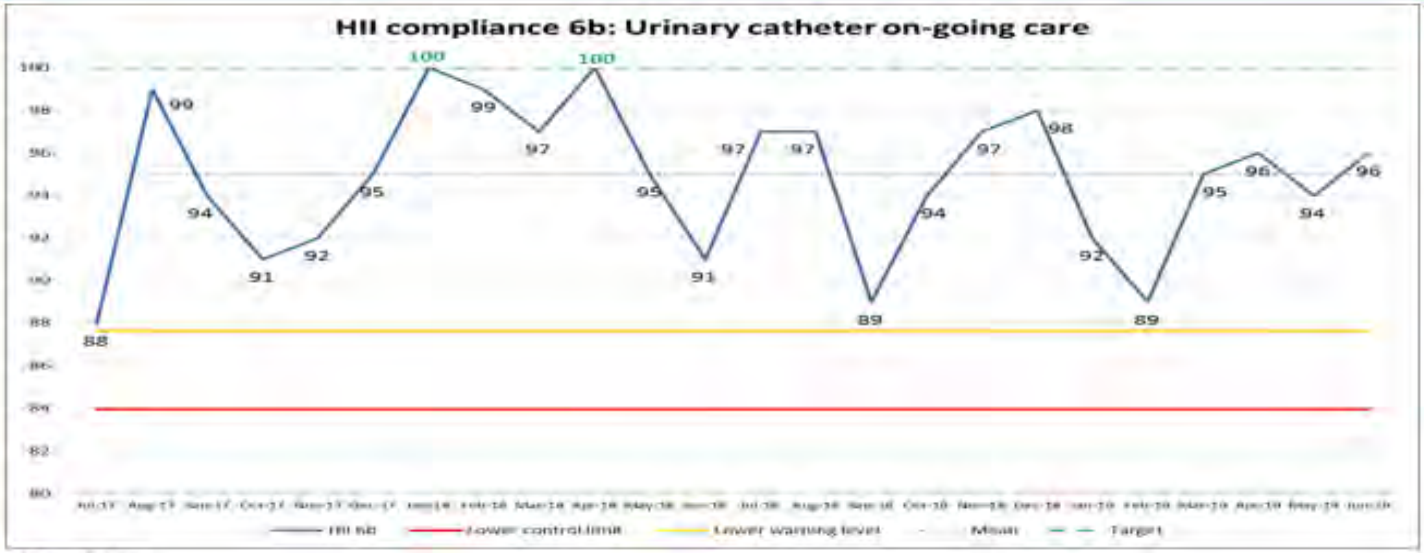
5. Exception reports – Safe

High Impact Interventions (HIIs)



Narrative

What	Performance is measured against a target of 100% for each High impact intervention (HII). In June, all of the HIIs achieved 100% except HII 6b: Urinary catheter on-going care, which has not achieved 100% since April 2018.
Why	Failures in 6b (on wards G4 and G8) brought performance down.
How	The Matrons will be working closely with the teams to ensure performance improves for August
When	An HII annual review is 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.

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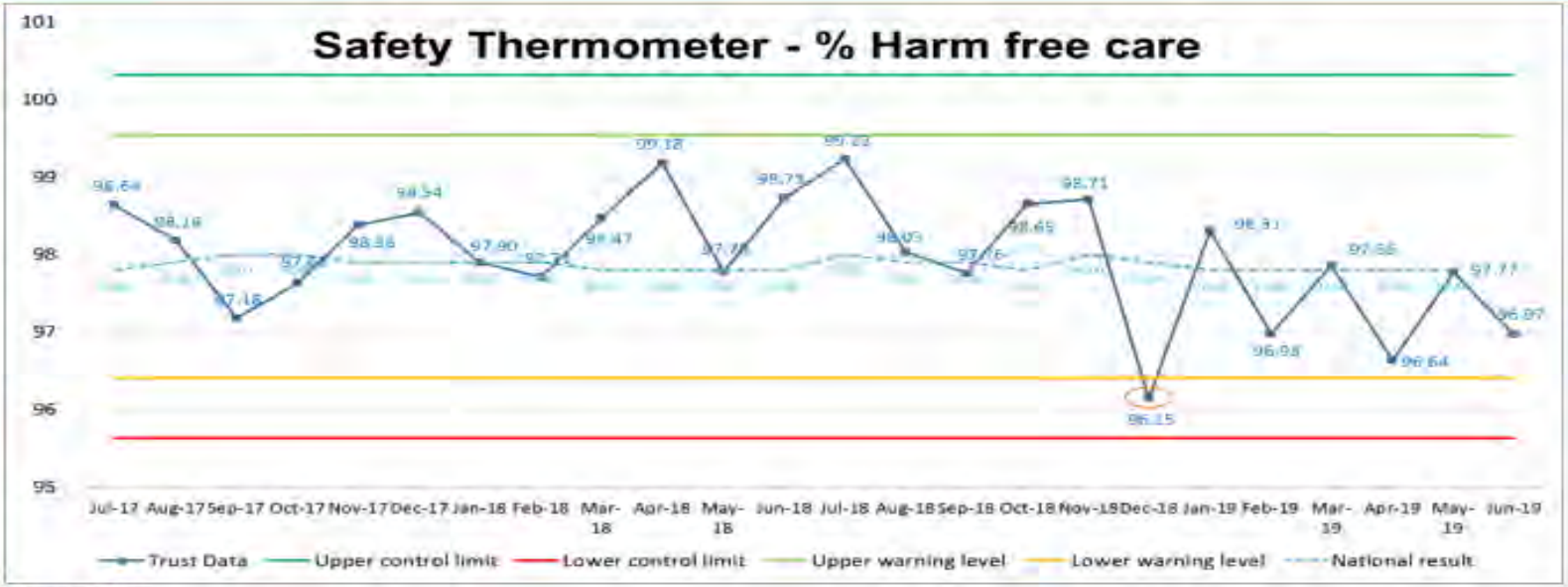
Safety Thermometer



Narrative

What	The Trust harm free care was reported as 96.97 for June. The National figure for June is not yet available for comparison. This (local) figure is an deterioration compared to May (97.7%) and still within the SPC normal variation although there is a possible slight downward trajectory over the last ten months with one month (December) falling below the lower warning level.
Why	The National 'Harm Free' care composite measure is defined as the proportion of patients without a pressure ulcer (ANY origin, category II - IV), hare 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.
How	The national benchmark can be used as an additional point of comparison as well as local performance over time. The SPC chart shows the Trust Harm Free care compared to the National benchmark for the period July 2017 to June 2019.
When	Safety Thermometer reports quarterly to CSEC and each element contained within is also the subject of an individual committee with action plans to improve outcomes, which are also reported to CSEC. The next CSEC report (due Sept 19) will contain an outline of the individual action plans and a consideration of any concerns relating to the potential downward trend in scores

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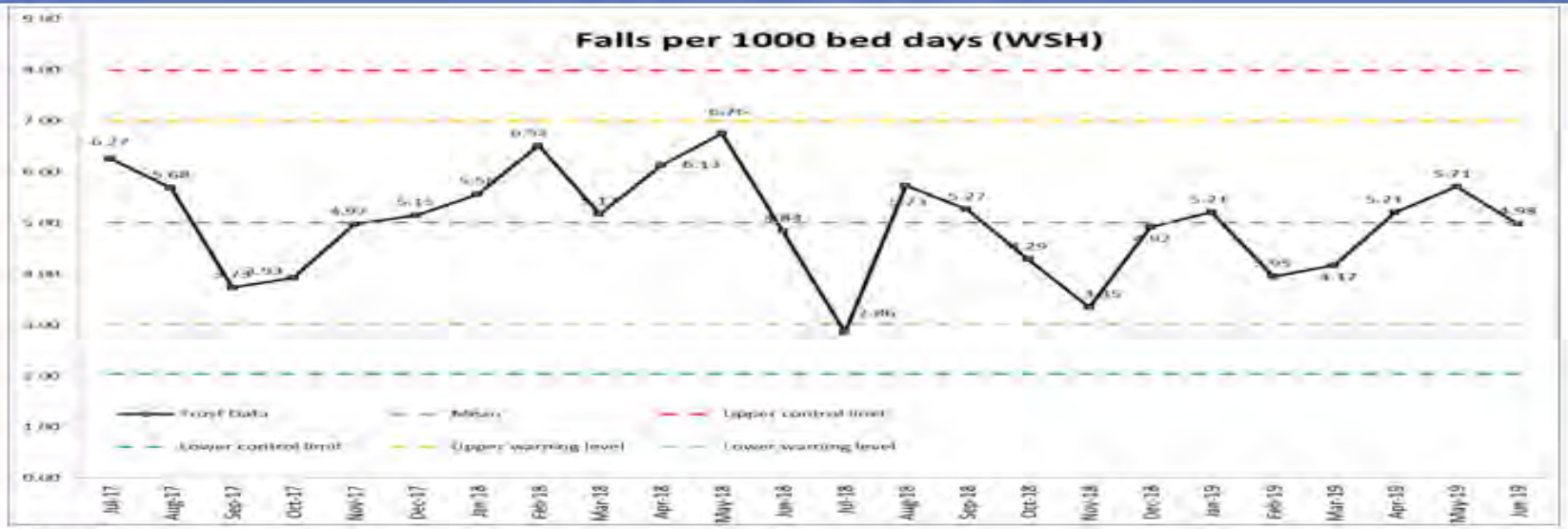
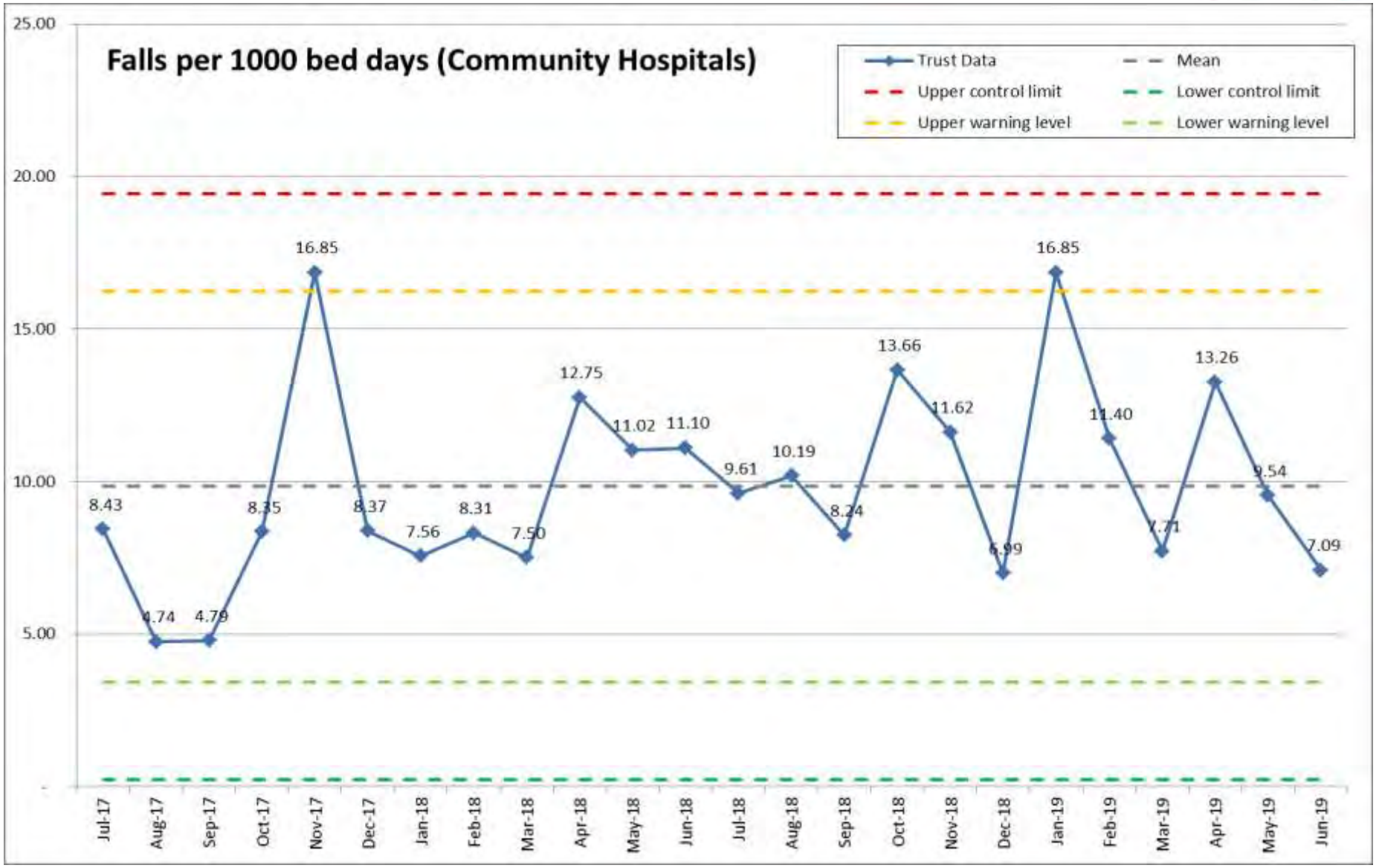
Falls



Narrative

What	The total number of Trust inpatient fell in June to total of 61 (53 in WSH & 8 in Community beds) and the falls per 1,000 bed days also fell to 4.98 maintaining a value within the expected range. In the Community Hospitals we continue to promote a positive risk taking environment where patients are encourage to maintain and regain independence prior to discharge.
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. In June, there were ten individuals who fell twice or more, including three who each fell three times contributing to the overall number. There were no falls resulting in serious harm in June (although there have been two so far in July). One patient in CDU fell and sustained a # NoF, and one patient fell on F6 resulting in # right NoF. Full investigations are ongoing into these incidents. Following the four falls with serious harm in April, an SPC chart has been included in the IQPR (see 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 are attending a National conference in September focusing on falls prevention and the CQUIN and NICE quality standards. We are planning on trailing new technology during August on three 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. From August, we will have some dedicated Matron hours focused on falls training and quality improvements within the Trust.

Safe



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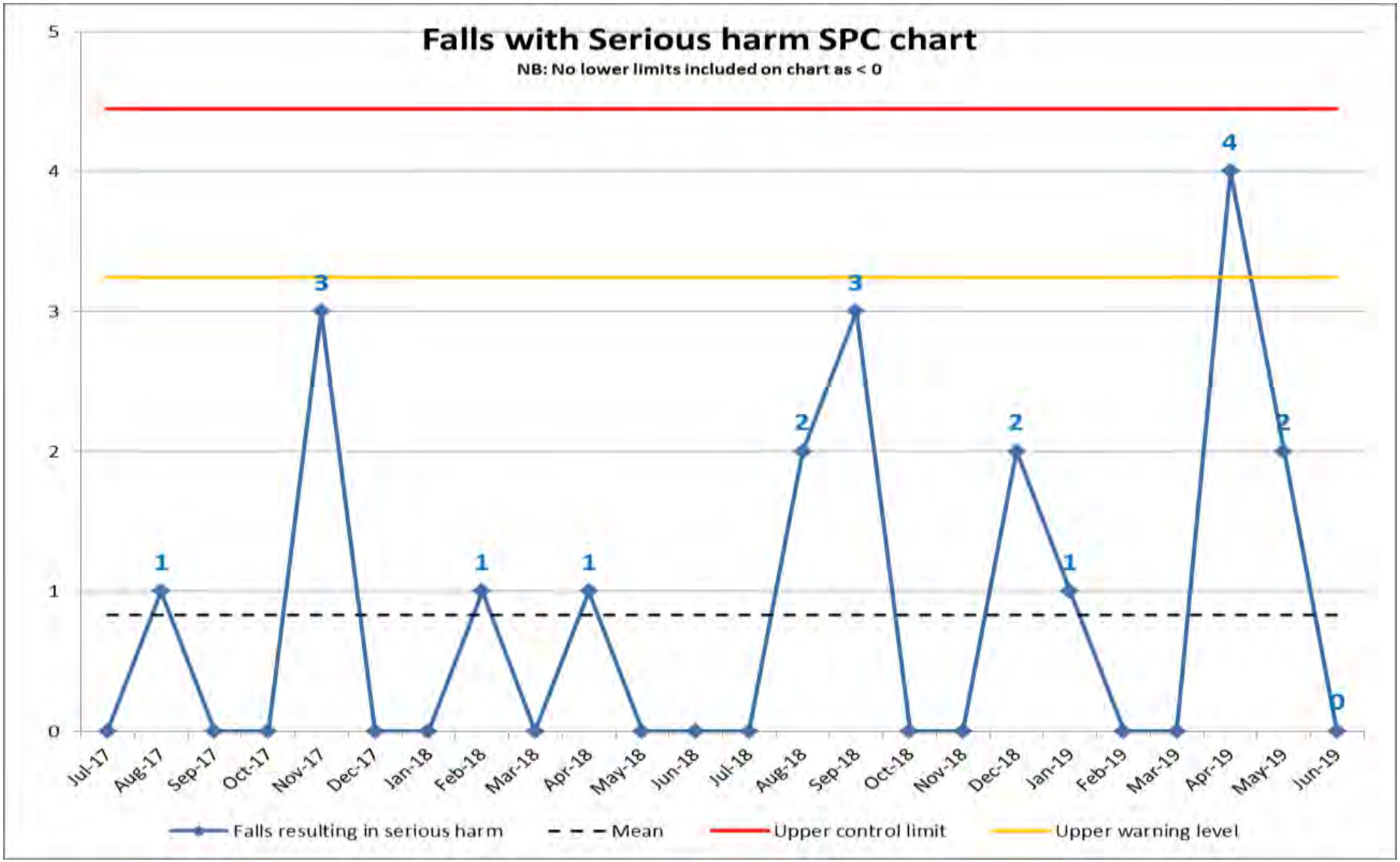

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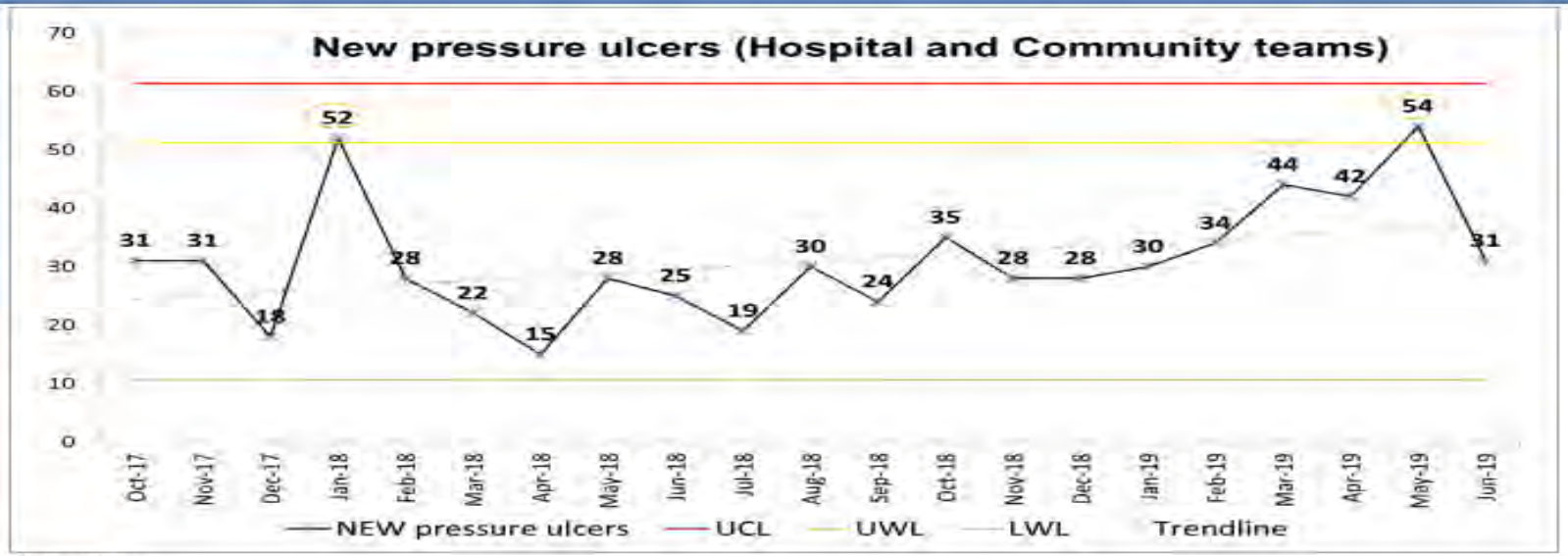
Pressure ulcers



Narrative

What	It is pleasing to note the reduction this month in the number of new pressure ulcers reported as an organisation. The total number of Cat 2 pressure ulcers reduced to 21 during May (from 45 last month), Unstageable pressure ulcers also saw a small decrease to 5 (from 6 during May 2019), however Cat 3 pressure ulcers increased to 5 (from 3 during May 2019).
Why	A number of the initiatives detailed last month continue, but it is always important to note our aspirational target of zero new pressure ulcers, balanced with the potential for skin damage occurrence when caring for sick and often frail patients. All teams (both acute and community) continue to work to capacity; it is pleasing to have seen the closure of some escalation areas, allowing clinical staff to return to base wards. Within the community setting, where caseload/acuity is more difficult to quantify, communication continues on a daily basis to match clinical capacity to demand in terms of patients cared for in their own homes. It is interesting to note that despite a significant reduction in the number of new pressure ulcers reported last month, the number of pressure ulcers present on admission to the organisation has remained at very similar levels
How	Almost all new team members recruited to the Integrated Tissue Viability Team are now in post. Bite-size teaching sessions have recommenced with the TVS visiting areas on an ad-hoc basis to support staff in the clinical area.
When	This proactive approach to reducing the incidence of new pressure ulcers continues; during the PUPG meeting on 18.07.19 an Action Plan will be developed to first identify the current position in terms of good nutritional assessment and appropriate interventions in place to reduce the risk and promote wound healing and to set goals to improve this position. It is anticipated that an improvement in nutritional assessments for this group of patients will be evidenced within reporting for September 2019. The team continue to respond to trends in a responsive way by reviewing new PU's for each month at the Monthly Pressure Ulcer Review Meetings.

Safe

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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

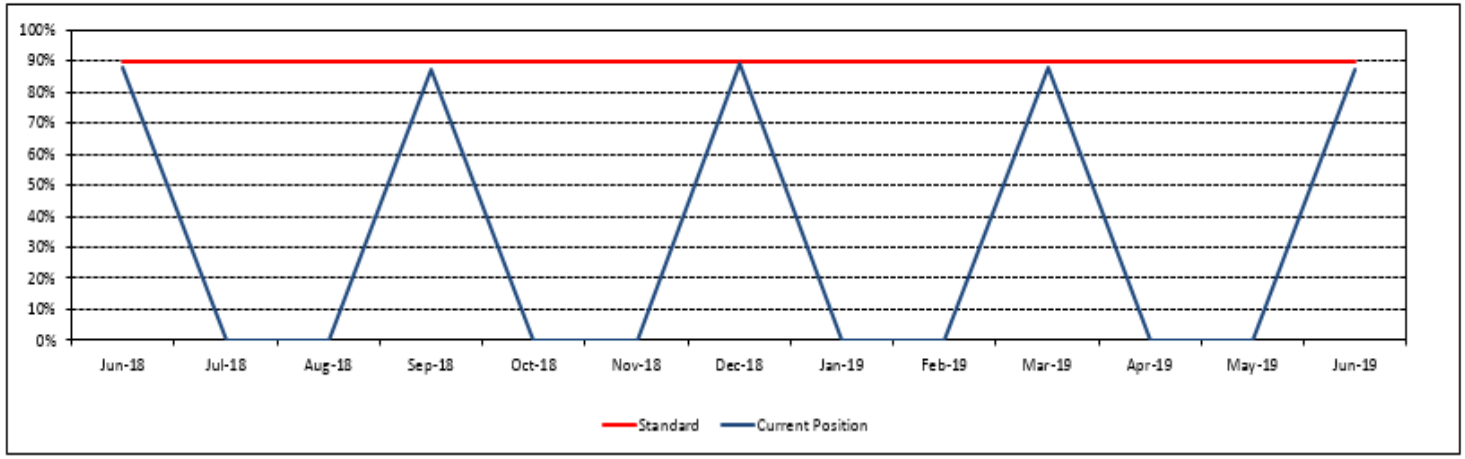
Indicator	MRSA Quarterly Std (including admission and LOS screens)
Standard	90%
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

MRSA screening compliance is 87% during Quarter 1.
The main areas of non-compliance this quarter continue to relate to the post 21 day screens and weekly thereafter and the weekly screening of patients known to be MRSA positive. Ad-hoc training continues in relation to the function of requesting MRSA screening for a future date/regular day and the option of adding to 'favourites' on e-Care. Discussions take place with Ward Managers/Senior Nurses at the time of audit if there is a high rate of non-compliance, including patterns high-lighted and realistic planning of how their ward manage MRSA screening moving forward. For one of the Medical wards with a low compliance there is an action plan in place with the newly appointed ward manager.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	88.0%	NA	NA	87.0%	NA	NA	89.0%	NA	NA	88.0%	NA	NA	87.0%

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

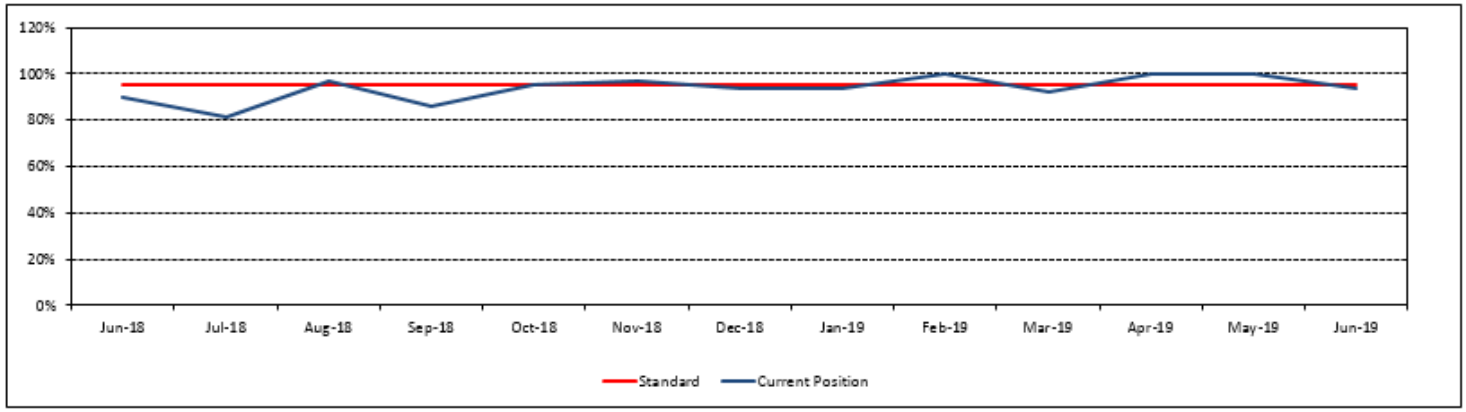
Indicator	MRSA - Decolonisation
Standard	95%
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

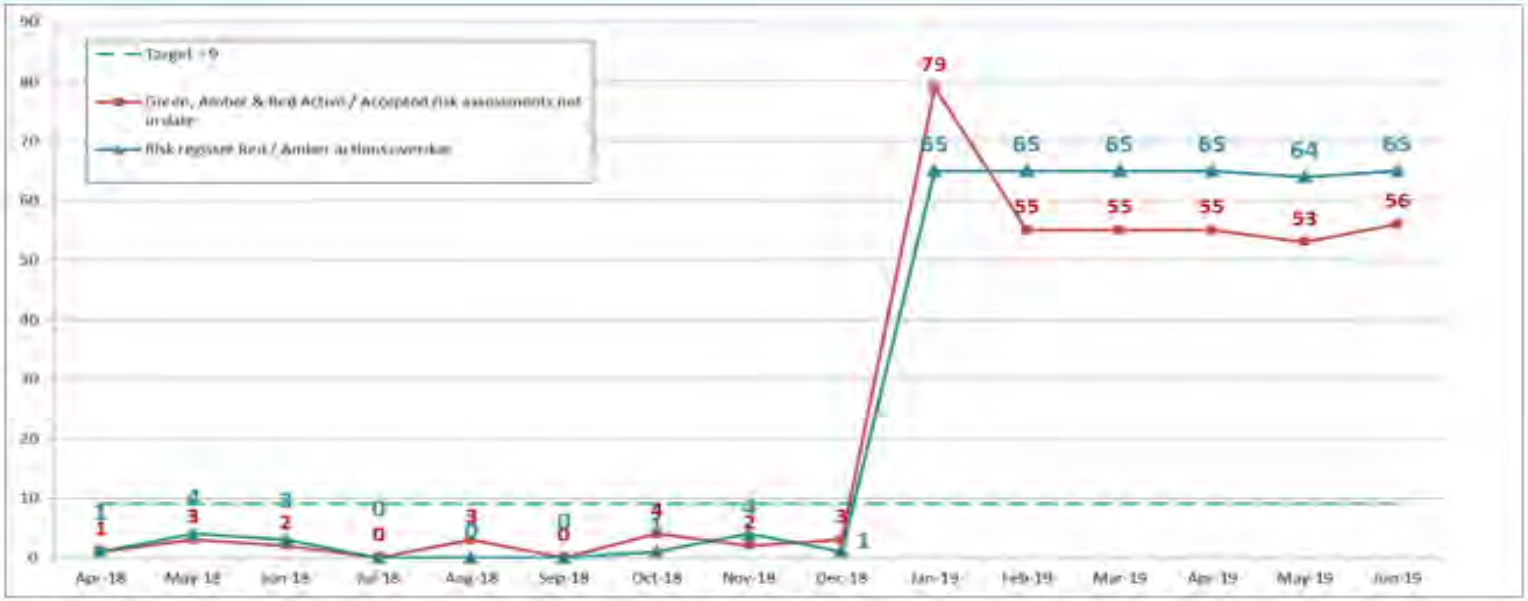
Of the 7 patients who met the criteria for in patient decolonization 6 of the patients commenced the decolonization within 12 hours of the result 1 patient was delayed by another 6 hours. The ward team and matron for the area have been contacted in respect of the incident and process reiterated

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	90.0%	81.0%	97.0%	86.0%	95.0%	97.0%	94.0%	94.0%	100%	92.0%	100%	100%	94.0%

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



Risk assessments

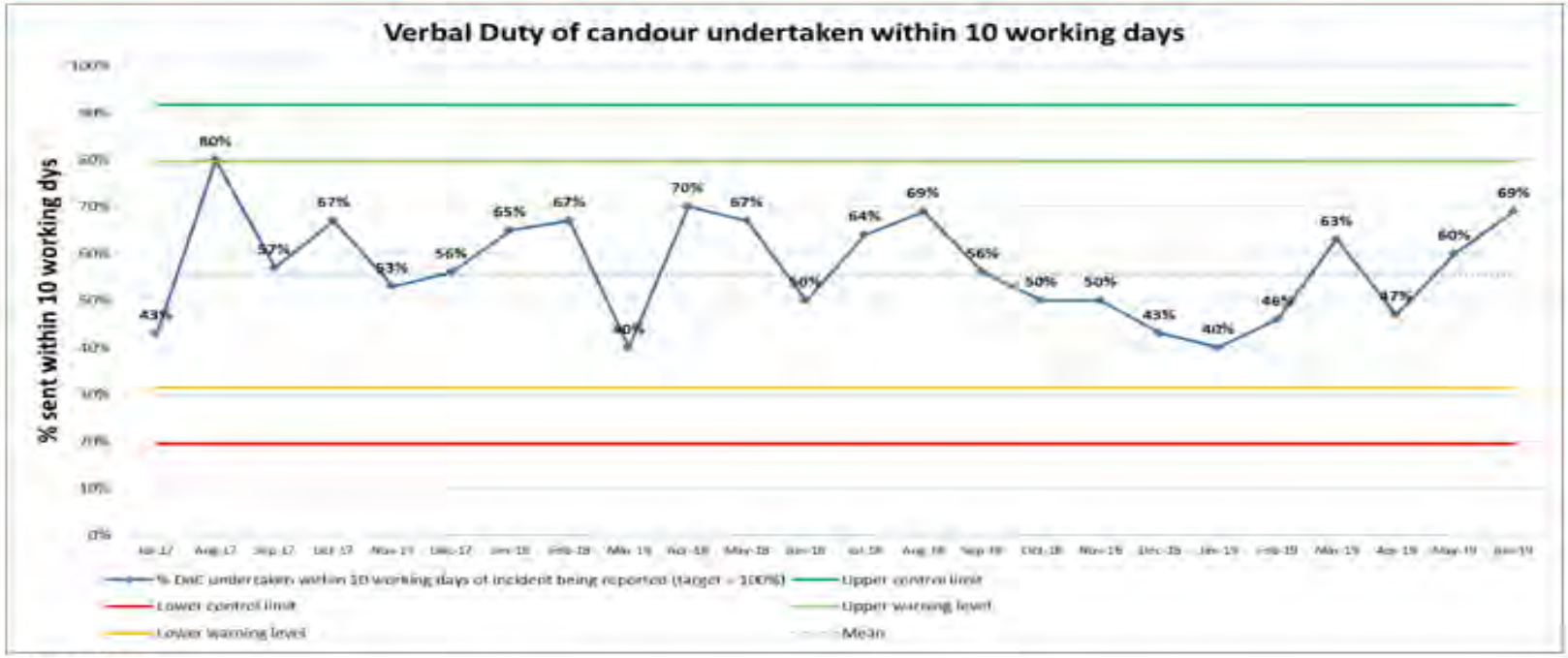


Narrative

What	Six months ongoing failure to hit target (n = 0) which is usually achieved each month
Why	56 out of date risk assessments and 65 actions
How	These out of date risk assessments and actions are associated to the fire risk assessment being managed by Estates. The work to update the risk assessments began at the beginning of May using an external resource.
When	Progress to complete this backlog was reported to the Corporate Risk Committee (17/05/19) which noted that "The contractors have now commenced the fire risk assessment work which should be completed by the next meeting" The next CRC meeting is in August at which time the status of the 'catch up' process will be re-assessed.

Safe

Duty of Candour

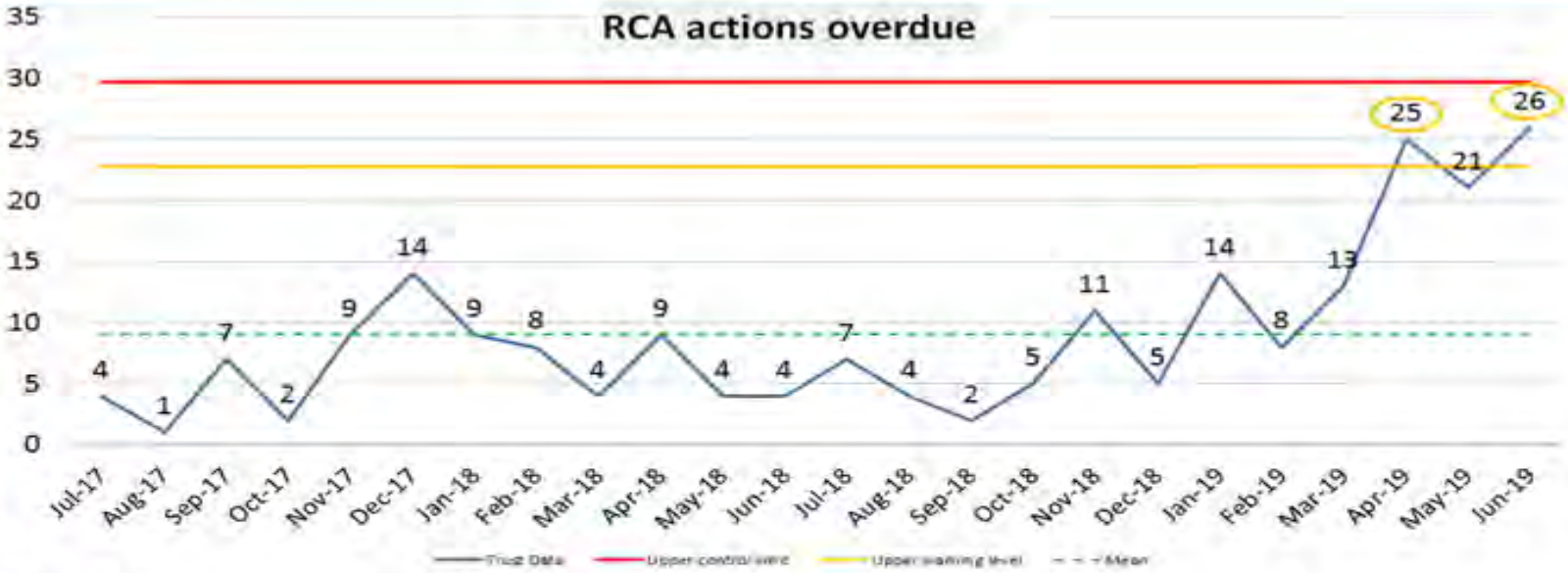


Narrative

What	A new SPC chart is provided which measures timely verbal DoC against the national requirement of 10 working days. In addition, indicators counting how many cases are still overdue both verbal and written are provided.
Why	Compliance with the 10 day target varies month on month however it not usually adversely affected by total number of cases
How	Targeted follow up of the individuals responsible for undertaking DoC by the Patient Safety team with escalation to the Divisional steering groups and Clinical Directors meeting.
When	Whilst timely completion of verbal DoC has improved over the last quarter there are still cases pending for both written and verbal each month. In September, a review of options to improve these indicators will be undertaken.

Safe

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	A more structured approach to action setting and follow up is being developed with a monthly 'RCA actions review meeting' in the Patient Safety team and a 3-month post-report follow up ('wash-up meeting') for key SIs (such as those which are also the subject of an Inquest or have a complex action plan)
When	The first of these review meetings will take place in August and the first wash-up meeting as also planned for August (as it relates to an inquest scheduled for early September). It is envisaged the upward trajectory should therefore start to be reversed in the next couple of months' reports.

Safe

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

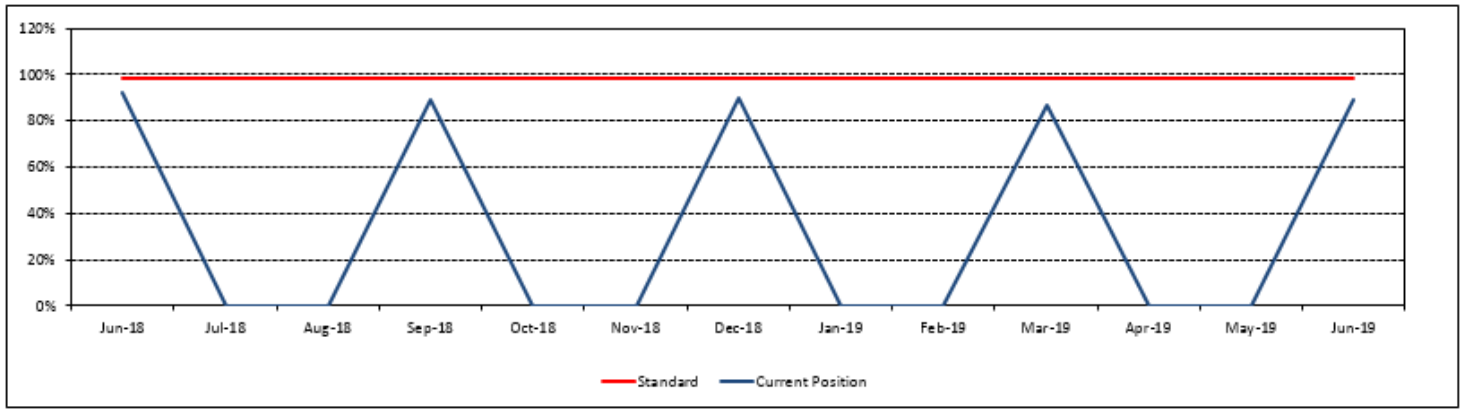
Indicator	Quarterly antibiotic audit
Standard	98%
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

In Quarter One, the Trust overall achieved 89% compliance against a target of 98%, up from 87% achieved in Quarter four.
The main issues for concern this quarter continue to 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 on e-Care only 35 out of 80 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. This is a slight increase from last quarter but remains below the compliance standard. We continue to encourage the use of the ##antibiotic review auto-text that was developed by a previous FY1 doctor within the Trust to support medical staff undertaking antibiotic reviews.
The Audit team are seeking the views of the Junior Doctors on how to make this process more user friendly.
The audits continue to identify that restricted antibiotics, for example Meropenem and Tigecycline, are not always discussed with a Consultant Microbiologist when the course exceeded 72 hours, as per Trust guidance. This requirement applies even if the restricted antibiotic is 1st line treatment as stated in the Trust Antibiotic Guideline. A change has recently been made to e-Care so that this requirement is clearly stated on the prescription of restricted antibiotics. This information is also easily accessible in both the Trust antibiotic guideline on the Pink Book and on the Microguide App.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Current Position	92.2%	NA	NA	89.0%	NA	NA	90.0%	NA	NA	87.0%	NA	NA	89.0%

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



Putting you first

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

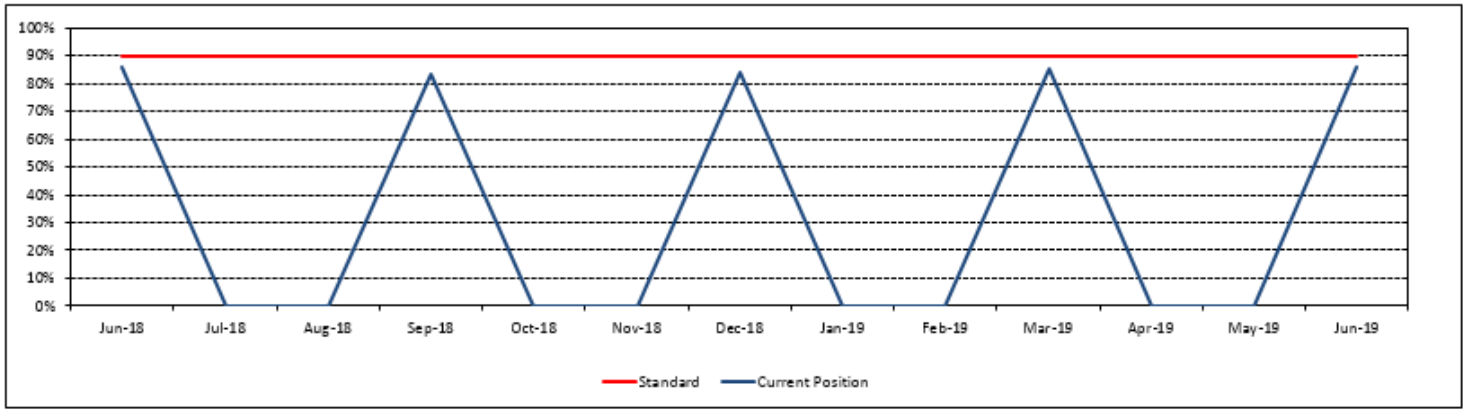
Indicator	Quarterly VIP score documentation
Standard	90%
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

VIP score compliance rates have increased from 85% to 86% 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.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
There is currently a Quality Improvement Project in progress involving care of and documentation of the intravenous peripheral cannula, this is being led by a Junior Doctor within the Trust. As part of this process, the required documentation to complete for 'care if the IV peripheral cannula' is also being reviewed.			



Putting you first

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

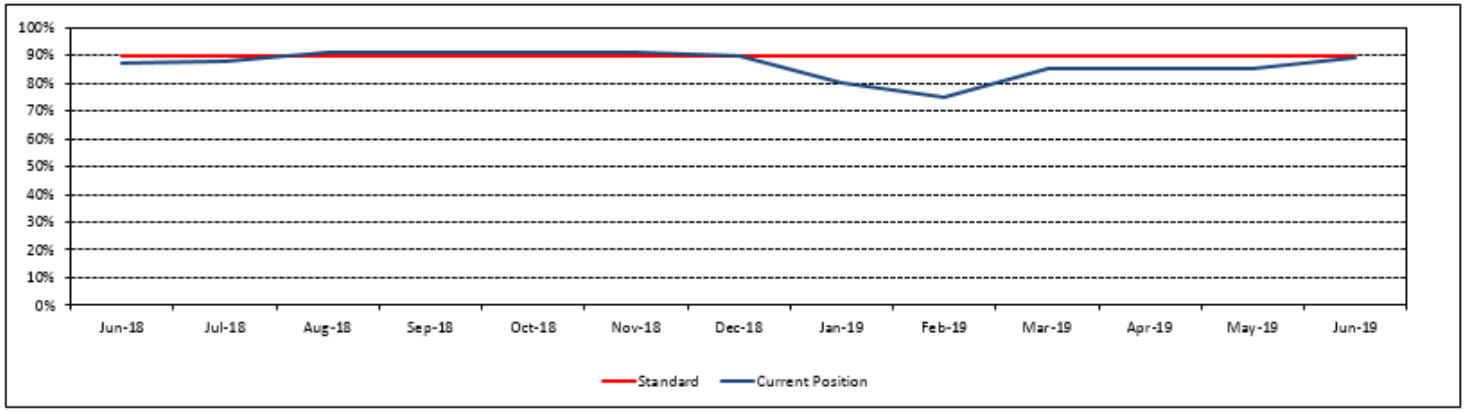
Summary of Current performance & Reasons for under performance

Compliance with Isolation is at 89%. There were 4 case for whom isolation was delayed, these cases were on 4 different wards and there were no links or themes apparent on investigation. One incident is concerning in that a patient on F3 was identified on admission screening to be colonized with MRSA the ward were unable to isolate and escalated appropriately however it took a further 48 h for the isolation plan to be achieved. In mitigation there were no further cases identified on contact screening and the patient was successfully decolonized which further mitigated the risk. This incident has been discussed with the ward teams/bed flow & the Matron concerned to ensure learning has been embedded.

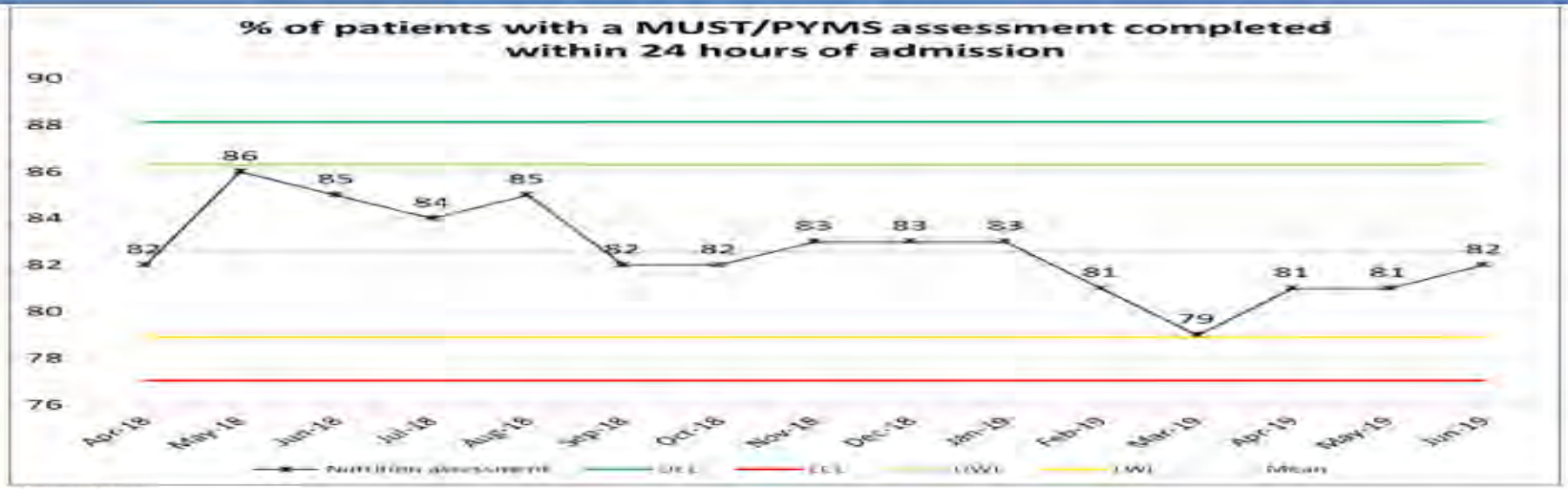
The side room capacity is monitored daily (Mon to Fri) by the Infection Prevention Nurses(IPN) and occupancy is risk assessed throughout the day, including a daily review of patients on the Infection Prevention Nurses ward visits and this information is provided to the site capacity/bed flow meetings. 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.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	87.0%	88.0%	91.0%	91.0%	91.0%	91.0%	90.0%	80.0%	75.0%	85.0%	85.0%	85.0%	89.0%

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



Nutrition



Narrative

What	A slight improvement in June (82%) compared to May (81%). NB: data for previous months (Sept to Nov) has been updated following clarification of parameters and 2018 data prior to Sept18 has been updated to reflect e-Care data not manual audit). The chart shows a slight downward 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 impact on the trust overall percentage).
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 next due to be updated for the August Nutrition group meeting and will be included in the next report to CSEC 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	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	YTD(Apr19-Jun19)
2.Effective	Incidents/Reports	2.05	Cardiac arrests	NT	2	7	3	6	9	ND	3	5	5	3	4	5	0	9
		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	48	47	41	49	48	43	42	35	33	28	19	15	17	51
		2.10	WHO Checklist (Qrtly)	100%	99.0%	NA	NA	98.0%	NA	NA	99.0%	NA	NA	99.0%	NA	NA	ND	NA
		2.11	National clinical audit report baseline & risk assessments not completed within 6 months of publication	5	17	18	18	18	18	19	21	26	28	29	19	16	13	48
		2.12	Av. Elective LOS (excl. 0 days)	NT	2.66	2.85	3.29	2.60	3.25	3.50	3.35	2.81	3.92	2.74	3.17	2.89	2.69	2.92
		2.13	Av NEL LOS (excl 0 days)	NT	7.24	7.87	8.09	7.98	7.66	7.61	7.56	7.43	8.69	8.05	8.46	8.70	7.94	8.37
		2.14	% of NEL 0 day LOS	NT	15.7%	15.0%	13.3%	14.0%	14.4%	15.9%	15.4%	14.6%	13.8%	14.9%	14.2%	13.7%	13.4%	13.8%
		2.15	NHS number coding	99%	99.8%	99.8%	99.3%	99.7%	99.8%	99.8%	99.8%	99.7%	99.7%	99.8%	99.8%	99.8%	99.7%	99.8%
		2.16	Fractured Neck of Femur : Surgery in 36 hours	85%	100%	94.4%	100%	90.3%	96.9%	100%	100%	97.0%	100%	92.8%	96.2%	92.9%	96.9%	95.3%
		2.17	Discharge Summaries (OP 85% 3d)	85%	63.0%	54.0%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND
		2.18	Discharge Summaries (A&E 95% 1d)	95%	86.1%	86.4%	88.4%	86.9%	85.8%	82.2%	80.5%	83.7%	84.0%	81.7%	83.2%	82.8%	85.0%	83.7%
		2.19	Non-elective Discharge Summaries (IP 95% 1d)	95%	78.1%	76.6%	76.9%	75.3%	77.9%	72.4%	72.9%	76.6%	78.0%	74.9%	81.8%	80.7%	82.1%	81.5%
		2.20	Elective Discharge Summaries (IP 85% 1d)	85%	72.1%	69.5%	70.8%	79.8%	80.8%	84.5%	84.8%	84.7%	84.6%	87.9%	80.8%	87.7%	86.7%	85.1%
		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%	91.9%	90.0%	83.8%	86.7%	77.5%	100%	91.7%	82.8%	100%	73.3%	79.2%	93.3%	100%	90.8%
		2.23	Canc. Ops. - No. Cancelled for a 2nd time	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

EXCEPTION REPORTS – EFFECTIVE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

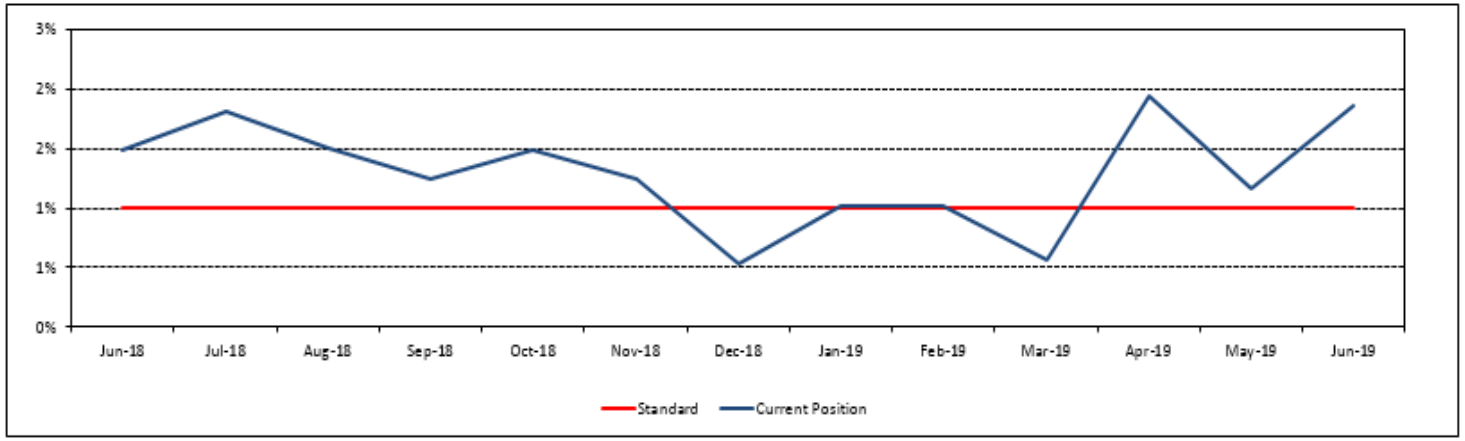
Indicator	Canc. Ops - Cancellations for non-clinical reasons
Standard	1%
Executive Lead	Helen Beck
Month	Jun-19
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

There was an increase in the amount of patients cancelled on the day of surgery, this was due to a combination of surgeon/anaesthetic unavailable as well as theatres sessions in the Eye treatment centre due to an infestation of flying ants causing a need for decontamination.

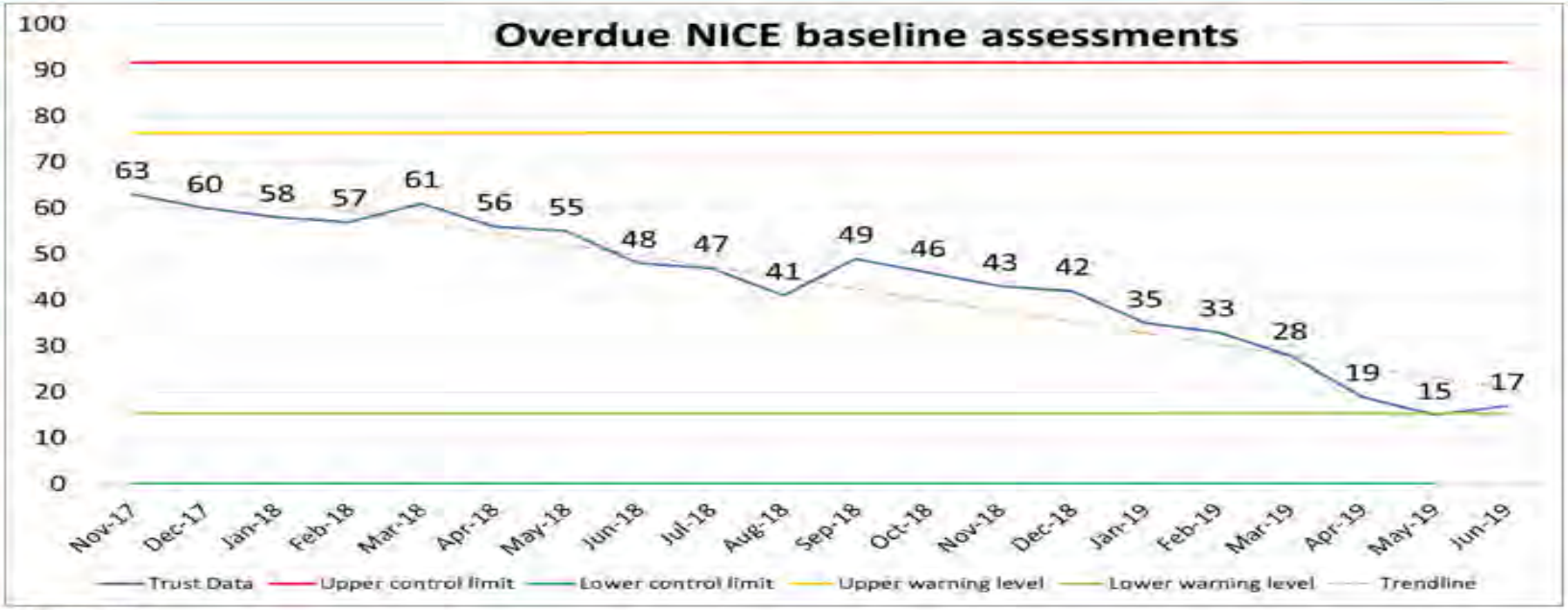
Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
Current Position	1.5%	1.8%	1.5%	1.2%	1.5%	1.3%	0.5%	1.0%	1.0%	0.6%	1.9%	1.2%	1.9%

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



Putting you first

NICE

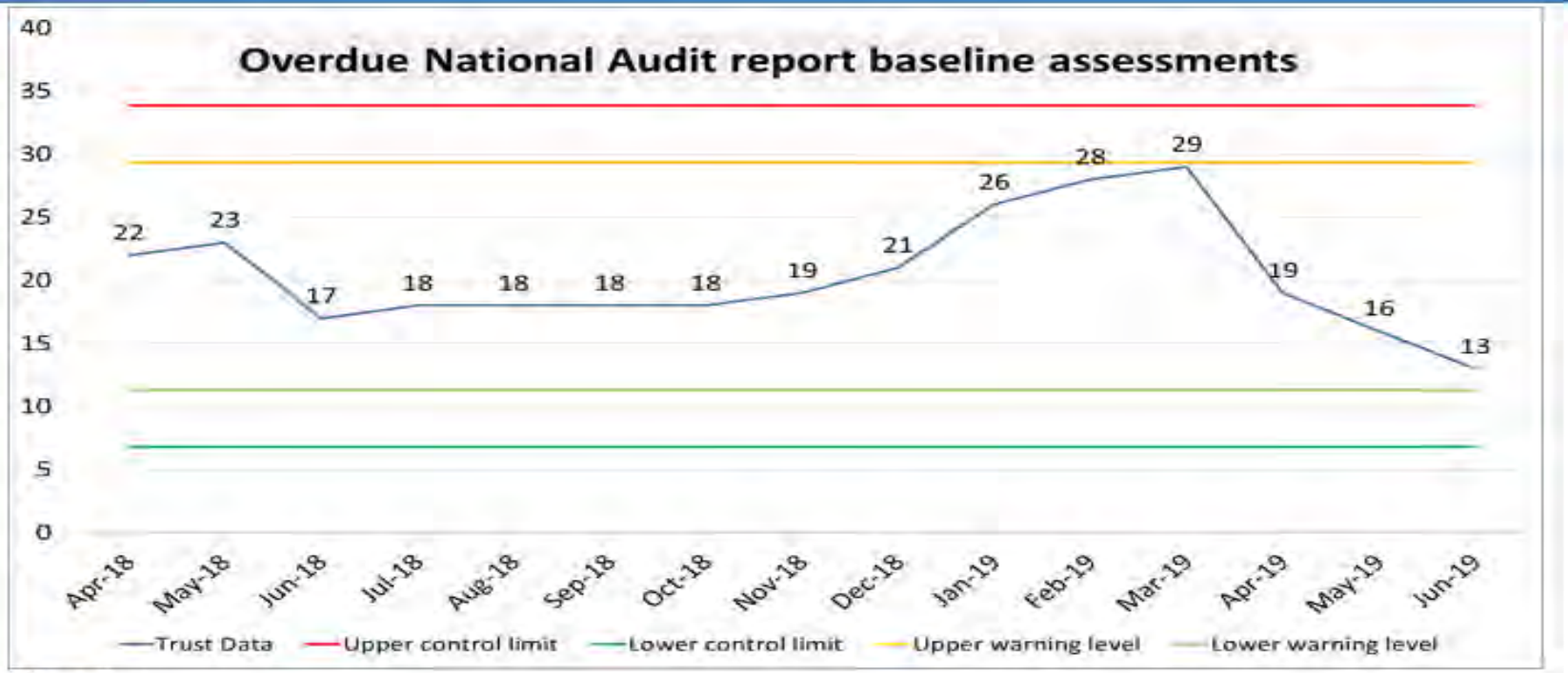


Narrative

What	Positive downward trend, which crossed the Lower warning Level in May. A small increase in June is possibly more as a consequence of a higher number of baseline assessment coming due (6) than were complete in month (4) rather than a 'real' deterioration.
Why	The target of <10 overdue is no longer aspirational and if the downward trend can be maintained is achievable.
How	Targeted follow up of the Clinical leads by the Patient Safety Managers. Escalation to Clinical Directors meeting and reporting to the Quality group provides an oversight.
When	The downward trajectory is monitored monthly and it is anticipated that the target of <10 overdue should be achieved before the end of 2019 with an aim to maintain this ongoing in 2020 and beyond.

Effective

Audit



Narrative	
What	There was a considerable improvement in April/May following targeted input, which has been maintained in June The improvement trajectory is aiming to match that of NICE as the relevant individuals to complete the baseline assessments are mainly the same group of staff (Clinical leads)
Why	The target of <10 overdue is no longer aspirational and if the downward trend can be maintained is achievable.
How	Targeted follow up of the Clinical leads by the Patient Safety Managers. Escalation to the Clinical Directors meeting.
When	The downward trajectory is monitored monthly and it is anticipated that the target of <10 overdue should be achieved before the end of 2019 with an aim to maintain this ongoing in 2020 and beyond.

Effective

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NHS West Suffolk NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

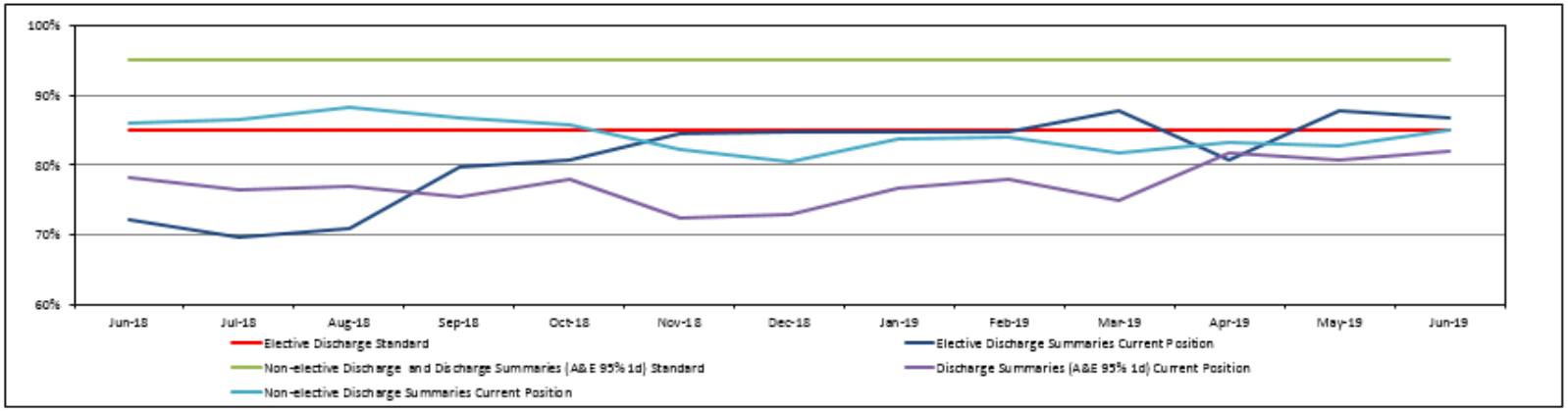
Indicator	Discharge Summaries
Standard	85%, 95%
Executive Lead	Nick Jenkins
Month	Jun-19
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

Training on discharge summaries (around timeliness and quality) has been delivered in the last month. Evaluation for both sessions was high with juniors committing to changing their behaviours as a result. The improvements shown here are hopefully reflective of that. We will be ensuring that the new junior rotation in August receive this training much earlier in their tenure. In addition the Chief Operating Officer continues to receive monthly reports on performance and works with the Associate Director of Operations for each area to address areas that require support. The content of this report is being reviewed currently.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Elective Discharge Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Elective Discharge Summaries Current Position	72.1%	69.5%	70.8%	79.8%	80.8%	84.5%	84.8%	84.7%	84.6%	87.9%	80.8%	87.7%	86.7%
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	78.1%	76.6%	76.9%	75.3%	77.9%	72.4%	72.9%	76.6%	78.0%	74.9%	81.8%	80.7%	82.1%
Non-elective Discharge Summaries Current Position	86.1%	86.4%	88.4%	86.9%	85.8%	82.2%	80.5%	83.7%	84.0%	81.7%	83.2%	82.8%	85.0%

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



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	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	YTD(Apr19-Jun19)
3. Caring	Other Friends and Family Test Scores	3.09	IP overall experience result	90%	97.0%	97.0%	95.0%	97.0%	95.0%	95.0%	98.0%	95.0%	94.0%	95.0%	94.0%	90.0%	98.0%	94.0%
		3.10	OP overall experience result	90%	97.0%	97.0%	96.0%	96.0%	97.0%	97.0%	97.0%	97.0%	98.0%	98.0%	98.0%	97.0%	98.0%	97.7%
		3.11	A&E overall experience result	90%	94.0%	95.0%	97.0%	94.0%	95.0%	95.0%	95.0%	95.0%	95.0%	96.0%	93.0%	85.0%	93.0%	90.3%
		3.12	Short-stay overall experience result	90%	99.0%	98.0%	99.0%	100%	99.0%	96.0%	98.0%	98.0%	99.0%	98.0%	98.0%	99.0%	99.0%	98.7%
		3.13	Short-stay Extremely likely or Likely to recommend (FFT)	90%	98.0%	98.0%	99.0%	99.0%	100%	99.0%	99.0%	97.0%	97.0%	97.0%	99.0%	99.0%	99.0%	99.0%
		3.14	Maternity - overall experience result	90%	96.0%	100%	97.0%	94.0%	97.0%	91.0%	99.0%	100%	96.0%	ND	ND	ND	ND	ND
		3.15	Maternity postnatal community - extremely likely or likely to recommend (FFT)	90%	96.0%	100%	100%	98.0%	98.0%	100%	100%	100%	100%	100%	100%	100%	96.0%	98.7%
		3.16	Maternity birthing unit - extremely likely or likely to recommend (FFT)	90%	ND	100%	100%	100%	100%	ND	ND	ND	ND	ND	ND	ND	ND	ND
		3.17	Maternity antenatal community - extremely likely or likely to recommend (FFT)	90%	94.0%	97.0%	100%	100%	100%	100%	100%	ND	ND	ND	ND	ND	ND	ND
		3.18	Children's services overall result	90%	96.0%	95.0%	98.0%	95.0%	85.0%	95.0%	93.0%	100%	100%	98.0%	96.0%	98.0%	98.0%	97.3%
		3.19	F1 Parent - overall experience result	90%	96.0%	95.0%	98.0%	95.0%	95.0%	98.0%	94.0%	97.0%	97.0%	95.0%	99.0%	98.0%	99.0%	98.7%
		3.20	F1 - Extremely likely or likely to recommend (FFT)	90%	96.0%	95.0%	94.0%	91.0%	100%	96.0%	87.0%	100%	100%	100%	96.0%	98.0%	100%	98.0%
		3.21	F1 Children - Overall experience result	90%	96.0%	99.0%	91.0%	95.0%	93.0%	95.0%	93.0%	100%	100%	98.0%	86.0%	89.0%	98.0%	91.0%
		3.22	Rosemary ward - extremely likely or likely to recommend (FFT)	90%	88.0%	76.0%	100%	90.0%	100%	100%	100%	100%	80.0%	100%	80.0%	95.0%	100%	91.7%
		3.23	King suite - extremely likely or likely to recommend	90%	100%	75.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		3.24	Community paediatrics - extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	94.0%	100%	100%	100%	100%	96.0%	100%	100%	100%	94.0%	98.0%
		3.25	Community health teams - extremely likely or likely to recommend (FFT)	90%	100%	66.0%	89.0%	100%	100%	100%	100%	93.0%	93.0%	100%	100%	97.0%	90.0%	95.7%
		3.27	Stroke Care - Overall Experience Result	90%	100%	100%	100%	90.0%	100%	93.0%	ND	ND	89.0%	97.0%	96.0%	95.0%	97.0%	96.0%
		3.28	Stroke Care - extremely likely or likely to recommend	90%	100%	95.0%	97.0%	97.0%	100%	100%	100%	ND	93.0%	89.0%	100%	100%	100%	100%
	Complaint Handling	3.29	Complaints acknowledged within 3 working days	90%	100%	100%	88.0%	66.0%	100%	100%	100%	100%	88.0%	84.0%	94.0%	83.0%	81.0%	86.0%
		3.30	Complaints responded to within agreed timeframe	90%	50.0%	40.0%	83.0%	100%	83.0%	88.0%	83.0%	75.0%	100%	94.0%	86.0%	77.0%	71.0%	78.0%
		3.31	Number of second letters received	1	6	2	1	0	2	1	1	3	2	0	2	2	4	8
		3.32	Ombudsman referrals accepted for investigation	1	0	0	0	1	0	0	0	0	0	0	0	0	0	0
		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	214	275	233	198	224	219	143	231	211	228	184	190	191	565
		3.35	No. of PALS contacts becoming formal complaints	<=5	4	4	2	2	1	3	0	2	5	4	2	5	6	13

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EXCEPTION REPORTS –CARING

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

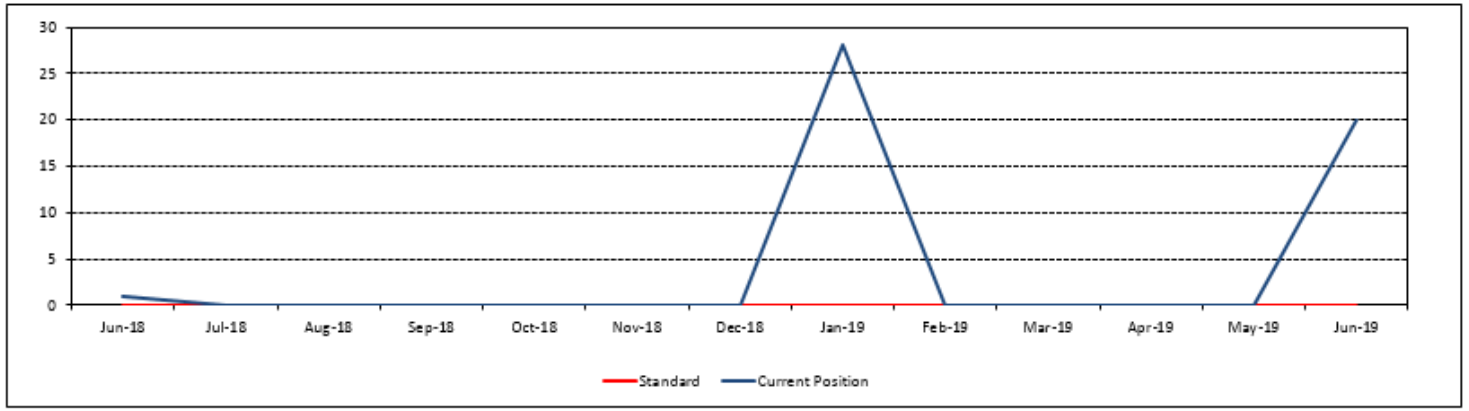
Indicator	Mixed Sex Accommodation Breaches
Standard	0
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Ambulatory Emergency Care - currently located in one area on Acute Assessment Area whilst building work is completed. This has reduced capacity in AAU by 5 trolley's. High level of patients requiring admission through ED on the date that breaches occurred. Decision made at Director level to use ambulatory area as escalation for inpatients overnight, decision reversed at Director level in the morning however only able to partially convert back to day patients. Mitigation in place to preserve privacy and dignity of patients. Plan to move ambulatory area into dedicated unit September 2019 thus releasing 5 trolley's back to assessment/inpatient use for correct cohort of patients.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	1	0	0	0	0	0	0	28	0	0	0	0	20

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Complaints acknowledged within 3 working days
Standard	90%
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Caring

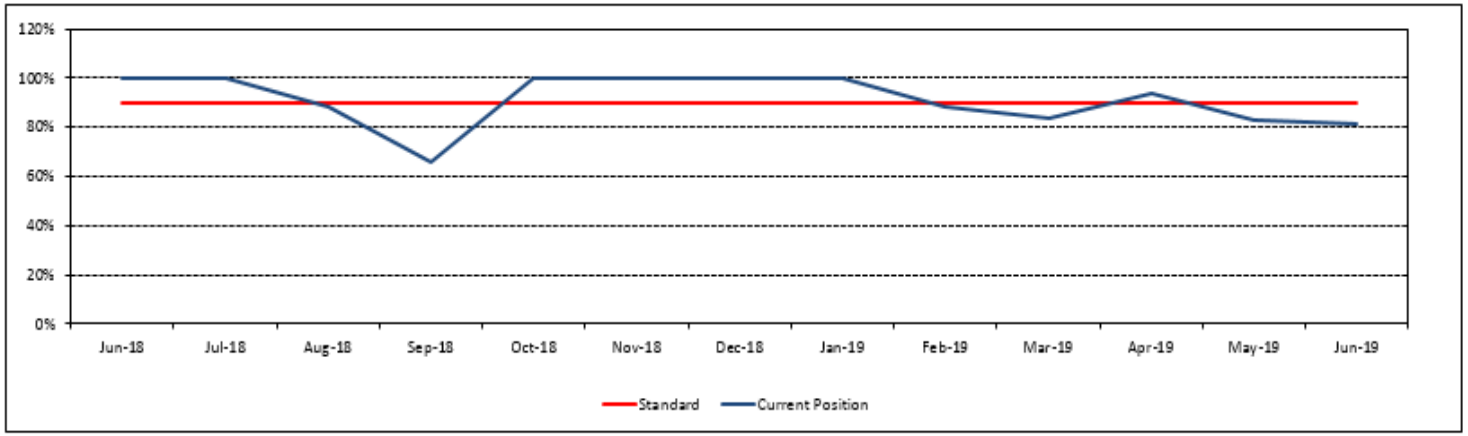
Summary of Current performance & Reasons for under performance

This deterioration is due to workload capacity in the patient experience team, in line with increased formal complaints and reduced resources. This is being monitored and a plan made.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	100%	100%	88.0%	66.0%	100%	100%	100%	100%	88.0%	84.0%	94.0%	83.0%	81.0%

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

Description	Owner	Start	End



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

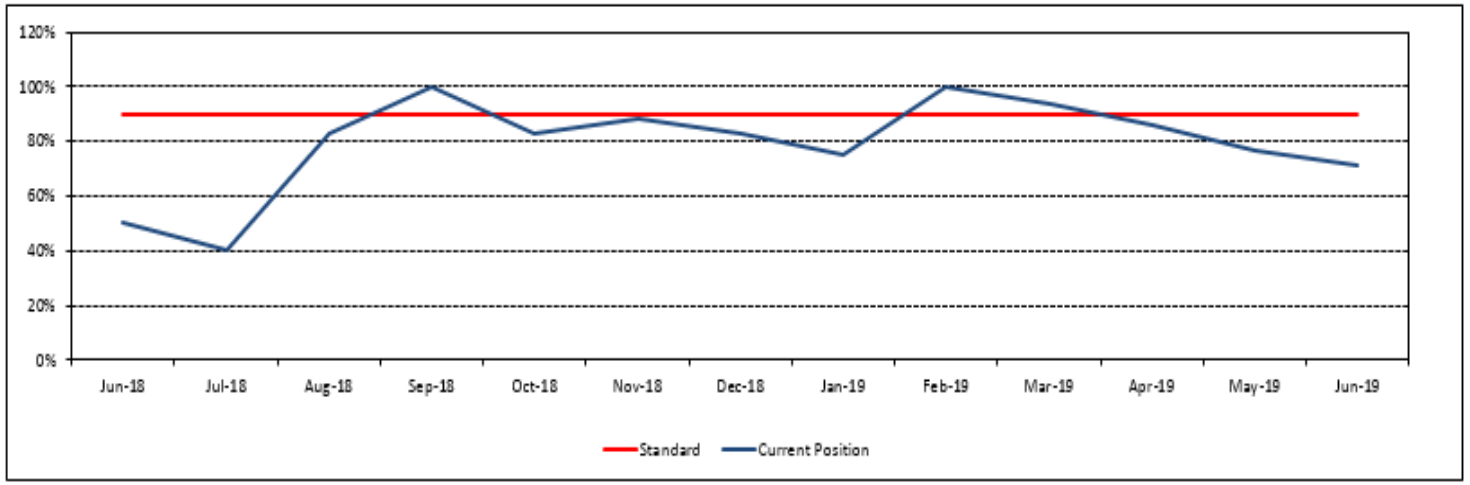
Indicator	Complaints responded to within agreed timeframe
Standard	90%
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

5 out of 7 responses due were sent in their timeframe, with a high number having to have deadline extensions into July. This deterioration is due to workload capacity in the patient experience team, in line with increased formal complaints and reduced resources. This is being monitored and a plan made.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	50.0%	40.0%	83.0%	100%	83.0%	88.0%	83.0%	75.0%	100%	94.0%	86.0%	77.0%	71.0%

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

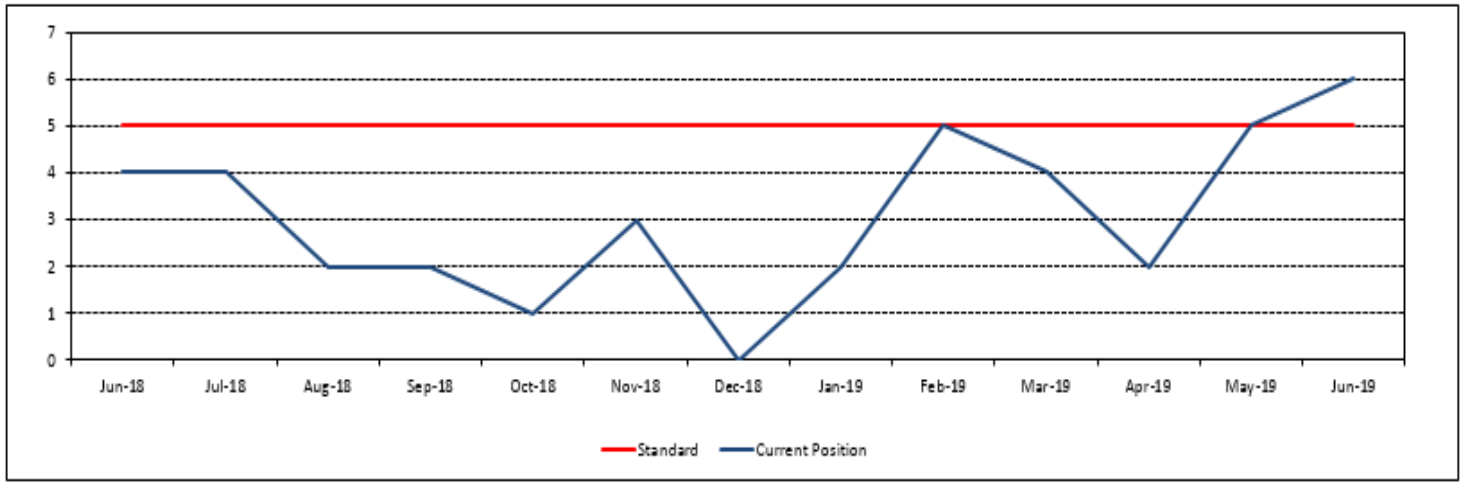
Indicator	No. of PALS contacts becoming formal complaints
Standard	5
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

We have seen an increase in complex PALS enquiries and formal complaints and this referral rate is therefore not unexpected. There has also been a vacancy in the PALS team resulting in some cases being open for longer than we would hope, which may have impacted on these escalating formally.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	5	5	5	5	5	5	5	5	5	5	5	5	5
Current Position	4	4	2	2	1	3	0	2	5	4	2	5	6

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



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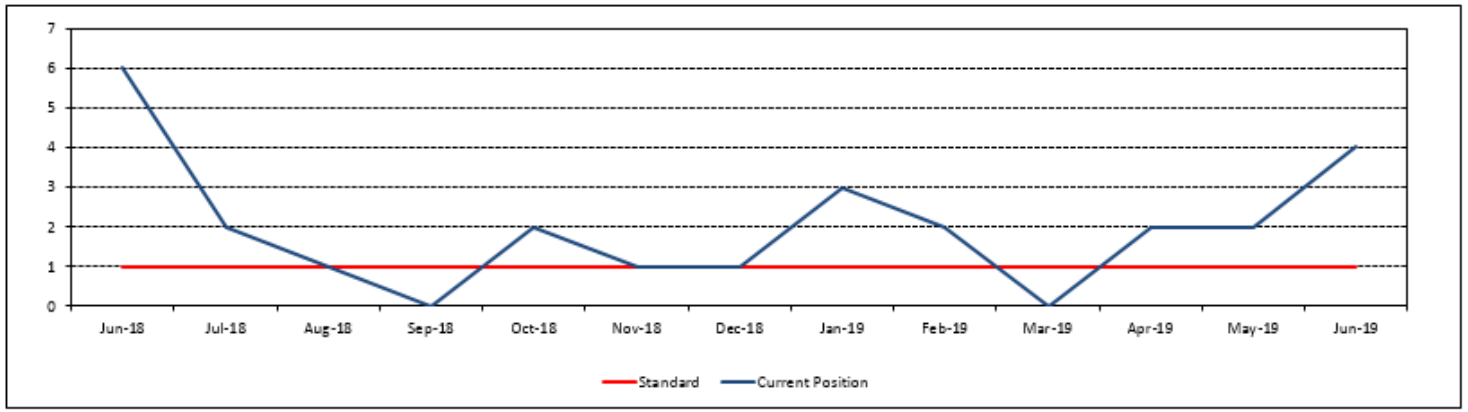
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	Number of second letters received
Standard	1
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Throughout the calendar year so far we have noticed an increase in more complex complaints, which require a higher level of investigation. An increase in second letters reflects this and the complexity of some of the investigations/desired outcomes.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	1	1	1	1	1	1	1	1	1	1	1	1	1
Current Position	6	2	1	0	2	1	1	3	2	0	2	2	4

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



7. DETAILED REPORTS - RESPONSIVE

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

Are we..		Ref.	KPI	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	YTD(Apr19-Jun19)
4. Responsive	A&E	4.13	Number of Delayed Transfer of Care - (DTOCs)	NT	203	165	302	224	270	268	320	287	389	460	447	404	425	425
		4.14	A&E time to treatment in department (median) for patients arriving by ambulance - CDM	120	49	49	46	39	46	45	46	47	43	43	46	46	43	45
		4.15	A&E - Single longest Wait (Admitted & Non-Admitted)	6 hrs.	12.22	14.49	15.54	12.23	16.17	13.05	15.35	20.32	14.35	13.55	14.35	13.23	20.01	15.86
		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	8	15	31	10	31	24	54	125	113	65	155	105	119	379
		4.18	A&E - To inpatient Admission Ratio	32%	25.0%	23.9%	25.7%	28.3%	28.6%	30.3%	31.2%	31.3%	31.6%	29.7%	29.0%	28.8%	27.2%	28.3%
		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%	92.8%	91.3%	90.1%	91.0%	93.1%	94.7%	95.0%	94.9%	96.5%	95.4%	95.3%	95.6%	96.4%	95.8%
		4.21	A&E - Amb. Handover above 30m	0	13	21	24	6	21	15	40	61	33	41	46	41	41	87
		4.22	A&E - Amb. Handover above 60m	0	5	31	16	2	30	8	14	59	10	15	13	36	28	49
	RTT	4.25	RTT waiting List	<15396	16739	16715	16601	18105	18071	17915	18426	19601	18341	19730	20427	21061	21253	20914
		4.26	RTT waiting list over 18 weeks	NT	1443	1433	1775	1830	1766	1855	2149	2999	3005	3006	3111	2985	3101	3066
		4.27	RTT 18 weeks Non-Consultant led services - Community	90%	100%	98.7%	99.0%	99.0%	99.0%	99.0%	100%	99.7%	99.6%	100%	99.0%	99.4%	94.0%	97.5%
		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%	77.7%	76.3%	84.4%	93.3%	64.0%	84.0%	80.0%	83.0%	75.5%	84.4%	75.8%	75.0%	80.0%	76.9%
		4.30	Stroke - % patients scanned within 12 hrs.	96%	100%	89.5%	100%	100%	100%	100%	97.5%	94.3%	98.1%	95.6%	97.0%	97.2%	95.0%	96.4%
		4.31	Stroke - % Patients admitted directly to stroke unit within 4h	75%	84.1%	75.0%	79.6%	82.8%	73.3%	83.7%	78.4%	78.4%	61.5%	78.6%	75.0%	71.4%	81.6%	76.0%
		4.32	Stroke - Greater than 80% of treatment on stroke unit	90%	100%	88.9%	88.6%	96.6%	88.9%	93.9%	91.9%	94.1%	84.3%	81.0%	96.9%	88.6%	86.8%	90.8%
		4.33	Stroke - % of patients treated by the SESDC	48%	58.5%	50.0%	53.9%	69.2%	52.4%	63.6%	48.0%	63.2%	49.1%	66.7%	54.2%	73.3%	55.0%	60.8%
		4.34	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start	80%	97.8%	92.1%	97.8%	96.7%	94.0%	88.0%	90.0%	96.2%	86.8%	91.1%	90.6%	88.9%	90.0%	89.8%
		4.35	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72h	75%	88.6%	89.2%	79.6%	86.2%	73.5%	89.6%	78.4%	87.5%	89.6%	80.0%	76.2%	75.0%	77.1%	76.1%
		4.36	Stroke -% of eligible patients given thrombolysis	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		4.37	Stroke -% of stroke survivors who have 6mth f/up	50%	ND	ND	ND	ND	ND	ND	61.0%	ND	ND	ND	ND	ND	ND	ND
		4.38	Stroke -Provider rating to remain within A-C	C	C	NA	NA	C	NA	NA	C	NA	NA	ND	NA	NA	NA	NA

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Are we..		Ref.	KPI	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	YTD(Apr19-Jun19)
4. Responsive	Other	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	95%	100%	100%	100%	ND	100%	100%	100%	ND	100%	100%	100%	100%	100%	100%
		4.40	Nursing & therapy Red referrals seen within 4hrs - Community	95%	100%	98.2%	100%	100%	100%	100%	100%	96.6%	100%	100%	100%	100%	100%	100%
		4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	95%	99.5%	97.4%	99.4%	99.5%	99.0%	99.9%	100%	99.0%	98.8%	99.3%	99.2%	99.5%	99.3%	99.3%
		4.42	Nursing & therapy Green referrals seen within 18 wks -Community	95%	100%	100%	100%	99.6%	99.7%	99.2%	98.0%	99.5%	99.5%	99.5%	99.4%	99.5%	100%	99.5%
		4.43	Wheelchair waiting times – Child (Community)	92%	95.2%	90.9%	100%	100%	100%	83.3%	83.3%	81.8%	94.1%	100%	100%	100%	100%	100%
		4.44	Wheelchair waiting times - Adult (Community)	NT	80.0%	54.9%	100%	73.1%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND
		4.45	Sepsis - 1 hr neutropenic sepsis	100%	57.9%	80.0%	72.2%	90.9%	90.0%	75.0%	77.8%	81.0%	75.0%	87.5%	100%	91.7%	92.9%	94.8%
		4.48	% of initial health assessments completed within 15 working days of receiving all relevant paperwork.	95%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93.3%	40.0%	46.2%	59.8%
		4.46	Percentage of Children in Care initial health assessments completed within 28 calendar days of becoming a child in care	100%	8.0%	23.1%	31.6%	11.8%	33.3%	21.4%	15.4%	0.0%	20.0%	14.3%	33.3%	40.0%	38.5%	37.3%
		4.47	Percentage of Service Users (children) assessed to be eligible for NHS Continuing Healthcare whose review health assessment is completed annually	80%	ND	ND	ND	86.7%	86.2%	90.0%	97.0%	100%	100%	ND	99.0%	96.2%	100%	98.4%

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EXCEPTION REPORTS – RESPONSIVE

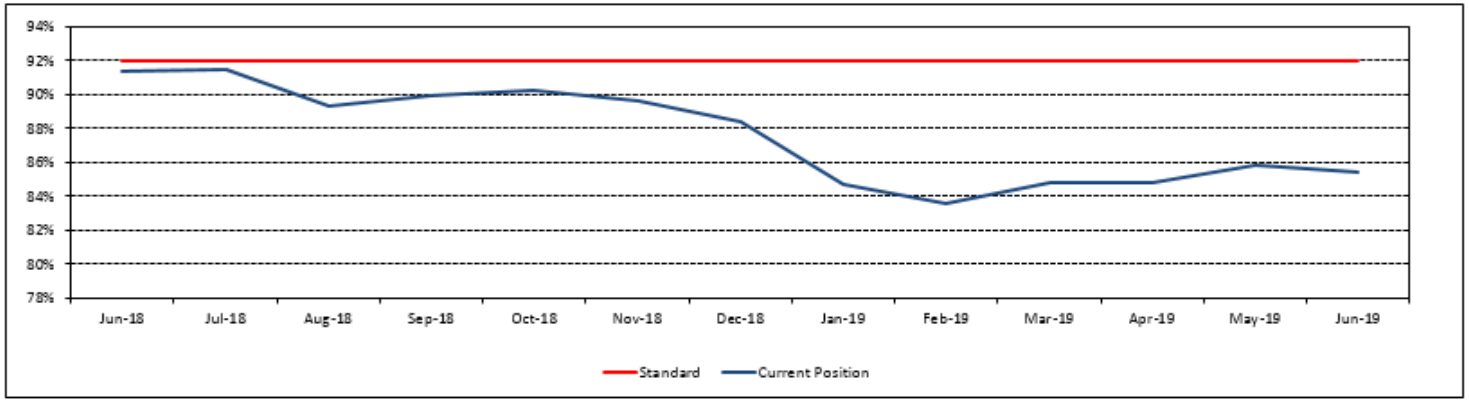
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	RTT: % incomplete pathways within 18 weeks
Standard	92%
Executive Lead	Helen Beck
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Performance much the same in June as May/ Patients are exceeding their waiting times in multiple specialities, with significant impact in Vascular, Ophthalmology, General Surgery, T&O, Urology and Gynaecology. Waiting times for first appointment in Vascular, Cataract surgery in Ophthalmology, Joint surgery in T&O and first appointment and Urogynae in Gynaecology are the main focus.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Current Position	91.4%	91.4%	89.3%	89.9%	90.2%	89.7%	88.3%	84.7%	83.6%	84.8%	84.8%	85.8%	85.4%

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	
Capacity and Demand models to be refreshed	HK/AB	Jun-19	Jul-19
Full action plan to be completed with all options for out/in sourcing and additional internal activity	AB	Jun-19	Jul-19



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

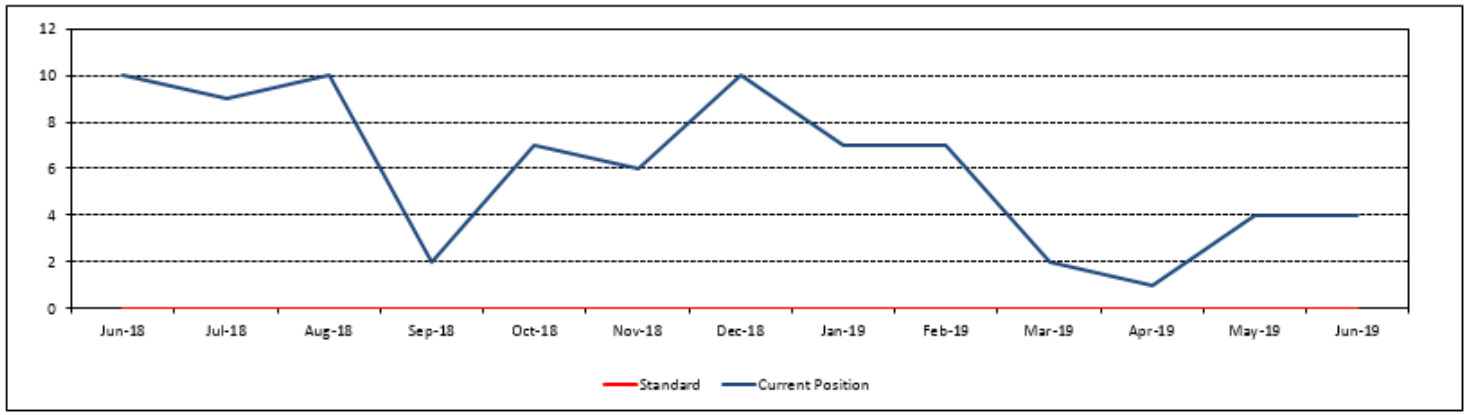
Indicator	52 week waiters
Standard	0
Executive Lead	Helen Beck
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

4 patients waited over 52 weeks as at the end of June. These consisted of 1 Trauma and Orthopaedics, 2 Vascular and 1 Ophthalmology. All 4 patients were offered dates prior to their 52 week breach date but chose to have their surgery in July. All 4 patients have now been completed.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	10	9	10	2	7	6	10	7	7	2	1	4	4

Actions in place to recover the performance		Expected timeframes for improvements	
Description	Owner	Start	End
Continue to monitor long waits through Trust access meeting	HK	Nov-17	
Escalation process in place for any patients at risk	HK	Mar-19	
Learning from 52 week breaches session held with operational leads	HK	Jun-19	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

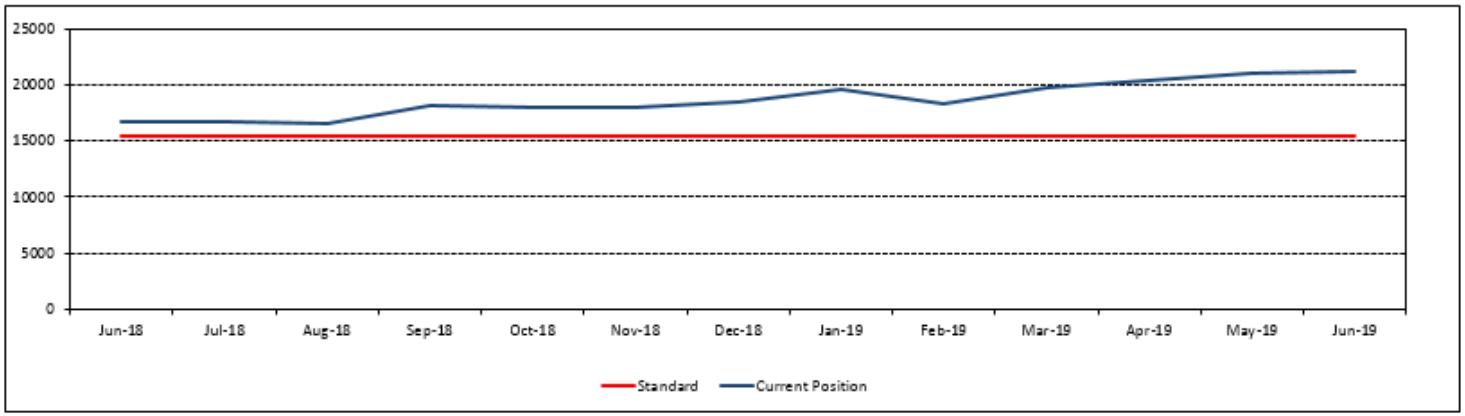
Indicator	RTT waiting List
Standard	15396
Executive Lead	Helen Beck
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Waiting list number much the same from May to June. Numbers much the same, but a slight reduction seen in Cardiology and slight increase in Gynaecology and Ophthalmology.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396
Current Position	16739	16715	16601	18105	18071	17915	18426	19601	18341	19730	20427	21061	21253

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	
Capacity and Demand models to be refreshed	HK/AB	Jun-19	Jul-19
Full action plan to be completed with all options for out/in sourcing and additional internal activity	AB	Jun-19	Jul-19



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

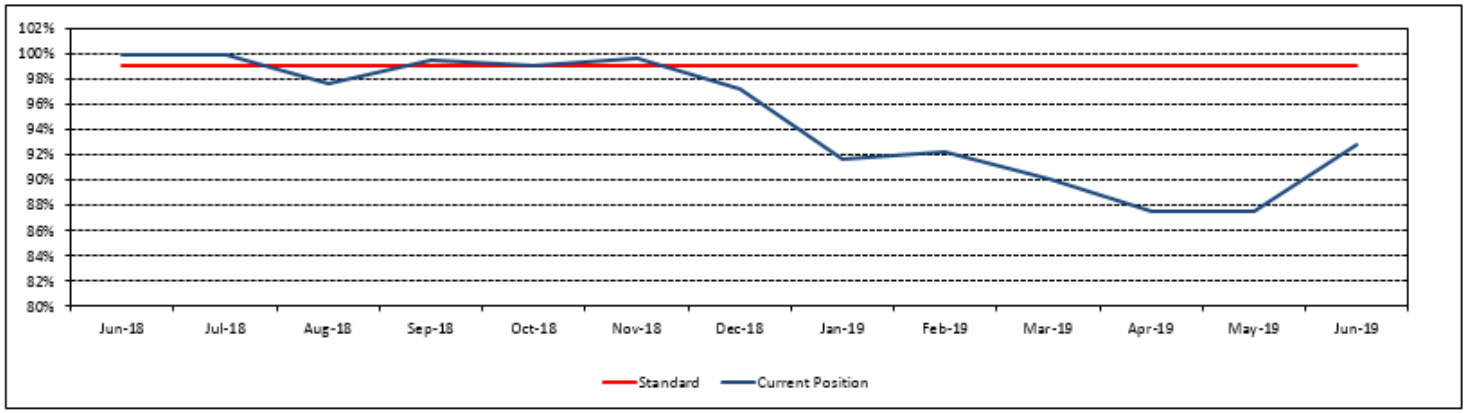
Indicator	Diagnostics within 6 weeks
Standard	99%
Executive Lead	Helen Beck
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Cystoscopy - on going capacity issues are impacting this element of the service, compounded by clinician absence. An improvement is anticipated in July with longer term service developments being worked on to stabilise this for the future.
Cardiology - There is a recovery plan for cardiology diagnostics in place with anticipated compliance by the end of July.
Endoscopy - capacity has been challenged this month with a combination of reduction in additional sessions and the washer replacement programme. Insourcing has been arranged for July to support recovery of the endoscopy position.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Current Position	99.8%	99.9%	97.6%	99.5%	99.0%	99.6%	97.1%	91.7%	92.2%	90.0%	87.5%	87.6%	92.8%

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

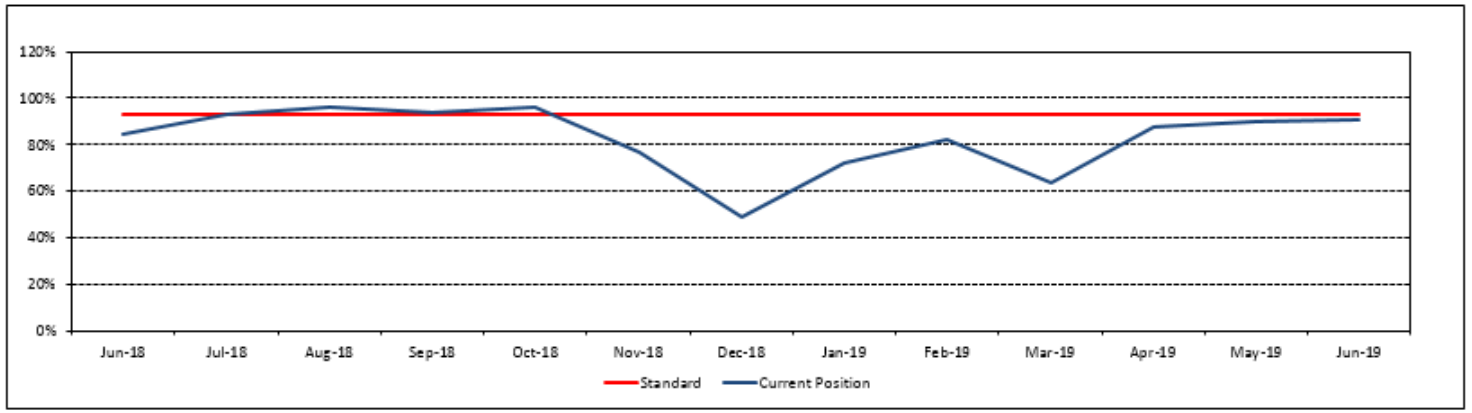
Indicator	Cancer 2w wait breast symptoms
Standard	93%
Executive Lead	Helen Beck
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current Performance- 90.9% this is primarily due to patient choice factors on 12/14 breaches and the referral numbers are also sustained.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	84.9%	92.8%	95.9%	93.9%	96.4%	76.7%	48.8%	72.1%	82.0%	63.5%	87.8%	90.2%	90.9%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Work to introduce new 2WW breast referral forms is now in the final stage of formalisation by the CCGs which once in place will help improve the quality of incoming referral .	HK	Jul-19	
Conversion of one of the screening clinics to enhance the capacity to book 1st appointments for 2 WW patients	AP	Apr-19	
Additional clinic set up for Breast Pain patients	AP	May-19	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

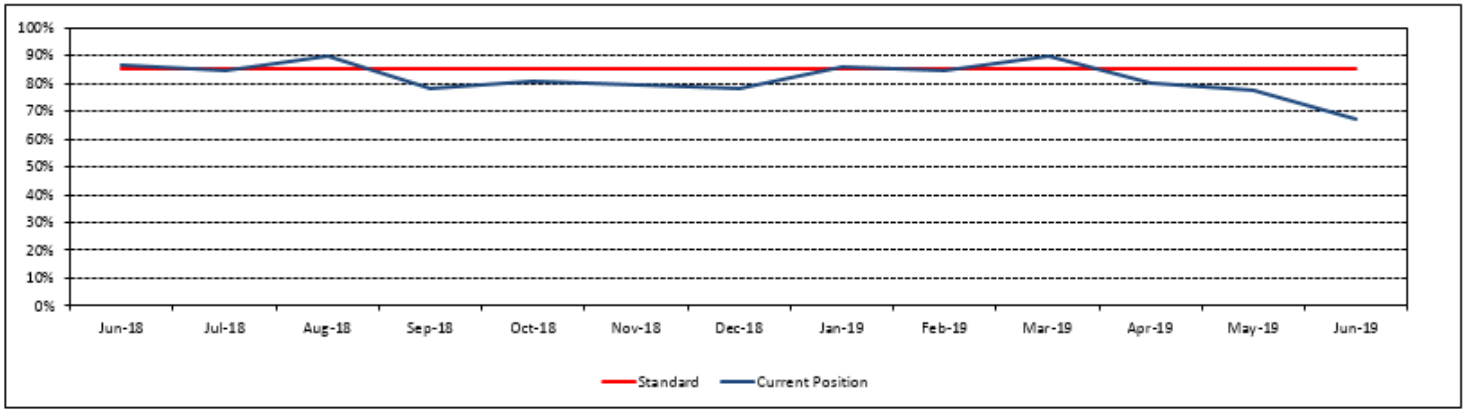
Indicator	Cancer 62 d GP referral
Standard	85%
Executive Lead	Helen Beck
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current performance 67.2%: Owing to high number of referrals and delay in diagnostics/ staging in colorectal pathways in particular with 10 colorectal breaches. In addition there were 2 Lung, 2 Skin, 2 Upper GI and 2 Urology breaches locally in the Trust and 4 shared pathway breaches: Breast- 1, Gynae -2, Head/Neck -1, some involving cases of late referrals. Both skin patients contributed to the breach by declining to attend an earlier appointment with plastic surgeons to agree for excision. 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.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Current Position	86.5%	84.8%	89.9%	78.0%	80.6%	79.5%	78.3%	85.5%	84.8%	90.0%	79.8%	77.7%	67.2%

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

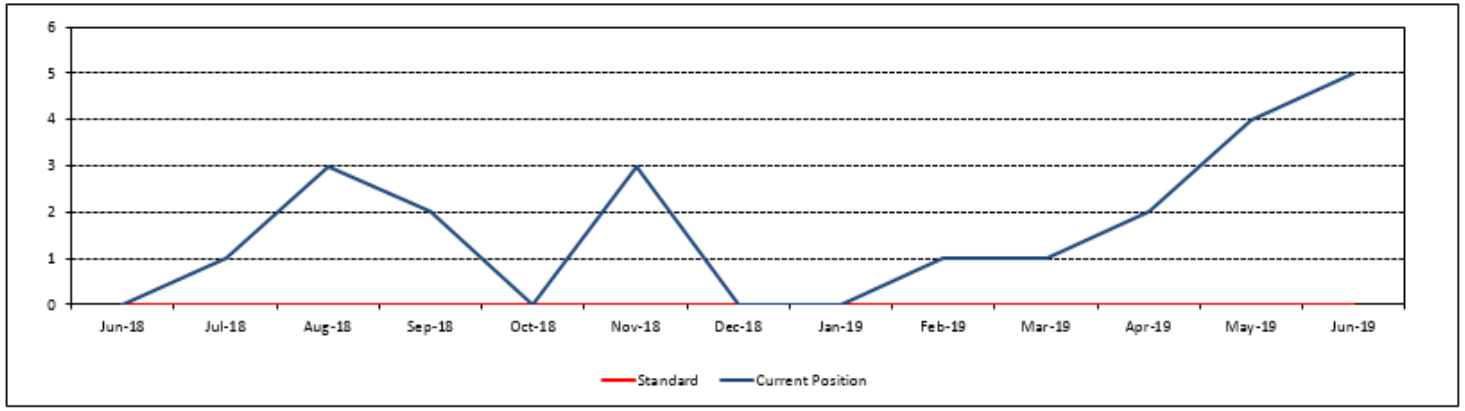
Indicator	Incomplete 104 day waits
Standard	0
Executive Lead	Helen Beck
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

3 Colorectal pathway breach owing to delay in diagnosis/ staging due to capacity issues within Endoscopy and Radiology, one patient not fit for treatment initially requiring further investigation to commence chemo causing delays.
2 Urology Pathway breach owing to no cancer on initial diagnostic and delay in MRI scan due to comorbidity and multi staged investigations delaying tissue diagnosis.

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

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	



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

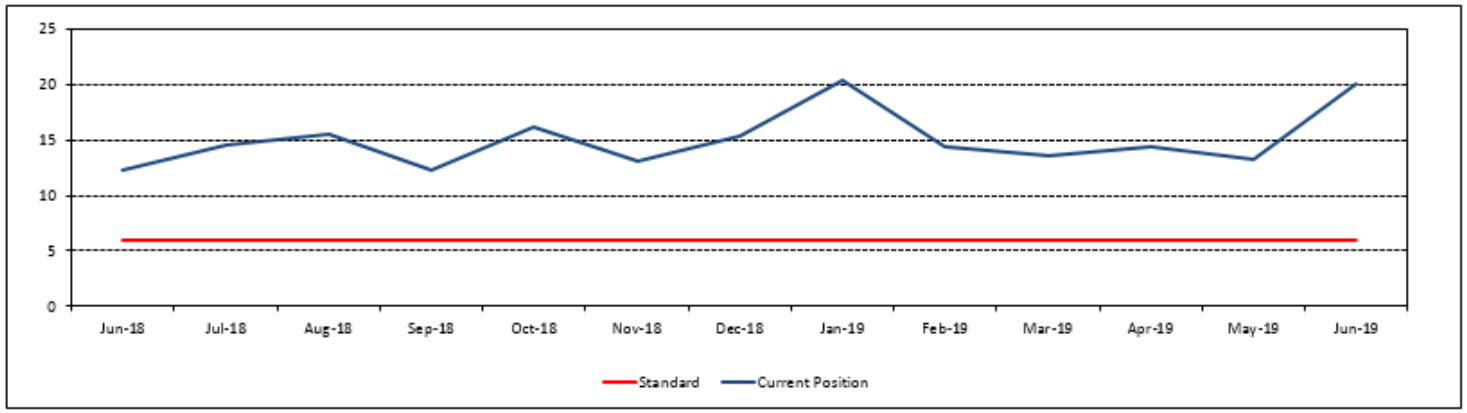
Indicator	A&E - Single longest Wait (Admitted & Non-Admitted)
Standard	6
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

The longest wait in June 2019 was 20 hours and 1 minute. This was a mental health patient who arrived in the department at 21.04 and referred to psychiatric liaison. Delay to assessment and requirement for admission following day. National capacity problems for mental health beds resulted in a long wait for a bed to become available.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	6	6	6	6	6	6	6	6	6	6	6	6	6
Current Position	12.22	14.49	15.54	12.23	16.17	13.05	15.35	20.32	14.35	13.55	14.35	13.23	20.01

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Delivery of the ED, Hospital and System wide improvement plan. Continue weekly medical staffing meetings and drive recruitment to medical and nursing vacancies. Work with mental health teams to identify any thing we could do differently to support mental health patients in ED.	ED Team	Nov-18	Ongoing



NHS West Suffolk NHS Foundation Trust

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

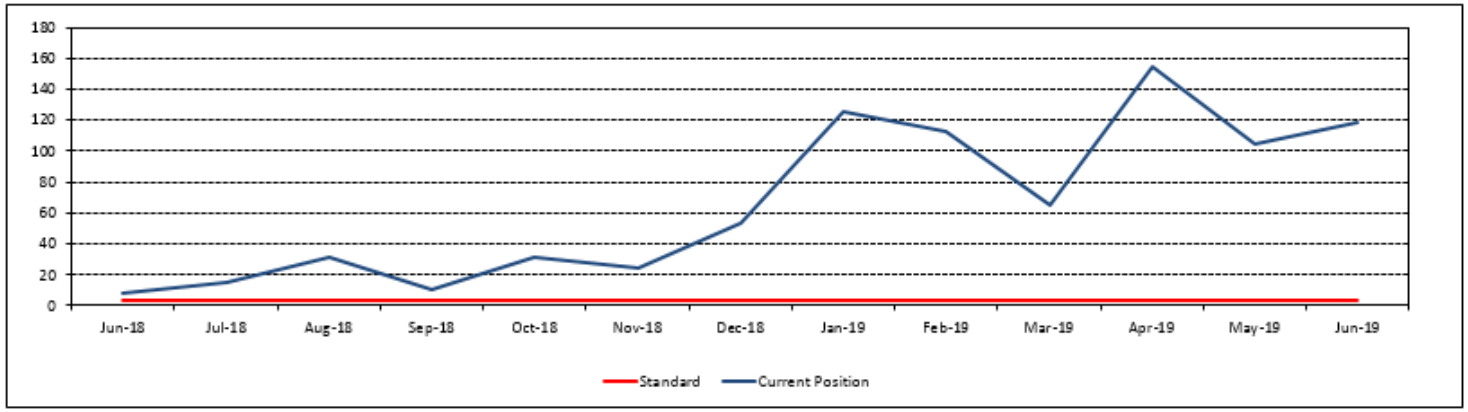
Indicator	A&E - Admission waiting 4-12 hours from dec. to admit
Standard	4
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

119 patients waited between 4-12 for a bed following a decision to admit. This has increase since May remains high due to the impact of high demand resulting in bed pressures within the hospital.
The 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	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	4	4	4	4	4	4	4	4	4	4	4	4	4
Current Position	8	15	31	10	31	24	54	125	113	65	155	105	119

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Delivery of the ED, Hospital and System wide improvement plan aiming to improve patient flow.	ED Team	Nov-18	Ongoing



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	A&E - Amb. Handover above 30m
Standard	0
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

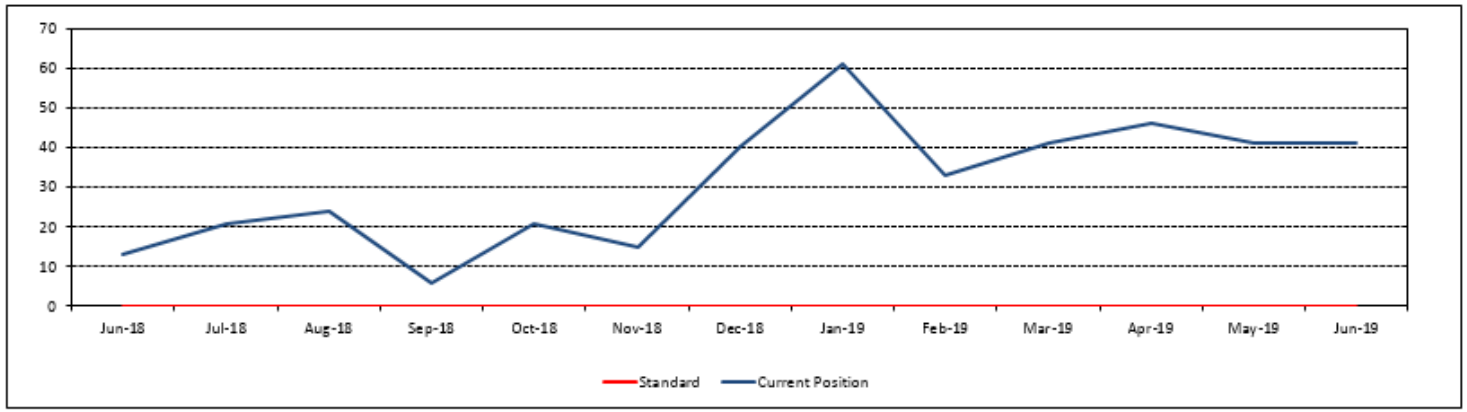
Summary of Current performance & Reasons for under performance

In June there were 41 ambulance handovers over 30 minutes between arrival and handover. This is due to ongoing high demand and space restrictions within the Emergency Department.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	13	21	24	6	21	15	40	61	33	41	46	41	41

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

Description	Owner	Start	End
A comprehensive action plan has been agreed by WSFT and EEAST and has been presented to A&E delivery board.	NC	Jan-19	Mar-20



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

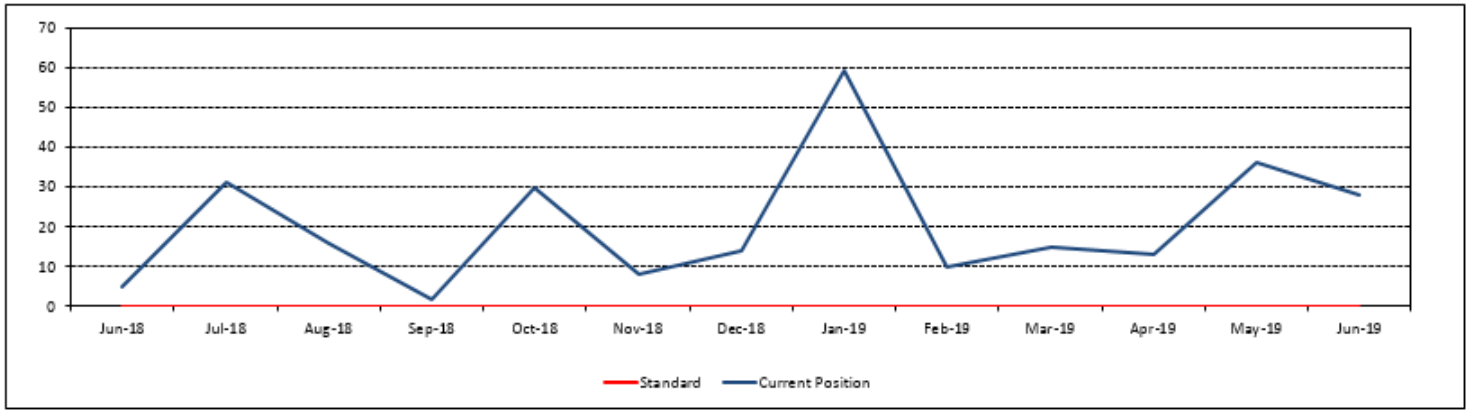
Indicator	A&E - Amb. Handover above 60m
Standard	0
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

In June there were 28 ambulance handovers over 60 minutes, between arrival and handover. This is due to ongoing high demand and space restrictions in the Emergency Department.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	5	31	16	2	30	8	14	59	10	15	13	36	28

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
A comprehensive action plan has been agreed between EEAST and WSFT and has been presented to A&E delivery board. RCAs are not taking place for all handovers over 60 minutes, to understand the themes and share learning.	NC	Jan-19	Mar-20



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

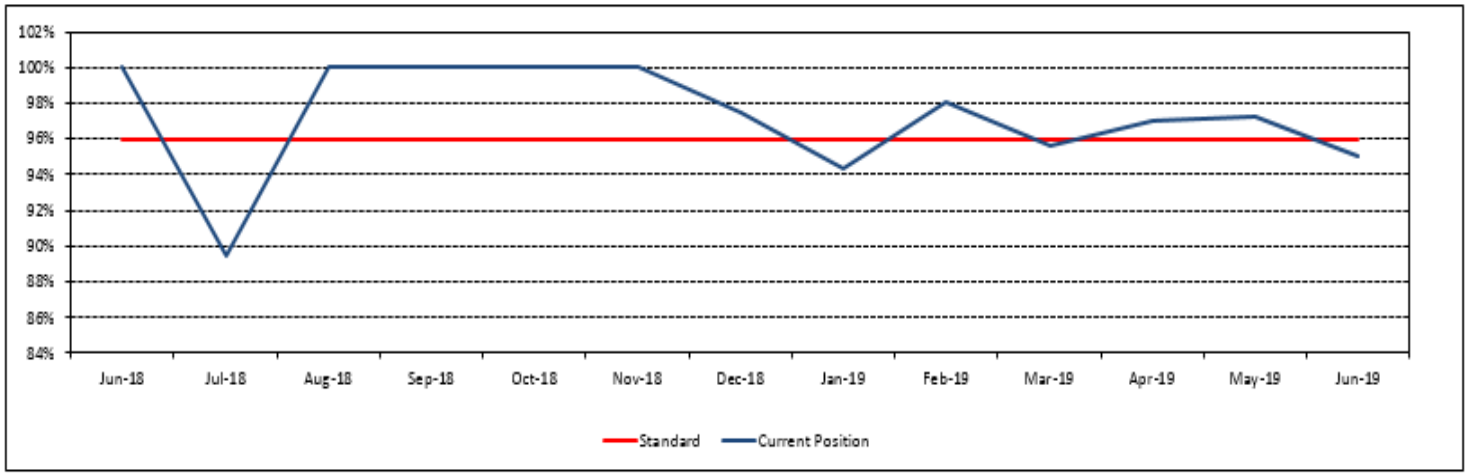
Indicator	Stroke - % patients scanned within 12 hrs.
Standard	96%
Executive Lead	Helen Beck
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Narrowly missed target by 1%. Two patients breached this target, one was a patient with an unusual presentation, thought not to be a stroke, and one was a surgical inpatient also initially not felt to be a stroke.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
Current Position	100%	89.5%	100%	100%	100%	100%	97.5%	94.3%	98.1%	95.6%	97.0%	97.2%	95.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
For these two patients the initial diagnosis was not thought to be a stroke as they presented atypically.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

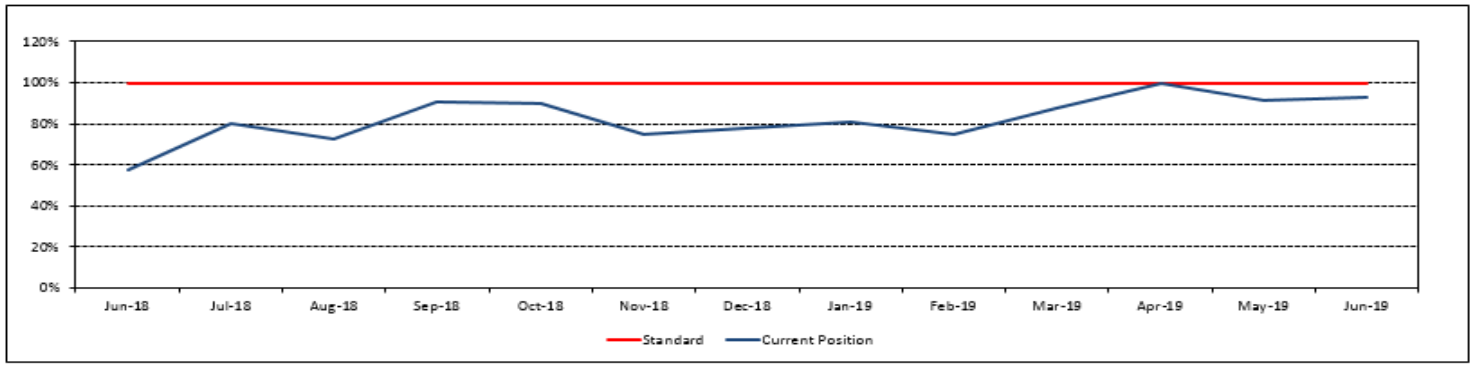
Indicator	Sepsis - 1 hr neutropenic sepsis
Standard	100%
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Performance against national standards for Door to Needle time for Neutropenic was 92.9% for the month of June. 4 patient's were admitted to G1 and all received required treatment with the 1 hour time scale. Of the 10 patients who were admitted through ED, 9 were treated within the hour (90%) - 1 breached the national standard. Please see below action plan to address the issues and improve performance against this standard.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	57.9%	80.0%	72.2%	90.9%	90.0%	75.0%	77.8%	81.0%	75.0%	87.5%	100%	91.7%	92.9%

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

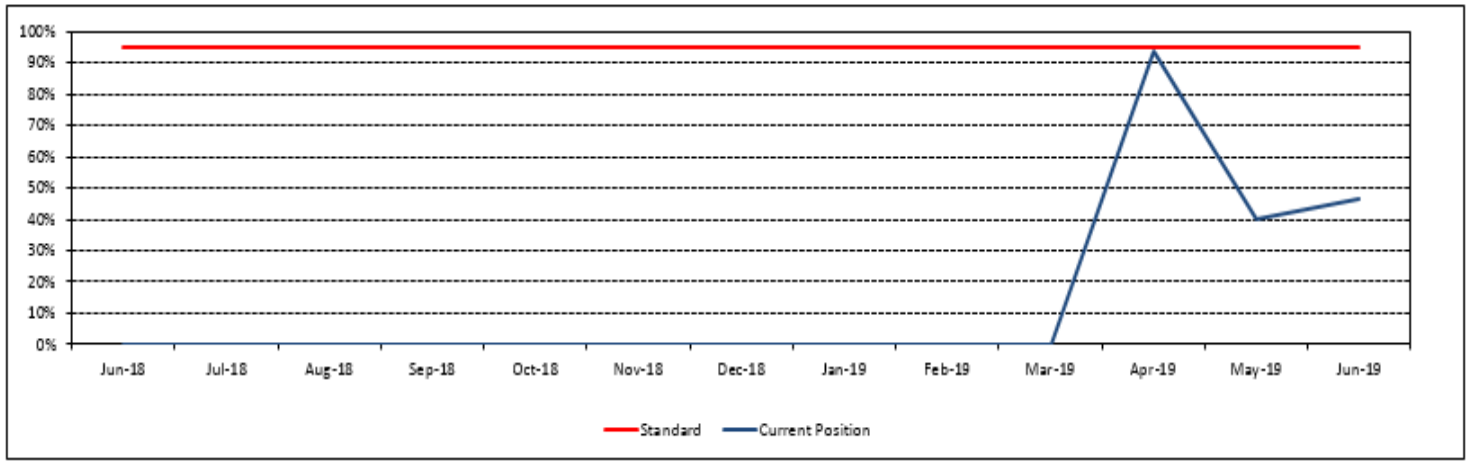
Indicator	% of initial health assessments completed within 15 working days of receiving all relevant paperwork.
Standard	95%
Executive Lead	Helen Beck
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

6 out of 13 children seen within 15 days of the service being notified of them
The 7 breaches ranged from 32 days to 48 days. the two longest waits of 35 and 48 days were offered initial health appointments for days 13 and 14 but these dates were either declined, DNA'ed or both. In addition 2 of the other 5 children's carers were also offered earlier appointments but declined these for later dates.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Children and Young People are booked onto the first available Children in Care appointment with clinician unless there is a clinical or safety reason to delay. Performance is impacted on challenges with engagement and acceptance of first offered appointment, variance in referral demand and placement of the child, clinical need and clinician capacity.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

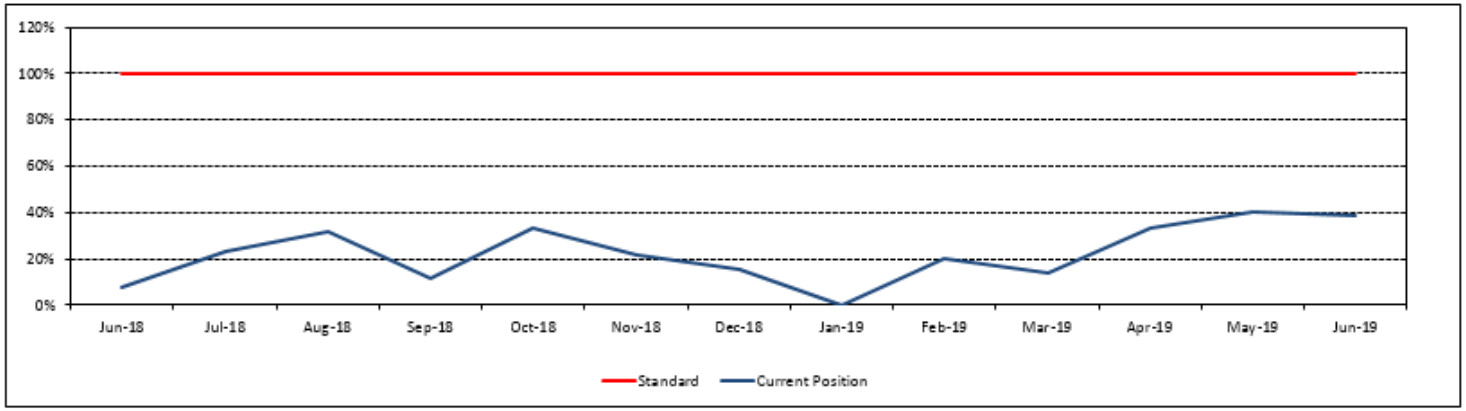
Indicator	Children in Care initial health assessments completed within 28 calendar days of becoming a child in care
Standard	100%
Executive Lead	Helen Beck
Month	Jun-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

5 out of 13 children seen within 28 days of becoming a Child in Care
8 breaches (ranging from 37 days to 57 days), the 4 longest waits of 3 x 57 days and 1 x 56 days had delays of notifying the service of 25 and 23 days respectively.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	8.0%	23.1%	31.6%	11.8%	33.3%	21.4%	15.4%	0.0%	20.0%	14.3%	33.3%	40.0%	38.5%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Service capacity and partnership liaison is under continual review within the 4-6weekly performance interagency performance to monitor issues with transfer of information. A pilot is being undertaken by the CCG in the east of the county with GP's to increase core capacity, however only one GP has been appointed and this has had minimal impact on activity as very few children have been seen. Recent performance in the ICPS team has been impacted on by young people declining appointment and therefore agreement has been given to complete paper based assessments of care needs outside of the usual assessment timescale.			



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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	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	YTD(Apr19 Jun19)
5. Well Led	Agency, WTE & vacancies	5.09	Agency Spend Cap	486	330	433	507	393	381	620	500	486	486	486	461	461	482	468
		5.10	Bank Spend		1015	1045	1294	1212	1222	1140	1167	1114	971	1277	698	638	637	658
		5.12	Proportion of Temporary Staff	12%	9.7%	11.3%	12.7%	12.0%	11.8%	12.8%	12.1%	12.7%	9.4%	13.1%	12.3%	12.3%	12.2%	12.3%
		5.13	Locum and Medical agency spend	NT	468	624	524	434	524	570	555	522	389	448	487	238	408	378
		5.57	Additional sessions	NT	207	161	270	250	338	288	266	216	274	283	272	272	273	272
		5.16	% Staff on Maternity/Paternity Leave	NT	2.38%	2.43%	2.60%	2.64%	2.65%	2.73%	2.83%	2.80%	2.64%	2.58%	2.82%	2.67%	2.49%	2.66%
	Other	5.58	New grievance or employment tribunals in the month	NT	0	0	0	0	1	4	0	2	0	1	1	0	0	0
		5.18	Recruitment Timescales - Av no. of weeks to recruit	7	5.4	5.4	5.0	6.1	6.4	6.4	6.4	5.3	4.8	5.2	6.0	6.1	5.0	5.7
		5.19	DBS checks	95%	98.0%	98.0%	98.0%	98.0%	98.5%	97.5%	97.5%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
		5.20	Staff appraisal Rates	90%	69.3%	75.8%	75.2%	76.9%	76.0%	79.0%	76.4%	77.0%	76.0%	79.0%	77.0%	80.0%	81.0%	79.3%

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Are we.		Ref.	KPI	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	YTD(Apr19 Jun19)
5. Well Led	Training	5.22	Infection Control Training (classroom)	90%	94.0%	95.0%	95.0%	95.0%	94.0%	95.0%	94.0%	96.0%	96.0%	93.0%	94.0%	95.0%	95.0%	94.7%
		5.23	Infection Control Training (eLearning)	90%	91.0%	90.0%	87.0%	90.0%	89.0%	90.0%	91.0%	91.0%	91.0%	81.0%	82.0%	82.0%	89.0%	84.3%
		5.24	Manual Handling Training (Patient)	90%	77.0%	75.0%	79.0%	76.0%	77.0%	76.0%	76.0%	80.0%	77.0%	78.0%	69.0%	80.0%	78.0%	75.7%
		5.25	Manual Handling Training (Non Patient)	90%	83.0%	83.0%	81.0%	85.0%	82.0%	86.0%	84.0%	87.0%	88.0%	67.0%	56.0%	76.0%	62.0%	64.7%
		5.26	Staff Adult Safeguarding Training	90%	92.0%	90.0%	89.0%	91.0%	91.0%	90.0%	90.0%	91.0%	91.0%	85.0%	85.0%	87.0%	89.0%	87.0%
		5.27	Safeguarding Children Level 1	90%	89.0%	89.0%	88.0%	89.0%	89.0%	90.0%	91.0%	91.0%	90.0%	91.0%	91.0%	92.0%	92.0%	91.7%
		5.28	Safeguarding Children Level 2	90%	91.0%	91.0%	89.0%	90.0%	90.0%	90.0%	91.0%	91.0%	91.0%	86.0%	86.0%	90.0%	90.0%	88.7%
		5.29	Safeguarding Children Level 3	90%	94.0%	94.0%	89.0%	91.0%	91.0%	90.0%	90.0%	91.0%	91.0%	57.0%	51.0%	71.0%	61.0%	61.0%
		5.30	Health & Safety Training	90%	91.0%	91.0%	89.0%	90.0%	89.0%	89.0%	90.0%	89.0%	89.0%	87.0%	87.0%	88.0%	90.0%	88.3%
		5.31	Security Awareness Training	90%	91.0%	90.0%	89.0%	89.0%	88.0%	89.0%	89.0%	89.0%	88.0%	81.0%	83.0%	87.0%	88.0%	86.0%
		5.32	Conflict Resolution Training (eLearning)	90%	87.0%	88.0%	82.0%	83.0%	83.0%	85.0%	86.0%	86.0%	86.0%	68.0%	70.0%	74.0%	81.0%	75.0%
		5.33	Conflict Resolution Training	90%	70.0%	71.0%	73.0%	71.0%	69.0%	74.0%	75.0%	72.0%	72.0%	77.0%	74.0%	78.0%	76.0%	76.0%
		5.34	Fire Training (eLearning)	90%	81.0%	81.0%	84.0%	91.0%	83.0%	85.0%	88.0%	85.0%	83.0%	83.0%	78.0%	83.0%	83.0%	81.3%
		5.35	Fire Training (classroom)	90%	90.0%	89.0%	90.0%	84.0%	89.0%	88.0%	86.0%	89.0%	87.0%	89.0%	88.0%	89.0%	89.0%	88.7%
		5.36	IG Training	95%	83.0%	84.0%	82.0%	82.0%	80.0%	83.0%	82.0%	81.0%	83.0%	78.0%	79.0%	81.0%	94.0%	84.7%
		5.37	Equality and Diversity	90%	79.0%	79.0%	79.0%	80.0%	81.0%	82.0%	84.0%	85.0%	85.0%	87.0%	86.0%	88.0%	90.0%	88.0%
		5.38	Majax Training	90%	89.0%	88.0%	88.0%	88.0%	89.0%	89.0%	90.0%	90.0%	89.0%	78.0%	80.0%	82.0%	84.0%	82.0%
		5.39	Medicines Management Training	90%	88.0%	89.0%	87.0%	86.0%	87.0%	87.0%	87.0%	87.0%	86.0%	80.0%	81.0%	83.0%	86.0%	83.3%
		5.40	Slips, trips and falls Training	90%	86.0%	86.0%	86.0%	85.0%	86.0%	85.0%	87.0%	86.0%	86.0%	74.0%	76.0%	79.0%	82.0%	79.0%
		5.41	Blood-borne Viruses/Inoculation Incidents	90%	87.0%	88.0%	85.0%	86.0%	87.0%	88.0%	89.0%	89.0%	87.0%	78.0%	80.0%	83.0%	85.0%	82.7%
		5.42	Basic life support training (adult)	90%	76.0%	75.0%	79.0%	79.0%	79.0%	80.0%	80.0%	81.0%	80.0%	79.0%	73.0%	81.0%	81.0%	78.3%
		5.43	Blood Products & Transfusion Processes (Refresher)	90%	73.0%	74.0%	74.0%	73.0%	74.0%	75.0%	76.0%	77.0%	76.0%	65.0%	62.0%	68.0%	77.0%	69.0%
		5.44	Mandatory Training Compliance	90%	85.0%	84.0%	84.0%	85.0%	85.0%	86.0%	86.0%	85.0%	86.0%	82.0%	82.0%	85.0%	86.0%	84.3%

EXCEPTION REPORTS – WELL LED

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

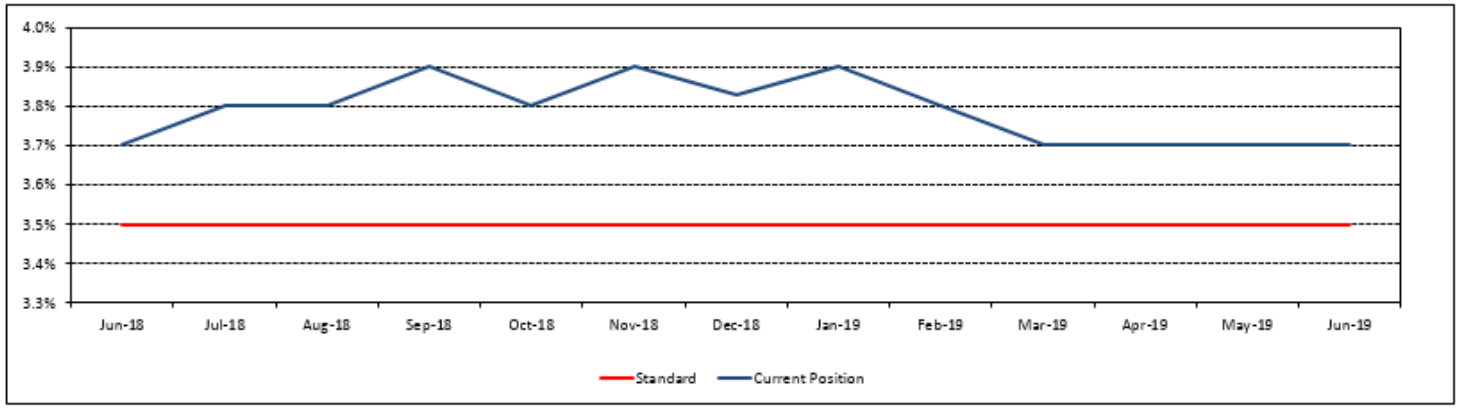
Indicator	Sickness Absence
Standard	3.5%
Executive Lead	Jan Bloomfield
Month	Jun-19
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

The sickness absence absence figure remains at 3.7%.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
A report has been produced that went to the Trust Executive Group outlining the trends with regard to reason for absence. They were as follows; 1. Anxiety/ stress/depression/other psychiatric illness. 2. Cold, Cough, Flu – influenza, 3. Gastro-intestinal problems, 4. Other known causes – not elsewhere classified, 5. Other musculoskeletal problems. Actions have been identified as a result.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

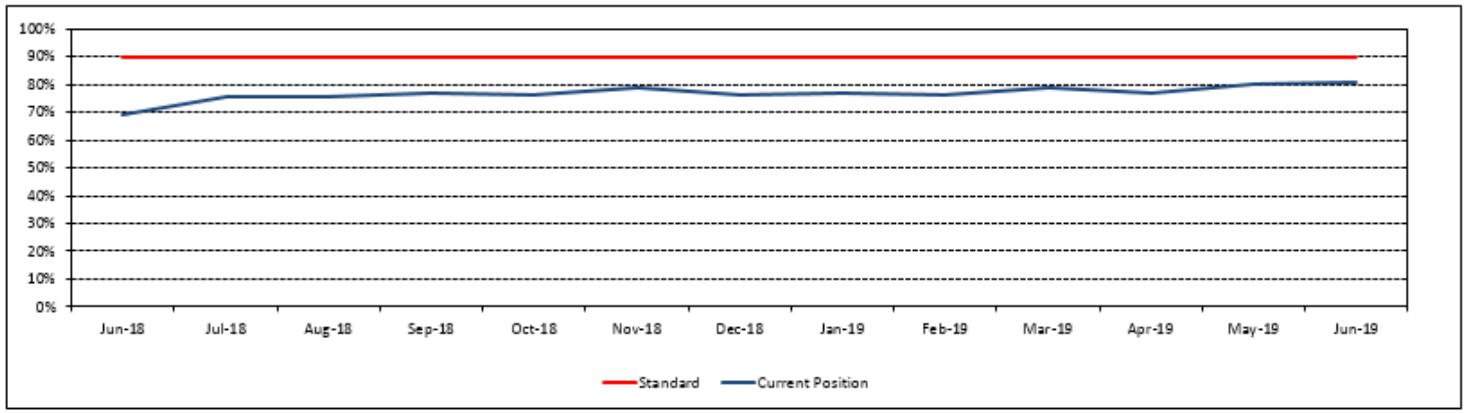
Indicator	Staff appraisal Rates
Standard	90%
Executive Lead	Jan Bloomfield
Month	Jun-19
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Compliance has increased by 1% towards the target rate. Under performance was discussed at the June meeting.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	69.3%	75.8%	75.2%	76.9%	76.0%	79.0%	76.4%	77.0%	76.0%	79.0%	77.0%	80.0%	81.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
the trust board received a paper outlining the issues, and proposed actions at the June meeting.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

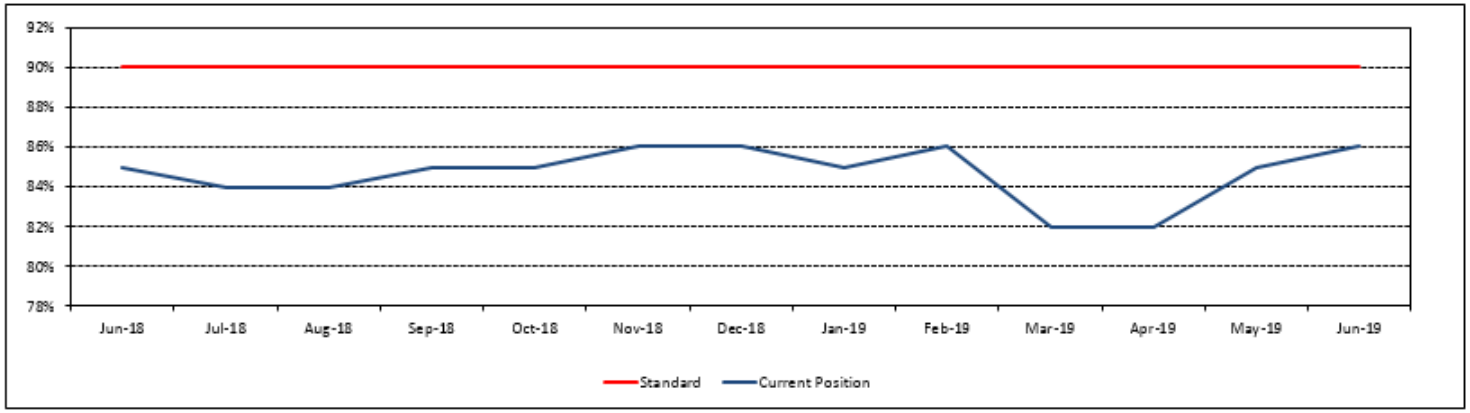
Indicator	Mandatory Training Compliance
Standard	90%
Executive Lead	Jan Bloomfield
Month	Jun-19
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Mandatory training compliance has increased by 1%. The trust continues to catch up from issues with attendance at face to face training, and during winter pressures, we are still resolving issues with staff accessing e-learning, and rectifying competency anomalies with regard to community staff (this is due to amalgamating community and acute from a reporting perspective)

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	85.0%	84.0%	84.0%	85.0%	85.0%	86.0%	86.0%	85.0%	86.0%	82.0%	82.0%	85.0%	86.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
an action plan was presented to the board last month, and is currently being actioned.			



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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	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	YTD(Apr19-Jun19)
6. Productive	Activity	6.07	A&E Activity	NT	6161	6564	6072	6042	6256	6114	6155	6371	5741	6695	6729	6946	6692	20367
		6.08	NEL Activity	NT	2491	2465	2394	2356	2638	2770	2520	2750	2467	2604	2464	2700	2367	7531
		6.09	OP - New Appointments	NT	6379	6598	6007	6113	7381	7255	5995	7059	6419	7086	8369	8947	8537	25853
		6.10	OP- Follow-Up Appointments	NT	11520	11750	10929	10879	12773	12289	9834	12610	11107	11536	22314	19866	19590	61770
		6.11	Electives (Incl Daycase)	NT	2799	2870	2786	2379	3033	3047	2519	3202	2957	2971	2807	2975	2757	8539
	Finance	6.12	Financial Position (YTD)	Var	-3159	-4420	-5641	-7119	-7122	-7494	-6534	-8691	-7955	-287	-883	-1447	-2360	-4690
		6.13	Financial Stability Risk Rating	Var	3	3	3	3	3	3	3	3	3	3	3	3	3	9
		6.14	Cash Position (YTD £000s)	Var	2239	6852	7231	3934	1338	5162	3518	4924	6870	3600	11140	5825	1467	18432
	Ratios	6.15	% Consultant to Consultant Referrals	NT	16.0%	16.0%	16.0%	15.0%	14.0%	15.0%	17.0%	16.0%	17.0%	15.0%	17.0%	16.0%	16.0%	16.3%
		6.16	New to FU Ratios	NT	2.34	2.23	2.32	2.34	2.27	2.16	2.16	2.31	2.37	2.20	2.66	2.22	2.29	2.39

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EXCEPTION REPORTS – PRODUCTIVE

The finance report contains full details.

10. DETAILED REPORTS- MATERNITY

Are we..		Ref.	KPI	Target	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	YTD(Apr19-Jun19)
7.Maternity	Safe	7.09	Elective Caesarean Sections	12%	7.6%	4.7%	7.8%	9.6%	8.6%	10.4%	9.1%	6.7%	9.3%	11.2%	9.3%	11.3%	7.8%	9.5%
		7.10	Emergency Caesarean Sections	14%	10.6%	12.4%	9.2%	13.0%	14.1%	15.4%	16.3%	16.2%	11.0%	15.6%	11.5%	11.8%	18.0%	13.8%
		7.11	Grade 1 Caesarean Section (Decision to delivery time met)	100%	100%	100%	100%	100%	40.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)	80%	90.0%	58.0%	64.0%	82.0%	71.0%	57.0%	79.0%	76.1%	92.3%	87.0%	100%	85.0%	81.0%	88.7%
		7.13	Homebirths	2%	1.5%	2.4%	1.5%	3.8%	1.8%	2.0%	1.0%	2.2%	2.9%	2.8%	3.8%	3.1%	1.5%	2.8%
		7.14	Midwifery led birthing unit (MLBU) births	>13%	11.4%	18.8%	17.0%	11.5%	14.4%	NA	NA	NA	NA	NA	24.0%	14.4%	16.1%	18.2%
		7.15	Labour Suite births	77.5%	86.9%	78.2%	80.6%	83.7%	82.7%	82.6%	83.0%	78.8%	77.9%	82.1%	71.0%	82.1%	82.0%	78.4%
		7.16	Induction of Labour	29.3%	40.9%	37.6%	36.4%	34.1%	35.5%	38.3%	42.1%	40.8%	39.0%	42.2%	35.0%	39.5%	39.0%	37.8%
		7.17	Instrument Assisted Deliveries (Forceps & VentoUse)	>14%	10.1%	10.0%	12.6%	11.5%	11.8%	13.9%	8.1%	8.9%	12.2%	11.7%	8.2%	8.2%	12.2%	9.5%
		7.18	Critical Care Obstetric Admissions	0	1	0	1	1	0	0	3	1	0	0	0	0	0	0
		7.19	Eclampsia	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0
	Effective	7.20	Shoulder Dystocia	2	8	5	6	9	9	4	4	6	4	4	9	2	7	18
		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	1	2	0	0	1	0	1	1	0	1	1	0	0	1
		7.23	3rd and 4th degree tears (all deliveries)	12	6	4	7	7	3	8	2	6	2	0	7	2	4	13
	Caring	7.24	Maternal death	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
		7.25	Stillbirths	NT	0	1	0	0	0	0	0	0	0	0	1	1	2	4
		7.26	Complaints	NT	0	3	1	0	1	1	0	3	3	1	0	3	0	3
		7.27	No. of babies admitted to Neonatal Unit (>36+6)	NT	9	7	13	8	9	10	15	7	7	9	8	8	16	32
	Responsive	7.28	No. of babies transferred for therapeutic cooling	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
		7.29	One to one care in established labour	100%	92.3%	97.0%	97.0%	100%	100%	100%	99.0%	100%	100%	100%	100%	100%	100%	100%
		7.30	Reported Clinical Incidents	50	48	27	39	44	34	42	38	50	40	59	56	47	43	146
		7.31	Hours of dedicated consultant cover per week	60	93	93	90	87	87	99	93	105	87	98	96	105	90	291
		7.32	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	10	30
		7.34	No. of women identified as smoking at booking	NT	22	19	21	23	22	20	34	20	18	28	23	25	22	70
		7.35	No. of women identified as smoking at delivery	NT	14	15	27	21	22	18	31	18	16	27	20	20	21	61
		7.36	UNICEF Baby friendly audits	10	10	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	24	NA	24
		7.37	Proportion of parents receiving Safer Sleeping Suffolk advice	80%	81.8%	88.0%	80.0%	96.0%	97.0%	95.0%	97.5%	96.1%	97.0%	94.5%	95.0%	85.6%	80.0%	86.9%
	Other	7.38	No. of bookings (First visit)	NT	237	252	236	231	234	222	206	278	226	242	231	251	241	723
		7.39	Women booked before 12+6 weeks	95%	96.6%	94.4%	96.0%	92.0%	92.0%	98.0%	95.1%	96.0%	96.4%	92.0%	95.0%	95.0%	94.0%	94.7%
		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

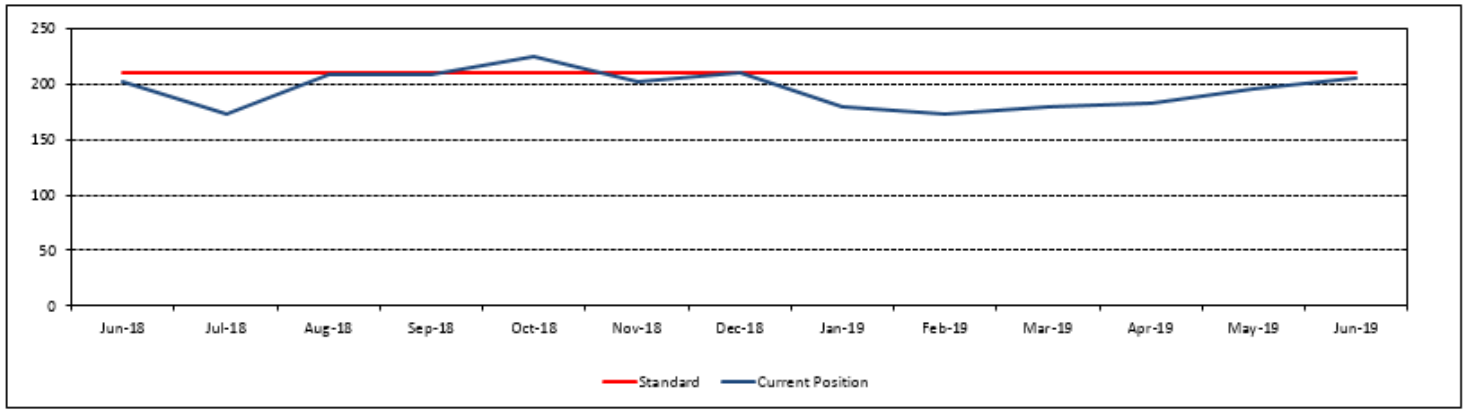
Indicator	Total number of deliveries (births)
Standard	210
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Total number of births appears to be increasing steadily over the last few months and June figures show an increase to 205. The decline appears to reflect the period of the refurbishment which is moving towards completion. Once the refurbishment is fully complete the service is planning a promotion aimed at the public in particular those women who live on the borders of the west Suffolk area.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Promotion of the new Labour Suite following completion of the refurbishment			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

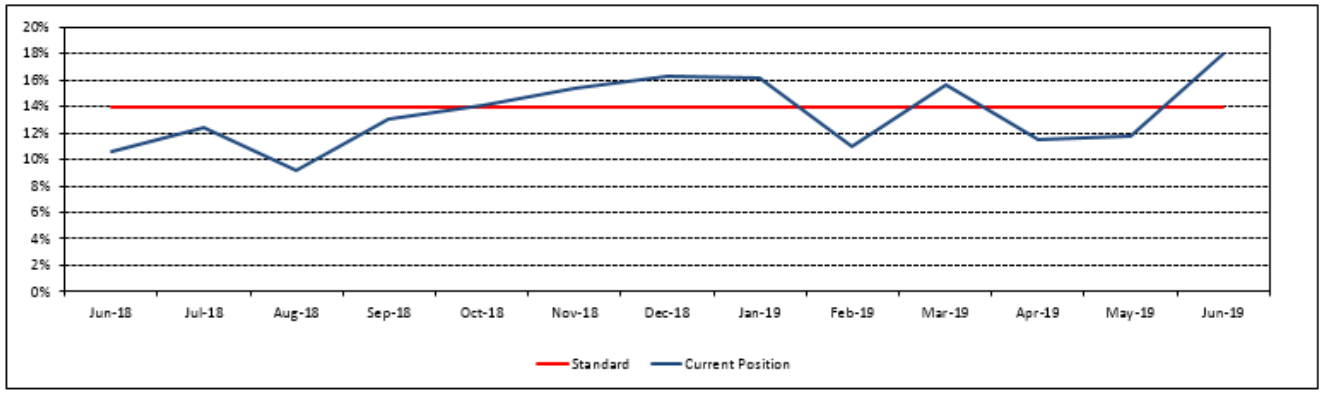
Summary of Current performance & Reasons for under performance

The was a significant rise in Emergency Caesarean Sections in June 18% compared to the previous two months of around 11% Emergency Caesarean Sections include grade 1 2 and grade 3 Caesarean Sections and all three grades had a higher number than usual, however this is reflected in the reduced number of elective Caesarean Sections, this possibly is due to women booked for Elective Caesarean Sections who go into labour early and require urgent Caesarean Sections. It may also be the number of high risk cases this particular month. The service had 7 sets of twins of which 3 required emergency Caesarean Sections. Where expedited birth is required in the first stage of labour Caesarean Sections is the only available option. Despite the increased rate of Emergency Caesarean Sections this month the overall rate is within the standard. The service continues to monitor weekly Caesarean Sections as a learning forum for all staff.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%	14%
Current Position	10.6%	12.4%	9.2%	13.0%	14.1%	15.4%	16.3%	16.2%	11.0%	15.6%	11.5%	11.8%	18.0%

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

Description	Owner	Start	End
Continue to monitor all emergency Caesarean Sections each week led by a consultant obstetrician as a forum for teaching and learning.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

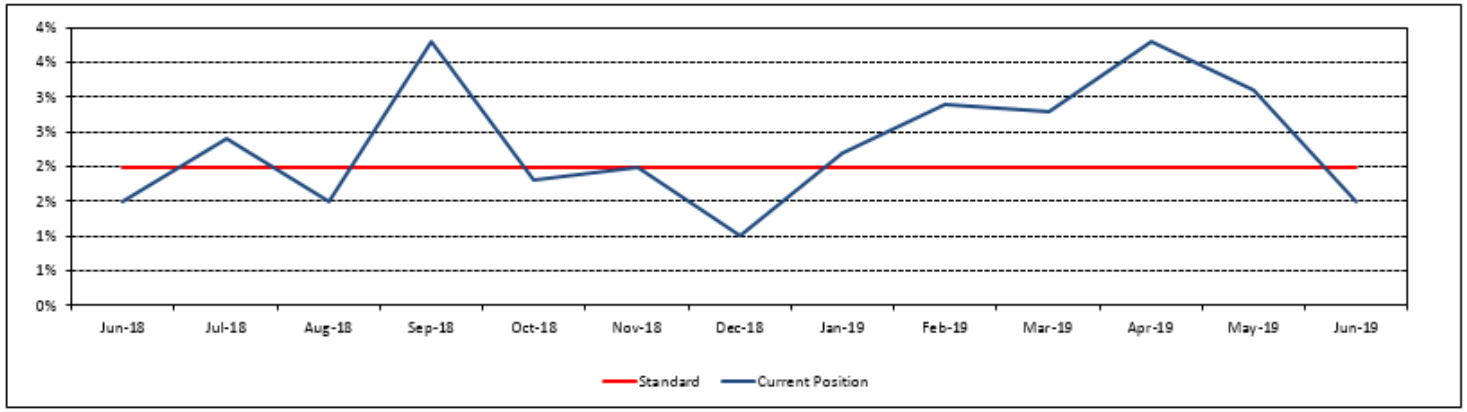
Indicator	Homebirths
Standard	2%
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Having had an increase in homebirths for the previous 4 months the rate has fallen this month. It is not clear why, with the introduction in Continuity of care for home birth it is expected that we see a rise in this rate of women who choose this option for delivery.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Current Position	1.5%	2.4%	1.5%	3.8%	1.8%	2.0%	1.0%	2.2%	2.9%	2.8%	3.8%	3.1%	1.5%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Ongoing promotion of Home birth as part of better Births			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

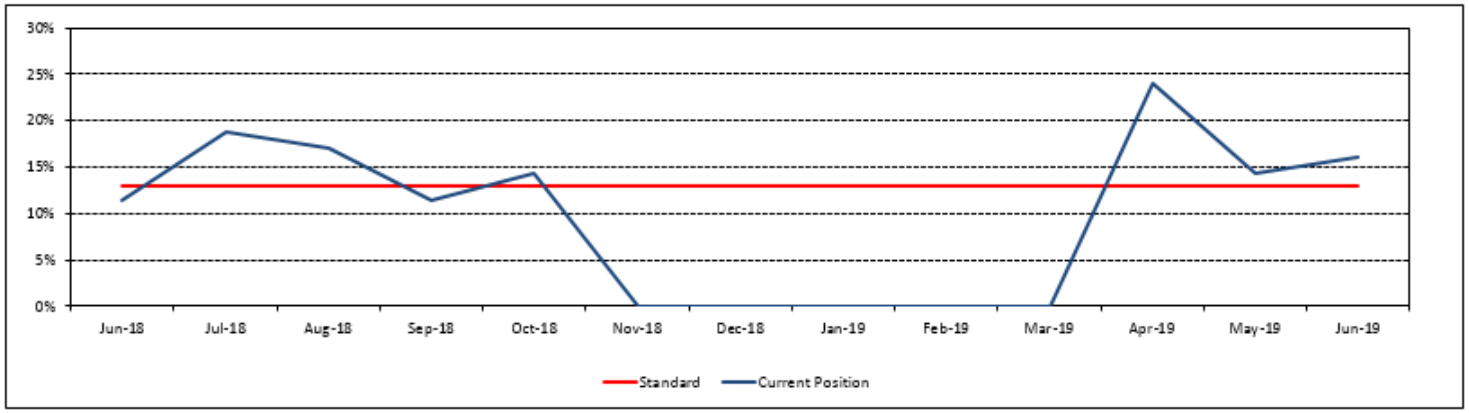
Indicator	Midwifery led birthing unit (MLBU) births
Standard	13%
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

It was agreed that until the refurbishment of the labour Suite is completed the deliveries on Midwifery led birthing unit are not accurate as both high and low risk women are cared for because of the reduced number of available rooms on the Labour Suite. Phase two is due for completion soon and at this point the Labour Suite and Midwifery led birthing unit will be completely separate and accurate data collection of low risk births can resume.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%
Current Position	11.4%	18.8%	17.0%	11.5%	14.4%	NA	NA	NA	NA	NA	24.0%	14.4%	16.1%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Await completion of Labour Suite refurbishment for accurate data collection of low risk births.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

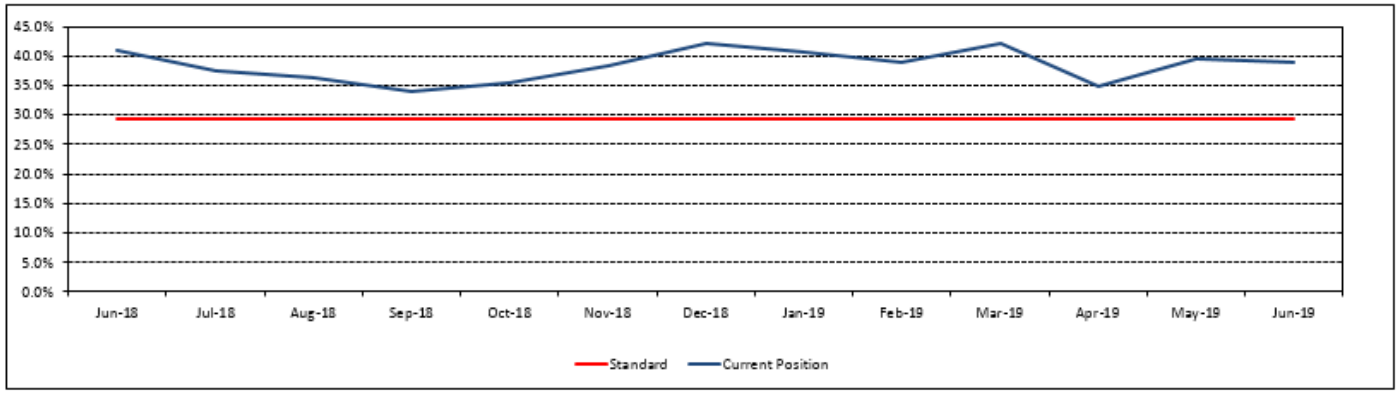
Indicator	Induction of Labour
Standard	29.3%
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

There are a number reasons why Induction of Labour remains above the standard of 29%. When this was set in 2016 there has been many changes to the way we deliver care such as identification of Gestational diabetes, increased scanning and identification of small babies, induction for post maturity. In many of these situations the only option is for an elective Caesarean Section as the services Caesarean Section is generally low this has an impact on this. A recent audit of Induction of Labour identified that the majority of Inductions were appropriate, there was an action to consider whether reasons for Induction of Labour e.g. assisted conceptions such as IVF/macrosomia babies are appropriate and further review agreed.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-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	40.9%	37.6%	36.4%	34.1%	35.5%	38.3%	42.1%	40.8%	39.0%	42.2%	35.0%	39.5%	39.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Further review for Induction of Labour in specific circumstances agreed following a recent audit.			



Putting you first

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

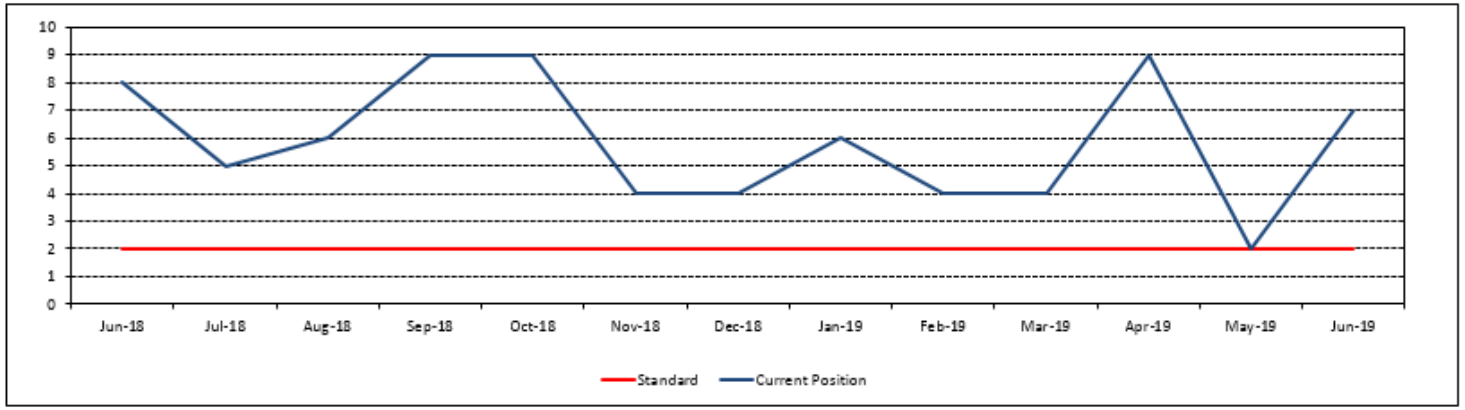
Indicator	Shoulder Dystocia
Standard	2
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Shoulder dystocia is an obstetric emergency, where following delivery of the head the shoulder do not deliver with the next contraction. Whilst the service does not want to deter staff from calling a shoulder dystocia we are aware that staff do not always consider the mechanism of labour and on reviewing the records do not always wait for restitution of the head. This issue has been a focus on PROMPT training. Shoulder Dystocia is not usually predictable and all staff attend PROMPT training for the management of this emergency which is key to good outcomes. There has been no birth injury or maternal injury reported. Shoulder dystocia has a significant impact on a woman's future delivery and place of birth therefore it is important when reporting a Shoulder Dystocia it is accurate.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	2	2	2	2	2	2	2	2	2	2	2	2	2
Current Position	8	5	6	9	9	4	4	6	4	4	9	2	7

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to focus on training staff for this unpredictable emergecy situation.			



Putting you first

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

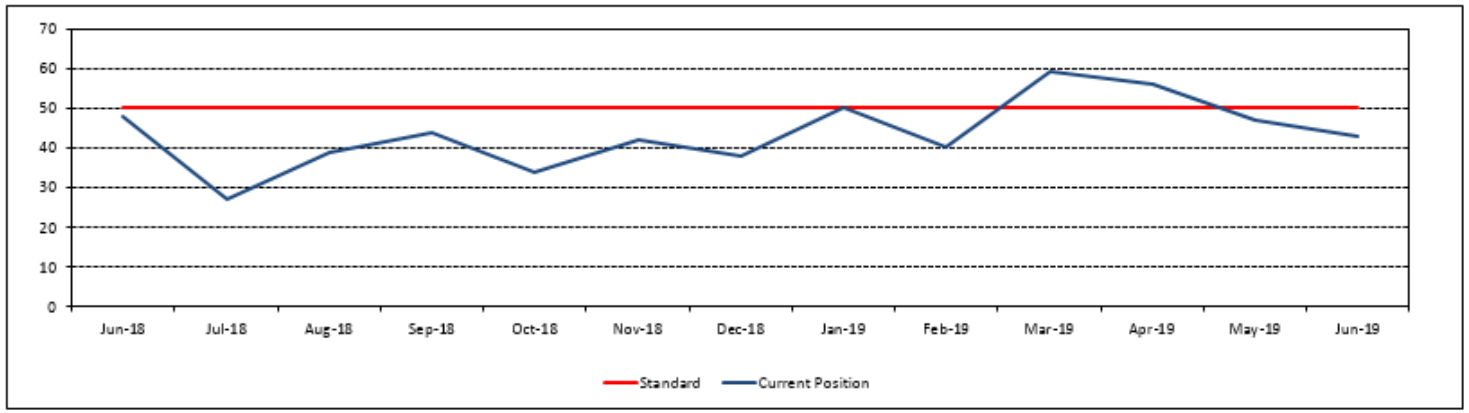
Indicator	Reported Clinical Incidents
Standard	50
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

This month saw a slight fall in incident reporting. It is difficult to know why there was a reduction. It appears that certain staff are more likely to complete datix and all staff are aware they can have help from the maternity risk office to complete datix. The Risk manager meets with all new staff as part of the induction programme. The maternity service has a trigger list of incidents which is clearly displayed in all staff areas. Risky business reminds staff regularly of the requirement to complete datix.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	50	50	50	50	50	50	50	50	50	50	50	50	50
Current Position	48	27	39	44	34	42	38	50	40	59	56	47	43

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Reminder to all staff on Take 5 the importance of completing datix.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

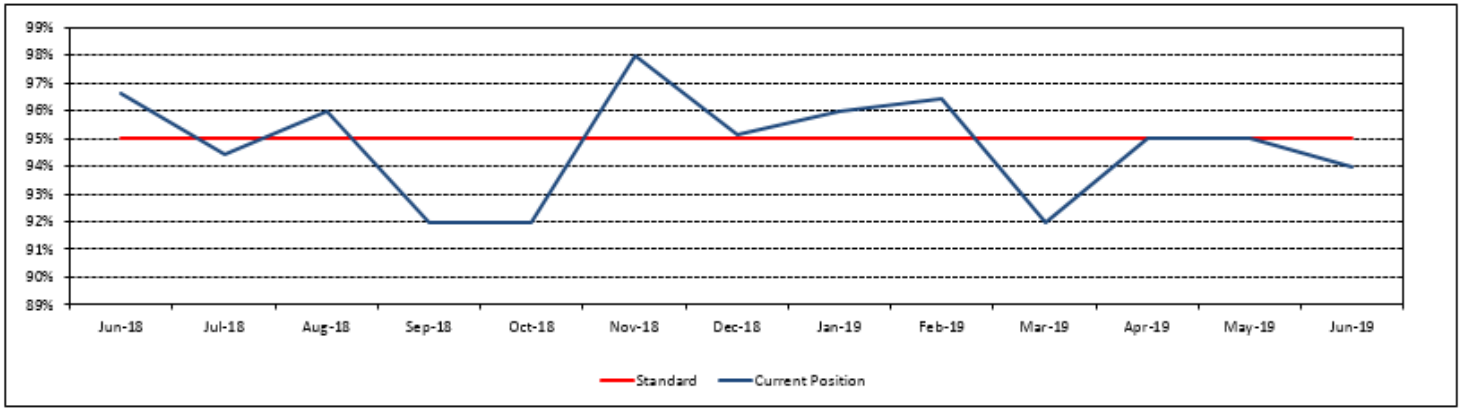
Indicator	Women booked before 12+6 weeks
Standard	95%
Executive Lead	Rowan Procter
Month	Jun-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

There was a decrease in the percentage of women by 12+6 of pregnancy. None were due to the service being unable to offer timely appointment. Included in the figures are women who refer for care late or are unaware of the pregnancy. The reasons given are highlighted to the outpatient services manager each month to monitor.

Month	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	96.6%	94.4%	96.0%	92.0%	92.0%	98.0%	95.1%	96.0%	96.4%	92.0%	95.0%	95.0%	94.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to promote to women the importance of early referral via GP practices, children's services etc.			



9. Winter learning and planning report

To APPROVE the report recommendations

For Approval

Presented by Helen Beck

TRUST BOARD – 26 July 2019

Agenda item:	9			
Presented by:	Helen Beck, Chief Operating Officer			
Prepared by:	Helen Beck, Chief Operating Officer			
Date prepared:	22 July 2019			
Subject:	Winter capacity plan 2019/20			
Purpose:		For information	x	For approval

Executive summary:

This paper provides the board with an update on the current progress with planning for the winter period 2019/20.

This paper sets out the proposal for the utilisation of additional bed capacity over the winter of 2019/20, taking into account the predicted demand for beds and the physical space available.

This paper should be viewed alongside the demand management section of the transformation board report, the nurse staffing and recruitment report and the finance report.

Physical capacity within the organisation is a significant constraining factored in the ability of the Trust to cope with winter pressures. This paper sets out the plan to staff and open the available capacity in a planned and phased way, designating some as planned escalation capacity with an additional area designated as surge capacity to be opened on a more ad hoc basis as demand dictates. The plan takes account of feedback and lessons learnt from winter 18/19 as well as the significantly improved nurse staffing and recruitment plan.

The demand management initiatives referred to in the transformation paper have not currently been assumed to deliver any reduction in the required bed base. Although further work is ongoing across the system to quantify these schemes it is anticipated that any impact will mitigate against growth above that included in the bed model (4%) or reduce the need to open surge capacity.
The board is asked to note progress to date in terms of planning for winter 2019/2020 with a further update to be provided at the September board.

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

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*
	✓	✓	✓		✓	✓	✓

Previously considered by:	Agreed by Divisional Triumvirate
Risk and assurance:	Failure to provide quality care to patients who require admission to hospital. Reputational risks around failure to achieve required standards and targets. Risk to relationships with external agencies.
Legislation, regulatory, equality, diversity and dignity implications	Need to ensure privacy and dignity maintained in additional capacity areas, including same-sex accommodation requirements
Recommendation: For the Board team to note content of paper, and approve the approach	

1.0 Background

During the winter period, the hospital traditionally suffers capacity issues as a consequence of diarrhoea & vomiting outbreaks, flu or exceptionally cold weather spells that inevitably lead to an increase in emergency admissions. In previous years, additional winter beds have been opened to meet this demand, in conjunction with initiatives to improve patient flow.

Despite significant planning, winter 2019/20 was particularly challenging due to staffing shortages and demand levels significantly higher than planned for. A paper outlining lessons learnt was presented to board in May 2019 and the recommendations contained in that paper have been included in the planning for 2019/2020. .

The aim for winter 2019/20 is to finalise plans early to enable the safe and timely implementation of additional capacity to meet demand. It is also recognised that there is a need to address the underlying deficit in bed capacity within the Medicine Division, year-round.

A recognised shortfall in 2018/2019 was the lack of any specific planning for paediatrics and this is currently being addressed within the division through seasonal variations to the consultant job plans.

The physical space available for additional adult bed capacity could include the remaining space on G3,and all of G9, F10 and F14.

We are also pursuing options for the system to purchase 20 additional community beds during the period of peak pressure as we did last winter.

Weekly winter pressures meetings are already in place to monitor and co-ordinate the work streams to deliver additional capacity. These are jointly chaired by the Executive Chief Operating Officer and Executive Chief Nurse.

2.0 Objectives

The proposal outlined below aims to achieve the following objectives:

- Ensure there is sufficient bed capacity on an ongoing basis and for the winter 2019/20 to deliver high quality and safe care in a suitable environment for patients requiring acute hospital beds
- Match the bed demand predictions based on historical demand and expected growth
- Make best use of space available
- Identify the cost impact of additional capacity

3.0 Bed model

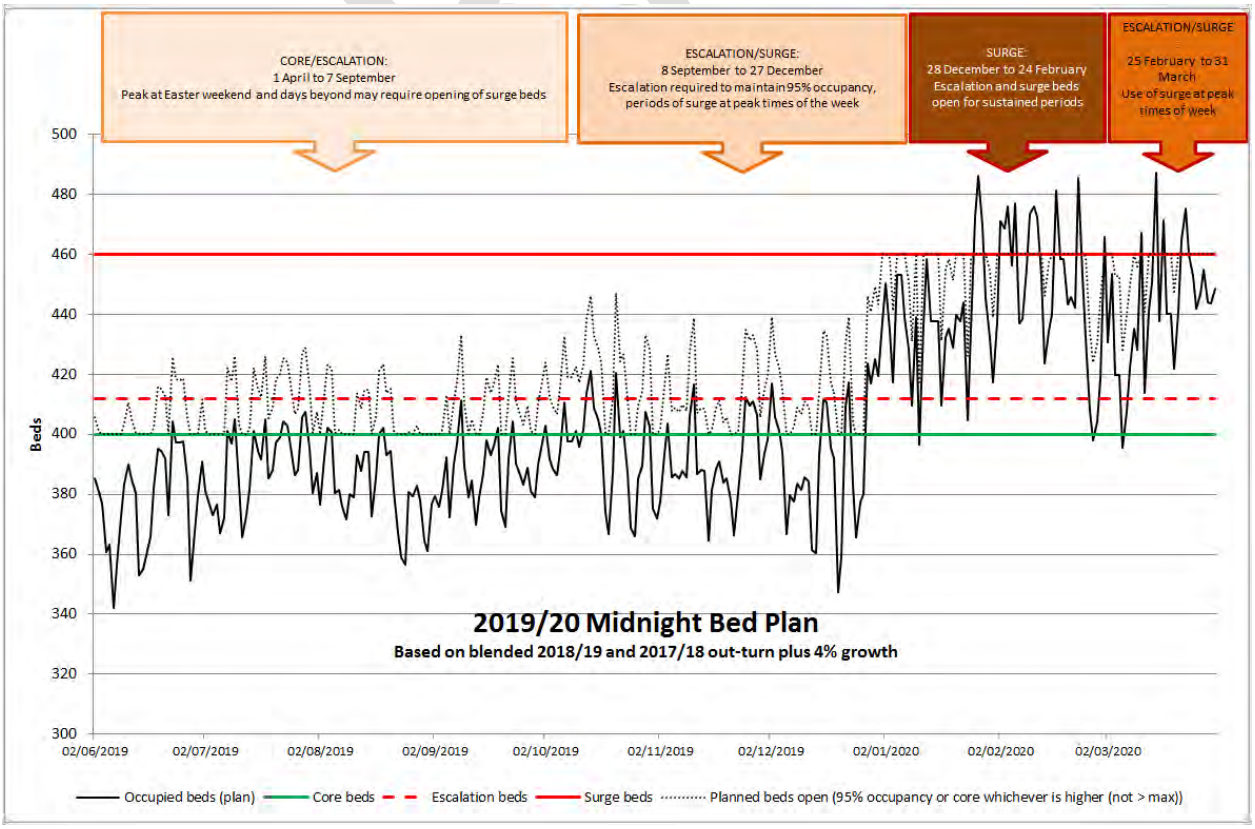
3.1 Physical capacity assumptions

- Availability of additional physical space
    - Potential for 6 beds on F5 and 6 beds on F6 through implementation of the surgical assessment unit. (business case still to be agreed)
    - 13 beds on G3 for an additional 6 months of the year (in reality these have been opened as surge capacity all year)
    - 29 beds on G9
    - 24 beds onF10 following relocation of gynaecology back to F14

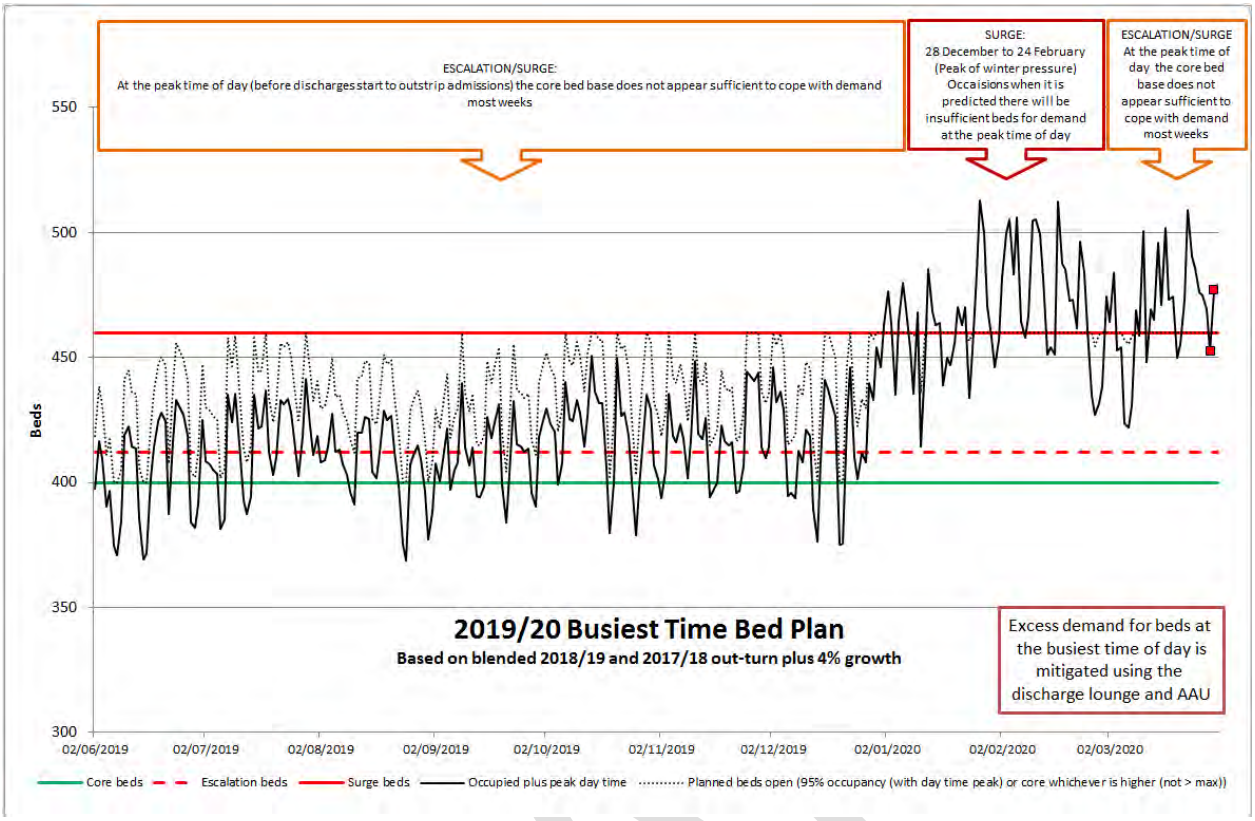
3.2 Bed model activity assumptions

- The bed model assumes 4% non-elective growth year on year although in the new model this can be adjusted to test the impact.
- It should be noted that the SAU model assumes the reduction of 12 beds in surgery; the capacity and demand sides of the model have not currently been adjusted as the business case has not been approved. These beds could be part of escalation or surge capacity with minimal additional staffing.
- The bed model currently includes the two recovery trolley spaces on F8 and the counselling room on G1 as surge capacity. For safety and patient experience reasons it has been agreed that these will be removed from the model and the operational plan.
- In addition the HASU configuration on G8 from 1st September 2019 reduces numbers of beds available by 2, these are currently included in the bed model.
- These reductions will be addressed by meeting the requirement for 70 hours of frailty service at the front door, remodelling GP streaming, and expanding Same Day Emergency Care and the opening of the 5 monitored bays on AAU from 1st September 2019.
- The bed model assumes the use of all beds that have been used in 2018/19 and therefore as a minimum, those beds should be planned for 2019/20. Any efficiencies achieved through patient flow initiatives and admission avoidance will only address the capacity shortfall in the current model
- According to the bed model, the Medicine Division never has sufficient bed capacity and is reliant on opening escalation or outlying patients all year round
- The bed model is currently being refined and therefore the exact numbers may change slightly.
- This year we have modelled capacity requirements at the busiest time of the day as well as at midnight. This clearly shows a greater capacity gap which is mitigated through use of the DWA and AAU.
- This year we have also modelled capacity at a specialty level.

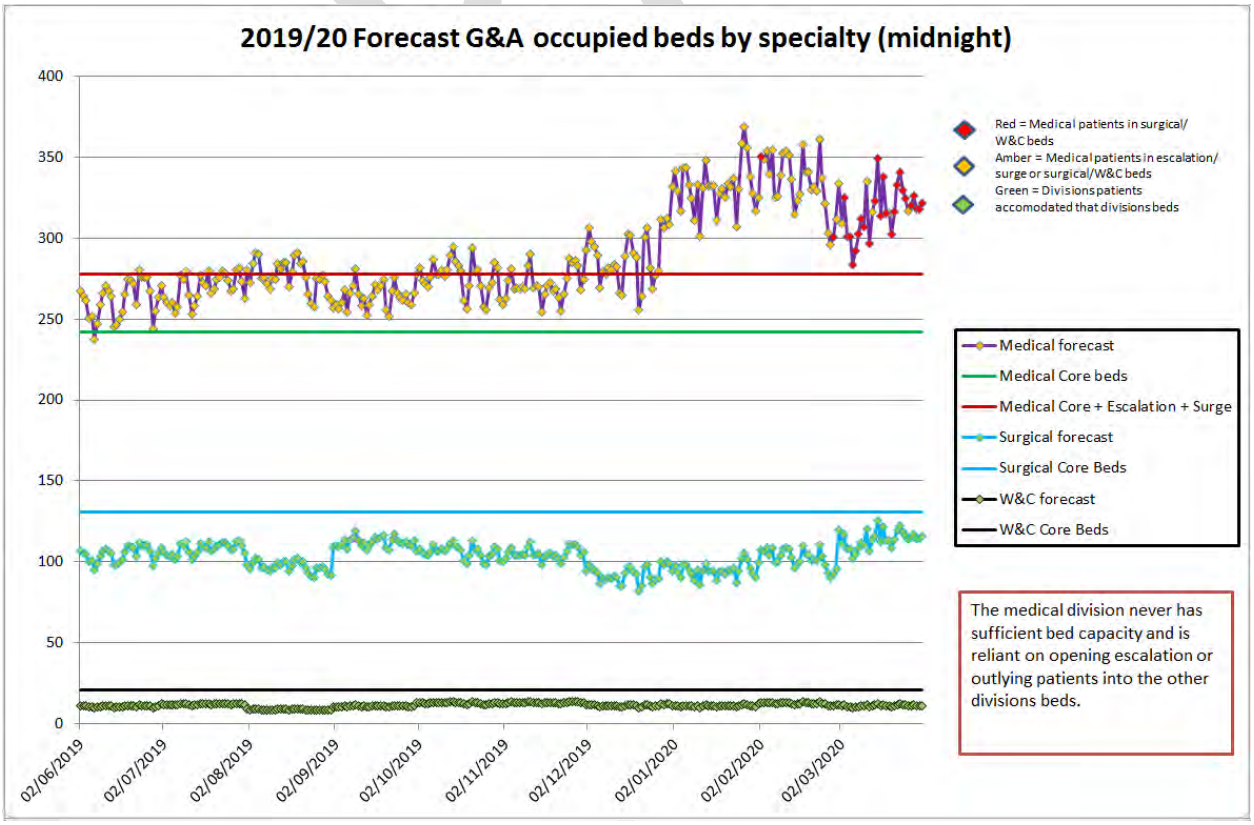
- **Midnight bed plan (beds occupied at midnight):**



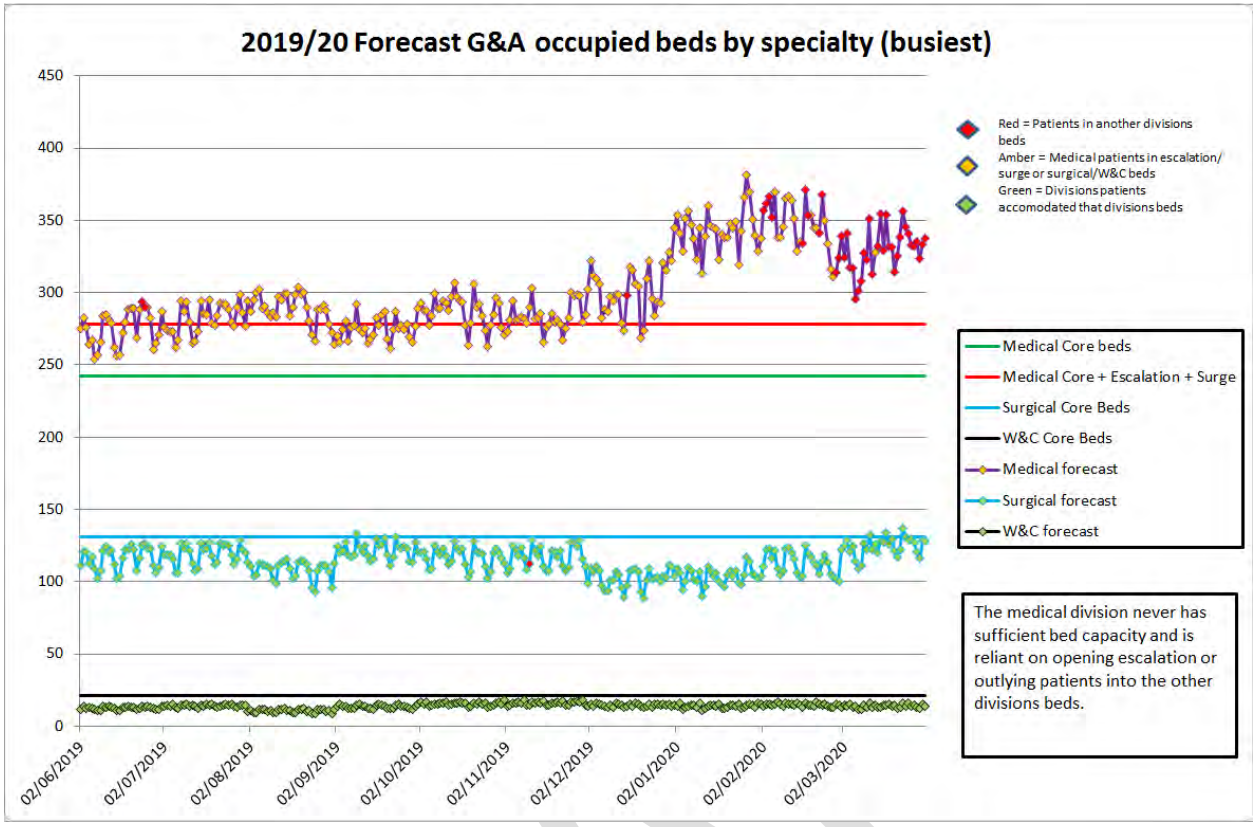
- **Busiest time bed plan (beds occupied at busiest time):**



- **Midnight occupancy:**



- **Busiest time occupancy:**



3.3 Financial assumptions

- Fully opening ward G3 for the winter period is included in the budget for the medicine division
- Fully opening G9 for the winter period is included in the budget for the medicine division
- Assuming that gynaecology relocate to F14 their budget is set at their historic staffing levels
- There is no identified budget for F10
- There is no identified budget for the use of any beds closed in surgery as surge capacity
- Additional support costs may be incurred which are not included in budgets – these are currently being quantified and will need to be subject to operational and financial risk assessment.

In summary escalation capacity is funded and surge capacity is not.

6.0 Capacity Plan

6.1 Physical Capacity

It is proposed that the following capacity is opened in a phased way in line with the predictions contained in the bed model.

- Fully openG3 to 32 beds to increase the medicine core bed base all year round.
- Fully open ward G9 to 30 beds as planned escalation from mid December 2019 to end of May 2020
- Designate 12 beds in surgery released as part of the SAU as surge capacity.
- Use the discharge waiting area overnight as surge capacity.(6 spaces)

- Relocate gynaecology to ward F14 and prepare ward F10 to be used as surge capacity as a last resort in periods of extended high demand
- Continue to work to secure system funding for an additional 20 care home beds through January and February 2020

6.2 Operational and clinical management of escalation capacity

- The winter ward would sit within a defined business unit within the Medicine Division, with an allocated Service Manager, Senior Operations Manager and Matron, with reporting to business unit meetings, Divisional Board and PRM
- To reduce disruption and risk of increased length of stay patients will not be moved just for the last part of discharge planning. This will also support ownership of discharge processes and identification of golden patients by base wards
- A consistent ward manager is vital to the smooth running and high quality of care on the winter ward. The Medicine Division will recruit a ward manager for the additional escalation capacity (G9) , who would then be a peripatetic ward manager when the additional capacity closes. A permanent position is more likely to attract a suitable candidate and there are frequently situations where a replacement or “buddy” ward manager is required within the Trust.
- In addition, a care co-ordinator and ward clerk will be recruited permanently, who will work on the winter ward and subsequently as a mobile resource
- It is recommended that a locum winter consultant is recruited, plus 2 junior doctors to support the ward
- The Medicine Division also plans to explore a dedicated medical lead role for winter planning, to take corporate responsibility for delivering winter plans and providing leadership to medical colleagues in embedding patient flow initiates.

6.3 Operational and clinical management of surge capacity.

- Opening of surge capacity in established areas will be managed by the patient flow and matron of the day teams who will identify the capacity requirement and manage the movement of staff accordingly as per normal business as usual arrangements.
- Ward F10 will be prepared for use and secured to maintain adequate stocks of equipment.
- A potential leadership team will be identified for ward F10
- The current recruitment plan indicates that we will not be reliant on bank and agency staff to run core capacity by January 2020, therefore we anticipate having sufficient temporary staffing available to open F10 as a surge ward if required.

7.0 Demand Management

As noted in this month’s transformation report there are a number of Trust and system wide demand management initiatives currently in development. The key initiatives aimed at reducing demand for beds are:

- Ongoing development of Same Day Emergency Care model including frailty, AEC and SAU, to avoid unnecessary overnight admissions
    - Surgical Assessment Unit and surgical Ambulatory emergency care business case
    - ESICST supporting Frailty model test and learn during August to assess potential impact
- Expansion of Pathway 1 as planned, to include the winter ward and also to include reciprocal arrangements with neighbouring CCG areas to expedite discharge of out of area patients
- Implementation of virtual ward
- Increase community IV therapy assessment and delivery through use of Baxter pumps

- Stepping home and Lofty Heights transformation funded initiatives
- High Intensity Users project
- Care Home project
- Management of Stranded patients

Currently no assumptions in terms of bed savings have been factored into the capacity plan, pending the conclusion of the system wide demand management work in August. Potential bed savings from each scheme will be identified and mapped into a modelling tool which can then be monitored for delivery on a weekly/ monthly basis over the winter period.

8.0 Conclusion

Planning for winter 2019/202 is well underway across the organisation, led jointly by the Executive Chief Operating Officer and the Executive Chief Nurse. Currently recruitment plans indicate that we will have sufficient staff to open planned escalation throughout the winter period and also ad hoc surge capacity when required through the use of temporary staffing. Funding for planned escalation has been identified within budgets although any additional surge capacity required will result in a cost pressure to the Trust. Further work is required to finalise the impact of the various system and Trust demand management initiatives, which will then be mapped into a demand management model to enable close monitoring of delivery over the winter period.
A further update to this paper will be provided to the September Board outlining the final details of the winter capacity and demand plan.

10. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – 26 July 2019

Agenda item:	10			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	19th July 2019			
Subject:	Finance and Workforce Board Report – June 2019			
Purpose:	x	For information		For approval

Executive summary:
The reported I&E for June 2019 is a deficit of £914k, against a planned deficit of £629k. This results in an adverse variance of £284k in June (£832k YTD).

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 £4m, as well as escalation costs to fund winter pressures of around £1m.

The reported forecast assumes we deliver this recovery plan and will therefore receive all our PSF (£10.1m).The June YTD position includes PSF of £1.9m including £0.9m that relates to financial performance.

Across the STP we have been asked to reduce our capital programme by 20% - ie a reduction in the Trusts capital programme of £3.7m. This will have a significant impact on our capital programme, most notably Theatre 1, ED development and the roof replacement. The proposal is that these schemes are delayed into the early part of 2020-21

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

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

Previously considered by:	*This report is produced for the monthly trust board meeting only*
Risk and assurance:	*These are highlighted within the report*
Legislation, regulatory, equality, diversity and dignity implications	*None*
Recommendation: *The Board is asked to review this report*	

FINANCE AND WORKFORCE REPORT
June 2019 (Month 3)

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

Financial Summary

I&E Position YTD	£2.4m	loss
Variance against plan YTD	-£0.8m	adverse
Movement in month against plan	-£0.3m	adverse
EBITDA position YTD	-£1.5m	adverse
EBITDA margin YTD	-2.3%	adverse
Total PSF Received	£1.932m	accrued
Cash at bank	£1.5m	

Executive Summary

- The planned deficit for the year to date was £1.6m but the actual deficit was £2.4m, an adverse variance of £0.8m.
- 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 £4m, as well as escalation costs to fund winter pressures of around £1m.
- The reported forecast assumes we deliver this recovery plan and will therefore receive all our PSF (£10.1m).
- Across the STP we have been asked to reduce our capital programme by 20% - ie a reduction in the Trusts capital programme of £3.7m

Key Risks

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

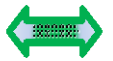
SUMMARY INCOME AND EXPENDITURE ACCOUNT - June 2019	Jun-19			Year to date			Year end forecast		
	Budget £m	Actual £m	Variance F/(A) £m	Budget £m	Actual £m	Variance F/(A) £m	Budget £m	Actual £m	Variance F/(A) £m
NHS Contract Income	17.1	17.4	0.3	51.9	52.4	0.5	209.6	212.1	2.5
Other Income	3.1	2.8	(0.3)	9.1	8.7	(0.4)	37.4	36.1	(1.3)
Total Income	**20.2**	**20.2**	**(0.0)**	**61.0**	**61.1**	**0.1**	**247.0**	**248.2**	**1.2**
Pay Costs	14.1	14.3	(0.2)	42.3	42.8	(0.4)	170.0	170.8	(0.8)
Non-pay Costs	6.4	6.5	(0.2)	19.3	19.8	(0.6)	75.3	76.5	(1.2)
Operating Expenditure	**20.5**	**20.8**	**(0.4)**	**61.6**	**62.6**	**(1.0)**	**245.4**	**247.3**	**(2.0)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**(0.3)**	**(0.6)**	**(0.4)**	**(0.6)**	**(1.5)**	**(0.9)**	**1.7**	**0.9**	**(0.7)**
Depreciation	0.7	0.6	0.1	2.0	1.8	0.2	7.9	7.4	0.5
Finance costs	0.3	0.4	(0.0)	1.0	1.0	(0.1)	3.9	3.7	0.2
SURPLUS/(DEFICIT)	**(1.3)**	**(1.6)**	**(0.3)**	**(3.5)**	**(4.3)**	**(0.8)**	**(10.1)**	**(10.1)**	**(0.0)**
Provider Sustainability Funding (PSF)									
PSF - Financial Performance	0.6	0.6	0.0	1.9	1.9	0.0	10.1	10.1	0.0
SURPLUS/(DEFICIT) incl PSF	**(0.6)**	**(1.0)**	**(0.3)**	**(1.6)**	**(2.4)**	**(0.8)**	**0.0**	**(0.0)**	**(0.0)**

FINANCE AND WORKFORCE REPORT - JUNE 2019

Contents:

Key:

Performance better than plan and improved in month	
Performance better than plan but worsened in month	
Performance worse than plan but improved in month	
Performance worse than plan and worsened in month	

Performance better than plan and maintained in month	
Performance worse than plan and maintained in month	
Performance meeting target	
Performance failing to meet target	

FINANCE AND WORKFORCE REPORT - JUNE 2019

Income and Expenditure Summary as at June 2019

The reported I&E for June 2019 is a deficit of £914k, against a planned deficit of £629k. This results in an adverse variance of £284k in June (£832k YTD).

We are planning to break even in 2019-20, but the current position indicates a deficit of £4m plus costs associated with additional winter capacity (c. £1m).

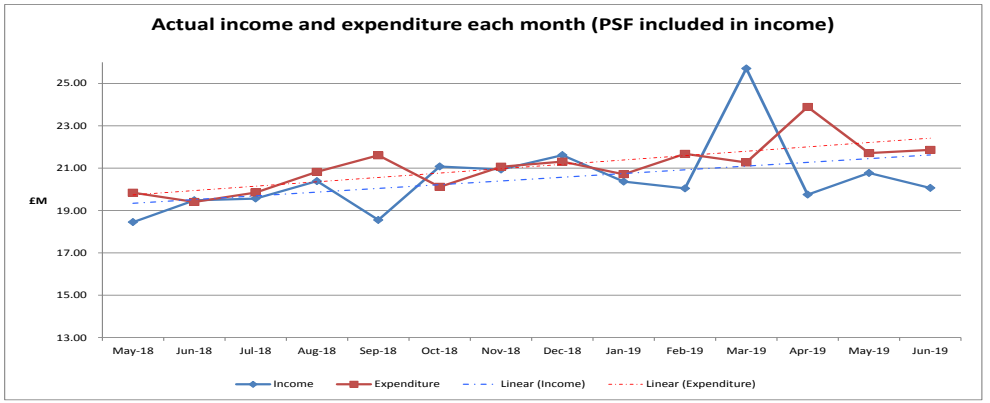
The YTD variance relates to demand being significantly higher than planned and the costs of extra capacity to meet this demand being beyond that funded by around £200k per month. The Trust has also incurred non-recurring costs relating to overseas recruitment (£200k) and community equipment (£150k).

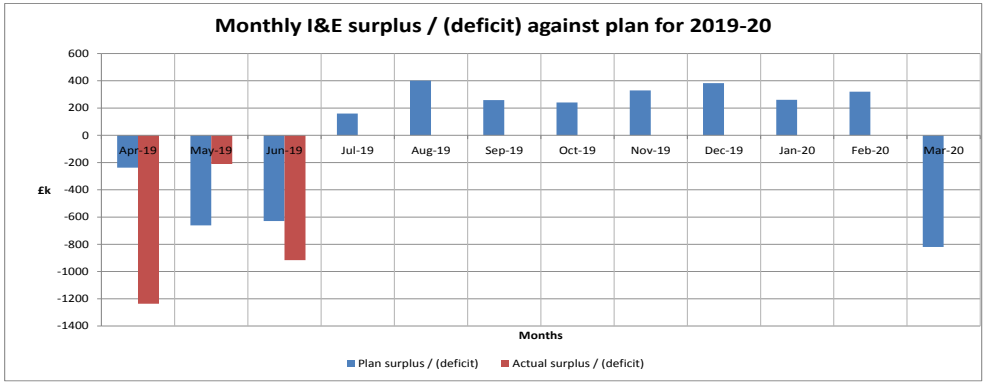
Failing to meet our financial control total would have a detrimental impact on our PSF since £6.0m of our PSF relates to financial performance. The reported forecast assumes we enact a recovery plan that will ensure we meet our break even control total by the year end and will therefore receive all our PSF (total £10.1m). Therefore the June YTD position includes PSF of £1.9m including £0.9m that relates to financial performance.

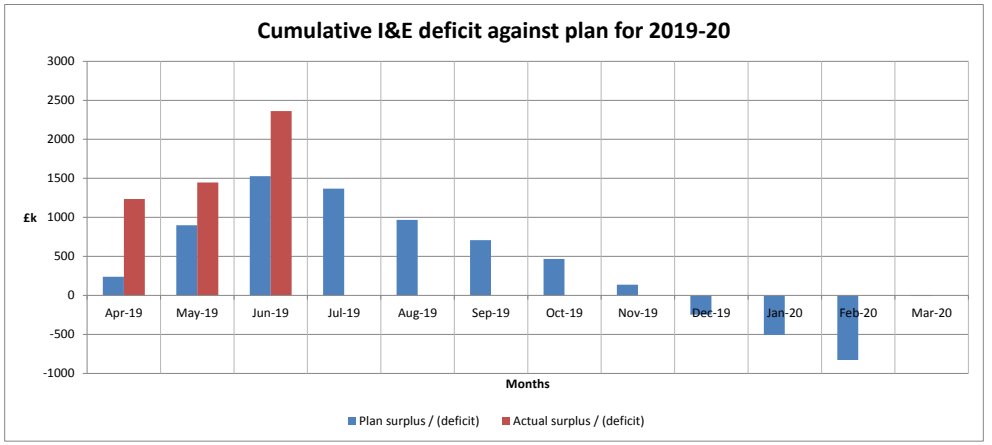
Each Division is preparing a recovery plan in order to deliver the funded activity within their 2019-20 budget. These will be discussed and prioritised over the coming days in order to compile a Trust wide recovery plan.

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)	(629)	(914)	(284)	↓	Red
YTD surplus / (deficit)	(1,528)	(2,360)	(832)	↑	Red
Forecast surplus / (deficit)	9	9	0	↔	Amber
EBITDA (excl STF) YTD	(519)	(1,466)	(947)	↑	Red
EBITDA (%)	(0.8%)	(2.3%)	(1.5%)	↔	Red
Clinical Income YTD	(51,908)	(52,355)	447	↑	Green
Non-Clinical Income YTD	(11,058)	(10,641)	(418)	↑	Amber
Pay YTD	42,303	42,702	(399)	↑	Red
Non-Pay YTD	22,192	22,654	(462)	↑	Red
CIP target YTD	2,341	2,295	(46)	↓	Amber



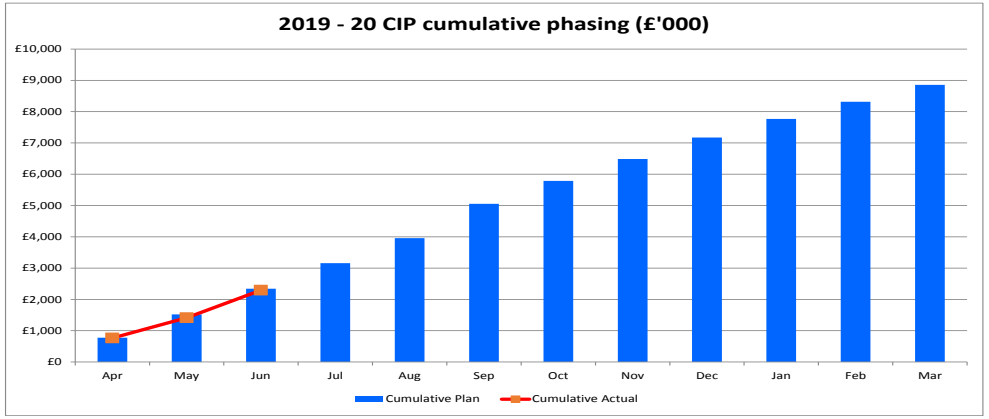


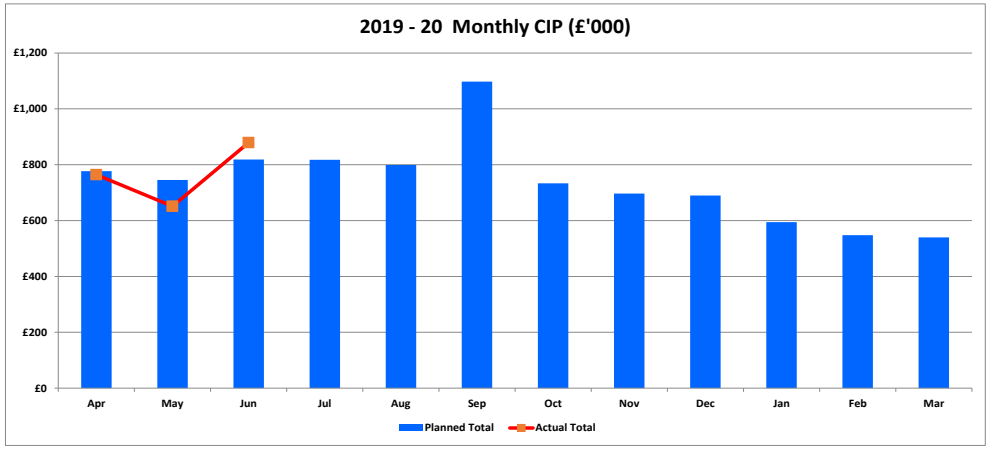


Cost Improvement Programme (CIP) 2019-20

In order to deliver the Trust's control target in 2019-20 we needed to deliver a CIP of £8.9m (4%). In June we planned to achieve £1,522k (26.4% of the annual plan) but achieved £2,295k (£46k behind plan).

Recurring/Non Recurring Summary	2019-20 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	100	25	19
Procurement	712	169	195
Activity growth	-	-	-
Additional sessions	15	4	0
Community Equipment Service	575	253	222
Drugs	1,787	537	495
Estates and Facilities	79	18	16
Other	1,344	166	391
Other Income	1,743	527	373
Pay controls	361	85	71
Service Review	20	-	-
Staffing Review	1,076	287	175
Theatre Efficiency	178	20	28
Recurring Total	**7,992**	**2,091**	**1,986**
Non-Recurring			
Estates and Facilities	87	32	-
Other	403	90	5
Pay controls	376	128	304
Non-Recurring Total	**865**	**250**	**309**
Grand Total	**8,856**	**2,341**	**2,295**

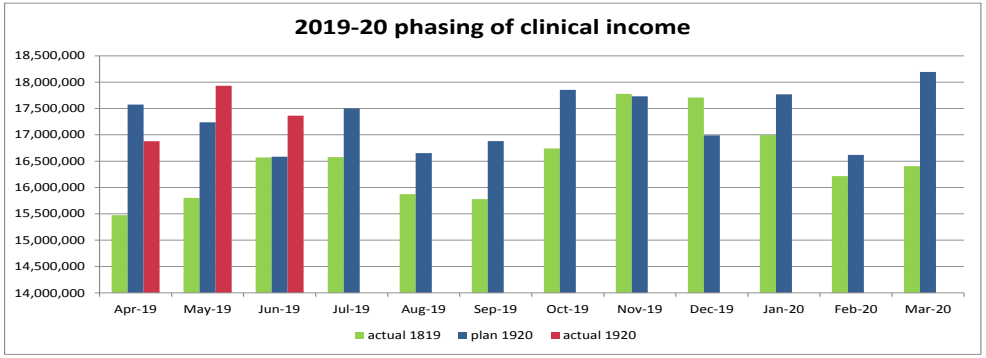




FINANCE AND WORKFORCE REPORT - JUNE 2019

Income Analysis

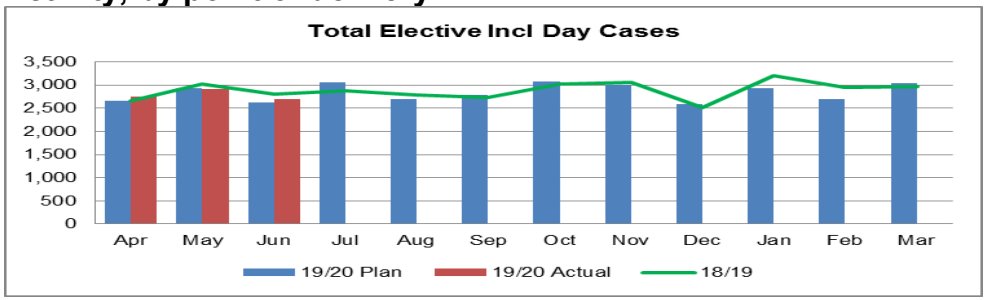
The chart below demonstrates the phasing of all clinical income plan for 2019-20, including Community Services. This phasing is in line with phasing of activity.

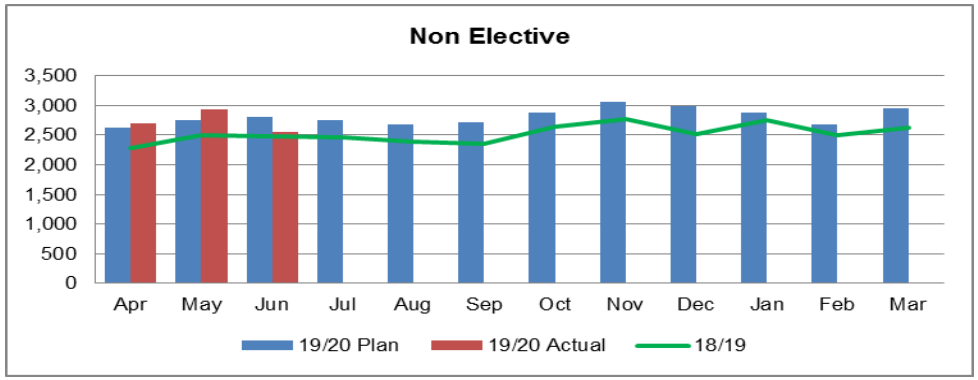


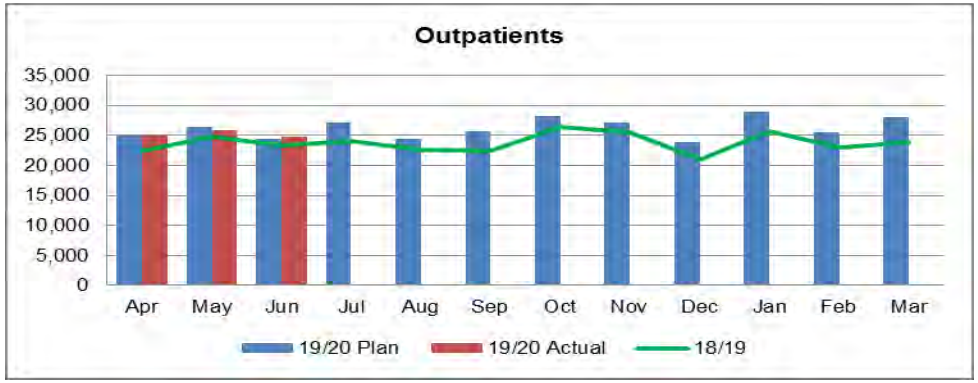
The income position was ahead of plan for June. The main area of over performance was Elective activity.

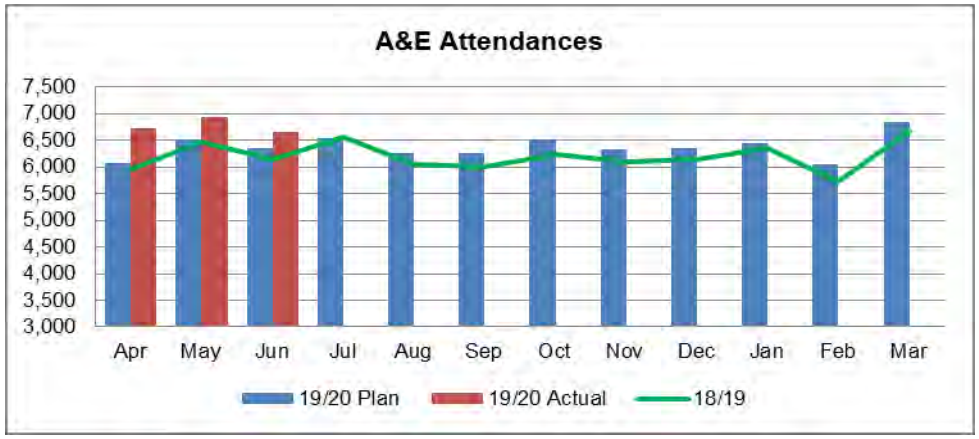
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	904	954	51	2,693	2,904	211
Other Services	1,512	1,725	213	4,683	5,011	327
CQUIN	166	168	3	503	506	3
Elective	2,568	2,730	162	8,087	7,998	(89)
Non Elective	6,133	5,972	(162)	18,174	18,184	10
Emergency Threshold Adjustment	(341)	(341)	0	(1,009)	(1,009)	0
Outpatients	2,930	3,000	70	9,113	9,117	3
Community	3,221	3,215	(6)	9,663	9,645	(18)
Total	**17,093**	**17,423**	**330**	**51,908**	**52,355**	**447**

Activity, by point of delivery

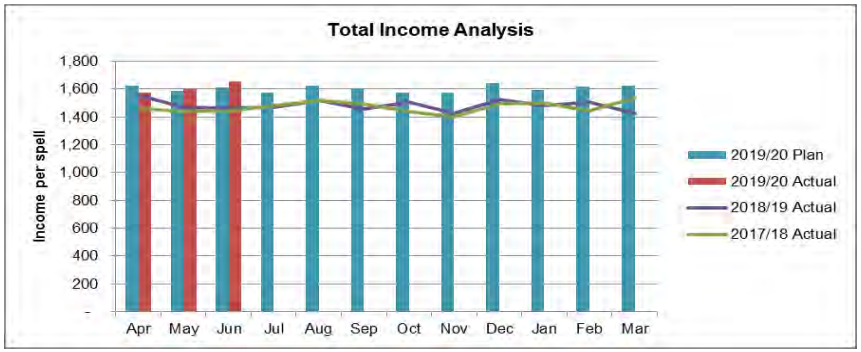


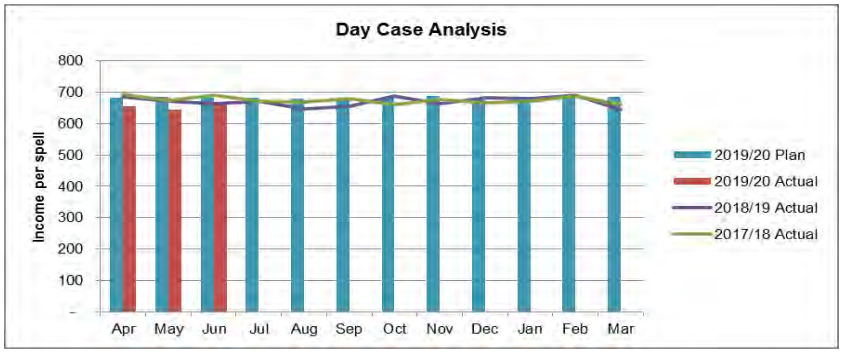


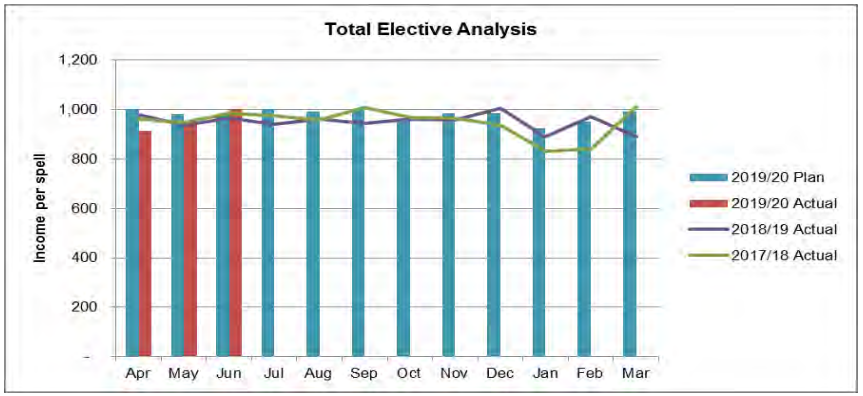


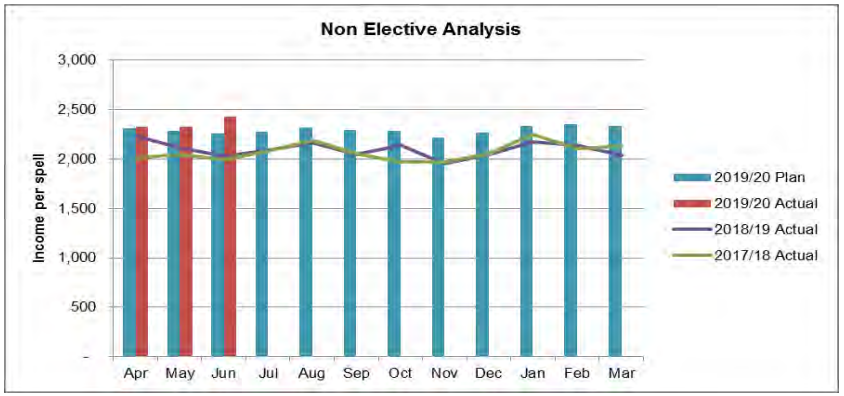


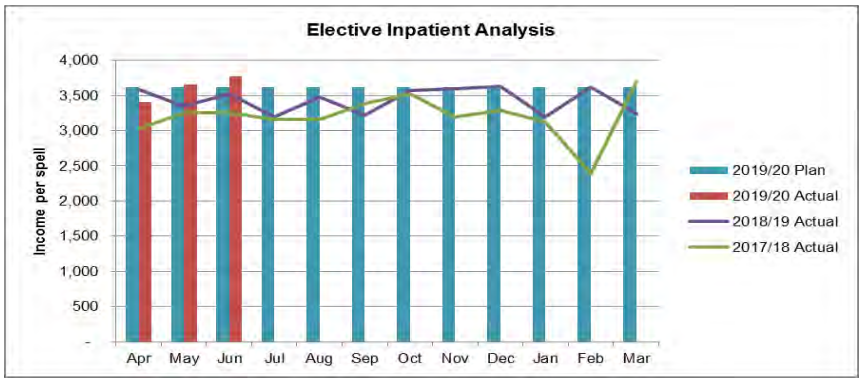
Trends and Analysis

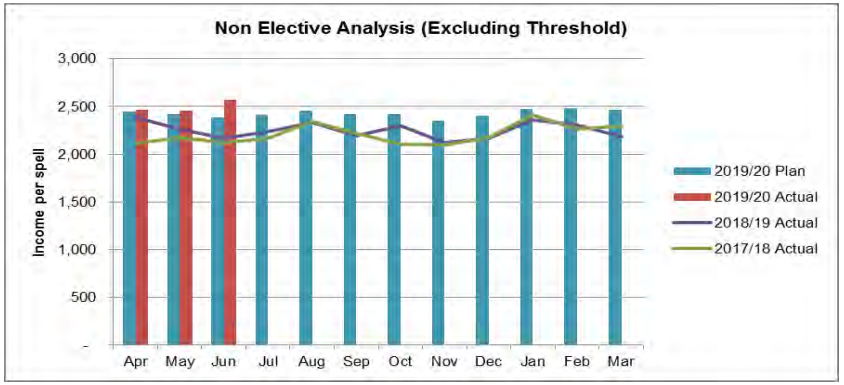












FINANCE AND WORKFORCE REPORT - JUNE 2019

Workforce

Monthly Expenditure (£) Acute services only				
As at June 2019	Jun-19	May-19	Jun-18	YTD 2019/20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**12,396**	**12,437**	**11,092**	**37,195**
Substantive Staff	11,116	10,777	9,943	33,092
Medical Agency Staff (includes 'contracted in' staff)	150	92	167	424
Medical Locum Staff	240	134	224	660
Additional Medical sessions	213	313	248	835
Nursing Agency Staff	181	160	89	495
Nursing Bank Staff	282	318	231	863
Other Agency Staff	107	48	20	192
Other Bank Staff	135	118	117	404
Overtime	167	179	102	567
On Call	71	66	60	204
Total temporary expenditure	1,546	1,428	1,259	4,643
Total expenditure on pay	**12,662**	**12,205**	**11,201**	**37,735**
Variance (F/(A))	(266)	232	(110)	(540)
Temp Staff costs % of Total Pay	12.2%	11.7%	11.2%	12.3%
Memo : Total agency spend in month	438	300	276	1,111

Monthly Whole Time Equivalents (WTE) Acute Services only			
As at June 2019	Jun-19	May-19	Jun-18
	WTE	WTE	WTE
Budgeted WTE in month	**3,323.6**	**3,400.3**	**3,130.9**
Employed substantive WTE in month	2956.93	2927.92	2771.73
Medical Agency Staff (includes 'contracted in' staff)	10.94	7.79	11.48
Medical Locum	17.94	12.77	20.84
Additional Sessions	16.22	21.05	17.79
Nursing Agency	26.07	22.41	17.55
Nursing Bank	79.3	81.85	73.62
Other Agency	10.1	6.42	5.71
Other Bank	59.51	56.37	56.46
Overtime	46.93	47.76	30.59
On call Worked	6.82	6.38	7.33
Total equivalent temporary WTE	**273.8**	**262.8**	**241.4**
Total equivalent employed WTE	**3,230.8**	**3,190.7**	**3,013.1**
Variance (F/(A))	92.9	209.6	117.8
Temp Staff WTE % of Total Pay	8.5%	8.2%	8.0%
Memo : Total agency WTE in month	47.1	36.6	34.7
Sickness Rates (May / Apr)	3.55%	3.39%	3.79%
Mat Leave	2.73%	3.01%	2.56%

Monthly Expenditure (£) Community Service Only				
As at June 2019	Jun-19	May-19	Jun-18	YTD 2019-20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,703**	**1,687**	**1,516**	**5,108**
Substantive Staff	1,563	1,595	1,473	4,716
Medical Agency Staff (includes 'contracted in' staff)	13	7	12	32
Medical Locum Staff	4	5	3	17
Additional Medical sessions	4	0	1	5
Nursing Agency Staff	10	30	6	51
Nursing Bank Staff	25	35	12	96
Other Agency Staff	(12)	5	13	(0)
Other Bank Staff	3	8	8	17
Overtime	9	5	6	21
On Call	4	3	3	11
Total temporary expenditure	60	97	63	250
Total expenditure on pay	**1,623**	**1,692**	**1,536**	**4,966**
Variance (F/(A))	80	(5)	(20)	141
Temp Staff costs % of Total Pay	3.7%	5.7%	4.1%	5.0%
Memo : Total agency spend in month	11	42	30	82

Monthly Whole Time Equivalents (WTE) Community Services Only			
As at June 2019	Jun-19	May-19	Jun-18
	WTE	WTE	WTE
Budgeted WTE in month	**528.62**	**531.17**	**485.56**
Employed substantive WTE in month	476.72	478.09	473.95
Medical Agency Staff (includes 'contracted in' staff)	0.85	0.44	0.74
Medical Locum	0.35	0.35	0.35
Additional Sessions	0.00	0.00	0.00
Nursing Agency	1.53	4.19	1.01
Nursing Bank	6.91	8.88	3.78
Other Agency	2.23	1.58	4.41
Other Bank	0.68	1.46	3.02
Overtime	2.62	1.68	2.02
On call Worked	0.00	0.00	0.04
Total equivalent temporary WTE	**15.2**	**18.6**	**15.4**
Total equivalent employed WTE	**491.9**	**496.7**	**489.32**
Variance (F/(A))	36.73	34.50	(3.76)
Temp Staff WTE % of Total Pay	3.1%	3.7%	3.1%
Memo : Total agency WTE in month	4.6	6.2	6.2
Sickness Rates (May /April)	4.29%	4.13%	3.67%
Mat Leave	2.55%	2.81%	3.11%

FINANCE AND WORKFORCE REPORT - JUNE 2019

Pay Trends and Analysis

Nursing – Staffing levels and Recruitment

There has been discussion around nursing levels and the recruitment strategy to fill both vacant positions (the majority of which are currently covered by temporary staff) and additional capacity (essentially to cover winter pressures).

Staffing levels

The tables below compare actual registered and unregistered nursing within ward based and non-ward based services between April 2018 and June 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 15 months there has been a total increase in nursing of around 56 WTEs in ward based areas.

Nursing WTE Actual Increase / (Decrease)

	April 18 to April 19			May 18 to May 19			June 18 to June 19			April 18 to June 19		
	Ward Based	Non Ward Based	Total	Ward Based	Non Ward Based	Total	Ward Based	Non Ward Based	Total	Ward Based	Non Ward Based	Total
Registered	7.22	31.1	**38.32**	(4.58)	29.61	**25.03**	29.84	28.32	**58.16**	(0.73)	19.75	**19.02**
Unregistered	43.22	6.26	**49.48**	78.29	5.42	**83.71**	73.31	4.77	**78.08**	57.07	6.08	**63.15**
Total	**50.44**	**37.36**	**87.80**	**73.71**	**35.03**	**108.74**	**103.15**	**33.09**	**136.24**	**56.34**	**25.83**	**82.17**

Nursing WTE % Increase / (Decrease)

	April 18 to April 19			May 18 to May 19			June 18 to June 19		
	Ward Based	Non Ward Based	Total	Ward Based	Non Ward Based	Total	Ward Based	Non Ward Based	Total
Registered	1.3%	6.0%	**3.6%**	(0.8%)	5.8%	**2.4%**	6%	5.5%	**5.7%**
Unregistered	12.5%	4.3%	**10.1%**	24.6%	3.8%	**18.1%**	22.3%	3.3%	**16.4%**
Total	**5.7%**	**5.6%**	**5.7%**	**8.6%**	**5.3%**	**7.2%**	**12.2%**	**5.0%**	**9.1%**

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 1.66 WTE.

WTEs incl A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19
Average Beds	445	462	432	458	430	467
Registered WTEs	404	406	406	398	378	408
Unregistered WTEs	313	354	286	362	297	367
Total	717	760	692	760	675	775

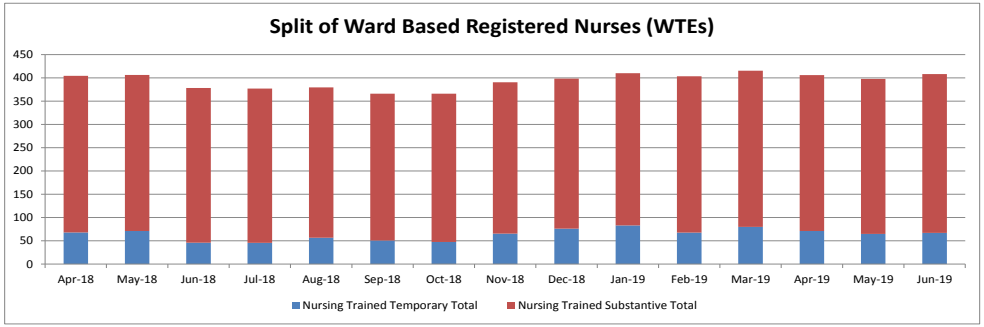
All wards incl A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19
Registered per bed	0.91	0.88	0.94	0.87	0.88	0.87
Unregistered per bed	0.70	0.77	0.66	0.79	0.69	0.79
Total Nursing per bed	1.61	1.64	1.60	1.66	1.57	1.66

Excluding A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19
Registered per bed	0.76	0.73	0.79	0.73	0.75	0.72
Unregistered per bed	0.65	0.72	0.61	0.74	0.64	0.73
Total Nursing per bed	1.42	1.45	1.31	1.47	1.39	1.45

The average funded establishment for a 32 bed ward (G4, G5 F3, F5, F6) as at June 19 is 19.3 WTE registered and 19.7 WTE unregistered, which is a funded ratio of around 0.63 WTE of both registered and unregistered nurses per bed.

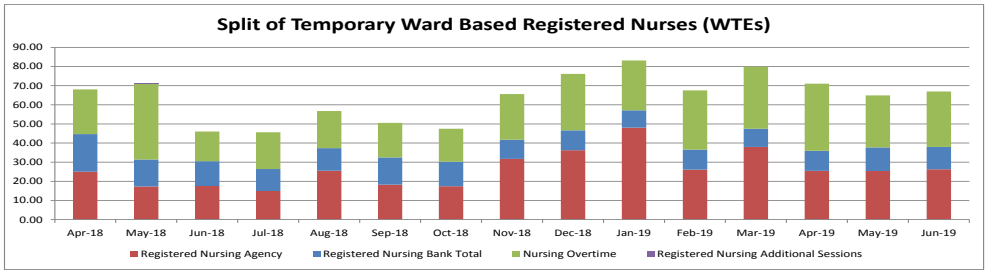
The 'excluding A&E' table above suggests we currently have staffing levels higher than this (although further analysis needs to be done to ensure that the WTE used in calculating this ratio are only employed in ward/bed based areas).

Excluding escalation areas there were around 83 WTE vacancies by the end of June 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.

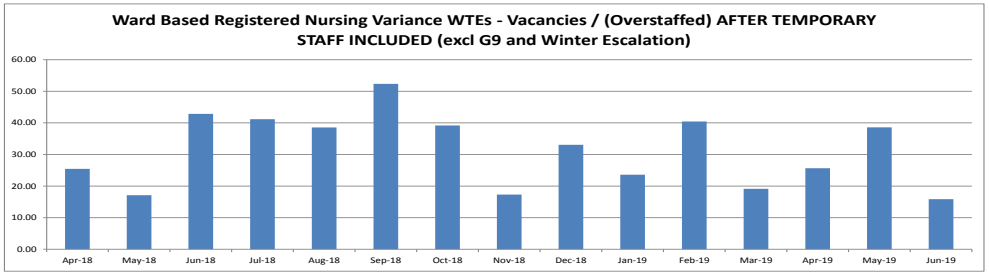


We used 66.9 temporary WTEs to fill the majority of vacant posts during June.

FINANCE AND WORKFORCE REPORT - JUNE 2019



However, after using temporary nursing staff there remained 15.9 WTE uncovered Ward Based Registered Nursing Vacancies during June 2019



Division	Ward Area	Plan April 19	Actual April 19	NET Vacancies (over / (under)) April 19	Sum of plan may 19	Sum of Actual may 19	NET vacancies (over / (under)) May 19	Sum of plan june 19	Sum of Actual june 19	NET vacancies (over / (under)) June 19
Medical Services	A&E Medical Staff	6.12	4.11	(2.01)	6.12	6.06	(0.06)	6.12	4.12	(2.00)
	Accident & Emergency	61.81	63.38	1.57	61.81	55.36	(6.45)	61.81	65.7	3.89
	C.C.U.	0	0	0.00	0	0.03	0.03	0	1	1.00
	Ward F9	20.31	18.37	(1.94)	20.31	20.32	0.01	20.31	20.55	0.24
	Ward F12	11.02	11.16	0.14	11.02	9.89	(1.13)	11.02	10.08	(0.94)
	Ward G1 Hardwick Unit	23.74	22.28	(1.46)	23.74	19.37	(4.37)	23.74	19.5	(4.24)
	Cardiac Ward	14.28	12.27	(2.01)	14.28	11.09	(3.19)	16.9	18.09	1.19
	Ward G4	19.17	19.22	0.05	19.17	17.13	(2.04)	19.17	19.1	(0.07)
	Ward G5	18.41	20.77	2.36	18.41	17.73	(0.68)	18.41	17.6	(0.81)
	Ward G8	23.15	19.84	(3.31)	23.15	17.43	(5.72)	23.15	18.3	(4.85)
	Medical Treatment Unit	7.04	5.98	(1.06)	7.04	6.04	(1.00)	7.04	7.07	0.03
	Respiratory Ward	19.9	21.48	1.58	19.9	20.87	0.97	19.9	21.48	1.58
	Cardiac Centre	40.14	33.41	(6.73)	40.14	34.77	(5.37)	40.14	29.86	(10.28)
	AAU	27.3	20.85	(6.45)	27.3	18.98	(8.32)	20.96	19.76	(1.20)
	Ward F7 Short Stay	21.84	20.94	(0.90)	21.84	20.88	(0.96)	21.84	23.17	1.33
Medical Services Total		314.23	294.06	(20.17)	314.23	275.95	(38.28)	310.51	295.38	(15.13)
Surgical Services	Ward F3	19.69	17.92	(1.77)	19.69	18.98	(0.71)	19.57	18.05	(1.52)
	Ward F4	13.78	12.72	(1.06)	13.78	14.29	0.51	13.78	13.27	(0.51)
	Ward F5	19.59	19.46	(0.13)	19.59	18.66	(0.93)	19.59	20.16	0.57
	Ward F6	19.57	18.72	(0.85)	19.57	19.07	(0.50)	19.57	19.75	0.18
Surgical Services Total		72.63	68.82	(3.81)	72.63	71	(1.63)	72.51	71.23	(1.28)
Woman & Children S	Gynae Ward (On F14)	11.18	11.73	0.55	11.18	11.47	0.29	11.18	13.03	1.85
Woman & Children Services Total		11.18	11.73	0.55	11.18	11.47	0.29	11.18	13.03	1.85
Community	Newmarket Hosp-Rosemary ward	12.43	10.89	(1.54)	12.43	14.1	1.67	12.43	10.97	(1.46)
	Community - Glastonbury Court	11.69	11	(0.69)	11.69	11.06	(0.63)	11.69	11.85	0.16
Community Total		24.12	21.89	(2.23)	24.12	25.16	1.04	24.12	22.82	(1.30)
Grand Total		**422.16**	**396.5**	**(25.66)**	**422.16**	**383.58**	**(38.58)**	**418.32**	**402.46**	**(15.86)**

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Ward Based Unregistered Nurses were over established by 15.5 WTE during June 2019 after utilising temporary unregistered nurses, broken down as below :

Division	Ward Area	Plan April 19	Actual April 19	NET Vacancies (over / (under)) April 19	Sum of plan may 19	Sum of Actual may 19	Sum of Variance (over / (under)) May 19	Sum of plan june 19	Sum of Actual june 19	Sum of Variance (over / (under)) June 19
Medical Services	Accident & Emergency	24.43	21.83	(2.60)	24.43	22.66	(1.77)	24.43	25.92	1.49
	C.C.U.	0	0	0.00	0	0	0.00	0	0	0.00
	Ward F9	22.56	23.72	1.16	22.56	20.85	(1.71)	22.56	22.04	(0.52)
	Ward F12	5	5.29	0.29	5	5.48	0.48	5	5.64	0.64
	Ward G1 Hardwick Unit	9.01	9.17	0.16	9.01	9.3	0.29	9.01	11.98	2.97
	Cardiac Ward	18.03	9.64	(8.39)	18.03	10.28	(7.75)	18.6	17.3	(1.30)
	Ward G4	24.36	26.84	2.48	24.36	27.9	3.54	24.36	25.15	0.79
	Ward G5	22.66	25.82	3.16	22.66	25.02	2.36	22.66	26.07	3.41
	Ward G8	23.87	26.49	2.62	23.87	26.79	2.92	23.87	28.7	4.83
	Respiratory Ward	21.13	19.01	(2.12)	21.13	19.15	(1.98)	21.13	19.82	(1.31)
	Cardiac Centre	15.2	20.34	5.14	15.2	19.86	4.66	15.2	15.49	0.29
	AAU	29.59	28.92	(0.67)	29.59	27.7	(1.89)	25.51	27.79	2.28
	Ward F7 Short Stay	30.94	26.9	(4.04)	30.94	29.05	(1.89)	30.94	28.81	(2.13)
Medical Services Total		246.78	243.97	(2.81)	246.78	244.04	(2.74)	243.27	254.71	11.44
Surgical Services	Ward F3	22.26	22.97	0.71	22.26	25.27	3.01	22.26	20.95	(1.31)
	Ward F4	9.61	8.38	(1.23)	9.61	8.59	(1.02)	9.61	8.41	(1.20)
	Ward F5	14.51	14.65	0.14	14.51	15.42	0.91	14.51	16.28	1.77
	Ward F6	14.51	17.61	3.10	14.51	17.29	2.78	14.51	17.6	3.09
Surgical Services Total		60.89	63.61	2.72	60.89	66.57	5.68	60.89	63.24	2.35
Woman & Children Services	Gynae Ward (On F14)	1	4.81	3.81	1	4.69	3.69	1	4.01	3.01
Woman & Children Services Total		1	4.81	3.81	1	4.69	3.69	1	4.01	3.01
Community	Newmarket Hosp-Rosemary ward	13.47	12.26	(1.21)	13.47	12.34	(1.13)	13.47	13.14	(0.33)
	Community - Glastonbury Court	12.64	12.43	(0.21)	12.64	12.66	0.02	12.64	11.67	(0.97)
Community Total		26.11	24.69	(1.42)	26.11	25	(1.11)	26.11	24.81	(1.30)
Grand Total		**334.78**	**337.08**	**2.30**	**334.78**	**340.3**	**5.52**	**331.27**	**346.77**	**15.50**

Recruitment

Whilst there are currently 83 WTE vacancies for registered nurses on ward based areas we also have a pipeline of 74 WTE nurses who will become available over the coming months.

Since winter escalation plans assume another 50 beds are opened, at a ratio of 0.63 registered nurses per bed 32 further WTE registered nurses will also be needed, as well as replacing staff who leave at a rate of around 2 per month.

The following table gives a trajectory from June 2019 –June 2020 for filling these posts. This trajectory, including winter planning, is across

- Medical and Surgical Wards and Gynaecology,
- Rosemary Ward and Glastonbury Court,
- AAU and A&E,

but excludes Critical Care Service, Theatre staff, Discharge Waiting Area, Paediatrics, Neonates, Maternity and Community Teams.

FINANCE AND WORKFORCE REPORT - JUNE 2019

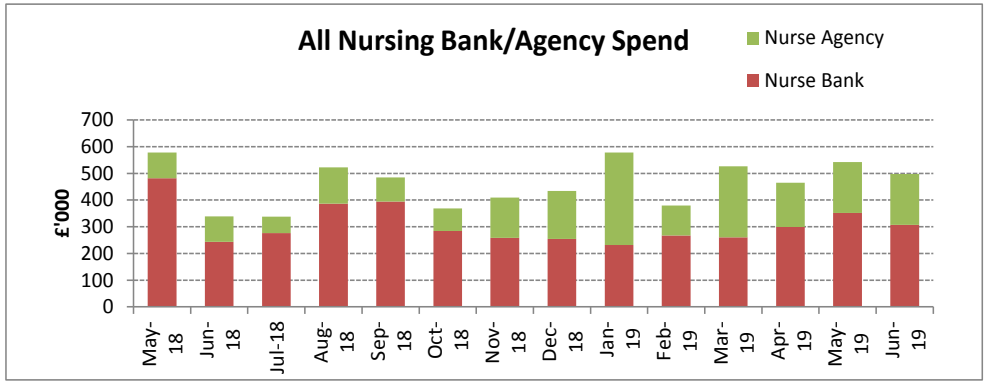
	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Funded vacancies b'f	91.6	82.8	69.8	62.2	52.4	23.4	2.8	23.0	15.4	8.6	1.0	(6.6)	(14.2)
leavers	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
maternity leave commenced	0.0	0.0	2.0	0.0	0.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
increased establishment :													
winter : G3 (already staffed)	0.0												
winter : G9							16.0						
winter : F10							16.0						
quality													
other developments													
new staff													
new starters (from below)	(10.0)	(15.0)	(10.0)	(11.0)	(31.0)	(23.0)	(15.0)	(10.0)	(10.0)	(10.0)	(10.0)	(10.0)	(10.0)
return from maternity leave (assume average drop to 0.8	(0.8)		(1.6)	(0.8)		(1.6)	(0.8)	(1.6)	(0.8)	(1.6)	(1.6)	(1.6)	(1.6)
Total vacancies c'fwd	82.8	69.8	62.2	52.4	23.4	2.8	23.0	15.4	8.6	1.0	(6.6)	(14.2)	(21.8)
filled by temporary staff :													
bank	11.7	11.7	30.0	30.0	20.0	0.0	10.0	5.0	0.0				
agency	26.3	26.3	10.0										
overtime	29.0	29.0	0.0										
Providing staffing to fill vacant posts	**66.9**	**66.9**	**40.0**	**30.0**	**20.0**	**0.0**	**10.0**	**5.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Net vacancies in month (average c. 40 before BBN)	15.9	2.9	22.2	22.4	3.4	2.8	13.0	10.4	8.6	1.0	(6.6)	(14.2)	(21.8)

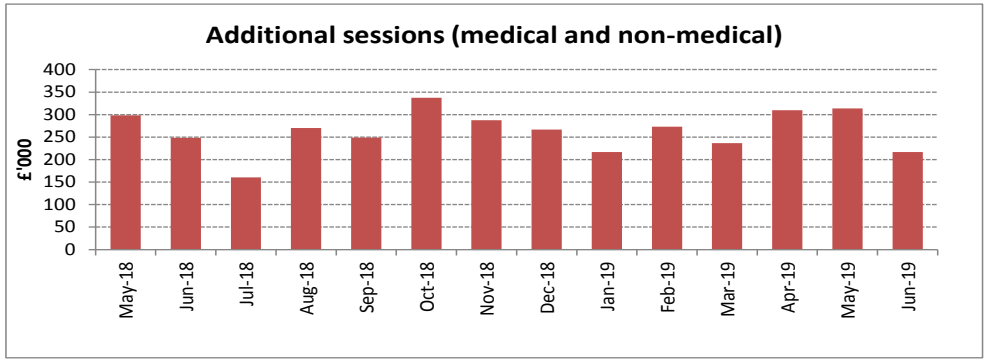
June 19 - June 20	WTE
B'f vacancies	91.6
Turnover	26.0
Net Maternity leavers	3.6
Additional capacity requirement	32.0
Total Recruitment required	153.2
Nurses in pipeline not yet in post b'f	73.0
Nurses in pipeline not yet in post c'f	12.0
Planned recruitment	91.0
	176.0
Over recruitment	22.8

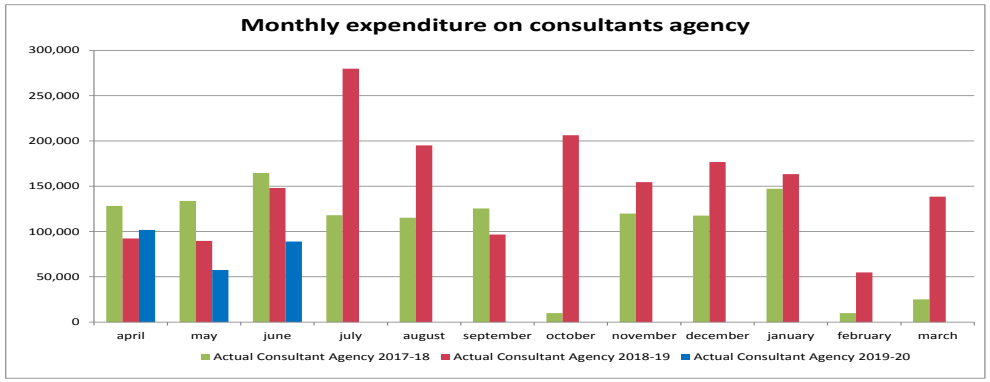
Analysis of offered posts (pipeline)	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Offered but not yet available b'fwd	73.0	74.0	77.0	81.0	95.0	55.0	43.0	38.0	33.0	23.0	13.0	3.0	(7.0)
new starter onto B5 Ward rota (incl transfer from B3)	(10.0)	(15.0)	(10.0)	(11.0)	(31.0)	(23.0)	(15.0)	(10.0)	(10.0)	(10.0)	(10.0)	(10.0)	(10.0)
On site but working as B3 (monthly movement, incl transfer to B5)	0.0	(2.0)	4.0	15.0	(19.0)	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Offers made in month but not yet available for B3 or B5	11.0	20.0	10.0	10.0	10.0	10.0	10.0	5.0	0.0	0.0	0.0	0.0	5.0
Offered but not yet available c'fwd ('pipeline' of qualified nurses)	74.0	77.0	81.0	95.0	55.0	43.0	38.0	33.0	23.0	13.0	3.0	(7.0)	(12.0)

Pay Costs and Analysis

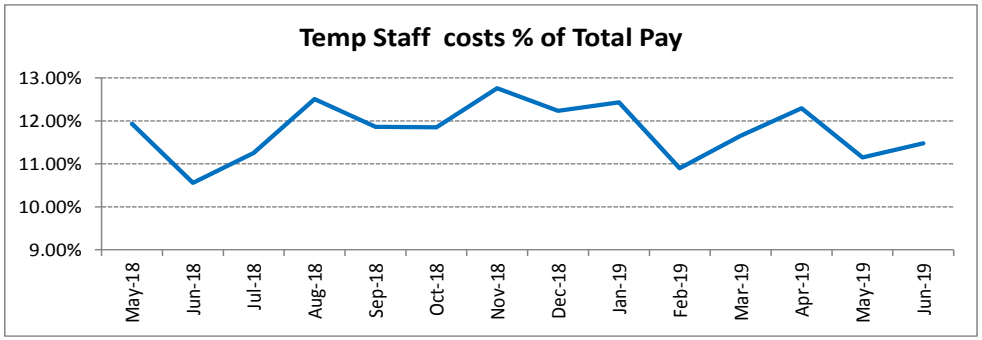
The Trust has spent £339k more on pay than budgeted year to date.



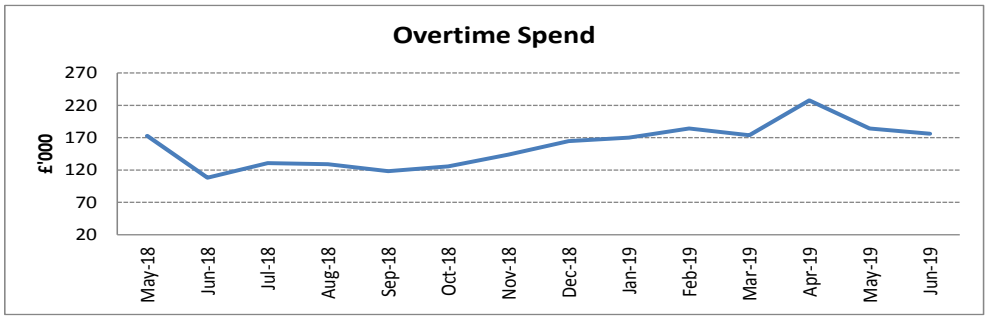




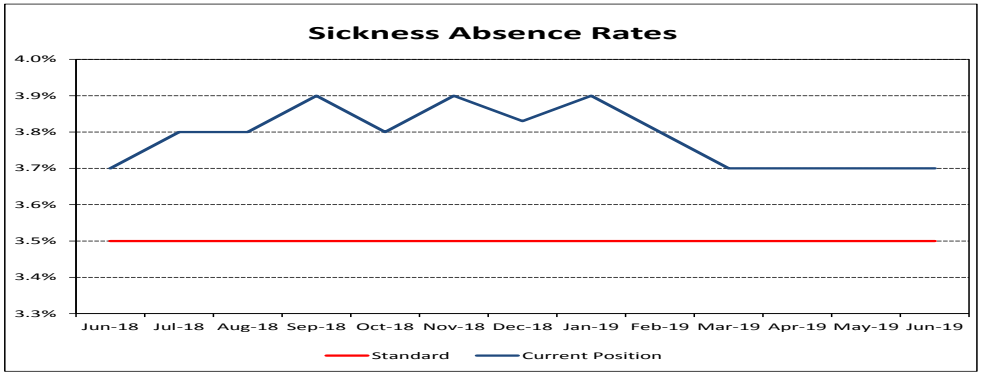
FINANCE AND WORKFORCE REPORT - JUNE 2019

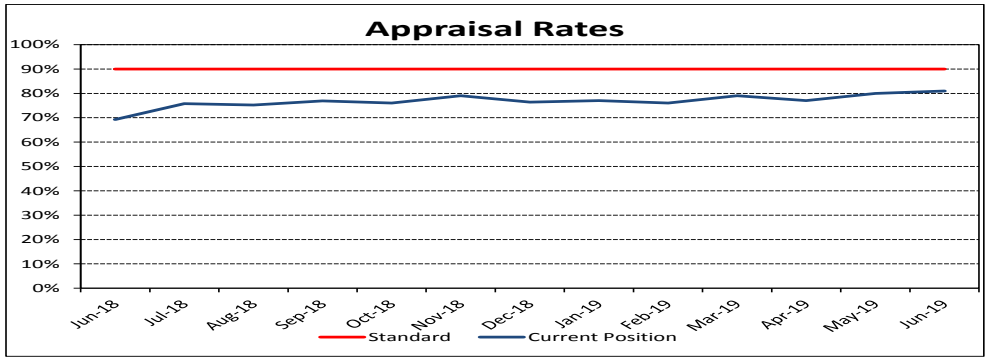


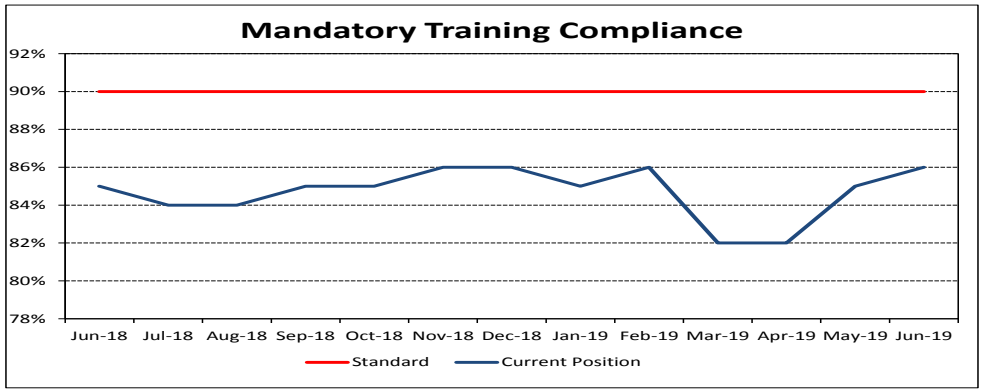
We expect overtime costs to fall significantly as a result of an initiative to replace planned overtime with bank shifts (that do not attract the overtime premium).



The following charts report on sickness absence performance, appraisal rates and mandatory training compliance, for acute and community staff







Our staff recommended scores for the period April to June 2019 are as below

	1 – Extremely likely	2 - Likely	3 – Neither likely nor unlikely	4 - Unlikely	5 – Extremely unlikely	6 – Don't know	7 – No response	Total		
How likely are you to recommend this organisation to friends and family if they needed care or treatment?	668	484	68	11	13	8	2	1254	1152	91.9%
How likely are you to recommend this organisation to friends and family as a place to work?	517	474	155	59	40	4	5	1254	991	79.0%

FINANCE AND WORKFORCE REPORT - JUNE 2019

Summary by Division

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS (NET CONTRIBUTION) - June 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	(6,809)	(7,073)	264	(21,202)	(21,601)	399
Pay Costs	3,838	4,045	(207)	11,821	12,090	(269)
Non-pay Costs	1,681	1,596	85	4,633	4,643	(11)
Operating Expenditure	**5,518**	**5,640**	**(122)**	**16,454**	**16,734**	**(280)**
SURPLUS / (DEFICIT)	**1,291**	**1,433**	**142**	**4,748**	**4,867**	**119**
SURGERY						
Total Income	(5,126)	(5,296)	169	(15,497)	(15,419)	(78)
Pay Costs	3,018	2,999	19	9,170	9,189	(19)
Non-pay Costs	1,123	1,031	93	3,415	3,281	133
Operating Expenditure	**4,141**	**4,029**	**112**	**12,584**	**12,470**	**114**
SURPLUS / (DEFICIT)	**985**	**1,266**	**281**	**2,913**	**2,949**	**36**
WOMENS and CHILDRENS						
Total Income	(1,881)	(1,986)	105	(5,673)	(5,556)	(116)
Pay Costs	1,193	1,262	(69)	3,578	3,707	(129)
Non-pay Costs	161	118	43	468	383	85
Operating Expenditure	**1,353**	**1,380**	**(26)**	**4,046**	**4,090**	**(44)**
SURPLUS / (DEFICIT)	**528**	**607**	**79**	**1,626**	**1,466**	**(160)**
CLINICAL SUPPORT						
Total Income	(827)	(807)	(20)	(2,477)	(2,512)	35
Pay Costs	1,514	1,513	1	4,508	4,447	61
Non-pay Costs	1,046	1,087	(41)	3,087	3,179	(92)
Operating Expenditure	**2,560**	**2,600**	**(40)**	**7,595**	**7,626**	**(31)**
SURPLUS / (DEFICIT)	**(1,733)**	**(1,793)**	**(60)**	**(5,118)**	**(5,113)**	**5**
COMMUNITY SERVICES						
Total Income	(2,550)	(2,476)	(74)	(8,753)	(8,639)	(114)
Pay Costs	2,287	2,220	67	6,855	6,724	131
Non-pay Costs	949	956	(7)	2,836	3,031	(195)
Operating Expenditure	**3,236**	**3,176**	**60**	**9,691**	**9,756**	**(65)**
SURPLUS / (DEFICIT)	**(686)**	**(700)**	**(15)**	**(938)**	**(1,116)**	**(178)**
ESTATES and FACILITIES						
Total Income	(344)	(373)	30	(1,212)	(1,143)	(69)
Pay Costs	874	877	(3)	2,622	2,588	34
Non-pay Costs	518	655	(137)	1,584	1,783	(198)
Operating Expenditure	**1,392**	**1,532**	**(140)**	**4,206**	**4,370**	**(164)**
SURPLUS / (DEFICIT)	**(1,048)**	**(1,159)**	**(111)**	**(2,994)**	**(3,227)**	**(233)**
CORPORATE (excl Reserves)						
Total Income	(3,324)	(2,856)	(468)	(8,153)	(8,125)	(28)
Pay Costs	1,376	1,369	6	3,749	3,957	(208)
Non-pay Costs (net of Contingency and Reserves)	934	1,094	(160)	3,228	3,528	(300)
Finance & Capital	980	960	20	2,941	2,826	115
Operating Expenditure	**3,290**	**3,423**	**(133)**	**9,918**	**10,310**	**(392)**
SURPLUS / (DEFICIT)	**34**	**(568)**	**(601)**	**(1,765)**	**(2,186)**	**(420)**
TOTAL						
Total Income	(20,861)	(20,868)	7	(62,966)	(62,995)	29
Pay Costs	14,099	14,285	(186)	42,303	42,702	(399)
Non-pay Costs	6,411	6,536	(125)	19,251	19,828	(578)
Finance & Capital	980	960	20	2,941	2,826	115
Operating Expenditure	**21,490**	**21,781**	**(291)**	**64,494**	**65,356**	**(861)**
SURPLUS / (DEFICIT)	**(629)**	**(914)**	**(284)**	**(1,528)**	**(2,360)**	**(832)**

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

Medicine (Nicola Cottington)

The division reported a favourable variance of £142k in June (£119k YTD).

Clinical Income exceeded plan by £310k in month and is largely driven by both increased ED attendances and increased outpatient attendances to improve the diagnostic waits position.

Pay is reported at £207k behind plan in month, £100k of which is the result of correcting the budget profile for both AAU and Ward G3 to ensure they align with the expected increases in capacity in the coming months.

The remaining variance is largely explained by the continuation of increased activity within ED (13.8% higher than planned in month and 8.9% higher than the same point in 2018). The increase in attendances continued to impact throughout the Trust and inevitably put pressure on Medical staffing costs within ED and AMU/EAU through sustained locums and agency usage. The improvement in the echocardiography diagnostic performance (87% in June vs 59% in May) has contributed to a cost pressure of £17k in Cardiology Medical staffing.

The non-pay variance (£85k underspend in month) is driven by a claim in month of excluded drugs for the first quarter of 19/20 (£70k), improving the YTD position to a £91k underspend. This offsets continuing high levels of expenditure on pacemakers, internal loop recorders and other Cath Lab high cost consumables, reflecting the increase in demand noted since the Cardiac Centre opened.

Using YTD actuals as a guide, if nothing changes Medicine would overspend by around £0.9m against the expenditure budget for the full year 2019-20. A financial recovery plan has been drafted, and will be worked through with reference to non-financial risks to ensure that patient safety and quality is not compromised.

Surgery (Simon Taylor)

The division reported a favourable variance of £281k in June (£36k YTD).

Income has overachieved by £169k in month but is under achieving by £78k YTD. Both Elective inpatients and Outpatients over achieved plan in month whilst day cases and non-elective underachieved. Private patients continue to be significantly below last year's levels.

Pay reported a £19k underspend in the month (£19k YTD). There has been some one off adjustments this month that have benefited the position as well as a drop in the overspend relating to Nursing due to recruitment of substantive

staff. However, consultants costs and additional sessions continue to overspend. This is due in part to non achievement of CIP relating to additional sessions as well as temporary cover needed for consultants unable to work.

Non pay reported a £93k underspend in month (YTD £133k). There has been system cleaning in purchasing that has benefited the position as well as continuing to underspend on prostheses related to current consultant vacancies.

If nothing changes Surgery would overspend by around £1.1million this financial year. The division is actively looking at ways to reduce this cost pressure on the Trust. All options are being considered and are currently being discussed with the senior team.

Women and Children's (Rose Smith)
The division reports a favourable variance of £79k in June (£160k adverse YTD).

Income reported £105k ahead of plan in-month and is £116k behind plan YTD. In the month, the Division experienced high volumes of inpatient, outpatient and neonatal activity. YTD, the division has experienced lower volumes of neonatal and maternity activity. This YTD underperformance against plan is unlikely to become a trend as outpatient activity is increasing as the Obstetric and Gynaecology service addresses its RTT backlog.

Pay reported a £69k overspend in-month (£129k YTD). In-month and YTD, the Division has experienced cost pressures from gaps on the tier two medical staffing rota in Paediatrics, the staffing on F1 and the escalation staff working on F10. An action plan is being produced by the Division which will detail the options available to control expenditure on Paediatric medical staff, since the business case to recruit more staff was deferred pending further information.

Non-pay reported a £43k underspend in-month (£85k YTD). This relates to the cost of recharging escalation staff working on F10.

Clinical Support (Rose Smith)
The division reported an adverse variance of £60k in June (favourable £5k YTD).

Income for Clinical Support reported £20k behind plan in-month and is £35k ahead of plan YTD. In month, outpatient activity was 25% higher than plan which helped address the YTD slippage against plan. The in-month activity in Radiology was slightly higher than plan and has been all year. This situation will need to continue if the YTD slippage is to be addressed.

Pay is £1k underspent in-month (£61k YTD) due to both Outpatients and Pharmacy struggling to fill vacancies. The Outpatient staffing review has been concluded and the department is planning to recruit in line with this. The Pharmacy service is in the process of recruiting to the vacant posts.

Non-pay reported a £41k overspend in-month (£92k YTD). In month, the Pharmacy Service issued a one-off credit note to conclude a contractual dispute with Cambridge Community Services. YTD, the Radiology non-pay budget has been overspending because of the activity pressures on consumables in Endoscopy and CT.

Community Services and Integrated Therapies (Michelle Glass)
The division reported an adverse variance of £15k in June (£178k YTD).

Income reported a £74k under recovery in month, with a year to date adverse variance of £114k. This is under review to ensure the income position continues to improve, with risks addressed within the Division. A focused piece of work with CCG Commissioners is underway to ensure all changes relating to in-year investment and accompanying Contract CVs are reflected.

An in-month under spend on pay of £67k was realised, through effective vacancy management and limited prioritised backfill to vacancies through locum and agency staff, according to clinical priority. The Division's year to date position remains favourable with a £131k over recovery achieved.

Non-pay reported a year to date adverse variance of £195k, primarily due to higher than expected monthly spend on Community Equipment to support patients at home, in the community and to support timely discharge from the hospital. However, using analysis of the profile of prior year expenditure, we continue to monitor that the phasing of expected spend should be further updated according to expected seasonal variation. In addition wheelchair services and IT Hardware have incurred expenditure higher than expected in order to meet service demand and deliver system transformation to help manage waiting lists and support mobile working.

If nothing changes the division would overspend by around £150k in 19-20. However, a Budget Recovery Plan has been drafted to ensure a breakeven position is achieved without adversely impacting patient care. Pipeline CIP proposals and in-year mitigations for cost avoidance and additional income recovery are expected to deliver.

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.

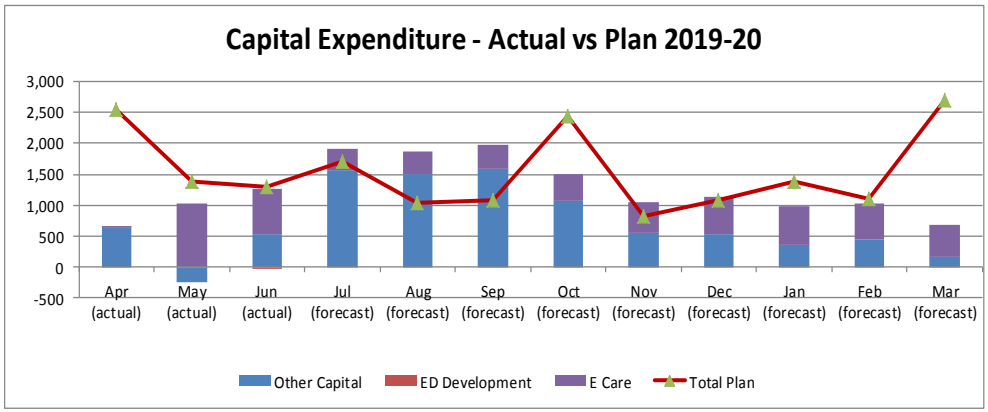
Metric	Value	Score	Plan
Capital Service Capacity rating	-0.1	4	4
Liquidity rating	-22.9	4	4
I&E Margin rating	-5.2%	4	2
I&E Margin Variance rating	-2.7%	4	1
Agency	-8%	1	1
Use of Resources Rating after Overrides		3	3

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.

Although the Trust is planning for a balanced revenue position in 2019/20, this would 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 Forecast £'000	Aug Forecast £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2018-19 £'000
E Care	34	1,019	743	357	356	371	415	504	601	626	579	529	6,133
ED Development	0	0	-0	0	0	0	0	0	0	0	0	0	0
Other Schemes	636	-242	534	1,564	1,506	1,599	1,080	550	538	363	451	161	8,741
Total / Forecast	670	777	1,276	1,921	1,862	1,970	1,495	1,054	1,139	989	1,030	689	14,874
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 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 due to commence in the latter part of the financial year.

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 that this is received and the schemes will commence in July /August. Until this loan is approved the minimum level of estates capital to support ongoing projects is being undertaken.

At this stage in the financial year the schemes are forecast to remain in line with the initial budget approved. There are no major variances to report at this stage. The difference in the total plan to the forecast relates to donated assets which are funded through MyWish.

We have prepared a Capital Programme totalling £18.6m expenditure in 2019-20. This is underpinned by around £10.5m of further PDC (subject to approval). However, 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 WSFT proposing a reduction to our programme of £3.7m (to £14.9m).

Our Capital programme has already prioritised those schemes that improve patient safety and we are contractually committed to many of them. Therefore we feel there is little room to reduce the programme although there is always likely to be slippage against some schemes. However, we have been asked to provide specific reductions in our capital programme and have suggested these come from the following :

Capital Scheme	£'000
Theatre upgrades	1,120
ED Development	1,100
Replacement Roof	832
Site Electrical Infrastructure Capacity	282
Microbiology and Xray area investigations/works	90
Link Corridor flooring	10
Medical Equipment replacement	60
Community IT Investment (centrally managed)	39
Other IT Investment	72
Labour Suite refurbishment	40
Various Feasability Studies	73
	3,718

The three large schemes were the only schemes of significant enough value that weren't already committed and we would propose that any delay is merely into the very early part of 2020-21.

Whilst this may have implications on patient safety the Trust will do everything possible to mitigate these risks. The revised capital programme for 2019-20 and 2020-21 is proposed as below.

FINANCE AND WORKFORCE REPORT - JUNE 2019

Revised Capital Programme

	2019-20 £'000	2020-21 £'000
Development team & CAD Subscription	520	525
Ambulatory Assessment Unit	1,500	-
Site electrical infrastructure	2,327	157
Vacuum plant	230	
Street lighting	110	347
Labour suite	660	40
Pharmacy Robot	60	
Fire compartmentation	400	250
Fire alarms	275	
Emergency Lighting	30	30
Roof replacement	268	882
Theatre 1	-	1,120
Hot & Cold Water Systems	100	100
Structural Wall Panels	30	70
Road Repairs and relining	40	60
Secure Access/ CCTV/ mag locks	30	30
Theatre Upgrades feasibility	35	
E-Care	1,559	
SAN Upgrade	100	
GDE Upgrades	700	
Wireless Network	296	
E-Care Software	160	
CCN011	1,763	
Community	211	289
Recovery Monitoring	420	1,061
Other IT projects	42	
Purchase medical equipment	300	300
Finance Leases- Radiology/ Endoscopy	1,340	2,050
Mortuary	-	1,400
Critical Care	-	3,000
Other	-	3,673
Other feasibilities	-	200
SCCM Upgrade	-	273
Other IT projects internal funding	916	
ED Reconfiguration	-	11,000
E-Care	-	1,179
SAN Upgrade	-	100
GDE Upgrades	-	800
E-Care Software	-	160
Energy efficient lighting	217	
Energy efficient lighting	218	
Link Corridor flooring	3	10
St Helens House	2	
Residences additional	12	
Feasibility studies	-	73
Total	**14,874**	**29,179**

FINANCE AND WORKFORCE REPORT - JUNE 2019

Statement of Financial Position at 30th June 2019

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2019	Plan 31 March 2020	Plan YTD 30 June 2019	Actual at 30 June 2019	Variance YTD 30 June 2019
	£000	£000	£000	£000	£000
Intangible assets	33,970	35,940	34,675	34,218	(457)
Property, plant and equipment	103,223	115,395	110,948	103,888	(7,060)
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**	**150,048**	**143,160**	**(6,888)**
Inventories	2,698	2,700	2,700	2,820	120
Trade and other receivables	22,119	20,000	20,000	24,054	4,054
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	6,106	1,467	(4,639)
Total current assets	**29,324**	**23,750**	**28,806**	**28,341**	**(465)**
Trade and other payables	(28,341)	(32,042)	(30,082)	(26,932)	3,150
Borrowing repayable within 1 year	(12,153)	(3,134)	(3,134)	(7,564)	(4,430)
Current Provisions	(47)	(20)	(20)	(47)	(27)
Other liabilities	(1,207)	(992)	(8,481)	(6,714)	1,767
Total current liabilities	**(41,748)**	**(36,188)**	**(41,717)**	**(41,257)**	**460**
Total assets less current liabilities	**129,823**	**143,322**	**137,137**	**130,244**	**(6,893)**
Borrowings	(84,956)	(99,186)	(95,514)	(88,216)	7,298
Provisions	(111)	(150)	(150)	(111)	39
Total non-current liabilities	**(85,067)**	**(99,336)**	**(95,664)**	**(88,327)**	**7,337**
Total assets employed	**44,756**	**43,986**	**41,473**	**41,917**	**444**
Financed by					
Public dividend capital	69,113	70,430	69,167	69,112	(55)
Revaluation reserve	6,931	9,832	8,021	6,451	(1,570)
Income and expenditure reserve	(31,288)	(36,276)	(35,715)	(33,646)	2,069
Total taxpayers' and others' equity	**44,756**	**43,986**	**41,473**	**41,917**	**444**

Non-Current Assets

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.

Trade and Other Receivables

These have increased by £2.5m since May and are £4m more than planned at the end of June. Included within the total is £4m of the 2018/19 Provider Sustainability Funding and £2m prepayments for contracts and leases as well as £7m for invoices raised.

Cash

Cash is £4.6m less than plan due to the timing of the receipt of £4m of the 2018/19 Provider Sustainability Funding.

Trade and Other Payables

These are £3m less than plan at the end of June. This is mainly due to the work completed to improve the Trust's performance against the Better Payment Practice Code, which means that payments are being made quicker to suppliers.

Other Liabilities

This reflects the amount of income received in advance not yet recognised. This is £1.7m less than planned.

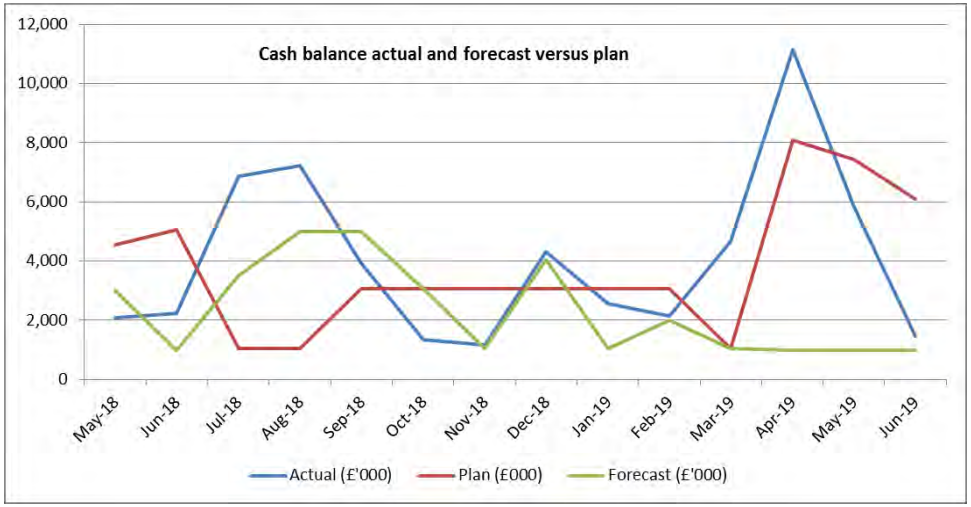
Borrowing

No borrowing has been required so far this year, but this will be kept under close review. The Trust is required to repay £4.2m of loans by 31 March 2020.

FINANCE AND WORKFORCE REPORT - JUNE 2019

Cash Balance Forecast for the year

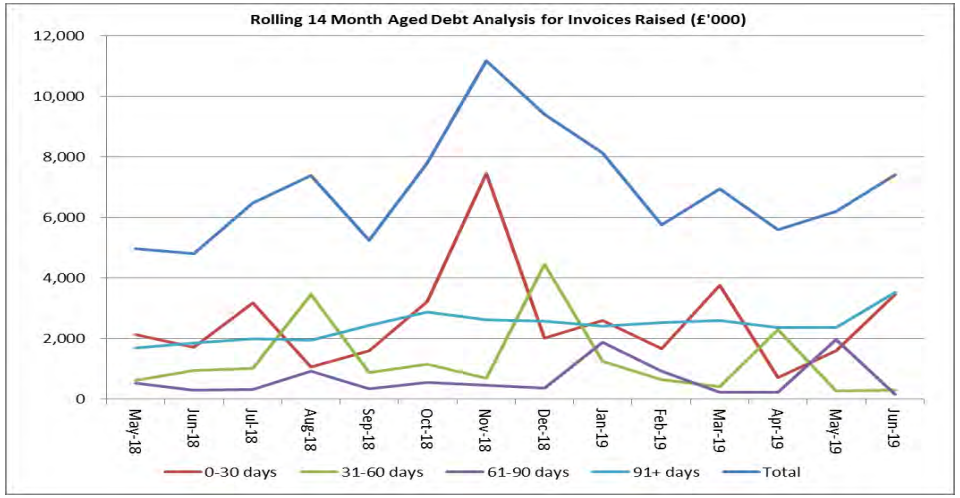
The graph illustrates the cash trajectory since June 2018. The Trust is required to keep a minimum balance of £1 million.



The June 2019 cash position is lower than planned. This is due to the plan taking into account £4m of 2018/19 Provider Sustainability Funding that was expected to be received, however this will not be received until mid-July. The timing of receipts and the payment run also had an impact on the cash balance.

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 increased by £1.2m since May. Over 82% of these relate to NHS Organisations.

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

11. Transformation report Q1

To APPROVE the report recommendations

For Approval

Presented by Helen Beck

Trust Board - 26 July 2019

Agenda item:	11			
Presented by:	Helen Beck - Chief Operating Officer			
Prepared by:	Lesley Standring – Head of Operational Improvement, WSFT Sandie Robinson - Associate Director of Transformation, CCG Jane Rooney - Head of Planned Care Transformation, CCG John Connelly - Head of PMO, WSFT Sheila Broadfoot - CQUIN Lead, WSFT			
Date prepared:	17 July 2019			
Subject:	Transformation Board Report			
Purpose:	√	For information		For approval

Executive summary:
This report provides an update from the last reporting period and relates to the programs of work being undertaken by the joint transformation teams, the Trust PMO and progress against CQUIN.
The Hospital transformation team continues its focus on improvements in hospital flow and improvement of pathways to reduce admissions and improve discharges.
The Integrated Care team are focussed on the current system wide programme of demand management initiatives in urgent and emergency care and is a key element of our winter planning and preparedness.
The work of the planned care team is aimed at supporting the recovery of the trusts RTT and cancer performance through a series of service reviews and elective demand management schemes.
The PMO update in section five gives details of the Allocate medical rostering and appraisal software implementation, aimed at improving efficiency and productivity through better planning.
The final CQUIN section provides the final report for the year 18/19 and the details of the projects to be delivered in 19/20.

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:	Planned Care Board A&E Delivery Board TEG
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	
Recommendation: The board is asked to note the content of the report and progress in a number in a number of key system wide transformation initiatives	

1.0 Update on Hospital Transformation

1.1 Red to Green (R2G)/SAFER

Throughout May the transformation team completed a rapid improvement event across wards F3 and G5 to assess the implementation of the R2G and SAFER process.

The results have been shared with the operational managers and the heads of nursing. An action plan has been developed with the ward staff to address the issues highlighted and the transformation team will support the wards with the change management required.

During August the team will continue to support ward F3 and move onto F8 (respiratory) with support from the senior nursing and operational teams.

1.2 Diagnostic Virtual Ward (DVW)

Transformation funding was agreed to test a DVW. We are running the service from the discharge waiting area.

Currently the patient cohort consists of:
Surgical patients waiting for USS and CT

Next steps planned are to discuss with the frailty team the support available via a DVW as they may have a patient cohort suitable.

1.3 Delayed Transfer of Care (DTOC)

Over recent months we have seen an increase in Suffolk DTOC's in both acute and community bed bases. From the 4th July we will be reporting long length of stay and reasons to NHSI the data collected will allow us to review the patient cohort by reason, age, local authority and CCG.

1.4 High Intensity user Co-Ordinator

The project manager is now in post and the first 'umbrella' MDT is planned for mid-July. There has been excellent engagement from NSFT, EEAST, Care UK 111, Social Care and police. Data sharing agreements will be in place and by September MDTs will start to take place in localities.

1.5 Frailty

The trust is engaged with the NHS Frailty Collaborative. This project includes ensuring we get the frailty score accurately recorded within 30 minutes of presentation to ED. This will help to ensure the patients are appropriately picked up by the frailty team.

ECIST spent the day with the trust on the 15th July reviewing the frailty pathway and working with us and the clinical teams to understand how we can deliver a 70 hour a week service by the end of the year. A 2 week pilot for a revised service model is currently being planned to take place during August.

Geriatricians also supported a test and learn model for frailty within Market Cross surgery in Mildenhall. 25 patients were referred to the community matron who carried out a modified Comprehensive Geriatric assessment. Patients who require extra support will be seen by the geriatrician – out of the 25 patients reviewed 2 require the service of the geriatrician.

1.6 IV antibiotics in the community

A bid to the CCG was successful in gaining a year's funding to test and learn patients on multiple doses of IV antibiotics who could benefit from the use of a Baxter pump.
The community nursing teams are not able to facilitate multiple daily dosing of intravenous therapy due to time constraints, availability of staffing and appropriate skill mix. Therefore, patients who require multiple daily doses of intravenous antimicrobials are taught to self-administer. Not all patients or carers

can be taught to self-administer due to the complexity of the traditional method which means that they remain in hospital for several weeks to complete their treatment. The infusion pumps are disposable devices that allow the infusion of a drug over a specified time period. They are easy to attach and change, and require no specialist skills to operate. Pumps are needle free.
These elastomeric pumps will be purchased specifically for individual patients who cannot be supported by community nurses and cannot be taught to self-administer by conventional methods.

2.0 Integrated Care Programme Project Highlights

2.1 Urgent Care Demand Management

2.0 Defining the problem

2.1 Parts of the system are reporting significant increases in demand placing extreme pressure on services.

2.2 **Ambulance** calls have increased by 10% and an 8.7% associated increase in conveyances.

2.3 **WSFT ED** saw a 4.9% increase in 18/19 on attendance compared to 17/18, with WSCCG patients at WSFT increasing by 3.6%. However if the demand for patients referred directly to assessment wards by GP's is taken into account, there has been a 10% rise in demand at the front door. In June 2019 WSFT had 6693 attendances (9% increase on June 18).

GP referrals in the over 75 age group in April and May were up by 57% on 18/19

Readmission rates were up by 39% in the first two months of this year and 25.5% (84/330) of these readmissions were readmitted within 48 hours of discharge. It is proposed to undertake a deep dive into the rising readmission rate

2.4 **WSFT** community respiratory referral activity is below plan (following a long period of staff vacancies) and with the majority of activity focussing on oxygen home assessments.

The Early Intervention Team activity has increased with a recent swing to seeing more activity from the hospital v community (probably as a result of hospital pressures to improve flow). The Rapid Intervention Vehicle has received over 600 referrals since October and has a 75.2% non-conveyance rate.

2.5 **NHS111** call volumes have remained steady. However, performance against the 95% of calls answered in 60 seconds has been poor due to challenges in staffing the service at peak times. The new service has also struggled to recruit clinicians into the CAS which has had an impact on ambulance validation resulting in an increase in referrals for ambulance dispatch.

2.6 **Bury Town, Sudbury and Haverhill** localities are the main drivers of high demand.
Haverhill A&E activity has seen a large increase this year, although not to the scale of Bury Town. April attends increased by 29% (65) and May 17.2% (42 and it is reported that similar increases from Haverhill are being seen into Addenbrookes.

A request has been made to have access to GP consultation rates to better understand primary care demand.

2.7 **Enhanced Health in Care Homes** – The demand management programme is now well established and a 12 month evaluation has been completed. There has been a decrease (comparing monthly performance for 17/18 against 18/19) of 1.4% in ED attendances for Care Home residents to WSFT against an increase of 3.7% (for all ages).

System DToC in West Suffolk have been positively impacted by the programme with the Trusted Assessor at WSFT completing 213 trusted assessments to date, directly contributing to a 43.5% reduction in DTOCs and saving an average of 64 bed days a month for Care home residents.

With earlier mobilisation of schemes in year 1 (Interface Geriatrician project, Dementia Nurse Specialist, Trusted Assessor in place and EIT enhanced support to Care Homes) there has also been a positive variance comparing monthly performance for 17/18 against 18/19 (August to March) in acute admissions, ambulance call outs and conveyances.

3.0 System plan

3.1 In May, system managers, on behalf of the A&E delivery board, met to develop a demand management plan. This plan was presented to the AEDB in July.

3.2 A second meeting is set for 2 August to reflect on this plan and to take forward the actions that fell out of the AEDB meeting on 10 July. Work is ongoing to define the impact of each scheme in terms of reduced attendances and admissions and this will feed into the Trusts demand and capacity plans for winter.

3.3 **Locality approach –** a meeting with the PCN Clinical Director of Bury Town and WSFT is being planned to agree a way forward to address the growth in A&E demand for this locality.

3.4 **Service optimisation**:
- GP plus utilisation remains poor – 62% in May - and the AEDB is seeking options to explore a different approach that focusses the resource supporting higher demand areas such as Bury Town.
- NHS111 CAS requires access to care of the elderly and paediatrics clinical expertise. Plans in place to deliver this across the ICS and triangulate the request from EEAST to access frailty expertise.
- NHS111 call validation requires joint working with EEAST to improve performance and reduce numbers of calls referred to the ambulance service
NHS111 Direct Booking into general practice has been delayed from 1 July to end of August. An action plan is in place to ensure delivery by this deadline does not slip.
- High Intensive Users of A&E requires the data sharing agreement to be completed by all organisations before the first MDT goes live in August
- GP Streaming – the AEDB approved the draft proposal for a new model at the July meeting and a final paper is planned to return to the August Board meeting. A condition of the new model is all shifts will be filled.

3.5 **Frailty**
- **Integrated Neighbourhood Teams –** these are in development but much work is still needed to ensure the functionality of INTs is fully operational. Locality plans are being developed outlining the short term interventions needed to improve the integration of health and social care teams which will include the implementation of ageing well programme supporting the early identification of people living with moderate frailty. INTs will work with GPs using the Electronic Frailty Index and clinical judgement to identify people at risk of adverse health outcomes and provide them with tailored care
- **Interface Geriatrician** – it has not been possible to progress the interface with community as planned and discussions are in place to commit dedicated resource to the community. Focussed work is in progress to ensure the front door model is fully operational by winter.
- **Virtual Ward** – this test and learn will launch in October and will include two ring-fenced step up beds

3.6 **Rapid Intervention Vehicle** – A review of this service will be presented to the August AEDB. It remains hugely popular with many GP surgeries but further optimisation is believed to be possible.

3.7 **Enhanced Health in Care Homes** – Implementation of year two of the demand management programme with focus on:
- Recruitment of second trusted assessor post
- Implementation of the medicines optimisation programme
- Align homes to GP practices. Clinical Directors to lead implementation in PCNs

- EIT to continue enhanced offer to homes
- Embed Dementia Nurse Specialist

3.8 **Transformation Funding** – The CCG had a small pot of funding (£300k) for system spend on demand management this year. Approval has been through the AEDB and five proposals have been agreed so far:

- Baxter Pumps – to increase number of patients supported at home needing IV therapy
- Trusted Assessor for care homes – second post to work alongside existing post holder
- Stepping Homes – a joint project with Lofty Heights, Housing and WSFT to support discharges
- Lofty heights – extension of homeward bound hospital discharge service
- Extension of dedicated clinical digital project management to accelerate trusted assessment

4.0 Planned Care Programme Project Highlights

4.1 Turbo Projects and Service Reviews

As part of the programme to deliver the regulatory requirements (RTT, Waiting list size, zero 52 week waits and reduction in follow ups) we have now finalised a programme of service reviews to sit alongside the turbo projects which have been developed. From mid-August, using 100 day methodology, we will be carrying out service reviews in urology, general surgery, trauma and orthopaedics, cardiology and gynaecology. These service reviews will include specific focus on9 low priority procedures) LPPs, video conferencing, advice and guidance and pre-referral guidance. Workshops will take place in August to include clinical and operational staff and identify the 100 day plans.
Outsourcing of backlog is included as part of this programme and will be led by the WSFT operational teams with support from transformation

4.2 Right Care Programme – Cardiovascular Disease (Atrial Fibrillation) and Stroke

'RightCare' is about the whole health system taking an evidence-based approach to focus on key areas that will improve health outcomes for the population, reduce unwarranted variation in care and save money. Going forward, RightCare will be working more closely with the GIRFT team to ensure that the two programmes are aligned and no opportunities are missed.

Good progress has been made on the Stroke agenda and a procurement process for Early Supported Discharge (ESD) is now taking place with a view to a new provider being in place by April 2020. Work will now take place to progress the specification development for the additional community services to support stroke.

A new project manager has been employed to support atrial fibrillation (AF) in the 'detect and prevent' phase working across the Alliance. She starts as part of the wider team in August 2019.

4.3 Ophthalmology

The minor eye pilot has ended and the initial reports are positive. A business case is now being developed by the Trust and the CCG to demonstrate the savings and benefits available by implementing this service. It is likely that savings could be upwards of £150k per annum (recurrent).
Work is ongoing to clear the cataract backlog. The teams are working with several providers and the procurement team to find the best route to market and best VfM.

4.4 Vascular

The varicose veins backlog continues to grow with a significant number of patients now booked in for first appointments 30+ weeks into their pathway. This presents a potential 52-week breach risk as the pathway from first appointment is usually 40+ weeks. Various activity is taking place to mitigate this

risk. Discussions are being held at exec level with the consultants and insourcing providers are also in discussion with the Trust.

4.5 Demand Management

The Teledermatology service is now operating at the levels of activity it had reached prior to it being withdraw two years ago. This is an improvement but there still remain around 40% of practices who are not using Teledermatology correctly. Anecdotally, the service is still receiving high numbers of inappropriate 2ww patients. Conversations have taken place to consider changing the patient pathway to make Teledermatology mandatory and this should now be revisited.

Demand within the Trust is not increasing but other demand reduction processes will be considered as part of the service reviews where it is more appropriate for the patient to stay in primary care

5.0 PMO Update

5.1 CIP Programme

The 2019/20 cost improvement programme has identified opportunities with a gross value of £8.6M at July 2019.

The focus over the next quarter is the delivery of cross cutting schemes to bridge any remaining gap against divisional targets which have been set at 4% of the Trust expenditure budget.

5.2 Medical e-Rostering (Allocate)

E-Appraisal
The E-Appraisal build is now complete. Appraisal information will transfer from SARD on completion of Appraisals until September 2019. The E-Appraisal module will be handed over to PGME 1st October 2019.

Medical Rostering
The Medical Rostering module for Junior Doctor's has been handed over to rota co-ordinators with the exception of Obstetrics and Gynaecology / Paediatrics who are still awaiting the recruitment of a Rota Coordinator. The annual leave calculations model, for Consultants and SAS Doctors, has been agreed with clinicians and calculations will commence once the job plans are signed off.

Activity Manager
The Anaesthetics department has been built. The PMO is working closely with clinicians and rota coordinators in the department to test the build so the department can view the rosters in real time. The department intend to run Allocate alongside their current rostering system to ensure there are no issues before the current system is retired.

Data gathering and build work for surgical specialties has commenced. The implementation is being hindered as job plans have not been signed off for 2019-20. At present the data which feeds through is from the 2018-19 job plans and therefore the PMO has to manually adjust these.

Locum on Duty
All junior doctor locum bank and agency shifts are now being rostered and booked via Allocate. Junior Doctors now have access to book shifts directly through Medic Online or the MeApp. For shifts sent out so far for the period July to September, 77% of these have been booked directly online by the doctor themselves.

Junior Doctor shifts worked in June have been sent electronically to payroll for payment in July. The approximate reduction in paper timesheets sent to payroll is 64%.

Business As Usual
The plan is to have the e-Rostering Business Manager and the Workforce Information Administrator in post by 1st November when the project will be handed over to the Workforce Information Team.

5.3 Procurement: Category Towers

The Category Towers are now fully mobilised with active work plans and the Trust is fully engaged.

The following are the category towers contracts:

1. Ward Based Consumables (DHL)
2. Sterile Interventions Equipment and Associated Consumables (CPP)
3. Infection Control and Ward Care (DHL)
4. Orthopaedics, Trauma and Spine, Ophthalmology (CPP)
5. Rehabilitation Disable Services, Women's Health and Associated Consumables (CPP)
6. Cardio-Vascular, Radiology, Audiology and Pain Management (HST)
7. Large diagnostic or capital devices
8. Diagnostic equipment and consumables
9. Office Solutions
10. Food
11. NHS Hotel Services

6.0 CQUIN Projects 2018-19 Total year 98.38% met

<table>
<tr><th>Staff CQUINs title:</th><th>Progress</th><th>RAG</th></tr>
<tr><td>1a) Staff Health & Wellbeing:
Improve two specific results by 5% from 2016 on the national Staff Questionnaire re:
H&W provision &
MSK & Stress not ‘due to work’.</td><td>National Survey 2018 vs baseline year 2016: all Trusts no improvements & WSFT better than average. Other questions positive & put forward some national issues out of Trust control.
<table>
<tr><th>Question</th><th>2016-7</th><th>Target</th><th>2018-9</th></tr>
<tr><td>H&W provision</td><td>40%</td><td>Increase to 45%</td><td>39%</td></tr>
<tr><td>Work caused MSK</td><td>23%</td><td>Decrease to 18%</td><td>24.7%</td></tr>
<tr><td>Work caused stress</td><td>34%</td><td>Decrease to 29%</td><td>34.9%</td></tr>
</table></td><td>Q4
Case put forward agreed as met</td></tr>
<tr><td>1b) Food & Drinks sold at WSFT:
Continue changes 2016-7 re: items high in fat, sugar or salt and new targets re 3 shelf changes.</td><td>All in place including liaison with W H Smith.
10% sales max of sugary drinks (no ban); by March 2019 20% of shelf allowed re: >250kcal sweets & 25% shelf re: >400kcal sandwich/wraps/salads. Submit data for NHS Digital.</td><td></td></tr>
<tr><td>1c) Flu vaccination of staff:
75% uptake by end of February.</td><td>Front line staff 2018-9 ‘target met’ 75.1%.
NB. 2019-20 target 80%.</td><td></td></tr>
<tr><th>Patient CQUINs title:</th><th>Progress</th><th>RAG</th></tr>
<tr><td>2a) Sepsis screening of all ED and inpatients. Target 90%</td><td>eCare adds symptoms together & prompts ‘Suspected Sepsis’.
NEWS 2 criteria - eCare updated. Paediatrics yet to have alerts.
Q1-4 met.</td><td></td></tr>
<tr><td>2b) Severe/ High Risk Sepsis treatment ED & Inpatients: IV anti-biotic within 1 hour of diagnosis. Target 90%</td><td>Improvements required. Q4 ED 75%, Inpatient 51%.
Sepsis Nurse now in post re: education & audit.
Paediatrics yet to have alerts.</td><td>Q1-4</td></tr>
<tr><td>2c) Severe/ High Risk Sepsis - ED & Inpatients: antibiotic prescription review & assessment.
Q4 target 90%</td><td>Noted: additional criteria – review within 72 hours & additional documentation & IV to oral switch assessment.
Data submitted to Public Health England.</td><td></td></tr>
<tr><td>2d) Higher % reduction in ‘total all’ & Carbapenem Antibiotic use vs 2016. Increase usage within Access group AWaRe (Access, Watch & Reserve).</td><td>Note: a) Total antibiotics & b) Carbapenems increased 2017-8-9 re: Tazocin shortage. Challenge to reduce 1% & 2%.

c) Increase, for in & outpatients, by 3% vs 2016 antibiotics within the Access group of AWaRe category – target met.</td><td>b) Case put forward & agreed as met
Q4</td></tr>
<tr><td>4) Mental Health need in ED – Selected 2 cohorts: reduced ED attendance.
Outcomes information.
Increased use of MH on ECDS, including audit & improvement plan</td><td>NSFT & ED targets met:
Maintained reduced attendance of year 1 cohort.
Year 2 cohort of frequent attenders: reduced over 20%.
Use of ‘MH diagnosis’ increased. Data quality plan - met Q2-4.
Q4: plan for BAU met.
Data on cohort attendance - submitted to NHS Digital.
EDCS – Injury Intent data to improve.</td><td></td></tr>
<tr><td>6) Advice & Guidance to GP pre referral via eRS. Specialties offering A&G covered at least 75% of referrals received 2016-7 (NHSE aim A&G reduce referrals).</td><td>Phased monitoring for a total of 20 specialties offering A&G to GPS via eRS. Reminders sent during the CQUIN period. Varied compliance of 2 day turnaround. If GPs do not receive timely response: may refer / complain & patients waiting. CCG – GPs to only use facility for A&G (not referral). 2019-20: Tariff £.</td><td></td></tr>
<tr><td>9) Adult Inpatients – preventing ill health (excluding Maternity):

Improve on Quarter (Targets aim):
9a) Tobacco Screening 90%
9b) Tobacco Brief Advice (if yes) 90%
9c) Tobacco Referral and Medication Offer 30%
9d) Alcohol Screening 50%
9e) Alcohol Brief Advice Or Referral (if high score) 80%</td><td>Screening noting Alcohol drinking levels; plus recording ‘Yes given’ Brief Advice, Referrals, Prescribe.
Q4: improved on most Q3. eCare change requests now live:
1) Activity Daily Life to capture alcohol levels
2) Brief Advice, Refer & Prescribe (NRT) - doctor role: so task prompts improve data recording: (but no hard stop so can continue on with more urgent patient data).
• Education & communication being updated.
• Part of the Trust’s Quality Priorities Plan.
Aware above is non-mandatory data & other patient data takes precedence.
Activity occurring, but need to improve recording.
Carrying on as a CQUIN 2019-20 with higher targets.</td><td>9a Q4 < Q3

9b, 9c, 9d*, 9e improved *or similar versus Q3</td></tr>
<tr><td>10) STP (Suffolk Transf) Support</td><td>Local CQUIN. Met re: evidence of meetings.</td><td></td></tr>
</table>

2019-20 CQUIN NHS England Spec for Acute. Targets: total Q1-Q4.

- New structure: If underperform early quarters, need to over-perform later quarters.
- Multi-Trust x 22: letters sent to NHS E to request change to this reward structure.
- Put forward to CCG in Q1 report 15/7: Locally agree Q1 used to review (including further updates from NHS E May-July) & info build as before. Measure on Q4 % performance.
-

CQUINs title:	Description / Progress	RAG
Antimicrobial Resistance: **1a) Lower Urinary Tract Infections in Older People** *Part manual audit – resource arranged*	Achieve 90% of antibiotic prescriptions for lower UTI in older people (age 65 and over) meeting NICE guidance & PHE Diagnosis Guidance. 4 audit criteria met and recorded: a) Diagnosis based on clinical signs/ symptoms (April-May 94%); b) Diagnosis excludes use of urine dip stick (*Note: dip stick figures are total used incl needed for other tests – propose to exclude b*); c) Antibiotic prescribed relevant (April-May 80%); d) Urine sample sent to microbiology (April-May 83%). Propose lower % targets a, c, d).	a) b) – propose remove c) & d)
1b) Antibiotic Prophylaxis for Elective Colorectal Surgery (adults)	Achieve 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines. (April-May 100%).	
2) Staff Flu vaccination	Achieve an 80% uptake of flu vaccinations by frontline clinical staff by February 28th 2020. *(Note: 2018-9 achieved target 75%)*	
Inpatient: Tobacco & Alcohol **3a) Screening**	Achieve 80% of inpatients admitted to a ward for at least 1 night who are screened for both smoking and alcohol use (unique patients is non-repeat admission during the duration of the CQUIN). Exclude maternity. Propose lower targets. *(Note: 2018-9 alcohol screen incl number of alcohol units target was 50%. Current: 50% tobacco, 52% alcohol but only 14% levels of alcohol)*	Propose lower target
3b) Tobacco Brief Advice (incl offer NRT)	Achieving 90% of identified smokers given brief advice (incl offer of NRT). (*Note: 2018-9, only NRT prescriptions is robust data*)	As a)
3c) Alcohol Brief Advice (incl offer referral where relevant)	Achieving 90% of patients identified as drinking above low risk levels given brief advice or offered a specialist referral (if potentially dependent). (*Note: 2018-9, only referrals is robust data)*	As a)
7) Preventing Hospital Falls - Admitted patients aged over 65 years, with LOS at least 48 hours. Exclusions: Patients who were bedfast and/or hoist dependant throughout their stay. Patients who RIP during their hospital stay. **Manual audit resource*	Achieving 80% of older inpatients receiving all 3 key falls prevention actions met and recorded: • Lying and standing blood pressure recorded at least once (current data to be reviewed as April 98% - seems high). • No hypnotics or antipsychotics or anxiolytics given during stay *OR rationale for giving hypnotics or antipsychotics or anxiolytics documented. (April 91%). • Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatients. (April 94%).	Tbc green
11) Suitable for (SDEC) Same Day Emergency Care x 3 CQUINs • **Aged 18 and over, 75% managed in a same day setting where clinically appropriate (specifications give details) and discharged within 24 hours.** • **Note: NHS England specifications final versions yet to be published.** • **Locations:** ED, AAU, AEC, CDU. (Noting also separate short stay setting on F7). **Observation raised:** Patients are not allocated 'SDEC' specific, especially as review and tests can take place. Many may not be suitable to be discharged within 24 hours and may go on to be admitted to main inpatient wards for relevant reasons, therefore only those suitable will be discharged which then = 100% compliant.		
11a) Pulmonary Embolus	Above criteria patients with confirmed pulmonary embolus (PE).	TBC
11b) Tachycardia with Atrial Fibrillation	Above criteria patients with confirmed atrial fibrillation (AF).	TBC
11c) Community Acquired Pneumonia	Above criteria patients with confirmed Community Acquired Pneumonia (CAP).	TBC

12. Nurse staffing report

To ACCEPT a report on monthly nurse staffing levels

For Report

Presented by Rowan Procter

Trust Board – 26th July 2019

Agenda item:	12			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Rowan Procter, Executive Chief Nurse, and Sinead Collins, Clinical Business Manager			
Date prepared:	19th July 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 but further changes are required to fit in NQB requirements.

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 June'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 NHSI. Multi-disciplinary meeting occurred in June, and agreed that each clinical department will do an annual review process. Task & Finish Group to be set up to get QIA methodology and review process. New areas have been added to this report in line with guidance – however some information is required to complete the rows – this will be available in July

Nursing vacancy accuracy position – June figures are still over predicted the vacancies and Healthroster accuracy to be continually looked at again by HR – it has improved and have included within the dashboard. Updating process of Healthroster to be implemented with a review of time taken to complete this taken to account. Kate Read and Nick McDonald to meet to discuss steps forward. Also a relaunch of Healthroster to be coordinated by HR team

Healthroster implementation into community – Newmarket CHT will be the pilot team. ESR data sent to check for accuracy. Meeting to be organised with Newmarket team to introduce

Overview of June nurse staffing position

Are we safe?
Across the month of June staff fill rate has improved in comparison to the month of May.

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.

Complaints are higher put this is due to including areas that were required to respond to the complaint and not just who owns it. So one complaint could cover numerous areas

Are we efficient?
The sickness has improved this month in comparison to May.

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.

In line with NQB standards – some areas/wards record on the Risk Register on Datix that there are staffing concerns and mitigated actions taken.

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
Total	74

Information as at 16 June 2019:
52 overseas nurses have passed their OSCE and are now working as Band 5 Nurses
5 OSCE booked for 31 July 2019
4 OSCE Exams booked for 5 August 2019
2 OSCE resits to be booked for end of July 2019
2 awaiting decision letters
9 Undertaking OSCE preparation - OSCE to be booked for end of August
9 Nurses due to arrive on 27th June 2019 for July's cohort/Induction

WSH Existing Staff:
1 WSH NA passed her OSCE on 3rd June 2019 and will commence her Band 5 role on F7 from July 2019 when she returns from Maternity Leave.

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Jun-19		Establishment for the Financial Year 2018/19		Data for June 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	90.8%	101.5%	101.7%	152.5%	7.7%	10.9%	N/A	-14.10	-0.30	2.40%	14.70%	2.90%	N/A	8	0	0	3	6
WSFT	AAU	Acute Admission Unit	27.30	29.59	75.8%	51.9%	75.5%	115.0%	3.5%	1.9%	10.3	-8.10	1.80	3.80%	13.20%	3.80%	0	1	2	0	0	0
WSFT	F7	Short Stay Ward	22.84	30.94	63.5%	70.6%	104.0%	109.1%	10.8%	4.6%	6.3	-4.80	-2.80	4.40%	14.10%	5.40%	0	3	1	0	0	0
WSFT	CCS	Critical Care Services	41.07	1.88	95.0%	93.8%	N/A	N/A	3.1%	6.3%	26.7	-4.10	2.00	2.30%	9.40%	4.60%	0	2	0	0	0	0
WSFT	Theatres	Theatres	61.68	22.27	107.0%	100.1%	N/A	N/A	3.2%	0.0%	N/A	-2.70	0.80	7.90%	12.50%	0.90%	0	4	0	0	1	0
WSFT	Recovery	Theatres	21.23	0.96	152.2%	113.3%	61.1%	N/A	2.0%	0.0%	N/A	0.50	0.00	5.30%	12.90%	4.30%	0	1	N/A	0	0	0
WSFT	Day Surgery Unit	Theatres	28.43	8.59	53.6%	N/A	100.2%	N/A	0.4%	0.0%	N/A	1.30	1.50	7.10%	12.90%	0.00%	0	0	0	0	0	0
	Day Surgery Wards		11.76	1.79					9.9%	0.0%		-2.40	-0.10	5.20%	12.00%	0.00%						
WSFT	ETC	Opthalmology	TBC	TBC	TBC	TBC	TBC	TBC	0.9%	0.0%	N/A	TBC	TBC	5.10%	11.50%	1.90%	0	1	0	0	1	1
WSFT	Endoscopy	Endoscopy	TBC	TBC	TBC	TBC	TBC	TBC	0.0%	0.0%	N/A	TBC	TBC	4.20%	13.90%	2.20%	0	0	0	0	0	1
WSFT	Cardiac Centre	Cardiology	38.14	15.20	67.6%	98.3%	107.4%	110.0%	1.7%	0.3%	4.6	-5.80	4.10	2.10%	13.00%	2.90%	1	1	0	0	0	3
WSFT	G1	Palliative Care	23.96	8.31	77.7%	106.9%	101.7%	N/A	12.0%	2.3%	7.7	-2.40	0.90	6.70%	11.50%	5.50%	1	4	0	1	0	0
WSFT	G3	Endocrine & Medicine	TBC	TBC	115.5%	148.3%	150.8%	126.6%	15.3%	8.6%	6.0	2.20	8.90	3.40%	13.10%	0.00%	0	5	2	0	0	0
WSFT	G4	Elderly Medicine	19.16	24.36	81.6%	78.1%	103.0%	114.9%	16.3%	4.6%	5.8	-4.70	-0.90	7.40%	12.30%	4.60%	0	0	2	0	1	0
WSFT	G5	Elderly Medicine	18.41	22.66	90.6%	95.0%	89.5%	119.2%	14.7%	3.7%	8.1	-3.00	-4.30	9.80%	12.00%	3.30%	2	3	2	0	3	1
WSFT	G8	Stroke	23.15	28.87	80.9%	88.7%	99.8%	103.8%	9.9%	9.2%	6.4	-7.70	3.00	3.30%	11.90%	10.90%	2	1	1	0	0	1
WSFT	F1	Paediatrics	18.13	7.16	122.5%	154.4%	86.7%	N/A	16.0%	0.0%	10.2	-1.20	1.70	6.60%	14.90%	0.00%	N/A	2	N/A	0	0	0
WSFT	F3	Trauma and Orthopaedics	19.58	22.27	85.5%	95.9%	83.3%	110.5%	11.0%	7.8%	5.5	-4.60	-3.20	7.30%	15.40%	5.30%	2	9	1	1	0	1
WSFT	F4	Trauma and Orthopaedics	12.78	10.59	81.0%	85.0%	95.0%	168.9%	4.1%	2.0%	8.7	-3.10	-0.80	1.70%	13.60%	4.30%	1	0	0	0	0	2
WSFT	F5	General Surgery & ENT	19.58	14.51	88.9%	94.5%	95.0%	113.6%	5.0%	0.5%	5.2	2.00	-0.80	5.10%	14.30%	4.90%	0	0	0	0	1	3
WSFT	F6	General Surgery	19.57	14.51	97.3%	90.0%	95.4%	116.2%	2.7%	1.9%	5.2	-1.80	1.80	5.00%	9.60%	1.40%	1	4	0	0	1	0
WSFT	F8	Respiratory	19.90	20.13	99.3%	82.6%	93.2%	106.6%	6.4%	7.5%	6.7	-3.70	-1.80	6.00%	16.50%	0.00%	0	0	1	0	0	0
WSFT	F9	Gastroenterology	20.32	22.56	97.2%	91.8%	78.6%	137.7%	17.7%	1.3%	5.4	-3.50	-3.60	8.90%	13.60%	5.70%	0	3	1	0	1	0
WSFT	F11	Maternity	49.58	13.89	122.1%	90.2%	77.0%	65.9%	12.6%	0.0%	N/A	2.60	-0.30	9.10%	15.20%	5.20%	0	2	0	0	1	0
WSFT	MLBU	Midwifery Led Birthing Unit															0	0	0	0	0	0
WSFT	Labour Suite	Maternity															0	1	0	1	0	0
WSFT	Antenatal Clinic	Maternity	TBC	TBC	TBC	TBC	TBC	TBC	6.5%	0.0%	N/A	TBC	TBC	11.60%	12.90%	0.00%	0	0	0	0	1	0
Community	Community Midwifery	Maternity	TBC	TBC	TBC	TBC	TBC	TBC	7.8%	0.0%	N/A	-2.20	0.00	6.50%	16.70%	8.00%	0	0	0	0	0	0
WSFT	F12	Infection Control	11.02	5.00	79.7%	89.4%	37.1%	121.0%	6.5%	0.6%	9.0	-1.90	-0.10	2.90%	13.60%	0.00%	1	0	0	0	0	4
WSFT	F10	Gynaecology	11.18	1.00	98.9%	113.1%	N/A	N/A	34.2%	2.9%	6.6	-1.90	0.00	10.50%	14.30%	0.00%	0	0	0	0	0	0
WSFT	MTU	Medical Treatment Unit	7.04	1.80	66.4%	N/A	90.2%	N/A	1.4%	0.0%	N/A	-0.20	0.00	17.00%	7.30%	0.00%	0	0	0	0	0	0
WSFT	NNU	Neonatal	20.85	3.64	100.4%	78.9%	33.3%	66.7%	0.2%	0.0%	29.3	-1.60	-1.00	1.40%	12.80%	4.40%	N/A	0	N/A	1	0	0
WSFT	Outpatients	Outpatients	TBC	TBC	TBC	TBC	TBC	TBC	4.7%	0.0%	N/A	TBC	TBC	6.80%	16.80%	3.40%	0	0	0	0	0	0
WSFT	Radiology Nursing	Radiology	TBC	TBC	TBC	TBC	TBC	TBC	9.2%	0.0%	N/A	TBC	TBC	2.30%	10.10%	3.30%	0	0	0	0	0	0
Newmarket	Rosemary Ward	Step - down	12.34	13.47	134.9%	93.8%	111.0%	95.4%	7.9%	17.8%	5.8	-1.20	-2.60	5.30%	12.10%	0.00%	0	1	3	0	0	0
Glastonbury Court	Kings Suite	Medically Fit	11.50	12.64	115.1%	103.2%	98.1%	100.0%	10.0%	0.0%	4.8	-3.10	-0.40	5.40%	13.70%	0.00%	0	0	1	0	1	0
					94.10% AVG	96.36% AVG	92.91% AVG	115.50% AVG				-81.20 TOTAL	3.50 TOTAL	5.88% AVG	13.07% AVG	2.91% AVG	11 TOTAL	56 TOTAL	17 TOTAL	4 TOTAL	15 TOTAL	23 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	1386.27	82	-2.94	0.20	4.54%	Not available comprehensively till Healthroster implemented	Not available this month	7	1	0	0	0	0
Community	Bury Rural	Community Heath Team	10.00	1.20	715.50	31	-0.30	-1.00	3.55%			6	0	0	0	0	0
Community	Mildenhall & Brandon	Community Heath Team	12.59	3.91	839.00	30	-0.60	-0.11	4.33%			3	0	0	0	0	0
Community	Newmarket	Community Heath Team	8.10	2.75	522.95	29	0.00	0.00	3.44%			2	2	0	0	0	0
Community	Sudbury	Community Heath Team	18.03	8.36	1209.85	55	-4.40	0.00	7.50%			0	0	0	0	0	0
Community	Haverhill	Community Heath Team	8.97	4.23	887.25	53	-2.60	0.00	5.08%			1	0	0	0	0	0
Community	Admission Prevention Service	Specialist Services	11.28	3.45	136.68	0	TBC	TBC	14.52%			0	0	0	0	0	0
Community	Specialist Services	Cardiac Rehab and Heart Failure	Data to be obtained						0.00%			0	0	0	0	0	0
Community	Children	Community Paediatrics	16.37	15.01	1288.08	2	0.00	-0.24	6.43%			N/A		0	0	1	0
					6985.58 TOTAL	282.00 TOTAL	-10.84 TOTAL	-1.15 TOTAL	5.49% AVG	#DIV/0! AVG	#DIV/0! AVG	19 TOTAL	3 TOTAL	0 TOTAL	0 TOTAL	1 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

13. Safe staffing guardian report

To APPROVE the report recommendations

For Approval

Presented by Nick Jenkins

Trust Board – 26 July 2019

Agenda item:	13			
Presented by:	Dr Nick Jenkins, Executive Medical Director			
Prepared by:	Francesca Crawley			
Date prepared:	April 2019			
Subject:	Safe staffing guardian report: 1 April – 30 June 2019			
Purpose:	x	For information		For approval

Executive summary:

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.

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.

QUARTERLY REPORT ON SAFE WORKING HOURS
DOCTORS AND DENTISTS IN TRAINING
1st April 2019 – 30th June 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 and BMA representatives, and 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:	1 PAs / 4 hours per week
Admin support provided to the guardian (if any):	0.5WTE
Amount of job-planned time for educational supervisors:	0.125 PAs per trainee[1]
Amount of job-planned time for Clinical Supervisors:	0, included in 1.5 SPA time[1]

1. Exception reporting: 1st April 2019 – 30th June 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 of 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 AND OVERTIME HOURS CLAIMED							
Department	Grade	Total no of doctors in staff group	Pattern of Hours worked	Educational Opportunities or available Support	Support available during Service Commitments	Hours of Work	Total overtime hours claimed
Surgery	F1	9				7	13.15
	F2/GPST /CST1-2	6				11	17.30
	ST3+	5				1	3.00
Medicine	F1	16				32	50.45
	F2/GPST /CMT1-2	36				26	31.45
Total						**77**	**116.25**

Exception reports by SPECIALTY & GRADE					
Department	Grade	Exceptions carried over from before 1st April 19	Exceptions raised	Exceptions closed	Exceptions outstanding
Surgery	F1	0	7	7	0
	F2/GPST/ CMST1-2	0	11	11	0
	ST3+	1	0	1	0
Medicine	F1	1	32	27	6
	F2/GPST/ CMT1-2	0	26	26	0
	ST3+	2	0	2	0
Total		**4**	**76**	**74**	**6**

There were no Exception Reports logged for Women and Children during this period.

Exception reports – RESPONSE TIME			
Department	Addressed within 48 hrs	Addressed within 7 days	Addressed in longer than 7 days
Surgery	0	11	8
Medicine	2	21	37
Woman & Child	2	0	0
Total	**4**	**32**	**45**

b) Work schedule reviews for period 1st April 2019 – 30th June 2019

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

2. Fines - 1st April 2019 – 30th June 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 £4,585.59.

Matters Arising

- Exception reports were raised by General Surgery F2's regarding lack of SpR support during evening and nights. The General Surgical Department are now reviewing both F2 and SpR Rota's and Duties, in consultation with the SpR's, to see how more support can be incorporated. There is a new Rota going live for the next rotation in August, and we will monitor this issue.

- During the Guardian Forum's, large numbers of complaints regarding the Trust's Knowles mileage and expenses system has been raised. The Finance Department have confirmed the expenses system will be out for tender in October 2019. The Junior Doctors and HR would like to be involved in the choice of a new system in future, as the doctors are the largest staff group to regularly use the mileage systems under their training contracts.

- The chair of the regional trainees committee has surveyed all East of England trainees. Over 1600 replied: about 32% of all trainees. The results were as follow:

  64 responses were received from trainees at WSFT. WSFT was the highest scoring acute trust for:

  - Percentage of trainees aware of rest facilities
  - Percentage of trainees who can take their breaks during the day
  - Receipt of work schedule 8/52 before the current rotation
  - Receipt of rota 6/52 before the current rotation

  We were third out of acute trusts for 'awareness of how to exception report'

  We scored poorly on the ability to take breaks at night (46% of respondents can take breaks at night always or >75% of the time, average across all acute trusts 51%)

  These results have been shared with the MD, DME, HR and the GOSW. They will be shared with trainees at the next GOSW meeting (July 27th). The GOSW has access to the results and will look at the 'breaks at night' data across specialities (although we suspect that medicine is the most challenging speciality to take these breaks). That data will be shared when available.

  Overall, these are to be proud of, though of course we can still improve. Particular thanks to Helen Kroon's team in HR for leading on many of these achievements and to Pete Harris as DME.

- The GOSW is on leave for changeover but is making a short video with the support of the comms team to explain the role of the GOSW and how WSFT is engaged with improving the working lives of our junior doctors.

- We were able to share the achievements this training year with all doctors and service mangers via email:

August 2018-2019: 6 additional Foundation doctors in medicine and 6 in surgery

Funded bed to sleep post nights

Welcome package for new starters 2019

Time Out food 24/7 via vending machine

PA in gastro

14. CNST Incentive Scheme

To approve the report

For Approval

Presented by Craig Black

Trust Board - 26th July 2019

Agenda item:	14			
Presented by:	Craig Black			
Prepared by:	Lynne Saunders			
Date prepared:	19th July 2019			
Subject:	Submission for CNST Incentive Scheme 2019			
Purpose:		For information	√	For approval

Executive summary:

NHS Resolution is operating a second year of Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care, those Trusts demonstrating that they have achieved all ten of the safety actions will recover an element of their contribution relating to the CNST maternity incentive fund.

The scheme consists of ten safety actions which must be achieved. The Board declaration must be signed and the content of the board declaration form must have been discussed with the commissioners of the Trusts maternity services.

The attached report demonstrates the current position of the maternity services at WSH and demonstrates that it considers that it is compliant with all ten safety standards. Evidence supporting this position has been reviewed by the exec lead.

A concise version of the report was shared with commissioners at the West Suffolk Quality and Contracts Performance Monitoring Group (QCPM) on 10th July 2019; no questions were raised in this forum.

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

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

Previously considered by:	Constituent parts of the report have been seen by the Scrutiny committee and

	the final submission has been reviewed by C Black Director of Finance and Information.
Risk and assurance:	N/A
Legislation, regulatory, equality, diversity and dignity implications	N/A

Recommendation:
The Board approves this submission including the Board declaration set out below:

> The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

Update on compliance with CNST Incentive Scheme 2019 for Trust Board

July 2019

Safety Action No.	Maternity Safety Action	Current position	Action met
1.	**Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?**	The National Perinatal Mortality Review Tool is in use. There have been four eligible cases the timeframe in this safety action, all were reported within the required timeframe. All parents are informed of an investigation and given the opportunity to be involved and to ask any questions they may have. As required quarterly reports have been submitted to the Scrutiny committee which was given delegated authority.	Yes
2.	**Are you submitting data to the Maternity Services Data Set to the required standard?**	All required data sets submitted. October 2018 to March 2019 data submitted within deadline, this included the required number of mandatory criteria. April 2019 data for MDS version 2 was submitted within timescale and included mandatory criteria.	Yes
3.	**Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?**	There is an Operational policy in place for Transitional care which was jointly developed between maternity and neonatal services. All required reporting of HRG 4/xA04 in place An ongoing action plan is in place addressing local findings of Avoiding Term Admissions Into Neonatal units (ATAIN) and has been presented within required timeframes to Local Maternity Board and approved by Operational Delivery Network. Evidence attached. Action plan attached.	Yes
4.	**Can you demonstrate an effective system of medical workforce planning to the required standard?**	Results of GMC survey 2018 for obstetrics and gynaecology trainees noted and actions taken to address. These included the recruitment of acute consultants to support the Tier 2 rota. Additionally the rotas were changed to make them more resilient Trust has ACSA accreditation which is due reassessment in September 2019 therefore no action plan is required.	Yes
5.	**Can you demonstrate an**	The maternity services at WSH have recently had a Birthrate Plus	Yes

	effective system of midwifery workforce planning to the required standard?	assessment undertaken by Birthrate Plus® funded by the CCG as part of the Better Births Transformation programme this indicated that the service is appropriately staffed for the current birth numbers at WSH, not considering the impact of continuity of carer models. A copy of the report attached. There is a senior midwife on each shift and on most occasions this midwife has supernumerary status. Clear escalation processes are in place for when this is not achievable and the senior midwife feels additional staffing is required. All women receive one to one care in established labour and this is recorded monthly on the maternity dashboard. Midwife to Birth ratio is included on the maternity dashboard monthly. A copy of the 2018/19 dashboard is attached. The maternity service included the requirement to report red flag incidents in the updated version of its Risk Management Strategy in January 2019, and this was included in *Risky Business* in February 2019 Copy attached). To date there have been limited reports and these have not been at the time of the concern to allow prompt investigation.	
6.	**Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?**	All elements of Saving Babies Lives version 1 are now implemented at WSH. The final element (Element 2) was implemented in April 2019	Yes
7.	**Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?**	There is a well established Maternity Voices Partnership in place at WSH. The group meets regularly and provides user feedback on a variety of topics which the maternity service addresses. Sample minutes attached and annual report attached both demonstrating action on feedback. The results of the latest CQC patient Survey have been discussed with MVP. There is individual user involvement in investigations, all parents are aware	Yes

		of any investigation, they have an opportunity to raise any concerns or questions and always receive feedback in a format of their choice. .	
8.	**Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?**	The maternity services at WSH have had multidisciplinary PROMPT training in place for a number of years. These sessions are attended by the multidisciplinary team and a number of additional members of the wider team including local paramedics. Live drills are also usually run on the Labour Suite and Midwifery Led Birthing Unit; these have been reduced in number whilst the refub has been ongoing. Maternity Support Workers and Maternity Care Assistants have more recently been included in PROMPT but have always been part of the live drill. Training records at the end of July demonstrate 90% compliance for those available for training (long term sickness and maternity leave excluded)	Yes
9.	**Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?**	Maternity safety champions are in place within the maternity service and have regular communication with the board level champions. Both are engaged locally with the Local Learning set and have attended a national learning event this year - Launch of Saving Babies Lives Version 2. WSH is engaged with the QI project chosen by the LLS and have attended the initial session on this. Board level safety champions are available at weekly open sessions for staff and are additional visible and available to all staff at all times. No safety concerns have been raised by staff recently.	Yes
10.	**Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?**	We have reported under the NHS Resolution's Early Notification scheme since 2018. All qualifying incidents have been reported in 2018/19. Confirmation email attached	Yes

15. Consultant appointment

To NOTE the report

For Report

Presented by Kate Read

BOARD OF DIRECTORS – 26 July 2019

Agenda item:	15			
Presented by:	Jan Bloomfield, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	17th July 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 Community Paediatrician
DATE OF INTERVIEW:	Thursday 13th June 2019
REASON FOR VACANCY:	New Post
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]

QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	1 1 1

POST:	Resident On Call Consultant in Obstetrics & Gynaecology
DATE OF INTERVIEW:	Tuesday 25th June 2019
REASON FOR VACANCY:	Fast Track Post
CANDIDATE APPOINTED:	[redacted]
START DATE:	Tuesday 25th June 2019
PREVIOUS EMPLOYMENT:	[redacted]

QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	1 1 1

16. Putting you first award

To NOTE a verbal report of this month’s winner

For Report

Presented by Kate Read

17. Annual clinical excellence awards report

To NOTE report

For Report

Presented by Nick Jenkins

Trust Board – 26th July 2019

Agenda item:	17			
Presented by:	Kate Read			
Prepared by:	Lesley Ridge			
Date prepared:	18th July 2019			
Subject:	Employers Based Awards Committee (Local Clinical Excellence Awards)			
Purpose:	X	For information		For approval

Executive summary:

Attached is confirmation of the awards given at the recent Employers Based/Local Clinical Excellence Awards Committee for the year 2018/19.

CONFIRMATION OF INVESTMENT FOR 2018/19 AWARDS, AND REVIEW APPLICANTS' MANDATORY TRAINING, JOB PLANNING AND APPRAISAL RECORDS

The Committee were advised by the Executive Director of Workforce and Communications that this was the first year of the new rules and that awards are now non-consolidated and non-pensionable and paid annually in one lump sum. She advised that awards are now on a reducing time limit, with this year 2018/19 awards being for 3 years, 2019/20 awards for 2 years and 2020/21 awards for 1 year. The new formula with the new rules for the investment gives a total of £145,672.80.

She added that this is a large amount and that the total does not have to be awarded; the awards are only for excellence and there have always been some years that are a lot lighter.

The Medical Director suggested in future it would be useful for the Committee to have the previous year's scores for comparison, to allow the panel to compare what level the scores are that year against what scores had had points awarded previously.

The Executive Director of Workforce and Communications advised they must be careful as the scores are only indicative and there are also the high level, single domain scores that can be awarded, which often happens for applicants at the lower end of the average scores. She added that the average scores for the last 5 years would be useful and agreed that these would be supplied in future.

There was further discussion around the fact that the scores were lower this year; more junior consultants were applying and that the tax/pension issue and perhaps the changed timing of the awards had probably created this. It was confirmed that the tax/pension issue would be discussed under AOB. The pattern of specialties that do apply was also discussed and the fact that there is only one applicant from CSS and none from O&G or Acute Medicine was highlighted. The Executive Director of Workforce and Communications said they may need to describe what is meant by excellence and include local contribution and that she would do this with Chief Operating Officer and the Medical Director.

It was suggested that the CDs ask their Clinical Leads to encourage appropriate people to apply. This was agreed this was a very good idea and it would be discussed further at the Review meeting.

There was positive discussion around the Workshop put on by the Deputy Medical Director and the Medical Staffing Manager, which the panel felt had been helpful. It was suggested that this happens

every year; this would also need agreement at the Review meeting.

The Chairman of the Committee checked that all submissions were compliant with the mandatory training, appraisal and job planning. The Director of Workforce and Communications advised that she was very pleased to advise that there were no issues this year.

TO AWARD CLINICAL EXCELLENCE POINTS – 2018/19 CVQs

Shweta Bhagat
Dr Bhagat was awarded 3 points from 1st April 2019, payable in July 2019.

The points were awarded for taking on and resolving the long-standing methotrexate prescribing issue and for her leadership, resulting in the Rheumatology peer review saying it was the best department they had seen.

Carolyn Cates
Mrs Cates was awarded 1 point from 1st April 2019, payable in July 2019.

The point was awarded for her work in ocular plastic surgery and her excellent work in the ophthalmology service.

Karine Cesar
Dr Cesar was awarded 3 points from 1st April 2019, payable in July 2019.

The points were awarded for her leadership and for revolutionising the acute paediatric services during a challenging time in paediatrics.

Eamonn Coveney
The Committee considered Mr Coveney's submission and on this occasion awarded no points.
No points were awarded as his submission had not demonstrated sufficient change since his last application.

Vijay Gopal
Dr Gopal was awarded 2 points from 1st April 2019, payable in July 2019.

These points were awarded for moving intensive care to the 21st century model with bedside echo and ultrasound and for continuing the formal teaching of trainees.

Abigail Hallett
Dr Hallett was awarded 3 points from 1st April 2019, payable in July 2019.

The points were awarded for her contribution across all domains and especially for her superlative input to education and training.

Wasim Huda
Dr Huda was awarded 1 point from 1st April 2019, payable in July 2019.

The point was awarded for his excellent work on the anaphylaxis pack and guideline.

Maryam Jadidi
Dr Jadidi was awarded 3 points from 1st April 2019, payable in July 2019.

The points were awarded for her exceptional teamwork with eCare and her colleagues, being the most successful and virtually seamless implementation of eCare in the Trust.

It was suggested that at the Review meeting the Committee discuss the section of the application that asks what points applicants are applying for.

Sonja Jovanoska
Dr Jovanoska was awarded 1 point from 1st April 2019, payable in July 2019.

The point was awarded for her work in research and teaching.

Alexander Martin
Dr Martin was awarded 2 points from 1st April 2019, payable in July 2019.

The points were awarded for his local, regional and national input into the research of stereotactic radiotherapy and his leadership in implementing these new practices across 3 Trusts, making an impact at WSH.

Marcos Martinez Del Pero
Mr Martinez Del Pero was awarded 2 points from 1st April 2019, payable in July 2019.

The points were awarded for his impressive change management work in moving ENT forward service improvements. He had the highest score in Domain 3, Managing and Leading a High Quality Service.

The Medical Director suggested that Marcos would have ranked differently if it was done by highest score in an individual domain. It was agreed this could be done as well as providing the average scores. This may need discussion at the Review meeting.

Dan Patterson
Dr Patterson was awarded 1 point from 1st April 2019, payable in July 2019.

The point was awarded for his leading work in the oncology service and his contributions to teaching and research.

Arun Saraswatula
Dr Saraswatula was awarded 2 points from 1st April 2019, payable in July 2019.

The points were awarded for his excellent work developing the tongue-tie service which also created positive publicity and for his work in making paediatrics more active in research.

The Deputy Medical Director noted that the word count had been exceeded and asked that this is reviewed so that the application form does not allow further input when the limit is reached, as it had been some years ago.

Anup Sengupta
Mr Sengupta was awarded 1 point from 1st April 2019, payable in July 2019.

The point was awarded for his development of urology services and for his exceptionally high levels of work.

Antony Sillitoe
Mr Sillitoe was awarded 1 point from 1st April 2019, payable in July 2019

The point was awarded for his excellent work in managing and leading the Plastic Surgery service.

Thanos Vardarinos
Mr Vardarinos was awarded 1 point from 1st April 2019, payable in July 2019.

The point was awarded for his impressive work in obtaining capital from Novartis for the AMD service and also for his development of non-medical practitioners.

Philip Vaughan
Mr Vaughan was awarded 1 point from 1st April 2019, payable in July 2019.

This point was awarded for his innovation and development in the foot/ankle service, including the diabetic foot clinic.

Nicholas Ward
Mr Ward was awarded 2 points from 1st April 2019, payable in July 2019.

The points were awarded for his service developments in colorectal surgery and implementation of a national study.

Katrina Williams
Dr Williams was awarded 1 point from 1st April 20189, payable in July 2019.

The point was awarded for her work in teaching and training, in particular for leading the Airways Skills workshop twice a year.

Before the final award levels were agreed, there was further discussion around the points for the following 8 applicants:-

Nicholas Ward, Vijay Gopal, Shweta Bhagat, Arun Saraswatula, Alexander Martin, Abigail Hallett, Karine Cesar, Maryam Jadidi.

It was noted that extreme success in one domain may be worth more than the average across all domains. It was also noted that the panel have changed what they have always done as he had never known 3 points to be awarded before. He added that after the 3 year term of the award, 3 points is a significant income loss.

The Director of Workforce and Communications advised she had seen 3 points awarded in previous years. The Medical Director commented that there has not been much in the Trust's gift for discretionary work and now awards are not forever. He added that people might want to try again in 3 years for 3 points.

He advised the serious point that cannot wait for the review meeting is advising those awarded to take financial advice. He said that they could accept 1, or 2 or 3 points. The Director of Resources suggested that applicants are advised what points they have been awarded and if they come back after taking financial advice with an alternative request, the Trust will be happy to consider this.

The Deputy Medical Director suggested that particular note is made in the advice concerning financial thresholds and the associated costs. The Director of Workforce and Communications advised the matter was extremely complex.

The Chair of the committee confirmed that the letter to applicants would refer to the tax issue and it was agreed that The Director of Resources and the Director of Workforce and Communications would prepare this communication.

At the conclusion of the awarding of points, the investment for the awards was reviewed. Gary Norgate confirmed that 31 points had been awarded totalling £93,496 of the £145,672.80 investment, leaving £52,176.80 to carry over.

Appendices 1 and 1a provide the values of the New and Existing awards for each consultant and the demographic detail for 2018/19.

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	X	X	X	X	X	X
Previously considered by:	Not Applicable						
Risk and assurance:	Not Applicable						
Legislation, regulatory, equality, diversity and dignity implications	Not Applicable						
Recommendation: For Information							

DEMOGRAPHIC Split – EBAC/LCEA Applicants (19) 2018/19

18 of 19 applicants were successful in gaining a New LCEA in the 2018/19 round

Sex		Ethnicity					Age					Full/Part time	
Female	Male	British Other	Indian	British Indian	White Other	White British	35-39	40-44	45-49	50-59	60+	Full	Part
6	13	2	2	3	4	8	1	9	5	3	1	16	3

Divisional Split of Applicants

Community Paediatrics	CSS / W&C		Medical		Surgical	
Community Paeds	CSS	W&C	Acute/ED	Specialist	Anaesthetics	Surgery
0	1	2	0	3	5	8

Clinical Excellence Awards 2018/19

NHS West Suffolk NHS Foundation Trust

Title	Initial	Surname	Job Title	New CEA 2018/19	Local Award reason/other notes and comments
Dr	S	Bhagat	Consultant Rheumatologist	3	The points were awarded in recognition of taking on and resolving the long-standing methotrexate prescribing issue and for her leadership, resulting in the Rheumatology peer review saying this was the best department they had seen.
Mrs	C	Cates	Consultant Ophthalmology	1	The point was awarded in recognition of her work in ocular plastic surgery and her excellent work in the ophthalmology service.
Dr	K	Cesar	Consultant Paediatrician	3	The points were awarded in recognition of her leadership and for revolutionising the acute paediatric services during a difficult time in paediatrics.
Dr	V	Gopal	Consultant Anaesthetics	2	The points were awarded in recognition of his excellent work in moving intensive care to the 21st century model with bedside echo and ultrasound and for continuing the formal teaching of trainees.
Dr	A	Hallett	Consultant Anaesthetist	3	The points were awarded in recognition of her contribution across all domains and especially for her superlative input to education and training.
Dr	W	Huda	Consultant Anaesthetist	1	The point was awarded in recognition of his excellent work on the anaphylaxis pack and guideline.
Dr	M	Jadidi	Consultant Anaesthetist	3	The points were awarded in recognition of her exceptional teamwork with eCare and her colleagues, being the most successful and virtually seamless implementation of eCare in the Trust..
Dr	S	Jovanoska	Consultant Radiologist	1	The point was awarded in recognition of her work in research and teaching.
Dr	A	Martin	Consultant Oncologist	2	The points were awarded in recognition of his local, regional and national input into the research of stereotactic radiotherapy and his leadership in implementing these new practices across 3 Trusts, making an impact at WSH.
Mr	M	Martinez Del Pero	Consultant ENT Surgeon	2	The points were awarded in recognition of his impressive change management work, moving ENT forward from sub-standard delivery of service. He had the highest score in Domain 3, Managing and Leading a High Quality Service.
Dr	D	Patterson	Consultant Oncologist	1	The point was awarded in recognition of his leading work in the oncology service and his contributions to teaching and research.
Dr	A	Saraswatula	Consultant Paediatrician	2	The points were awarded in recognition of his excellent work developing the tongue-tie service which also created positive publicity and for his work in making paediatrics more active in research.
Mr	A	Sengupta	Consultant Urology	1	The point was awarded in recognition of his development of urology services and his exceptionally high levels of work.
Mr	A	Sillitoe	Consultant Plastics	1	The point was awarded in recognition of his excellent work in managing and leading the Plastic Surgery service.
Dr	A	Vardarinos	Consultant Ophthalmology	1	The point was awarded in recognition of his impressive work in obtaining capital from Novartis for the AMD service and also for his development of non-medical practitioners.
Mr	P	Vaughan	Consultant Orthopaedics	1	The point was awarded in recognition of his innovation and development in the foot/ankle service, including the diabetic foot clinic.
Mr	N	Ward	Consultant General Surgeon	2	The points were awarded in recognition of his service developments in colorectal surgery and the implementation of a national study.
Dr	K	Williams	Consultant Anaesthetist	1	The point was awarded in recognition of her work in teaching and training, in particular for leading the Airways Skills workshop twice a year.
	2018/19		**Total Spend**	**£93,496**	

Investment calculation 2018/19

2018/19 Investment*	**£145,673** -	
Minus 2018/19 spend	£93,496	= £52,177

2018/19 carry over	£52,177	
Minus 2017/18 carry over	£0	= £52,177
	= £52,177	Carry over (to 2019/20)

**161 eligible consultants @ 01/04/18*
161 x 0.30 = 48.3 x 3,016 = £145,672.80

Existing LCEAs (pre 2018/19)

(2018/19 Awards are New LCEAs and are therefore excluded from this list)

Name	Existing LCEA	Name	Existing LCEA	Name	Existing LCEA
J Aitken	1	M Karanth	2	E Senior	2
J Alberts	6	N Keeling	3	D Sharpstone	1
B Anand	2	S Keoghane	3	V Shenoy	3
R Ayyamuthu	2	A Khan	1	A Sinha	2
A Azim	4	N Levy	8	S Sinha	1
J Barrett	1	K Love	2	S Sjolin	2
K Basavaraju	1	M Macfarlane	1	M Suresh	2
S Bhagat	1	J Majeed	3	C Swanevelder	2
K Bhowmick	2	A Martin	1	R Tilley	3
C Brierley	4	A Mathur	1	A Vardarinos	1
E Bright	6	J Mauger	5	M Vella	2
C Cates	4	P Mills	7	C Vickery	3
DChitnavis	2	A Modi	2	S Whalley	2
E Coveney	6	P Molyneux	9	J White	2
V Crawley	5	M Moody	5	N Wijenaike	4
R Darrah	3	P Nicolai	2	K Williams	1
S Deakin	2	M Noone	1	G Wilson	3
FFahmy	4	D O'Riordan	8	M Wood	4
E Fraser-Andrews	1	M Palmer	4	C Woodward	5
I Frost	2	S Partridge	4	V Yiu	1
R Guirguis	3	D Patterson	1	S Young-Min	1
N Gupta	1	K Piccinelli	1		
E Hamilton	2	M Prasad	3		
I Hanspal	2	T Pulimood	3		
P Harris	2	V Rajagopal	1		
T Houghton	1	A Ranasinghe	1		
M Hunt	2	L Ranasinghe	1		
M Iles (prev. Clements)	7	J Reeve	2		
R Jenkins	2	P Salahshouri	2		
L Jeynes	1	A Saraswatula	1		
M Judd	5	A Sauvage	3	**Total Annual Spend**	**£705,744**