Board of Directors (In Public)

Schedule	Friday 27 September 2019, 9:15 — 11:30 BST
Venue	Northgate Room, Quince House, WSFT
Description	A meeting of the Board of Directors will take place on Friday, 27 September 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 Sheila Childerhouse

Agenda Open Board 27 Sept 2019 .docx

9:15 GENERAL BUSINESS
Presented by Sheila Childerhouse

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

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

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

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

NHS
West Suffolk
NHS Foundation Trust

5. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 26 July 2019
   For Approval - Presented by Sheila Childerhouse

   Item 5 - Open Board Minutes 2019 07 26 July Draft.docx

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

   Item 6 - Action sheet report.doc

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

   Item 7 - Chief Exec Report Sept '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 August19.pdf

   Item 8 - Integrated Quality & Performance Report_August 19_Draft_v1.docx

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9. Quality and learning report - Q1
   To ACCEPT the report
   For Report - Presented by Nick Jenkins and Rowan Procter

   Item 9 - 19-09-27 Quality and Learning report - Sept 2019.docx

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

    Item 10 - Board report Cover sheet - M05.docx

    Item 10 - Finance Report August 2019 Finalv2.docx

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

    Item 11 - EU Exit report Sept 2019.doc

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

    Item 12 - WSFT Trust Board NEPTS report 170919.doc

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

    Item 13 - Board report - Winter planning v1.0 200919.doc

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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

    Item 14 - Board Report - Staffing Dashboard - JulyAugust 2019 data.docx

    Item 14 - WSFT Dashboard - JulyAugust 2019.xls

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15. National patient survey report
    To ACCEPT a report and action plan
    For Report - Presented by Rowan Procter

    Item 15 - CQC inpatient survey 2018 - Board report.doc

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16. Education report
    To ACCEPT the report, including undergraduate training update
    For Report - Presented by Kate Read

    Item 16 - Education & Trust paper for Board September 19.docx

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17. Interim people plan
    To APPROVE the report recommendations
    For Report - Presented by Kate Read

    Item 17 - Interim People Plan - Summary of Work Streams 30 August 2019.doc

    Item 17 Appendix B - Improving People Practices Action Plan.VERSION 2.docx

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18. Annual reports:
    To ACCEPT the reports

18.1. Equality
For Report - Presented by Kate Read

Item 18.1 - Trust Board Annual EDI 2019 report final.docx

18.2. Infection prevention
For Report - Presented by Rowan Procter

Item 18.2 - Infection Prevention Annual Report 2018-19.doc

18.3. Safeguarding children and adults
For Report - Presented by Rowan Procter

Item 18.3 - Safeguarding children annual report 2019 v1.doc

Item 18.3 - Safeguarding children development plan May 2019.docx

Item 18.3 - WSFT Final Annual Safeguarding Adults Report 2018-19 (3).doc

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

Item 19 - Consultant appointment report - September 2019.doc

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

11:10 BUILD A JOINED-UP FUTURE

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

Item 21 - WSFT Board Sep - Alliance Update_Final.doc

Item 21 - WSFT Sept Board - Appendix 1.pdf

11:20 GOVERNANCE

22. Trust Executive Group report
To ACCEPT the report and APPROVE the quality improvement framework
For Report - Presented by Stephen Dunn

Item 22 - TEG report.doc

Item 22 -Annex Quality improvement framework.pdf

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23. Audit Committee report
To APPROVE the report recommendations
For Approval - Presented by Angus Eaton

Item 23 - Audit Committee Report September 19.doc

Item 23 -Audit Committee Annual Report 1819.doc

Item 23 -Review of Terms of Reference 1819.doc

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24. Digital board report
To ACCEPT the report, including update on community IT
For Report - Presented by Craig Black

Item 24 - Trust board - digital update - Sept 2019.doc

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25. Council of Governors report
To ACCEPT the report
Presented by Sheila Childerhouse

Item 25 - CoG Report to Board Sept 2019.doc

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

Item 26 - Items for next meeting.doc

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27. Use of Trust seal
To NOTE report
For Report - Presented by Richard Jones

Item 27 - Use of Trust Seal Report 27 Sept 2019.doc

11:30 ITEMS FOR INFORMATION

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

29. Date of next meeting

29.1. To NOTE that the next meeting will be held on Friday, 1 November 2019 at 9:15 am in Quince House, West Suffolk Hospital
For Reference - Presented by Sheila Childerhouse

29.2. To NOTE meeting dates for 2020/21
For Reference - Presented by Sheila Childerhouse

Item 29.2 - Board Dates 2020-21.doc

RESOLUTION TO MOVE TO CLOSED SESSION

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

AGENDA

Presented by Sheila Childerhouse

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 27 September 2019 at 9.15** in the Northgate Room, 2nd Floor Quince House, West Suffolk Hospital, Bury St Edmunds

Sheila Childerhouse
Chair

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**Introductions and apologies for absence** To note any apologies for the meeting and request that mobile phones are set to silent.	Sheila Childerhouse
2.	**Questions from the public relating to matters on the agenda** (verbal) To receive questions from members of the public of information or clarification relating only to matters on the agenda	Sheila Childerhouse
3.	**Review of agenda** To agree any alterations to the timing of the agenda	Sheila Childerhouse
4.	**Declaration of interests for items on the agenda** To note any declarations of interest for items on the agenda	Sheila Childerhouse
5.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 26 July 2019	Sheila Childerhouse
6.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
7.	**Chief Executive's report (attached)** To accept a report on current issues from the Chief Executive	Steve Dunn
9:40 DELIVER FOR TODAY		
8.	**Integrated quality and performance report (attached)** To accept the report	Helen Beck/ Rowan Procter
9.	**Quality and learning report - Q1 (attached)** To accept the report	Rowan Procter / Nick Jenkins
10.	**Finance and workforce report (attached)** To accept the report	Craig Black
11.	**EU Exit report (attached)** To accept report	Helen Beck
12.	**Non-urgent patient transport update (attached)** To accept report	Helen Beck
13.	**Winter planning - tracking report (attached)** To accept report	Helen Beck

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
14.	**Nurse staffing report (attached)** To accept a report on monthly nurse staffing levels	Rowan Procter
15.	**National patient survey report (attached)** To accept a report and action plan	Rowan Procter
16.	**Education report (attached)** To accept the report, including undergraduate training update	Kate Read
17.	**Interim people plan (attached)** To approve the report recommendations	Kate Read
18.	**Annual reports for:** 18.1 Equality (**attached**) 18.2 Infection prevention (**attached**) 18.3 Safeguarding children and adults (**attached**)	 Kate Read Rowan Procter Rowan Procter
19.	**Consultant appointment report (attached)** To note the report	Kate Read
20.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Kate Read
11:10 BUILD A JOINED-UP FUTURE		
21.	**West Suffolk Alliance report (attached)** To accept the report	Kate Vaughton
11:20 GOVERNANCE		
22.	**Trust Executive Group report (attached)** To accept the report and approve the quality improvement framework	Steve Dunn
23.	**Audit Committee report (attached)** To approve the report recommendations	Angus Eaton
24.	**Digital board report (attached)** To accept the report, including update on community IT	Craig Black
25.	**Council of Governors report (attached)** To accept the report	Sheila Childerhouse
26.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
27.	**Use of Trust seal (attached)** To note report	Richard Jones
11:30 ITEMS FOR INFORMATION		
28.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse

29.	**Date of next meeting** 29.1 To note that the next meeting will be held on Friday, 1 November 2019 at 9:15 am in Quince House, West Suffolk Hospital. 29.2 To note meeting dates for 2020/21 (**attached**)	Sheila Childerhouse
RESOLUTION TO MOVE TO CLOSED SESSION		
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Presented by Sheila Childerhouse

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For Reference

Presented by Sheila Childerhouse

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For Reference

Presented by Sheila Childerhouse

4. Declaration of interests for items on the agenda

To NOTE any declarations of interest for items on the agenda

For Reference

Presented by Sheila Childerhouse

5. Minutes of the previous meeting

To APPROVE the minutes of the meeting held on 26 July 2019

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 26 JULY 2019

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Sheila Childerhouse	Chair		•
Helen Beck	Chief Operating Officer	•	
Craig Black	Executive Director of Resources	•	
Richard Davies	Non Executive Director	•	
Steve Dunn	Chief Executive		•
Angus Eaton	Non Executive Director	•	
Nick Jenkins	Executive Medical Director	•	
Gary Norgate	Non Executive Director	•	
Louisa Pepper	Non Executive Director	•	
Rowan Procter	Executive Chief Nurse	•	
Alan Rose	Non Executive Director	•	
In attendance			
Georgina Holmes	Trust Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Kate Read	Interim Deputy Director of Workforce		
Tara Rose	Head of Communications		
Kate Vaughton	Director of Integration and Partnerships		
Governors in attendance (observation only)			
Peter Alder, Florence Bevan, Justine Corney, Jo Pajak, Liz Steele			

Action

GENERAL BUSINESS

19/145 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

Apologies were noted from Sheila Childerhouse and Stephen Dunn.

Alan Rose chaired the meeting in the absence of the Chair. He welcomed everyone to the meeting and apologised that the air conditioning was not working.

19/146 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

Liz Steele explained that the governors had had an informal meeting on Monday and the questions they had raised would be taken to the Council of Governors meeting on 6 August. Therefore in light of this and the heat they would not be asking any questions at the meeting today.

Alan Rose reported that Barry Moult had submitted a question about the high number of mixed sex accommodation breaches. It was agreed that Rowan Procter would address this in her report.

19/147 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

19/148 DECLARATION OF INTERESTS

None to report.

19/149 MINUTES OF THE MEETING HELD ON 28 JUNE 2019

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

19/150 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following updates given:

Item 1704; provide a trajectory for improvement of nutrition compliance as a result of the work with e-Care. Gary Norgate noted that nutrition appeared to be improving and asked if there would be a report in September. Rowan Procter said that she would pick this up in her report. It was noted that the appendix had been included in the papers for the previous meeting.

Item 1723; provide an update on progress/developments with non-urgent patient transport. Helen Beck explained that the CCG had issued a contract notice and there was a rapid improvement plan in place. At the beginning of this week the interim data for the KPIs from Ezec had not really shown any improvement which was disappointing. A workshop would be taking place next Friday to go through this data in more detail as there were also concerns about the methodology that was being used for recording against some of the KPIs. If by the time the July figures were received there was no improvement the CCG would be issuing contract penalties which would mean withholding money. Helen Beck was not sure that this would make much difference, therefore providing logistics expertise to assist them was being considered; this would be done by the CCG, supported by WSFT.

The completed actions were reviewed and the following comments made:

Item 1721; the narrative in the 'when' box in the IQPR to be developed to focus on the outcome to be achieved and the timescale for delivery. Craig Black said that this was work in progress and explained that the relevant areas were continually being pushed to identify trajectories and target dates for all of these.

19/151 CHIEF EXECUTIVE'S REPORT

Craig Black reported that the hospital had been unbearable at times during the hot weather and everyone needed to be aware that this was the case for colleagues and patients in the main building. Ice lollies had been distributed to staff and patients in the hospital this week and fruit in the community as a token to acknowledge the difficult conditions. The reason that this was so bad was that the building was originally designed to be kept cool through air flow. However since then, due to legislation, it was now not possible to open the windows very wide at all which meant that there was little or no air flowing through.

The new accommodation had been officially opened and the new labour suite and second phase of the acute assessment unit (AAU) were all examples of capital programme work that was being undertaken to improve facilities and conditions for both patients and staff.

WSFT was working with partners and colleagues to progress the transfer of Newmarket hospital and develop it to become a local community hub.

Notification had been received that the CQC would be visiting in the autumn and preparations were ongoing throughout the organisation, however this was business as usual and the Trust was prepared for them to visit at any time.

The results of the General Medical Council's doctors in training survey was a fundamental part of what WSFT did as a hospital and to be ranked as number one Trust in the east of England was a great achievement and something to be proud of.

Angus Eaton referred to the awards that had been made to a number of doctors and proposed that the board should express their congratulations to these individuals. **S Childerhouse**

Alan Rose asked if the doctors in training survey received any publicity amongst junior doctors. Nick Jenkins confirmed that this was the case; he explained that the trainees completed the survey but it was the consultants and doctors who trained the junior doctors. There was not another district general hospital (DGH) in the top three and these results had been published more widely than within WSFT and the east of England. Tara Rose confirmed that a press release was in the process of being signed off.

Richard Davies noted that acute nephritis which was referred to the first paragraph of this report was a kidney not liver condition.

Gary Norgate highlighted Medic Bleep as another success for the Trust. It was reviewed at the eCare board yesterday and had been received in a very positive way. From next week when the new junior doctors arrived all bleeps would be removed and Medic Bleep would be used across the whole Trust.

It was noted that Matthew Hancock was remaining as Health Secretary which was positive for WSFT.

Alan Rose asked if work was continuing on Brexit. Helen Beck confirmed that this was reviewed on a regular basis as it was one of the Trust's red risks. A report would come to the September board meeting. **R Jones / H Beck**

DELIVER FOR TODAY

19/153 INTEGRATED QUALITY AND PERFORMANCE REPORT

Rowan Procter reported that pressure ulcers had reduced this month and it was hoped to see a continuation of this reduction over the next few months. The level of falls per 1000 bed days had been maintained.

Complaints had reduced to 16 this month versus 25 last month. Rowan Procter and Nick Jenkins had reviewed the 25 from last month and a paper with the findings would be circulated after this meeting but no significant trends had been identified. **R Procter**

There was an increase in root cause analysis (RCA) actions overdue. A significant piece of work focusing on this would be undertaken during August and it was hoped that these would reduce and then the level maintained.

A positive improvement in national audit reports and responses continued to be seen; these were now at 13 against a target of 10.

There had been 20 mixed sex accommodation breaches in the acute assessment area. It was explained that due to the pressures on the organisation the decision had been made to use the trolley area in AAU which meant that all patients in this area were breaches, although screens had been used. Rowan Procter explained that this was the right thing to do for patient safety and the situation was rectified the next morning.

The report showed four outstanding duties of candour; three had now been resolved but one was still outstanding.

There had been a reduction in responses to complaints within an agreed timeframe. This was because complaints were quite complex at the moment and the investigation/response needed to go through a number of services. It was important to ensure that the Trust was sending comprehensive responses rather than meeting the timeframe.

There was one case of PALs contacts becoming a formal complaint. Rowan Procter explained that she had spoken to the family to instigate this in order to ensure an appropriate investigation.

Whilst there had been a decrease in performance for sepsis this only equated to one patient. All breaches were going through the RCA process.

Louisa Pepper referred to complaints response times and asked for assurance that the patient experience team had the capacity to respond to these or if further support was required. Rowan Procter explained that the team's capacity had reduced and the CCG team would be assisting with responses for two days a week.

Angus Eaton asked if the Trust was doing enough to learn from complaints, particularly as they were becoming more complex. Rowan Procter explained that with a number of complaints this involved complex clinical pathways and managing a number of different conditions and not explaining things clearly enough to families and meeting their expectations. An example of this was the use of terminology and their understanding what it meant, if a patient was asked if they had a been offered a chaperone they would say no, when in fact they had asked been asked if they had been asked if they would like a family member to be with them. All formal complaints were recorded on Datix which meant that they were investigated and there was formal learning from them. Families were told if the deadline for a response would not be met due to the need to ensure that a thorough investigation was undertaken and that they received a comprehensive response.

Gary Norgate asked for a comment on nutrition and hydration recording and the forthcoming use of e-Care. Rowan Procter explained that this was a matter of nurses' time and also their understanding of the impact of poor nutrition and the benefits of good nutrition and everything that this affected, eg falls, pressure ulcers, length of stay. Therefore further training was being put in place for staff and a pilot was being undertaken on F9 which would include the use of e-Care to make the recording of assessments easier for staff.

Richard Davies referred to antibiotic prescribing compliance which appeared to be fairly poor in medicine, particularly the 72 hour review. He asked if there was a problem in the way that junior doctors were prescribing antibiotics. Nick Jenkins explained that he had followed this up when he received this data, ie results of the audit, and the antibiotic pharmacist was clearly of the view that this was about documentation and failing to record that a review had been undertaken.

Helen Beck referred to discharge summary performance and explained that there would be a further drive on this with the new junior doctors. Changes had been made within the emergency department with the introduction of an overlap at handover to allow time for completion of discharge summaries and other admin but this did not appear to be working. Discharge summaries were particularly challenging in this area as hundreds of patients were discharged every day. One of the main challenges for the department was clinicians from other departments rather than emergency department doctors and work continued to be undertaken to

address this.

Discharge summary performance for elective inpatients had improved considerably and Helen Beck received weekly reports and was focussing on areas where there were issues. Non-elective discharge summaries were more challenging as well as maternity patients who correctly appeared in the data as emergency admissions even though most of them were planned admissions. This continued to be focussed on.

RTT performance was not making the required progress. Several of the NEDs had attended a number of performance meetings and attested to the rigour that the operational teams had around this. There were now backlogs that required further action and Helen Beck had spoken to the CCG executive team last Wednesday who had approved an additional £1m funding to support this. However, money was not the only issue and capacity now needed to be identified to address this through both in-house and external support. A very detailed capacity and demand analysis by service had been undertaken over the past few months which meant that the requirements to address this for each service were now known.

The scrutiny committee was looking at this in more detail but the 'when' section of the SPC would not be completed until it was known when the capacity would be available.

Alan Rose asked if many complaints had been received from patients about this. Helen Beck said that there tended to be more informal rather than formal complaints, ie telephone calls to the booking team.

Helen Beck referred to diagnostics within six weeks and explained that this had recently been a real problem in cardiology with the move to the new facility, a new recording system and an increase in referrals for echocardiograms. However, the latest report showed that cardiology was now back on track and reporting as green which meant that the recovery plan had delivered as expected. Unfortunately there was a now a problem in endoscopy due to upgrading and replacing equipment which had reduced capacity. There had also been a significant increase in referrals which had had a major impact. As a result the Trust was insourcing at weekends and it was anticipated that this would be back on track by the end of August.

The cancer two week wait for urgent GP referrals had been achieved this month and the Trust continued to focus on capacity in all the relevant areas to ensure that this was maintained. Currently the usual issues with dermatology in the summer months were not being seen.

The two week wait for breast symptoms was more of a concern; however the majority of the breaches were due to patient choice and their not accepting appointments within two weeks. Work was therefore being undertaken with GPs around setting the expectations of patients at the point of referral as to why they needed to attend an early appointment.

The cancer 62 day wait performance had been very disappointing. This was linked to diagnostic issues within endoscopy. A significant proportion of breaches were in the colorectal cancer pathway and there had been a detailed review for each of these patients. This area was therefore being focussed on to improve performance and a new pathway was being developed to help to reduce the time scales. The team was also working on the implementation of the lung pathway in order to improve performance and timescales.

Gary Norgate asked when an improvement in this could be expected. Helen Beck said that she expected to see an improvement in endoscopy capacity in August, however there could be a four to six week lag in terms of the impact on 62 day performance.

Richard Davies asked if there was a plan to increase capacity in the long term in endoscopy as referrals would continue to increase. Helen Beck confirmed that the new equipment would help to increase capacity and additional staff were also being recruited for this area. Therefore there should be sufficient capacity to manage the increase in referrals.

The number of cancelled operations had slightly increased this month and the reasons for this were given in the report, ie unplanned sickness in the clinical team and also estates issues which had impacted on a number of patients. All patients had been re-booked within 28 days.

Louisa Pepper asked about data quality issues for referral to treatment times (RTT) and if this had been resolved. Helen Beck explained that this would never be fully resolved but it still needed to improve. Currently validators were processing 1000 pathways which was far too high a number. Part of the additional funding from the CCG would provide support to bring in additional validators. In-house experts were also being released to undertake a training programme, ie all medical secretaries, TAC team and there had also been good engagement from consultant speciality groups. The validation resource was also being redirected to the front end of the pathway which was helping to improve the situation and identify issues that could then be addressed.

Gary Norgate asked Helen Beck how the board could be assured that RTT performance was not leading to patient harm. Helen Beck said that complaints were not being received or clinical incidents reported; also all patients who waited 52 weeks or more had a clinical harm review. Patients who cancelled and rebooked were also reviewed by clinicians, if there was a concern this would be identified but this was not the case. Kate Vaughton said that GPs also saw these patients on a regular basis and would flag up any issues.

Gary Norgate noted that the longest wait in the emergency department looked to be very long. He asked if this was due to anything additional or different that was being done in this area as a result of the pilot that WSFT was taking part in. Helen Beck explained that this was an issue for one patient who was a mental health patient waiting for an assessment. She said that they were now looking at the number of patients waiting for 12 hours from arrival and this had halved. She explained that in some cases the new way of working was making it better for patients but it definitely wasn't making it worse.

Nick Jenkins agreed and said that the number of people waiting for the longest time had halved and this was likely to be the same across the other pilot sites. The new standard meant that Trusts did not stop focussing on patients once they had missed the four hour target. Helen Beck did not consider that consultant behaviour had changed due to the pilot and different standards.

Gary Norgate referred to children in care health assessments and acknowledged that this was very difficult. He asked if there was a metric that could be used to provide assurance that this was not getting any worse and was due to people not turning up for appointments. Helen Beck said that she had asked for a timeline for a number of patients and in two instances there could have been a capacity issue.

For the other cases she was assured that they had been offered multiple dates which they had not attended. This information meant that this could be followed up with the foster parents/carers. Further detail would be provided in this report for the next meeting. **H Beck**

Angus Eaton noted that the main reason for sickness absence was anxiety, stress, depression or other psychiatric illness. He asked for assurance that there was not a significant issue that was brewing which needed to be addressed across all staff. Kate Read explained that this was being looked at in detail. A plan was being put together which would go to TEG and initially looked at medical staff and the provision of additional clinical psychiatric support. This was also being looked at by other Trusts. She assured the board that trends were looked at on a regular basis and taken to TEG.

Richard Davies referred to mandatory training and noted that there was no 'when'. He would have expected this to have started to improve after the winter period. Kate Read explained that a plan and trajectory for improvement went to the last board meeting. All new starters were now able to complete their mandatory training before their arrival at the Trust and FY1s were already undertaking mandatory training before they joined the Trust. A communication had been sent to all staff yesterday about accessing their online training in an easier way and all the work in the action plan was ongoing. Tara Rose explained that mandatory training should now be accessible via a tablet or mobile phone which should make it easier for staff to complete.

Louisa Pepper asked Kate Vaughton what metrics it would be helpful to include for community in the SPC charts. Kate Vaughton explained that some of the information /data could not be separated eg RTT, demand management, therefore this would need to be included in the narrative. However, she had discussed what metrics could be used for localities, eg demand on a quarterly basis, particularly where there were key issues and what actions were being taken that were having a positive impact. She said that she would like to be able to report this as part of the integrated quality and performance report (IQPR) but this would be an ongoing challenge. **K Vaughton**

Gary Norgate noted the significant improvement in the appraisal rate and congratulated the organisation on achieving this. Helen Beck assured the board that there were not many people who were more than a year behind on their appraisal, and if this was the case it was due to maternity leave or long term sickness.

19/153 WINTER LEARNING AND PLANNING REPORT

Helen Beck explained that the board had requested that there should be a system report for this meeting. However, a further update would be provided as some of the demand management initiatives were still being worked through. Currently no demand management initiatives had been included in the bed model. A separate model would be created that looked at the initiatives and this would be included in the next iteration of this report.

The organisation was constrained by three things in terms of winter planning; finance, nurse staffing capacity and bed capacity all of which had to be taken into account. Therefore this paper needed to be read in conjunction with staffing/recruitment, finance and transformation plans.

Item 3 looked at the physical capacity available in the organisation to open additional beds in the winter. There was potential additional capacity of 12 beds in surgery, 13 beds on G3 which the Trust had not been able to close yet this year, 29 beds on G9 which could be opened as escalation beds and 24 beds on F10 that could be used

during the winter when gynaecology was relocated to F14.

The bed model made various assumptions and the charts in the report showed data that could be looked at to understand what was required. Conversations were currently being had with the CCG and Social Care to obtain funding to purchase 20 community beds during January and February which would help from a financial, capacity and staffing point of view.

A bed model was also being produced on a divisional level, ie medicine, surgery, women and children.

The proposals for what would be done with the current core capacity were detailed in item 6. Helen Beck reminded the board of the difference between escalation capacity and surge capacity and that there was no budget or staff recruitment plans to cover surge capacity. Item 3.3 showed what was and was not budgeted for.

The feedback from last winter was that there was a lack of strong operational and clinical leadership in some of the escalation areas. Therefore this would be addressed in terms of recruiting appropriate staff for these areas. Surge capacity would be managed by leadership in shadow form. It was anticipated that by the time surge capacity was required the planned staffing recruitment for the wards would have been achieved, therefore staff could be moved across from other areas.

Item 7 outlined the demand management initiatives that were being worked through. Helen Beck highlighted the increase in intravenous therapy in the community using Baxter pumps which could also be used in care homes.

Richard Davies considered this to be a very good paper but asked about the assumption of a 4% increase in demand when there had been a 7% increase this year. He was concerned that the organisation was setting itself up to fail if it was assuming a figure which was probably below reality. Helen Beck acknowledged this concern and explained that the model could be changed to a different percentage if required, ie 6% or 7%. The demand management initiative would also try to address this but following the workshop that was taking place if it looked like this could not be achieved the bed model would be revisited.

Angus Eaton agreed that this was a very helpful report but was concerned that the hospital continued to be extremely busy and appeared to be busier than in the winter. Helen Beck explained that there were more emergency department attendances at this time of year due to sports injuries etc but these did not translate into admissions. However the winter cohort of patients had reduced as the summer cohort arrived. Demand on the hospital in the winter was more likely to result in a requirement for a bed than in the summer.

Nick Jenkins explained that beds could be mistaken for capacity, ie the ability to process patients through whatever treatment they required. The more patients there were in beds the ability to process patients slowed down, eg diagnostics. More nurses and junior doctors were being recruited as the organisation approached winter.

Helen Beck explained that a lot of the demand management initiatives focussed on providing patients with the treatment they required without putting them in a bed. The new frailty model would be tested in August, ie use of trollies, changes in job plans for frailty specialist consultants so that patients did not have to be admitted to a bed.

Alan Rose asked why the Trust had not budgeted for surge capacity when it was known that it would have to spend money on this.

Craig Black said that budget for surge capacity should not be required as this should be an exception; there was a contingency budget for exceptional items.

Alan Rose asked if buying 20 beds in the community meant that some people did not have to come into an acute hospital, why the Trust didn't also do this in the summer. Rowan Procter explained that the Trust spot purchased when necessary, ie two weeks respite/rehabilitation care when required.

Gary Norgate said that the organisation needed to be clear on demand forecast, staffing, recruitment of additional staff and purchase of community beds. Helen Beck said it was not difficult to get to full capacity but there was also the issue of funding. Gary Norgate agreed that there was also a question of funding, he asked for a report that tracked these four metrics which would alert the board if there was an issue. **H Beck**

The board approved this report and noted that a further update would be provided to in September. **H Beck**

19/154 FINANCE AND WORKFORCE REPORT

Craig Black explained that as usual the Trust's financial position was related to previous discussions at today's meeting, ie additional demand etc. Month three was a continuation of months one and two and this would continue in July. Currently the Trust was over spent by just over £800K for the first three months of the year. If this trend continued and if there was additional pressure in the winter the year end position could be a deficit of £5m against a control total of breakeven. If this was the case the Trust would lose some of sustainability and transformation funding (STF) which would make the position even worse.

In response to this all the divisions had been asked to come up with recovery plans and they were all working on this.

There was also an issue around capital funding which would have an effect on the number of beds in the organisation and the ability to invest in the future. The national total of all organisations exceeded the capital budget of the NHS by £1b. The response to this from the department of health (DH) had been to go back to individual organisations and ask them to reduce their capital plan by 20%.

To be able to spend money on the capital programme WSFT needed a loan of £10m from the DH. The Trust had therefore gone back to the DH explaining that 20% meant that £3.7m would be taken off the capital programme, ie theatre one, the emergency department scheme which had not yet been approved and the work on the roof this summer. The emergency department programme business case would be submitted at the end of November, therefore the money might not be spent this year but in the early months of the next financial year. In response to the 20% reduction WSFT had said that all it could do was to delay these schemes as they were all an essential part of the Trust's sustainability programme.

Details of the Trust's recruitment plans and how these would impact on its financial performance were given in the report. The aim was to increase the number of substantive staff so that there was not the requirement for the use of agency staff. As the establishment of permanent staff increased a reduction in the use of temporary/bank staff and overtime should be seen.

The plan for registered nurses and the number of vacancies at the end of June was shown on page 10 of the report. 175 nurses were being recruited over the next year. Craig Black explained that the deficit would start to fall until this time next year when he would expect there to be a surplus.

The cash position had deteriorated as expected. The Trust had received a significant amount of cash (£7m) in relation to its 2018/19 performance; however this would start to be spent fairly quickly, particularly if the I&E forecast was not being achieved. WSFT had not taken out any loan funding yet this financial year but it would need to start to draw on this as it moved forward.

Angus Eaton asked how the decision was reached about which capital programmes were delayed. Craig Black explained that all capital programmes had been through a prioritisation process and some were more essential than others. The decision about how to meet the 20% saving would consider what it was possible to stop spending on now. However, the Trust already had a number of financial commitments and it would also need to look at where further capital spend could be delayed as it got nearer March next year.

Alan Rose asked Craig Black if he could provide NEDs with the information on what would be delayed. Craig Black explained that apart from theatre one, the emergency department and roof this was not yet known or had not yet been agreed.

Gary Norgate asked about the existing CIPs and how confident Craig Black was that these would be delivered. Craig Black explained that all of these schemes had been risk assessed and reviewed on a monthly basis and he was reasonably confident about delivering the £8.9m programme. Part of the recovery plan would be to look at some of these schemes and where the full value could be delivered rather than the risk assessed value. Helen Beck said that the divisions were still looking at identifying further schemes and this was an ongoing process.

Angus Eaton asked for assurance at the next board meeting about the CIP programme and that additional CIPs had been identified. Craig Black explained that conversations were being had internally about recovery plans. External conversations were also taking place about demand on the system and the financial consequences and a system wide response to this was needed. **C Black**

Richard Davies asked about the recovery plan and if there was a risk that the Trust would need to re-visit some of the CIPs that had originally been put forward but were assessed as potentially having an impact on patient safety. Craig Black said that there was a possibility that these might need to be looked at again. He explained that there was always a balance between patient safety, quality of care and finance but the focus of the organisation was always around patient safety.

Angus Eaton said that the board concurred with this, ie patient safety first

Gary Norgate referred to the move to e-Care and the decision that was made that it would be better to have a block contract. He asked at what point the Trust would consider moving back to a tariff based contract as demand increased. Craig Black said that he could not see this happening. Relationships had improved considerably with the commissioner and changing back to a tariff based contract would not change the amount of money that was coming into the system. Gary Norgate recalled the work undertaken by PWC around generating and increasing business; he requested that this should be revisited to see if there was a point at which the Trust should move back to a tariff based contract. It was agreed to defer this discussion to a future meeting. **C Black**

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

19/155 TRANSFORMATION REPORT Q1

Helen Beck explained that internally hospital transformation was about efficiency and making sure that patients were not in beds any longer than necessary and also about demand management. Integrated care was about mitigating demand and RTT was about addressing issues through demand.

The project management office (PMO) was focussing on the latest update of 'Allocate' which would assist in managing resources more efficiently.

Richard Davies noted that item 4.5, demand management, intimated that there were a high number of inappropriate referrals in dermatology which he did not agree with. He asked what inappropriate meant and said that this was subjective. Helen Beck gave examples of where inappropriate referrals had been made. He acknowledged this but said that it was very difficult to make a diagnosis of skin cancer in primary care. Helen Beck agreed and apologised for the wording. She explained that the Trust had implemented the Teledermatology initiative but it was struggling to get GPs to use this.

19/156 NURSE STAFFING REPORT

Gary Norgate asked how the Filipino nurses were settling in. Rowan Procter confirmed that they were settling in very well and that they were very enthusiastic. It was proposed that there should be a staff story from the Filipino nurses at a Quality and Risk Committee meeting. **R Procter**

19/157 SAFE STAFFING GUARDIAN REPORT

The board noted the content of this report.

19/158 CNST INCENTIVE SCHEME

Craig Black explained that this was an insurance scheme through the NHS to cover clinical negligence. It was designed specifically in terms of the value of claims against maternity services.

Last year was the first year that the CNST had introduced an incentive scheme, ie if a Trust improved safety and procedures within the organisation they would be eligible for a discount on their premium. This was year two of the incentive scheme and details of the ten key actions that were required in order to benefit from this were given in the report.

Trusts were required to submit their response by the end of July and WSFT was saying that it was compliant with all ten actions.

Angus Eaton referred to action 2 and queried the date range of October 2018 to March 2019. Craig Black explained that the evidence required was for six months of data.

Alan Rose asked what the saving would be if this was accepted. Craig Black explained that it would be approximately £350k which was already included in the CIP programme. He said that there was likely to be a similar set of standards for this year.

The board approved this submission including the following declaration:

"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."

Nick Jenkins reported that yesterday the Getting It Right First Time (GIRFT) team had visited WSFT to look at orthopaedic litigation as WSFT had one of the lowest orthopaedic litigation claims in England.

19/159 CONSULTANT APPOINTMENT REPORT

The board noted the appointment of the following:

Dr Manal Issa, Consultant Community Paediatrician
Miss Christine Portelli, Resident On Call Consultant in Obstetrics & Gynaecology

19/160 PUTTING YOU FIRST

Kate Read reported that there had been three nominations for a Putting You First award this month: the Medical treatment unit (MTU) team; Lhara Ghowry, speech and language therapist; Sarah Monksfield and the staff and PDSNs on ward G3.

Medical treatment unit (MTU) team demonstrated high standards of care and all members of the team could explain any drug or treatment and refer them back to a patient's condition, but the most impressive thing was their caring attitude

They would change shifts to ensure that the unit was safe and adjust their workload and go the 'extra mile' to accommodate more patients and would listen to the doctors and RNs to support them with PICC line referrals and care. The MTU staff often supported other teams with blood transfusions and accommodates patients requiring surgery, adjusting their off-duty rotas if required. Even when under pressure, they would triage patients and work around lists to ensure that they supported other wards as much as possible.

The team always strived to foster a good rapport with their patients to help them feel comfortable before starting any treatment. They deserved to be recognised for the amazing job they did and for always having time to talk to their patients, for the reassurance that they gave and for their work ethic and flexibility.

Lhara Ghowryis a newly-qualified speech and language therapist joined the SALT team in January and recently completed her first rotation in the early supported discharge team (ESD). Feedback about Lhara included commendations on her dedication, commitment and knowledge, her organisational and communication skills and her superb engagement with all team members. She had set the way for a great working relationship with ESD was a credit to the SALT team.

Sarah Monksfield and her team, together with the PDSNs, recently cared for a 17 year old girl with a learning disability, type 1diabetes and complex social circumstances. The whole team ensured that this young person received exemplary, safe and holistic 24-hour care in often difficult circumstances.

Ward manager Sarah, was appointed to her post approximately three months ago. In her short time on G3 she had made tremendous progress, establishing her ward as a permanent after a period of use as a winter escalation area.

She was an inspirational leader and set high standards which she modelled herself in daily practice. She had established a new and enthusiastic band six team who had in turn had a positive effect in leading the wider nursing team. Her energy and enthusiasm were a great credit to her, and her efforts were appreciated across the Trust. She was proving to be an excellent ward manager and had all the attributes of a great leader.

The board congratulated the above on their awards. It was explained that individuals received a certificate and this was also shared on social media and in the green sheet.

19/161 ANNUAL CLINCIAL EXCELLENCE AWARDS REPORT

Richard Jones explained that there had been a change in requirements to the public reporting of these; therefore more details were being provided to the board.

Nick Jenkins explained that clinical excellence awards had traditionally been for ever and were not pensionable; however this would reduce from three years to one year over the next three years and would also become pensionable. He explained how these awards were made and the criteria that were considered. This was the only way that Trusts could financially incentivise consultants for any additional work they had undertaken or effort they put in. The benefits of the changes were that people would need to continue to provide excellence in the subsequent years in order to maintain their salary.

Gary Norgate considered this to be a very well run process with robust challenge. He said that it was important to continue to encourage consultants to apply for these awards.

Nick Jenkins confirmed that these had also been published internally before going to the board.

BUILD A JOINED-UP FUTURE

19/162 WEST SUFFOLK ALLIANCE REPORT

Kate Vaughton referred to the development of the clinical community leadership programme and that it had taken nearly three years to get to this point. The programme was now in place and there were key leaders within the localities. They were encouraged to work together and consider initiatives and new/different ways of working. There had been a great deal of interest from individuals with a number of very good applicants and this was seen as a very positive programme. She explained that this should help with addressing issues such as demand management across the whole system.

Alan Rose asked Kate Vaughton what she thought the next major change would be to drive the alliance and community programme forward. She said that the leadership team in each of the localities were working to identify what was needed to help different individuals to adapt to the changes. She stressed that this could be a long term thing; Nick Jenkins agreed and said that this was likely to take 12 months.

Kate Vaughton explained that the benefits should be seen in tandem with the quality improvement programme which should start delivering towards the end of this year and into next year. This, linked with the leadership programme, should be the next major initiative.

Richard Davies referred to the work undertaken by Emma Williams on developing a holistic wound care clinic and said that this was an outstanding example of an individual driving improvement.

GOVERNANCE

19/163 TRUST EXECUTIVE GROUP REPORT

The board approved the updated risk management strategy.

19/164 QUALITY AND RISK COMMITTEE REPORT

The board received and noted the content of this report.

It was noted that Liz Steele had also attended the presentation but this had not been recorded.

19/165 ANNUAL REPORT AND ACCOUNTS

It was noted that annual report and accounts had now been laid before parliament and therefore could now be published and brought to the open board meeting.

19/166 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were noted and approved. It was agreed that a report on Brexit would also be included. **R Jones**

ITEMS FOR INFORMATION

19/167 ANY OTHER BUSINESS

It was confirmed that the IQPR and finance report would be circulated to the board at the end of August. **R Jones**

19/168 DATE OF NEXT MEETING

No meeting in August. The next meeting would take place on Friday 27 September at 9.15am in the Northgate Room, Quince House, West Suffolk NHS Foundation Trust.

RESOLUTION TO MOVE TO CLOSED SESSION

19/169 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.

DRAFT

6. Matters arising action sheet

To ACCEPT updates on actions not covered elsewhere on the agenda

For Report

Presented by Sheila Childerhouse

Board of Directors – 27 September 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 September 2019			
Subject:	Matters arising action sheet			
Purpose:		For information	X	For approval

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

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

Actions are RAG rating as follows:

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

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**			**Invest in quality, staff and clinical leadership**		**Build a joined-up future**	
	X			X		X	
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	The Board received a monthly report of new, ongoing and closed actions.						
Risk and assurance:	Failure effectively implement action agreed by the Board						
Legislation, regulatory, equality, diversity and dignity implications	None						

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

Ongoing actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1736	Open	26/7/19	Item 8	Provide quarterly reporting on locality baseline reviews (within IQPR or Alliance report)	Scheduled to complete first round of reviews in October, so report to Board in November.	KV	29/11/19	Green
1740	Open	26/7/19	Item 16	Include Filipino staff story on the quality and risk committee agenda for September	Agenda for Q&RC meeting on 27 September	RP	27/09/19	Green

Closed 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 received by Board. Improvement trajectory to be received by Board following pilot on F9 (available August). **Included in Q1 quality and learning report**	RP	27/9/19 (revised)	Complete
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 was received at the Council of Governors meeting on 6 August. This will remain an item for active discussion by the Governors.**	NJ/RJ	27/09/19	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
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)	Further work is required to ensure consistent narrative for the IQPR and SPC report. **Updates made in IQPR and will continue to be kept under review.**	CB	27/09/19	Complete
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. **Included in IQPR**	NJ	27/09/19	Complete
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**. Part of Alliance update in closed session as being finalised**	KV	27/09/2019 (revised)	Complete
1732	Open	26/7/19	Item 7	Share the Board's congratulations with the chief residence on their success at this year's Chief Resident Clinical Leadership and Management Development Programme	Letter sent from Chair	SC	27/09/19	Complete
1733	Open	26/7/19	Item 7	Schedule exception reports on Brexit	**AGENDA ITEM**	RJ	27/09/19	Complete
1734	Open	26/7/19	Item 8	Circulate the findings of the complaint thematic review undertaken by Rowan Procter and Nick Jenkins	**AGENDA ITEM Included in Q1 quality and learning report**	RP	27/09/19	Complete
1735	Open	26/7/19	Item 8	Children in care: provide more detailed review and narrative to inform improvement plan	**Included in IQPR**	HB	27/09/19	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1737	Open	26/7/19	Item 9	Develop a report which tracks the key metrics for winter planning to provide visibility of progress/concerns - staffing, capacity, funding. To include both Trust and system perspective	**AGENDA ITEM**	HB	27/09/19	Complete
1738	Open	26/7/19	Item 10	Set out the cost benefit analysis for the strategic position re block versus payment by results contract	**Covered in the finance report**	CB	27/09/19	Complete
1739	Open	26/7/19	Item 10	Provide a details analysis of the cost improvement plan position along with commissioner support and additional recovery plans	**Included in financial report**	CB	27/09/19	Complete

7. Chief Executive’s report

To ACCEPT a report on current issues from the Chief Executive

For Report

Presented by Stephen Dunn

Board of Directors – 27 September 2019

Agenda item:	7			
Presented by:	Steve Dunn, Chief Executive Officer			
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

It seems like we've blinked and it's suddenly autumn! We've had a very busy few months since our last public Board meeting; **although operationally pressured we are coping** I can safely say that long gone are the days where we used to get a 'lull' over the summer months. I have often made the joke that working in the NHS is sometimes like being in Narnia, where it's perpetually winter and never Christmas!

In seriousness, our **staff have continued to work hard** as ever over the last few months and it's through their efforts that we've coped as well as we have, despite attendance and admission numbers continuing to creep, and sometimes leap, upwards. However we are in a better staffing position than we have been for some time; we have welcomed 100 overseas nurses to our team this year alone. We hope that in time we'll start to see a reduction in our agency spend, but we aren't complacent and we know that we might have to bolster our staffing numbers in this way over winter.

Of course, this puts pressure on our **financial position** and money is very much on our minds. I am extremely concerned that we have seen a deterioration in our financial performance with the month five position reporting a deficit of £4.1m which is £2.6m worse than plan. We agreed a control total to breakeven which means we need to deliver a cost improvement programme of £8.9m. We continue to forecast to meet our plan to break even in 2019-20. However, this requires a recovery plan to reduce the current rate of expenditure by around £10m. We do have recovery plans in place but it's clearly going to take a huge effort from all colleagues to get us to where we were aiming to be, which was to break even at the end of this financial year.

But we have launched a fantastic new **recruitment campaign, #BeKnown**, to help us keep staffing numbers ticking over and further reduce our use of more expensiver agency and overtime. #BeKnown tells the stories of Trust staff and what they're known for amongst their close knit working community. Because we know that, big or small, everyone makes a contribution to the Trust and its patients. Initially focused on a variety of clinical roles across the Trust, including doctors, nurses, pharmacists, and allied health professionals like occupational therapists and physiotherapists, we're calling on people to consider developing the next stage of their health career here with us at WSFT. Visit https://beknown.wsh.nhs.uk/ for more.

In the meantime, we plough on with **our developments** including opening phase 2 of our acute admission unit (AAU) – a key part of our plans for the winter. This state of the art facility demonstrates again the benefit of moving executive and corporate staff from this area of the hospital into Quince House - providing vital clinical capacity within the main hospital. The refurbishments F3 and the labour suite have also been completed providing fantastic upgrades. We are also progress plans to take on ownership of the Newmarket Hospital site in October.

Overall in terms of August's **quality and performance** we continue to be challenged against a range of metrics. There were 62 falls and 44 Trust acquired pressure ulcers. There was one hospital attributable MRSA bacteraemia case and two C. difficile infections. We failed to deliver on the cancer targets for three areas: 2 week wait breast symptoms (90.3%), Cancer 62 day GP referral (79.6%) and incomplete 104 days wait with three breaches reported in August 2019. Referral to treatment performance for June was 83.6%, with two 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 **Medicines and Healthcare products Regulatory Agency** (MHRA) undertook a one-day inspection at West Suffolk on 17 September. While we know there is still more to be done, it was

reassuring that the inspector recognised the improvements the laboratory has made. Formal written feedback from the visit is expected in the next two weeks.

We hosted our **annual members meeting** last week, and were delighted to see so many members and colleagues there. More than 150 people joined us at the event in the Apex in the centre of Bury St Edmunds. It's a real opportunity to share some of our achievements and challenges over the last year, and the audience was also treated to a specialist clinical talk on diabetes by our diabetes consultant Dr John Clark. I learned a lot! We were very grateful to our governors their support in planning and hosting the event. Thank you.

Since my last report we've also added a **new accolades** to our list; we were once again named as a CHKS Top 40 Hospital in the CHKS 2019 awards. These prestigious, national awards recognise hospitals that are safer for patients, more effective, more efficient and have lower mortality, comparing the performance of all hospitals throughout England, Northern Ireland and Wales. More than 20 indicators of performance were analysed by CHKS, healthcare improvement specialists, spanning things like clinical effectiveness, health outcomes, efficiency, patient experience and quality of care (including inpatient surveys), reported C-difficile rate for patients aged 2 and over, the NHS staff survey, and emergency readmission rates. It is once again an incredible achievement to be recognised.

We were also rated as the **top acute in the region for doctors' training** satisfaction, meaning we've now held the top spot for two years in a row. The doctors surveyed by the General Medical Council (GMC) at our Trust rated their overall satisfaction at 82%, a 3% increase on last year. Each year the GMC asks doctors in training questions based on a number of criteria, including clinical supervision, educational supervision, induction, teamwork and supportive environment, to ensure that doctors receive high quality training in a safe and effective clinical environment. As a Trust we care about personal development, so it's fantastic to see this yield results. Ensuring doctors are highly-skilled and knowledgeable about up-to-date clinical research isn't just great for them; our patients will have better care and a better experience too. So ensuring a great training experience for the NHS doctors of the future is so important.

I was so honoured to be able to give an extra special 'thank you' to six of our WSFT team this month, as I got to choose six colleagues to be invited to 10 Downing Street to attend a **tea party hosted by Prime Minister** Boris Johnson. Helen Ballam, ward manager at Newmarket Community Hospital; Sue Deakin, trauma and orthopaedics consultant; Ali Devlin, clinical practice facilitator; Marilou Franco, theatre nurse; Gylda Nunn, integrated therapies manager; and Dr Vivek Rajagopal, clinical director for medicine, made their way to London to discuss the challenges faced by the NHS, potential solutions to issues, and to share stories of how our WSFT staff go the extra mile for their patients. I understand they had a fabulous day, and had lots to say to the Prime Minister not just about the great parts of the NHS, but the challenges our NHS staff face too.

And we will round off the month with the first of our **Care Quality Commission (CQC) inspections** for the year, set for 24 and 25 September. At the time of writing this the inspectors haven't yet visited us, but we are looking forward to showing them what it means to #BeKnown at this Trust and what we're all about. We have always said that outstanding does not mean perfect, and we know we have areas where we need to improve. But we have much to celebrate, and most of all I look forward to the inspectors seeing how outstanding our staff are at caring.

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

Chief Executive blog
What will you #BeKnown for?: https://www.wsh.nhs.uk/News-room/news-posts/What-will-you-BeKnown-for.aspx

Deliver for today

Stop sepsis save lives

During the week commencing 9 September, members of the deteriorating patient group were raising awareness of sepsis. On the morning of World Sepsis Day (13 September) an information stand was available in the hospital's main reception area for patients and visitors. Sepsis is characterised by a life-threatening organ dysfunction due to a dysregulated host response to infection. It is one of the most prevalent reasons for deterioration in hospital, with national mortality rates over 25%. This highlights the importance of implementing the Sepsis 6 protocol within an hour of diagnosis, combined with adequate monitoring and escalation to the critical care outreach team. e-Care generates alerts for sepsis and these should be reviewed and completed by a doctor within the hour, confirming or ruling out a diagnosis of sepsis and implementing subsequent actions.

Creating a vocal legacy for patients

People in west Suffolk with a devastating condition which affects their speech are being supported to use pioneering technology to create a permanent "voice bank" for their loved ones. Voice banking allows a person to record phrases which can then be converted to create a personal synthetic voice when they no longer have the ability to use their own. Patients diagnosed with motor neurone disease (MND) work with speech and language therapists and a staff volunteer from our Trust (WSFT), with support from the MND Association and St Nicholas Hospice. Voice banking means that people who feel they are losing much of their identity can still "speak" to their friends and family. Most people with MND (80-95%) experience weakness in the mouth, throat and tongue, so voice banking allows them to record an infinite number of words and sentences that can be generated in a synthetic voice that bears a resemblance to the person's speech.

Frailty at the front door pilot

The Trust's 'test and learn' pilot, which has been looking at ways to improve outcomes for older patients living with frailty, completed in August. A multidisciplinary team had been brought together to assess the benefits of a frailty assessment unit, which recognises that patients living with frailty have unique needs and circumstances, and aimed to reduce unnecessary hospital stays by expediting prompt discharge and/or referral to an alternative pathway by:

- early identification of those with frailty
- initiating of a rapid response service
- early assessment and an individual multidisciplinary team care plan
- development of clinical professional standards to reduce variation in care
- strengthening of links in and out of the hospital.

During the pilot, the medically-optimised team identified a community assessment bed for use each day. There have been daily team 'huddles' - one at 8.30am to set the day's plan and another at 3.30pm. The lessons from the pilot will be used to inform next steps.

Invest in quality, staff and clinical leadership

Sarah on board to support community services

Sarah Judge has joined the team working to improve staff experience and patient care for our community services through the Trust's digital programme. Sarah, a physiotherapist by background who joined the Trust in 2000, has had a key role in developing e-Care and other IT systems as the digital operational lead. Now she has an additional role as chief clinical information officer, working with Andrew Smith and the information management and technology team to push forward digital progress in the community. The community digital programme is looking at three priority areas amongst the larger programme of work: connectivity, such as reliable Wi-Fi in the

community bases; the rollout of new mobile phones to community staff; and improving the hardware for our teams across the county. These will allow us to develop the integration of Trust services across Suffolk, and drive our focus on joined-up working across the whole health and care system.

Working towards a fairer Trust
As part of a drive to improve the working lives of colleagues with a disability, we recently held an open forum to share the views and experiences of people across the Trust. From this productive session, we have identified actions that will not only benefit people with a disability but all our staff, and therefore our patients too.

Soapbox success!
Our second soapbox challenge took place last week and we are thrilled to announce we raised an astonishing £19,000. To say we are chuffed is an understatement! The day started nice and early at 6.00am, when Mount Road was officially closed to traffic. It was then all hands on deck as we unloaded 100 crowd barriers, 100 road separators and 200 straw bales to line the course. This year we had so many amazing volunteers and they were all fantastic. Before we knew it, the course was complete with staging, ramps, jumps and a chicane. Soapbox City was ready to receive the teams and the food stations were up and running. A huge thank you to all our volunteers - we couldn't have done it without each and every one of them. We will be back in 2020 so, and will let you know as soon as we have a date in the diary.

Leaving a gift in your will
For those of you who like us on Facebook, you may have seen that this week is 'Remember a Charity in Your Will' week. Did you know that, on our neonatal unit, at least one tiny baby a day is treated with equipment purchased by a very generous gift left by a grateful patient? Gifts in wills provide an important part of our funding. Once you have considered all the important people in your life, leaving a precious gift in your will to My WiSH Charity, will make a real difference to the care your loved ones and future generations will receive. Your gift could provide state-of-the-art medical equipment, specialist therapies and services, in addition to the outstanding care that is already provided by the NHS. If you would like to find out more or want to talk to Michele about all things legacy related, give her a call on 01284 712952.

Build a joined-up future

Development programme for non-medical prescribers launched
Staff working across the alliance are being invited to take part in a continued professional development programme for non-medical prescribers (NMPs) which has been developed by Suffolk GP Federation. The programme is designed to offer alliance staff a single place to receive training, in turn reducing duplication and ensuring consistency. It includes an annual conference, three forums and two masterclasses, which give NMPs the chance to network, share best practice, listen to guest speakers and work through case studies. It is hoped the programme will help staff meet the requirements of the Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC) and Royal Pharmaceutical Society (RPS), which all ask their NMPs to complete continued professional development. The GP Federation is now working with the CCG and acute colleagues with the aim of introducing further joint training programmes in the future.

New independent chair appointed to Suffolk and North East Essex Integrated Care System
Professor William Pope will join the Suffolk and North East Essex Integrated Care System (ICS) as the new ICS independent chair. Professor Pope started his role in a part-time capacity in September, working closely with executive lead Dr Ed Garratt and other local leaders to help to further develop the vision to work together to improve health and care for local people. His appointment follows a competitive selection process involving a wide range of local and regional stakeholders, as well as formal approval by chief executive of the NHS, Simon Stevens.

Patients receive extra help at home
The British Red Cross Support at Home Service is based at West Suffolk Hospital; it offers support for people after being discharged from a hospital setting back into their normal routine by helping them to regain confidence and independence. The service can also support anyone who is experiencing a crisis following a hospital discharge. Types of support offered includes:

- shopping
- light housework
- collecting prescriptions
- confidence building and befriending
- signposting to other agencies for information, advice and long-term support for new or changing needs
- telephone support for up to six weeks for patients who are anxious about leaving hospital.

National news

Deliver for today

Duty of care? The impact on midwives of NHS charging for maternity care
This is the first study to investigate the impact of the policy of charging 'overseas visitors' for NHS care on midwives' practice or professional responsibilities. This study aimed to explore midwives' experience of looking after women who had been charged, especially in relation to the impact of NHS charging on their professional practice.

Patient experience in adult NHS services [NICE Quality Standard]
This quality standard covers improving the quality of the patient experience for people who use adult NHS services. It describes high-quality care in priority areas for improvement. It does not cover people using NHS services for mental health or the experiences of carers of people using NHS services. A separate quality standard, service user experience in adult mental health services, has been developed for people using NHS mental health services.

Emergency admissions to hospital from care homes: how often and what for?
Analysis by the Health Foundation found that care home residents aged 65 or over went to A&E 0.98 times and were admitted 0.70 times. Emergency admissions were particularly high in care home residents compared to nursing home residents. Around 41% of these admissions were for avoidable reasons for conditions that were manageable, treatable or preventable outside of a hospital setting.

Invest in quality, staff and clinical leadership

Freedom to Speak Up: guidance for NHS trust and NHS foundation trust boards

This revised guide by NHS Improvement contributes to the need to develop a more open and supportive culture that encourages staff to speak up about any issues of patient care, quality or safety.

Digital diabetes prevention rolled out as part of NHS Long Term Plan
Thousands of people who are at risk of Type 2 diabetes will receive digital support to prevent them developing the condition as part of the NHS Long Term Plan. In pilot schemes, offering convenient, 24/7 access to online advice significantly boosted the numbers taking up the flagship Diabetes Prevention Programme (DPP). People who are at risk of developing Type 2 but who cannot make face-to-face support sessions will be the first to benefit from the expansion which starts this month. They will receive:

- Wearable tech that monitors levels of exercise;

    - Apps which allow users to access health coaches and educational content
- Online peer support groups;
    - The ability to set and monitor goals electronically.

Unrelieved pain in palliative care in England
This study estimates that currently there are approximately 125,971 end-of-life patients receiving, or in need of, palliative care suffering from unrelieved pain. Of these, an estimated 16,130 patients experience no relief from their pain at all in the last three months of life. Some of these patients suffer unnecessarily because of variations in the quality of care across care settings (for example, hospice versus at home services).

Pension tax guidance for employers
In August 2019, the government announced that it will act to introduce pension changes to enable senior clinicians to take on additional clinical activities without incurring unexpected pension tax bills. This guidance has been prepared to help employers to support staff who are likely to be affected by these pension tax issues.

Build a joined-up future

Smoking, drinking and drug use among young people in England 2018
This report contains results from a biennial survey of secondary school pupils in England in years 7 to 11 (mostly aged 11 to 15). It focuses on smoking, drinking and drug use. It covers a range of topics including prevalence, habits, attitudes and – for the first time in 2018 – wellbeing.

Bleak houses: tackling the crisis of family homelessness in England
This report shines a light on this homelessness crisis and shares the experiences of some of those children. The Children's Commission visited children and families living in temporary accommodation, and spoke with them and some of the frontline professionals who work with them. The CC also carried out new data analysis to identify the scale of the problems.

E-cigarettes: an evidence update
This review explains the relative risks and benefits of e-cigarettes – in terms of harm reduction when compared with cigarettes and as an aid to quitting. It reviews latest evidence to conclude that e-cigarettes are around 95 per cent safer than smoked tobacco and they can help smokers to quit.

UK Chief Medical Officers' physical activity guidelines
These guidelines are for health professionals, policy-makers and others working to promote physical activity, sport and exercise for health benefits. They emphasise the importance of building strength and balance for adults, and include recommendations for pregnant women, new mothers and people with disabilities.

Pour decisions? The case for reforming alcohol duty
This report says that duty on alcohol should be dramatically overhauled so that the stronger a drink is, the more tax it incurs. It proposes a shift in the burden of taxation towards high-strength drinks bought for consumption at home, and away from weaker products bought in pubs and bars.

An evidence summary of health inequalities in older populations in coastal and rural areas
This report provides evidence on the health inequalities experienced by older populations in coastal and rural areas, together with a summary of key considerations to reduce inequalities and promote healthy ageing in these areas. It comprises a literature review supplemented with case studies, and brings together a range of information in one place with links to published research.

Navigating the uncharted waters: population ageing in the UK (International Longevity Centre UK)

This report argues that the UK's unprecedented population ageing poses a set of daunting, yet not insurmountable, challenges for policymakers, institutions and health care providers to design better solutions fit for an ageing society. It calls for health policy reforms that focus on preventing, rather than curing disease to enable people to stay active and healthy for longer.

Home from hospital

A report from the National Housing Federation on how housing services are relieving pressure on the NHS.

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 – 27th September 2019

Agenda item:	Integrated Quality & Performance Report			
Presented by:	Craig Black			
Prepared by:	Joanna Rayner, Head of Performance and Efficiency			
Date prepared:	19th September 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.

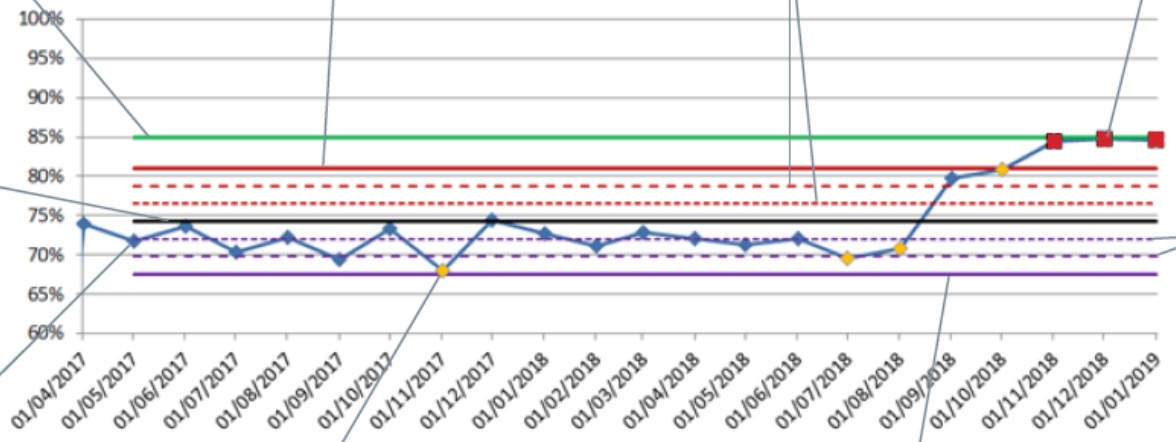
A control chart always has:

- 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	Aug-19

Safe domain	Standard	Actual	Trend	Assurance	Notes
New Pressure Ulcers - Trust	0	44	Common Cause Variation	Consistently above target	
Falls per 1,000 bed days	No target	5.6	Common Cause Variation	No target	

Effective domain	Standard	Actual	Trend	Assurance	Notes
Discharge Summaries: Outpatients	85%	ND	ND	Consistently below target	No data since August 2018
Discharge Summaries: A&E	95%	84%	Special Cause Variation - Low	Consistently below target	
Discharge Summaries: Non Elective Admissions	95%	81%	Special Cause Note/Investigation - High	Consistently below target	
Discharge Summaries: Elective Admissions	85%	76%	Special Cause Note/Investigation - High	Consistently below target	

Caring domain	Standard	Actual	Trend	Assurance	Notes
Compliments	No target	16	Common Cause Variation	No target	
Complaints	20	10	Common Cause Variation	Hit and miss against target	

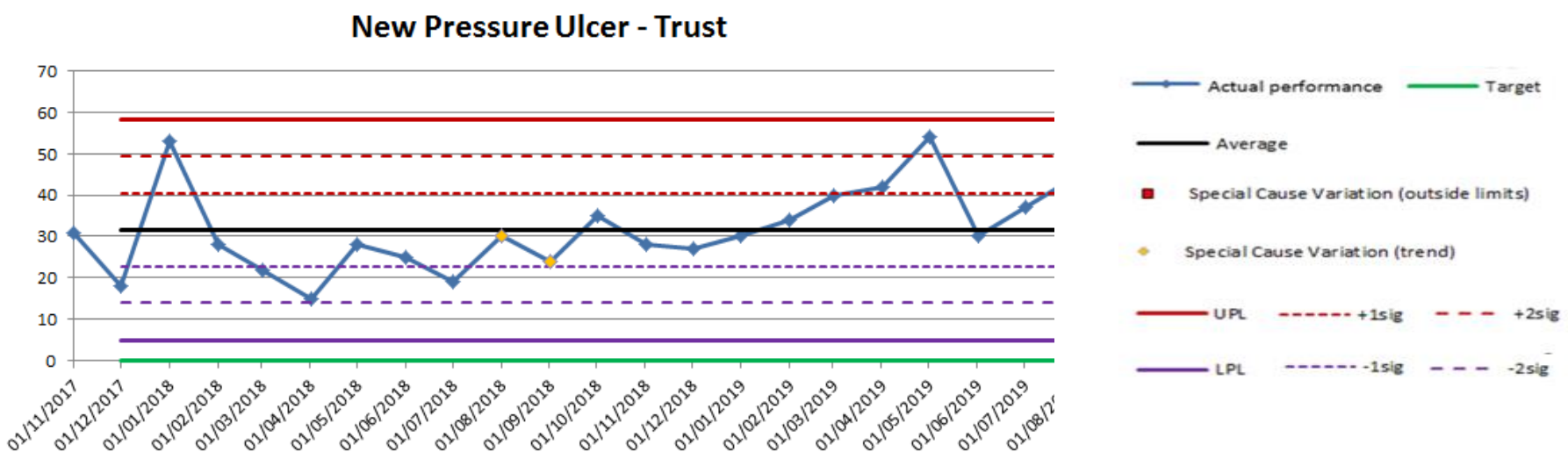
Responsive domain	Standard	Actual	Trend	Assurance	Notes
Referral to Treatment 18 week standard	92%	84%	Special Cause Variation - Low	Hit and miss against target	
Diagnostics 6 week standard	99%	95%	Special Cause Variation - Low	Hit and miss against target	
Sepsis	100%	90%	Special Cause Note/Investigation - 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%	90%	Special Cause Variation - Low	Hit and miss against target	
Cancer 62 day referral to treatment standard	85%	80%	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%	14%	Special Cause Note/Investigation - High	Hit and miss against target	

Maternity	Standard	Actual	Trend	Assurance	Notes
Number of deliveries (births)	210	215	Special Cause Variation - High	Hit and miss against target	
Caesarean Section rate	22.6%	21%	Special Cause Variation - High	Hit and miss against target	
Breast Feeding Initiation	80%	81%	Common Cause Variation	Hit and miss against target	

Pressure Ulcers - Trust

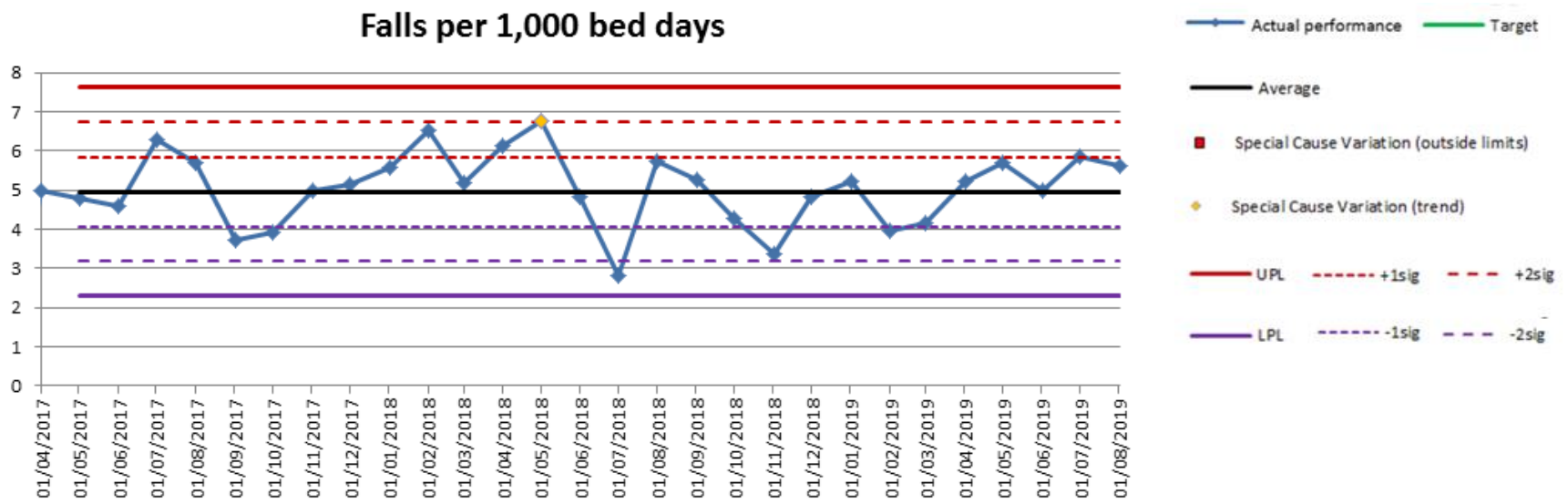
Safe



Narrative

What	At the time of writing, we note an overall increase in the number of new Pressure ulcers recorded during August. Whilst the number of Cat 2 Pressure ulcers reported remained static during the month, we experienced an unfortunate increase in Cat 3 (↑2), Cat 4 (↑3) and unstageable Pressure ulcers (↑2) reported. It is notable that an increase was also seen around Pressure ulcers present on admission to our service over the month of August when compared to July (↑24).
Why	We continue our aspiration of harm free care for patients and it is disappointing to see an increase in Pressure ulcer incidence during the month. All clinical areas and teams continue to work as effectively as possible, however the increasing complexity of patients in our care ensures that this remains a challenge, particularly for teams who care for patients in their own homes, where we have seen the greatest increase in incidence and severity.
How	We have reviewed and re-launched our internal monitoring process for Pressure Ulcer Prevention, to move to a more robust and systematic approach to investigation of PUs. This will involve a Panel review of randomised Root Cause Analysis investigations; recognition of themes requiring improvement and an integrated approach to learning will be agreed. We have extended the remit of this group to incorporate chronic and non-healing wounds, which we feel is vital – as an integrated organisation, we are keen to capture the impact of non-healing chronic wounds on people in their own homes. We have updated the group Action Plan to reflect this and our objectives.
When	Our focus remains around raising awareness and understanding of regular repositioning and the importance of good nutrition in wound healing. We have committed to a goal of a 5% reduction in the incidence of New Pressure ulcers by 30.03.20. There will a report on the outcome and learning from Pressure ulcer RCAs included in the November Board learning report.

Inpatient Falls - Trust

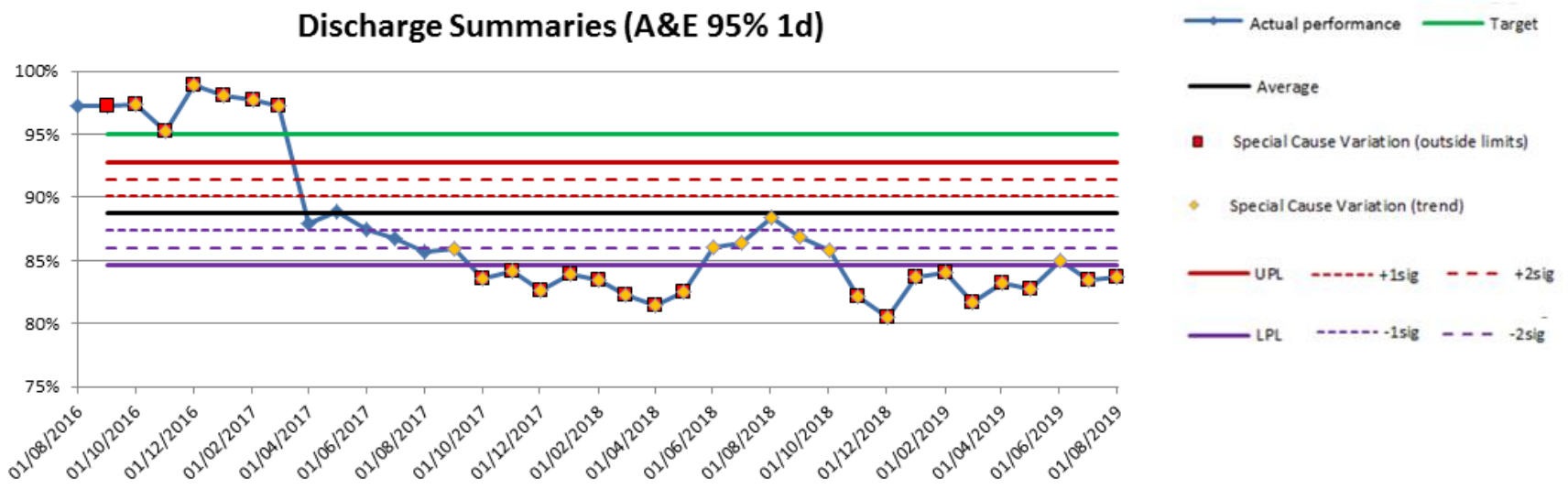


Narrative

What	The total number of Trust inpatient falls fell in August to a total of 62 (58 in WSH & 4 in Community beds), the falls per 1,000 bed days is 5.6 maintaining a value within the expected range.
Why	The Trust monitor trends in patient falls on a monthly basis including the impact of higher levels of bed occupancy and/or patient acuity. In August, there were six individuals who fell twice or more, including one who fell six times contributing to the overall number. There was one fall resulting in serious harm in August, a Neck of Femur on F5. A full investigation is ongoing into this incident. YTD we have had 9 falls with serious harm
How	In 2019/20 the new CQUIN Preventing Hospital Falls - Admitted patients aged over 65 years, with LOS at least 48 hours will drive further improvements. We are planning on trailing new technology during September/October beginning on G8 and then trialling in other clinical areas including the community. Our training package is being reviewed and updated by the falls Matron.
When	This is an ongoing work plan and quality improvement initiatives will continue to be progressed via the Falls Group including ongoing liaison with the contacts gained through the previous work in the regional NHSI collaborative. We now have some dedicated Matron hours focused on falls training and quality improvements within the Trust.

Safe

Discharge Summaries ED

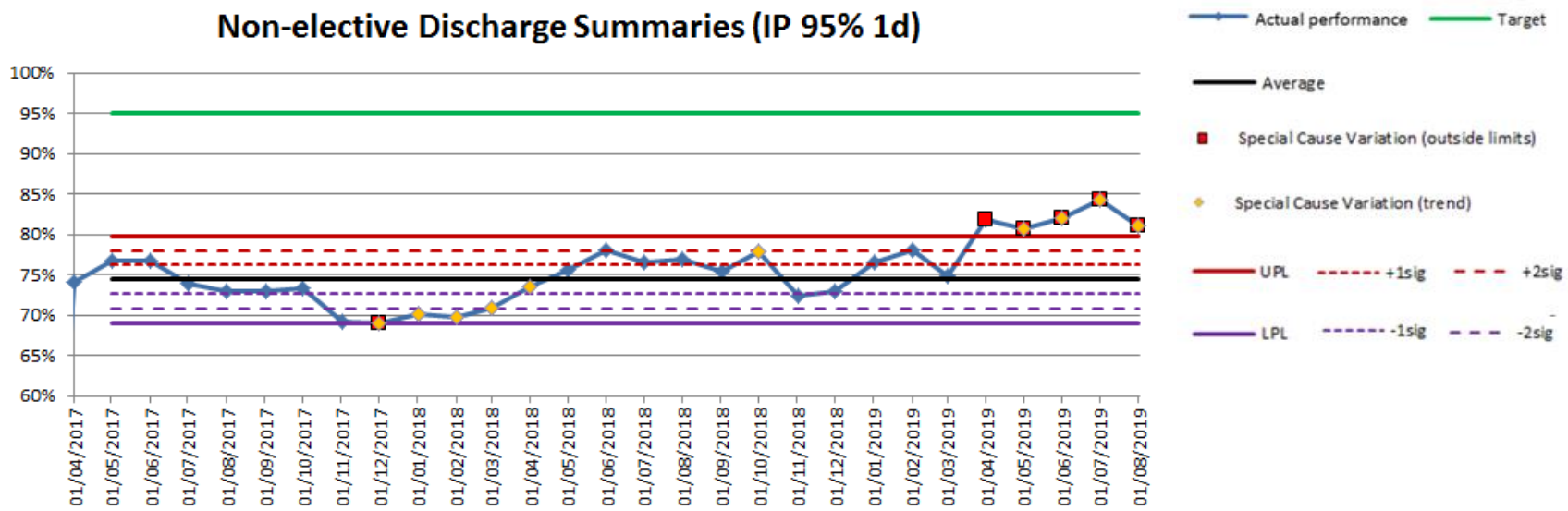


Narrative

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

Effective

Discharge Summaries Non elective admissions

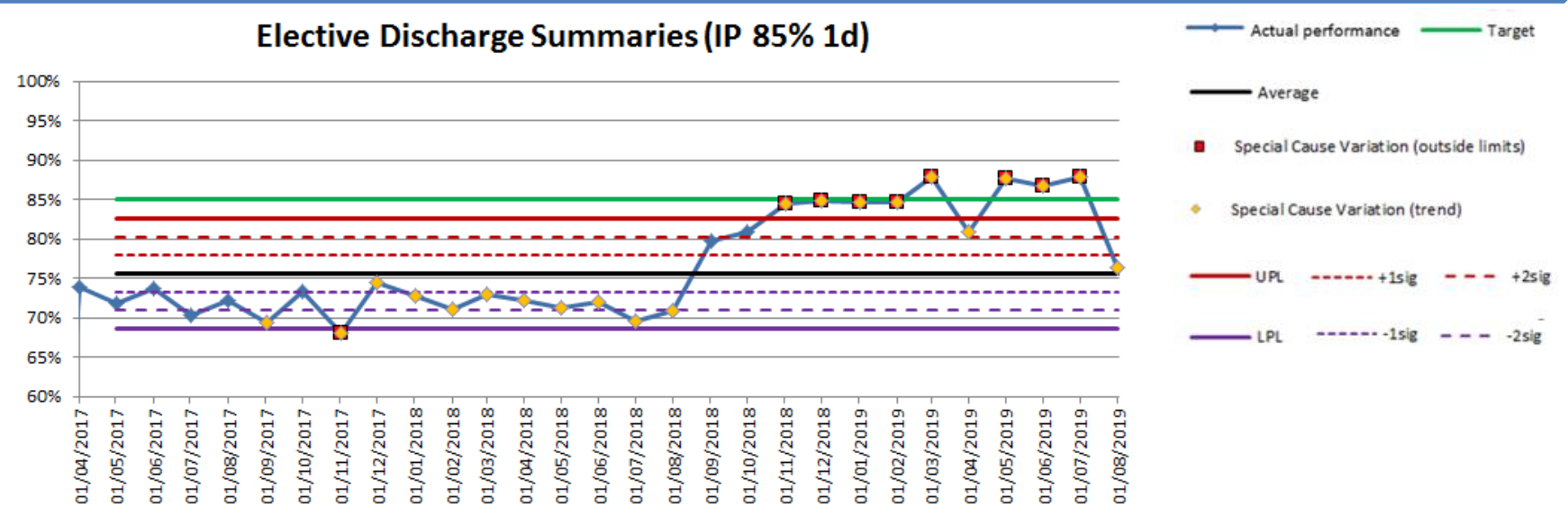


Narrative

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

Effective

Discharge Summaries Elective admissions

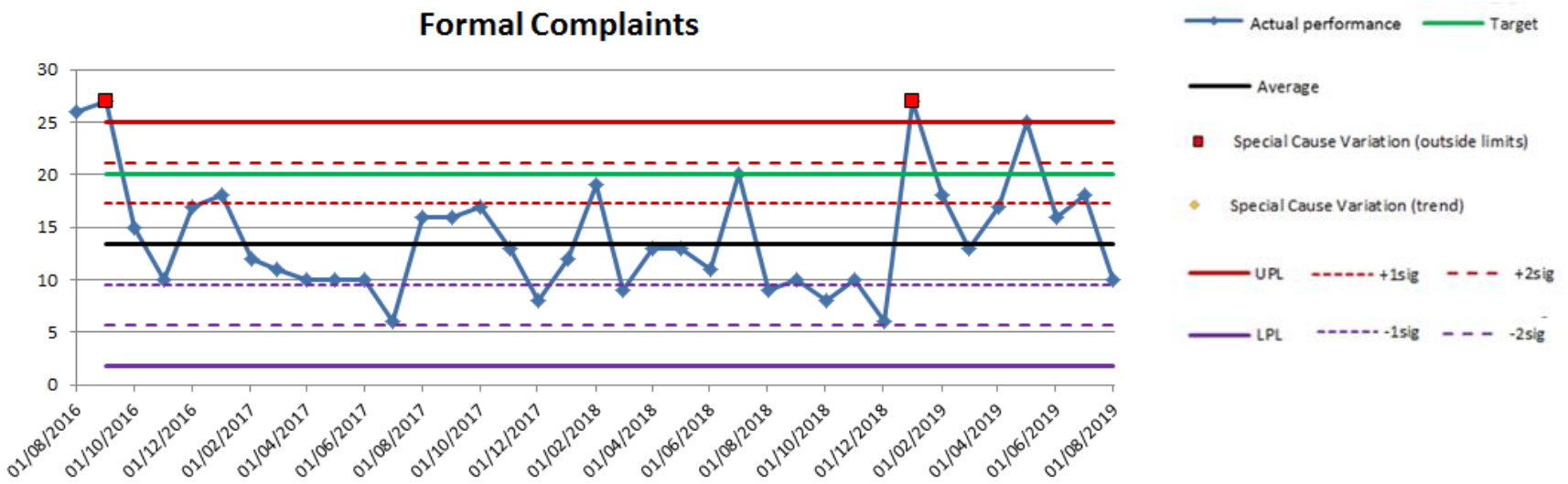


Narrative

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

Effective

Complaints

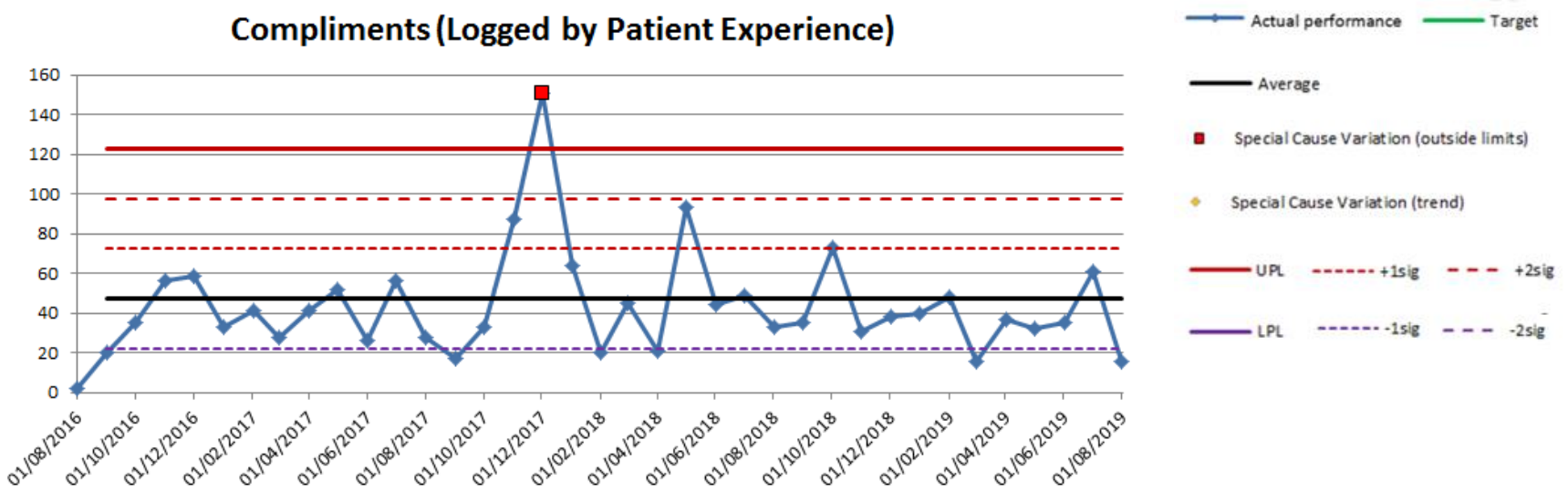


Narrative

What	Common Cause Variance, this has come down from last month and is still below national targets.
Why	-
How	-
When	-

Caring

Compliments

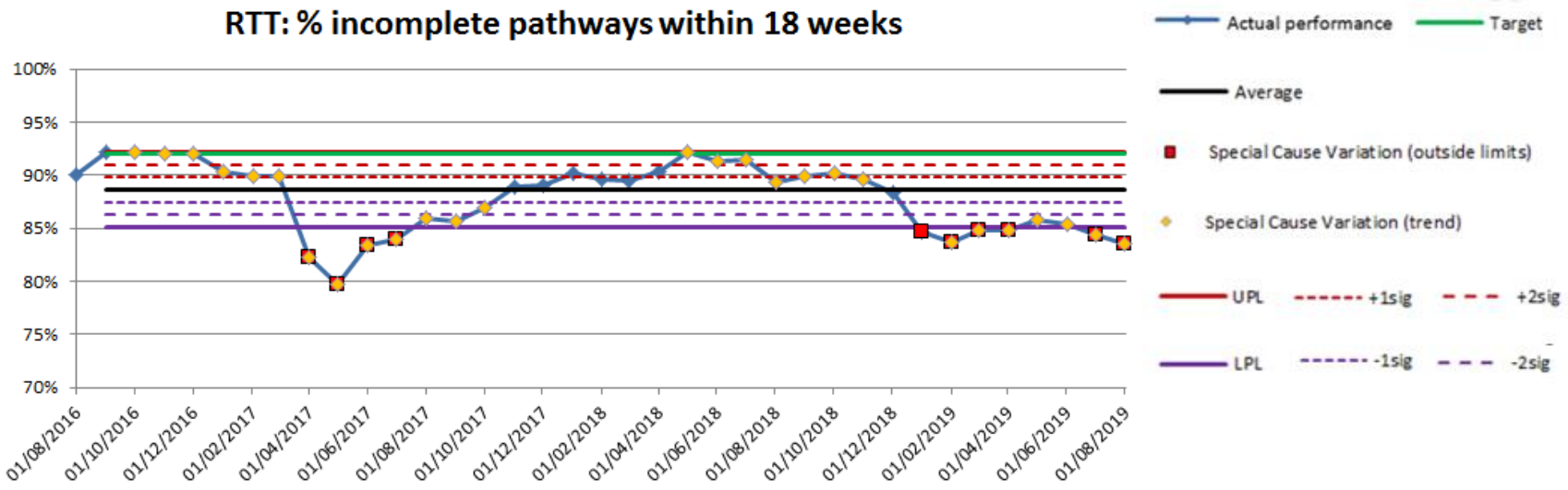


Narrative

What	Common Cause Variation with a decrease this month.
Why	Additional compliments shared with the patient experience team for centrally logging.
How	Our aim is for all compliments to be shared with the patient experience team.
When	On-going message across Trust highlighting this.

Caring

RTT

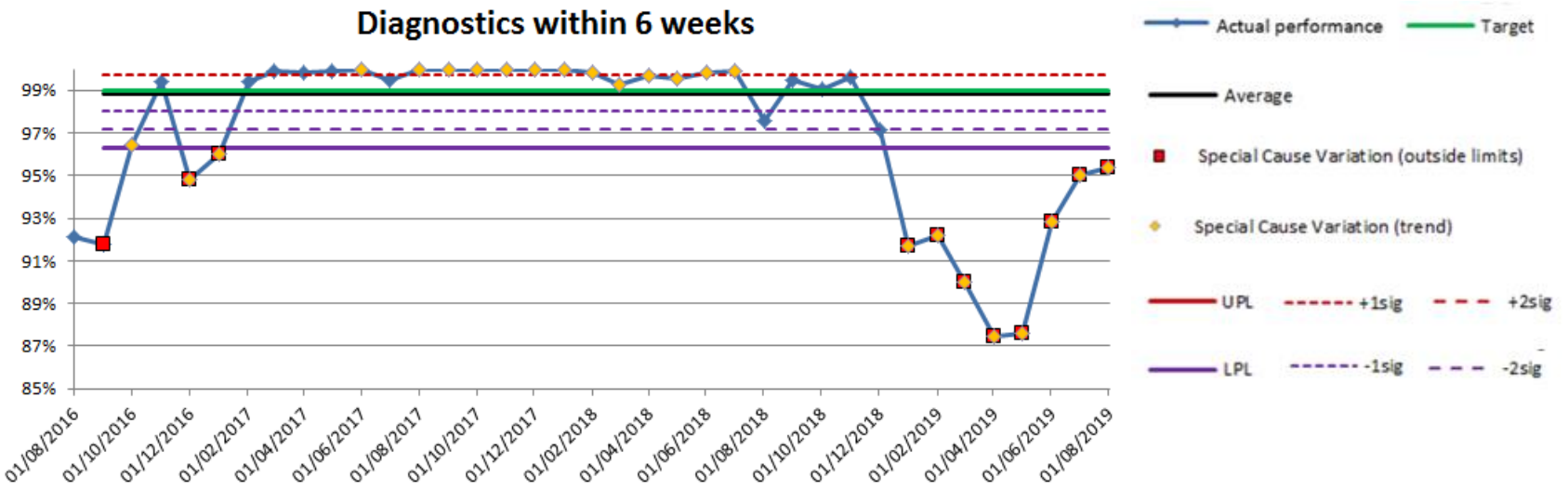


Narrative

What	Special Cause Variation - Low
Why	There is underachievement of the standard within General Surgery, Urology, Trauma and Orthopaedics, Ophthalmology, Gastroenterology, Cardiology, Thoracic medicine and Gynaecology.
How	Action plan for recovery in place for all specialities not meeting performance, continue to monitor long waits at weekly access meeting.
When	-

Responsive

Diagnostics within 6 weeks

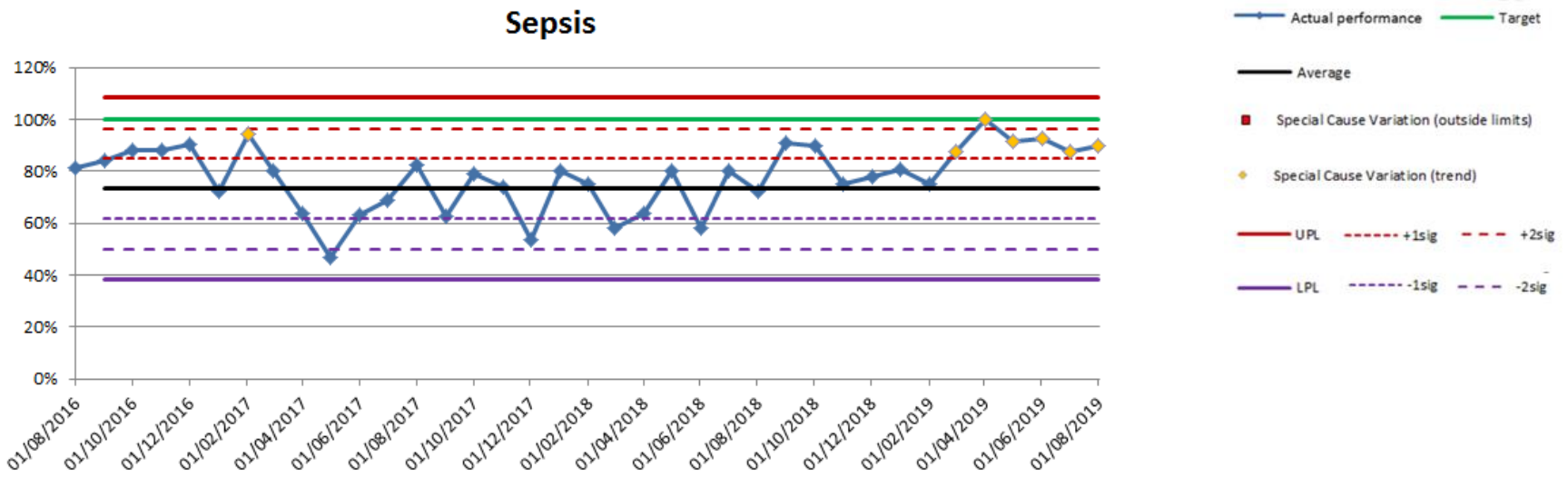


Narrative

What	Special Cause Variance - Low
Why	Diagnostic performance has improved again this month although capacity issues continue to impact on waiting times for endoscopy related diagnostic procedures.
How	Work continues on the colorectal and urology (cystoscopy) pathways in particular to provide long term sustainability.
When	-

Responsive

Sepsis

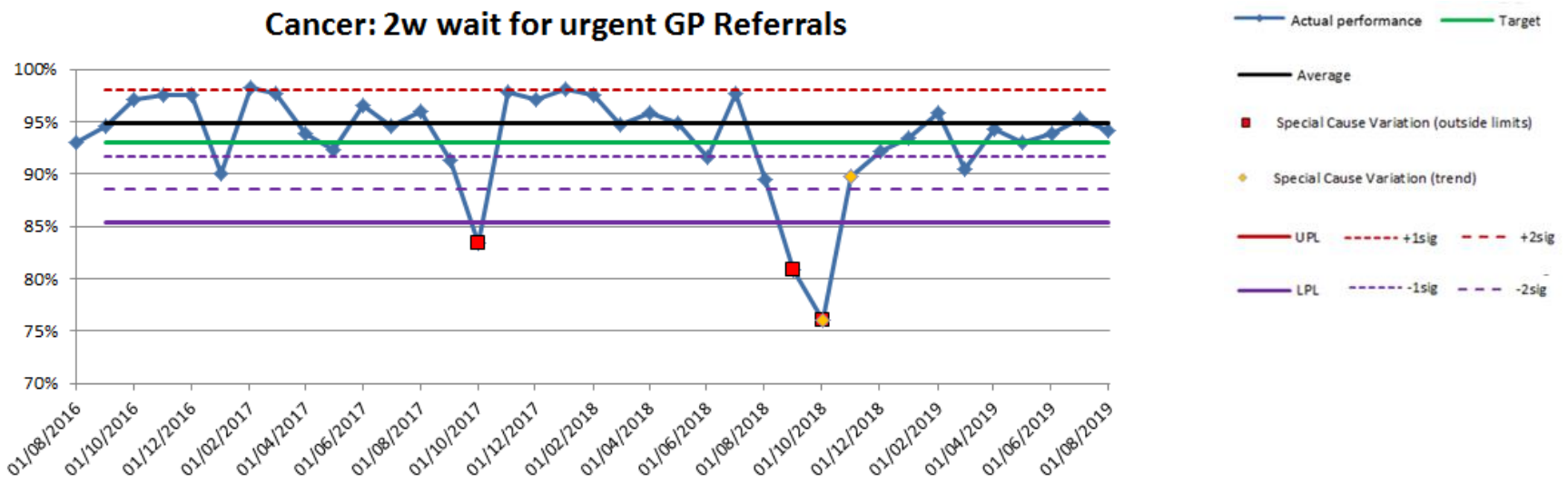


Narrative

What	Special Cause Note/Investigation – High
Why	Performance against national standards for Door to Needle time for Neutropenic was 90% for the month of August. 2 patients were admitted to G1 and both received the required treatment within the 1 hour time scale. Of the 8 patients who were admitted through ED, 7 were treated within the hour (87.5%) - 1 breached the national standard.
How	Introduction of the Emergency Department Neutropenic Sepsis FastTrack Pathway NSFP (Red Folder) copy displayed on info board in ED staff room.
When	Ongoing

Responsive

Cancer 2 week referral

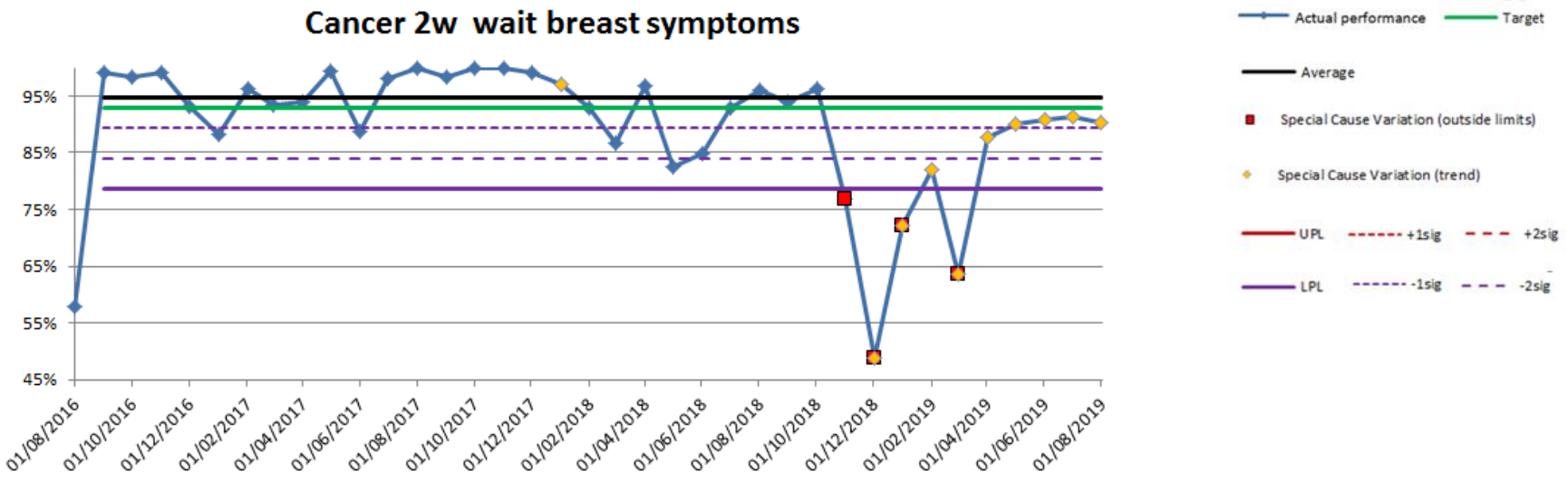


Narrative

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

Responsive

Cancer 2 week referral Breast

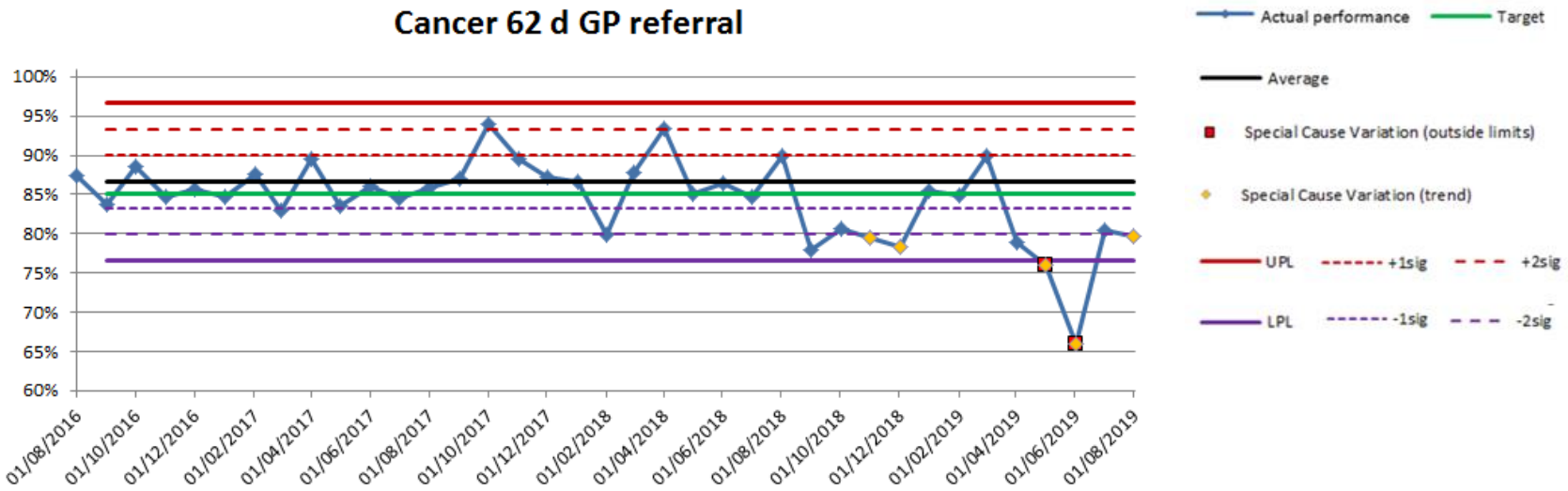


Narrative

What	Special Cause Variance - Low
Why	This is primarily due to patient controlled factors including 7/12 away on holidays and other 5/12 had one or other factor to cancel the offered appointment date within 14 days of receipt of referral.
How	Capacity has been increased by an additional clinic on Friday PM for breast pain symptom patients. Patient if required further radiological investigation are booked in to the earliest available next slot week.
When	-

Responsive

Cancer 62 Day

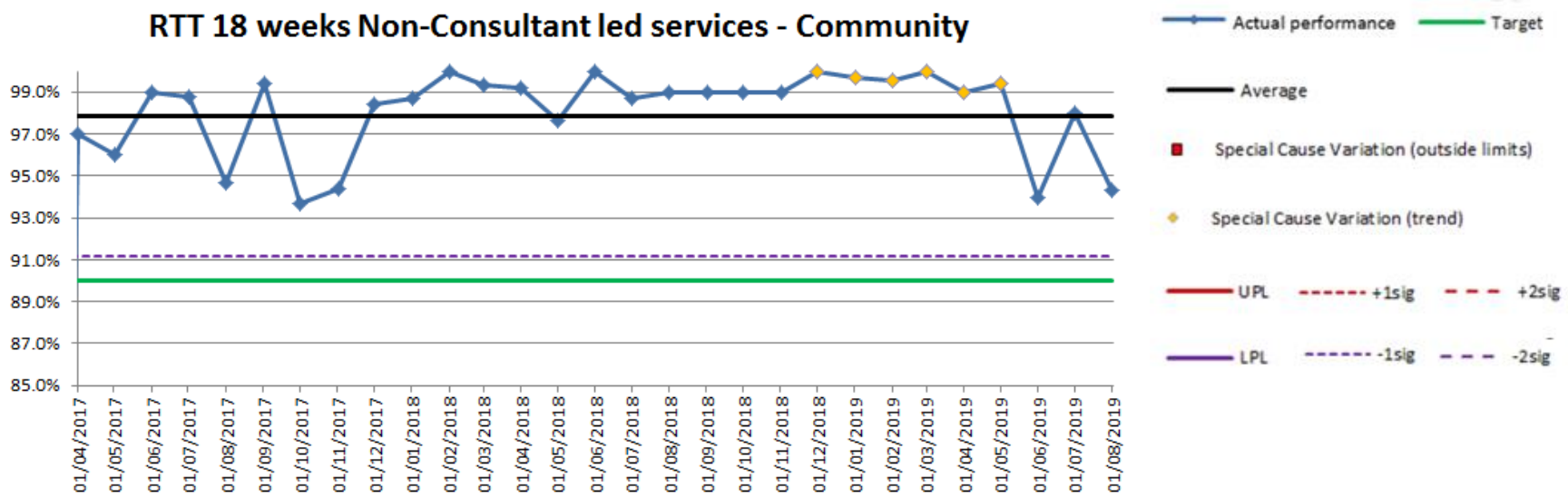


Narrative

What	Special Cause Variance - Low
Why	Owing to high number of referrals and pathway issues resulting to delays in prostate cancer tissue diagnosis- 4/15 and ongoing diagnostic/staging delays in colorectal – 2/15 along with Skin – 4/15 owing to delays between Dermatology and Plastics for excisions, and one breach each in gynaecology, Haem, H/N, Lung, Upper GI pathways due to mixture of complex pathways requiring more than usual diagnostics and staging investigations and capacity issues locally in the Trust.
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	March 2020

Responsive

RTT non consultant led

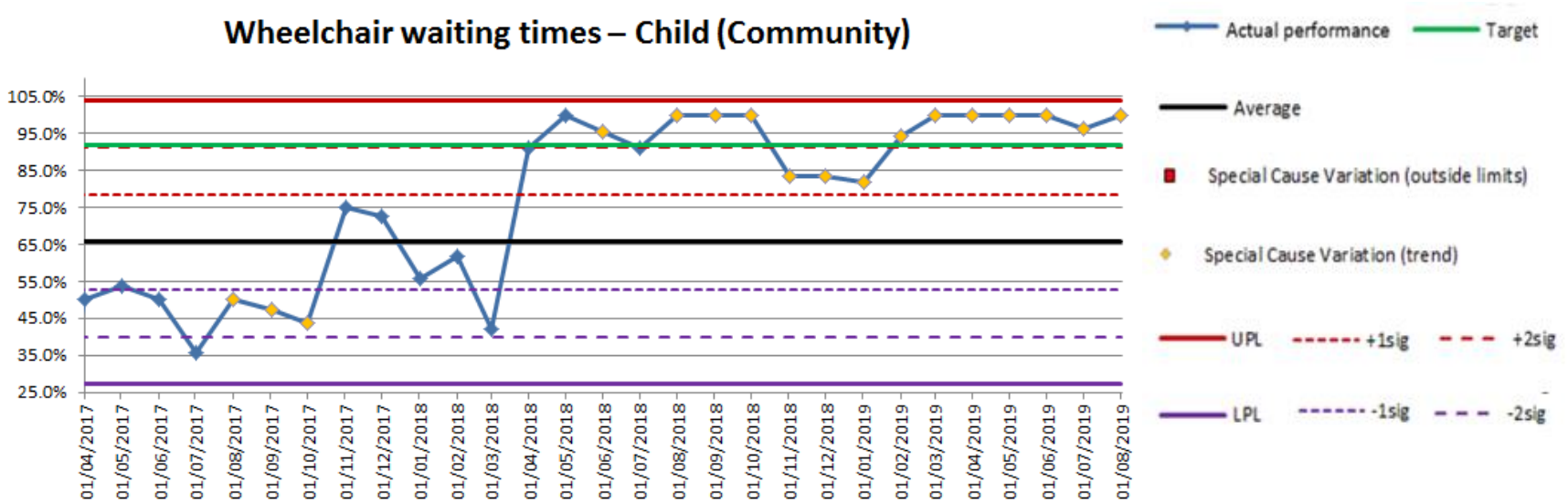


Narrative

What	Common Cause Variance, we have seen a drop this month.
Why	-
How	-
When	-

Community

Wheelchair waiting times – Child (Community)

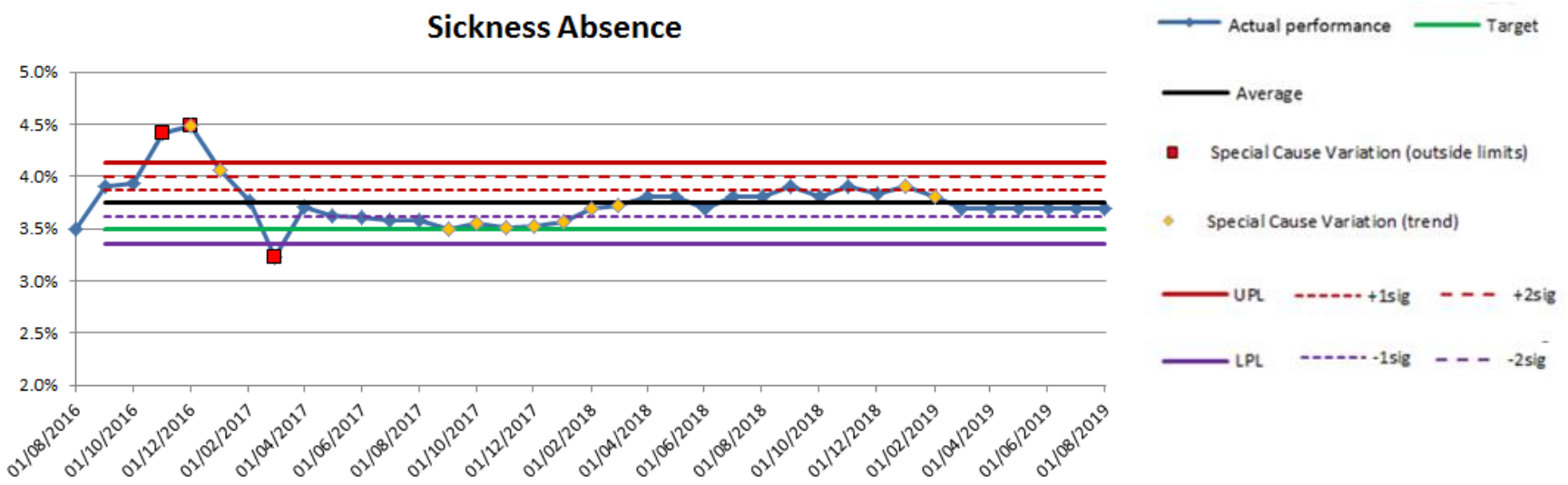


Narrative

What	Special Cause Variance – High, we have seen an increase this month.
Why	-
How	-
When	-

Community

Sickness absence

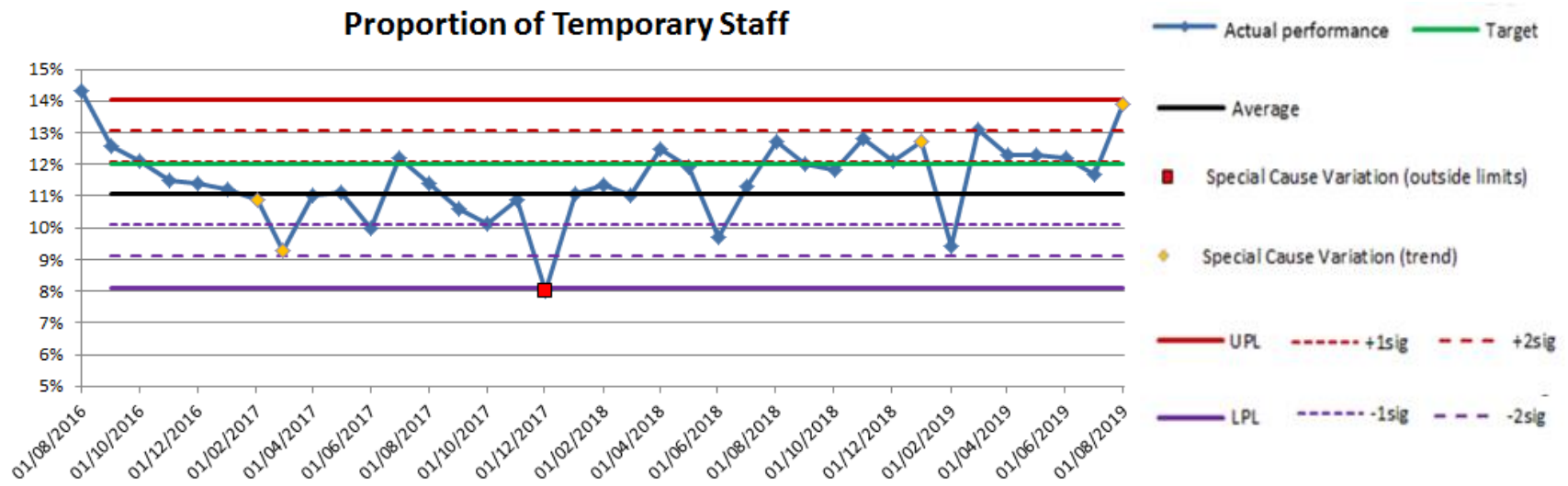


Narrative

What	Common Cause Variance
Why	Sickness absence has remained at 3.7% for the last six months. This percentage represents both short and long term sickness. There does not appear to be one single cause for under performance of the target.
How	Managers, supported by HR, continue to support staff in line with the policy. The Health & wellbeing committee have recently discussed the top five reasons for absence and proposed actions to assist staff.
When	-

Well Led

Proportion of temporary staff

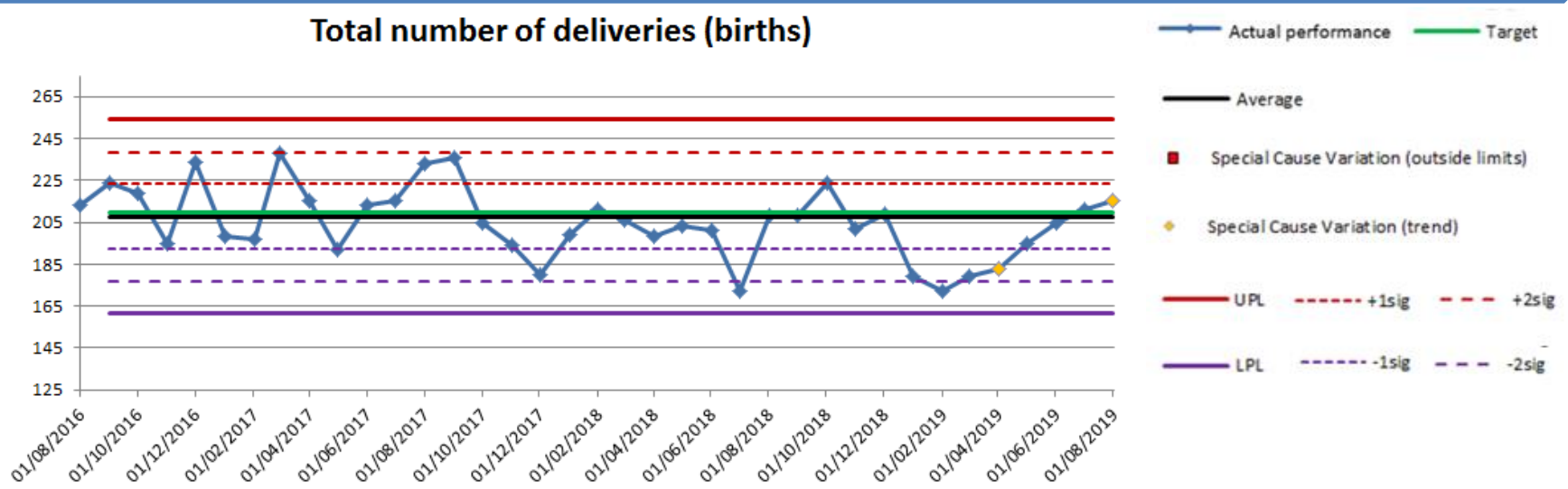


Narrative

What	Special Cause Note/Investigation – High
Why	-
How	-
When	-

Well Led

Total number of deliveries

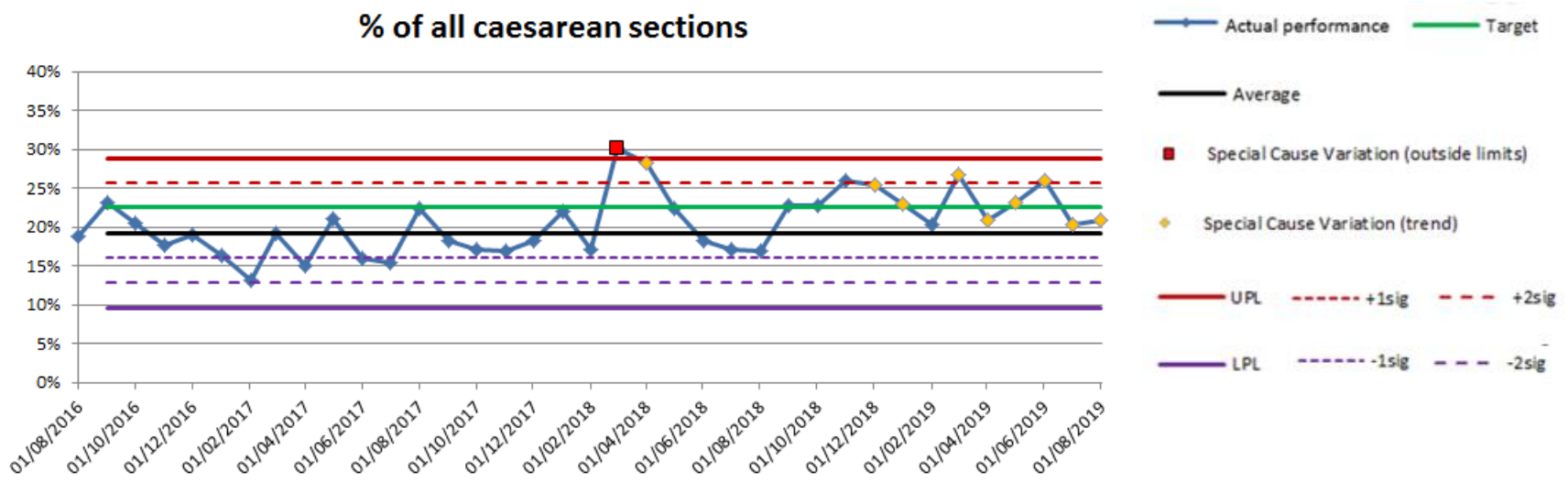


Narrative

What	Special Cause Variance –High, we have remained above the target for this month.
Why	-
How	-
When	-

Maternity

Caesarean section rate

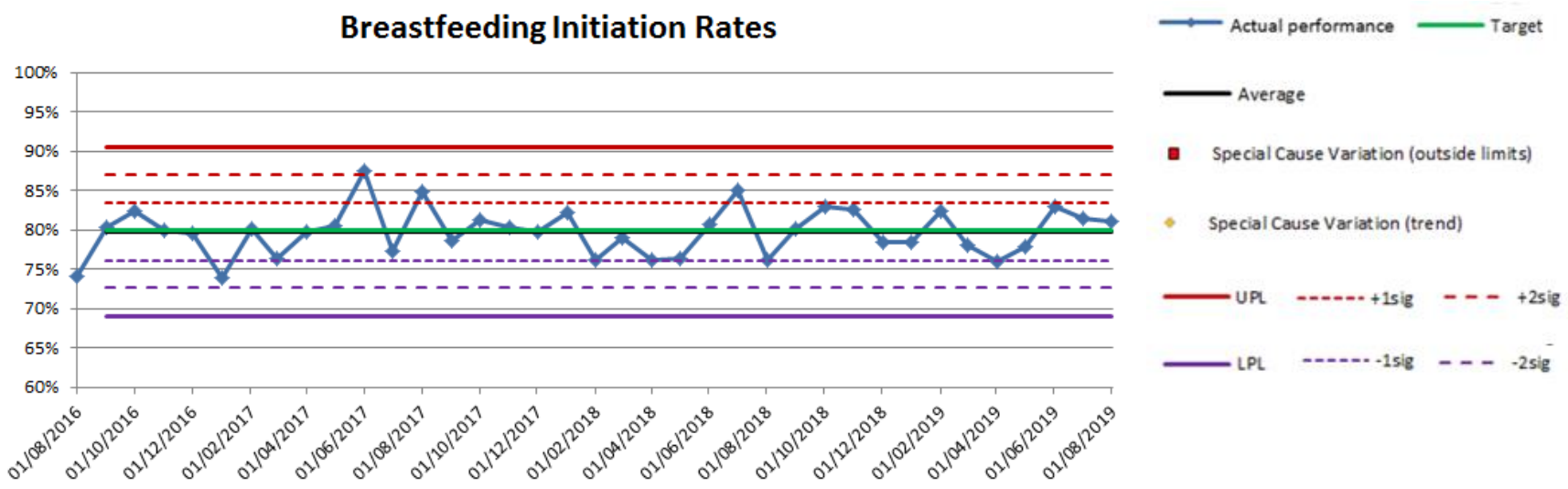


Narrative

What	Special Cause Variance - High
Why	-
How	-
When	-

Maternity

Breast feeding initiation



Narrative

What	Common Cause Variance, we have seen a slight fall but remain above the target this month.
Why	-
How	-
When	-

Maternity

Trust Board – September 2019

Agenda item:	Integrated Quality & Performance Report			
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:	September 2019			
Subject:	Trust Integrated Quality & Performance Report			
Purpose:	x	For information		For approval
Executive summary:	The attached report provides an overview of the key performance measures for the Trust. A detailed section is included from page 15 onwards.			

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

The Trust Board notes the monthly performance report.</td></tr>
</table>

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Integrated quality and performance report



Month Five: August 2019

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ARE WE SAFE?

Healthcare associated infections (HCAIs) – There was one MRSA Bacteraemia - hospital attributable case in August 2019 (Exception report at page 19) and there were 2 hospital attributable clostridium difficile cases within the month. The trust compliance with decolonisation increased in August to 95%.

CAS (Central Alerting System) Open (PSAs) – 1 Patient Safety Alerts has been received in August 2019. All of the alerts have been implemented within timescale this year to date.

Patient Falls (All patients) – 62 patient falls occurred in August 2019, which is a decrease from 73 in July 2019. (Exception report at page 21)

Pressure Ulcers – 44 cases occurred in August 2019, which is an increase from 37 in July 2019. (Exception report at page 24)

ARE WE EFFECTIVE?

Cancelled Operations for non-clinical reasons – The rate of cancelled operations for non-clinical reasons was recorded at 1.6% in July 2019. (Exception report at page 33)

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 94.9% in August 2019 compared to 90.0% in July 2019. (Exception report at page 35)

Discharge Summaries - A&E has achieved a rate of 83.7% in August 2019, whereas inpatient services have achieved a rate of 76.3% (Non-elective) and 81.0% (Elective). (Exception report at page 34)

ARE WE CARING?

Mixed Sex Accommodation breaches (MSA) – 10 Mixed Sex Accommodation breaches occurred in August 2019, arising for 2 Breaches. (Exception report at page 37)

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 – August 2019 reported performance at 44.0% compared to 60.0% in July 2019. (Exception report at page 42)

ARE WE RESPONSIVE?

Cancer –The challenge of demand and capacity continues with three areas failing the target for August 2019. These areas were Cancer 2 week wait breast symptoms with performance at 90.3%, Cancer 62 d GP referral with performance at 79.6% and Incomplete 104 day wait with 3 breaches reported in August 2019. (Exception report at pages 50-52)

Referral to Treatment (RTT) – The percentage of patients on an incomplete pathway within 18 weeks for August was 83.6%. The total waiting list was 20942 as at the end of August 2019, with 2 patients who breached the 52-week standard. (Exception report at pages 45-47)

ARE WE WELL LED?

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

Sickness Absence – The Sickness Absence rate for August 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	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Av/YTD
1. Safe	1.01	CAS (Central Alerting System) Open	NT	4	5	4	7	8	8	13	11	10	6	6	1	1	24
	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%	93.7%	94.0%	96.0%	96.1%	94.4%	94.6%	95.2%	95.4%	95.0%	95.4%	95.1%	95.2%	94.1%	94.9%
	1.05	Clostridium Difficile infection - Hospital Attributable	20	1	1	1	2	0	0	4	1	1	2	1	1	2	7
	1.06	MRSA Bacteraemias - Hospital Attributable	0	1	0	0	0	0	0	0	0	0	1	0	0	1	2
	1.07	Patient Safety Incidents Reported	NT	521	488	511	478	546	766	625	646	670	651	587	617	622	3147
	1.08	Never Events	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0
2. Effective	2.02	Canc. Ops - Cancellations for non-clinical reasons	1%	1.5%	1.2%	1.5%	1.3%	0.5%	1.0%	1.0%	0.6%	1.9%	1.2%	1.9%	0.8%	1.6%	1.5%
3. Caring	3.01	Compliments (Logged by Patient Experience)	NT	33	35	73	31	38	40	48	16	37	32	35	61	16	181
	3.02	Formal Complaints	20	9	10	8	10	6	27	18	13	17	25	16	18	10	86
	3.03	Mixed Sex Accommodation Breaches	0	0	0	0	0	0	28	0	0	0	0	20	2	10	32
	3.04	IP - Extremely likely or Likely to recommend (FFT)	90%	99.0%	99.0%	96.0%	98.0%	98.0%	98.0%	97.0%	97.0%	95.0%	95.0%	98.0%	97.0%	97.0%	96.4%
	3.05	OP - Extremely likely or Likely to recommend (FFT)	90%	98.0%	96.0%	96.0%	96.0%	97.0%	97.0%	97.0%	97.0%	97.0%	96.0%	97.0%	96.0%	96.0%	96.4%
	3.06	A&E - Extremely likely or Likely to recommend (FFT)	90%	95.0%	97.0%	96.0%	96.0%	97.0%	96.0%	97.0%	99.0%	94.0%	88.0%	95.0%	87.0%	89.0%	90.6%
	3.07	Maternity - Extremely likely or likely to recommend (FFT)	90%	95.0%	92.0%	100%	93.0%	100%	100%	100%	ND	ND	ND	ND	ND	ND	ND
	3.08	Community - Extremely likely or likely to recommend	80%	98.0%	95.0%	100%	100%	97.0%	98.0%	95.0%	100%	95.0%	97.0%	95.0%	94.3%	95.2%	95.3%
4. Responsive	4.02	RTT: % incomplete pathways within 18 weeks	92%	89.3%	89.9%	90.2%	89.7%	88.3%	84.7%	83.6%	84.8%	84.8%	85.8%	85.4%	84.4%	83.6%	84.8%
	4.03	52 week waiters	0	10	2	7	6	10	7	7	2	1	4	4	2	2	13
	4.04	Diagnostics within 6 weeks	99%	97.6%	99.5%	99.0%	99.6%	97.1%	91.7%	92.2%	90.0%	87.5%	87.6%	92.8%	95.0%	95.4%	91.7%
	4.05	Cancer: 2w wait for urgent GP Referrals	93%	89.5%	80.9%	76.1%	89.8%	92.2%	93.4%	95.8%	90.5%	94.3%	93.1%	93.8%	95.3%	94.2%	94.2%
	4.06	Cancer 2w wait breast symptoms	93%	95.9%	93.9%	96.4%	76.7%	48.8%	72.1%	82.0%	63.5%	87.8%	90.6%	90.8%	91.3%	90.3%	90.2%
	4.07	Cancer 31 d First Treatment	96%	100%	100%	99.3%	100%	100%	99.2%	100%	100%	100%	98.0%	99.0%	99.0%	99.0%	99.0%
	4.08	Cancer 31 d Drug Treatment	98%	98.7%	98.5%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.09	Cancer 31 d Surgery	94%	100%	100%	100%	100%	100%	94.4%	100%	100%	100%	95.0%	100%	100%	100%	99.0%
	4.10	Cancer 62 d GP referral	85%	89.9%	78.0%	80.6%	79.5%	78.3%	85.5%	84.8%	90.0%	78.4%	76.9%	65.9%	81.8%	79.6%	76.5%
	4.11	Cancer 62 d Screening	90%	100%	90.5%	80.0%	93.8%	87.9%	100%	100%	95.2%	92.9%	90.5%	86.7%	100%	100%	94.0%
	4.12	Incomplete 104 day waits	0	3.0	2.0	0	3.0	0	0	1.0	1.0	2.0	4.0	5.0	6.0	3.0	20.0

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INTEGRATED QUALITY & PERFORMANCE REPORT																
Are we..	Ref.	KPI	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Av/YTD
5. Well Led	5.01	NHS Staff Survey (Staff Engagement score -Annual)	NT	NA	NA	NA	NA	NA	NA	7.4%	NA	NA	NA	NA	NA	NA	NA
	5.02	Staff F&F Test % Recommended - care (Qrtly)	75%	95.0%	NA	93.0%	NA	NA	NA	91.0%	NA	NA	NA	92.0%	NA	NA	92.0%
	5.03	Staff F&F Test % Recommended - place to work (Qrtly)	75%	82.0%	NA	82.0%	NA	NA	NA	78.0%	NA	NA	NA	79.0%	NA	NA	79.0%
	5.04	Turnover (Rolling 12 mths)	<10%	8.6%	8.7%	8.0%	8.0%	8.0%	8.0%	7.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%
	5.05	Sickness Absence	<3.5%	3.8%	3.9%	3.8%	3.9%	3.8%	3.9%	3.8%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%	3.7%
	5.06	Executive Team Turnover (Trust Management)	<20%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	17.0%	0.0%	0.0%	0.0%	0.0%	3.4%
	5.07	Agency Spend	550	507	393	381	620	500	637	330	524	426	366	482	364	530	434
	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	-6.80%	-7.20%	-6.40%	-6.00%	ND	-6.10%	-5.80%	-5.50%	-5.80%	-6.70%	-7.60%	-6.90%	-7.60%	-6.92%
	6.03	Capital service cover	Var	0.87	-0.92	-0.63	-0.50	ND	-0.42	-0.25	-0.27	0.34	0.23	0.12	0.17	0.22	1.08
	6.04	Liquidity (days)	NT	14.36	19.19	17.56	21.57	ND	15.86	15.18	26.80	24.13	24.98	22.90	32.70	37.91	28.5
	6.05	Long Term Borrowing (£m)	4	74.2	75.3	75.5	76.5	ND	85.5	64.1	65.4	95.7	85.0	88.2	82.2	83.4	86.9
	6.06	CIP (Variance YTD £'000s)	1.9	-120	-38	-28	-46	-53	-45	-48	0	-32	-75	-46	-70	ND	-55.8
7. Maternity	7.01	Total number of deliveries (births)	210	208	208	224	202	209	179	172	179	183	195	205	211	215	1009
	7.02	% of all caesarean sections	26%	17.0%	22.8%	22.7%	25.9%	25.4%	22.9%	20.3%	26.8%	20.8%	23.1%	25.9%	20.4%	20.9%	22.2%
	7.03	Midwife to birth ratio	1.32	1.30	1.30	1.31	1.29	1.30	1.28	1.26	1.27	1.27	1.28	1.29	1.30	1.31	1.29
	7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.05	Completion of WHO checklist	95%	95.0%	93.0%	93.0%	94.4%	95.0%	96.0%	95.0%	93.0%	94.0%	93.0%	97.0%	97.0%	93.0%	94.8%
	7.06	Maternity SIs	NT	0	0	1	0	0	0	1	0	1	1	2	0	0	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%	76.2%	80.2%	83.0%	82.6%	78.5%	78.5%	82.4%	78.1%	76.0%	77.8%	83.0%	81.5%	81.0%	79.9%
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%	99.0%	99.0%	99.0%	99.0%	100%	99.7%	99.6%	100%	99.0%	99.4%	94.0%	98.0%	94.4%	96.9%
	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	95%	100%	ND	100%	100%	100%	NA	100%	100%	100%	100%	100%	100%	100%	100%
	4.40	Nursing & therapy Red referrals seen within 4hrs - Community	95%	100%	100%	100%	99.9%	100%	96.6%	100%	100%	100%	100%	100%	93.8%	97.3%	98.2%
	4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	95%	99.4%	99.5%	99.0%	99.2%	98.4%	99.0%	98.8%	99.3%	100%	99.5%	99.3%	98.8%	99.5%	99.4%

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3. IN THIS MONTH –AUGUST 2019, MONTH 5

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

From Month Year	Aug-2019

To Month Year	Aug-2018

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

In this month.... Aug-2019

Mth We Received.....	Aug-19	Aug-18	Variance	Var. %	Traffic
GP Referrals	5,225	6,330	-1,105	-17.5%	↓
Other Referrals	4,293	5,308	-1,015	-19.1%	↓
Ambulance Arrivals	1,925	1,669	256	15.3%	↑
Cancer Referrals*	1,003	1,042	-39	-3.7%	↓
Urgent Referrals*	2,395	2,608	-213	-8.2%	↓

YTD We Received.....	2019	2018	Variance	Var. %	Traffic
GP Referrals	30,354	32,892	-2,538	-7.7%	↓
Other Referrals	25,449	27,282	-1,833	-6.7%	↓
Ambulance Arrivals	9,606	8,882	724	8.2%	↑
Cancer Referrals*	5,355	5,333	22	0.4%	↑
Urgent Referrals*	13,407	13,689	-282	-2.1%	↓

Mth We Delivered.....	Aug-19	Aug-18	Variance	Var. %	Traffic
ED Attendances (excluding GP Expected/Streamed)	6,091	5,220	871	16.7%	↑
**ED Attendances(Adjusted)	7,009	6,481	528	8.1%	↑
GP Expected via ED	535	471	64	13.6%	↑
GP Streamed	ND	ND	ND	ND	ND
GP Expected direct to AAU/AEC	348	409	-61	-14.9%	↓

YTD We Delivered.....	2019	2018	Variance	Var. %	Traffic
ED Attendances (excluding GP Expected/Streamed)	29,610	26,407	3,203	12.1%	↑
**ED Attendances(Adjusted)	36,191	32,896	3,295	10.0%	↑
GP Expected via ED	2,875	2,793	82	2.9%	↑
GP Streamed	ND	ND	ND	ND	ND
GP Expected direct to AAU/AEC	1,868	1,634	234	14.3%	↑

A&E - To IP Admission Ratio	26.1%	25.7%	0.4%	0.4%	↑
Outpatient Attendances	24,148	24,668	-520	-2.1%	↓
Inpatient Admissions	5,910	5,733	177	3.1%	↑
Elective Admissions	35	381	-346	-90.8%	↓
Non Elective Admission	2,802	2,667	135	5.1%	↑
Inpatient Discharges	5,923	5,776	147	2.5%	↑
Elective Discharges	3,121	3,066	55	1.8%	↑
Non Elective Discharges	2,792	2,675	117	4.4%	↑
New Births	215	208	7	3%	↑

A&E - To IP Admission Ratio	27.3%	25.7%	1.6%	6.4%	↑
Outpatient Attendances	129,761	126,958	2,803	2.2%	↑
Inpatient Admissions	30,053	29,251	802	2.7%	↑
Elective Admissions	14,126	13,640	486	3.6%	↑
Non Elective Admission	15,912	15,611	301	1.9%	↑
Inpatient Discharges	30,070	29,296	774	2.6%	↑
Elective Discharges	14,527	13,633	894	6.6%	↑
Non Elective Discharges	15,558	15,663	-105	-0.7%	↓
New Births	1,009	982	27	3%	↑

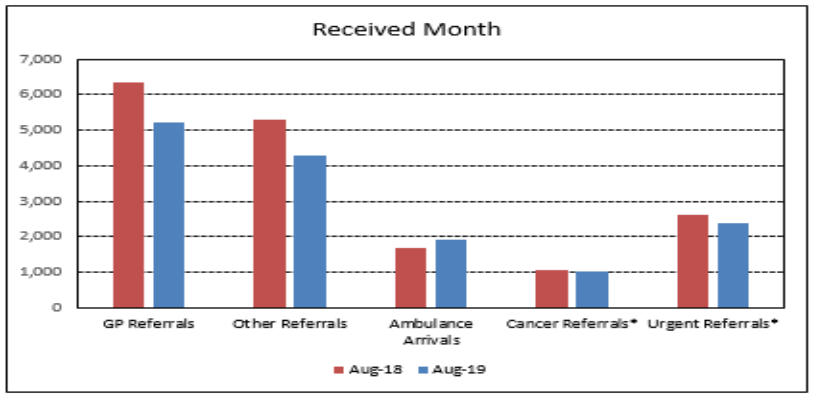
* - Included in Referrals Above

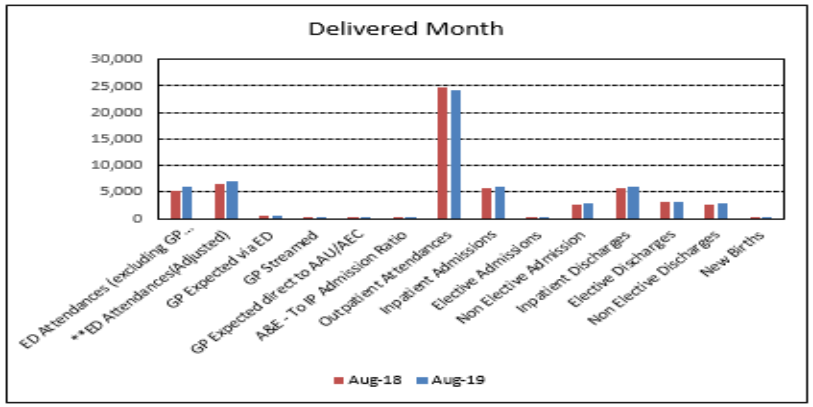
** - The ED adjusted figure adds ED attendances, GP Streamed and all GP expected (Including direct to AAU/AEC) together to reflect the position in 2017 when these were reported together.

A&E Attendances Year chart (Adjusted)

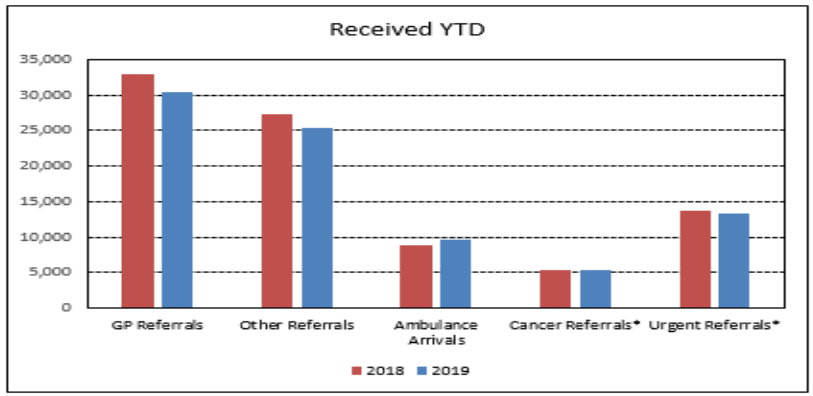
GP, cancer referrals and other referrals demonstrate a reduction year on year. A&E attendances continue to show an increase and incomplete RTT pathways are higher than last year.

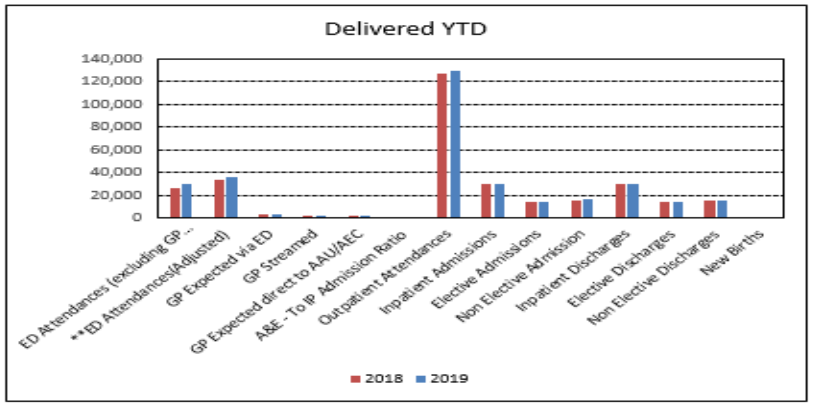
Monthly





Yearly





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DETAILED REPORTS

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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	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	YTD(Apr19-Aug19)
1.Safe	Incidents	1.21	RIDDOR Reportable Incidents	NT	1	0	3	2	3	1	3	3	2	2	2	0	1	7
		1.22	Total No of E. Coli (Trust level only)	NT	0	0	0	0	1	2	0	1	1	3	2	4	3	13
		1.23	No of Inpatient falls - Trust	NT	75	64	61	48	61	81	54	56	74	75	61	73	62	345
		1.24	No of Inpatient falls - WSH	<48	63	55	47	35	53	61	42	47	60	66	53	65	58	302
		1.25	No of Inpatient falls - Community Hospitals	NT	12	9	14	13	8	20	12	9	14	11	8	8	4	45
		1.26	Falls per 1,000 bed days	NT	5.73	5.27	4.29	3.35	4.82	5.21	3.95	4.17	5.21	5.71	4.98	5.87	5.60	5.47
		1.27	No of Inpatient falls resulting in harm - Trust	NT	24	12	12	17	15	25	14	15	21	15	18	22	15	91
		1.28	No of Inpatient falls resulting in harm - WSH	NT	20	12	11	13	12	22	10	13	16	14	14	20	14	78
		1.29	No of Inpatient falls resulting in harm - Community Hospitals	NT	4	0	1	4	3	3	4	2	5	1	4	2	1	13
		1.30	No of avoidable serious injuries or deaths resulting from falls - Trust	0	0	0	0	0	2	1	0	0	4	2	1	2	1	10
		1.31	No of avoidable serious injuries or deaths resulting from falls - WSH	0	0	0	0	0	2	1	0	0	4	2	1	2	1	10
		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	68	73	77	71	78	99	69	87	89	90	88	62	89	418
		1.70	PU present on admission to service – Inpatients	NT	53	58	60	57	61	77	49	58	60	62	64	35	72	293
		1.71	PU present on admission to service – Community teams	NT	15	17	17	14	17	22	20	29	29	28	31	27	17	132
		1.33	Number of medication errors	NT	61	63	71	54	61	79	78	72	89	76	65	89	56	375
		1.72	New PU - Trust	0	30	24	35	28	27	30	34	40	42	54	31	37	44	208
		1.67	New PU – Inpatients	0	10	14	13	19	17	11	16	21	20	25	11	17	18	91
		1.68	New PU – Community teams	0	20	10	22	9	10	19	18	19	22	29	20	20	26	117
		1.73	Moisture associated skin damage	0	NA	NA	NA	NA	NA	17	18	22	18	14	14	26	21	93
		1.74	Device related (% of total)	NT	NA	NA	NA	NA	NA	2.0%	6.0%	5.0%	4.0%	5.0%	3.0%	2.0%	4.0%	3.6%
		1.60	% of patients at risk of falls (with a Falls assessment)	NT	72.8%	72.0%	73.3%	72.7%	71.6%	73.0%	71.9%	73.9%	73.2%	73.7%	73.1%	73.2%	74.7%	73.6%

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Are we..		Ref.	KPI	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	YTD(Apr19-Aug19)
1. Safe	Reporting	1.38	MRSA Quarterly Std (including admission and LOS screens)	90%	NA	87.0%	NA	NA	89.0%	NA	NA	88.0%	NA	NA	87.0%	NA	NA	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	5	4	3	2	2	4	1	6	3	4	3	5	1	16
		1.41	MRSA - Decolonisation	95%	97.0%	86.0%	95.0%	97.0%	94.0%	94.0%	100%	92.0%	100%	100%	94.0%	100%	95.0%	97.8%
		1.42	MRSA - RCA Reports	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		1.43	MSSA (Hospital)	NT	0	0	1	1	0	0	0	2	0	0	1	1	2	4
		1.44	SIRI final reports due in month submitted beyond 60 working days	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
		1.45	SIRIs reported >2 working days from identification as red	0	0	0	0	0	0	0	0	1	0	0	0	1	0	1
		1.46	Green, Amber & Red Active / Accepted risk assessments not in date	0	3	0	4	2	3	79	55	55	55	53	56	53	19	236
		1.47	Datix Risk Register Red / Amber actions overdue	0	0	0	1	4	1	65	65	65	65	64	65	41	30	265
		1.48	Rapid access chest pain clinic access within 2 wks.	95%	96.7%	98.6%	99.2%	99.2%	100%	100%	100%	100%	100%	100%	100%	100%	97.5%	99%
		1.75	Verbal DoC undertaken within 10 working days of incident report	NT	NA	NA	NA	NA	NA	NA	NA	NA	47.0%	60.0%	69.0%	63.0%	55.0%	58.8%
		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	4	3	5	8	5	25
		1.49	Verbal Duty of Candour outstanding at month-end	0	0	0	0	0	6	0	4	5	4	4	2	5	2	17
		1.50	Hand Hygiene Audits	100%	100%	100%	100%	99.6%	98.8%	100%	100%	99.7%	100%	100%	99.5%	100%	97.0%	99.3%
		1.51	Quarterly antibiotic audit	98%	NA	89.0%	NA	NA	90.0%	NA	NA	87.0%	NA	NA	89.0%	NA	NA	89.0%
		1.52	Serious Incident RCA actions beyond deadline for completion	0	4	2	5	11	5	14	8	13	25	21	26	19	14	105
		1.53	% of Green Patient Safety incidents investigated	NT	59.0%	63.0%	64.0%	60.0%	59.0%	71.0%	72.0%	71.0%	63.0%	74.0%	63.0%	68.0%	67.0%	67.0%
		1.54	Quarterly Environment/Isolation	90%	NA	93.0%	NA	NA	93.0%	NA	NA	92.0%	NA	NA	92.0%	NA	NA	92.0%
		1.55	Quarterly VIP score documentation	90%	NA	83.0%	NA	NA	84.0%	NA	NA	85.0%	NA	NA	86.0%	NA	NA	86.0%
		1.56	Isolation data (Trust Level only)	90%	91.0%	91.0%	91.0%	91.0%	90.0%	80.0%	75.0%	85.0%	85.0%	85.0%	89.0%	85.0%	87.0%	86.2%
		1.57	Pain Mgt. internal report	80%	NA	NA	85.5%	NA	NA	84.5%	NA	NA	85.2%	84.1%	84.3%	83.2%	84.3%	84.2%
		1.58	Nutrition % of patients with a MUST/PYMS assessment completed for within 24hrs	95%	88.0%	82.0%	83.0%	83.0%	84.0%	83.0%	81.0%	79.0%	81.0%	81.0%	82.0%	83.0%	84.0%	82.2%
		1.59	Median NRLS (national reporting & Learning system) upload 6 month rolling average (No. of days)	41	51	40	75	84	98	78	82	38	57	70	92	ND	ND	73
		1.61	E coli - Hospital Attributable	NT	1	1	2	0	1	2	0	1	1	3	2	4	3	13
		1.62	E coli - Community Attributable	NT	15	13	14	13	11	8	9	16	12	18	17	24	24	95
		1.63	Klebsiella spp. - Hospital Attributable	NT	0	0	0	0	1	0	1	0	1	0	0	1	1	3
		1.64	Klebsiella spp. - Community Attributable	NT	2	3	1	3	2	1	1	1	2	3	4	6	1	16
		1.65	Pseudomonas - Hospital Attributable	NT	1	0	0	0	0	0	1	0	2	0	0	0	0	2
		1.66	Pseudomonas - Community Attributable	NT	0	1	1	0	1	1	2	0	0	1	3	4	1	9

SAFE – DIVISIONAL LEVEL ANALYSIS

	June			July			August		
Indicator	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
HII compliance 1a: Central venous catheter insertion	100	100		100	100		78	100	
HII compliance 1b: Central venous catheter ongoing care	100	100		100	100		100	100	
HII compliance 2a: Peripheral cannula insertion	100	100		100	100	100	90	85	100
HII compliance 2b: Peripheral cannula ongoing	100	100		100	98.53	100	100	100	100
HII compliance 4a: Preventing surgical site infection preoperative	100			100			100		
HII compliance 4b: Preventing surgical site infection perioperative	100			100			100		
HII compliance 5: Ventilator associated pneumonia	100			100			100		
HII compliance 6a: Urinary catheter insertion		100		100	100		100	100	
HII compliance 6b: Urinary catheter on-going care	100	94.6		100	100		100	100	
HII compliance: Antibiotic Prescribing - All care setting	100	70	100		88		100	76	
HII compliance: Antibiotic Prescribing - Secondary Care	90	60			76		63	83	
HII compliance: Chronic Wounds									
Total no of MRSA bacteraemias: Hospital	0	0	0	0	0	0	1	1	0
Quarterly MRSA (including admission and length of stay screens)	96	79	87						
Hand hygiene compliance	100	98.3		100	100	100	91	98	100
Total no of MSSA bacteraemias: Hospital	0	1	0	0	1	0	1	1	0
Quarterly Environment & Standard Principles Compliance	93	92	91						
Total no of C. diff infections: Hospital	0	1	0	0	0	0	0	2	0
Quarterly Antibiotic Audit	90	89	97						
Quarterly VIP score documentation	81	89	84						

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Indicator	June			July			August		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
Quarterly VIP score documentation	81	89	84						
No of patient falls	5	48	0	16	45	4	9	47	2
No of patient falls resulting in harm	2	12	0	5	16	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	3	8	0	3	14	0	9	7	0
No of avoidable ward acquired pressure ulcers									
Nutrition: Assessment and monitoring	82	89	65	81	88	62	78	91	51
No of SIRIs	0	0	0	0	2	1	0	0	0
No of medication errors	22	29	5	18	44	10	11	30	6
Cardiac arrests	0	0	0	2	5	0	No Data	No Data	No Data
Cardiac arrests identified as a SIRI	0	0	0	0	0	0	0	0	0
Pain Management	84.9	88.3	52.8	84.6	86.4	55.5	86.3	86.2	54
VTE: Completed risk assessment (monthly Unify audit)	97.2	93.8	91.9	95.9	94.9	91.2	97.1	95.1	64.8
Quarterly VTE: Prophylaxis compliance									
Safety Thermometer: % of patients experiencing new harm-free care	98.8	93.5	100.0	100.0	97.9	100.0	93.9	97.2	90.0

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Indicator	June			July			August		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
Patient Satisfaction: In-patient overall result	93.0	89.0		92.0	88.0		95.0	85.0	83.0
How likely are you to recommend our services to friends and family if they need similar care or treatment	98.0	98.0		98.0	95.0		99.0	95.0	100.0
In your opinion, how clean was the hospital room or ward you were in?	98.0	96.0		97.0	95.0		97.0	96.0	97.0
How was the food choice during your hospital stay?	89.0	90.0		87.0	89.0		92.0	86.0	81.0
How was the food taste and quality during your hospital stay?	89.0	89.0		86.0	89.0		93.0	86.0	81.0
Did you feel you were treated with respect and dignity by staff?	99.0	100.0		98.0	97.0		99.0	97.0	97.0
Were staff caring and compassionate in their approach?	98.0	100.0		98.0	97.0		99.0	97.0	100.0
Did you find a member of staff to talk to about your worries and fears?	97.0	97.0		99.0	96.0		99.0	92.0	92.0
Were you involved as much as you wanted to be in decisions about your care and treatment?	96.0	92.0		94.0	90.0		97.0	88.0	92.0
Did you experience any noise in the night time?	87.0	82.0		88.0	82.0		91.0	82.0	95.0
Did you get enough help from staff to eat your meals?	100.0	98.0		98.0	100.0		98.0	98.0	100.0
Minutes after you used the call button did it take to get help?	81.0	81.0		89.0	70.0		86.0	71.0	85.0
Did someone from pharmacy discuss your medications with you at any time during your hospital stay?	88.0	78.0		84.0	78.0		88.0	63.0	17.0
Were you given clear written or printed information about your take-home medications?	95.0	77.0		96.0	87.0		97.0	75.0	53.0
Were the purposes of your take-home medications explained to you in a way you could understand?	95.0	77.0		89.0	78.0		96.0	71.0	68.0
Number of Inpatient surveys completed	225	145		293	245		233	183	39
Same sex accommodation: total patients	0	20	0	0	2	0	10	0	0
Complaints	6	7	3	3	10	3	1	5	2
Environment and Cleanliness	93.9	92.7	94.6	94.3	92.0	94.5	94.6	92.3	94.8

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5. Exception reports – Safe

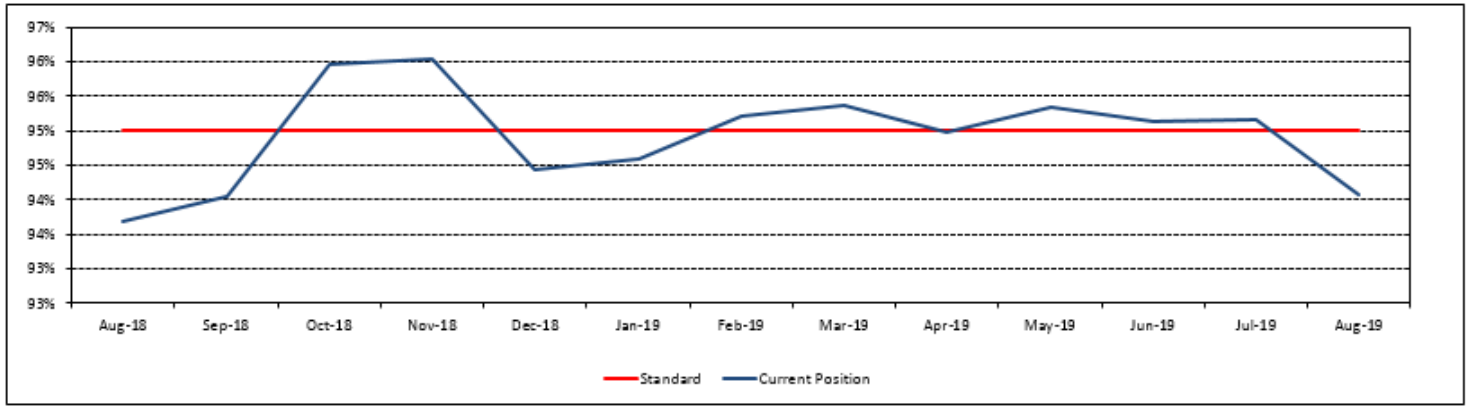
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	All relevant inpatients undergoing a VTE Risk assessment
Standard	95%
Executive Lead	Helen Beck
Month	Aug-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Medicine and surgery performed well in August achieving 95.1% and 97.14 % respectively. The dip in performance to below 95% is due to low compliance in women and children 64.77 % This is specifically F10 and relates to ecare implementation replacing the paper system there. Dr Moody met on 13/9/19 with Hayley Gilbrook to discuss ecare implementation for VTE assessment and prevention in maternity. The obstetricians are very aware of the importance of VTE prevention and the figures should improve.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	93.7%	94.0%	96.0%	96.1%	94.4%	94.6%	95.2%	95.4%	95.0%	95.4%	95.1%	95.2%	94.1%

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	MRSA Bacteraemias - Hospital Attributable
Standard	0
Executive Lead	Rowan Procter
Month	Aug-19
Data Frequency	Monthly
CQC Area	Safe

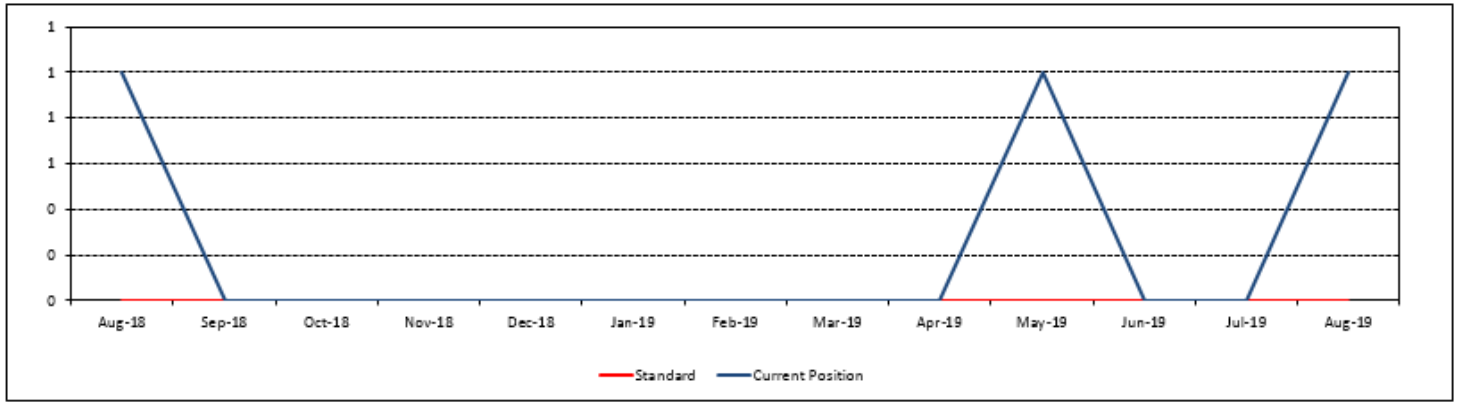
Summary of Current performance & Reasons for under performance

MRSA bacteraemia identified in patient admitted to F9 very unclear source the investigation is underway.

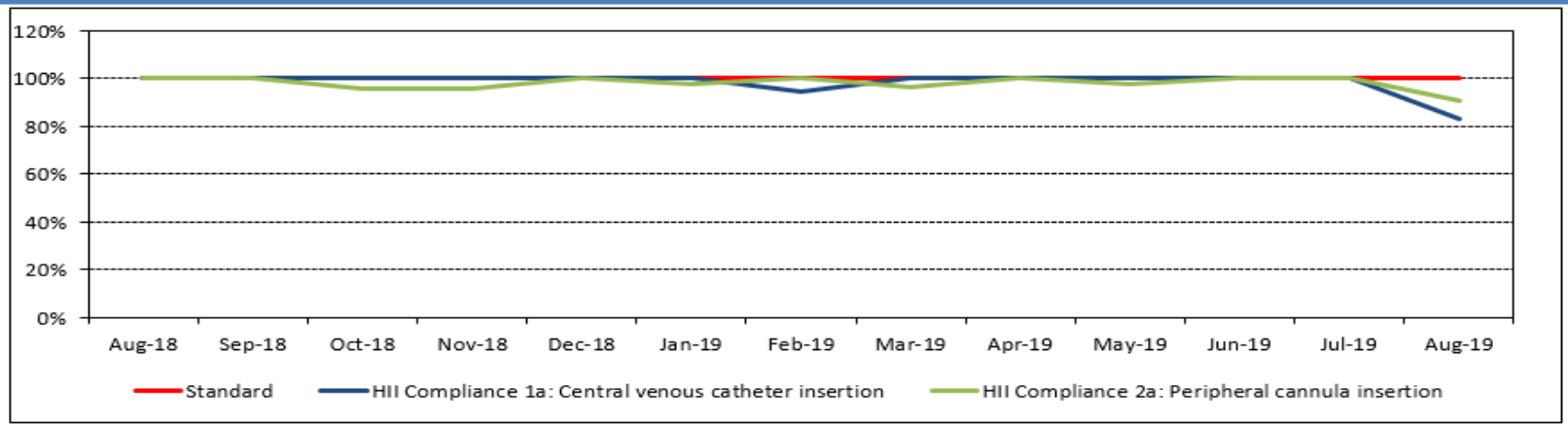
To date there has not been a source identified the patient is well and has been discharged, the post infection review meeting will be available for the next report.

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

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



High Impact Interventions (HIIs)

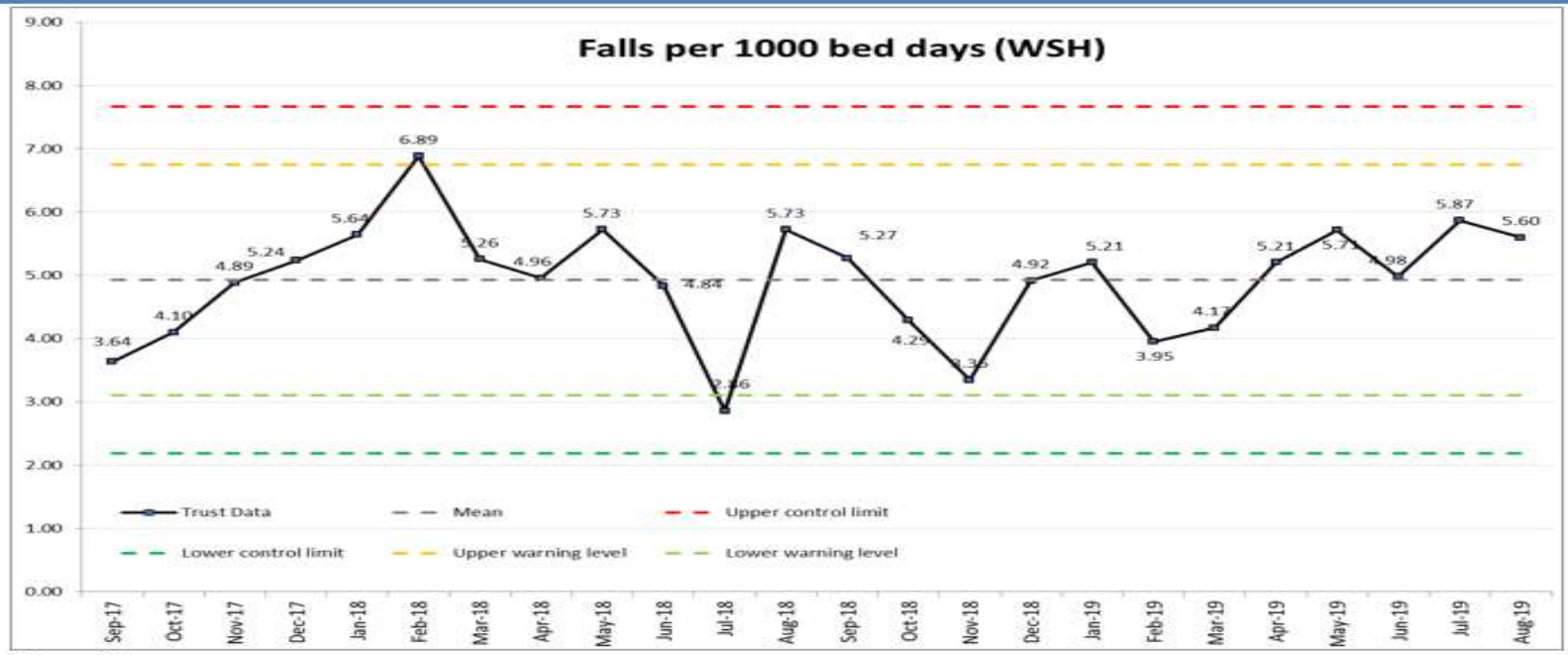


Safe

Narrative

What	Performance is measured against a target of 100% for each High impact intervention (HII). In August, all of the HIIs achieved 100% except HII 1a: Central venous cannula insertion and 2a: Peripheral cannula insertion. It should be noted that HII 6b - Urinary catheter on-going care maintained the 100% achieved in July.
Why	Failure in 1a (in Critical Care) and 2a (on Critical Care and ward G1) brought performance down.
How	The fails on Critical Care this month both relate to incomplete documentation. The medical staff should be documenting the insertion, but often this is left for the nursing staff to complete. They do not always have all the appropriate information regarding the ANTT techniques, hence the incomplete documentation. This has been raised with the medical team to ensure they complete the documentation themselves following the insertion of all invasive lines. On the wards the Matrons work closely with the teams to ensure performance is maintained and (where necessary) improves
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 (although it did achieve 100% in July and August).

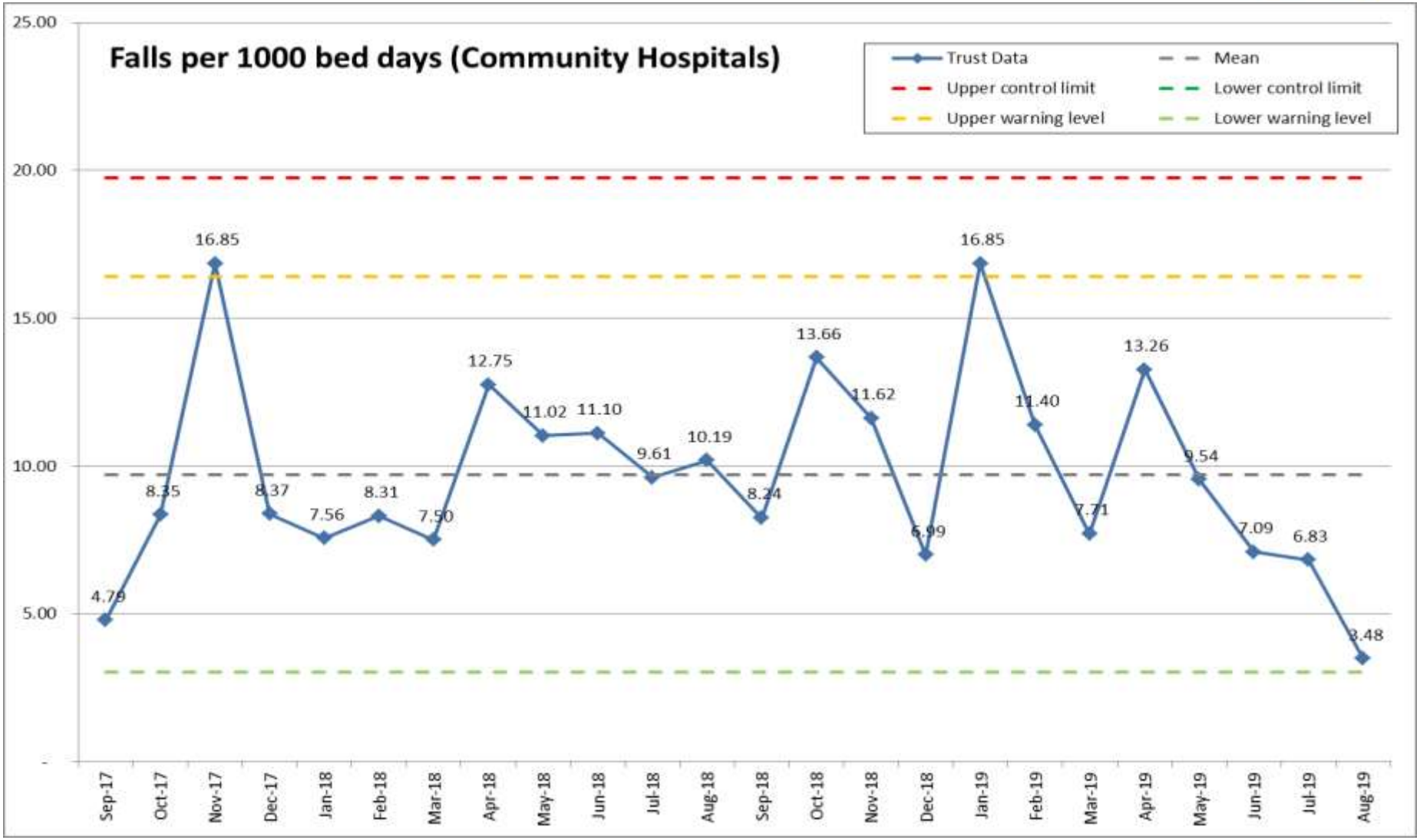
Falls



Narrative

What	The total number of Trust inpatient falls fell in August to a total of 62 (58 in WSH & 4 in Community beds), the falls per 1,000 bed days is 5.6 maintaining a value within the expected range.
Why	The Trust monitor trends in patient falls on a monthly basis including the impact of higher levels of bed occupancy and/or patient acuity. In August, there were six individuals who fell twice or more, including one who fell six times contributing to the overall number. There was one fall resulting in serious harm in August, a Neck of Femur on F5. A full investigation is ongoing into this incident. YTD we have had 9 falls with serious harm (see SPC chart below)
How	In 2019/20 the new CQUIN Preventing Hospital Falls - Admitted patients aged over 65 years, with LOS at least 48 hours will drive further improvements. We are planning on trailing new technology during September/October beginning on G8 and then trialling in other clinical areas including the community. Our training package is being reviewed and updated by the falls Matron.
When	This is an ongoing work plan and quality improvement initiatives will continue to be progressed via the Falls Group including ongoing liaison with the contacts gained through the previous work in the regional NHSI collaborative. We now have some dedicated Matron hours focused on falls training and quality improvements within the Trust.

Safe



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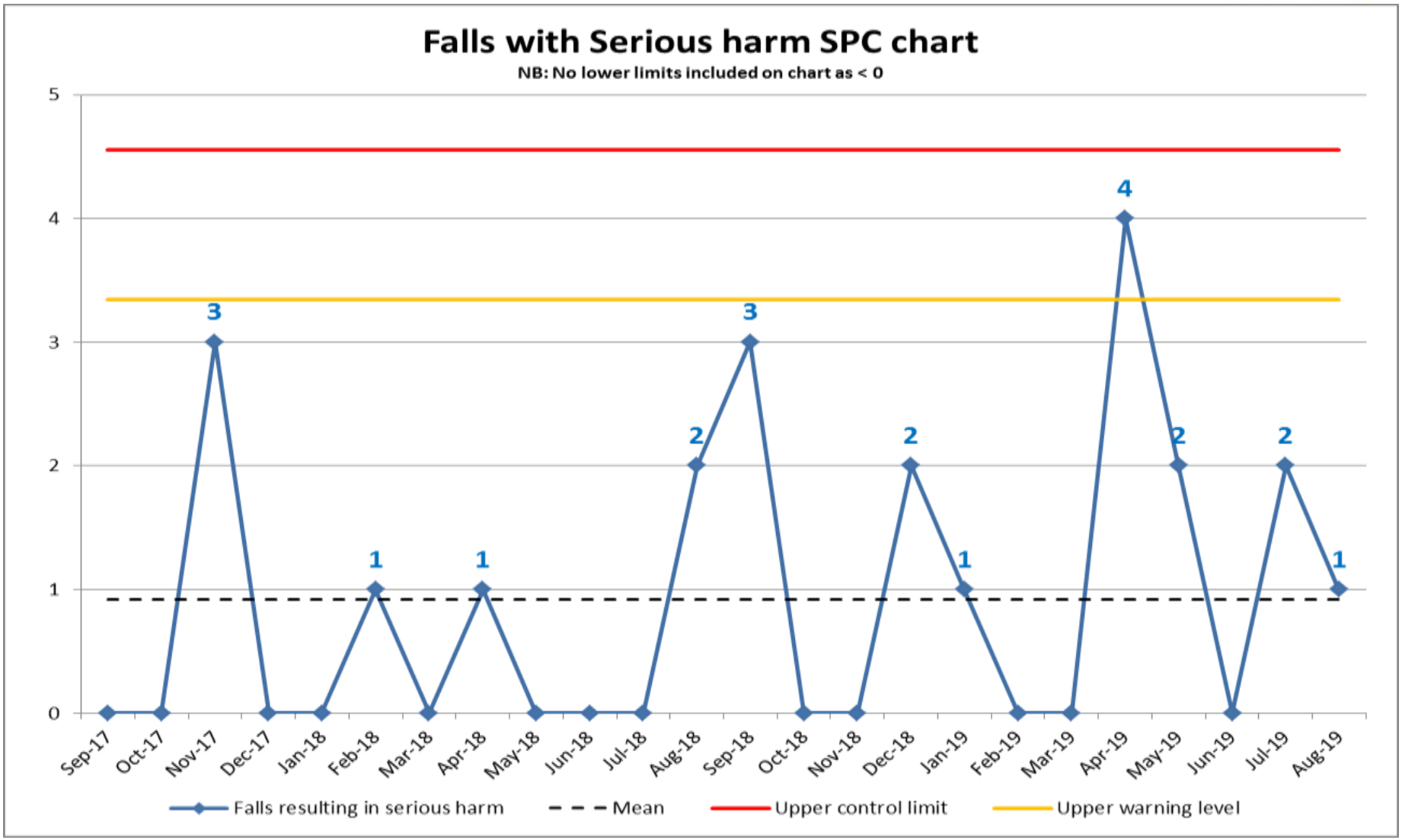
Putting you first



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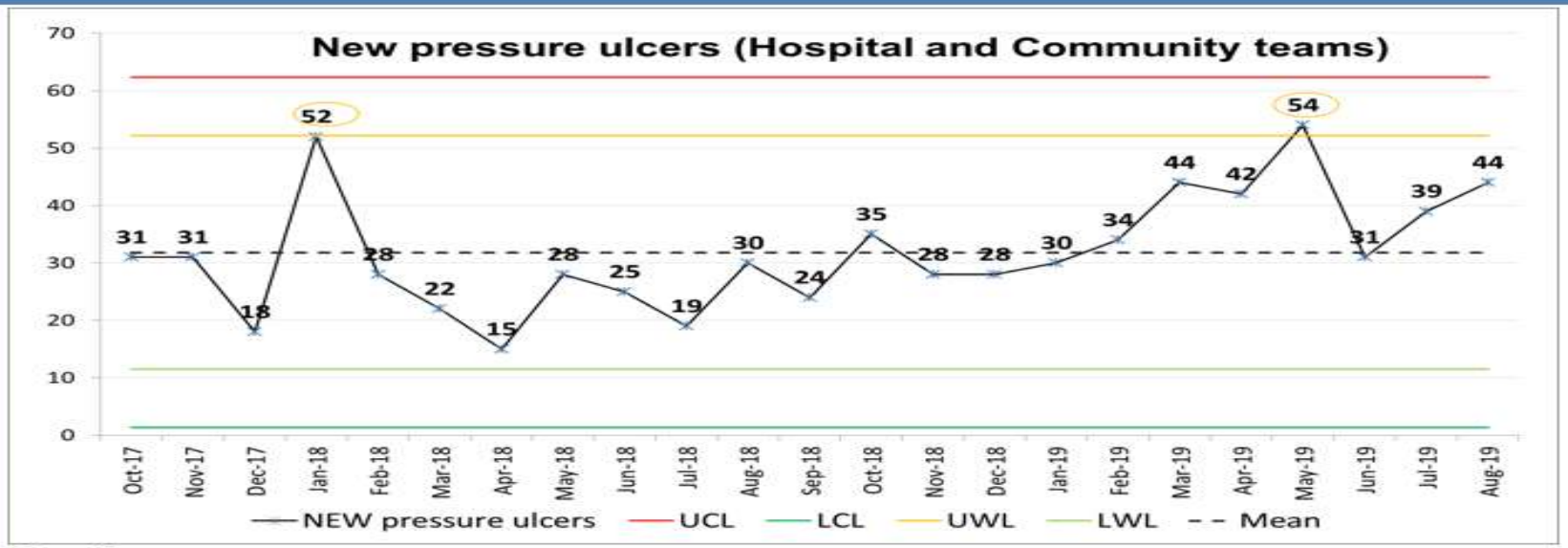
Pressure ulcers

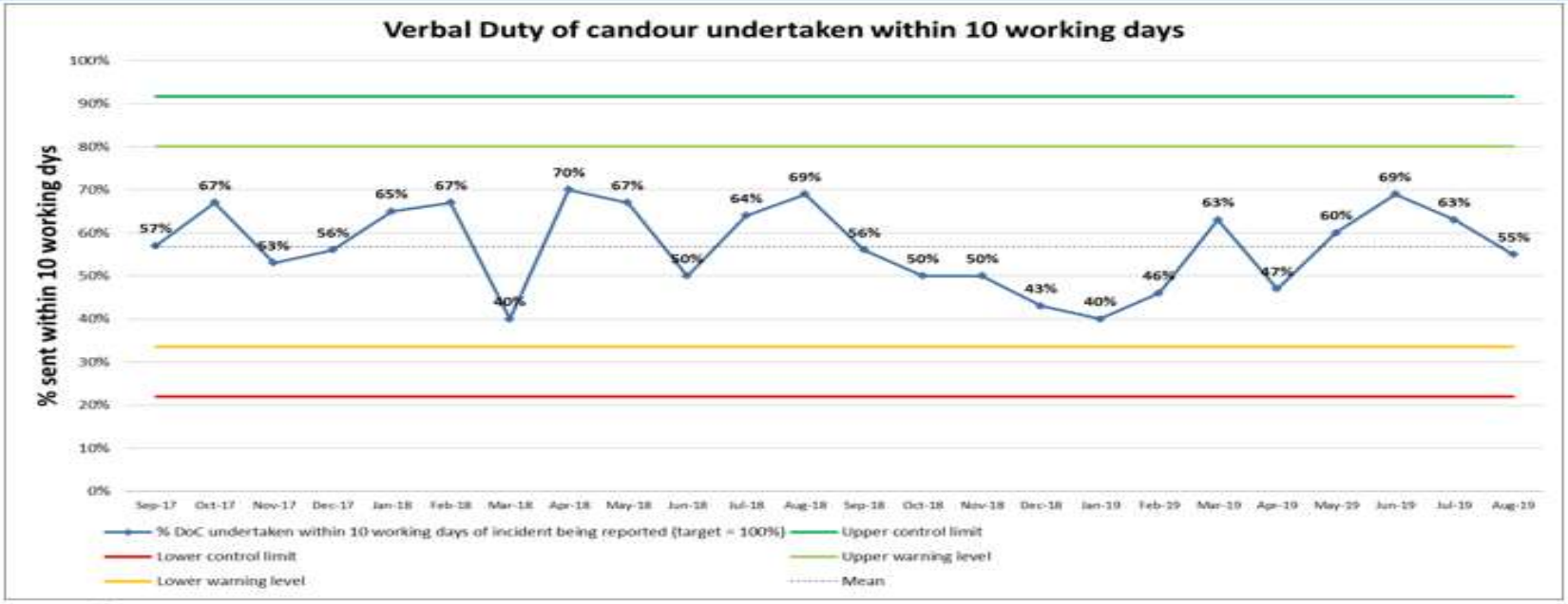


Narrative

What	At the time of writing, we note an overall increase in the number of new Pressure ulcers recorded during August. Whilst the number of Cat 2 Pressure ulcers reported remained static during the month, we experienced an unfortunate increase in Cat 3 (↑2), Cat 4 (↑3) and unstageable Pressure ulcers (↑2) reported. It is notable that an increase was also seen around Pressure ulcers present on admission to our service over the month of August when compared to July (↑24).
Why	We continue our aspiration of harm free care for patients and it is disappointing to see an increase in Pressure ulcer incidence during the month. All clinical areas and teams continue to work as effectively as possible, however the increasing complexity of patients in our care ensures that this remains a challenge, particularly for teams who care for patients in their own homes, where we have seen the greatest increase in incidence and severity.
How	We have reviewed and re-launched our internal monitoring process for Pressure Ulcer Prevention, to move to a more robust and systematic approach to investigation of PUs. This will involve a Panel review of randomised Root Cause Analysis investigations; recognition of themes requiring improvement and an integrated approach to learning will be agreed. We have extended the remit of this group to incorporate chronic and non-healing wounds, which we feel is vital – as an integrated organisation, we are keen to capture the impact of non-healing chronic wounds on people in their own homes. We have updated the group Action Plan to reflect this and our objectives.
When	Our focus remains around raising awareness and understanding of regular repositioning and the importance of good nutrition in wound healing. We have committed to a goal of a 5% reduction in the incidence of New Pressure ulcers by 30.03.20. There will a report on the outcome and learning from Pressure ulcer RCAs included in the November Board learning report

Safe

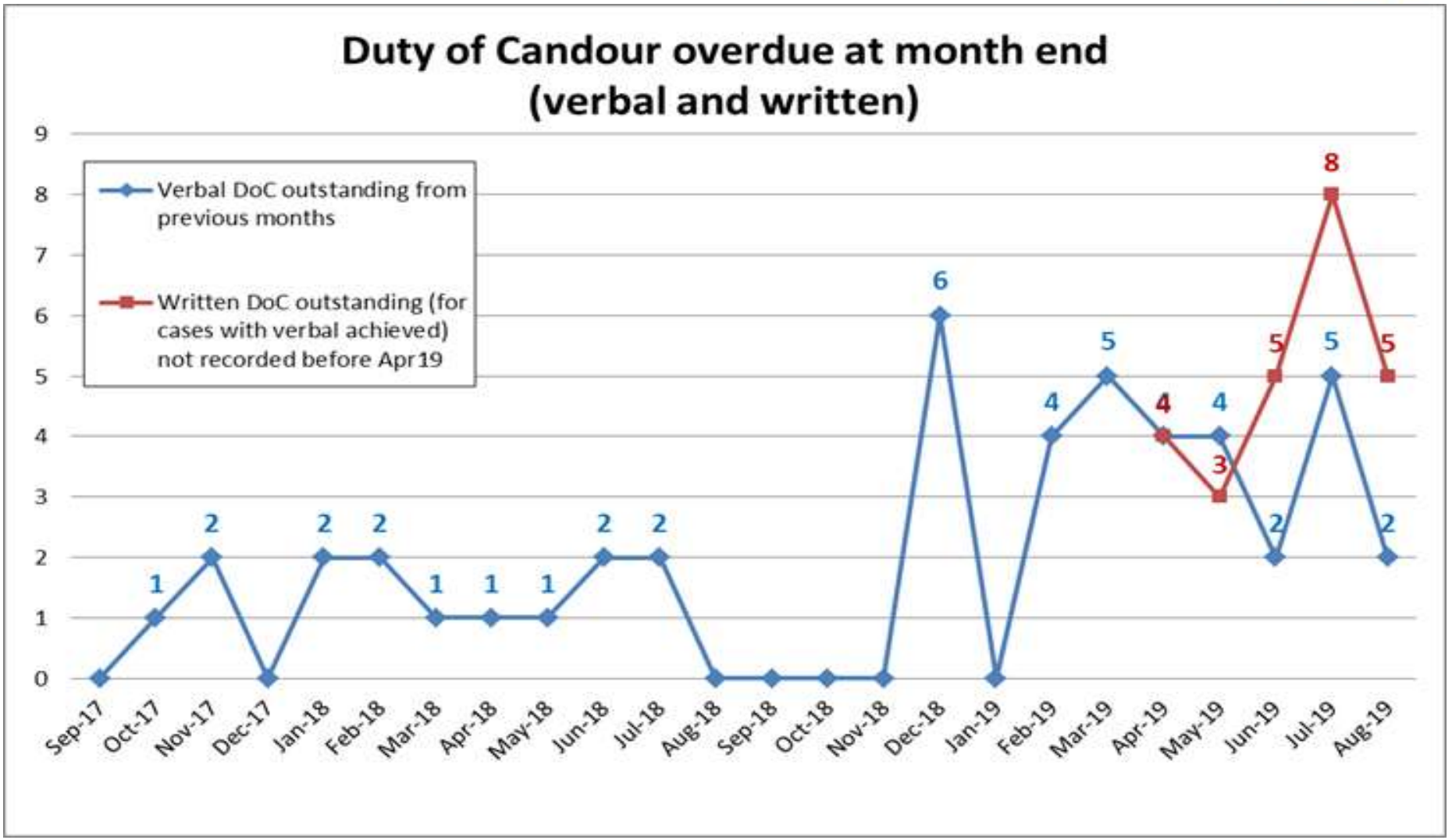
Duty of Candour



Narrative

What	An 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 in a run-chart.
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 the time taken to achieve verbal DoC (against the target of 10 working days) has improved over the last quarter, there are still cases pending for both written and verbal each month and this has been increasing over the last qtr. In September, a review of options to improve these indicators will be undertaken.

Safe



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

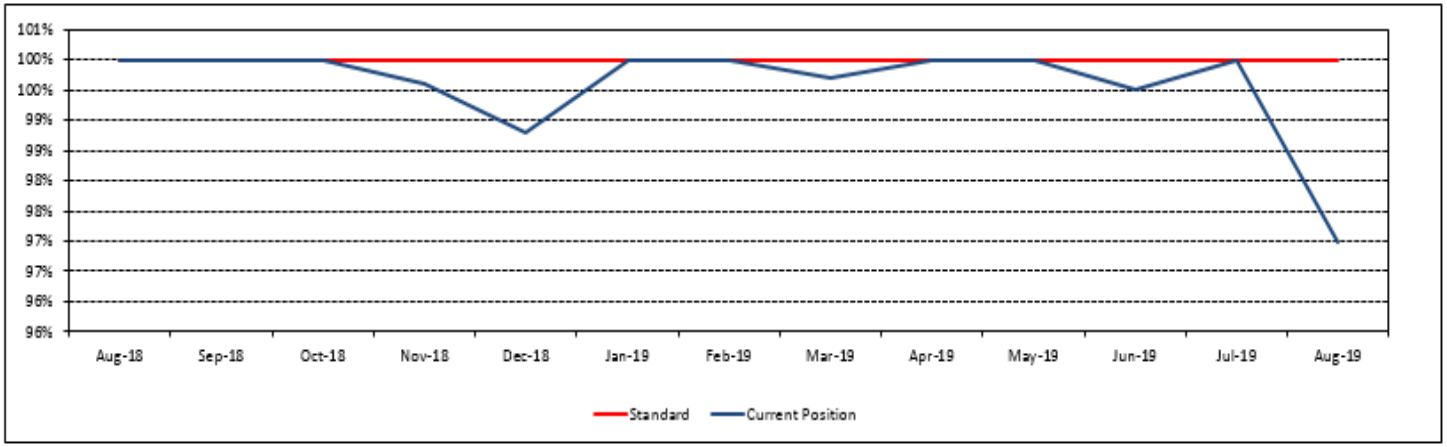
Indicator	Hand Hygiene Audits
Standard	100%
Executive Lead	Paul Morris
Month	August
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

There is a decline in the hand hygiene results predominantly due to an error in the audit on one ward. There were no actual fails on the ward regarding hand hygiene, however there was one fail regarding bare below the elbows. The issue of the error with the audit has been addressed and reported to the information team.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Address issue of audit with individual.	HoN	Complete	



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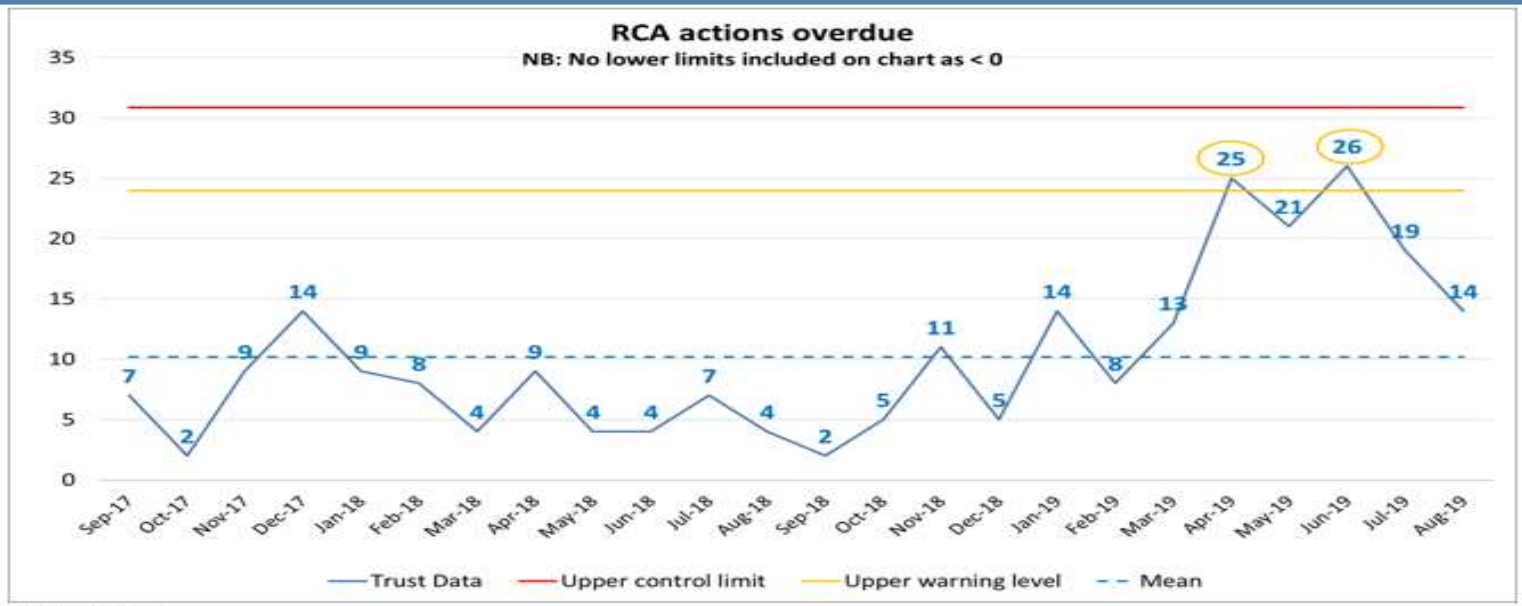
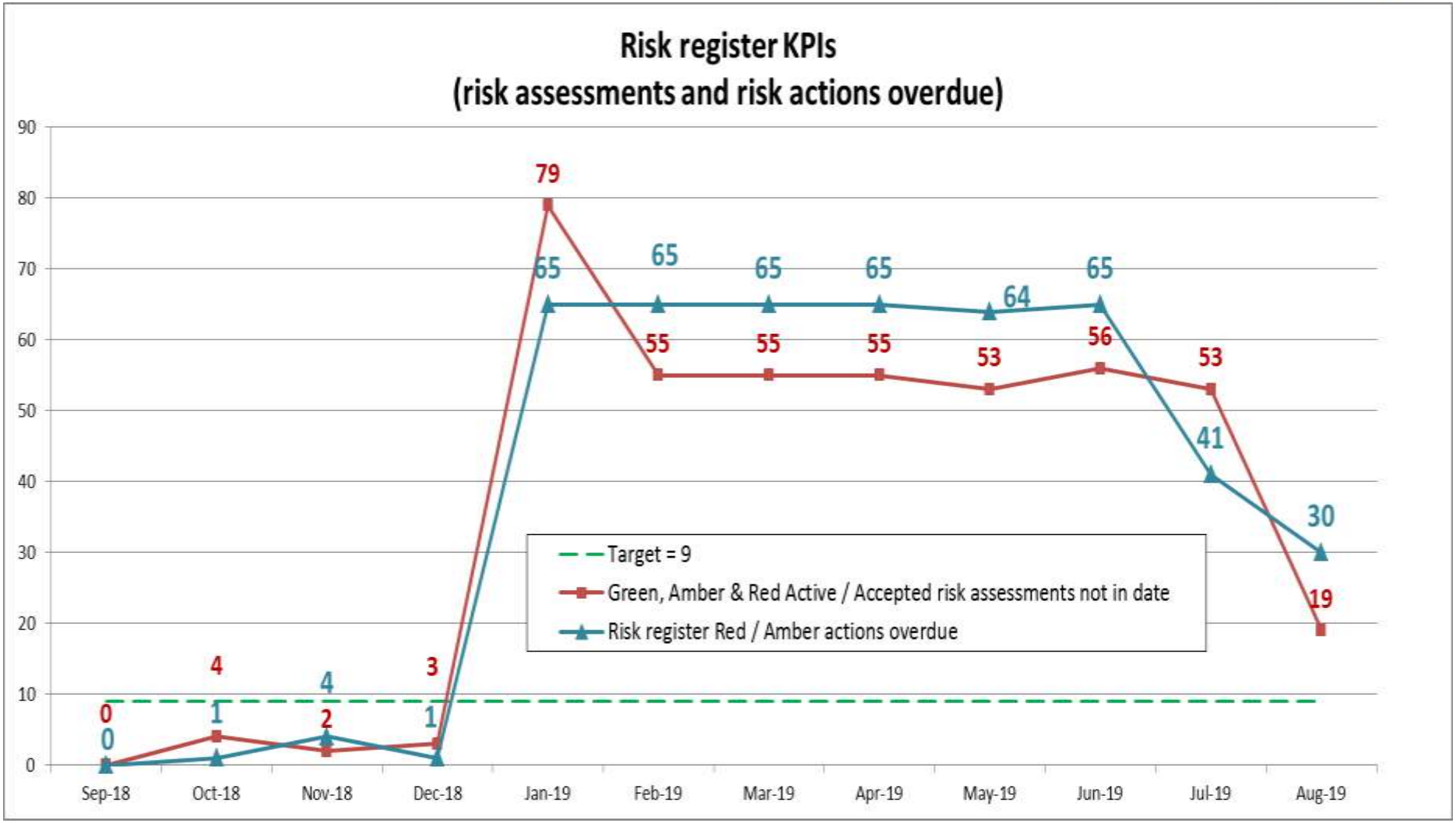
RCA actions



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). The Trust is also participating in the national pilot of the new SI framework (first meeting Sept/Oct 19). This is likely to impact on this indicator in the future although this will be in the longer term.
When	The RCA action review meetings are now in place and the first wash-up meeting took place in August (it related to an inquest held in September). It is envisaged the upward trajectory should therefore start to be reversed in the next couple of months' reports.

Safe



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

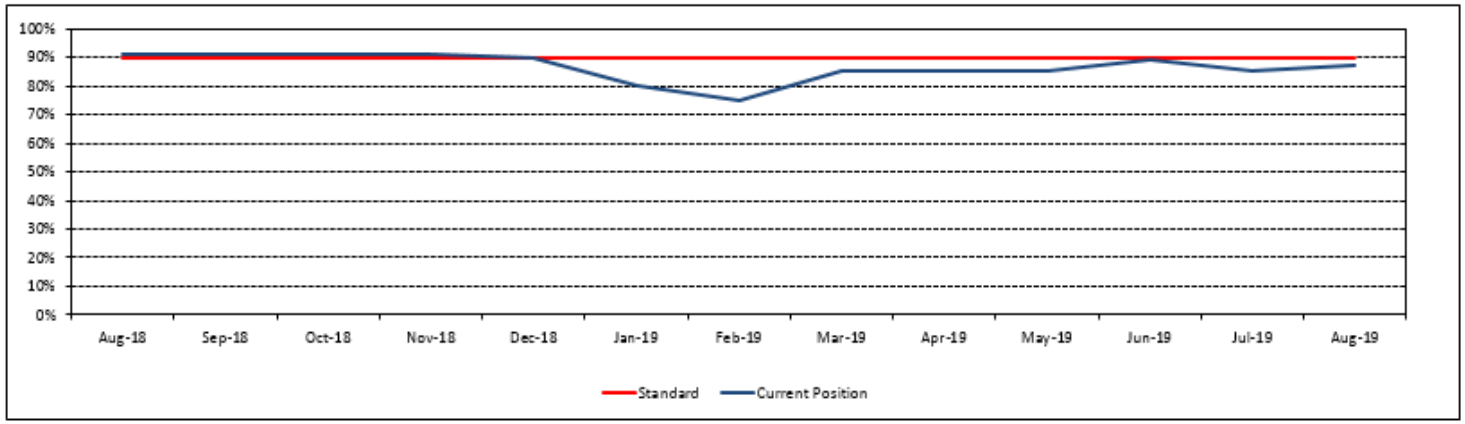
Indicator	Isolation data (Trust Level only)
Standard	90%
Executive Lead	Rowan Procter
Month	Aug-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

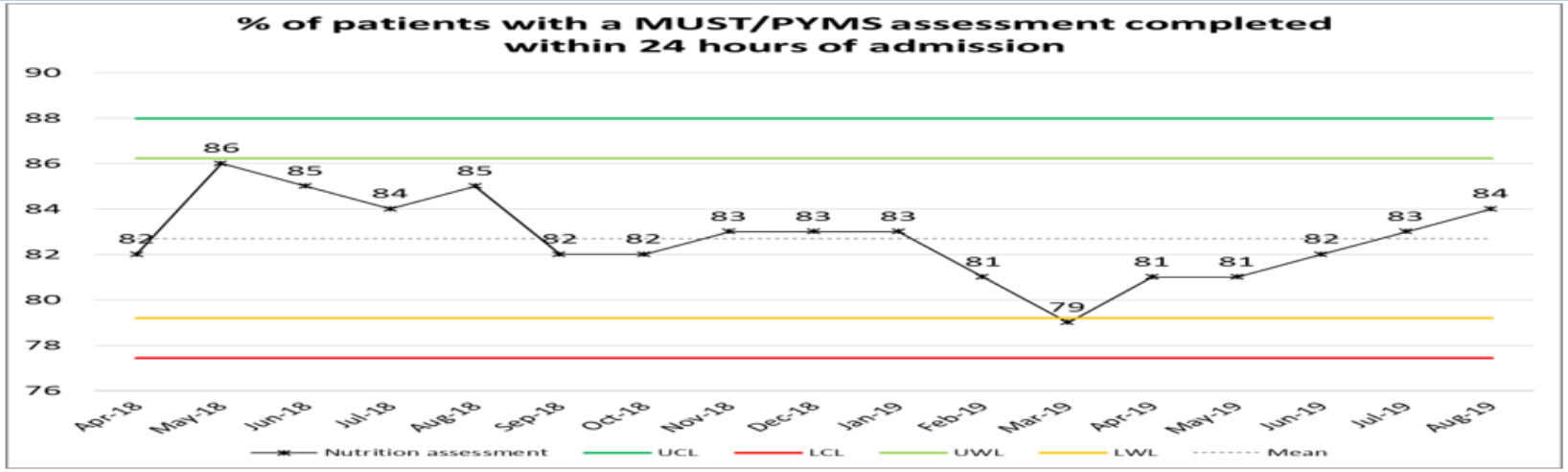
The side room capacity is monitored daily (Mon to Fri) by the Infection Prevention Nurses and occupancy is risk assessed throughout the day, including a daily review of patients on the Infection Prevention Nurses ward visits and this information is provided to the site capacity/bed flow meetings. Wards 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.
August 2019 there were two cases for whom isolation was not achievable for patients with multi resistant gram negative organisms. All measures to prevent onward transmission were discussed with the ward areas and implemented

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

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



Nutrition



Narrative

What	The chart shows an upward trend but still within the SPC parameters. There have been significant improvements in some areas, specifically Stroke, general medicine and cardiac, however, the surgical wards have seen a decline with compliance.
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). There has been some improvement in this area and it continues to be an area of focus for the team. There is continued promotion by the Senior Matrons within the Surgical Division to improve and maintain compliance. This is being achieved with engagement of the Ward Managers and Band 6 team leads by daily review of the Ward Patient Safety Dashboard.
How	Following the completion of the NHS Improvement nutrition collaborative the work continues on progressing activity to improve nutritional assessments, referrals and care planning in addition, reviewing and enhancing the implementation of protected meal times. Work has also been undertaken on reviewing the multiple data and measurement sets that existed for food, fluid and nutrition and these have been streamlined, these will form part of the patient safety report. We have been working with the communication team to improve this process and are aiming to have a process of 3 measures to feedback to teams: • Information on compliance from Patient safety dashboard monthly. • A quarterly audit to review accuracy and Monthly assurance via 'Perfect Ward'. • In addition there will be a quarterly protected mealtime audit. Nutritional care is also monitored via the Perfect Ward App. There is also specific work commencing with focus on the Stroke patients following the publication of the 2018 Sentinel Stroke National Audit Programme
When	This is an ongoing work plan and quality improvement initiatives will continue to be progressed via the Nutrition Group and by the Matrons / Ward Managers through the use of the Nutrition dashboard and Perfect Ward audit data. There is also now a Nutrition Quality improvement sub-group set up with a structured action plan, which has recently been updated for the August Nutrition group meeting and included in the report to CSEC and the Trust Board learning report scheduled for 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	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	YTD(Apr19-Aug19)
2.Effective	Incidents/Reports	2.05	Cardiac arrests	NT	3	6	9	ND	3	5	5	3	4	5	0	7	ND	16
		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	41	49	48	43	42	35	33	28	19	15	17	16	16	83
		2.10	WHO Checklist (Qrtly)	100%	NA	98.0%	NA	NA	99.0%	NA	NA	99.0%	NA	NA	99.0%	NA	NA	99.0%
		2.11	National clinical audit report baseline & risk assessments not completed within 6 months of publication	5	18	18	18	19	21	26	28	29	19	16	13	13	14	75
		2.12	Av. Elective LOS (excl. 0 days)	NT	3.29	2.60	3.25	3.50	3.35	2.81	3.92	2.74	3.17	2.89	2.69	3.16	2.44	2.87
		2.13	Av NEL LOS (excl 0 days)	NT	8.09	7.98	7.66	7.61	7.56	7.43	8.69	8.05	8.46	8.70	8.93	8.17	7.89	8.43
		2.14	% of NEL 0 day LOS	NT	13.3%	14.0%	14.4%	15.9%	15.4%	14.6%	13.8%	14.9%	14.2%	13.7%	13.3%	11.8%	13.4%	13.3%
		2.15	NHS number coding	99%	99.3%	99.7%	99.8%	99.8%	99.8%	99.7%	99.7%	99.8%	99.8%	99.8%	99.7%	99.5%	99.8%	99.7%
		2.16	Fractured Neck of Femur : Surgery in 36 hours	85%	100%	90.3%	96.9%	100%	100%	97.0%	100%	92.8%	96.2%	92.9%	96.9%	100%	96.0%	96.4%
		2.17	Discharge Summaries (OP 85% 3d)	85%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND
		2.18	Discharge Summaries (A&E 95% 1d)	95%	88.4%	86.9%	85.8%	82.2%	80.5%	83.7%	84.0%	81.7%	83.2%	82.8%	85.0%	83.4%	83.7%	83.6%
		2.19	Non-elective Discharge Summaries (IP 95% 1d)	95%	76.9%	75.3%	77.9%	72.4%	72.9%	76.6%	78.0%	74.9%	81.8%	80.7%	82.1%	84.3%	81.0%	82.0%
		2.20	Elective Discharge Summaries (IP 85% 1d)	85%	70.8%	79.8%	80.8%	84.5%	84.8%	84.7%	84.6%	87.9%	80.8%	87.7%	86.7%	87.8%	76.3%	83.9%
		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%	83.8%	86.7%	77.5%	100%	91.7%	82.8%	100%	73.3%	79.2%	93.3%	100%	90.0%	94.9%	91.5%
		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

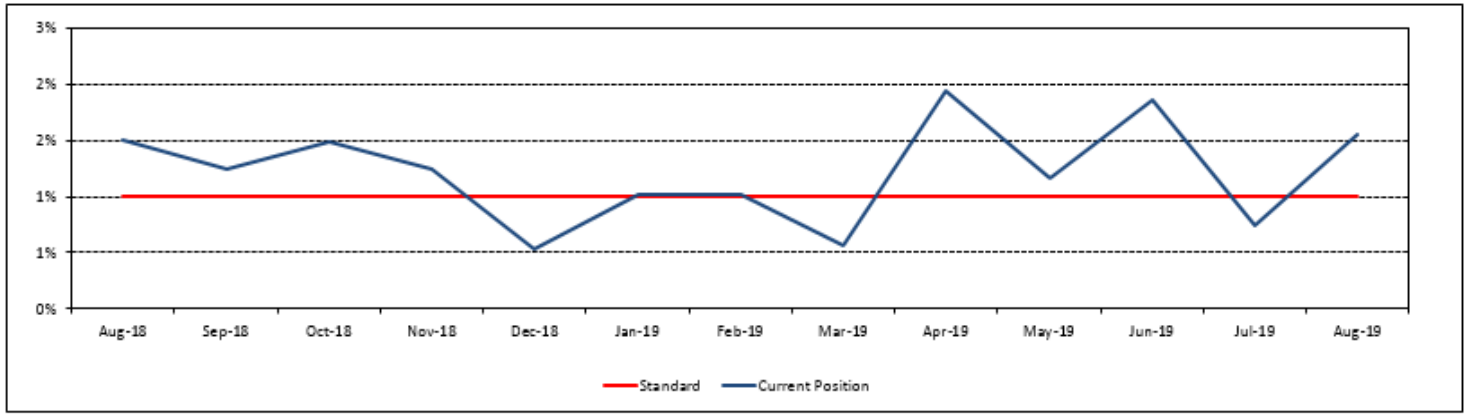
Indicator	Canc. Ops - Cancellations for non-clinical reasons
Standard	1%
Executive Lead	Helen Beck
Month	Aug-19
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

Increase in number of patients cancelled on the day this month, the increase is largely due to anaesthetic sickness.

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

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



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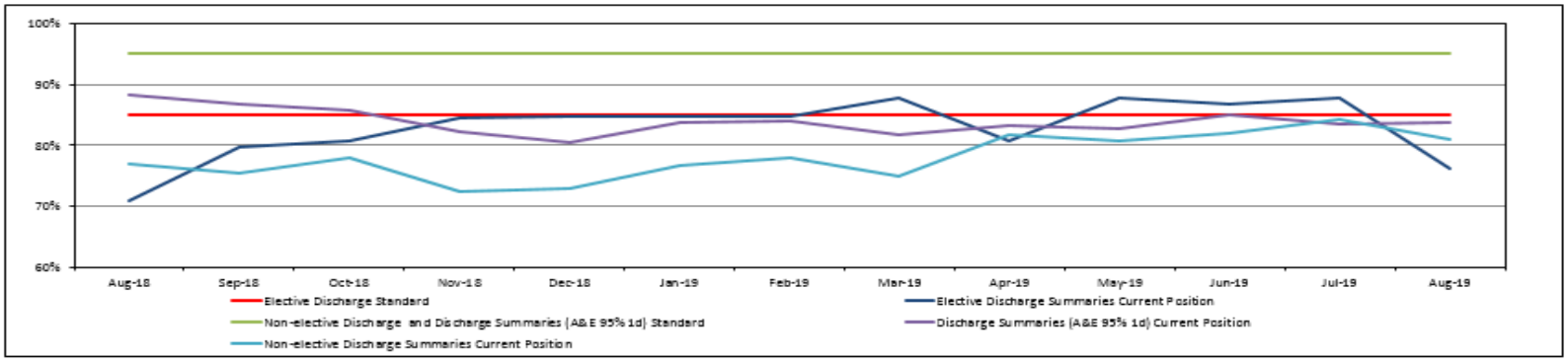
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	Discharge Summaries
Standard	85%, 95%
Executive Lead	Nick Jenkins
Month	Aug-19
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

The position has deteriorated compared to the previous month for elective and non-elective discharge summaries, but has improved slightly for ED. We continue to work with departments to try and improve timeliness of discharge summaries. Reports identify which specific areas may need support and this is targeted through the operational divisions. We will be repeating the training that we delivered to juniors in September. This showed a demonstrable improvement for the last intake when completed.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Elective Discharge Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Elective Discharge Summaries Current Position	70.8%	79.8%	80.8%	84.5%	84.8%	84.7%	84.6%	87.9%	80.8%	87.7%	86.7%	87.8%	76.3%
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	88.4%	86.9%	85.8%	82.2%	80.5%	83.7%	84.0%	81.7%	83.2%	82.8%	85.0%	83.4%	83.7%
Non-elective Discharge Summaries Current Position	76.9%	75.3%	77.9%	72.4%	72.9%	76.6%	78.0%	74.9%	81.8%	80.7%	82.1%	84.3%	81.0%

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

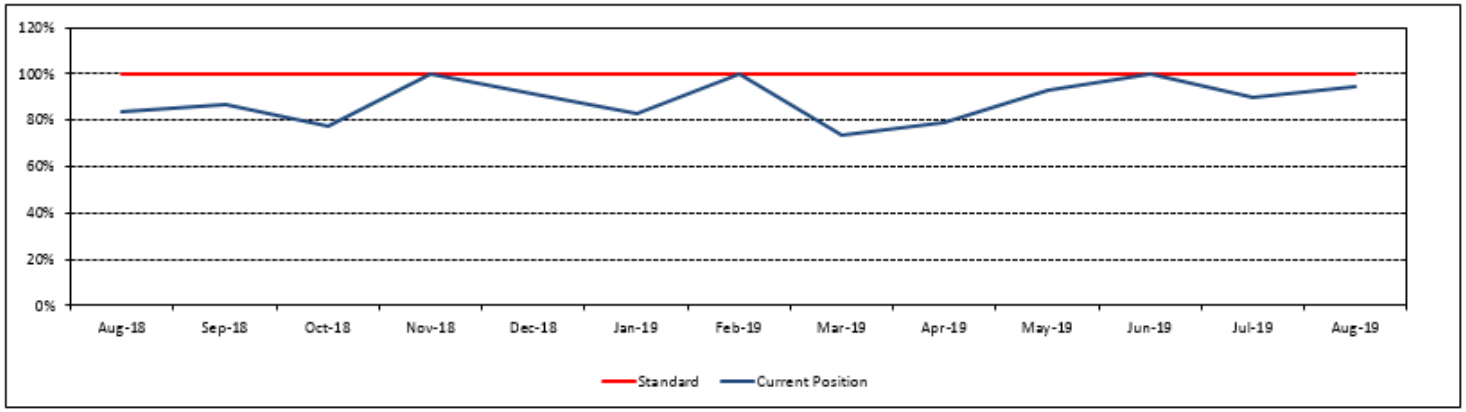
Indicator	Canc. Ops - Patients offered date within 28 days
Standard	100%
Executive Lead	Helen Beck
Month	Aug-19
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

Improvement seen in this standard in August, however 2 patients were not booked within 28 days of their operation being cancelled. One needed to be seen in clinic to discuss the procedure and the other there was not suitable list for with the 28 day timeframe.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	83.8%	86.7%	77.5%	100%	91.7%	82.8%	100%	73.3%	79.2%	93.3%	100%	90.0%	94.9%

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



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6. DETAILED REPORTS - CARING

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

Are we..		Ref.	KPI	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	YTD(Apr19-Aug19)
3. Caring	Other Friends and Family Test Scores	3.09	IP overall experience result	90%	95.0%	97.0%	95.0%	95.0%	98.0%	95.0%	94.0%	95.0%	94.0%	90.0%	92.0%	91.0%	90.0%	91.4%
		3.10	OP overall experience result	90%	96.0%	96.0%	97.0%	97.0%	97.0%	97.0%	98.0%	98.0%	98.0%	97.0%	98.0%	96.0%	96.0%	97.0%
		3.11	A&E overall experience result	90%	97.0%	94.0%	95.0%	95.0%	95.0%	95.0%	95.0%	96.0%	93.0%	85.0%	93.0%	86.0%	87.0%	88.8%
		3.12	Short-stay overall experience result	90%	99.0%	100%	99.0%	96.0%	98.0%	98.0%	99.0%	98.0%	98.0%	99.0%	99.0%	98.0%	99.0%	98.6%
		3.13	Short-stay Extremely likely or Likely to recommend (FFT)	90%	99.0%	99.0%	100%	99.0%	99.0%	97.0%	97.0%	97.0%	99.0%	99.0%	99.0%	98.0%	99.0%	98.8%
		3.14	Maternity - overall experience result	90%	97.0%	94.0%	97.0%	91.0%	99.0%	100%	96.0%	ND	ND	ND	ND	ND	ND	ND
		3.15	Maternity postnatal community - extremely likely or likely to recommend (FFT)	90%	100%	98.0%	98.0%	100%	100%	100%	100%	100%	100%	100%	96.0%	100%	98.0%	98.8%
		3.16	Maternity birthing unit - extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND
		3.17	Maternity antenatal community - extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	100%	100%	ND	ND	ND	ND	ND	ND	ND	ND	ND
		3.18	Children's services overall result	90%	98.0%	95.0%	85.0%	95.0%	93.0%	100%	100%	98.0%	96.0%	98.0%	98.0%	100%	100%	98.4%
		3.19	F1 Parent - overall experience result	90%	98.0%	95.0%	95.0%	98.0%	94.0%	97.0%	97.0%	95.0%	99.0%	98.0%	99.0%	98.0%	99.0%	98.6%
		3.20	F1 - Extremely likely or likely to recommend (FFT)	90%	94.0%	91.0%	100%	96.0%	87.0%	100%	100%	100%	96.0%	98.0%	100%	100%	100%	98.8%
		3.21	F1 Children - Overall experience result	90%	91.0%	95.0%	93.0%	95.0%	93.0%	100%	100%	98.0%	86.0%	89.0%	98.0%	100%	100%	94.6%
		3.22	Rosemary ward - extremely likely or likely to recommend (FFT)	90%	100%	90.0%	100%	100%	100%	100%	80.0%	100%	80.0%	95.0%	100%	86.0%	100%	92.2%
		3.23	King suite - extremely likely or likely to recommend	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95.0%	99%
		3.24	Community paediatrics - extremely likely or likely to recommend (FFT)	90%	100%	94.0%	100%	100%	100%	100%	96.0%	100%	100%	100%	94.0%	97.0%	98.0%	97.8%
		3.25	Community health teams - extremely likely or likely to recommend (FFT)	90%	89.0%	100%	100%	100%	100%	93.0%	93.0%	100%	100%	97.0%	90.0%	95.0%	92.0%	94.8%
		3.27	Stroke Care - Overall Experience Result	90%	100%	90.0%	100%	93.0%	ND	ND	89.0%	97.0%	96.0%	95.0%	97.0%	98.0%	89.0%	95.0%
		3.28	Stroke Care - extremely likely or likely to recommend	90%	97.0%	97.0%	100%	100%	100%	ND	93.0%	89.0%	100%	100%	100%	100%	100%	100%
	Complaint Handling	3.29	Complaints acknowledged within 3 working days	90%	88.0%	66.0%	100%	100%	100%	100%	88.0%	84.0%	94.0%	83.0%	81.0%	94.0%	80.0%	86.4%
		3.30	Complaints responded to within agreed timeframe	90%	83.0%	100%	83.0%	88.0%	83.0%	75.0%	100%	94.0%	86.0%	77.0%	71.0%	60.0%	44.0%	67.6%
		3.31	Number of second letters received	1	1	0	2	1	1	3	2	0	2	2	4	1	1	10
		3.32	Ombudsman referrals accepted for investigation	1	0	1	0	0	0	0	0	0	0	0	0	1	1	2
		3.33	No. of complaints to Ombudsman upheld	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		3.34	No. of PALS contacts	NT	233	198	224	219	143	231	211	228	184	190	191	252	207	1024
		3.35	No. of PALS contacts becoming formal complaints	<=5	2	2	1	3	0	2	5	4	2	5	6	4	2	19

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EXCEPTION REPORTS –CARING

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

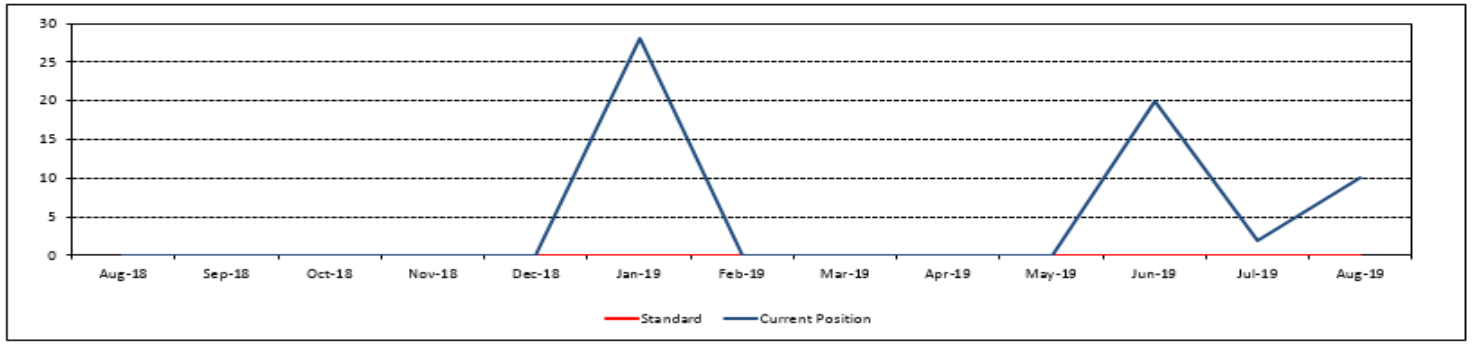
Indicator	Mixed Sex Accommodation Breaches
Standard	0
Executive Lead	Rowan Procter
Month	Aug-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

There were 2 Breaches in August on G9 involving a total of 10 patients:
6 August – 3 patients – F3 on G9
9 August – 7 patients – F3 on G9
G9 is a unique ward layout and was a temporary arrangement for the Ward F3 team due to a minor refurbishment taking place on Ward F3. On the 6th August a blocked toilet was delayed in being repaired which resulted in 2 female patients walking across a male open sided cubicle creating the breach. The issue was reported straight away to the Estates team, however there was a delay in responding to this. Following escalation to the Head of Nursing, this was repaired by the estates team.
On the 9th August a male patient was moved into the side room by the patient flow team from another Surgical Ward. The side room is located at the end of a female bay and there is a shared toilet. The team were aware of the breach but there were pressures to complete the move to facilitate a surgical bed for a patient in ED.
These incidents will be shared with the appropriate teams for learning and future prevention of incidents. This has also been shared with the Medical Division in preparation for the use of Ward G9 for winter escalation

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	0	0	0	0	0	28	0	0	0	0	20	2	10

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

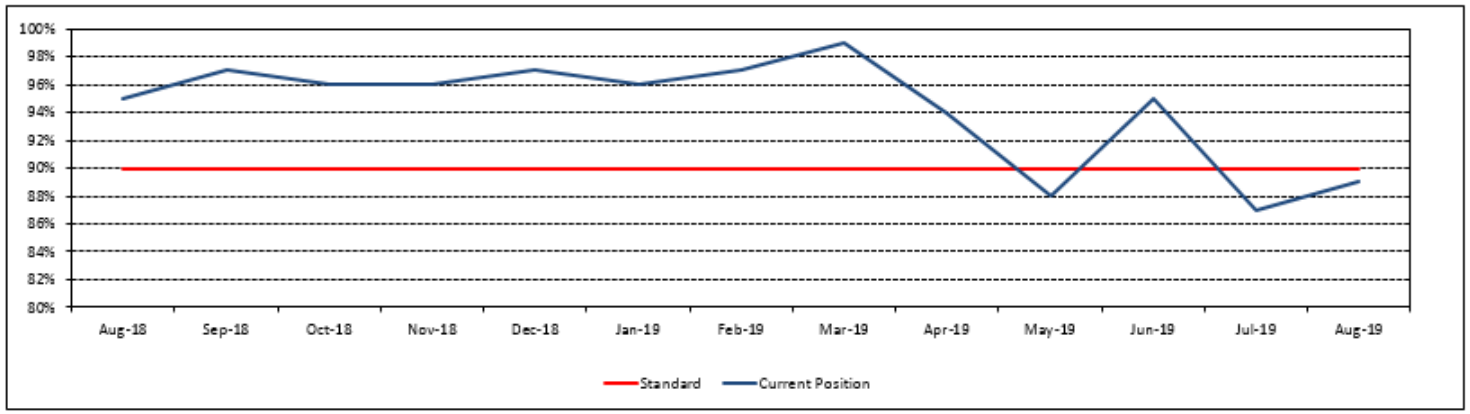
Indicator	A&E - Extremely likely or Likely to recommend (FFT)
Standard	90%
Executive Lead	Rowan Procter
Month	August
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

The ED are now collecting FFT and patient satisfaction data via SMS which has impacted on the performance. This is felt to be due to patients being more honest about their experience once in their home environment. The SMS system had some issues in June which explains why the results improved again in this month (paper surveys were being completed only). Survey satisfaction is discussed at the departmental governance meeting to ensure issues are being monitored.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	95.0%	97.0%	96.0%	96.0%	97.0%	96.0%	97.0%	99.0%	94.0%	88.0%	95.0%	87.0%	89.0%

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

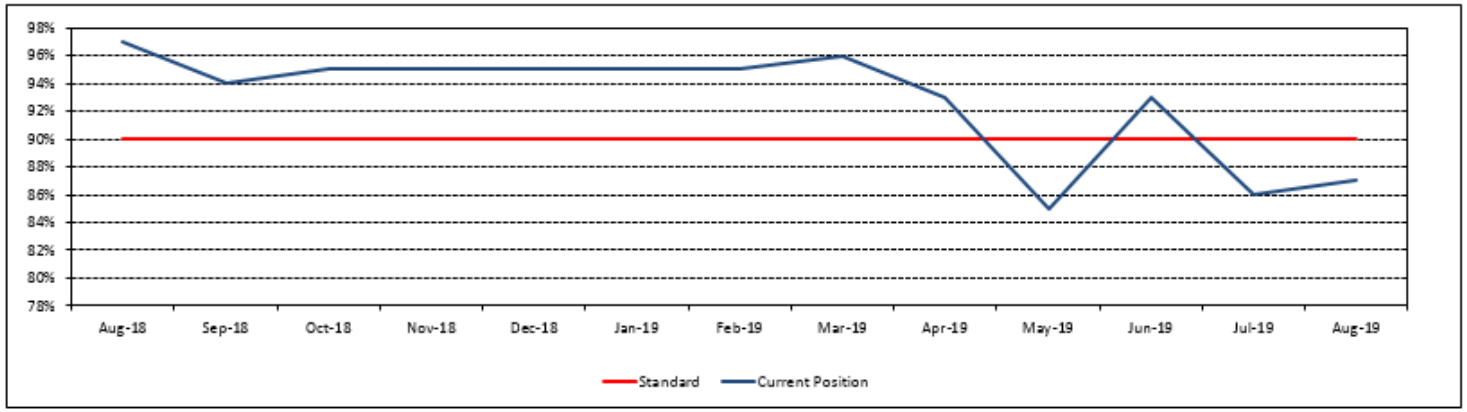
Indicator	A&E overall experience result
Standard	90%
Executive Lead	Rowan Procter
Month	August
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

The ED are now collecting FFT and patient satisfaction data via SMS which has impacted on the performance. This is felt to be due to patients being more honest about their experience once in their home environment. The SMS system had some issues in June which explains why the results improved again in this month (paper surveys were being completed only).

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	97.0%	94.0%	95.0%	95.0%	95.0%	95.0%	95.0%	96.0%	93.0%	85.0%	93.0%	86.0%	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

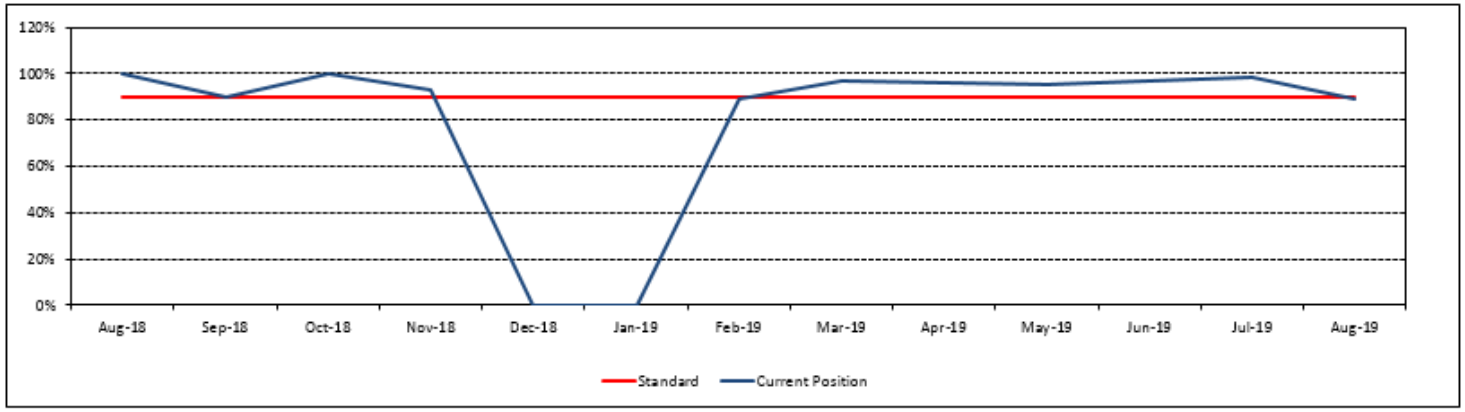
Indicator	Stroke Care - Overall Experience Result
Standard	90%
Executive Lead	Rowan Procter
Month	August
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Delays in responding to call bells was flagged as an issue on G8 in August, this question has caused the overall satisfaction rating to have decreased. This has been fed back to the ward manager and senior matron.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	100.0%	90.0%	100.0%	93.0%	ND	ND	89.0%	97.0%	96.0%	95.0%	97.0%	98.0%	89.0%

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

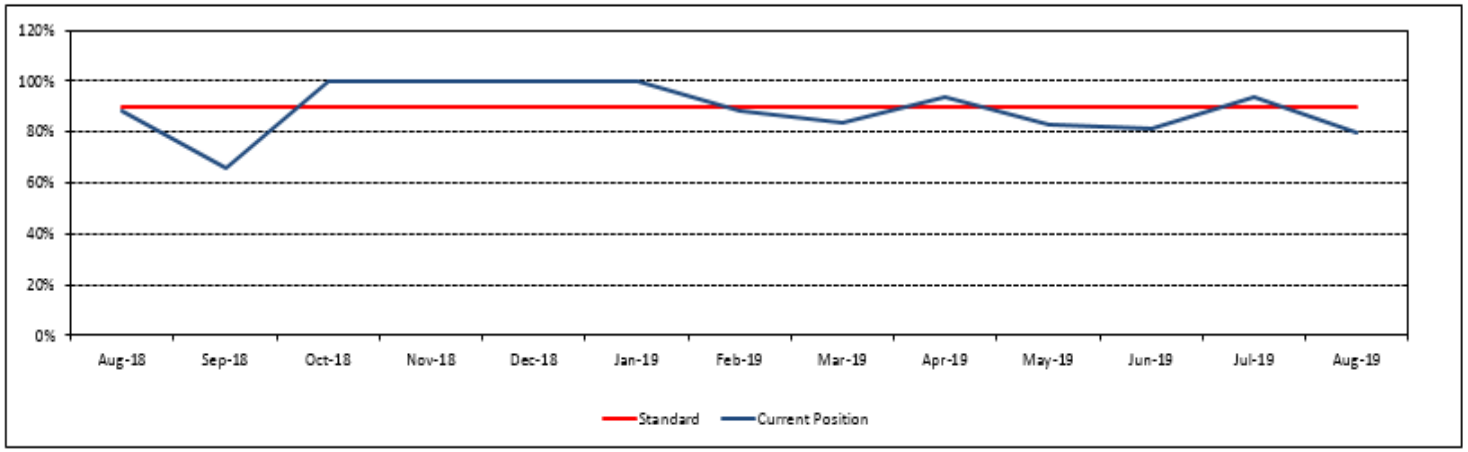
Indicator	Complaints acknowledged within 3 working days
Standard	90%
Executive Lead	Rowan Procter
Month	August
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Increased demand has impacted on the acknowledgement timeframes however we are currently receiving bank assistance with complaint responses which will improve overall performance in the short term.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	88.0%	66.0%	100.0%	100.0%	100.0%	100.0%	88.0%	84.0%	94.0%	83.0%	81.0%	94.0%	80.0%

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

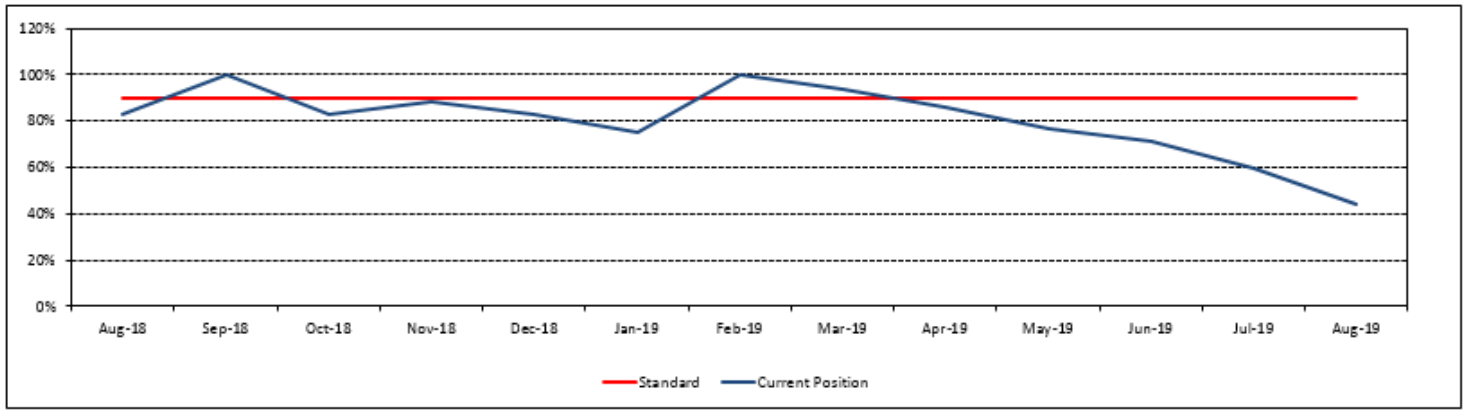
Indicator	Complaints responded to within agreed timeframe
Standard	90%
Executive Lead	Rowan Procter
Month	August
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Increased demand has impacted on timeframes however we are currently receiving bank assistance with complaint responses which will improve overall performance in the short term.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	83.0%	100.0%	83.0%	88.0%	83.0%	75.0%	100.0%	94.0%	86.0%	77.0%	71.0%	60.0%	44.0%

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



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7. DETAILED REPORTS - RESPONSIVE

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

Are we..		Ref.	KPI	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	YTD(Apr19-Aug19)
4. Responsive	A&E	4.13	Number of Delayed Transfer of Care - (DTOCs)	NT	302	224	270	268	320	287	389	460	447	404	425	432	406	423
		4.14	A&E time to treatment in department (median) for patients arriving by ambulance - CDM	120	46	39	46	45	46	47	43	43	46	46	43	55	33	45
		4.15	A&E - Single longest Wait (Admitted & Non-Admitted)	6 hrs.	15.54	12.23	16.17	13.05	15.35	20.32	14.35	13.55	14.35	13.23	20.01	17.18	20.35	17.02
		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	31	10	31	24	54	125	113	65	155	105	119	133	33	545
		4.18	A&E - To inpatient Admission Ratio	32%	25.7%	28.3%	28.6%	30.3%	31.2%	31.3%	31.6%	29.7%	29.0%	28.8%	27.2%	25.5%	26.1%	27.3%
		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%	90.1%	91.0%	93.1%	94.7%	95.0%	94.9%	96.5%	95.4%	95.3%	95.6%	96.4%	94.7%	ND	95.5%
		4.21	A&E - Amb. Handover above 30m	0	24	6	21	15	40	61	33	41	46	41	41	129	ND	257
		4.22	A&E - Amb. Handover above 60m	0	16	2	30	8	14	59	10	15	13	36	28	74	ND	151
	RTT	4.25	RTT waiting List	<15396	16601	18105	18071	17915	18426	19601	18341	19730	20427	21061	21253	20937	20942	20924
		4.26	RTT waiting list over 18 weeks	NT	1775	1830	1766	1855	2149	2999	3005	3006	3111	2985	3101	3270	3514	3196
		4.27	RTT 18 weeks Non-Consultant led services - Community	90%	99.0%	99.0%	99.0%	99.0%	100%	99.7%	99.6%	100%	99.0%	99.4%	94.0%	98.0%	94.4%	96.9%
		4.28	RTT 52 weeks Non-Consultant led services - Community	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Stroke	4.29	Stroke - % Patients scanned within 1 hr.	77%	84.4%	93.3%	64.0%	84.0%	80.0%	83.0%	75.5%	84.4%	75.8%	75.0%	80.0%	69.6%	70.6%	74.2%
		4.30	Stroke - % patients scanned within 12 hrs.	96%	100%	100%	100%	100%	97.5%	94.3%	98.1%	95.6%	97.0%	97.2%	95.0%	95.7%	94.1%	95.8%
		4.31	Stroke - % Patients admitted directly to stroke unit within 4h	75%	79.6%	82.8%	73.3%	83.7%	78.4%	78.4%	64.5%	78.6%	75.0%	71.4%	81.6%	77.5%	63.6%	73.8%
		4.32	Stroke - Greater than 80% of treatment on stroke unit	90%	88.6%	96.6%	88.9%	93.9%	91.9%	94.1%	84.3%	81.0%	96.9%	88.6%	86.8%	90.0%	97.0%	91.9%
		4.33	Stroke - % of patients treated by the SESDC	48%	53.9%	69.2%	52.4%	63.6%	48.0%	63.2%	49.1%	66.7%	54.2%	73.3%	55.0%	40.0%	71.4%	58.8%
		4.34	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start	80%	97.8%	96.7%	94.0%	88.0%	90.0%	96.2%	86.8%	91.1%	90.6%	88.9%	90.0%	84.8%	85.3%	87.9%
		4.35	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72h	75%	79.6%	86.2%	73.5%	89.6%	78.4%	87.5%	89.6%	80.0%	76.2%	75.0%	77.1%	92.9%	80.0%	80.2%
		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%	NA	65.0%	NA	NA	56.0%	NA	NA	57.0%	NA	NA	68.0%	NA	NA	68.0%
		4.38	Stroke -Provider rating to remain within A-C	C	NA	C	NA	NA	C	NA	NA	C	NA	NA	C	NA	NA	C

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Are we..		Ref.	KPI	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	YTD(Apr19-Aug19)
4. Responsive	Other	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	95%	100%	ND	100%	100%	100%	ND	100%	100%	100%	100%	100%	100%	100%	100%
		4.40	Nursing & therapy Red referrals seen within 4hrs - Community	95%	100%	100%	100%	100%	100%	96.6%	100%	100%	100%	100%	100%	93.8%	100%	98.8%
		4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	95%	99.4%	99.5%	99.0%	99.9%	100%	99.0%	98.8%	99.3%	99.2%	99.5%	99.3%	98.8%	97.3%	98.8%
		4.42	Nursing & therapy Green referrals seen within 18 wks -Community	95%	100%	99.6%	99.7%	99.2%	98.0%	99.5%	99.5%	99.5%	99.4%	99.5%	100%	99.6%	99.5%	99.5%
		4.43	Wheelchair waiting times – Child (Community)	92%	100%	100%	100%	83.3%	83.3%	81.8%	94.1%	100%	100%	100%	100%	96.3%	100%	99.3%
		4.44	Wheelchair waiting times - Adult (Community)	NT	100%	73.1%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND
		4.45	Sepsis - 1 hr neutropenic sepsis	100%	72.2%	90.9%	90.0%	75.0%	77.8%	81.0%	75.0%	87.5%	100%	91.7%	92.9%	87.5%	90.0%	92.4%
		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	93.3%	40.0%	46.2%	50.0%	20.0%	49.9%
		4.46	Percentage of Children in Care initial health assessments completed within 28 calendar days of becoming a child in care	100%	31.6%	11.8%	33.3%	21.4%	15.4%	0.0%	20.0%	14.3%	33.3%	40.0%	38.5%	50.0%	20.0%	36.4%
		4.47	Percentage of Service Users (children) assessed to be eligible for NHS Continuing Healthcare whose review health assessment is completed annually	80%	ND	86.7%	86.2%	90.0%	97.0%	100%	100%	ND	99.0%	96.2%	100%	100%	100%	99.0%

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	Aug-19
Data Frequency	Monthly
CQC Area	Responsive

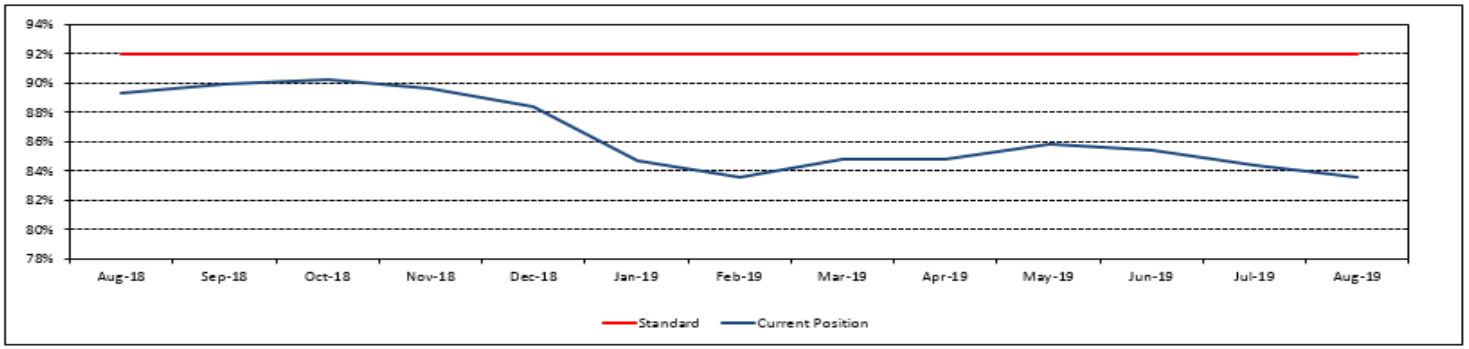
Summary of Current performance & Reasons for under performance

The overall position has deteriorated from July to August in this standard. There is underachievement of the standard within General Surgery, Urology, Trauma and Orthopaedics, Ophthalmology, Gastroenterology, Cardiology, Thoracic medicine and Gynaecology. Whilst some of these areas have shown minor improvement from July to August, Trauma and Orthopaedics, Gastro and Gynaecology have each dropped by at least 2%.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Current Position	89.3%	89.9%	90.2%	89.7%	88.3%	84.7%	83.6%	84.8%	84.8%	85.8%	85.4%	84.4%	83.6%

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	
Full action plan completed with all options for out/in sourcing and additional internal activity	AB	Jun-19	Jul-19
Demand and Capacity to be completed for Cardiology and Gastroenterology	HK	Aug-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	Aug-19
Data Frequency	Monthly
CQC Area	Responsive

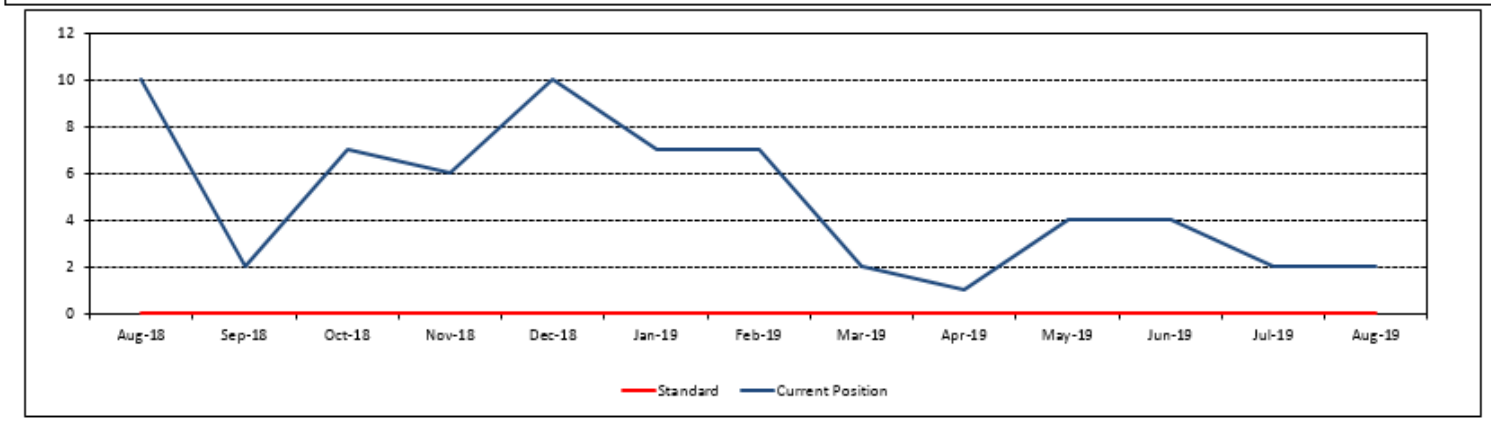
Summary of Current performance & Reasons for under performance

Two patients breached 52 weeks in August. One was a General Surgery patient, who's pathway had a 6 month delay due to a national shortage of markers for the Colonic Transit Study to be completed. This patient has required other diagnostics and has a surgery date currently for the 25th September, however this is also likely to be purely diagnostic but will determine the need for major surgery. The second patient is a Gynaecology patient, they did have a TCI date for the 30th August 2019 so would have been completed prior to the month end, however this had to be cancelled the day before to make way for an emergency patient, this patient had surgery completed on the 17/09/2019.

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

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

Description	Owner	Start	End
Monitor of long waiting patients at weekly access meeting	HB		
RCA's completed for all patients who breach 52 weeks, with clinical harm review	HK	Jun-18	TBC



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

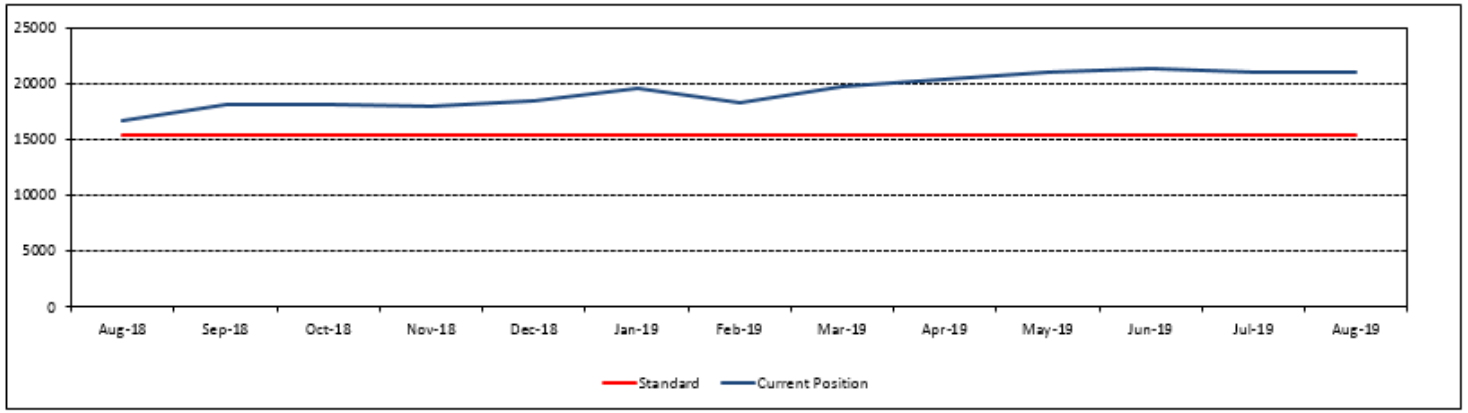
Indicator	RTT waiting List
Standard	15396
Executive Lead	Helen Beck
Month	Aug-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Overall waiting list size remains very much the same from July to August, despite a reduction in clock stops during the month of August due to peak summer holidays. There has been an increase in waiting list numbers for Ophthalmology and Trauma and Orthopaedics, however improvement continues to be made in Cardiology and a reduction has also been seen this month for Gynaecology.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396
Current Position	16601	18105	18071	17915	18426	19601	18341	19730	20427	21061	21253	20937	20942

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Action plan for recovery in place for all specialities not meeting performance	HK	Dec-18	
Continue to monitor long waits at weekly access meeting	HK	Aug-18	
Options for in/out sourcing being explored using CCG funding - Ophthalmology has been out to interest for Cataracts, Locum consultants in place for Respiratory, and to start soon in ENT and Trauma and Orthopaedics	AB	Jul019	Apr-20



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

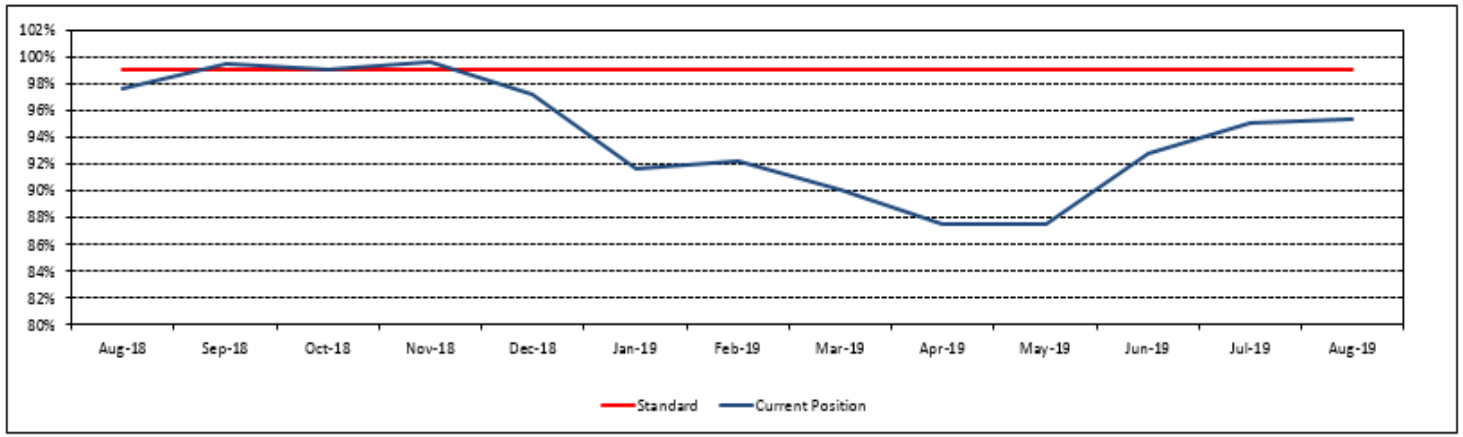
Indicator	Diagnostics within 6 weeks
Standard	99%
Executive Lead	Helen Beck
Month	Aug-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Diagnostic performance has improved again this month although capacity issues continue to impact on waiting times for endoscopy related diagnostic procedures. Work continues on the colorectal and urology (cystoscopy) pathways in particular to provide long term sustainability.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%
Current Position	97.6%	99.5%	99.0%	99.6%	97.1%	91.7%	92.2%	90.0%	87.5%	87.6%	92.8%	95.0%	95.4%

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



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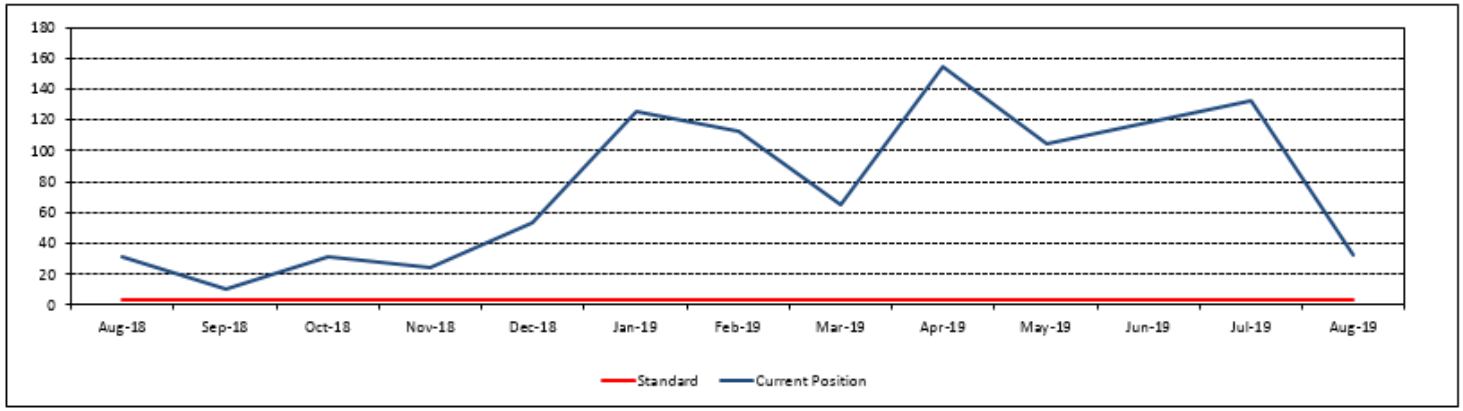
Indicator	A&E - Admission waiting 4-12 hours from dec. to admit
Standard	4
Executive Lead	Rowan Procter
Month	Aug-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

33 patients waited between 4-12 for a bed following a decision to admit. This has decreased significantly since July which saw the highest ever number of attendances.
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	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	4	4	4	4	4	4	4	4	4	4	4	4	4
Current Position	31	10	31	24	54	125	113	65	155	105	119	133	33

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

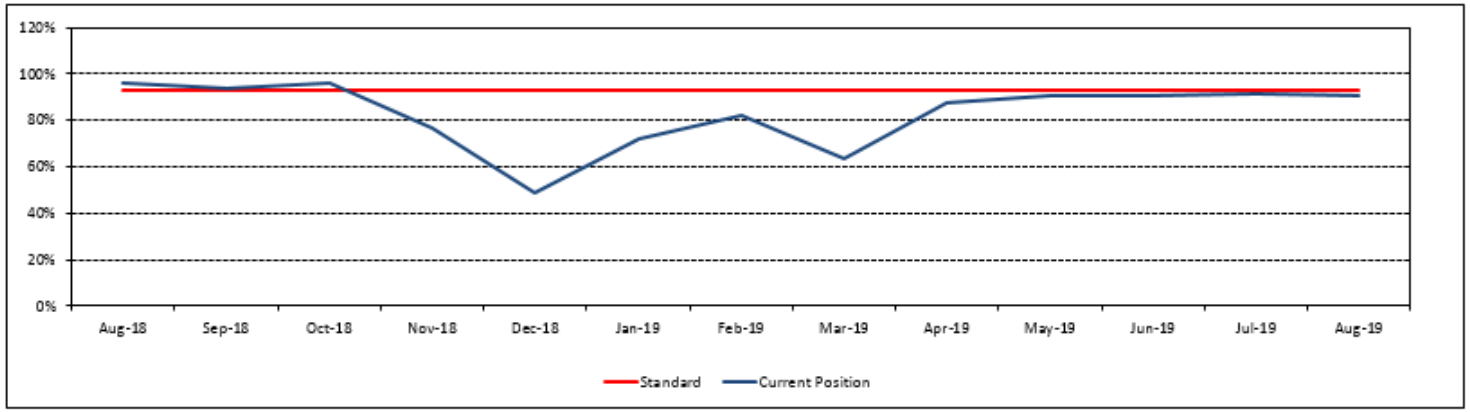
Indicator	Cancer 2w wait breast symptoms
Standard	93%
Executive Lead	Helen Beck
Month	Aug-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

This is primarily due to patient controlled factors including 7/12 away on holidays and other 5/12 had one or other factor to cancel the offered appointment date within 14 days of receipt of referral.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	95.9%	93.9%	96.4%	76.7%	48.8%	72.1%	82.0%	63.5%	87.8%	90.6%	90.8%	91.3%	90.3%

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

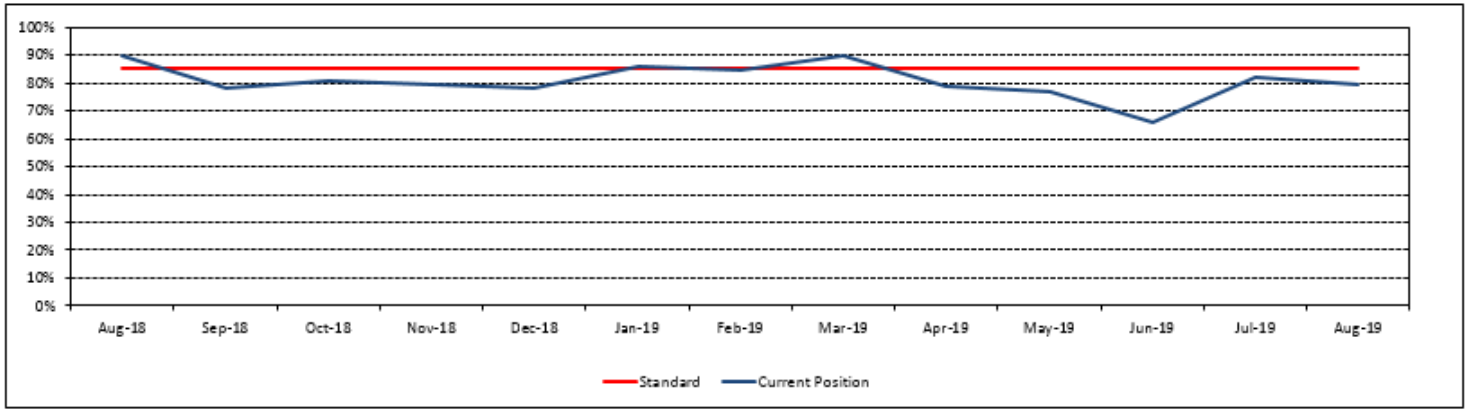
Indicator	Cancer 62 d GP referral
Standard	85%
Executive Lead	Helen Beck
Month	Aug-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Owing to high number of referrals and pathway issues resulting to delays in prostate ca tissue diagnosis- 4/15 and ongoing diagnostic/staging delays in colorectal – 2/15 along with Skin – 4/15 owing to delays between Dermatology and Plastics for excisions, and one breach each in gynaecology, Haem, H/N, Lung, Upper GI pathways due to mixture of complex pathways requiring more than usual diagnostics and staging investigations and capacity issues locally in the Trust.
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	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Current Position	89.9%	78.0%	80.6%	79.5%	78.3%	85.5%	84.8%	90.0%	78.4%	76.9%	65.9%	81.8%	79.6%

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

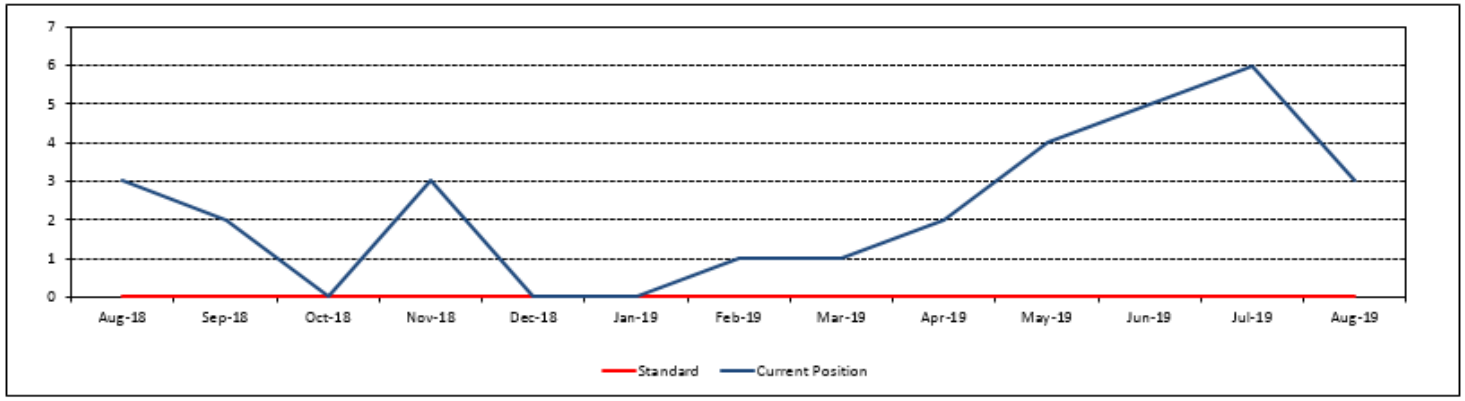
Indicator	Incomplete 104 day waits
Standard	0
Executive Lead	Helen Beck
Month	Aug-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Improvement seen from July to August in the number of 104 day patients, showing that there is high focus on this area. 3 patients are broken down as follows: 1 Colorectal pathway delay in diagnosis/staging due to capacity issues within Endoscopy and Radiology followed by Surgical multidisciplinary team review and the need for further diagnostics to confirm mets causing further delay in surgery of primary cancer.
1 Lung – complex pathway with suspected 2 synchronous primaries, delay in diagnosis/staging at the centre, returned late on day 86 as only suitable for local Chemotherapy.
1 Urology Pathway breach as following negative Truss results patient required further diagnostic template biopsy in a case of ongoing suspicion.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
All patients over 62 days discussed in detail at weekly cancer PTL meeting for escalation	HK	Mar-19	
104 day breaches to be submitted via DATIX and full investigation to be carried out with clinical engagement and opportunities for learning	SD	Dec-18	
Template biopsy capacity increased from August 2019, and training being undertaken in September 2019 to enable these to be carried out under LA	AP/AS	Aug-19	TBC
Discussions underway with Dermatology and Plastics teams to ensure the pathway has no process delays	AP	Aug-19	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

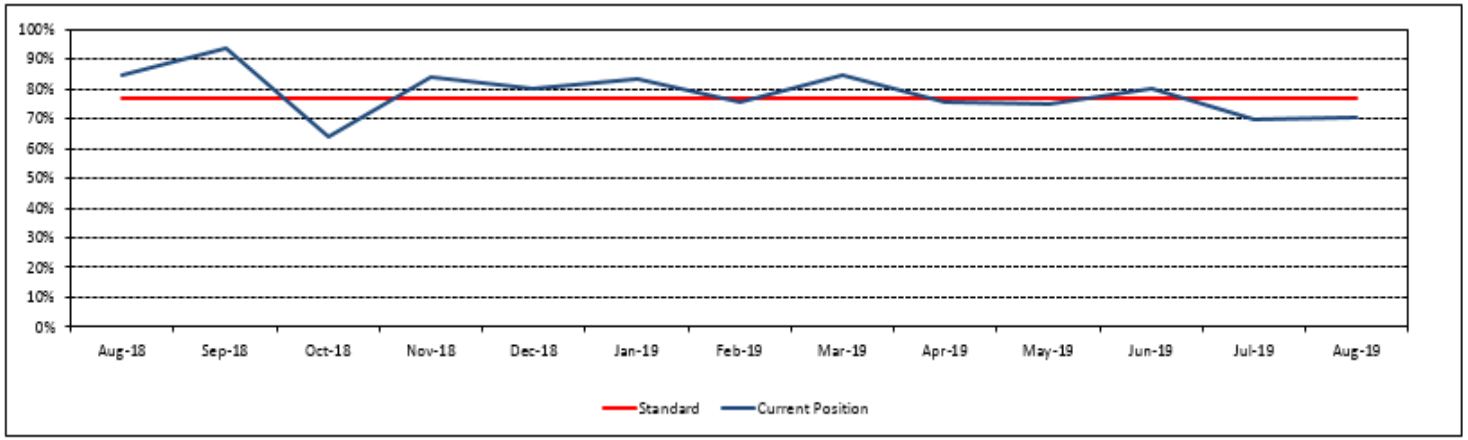
Indicator	Stroke - % Patients scanned within 1 hr.
Standard	77%
Executive Lead	Helen Beck
Month	August
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Eight of the ten breaches occurred out of hours. Five breaches occurred due to delays in ED, either with stroke alerts, timely identification of stroke symptoms, and the ordering of CT scans. Three breaches were due to patients presenting with atypical symptoms. The remaining breaches were due to delays in the patients being seen by the Med Reg and the Emergency Stroke Outreach Team being alerted post CT.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continued validation of breaches with ED. New plan for feedback of identified learning points. Ongoing training with ED Triage by Early Stroke outreach team. For further investigation, booking of CT scans OOH when the Med Reg is delayed in assessing a potential stroke patient.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

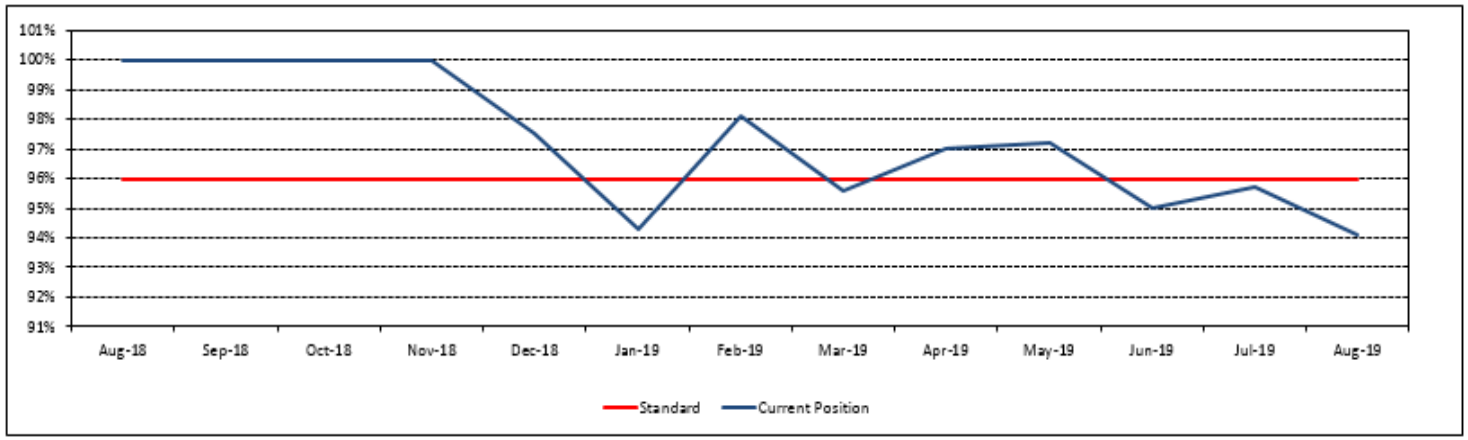
Indicator	Stroke - % patients scanned within 12 hrs.
Standard	96%
Executive Lead	Helen Beck
Month	August
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

One patient presented with atypical symptoms, and was not referred to Early Stroke outreach team until three days after arrival. One patient did have some elements of stroke symptoms on arrival but was not referred to Early Stroke outreach team on arrival.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continued validation of breaches with ED. New plan for feedback of identified learning points. Ongoing training with ED Triage by Early Stroke outreach team.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

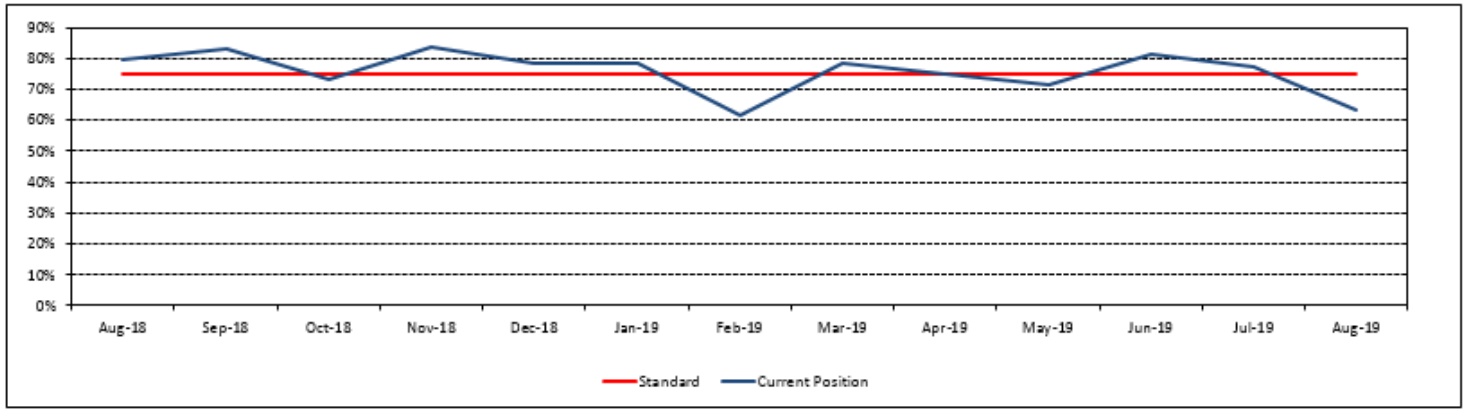
Indicator	Stroke - % Patients admitted directly to stroke unit within 4h
Standard	75%
Executive Lead	Helen Beck
Month	August
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Six breaches occurred due to delays in the patient being referred to the stroke team. Two patients did not have stroke symptoms identified in ED and were therefore not admitted directly to the stroke unit. Three patients were not admitted to the stroke unit within 4 hours due to no ring fenced beds being available. One patient breached due to ED not being available to hand the patient over to the Stroke Unit.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
Current Position	79.6%	82.8%	73.3%	83.7%	78.4%	78.4%	61.5%	78.6%	75.0%	71.4%	81.6%	77.5%	63.6%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continued validation of breaches with ED. New plan for feedback of identified learning points. Ongoing training with ED Triage by Early Stroke outreach team. Reconfiguration of the stroke unit should now see an improvement in bed availability.			



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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	Aug-19
Data Frequency	Monthly
CQC Area	Responsive

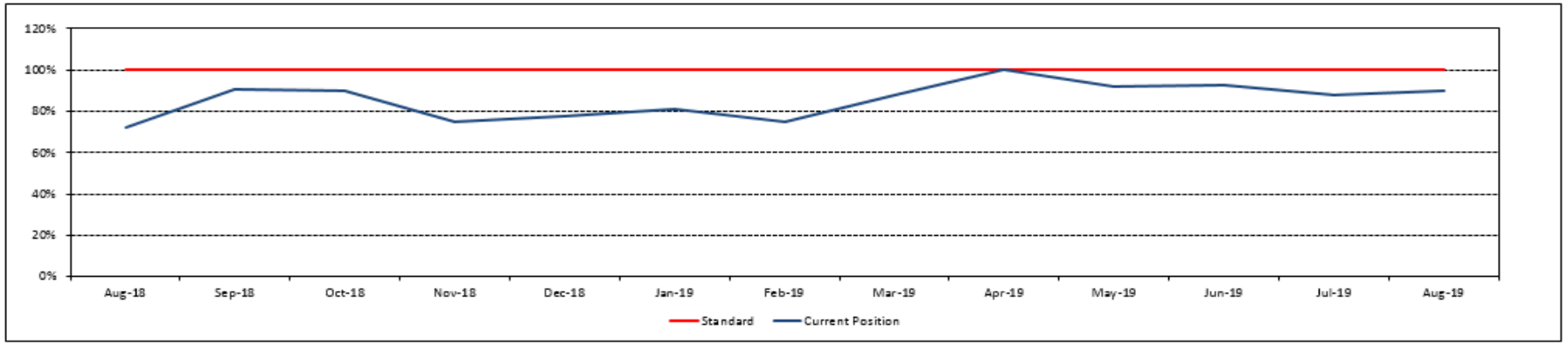
Summary of Current performance & Reasons for under performance

Performance against national standards for Door to Needle time for Neutropenic was 90% for the month of August. 2 patients were admitted to G1 and both received the required treatment within the 1 hour time scale. Of the 8 patients who were admitted through ED, 7 were treated within the hour (87.5%) - 1 breached the national standard. Please see below action plan to address the issues and improve performance against this standard.

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

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

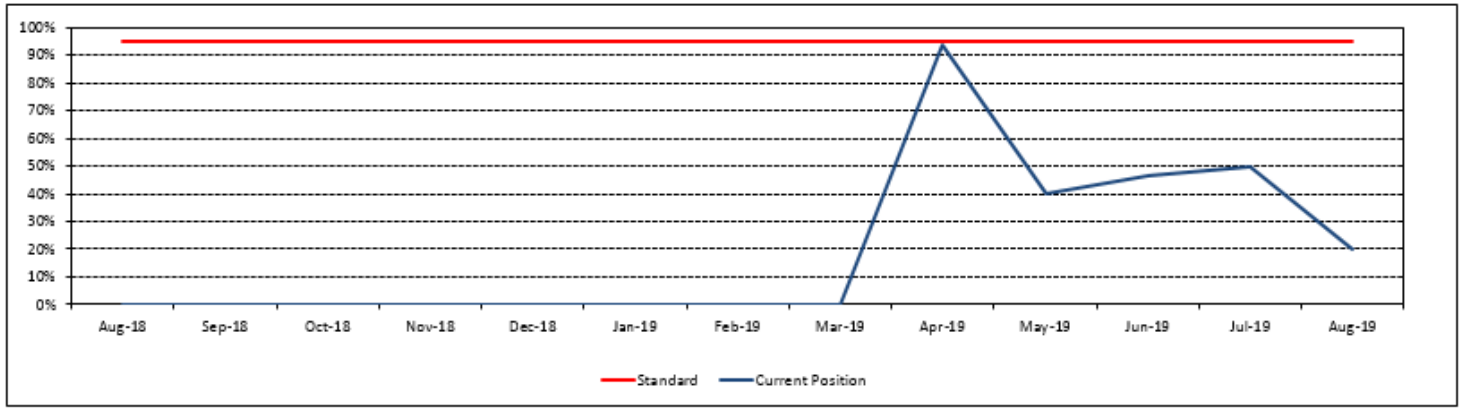
Summary of Current performance & Reasons for under performance

1 out of 5 initial health appointments were completed with 15 working days of the service receiving all the paperwork.
The remaining 4 were completed on working days 26, 30, 30 and 39.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-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	93.3%	40.0%	46.2%	50.0%	20.0%

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

Description	Owner	Start	End
Meeting scheduled on 18 Sept 2019, with Designated Nurse for Children in Care within the CCG, along with Social Work Manager to review capacity and support available from within the General Practitioner with Special Interest workforce. There is the potential for one of the current General Practitioner with Special Interest to increase clinical sessions and this will be explored to ascertain if funding will be available to support this.	NSH		



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

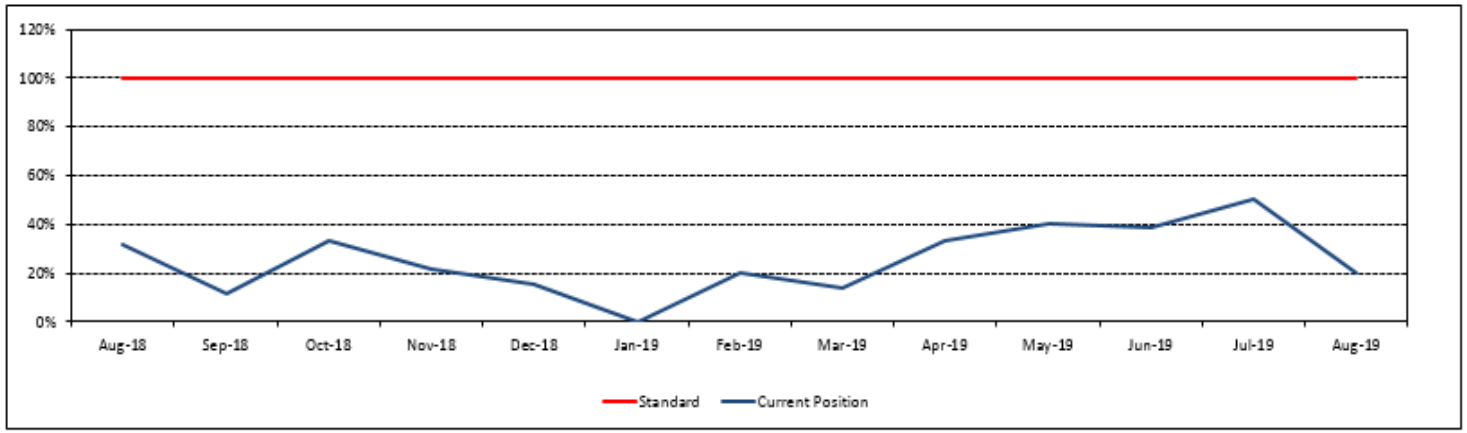
Indicator	Percentage of Children in Care initial health assessments completed
Standard	100%
Executive Lead	Helen Beck
Month	Aug-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

1 out of 5 initial health assessments were completed within 28 calendar days of the child being placed in care.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	31.6%	11.8%	33.3%	21.4%	15.4%	0.0%	20.0%	14.3%	33.3%	40.0%	38.5%	50.0%	20.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Meeting scheduled on 18 Sept 2019, with Designated Nurse for Children in Care within the CCG, along with Social Work Manager to review capacity and support available from within the General Practitioner with Special Interest workforce. There is the potential for one of the current General Practitioner with Special Interest to increase clinical sessions and this will be explored to ascertain if funding will be available to support this.			



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Timeline for Patients that Breached the Standard

Working Days	Date	Patient 1
0	28-Jun-19	Forms received by service
1	01-Jul-19	
2	02-Jul-19	
3	03-Jul-19	
4	04-Jul-19	
5	05-Jul-19	
6	08-Jul-19	
7	09-Jul-19	
8	10-Jul-19	
9	11-Jul-19	
10	12-Jul-19	
11	15-Jul-19	
12	16-Jul-19	
13	17-Jul-19	
14	18-Jul-19	
15	19-Jul-19	1st appointment - cancelled by service
16	22-Jul-19	
17	23-Jul-19	
18	24-Jul-19	
19	25-Jul-19	
20	26-Jul-19	
21	29-Jul-19	
22	30-Jul-19	
23	31-Jul-19	
24	01-Aug-19	
25	02-Aug-19	
28	05-Aug-19	2nd appointment date - rebooked - Attended and seen by Paediatrician

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Working Days	Date	Patient 2
0	18-Jul-19	Forms received by service
1	19-Jul-19	
2	22-Jul-19	
3	23-Jul-19	
4	24-Jul-19	
5	25-Jul-19	
6	26-Jul-19	
7	29-Jul-19	
8	30-Jul-19	
9	31-Jul-19	
10	01-Aug-19	
11	02-Aug-19	
12	05-Aug-19	
13	06-Aug-19	
14	07-Aug-19	
15	08-Aug-19	
16	09-Aug-19	
17	12-Aug-19	
18	13-Aug-19	1st appointment declined by carer
19	14-Aug-19	
20	15-Aug-19	
21	16-Aug-19	
22	19-Aug-19	
23	20-Aug-19	
24	21-Aug-19	
25	22-Aug-19	
26	23-Aug-19	
27	27-Aug-19	
28	28-Aug-19	
29	29-Aug-19	
30	30-Aug-19	2nd appointment - Attended and seen by Paediatrician

Working Days	Date	Patient 3
0	18-Jul-19	Forms received by service
1	19-Jul-19	
2	22-Jul-19	
3	23-Jul-19	
4	24-Jul-19	
5	25-Jul-19	
6	26-Jul-19	
7	29-Jul-19	
8	30-Jul-19	
9	31-Jul-19	
10	01-Aug-19	
11	02-Aug-19	
12	05-Aug-19	
13	06-Aug-19	
14	07-Aug-19	
15	08-Aug-19	
16	09-Aug-19	
17	12-Aug-19	
18	13-Aug-19	1st appointment declined by carer
19	14-Aug-19	
20	15-Aug-19	
21	16-Aug-19	
22	19-Aug-19	
23	20-Aug-19	
24	21-Aug-19	
25	22-Aug-19	
26	23-Aug-19	
27	27-Aug-19	
28	28-Aug-19	
29	29-Aug-19	
30	30-Aug-19	- Attended and seen by Paediatrician

Working Days	Date	Patient 4
0	23-Jul-19	Forms received by service
1	24-Jul-19	
2	25-Jul-19	
3	26-Jul-19	
4	29-Jul-19	
5	30-Jul-19	
6	31-Jul-19	
7	01-Aug-19	
8	02-Aug-19	
9	05-Aug-19	
10	06-Aug-19	
11	07-Aug-19	
12	08-Aug-19	
13	09-Aug-19	
14	12-Aug-19	
15	13-Aug-19	
16	14-Aug-19	
17	15-Aug-19	
18	16-Aug-19	
19	19-Aug-19	
20	20-Aug-19	
21	21-Aug-19	
22	22-Aug-19	
23	23-Aug-19	
24	27-Aug-19	
25	28-Aug-19	4th appointment offered (went back to carer (31-7) as this is a cancellation appointment) - attended and seen by Paediatrician
26	29-Aug-19	
27	30-Aug-19	
28	02-Sep-19	1st appointment declined by carer (offered 29-7)
29	03-Sep-19	
30	04-Sep-19	
31	05-Sep-19	
32	06-Sep-19	
33	09-Sep-19	
34	10-Sep-19	2nd appointment declined by carer (offered 29-7)
35	11-Sep-19	
36	12-Sep-19	
37	13-Sep-19	
38	16-Sep-19	
39	17-Sep-19	3rd appointment declined by carer (offered 29-7)

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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	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	YTD(Apr19 Aug19)
5. Well Led	Agency, WTE & vacancies	5.09	Agency Spend Cap	486	507	393	381	620	500	486	486	486	461	461	461	461	461	461
		5.10	Bank Spend		1294	1212	1222	1140	1167	1114	971	1277	992	777	1000	868	1222	972
		5.12	Proportion of Temporary Staff	12%	12.7%	12.0%	11.8%	12.8%	12.1%	12.7%	9.4%	13.1%	12.3%	12.3%	12.2%	11.7%	13.9%	12.5%
		5.13	Locum and Medical agency spend	NT	524	434	524	570	555	522	389	448	487	238	408	389	626	430
		5.57	Additional sessions	NT	270	250	338	288	266	216	274	283	272	272	273	221	286	265
		5.16	% Staff on Maternity/Paternity Leave	NT	2.60%	2.64%	2.65%	2.73%	2.83%	2.80%	2.64%	2.58%	2.82%	2.67%	2.49%	2.40%	2.23%	2.52%
	Other	5.58	New grievance or employment tribunals in the month	NT	0	0	1	4	0	2	0	1	1	0	0	1	0	2
		5.18	Recruitment Timescales - Av no. of weeks to recruit	7	5.0	6.1	6.4	6.4	6.4	5.3	4.8	5.2	6.0	6.1	5.0	8.0	5.4	6.1
		5.19	DBS checks	95%	98.0%	98.0%	98.5%	97.5%	97.5%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
		5.20	Staff appraisal Rates	90%	75.2%	76.9%	76.0%	79.0%	76.4%	77.0%	76.0%	79.0%	77.0%	80.0%	81.0%	81.0%	79.0%	79.6%

Area.		Ref.	KPI	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	YTD(Apr19 Aug19)
5. Well Led	Training	5.22	Infection Control Training (classroom)	90%	95.0%	95.0%	94.0%	95.0%	94.0%	96.0%	96.0%	93.0%	94.0%	95.0%	95.0%	95.0%	96.0%	95.0%
		5.23	Infection Control Training (eLearning)	90%	87.0%	90.0%	89.0%	90.0%	91.0%	91.0%	91.0%	81.0%	82.0%	82.0%	89.0%	90.0%	91.0%	86.8%
		5.24	Manual Handling Training (Patient)	90%	79.0%	76.0%	77.0%	76.0%	76.0%	80.0%	77.0%	78.0%	69.0%	80.0%	78.0%	80.0%	81.0%	77.6%
		5.25	Manual Handling Training (Non Patient)	90%	81.0%	85.0%	82.0%	86.0%	84.0%	87.0%	88.0%	67.0%	56.0%	76.0%	62.0%	67.0%	70.0%	66.2%
		5.26	Staff Adult Safeguarding Training	90%	89.0%	91.0%	91.0%	90.0%	90.0%	91.0%	91.0%	85.0%	85.0%	87.0%	89.0%	88.0%	89.0%	87.6%
		5.27	Safeguarding Children Level 1	90%	88.0%	89.0%	89.0%	90.0%	91.0%	91.0%	90.0%	91.0%	91.0%	92.0%	92.0%	92.0%	93.0%	92.0%
		5.28	Safeguarding Children Level 2	90%	89.0%	90.0%	90.0%	90.0%	91.0%	91.0%	91.0%	86.0%	86.0%	90.0%	90.0%	89.0%	92.0%	89.4%
		5.29	Safeguarding Children Level 3	90%	89.0%	91.0%	91.0%	90.0%	90.0%	91.0%	91.0%	57.0%	51.0%	71.0%	61.0%	58.0%	84.0%	65.0%
		5.30	Health & Safety Training	90%	89.0%	90.0%	89.0%	89.0%	90.0%	89.0%	89.0%	87.0%	87.0%	88.0%	90.0%	90.0%	92.0%	89.4%
		5.31	Security Awareness Training	90%	89.0%	89.0%	88.0%	89.0%	89.0%	89.0%	88.0%	81.0%	83.0%	87.0%	88.0%	88.0%	91.0%	87.4%
		5.32	Conflict Resolution Training (eLearning)	90%	82.0%	83.0%	83.0%	85.0%	86.0%	86.0%	86.0%	68.0%	70.0%	74.0%	81.0%	82.0%	85.0%	78.4%
		5.33	Conflict Resolution Training	90%	73.0%	71.0%	69.0%	74.0%	75.0%	72.0%	72.0%	77.0%	74.0%	78.0%	76.0%	76.0%	75.0%	75.8%
		5.34	Fire Training (eLearning)	90%	84.0%	91.0%	83.0%	85.0%	88.0%	85.0%	83.0%	83.0%	78.0%	83.0%	83.0%	83.0%	87.0%	82.8%
		5.35	Fire Training (classroom)	90%	90.0%	84.0%	89.0%	88.0%	86.0%	89.0%	87.0%	89.0%	88.0%	89.0%	89.0%	89.0%	91.0%	89.2%
		5.36	IG Training	95%	82.0%	82.0%	80.0%	83.0%	82.0%	81.0%	83.0%	78.0%	79.0%	81.0%	94.0%	86.0%	91.0%	86.2%
		5.37	Equality and Diversity	90%	79.0%	80.0%	81.0%	82.0%	84.0%	85.0%	85.0%	87.0%	86.0%	88.0%	90.0%	90.0%	93.0%	89.4%
		5.38	Majax Training	90%	88.0%	88.0%	89.0%	89.0%	90.0%	90.0%	89.0%	78.0%	80.0%	82.0%	84.0%	84.0%	88.0%	83.6%
		5.39	Medicines Management Training	90%	87.0%	86.0%	87.0%	87.0%	87.0%	87.0%	86.0%	80.0%	81.0%	83.0%	86.0%	86.0%	86.0%	84.4%
		5.40	Slips, trips and falls Training	90%	86.0%	85.0%	86.0%	85.0%	87.0%	86.0%	86.0%	74.0%	76.0%	79.0%	82.0%	81.0%	85.0%	80.6%
		5.41	Blood-borne Viruses/Inoculation Incidents	90%	85.0%	86.0%	87.0%	88.0%	89.0%	89.0%	87.0%	78.0%	80.0%	83.0%	85.0%	85.0%	89.0%	84.4%
		5.42	Basic life support training (adult)	90%	79.0%	79.0%	79.0%	80.0%	80.0%	81.0%	80.0%	79.0%	73.0%	81.0%	81.0%	81.0%	81.0%	79.4%
		5.43	Blood Products & Transfusion Processes (Refresher)	90%	74.0%	73.0%	74.0%	75.0%	76.0%	77.0%	76.0%	65.0%	62.0%	68.0%	77.0%	75.0%	77.0%	71.8%
		5.44	Mandatory Training Compliance	90%	84.0%	85.0%	85.0%	86.0%	86.0%	85.0%	86.0%	82.0%	82.0%	85.0%	86.0%	86.0%	87.0%	85.2%

EXCEPTION REPORTS – WELL LED

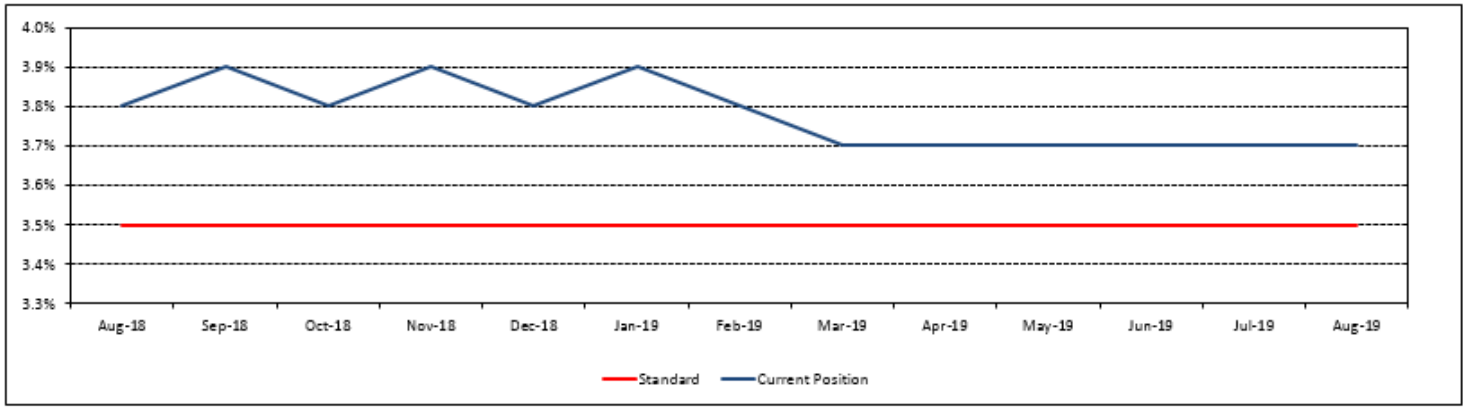
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	Sickness Absence
Standard	<3.5%
Executive Lead	Jan Bloomfield
Month	August
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

sickness absence has remained at 3.7% for the last six months. This percentage represents both short and long term sickness. There does not appear to be one single cause for under performance of the target. The NHS as a whole is currently showing a 4% figure.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Managers, supported by HR, continue to support staff in line with the policy. The Health & wellbeing committee have recently discussed the top five reason for absence and proposed actions to assist staff.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

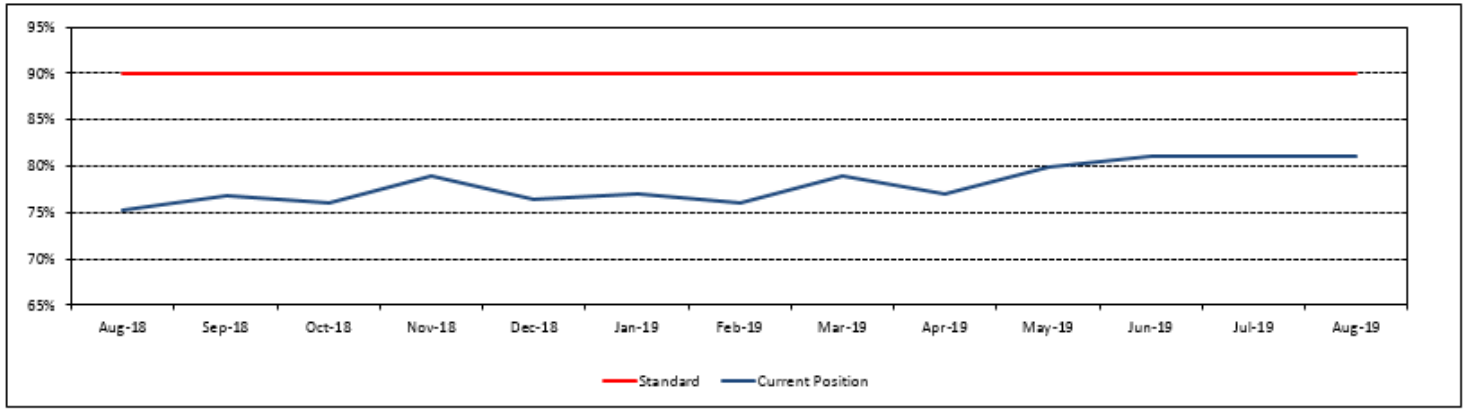
Indicator	Staff appraisal Rates
Standard	90%
Executive Lead	Jan Bloomfield
Month	August
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Appraisal performance has been estimated for August while a date quality exercise is completed, full report anticipated from next month.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Managers receive their compliance figures on a monthly basis, and senior management have been performance managing compliance at divisional level. In addition to this, member of the HR	Denise Needle		



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

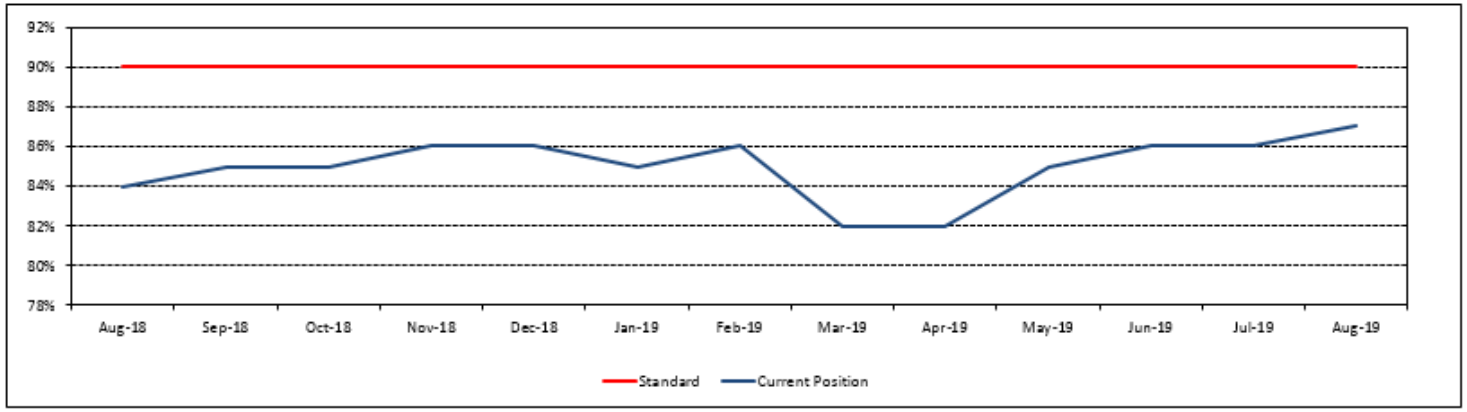
Indicator	Mandatory Training Compliance
Standard	90%
Executive Lead	Jan Bloomfield
Month	August
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

compliance has increased by 1%, which is a good result. Normally we would expect a slight reduction as a result of annual leave and the new intake of doctors in early august.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	84.0%	85.0%	85.0%	86.0%	86.0%	85.0%	86.0%	82.0%	82.0%	85.0%	86.0%	86.0%	87.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
The Trust has had a review of all mandatory subjects reported to the trust board. This review will make some changes to renewal dates, method of completion and delivery (i.e. face to face or elearning). although this will take a while to implement, it should have a positive impact upon competency, staff experience, and compliance levels going forward.			



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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	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	YTD(Apr19-Aug19)
6. Productive	Activity	6.07	A&E Activity	NT	6072	6042	6256	6114	6155	6371	5741	6695	6729	6946	6692	7300	6661	34328
		6.08	NEL Activity	NT	2394	2356	2638	2770	2520	2750	2467	2604	2464	2695	2379	2496	2465	12499
		6.09	OP - New Appointments	NT	6007	6113	7381	7255	5995	7059	6419	7086	8369	8947	8536	9365	7660	42877
		6.10	OP- Follow-Up Appointments	NT	10929	10879	12773	12289	9834	12610	11107	11536	22314	19866	19733	21458	19079	102450
		6.11	Electives (Incl Daycase)	NT	2786	2379	3033	3047	2519	3202	2957	2971	2806	2974	2755	3095	2886	14516
	Finance	6.12	Financial Position (YTD)	Var	-5641	-7119	-7122	-7494	-6534	-8691	-7955	-287	529	-481	-1681	-2106	-4239	-7978
		6.13	Financial Stability Risk Rating	Var	3	3	3	3	3	3	3	3	3	3	3	3	3	15
		6.14	Cash Position (YTD £000s)	Var	7231	3934	1338	5162	3518	4924	6870	3600	11140	5825	1467	2119	1787	22338
	Ratios	6.15	% Consultant to Consultant Referrals	NT	16.0%	15.0%	14.0%	15.0%	17.0%	16.0%	17.0%	15.0%	17.0%	16.0%	16.0%	16.0%	15.0%	16.0%
		6.16	New to FU Ratios	NT	2.32	2.34	2.27	2.16	2.16	2.31	2.37	2.20	2.66	2.22	2.31	2.29	2.49	2.39

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EXCEPTION REPORTS – PRODUCTIVE

The finance report contains full details.

10. DETAILED REPORTS- MATERNITY

Are we..		Ref.	KPI	Target	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	YTD(Apr19-Aug19)
7.Maternity	Safe	7.09	Elective Caesarean Sections	12%	7.8%	9.6%	8.6%	10.4%	9.1%	6.7%	9.3%	11.2%	9.3%	11.3%	7.8%	9.5%	9.8%	9.5%
		7.10	Emergency Caesarean Sections	14%	9.2%	13.0%	14.1%	15.4%	16.3%	16.2%	11.0%	15.6%	11.5%	11.8%	18.0%	10.9%	11.2%	12.7%
		7.11	Grade 1 Caesarean Section (Decision to delivery time met)	100%	100%	100%	40.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)	80%	64.0%	82.0%	71.0%	57.0%	79.0%	76.1%	92.3%	87.0%	100%	85.0%	81.0%	82.0%	64.0%	82.4%
		7.13	Homebirths	2%	1.5%	3.8%	1.8%	2.0%	1.0%	2.2%	2.9%	2.8%	3.8%	3.1%	1.5%	2.4%	2.3%	2.6%
		7.14	Midwifery led birthing unit (MLBU) births	20%	17.0%	11.5%	14.4%	NA	NA	NA	NA	NA	24.0%	14.4%	16.1%	19.4%	12.9%	17.4%
		7.15	Labour Suite births	77.5%	80.6%	83.7%	82.7%	82.6%	83.0%	78.8%	77.9%	82.1%	71.0%	82.1%	82.0%	77.3%	85.1%	79.5%
		7.16	Induction of Labour	29.3%	36.4%	34.1%	35.5%	38.3%	42.1%	40.8%	39.0%	42.2%	35.0%	39.5%	39.0%	38.9%	35.8%	37.6%
		7.17	Instrument Assisted Deliveries (Forceps & VentoUse)	>14%	12.6%	11.5%	11.8%	13.9%	8.1%	8.9%	12.2%	11.7%	8.2%	8.2%	12.2%	8.5%	10.7%	9.6%
		7.18	Critical Care Obstetric Admissions	0	1	1	0	0	3	1	0	0	0	0	0	0	0	0
		7.19	Eclampsia	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0
	Effective	7.20	Shoulder Dystocia	2	6	9	9	4	4	6	4	4	9	2	7	5	0	23
		7.21	Post-partum Hysterectomies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		7.22	Women requiring a blood transfusion of 4 units or more	0	0	0	1	0	1	1	0	1	1	0	0	0	0	1
		7.23	3rd and 4th degree tears (all deliveries)	12	7	7	3	8	2	6	2	0	7	2	4	6	4	23
	Caring	7.24	Maternal death	0	0	0	1	0	0	0	0	0	0	1	0	0	0	1
		7.25	Stillbirths	NT	0	0	0	0	0	0	0	0	1	1	2	1	0	5
		7.26	Complaints	NT	1	0	1	1	0	3	3	1	0	3	0	0	0	3
		7.27	No. of babies admitted to Neonatal Unit (>36+6)	NT	13	8	9	10	15	7	7	9	8	8	16	4	12	48
	Responsive	7.28	No. of babies transferred for therapeutic cooling	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
		7.29	One to one care in established labour	100%	97.0%	100%	100%	100%	99.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		7.30	Reported Clinical Incidents	50	39	44	34	42	38	50	40	59	56	47	43	61	78	285
		7.31	Hours of dedicated consultant cover per week	60	90	87	87	99	93	105	87	98	96	105	90	102	90	483
		7.32	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	10	50
		7.34	No. of women identified as smoking at booking	NT	21	23	22	20	34	20	18	28	23	25	22	23	27	120
		7.35	No. of women identified as smoking at delivery	NT	27	21	22	18	31	18	16	27	20	20	21	22	28	111
		7.36	UNICEF Baby friendly audits	10	NA	NA	NA	NA	NA	NA	NA	NA	NA	24	NA	NA	NA	24
		7.37	Proportion of parents receiving Safer Sleeping Suffolk advice	80%	80.0%	96.0%	97.0%	95.0%	97.5%	96.1%	97.0%	94.5%	95.0%	85.6%	80.0%	93.0%	81.0%	86.9%
	Other	7.38	No. of bookings (First visit)	NT	236	231	234	222	206	278	226	242	231	251	241	257	232	1212
		7.39	Women booked before 12+6 weeks	95%	96.0%	92.0%	92.0%	98.0%	95.1%	96.0%	96.4%	92.0%	95.0%	95.0%	94.0%	98.0%	97.0%	95.8%
		7.40	Female Genital Mutilation (FGM)	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0

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EXCEPTION REPORTS – MATERNITY

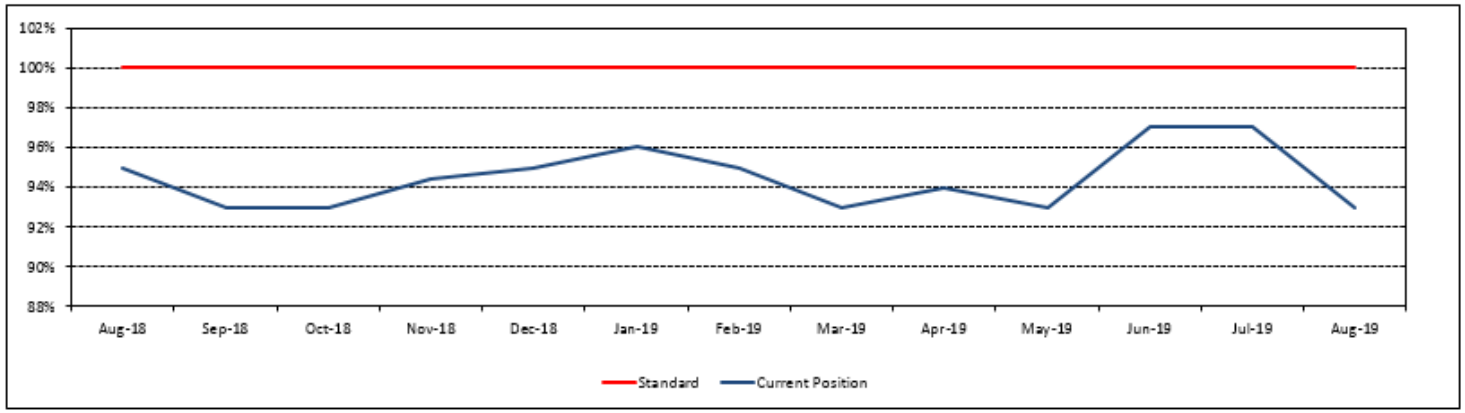
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	Completion of WHO checklist
Standard	100%
Executive Lead	Rowan Procter
Month	Aug-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Following the last two months improvement in the figures, this month was very disappointing. Although there has been improvements with Outpatient department practitioners and scrub nurses they remain the largest non compliant group. (9 cases) The reduction in percentage has not helped by an increase in the number of non-compliance from Obstetric medical staff new to the Trust. Both the obstetric lead consultant and Clinical Director as well as the Assistant director operations for surgery have been made aware of the fall in this months figures.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	95.0%	93.0%	93.0%	94.4%	95.0%	96.0%	95.0%	93.0%	94.0%	93.0%	97.0%	97.0%	93.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Further improvements needed senior staff made aware.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

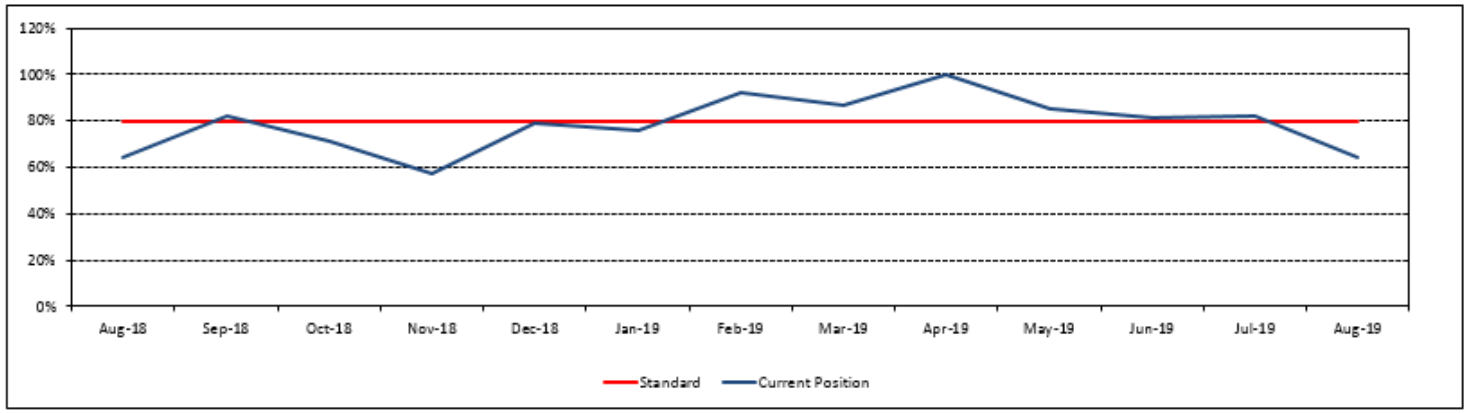
Indicator	Grade 2 Caesarean Section (Decision to delivery time met)
Standard	80%
Executive Lead	Rowan Procter
Month	Aug-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

This months figures unfortunately have showed a significant decrease to 64 percent (4 cases) in our decision to delivery rate of Grade two Caesarean Section. All of these cases had been discussed at the Case Management Meeting which is led by a consultant obstetrician. All cases were agreed to have been appropriate and ranged from significant adhesions following Knife to skin to repeat of blood test required prior to surgery. The remaining two were due to high activity and other more urgent cases required delivery, therefore a second theatre was opened. All cases noted that the baby was not compromised when the decision was made and babies were born in good condition. Discussed at the Women Health Governance 16/09/19. No immediate action required continue to monitor weekly expected to recover.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Current Position	64.0%	82.0%	71.0%	57.0%	79.0%	76.1%	92.3%	87.0%	100%	85.0%	81.0%	82.0%	64.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor appropriateness of delay.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

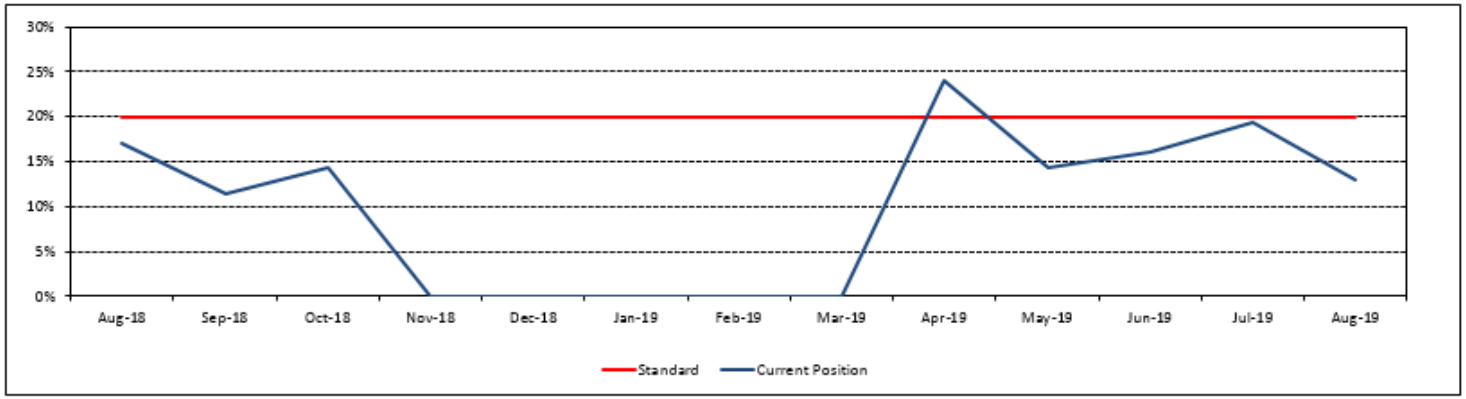
Indicator	Midwifery led birthing unit (MLBU) births
Standard	20%
Executive Lead	Rowan Procter
Month	Aug-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The National Maternity and Perinatal Audit National Maternity and Perinatal Audit published this month reports births in England in an alongside midwifery unit (Midwifery led birthing unit) was 10.1%. However NICE and the maternity reviews agree that pregnant women at low risk of complications should be encouraged to plan birth at home or in a midwife unit. The maternity service currently encourage low risk women to give birth on the Midwifery led birthing unit however there are a number of women lost due to Induction of Labour or require transfer at some stage of labour and therefore are not included if they do not give birth there. More work needs to be done in the light of the National Maternity and Perinatal Audit national reviews together with maternal choice to improve the women who give birth on Midwifery led birthing unit.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Standard	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
Current Position	17.0%	11.5%	14.4%	NA	NA	NA	NA	NA	24.0%	14.4%	16.1%	19.4%	12.9%

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

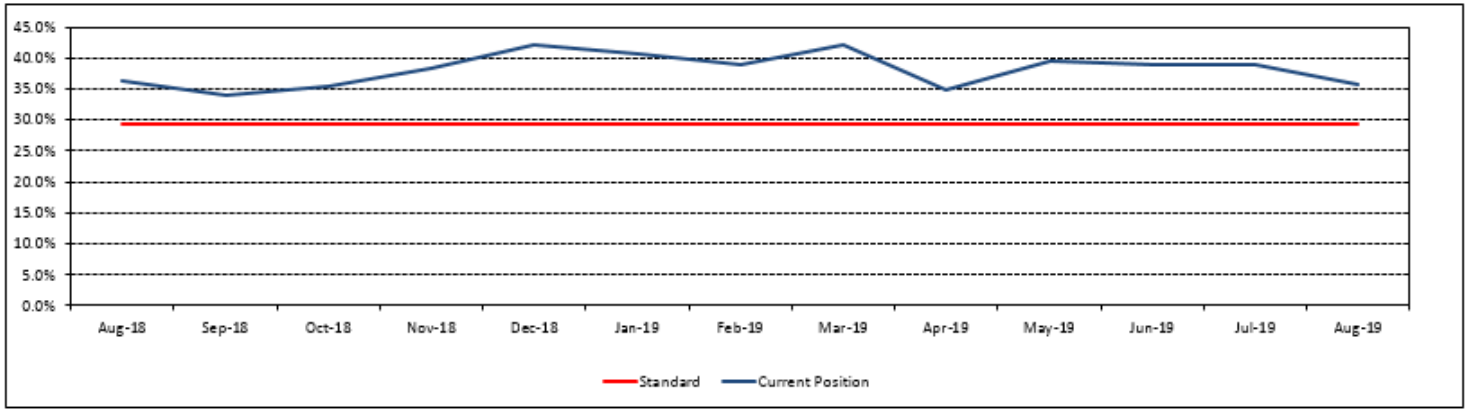
Indicator	Induction of Labour
Standard	29.3%
Executive Lead	Rowan Procter
Month	Aug-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The clinical report from the National Maternity and Perinatal audit was published this month. Data from 2016-17 shows a small increase in the induction of labour rate and a small decrease in the proportion of small for gestational age babies at or after 40 weeks. This appears to coincide with the introduction of Saving Babies Lives. Initial review shows some variation nationally, the maternity service to review the data from the National Maternity and Perinatal audit and benchmarking ourselves both locally and nationally.

Month	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-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	36.4%	34.1%	35.5%	38.3%	42.1%	40.8%	39.0%	42.2%	35.0%	39.5%	39.0%	38.9%	35.8%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Review the data from the NMPA			



Putting you first

9. Quality and learning report - Q1

To ACCEPT the report

For Report

Presented by Nick Jenkins and Rowan Procter

Trust Open Board – 27th September 2019

Agenda item:	9			
Presented by:	Rowan Procter – Executive Chief Nurse			
Prepared by:	Governance Department			
Date prepared:	September 2019			
Subject:	Quality and Learning report			
Purpose:	X	For information		For approval

Executive summary:

This report provides a summary of key learning points, trend analysis and opportunities for improvement that have arisen from in the quarter ending 31/06/19.

Information has been obtained from the following data sources:

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

Key highlights in this report are as follows:

- Learning from Deaths Q1 report
- Theme reports on Sepsis and Nutrition
- Learning events and bulletin
- 'Greatix' / learning from Excellence
- Thematic review of complaints

Please note:

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

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

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

Activity within the quarter

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

1. Learning themes from investigations in the quarter

SI RCA reports submitted in Q1

There were 10 SI reports submitted in Q1 including one Never Event. There were no reports submitted on behalf of other organisations in the Qtr and no cases were reported to the HSIB (Healthcare Safety Investigation branch) for external investigation.

Incident details	Learning
WSH-IR-45993 Wrong site breast biopsy	This was reported as a **Never Event**. **Root causes / Contributory factors** • The LocSSIP* checklist for invasive procedures was not completed / used. • At least 2 pieces of clinical information were cross referenced prior to the commencement of the procedure. • The Breast Care Nurse was not present in the room at the start of the patient consultation. **Actions** • Remind all staff via the medical directors bulletin staff to use the 'Approved Standard for Invasive Procedures Checklist' on e-Care prior to any invasive procedure. • Posters to remind staff to use the 'Approved Standard for Invasive Procedures Checklist' on e-Care prior to any invasive procedure. • Ensure that wherever possible the Breast Care Nurse is in the room at time of checklist being completed and the procedure taking place. • All staff both medical and nursing to be made aware at induction that this must be completed for all invasive procedures. • Review/Update clinical guidelines for the marking of invasive sites in certain circumstances.

Incident details	Learning
	* National Safety Standards for Invasive Procedures (NatSSIPs) highlights that the National Institute for Health and Care Excellence (NICE) defines “interventional procedure” as a procedure used for diagnosis or treatment within their scope they identify that biopsies and other invasive tissue sampling meet this criteria. Within section 4.6 of NatSSIPs it discusses the procedure of verification of site marking and state that organisations must develop and implement ‘local safety standards for invasive procedures’ (LocSSIPs) that ensure that patients undergo the correct procedure on the correct sites and sides. Part 3 of this section states that surgical site marking is mandatory for all procedures for which it is possible. WSFT local safety standards for invasive procedures (LocSIPPs) – see trust policy PP299
WSH-IR-44466 Patient subject of an assault by another patient	**Root causes / Contributory factors** Potentially aggressive and violent patient on the ward area not supervised at all times during their stay. (root cause) Lack of formal documentation to support decisions made regarding the withdrawal of the one to one supervision of a patient with a history of violent and aggressive behaviour. There was a reduced resource of one to one security provision at the time of the incident. The ward was busy and had high acuity and the Trust did not have the capacity to offer additional staff to this ward area. **Lessons learned** The need for the development of a policy/guideline documenting a formal risk assessment to cover the global needs of any Trust area in relation to the supervision of patient who may become potentially violence and aggressive or have a history of violence and aggression . **Actions** • Introduction of a Formal documented risk assessment to establish the need of patients requiring one to one supervision and guidance on withdrawal of this support. • Review of the current security team establishment in order to provide adequate global patient supervision within the trust. This SI was also the subject of a family complaint and the CQC was notified (by staff in the patient’s care home) and were provided with a copy of the final report.
WSH-IR-44599 and 44709 Norovirus outbreaks on wards G4 and F8	**Root causes / Contributory factors** The lack of a physical barrier on the entrance to the bays means that it was not possible to separate “infected “patients from “non-infected” patients. This does not support effective infection practice. This is a known issue and is recorded on the Trust Risk Register - management of outbreaks no.627 (red rating). It has been agreed by the Trust management team that the provision of doors on bays will be included in any new builds or refurbishment of wards The bays (on F8 and on G4) do not have access to a sink within the bay and staff therefore need to leave the bay and use a sink located in the main corridor. Additional portable hand wash basins are supplied to wards affected with norovirus, however they cannot be sited within the bays due to the noise factor. **Good practice** In both cases the suspicion of an outbreak was detected promptly by the nursing staff and escalated to the on call Microbiologist. This enabled prompt closure of the wards and the instigation of infection prevention measures. This is likely to have prevented the spread of infection to other areas in the Trust and to external health care organisations. **Action** • Review the provision of portable sinks within the Trust.
WSH-IR-44631 Patient fall resulting in a #NoF	**Root causes / Contributory factors** The patient was independently mobile and chose to mobilise of own accord however this was judged as a preventable fall as there were omissions in the provision of safety assessment, particularly monitoring of lying and standing blood pressures and fall risk assessments were not always fully completed. The investigation acknowledged that reduced staffing numbers on the night shift could also have impacted this incident and it was recognised that the patient was on Haloperidol for agitation which could have increased the risk of falls.

Incident details	Learning
	Actions • Teaching has been set up on the ward • Practice development team to introduce this as a topic on the nursing induction days. • Ward to identify a Falls link champion forward to attend Trust study sessions

WSH-IR-45985
Patient suffered a stroke following hip surgery. Warfarin had not been re-started as planned
	Root causes
	Patient taken off coagulation therapy during and post-surgery as per protocol (accepted risk) however there was poor communication between medical and nursing staff regarding re-commencement of coagulation therapy and therefore the Warfarin therapy was not administered by nursing staff on day three post operatively as per protocol.
	Lessons learned
	Need for consistency across the organisation with warfarin card placement and administration.
	Actions
	• Warfarin card placement and administration consistency
	  ○ All warfarin cards to be placed at the end of patients beds
	  ○ Clip boards to be provided to all wards for the above purpose
	  ○ All relevant staff (nursing, medical, pharmacy) to be made aware of the above on induction)
	  ○ e-Care team to create an additional nursing activity that indicates that warfarin will need to be administered at 18:00 and to ensure that the chart is available. To be triggered at 12:00 hours.
	• Handover to be consistent across the trust using the SBAR tool giving assurance that all information is clearly disseminated
	This incident was also the subject of an inquest hearing in Sept19 which recorded a narrative verdict and did not issue any Regulation 28 notices. In preparation for the inquest the trust had commissioned an independent review of the case which concluded that '*on the balance of probabilities … the failure to administer the warfarin did not cause the stroke'*

Data protection breach	There were four SI reports submitted in Q1 relating to Data protection breach (WSH-IR-44299, WSH-IR-44658, WSH-IR-46733 and WSH-IR-47132). Individuals involved in any data protection breach are investigated via the trust's disciplinary process. This can on occasion lead to staff dismissal.

2. Learning from Deaths

'Learning into action' in Q1

The Learning from deaths group, meets monthly to oversee the process associated with all learning aligned to Learning from Deaths. The learning from deaths (LfD) reviews in Q1 identified the following themes in addition to those reported as an SI (of which there were none in Q1).

Themes from poor care:

No new themes were identified in Q1. There were further examples highlighting the previously noted themes of:

- Failed / delayed recognition of end of life
- Continued active treatment after palliation started.
- Inappropriate resuscitation

Two cases were highlighted for review as a serious incident in Q1. One was downgraded at an initial Day two review meeting and the other was already the subject of an SI prior to the LfD review (a fall resulting in serious harm).

Outcome from SIs reported in last qtr. (n=1) was as follows:

Incident details	Learning
WSH-IR-47143 Failure to respond to deteriorating NEWS score	The incident was downgraded following investigation as it was confirmed that the patient passed away from natural causes. Care and treatment was appropriate, it was noted there was a delay in escalating the NEWS score overnight but this would not have impacted the outcome in this case. The case was successfully retracted from STEIS The following contributory factor was identified: Nurse was an Agency Nurse and may not have been fully aware of protocol. Agency nurses receive minimal Trust specific official induction. They do however have a short shadow shift with a Trust Registered Nurse and complete an online e-care training programme. Training is the responsibility of the individual qualified nurse and is signed off by the agency in which they belong as safe to practice. The NEWS score to recognise deterioration in patients' health state is nationally recognised as a tool to monitor patients so this should not impact agency nurses who work in a variety of environments.

Learning into action

The LfD group in February considered a proposal for a set of actions to address these areas of concern. In brief these include:

- Quality improvement (QI) projects on timely completion of EPARS status and implementation of the AMBER care bundle.
- A coordinated education programme, making use of publically available resources and system expertise, for doctors, nurses, allied health professionals and other ward staff

A plan to re-structure the way that LfD is undertaken will enable greater resource to be allocated to implementation of learning through a series of projects. More information will be available in future reports.

Examples of excellence:

Within the SJR review process care is often recognised as Excellent / Outstanding. This can be at the levels of: Whole care episode, Team / Ward or Named individual.

Example narrative from reviews in Q1

The clerking from a physician's associate was nothing short of outstanding. This provided a solid basis from which to understand the context of the presenting problem(s) and ensure a good plan was reached. That the Consultant post-take ward round was confirmatory demonstrates how good this assessment was.

Excellent communication with the family by FY1 - gentle, kind and empathetic entry in the notes. I spoke to the patient's granddaughter who specifically commented on FY1's care as "brilliant, lovely, honest and kind. He didn't fill the space after he gave us the bad news and gave us time to think"

Further plans to ensuring learning from excellent care is identified and shared include:

- Formalising the feedback and reporting upon this activity (using Greatix).
- Outstanding cases to be invited as case presentation at a shared learning event or a case study in the shared learning bulletin.
- Exploring options for family members to provide video feedback on their experiences.
- Consideration how the LfD group family representative (could act as an ambassador to invite and support families to share their experiences - both positive and negative.

Section 5 of this board report includes an example that has been reported through the new Greatix pathway.

Table 1: LfD Reviews completed

Qtr.	Deaths		SJR* identified	
	Total	With SJR* completed	Poor / very poor care	Excellent care
Q2 18/19	218	218	19	71
Q3 18/19	227	227	16	52
Q4 18/19	274	147	18	41
Q1 19/20	257	102	9	32

* SJR = Structured judgement review

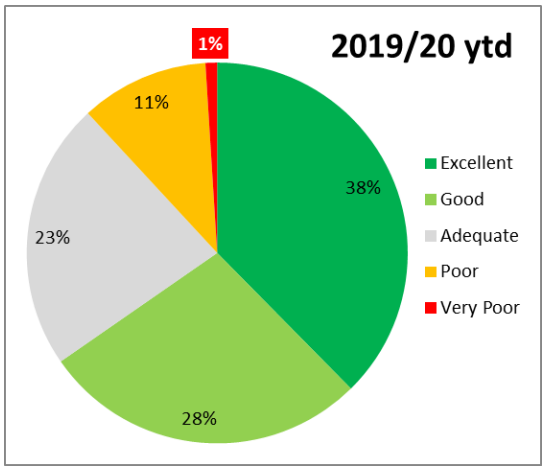


Chart 1: SJR outcome classifications

NB: this excludes IUDs and Neonatal deaths which are reported separately.

Some cases are reported which are subsequently classified as not Inpatient deaths (e.g. ED deaths) however they are included in the chart if a review has been undertaken.

Of the 102 cases reviewed in 2019/20 to date only 9 (12%) were classified as Poor or Very poor. 67 (66%) were classified as Good or Excellent.

(data prepared as at September 2019)

Table 2: Outcome of SJR rating

Qtr.	Total	Poor care / Very poor care case outcome following Exec review				
		Awaiting classification	Straightforward (includes theme)	Complex case	NFA required	SI consideration required
Q2 18/19	19	0	6	2	8	3 0/3 confirmed as SI
Q3 18/19	16	0	4	0	9	3 2/3 confirmed as SI
Q4 18/19	18	0	12	2	3	1 0/1 confirmed as SI
Q1 19/20	9	0	4	2	1	2 1/2 confirmed as SI

Of the nine cases of Poor / Very poor care in Q1; all have had an executive review to highlight investigation or action requirements resulting in two cases being classified as a requiring Serious incident (SI) decision making with the remainder requiring either local M&M review, green incident investigation or falling into the previously highlighted theme of delayed recognition of End of Life.

Table 3: Outcome of SJR rating

Qtr	SIs reported in Qtr* (for inpatient deaths in that period)	SI report presented to LfD led to judgement that death was:	
		Unlikely to have been due to problems in the care provided to the patient'	More likely than not to have been due to problems in the care provided to the patient
Q2 18/19	3	1	2
Q3 18/19	3	2	0
Q4 18/19	1	0	0
Q1 19/20		pending	pending

* NB: a case may be reported as an SI even if there has not been a SJR poor care outcome (e.g. most often a death following a fall which is an automatic SI) and so these numbers include additional cases not included in the previous table.

Of the seven deaths in 2018/19 which were the subject of an SI investigation, three were found to be "*More likely than not to have been due to problems in the care provided to the patient*", three were not and one is still pending presentation to LFD group (scheduled to be discussed in October meeting).

3. Quality Walk About from Q1

During Q1 there were Executive led quality walkabout visits to medical wards; F7 and F9, surgical wards; F3 and F6 and specialty areas including radiology, theatres, DSU and ED. The areas are chosen by the patient safety and quality team to ensure a variety of settings across the Trust and community. Community visits have been difficult to establish due to the logistics and practicalities of visiting teams covering a wide geography. There are plans to visit our inpatient community beds on the schedule and quality assurance visits are taking place for community colleagues.

There have been many highlights including examples of positive nursing leadership on F7 and F9 leading to a reduction in incidents and negative patient experience, and the introduction of a falls board on F6 in response to a serious incident.
Some areas of change have also been highlighted including the revamp of ward boards for displaying quality information which is inconsistent across the Trust. This is currently being actioned by the Matrons and ward boards are updated as ward refurbishment programmes take place. The changing of curtains to lighten areas which previously felt dark and staffing reviews to ensure service delivery meets the acuity of the patient base.

The actions from walkabouts are vast and cover simple ward based changes such as addressing storage issues and inconsistent checking of controlled drugs to complete service reviews and environmental changes. The use of Datix to monitor and share these actions with the ward and divisional leaders is seen as positive progress and an opportunity for divisional thematic review. It also enables actions to be reviewed and escalated if necessary on a monthly basis to the Trust's quality group

The reports from the visits are shared with the nursing and operational teams for the area for information and action. If there is an action for an Executive this is escalated accordingly. The patient safety and quality team have worked hard to ensure the reports are written and uploaded in a timely manner. The patient safety and quality team work alongside the operational teams to ensure these are completed or progressed as necessary and this will be monitored through Datix and re-visits. A summary of actions will be available for the next quarterly review.

4. Learning Events / Learning bulletin

Following successful learning events in 2018/19 presenting cases such as the SI of a case of difficult intubation (which led to the introduction of the emergency front of neck access kit) and the multidisciplinary team presentation of the care of a dying patient on G3, a schedule of learning events on a bimonthly basis have been set up for 2019/20. The second of these took place on 29th July with presentations by a cohort of junior doctors presenting their AKI audit data results and a Senior Matron presenting a fall with a #NOF and subsequent death.

Also in 2018/19 a new 'shared learning bulletin' was issued for the first time, available on Intranet This is planned to continue in 2019/20, supported by the Library and there has been a second edition published in July.
http://staff.wsha.local/Intranet/Documents/EM/LeadershipandQualityImprovementFaculty/Sharedlearningbulletin.asp
On reflection these will continue quarterly in the same month as the learning events to enable sharing of the same subject covered in the learning events (so those unable to attend can share the learning) as well as other sharing the output of subjects such as QI projects, learning from death vignettes, human factor case studies etc.

Initially available in paper format and on the staff intranet, future opportunities for a truly 'digital' approach including availability on staff mobile devices are being explored with the Communication team.

5. Learning from Excellence ('Greatix')

In August 2019 the Trust launched 'Greatix; set up to capture excellent practice, positive incidences and ideas, and share them across the Trust. This is based on the national concept of learning from excellence which explains that

'Safety in healthcare has traditionally focused on avoiding harm by learning from error. This approach may miss opportunities to learn from excellent practice. Excellence in healthcare is highly prevalent, but there is no formal system to capture it. We tend to regard excellence as something to gratefully accept, rather than something to study and understand.' https://learningfromexcellence.com

To date there have been 42 Greatix submitted, some for individuals and others for whole teams.

- Many relate to staff going above and beyond in their daily work with examples such as:

On Sunday we had a 6 hour shut down of eCare. I was the shift coordinator and X was the ward clerk. Because of her excellent organisations skills we ran as smoothly as we do with eCare running. X made sure that I had everything I needed to coordinate the ward and she helped me prepare the staff at the beginning of the shift. I was very concerned about the pending shut down but all my fears were allayed by X.

DSU staff accommodated a very nervous/anxious patient to successfully have their surgery by allowing a family member to attend with them. The patient contacted PALS and the Ward Sister contacted the patient and arranged for sister to attend with her for support. The ward allocation of beds was adjusted to meet this need without any impact on other patients' privacy and dignity. This enabled the patient to come in for surgery with reduced anxiety.

- Other examples highlighted opportunities to share practice wider

X highlighted to the resus team that an emergency resus trolley held by the Pain dept and PAU was being locked away overnight when clinics were still running and that if the trolley were to be needed it could not be accessed by OPD staff. Or indeed if a cardiac arrest happened in the corridor outside the pain clinic or PAU of an evening and people ran to access the nearest emergency trolley in this area it could not be accessed.

- Others noted prevention of clinical incidents

X spotted the Doctor had prescribed Tetrabenazine instead of Tinzaparin and questioned them. The Doctor then realised she had clicked on the wrong drug when selecting the prescription.

- And the wider patient, family and carer experience

A grieving husband was desperate to track down the nurse who looked after his wife in her final hours - his wife had said lovely things about her but he forgot to ask for the details. He called F9 to try and track down this nurse. The nurse who answered the phone thought X fitted the description, and asked them to call the husband. X wasn't the nurse but she stayed in touch with him. I spoke to him as part of the LfD review and we worked out that the nurse might be an HCA. I told X who managed to find the HCA from the rota, and both X and the HCA phoned the husband to talk to him. I was so impressed that the care of our patients extends to their family, and that a nurse would continue to talk to and support a grieving relative in the weeks that followed.

Greatix is only in its infancy at WSFT but it is hoped that through wider feedback, thanking the named individuals (and those who reported the events) and seeking ways to share the learning we can make learning from excellence as wide an opportunity for improvement as learning from incidents.

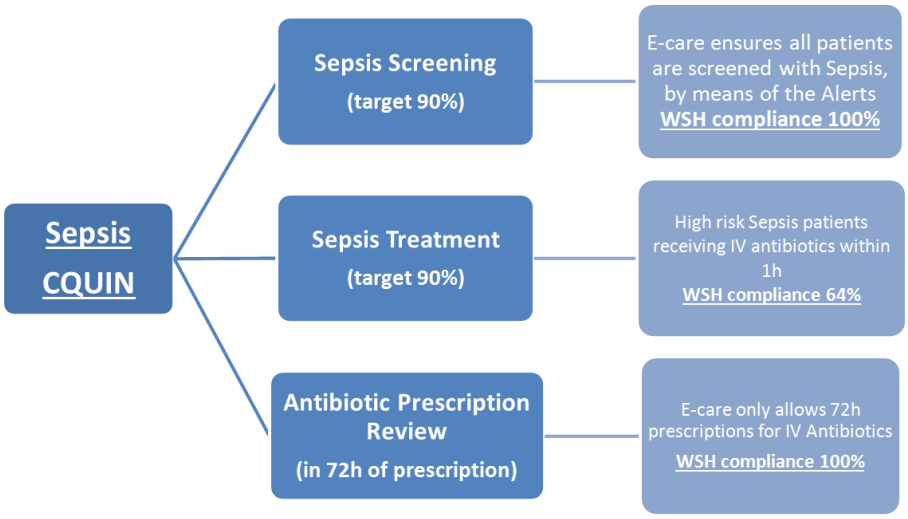
6. Other learning themes / Updates from reports in previous quarters

Subject / Theme Sepsis
Source Audit, CQUIN
Risk register entry Identification of preventable elements contributing to mortality (RR1686 accepted risk)
Trust owner Deteriorating patient group

Summary of learning and areas for improvement in this topic

Sepsis Facts

- Up to 250.000 people will develop Sepsis in 2019 and up to 67.000 will die (1 in 4 mortality);
- On average, an 11.5% yearly rise in Sepsis cases;
- Sepsis is twice more frequent that Heart Attacks and kills more people than Lung cancer alone and Breast, Prostate and Bowel cancer combined;
- Sepsis estimated cost to NHS is 2 billion pounds



The Sepsis CQUIN finished in March 2019 and since then reports have been directed at West Suffolk CCG. The aim for this local audit is now to understand the hospital compliance to each component of the Sepsis6 Protocol within one hour of diagnosis, according to the following indicators (target = 100%)

Indicator	Apr19	Mat19	Jun19	Jul19
Give Oxygen	100%	100%	100%	100%
Sampling of blood cultures in patients with suspected sepsis	70%	70%	80%	95%
IV Antibiotics	90%	90%	90%	90%
IV Fluids resuscitation	80%	85%	75%	80%
Lactate monitoring	90%	95%	80%	95%
Measure urine output for 48h	50%	85%	50%	50%

Over the last year (2018/19), on average:

- 730 patients per month trigger the Sepsis Alert on e-Care;
- 75% of those alerts are True cases of Sepsis – 545 cases monthly;
- Estimated 136 deaths in WSH alone;
- 46% of patients who triggered e-Care had Blood Cultures (target 100%);
- 62% of Patients with Severe Sepsis did not had Blood Culture taken (target 100%)

Current training in place

- Sepsis Bitesize Sessions for inpatient wards – 15 min sessions twice weekly
- Sepsis Community training – 2h sessions every other month
- Sepsis and AKI Study Day – all day, every other month
- Simulation Scenarios in ED and AAU – based in common findings, one day a month
- Twice weekly Sepsis Alert Review on E-care;
- Subsequent debrief with respective staff;
- World Sepsis Day 13th September 2019 (https://www.worldsepsisday.org)
- AKI Card construction

Actions in place

- Introduced NEWS2, more sensitive scoring system that helps staff in early identification of sepsis;
- e-Care automatic alerts generation, prompting for sepsis screening;
- Sepsis part of the Induction and Mandatory Trainings for appropriate staff;
- Sepsis and AKI project nurse in post
- Neutropenic Sepsis Pathway created and monitored to target specific needs of its users;

Areas for further improvement

- Full completion of Sepsis 6; blood cultures and other samples are often missed or taken after 24h antimicrobial therapy was initiated
- Septic patients require daily routine bloods in order to monitor progress. ABG and VBG should also be routinely repeated.
- Provide adequate and accurate e-Care documentation – sepsis confirmation form, ##AKI and AKI7 Care Plan are not routinely used and fluid balance charts aren't always accurately kept;

New quality improvement projects launched

- Improve the sampling of blood cultures in patients with suspected sepsis - improving current compliance (46%) to 80% within the next 6months
- HAT (Hydrocortisone, Ascorbic Acid and Thiamine) combination as adjunctive therapy in treatment of severe sepsis in intensive care

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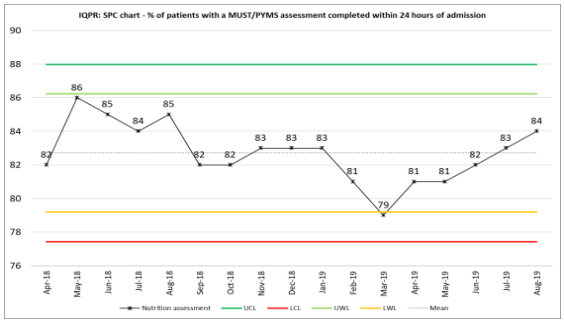
Subject / Theme	Nutrition
Source	eCare, Audit, Perfect Ward, NHSI collaborative
Risk register entry	No specific trust-wide (active) risks / multiple local risk entries
Trust owner	Nutrition steering group

Summary of learning and areas for improvement in this topic

NB: The full remit of the Nutrition Steering Group is responsible for ensuring that all systems are in place for the management of Nutritional Care throughout the organisation and to ensure that audit of National and Local Nutrition Standards are managed effectively. This report addresses just the outcome of the Nutrition collaborative and two quality improvement outcome / initiatives that have resulted:

1. **Outcome monitoring / measures**
2. **Protected mealtimes**



In 2017/18 an NHS Improvement nutrition collaborative (network with multiple trusts from acute, community and mental health services) involved focused work on two chosen wards (F3 and G4), over six months, on improving nutritional outcomes for patients in our care, with the primary focus being to:

- Improve compliance with MUST scoring
- Improve accuracy of MUST scores
- Improve recording of actual weights
- Gain assurance nutrition plans are being implemented
- Re-launch Protected mealtimes

An evaluation of the focused project identified significant achievements and challenges:

Achievements:	**Challenges:**
Staff engagement	Time and resources
Raising awareness	Capacity pressures
Blanket enriched diets for both cohorts	High acuity and staff deficits
Improvement in actual weights being recorded	Feedback to teams
Improvement in initiating nutrition care plans	Maintaining engagement
Improvement with accuracy of MUST scoring	
Protected mealtime relaunch	
Trust-wide communication	
Updated information on wards regarding protected mealtimes	
Collaborative working with dieticians	

Following this focused work, it was clear that there needed to be improvements with how compliance and accuracy is measured and monitored.

Quality Improvement opportunity 1 - streamline outcome measures used to report nutrition

These have since been reviewed and streamlined to enable focused monitoring of improvements. Since September 2018, data has been sourced and reported using e-Care, allowing all patients to be reviewed and reported in the monthly 'Patient safety report' provided by the information team. In addition, there are monthly Perfect ward audits and a quarterly ward assurance audit programme run by Dietetics which checks the validity and implementation of MUST screening and care pathways and provides a more in depth review of the accuracy of the assessment and implementation of appropriate plans. Prior to this, compliance was measured via a monthly audit, reviewing 10 patients per ward.

The current process of data collection is reported via the Nutrition Steering group and to CSEC with a headline indicator from the patient safety report included in the IQPR (see screenshots overleaf).

Example of monthly Patient Safety Dashboard results

Patient Safety Report NUTRITION (Apr-Jul 2019)			
	Adults	Paediatrics	Overall
Number of patients discharged	5149	135	5284
Number of patients with Measured Weight	3895	123	4018
% of patients with Measured Weight	75.6%	91.1%	76.0%
Number of patients with Measured Weight within 24hrs from admission	2880	78	2958
% of patients with Measured Weight within 24hrs from admission	55.9%	57.8%	56.0%
Number of patients with a MUST/PYMS assessment completed	4576	42	4618
% of patients with a MUST/PYMS assessment completed for the encounter	88.9%	31.1%	87.4%
Number of patients with a MUST/PYMS assessment completed within 6 hours of admission	3530	16	3546
% of patients with a MUST/PYMS assessment completed within 6 hours of admission	68.6%	11.9%	67.1%
Number of patients with a MUST/PYMS assessment completed within 24 hours of admission	4292	29	4321
% of patients with a MUST/PYMS assessment completed within 24 hours of admission	83.4%	21.5%	81.8%
Number of patients with a first MUST score of 2 and above	447	N/A	447
Number of patients with a first PYMS score of 1	N/A	3	3
Number of patients with a first PYMS score of 2 and above	N/A	8	8
Number of patients with a MUST Score >=2 that have a Food Chart	340	N/A	340
% of patients with a MUST >= 2 assessment that have a Food Chart	76.1%	N/A	76.1%
Number of patients with a MUST/PYMS score > 0 that have a Nutrition Care Plan	489	0	489
% of patients with a MUST/PYMS score > 0 that have a Nutrition Care Plan	59.9%	0.0%	59.1%
Number of Patients with MUST >= 2 or PYMS >= 1 that have a Referral To Dietitian	324	3	327
% of Patients with MUST >= 2 or PYMS >= 1 that have a Referral To Dietitian	72.5%	27.3%	71.4%
Number of Patients with MUST >= 2 or PYMS >= 1 that have a Dietitian Contact within 2 working days from Dietitian Referral	254	3	257
% of Patients with MUST >= 2 or PYMS >= 1 that have a Dietitian Contact within 2 working days from Dietitian Referral	78.4%	100.0%	78.6%

Example of Perfect ward monthly results

	Has the weight been recorded on admission and updated as required?	Has the nutritional risk assessment been completed adequately?	Has the nutritional care plan been filled in appropriately?	Has the Food chart has been completed, if required?	Has the Fluid chart has been completed, if required?	Has the Bristol stool chart been completed where appropriate?
ED	N/A	100%	100%	N/A	100%	N/A
CDU	Not required	Not required	Not required	Not required	Not required	N/A
F7	60%	100%	Not required	Not required	100%	100%
AAU	20%	100%	100%	100%	67%	100%
F9	100%	75%	100%	50%	100%	100%
F8 (Old F1	No data	No data	No data	No data	No data	No data
F12	100%	100%	100%	100%	100%	100%
F14 (On F	100%	60%	Not required	Not required	Not required	100%
G1	No data	No data	No data	No data	No data	No data
G3 WEW	No data	No data	No data	No data	No data	No data
G4	60%	40%	100%	100%	100%	100%
G5	80%	40%	50%	100%	67%	100%
G8	100%	20%	20%	100%	100%	100%
F1	No data	No data	No data	No data	No data	N/A
NNU	100%	Not required	100%	Not required	100%	N/A
CCS	100%	100%	100%	100%	100%	100%
Recovery	N/A	N/A	N/A	N/A	No data	N/A
Cardiac Su	100%	80%	40%	Not required	Not required	Not required
MTU	No data	No data	No data	N/A	N/A	N/A
F3	80%	80%	100%	100%	100%	100%
F4	0%	0%	0%	Not required	Not required	Not required
F5	80%	100%	100%	100%	100%	80%
F6	100%	100%	100%	100%	100%	100%

Example of Quarterly audit report to CSEC

Indicator	CCS	G1	G3	G5	G4	Cardiac
ACTUAL WEIGHT WITHIN RECORDED WITHIN 24 HR?	25%	89%	40%	50%	80%	50%
HAS BMI BEEN CALCULATED CORRECTLY?	63%	100%	80%	90%	70%	80%
HAS PERCENTAGE WEIGHT LOSS BEEN CALCULATED ACCURATELY OR APPROPRIATE ALTERNATIVE WEIGHT LOSS INDICATOR BEEN IDENTIFIED?	63%	89%	50%	40%	30%	80%
HAS APPROPRIATE A.D.E. BEEN SELECTED?	63%	100%	90%	90%	60%	80%
MUST SCORE ACCURATE?	63%	89%	70%	90%	40%	80%
MUST COMPLETED WITHIN 24HR?	38%	100%	90%	90%	60%	70%
If MUST >0, HAS CORRECT CARE PLAN BEEN IMPLEMENTED?	40%	33%	67%	0%	14%	0%
IS THE PATIENT RECEIVING CARE PLAN AS RECOMMENDED? (MUST >0)	40%	33%	67%	0%	29%	0%
If MUST >0, IS PATIENT RECEIVING ENRICHED MENU'S (VERIFY WITH CATERING)?	20%	0%	67%	0%	57%	0%

In addition to this, and to promote compliance, the Dietetic team have provided a variety of training sessions, specifically targeting areas where compliance and accuracy is poor.

All monthly and quarterly results are fed back to the teams to promote improvements and recognise achievements. To date, there have been considerable improvements in many areas, significantly on the Stroke Ward (G8), Elective Surgery (F4), Cardiac Unit (G7) and Wards F9, G4 and G5. Where a ward / area is continuing to struggle to achieve the expected levels of compliance; a targeted action plan is put into place supported by the Ward Manager and Senior Matron for their area. An example is shown below for Ward F5:

Performance Issues	Actions to be taken
Nutritional Assessments are not being completed in a timely fashion.	▪ Support from eCare coach to educate Ward Manager and Matron on completion of the Nutritional assessment ▪ Laminates to be created with a clear guidance to aid staff to complete the assessment ▪ Daily prompts to be made from Ward Manager to Nurse in charge to focus on this area ▪ RNs to be encouraged to view the patient in the patient safety dashboard ▪ Ward Manager to review patient safety dashboard daily in order to have an overview of compliance ▪ Daily prompts to be made by the Nurse in charge to all RN's to complete nutritional assessment and ensure weights are documented with 24 hours. ▪ Nurse in charge to seek assurance from RNS around completion of Nutritional assessment. ▪ Communication to go out to all registered nurses explaining the importance of the timely completion of the assessment ▪ Matron to continue running spot checks
MUST scores are not being completed within a 24 hour period.	
Continued issues around low scores month on month.	
New starters are not confident in the completion of safety assessments.	

Quality Improvement opportunity 2 - Test / further strengthen 'Protected mealtimes' initiative through a 'Ward host' pilot

In 2019 a Ward Host role has being trialled on Ward F9. Since the beginning of June a full-time role (7am-3pm) Mon-Fri has been in place to undertake a series of tasks to ensure patients receive high standards of care when it comes to nutrition and hydration, as well as, promoting the completion of MUST scores and maintaining high standards of documentation relating to monitoring nutritional and fluid intake.

Time	Planned Actions
07:00 to 07:10	✓ Handover from the Nursing Assistant in charge of the night shift. This must include all patients in the Ward
07:10 to 08:00	✓ 1st round of preparation of supplement drinks to appropriate patients. Encourage patients to drink and document on Fluid Balance chart if appropriate ✓ Ensure patients' bedside tables are clear for breakfast trays ✓ Assist with Hand hygiene for patients requiring assistance ✓ Ensure Ward is tidy and equipment restocked (consumables).
08:00 to 09:00	✓ Assist with Breakfast delivery/collection and feeding patients ✓ Document intake on Food diary/Fluid balance
09:00 to 11:30 (Including 15 min paid Break 10:00 to 10:15	✓ Assist patients with eating and drinking, documenting outcomes on the respective fluid balance/food diary records ✓ Liaise with the Nursing Team to determine which patients are on a fluid balance chart and ensure fluid intake records are up-to-date for all patients being monitored.
11:30 to 12:00	✓ Ensure Patients' bedside tables are clear for lunch trays ✓ Assist with hand hygiene for patients requiring assistance ✓ Ensure Ward is tidy
12:00 to 13:30	✓ Assist with Lunch delivery/collection and feeding patients ✓ Document intake on Food diary/Fluid balance
13:30 to 14:00	✓ Unpaid lunch break of 30 min
14:00 to 14:50	✓ 2nd round of preparation of supplement drinks to appropriate patients. Encourage patients to drink and document on Fluid Balance chart if appropriate ✓ Assist with filling out Menus
14:50 to 15:00	✓ Handover to Senior Nursing Assistant in charge

The first PDSA cycle has completed with initial feedback. Following review it has been agreed to proceed with phase 2 of the trial with 3 subsequent months with a new Ward Host in post using the learning (below) to establish new objectives and data collection. No data was collected on the first phase mainly due to amendments to the job description and some challenges with the integration and fulfilment of the role in the ward environment.

Benefits:

Good system with the menus as it was an opportunity to communicate with patients and carry out duties.

Enjoyed providing the meals to patients and assisting the Nursing Team with this task.

Ability for the role to assist the Nursing Team with transferring patients from bed to chair after washing due to MH training.

Start of the role was well welcomed.

Working alongside the staff was highly rewarding.

A big help for the staff, particularly in the mornings. In X's words: "*It has been an honour*".

Improved compliance with weighing patients

Improved compliance with completing MUST assessments

Challenges:

Amount of food diaries

Amount of fluid diaries to record and monitor.

Training only provided after already in the role made induction and integration in the role slightly more challenging.

Nutrition care/monitoring evolved as time went on which required host to accommodate to the expectations of the role.

Often patients would take their medicines with tea/coffee/water and this was not always recorded.

Communication with patients initially challenging, likely due to no previous experience in a role where this was required frequently.

Poor initial understanding (self and team) to what job description was specifically.

Ongoing focus

Work is ongoing to continue to monitor and improve compliance and accuracy of nutrition assessments and embed the process of protected mealtimes for patients. A sub group of the Nutrition Steering Group continues to focus on these objectives and has a rolling action plan to achieve this as part of the wider Nutrition steering group action plan. Compliance is improving gradually, month by month, however, the group recognises that there are specific wards and departments which need special focus and this is being achieved with the support of the Senior Matron team.

7. Mitigated red risks

Due to mitigation the below 5 red risks have been downgraded to amber or closed:

- **Returning results to referrers without the audit benefits offered by an order communications system.** (Datix 287)
  The risk assessment has been downgraded to Amber (5 Yearly x Catastrophic=Amber)
  The current mitigation includes:
  1) Policy in place PP203 validation of results- recently reviewed with Pathology
  2) Trust wide processes for report confirmation have been reviewed

- **Upgrade of Clinichemo from DOS based programme to Windows based programme.** (Datix 3434)
  The risk assessment has been downgraded to Amber (Quarterly x Moderate=Amber)
  The current mitigation includes:
  1) Test system has been uploaded and label templates created and validation has been completed
  2) If the DOS system fails we could operate by using the test system in the short term
  3) test system is scheduled to be updated into the live environment

- **The Blood Audit & Release (BARS) system will be unsupportable after September 2016** (Datix 2162)
  This risk assessment has been closed as a new system is now in place called Haemonetics BloodTrack. This new system was implemented on the 4th of March

- **Management and usage of all nearside testing equipme**nt (2539)
  The risk assessment has been downgraded to Amber (5 Yearly x Catastrophic=Amber)
  The current mitigation includes:
  1) Point of Care lead now in place
  2) Staff trained

- **Current condition of the Containment Level 3 Facility.** (Datix 3474)
  The risk assessment has been downgraded to Amber (5 Yearly x Catastrophic=Amber)
  The current mitigation includes:
  1) SOP and business continuity plans written and in place
  2) Increased frequency of sealability testing in place
  2) Plan in place to refurb current CL3

8. Learning from RIDDOR incidents

During Q1 the number of incidents reported to the HSE under RIDDOR stayed the same as the previous quarter (six incidents). Learning and mitigation included:

- Moving and handling training
- Conflict resolution training

9. Learning from patient and public feedback:

Seven complaints received in Q1 were deemed to be upheld at the time of producing this report. Actions from these were as follows:

Ref.	Issues identified	Actions and learning

WSH-COM-1483	New mother experienced delays in administering epidural, blood transfusion and was placed in a side room where the call bell was not working. Her baby, on the neonatal unit, was also fed another mother's expressed breast milk in error.	• Procedure for checking call bells distributed to staff.
		  • Pens now used in milk kitchen to enhance legibility, as opposed to pencils.
		  • Two-check process and documentation now in place for administration of milk.
		  • Discussed at departmental governance meeting and Risky Business staff newsletter.

WSH-COM-1513	Incorrect surgical appliance (calipers) prescribed, resulting in reduced mobility.	• Patient has received several calipers from alternative NHS Trusts. She has therefore been advised to bring all along to an extended appointment to ensure she only has the suitable equipment.
WSH-COM-1507	Father feels community paediatric SALT support for his daughter has been lacking which has impacted on her development.	• Capacity pressures had impacted on the team's ability to review this patient as frequently as planned, however the school and family have been provided with therapies tools for use in the meantime. • Apologies given that EHCP was not followed and assurances given that this will be updated. • Therapies to attend a dual-placement meeting with the teacher to make a plan for this patient. • Overall re-design of therapy services in special schools across Suffolk has occurred with approval to increase funding.
WSH-COM-1514	Delay in completing cremation forms resulting in body being held for longer than expected.	• Feedback provided to the doctor involved and integrated into junior doctor training. • Information relating to the process around cremation forms, which is more complex than a burial, included in the bereavement support booklet to let families know what to expect.
WSH-COM-1479	Long-term damage caused as a result of multiple failed attempts at catheterisation.	• Reflection has occurred with the doctor who made the attempts at catheterisation in relation to escalation processes and good practice. • Departmental staff reflection to prevent similar occurrences in future. • Patient is being cared for by the urology team to assist with his long-term management.
WSH-COM-1504	Incorrect documentation stating that family discussion took place around resuscitation status, however this had not occurred and DNACPR status was placed on the patient in error. No harm occurred (near miss) but family saw the status on the records which was of obvious concern to them.	• Apologies given and resuscitation status updated on patient record. • Discussed at departmental governance meeting for reflection on importance of this, and importance of involving patient and family in these discussions.
WSH-COM-1528	Error in referral for rapid access patient, resulting in failure to see within the required timeframe.	• Reflection with doctor around the correct process to be followed. • Appointment made for patient at nearest opportunity.

Six FT governor area observations took place in quarter one in the following areas:

- Fracture clinic: six actions identified
- Gynaecology and antenatal clinic outpatient area
- Eye treatment centre
- Pre-assessment unit
- Main outpatient department
- Outpatient area D

All feedback and real-time actions were completed immediately, some of which included feedback to staff about their conduct (all positive) and quick resolutions such as tidying magazine areas and moving posters.

Seven out of twelve of the more complex actions identified have been completed. The patient experience team continue to liaise with the area managers to check progress and actions are discussed at the governors' engagement committee.

Thematic review of complaints

An increase in formal complaints has been noted and therefore an in-depth review has taken place. Themes can be identified linking the high acuity of our patients this year with a breakdown in communication between staff and relatives; which features more frequently than usual with many loved ones raising concerns about not being kept informed. Upon review, in high acuity situations where time is limited, staff are required to prioritise physical care and treatment with less availability to update families as regularly as they would hope. In our quieter periods complaints around poor communication are fewer.

Issues around the loss of personal property have featured as a trend, with inpatients and families complaining about their valuables being misplaced resulting in claims for compensating a replacement. The patient and carer experience group is forming a task and finish group to identify a quality improvement initiative that can help to minimise the risk of this occurring.

There are no other obvious patterns occurring in specific areas, as the formal complaints received are widespread across the organisation.

The complexity of complaints however has increased due to a number of contributory factors:

- Higher expectations from complainants and therefore higher demand on service.
- Majority of complaints are now received via email with a Word attachment; this increases the likelihood of the complaint being much longer than we would previously see and the opportunity for complainants to fully reflect on their experience and add to their account of their journey.
- The aforementioned point around more lengthy complaints also means they are often several issues raised relating to multiple areas. This increases the likelihood of complaints containing points that we would consider to be partially upheld (some upheld and some not). We know that when investigations identify failings, complainants are less likely to accept points in which we have defended practice; resulting in more challenging resolution.
- Meeting with complainants occurs more frequently, often more than once throughout the process when the complaint is more complex.
- Closer working with the patient safety team. As the patient experience team is the point of contact for complaints, when an SI is identified as part of the complaint process the patient experience team will liaise with the patient or family throughout the 60 working day + period. This often involves meeting with the patient or family throughout the process.
- Full integration of community services (which patients and families now seem to be more aware of) has impacted on the patient experience team due to many people in this area being 'long-term' patients e.g. integrated community paediatrics, wheelchair services. This means the relationship with the complainants can also be stretched over a long period of time, as opposed to acute patients; the majority of which will have a singular hospital stay or encounter which does not require long term treatment. This results in more frequent contact and also a higher likelihood of contact from previous complainants should they experience further issues.

10. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

Board of Directors – September 2019

Agenda item:	Item 10			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	20th September 2019			
Subject:	Finance and Workforce Board Report – August 2019			
Purpose:	x	For information		For approval

Executive summary:
The reported I&E for August 2019 is a deficit of £1.3m, against a planned deficit of £0.1m. This results in an adverse variance of £1.2m in August, (£2.6m adverse variance YTD). The YTD loss is now £4.1m which would suggest a loss of £10.0m should this continue.

We continue to forecast to meet our plan to break even in 2019-20. However, this requires a significant recovery plan which is being developed and will be managed through the PMO who will ensure the same governance that is in place for all other Cost Improvement Programmes, including Quality Impact Assessment and Project Management.

The reported forecast assumes we deliver this recovery plan and will therefore receive all our PSF (£10.1m).

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
AUGUST 2019 (Month 5)

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

Financial Summary

I&E Position YTD	£4.1m	loss
Variance against plan YTD	-£2.6m	adverse
Movement in month against plan	-£1.2m	adverse
EBITDA position YTD	-£2.8m	adverse
EBITDA margin YTD	-2.9%	adverse
Total PSF Received	£3.700m	accrued
Cash at bank	£1.8m	

Executive Summary

- The planned deficit for the year to date was £1.5m but the actual deficit was £4.1m, an adverse variance of £2.6m.
- We continue to forecast to meet our plan to break even in 2019-20. However, this requires a recovery plan which will include prioritising the financial position against quality and performance targets.
- The reported forecast assumes we deliver this recovery plan and will therefore receive all our PSF (£10.1m).

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 - August 2019	Aug-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	17.6	17.6	(0.0)	87.2	87.4	0.2	209.6	209.5	(0.1)
Other Income	3.3	3.3	(0.0)	15.8	15.2	(0.6)	37.9	38.6	0.7
Total Income	**21.0**	**20.9**	**0.0**	**103.0**	**102.6**	**(0.4)**	**247.5**	**248.1**	**0.6**
Pay Costs	14.1	14.7	(0.6)	70.2	71.7	(1.5)	169.9	170.5	(0.6)
Non-pay Costs	6.7	7.4	(0.7)	32.7	33.9	(1.2)	75.9	76.4	(0.5)
Operating Expenditure	**20.9**	**22.0**	**(1.2)**	**103.0**	**105.7**	**(2.7)**	**245.8**	**246.9**	**(1.1)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**0.1**	**(1.1)**	**(1.2)**	**(0.0)**	**(3.1)**	**(3.1)**	**1.7**	**1.2**	**(0.5)**
Depreciation	0.7	0.6	0.1	3.3	3.0	0.3	7.9	7.4	0.5
Finance costs	0.3	0.4	(0.1)	1.6	1.7	(0.1)	3.9	3.9	(0.0)
SURPLUS/(DEFICIT)	**(0.9)**	**(2.1)**	**(1.2)**	**(4.9)**	**(7.8)**	**(2.9)**	**(10.1)**	**(10.1)**	**(0.0)**
Provider Sustainability Funding (PSF)									
PSF - Financial Performance	0.7	0.7	0.0	3.4	3.7	0.3	10.1	10.1	0.0
SURPLUS/(DEFICIT) incl PSF	**(0.1)**	**(1.4)**	**(1.2)**	**(1.5)**	**(4.1)**	**(2.6)**	**0.0**	**0.0**	**(0.0)**

FINANCE AND WORKFORCE REPORT - AUGUST 2019

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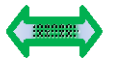
- 2019-20 CIP Page 4
- Income Analysis Page 5
- Workforce Planning and Analysis Page 7
- Divisional Positions Page 11
- Use of Resources (UoR) Page 13
- Capital Page 14
- Balance Sheet Page 15
- Cash and Debt Management Page 16

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 - AUGUST 2019

Income and Expenditure Summary as at August 2019

The reported I&E for August 2019 is a deficit of £1.3m, against a planned deficit of £0.1m. This results in an adverse variance of £1.2m in August (£2.6m YTD).

We are planning to break even in 2019-20, but the current position indicates a deficit of £10m if we do nothing, and that we can hold demand at present levels.

The YTD variance largely relates to:

- Additional capacity to meet demand (£150k per month)
- Recruitment and relocation costs for overseas nurses (£60k per month)
- Community equipment to help enable discharges (£50k per month)
- Private patient income below plan (£40k per month).

However, the August position also included non-recurring costs of £900k relating to prior periods, most notably

- Wheelchair service (£330k)
- Medical and Nursing Agency staff (£300k)
- Electricity and IT invoices (£140k)
- Endoscopy (85k) and
- Pathology (£45k).

Each Division is preparing a recovery plan in order to deliver the funded activity within their 2019-20 budget.

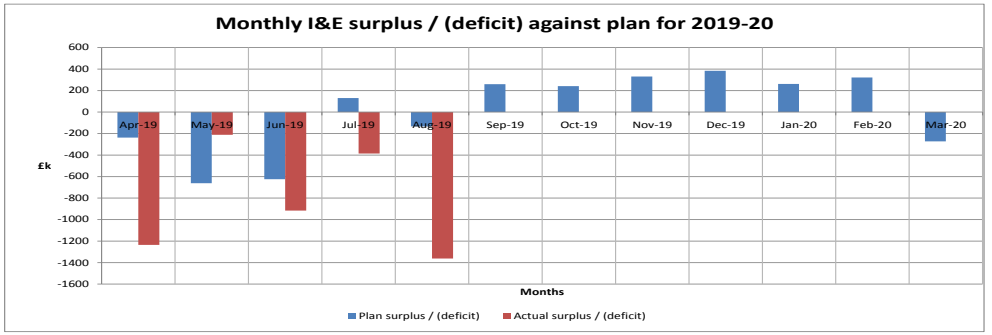
Whilst our guaranteed income contract (GIC) assures our income stream and protects us against penalties, the actual overperformance is £2.5m as at August. We are discussing the potential for additional funding to reflect these costs with WSCCG as well as the impact of any schemes that they are progressing which may alleviate the pressure (and costs) at WSFT.

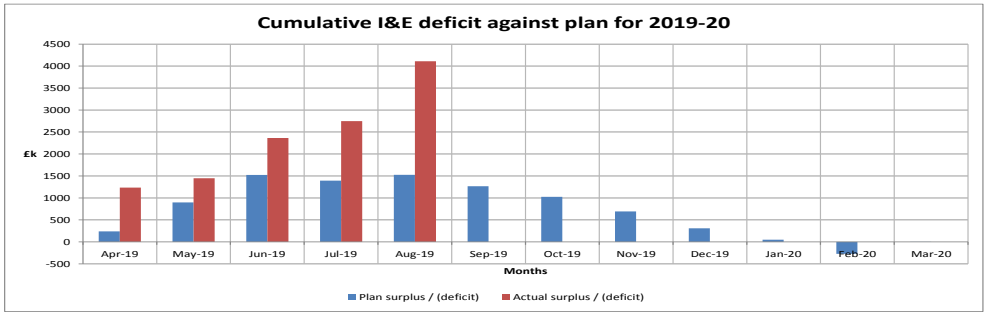
We could also consider action that will not compromise patient safety but would have an impact on quality and performance, for example:

- close escalation capacity (patient flow)
- reducing locum spend (ED performance)
- reducing extra sessions (waiting times / RTT)

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)	(130)	(1,359)	(1,228)	↑	Red
YTD surplus / (deficit)	(1,522)	(4,104)	(2,581)	↑	Red
Forecast surplus / (deficit)	9	9	0	↔	Amber
EBITDA (excl STF) YTD	(41)	(3,097)	(3,056)	↑	Red
EBITDA (%)	(0.0%)	(2.9%)	(2.9%)	↑	Red
Clinical Income YTD	(87,190)	(87,388)	199	↓	Green
Non-Clinical Income YTD	(19,185)	(18,882)	(303)	↑	Amber
Pay YTD	70,248	71,739	(1,491)	↑	Red
Non-Pay YTD	37,649	38,636	(986)	↑	Red
CIP target YTD	3,957	3,758	(199)	↓	Amber

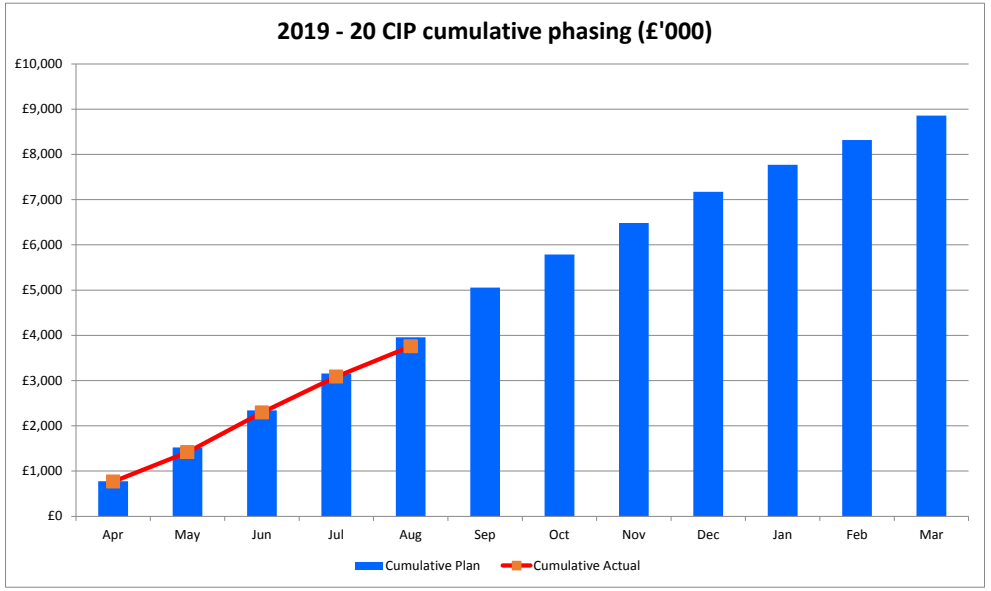


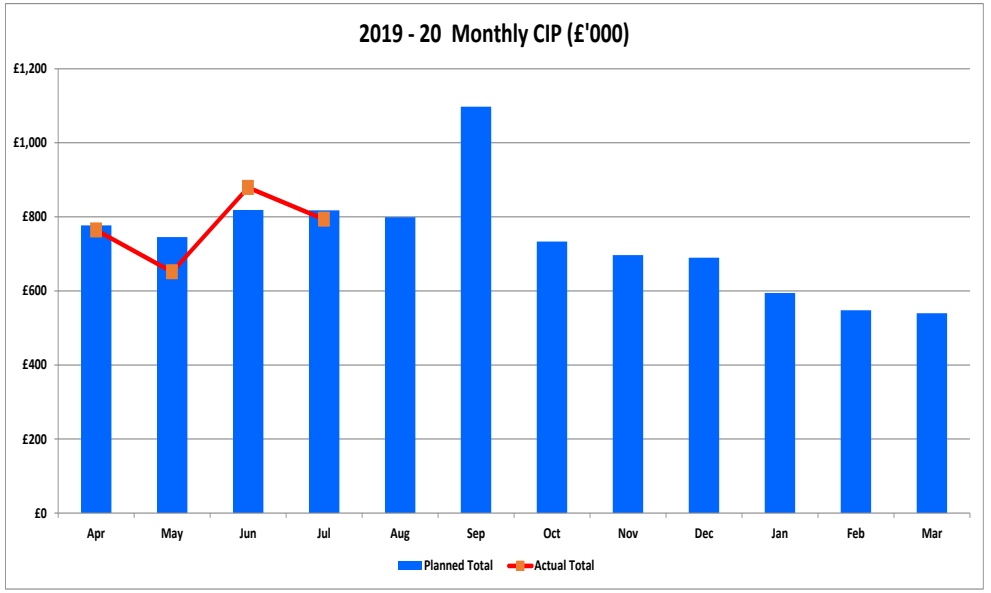


Cost Improvement Programme (CIP) 2019-20

In order to deliver the Trust's control target in 2019-20 we needed to deliver a CIP of £8.9m (4%). By August we planned to achieve £3,957k (44.7% of the annual plan) but achieved £3,758k (£199k behind plan).

Recurring/Non Recurring Summary	2019-20 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	100	42	36
Procurement	731	298	349
Activity growth	-	-	-
Additional sessions	15	6	0
Community Equipment Service	575	422	370
Drugs	1,840	934	901
Estates and Facilities	60	24	18
Other	1,344	323	496
Other Income	1,743	850	675
Pay controls	361	146	118
Service Review	20	4	-
Staffing Review	1,076	480	366
Theatre Efficiency	178	55	51
Recurring Total	**8,044**	**3,585**	**3,380**
Non-Recurring			
Estates and Facilities	87	44	-
Other	350	142	10
Pay controls	376	186	367
Non-Recurring Total	**812**	**372**	**377**
Grand Total	**8,856**	**3,957**	**3,758**

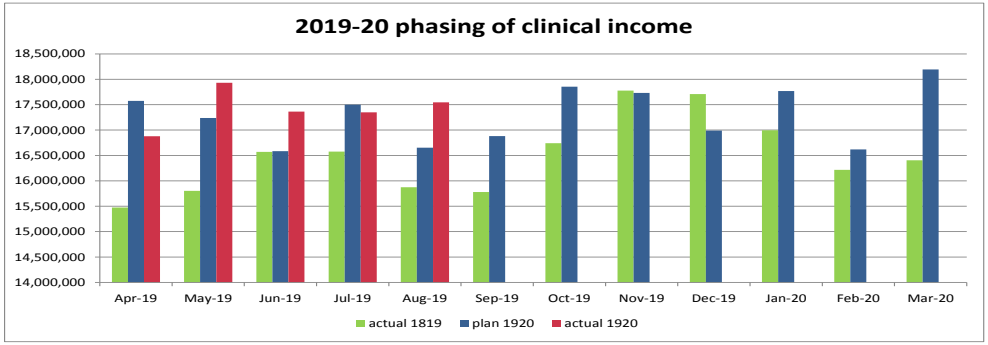




FINANCE AND WORKFORCE REPORT - AUGUST 2019

Income Analysis

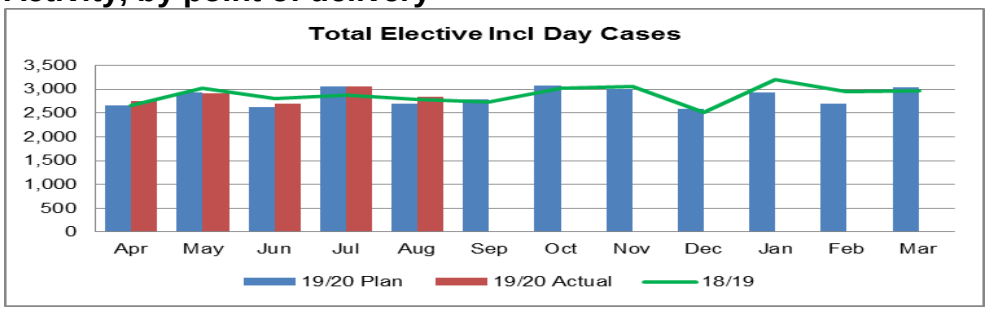
The chart below demonstrates the phasing of all clinical income plan for 2019-20, including Community Services. This phasing is in line with phasing of activity.

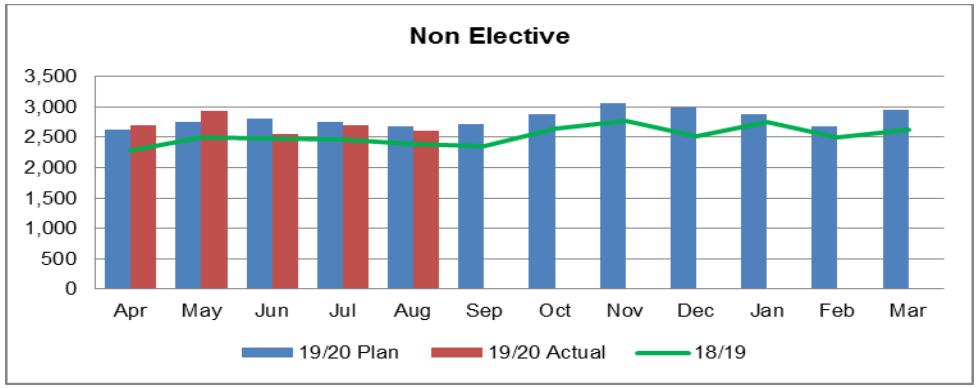


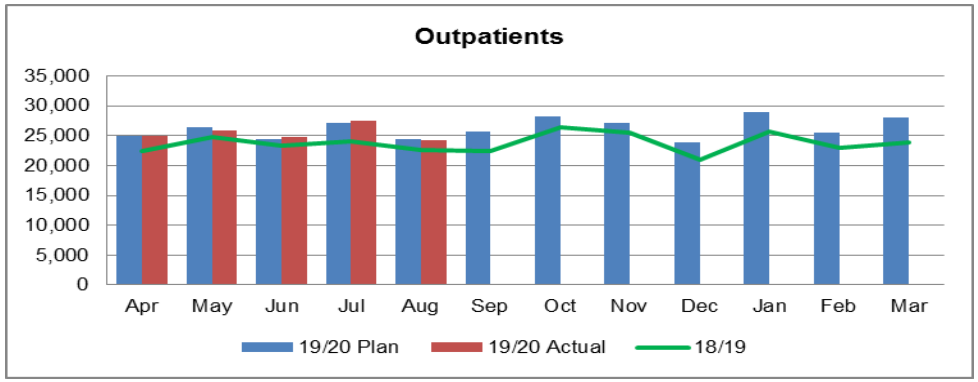
The income position was slightly behind plan for August. The main area of underperformance was Elective activity.

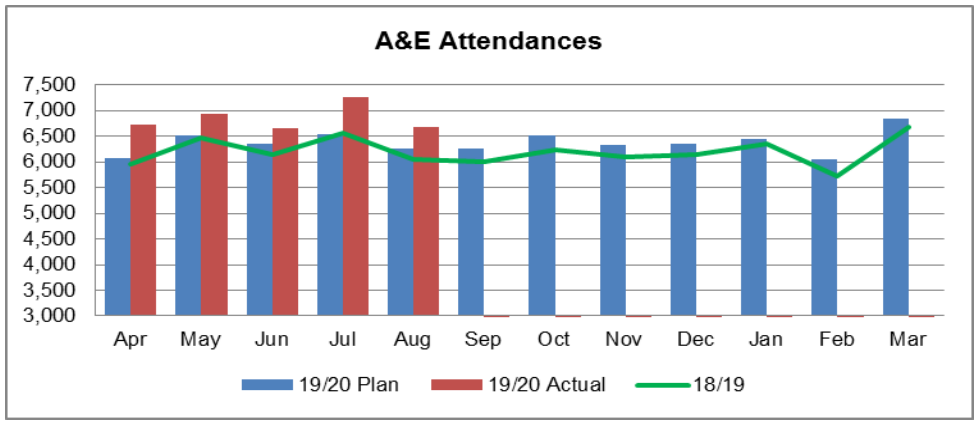
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	890	963	73	4,514	4,917	403
Other Services	2,060	2,353	293	8,006	8,414	408
CQUIN	166	161	(5)	846	842	(4)
Elective	2,658	2,480	(178)	13,801	13,283	(518)
Non Elective	6,044	5,954	(90)	30,305	30,264	(40)
Emergency Threshold Adjustment	(333)	(333)	0	(1,683)	(1,683)	0
Outpatients	2,930	2,818	(113)	15,296	15,275	(21)
Community	3,221	3,215	(6)	16,105	16,075	(30)
Total	**17,636**	**17,611**	**(25)**	**87,190**	**87,388**	**199**

Activity, by point of delivery



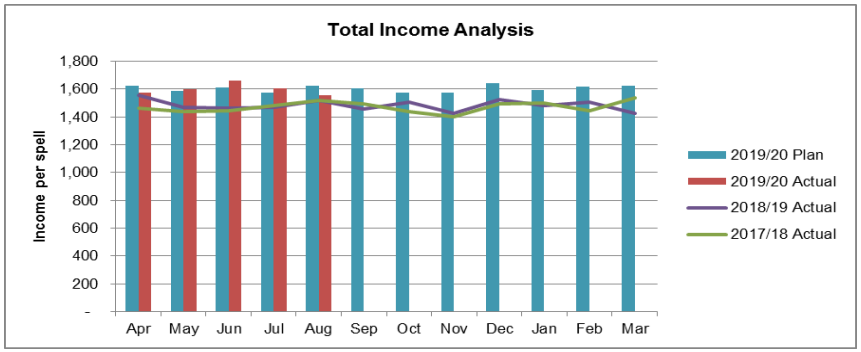


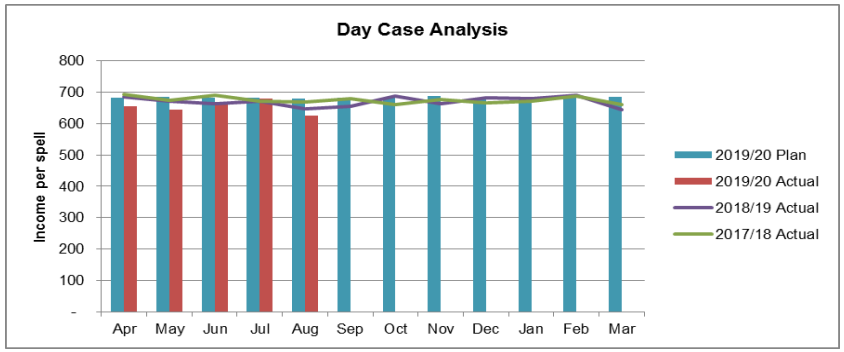


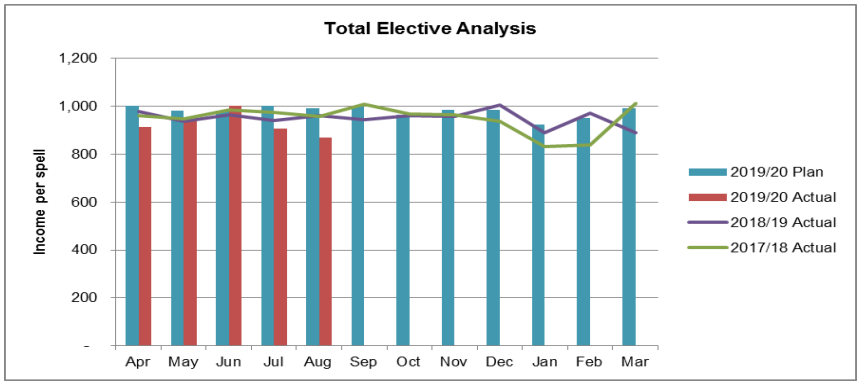


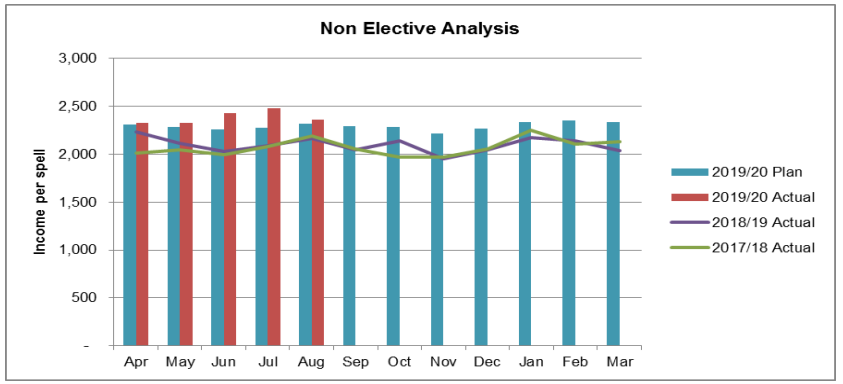
FINANCE AND WORKFORCE REPORT - AUGUST 2019

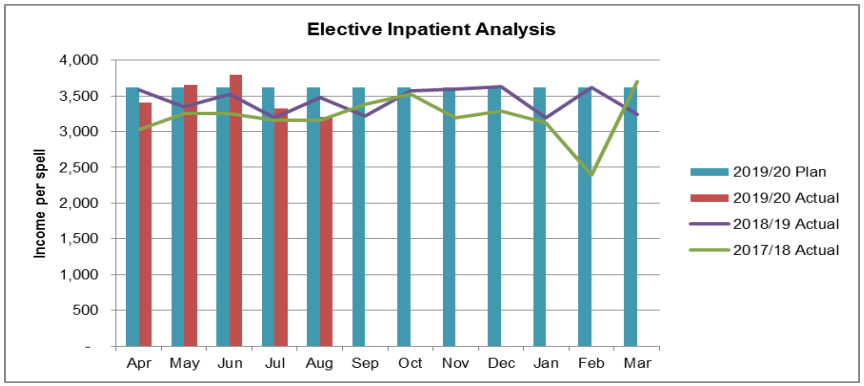
Trends and Analysis

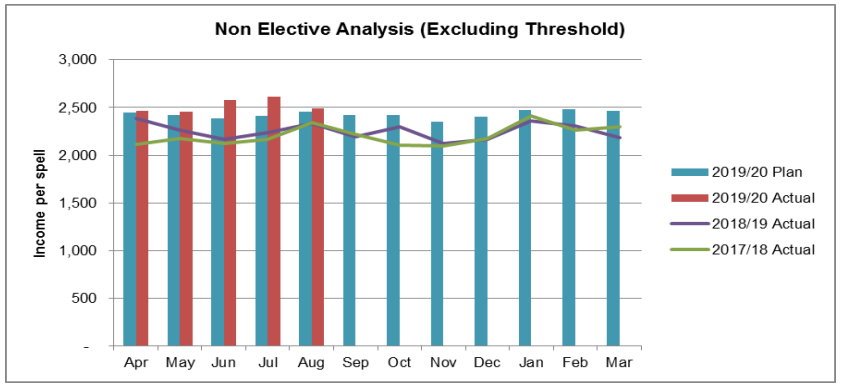












FINANCE AND WORKFORCE REPORT - AUGUST 2019

Workforce

Monthly Expenditure (£) Acute services only				
As at August 2019	Aug-19	Jul-19	Aug-18	YTD 2019/20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**12,415**	**12,396**	**12,539**	**61,735**
Substantive Staff	11,186	11,116	10,890	55,411
Medical Agency Staff (includes 'contracted in' staff)	201	150	268	714
Medical Locum Staff	399	240	241	1,344
Additional Medical sessions	331	213	269	1,423
Nursing Agency Staff	180	181	125	797
Nursing Bank Staff	242	282	365	1,356
Other Agency Staff	79	107	39	363
Other Bank Staff	162	135	192	729
Overtime	144	167	121	863
On Call	69	71	61	342
Total temporary expenditure	1,807	1,546	1,681	7,931
Total expenditure on pay	**12,993**	**12,662**	**12,571**	**63,342**
Variance (F/(A))	(578)	(266)	(31)	(1,608)
Temp Staff costs % of Total Pay	13.9%	12.2%	13.4%	12.5%
Memo : Total agency spend in month	460	438	431	1,874

Monthly Whole Time Equivalents (WTE) Acute Services only			
As at August 2019	Aug-19	Jul-19	Aug-18
	WTE	WTE	WTE
Budgeted WTE in month	**3,323.4**	**3,326.0**	**3,141.7**
Employed substantive WTE in month	3023.43	2964.48	2776.83
Medical Agency Staff (includes 'contracted in' staff)	11.97	7.01	22.09
Medical Locum	35.02	26.5	21.38
Additional Sessions	24.57	19.58	19.4
Nursing Agency	25.28	18.38	24.65
Nursing Bank	77.42	77.6	86.38
Other Agency	19.47	24.35	11.6
Other Bank	72.73	72.24	73.64
Overtime	38.36	41.99	33.03
On call Worked	6.69	6.45	7.21
Total equivalent temporary WTE	**311.5**	**294.1**	**299.4**
Total equivalent employed WTE	**3,334.9**	**3,258.6**	**3,076.2**
Variance (F/(A))	(11.5)	67.4	65.5
Temp Staff WTE % of Total Pay	9.3%	9.0%	9.7%
Memo : Total agency WTE in month	56.7	49.7	58.3

Sickness Rates (June/May)	3.31%	3.61%	3.83%
Mat Leave	2.54%	2.73%	2.94%

Monthly Expenditure (£) Community Service Only				
As at August 2019	Aug-19	Jul-19	Aug-18	YTD 2019-20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,703**	**1,703**	**1,633**	**8,513**
Substantive Staff	1,607	1,647	1,615	7,970
Medical Agency Staff (includes 'contracted in' staff)	12	12	12	55
Medical Locum Staff	3	3	3	23
Additional Medical sessions	2	0	1	7
Nursing Agency Staff	23	21	12	96
Nursing Bank Staff	21	27	22	144
Other Agency Staff	12	7	17	18
Other Bank Staff	9	4	13	31
Overtime	7	6	8	35
On Call	3	3	3	17
Total temporary expenditure	93	83	89	426
Total expenditure on pay	**1,700**	**1,730**	**1,704**	**8,397**
Variance (F/(A))	2	(27)	(71)	117
Temp Staff costs % of Total Pay	5.5%	4.8%	5.2%	5.1%
Memo : Total agency spend in month	47	39	40	169

Monthly Whole Time Equivalents (WTE) Community Services Only			
As at August 2019	Aug-19	Jul-19	Aug-18
	WTE	WTE	WTE
Budgeted WTE in month	**528.7**	**528.82**	**486.93**
Employed substantive WTE in month	489.72	486.65	468.57
Medical Agency Staff (includes 'contracted in' staff)	0.74	0.74	0.00
Medical Locum	0.35	0.35	0.35
Additional Sessions	0.00	0.00	0.00
Nursing Agency	3.29	3.10	1.88
Nursing Bank	6.90	8.10	5.46
Other Agency	4.97	2.43	4.17
Other Bank	2.41	0.70	2.83
Overtime	2.20	1.83	2.39
On call Worked	0.02	0.00	0.00
Total equivalent temporary WTE	**20.9**	**17.3**	**17.1**
Total equivalent employed WTE	**510.6**	**503.9**	**485.65**
Variance (F/(A))	18.10	24.92	1.28
Temp Staff WTE % of Total Pay	4.1%	3.4%	3.5%
Memo : Total agency WTE in month	9.0	6.3	6.1

Sickness Rates (July/June)	3.69%	4.09%	3.79%
Mat Leave	2.49%	2.64%	2.82%

FINANCE AND WORKFORCE REPORT - AUGUST 2019

Pay Trends and Analysis

Nursing – Staffing levels

The tables below compare actual registered and unregistered nursing within ward based and non-ward based services between April 2018 and August 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 17 months there has been a total increase in nursing of around 58 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			July 18 to July 19			August 18 to August 19			April 18 to August 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	Ward Based	Non Ward Based	Total	Ward Based	Non Ward Based	Total
Registered	1.54	28.29	**29.83**	(8.60)	25.36	**16.76**	29.63	21.24	**50.87**	24.06	23.54	**47.6**	28.67	27.53	**56.20**	4.02	25.90	**29.92**
Unregistered	41.28	8.15	**49.43**	75.73	7.98	**83.71**	70.39	7.69	**78.08**	67.38	8.05	**75.43**	56.71	9.81	**66.52**	54.18	12.42	**66.60**
Total	**42.82**	**36.44**	**79.26**	**67.13**	**33.34**	**100.47**	**100.02**	**28.93**	**128.95**	91.44	31.59	**123.03**	85.38	37.34	**122.72**	58.20	38.32	**96.52**

Nursing WTE % Increase / (Decrease)

	April 18 to April 19			May 18 to May 19			June 18 to June 19			July 18 to July 19			August 18 to August 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	Ward Based	Non Ward Based	Total
Registered	0.4%	4.3%	**2.8%**	(2.12%)	3.9%	**1.6%**	7.8%	3.3%	**5.0%**	6.4%	3.6%	**4.6%**	7.6%	4.2%	**5.4%**
Unregistered	13.2%	4.6%	**10.1%**	26.5%	4.6%	**18.1%**	23.7%	4.3%	**16.4%**	22.3%	4.5%	**15.7%**	18.3%	5.5%	**13.6%**
Total	**6.0%**	**4.4%**	**5.1%**	**9.7%**	**4.0%**	**6.6%**	**14.8%**	**3.5%**	**8.6%**	13.5%	3.8%	**8.1%**	12.4%	4.5%	**8.0%**

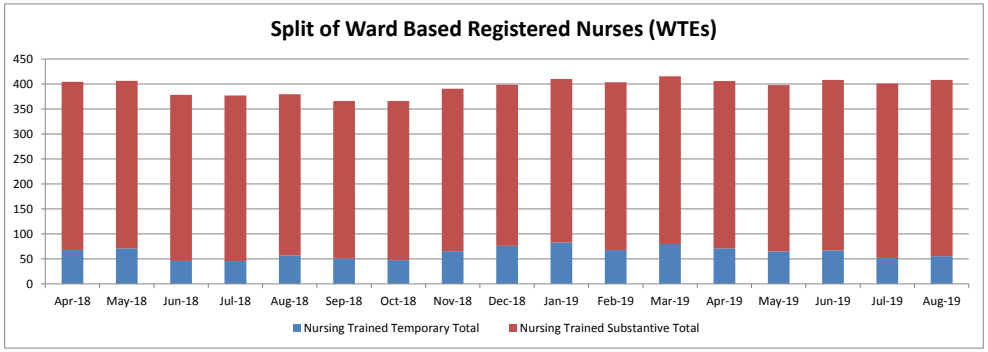
Due to increasing bed capacity the next table compares ward based nursing WTEs with average beds open in each month to demonstrate whether the increase in staffing is in line with growth in capacity. Looking at the total increase in nursing negates changes associated with the implementation of bay based nursing. It can be seen that the ratio of total nurses to beds has increased from 1.61 WTE per bed to 1.72 WTE, an increase of almost 5%.

WTEs incl A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19	Jul-18	Jul-19	Aug-18	Aug-19	
Average Beds	445	462	432	458	430	467	438	473	419	450	
Registered WTEs	404	406	406	398	378	408	377	401	380	408	
Unregistered WTEs	313	354	286	362	297	367	302	369	310	367	
Total	717	760	692	760	675	775	679	770	690	775	
All wards incl A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19	Jul-18	Jul-19	Aug-18	Aug-19	yr on yr
Registered per bed (incl Agency)	0.91	0.88	0.94	0.87	0.88	0.87	0.86	0.85	0.91	0.91	100.1%
Unregistered per bed	0.70	0.77	0.66	0.79	0.69	0.79	0.69	0.78	0.74	0.82	110.1%
Total Nursing per bed	1.61	1.64	1.60	1.66	1.57	1.66	1.55	1.63	1.65	1.72	104.6%
Excluding A&E	Apr-18	Apr-19	May-18	May-19	Jun-18	Jun-19	Jul-18	Jul-19	Aug-18	Aug-19	yr on yr
Registered per bed (incl Agency)	0.76	0.73	0.79	0.73	0.75	0.72	0.72	0.71	0.76	0.75	99.7%
Unregistered per bed	0.65	0.72	0.61	0.74	0.64	0.73	0.64	0.72	0.69	0.76	110.8%
Total Nursing per bed	1.42	1.45	1.31	1.47	1.39	1.45	1.36	1.43	1.44	1.52	105.3%

The average funded establishment for a 32 bed ward (G4, G5 F3, F5, F6) as at June 2019 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.

Excluding escalation areas there were around 68 WTE vacancies at the end of August 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.



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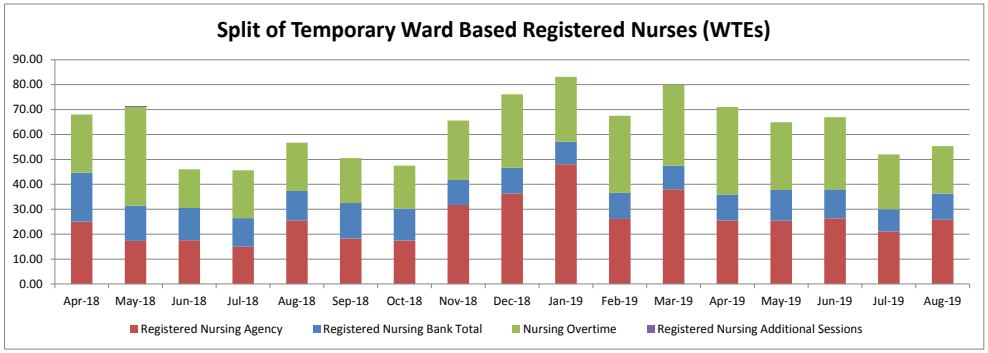
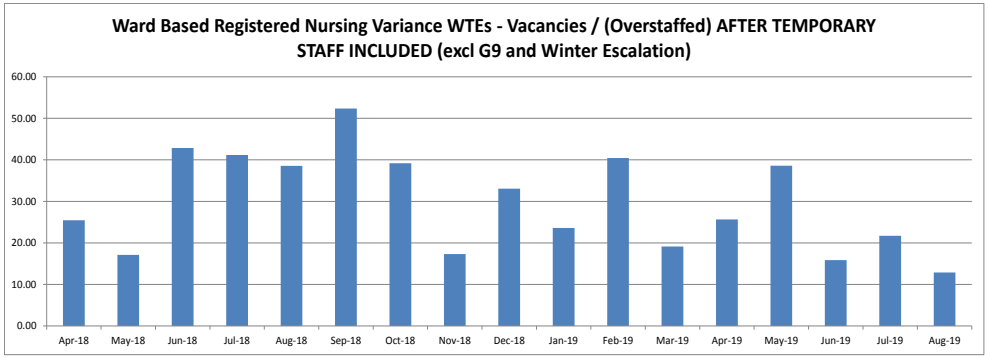
We used 55 temporary WTEs to fill the majority of vacant posts during August.



However, after using temporary nursing staff there remained 12.9 WTE uncovered Ward Based Registered Nursing Vacancies during August 2019, the lowest level over the last 17 months



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	Sum of plan july 19	Sum of Actual july 19	NET Vacancies (over / (under)) July 19	Sum of plan august 19	Sum of Actual august 19	NET vacancies (over / (under)) August 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)	6.12	4	(2.12)	6.12	7.01	0.89
	Accident & Emergency	61.81	63.38	1.57	61.81	55.36	(6.45)	61.81	65.7	3.89	61.81	60.14	(1.67)	61.81	61.78	(0.02)
	C.C.U.	0	0	0.00	0	0.03	0.03	0	1	1.00	0	0	0.00	0	0	0.00
	Ward F9	20.31	18.37	(1.94)	20.31	20.32	0.01	20.31	20.55	0.24	20.31	19.68	(0.63)	20.31	19.32	(0.99)
	Ward F12	11.02	11.16	0.14	11.02	9.89	(1.13)	11.02	10.08	(0.94)	11.02	10.03	(0.99)	11.02	10.23	(0.79)
	Ward G1 Hardwick Unit	23.74	22.28	(1.46)	23.74	19.37	(4.37)	23.74	19.5	(4.24)	23.74	18.9	(4.84)	23.74	20.7	(3.04)
	Cardiac Ward	14.28	12.27	(2.01)	14.28	11.09	(3.19)	16.9	18.09	1.19	16.9	16.8	(0.10)	16.9	18.07	1.17
	Ward G4	19.17	19.22	0.05	19.17	17.13	(2.04)	19.17	19.1	(0.07)	19.17	18.34	(0.83)	19.17	16.66	(2.51)
	Ward G5	18.41	20.77	2.36	18.41	17.73	(0.68)	18.41	17.6	(0.81)	18.41	18.25	(0.16)	18.41	18.17	(0.24)
	Ward G8	23.15	19.84	(3.31)	23.15	17.43	(5.72)	23.15	18.3	(4.85)	23.15	20.14	(3.01)	23.15	21.45	(1.70)
	Medical Treatment Unit	7.04	5.98	(1.06)	7.04	6.04	(1.00)	7.04	7.07	0.03	7.04	7.17	0.13	7.04	7.13	0.09
	Respiratory Ward	19.9	21.48	1.58	19.9	20.87	0.97	19.9	21.48	1.58	19.9	19.07	(0.83)	19.9	21.73	1.83
	Cardiac Centre	40.14	33.41	(6.73)	40.14	34.77	(5.37)	40.14	29.86	(10.28)	40.14	34.32	(5.82)	40.14	34.65	(5.49)
	AAU	27.3	20.85	(6.45)	27.3	18.98	(8.32)	20.96	19.76	(1.20)	20.96	19.59	(1.37)	20.96	19.28	(1.68)
	Ward F7 Short Stay	21.84	20.94	(0.90)	21.84	20.88	(0.96)	21.84	23.17	1.33	21.84	21.94	0.10	21.84	23.61	1.77
Medical Services Total		314.23	294.06	(20.17)	314.23	275.95	(38.28)	310.51	295.38	(15.13)	310.51	288.37	(22.14)	310.51	299.79	(10.72)
⊟Surgical Services	Ward F3	19.69	17.92	(1.77)	19.69	18.98	(0.71)	19.57	18.05	(1.52)	19.57	16.84	(2.73)	19.57	17.99	(1.58)
	Ward F4	13.78	12.72	(1.06)	13.78	14.29	0.51	13.78	13.27	(0.51)	13.78	12.86	(0.92)	13.78	11.51	(2.27)
	Ward F5	19.59	19.46	(0.13)	19.59	18.66	(0.93)	19.59	20.16	0.57	19.59	20.19	0.60	19.59	20.5	0.91
	Ward F6	19.57	18.72	(0.85)	19.57	19.07	(0.50)	19.57	19.75	0.18	19.57	20.19	0.62	19.57	19.04	(0.53)
Surgical Services Total		72.63	68.82	(3.81)	72.63	71	(1.63)	72.51	71.23	(1.28)	72.51	70.08	(2.43)	72.51	69.04	(3.47)
⊟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	11.18	12.86	1.68	11.18	12.7	1.52
Woman & Children Services Total		11.18	11.73	0.55	11.18	11.47	0.29	11.18	13.03	1.85	11.18	12.86	1.68	11.18	12.7	1.52
⊟Community	Newmarket Hosp-Rosemary ward	12.43	10.89	(1.54)	12.43	14.1	1.67	12.43	10.97	(1.46)	12.43	13.9	1.47	12.43	12.62	0.19
	Community - Glastonbury Court	11.69	11	(0.69)	11.69	11.06	(0.63)	11.69	11.85	0.16	11.69	11.39	(0.30)	11.69	11.3	(0.39)
Community Total		24.12	21.89	(2.23)	24.12	25.16	1.04	24.12	22.82	(1.30)	24.12	25.29	1.17	24.12	23.92	(0.20)
Grand Total		**422.16**	**396.5**	**(25.66)**	**422.16**	**383.58**	**(38.58)**	**418.32**	**402.46**	**(15.86)**	**418.32**	**396.6**	**(21.72)**	**418.32**	**405.45**	**(12.87)**

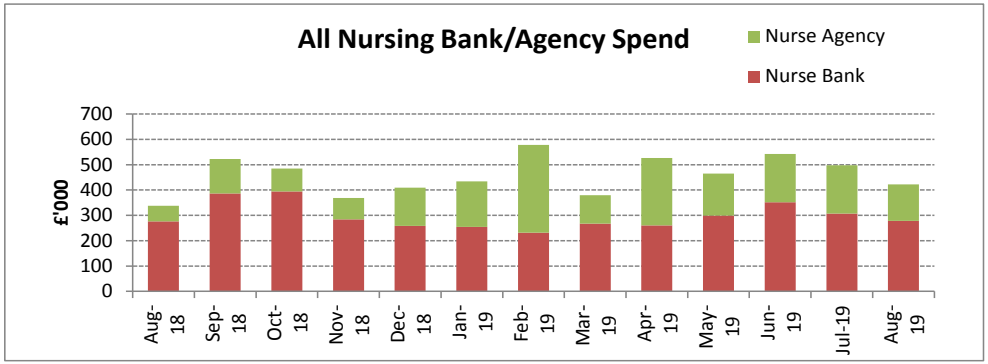
Ward Based Unregistered Nurses were over established by 30.9 WTE during August after utilising temporary unregistered nurses, broken down as below :

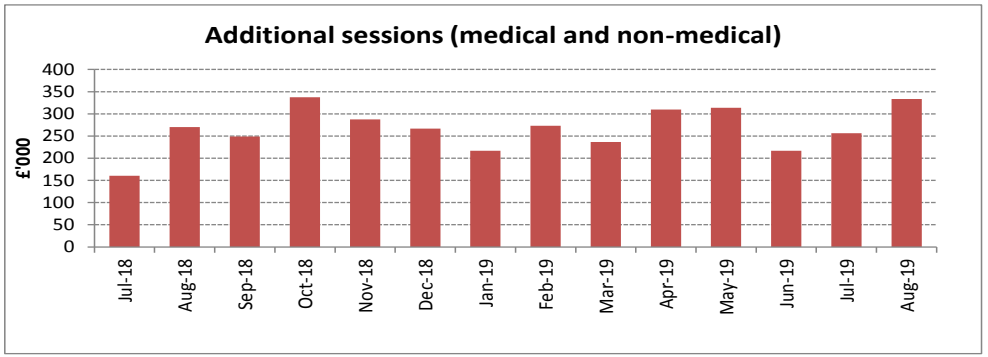
Division	Ward Area	Plan April 19	Actual April 19	NET Vacancies (over / (under)) April 19	Sum of plan may 19	Sum of Actual may 19	NET vacancies (over / (under)) May 19	Sum of plan june 19	Sum of Actual june 19	NET vacancies (over / (under)) June 19	Sum of plan july 19	Sum of Actual july 19	NET vacancies (over / (under)) July 19	Sum of plan august 19	Sum of Actual august 19	NET vacancies (over / (under)) August 19
⊟Medical Services	Accident & Emergency	24.43	21.83	(2.60)	24.43	22.66	(1.77)	24.43	25.92	1.49	24.43	28.46	4.03	24.43	24.2	(0.23)
	C.C.U.	0	0	0.00	0	0	0.00	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)	22.56	25.73	3.17	22.56	24.71	2.15
	Ward F12	5	5.29	0.29	5	5.48	0.48	5	5.64	0.64	5	5.48	0.48	5	6.71	1.71
	Ward G1 Hardwick Unit	9.01	9.17	0.16	9.01	9.3	0.29	9.01	11.98	2.97	9.01	11.31	2.30	9.01	9.64	0.63
	Cardiac Ward	18.03	9.64	(8.39)	18.03	10.28	(7.75)	18.6	17.3	(1.30)	18.6	20.27	1.67	18.6	22.05	3.45
	Ward G4	24.36	26.84	2.48	24.36	27.9	3.54	24.36	25.15	0.79	24.36	28.52	4.16	24.36	28.72	4.36
	Ward G5	22.66	25.82	3.16	22.66	25.02	2.36	22.66	26.07	3.41	22.66	24.99	2.33	22.66	24.69	2.03
	Ward G8	23.87	26.49	2.62	23.87	26.79	2.92	23.87	28.7	4.83	23.87	28.25	4.38	23.87	26.6	2.73
	Respiratory Ward	21.13	19.01	(2.12)	21.13	19.15	(1.98)	21.13	19.82	(1.31)	21.13	20.08	(1.05)	21.13	19.85	(1.28)
	Cardiac Centre	15.2	20.34	5.14	15.2	19.86	4.66	15.2	15.49	0.29	15.2	18.67	3.47	15.2	17.42	2.22
	AAU	29.59	28.92	(0.67)	29.59	27.7	(1.89)	25.51	27.79	2.28	25.51	29.32	3.81	25.51	29.98	4.47
	Ward F7 Short Stay	30.94	26.9	(4.04)	30.94	29.05	(1.89)	30.94	28.81	(2.13)	30.94	30.05	(0.89)	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	243.27	271.13	27.86	243.27	263.38	20.11
⊟Surgical Services	Ward F3	22.26	22.97	0.71	22.26	25.27	3.01	22.26	20.95	(1.31)	22.26	21.71	(0.55)	22.26	25.02	2.76
	Ward F4	9.61	8.38	(1.23)	9.61	8.59	(1.02)	9.61	8.41	(1.20)	9.61	8.18	(1.43)	9.61	8.59	(1.02)
	Ward F5	14.51	14.65	0.14	14.51	15.42	0.91	14.51	16.28	1.77	14.51	14.83	0.32	14.51	15.65	1.14
	Ward F6	14.51	17.61	3.10	14.51	17.29	2.78	14.51	17.6	3.09	14.51	17.24	2.73	14.51	17.56	3.05
Surgical Services Total		60.89	63.61	2.72	60.89	66.57	5.68	60.89	63.24	2.35	60.89	61.96	1.07	60.89	66.82	5.93
⊟Woman & Children Ser	Gynae Ward (On F14)	1	4.81	3.81	1	4.69	3.69	1	4.01	3.01	1	4.22	3.22	1	4.41	3.41
Woman & Children Services Total		1	4.81	3.81	1	4.69	3.69	1	4.01	3.01	1	4.22	3.22	1	4.41	3.41
⊟Community	Newmarket Hosp-Rosemary ward	13.47	12.26	(1.21)	13.47	12.34	(1.13)	13.47	13.14	(0.33)	13.47	13.33	(0.14)	13.47	13.49	0.02
	Community - Glastonbury Court	12.64	12.43	(0.21)	12.64	12.66	0.02	12.64	11.67	(0.97)	12.64	12.89	0.25	12.64	14.04	1.40
Community Total		26.11	24.69	(1.42)	26.11	25	(1.11)	26.11	24.81	(1.30)	26.11	26.22	0.11	26.11	27.53	1.42
Grand Total		**334.78**	**337.08**	**2.30**	**334.78**	**340.3**	**5.52**	**331.27**	**346.77**	**15.50**	**331.27**	**363.53**	**32.26**	**331.27**	**362.14**	**30.87**

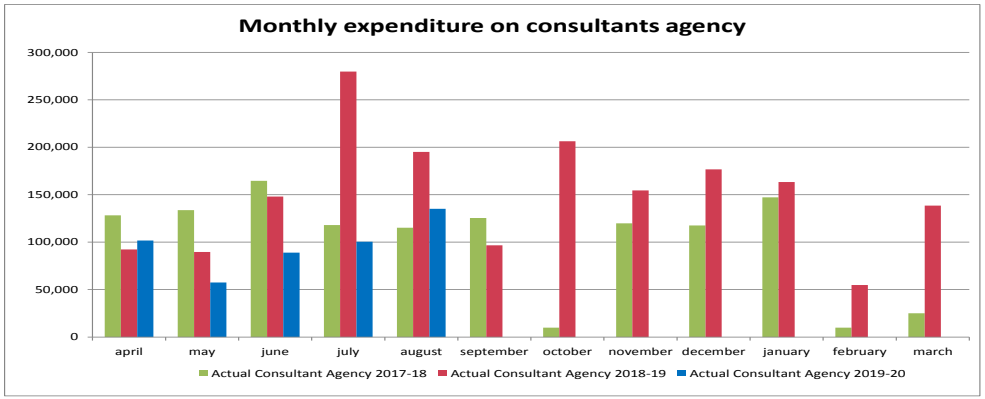
FINANCE AND WORKFORCE REPORT - AUGUST 2019

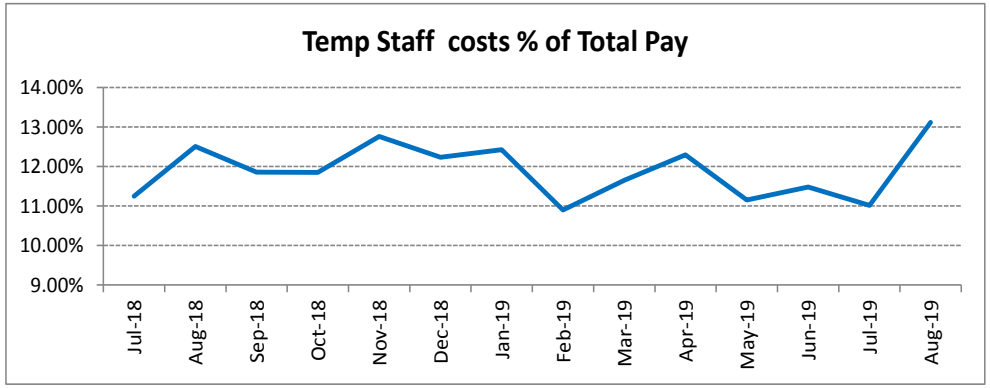
Pay Costs and Analysis

The Trust has overspent £575k on pay during August (£1,491k YTD).

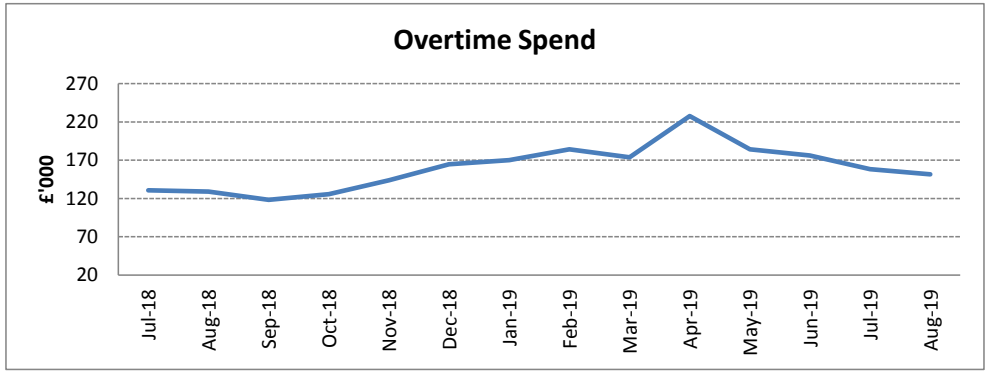








We expect overtime costs to fall significantly as a result of an initiative to replace planned overtime with bank shifts (that do not attract the overtime premium).



FINANCE AND WORKFORCE REPORT - AUGUST 2019

Summary by Division

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS (NET CONTRIBUTION) - August 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	(7,467)	(7,718)	251	(35,715)	(36,063)	347
Pay Costs	3,932	4,233	(301)	19,678	20,292	(614)
Non-pay Costs	1,415	1,430	(15)	7,675	7,712	(36)
Operating Expenditure	**5,347**	**5,663**	**(316)**	**27,353**	**28,003**	**(650)**
SURPLUS / (DEFICIT)	**2,120**	**2,054**	**(66)**	**8,362**	**8,059**	**(303)**
SURGERY						
Total Income	(4,666)	(4,650)	(17)	(26,033)	(26,004)	(30)
Pay Costs	3,048	3,195	(147)	15,263	15,461	(198)
Non-pay Costs	1,186	1,191	(5)	5,746	5,559	187
Operating Expenditure	**4,234**	**4,386**	**(152)**	**21,008**	**21,020**	**(12)**
SURPLUS / (DEFICIT)	**433**	**264**	**(169)**	**5,025**	**4,983**	**(42)**
WOMENS and CHILDRENS						
Total Income	(2,140)	(2,029)	(110)	(9,803)	(9,728)	(75)
Pay Costs	1,207	1,267	(60)	5,978	6,248	(271)
Non-pay Costs	132	157	(25)	760	680	80
Operating Expenditure	**1,339**	**1,424**	**(85)**	**6,738**	**6,928**	**(190)**
SURPLUS / (DEFICIT)	**801**	**606**	**(195)**	**3,065**	**2,799**	**(266)**
CLINICAL SUPPORT						
Total Income	(833)	(999)	166	(4,166)	(4,269)	102
Pay Costs	1,538	1,510	29	7,548	7,456	93
Non-pay Costs	975	1,228	(253)	5,082	5,464	(382)
Operating Expenditure	**2,514**	**2,738**	**(224)**	**12,631**	**12,920**	**(289)**
SURPLUS / (DEFICIT)	**(1,680)**	**(1,739)**	**(58)**	**(8,464)**	**(8,651)**	**(187)**
COMMUNITY SERVICES						
Total Income	(2,550)	(2,670)	120	(13,852)	(13,863)	11
Pay Costs	2,287	2,293	(5)	11,429	11,371	58
Non-pay Costs	904	1,395	(491)	4,881	5,401	(519)
Operating Expenditure	**3,191**	**3,687**	**(496)**	**16,310**	**16,771**	**(461)**
SURPLUS / (DEFICIT)	**(641)**	**(1,018)**	**(376)**	**(2,458)**	**(2,908)**	**(450)**
ESTATES and FACILITIES						
Total Income	(404)	(362)	(42)	(2,020)	(1,918)	(102)
Pay Costs	874	875	(1)	4,370	4,352	18
Non-pay Costs	603	701	(98)	2,923	3,116	(192)
Operating Expenditure	**1,477**	**1,576**	**(100)**	**7,293**	**7,467**	**(174)**
SURPLUS / (DEFICIT)	**(1,073)**	**(1,215)**	**(142)**	**(5,274)**	**(5,550)**	**(276)**
CORPORATE (excl Reserves)						
Total Income	(3,651)	(3,235)	(416)	(14,935)	(14,427)	(508)
Pay Costs	1,232	1,321	(89)	5,983	6,560	(577)
Non-pay Costs (net of Contingency and Reserves)	1,528	1,254	274	5,829	5,997	(168)
Finance & Capital	980	972	8	4,902	4,707	194
Operating Expenditure	**3,741**	**3,547**	**193**	**16,714**	**17,264**	**(550)**
SURPLUS / (DEFICIT)	**(89)**	**(312)**	**(223)**	**(1,779)**	**(2,837)**	**(1,058)**
TOTAL						
Total Income	(21,711)	(21,663)	(49)	(106,525)	(106,271)	(254)
Pay Costs	14,118	14,693	(575)	70,248	71,739	(1,491)
Non-pay Costs	6,743	7,356	(613)	32,897	33,928	(1,031)
Finance & Capital	980	972	8	4,902	4,707	194
Operating Expenditure	**21,842**	**23,022**	**(1,180)**	**108,047**	**110,374**	**(2,327)**
SURPLUS / (DEFICIT)	**(130)**	**(1,359)**	**(1,228)**	**(1,522)**	**(4,104)**	**(2,581)**

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).

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Medicine (Nicola Cottington)

The division reported an adverse variance of £66k in August (£303k YTD).

Pay expenditure exceeded plan by £301k in month. The change in HR systems during June allows us to more accurately monitor use of agency and locum medical staff. However, there has been a catch up which is reflected in the August position.

Underneath this skewed financial position, ED (£121k above plan in month) have managed to reduce the number of temporary medical staffing hours by 25% in August and are looking to maintain this whilst still coping with increased activity against both prior year and plan (10% and 16% respectively).

The non-pay budget is £15k overspent in month. The Angio-pacing suite continues to overspend on high cost consumables (£74k in month) reflecting the increase in demand experienced since opening in November 2018. It is hoped that this may be funded by an increase in income outside of the block contract. This overspend is partly offset in month by an underspend against Drugs (47k) across the division.

Medicine Division is forecasting an overspend of £1.1m for this financial year and a financial recovery plan has been drafted and is being worked through with reference to non-financial risks to ensure that patient safety and quality is not compromised.

Surgery (Simon Taylor)

The division reported an adverse variance of £169k in August (£42k YTD).

Income has underachieved by £17k in month (£30k YTD). Private patients overachieved in month however continues to be significantly below plan based on previous years income.

Pay reported a £147k overspend in the month (£198k YTD). There has been an increase in expenditure relating to temporary medical staffing partly related to due to increased usage of locum medics as well as the change in system mentioned under the Medicine commentary. The Division has implemented new controls to measure additional session and locum usage. Temporary nursing staff continues to overspend.

Non pay reported a £5k overspend in month and YTD £187k underspent.

Through actions within the division the forecast is for an overspend of £619k by year end. The Division has identified options that could reduce this by another £100k although there are concerns that quality of service may be compromised and therefore further discussions need to take place.

Women and Children's (Rose Smith)
The division reports an adverse variance of £195k in August (£266k YTD).

Income reported £110k behind plan in-month and is £75k behind plan YTD. In-month non-elective, maternity, outpatient and neonatal activity were behind plan.

Pay reported a £60k overspend in-month (£271k YTD). In-month, half of the overspend relates to one off back payments made to medical staff and the other half relates to filling middle grade gaps in Paediatrics. Year to date, the Division has experienced cost pressures from covering gaps on the tier two medical staffing rota in Paediatrics, RTT medical staffing spends in Gynaecology and the escalation staff working on F10. The paediatric department have successfully recruited a tier two doctor which will help to reduce the gaps requiring cover on the rota. Also, it has been agreed that the Gynaecology & Early Pregnancy Assessment Unit will relocate to F14 as a smaller ward.

Non-pay reported a £25k overspend in-month and is £80k underspent YTD. This YTD underspend reflects low non-elective activity.

Clinical Support (Rose Smith)
The division reported an adverse variance of £58k in August (£187k YTD).

Income for Clinical Support reported £166k ahead of plan in-month and is £102k behind plan YTD.

Pay is £29k underspent in-month (£93k YTD) due to vacancies in Outpatients and Health Records. These have more than offset the pay pressures experienced from the high levels of demand experienced by Radiology. The Outpatient service is holding some vacancy gaps as part of the Division's financial recovery plan.

Non-pay reported a £253k overspend in-month (£382k YTD). In month, £82k was paid to InHealth for the sunday sessions they have supplied to address Endoscopy's capacity issues, £62k was paid to NEESPS as part of the agreement around the 2019/20 contract and £52k was spent on additional consumables in Radiology. Year to date, the demand related pressures in Radiology have put constant pressure on the area's non-pay budget. Work is currently underway to identify consumable savings in Endoscopy to help mitigate some of the cost pressures experienced.

Community Services and Integrated Therapies (Michelle Glass)
The division reported an adverse variance of £376k in August (£450k YTD).

Income reported a £120k over recovery in month. The year to date income position has improved to a favourable variance of £11k.

An in-month over spend on pay of £5k was due to time limited agency cover required to cover Newmarket Hospital's Rosemary Ward as nursing vacancies are filled. In addition, the Division continued to use agency staff to cover various vacancies across Integrated Therapy Services in order to meet demand, ensure service resilience and to support patient flow..

Non-pay reported an adverse variance of £491k in July, (£519k YTD). Final invoices for 2018/19 were submitted by the provider for wheelchair services and charges exceeded the estimates previously received. Consequently, the August position reflects a one off cost relating to equipment received in quarter 4 of 2018/19. In light of this, the accrual rate for the April to August charge has also been increased, to reflect ongoing increased activity undertaken by the service to meet service demand and the system wide transformation programme. This pressure was compounded because the monthly budget for wheelchair and community equipment was set low to reflect expected seasonal variation in spend. The year to date position also reflects higher increased expenditure on Community Equipment required to support patients at home, in the community and to support timely discharge from the hospital. To support Pathway One, equipment is issued early and there has been a marked increase in the number of requests for same day delivery to support this.

Due to the ongoing demand and cost pressures faced by the Division, a Budget Recovery Plan has been prepared which aims to deliver a breakeven position for the Division in 2019/20, without adversely impacting patient care.

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.

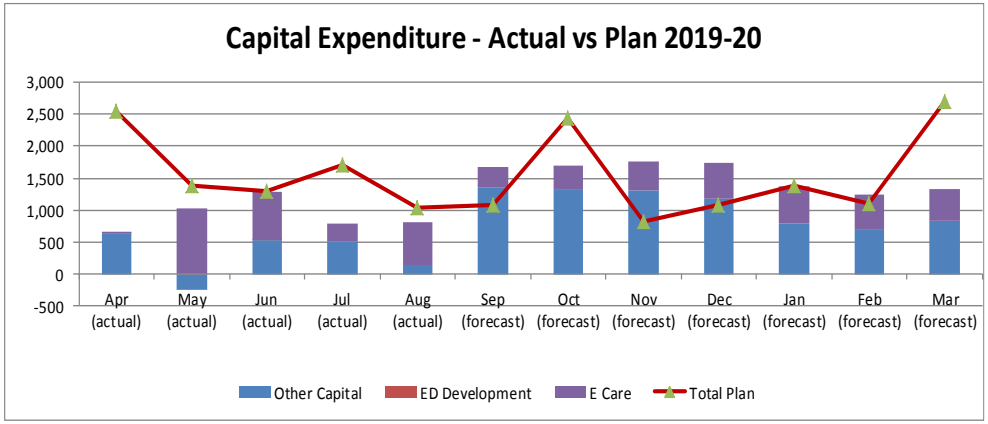
Metric	Value	Score	Plan
Capital Service Capacity rating	0.2	4	4
Liquidity rating	-37.9	4	4
I&E Margin rating	-5.8%	4	2
I&E Margin Variance rating	-4.1%	4	1
Agency	-6.0%	1	1
Use of Resources Rating after Overrides		3	3

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

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

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 Actual £'000	Aug Actual £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2019-20 £'000
E Care	34	1,019	743	290	679	324	368	458	554	579	532	487	6,066
ED Development	0	0	0	0	0	0	0	0	0	0	0	0	1
Other Schemes	636	-242	534	512	138	1,352	1,323	1,308	1,191	789	714	834	9,088
Total / Forecast	670	777	1,277	802	817	1,676	1,690	1,766	1,745	1,368	1,246	1,321	15,156
Total Plan	2,560	1,385	1,305	1,710	1,050	1,075	2,434	815	1,075	1,380	1,101	2,702	18,592

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

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

The Trust is awaiting final confirmation of a capital loan to support the capital programme. For this reason many of the estates projects are held awaiting this approval. The forecast assumes that this is received and the schemes will commence in late summer. 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 current budget approved. There are no major variances to report at this stage.

As reported previously the NHS Capital Budget is insufficient to fund all capital programmes and across our STP we have been asked to reduce our Capital programme by 20%. This has resulted in a reduction to our programme of £3.7m (to £14.9m). Although this decision has been partly reversed it still applies to those organisations that are supporting their capital programme with loan funding. Therefore the reduction still applies to WSFT.

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

FINANCE AND WORKFORCE REPORT - AUGUST 2019

Statement of Financial Position at 31st August 2019

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2019	Plan 31 March 2020	Plan YTD 31 August 2019	Actual at 31 August 2019	Variance YTD 31 August 2019
	£000	£000	£000	£000	£000
Intangible assets	33,970	35,940	34,849	34,444	(405)
Property, plant and equipment	103,223	115,395	112,228	104,091	(8,137)
Trade and other receivables	5,054	4,425	4,425	5,054	629
Other financial assets	0	0	0	0	0
Total non-current assets	**142,247**	**155,760**	**151,502**	**143,589**	**(7,913)**
Inventories	2,698	2,700	2,700	2,936	236
Trade and other receivables	22,119	20,000	20,000	18,457	(1,543)
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	3,524	1,787	(1,737)
Total current assets	**29,324**	**23,750**	**26,224**	**23,180**	**(3,044)**
Trade and other payables	(28,341)	(32,042)	(30,082)	(27,587)	2,495
Borrowing repayable within 1 year	(12,153)	(3,134)	(3,134)	(11,969)	(8,835)
Current Provisions	(47)	(20)	(20)	(47)	(27)
Other liabilities	(1,207)	(992)	(6,771)	(6,823)	(52)
Total current liabilities	**(41,748)**	**(36,188)**	**(40,007)**	**(46,426)**	**(6,419)**
Total assets less current liabilities	**129,823**	**143,322**	**137,719**	**120,343**	**(17,376)**
Borrowings	(84,956)	(99,186)	(96,318)	(83,389)	12,929
Provisions	(111)	(150)	(150)	(111)	39
Total non-current liabilities	**(85,067)**	**(99,336)**	**(96,468)**	**(83,500)**	**12,968**
Total assets employed	**44,756**	**43,986**	**41,251**	**36,843**	**(4,408)**
Financed by					
Public dividend capital	69,113	70,430	69,203	69,112	(91)
Revaluation reserve	6,931	9,832	8,021	6,451	(1,570)
Income and expenditure reserve	(31,288)	(36,276)	(35,973)	(38,720)	(2,747)
Total taxpayers' and others' equity	**44,756**	**43,986**	**41,251**	**36,843**	**(4,408)**

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.

Cash

Cash is £1.7m less than plan. The cash position is deteriorating and this is in line with the reported position. The cash position is being monitored on a daily basis to ensure that the minimum level requirement of £1m is maintained.

Trade and Other Payables

These are £2.5m less than plan and £3.3m more than in July. The improvement against the plan 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. The increase in creditors compared to last month is due to us holding back payments at the end of the month to ensure that our minimum cash balance of £1m was maintained.

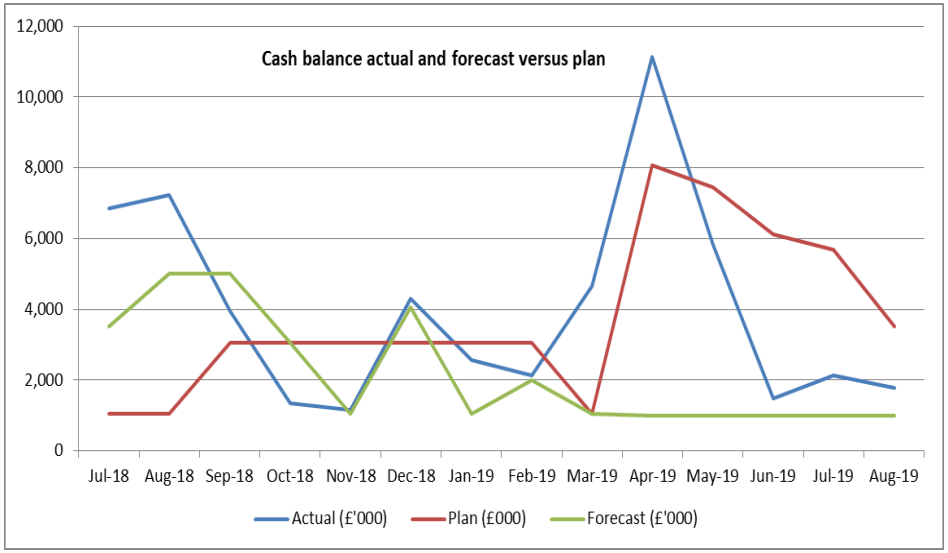
Borrowing

The Trust received a loan of £1m in August to ensure that we maintained our minimum cash level requirement. Our borrowing requirements are being kept under close review. A further loan of £1.8m has been requested for October. The Trust is required to repay £4.2m of loans by 31 March 2020.

FINANCE AND WORKFORCE REPORT - AUGUST 2019

Cash Balance Forecast for the year

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

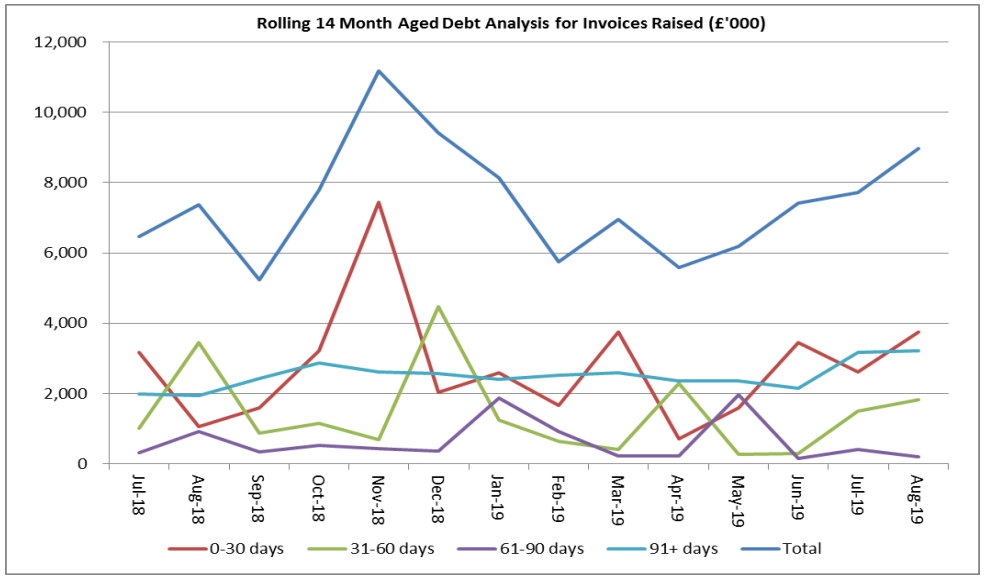


The August 2019 cash position is lower than planned and this is linked to the current financial position reported for August. The cash position is continuing to deteriorate. We have started to use up our cash reserves on capital spend, which we can recover once we receive our capital funding.

The cash position is being monitored on a daily basis to ensure that the minimum level requirement of £1m is maintained. We have applied for a revenue support loan of £1.8m for October and we anticipate the approval of our capital loan to be imminent.

Debt Management

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



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

The overall level of invoices raised but not paid has increased by £1.2m since July. Over 74% of these outstanding debts relate to NHS Organisations, with nearly 40% of these relating to old debts over 90 days. We are actively trying to agree a position with the corresponding NHS Organisation for these debtor balances.