NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday, 28 Jun 2019 9:15 AM — 12:00 PM BST
Venue	Northgate Room, Quince House, WSFT
Description	A meeting of the Board of Directors will take place on Friday, 24 May 2019 at 9.15 in the Northgate Room, 2nd Floor Quince House, West Suffolk Hospital, Bury St Edmunds
Organiser	Gemma Wixley

Agenda

AGENDA
Presented by Sheila Childerhouse

9:15 GENERAL BUSINESS
Presented by Sheila Childerhouse

1. Introductions and apologies for absence - Helen Beck,(Alex Baldwin, in attendance)
   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

   Agenda Open Board 28 June 2019 .docx

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

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5. Minutes of the previous meeting
   To APPROVE the minutes of the meeting held on 24 May 2019
   For Approval - Presented by Sheila Childerhouse

   Open Board Minutes 2019 05 24 May 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

   Item 6 - Mandatory Training and Appraisal Action Log Trust Board 28Jun 19.docx

   Item 6 - Annex Mandatory training and appraisal action log.docx

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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 June '19.doc

9:50 DELIVER FOR TODAY

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

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

   Item 8 - Master IQPR SPC May19.pdf

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9. Non-emergency patient transport report
   To APPROVE the report
   For Approval - Presented by Alex Baldwin

   Item 9 - Board report Cover sheet - M02.docx

   Item 9 - WSFT Trust Board NEPTS report 150519.doc

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

    Item 10 - Finance Report May 2019 Draft.docx

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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

    Item 11 - Board Report - Staffing Dashboard - June 2019 data.docx

    Item 11 - WSFT Dashboard - May 2019.xls

12. Medical Revalidation Annual Report
    To APPROVE the annual report
    For Approval - Presented by Nick Jenkins

    Item 12 - Responsible Officer Annual Report 18-19V2.doc

13. Seven Day services assurance report
    To APPROVE the report
    For Approval - Presented by Nick Jenkins

    Item 13 - Trust Board 7 day services report 240619.doc

    Item 13 - Appendix one_WSFT 7DS_self-assessment_assurance_framework_spring 2019.pdf

14. 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

15. Consultant appointment - None to report

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

    Item 16 combined.pdf

11:20 GOVERNANCE

17. Trust Executive Group report
To ACCEPT the report
For Report - Presented by Stephen Dunn

Item 17 - TEG report.doc

18. Charitable Funds Committee report (attached)
To ACCEPT the report
For Report - Presented by Gary Norgate

Item 18 - Charitable Funds Board Report 28th June 2019.doc

19. Audit Committee report (attached)
To ACCEPT
For Report - Presented by Angus Eaton

Item 19 - Audit Committee report May 2019.doc

20. General Condition 6 & Continuity of Services certificate (attached)
To APPROVE the recommendations
For Approval - Presented by Richard Jones

Item 20 - NHSI Certification June 19.doc

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

Item 21 - Items for next meeting.doc

11:30 ITEMS FOR INFORMATION

22. 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

23. Date of next meeting
To NOTE that the next meeting will be held on Friday, 26th July 2019 at 9:15 am in Quince House, West Suffolk Hospital
For Reference - Presented by Sheila Childerhouse

NHS
West Suffolk
NHS Foundation Trust

RESOLUTION TO MOVE TO CLOSED SESSION

24. 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

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Presented by Sheila Childerhouse

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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

Board of Directors

A meeting of the Board of Directors will take place on **Friday, 28 June 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 24 May 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
9:50 DELIVER FOR TODAY		
8.	**Integrated quality and performance report (attached)** To accept the report	Helen Beck/ Rowan Procter
9.	**Non-emergency patient transport report (attached)** To approve the report recommendations	Alex Baldwin
10.	**Finance and workforce report (attached)** To accept the report	Craig Black
10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
11.	**Nurse staffing report (attached)** To accept a report on monthly nurse staffing levels	Rowan Procter
12.	**Medical Revalidation annual report (attached)** To approve the report	Nick Jenkins
13.	**Seven day services assurance report (attached)** To approve the report	Nick Jenkins
14.	**Consultant appointment report** – none to report	

15.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Kate Read
11:10 BUILD A JOINED-UP FUTURE		
16.	**West Suffolk Alliance report (attached)** To accept the report	Kate Vaughton
11:20 GOVERNANCE		
17.	**Trust Executive Group report (attached)** To accept the report	Steve Dunn
18.	**Charitable Funds Committee report (attached)** To accept the report	Gary Norgate
19.	**Audit Committee report (attached)** To accept the report	Angus Eaton
20.	**General condition 6 and Continuity of Services certificate (attached)** To approve the recommendations	Richard Jones
21.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:30 ITEMS FOR INFORMATION		
22.	**Any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse
23.	**Date of next meeting** To note that the next meeting will be held on Friday, 26 July 2019 at 9:15 am in Quince House, West Suffolk Hospital.	Sheila Childerhouse
RESOLUTION TO MOVE TO CLOSED SESSION		
24.	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	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 24 May 2019

For Approval

Presented by Sheila Childerhouse

DRAFT

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 24 MAY 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	FT Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Kate Read	Interim Deputy Director of Workforce		
Kate Vaughton	Director of Integration and Partnerships		
Governors in attendance (observation only)			
Peter Alder, Florence Bevan, Judy Cory, Amanda Keighley, Jo Pajak, Liz Steele, Martin Wood			

Action

GENERAL BUSINESS

19/98 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

Apologies for absence were received from Richard Davies.

The Chair welcomed everyone to the meeting.

19/99 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

- Joe Pajak asked if there was any further information about the national dashboard for pathology that was being developed and whether something similar would be produced locally. Nick Jenkins explained that the 'Getting It Right First Time' programme would include the pathology arm that had just been launched. WSFT had been asked to complete a data set for this which would enable Trusts to be compared nationally. Turnaround times were also measured for performance indicators for a number of tests. At the pathology strategy board there had been a request for this data set to be reviewed as this was not fully representative.

  It had not yet been decided whether or where these would be visible to the public and he would follow this up. **N Jenkins**

- John Ellison, west Suffolk resident, asked what the latest figures were for registered and unregistered nurses (wte).

He referred to breast cancer referral times and noted that the action plan in the report stated that radiology resources would be more of a problem than surgical capacity. He asked for amplification of this position and whether it was due to staffing or resources.

He also referred to Rosemary ward and the Sudbury community health team where the position had been particularly challenging and asked how far staff were being stretched and if patients' needs were being met.

It was agreed that the above questions would be addressed by Helen Beck and Rowan Procter in their reports.

- Liz Steele, on behalf of the governors, congratulated the team on the very successful Shining Lights event. It was agreed that this was an excellent event and showed the commitment of staff and how much it meant to them to be nominated for an award.

  She referred to the item in the Chief Executive's report, 'supporting the mental health of doctors and medical students' and asked if there had been a similar study on the mental health of nurses and other frontline staff. She also asked if WSFT had looked at the reasons for sickness in both acute and community staff as separate issues, and if not if this could be looked at.

  The Chair said that providing mental health support was very important for all staff and that this was a real issue across the whole NHS. The Chief Executive explained that the Trust's health and wellbeing strategy was reviewed a couple of years ago. As a consequence it had been engaging with Suffolk Mind who had produced a programme of support for managers to help them identify issues. Access to mental health support was also being improved for staff and the public.

  The Trust was also looking at how to provide mental health support for doctors in a slightly different way to ensure that they were fully supported, as it was recdognised that they often do not access the usual resources

  An independent review of mental health and employers had been undertaken by Lord Dennis Stevenson and Paul Farmer. Lord Stevenson had visited WSFT and it appeared that the Trust matched up fairly well with this.

  It was noted that Angus Eaton was the board champion for the Trust's health and wellbeing agenda.

- Liz Steele reported that governors were being informed of issues with patient transport and asked for an update on this. Helen Beck confirmed that the board were very aware of the problem and the CGG were also very engaged in this and there was a detailed item for discussion in the closed board meeting. She would provide an update at the next public board. The Chair said that she would also update Liz Steele if there was anything appropriate. **H Beck**

19/100 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

19/101 DECLARATION OF INTERESTS

Nick Jenkins declared that he had been appointed as a NED for the Unity Schools Partnership and would be submitting an amended declaration of interests form. The board congratulated him on his appointment.

19/102 MINUTES OF THE MEETING HELD ON 26 APRIL 2019

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

Item 19/82, page 7, final sentence to read, "Craig Black explained that this would be reflected in the finance report."

19/103 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following issues raised:

Item 1667; agreed to work with ESNEFT to develop a shared briefing for governors. Richard Jones reported that good progress had been made with a point of contact who was leading on the production for these briefings and liaising with himself on this. It was hoped to issue something in between the May and August CoG meetings. Gary Norgate said that it was very important that the briefing came from both ESNEFT and WSFT as this was a partnership. He was concerned that this was taking so long and asked that the governors were kept updated in the interim; he said that openness was key and governors needed to be kept updated. **R Jones**

Item 1671: schedule a report which sets out learning from winter, including input across the system and Alliance partners. Helen Beck explained that the reason for the revised date was that the main focus was around demand management and a number of workshops were taking place, therefore the timing had been extended to allow more complex work to be undertaken.

Item 1682; provide a recovery trajectory and plan for children in care services. Helen Beck explained that this was reported against a target based on when a child came into care. One of the significant issues around this was being notified when a child came into care. Therefore it was proposed to report against both the current metric and also seeing a child within 14 days from when the Trust was made aware that a child had come into care.

Angus Eaton asked how WSFT was assured that what it should be doing was being done. Helen Beck said the Trust needed to see a child as soon as it was made aware of them; therefore it was difficult if it was not notified when a child came into care. There was a 28 day target which was broken down into 14 days for social care to inform WSFT that a child had come into care and 14 days for WSFT to see a child once they had been informed.

Rowan Procter explained that this was not just a Suffolk County Council issue as some children were placed from out of area into Suffolk. Kate Vaughton said that this was part of a bigger conversation about getting more visibility of these children in the localities.

It was proposed that this action should be shown as complete but it needed to remain a focus of the board and visibility was required. **H Beck**

Nick Jenkins reported that a family from Devon with a number of children had recently been placed in Suffolk, and two of these children had already attended the emergency department. The team already had this in hand and were alerted to this.

Gary Norgate said that the key word in this action plan was 'trajectory' and when an improvement could be expected to be seen, particularly in other areas, eg nutrition (item 1704).

Item 1704 (Appendix 2); nutrition rolling action plan. Rowan Procter explained that this was a work plan and that a trajectory would be a meaningless number until the pilot on F9 had been completed which would enable an understanding of what would be meaningful. Operationally work was being undertaken with housekeepers on what tasks they could be doing rather than nurses. Depending on the outcome this work would be rolled out with a more meaningful trajectory provided in the board papers for August.

Item 1705 (Appendix 1); progress update - appraisal and mandatory training. Kate Read explained that this was a short update on progress in response to discussions at the last board meeting. A programme of work would be developed to support compliance and the introduction of the agenda for change pay progression policy. She would be working closely with Yeovil District Hospital Foundation Trust who had managed to increase their compliance to over 90%.

Item 1707; drill down into community sickness absence performance to consider themes and improvement strategies. Rowan Procter reported that she had looked into this and the percentages were high as staffing numbers were low, which meant that this appeared to be a high percentage. There did not appear to be a particular theme; return to sickness interviews were being undertaken and there was no area of concern.

Alan Rose asked how many staff there were in the community. Rowan Procter referred him to agenda item 10 (nurse staffing report) which gave details of staffing numbers and percentage sickness rates for each team. Alan Rose asked if this was a number that would be expected in the community and if this sickness rate was normal. Rowan Procter said she would look into sickness rates in other Trusts. **R Procter**

Angus Eaton suggested that the board consider how to calibrate good and bad against the metrics it measured against. It was agreed that this would be a good idea.

The completed actions were reviewed and the following issues raised:

Item 1688; report on the outcome of the discussion with the CCG regarding delivery of the IT contract. Gary Norgate said that he was pleased to see a report on the meeting that had taken place and requested a further action on what WSFT was doing about this as he did not want the board to lose sight of community IT. Craig Black explained that there would be a quarterly update to the board on community IT and this would generate further action points.

19/104 CHIEF EXECUTIVE'S REPORT

The Chief Executive explained that this report continued to focus on how busy the organisation had been in April and the ongoing pressure on staff. There had been a 17% increase in attendances and a 7% increase in non-elective admissions. The surge ward (G9) had now closed which had taken a considerable amount of pressure off staff.

He thanked the governors, board and executive colleagues for their support in celebrating the Trust's Shining Lights and its wonderful staff. He also said a big thankyou to the Filipino community and Ali Devlin for all her work with these nurses.

This report also highlighted the marginal gains and improvements and new initiatives within the community and hospital, eg Haverhill bus service; afternoon tea in Time Out. The Chair said that it was the small things that made a difference to patients and that the visibility of the executive team was also very important to staff within the organisation.

Alan Rose referred to the increase in attendances and asked what assumption had been made in the plan for this in terms of growth. It was explained that this assumed a 4% increase compared to April 18, however there were some differences eg timing of bank holidays. The figures for May were not yet known but attendances continued to be high.

DELIVER FOR TODAY

19/105 INTEGRATED QUALITY AND PERFORMANCE REPORT

Rowan Procter reported that the outstanding duty of candours (page 65) had been completed during the past week. She referred to the significant increase in root cause analysis (RCA) actions overdue and explained that the actions that had been introduced. There was a new process and all the red cases would become serious incidents with a follow up meeting taking place three months after closure to ensure that actions were being completed. The patient safety team were also undertaking targeted work to reduce these with actions translating to learning.

Although overall sickness was 3.7%, this was higher in ward based nurses in the acute sector where it was 5.4%.

There had been a reduction in complaint response times in April due to staffing issues but this should improve. In month there had been two very complex cases that had resulted in second letters. These were being followed up with the complainants being offered face to face meetings.

Gary Norgate asked about pressure ulcers which had increased. Rowan Procter acknowledged that this was the case but explained that there had also been an increase in the number of beds and patients, which was relative. She took assurance from this increase as it meant that pressure ulcers were being identified and reported. She explained that within a few hours of admissions an ill, vulnerable patient could start to develop a pressure ulcer; staff therefore ensured that patients were encouraged to change position wherever possible and had access to adequate hydration and nutrition.

Gary Norgate asked if it was expected that an improvement would be seen, or if the board should be concerned about the increase which appeared to be a trend. Craig Black explained that this was common cause variation and was therefore currently not a concern. Gary Norgate acknowledged this but noted that this was showing an upward line. Nick Jenkins reiterated that this was a common cause variation and was not yet a reason for concern. The Chair agreed but explained that the NEDs did not yet have total confidence in this new way of reporting and whether it would ensure that they did not lose sight of upward trends.

Rowan Procter stressed that no pressure ulcer was considered to be acceptable, whether avoidable or unavoidable. She assured the board that staff were very focussed on this and not complacent. Different ways of working were being piloted to try to improve performance and prevent pressure ulcers.

Louisa Pepper agreed that this was an area of concern but referred to the training the board and governors had received on the new data and that an upward line did not become a trend until six points or more.

It was confirmed that this was the case and the board needed to gain confidence in this way of reporting.

Gary Norgate asked Rowan Procter to update the board on the Trust's caesarean section performance. Rowan Procter explained that this was reviewed at the monthly governance meeting and no areas of concern had been identified. Nick Jenkins said that this variation was probably because there was a relatively small number of births, therefore each case made a significant difference to the percentage. Craig Black noted that this was showing an upward trend over eight data points. Nick Jenkins explained that during the last year the Trust had been reliant on doctors acting down; however as there were now more trainees there was less senior decision making, particularly at night, therefore more caesarean sections were being undertaken.

Angus Eaton proposed that the 'when' section of the narrative should say when a decision should be made that something needed to be done differently. Nick Jenkins explained that there was nothing that could be done about this trend and it may continue to increase. It was possible that an increase would be seen in August and then a gradual decrease throughout the year.

It was agreed that narrative for 'when' should be completed wherever possible.

The Chief Executive said that it was a point of principal as to whether the board trusted the SPC charge or not. He queried whether further training was required. The Chair said that it was a matter of having confidence in this way of reporting and trusting the new statistics.

Nick Jenkins referred to NICE baseline assessments and explained that the Trust received these every time NICE made an announcement. The team had been working very hard over a number of months and had now managed to reduce the number outstanding, as indicated on the SPC chart (page 70). He explained that this was an important part of governance and it was pleasing to see an improvement. It was proposed that the title for this chart should be changed to indicate that it was reporting non-compliance. **R Jones**

Helen Beck explained that this was the last month that the board would see this way of reporting emergency department performance as WSFT was taking part in the pilot for the proposed new way of reporting. A briefing would be provided to the board next month on what was being reported and why. However there were some restrictions on what could be reported in public during this period. There would some benchmarking data on previous performance but the board would need to consider how to publish this.

There was an ongoing issue in diagnostics which was due to cardiology. Additional cardiology technicians and locums had now been recruited but it would take until July to clear the backlog. There was a detailed action plan to address this which the team was working on.

An improvement had been seen in the two week breast cancer wait performance. There was a requirement for additional radiology capacity in this area due to a surge in referrals and a multi-disciplinary team was required to manage this which was more of a challenge. The position had improved significantly but there was a concerning trend as a significant number of patients were choosing not to accept their appointments within two weeks for personal reasons. Therefore the Trust was working with the lead GP about the information given to patients when they were referred and why they needed to attend appointments.

There had been a significant variation in performance in the cancer 62 day wait due to a number of factors and the Trust may need to find a different way of reporting this.

She stressed that every breach was very important to WSFT and work was being

undertaken to improve this, particularly in high risk areas, eg colorectal, lung, prostate.

Angus Eaton congratulated Helen Beck on the performance for 52 week waits compared to a year ago.

Louisa Pepper asked about referral to treatment (RTT) figures and for assurance about outsourcing certain specialities and how this would affect the budget. Helen Beck explained that this was being looked at with the CCG; they were also very aware of patient choice and distance to travel.

19/106 FINANCE AND WORKFORCE REPORT

Craig Black reported that the Trust was currently £49k over budget for the month as a result of the additional pressure on the organisation referred to previously. £110k more on pay had been spent than planned due to the extra capacity that had been open during April. Additional work had also been undertaken to address the RTT position. The CCG were reviewing their plans and it was possible that additional funding would be available in the local system and one of the priorities was to address the RTT position.

The cash position was good at the end of April with the highest balance for a couple of years. The Trust had agreed the front loading of contract payments with the CCG which was more significant in April this year than previously. However, this balance would decline during the year in line with the plan.

Alan Rose referred to page 142; 'After using temporary nursing staff there remained 30 wte registered nursing uncovered vacancies on wards during April 2019 (excluding escalation areas)'. He asked if this was because the Trust could not find temporary staff or the decision had been made that this was an acceptable level of vacancies. It was confirmed that it was not possible to find temporary staff for these shifts and that this was not due to the price capping for temporary staff. Craig Black explained that this was a national issue which was why the Trust was focussing on recruiting substantive staff..

Kate Read reported that as of yesterday there were 40,000 nursing vacancies nationally.

Alan Rose suggested that the percentage of pay spent on temporary staff should be reported in SPC format; he had discussed this with Jo Rayner. Craig Black confirmed that this would be included in future reports.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

19/107 NURSE STAFFING REPORT

Rowan Procter reported that overall vacancies for registered nurses had reduced to 11 registered nurse vacancies in the community and one vacancy for a nursing assistant. There were 66 vacancies for registered nurses in the hospital and 16 vacancies for nursing assistants.

Work had been undertaken with the ward managers over the last week to try to understand what the next few months would look like and what was required to prepare for the winter. If there were no leavers, it looked like by September there would be only 17 registered nurse vacancies across the whole organisation which would be a very strong position moving forward. However the new starters in September would be newly qualified and would require support.

The Chair asked if these figures took into account community nurses and prospective leavers. Rowan Procter confirmed that these figures were for the whole of WSFT.

Amanda Keighley said that it was very good that a number of Filipino nurses had now joined the Trust. She explained that although this had not impacted directly on the community it had allowed staff working within the acute setting to move into the community which was very positive.

Gary Norgate said that it was very reassuring to see the increase in numbers; he asked how these numbers would be managed more effectively across the organisation and how Healthroster was progressing. Rowan Procter explained that Healthroster was being tightened up with senior matrons having an overview. She stressed that even though the vacancy rate had improved there was still pressure on qualified nurses to support the newly qualified nurses. As a result there had not been any nursing associate training within the organisation as it was not possible to provide the support required. She confirmed that Healthroster was embedded in the process but it was not yet being used to its full capability, therefore people were being trained so that it could be used more widely and to its full capability.

19/108 ANNUAL REVIEW OF NURSING STRATEGY

Rowan Procter explained that as well as focussing on leadership the organisation was also looking at succession planning with individuals receiving a variety of training. In the future it would also be implementing the next band five leadership course to develop them to band six.

We have received several requests from other organisations to share details of our nursing leadership programme.

19/109 QUALITY AND LEARNING REPORT

Rowan Procter assured the board that learning was taken very seriously, eg from root cause analysis and learning from deaths. This was not about blame but about getting it right and feeding back on both what went wrong and what went right.

Nick Jenkins referred to the learning from deaths dashboard and noted that this should say 18/19, not 19/20. This showed that the majority of care was excellent (75%). However there were 58 cases where care was classified as poor or very poor. Each of these cases were reviewed by Nick Jenkins, Paul Molyneux, Paul Morris and one of the heads of nursing to consider the care that had been provided and record this in the thematic review, eg Escalation Plan and Resuscitation Status (EPARS) completion; failure or delay in recognising that a patient was end of life. Individual cases were fed back to the team, or if they were complex or due to an incident that had occurred this would be followed up.

The learning from deaths group, chaired by Richard Davies, was the governance forum for overseeing this information.

Alan Rose said that he considered this to be the most important report of all the board papers and that the Trust should be very proud of this and that it was discussed in public. He complimented the teams on this report and the information provided and said that it gave the NEDs assurance that the Trust was doing the right thing.

Nick Jenkins said that public representative on the learning from deaths groups was a great asset and was very supportive of the group.

Kate Vaughton considered this to be a very good approach and said that the CCG was

looking at taking this out into the wider west Suffolk system.

19/110 CONSULTANT APPOINTMENT REPORT

The board noted the appointment of Dr Tyara Banarjee, consulted in gastroenterology. It was noted that this appointment had been reported verbally at the last board meeting and recorded in the minutes; this was not an additional appointment.

19/111 PUTTING YOU FIRST AWARD

Kate Read reported that the following individuals had been nominated for Putting You First awards this month:-

Amanda Finch, Vanessa Hynard, Eleanor-Grace Preston-Bloom, Kinga Rosolowska and Oliver Scott, pharmacy:
The department had been replacing the pharmacy robot, which has caused significant logistical challenges in having to relocate 20,000 medicines from the robot to a systematic shelving system. These five individuals had worked into the evening and sometimes night, across a Friday and a Saturday to ensure the dispensing system was safe and clinical colleagues had everything they needed. Their efforts meant any risk to patient safety was minimised as much as was feasibly possible, and they all went above the requirement of their roles.

Will Ferreria, new assistant service manager in medicine, gastroenterology:
Will is already great support to the gastro team, and was a rising star in the medical operational team. He had designed dashboards and created new ways of working digitally, and facilitated improved ways of working that created real efficiencies and improved the working lives of colleagues. The combination of his clinical knowledge and diplomatic leadership style was really making a difference to patient care and staff motivation.

Michelle Rowley**,** ward manager**,** acute assessment unit:
Michelle was nominated by one of her staff who had applied for a job as an outreach nurse, which was his dream job since starting his nursing career. Although his leaving would add to the ward's staffing challenges she had been fully supportive and helped with his preparation, going above and beyond what he would have expected and shown amazing managerial skills.

The board considered this to be a great example of staff across the Trust going the extra mile, and the contribution they had made to patients and the organisation.

BUILD A JOINED UP FUTURE

19/112 WEST ALLIANCE UPDATE

Kate Vaughton highlighted the governance review which had been to the West Suffolk System Executive Group (SEG). It had been agreed as a system to look at facilitating a joint conversation about performance and finance and streamlining some of the governance arrangements.

The primary care network proposal was submitted on 15 May. There was great enthusiasm for this and she was not envisaging any issues with final sign off. There were six primary care networks in west Suffolk with a good synergy with the localities. New individuals were coming forward for the clinical director roles and they were engaging well with the localities. It was very important to develop GP/primary care links with the locality teams so that they worked together.

Alan Rose said that it would be very interesting to see how the locality reports developed as they provided very helpful information. **K Vaughton**

19/113 ANNUAL REVIEW OF IM&T STRATEGY

Craig Black explained that the board had signed off the IM&T strategy in May last year and this was an annual review of the objectives detailed in the strategy. He noted that since this strategy was produced further additions had been made, ie introduction of Mmodal and Medic Bleep and more extensive work on Wi-Fi within the main building.

Issues with IT in the community were reflected in objectives set for this year not being achieved and actions were in place to move this forward.

Gary Norgate considered this to be a very good strategy and credited the team for this; he asked about Medic Bleep and how this was progressing. Nick Jenkins reported that yesterday the project team had signed off a bleep removal date for late June/early July. Communications about this would be put out across the organisation next week and there was a detailed work plan to ensure that remaining staff were signed up to this. It was noted that some areas of the organisation were already using Medic Bleep.

GOVERNANCE

19/114 TRUST EXECUTIVE GROUP REPORT

The board received and noted the content of this report.

19/115 REMUNERATION COMMITTEE REPORT

The board received and noted the content of this report.

19/116 COUNCIL OF GOVERNORS REPORT

The board received and noted the content of this report and approved the Engagement Strategy for April 2019 to March 2021.

The Chair thanked the members for the Engagement Committee for their input to this strategy.

19/117 AGENDA ITEMS FOR NEXT MEETING

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

ITEMS FOR INFORMATION

19/118 ANY OTHER BUSINESS

There was no further business.

19/119 DATE OF NEXT MEETING

The next meeting would take place on Friday 28 June at 9.15am in the Northgate Room, Quince House, West Suffolk NHS Foundation Trust.

RESOLUTION TO MOVE TO CLOSED SESSION

19/120 RESOLUTION

The Trust board agreed to adopt the following resolution:-
“That members of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest” Section 1(2) Public Bodies (Admission to Meetings) Act 1960.

6. Matters arising action sheet

To ACCEPT updates on actions not covered elsewhere on the agenda

For Report

Presented by Sheila Childerhouse

Board of Directors – 28 June 2019

Agenda item:	6			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	21 June 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
1667	Open	25/1/19	Item 6	Agreed to work with ESNEFT to develop a shared briefing for governors at both ESNEFT and WSFT	Andy Higby at ESNEFT has been identified as the responsible manager for preparing joint governors briefings. These will be signed off by the executive leads and be scheduled for issue between WSFT Council of Governor meetings. **Programme agreed with ESNEFT to issue updates at end of June, September and December. Confirmed with ESNEFT lead as on schedule for issue at end of June.**	SC / RJ	29/03/19	Red
1671	Open	25/1/19	Item 8	Schedule a report which sets out learning from winter, including input across the system and Alliance partners	Preliminary assessment of Trust learning as part of the closed. This will be expanded to provide a system-view and planning for 2019-20 which will conclude after the end of May. The outcome of this joint working will be reported to the Board by July and verbal updates provided.	HB	26/7/19 (revised)	Green
1704	Open	26/4/19	Item 8	Provide a trajectory for improvement of nutrition compliance as a result of the work with e-Care	Action plan provided as appendix to board actions - Agenda item 6 - Appendix 2. Improvement trajectory to be received by Board following pilot on F9 (available August).	RP	27/9/19 (revised)	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1707	Open	26/4/19	Item 12	Drill down into community sickness absence performance to consider themes and improvement strategies	At May meeting further clarity sought as to whether expect the community rate to be higher than acute and how our community performance benchmarks with other organisations. The benchmarking shows that community sickness elsewhere is similar to the acute and we are therefore flagging as having high rates. As part of the workforce plan a workstream will be established to tackle high sickness levels. The Board will maintain visibility of progress through the finance and workforce report and a specific update reporting will be scheduled for the Board meeting on 1 November.	RP	28/06/19	Green
1712	Open	24/5/19	Item 2	1. Send the draft pathology strategy to Governors after it has been shared with staff. 2. Consider how to make public the performance against the new getting it right first time (GIRFT) pathology dashboard.	1. The strategy has been updated and is due to be shared by the end of June. 2. The Trust has not yet been allocated a GIRFT review date. In due course, and in line with other specialties that have had a GIRFT review, a resulting action plan will be monitored through the agreed GIRFT reporting line.	NJ	26/07/19	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1682	Open	1/3/19	Item 8	Provide a recover trajectory and plan for children in care services	Additional funding has been allocated to services - awaiting confirmation of start dates for staff to meet the level of service demand. Agreed at meeting on 26/4/19 to keep this action open until the actions have impacted on performance. Update received at May meeting on ICPS review which includes children in care. **As agreed at May meeting performance against 14 day performance indicator (from when child known to service) is included in the IQPR. Visibility on progress with social services will be maintained through the Alliance report AGENDA ITEM**	HB / KV	26/7/19 (revised)	Complete
1705	Open	26/4/19	Item 10	Provide an update on the trajectory to improve mandatory training and appraisal compliance. And specifically the low reported compliance with IG mandatory training.	Update provided as appendix to board actions and progress will be monitored through the quarterly mandatory training report from July.	KR	28/06/19	Complete
1713	Open	24/5/19	Item 2	Provide a briefing on non-emergency patient transport issues	**AGENDA ITEM**	HB	28/06/19	Complete
1714	Open	24/5/19	Item 8	Change the title for the chart on NICE and national audit compliance in the IQPR to reflect that reporting non-compliance	**Amended in IQPR**	RJ	28/06/19	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1715	Open	24/5/19	Item 15	Provide more detail on local primary care network arrangements	**Included in Alliance report**	KV	28/06/19	Complete

Board of Directors – 28 June 2019

Agenda item:	Actions			
Presented by:	Kate Read, Deputy Director of Workforce (Interim)			
Prepared by:	Rebecca Rutterford, Workforce Development Manager			
Date prepared:	24th June 2019			
Subject:	Mandatory Training			
Purpose:	☑	For information	☑	For approval

Executive summary:
The following recovery plan sets out a clear set of actions to deliver a real and sustained improvement to compliance figures in relation to mandatory training and appraisal.

Whilst the expectation is that all staff are up to date in all domains of mandatory training and appraisal, the Trust target is set at 90% compliance across all areas in order to take in to account staff who fall in to the reporting period, but who are unable to undertake their training due to sick or parental leave.

The quarterly compliance report will be prepared for the July 2019 Board.

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

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

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

Recommendation:
Acceptance of the recovery plan to improve compliance

Mandatory Training Recovery Plan June 2019

Item No.	Requirement	Action	Summary Plan	Completion date	Responsibility	Predicted % improvement
1	Review Mandatory Training Subjects/Content	Address increase in mandatory training. (Trust has seen 30% increase in courses provided during previous 12 months)	Revise Terms of Reference of Mandatory Training Steering Group. Executive Director to chair full review of all mandatory training courses to ensure appropriateness, renewal period, relevance to staff group(s) Any changes to be managed in a safe auditable way, placing patient and employee safety as the top priority	30/09/19	Mandatory Training Steering Committee	4% (Dependant on outcome of review)
2	Improve accuracy of records	Update staff records to reflect requirements	Education & Training Team to input amendments made following the full mandatory training review (see item above)	31/12/19	Mandatory Training Team	Sustainability
3	Improve access to e-learning modules	Implement necessary changes to server	Firewall set up completed Mandatory training team to ensure e-learning packages are updated on Articulate Resolution of security issues on web servers required	19/07/19	Rob Smith Rob Howorth	2% (Dependant on take up of training)
4	Support streamlining for junior doctors	Continue to engage with streamlining projects Provide opportunities for mitigation where streamlining is not currently in place	Revision of induction timetable to include West-Suffolk specific mandatory training courses Work with Trusts across region to achieve best possible data transfer through Electronic Staff Record (ESR) system Utilisation of study leave for completion of any outstanding mandatory training modules within first 6-8 weeks	05/08/19	Lorna Lambert Helen Kroon Rota co-ordinators	0.5% (Dependant on take up of training)

Item No.	Requirement	Action	Summary Plan	Completion date	Responsibility	Predicted % improvement
5	Managers to have direct access to staff performance information including mandatory training	To implement ESR Supervisor Self Service	Implementation plan agreed with full roll out by March 2020	31/03/20	Workforce Team HR	Sustainability

Appraisal Recovery Plan June 2019

Item	Requirement	Action	Plan	Completion date	Responsibility	Predicted % improvement
1	Monitoring information	Improve management information	Revise appraisal report in order to support managers in easily identifying staff who require an appraisal	31/07/19	Workforce Team	3%*
			Implementation of ESR manager self service	31/12/19	Workforce Team	Sustainability
2	Overall compliance	Ensure all staff who are at work receive an appraisal on an annual basis	Implementation of agenda for change pay progression policy which will require all staff to have an up to date appraisal recorded on ESR	31/03/20	Workforce Team HR	4%*
			Support managers with on-going delivery of training	Ongoing	HR	Sustainability
			Dashboard on appraisal compliance to be produced for green sheet, raising the profile of appraisals and positive reinforcement for good practice	31/07/19	Workforce Team Communications Team	Sustainability

*Based on evidence provided by Trusts who have implemented Pay Progression Policy

Board of Directors – 28 June 2019

Agenda item:	Item 6 - Annex			
Presented by:	Kate Read, Deputy Director of Workforce (Interim)			
Prepared by:	Rebecca Rutterford, Workforce Development Manager			
Date prepared:	24 June 2019			
Subject:	Mandatory Training			
Purpose:	☑	For information	☑	For approval

Executive summary:
The following recovery plan sets out a clear set of actions to deliver a real and sustained improvement to compliance figures in relation to mandatory training and appraisal.

Whilst the expectation is that all staff are up to date in all domains of mandatory training and appraisal, the Trust target is set at 90% compliance across all areas in order to take in to account staff who fall in to the reporting period, but who are unable to undertake their training due to sick or parental leave.

The quarterly compliance report will be prepared for the July 2019 Board.

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

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

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

Recommendation:
Acceptance of the recovery plan to improve compliance

Mandatory Training Recovery Plan June 2019

Item No.	Requirement	Action	Summary Plan	Completion date	Responsibility	Predicted % improvement
1	Review Mandatory Training Subjects/Content	Address increase in mandatory training. (Trust has seen 30% increase in courses provided during previous 12 months)	Revise Terms of Reference of Mandatory Training Steering Group. Executive Director to chair full review of all mandatory training courses to ensure appropriateness, renewal period, relevance to staff group(s) Any changes to be managed in a safe auditable way, placing patient and employee safety as the top priority	30/09/19	Mandatory Training Steering Committee	4% (Dependant on outcome of review)
2	Improve accuracy of records	Update staff records to reflect requirements	Education & Training Team to input amendments made following the full mandatory training review (see item above)	31/12/19	Mandatory Training Team	Sustainability
3	Improve access to e-learning modules	Implement necessary changes to server	Firewall set up completed Mandatory training team to ensure e-learning packages are updated on Articulate Resolution of security issues on web servers required	19/07/19	Rob Smith Rob Howorth	2% (Dependant on take up of training)
4	Support streamlining for junior doctors	Continue to engage with streamlining projects Provide opportunities for mitigation where streamlining is not currently in place	Revision of induction timetable to include West-Suffolk specific mandatory training courses Work with Trusts across region to achieve best possible data transfer through Electronic Staff Record (ESR) system Utilisation of study leave for completion of any outstanding mandatory training modules within first 6-8 weeks	05/08/19	Lorna Lambert Helen Kroon Rota co-ordinators	0.5% (Dependant on take up of training)

Item No.	Requirement	Action	Summary Plan	Completion date	Responsibility	Predicted % improvement
5	Managers to have direct access to staff performance information including mandatory training	To implement ESR Supervisor Self Service	Implementation plan agreed with full roll out by March 2020	31/03/20	Workforce Team HR	Sustainability

Appraisal Recovery Plan June 2019

Item	Requirement	Action	Plan	Completion date	Responsibility	Predicted % improvement
1	Monitoring information	Improve management information	Revise appraisal report in order to support managers in easily identifying staff who require an appraisal	31/07/19	Workforce Team	3%*
			Implementation of ESR manager self service	31/12/19	Workforce Team	Sustainability
2	Overall compliance	Ensure all staff who are at work receive an appraisal on an annual basis	Implementation of agenda for change pay progression policy which will require all staff to have an up to date appraisal recorded on ESR	31/03/20	Workforce Team HR	4%*
			Support managers with on-going delivery of training	Ongoing	HR	Sustainability
			Dashboard on appraisal compliance to be produced for green sheet, raising the profile of appraisals and positive reinforcement for good practice	31/07/19	Workforce Team Communications Team	Sustainability

*Based on evidence provided by Trusts who have implemented Pay Progression Policy

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 – 28 June 2019

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

I've often said that the West Suffolk NHS Foundation Trust (WSFT) never rests on its laurels, and that's certainly been the case this month! Colleagues have been working hard to keep our patients cared for and things running smoothly across the hospital and in the community, but we've also been pushing on with some great new developments. At the time of writing two exciting projects are nearing fruition, that I hope will have completed by the time we reach June's physical Board meeting!

The first is the official opening and naming ceremony of the three **new accommodation blocks** at the back of the West Suffolk Hospital site. The scheme has replaces the previous 40-year-old hospital residences with three modern, five-story buildings, providing 160 en-suite bedrooms complete with communal kitchen and living areas. We are so proud to have built these stunning accommodation blocks as part of our estates investment plan. I'd like to formally thank colleagues, the architects and contractors for their hard work and collaboration on this exciting development; it looks fantastic, and is another example of how we're making our Trust a great place to work.

The second is the go-live of **Medic Bleep**, the new communication tool we'll be using to replace non-emergency bleeps. I hope to write more about this next month, but the journey here has been a long one with huge amounts of effort from both the WSFT Medic Bleep project team, and Medic Creations as the team behind the app, to get us to this point. This is another huge step on our digital agenda and, most importantly, it will give our staff more time back to do what they do best – care for patients. Because after all, our patients are what it's all about!

We continue to develop our **West Suffolk Alliance** to help make care more joined up for our community, and we are pleased to have launched a new repatriation' service in partnership with Addenbrooke's Hospital in Cambridge and the West Suffolk Clinical Commissioning Group. In simple terms, the stroke department at the West Suffolk Hospital is helping the local community to receive treatment for a stroke closer to home; if a patient has a stroke and is taken to Addenbrooke's Hospital via ambulance, but lives locally to the West Suffolk, they can now be transferred after their initial treatment to WSFT to ensure they are closer to family and friends. Prompt repatriation of patients to our stroke unit is a real plus, as patients can receive ongoing specialist management and rehabilitation nearer to their homes, making it easier for local relatives and carers to visit, which is crucial to a patient's wellbeing and recovery. Another example of great alliance working. I am delighted that **Dr Ed Garratt** has been appointed to the position of Accountable Officer for the clinical commissioning groups (CCGs) in Ipswich and east Suffolk, north east Essex and west Suffolk, as well as Executive Lead for the Suffolk and North East Essex Integrated Care System (ICS). I have absolutely no doubt that this appointment will maintain and strengthen the focus on partnership working and innovation in the west of Suffolk and the wider health and care system.

It is a time of year when we recognise and say thank you to **staff, volunteers and supporters**:

- At the end of May we held our annual **Shining Lights** staff and volunteer awards in Time Out, celebrating amazing achievements from the past year. More than 200 nominations were received for Shining Lights, from both acute and community teams. There were 16 award categories this year, including the new equality, diversity and inclusion award. I am so proud that even when our staff are under the pressure they are, we continue to see outstanding innovation that exemplifies our values by putting patients first. These awards, and the free hot drinks we have offered to all our staff in recent weeks, go some way to expressing our thanks for all they do.

- I had the absolute privilege to be a part of our **annual volunteer thank you event** a few weeks ago, where we take the time to rightly celebrate the generosity of our wonderful NHS volunteers. I presented a staggering 45 volunteer awards, to volunteers who had clocked up

415 years of service between them! One volunteer, Christine Hinchley, from Bury St Edmunds, was thanked for giving an incredible 30 years of service to West Suffolk Hospital as a volunteer in the Friends Shop. Our volunteers are the icing on the cake at our hospital, and truly make such a difference to improve the experience of our patients and staff. The impact our volunteers have on patient care cannot be underestimated; they collectively gave nearly 50,000 hours of time to our Trust last year – what a heroic achievement! Thank you to you all.

- The **Friends of West Suffolk Hospital charity** has donated £20,000 to purchase four new digital reminiscence screens to support patients with dementia – meaning there are now six across our Trust. These systems, called RITA (reminiscence interactive therapy activities), allow patients to look through archived photographs, video clips, relaxing music, and even play interactive games and quizzes while in hospital. This, like all the amazing work that the Friends do, makes such a difference for our patients, carers and staff.

We've also held our summer **leadership summit**, which brought leaders from across the Trust together to look at how we can improve quality through compassionate, inclusive leadership, and how we can ensure we have an inclusive culture to improve everyone's experience at work. Around 70 leaders came along, and the variety of topics we covered across the day was fantastic; from quality improvement methodology and group work on how we can ensure feel able to speak up when something isn't quite right, to an interactive, live theatre forum that saw actors show us good (and bad!) leadership and communication skills in a real-life setting. We also reflected on what outstanding meant to us as leaders, before hearing about what it means to the people we serve – our patients, and finally to our staff. It was a thought-provoking day, and I hope everyone took as much away from it as I did.

During may we have continued to experience **high levels of emergency attendances** and admit high numbers of very unwell patients, putting significant pressure on the hospital and staff with regular days with in excess of 250 patients attending the emergency department. Reflections and learning from winter and further review is being undertaken with our system colleagues. The key findings of this work and planning for the future will be reported to the next board meeting.

Overall in terms of **May's quality and performance** there were 77 falls and 54 Trust acquired pressure ulcers with two cases of C. difficile. We failed to deliver on the cancer targets for three areas: 2 week wait breast symptoms (90.2%), Cancer 62 day GP referral (75.9%) and incomplete 104 days wait with 4 breaches reported in May 2019. Referral to treatment performance for May was 85.8%, with four patients waiting longer than 52 weeks for treatment. The Trust is part of a pilot scheme trialling a number of new metrics for ED performance. These new metrics have replaced the longstanding 4-hour waits performance metric, so this has therefore been removed from this month's report moving forwards. When the new metrics have been agreed nationally they will be included for monitoring. The **month two financial position** reports a deficit of £1m which is £498k worse than plan. We agreed a control total to breakeven which means we need to deliver a cost improvement programme of £8.9m.

We have recently received the **CQC provider information request** and can therefore expect a planned CQC inspection within the next six-months. We continue to focus on quality improvement as part of CQC preparation which emphasises this should be part of our day-to-day activities to ensure we deliver the best possible care to our patients.

I was really proud to be part of the launch of the **identification card for young adult carers** across Suffolk. Working alongside our Trust, Suffolk Family Carers has pioneered the card to be used in healthcare settings but can also be used anywhere else useful for the young adult carer. The card will enable young people aged 16 to 24 in a caring role to be recognised as a young adult carer, to increase the confidence of the young adult carer to manage their caring role, and allow healthcare professionals to share appropriate information with the young adult carer (with patient

consent), and involve them as much as possible in appropriate discussions around those they care for.

The **interim NHS People Plan**, developed collaboratively with national leaders and partners, sets a vision for how people working in the NHS will be supported to deliver care and identifies the actions that NHS England will take to help them. Although the content and detailed planning is still in progress this will provide a valuable basis for local delivery.

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

Deliver for today

Continuity of carer: ensuring safe care based on mutual trust and respect
On 1 April our midwives introduced two new teams for women having a home birth or an elective caesarean, in line with the National Maternity Review's Better Births. These new teams provide continuity of carer for approximately 20 per cent of all pregnant women in our care. Since a monthly home birth group was introduced, where women and their partners meet midwives and find out more about having their babies at home, there has been a steady increase in requests for home births. And Jane Boulton and Linda Sore - midwives on our caesarean team - are continuing to look at ways of improving patient care and communication, and receive extremely positive feedback from both the women in their care and the wider multi-disciplinary team.

Biomedical Science Day - 20 June
Thanks to everyone who visited the Biomedical Science Day stand at the front of the hospital this week, from all the biomedical science staff based at the West Suffolk Hospital! Biomedical Science Day is a national event organised by the Institute of Biomedical Science (IBMS), the professional body for biomedical scientists and laboratory support staff. The awareness day aims to inform the public and empower patients by telling them about the practices in biomedical science, to strengthen interdisciplinary team work and communication in hospitals, and celebrate a profession that is at the heart of healthcare.

Invest in quality, staff and clinical leadership

Palliative care summer conference
More than 60 delegates heard lectures and visited marketplace stalls, and many more ward staff dropped by during their breaks to chat to exhibitors.

Congratulations! Silver level accreditation for our Trust work experience quality standard
Our Trust work experience, health ambassador and apprenticeship programmes have been awarded a sliver accreditation after a rigorous self-assessment process.

New Nursing and Midwifery Council (NMC) standards
Goodbye mentors, hello supervisors and assessors! From September 2019 new standards for student supervision and assessment (SSSA) will apply to all nurses and midwives on any NMC approved programme.

Staff supporters - senior independent director
As part of our staff supporters campaign we have highlighted the role of senior independent director contributes to patient safety and staff wellbeing by acting as the non-executive director lead for whistleblowing, and links with the Trust's 'freedom to speak up' and 'safe working guardians'.

Build a joined-up future

Running towards a healthier life
Haverhill community team lead Karen Line is spreading the word among our local GP practices about the benefits of park runs, an increasingly popular initiative that allows people to get more active in their local green spaces.

Could you save a life? Give blood
On Friday, 14 June, World Blood Donor Day, Helen Cockerill, paediatric research nurse, tweeted an amazing, personal video about how important blood donors can be to a family. **Click here** to see the video Helen and her son, Sebastian, made, to encourage more people to give blood.

National news

Deliver for today

The health effects of Sure Start
This report considers the overall impacts on health of the Sure Start programme as a whole between its inception in 1999 and its peak in the late 2000s. The report focuses on health outcomes as while Sure Start's services were multifaceted and varied between centres and over time, one of its main objectives was to improve children's health.

Physical activity: encouraging activity in the community
This quality standard covers how local strategy, policy and planning, and improvements to the built or natural physical environment such as public open spaces, workplaces and schools can encourage and support people of all ages and all abilities to be physically active.

RESPECT women: preventing violence against women
Violence against women is a major public health problem rooted in gender inequality and is a gross violation of women's human rights, affecting the lives and health of millions of women and girls. This framework outlines steps for a public health and human rights approach to scaling up programmes to prevent violence against women. It builds on the evidence compiled in the 2015 UN prevention of violence against women framework and from additional systematic reviews.

A new trend in elective hip surgery?
This Kings Fund blog explores the reasons for the decline in the number of elective hip surgeries, particularly in the over-65 age group, in the last couple of years. It suggests there are several reasons for the decline, which include investigation of alternative treatments via physiotherapy, tighter controls on eligibility criteria and funding from CCGs and that involving patients in decisions about their care may lead fewer to opt for surgery.

Invest in quality, staff and clinical leadership

What people have told us about health and social care – January to March 2019
The latest Healthwatch Report detailing what the public have to say about health and social care in England.

Achieving a digital NHS: lessons for national policy from the acute sector
As a new body, NHSX, becomes established to lead national policy for technology, digital and data, and with the Secretary of State for Health and Social Care firmly behind plans to create a fully digital NHS, this report seeks to understand how national policy for digitisation is working from

the perspective of acute trusts. Do digital leaders feel the commitment to digital over the past two decades is helping to move things forward? And what could be done differently to support digitisation on the ground?

Build a joined-up future

Independent review of local government spending need and funding
This report identifies a funding gap of more than £50 billion over the next six years for councils in England. It estimates that by 2025, 78 per cent of the 36 county authorities' spending will relate to four key service areas: adult social care, children's services, public health and education services.

Integrated care research and practice
This new digital resource aims to support the planning, commissioning and delivery of co-ordinated person-centred care. Based on the integration logic model, it brings together the evidence base and practice guidance on what good integrated care looks like. Funded by the Department of Health and Social Care, it is designed as a practical, digital tool and will be updated regularly in order to support the drive towards improvement and innovation.

Integrated Care Systems
This briefing from the BMA describes the format of an ICS and the various ways of working. The BMA sets out five principles which it believes must be met if ICS or any other model of integration is to be successful.

9:50 DELIVER FOR TODAY

8. Integrated quality and performance report

To ACCEPT the report

For Report

Presented by Rowan Procter and Alex Baldwin

Trust Board – June 2019

Agenda item:	Integrated Quality & Performance Report			
Presented by:	Rowan Procter, Executive Chief Nurse Alex Baldwin, Deputy Chief Operating Officer			
Prepared by:	Rowan Procter, Executive Chief Nurse Helen Beck, Chief Operating Officer Joanna Rayner, Head of Performance and Efficiency			
Date prepared:	May 2019			
Subject:	Trust Integrated Quality & Performance Report			
Purpose:	x	For information		For approval
Executive summary:	The attached report provides an overview of the key performance measures for the Trust. A detailed section is included from page 17 onwards.			

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

NHS
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NHS Foundation Trust

Integrated quality and performance report



Month Two: May 2019

3

Putting you first

CONTENTS

EXECUTIVE SUMMARY

DETAILED SECTIONS

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

ARE WE SAFE?

Healthcare associated infections (HCAIs) – There was one MRSA Bacteraemia - Hospital Attributable case in May 2019 (Exception report at page 18) and there were two hospital attributable clostridium difficile cases within the month. The trust compliance with decolonisation maintained in May at 100%.

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

Patient Falls (All patients) – 77 patient falls occurred in May 2019, which is an increase from 74 the previous month. (Exception report at page 21, 22)

Pressure Ulcers – 54 cases occurred in May 2019. (Exception report at page 23)

ARE WE EFFECTIVE?

Cancelled Operations for non-clinical reasons – The rate of cancelled operations for non-clinical reasons was recorded at 1.2% in May 2019 (Exception report at page 30)

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 93.3% in May 2019 compared to 79.2% in April 2019. (Exception report at page 31)

Discharge Summaries - A&E has achieved a rate of 82.8% in May 2019, whereas inpatient services have achieved a rate of 80.7% (Non-elective) and 87.7% (Elective). (Exception report at page 34)

ARE WE CARING?

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

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

Complaints responded to in time – May 2019 reported performance at 77.0% compared to 86.0% in April 2019. (Exception report at page 41)

ARE WE RESPONSIVE?

A&E 4 hour waits – The Trust are part of a pilot scheme that is 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 moving forwards. Once the new metrics have been agreed nationally, these will be included for monitoring against the new standards.

Cancer – Cancer has experienced significant increases in demand in the last few months. The challenge of demand and capacity continues with three areas failing the target for May 2019. These areas were Cancer 2 week wait breast symptoms with performance at 90.2%, Cancer 62 d GP referral with performance at 75.9% and Incomplete 104 day wait with 4 breaches reported in May 2019. (Exception reports at page 49-51)

Referral to Treatment (RTT) – The percentage of patients on an incomplete pathway within 18 weeks for May was 85.8%. The total waiting list was 21061 as at the end of May 2019, with 4 patients who breached the 52-week standard (Exception reports at page 45-47).

ARE WE WELL LED?

Appraisal - The appraisal rate for May 2019 is 80.0%. (Exception report at page 64)

Sickness Absence – The Sickness Absence rate for May 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	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Av/YTD
1. Safe	1.01	CAS (Central Alerting System) Open	NT	2	5	3	4	5	4	7	8	8	13	11	10	6	16
	1.02	CAS (Central Alerting System) Overdue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	1.04	All relevant inpatients undergoing a VTE Risk assessment	95%	94.1%	95.1%	93.0%	93.7%	94.0%	96.0%	96.1%	94.4%	94.6%	95.2%	95.4%	95.0%	95.4%	95.2%
	1.05	Clostridium Difficile infection - Hospital Attributable	20	0	0	1	1	1	1	2	0	0	4	1	1	2	3
	1.06	MRSA Bacteraemias - Hospital Attributable	0	0	0	0	1	0	0	0	0	0	0	0	0	1	1
	1.07	Patient Safety Incidents Reported	NT	579	465	469	521	488	511	478	546	766	625	646	670	649	1319
	1.08	Never Events	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0
2.Effective	2.02	Canc. Ops - Cancellations for non-clinical reasons	1%	0.8%	1.5%	1.8%	1.5%	1.2%	1.5%	1.3%	0.5%	1.0%	1.0%	0.6%	1.9%	1.2%	1.6%
3. Caring	3.01	Compliments (Logged by Patient Experience)	NT	93	44	49	33	35	73	31	38	40	48	16	37	32	69
	3.02	Formal Complaints	20	13	11	20	9	10	8	10	6	27	18	13	17	25	42
	3.03	Mixed Sex Accommodation Breaches	0	0	1	0	0	0	0	0	0	28	0	0	0	0	0
	3.04	IP - Extremely likely or Likely to recommend (FFT)	90%	99.0%	98.0%	99.0%	99.0%	99.0%	96.0%	98.0%	98.0%	98.0%	97.0%	97.0%	95.0%	95.0%	95.0%
	3.05	OP - Extremely likely or Likely to recommend (FFT)	90%	97.0%	97.0%	97.0%	98.0%	96.0%	96.0%	96.0%	97.0%	97.0%	97.0%	97.0%	97.0%	96.0%	96.5%
	3.06	A&E - Extremely likely or Likely to recommend (FFT)	90%	93.0%	94.0%	96.0%	95.0%	97.0%	96.0%	96.0%	97.0%	96.0%	97.0%	99.0%	94.0%	88.0%	91.0%
	3.07	Maternity - Extremely likely or likely to recommend (FFT)	90%	99.4%	96.7%	100%	95.0%	92.0%	100%	93.0%	100%	100%	100%	ND	ND	ND	ND
	3.08	Community - Extremely likely or likely to recommend	80%	98.0%	97.0%	90.0%	98.0%	95.0%	100%	100%	97.0%	98.0%	95.0%	100%	95.0%	97.0%	96.0%
4. Responsive	4.02	RTT: % incomplete pathways within 18 weeks	92%	92.2%	91.4%	91.4%	89.3%	89.9%	90.2%	89.7%	88.3%	84.7%	83.6%	84.8%	84.8%	85.8%	85.3%
	4.03	52 week waiters	0	14	10	9	10	2	7	6	10	7	7	2	1	4	5
	4.04	Diagnostics within 6 weeks	99%	99.6%	99.8%	99.9%	97.6%	99.5%	99.0%	99.6%	97.1%	91.7%	92.2%	90.0%	87.5%	87.6%	87.5%
	4.05	Cancer: 2w wait for urgent GP Referrals	93%	94.9%	91.6%	97.6%	89.5%	80.9%	76.1%	89.8%	92.2%	93.4%	95.8%	90.5%	94.3%	93.0%	93.7%
	4.06	Cancer 2w wait breast symptoms	93%	82.6%	84.9%	92.8%	95.9%	93.9%	96.4%	76.7%	48.8%	72.1%	82.0%	63.5%	87.8%	90.2%	89.0%
	4.07	Cancer 31 d First Treatment	96%	100%	100%	100%	100%	100%	99.3%	100%	100%	99.2%	100%	100%	100%	98.0%	99.0%
	4.08	Cancer 31 d Drug Treatment	98%	100%	100%	100%	98.7%	98.5%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.09	Cancer 31 d Surgery	94%	100%	100%	100%	100%	100%	100%	100%	100%	94.4%	100%	100%	100%	100%	100%
	4.10	Cancer 62 d GP referral	85%	85.1%	86.5%	84.8%	89.9%	78.0%	80.6%	79.5%	78.3%	85.5%	84.8%	90.0%	78.6%	75.9%	77.2%
	4.11	Cancer 62 d Screening	90%	100%	100%	88.2%	100%	90.5%	80.0%	93.8%	87.9%	100%	100%	95.2%	92.3%	94.4%	93.4%
	4.12	Incomplete 104 day waits	0	1.5	0	1.0	3.0	2.0	0	3.0	0	0	1.0	1.0	2.0	4.0	6.0

INTEGRATED QUALITY & PERFORMANCE REPORT																
Are we..	Ref.	KPI	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Av/YTD
5. Well Led	5.01	NHS Staff Survey (Staff Engagement score -Annual)	NT	NA	NA	NA	NA	NA	NA	NA	NA	NA	7.4%	NA	NA	NA	NA
	5.02	Staff F&F Test % Recommended - care (Qrtly)	75%	NA	95.0%	NA	95.0%	NA	93.0%	NA	NA	NA	91.0%	NA	NA	NA	NA
	5.03	Staff F&F Test % Recommended - place to work (Qrtly)	75%	NA	83.0%	NA	82.0%	NA	82.0%	NA	NA	NA	78.0%	NA	NA	NA	NA
	5.04	Turnover (Rolling 12 mths)	<10%	8.4%	8.5%	8.6%	8.6%	8.7%	8.0%	8.0%	8.0%	8.0%	7.0%	8.0%	8.0%	8.0%	8.0%
	5.05	Sickness Absence	<3.5%	3.8%	3.7%	3.8%	3.8%	3.9%	3.8%	3.9%	3.8%	3.9%	3.8%	3.7%	3.7%	3.7%	3.7%
	5.06	Executive Team Turnover (Trust Management)	<20%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	17.0%	0.0%	8.5%
	5.07	Agency Spend	550	196	330	433	507	393	381	620	500	637	330	524	426	366	396
	5.08	Monitor Use of Resources Rating	NT	3	3	3	3	3	3	3	3	3	3	3	3	3	3
6. Productive	6.01	I&E Margin	Var	-7.5%	-6.3%	-7.30%	-6.80%	-7.20%	-6.40%	-6.00%	ND	-6.10%	-5.80%	-5.50%	-5.80%	-6.70%	-6.25%
	6.03	Capital service cover	Var	1.64	-0.80	-0.93	0.87	-0.92	-0.63	-0.50	ND	-0.42	-0.25	-0.27	-0.34	-0.23	-0.57
	6.04	Liquidity (days)	NT	16.83	15.36	16.67	14.36	19.19	17.56	21.57	ND	15.86	15.18	26.80	24.13	24.98	24.56
	6.05	Long Term Borrowing (£m)	4	69.8	69.0	70.7	74.2	75.3	75.5	76.5	ND	85.5	64.1	65.4	95.7	85.0	95.7
	6.06	CIP (Variance YTD £'000s)	1.9	-47	-75	-100	-120	-38	-28	-46	-53	-45	-48	0	-32	-75	-32
7. Maternity	7.01	Total number of deliveries (births)	210	203	201	172	208	208	224	202	209	179	172	179	183	195	378
	7.02	% of all caesarean sections	26%	22.4%	18.2%	17.1%	17.0%	22.8%	22.7%	25.9%	25.4%	22.9%	20.3%	26.8%	20.8%	23.1%	22.0%
	7.03	Midwife to birth ratio	1.3	1.30	1.30	1.30	1.30	1.30	1.31	1.29	1.30	1.28	1.26	1.27	1.27	1.28	1.28
	7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.05	Completion of WHO checklist	100%	85.0%	88.0%	94.0%	95.0%	93.0%	93.0%	94.4%	95.0%	96.0%	95.0%	93.0%	94.0%	93.0%	93.5%
	7.06	Maternity SIs	NT	2	0	1	0	0	1	0	0	0	1	0	1	1	2
	7.07	Maternity Never Events	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.08	Breastfeeding Initiation Rates	80%	76.3%	80.7%	85.1%	76.2%	80.2%	83.0%	82.6%	78.5%	78.5%	82.4%	78.1%	76.0%	77.8%	76.9%
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%	97.6%	100%	98.7%	99.0%	99.0%	99.0%	99.0%	100%	99.7%	99.6%	100%	99.0%	99.4%	99.2%
	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	95%	100%	100%	100%	100%	ND	100%	100%	100%	NA	100%	100%	100%	100%	100%
	4.40	Nursing & therapy Red referrals seen within 4hrs - Community	95%	100%	100%	98.2%	100%	100%	100%	99.9%	100%	96.6%	100%	100%	100%	100%	100%
	4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	95%	99.4%	99.5%	97.4%	99.4%	99.5%	99.0%	99.2%	98.4%	99.0%	98.8%	99.3%	100%	99.5%	100%

3. IN THIS MONTH –MAY 2019, MONTH 2

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

From Month Year	May-2019	To Month Year	May-2018

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

In this month.... May-2019

Mth We Received.....	May-19	May-18	Variance	Var. %	Traffic
GP Referrals	5,714	6,848	-1,134	-16.6%	↓
Other Referrals	4,796	5,672	-876	-15.4%	↓
Ambulance Arrivals	1,902	1,789	113	6.3%	↑
Cancer Referrals*	1,112	1,137	-25	-2.2%	↓
Urgent Referrals*	2,581	2,853	-272	-9.5%	↓

YTD We Received.....	2019	2018	Variance	Var. %	Traffic
GP Referrals	11,616	13,338	-1,722	-12.9%	↓
Other Referrals	9,587	10,868	-1,281	-11.8%	↓
Ambulance Arrivals	3,802	3,676	126	3.4%	↑
Cancer Referrals*	2,164	2,171	-7	-0.3%	↓
Urgent Referrals*	5,112	5,465	-353	-6.5%	↓

Mth We Delivered.....	May-19	May-18	Variance	Var. %	Traffic
ED Attendances (excluding GP Expected/Streamed)	5,849	5,346	503	9.4%	↑
**ED Attendances(Adjusted)	7,331	6,758	573	8.5%	↑
GP Expected via ED	614	631	-17	-2.7%	↓
GP Streamed	482	521	-39	-7.5%	↓
GP Expected direct to AAU/AEC	386	260	126	48.5%	↑

YTD We Delivered.....	2019	2018	Variance	Var. %	Traffic
ED Attendances (excluding GP Expected/Streamed)	11,553	10,280	1,273	12.4%	↑
**ED Attendances(Adjusted)	14,436	12,840	1,596	12.4%	↑
GP Expected via ED	1,203	1,292	-89	-6.9%	↓
GP Streamed	916	892	24	2.7%	↑
GP Expected direct to AAU/AEC	764	376	388	103.2%	↑

A&E - To IP Admission Ratio	28.8%	25.8%	3.0%	3.0%	↑
Outpatient Attendances	26,454	26,809	-355	-1.3%	↓
Inpatient Admissions	6,226	6,117	109	1.8%	↑
Elective Admissions	482	521	-39	-7.5%	↓
Non Elective Admission	2,892	2,942	-50	-1.7%	↓
Inpatient Discharges	6,320	6,125	195	3.2%	↑
Elective Discharges	3,334	3,175	159	5.0%	↑
Non Elective Discharges	2,893	2,936	-43	-1.5%	↓
New Births	195	203	-8	-4%	↓

A&E - To IP Admission Ratio	28.9%	26.9%	2.0%	7.5%	↑
Outpatient Attendances	51,909	51,130	779	1.5%	↑
Inpatient Admissions	12,219	11,683	536	4.6%	↑
Elective Admissions	5,657	5,511	146	2.6%	↑
Non Elective Admission	6,559	6,172	387	6.3%	↑
Inpatient Discharges	12,250	11,692	558	4.8%	↑
Elective Discharges	6,066	5,504	562	10.2%	↑
Non Elective Discharges	6,183	6,188	-5	-0.1%	↓
New Births	378	401	-23	-6%	↓

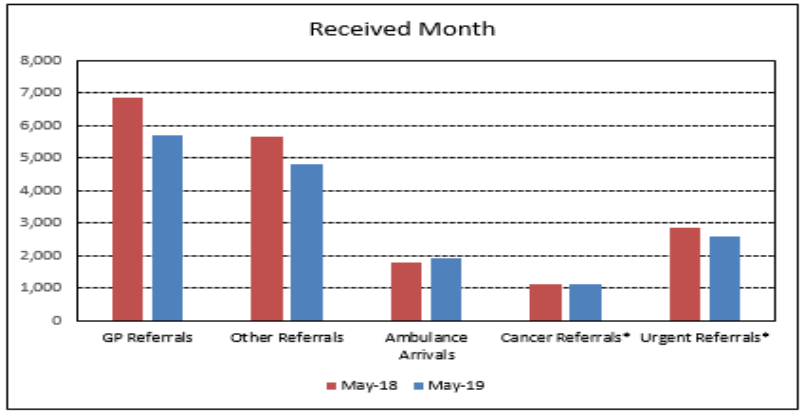
* - Included in Referrals Above

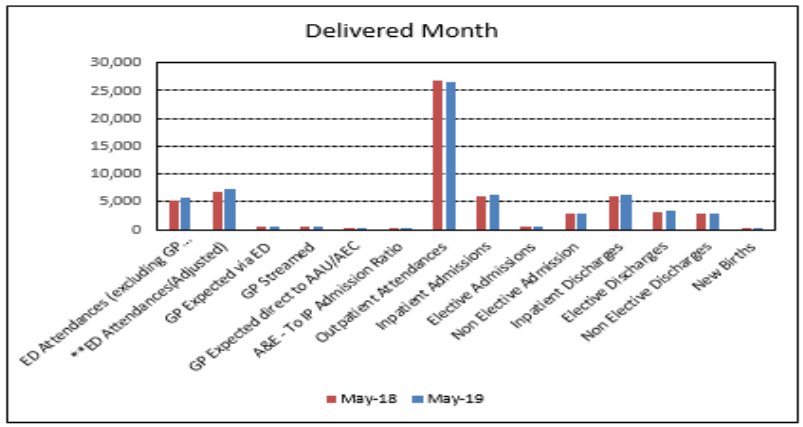
** - The ED adjusted figure adds ED attendances, GP Streamed and all GP expected (Including direct to AAU/AEC) together to reflect the position in 2017 when these were reported together.

A&E Attendances Year chart (Adjusted)

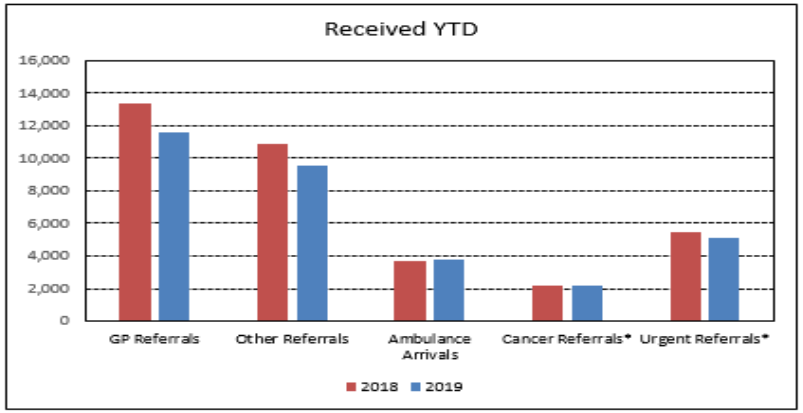
GP, cancer referrals and other referrals demonstrate a reduction year on year. A&E attendances continue to show an increase and incomplete RTT pathways are higher than last year.

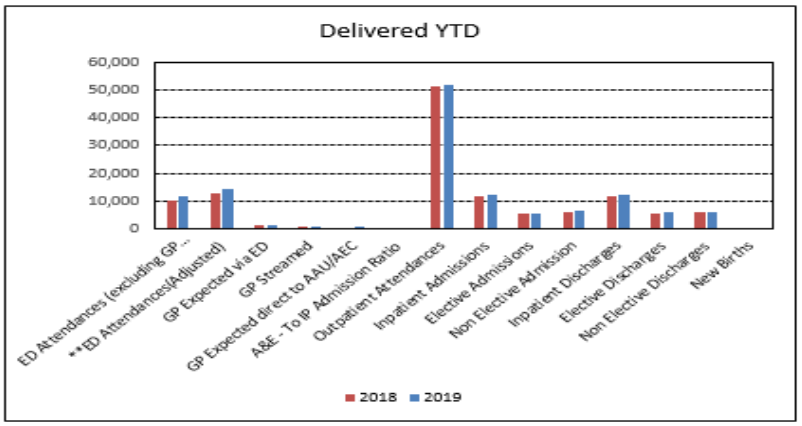
Monthly





Yearly





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DETAILED REPORTS

Putting you first

4. DETAILED SECTIONS – SAFE

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

Are we..		Ref.	KPI	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	YTD(Apr19-May19)
1.Safe	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	94.4%	100%	100%	100%	100%
		1.10	HII Compliance 1b: Central venous catheter on-going care	100%	95.0%	100%	91.0%	97.0%	95.0%	100%	96.0%	100%	96.2%	96.4%	87.1%	89.0%	100%	94.5%
		1.11	HII Compliance 2a: Peripheral cannula insertion	100%	100%	100%	100%	100%	100%	96.0%	96.0%	100%	97.9%	100%	96.4%	100%	98.0%	99.0%
		1.12	HII Compliance 2b: Peripheral cannula on-going	100%	98.0%	97.0%	98.0%	96.0%	88.0%	100%	100%	100%	97.0%	99.3%	99.2%	100%	99.4%	99.7%
		1.13	HII Compliance 4a: Preventing surgical site infection preoperative	100%	100%	100%	100%	100%	100%	100%	95.0%	100%	100%	100%	100%	100%	100%	100%
		1.14	HII Compliance 4b: Preventing surgical site infection perioperative	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.15	HII Compliance 5: Ventilator associated pneumonia	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90.0%	ND	90.0%	90.0%
		1.16	HII Compliance 6a: Urinary catheter insertion	100%	100%	100%	100%	100%	100%	100%	100%	100%	90.9%	100%	100%	ND	100%	100%
		1.17	HII Compliance 6b: Urinary catheter on-going care	100%	95.0%	92.0%	97.0%	97.7%	89.0%	94.0%	97.0%	98.0%	92.2%	88.8%	95.2%	96.0%	94.2%	95.1%
	Incidents	1.18	Safety Thermometer: % of patients experiencing new harm-free care-Trust	100%	97.8%	98.7%	99.2%	88.0%	97.8%	98.7%	98.7%	96.2%	98.3%	97.0%	97.9%	96.6%	97.8%	97.2%
		1.19	Safety Thermometer: % of patients experiencing new harm-free care - Community	100%	98.1%	99.0%	99.3%	99.1%	97.7%	98.9%	99.0%	96.4%	98.4%	97.0%	99.0%	96.1%	99.7%	97.9%
		1.20	No of SIRIs	NT	11	0	5	6	2	4	3	5	6	2	2	5	6	11
		1.21	RIDDOR Reportable Incidents	NT	4	1	1	1	0	3	2	3	1	3	3	2	2	4
		1.22	Total No of E. Coli (Trust level only)	NT	2	0	1	0	0	0	0	1	2	0	1	1	3	4
		1.23	No of Inpatient falls - Trust	NT	72	62	42	75	64	61	48	61	81	54	56	74	77	151
		1.24	No of Inpatient falls - WSH	<48	61	50	31	63	55	47	35	53	61	42	47	60	66	126
		1.25	No of Inpatient falls - Community Hospitals	NT	11	12	11	12	9	14	13	8	20	12	9	14	11	25
		1.26	Falls per 1,000 bed days	NT	6.76	4.84	2.83	5.73	5.27	4.29	3.35	4.82	5.21	3.95	4.17	5.21	5.71	10.92
		1.27	No of Inpatient falls resulting in harm - Trust	NT	24	22	13	24	12	12	17	15	25	14	15	21	15	36
		1.28	No of Inpatient falls resulting in harm - WSH	NT	19	22	11	20	12	11	13	12	22	10	13	16	14	30
		1.29	No of Inpatient falls resulting in harm - Community Hospitals	NT	5	0	2	4	0	1	4	3	3	4	2	5	1	6
		1.30	No of avoidable serious injuries or deaths resulting from falls - Trust	0	0	0	0	0	0	0	0	2	1	0	0	4	2	6
		1.31	No of avoidable serious injuries or deaths resulting from falls - WSH	0	0	0	0	0	0	0	0	2	1	0	0	4	2	6
		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	64	67	74	68	73	77	71	78	99	69	87	89	90	179
		1.70	PU present on admission to service – Inpatients	NT	50	57	61	53	58	60	57	61	77	49	58	60	62	122
		1.71	PU present on admission to service – Community teams	NT	10	13	15	15	17	17	14	17	22	20	29	29	28	57
		1.33	Number of medication errors	NT	85	43	56	61	63	71	54	61	79	78	72	89	75	164
		1.72	New PU - Trust	0	28	25	19	30	24	35	28	27	30	34	40	42	54	96
		1.67	New PU – Inpatients	0	9	9	6	10	14	13	19	17	11	16	21	20	25	45
		1.68	New PU – Community teams	0	19	16	13	20	10	22	9	10	19	18	19	22	29	51
		1.73	Moisture associated skin damage	0	NA	NA	NA	NA	NA	NA	NA	NA	17	18	22	18	14	32
		1.74	Device related (% of total)	NT	NA	NA	NA	NA	NA	NA	NA	NA	2.0%	6.0%	5.0%	4.0%	5.0%	4.5%
		1.60	% of patients at risk of falls (with a Falls assessment)	NT	71.6%	72.2%	74.6%	72.8%	72.0%	73.3%	72.7%	71.6%	73.0%	71.9%	73.9%	73.2%	73.7%	73.5%

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Are we..		Ref.	KPI	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	YTD(Apr19-May19)
1. Safe	Reporting	1.38	MRSA Quarterly Std (including admission and LOS screens)	90%	NA	88.0%	NA	NA	87.0%	NA	NA	89.0%	NA	NA	88.0%	NA	NA	NA
		1.39	MRSA Bacteraemias - Community Attributable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		1.40	Clostridium Difficile infection - Community Attributable	NT	1	1	4	5	4	3	2	2	4	1	6	2	0	2
		1.41	MRSA - Decolonisation	95%	91.0%	90.0%	81.0%	97.0%	86.0%	95.0%	97.0%	94.0%	94.0%	100%	92.0%	100%	100%	100%
		1.42	MRSA - RCA Reports	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		1.43	MSSA (Hospital)	NT	2	2	0	0	0	1	1	0	0	0	2	0	0	0
		1.44	SIRI final reports due in month submitted beyond 60 working days	0	3	0	1	0	0	0	1	0	0	0	0	0	0	0
		1.45	SIRIs reported >2 working days from identification as red	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0
		1.46	Green, Amber & Red Active / Accepted risk assessments not in date	0	3	2	0	3	0	4	2	3	79	55	55	55	53	108
		1.47	Datix Risk Register Red / Amber actions overdue	0	4	3	0	0	0	1	4	1	65	65	65	65	64	129
		1.48	Rapid access chest pain clinic access within 2 wks.	95%	97.3%	97.3%	96.2%	96.7%	98.6%	99.2%	99.2%	100%	100%	100%	100%	100%	100%	100%
		1.75	Verbal DoC undertaken within 10 working days of incident report	NT	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	47.0%	60.0%	53.5%
		1.76	Total written (initial notification letter) Duty of Candour still outstanding at month-end NB: Only includes cases where verbal has already been	3	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	4	3	4
		1.49	Verbal Duty of Candour outstanding at month-end	0	1	2	2	0	0	0	0	6	0	4	5	4	4	8
		1.50	Hand Hygiene Audits	100%	99.0%	99.0%	99.0%	100%	100%	100%	99.6%	98.8%	100%	100%	99.7%	100%	100%	100%
		1.51	Quarterly antibiotic audit	98%	NA	92.2%	NA	NA	89.0%	NA	NA	90.0%	NA	NA	87.0%	NA	NA	NA
		1.52	Serious Incident RCA actions beyond deadline for completion	0	4	4	7	4	2	5	11	5	14	8	13	25	21	46
		1.53	% of Green Patient Safety incidents investigated	NT	64.0%	61.0%	68.0%	59.0%	63.0%	64.0%	60.0%	59.0%	71.0%	72.0%	71.0%	63.0%	74.0%	68.5%
		1.54	Quarterly Environment/Isolation	90%	NA	92.0%	NA	NA	93.0%	NA	NA	93.0%	NA	NA	92.0%	NA	NA	NA
		1.55	Quarterly VIP score documentation	90%	NA	86.0%	NA	NA	83.0%	NA	NA	84.0%	NA	NA	85.0%	NA	NA	NA
		1.56	Isolation data (Trust Level only)	90%	88.0%	87.0%	88.0%	91.0%	91.0%	91.0%	91.0%	90.0%	80.0%	75.0%	85.0%	85.0%	85.0%	85.0%
		1.57	Pain Mgt. Quarterly internal report	80%	NA	NA	86.0%	NA	NA	85.5%	NA	NA	84.5%	NA	NA	85.2%	84.1%	84.7%
		1.58	Nutrition % of patients with a MUST/PYMS assessment completed for within 24hrs	95%	93.0%	88.0%	91.0%	88.0%	82.0%	83.0%	83.0%	84.0%	83.0%	81.0%	79.0%	80.7%	80.6%	80.7%
		1.59	Median NRLS (national reporting & Learning system) upload 6 month rolling average (No. of days)	41	31	60	59	51	40	75	84	98	78	82	38	ND	ND	ND
		1.61	E coli - Hospital Attributable	NT	2	2	1	1	1	2	0	1	2	0	1	1	3	4
		1.62	E coli - Community Attributable	NT	19	14	13	15	13	14	13	11	8	9	16	12	18	30
		1.63	Klebsiella spp. - Hospital Attributable	NT	0	0	2	0	0	0	0	1	0	1	0	1	0	1
		1.64	Klebsiella spp. - Community Attributable	NT	1	0	3	2	3	1	3	2	1	1	1	2	3	5
		1.65	Pseudomonas - Hospital Attributable	NT	0	0	0	1	0	0	0	0	0	1	0	2	0	2
		1.66	Pseudomonas - Community Attributable	NT	1	0	0	0	1	1	0	1	1	2	0	0	1	1

SAFE – DIVISIONAL LEVEL ANALYSIS

	April			May		
Indicator	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
HII compliance 1a: Central venous catheter insertion		100		100	100	
HII compliance 1b: Central venous catheter ongoing care	100	83		100	100	
HII compliance 2a: Peripheral cannula insertion		100	100	100	96.15	100
HII compliance 2b: Peripheral cannula ongoing	100	100	100	98.21	100	100
HII compliance 4a: Preventing surgical site infection preoperative	100			100		
HII compliance 4b: Preventing surgical site infection perioperative	100			100		
HII compliance 5: Ventilator associated pneumonia				90		
HII compliance 6a: Urinary catheter insertion					100	
HII compliance 6b: Urinary catheter on-going care	100	94		100	90	
HII compliance: Antibiotic Prescribing - All care setting		93		89	88	
HII compliance: Antibiotic Prescribing - Secondary Care		76			84	
HII compliance: Chronic Wounds						
Total no of MRSA bacteraemias: Hospital	0	0	0	0	1	0
Quarterly MRSA (including admission and length of stay screens)						
Hand hygiene compliance	100	100	100	100	100	100
Total no of MSSA bacteraemias: Hospital	0	0	0	0	0	0
Quarterly Standard principle compliance						
Total no of C. diff infections: Hospital	0	1	0	2	0	0
Quarterly Antibiotic Audit						
Quarterly Environment/Isolation						

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

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

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Putting you first

5. Exception reports – Safe

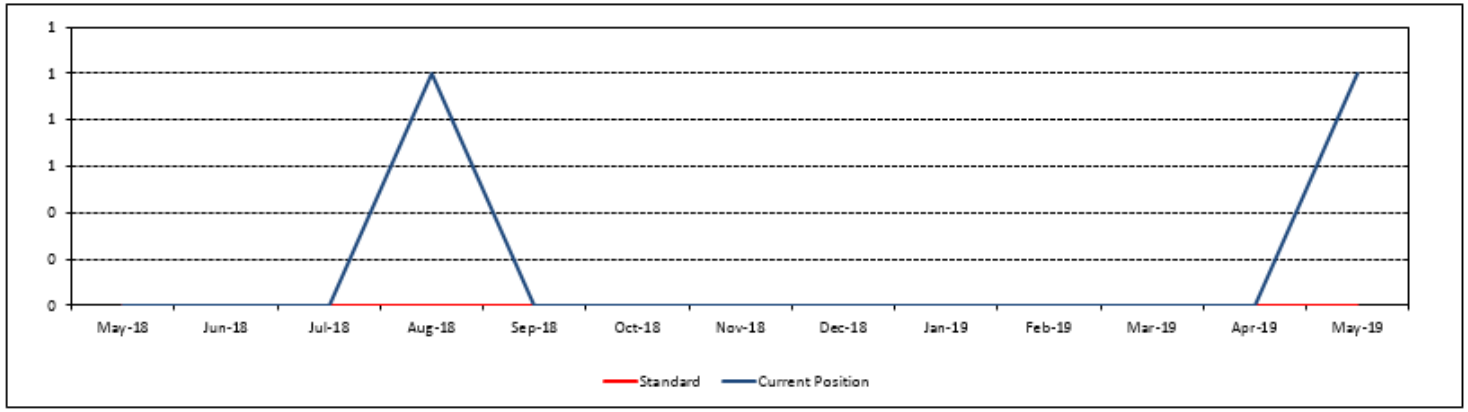
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	MRSA Bacteraemias - Hospital Attributable
Standard	0
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

MRSA bacteraemia from patient on G8 likely source peripherally inserted central cannulae. Post infection review investigation underway

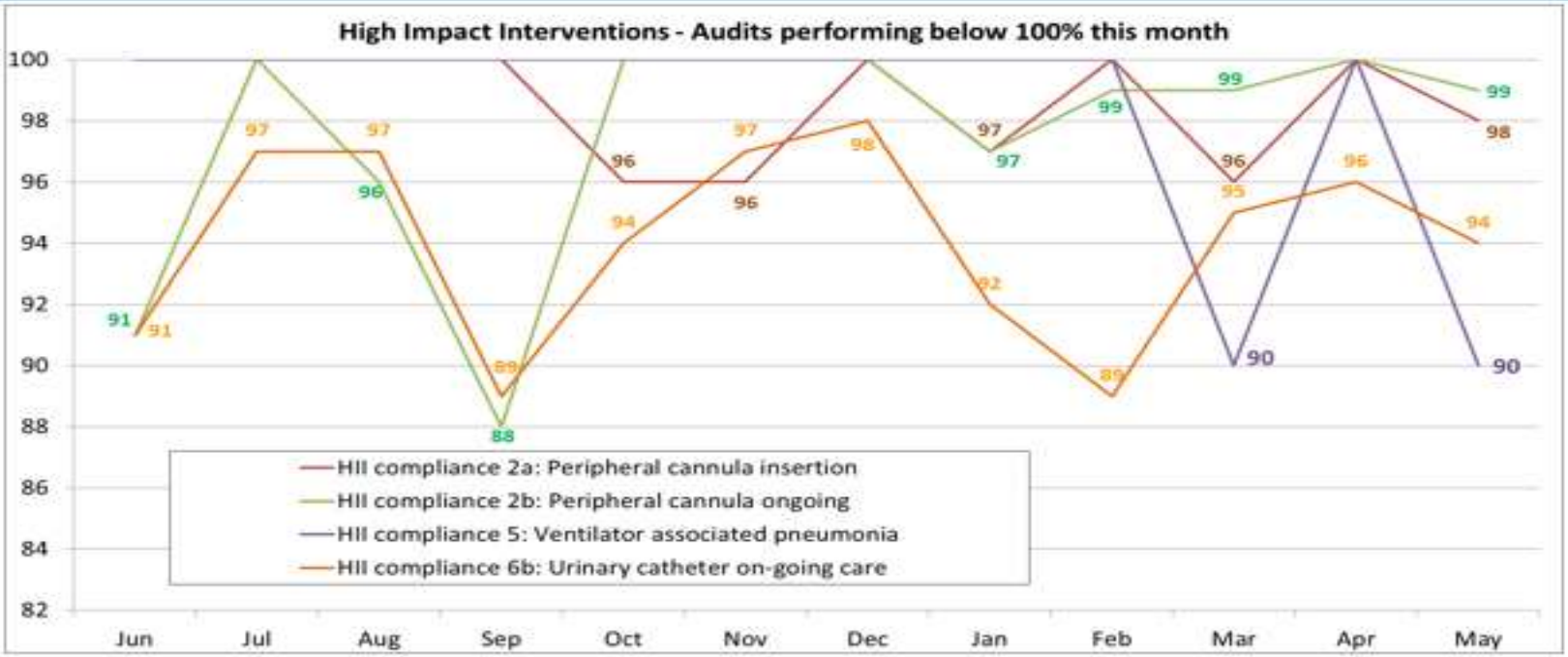
Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	0	0	0	1	0	0	0	0	0	0	0	0	1

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



Putting you first

High Impact Interventions (HIIs)



Narrative

What	**Performance is measured against a target of 100% for each High impact intervention (HII). In May four of the HIIs did not achieve this target.**
Why	**Failures in 2a (on ward G1), 2b (on ward F4), 5 (on CCS) and 6b (on wards G4 and G8) brought performance down. All other areas achieved 100% in the audits this month.**
How	**The Matrons will be working closely with the teams to ensure performance improves for June**
When	**Ongoing monthly**

Safe

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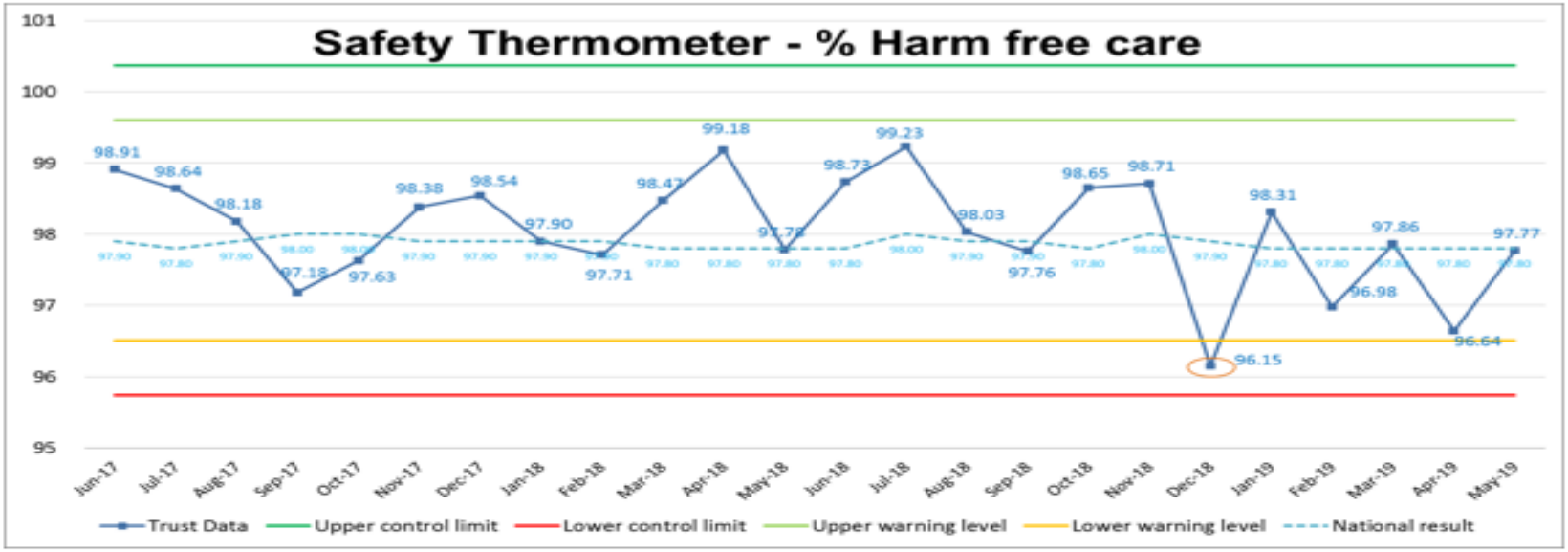
Putting you first

Safety Thermometer

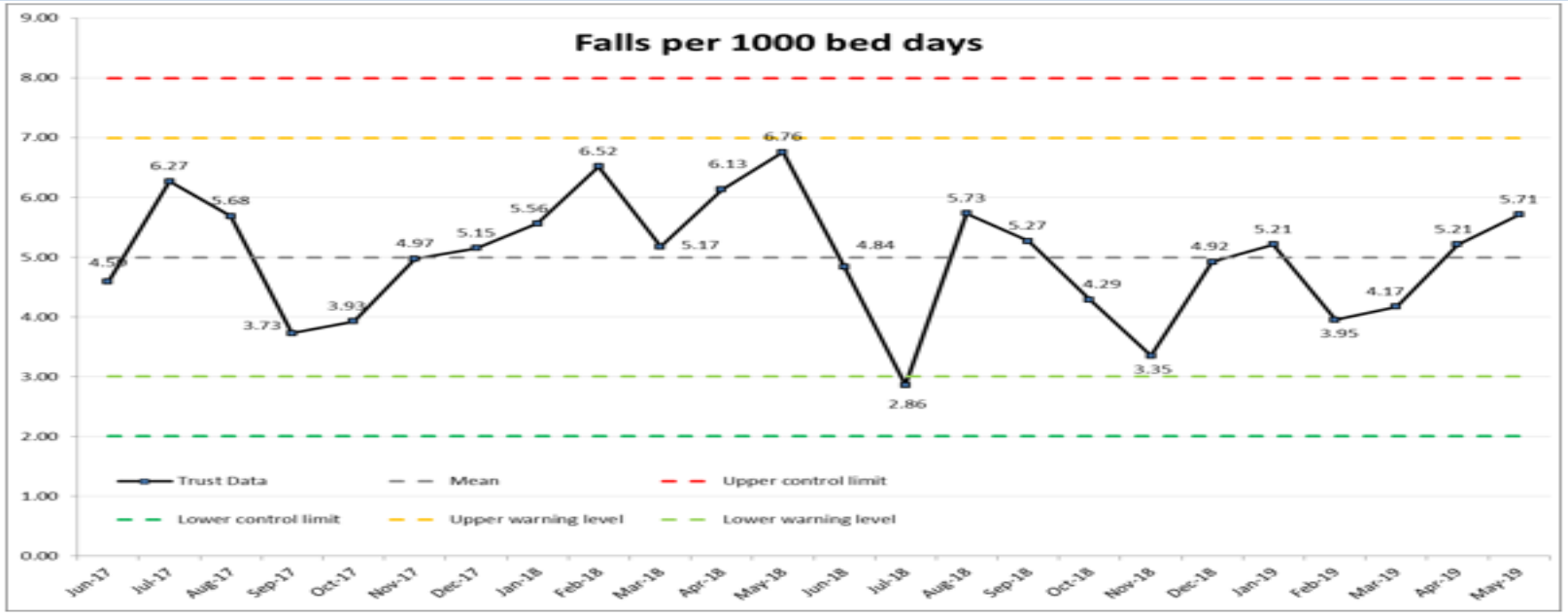


Narrative

What	The Trust harm free care was reported as 97.77 for May. The National figure for May (for comparison) remains at 97.8. This (local) figure is an improvement compared to April (96.64%) and still within the SPC normal variation although there is a possible slight downward trajectory over the last nine months with one month (December) falling below the lower warning level.
Why	The National 'Harm Free' care composite measure is defined as the proportion of patients without a pressure ulcer (ANY origin, category II - IV), hare from a fall in the last 72 hours, a urinary tract infection (in patients with a urethral urinary catheter) or new VTE treatment. It should be noted that the Safety Thermometer is a spot audit and data is collected on a specific day each month.
How	The national benchmark can be used as an additional point of comparison as well as local performance over time. The SPC chart shows the Trust Harm Free care compared to the National benchmark for the period June 2017 to May 2019.
When	Ongoing monthly

Safe

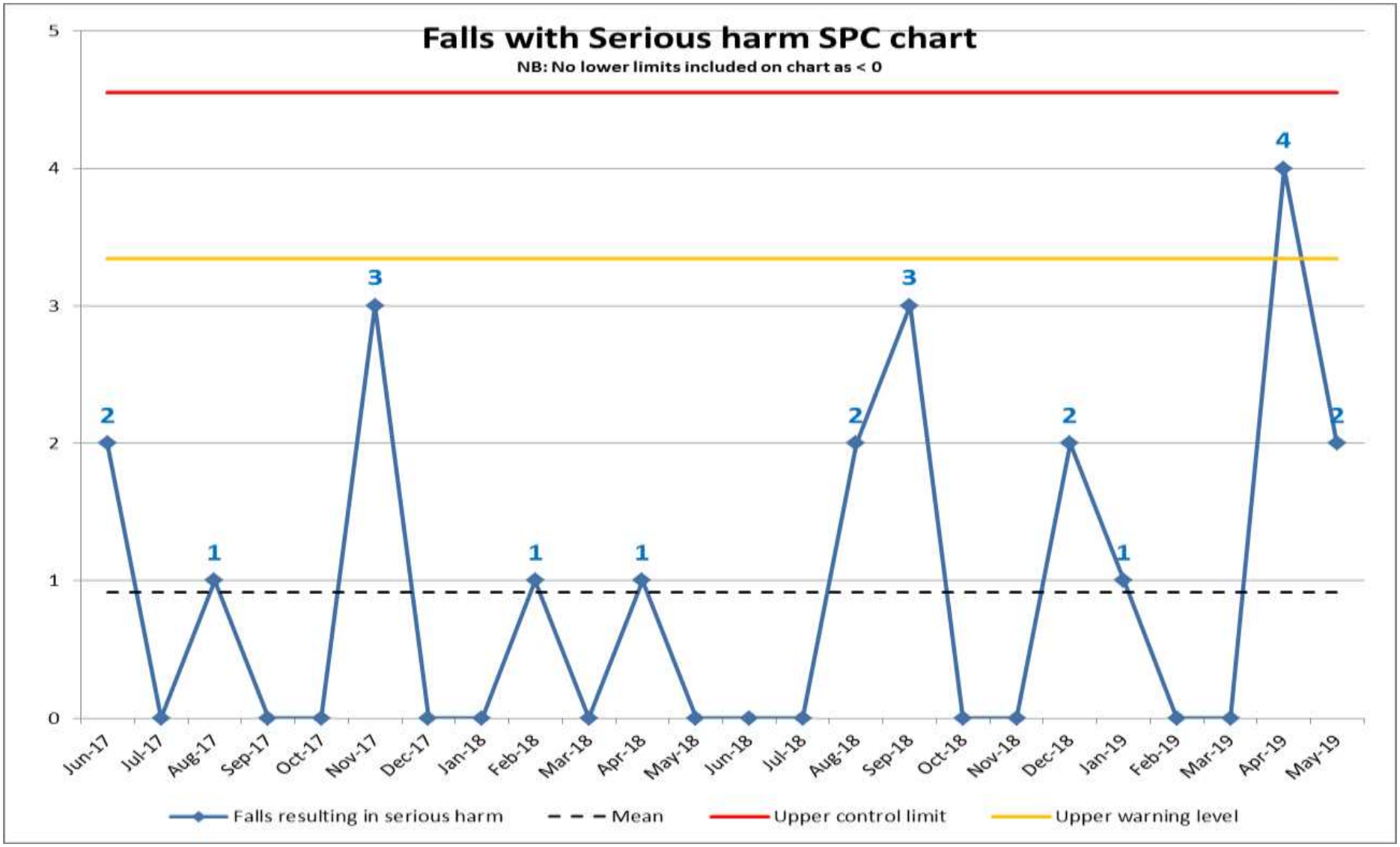
Falls



Narrative

What	The total number of Trust inpatient falls rose again in May to total of 77 (66 in WSH & 11 in Community beds), this was offset against increased occupancy and the falls per 1,000 bed days (5.71) was within the expected range. In the Community Hospitals we continue to promote a positive risk taking environment where patients are encourage to maintain and regain independence prior to discharge.
Why	The Trust monitor trends in patient falls on a monthly basis including the impact of higher levels of bed occupancy and/or patient acuity. In May there were eleven individuals who fell twice or more, including one who fell six times, and one who fell three times contributing to the overall number. Two falls resulted in serious harm (of which were frequent fallers). One patient in CDU fell and sustained a # NoF, and one patient fell on F6 resulting in right neck of the femur. Full investigations are ongoing into these incidents. Following the four falls with serious harm in April, an SPC chart has been included in the IQPR (see below)
How	In May our second Falls Champion study day was well attended and learning taken back into the clinical areas with Pledges of Change. We are looking at trialling further technology to assist in alerting staff when patients attempt mobilisation unattended. 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
When	This is an ongoing work plan and quality improvement initiatives will continue to be progressed via the Falls Group including ongoing liaison with the contacts gained through the previous work in the regional NHSI collaborative. From August, we will have some dedicated Matron hours focused on falls training and quality improvements within the Trust.

Safe



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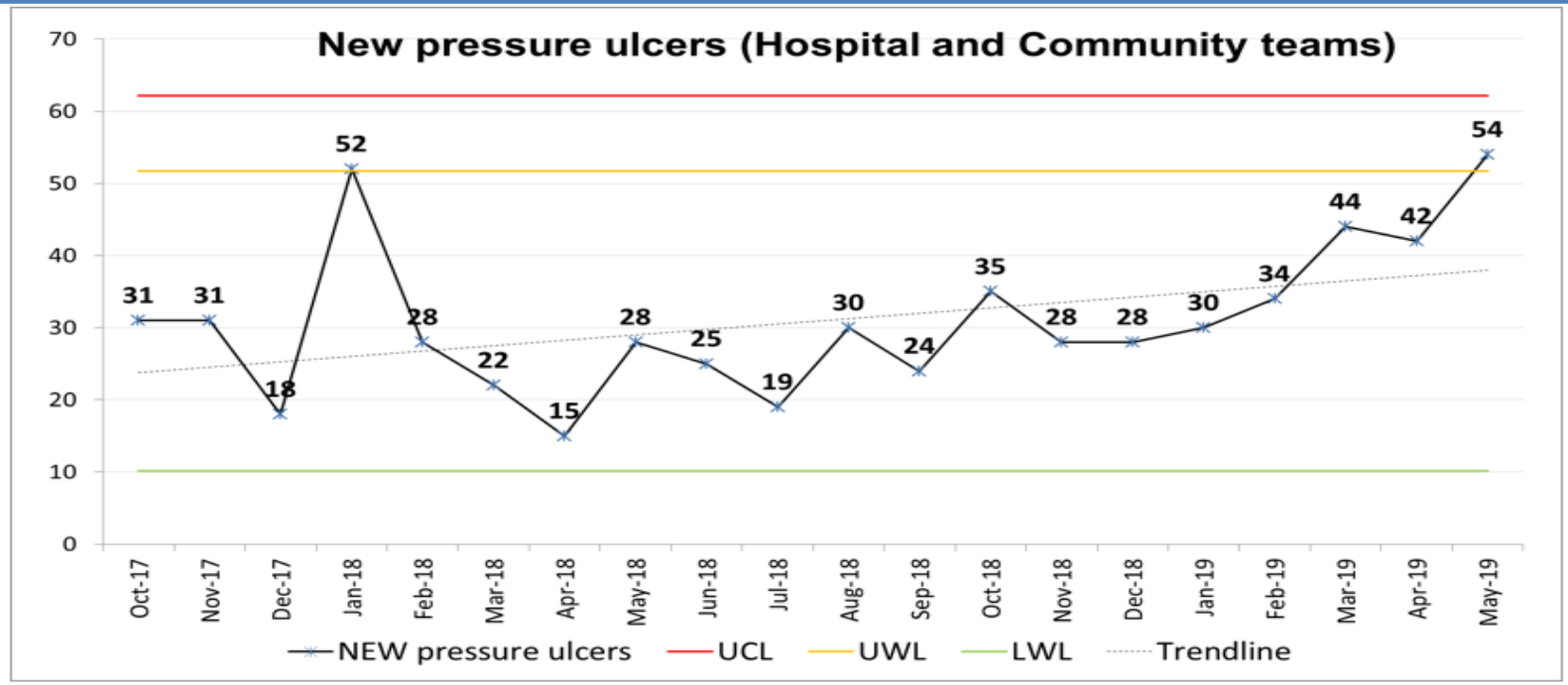
Putting you first

Pressure ulcers

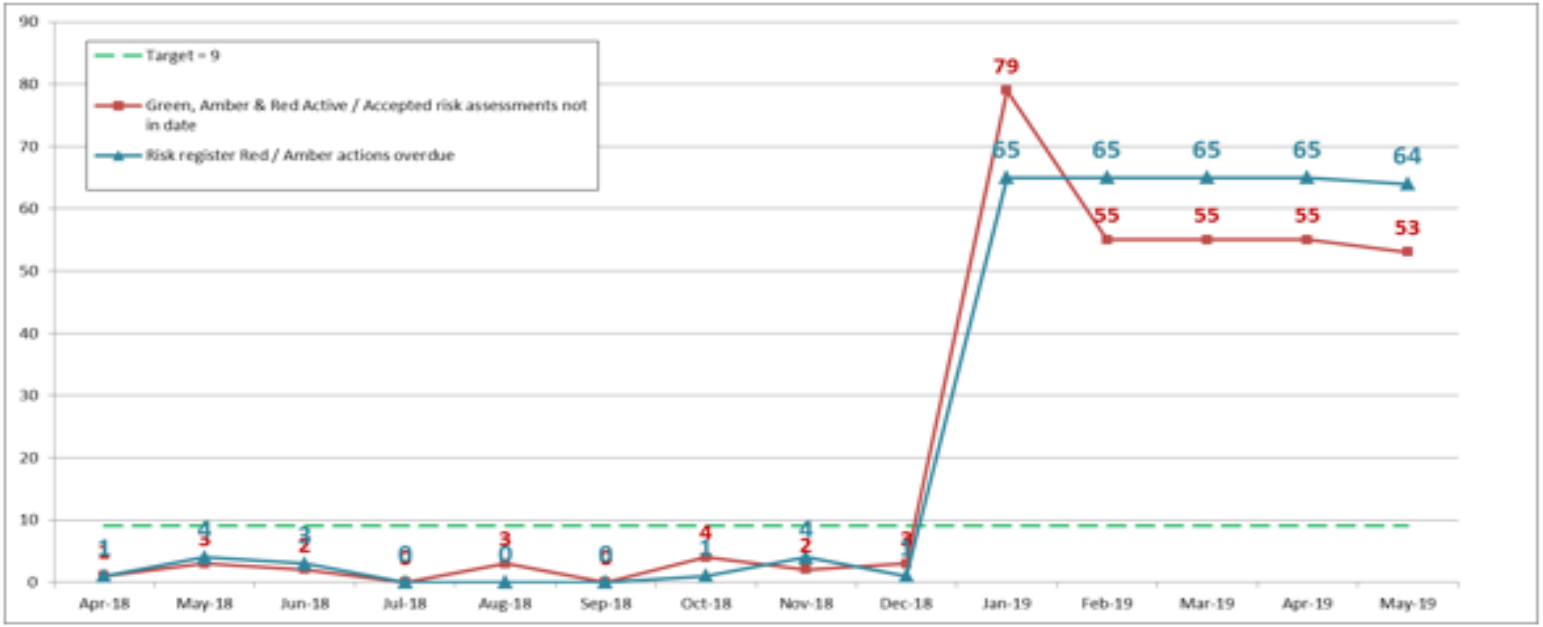


Narrative

What	The number of Pressure ulcers breached the upper warning level in May as a consequence of a small increase in Hospital and more significant increase in community pressure ulcers however there has been a concerted effort to improve reporting in the community teams with the support of the Senior matron. At the time of writing, May saw an increase in the number of new Category 2 pressure ulcers reported across the organisation, although Category 3 pressure ulcers reduced in occurrence, no Category 4 pressure ulcers were reported. 6 pressure ulcers have been reported as unstageable, which will impact reporting as the level of damage is revealed through wound healing. In total 54 new pressure ulcers were reported.
Why	Aspirational target of zero however recognition that potential for development of pressure ulcers is always present in the high-risk patient. Higher bed occupancy/number of patient contacts / greater acuity of patients will have an impact upon numbers. High acuity in acute beds continued through May, with escalation areas open. WSFT community teams recorded >12,000 face-to-face patient contacts through the month. All teams working to capacity; leaders working to develop dependency tool for community teams to better understand patient acuity and match capacity to demand.
How	Our Tissue Viability Team has now adopted an integrated approach to supporting patients across the whole organisation. Integration continues as two new team members joined the Tissue Viability Service – induction now underway. The Service will take part in a Strategy Meeting on 24.06.19 during which service development will be discussed and a plan formulated to continue to work towards improving pressure area care across the organisation. The WSFT Monthly Pressure Ulcer Monitoring Group identified a potential trend in terms of damage to heels; funding is being sought to provide hand held mirrors for staff to promote the inspection of heels for pressure damage.

Safe

Risk assessments

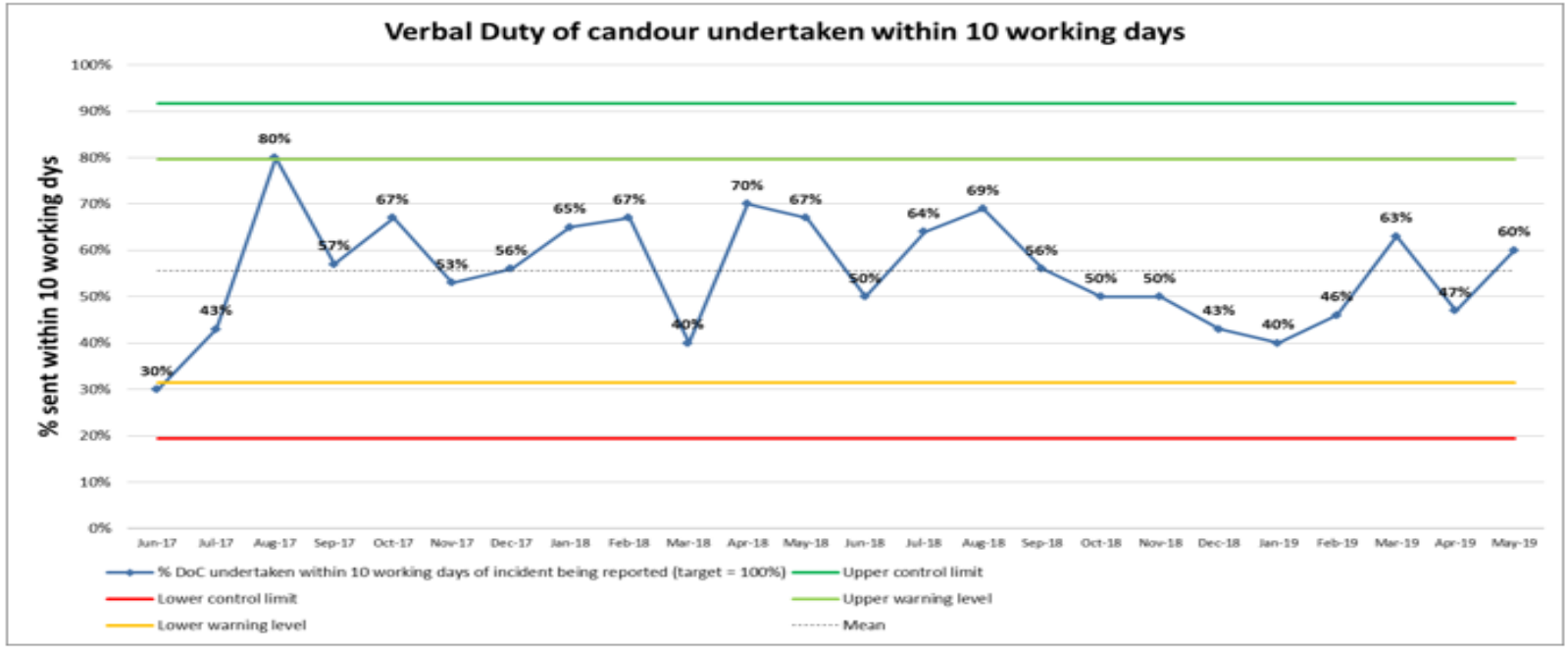


Narrative

What	Four months ongoing failure to hit target (n = 0) which is usually achieved each month
Why	53 out of date risk assessments and 64 actions
How	These out of date risk assessments and actions are associated to the fire risk assessment being managed by Estates. The work to update the risk assessments began at the beginning of May.
When	This position was reviewed at the Corporate Risk Committee (15/2/19) and external resource has been identified to complete this work. Progress to be reviewed at the next Corporate Risk Committee.

Safe

Duty of Candour

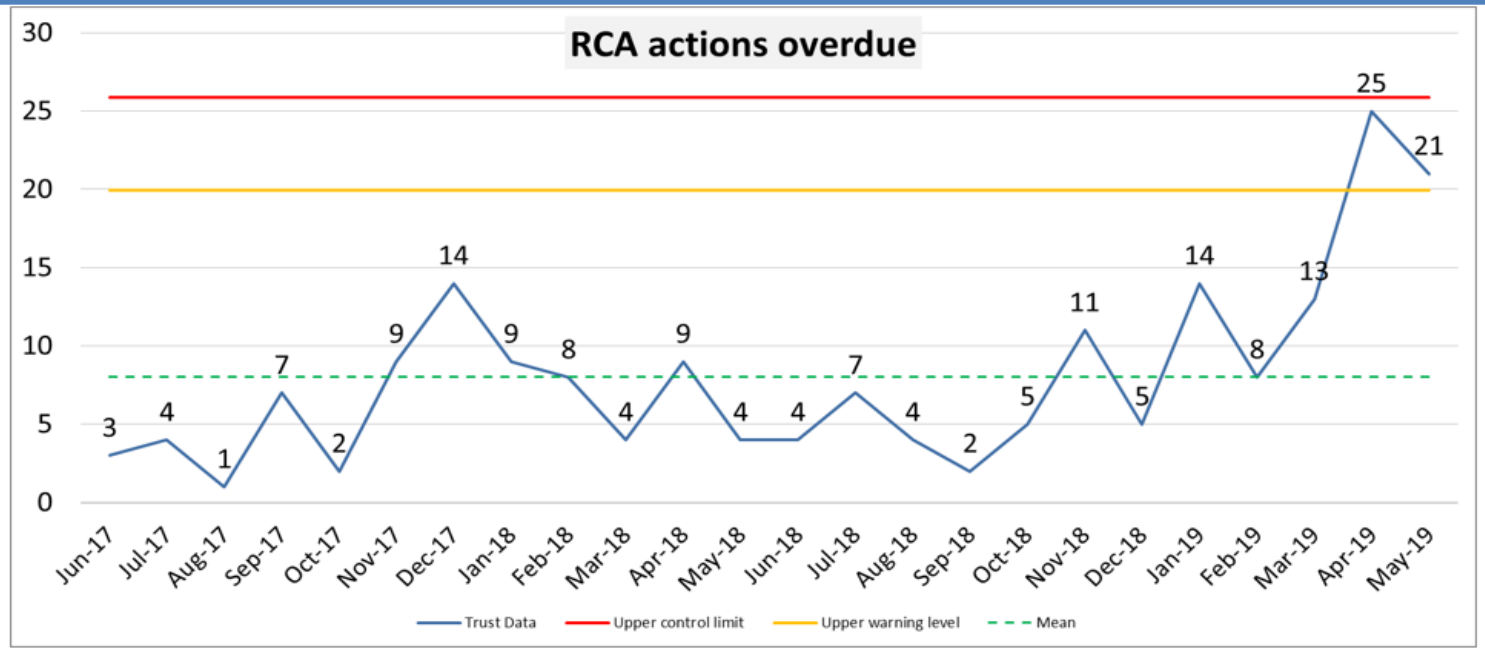


Narrative

What	A new SPC chart is provided which measures timely verbal Duty of candour against the national requirement of 10 working days. In addition, indicators counting how many cases are still overdue both verbal and written are provided.
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 Duty of candour by the Patient Safety team with escalation to the Divisional steering groups and Clinical Directors meeting.
When	Ongoing monthly

Safe

RCA actions



Narrative

What	Negative upward trend, which crossed the Upper control limit in April and remains above the Upper warning level in May.
Why	The target of <5 overdue has not been achieved since September 2018 despite targeted follow up of the Action owners by the Patient Safety team with escalation to the Divisional steering groups and Clinical Directors meeting.
How	A more structured approach to action setting and follow up is being developed with a monthly 'RCA actions review meeting' in the Patient Safety team and a 3-month post-report follow up ('wash-up meeting') for key SIs (such as those which are also the subject of an Inquest or have a complex action plan)
When	Ongoing monthly

Safe

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

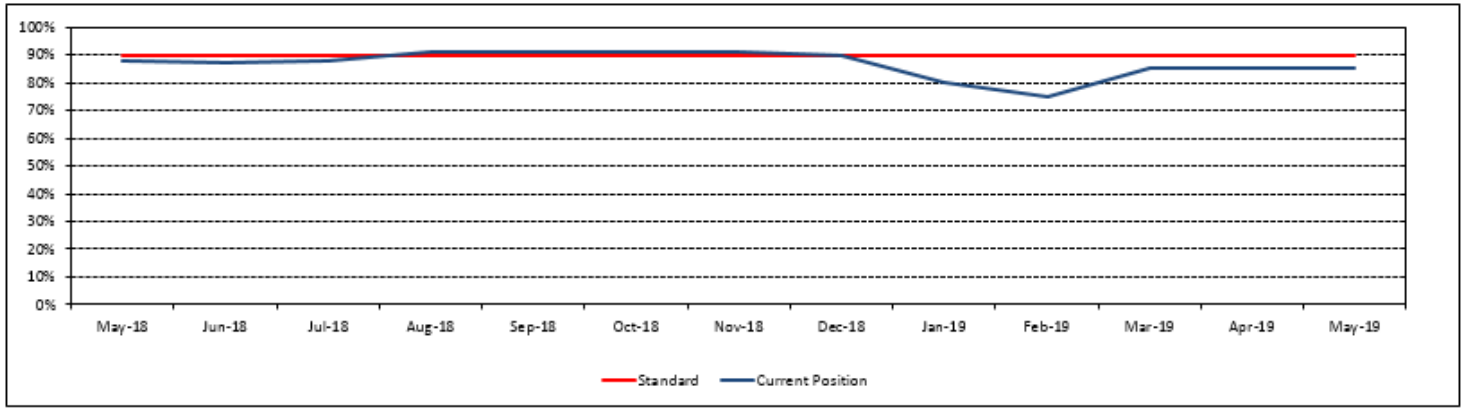
Indicator	Isolation data (Trust Level only)
Standard	90%
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Compliance with Isolation is at 85%. The Trust continued to see patients with seasonal influenza in May 2019. There was a bay closed on G4 (23/5/19) with 3 patients diagnosed with Influenza who were unable to be isolated, there were no available side rooms due to occupancy either with an acknowledged high risk infection or due to gender. Escalated internally and additional measures instituted on G4 with regard to practice, additional cleaning of frequently touched points, respiratory etiquette, and prophylaxis of contacts who met the Public Health England guideline criteria, additional personal protective equipment was available and patient information leaflet provided. The bay reopened 28/5/19 having completed countdown and no further cases.
A patient was admitted to the surgical unit who had undergone a procedure in Turkey and had subsequently developed a Streptococcal infection on there return, the Trust was unable to isolate them in the correct setting for 24hours, however all measures were in place to prevent onward transmission; no other cases detected on ward during this timeframe or after.
The side room capacity is monitored daily (Mon to Fri) by the Infection Prevention Nurses(IPN) and occupancy is risk assessed throughout the day, including a daily review of patients on the IPN ward visits and this information is provided to the site capacity/bed flow meetings. Wards were advised on the measures required to mitigate onward transmission. F12 Adult isolation ward has been utilized for optimum use to ensure that patients with the highest infection risk are managed there if at all possible.

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

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



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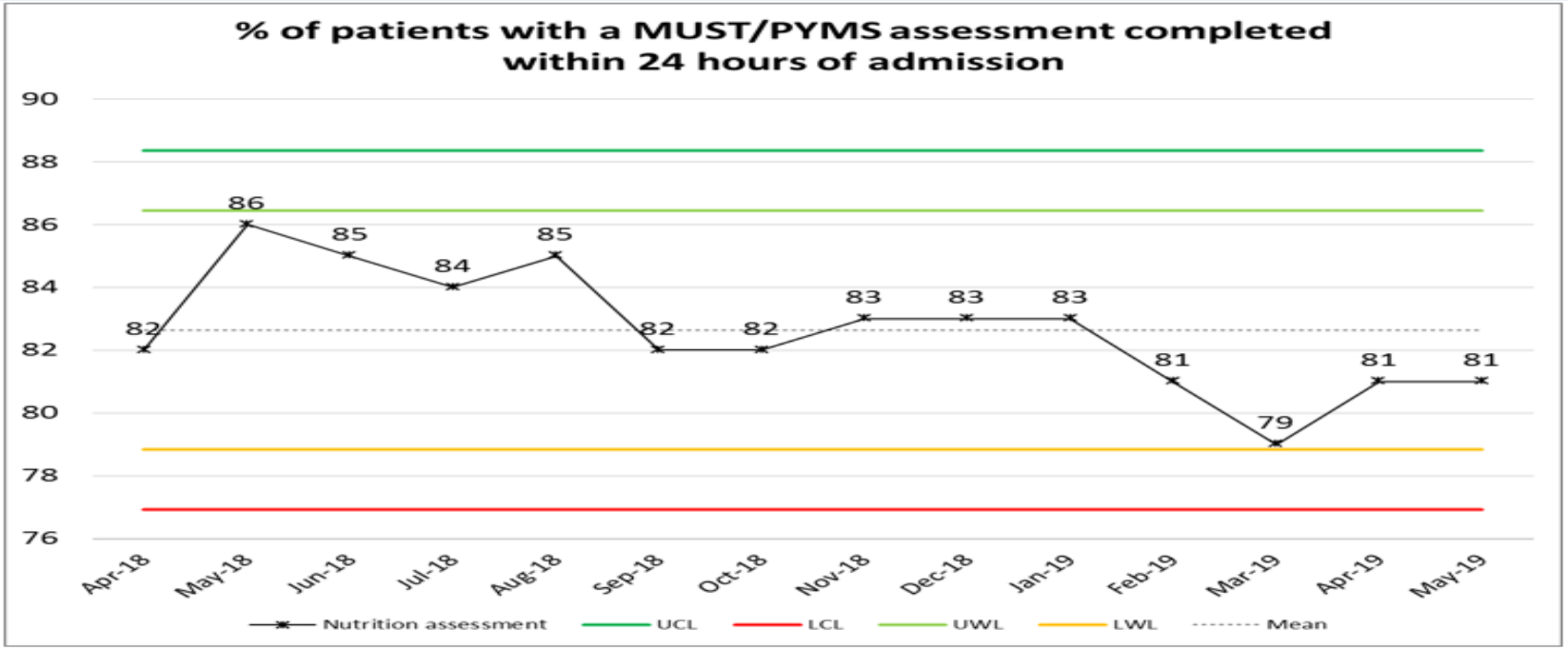
Putting you first

Nutrition



Narrative

What	No change in May (81%) compared to April (81%). NB: data for previous months (Sept to Nov) has been updated following clarification of parameters and 2018 data prior to Sept18 has been updated to reflect e-Care data not manual audit). The chart shows a slight downward trend but still within the SPC parameters.
Why	Head of Nursing has been in conversation with Paediatrics where performance continues to be poor and varies considerably between months (although this does not materially impact on the trust overall percentage).
How	Following the completion of the NHS Improvement nutrition collaborative the work continues on progressing activity to improve nutritional assessments, referrals and care planning in addition, reviewing and enhancing the implementation of protected meal times. Work has also been undertaken on reviewing the multiple data and measurement sets that existed for food, fluid and nutrition and these have been streamlined, these will form part of the patient safety report. We have been working with the communication team to improve this process and are aiming to have a process of 3 measures to feedback to teams: • Information on compliance from Patient safety dashboard monthly. • A quarterly audit to review accuracy and Monthly assurance via 'Perfect Ward'. • In addition there will be a quarterly protected mealtime audit. Nutritional care is also monitored via the Perfect Ward App. There is also specific work commencing with focus on the Stroke patients following the publication of the 2018 Sentinel Stroke National Audit Programme
When	This is an ongoing work plan and quality improvement initiatives will continue to be progressed via the Nutrition Group and by the Matrons / Ward Managers through the use of the Nutrition dashboard and Perfect Ward audit data.

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	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	YTD(Apr19-May19)
2.Effective	Incidents/Reports	2.05	Cardiac arrests	NT	4	2	7	3	6	9	ND	3	5	5	3	4	5	9
		2.06	Cardiac arrests identified as a SIRI	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		2.07	CAS (central alerts system) alerts overdue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		2.09	NICE guidance baseline and risk assessments not completed within 6 months of publication	10	55	48	47	41	49	48	43	42	35	33	28	19	15	34
		2.10	WHO Checklist (Qrtly)	100%	NA	99.0%	NA	NA	98.0%	NA	NA	99.0%	NA	NA	99.0%	NA	NA	NA
		2.11	National clinical audit report baseline & risk assessments not completed within 6 months of publication	5	23	17	18	18	18	18	19	21	26	28	29	19	16	35
		2.12	Av. Elective LOS (excl. 0 days)	NT	2.80	2.66	2.85	3.29	2.60	3.25	3.50	3.35	2.81	3.92	2.74	3.17	2.63	2.90
		2.13	Av NEL LOS (excl 0 days)	NT	7.93	7.24	7.87	8.09	7.98	7.66	7.61	7.56	7.43	8.69	8.05	8.46	8.31	8.39
		2.14	% of NEL 0 day LOS	NT	15.0%	15.7%	15.0%	13.3%	14.0%	14.4%	15.9%	15.4%	14.6%	13.8%	14.9%	14.2%	13.7%	14.0%
		2.15	NHS number coding	99%	99.8%	99.8%	99.8%	99.3%	99.7%	99.8%	99.8%	99.8%	99.7%	99.7%	99.8%	99.8%	99.8%	99.8%
		2.16	Fractured Neck of Femur : Surgery in 36 hours	85%	79.0%	100%	94.4%	100%	90.3%	96.9%	100%	100%	97.0%	100%	92.8%	96.2%	92.9%	94.5%
		2.17	Discharge Summaries (OP 85% 3d)	85%	57.0%	63.0%	54.0%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND
		2.18	Discharge Summaries (A&E 95% 1d)	95%	82.5%	86.1%	86.4%	88.4%	86.9%	85.8%	82.2%	80.5%	83.7%	84.0%	81.7%	83.2%	82.8%	83.0%
		2.19	Non-elective Discharge Summaries (IP 95% 1d)	95%	75.7%	78.1%	76.6%	76.9%	75.3%	77.9%	72.4%	72.9%	76.6%	78.0%	74.9%	81.8%	80.7%	81.2%
		2.20	Elective Discharge Summaries (IP 85% 1d)	85%	71.2%	72.1%	69.5%	70.8%	79.8%	80.8%	84.5%	84.8%	84.7%	84.6%	87.9%	80.8%	87.7%	84.2%
		2.21	All Cancer 2ww services available on C&B	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		2.22	Canc. Ops - Patients offered date within 28 days	100%	86.4%	91.9%	90.0%	83.8%	86.7%	77.5%	100%	91.7%	82.8%	100%	73.3%	79.2%	93.3%	86.3%
		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	May-19
Data Frequency	Monthly
CQC Area	Effective

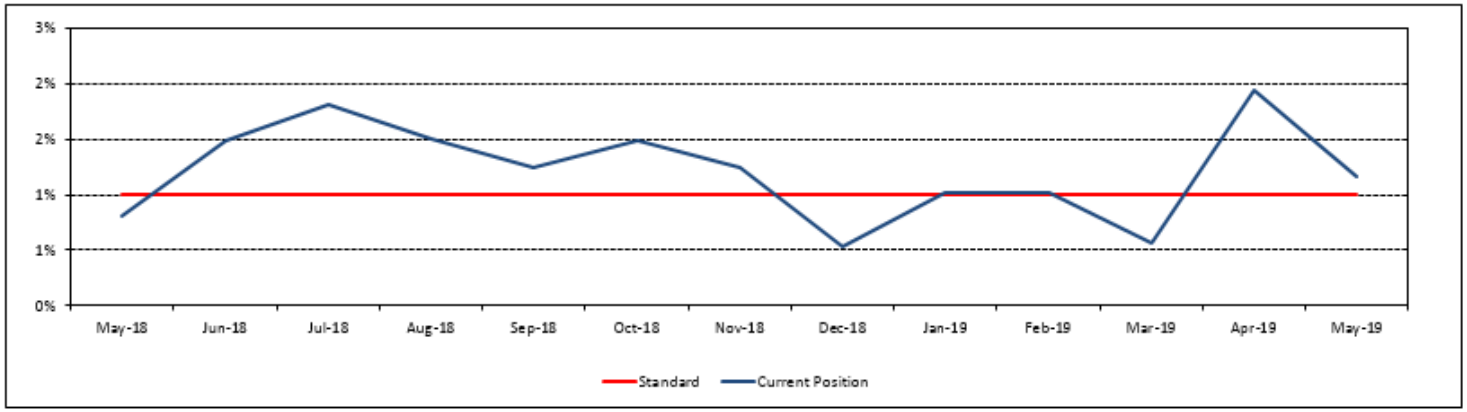
Summary of Current performance & Reasons for under performance

Reduction in numbers of cancelled ops on the day from April to May. Some on the day clinical sickness and equipment issues were the main causes.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
Current Position	0.8%	1.5%	1.8%	1.5%	1.2%	1.5%	1.3%	0.5%	1.0%	1.0%	0.6%	1.9%	1.2%

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

Description	Owner	Start	End
Continue to follow escalation & cancellation protocols.	AP	Mar-18	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

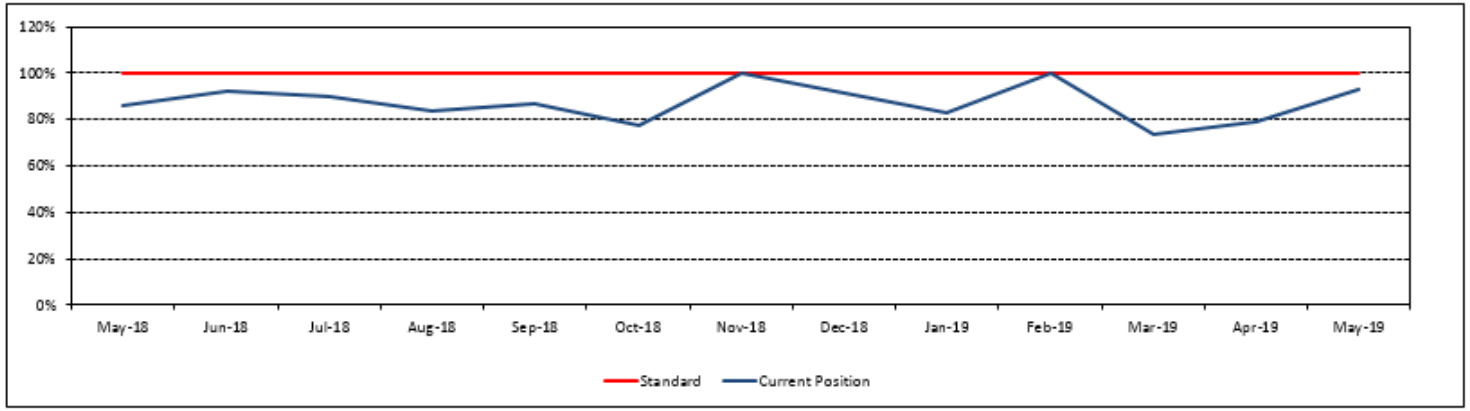
Indicator	Canc. Ops - Patients offered date within 28 days
Standard	100%
Executive Lead	Helen Beck
Month	May-19
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

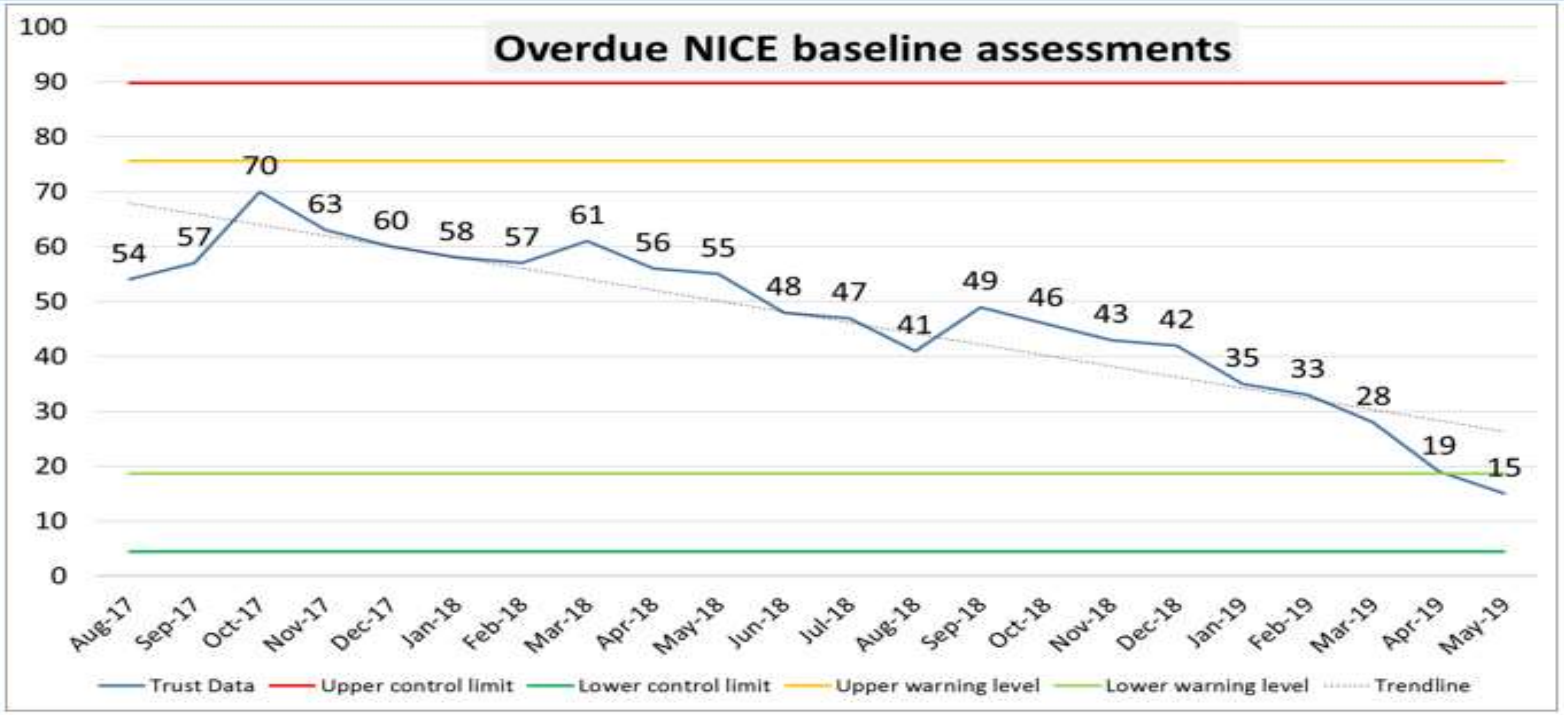
Two patients were unable to be re-booked within 28 days in May. One Urology case was unable to re-booked as all the lists were full of Rapid Access patients and one patient needed further input from a safeguarding point of view.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	86.4%	91.9%	90.0%	83.8%	86.7%	77.5%	100%	91.7%	82.8%	100%	73.3%	79.2%	93.3%

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.	HB	Jul-17	TBC



NICE



Narrative

What	Positive downward trend, which crossed the Lower warning level in April and continues to improve in May.
Why	The target of <10 overdue is no longer aspirational and if the downward trend can be maintained is achievable.
How	Targeted follow up of the Clinical leads by the Patient Safety Managers. Escalation to Clinical Directors meeting and reporting to the Quality group provides an oversight.
When	Ongoing monthly

Effective

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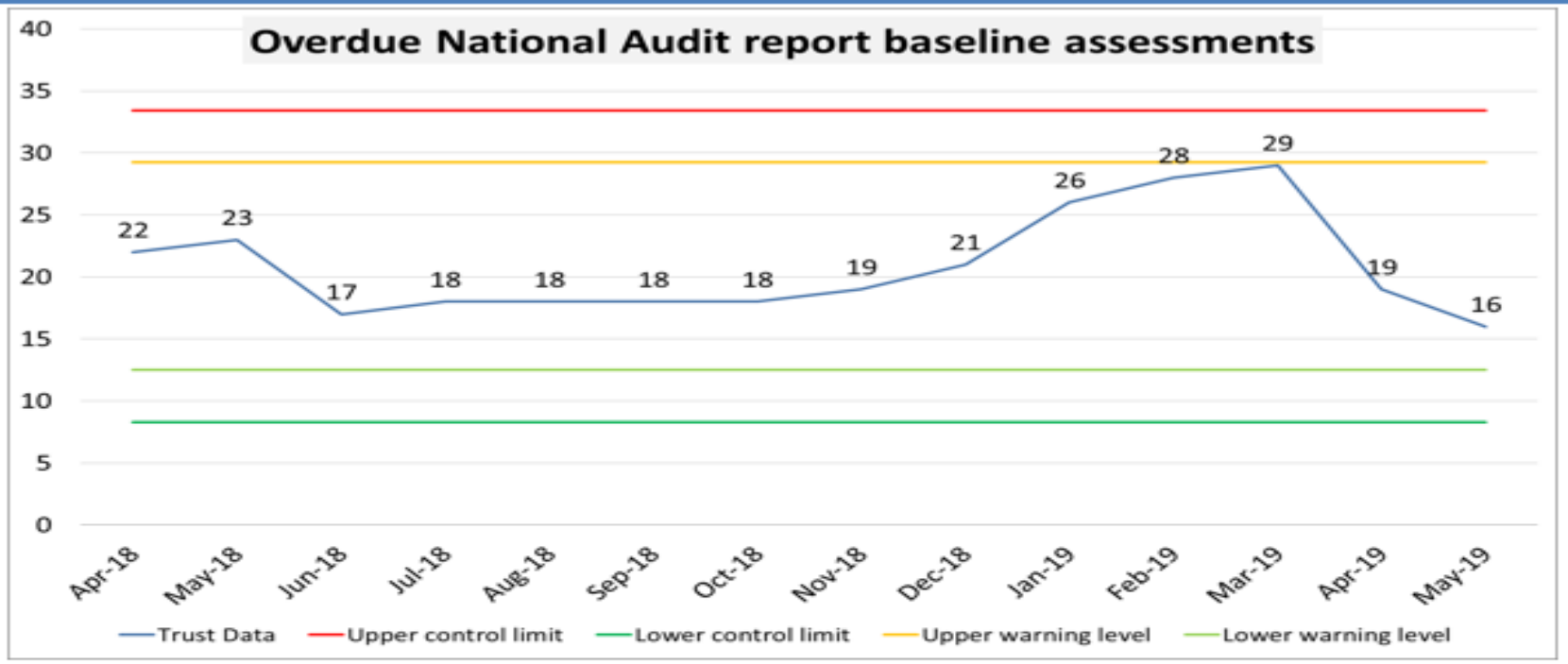
Audit



Narrative

What	There was a considerable improvement in April following targeted input, which has been maintained in May. The improvement trajectory is aiming to match that of NICE as the relevant individuals to complete the baseline assessments are mainly the same group of staff (Clinical leads)
Why	The target of <10 overdue remains aspirational however April's improvement shows that this is not unachievable.
How	Targeted follow up of the Clinical leads by the Patient Safety Managers. Escalation to the Clinical Directors meeting.
When	Ongoing monthly

Effective

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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

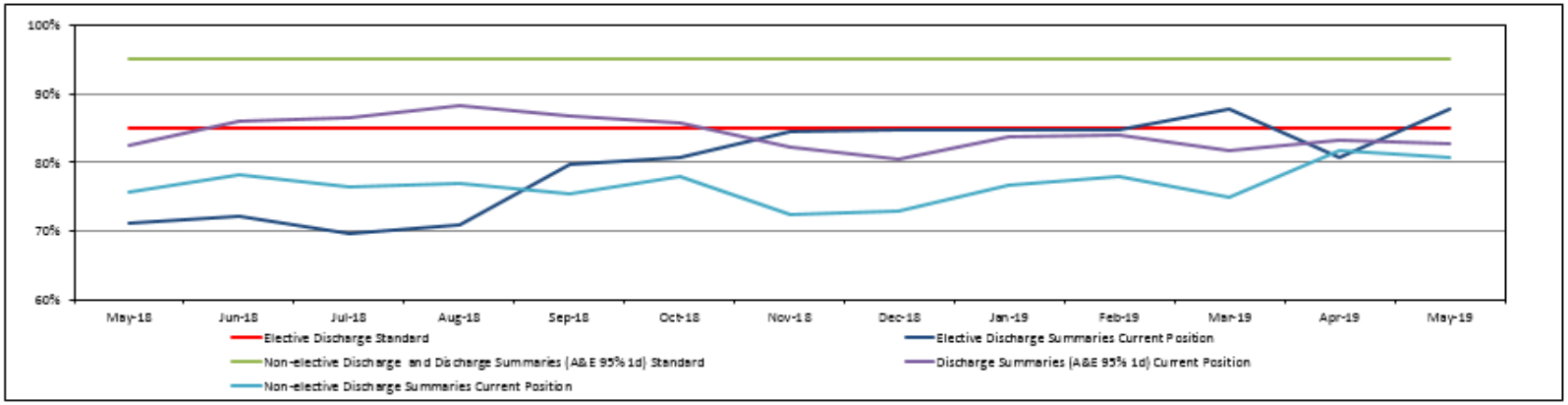
Indicator	Discharge Summaries
Standard	85%, 95%
Executive Lead	Nick Jenkins
Month	May-19
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

We continue to work closely with the CCG and managers to improve performance on discharge summaries. This includes delivering dedicated training sessions to all juniors on the important of timeliness and quality of summaries. We are targeting those areas that need specific support.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Elective Discharge Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Elective Discharge Summaries Current Position	71.2%	72.1%	69.5%	70.8%	79.8%	80.8%	84.5%	84.8%	84.7%	84.6%	87.9%	80.8%	87.7%
Non-elective Discharge and Discharge Summaries (A&E 95% 1d) Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Discharge Summaries (A&E 95% 1d) Current Position	82.5%	86.1%	86.4%	88.4%	86.9%	85.8%	82.2%	80.5%	83.7%	84.0%	81.7%	83.2%	82.8%
Non-elective Discharge Summaries Current Position	75.7%	78.1%	76.6%	76.9%	75.3%	77.9%	72.4%	72.9%	76.6%	78.0%	74.9%	81.8%	80.7%

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



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	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	YTD(Apr19-May19)
3. Caring	Other Friends and Family Test Scores	3.09	IP overall experience result	90%	97.0%	97.0%	97.0%	95.0%	97.0%	95.0%	95.0%	98.0%	95.0%	94.0%	95.0%	94.0%	90.0%	92.0%
		3.10	OP overall experience result	90%	97.0%	97.0%	97.0%	96.0%	96.0%	97.0%	97.0%	97.0%	97.0%	98.0%	98.0%	98.0%	97.0%	97.5%
		3.11	A&E overall experience result	90%	93.0%	94.0%	95.0%	97.0%	94.0%	95.0%	95.0%	95.0%	95.0%	95.0%	96.0%	93.0%	85.0%	89.0%
		3.12	Short-stay overall experience result	90%	99.0%	99.0%	98.0%	99.0%	100%	99.0%	96.0%	98.0%	98.0%	99.0%	98.0%	98.0%	99.0%	98.5%
		3.13	Short-stay Extremely likely or Likely to recommend (FFT)	90%	99.0%	98.0%	98.0%	99.0%	99.0%	100%	99.0%	99.0%	97.0%	97.0%	97.0%	99.0%	99.0%	99.0%
		3.14	Maternity - overall experience result	90%	95.0%	96.0%	100%	97.0%	94.0%	97.0%	91.0%	99.0%	100%	96.0%	ND	ND	ND	ND
		3.15	Maternity postnatal community - extremely likely or likely to recommend (FFT)	90%	97.0%	96.0%	100%	100%	98.0%	98.0%	100%	100%	100%	100%	100%	100%	100%	100%
		3.16	Maternity birthing unit - extremely likely or likely to recommend (FFT)	90%	ND	ND	100%	100%	100%	100%	ND	ND	ND	ND	ND	ND	ND	ND
		3.17	Maternity antenatal community - extremely likely or likely to recommend (FFT)	90%	100%	94.0%	97.0%	100%	100%	100%	100%	100%	ND	ND	ND	ND	ND	ND
		3.18	Children's services overall result	90%	99.0%	96.0%	95.0%	98.0%	95.0%	85.0%	95.0%	93.0%	100%	100%	98.0%	96.0%	98.0%	97.0%
		3.19	F1 Parent - overall experience result	90%	99.0%	96.0%	95.0%	98.0%	95.0%	95.0%	98.0%	94.0%	97.0%	97.0%	95.0%	99.0%	98.0%	98.5%
		3.20	F1 - Extremely likely or likely to recommend (FFT)	90%	100%	96.0%	95.0%	94.0%	91.0%	100%	96.0%	87.0%	100%	100%	100%	96.0%	98.0%	97.0%
		3.21	F1 Children - Overall experience result	90%	97.0%	96.0%	99.0%	91.0%	95.0%	93.0%	95.0%	93.0%	100%	100%	98.0%	86.0%	89.0%	87.5%
		3.22	Rosemary ward - extremely likely or likely to recommend (FFT)	90%	100%	88.0%	76.0%	100%	90.0%	100%	100%	100%	100%	80.0%	100%	80.0%	95.0%	87.5%
		3.23	King suite - extremely likely or likely to recommend	90%	100%	100%	75.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		3.24	Community paediatrics - extremely likely or likely to recommend (FFT)	90%	95.0%	100%	100%	100%	94.0%	100%	100%	100%	100%	96.0%	100%	100%	100%	100%
		3.25	Community health teams - extremely likely or likely to recommend (FFT)	90%	100%	100%	66.0%	89.0%	100%	100%	100%	100%	93.0%	93.0%	100%	100%	97.0%	98.5%
		3.27	Stroke Care - Overall Experience Result	90%	92.0%	100%	100%	100%	90.0%	100%	93.0%	ND	ND	89.0%	97.0%	96.0%	95.0%	95.5%
		3.28	Stroke Care - extremely likely or likely to recommend	90%	100%	100%	95.0%	97.0%	97.0%	100%	100%	100%	ND	93.0%	89.0%	100%	100%	100%
	Complaint Handling	3.29	Complaints acknowledged within 3 working days	90%	100%	100%	100%	88.0%	66.0%	100%	100%	100%	100%	88.0%	84.0%	94.0%	83.0%	88.5%
		3.30	Complaints responded to within agreed timeframe	90%	70.0%	50.0%	40.0%	83.0%	100%	83.0%	88.0%	83.0%	75.0%	100%	94.0%	86.0%	77.0%	81.5%
		3.31	Number of second letters received	1	2	6	2	1	0	2	1	1	3	2	0	2	2	4
		3.32	Ombudsman referrals accepted for investigation	1	0	0	0	0	1	0	0	0	0	0	0	0	0	0
		3.33	No. of complaints to Ombudsman upheld	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		3.34	No. of PALS contacts	NT	231	214	275	233	198	224	219	143	231	211	228	184	190	374
		3.35	No. of PALS contacts becoming formal complaints	<=5	4	4	4	2	2	1	3	0	2	5	4	2	5	7

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EXCEPTION REPORTS –CARING

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

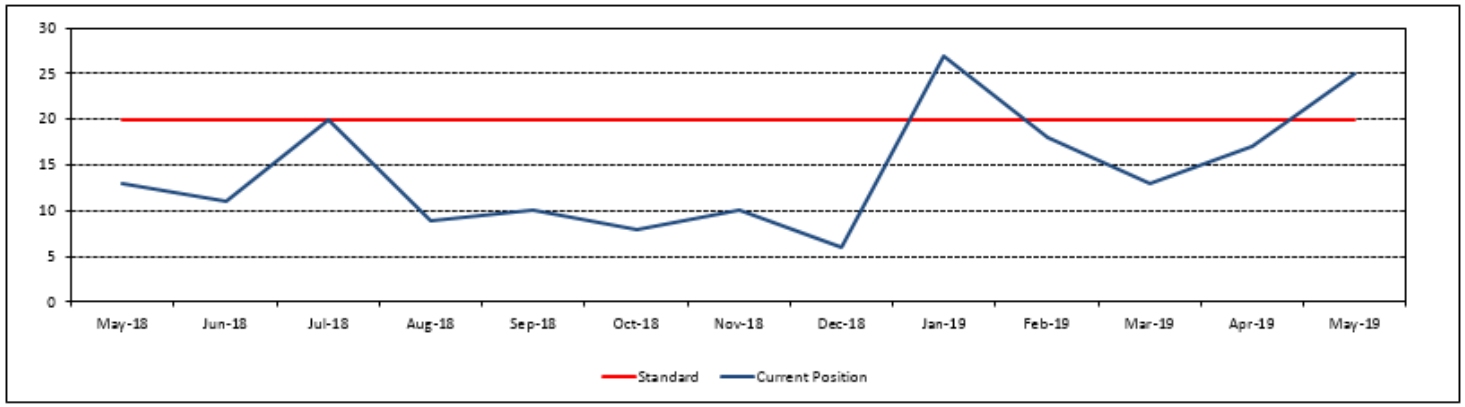
Indicator	Formal Complaints
Standard	20
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

A total of 25 complaints were received an increase from 17 in April. Themes seen in May included delays in patients receiving treatment or undergoing procedures and also with patient care where patients felt their care needs were not being adequately met.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	20	20	20	20	20	20	20	20	20	20	20	20	20
Current Position	13	11	20	9	10	8	10	6	27	18	13	17	25

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

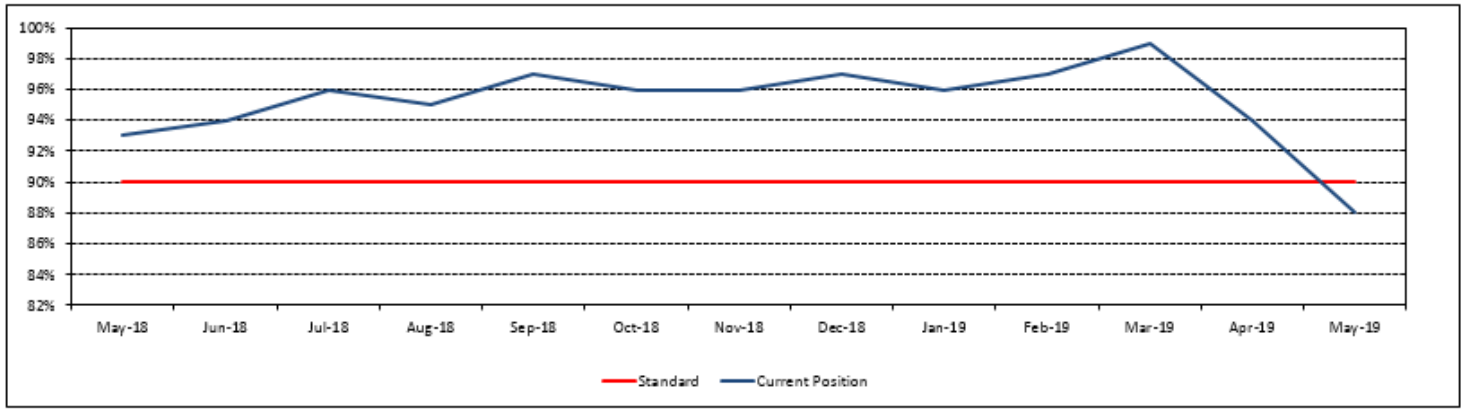
Indicator	A&E - Extremely likely or Likely to recommend (FFT)
Standard	90%
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

A decrease in recommender score was seen in May. This is likely due to the introduction of SMS surveying within the department. SMS surveys are received the day following admission and it is believed that this delay is allowing patients to be more reflective about their experiences. Many poor comments refer to long waiting times. Some comments also make reference to rude staff.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	93.0%	94.0%	96.0%	95.0%	97.0%	96.0%	96.0%	97.0%	96.0%	97.0%	99.0%	94.0%	88.0%

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

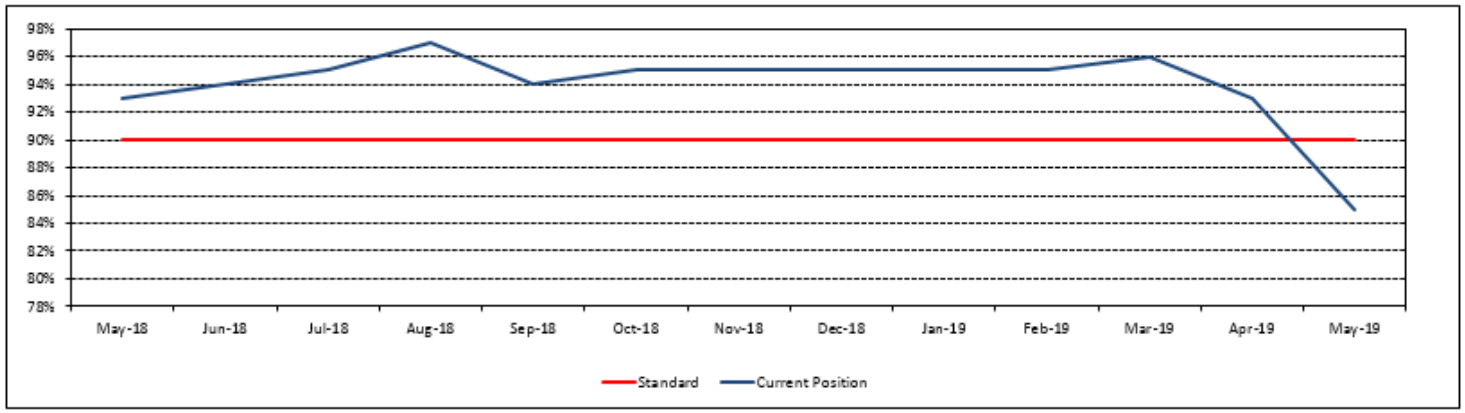
Indicator	A&E overall experience result
Standard	90%
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Reduction in overall experience result is again thought to be linked to introduction of SMS surveys allowing patients time to reflect on experiences.

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

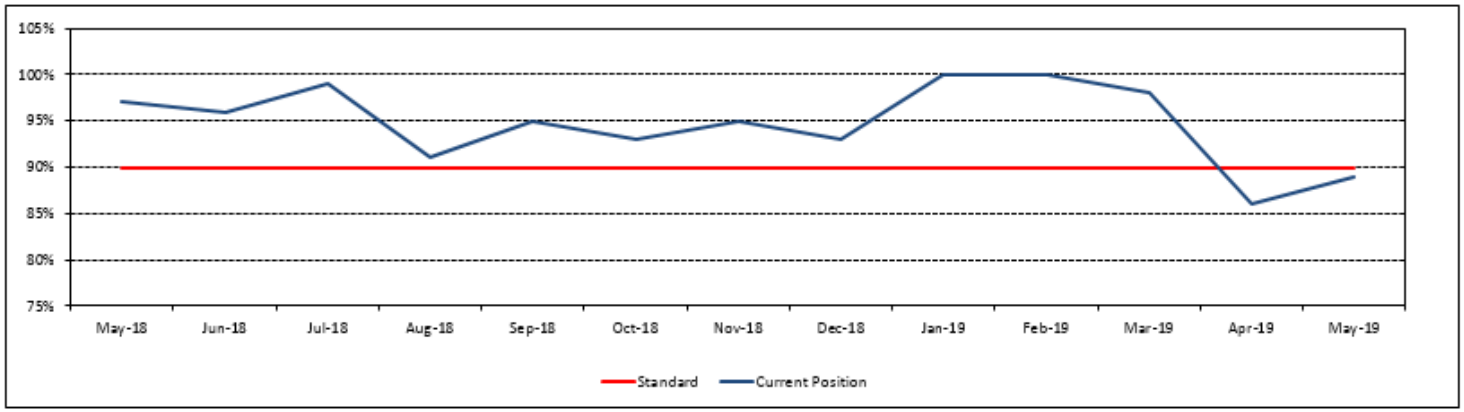
Indicator	F1 Children - Overall experience result
Standard	90%
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

F1 Children - overall experience result has increased to 89%. A total of 12 surveys were submitted by children or young persons in May. The lowest performing question was in relation to the activities available on the ward which scored 70%.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	97.0%	96.0%	99.0%	91.0%	95.0%	93.0%	95.0%	93.0%	100%	100%	98.0%	86.0%	89.0%

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

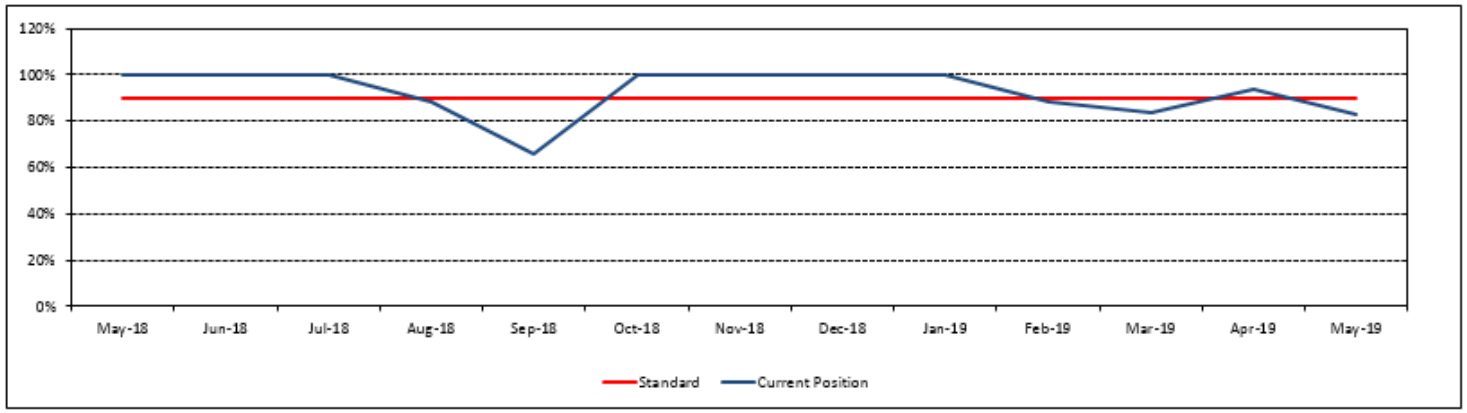
Indicator	Complaints acknowledged within 3 working days
Standard	90%
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

4 complaints were not acknowledged within the 3 working days time period due to short staffing within the patient experience team throughout May.

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

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

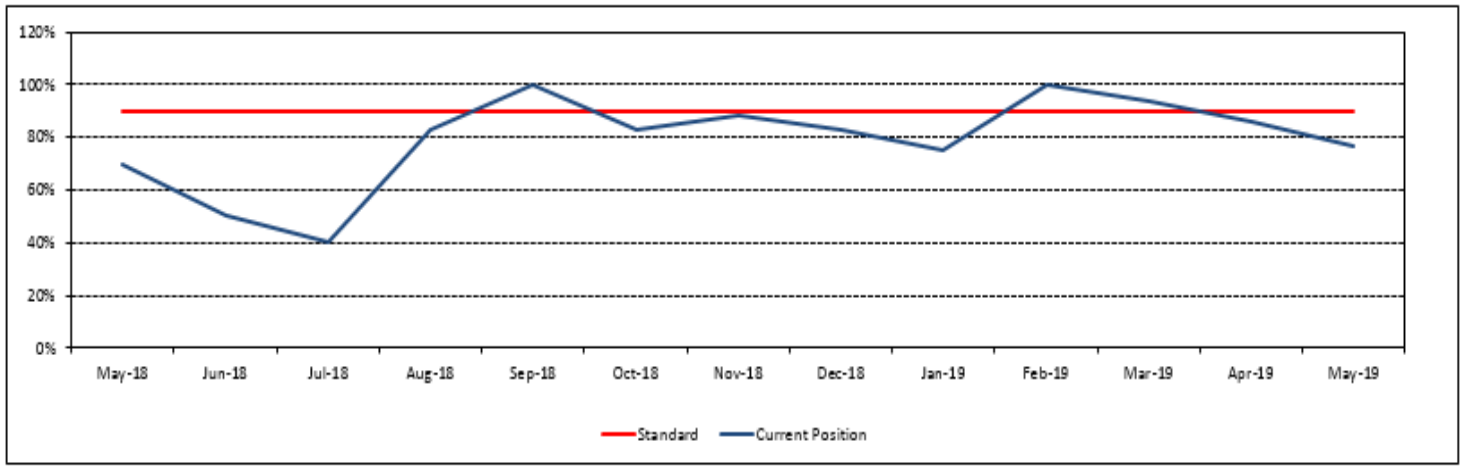
Indicator	Complaints responded to within agreed timeframe
Standard	90%
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

7 of 9 complaints were responded to within the agreed timeframe in May. Delays in responding were due to short staffing levels and workload capacity of the Patient Experience Team.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	70.0%	50.0%	40.0%	83.0%	100%	83.0%	88.0%	83.0%	75.0%	100%	94.0%	86.0%	77.0%

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

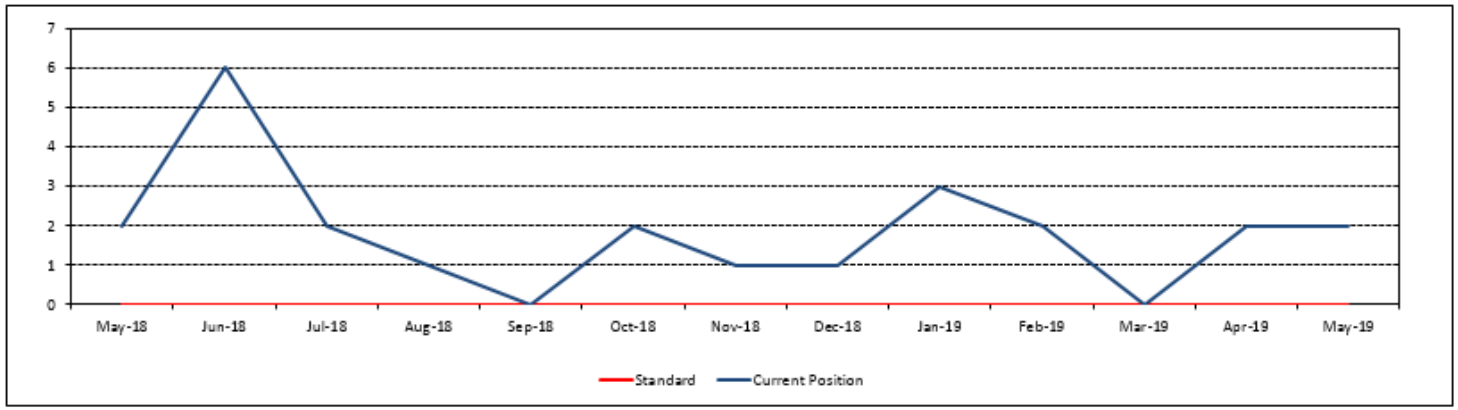
Indicator	Number of second letters received
Standard	0
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

2 second letters received. 1 relates to a patients discharge and the other raises many concerns about a patient's treatment process and possible delays following diagnosis. There are no common themes for these letters.

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

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



7. DETAILED REPORTS - RESPONSIVE

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

Are we..		Ref.	KPI	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	YTD(Apr19-May19)
4. Responsive	A&E	4.13	Number of Delayed Transfer of Care - (DTOCs)	NT	288	203	165	302	224	270	268	320	287	389	460	447	404	426
		4.14	A&E time to treatment in department (median) for patients arriving by ambulance - CDM	120	48	49	49	46	39	46	45	46	47	43	43	46	46	46
		4.15	A&E - Single longest Wait (Admitted & Non-Admitted)	6 hrs.	10.30	12.22	14.49	15.54	12.23	16.17	13.05	15.35	20.32	14.35	13.55	14.35	13.23	13.79
		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	4	8	15	31	10	31	24	54	125	113	65	155	105	260
		4.18	A&E - To inpatient Admission Ratio	32%	25.8%	25.0%	23.9%	25.7%	28.3%	28.6%	30.3%	31.2%	31.3%	31.6%	29.7%	29.0%	28.8%	28.9%
		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%	94.4%	92.8%	91.3%	90.1%	91.0%	93.1%	94.7%	95.0%	94.9%	96.5%	95.4%	95.3%	95.6%	95.5%
		4.21	A&E - Amb. Handover above 30m	0	84	13	21	24	6	21	15	40	61	33	41	46	41	87
		4.22	A&E - Amb. Handover above 60m	0	3	5	31	16	2	30	8	14	59	10	15	13	36	49
	RTT	4.25	RTT waiting List	<15396	16481	16739	16715	16601	18105	18071	17915	18426	19601	18341	19730	20427	21061	20744
		4.26	RTT waiting list over 18 weeks	NT	1294	1443	1433	1775	1830	1766	1855	2149	2999	3005	3006	3111	2985	3048
		4.27	RTT 18 weeks Non-Consultant led services - Community	90%	97.6%	100%	98.7%	99.0%	99.0%	99.0%	99.0%	100%	99.7%	99.6%	100%	99.0%	99.4%	99.2%
		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%	63.6%	77.7%	76.3%	84.4%	93.3%	64.0%	84.0%	80.0%	83.0%	75.5%	84.4%	75.8%	75.0%	75.4%
		4.30	Stroke - % patients scanned within 12 hrs.	96%	97.7%	100%	89.5%	100%	100%	100%	100%	97.5%	94.3%	98.1%	95.6%	97.0%	97.2%	97.1%
		4.31	Stroke - % Patients admitted directly to stroke unit within 4h	75%	73.2%	84.1%	75.0%	79.6%	82.8%	73.3%	83.7%	78.4%	78.4%	61.5%	78.6%	75.0%	71.4%	73.2%
		4.32	Stroke - Greater than 80% of treatment on stroke unit	90%	82.9%	100%	88.9%	88.6%	96.6%	88.9%	93.9%	91.9%	94.1%	84.3%	81.0%	96.9%	88.6%	92.8%
		4.33	Stroke - % of patients treated by the SESDC	48%	48.7%	58.5%	50.0%	53.9%	69.2%	52.4%	63.6%	48.0%	63.2%	49.1%	66.7%	54.2%	73.3%	63.8%
		4.34	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start	80%	81.8%	97.8%	92.1%	97.8%	96.7%	94.0%	88.0%	90.0%	96.2%	86.8%	91.1%	90.6%	88.9%	89.8%
		4.35	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72h	75%	92.5%	88.6%	89.2%	79.6%	86.2%	73.5%	89.6%	78.4%	87.5%	89.6%	80.0%	76.2%	75.0%	75.6%
		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%	57.0%	ND	ND	ND	ND	ND	ND	61.0%	ND	ND	ND	ND	ND	ND
		4.38	Stroke -Provider rating to remain within A-C	C	NA	C	NA	NA	C	NA	NA	C	NA	NA	ND	NA	NA	NA

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Are we..		Ref.	KPI	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	YTD(Apr19-May19)
4. Responsive	Other	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	95%	100%	100%	100%	100%	ND	100%	100%	100%	ND	100%	100%	100%	100%	100%
		4.40	Nursing & therapy Red referrals seen within 4hrs - Community	95%	100%	100%	98.2%	100%	100%	100%	100%	100%	96.6%	100%	100%	100%	100%	100%
		4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	95%	99.4%	99.5%	97.4%	99.4%	99.5%	99.0%	99.9%	100%	99.0%	98.8%	99.3%	99.2%	99.5%	99.3%
		4.42	Nursing & therapy Green referrals seen within 18 wks -Community	95%	99.9%	100%	100%	100%	99.6%	99.7%	99.2%	98.0%	99.5%	99.5%	99.5%	99.4%	99.5%	99.4%
		4.43	Wheelchair waiting times – Child (Community)	92%	100%	95.2%	90.9%	100%	100%	100%	83.3%	83.3%	81.8%	94.1%	100%	100%	100%	100%
		4.44	Wheelchair waiting times - Adult (Community)	NT	78.3%	80.0%	54.9%	100%	73.1%	ND	ND	ND	ND	ND	ND	ND	ND	ND
		4.45	Sepsis - 1 hr neutropenic sepsis	100%	80.0%	57.9%	80.0%	72.2%	90.9%	90.0%	75.0%	77.8%	81.0%	75.0%	87.5%	100%	91.7%	95.8%
		4.48	% of initial health assessments completed within 15 working days of receiving all relevant paperwork.	95%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93.3%	40.0%	66.7%
		4.46	Percentage of Children in Care initial health assessments completed within 28 calendar days of becoming a child in care	100%	4.8%	8.0%	23.1%	31.6%	11.8%	33.3%	21.4%	15.4%	0.0%	20.0%	14.3%	33.3%	40.0%	36.7%
		4.47	Percentage of Service Users (children) assessed to be eligible for NHS Continuing Healthcare whose review health assessment is completed annually	80%	ND	ND	ND	ND	86.7%	86.2%	90.0%	97.0%	100%	100%	ND	99.0%	96.2%	97.6%

EXCEPTION REPORTS – RESPONSIVE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

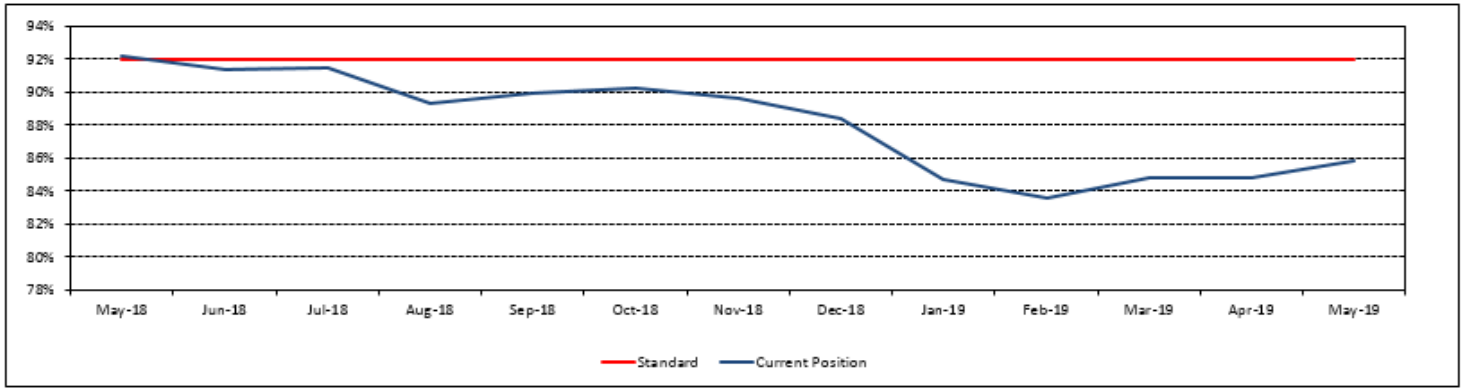
Indicator	RTT: % incomplete pathways within 18 weeks
Standard	92%
Executive Lead	Helen Beck
Month	May-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Slight improvement in performance from April to May. Patients are exceeding their waiting times in multiple specialities, with significant impact in Vascular, Ophthalmology, Cardiology, General Surgery, T&O and Gynaecology. Waiting times for first appointment in Vascular, Cataract surgery in Ophthalmology, ECHO's in Cardiology, Joints in T&O and first appointment and Urogynae in Gynaecology are the main focus.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%
Current Position	92.2%	91.4%	91.4%	89.3%	89.9%	90.2%	89.7%	88.3%	84.7%	83.6%	84.8%	84.8%	85.8%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Action plan for recovery in place for all specialities not meeting performance	HK	Dec-18	
Continue to monitor long waits at weekly access meeting	HK	Aug-18	
Capacity and Demand models to be refreshed	HK/AB	Jun-19	Jul-19
Full action plan to be completed with all options for out/in sourcing and additional internal activity	AB	Jun-19	Jul-19



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

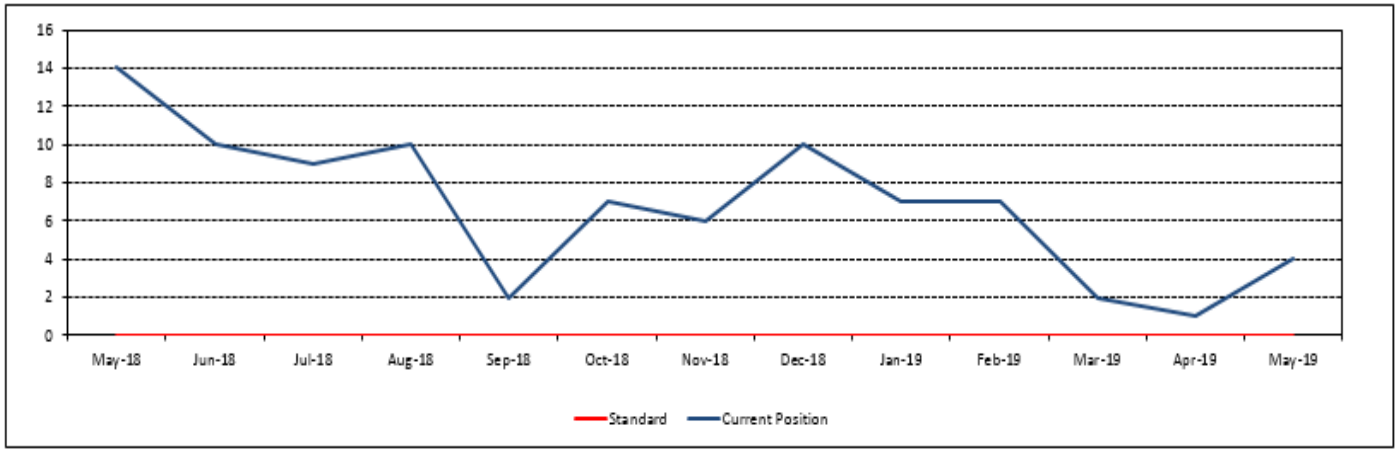
Indicator	52 week waiters
Standard	0
Executive Lead	Helen Beck
Month	May-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

4 patients were waiting over 52 weeks at the end of May. They consist of; 1 x Gynaecology/Colorectal - this is a major joint case that needed a lot of build up to surgery and a date for 2 surgeons to perform 2 operations plus the patient needed to be adequately counselled prior to surgery - TCI date is 19/06/2019. 1 x Trauma and Orthopaedic - unfortunately this patient had been incorrectly coded with a stop clock, when this was put right they were at 59 weeks, they were offered a date in July but unable to attend until 03/07/19 due to holidays. 1 x Vascular - extended wait for 1st appointment due to Vascular capacity and then multiple diagnostics, TCI date is 27/06/2019 and 1 x General Surgery - patient did have a date in May that had to be cancelled due to a chest infection, patient was then on holiday and unable to attend until TCI date of 13/06/2019.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	14	10	9	10	2	7	6	10	7	7	2	1	4

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

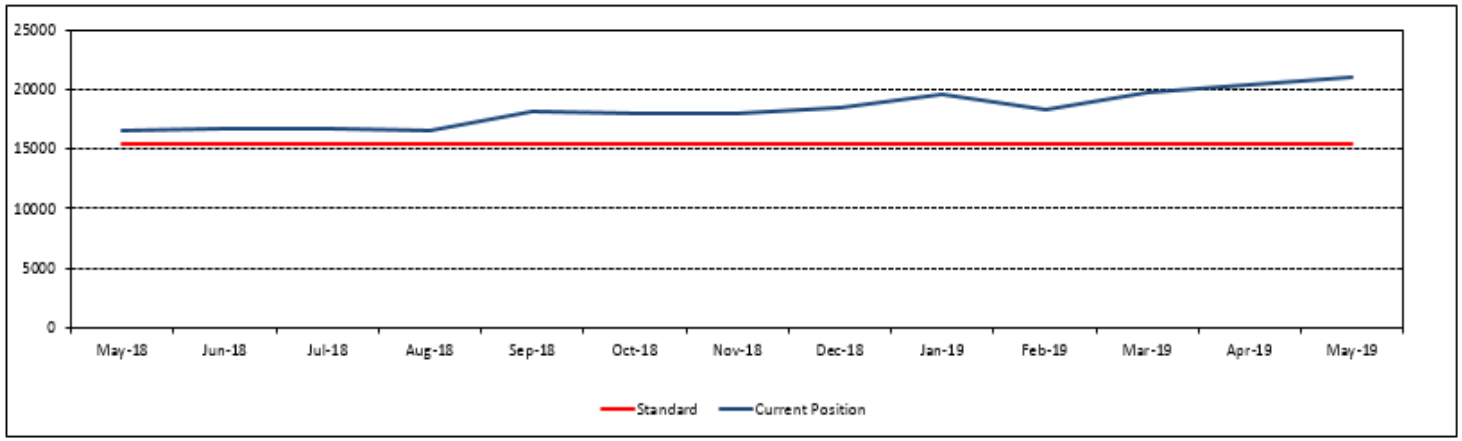
Indicator	RTT waiting List
Standard	15396
Executive Lead	Helen Beck
Month	May-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Overall number increase in Cardiology, Gastroenterology, General Surgery, Gynaecology and Ophthalmology.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396	15396
Current Position	16481	16739	16715	16601	18105	18071	17915	18426	19601	18341	19730	20427	21061

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Action plan for recovery in place for all specialities not meeting performance	HK	Dec-18	
Continue to monitor long waits at weekly access meeting	HK	Aug-18	
Capacity and Demand models to be refreshed	HK/AB	Jun-19	Jul-19
Full action plan to be completed with all options for out/in sourcing and additional internal activity	AB	Jun-19	Jul-19



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

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

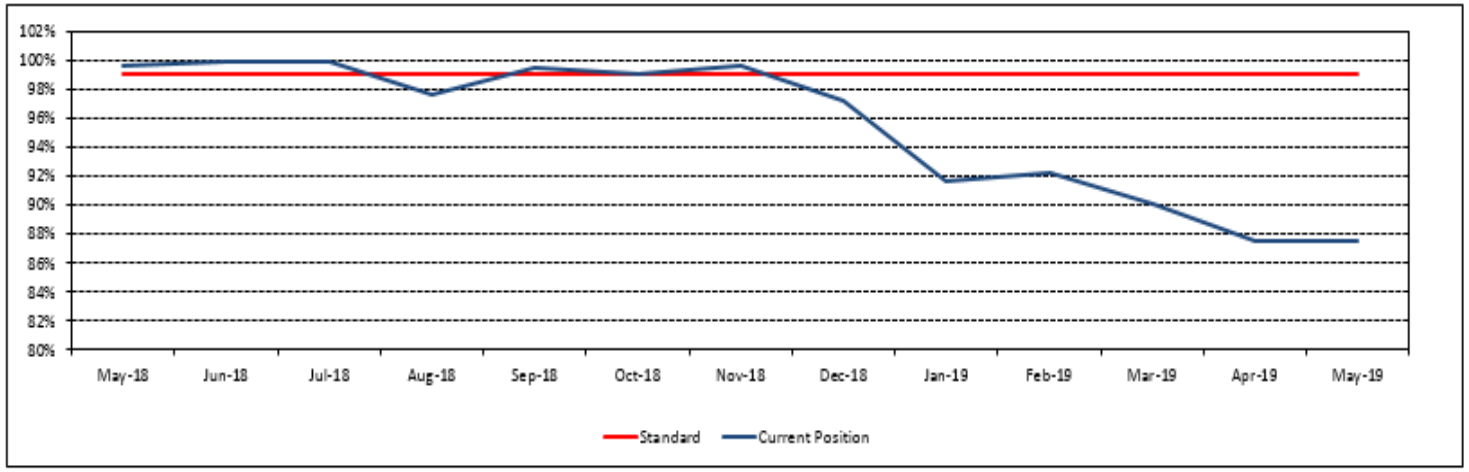
Summary of Current performance & Reasons for under performance

Cystoscopy performance continues to be impacted by capacity. Work is underway to add cystoscopy referrals in to eCare with change request now agreed. This will allow a better evaluation of demand and capacity in the diagnostic part of the urology service. Further work to look at using a portable cystoscope to increase capacity at peripheral clinics.

Cardiology -There is recovery action plan for cardiology diagnostics in place, with milestones being met. End of week snapshot performance is (16.6.19) 72.74% and end of June predicted at 80.46%. This means we are on target for compliance by the end of July.

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

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

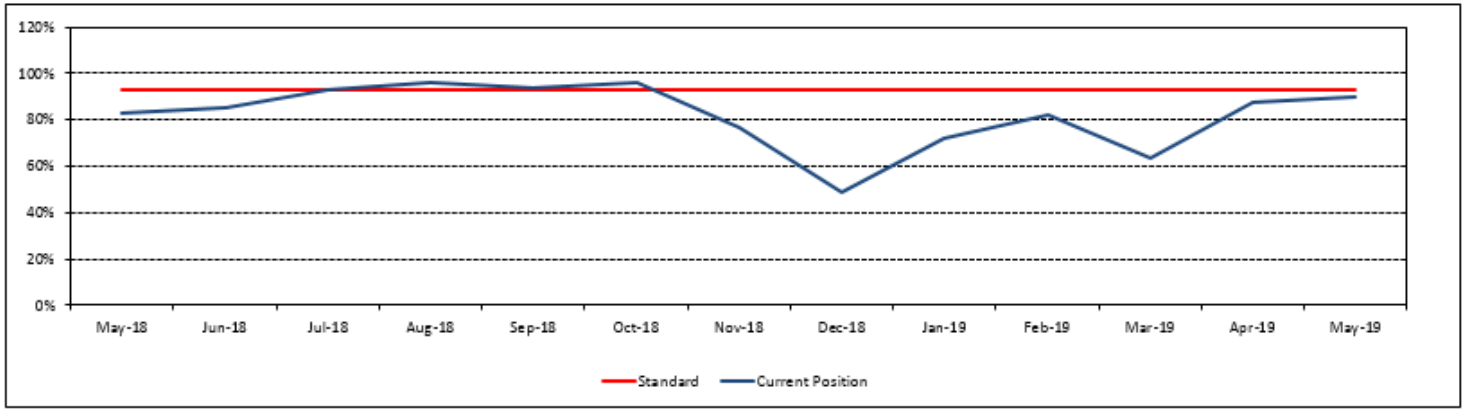
Indicator	Cancer 2w wait breast symptoms
Standard	93%
Executive Lead	Helen Beck
Month	May-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Performance continues to improve for Breast Symptomatic. The under performance is primarily due to patient choice, 15 out of 18 patients were booked outside of 2 weeks due to patients unavailability.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	82.6%	84.9%	92.8%	95.9%	93.9%	96.4%	76.7%	48.8%	72.1%	82.0%	63.5%	87.8%	90.2%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Revision of the 2WW referral form is in discussion to ensure appropriateness of referrals and allow allocation to correct clinics	HK	Jun-19	Aug-19
Script being devised for the booking team to highlight the importance of attending appointment within 2 weeks	HK	Jun-19	Aug-19



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

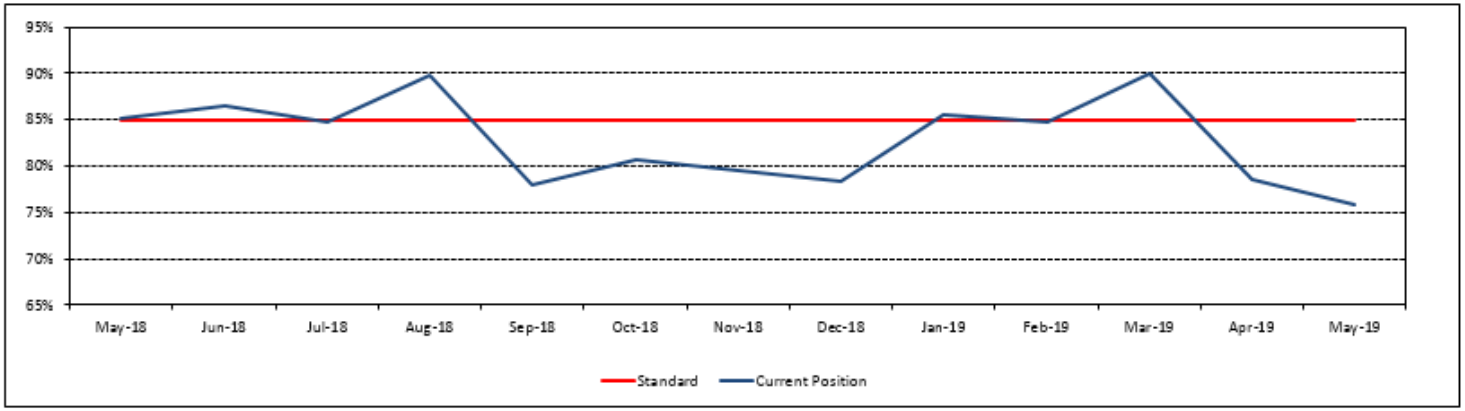
Indicator	Cancer 62 d GP referral
Standard	85%
Executive Lead	Helen Beck
Month	May-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current performance 75.9%: This remains a challenge owing to high number of referrals and delay in diagnostics. In May there are 5- Colorectal; 3- Urology; 2- Upper GI; 2 - Haematology; 1 - Lung; and 2 unexpected breaches in Skin locally in the Trust and five shared pathway breaches: Gynae -1, Head/Neck -1, Lung- 1, Upper GI -1 and Urology -1 some involving cases of late referrals.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Current Position	85.1%	86.5%	84.8%	89.9%	78.0%	80.6%	79.5%	78.3%	85.5%	84.8%	90.0%	78.6%	75.9%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
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	Mar-19	Mar-20
All long wait patients discussed at patient level detail at weekly cancer PTL meeting held with divisional representation	HK	Mar-19	TBC
Options for out/in sourcing of diagnostic work being developed as part of wider diagnostic plans	HK	Jun-16	TBC



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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	May-19
Data Frequency	Monthly
CQC Area	Responsive

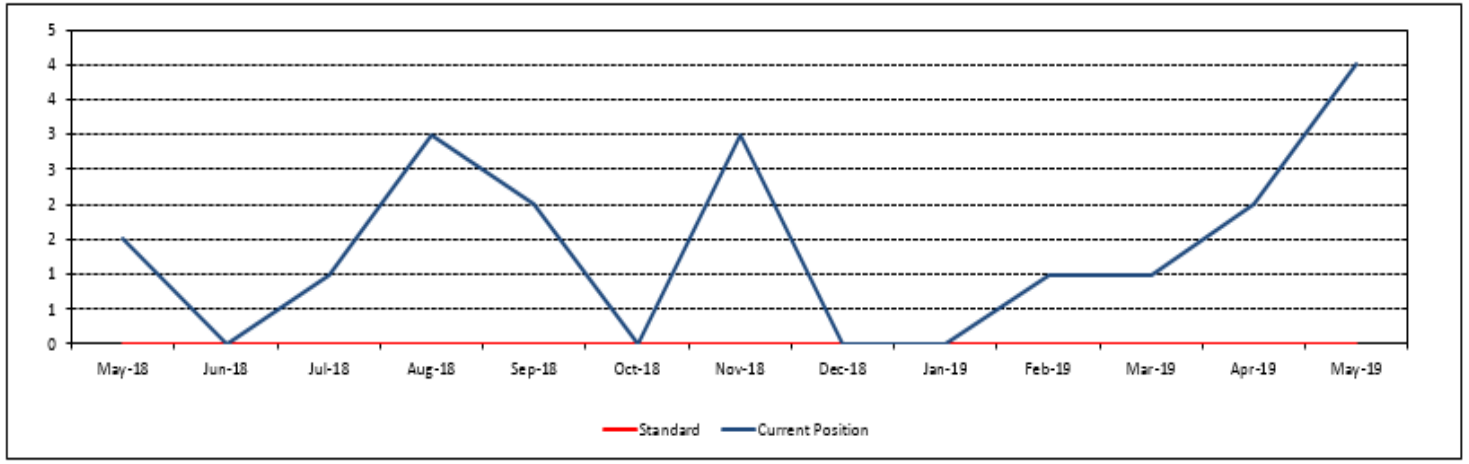
Summary of Current performance & Reasons for under performance

3 Colorectal pathway breach owing to delay in diagnosis/ staging – one patient declined initial investigations and also required medical optimisation before surgery causing delays. One patient delayed diagnostic pathway – by cancelling appointment, holiday reasons.
1 Urology Pathway breach owing to low suspicion and multi staged investigations delaying tissue diagnosis and patient suitable for monitoring.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	1.5	0	1.0	3.0	2.0	0	3.0	0	0	1.0	1.0	2.0	4.0

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	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

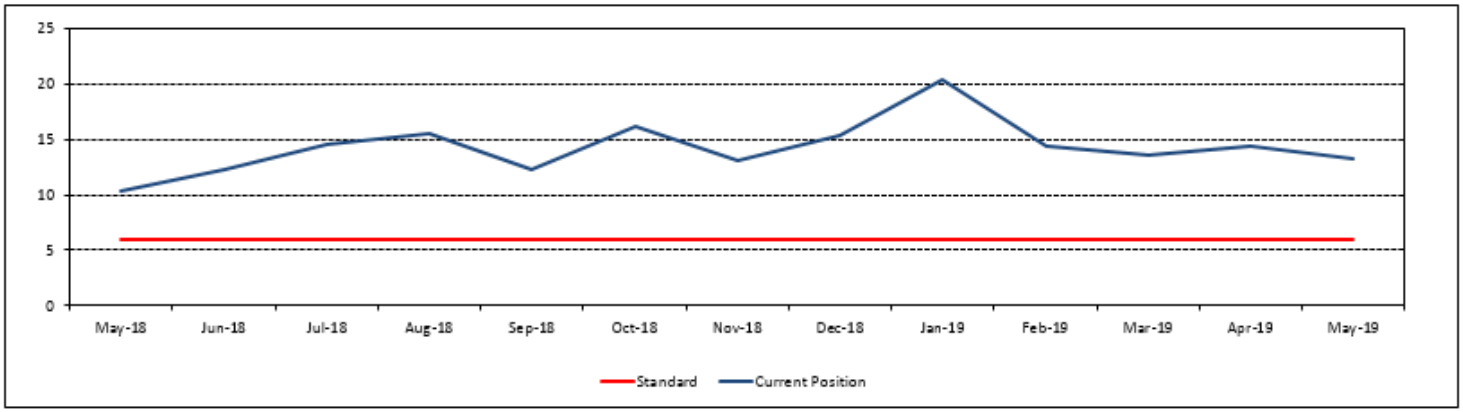
Indicator	A&E - Single longest Wait (Admitted & Non-Admitted)
Standard	6
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

The longest wait in ED in May 2019 was 13 hours 23 . This patient attended at a very busy time where there were 45 patients in department. Escalation was open and Resus was full. Patient arrived 22.01, was triaged in escalation at 22.12 (11 mins), seen by ED Doctor 00.23 (2 hours 22 mins), referred to medics, bed requested 02.45 (4 hours 44 mins) and patient admitted to AAU at 11.24.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	6	6	6	6	6	6	6	6	6	6	6	6	6
Current Position	10.30	12.22	14.49	15.54	12.23	16.17	13.05	15.35	20.32	14.35	13.55	14.35	13.23

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 to improve flow and reduce bed waits for patient requiring admission.	ED Team	Nov-18	Ongoing



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

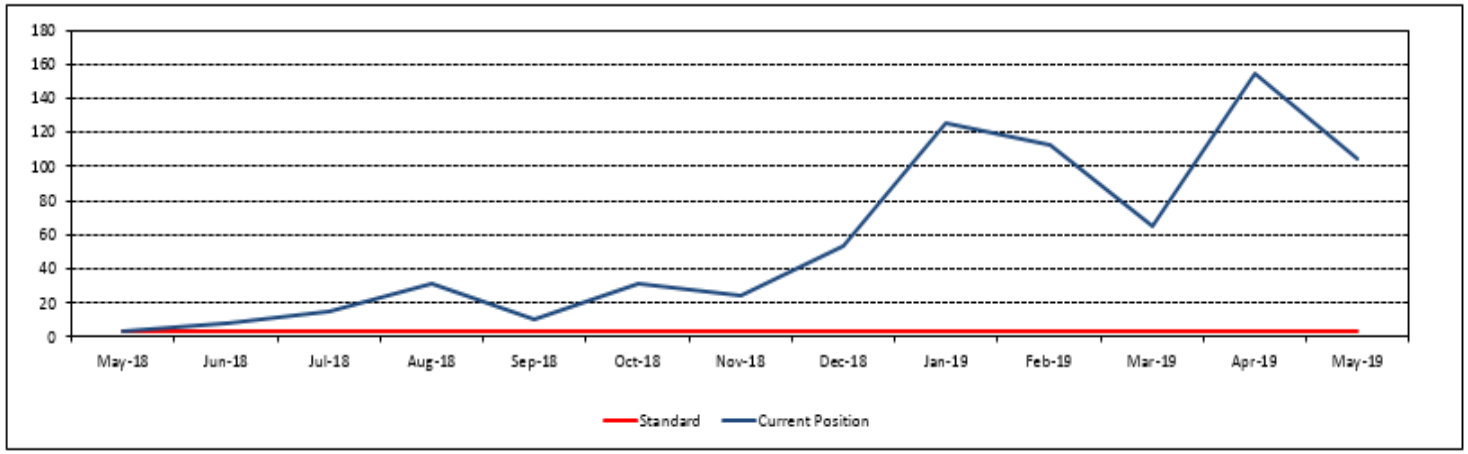
Indicator	A&E - Admission waiting 4-12 hours from dec. to admit
Standard	4
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

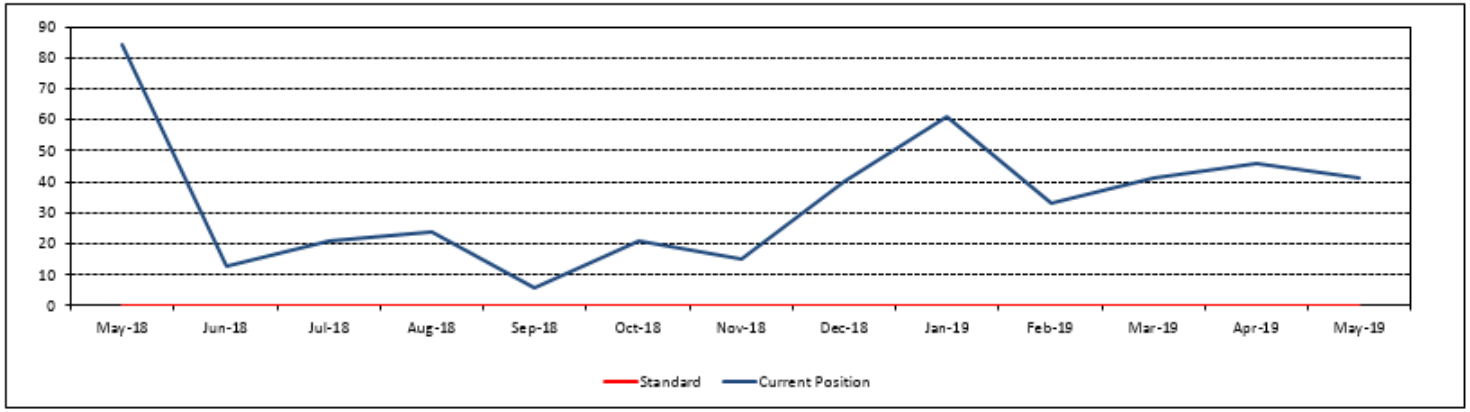
Indicator	A&E - Amb. Handover above 30m
Standard	0
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

There were 41 handovers above 30 minutes in May due to continued high level of activity and space limitations within ED.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	84	13	21	24	6	21	15	40	61	33	41	46	41

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Comprehensive joint recovery plan in place between WSFT and EEAST	IP	Jan-19	Sep-19



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

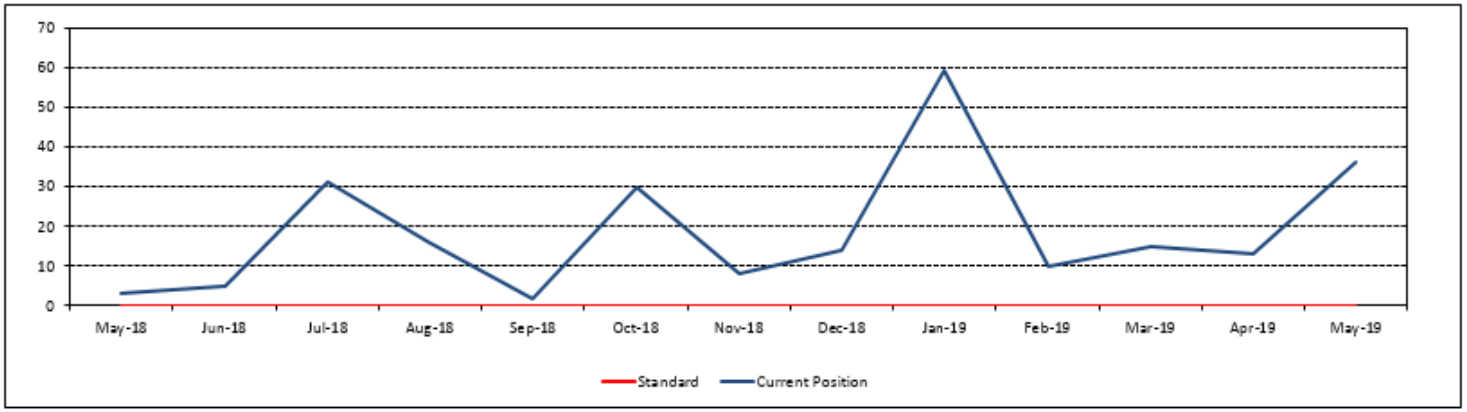
Indicator	A&E - Amb. Handover above 60m
Standard	0
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

There were 36 handovers over 60 minutes in May due to continued high activity and space limitations.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	3	5	31	16	2	30	8	14	59	10	15	13	36

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Comprehensive joint action plan in place between EEAST and WSFT	IP	Jan-19	Sep-19



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

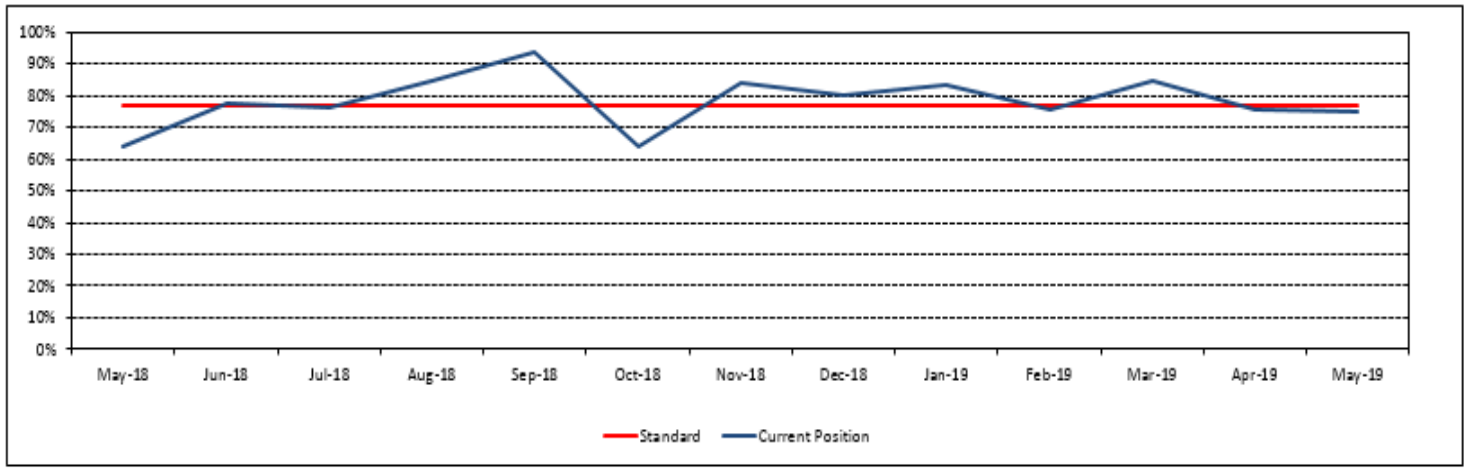
Indicator	Stroke - % Patients scanned within 1 hr.
Standard	77%
Executive Lead	Helen Beck
Month	May-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

There were nine breaches for patients scanned in one hour. Six patients presented with atypical symptoms, and were not initially thought to be stroke patients on arrival. Two patients were very near misses, one breaching by 3mins and one by 6mins, one of these was an inpatient where the patient was appropriately assessed before scanning, and one patient was delayed in getting to the scanner. Finally, one patient was referred to medics by Early Stroke outreach team initially as comorbidities and history were unconvincing for stroke on arrival.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%	77%
Current Position	63.6%	77.7%	76.3%	84.4%	93.3%	64.0%	84.0%	80.0%	83.0%	75.5%	84.4%	75.8%	75.0%

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

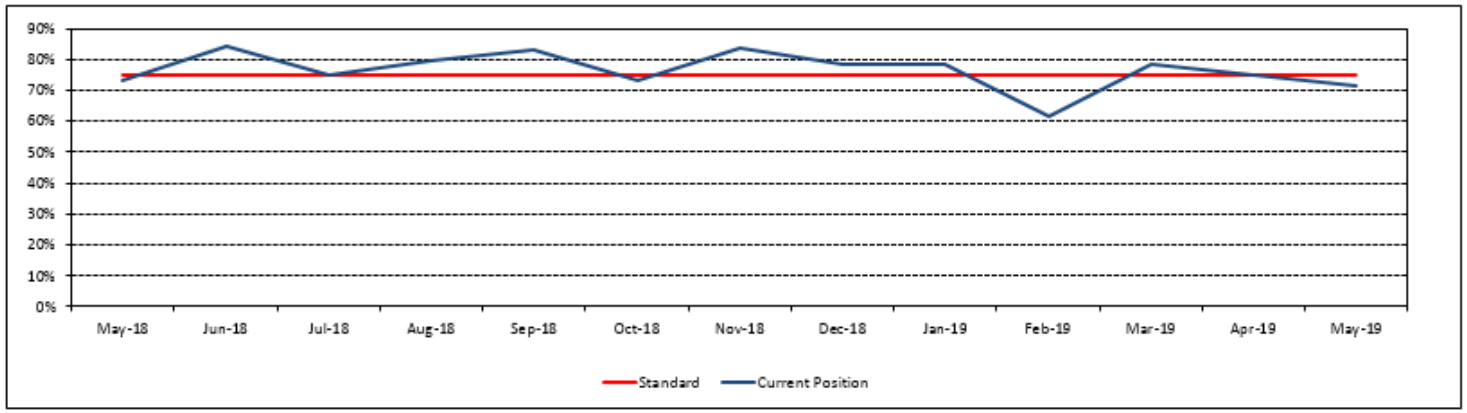
Indicator	Stroke - % Patients admitted directly to stroke unit within 4h
Standard	75%
Executive Lead	Helen Beck
Month	May-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Ten patients breached the 4 hours to scan target, four of these were caused by the lack of ring fenced beds. Six of these were caused by patients arriving with atypical presentations, they were not initially thought to be stroke patients on arrival, therefore, they were not admitted to the stroke unit directly or within 4 hours. All patients with a stroke diagnosis were admitted to the stroke unit after stroke team assessment.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
Current Position	73.2%	84.1%	75.0%	79.6%	82.8%	73.3%	83.7%	78.4%	78.4%	61.5%	78.6%	75.0%	71.4%

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

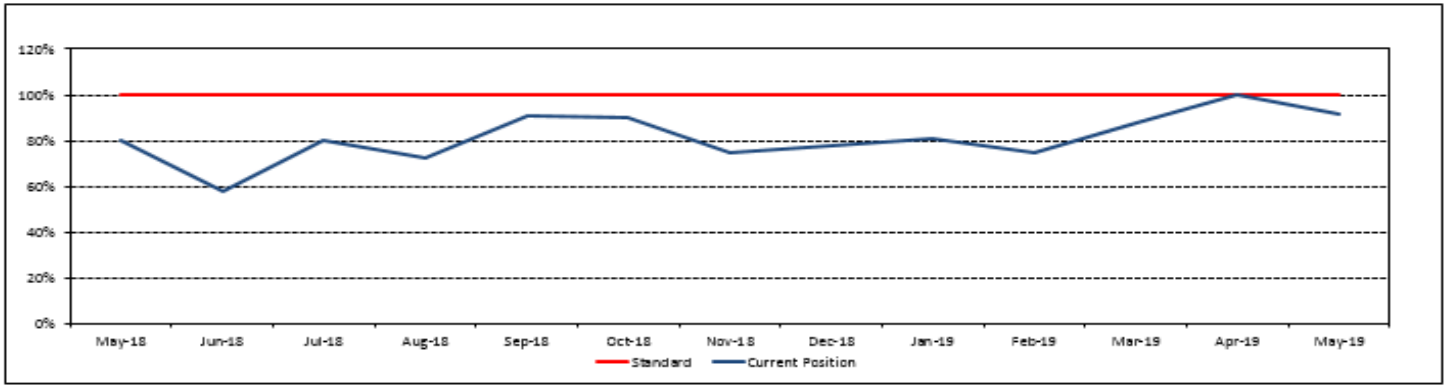
Indicator	Sepsis - 1hr neutropenic sepsis
Standard	100%
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Performance against national standards for Door to Needle time for Neutropenic was 91.7% for the month of May. 6 patient's were admitted to G1 and all received required treatment with the 1 hour time scale. Of the 6 patients who were admitted through ED, 5 were treated within the hour (83.3%) - 1 breached the national standard. Please see below action plan to address the issues and improve performance against this standard.

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

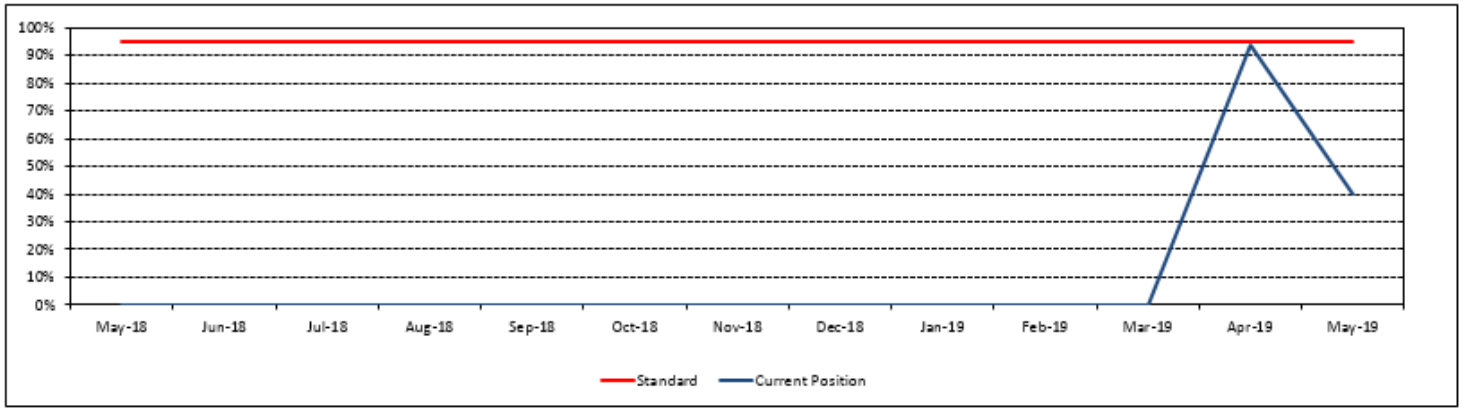
Indicator	% of initial health assessments completed within 15 working days of receiving all relevant paperwork.
Standard	95%
Executive Lead	Helen Beck
Month	May-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

4 out of 10 children were assessed within 15 working days of the service being notified. 2 of the remaining 6 were assessed within 18 working days and the remaining 4 were seen within 21 working days.

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

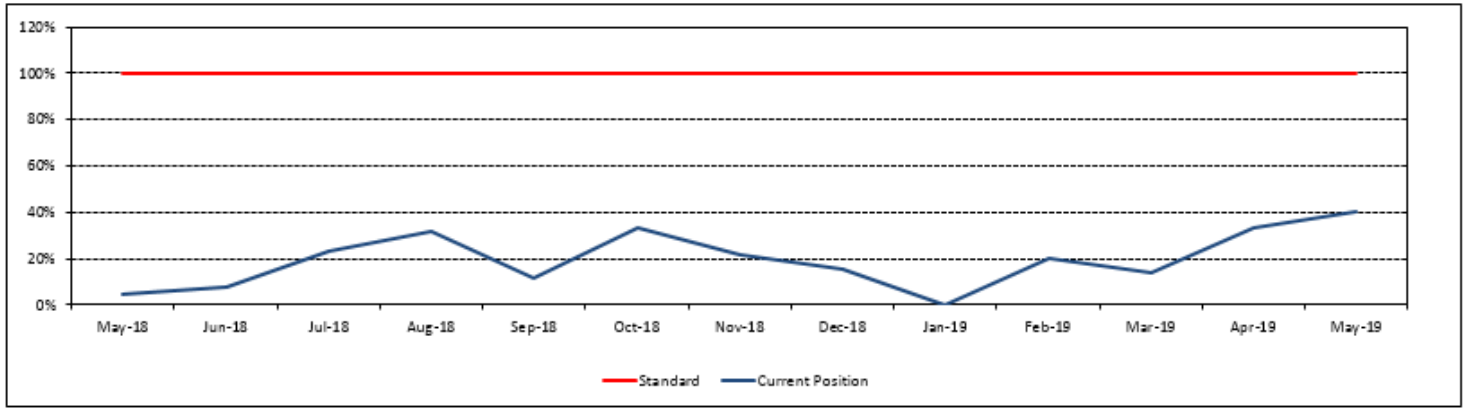
Indicator	Percentage of Children in Care initial health assessments completed within 28 calendar days of becoming a child in care
Standard	100%
Executive Lead	Helen Beck
Month	May-19
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

2 out of 10 children seen within 28 days of becoming a Child in Care
8 breaches, the 168 day breach was due to 140 day delay in notifying the service that the child have been placed in care. 4 of the remaining 7 breaches had a delay of 23 days or more of notifying the service.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	4.8%	8.0%	23.1%	31.6%	11.8%	33.3%	21.4%	15.4%	0.0%	20.0%	14.3%	33.3%	40.0%

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



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8. DETAILED REPORTS – WELL-LED

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

Are we.		Ref.	KPI	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	YTD(Apr19 May19)
5. Well Led	Agency, WTE & vacancies	5.09	Agency Spend Cap	486	196	330	433	507	393	381	620	500	486	486	486	461	461	461
		5.10	Bank Spend		1350	1015	1045	1294	1212	1222	1140	1167	1114	971	1277	698	638	668
		5.12	Proportion of Temporary Staff	12%	11.9%	9.7%	11.3%	12.7%	12.0%	11.8%	12.8%	12.1%	12.7%	9.4%	13.1%	12.3%	12.3%	12.3%
		5.13	Locum and Medical agency spend	NT	319	468	624	524	434	524	570	555	522	389	448	487	238	363
		5.57	Additional sessions	NT	238	207	161	270	250	338	288	266	216	274	283	272	272	272
		5.16	% Staff on Maternity/Paternity Leave	NT	2.30%	2.38%	2.43%	2.60%	2.64%	2.65%	2.73%	2.83%	2.80%	2.64%	2.58%	2.82%	2.67%	2.75%
	Other	5.58	New grievance or employment tribunals in the month	NT	4	0	0	0	0	1	4	0	2	0	1	1	0	1
		5.18	Recruitment Timescales - Av no. of weeks to recruit	7	5.6	5.4	5.4	5.0	6.1	6.4	6.4	6.4	5.3	4.8	5.2	6.0	6.1	6.1
		5.19	DBS checks	95%	97.5%	98.0%	98.0%	98.0%	98.0%	98.5%	97.5%	97.5%	98.0%	98.0%	98.0%	98.0%	98.0%	98.0%
		5.20	Staff appraisal Rates	90%	67.3%	69.3%	75.8%	75.2%	76.9%	76.0%	79.0%	76.4%	77.0%	76.0%	79.0%	77.0%	80.0%	78.5%

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Are we.		Ref.	KPI	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	YTD(Apr19 May19)
5. Well Led	Training	5.22	Infection Control Training (classroom)	90%	95.0%	94.0%	95.0%	95.0%	95.0%	94.0%	95.0%	94.0%	96.0%	96.0%	93.0%	94.0%	95.0%	94.5%
		5.23	Infection Control Training (eLearning)	90%	90.0%	91.0%	90.0%	87.0%	90.0%	89.0%	90.0%	91.0%	91.0%	91.0%	81.0%	82.0%	82.0%	82.0%
		5.24	Manual Handling Training (Patient)	90%	76.0%	77.0%	75.0%	79.0%	76.0%	77.0%	76.0%	76.0%	80.0%	77.0%	78.0%	69.0%	80.0%	74.5%
		5.25	Manual Handling Training (Non Patient)	90%	88.0%	83.0%	83.0%	81.0%	85.0%	82.0%	86.0%	84.0%	87.0%	88.0%	67.0%	56.0%	76.0%	66.0%
		5.26	Staff Adult Safeguarding Training	90%	91.0%	92.0%	90.0%	89.0%	91.0%	91.0%	90.0%	90.0%	91.0%	91.0%	85.0%	85.0%	87.0%	86.0%
		5.27	Safeguarding Children Level 1	90%	90.0%	89.0%	89.0%	88.0%	89.0%	89.0%	90.0%	91.0%	91.0%	90.0%	91.0%	91.0%	92.0%	91.5%
		5.28	Safeguarding Children Level 2	90%	90.0%	91.0%	91.0%	89.0%	90.0%	90.0%	90.0%	91.0%	91.0%	91.0%	86.0%	86.0%	90.0%	88.0%
		5.29	Safeguarding Children Level 3	90%	94.0%	94.0%	94.0%	89.0%	91.0%	91.0%	90.0%	90.0%	91.0%	91.0%	57.0%	51.0%	71.0%	61.0%
		5.30	Health & Safety Training	90%	90.0%	91.0%	91.0%	89.0%	90.0%	89.0%	89.0%	90.0%	89.0%	89.0%	87.0%	87.0%	88.0%	87.5%
		5.31	Security Awareness Training	90%	90.0%	91.0%	90.0%	89.0%	89.0%	88.0%	89.0%	89.0%	89.0%	88.0%	81.0%	83.0%	87.0%	85.0%
		5.32	Conflict Resolution Training (eLearning)	90%	87.0%	87.0%	88.0%	82.0%	83.0%	83.0%	85.0%	86.0%	86.0%	86.0%	68.0%	70.0%	74.0%	72.0%
		5.33	Conflict Resolution Training	90%	70.0%	70.0%	71.0%	73.0%	71.0%	69.0%	74.0%	75.0%	72.0%	72.0%	77.0%	74.0%	78.0%	76.0%
		5.34	Fire Training (eLearning)	90%	82.0%	81.0%	81.0%	84.0%	91.0%	83.0%	85.0%	88.0%	85.0%	83.0%	83.0%	78.0%	83.0%	80.5%
		5.35	Fire Training (classroom)	90%	90.0%	90.0%	89.0%	90.0%	84.0%	89.0%	88.0%	86.0%	89.0%	87.0%	89.0%	88.0%	89.0%	88.5%
		5.36	IG Training	95%	86.0%	83.0%	84.0%	82.0%	82.0%	80.0%	83.0%	82.0%	81.0%	83.0%	78.0%	79.0%	81.0%	80.0%
		5.37	Equality and Diversity	90%	80.0%	79.0%	79.0%	79.0%	80.0%	81.0%	82.0%	84.0%	85.0%	85.0%	87.0%	86.0%	88.0%	87.0%
		5.38	Majax Training	90%	88.0%	89.0%	88.0%	88.0%	88.0%	89.0%	89.0%	90.0%	90.0%	89.0%	78.0%	80.0%	82.0%	81.0%
		5.39	Medicines Management Training	90%	87.0%	88.0%	89.0%	87.0%	86.0%	87.0%	87.0%	87.0%	87.0%	86.0%	80.0%	81.0%	83.0%	82.0%
		5.40	Slips, trips and falls Training	90%	85.0%	86.0%	86.0%	86.0%	85.0%	86.0%	85.0%	87.0%	86.0%	86.0%	74.0%	76.0%	79.0%	77.5%
		5.41	Blood-borne Viruses/Inoculation Incidents	90%	86.0%	87.0%	88.0%	85.0%	86.0%	87.0%	88.0%	89.0%	89.0%	87.0%	78.0%	80.0%	83.0%	81.5%
		5.42	Basic life support training (adult)	90%	76.0%	76.0%	75.0%	79.0%	79.0%	79.0%	80.0%	80.0%	81.0%	80.0%	79.0%	73.0%	81.0%	77.0%
		5.43	Blood Products & Transfusion Processes (Refresher)	90%	72.0%	73.0%	74.0%	74.0%	73.0%	74.0%	75.0%	76.0%	77.0%	76.0%	65.0%	62.0%	68.0%	65.0%
		5.44	Mandatory Training Compliance	90%	84.0%	85.0%	84.0%	84.0%	85.0%	85.0%	86.0%	86.0%	85.0%	86.0%	82.0%	82.0%	85.0%	83.5%

EXCEPTION REPORTS – WELL LED

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

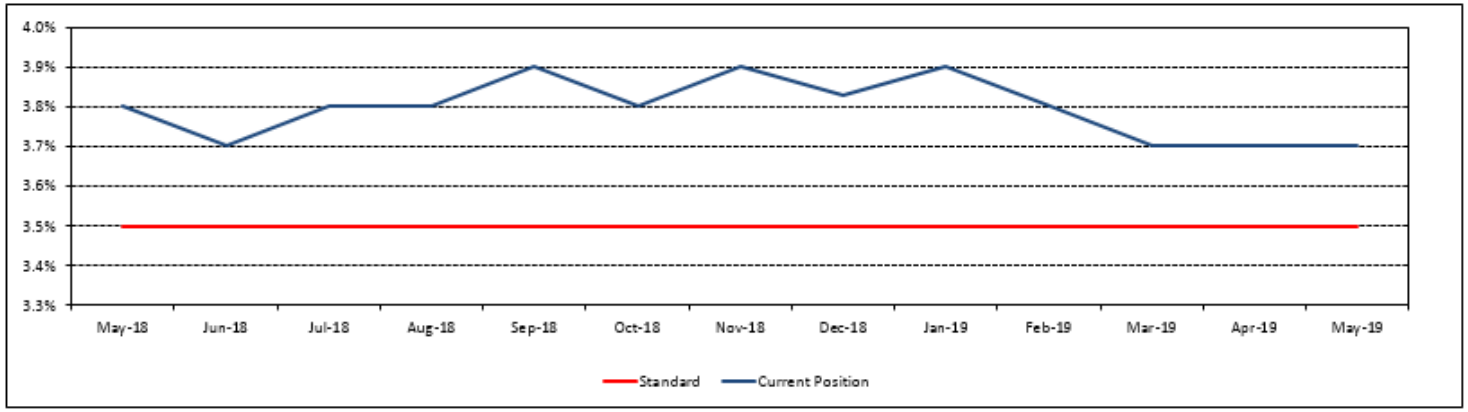
Indicator	Sickness Absence
Standard	3.5%
Executive Lead	Jan Bloomfield
Month	May-19
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Current performance remains at 3.7% and has been this for 3 months.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
The trust continues to monitor sickness absence in line with our policies, for both short and long term absences. We offer support to staff through a number of mechanisms; return to work meetings, occupational health, care first, staff physiotherapy, health & wellbeing initiatives etc. the trusts sickness average percentage is better that the acute average for the country, which is 3.82%	Denise Needle		



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

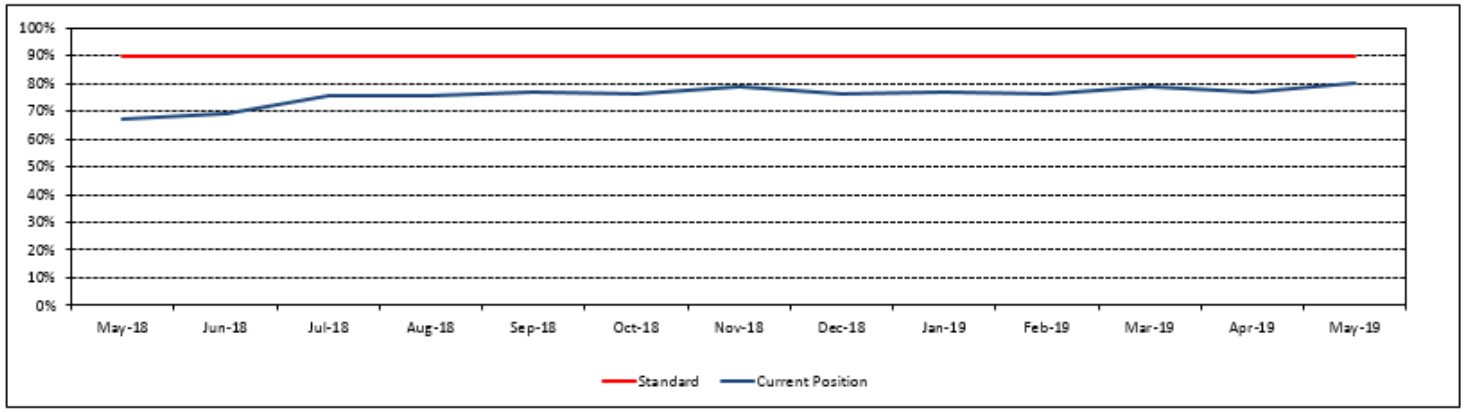
Indicator	Staff appraisal Rates
Standard	90%
Executive Lead	Jan Bloomfield
Month	May-19
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

The percentage increase has hit 80% this month. Showing a slow and steady rise towards 90%.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	67.3%	69.3%	75.8%	75.2%	76.9%	76.0%	79.0%	76.4%	77.0%	76.0%	79.0%	77.0%	80.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
A trust board paper will be presented to the June Board meeting outlining the actions proposed to improve compliance levels.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

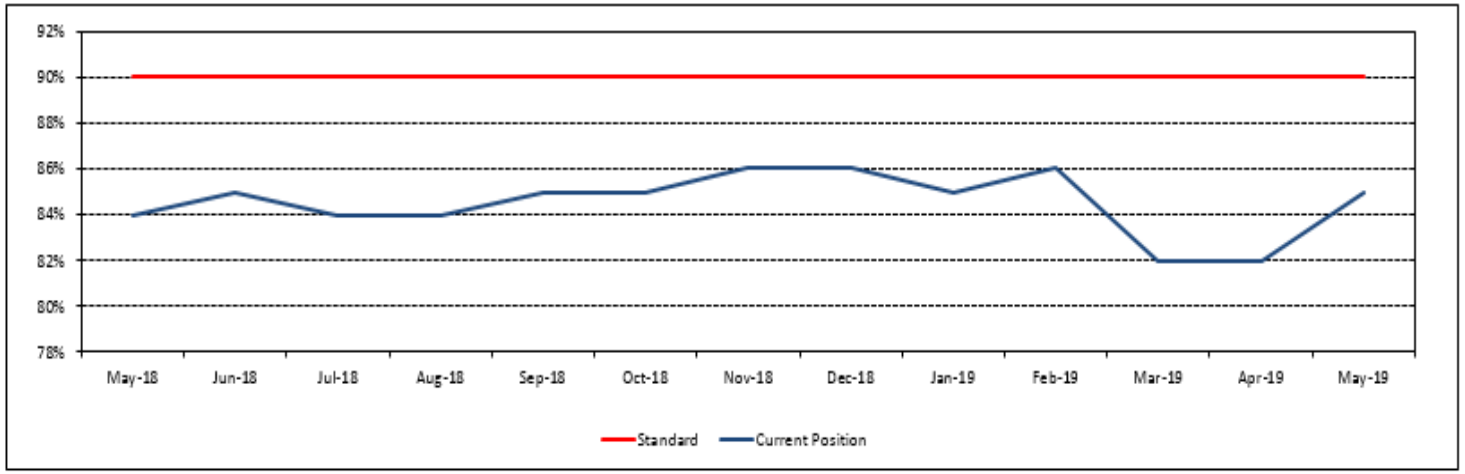
Indicator	Mandatory Training Compliance
Standard	90%
Executive Lead	Jan Bloomfield
Month	May-19
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Current performance shows a 3% increase on last month, which is likely to be the impact of the move away from winter pressures on staff undertaking mandatory training.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
A trust board report is being presented at the June board which will give a comprehensive action plan.			



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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	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	YTD(Apr19-May19)
6. Productive	Activity	6.07	A&E Activity	NT	6498	6161	6564	6072	6042	6256	6114	6155	6371	5741	6695	6729	6946	13675
		6.08	NEL Activity	NT	2491	2491	2465	2394	2356	2638	2770	2520	2750	2467	2604	2482	2711	5193
		6.09	OP - New Appointments	NT	6930	6379	6598	6007	6113	7381	7255	5995	7059	6419	7086	8382	8934	17316
		6.10	OP- Follow-Up Appointments	NT	12248	11520	11750	10929	10879	12773	12289	9834	12610	11107	11536	22314	19817	42131
		6.11	Electives (Incl Daycase)	NT	3020	2799	2870	2786	2379	3033	3047	2519	3202	2957	2971	2807	2974	5781
	Finance	6.12	Financial Position (YTD)	Var	-2793	-3159	-4420	-5641	-7119	-7122	-7494	-6534	-8691	-7955	-287	-883	-1447	-2330
		6.13	Financial Stability Risk Rating	Var	3	3	3	3	3	3	3	3	3	3	3	3	3	6
		6.14	Cash Position (YTD £000s)	Var	4550	2239	6852	7231	3934	1338	5162	3518	4924	6870	3600	11140	5825	16965
	Ratios	6.15	% Consultant to Consultant Referrals	NT	17.0%	16.0%	16.0%	16.0%	15.0%	14.0%	15.0%	17.0%	16.0%	17.0%	15.0%	17.0%	16.0%	16.5%
		6.16	New to FU Ratios	NT	2.25	2.34	2.23	2.32	2.34	2.27	2.16	2.16	2.31	2.37	2.20	2.66	2.22	2.44

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EXCEPTION REPORTS – PRODUCTIVE

The finance report contains full details.

10. DETAILED REPORTS- MATERNITY

Are we..		Ref.	KPI	Target	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	YTD(Apr19-May19)
7.Maternity	Safe	7.09	Elective Caesarean Sections	12%	10.9%	7.6%	4.7%	7.8%	9.6%	8.6%	10.4%	9.1%	6.7%	9.3%	11.2%	9.3%	11.3%	10.3%
		7.10	Emergency Caesarean Sections	14%	11.4%	10.6%	12.4%	9.2%	13.0%	14.1%	15.4%	16.3%	16.2%	11.0%	15.6%	11.5%	11.8%	11.7%
		7.11	Grade 1 Caesarean Section (Decision to delivery time met)	100%	100%	100%	100%	100%	100%	40.0%	100%	100%	100%	100%	100%	100%	100%	100%
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)	80%	93.0%	90.0%	58.0%	64.0%	82.0%	71.0%	57.0%	79.0%	76.1%	92.3%	87.0%	100%	85.0%	92.5%
		7.13	Homebirths	2%	5.0%	1.5%	2.4%	1.5%	3.8%	1.8%	2.0%	1.0%	2.2%	2.9%	2.8%	3.8%	3.1%	3.5%
		7.14	Midwifery led birthing unit (MLBU) births	>13%	11.4%	11.4%	18.8%	17.0%	11.5%	14.4%	NA	NA	NA	NA	NA	24.0%	14.4%	19.2%
		7.15	Labour Suite births	77.5%	83.0%	86.9%	78.2%	80.6%	83.7%	82.7%	82.6%	83.0%	78.8%	77.9%	82.1%	71.0%	82.1%	76.6%
		7.16	Induction of Labour	29.3%	37.8%	40.9%	37.6%	36.4%	34.1%	35.5%	38.3%	42.1%	40.8%	39.0%	42.2%	35.0%	39.5%	37.3%
		7.17	Instrument Assisted Deliveries (Forceps & VentoUse)	>14%	9.5%	10.1%	10.0%	12.6%	11.5%	11.8%	13.9%	8.1%	8.9%	12.2%	11.7%	8.2%	8.2%	8.2%
		7.18	Critical Care Obstetric Admissions	0	2	1	0	1	1	0	0	3	1	0	0	0	0	0
		7.19	Eclampsia	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0
	Effective	7.20	Shoulder Dystocia	2	6	8	5	6	9	9	4	4	6	4	4	9	2	11
		7.21	Post-partum Hysterectomies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		7.22	Women requiring a blood transfusion of 4 units or more	0	0	1	2	0	0	1	0	1	1	0	1	1	0	1
		7.23	3rd and 4th degree tears (all deliveries)	12	4	6	4	7	7	3	8	2	6	2	0	7	2	9
	Caring	7.24	Maternal death	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
		7.25	Stillbirths	NT	1	0	1	0	0	0	0	0	0	0	0	1	1	2
		7.26	Complaints	NT	ND	0	3	1	0	1	1	0	3	3	1	0	0	0
		7.27	No. of babies admitted to Neonatal Unit (>36+6)	NT	10	9	7	13	8	9	10	15	7	7	9	8	8	16
	Responsive	7.28	No. of babies transferred for therapeutic cooling	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
		7.29	One to one care in established labour	100%	93.0%	92.3%	97.0%	97.0%	100%	100%	100%	99.0%	100%	100%	100%	100%	100%	100%
		7.30	Reported Clinical Incidents	50	56	48	27	39	44	34	42	38	50	40	59	56	47	103
		7.31	Hours of dedicated consultant cover per week	60	90	93	93	90	87	87	99	93	105	87	98	96	105	201
		7.32	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	10	20
		7.34	No. of women identified as smoking at booking	NT	31	22	19	21	23	22	20	34	20	18	28	23	25	48
		7.35	No. of women identified as smoking at delivery	NT	26	14	15	27	21	22	18	31	18	16	27	20	20	40
		7.36	UNICEF Baby friendly audits	10	ND	10	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND
		7.37	Proportion of parents receiving Safer Sleeping Suffolk advice	80%	77.8%	81.8%	88.0%	80.0%	96.0%	97.0%	95.0%	97.5%	96.1%	97.0%	94.5%	95.0%	85.6%	90.3%
	Other	7.38	No. of bookings (First visit)	NT	251	237	252	236	231	234	222	206	278	226	242	231	251	482
		7.39	Women booked before 12+6 weeks	95%	96.0%	96.6%	94.4%	96.0%	92.0%	92.0%	98.0%	95.1%	96.0%	96.4%	92.0%	95.0%	95.0%	95.0%
		7.40	Female Genital Mutilation (FGM)	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0

EXCEPTION REPORTS – MATERNITY

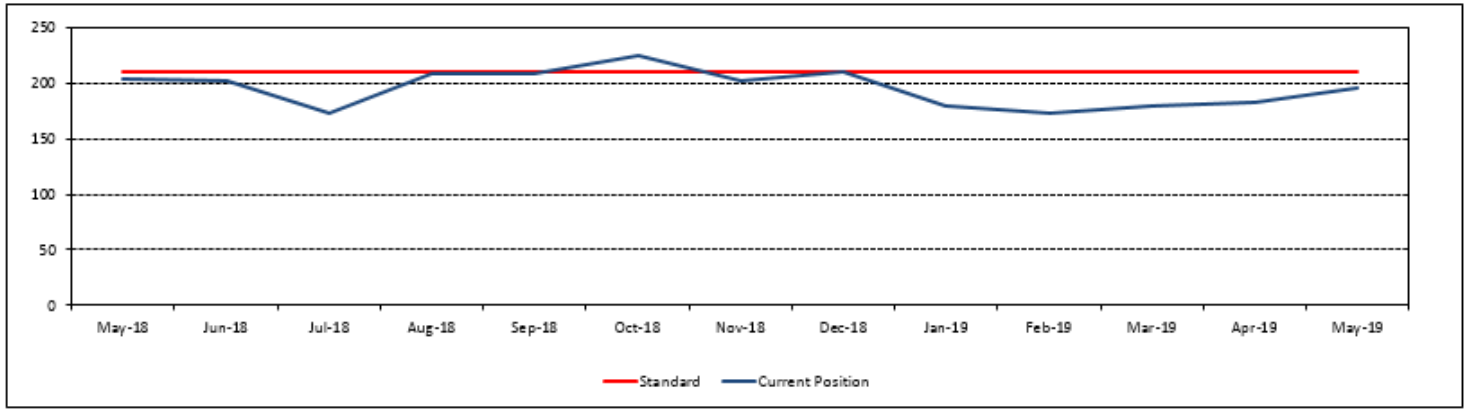
WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT	
Indicator	Total number of deliveries (births)
Standard	210
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Since the fall in delivery numbers in January there has been a slow but steady increase in the number of deliveries

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	210	210	210	210	210	210	210	210	210	210	210	210	210
Current Position	203	201	172	208	208	224	202	209	179	172	179	183	195

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

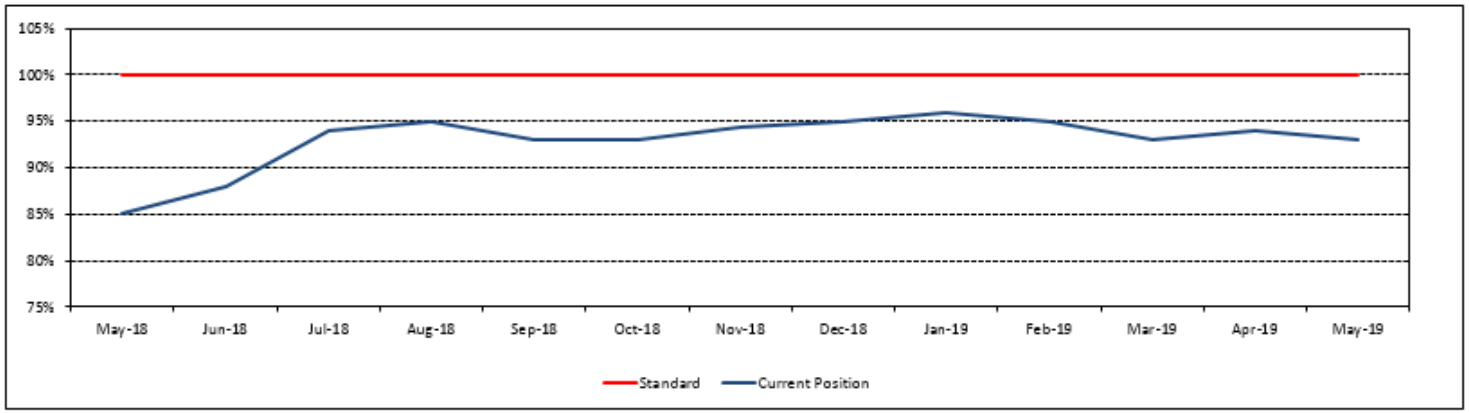
Indicator	Completion of WHO checklist
Standard	100%
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The figures for completion of the WHO checklist continue to be disappointing. The Operating department practitioner and Scrub nurse continue to have the biggest impact on the figures with 11 non compliance. However unusually the surgeons compliance over the last few month has dropped with 8 failures. The Manager for theatres receives a copy of the audit with the names of staff who have been non compliant. Medical staff receive an individual email the clinical director and lead consultants are copied in.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	85.0%	88.0%	94.0%	95.0%	93.0%	93.0%	94.4%	95.0%	96.0%	95.0%	93.0%	94.0%	93.0%

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

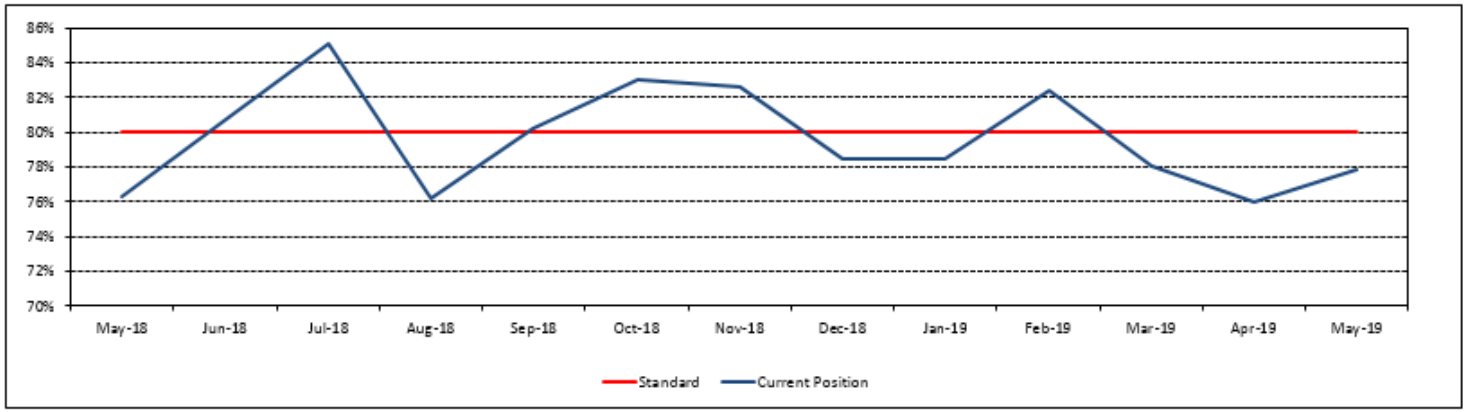
Indicator	Breastfeeding Initiation Rates
Standard	80%
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Breastfeeding initiation rate measures the rates of live born babies born between 34 and 42 +6 weeks. This month there is a small upward rise this month to 77.8%. Although this has not reach the standard of 80%, it is above the national figure of 74.1% in England the National Maternity and Perinatal Audit 2016. Last month we highlighted the low initiation rate and high supplementation rate which may have increased the focus on breastfeeding generally. We continue to promote the advantages of breastfeeding and support women in their choice of feeding.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Current Position	76.3%	80.7%	85.1%	76.2%	80.2%	83.0%	82.6%	78.5%	78.5%	82.4%	78.1%	76.0%	77.8%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to promote the advantages of breast feeding and support women in their choice of feeding.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

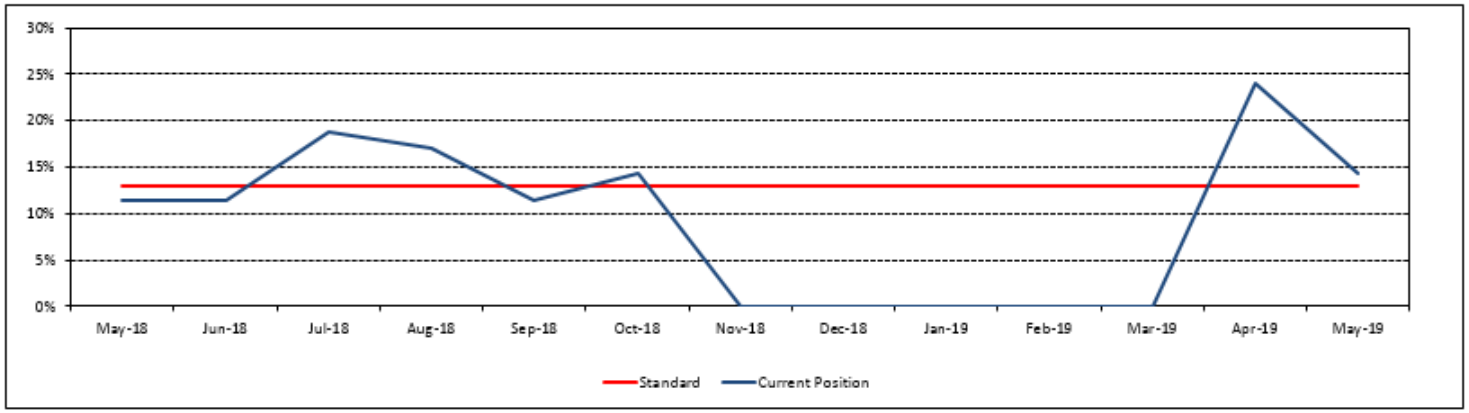
Indicator	Midwifery led birthing unit (MLBU) births
Standard	13%
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

During phase 2 the Labour Suite refurbishment both low risk women and lower end of high risk give birth on Midwifery led birthing unit and therefore cannot be calculated accurately. The completion of phase 2 should be over the next month when data should be more accurate assessment of Midwifery led birthing unit births.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
resume data collection for Midwifery led birthing unit after phase two completion.			



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

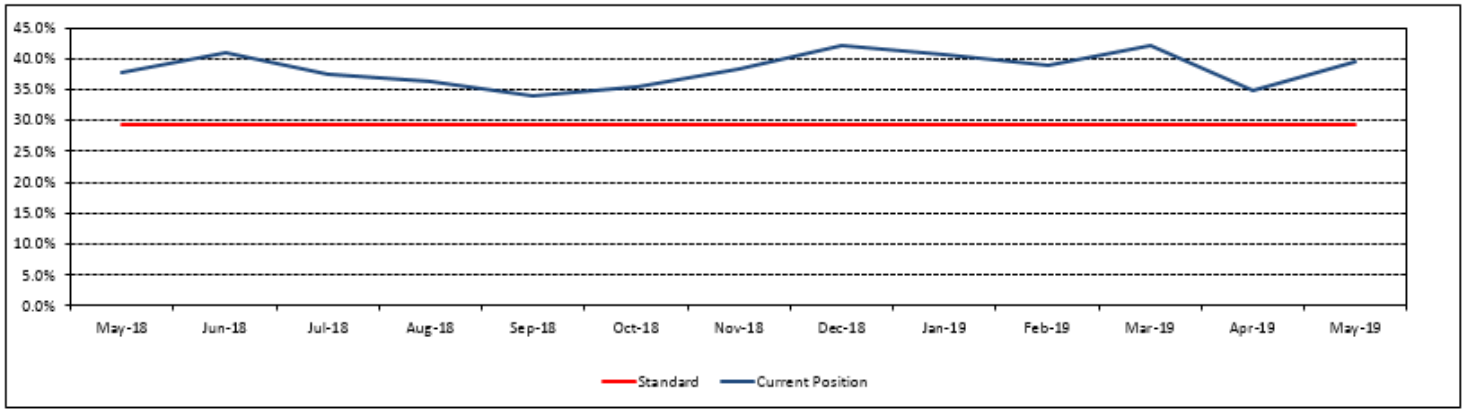
Indicator	Induction of Labour
Standard	29.3%
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Induction of Labour has been at a steady rate throughout the year and above the standard set. An audit presented last month showed an overall rate for 2018 was 38.3% compared to 26.8% in 2017. Increased scanning and identification of small for gestational age babies has contributed to the increase in Induction of Labour as well as NICE recommendation for Induction of Labour for women with Gestational Diabetes. However the audit did identify the need to look at the evidence for Induction of Labour for IVF pregnancies and macrosomia without gestational diabetes.

Month	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-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	37.8%	40.9%	37.6%	36.4%	34.1%	35.5%	38.3%	42.1%	40.8%	39.0%	42.2%	35.0%	39.5%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Further work planned to look at current evidence for IOL for IVF and macrosomia .			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

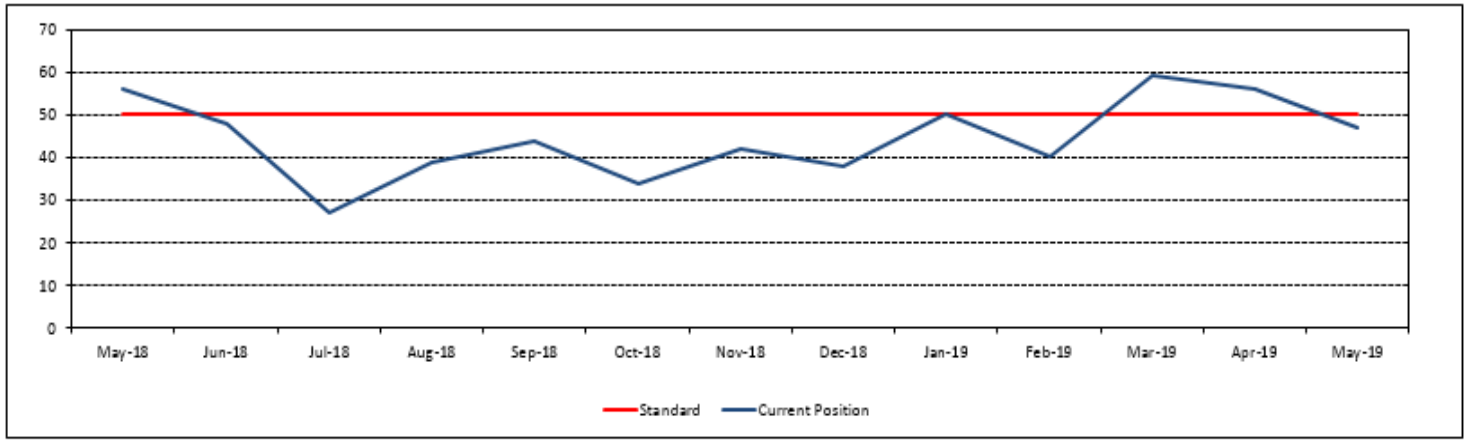
Indicator	Reported Clinical Incidents
Standard	50
Executive Lead	Rowan Procter
Month	May-19
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The service has recognised the reduction in reported incidents this month and although they had been for a period in 2018 the figure has been increasing as a result of highlighting the importance of reporting to all staff via Take 5 and monthly on Risky Business. However this month seems likely due to the significant reduction in incidents which automatically trigger a Datix such as 3rd degree tear, Post partum haemorrhage and Shoulder dystocia.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor and ensure staff follow reporting requirements on the Trigger list.			



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Trust Board – 28th June 2019

Agenda item:	Integrated Quality & Performance Report			
Presented by:	Craig Black			
Prepared by:	Joanna Rayner, Head of Performance and Efficiency			
Date prepared:	24th May 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.

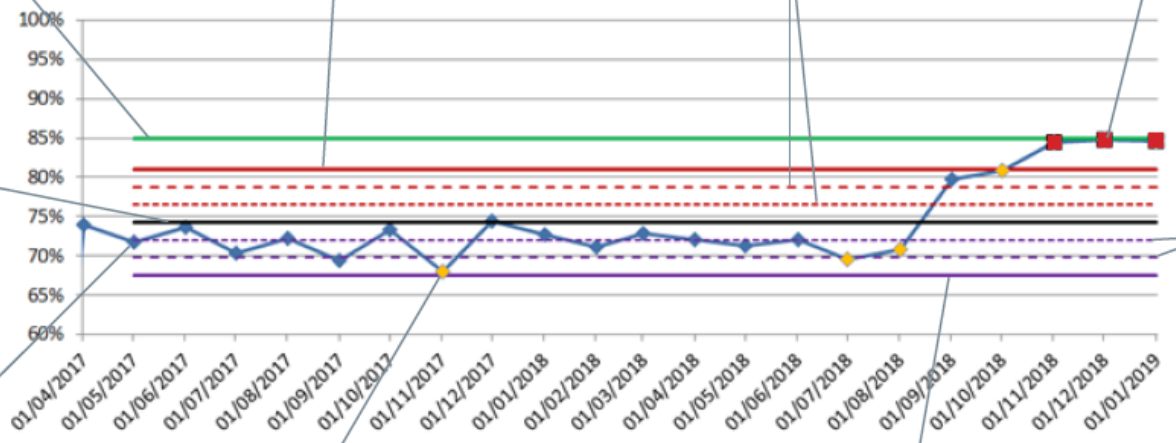
A control chart always has:

- 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	May-19

Safe domain	Standard	Actual	Trend	Assurance	Notes
New Pressure Ulcers - Trust	0	54	Common Cause Variation	Consistently above target	
Falls per 1,000 bed days	No target	5.71	Common Cause Variation	No target	

Effective domain	Standard	Actual	Trend	Assurance	Notes
Discharge Summaries: Outpatients	85%	FALSE	ND	Consistently below target	No data since August 2018
Discharge Summaries: A&E	95%	83%	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%	88%	Special Cause Note/Investigation - High	Consistently below target	

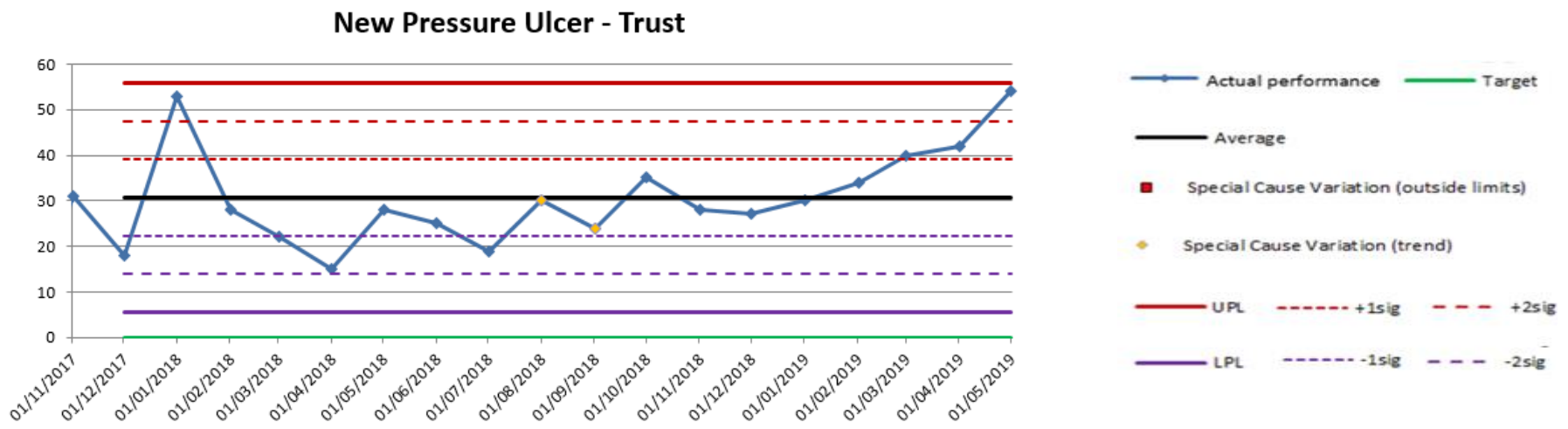
Caring domain	Standard	Actual	Trend	Assurance	Notes
Compliments	No target	32	Common Cause Variation	No target	
Complaints	20	25	Common Cause Variation	Hit and miss against target	

Responsive domain	Standard	Actual	Trend	Assurance	Notes
Referral to Treatment 18 week standard	92%	86%	Special Cause Variation - Low	Hit and miss against target	
Diagnostics 6 week standard	99%	88%	Special Cause Variation - Low	Hit and miss against target	
Sepsis	100%	92%	Special Cause Note/Investigation - High	Hit and miss against target	
Cancer 2 week GP referral to assessment standard	93%	93%	Common Cause Variation	Hit and miss against target	
Cancer 2 week breast referral to assessment standard	93%	90%	Special Cause Variation - Low	Hit and miss against target	
Cancer 62 day referral to treatment standard	85%	76%	Special Cause Variation - Low	Hit and miss against target	
Community referral to treatment within 18 weeks	90%	99%	Special Cause Note/Investigation - High	Hit and miss against target	
Wheelchair waiting times – Child (Community)	92%	100%	Special Cause Note/Investigation - High	Hit and miss against target	

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

Maternity	Standard	Actual	Trend	Assurance	Notes
Number of deliveries (births)	210	195	Common Cause Variation	Hit and miss against target	
Caesarean Section rate	22.6%	23%	Special Cause Variation - High	Hit and miss against target	
Breast Feeding Initiation	80%	78%	Common Cause Variation	Hit and miss against target	

Pressure Ulcers - Trust

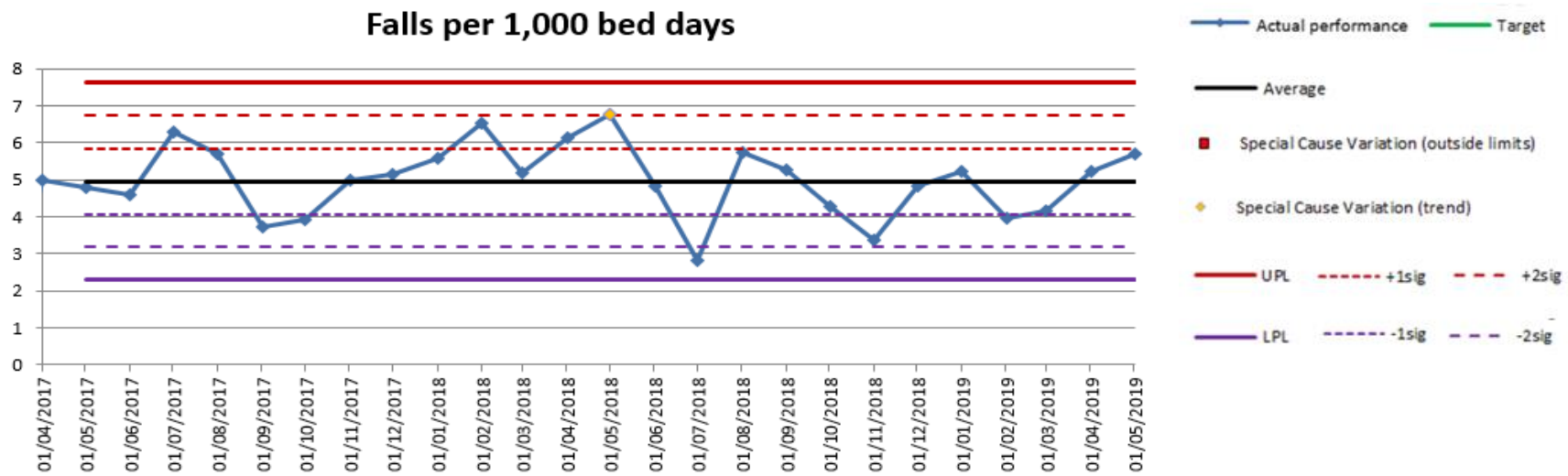


Narrative

What	Common Cause, are seeing an increase in Pressure Ulcers in the trust, this month we are close to the Upper Limits of the report
Why	Aspirational target of zero however recognition that potential for development of pressure ulcers is always present in the high-risk patient. Higher bed occupancy/number of patient contacts / greater acuity of patients will have an impact upon numbers. High acuity in acute beds continued through May, with escalation areas open. WSFT community teams recorded >12,000 face-to-face patient contacts through the month. All teams working to capacity; leaders working to develop dependency tool for community teams to better understand patient acuity and match capacity to demand.
How	Our Tissue Viability Team has now adopted an integrated approach to supporting patients across the whole organisation. Integration continues as two new team members joined the Tissue Viability Service – induction now underway. The Service will take part in a Strategy Meeting on 24.06.19 during which service development will be discussed and a plan formulated to continue to work towards improving pressure area care across the organisation. The WSFT Monthly Pressure Ulcer Monitoring Group identified a potential trend in terms of damage to heels; funding is being sought to provide handheld mirrors for staff to promote the inspection of heels for pressure damage.
When	This is an ongoing work plan and quality improvement initiatives will continue to be progressed via the Pressure Ulcer Prevention Group (PUPG) including ongoing liaison with the contacts gained through the previous work in the regional collaborative. The new reporting template has enabled data capture for audit as well as occurrence and the review of this data will further assist in identification of areas for improvement.

Safe

Falls per 1,000 bed days - Trust

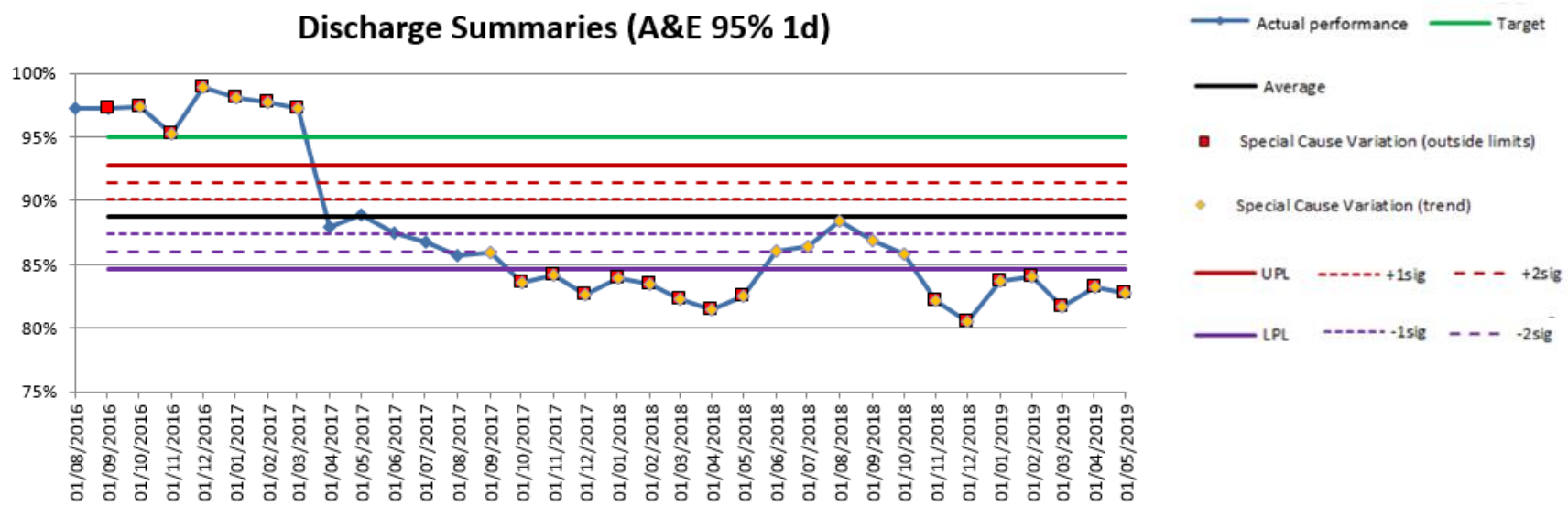


Narrative

What	Common Cause Variation with data points remaining inside the upper and lower process limits.
Why	-
How	-
When	-

Safe

Discharge Summaries ED

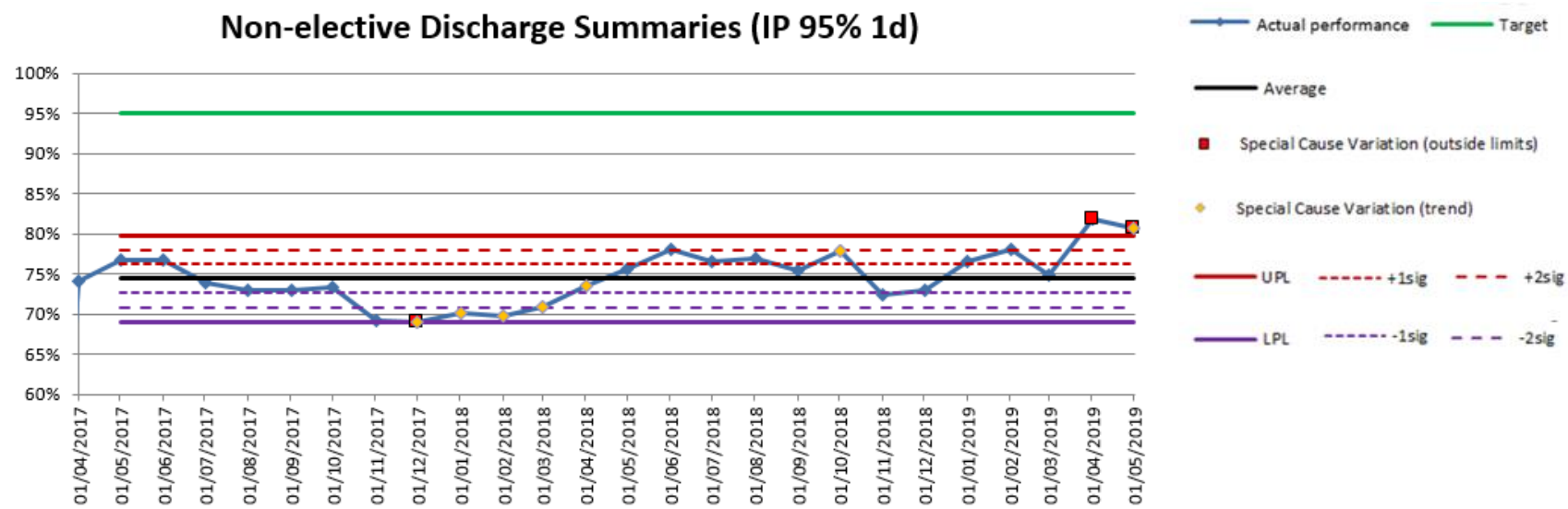


Narrative

What	The chart shows a deteriorating trend with performance outside of the control limits. The target is unlikely to be achieved under the current trajectory.
Why	The Chief Operating Officer is now taking personal responsibility for overseeing performance for each area. Weekly reports are distributed to each area and most areas have less than ten outstanding discharge summaries each week. Any areas with greater numbers than this are required to take immediate action.
How	We continue to work with the ED team and the visiting clinicians to try and address this.
When	Not known

Effective

Discharge Summaries Non elective admissions

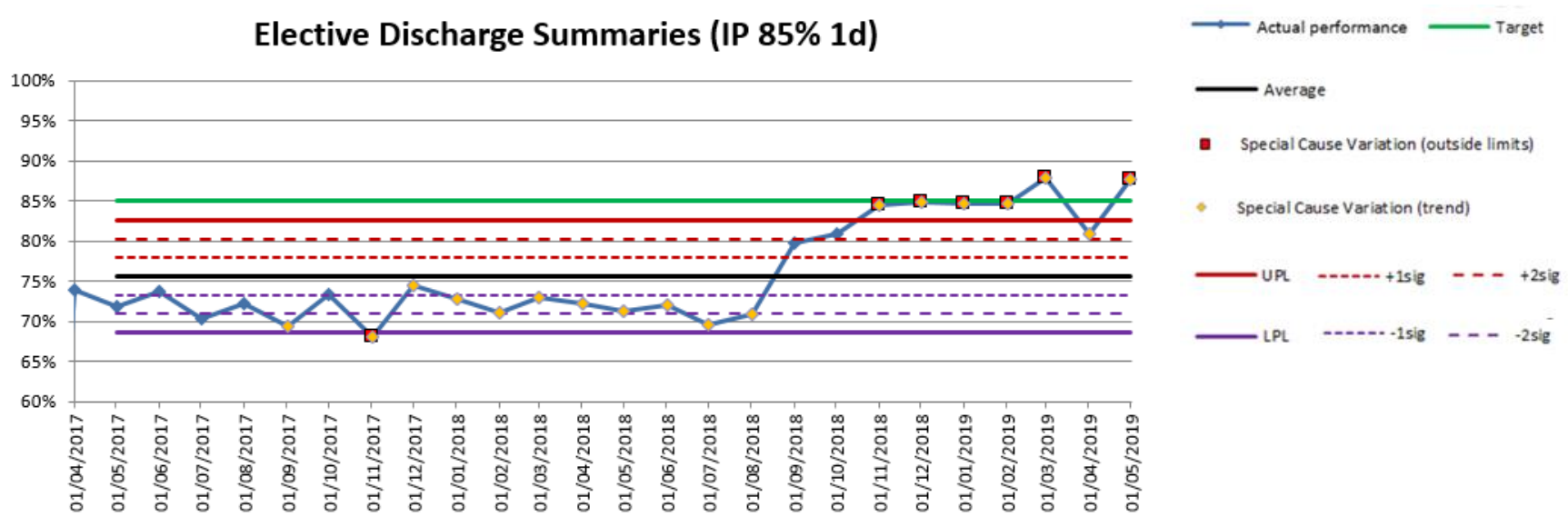


Narrative

What	The chart shows no trend but there is a Special Cause Variation- High with the April and now May's data point performing above the upper control limit.
Why	The Chief Operating Officer is now taking personal responsibility for overseeing performance for each area. Weekly reports are distributed to each area and most areas have less than ten outstanding discharge summaries each week. Any areas with greater numbers than this are required to take immediate action.
How	We continue to work with the team and the visiting clinicians.
When	Not known

Effective

Discharge Summaries Elective admissions

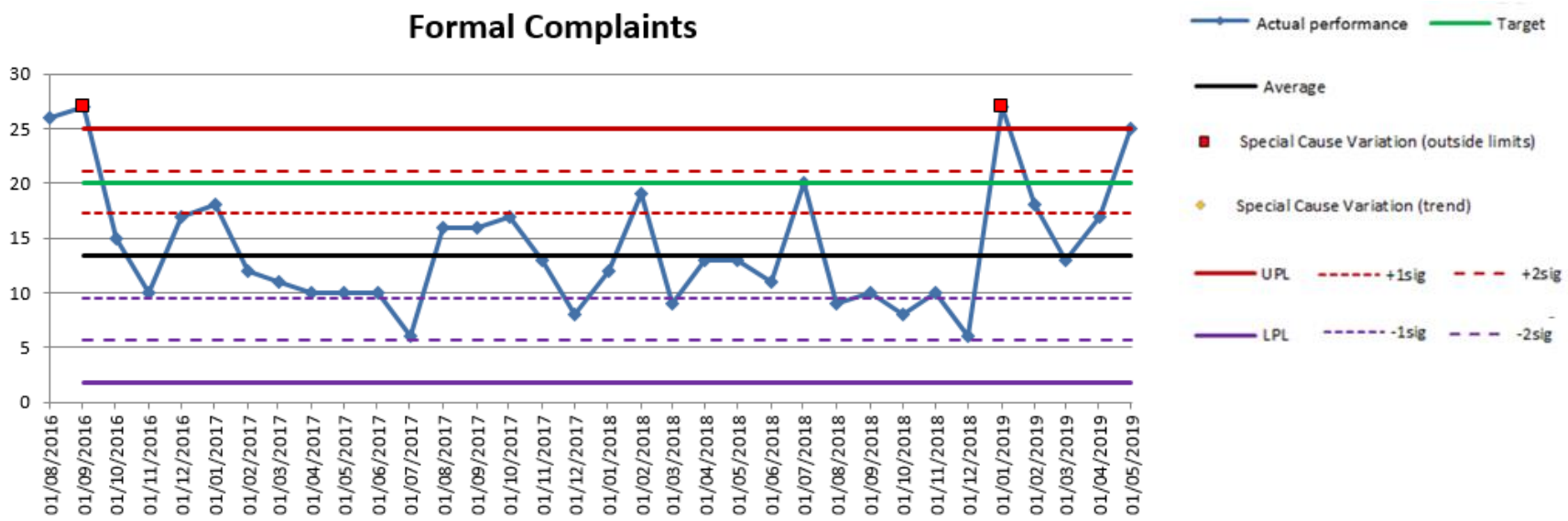


Narrative

What	The chart showed an improving trend
Why	The Chief Operating Officer is now taking personal responsibility for overseeing performance for each area. Weekly reports are distributed to each area and most areas have less than ten outstanding discharge summaries each week. Any areas with greater numbers than this are required to take immediate action.
How	We continue to work with the team and the visiting clinicians.
When	Not known

Effective

Complaints

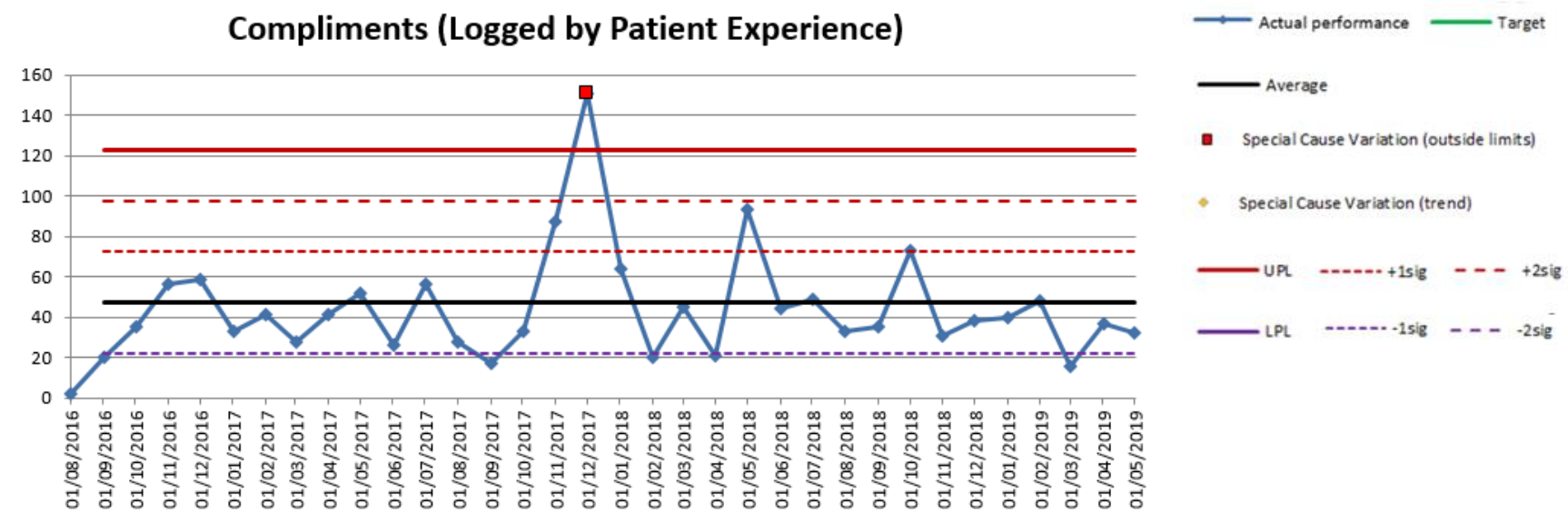


Narrative

What	25 formal complaints were recorded in May 2019. This is an increase of (total) when compared with the number received in April 2019
Why	On analysis eight complaints related to clinical treatment four of which had concerns about a delay in treatment. Six of the complaints related to patient care, particularly that patient needs were not being adequately met. Four complaints were raised about orthopaedic surgery although there were no standout themes Throughout May 2019 there was also a reduction of staff in the PALS team due to staff sickness and a vacancy within the team. This could account for the rise in formal complaints as five of the complaints were originally investigated as a PALS enquiry
How	A new member of staff has been recruited to the PALS team due to start in July therefore the PALS team will continue to try and deal with as many issues as possible to try and seek quick resolution before concerns are escalated to a complaint. This performance will continue to be monitored as the quarter progresses
When	-

Caring

Compliments



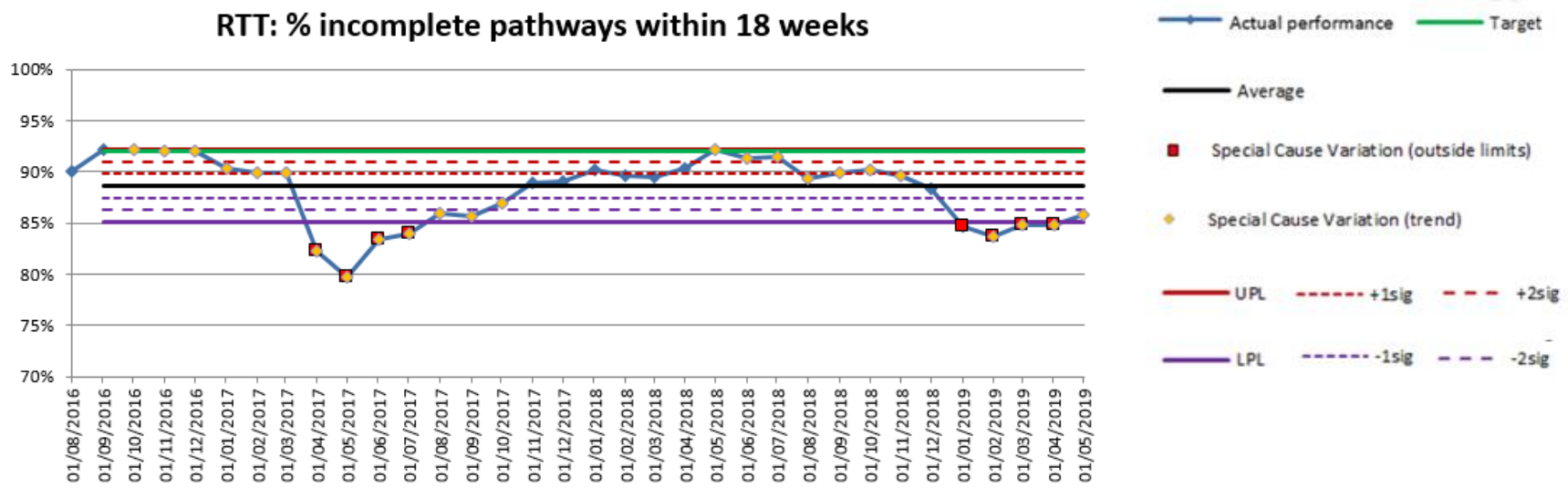
Narrative

What	Compliments received by the patient experience team remains below average. In May there was a decrease in the number shared for logging compared to April
Why	Staff continued to be reminded to share copies of their thank you letters. However, this often not achieved
How	Reminders continue to be given to wards and departments
When	-

Caring

RTT

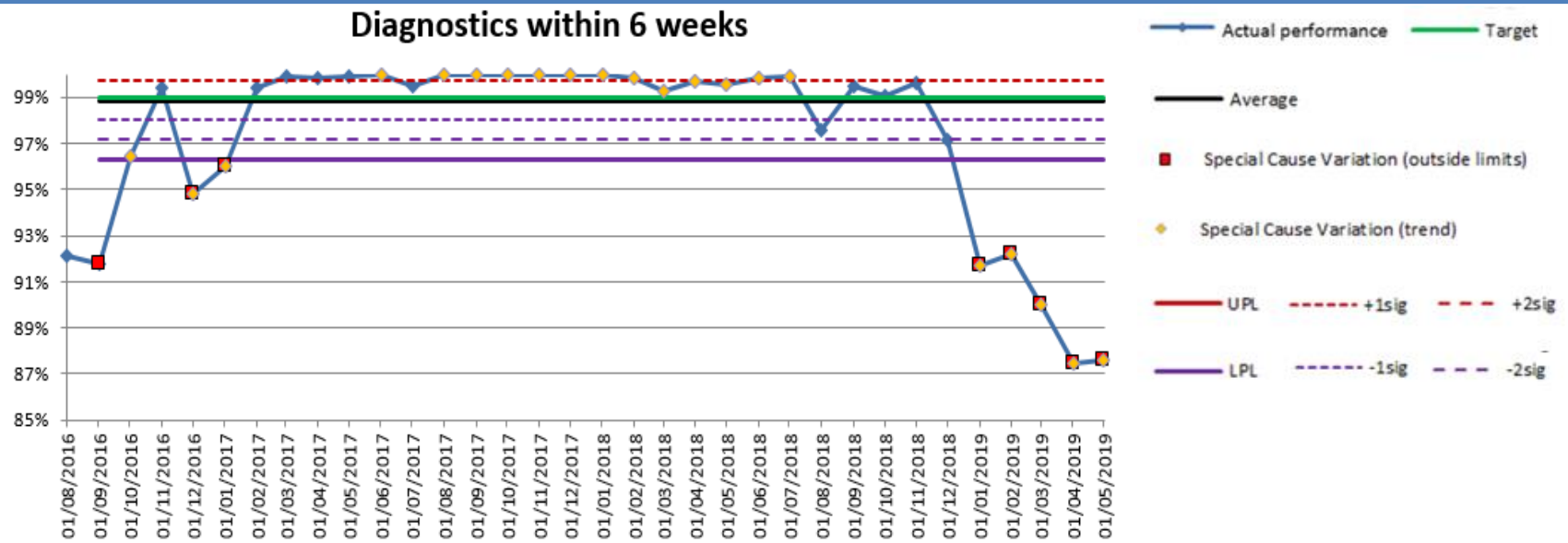
Responsive



Narrative

What	Special Cause Variation – Low, last 4months showing an improvement
Why	Improved performance in May. Services that are substantially underperforming are; Vascular, Ophthalmology, Cardiology, General Surgery, T&O and Gynaecology
How	-
When	-

Diagnostics within 6 weeks

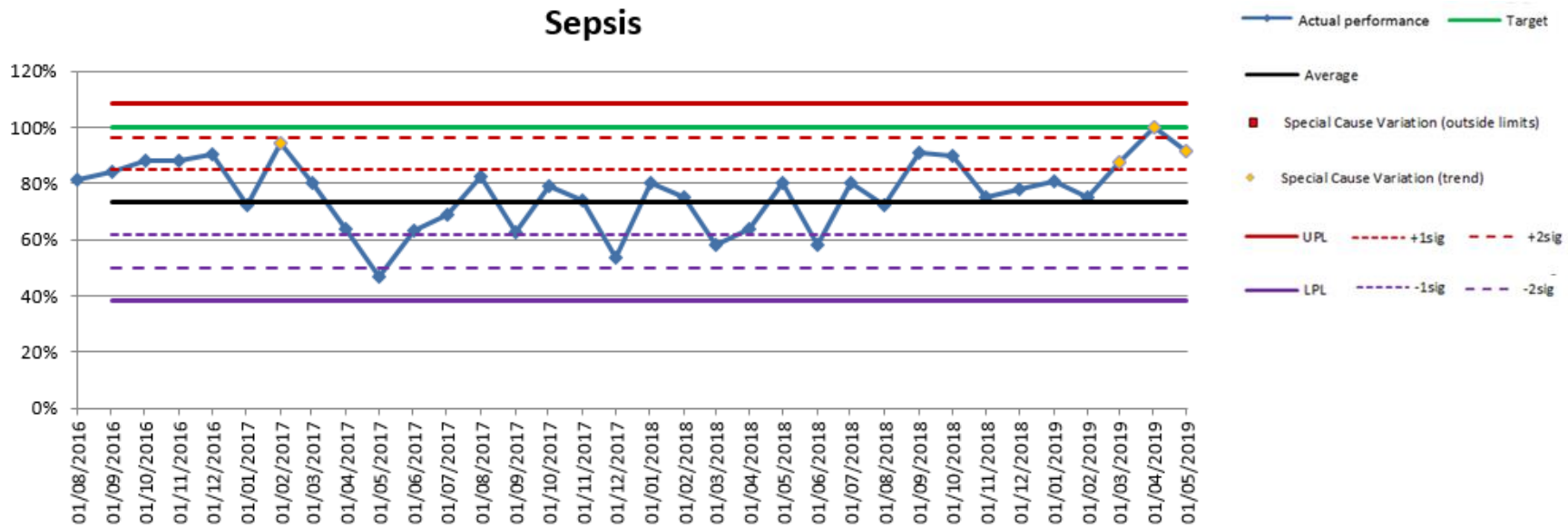


Narrative

What	Special Cause Variation – Low, this has seen a sharp deterioration but May as improved slightly
Why	Cystoscopy performance continues to be impacted by capacity
How	Further work to look at using a portable cystoscope to increase capacity at peripheral clinics.
When	-

Responsive

Sepsis

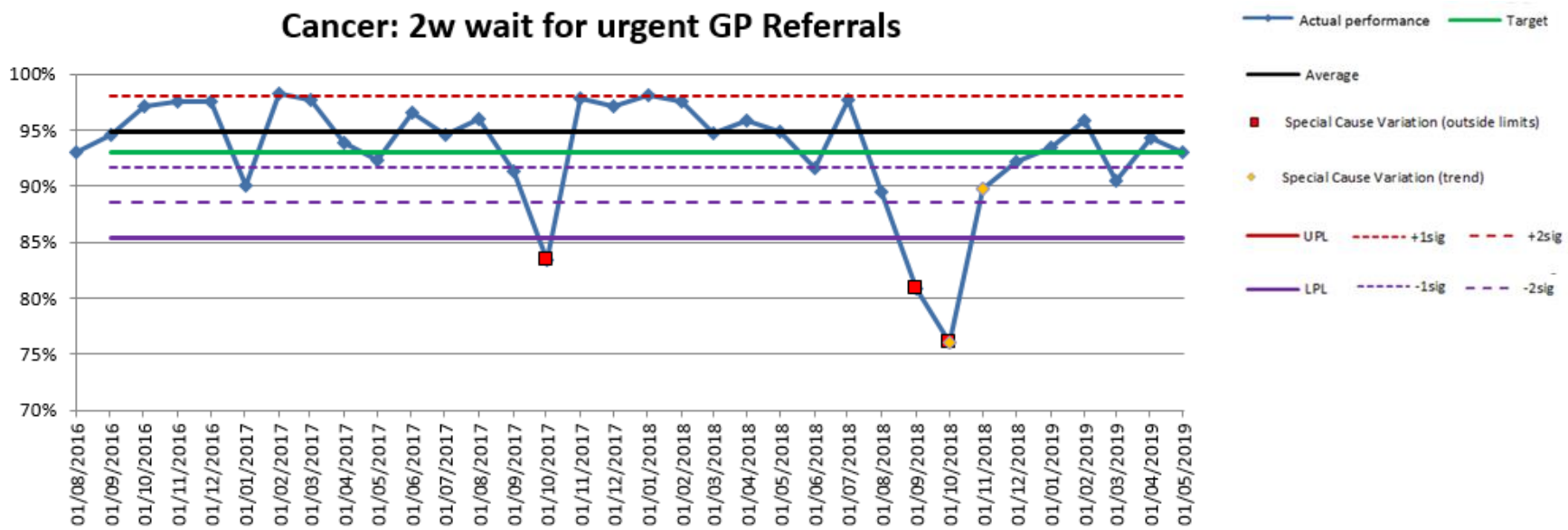


Narrative

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

Responsive

Cancer 2 week referral

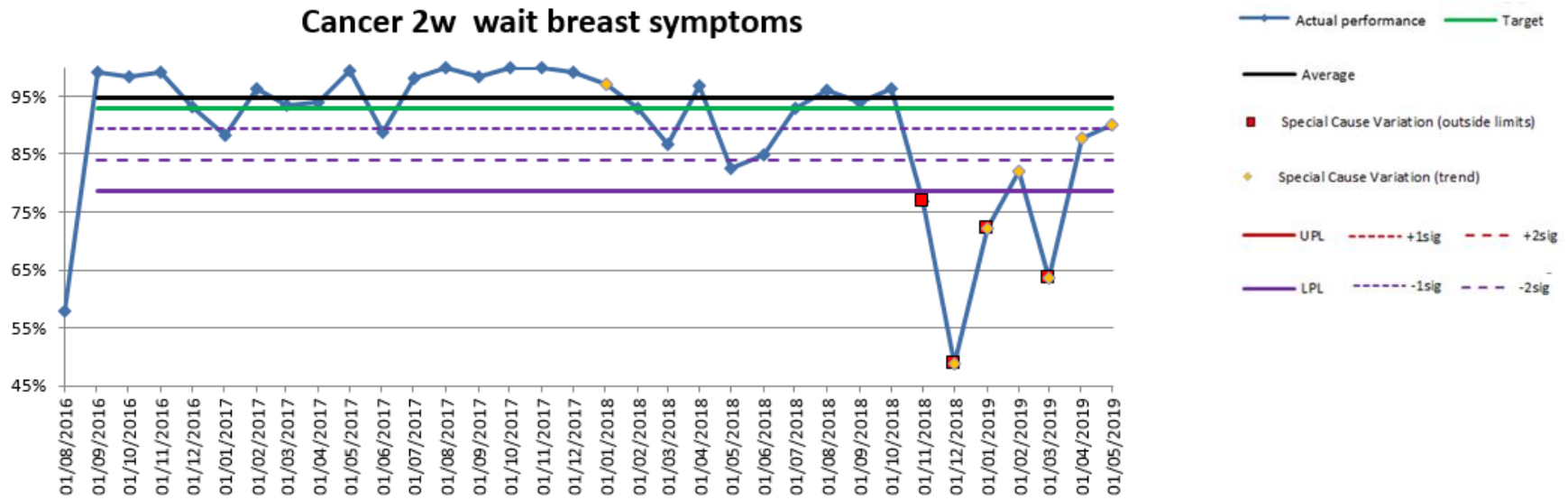


Narrative

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

Responsive

Cancer 2 week referral Breast

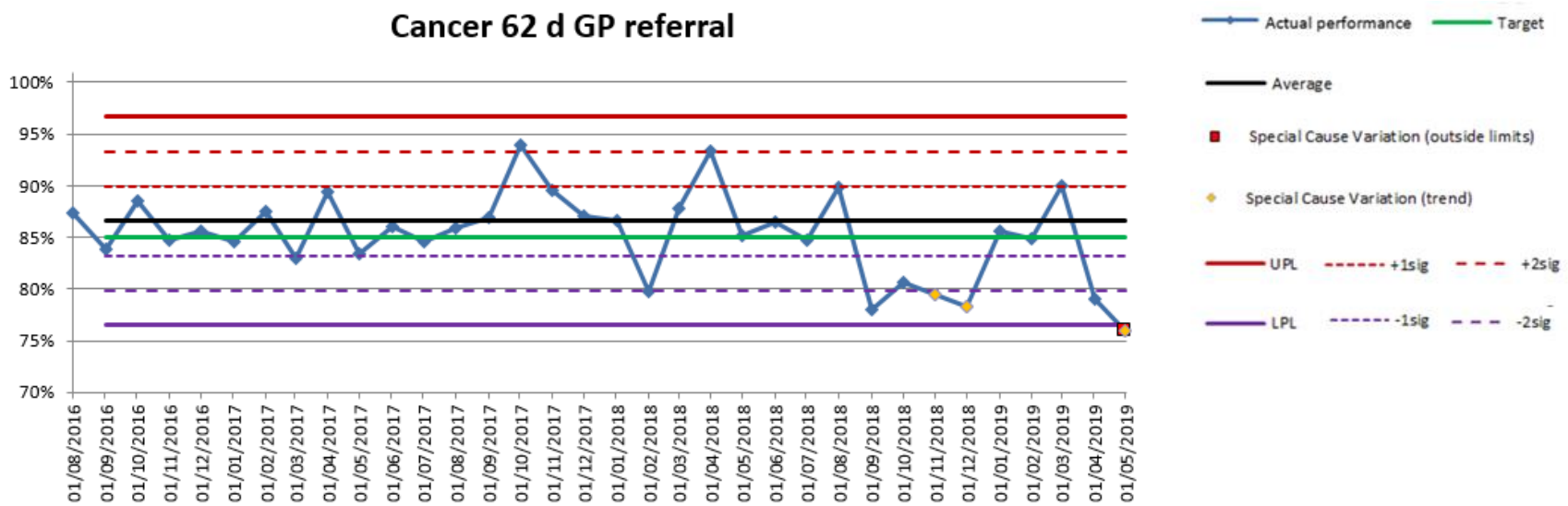


Narrative

What	Special Cause Variation – Low, we have seen an improvement this month
Why	The underperformance is primarily due to patient choice, 15 out of 18 patients were booked outside of 2 weeks due to patients' unavailability
How	-
When	-

Responsive

Cancer 62 Day

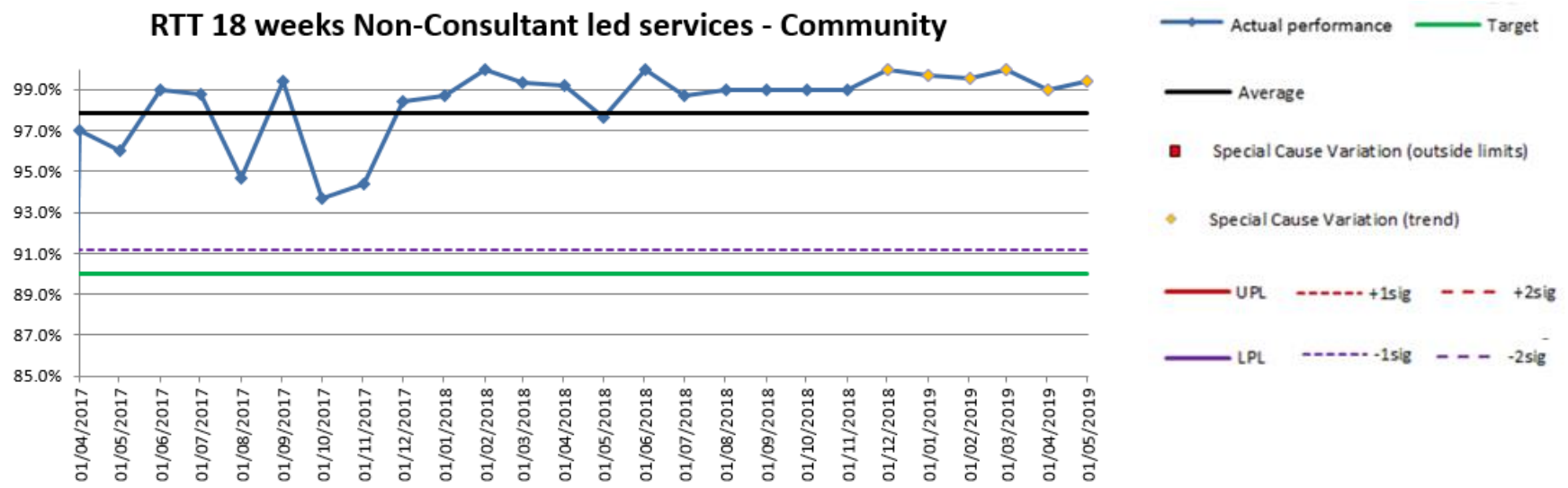


Narrative

What	Special Cause Variation – Low, we are seeing a downward progression appearing
Why	This remains a challenge owing to high number of referrals and delay in diagnostics
How	Focus on capacity within diagnostics
When	-

Responsive

RTT non consultant led

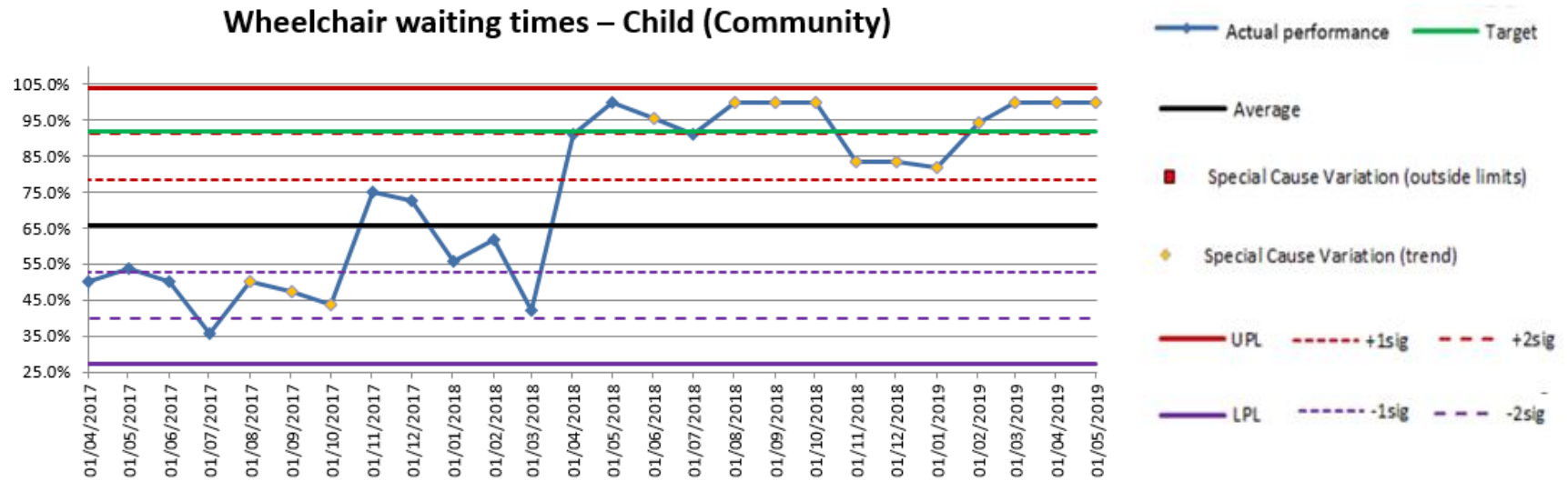


Narrative

What	The performance is consistently above the target and has high assurance of continuing to achieve the target.
Why	Process in place to ensure the target is achieved.
How	Current process to be continued
When	Continue to deliver

Community

Wheelchair waiting times – Child (Community)

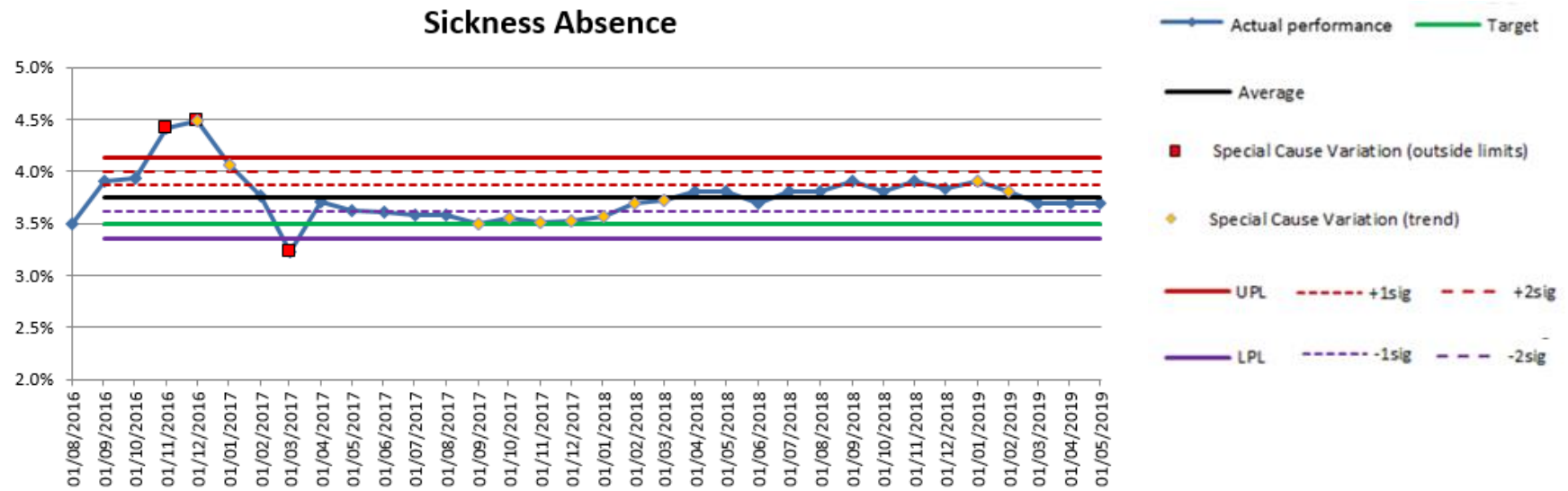


Narrative

What	Special Cause – High, we are seeing a positive trend appearing, hitting 100% for the last 3months
Why	-
How	-
When	-

Community

Sickness absence

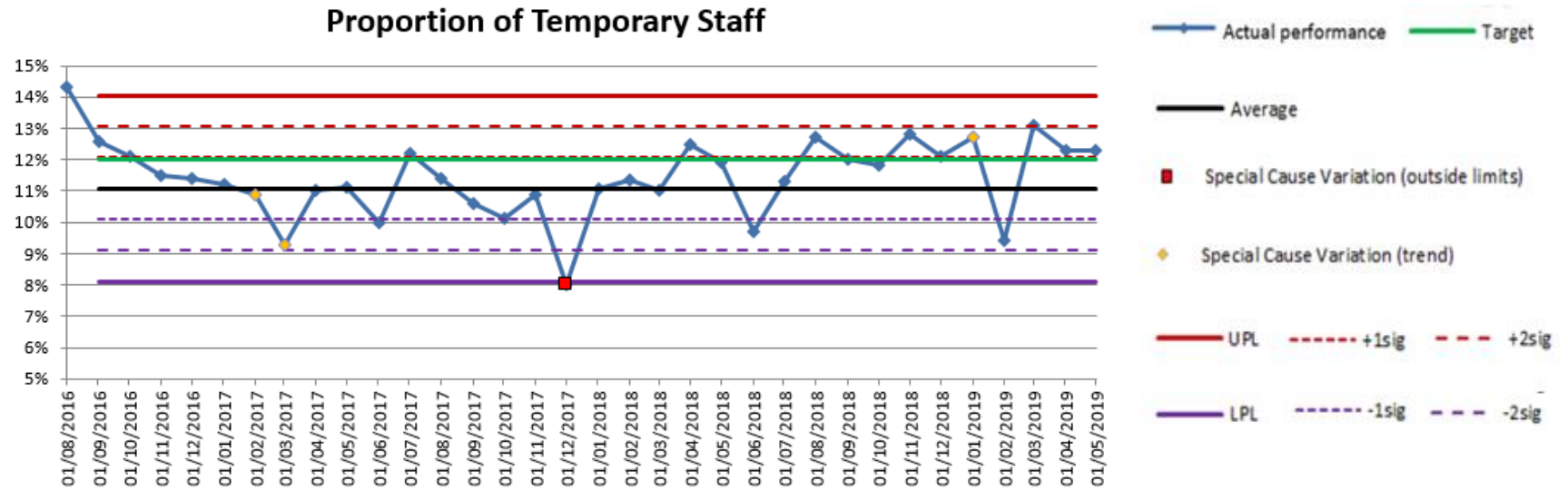


Narrative

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

Well Led

Proportion of temporary staff

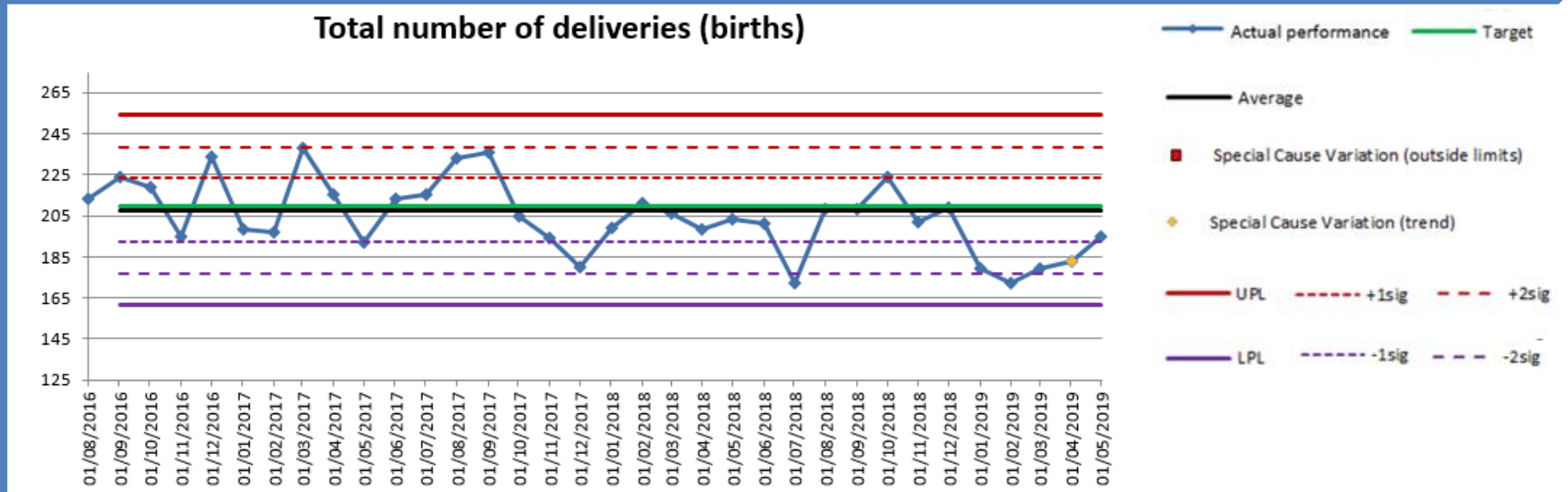


Narrative

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

Well Led

Total number of deliveries

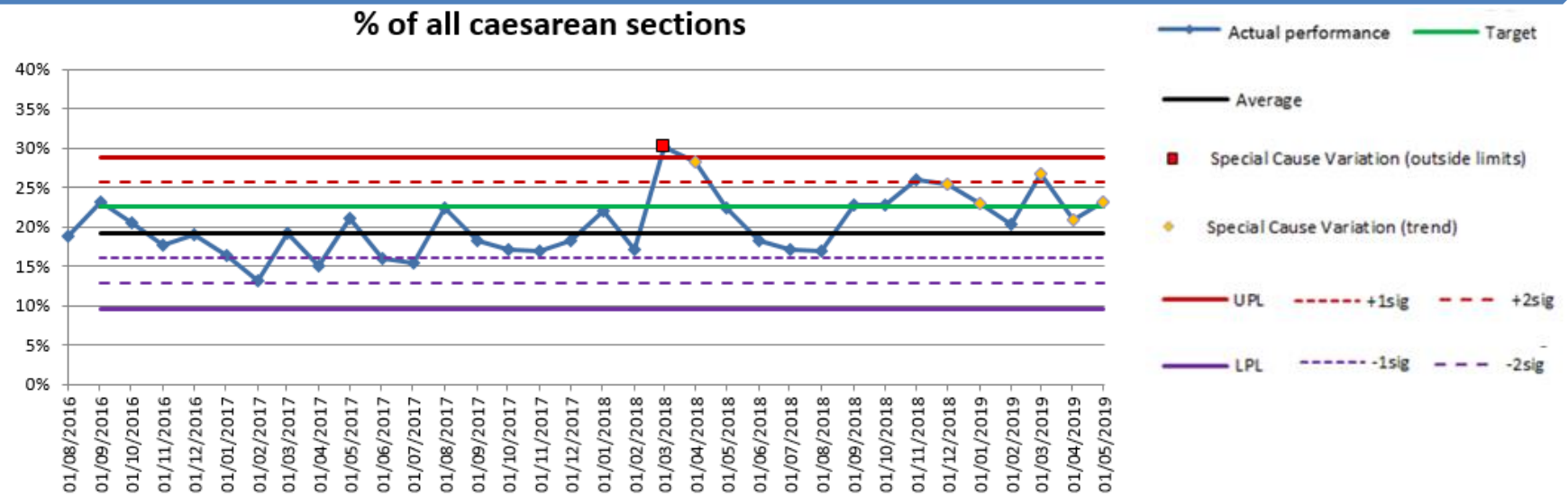


Narrative

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

Maternity

Caesarean section rate

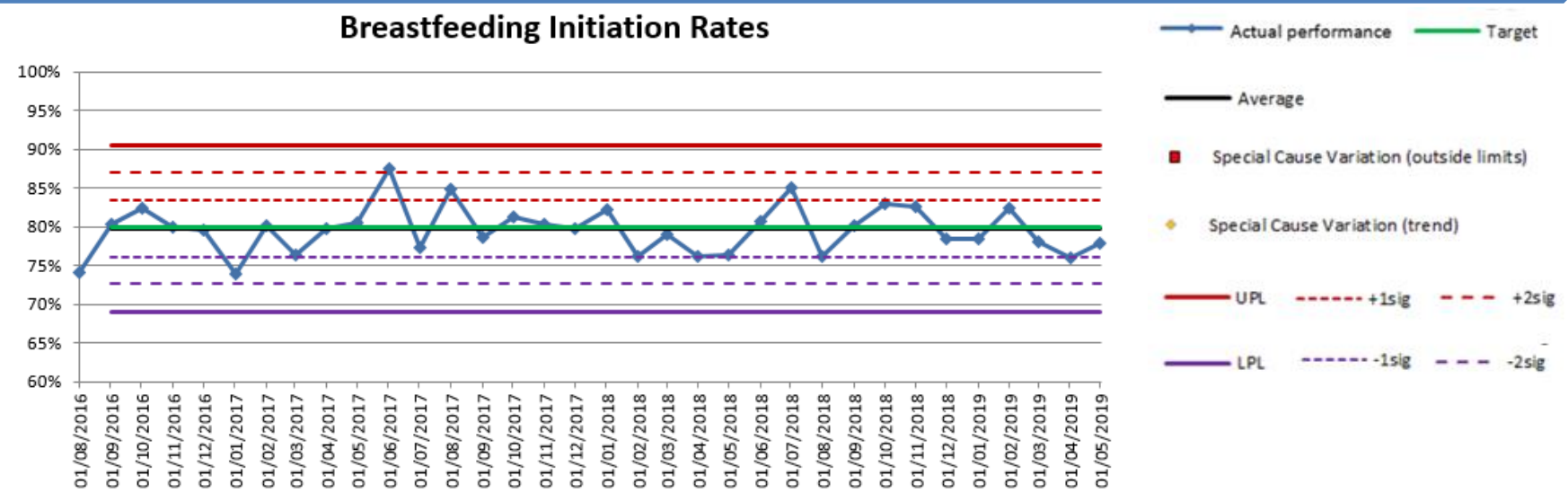


Narrative

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

Maternity

Breast feeding initiation



Narrative

What	Common cause variation, No trend
Why	-
How	-
When	-

Maternity

9. Non-emergency patient transport report

To APPROVE the report

For Approval

Presented by Alex Baldwin

Board of Directors – June 2019

Agenda item:	Item 9			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	17th June 2019			
Subject:	Finance and Workforce Board Report – May 2019			
Purpose:	x	For information		For approval

Executive summary:

The Trust agreed a control total to break even in 2019-20 which enabled Provider Sustainability Funding (PSF) of £4.2m should this be met. In order to achieve this total the Trust will need to deliver a Cost Improvement Programme of £8.9m.

The reported I&E for May 2019 is a deficit of £959k, against a planned deficit of £461k. This results in an adverse variance of £498k in May (£547k YTD).

This variance relates to demand being significantly higher than planned and the costs of extra capacity to meet this demand being beyond that funded by around £200k per month.

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*	

Trust Board – 28 June 2019

Agenda item:	9			
Presented by:	Alex Baldwin, deputy chief operating officer			
Prepared by:	Alex Baldwin, deputy chief operating officer			
Date prepared:	June 2019			
Subject:	Non-emergency patient transport (NEPTS)			
Purpose:	x	For information		For approval

Executive summary:

Non-emergency patient transport has been an area of concern for a number of months. Despite on-going engagement with the service provider, E-Zec, there has been limited improvement in service.

This paper provides a brief summary of performance to date and the current strategy for addressing concerns with the provider.

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

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

Previously considered by:	N/A
Risk and assurance:	*[Detail relevant issues within the report]*
Legislation, regulatory, equality, diversity and dignity implications	*Patient safety*

Recommendation:
The Board is asked to note the contents of this report and provide advice accordingly.

Introduction

West Suffolk NHS Foundation Trust receives its non-emergency patient transport services (NEPTS) from E-Zec Medical Transport Ltd (E-Zec). NEPTS include all forms of patient transport to and from the hospital for patients resident in Suffolk. This includes transport to the hospital for outpatient appointments, inter-hospital transfers for inpatient and outpatient care and high dependency transfers for patients who require equivalent or lower intensity care at another location.

[To note, it is the responsibility of EEAST to manage the transfer of patients who require higher intensity care in another environment, for example a patient transferred from ED at WSFT to ITU at CUHFT. Non-emergency transport for patients who reside in Norfolk is provided by ERS Medical.]

E-Zec are contracted to provide NEPTS for the Suffolk system. The contract for this service is held by West Suffolk and Ipswich and East Suffolk Clinical Commissioning Groups. The contract was awarded in late 2017 and came in to effect on 1st April 2018.

Initial concerns

The transfer of the service from the previous provider (EEAST) was not without difficulty. The number of staff electing to TUPE to E-Zec was not at the level expected, consequently E-Zec struggled to recruit at the rate required to maintain service provision at the standard set out in the contract. E-Zec were also reliant on third party vehicles to meet demand and there were initial concerns that E-Zec weren't using the available resource to its maximum potential. To compensate the Trust procured its own resource on an ad-hoc basis to supplement service provision.

Finally it transpired that the assessed contract volume had been underestimated resulting in greater demand than E-Zec had anticipated. This was resolved via a contract variation which was made in June 2018. Since the rebasing was carried out, the volume of journeys remains in line with the new expectation and the number of journeys YTD is sitting at 99.57% against plan.

The above provides some context for the initial disruption which was felt during the early weeks of April and May 2018. At that point in time the Trust and CCG were receiving daily complaints from patients and staff about the poor levels of service received from E-Zec, and unfortunately we continue to get examples of poor levels of patient experience.

Table 1 provides a selected summary of four key performance indicators E-Zec are required to achieve. Whilst there was some steady improvement in in-bound journeys (SUF_LQR_001) between June and November 2018 there has been general non-compliance with the number of end of life patient transferred within the mandated 2 hour window following initial booking (SUF_LQR_007)

E-Zec have appointed a number of middle managers to oversee the contract with varying degrees of success. Between July and December last year there was a general increase in service quality and a notable improvement in engagement with the hospital flow and CCG escalation team. It was noted at the time that the improvement was associated with an individual and unfortunately those improvements have not been sustained following their departure from the company in December 2018.

Ongoing issues

Since December 2018 we have seen a return to the poor service provision observed in the early months of the contract.

Escalation meetings are held twice a month with the CCG and E-Zec, often with the engagement of E-Zec's chief operating officer. Despite regular and at times exceptionally robust challenge these meetings have failed to have any significant impact on service provision.

Latterly the CCG have engaged E-Zec in what they have described as a “Red to Green” review from which a service development and improvement plan (SDIP) has been developed. The SDIP provides evidence of the breadth and depth of improvements that have been identified for E-Zec to address.

A further follow up event took place between 7 and 10 May 2019 and whilst formal findings have not yet been shared it is understood that insufficient action has been noted to provide assurance that E-Zec have addressed the concerns identified. It is important to note that to date the CCG has not issued a contract notice to E-Zec although it is anticipated that this will be the next course of action.

Furthermore, in early April the Trust was approached by a member of E-Zec staff who highlighted a number of patient care and safety concerns which are currently being considered under of whistleblowing policy and as such have been raised with the CCG quality team via the CCG chief nurse.

The Trust received a letter from E-Zec dated in May 2019 detailing management changes to the Suffolk contract. This includes a newly recruited contract manager and an area director whose focus will be exclusively on the Suffolk contract. Whilst these additions are welcome it is noted that we have received assurance regarding similar management changes in the past.

Despite assurances we are concerned that E-Zec,

- Do not have the capacity to deliver the contract to the required standard (and are unable to procure and retain the required capacity), or
- Do not have the capability to deliver the contract to the required standard.

In either case it is felt that the degree of goodwill towards E-Zec has been eroded such as there is little confidence that they will deliver a service of acceptable quality to the Trust or its patients.

Conclusions and further action

There is a significant service delivery challenge faced by E-Zec and consequently the Trust and patients. However there is currently no viable alternative provider immediately available to deliver the service as required.

The Board is asked to consider the issues set out here regarding the ongoing management of the NEPTS contract. The Board is also asked to support the escalated contract management action via the issue of a formal contract notice to E-Zec.

Following the SDIP review a further formal update is expected from the CCG in June/July 2019.

Provider: E-zec Medical

Report Date: March 2019

Period Covered: April 2018 to March 2019

KPI no.	Key Performance Indicator	Target	Previous YTD Peformance	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
				% / Journeys	% / Journeys	% / Journeys	% / Journeys	% / Journeys	% / Journeys	% / Journeys	% / Journeys	% / Journeys	% / Journeys	% / Journeys	% / Journeys
SUF_LQR_001	In-bound Journeys - % Service Users arriving between 5 and 60 minutes prior to their booked appointment time.	95%	*N/A*	52.83%	51.30%	47.31%	61.83%	70.81%	70.57%	78.66%	81.88%	81.76%	64.65%	66.78%	62.68%
				1588	1957	1634	2570	3025	2970	3346	3069	2632	2812	2682	2768
SUF_LQR_003a	Outbound Outpatient Journeys - % Service Users waiting no more than 60 minutes after their booked and confirmed collection time.	95%	*N/A*	*83.30%*	*82.44%*	*72.52%*	*86.35%*	*91.92%*	*89.85%*	91.48%	89.86%	90.78%	81.96%	84.88%	82.24%
				1461	*1748*	*1328*	*2300*	*2845*	*2710*	3074	2792	2397	2472	2421	2460
SUF_LQR_003b	Outbound Discharge & Transfer Journeys - % Service Users waiting no more than 60 minutes after their booked and confirmed collection time.	95%	*N/A*	*46.90%*	*43.92%*	*40.86%*	*48.26%*	*56.34%*	*62.51%*	79.00%	82.80%	81.80%	61.12%	76.34%	71.05%
				1064	*1234*	*1072*	*1239*	*1278*	*1147*	1319	1355	1341	1376	1285	1247
SUF_LQR_007	End of Life Transfers from acute hospitals to their choice of placement - % Bookings met within 2 hours of the original request.	95%	*N/A*	73.68%	73.08%	88.89%	76.19%	75.00%	100.00%	93.75%	81.82%	95.83%	77.78%	100.00%	100.00%
				19	26	9	21	20	12	16	11	24	9	11	17

Table 1: Notable KPI's as at end March 19.

10. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

West Suffolk NHS
NHS Foundation Trust

FINANCE AND WORKFORCE REPORT
May 2019 (Month 2)

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

Financial Summary

I&E Position YTD	£1.4m	loss
Variance against plan YTD	-£0.5m	on plan
Movement in month against plan	-£0.5m	on plan
EBITDA position YTD	£0.4m	favourable
EBITDA margin YTD	65.2%	favourable
Total PSF Received	£1.286m	accrued
Cash at bank	£5.8m	

Executive Summary

- The planned deficit for the year to date was £0.9m but the actual deficit was £1.4m, an adverse variance of £0.5m.
- We are planning to break even in 2019-20

Key Risks

- Delivery of £8.9m CIP programme
- Containing demand within budgeted capacity

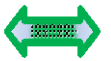
SUMMARY INCOME AND EXPENDITURE ACCOUNT - May 2019	May-19 Budget £m	May-19 Actual £m	May-19 Variance F/(A) £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance F/(A) £m
NHS Contract Income	17.2	17.3	0.0	34.8	34.9	0.1
Other Income	3.9	3.7	(0.2)	7.3	7.2	(0.1)
Total Income	**21.1**	**20.9**	**(0.2)**	**42.1**	**42.1**	**0.0**
Pay Costs	14.1	13.9	0.2	28.2	28.5	(0.3)
Non-pay Costs	6.5	7.1	(0.7)	12.8	13.3	(0.5)
Operating Expenditure	**20.6**	**21.0**	**(0.4)**	**41.0**	**41.7**	**(0.7)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**0.5**	**(0.1)**	**(0.7)**	**1.1**	**0.4**	**(0.7)**
Depreciation	0.7	0.5	0.1	1.3	1.2	0.1
Finance costs	0.3	0.3	0.0	0.6	0.7	(0.0)
SURPLUS/(DEFICIT)	**(0.5)**	**(1.0)**	**(0.5)**	**(0.9)**	**(1.4)**	**(0.5)**

FINANCE AND WORKFORCE REPORT - MAY 2019

Contents:

Key:

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

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

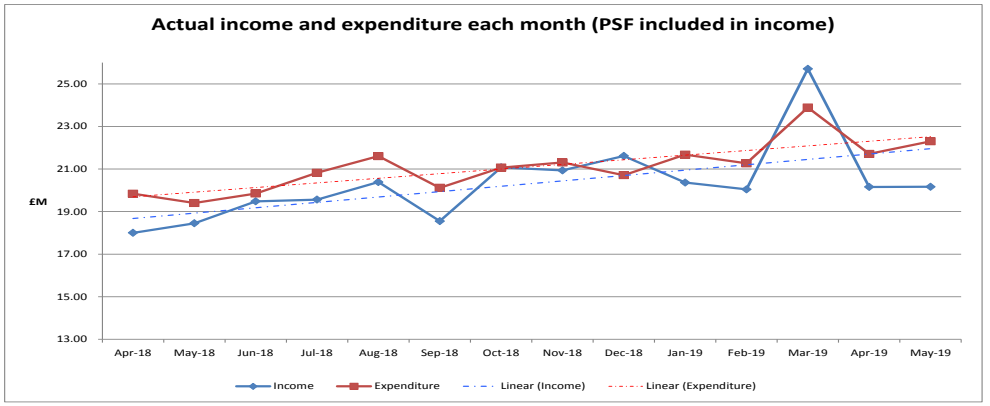
FINANCE AND WORKFORCE REPORT - MAY 2019

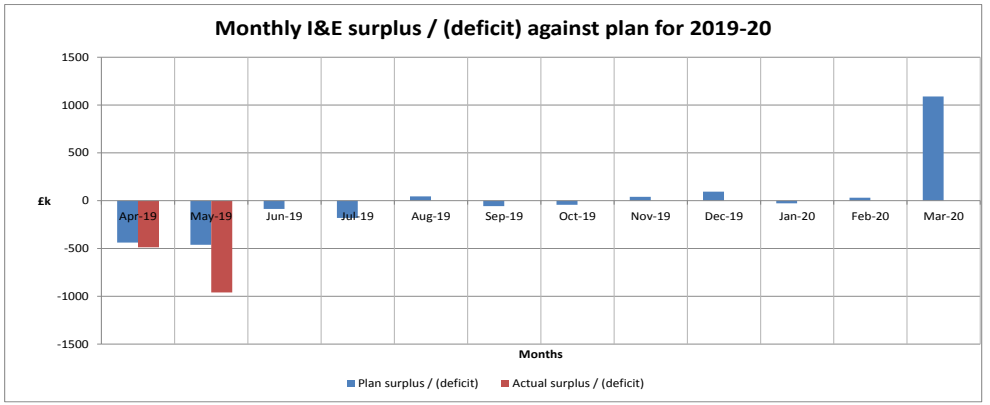
Income and Expenditure Summary as at May 2019

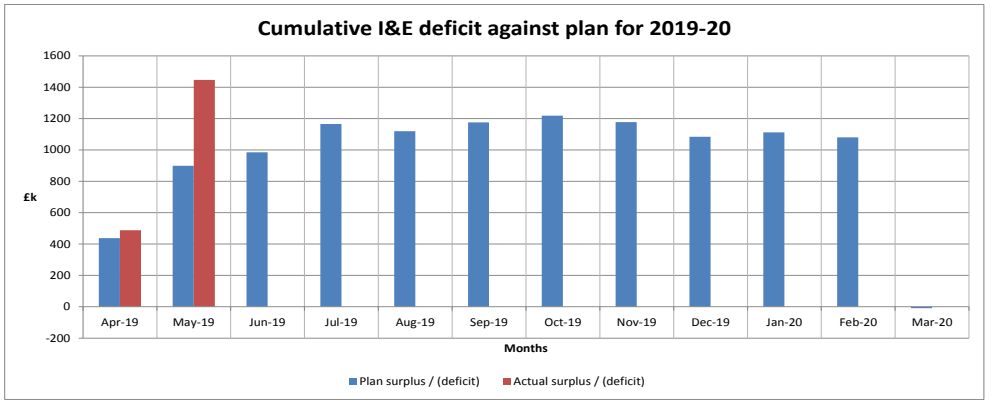
The Trust agreed a control total to break even in 2019-20 which enabled Provider Sustainability Funding (PSF) of £4.2m should this be met. In order to achieve this total the Trust will need to deliver a Cost Improvement Programme of £8.9m.

The reported I&E for May 2019 is a deficit of £959k, against a planned deficit of £461k. This results in an adverse variance of £498k in May (£547k YTD).

This variance relates to demand being significantly higher than planned and the costs of extra capacity to meet this demand being beyond that funded by around £200k per month.







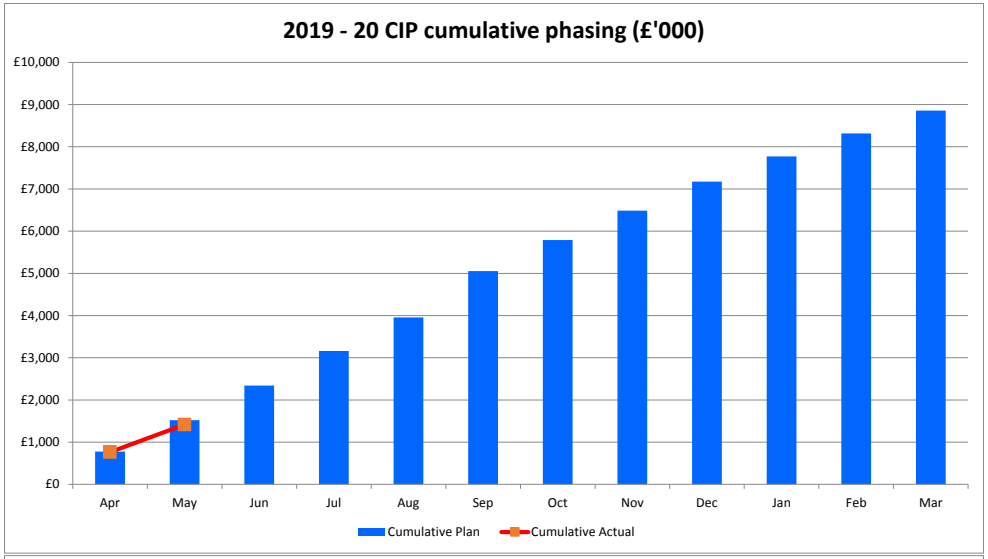
Summary of I&E indicators

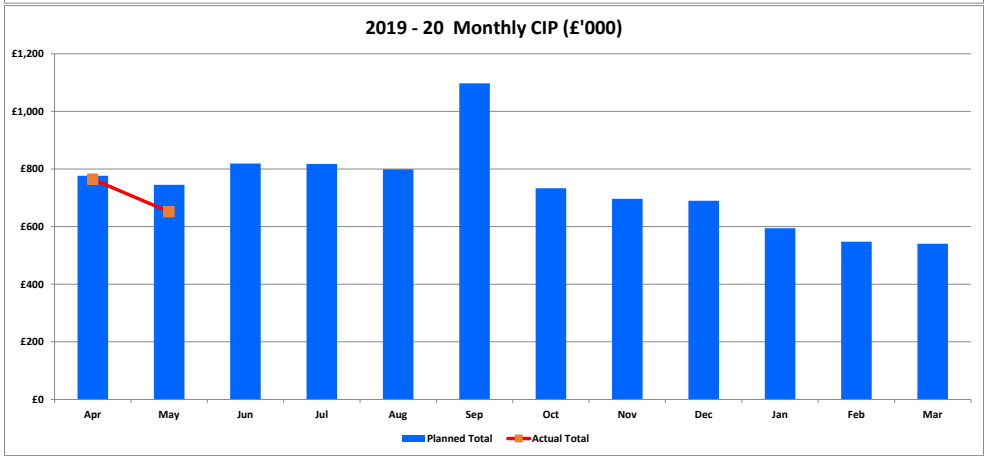
Income and Expenditure	Plan / target £'000	Actual / forecast £'000	Variance to plan (adv) / fav £'000	Direction of travel (variance)	RAG (report on Red)
In month surplus / (deficit)	(461)	(959)	(498)	↑	Red
YTD surplus / (deficit)	(899)	(1,446)	(547)	↑	Red
Forecast surplus / (deficit)	9	9	0	↔	Amber
EBITDA (excl STF) YTD	(224)	(867)	(643)	↑	Red
EBITDA (%)	(0.5%)	(2.1%)	(1.5%)	↔	Red
Clinical Income YTD	(34,815)	(34,931)	117	↑	Green
Non-Clinical Income YTD	(7,290)	(7,197)	(94)	↑	Amber
Pay YTD	28,204	28,417	(213)	↑	Red
Non-Pay YTD	14,800	15,158	(357)	↑	Red
CIP target YTD	1,522	1,415	(107)	↓	Amber

Cost Improvement Programme (CIP) 2019-20

In order to deliver the Trust's control target in 2019-20 we needed to deliver a CIP of £8.9m (4%). In May we planned to achieve £1522k (17% of the annual plan) but achieved £1415k (£107k behind plan).

Recurring/Non Recurring Summary	2019-20 Annual Plan	Plan YTD	Actual YTD
	£'000	£'000	£'000
Recurring			
Outpatients	100	17	11
Procurement	677	113	138
Activity growth	-	-	-
Additional sessions	15	3	-
Community Equipment Service	575	169	148
Drugs	1,687	351	251
Estates and Facilities	73	12	11
Other	1,309	87	289
Other Income	1,753	367	239
Pay controls	361	54	47
Service Review	20	-	-
Staffing Review	1,076	191	122
Theatre Efficiency	178	-	11
Recurring Total	**7,824**	**1,364**	**1,267**
Non-Recurring			
Estates and Facilities	128	21	-
Other	529	50	3
Pay controls	376	87	145
Non-Recurring Total	**1,033**	**158**	**149**
Grand Total	**8,857**	**1,522**	**1,415**

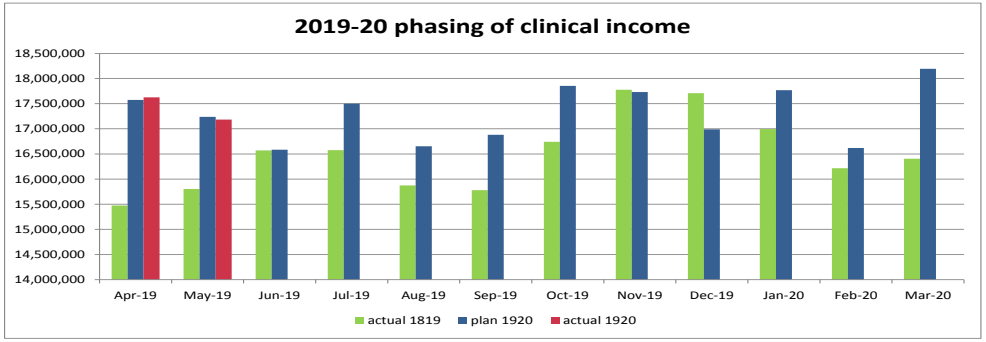




FINANCE AND WORKFORCE REPORT - MAY 2019

Income Analysis

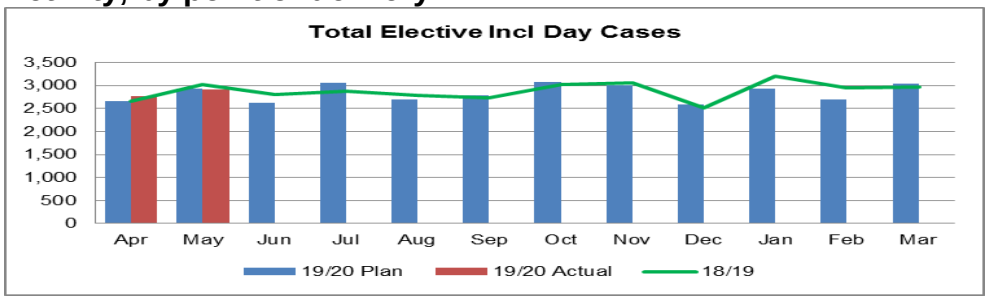
The chart below demonstrates the phasing of all clinical income plan for 2019-20, including Community Services. This phasing is in line with phasing of activity.

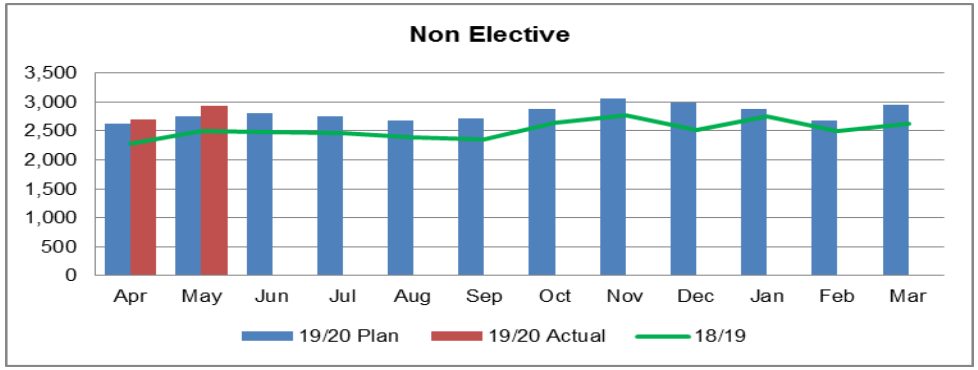


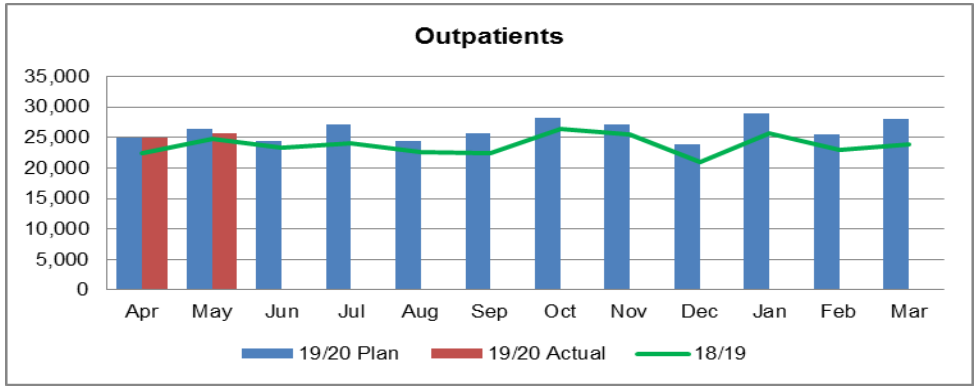
The income position was slightly ahead of plan for May. The main areas of underperformance were seen in the Elective services, with Non Elective demand higher than planned.

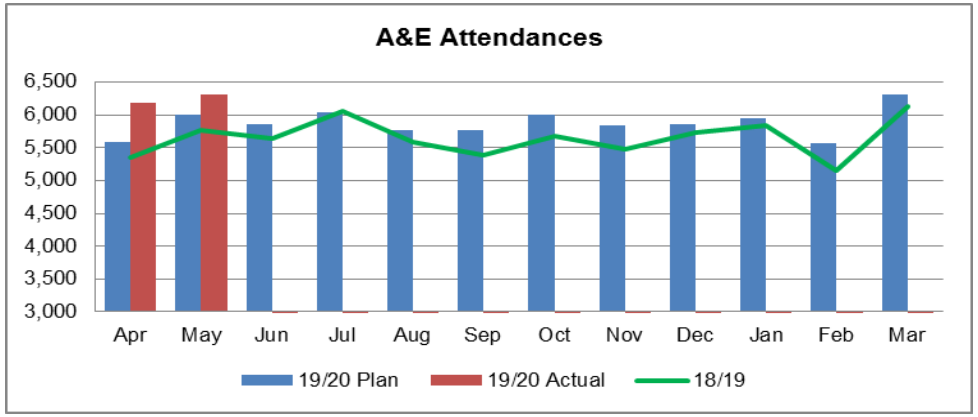
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	926	987	61	1,790	1,949	160
Other Services	1,066	1,076	10	3,171	3,289	119
CQUIN	173	173	(0)	338	338	1
Elective	2,872	2,745	(126)	5,519	5,267	(252)
Non Elective	6,140	6,298	157	12,041	12,214	173
Emergency Threshold Adjustment	(343)	(343)	0	(669)	(669)	0
Outpatients	3,183	3,099	(84)	6,183	6,113	(71)
Community	3,221	3,215	(6)	6,442	6,430	(12)
Total	**17,239**	**17,251**	**12**	**34,815**	**34,931**	**117**

Activity, by point of delivery



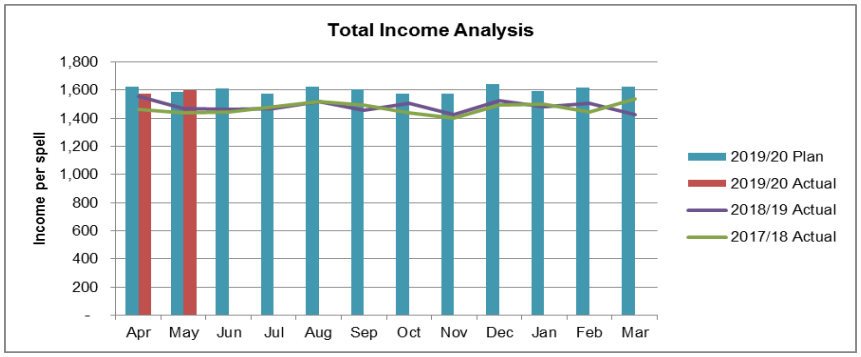


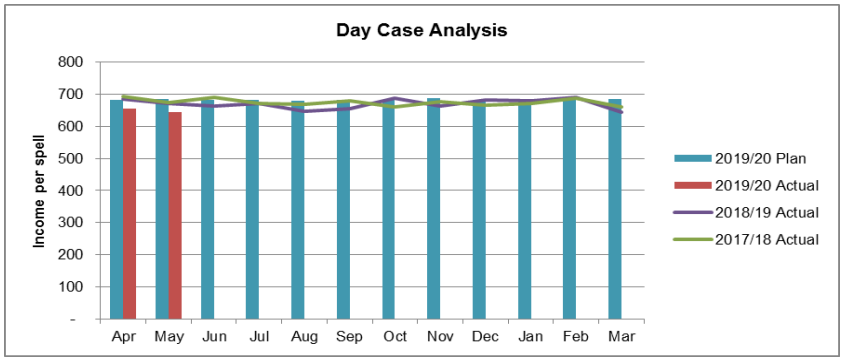


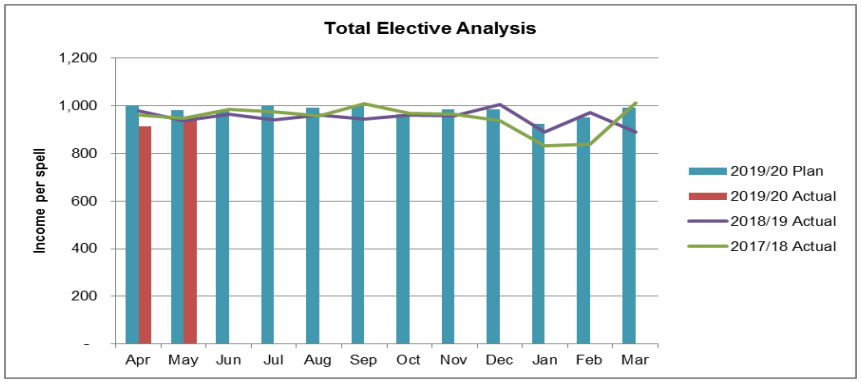


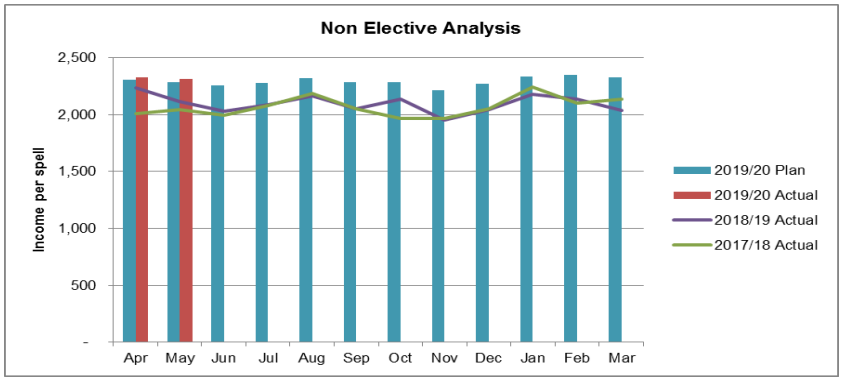
FINANCE AND WORKFORCE REPORT - MAY 2019

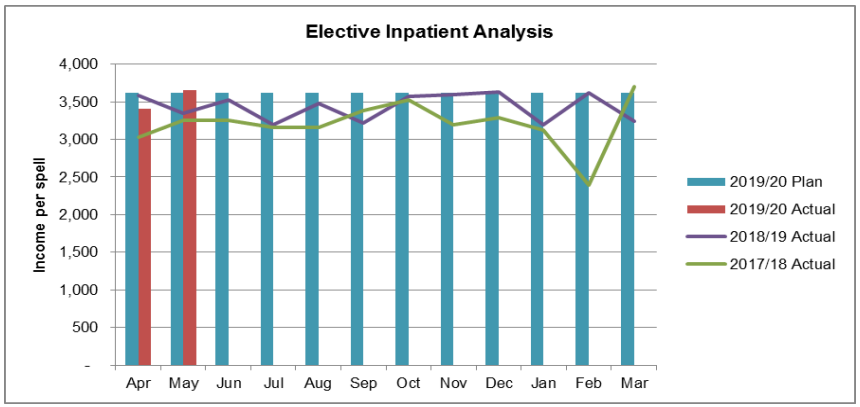
Trends and Analysis

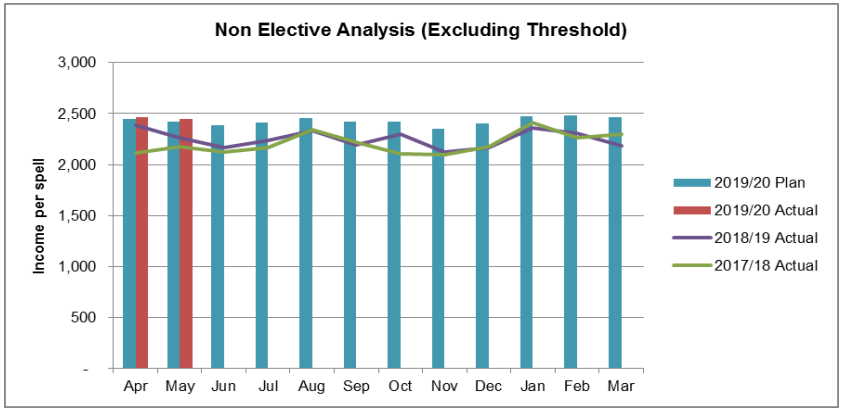












FINANCE AND WORKFORCE REPORT - MAY 2019

Workforce

Monthly Expenditure (£) Acute services only				
As at May 2019	May-19	Apr-19	May-18	YTD 2019/20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**12,437**	**12,338**	**11,109**	**24,799**
Substantive Staff	10,777	11,199	9,928	21,976
Medical Agency Staff (includes 'contracted in' staff)	92	182	76	274
Medical Locum Staff	134	286	225	420
Additional Medical sessions	313	308	298	622
Nursing Agency Staff	160	154	88	314
Nursing Bank Staff	318	263	459	581
Other Agency Staff	48	37	(6)	85
Other Bank Staff	118	151	104	269
Overtime	179	221	165	399
On Call	66	67	58	134
Total temporary expenditure	1,428	1,669	1,466	3,097
Total expenditure on pay	**12,205**	**12,868**	**11,394**	**25,073**
Variance (F/(A))	232	(530)	(285)	(275)
Temp Staff costs % of Total Pay	11.7%	13.0%	12.9%	12.4%
Memo : Total agency spend in month	300	373	157	673

Monthly Whole Time Equivalents (WTE) Acute Services only			
As at May 2019	May-19	Apr-19	May-18
	WTE	WTE	WTE
Budgeted WTE in month	**3,400.3**	**3,381.5**	**3,134.7**
Employed substantive WTE in month	2927.92	2991.82	2765.43
Medical Agency Staff (includes 'contracted in' staff)	7.79	12.87	9.43
Medical Locum	12.77	38.24	17.4
Additional Sessions	21.05	23.29	24.6
Nursing Agency	22.41	24.47	17.33
Nursing Bank	81.85	81.74	68.2
Other Agency	6.42	8.1	7.4
Other Bank	56.37	63.31	49.2
Overtime	47.76	61.25	56.39
On call Worked	6.38	6.92	7.74
Total equivalent temporary WTE	**262.8**	**320.2**	**257.7**
Total equivalent employed WTE	**3,190.7**	**3,312.0**	**3,023.1**
Variance (F/(A))	209.6	69.5	111.6
Temp Staff WTE % of Total Pay	8.2%	9.7%	8.5%
Memo : Total agency WTE in month	36.6	45.4	34.2
Sickness Rates (Apr / Mar)	3.39%	3.12%	3.77%
Mat Leave	3.01%	3.01%	2.13%

Monthly Expenditure (£) Community Service Only				
As at May 2019	May-19	Apr-19	May-18	YTD 2019-20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,687**	**1,718**	**1,516**	**3,405**
Substantive Staff	1,595	1,559	1,504	3,154
Medical Agency Staff (includes 'contracted in' staff)	7	12	15	18
Medical Locum Staff	5	8	3	13
Additional Medical sessions	0	1	0	1
Nursing Agency Staff	30	12	9	41
Nursing Bank Staff	35	36	23	70
Other Agency Staff	5	7	17	12
Other Bank Staff	8	7	7	14
Overtime	5	7	8	12
On Call	3	4	3	7
Total temporary expenditure	97	93	85	190
Total expenditure on pay	**1,692**	**1,651**	**1,589**	**3,344**
Variance (F/(A))	(5)	67	(73)	61
Temp Staff costs % of Total Pay	5.7%	5.6%	5.4%	5.7%
Memo : Total agency spend in month	42	30	42	72

Monthly Whole Time Equivalents (WTE) Community Services Only			
As at May 2019	May-19	Apr-19	May-18
	WTE	WTE	WTE
Budgeted WTE in month	**531.17**	**531.66**	**485.56**
Employed substantive WTE in month	478.09	474.34	465.73
Medical Agency Staff (includes 'contracted in' staff)	0.44	0.74	0.42
Medical Locum	0.35	0.35	0.35
Additional Sessions	0.00	0.00	0.00
Nursing Agency	4.19	1.64	1.96
Nursing Bank	8.88	11.13	3.95
Other Agency	1.58	2.19	3.93
Other Bank	1.46	2.43	2.23
Overtime	1.68	2.14	2.43
On call Worked	0.00	0.00	0.00
Total equivalent temporary WTE	**18.6**	**20.6**	**15.3**
Total equivalent employed WTE	**496.7**	**495.0**	**481.00**
Variance (F/(A))	34.50	36.70	4.56
Temp Staff WTE % of Total Pay	3.7%	4.2%	3.2%
Memo : Total agency WTE in month	6.2	4.6	6.3
Sickness Rates (April/ Mar)	4.13%	4.62%	3.62%
Mat Leave	2.81%	2.81%	1.13%

FINANCE AND WORKFORCE REPORT - MAY 2019

Pay Trends and Analysis

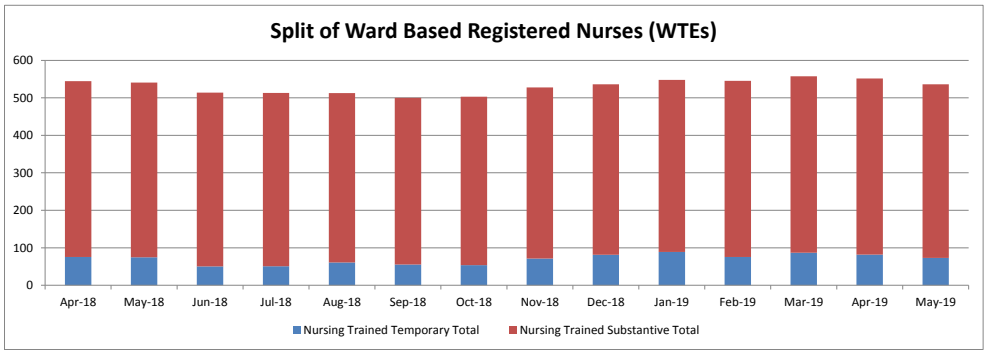
The Trust has spent £223k more on pay than budgeted year to date.

Nursing

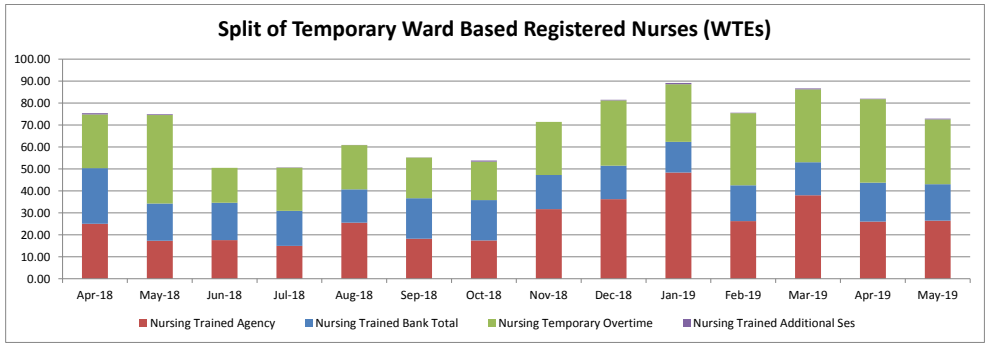
The tables below compare actual WTEs within ward based and non-ward based registered and unregistered nursing between April 2018 and May 2019. We will provide further analysis of the increases in non-ward based nursing in next months Board report.

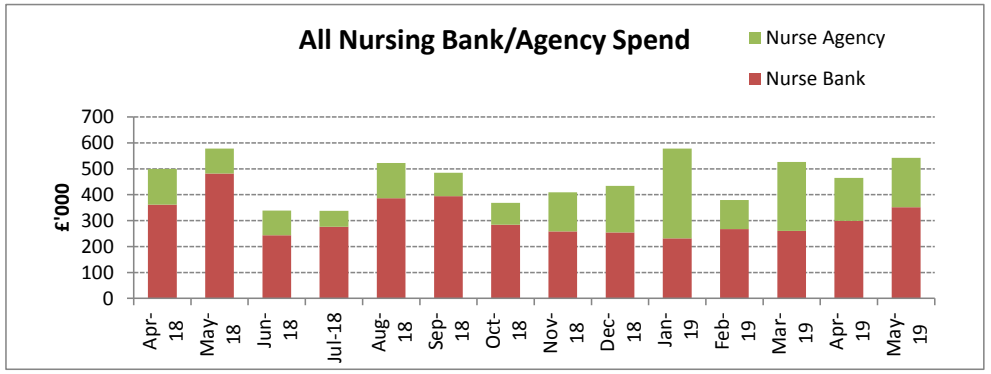
Nursing WTE Actual Increase / (Decrease) April 18 to April 19				May 18 to May 19		
	Ward Based	Non Ward Based	Total	Ward Based	Non Ward Based	Total
Registered	7.22	31.1	**38.32**	(4.58)	29.61	**25.03**
Unregistered	43.22	6.26	**49.48**	78.29	5.42	**83.71**
Total	**50.44**	**37.36**	**87.80**	**73.71**	**35.03**	**108.74**

Nursing WTE % Increase / (Decrease) April 18 to April 19				May 18 to May 19		
	Ward Based	Non Ward Based	Total	Ward Based	Non Ward Based	Total
Registered	1.3%	6.0%	**3.6%**	(0.8%)	5.8%	**2.4%**
Unregistered	12.5%	4.3%	**10.1%**	24.6%	3.8%	**18.1%**
Total	**5.7%**	**5.6%**	**5.7%**	**8.6%**	**5.3%**	**7.2%**

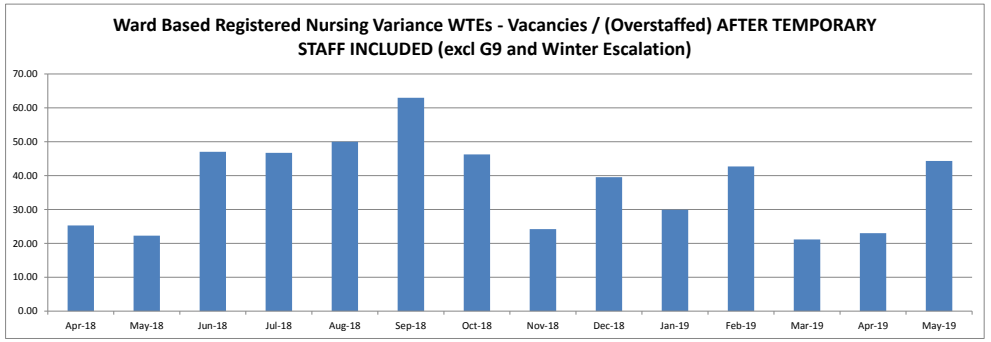


We used 72.88 temporary WTEs to fill the majority of vacant posts during May 2019





However, there remained 44 WTE uncovered Ward Based Registered Nursing Vacancies (excluding escalation areas) after filling with temporary staff.



FINANCE AND WORKFORCE REPORT - MAY 2019

After using temporary nursing staff there remained 44 WTE registered nursing uncovered vacancies on wards during May 2019 (excluding escalation areas)

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
Medical Services	A&E Medical Staff	6.12	4.11	(2.01)	6.12	6.06	(0.06)
	Accident & Emergency	61.81	63.38	1.57	61.81	55.36	(6.45)
	C.C.U.	0	0	0.00	0	0.03	0.03
	Ward F9	20.31	18.37	(1.94)	20.31	20.32	0.01
	Ward F12	11.02	11.16	0.14	11.02	9.89	(1.13)
	Ward G1 Hardwick Unit	23.74	22.28	(1.46)	23.74	19.37	(4.37)
	Cardiac Ward	14.28	12.27	(2.01)	14.28	11.09	(3.19)
	Ward G4	19.17	19.22	0.05	19.17	17.13	(2.04)
	Ward G5	18.41	20.77	2.36	18.41	17.73	(0.68)
	Ward G8	23.15	19.84	(3.31)	23.15	17.43	(5.72)
	Medical Treatment Unit	7.04	5.98	(1.06)	7.04	6.04	(1.00)
	Respiratory Ward	19.9	21.48	1.58	19.9	20.87	0.97
	Cardiac Centre	40.14	33.41	(6.73)	40.14	34.77	(5.37)
	AAU	27.3	20.85	(6.45)	27.3	18.98	(8.32)
	Ward F7 Short Stay	21.84	20.94	(0.90)	21.84	20.88	(0.96)
Medical Services Total		314.23	294.06	(20.17)	314.23	275.95	(38.28)
Surgical Services	Operating Theatres	60.93	60.86	(0.07)	60.93	59.12	(1.81)
	Critical Care Services	42.38	43.77	1.39	42.38	39.7	(2.68)
	Ward F3	19.69	17.92	(1.77)	19.69	18.98	(0.71)
	Ward F4	13.78	12.72	(1.06)	13.78	14.29	0.51
	Ward F5	19.59	19.46	(0.13)	19.59	18.66	(0.93)
	Ward F6	19.57	18.72	(0.85)	19.57	19.07	(0.50)
Surgical Services Total		175.94	173.45	(2.49)	175.94	169.82	(6.12)
Woman & Children Se	Ward F1 Paediatrics	18.13	20.47	2.34	19.13	20.17	1.04
	Gynae Ward (On F14)	11.18	11.73	0.55	11.18	11.47	0.29
	Neonatal Unit	20.85	19.56	(1.29)	20.85	19.29	(1.56)
Woman & Children Services Total		50.16	51.76	1.60	51.16	50.93	(0.23)
Community	Newmarket Hosp-Rosemary ward	12.43	10.89	(1.54)	12.43	14.1	1.67
	Community - Glastonbury Court	11.69	11	(0.69)	11.69	11.06	(0.63)
Community Total		24.12	21.89	(2.23)	24.12	25.16	1.04
Corporate Directorate	Discharge Waiting Area	1	1.25	0.25	1	0.28	(0.72)
Corporate Directorates Total		1	1.25	0.25	1	0.28	(0.72)
Grand Total		**565.45**	**542.41**	**(23.04)**	**566.45**	**522.14**	**(44.31)**

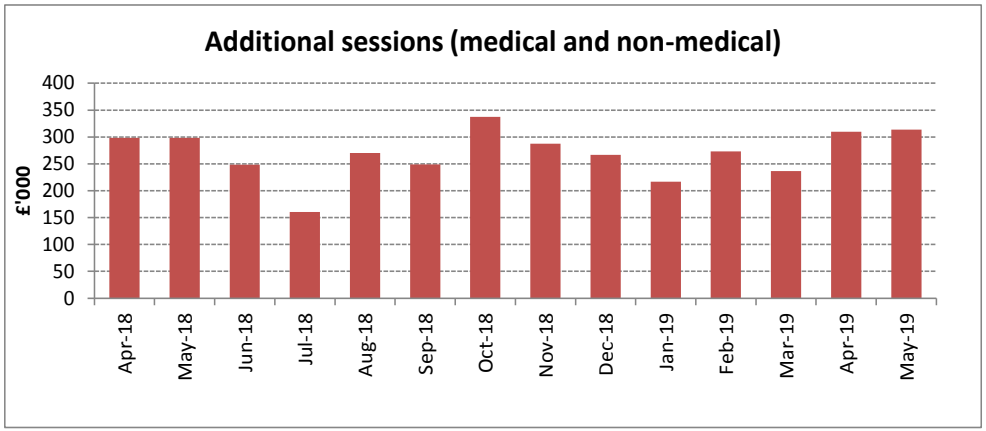
Ward Based Unregistered Nurses were over established during May, after utilising temporary unregistered nurses (5.8 wte over establishment). This excludes escalation areas.

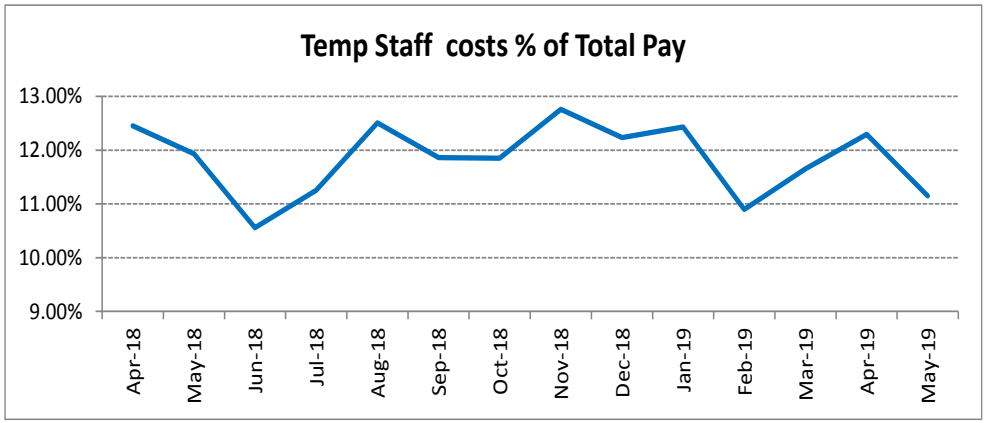
Division	Ward Area	Plan April 19	Actual April 19	NET Vacancies (over / (under)) April 19	Sum of plan may 19	Sum of Actual may 19	Sum of Variance (over / (under)) May 19
Medical Services	Accident & Emergency	24.43	21.83	(2.60)	24.43	22.66	(1.77)
	C.C.U.	0	0	0.00	0	0	0.00
	Ward F9	22.56	23.72	1.16	22.56	20.85	(1.71)
	Ward F12	5	5.29	0.29	5	5.48	0.48
	Ward G1 Hardwick Unit	9.01	9.17	0.16	9.01	9.3	0.29
	Cardiac Ward	18.03	9.64	(8.39)	18.03	10.28	(7.75)
	Ward G4	24.36	26.84	2.48	24.36	27.9	3.54
	Ward G5	22.66	25.82	3.16	22.66	25.02	2.36
	Ward G8	23.87	26.49	2.62	23.87	26.79	2.92
	Respiratory Ward	21.13	19.01	(2.12)	21.13	19.15	(1.98)
	Cardiac Centre	15.2	20.34	5.14	15.2	19.86	4.66
	AAU	29.59	28.92	(0.67)	29.59	27.7	(1.89)
	Ward F7 Short Stay	30.94	26.9	(4.04)	30.94	29.05	(1.89)
Medical Services Total		246.78	243.97	(2.81)	246.78	244.04	(2.74)
Surgical Services	Operating Theatres	22.28	21.1	(1.18)	22.28	21.22	(1.06)
	Critical Care Services	1.88	3.01	1.13	1.88	2.91	1.03
	Ward F3	22.26	22.97	0.71	22.26	25.27	3.01
	Ward F4	9.61	8.38	(1.23)	9.61	8.59	(1.02)
	Ward F5	14.51	14.65	0.14	14.51	15.42	0.91
	Ward F6	14.51	17.61	3.10	14.51	17.29	2.78
Surgical Services Total		85.05	87.72	2.67	85.05	90.7	5.65
Woman & Children Services	Ward F1 Paediatrics	7.16	7.54	0.38	7.16	7.47	0.31
	Gynae Ward (On F14)	1	4.81	3.81	1	4.69	3.69
	Neonatal Unit	2.64	2.78	0.14	2.64	2.64	0.00
Woman & Children Services Total		10.8	15.13	4.33	10.8	14.8	4.00
Community	Newmarket Hosp-Rosemary ward	13.47	12.26	(1.21)	13.47	12.34	(1.13)
	Community - Glastonbury Court	12.64	12.43	(0.21)	12.64	12.66	0.02
Community Total		26.11	24.69	(1.42)	26.11	25	(1.11)
Grand Total		**368.74**	**371.51**	**2.77**	**368.74**	**374.54**	**5.80**

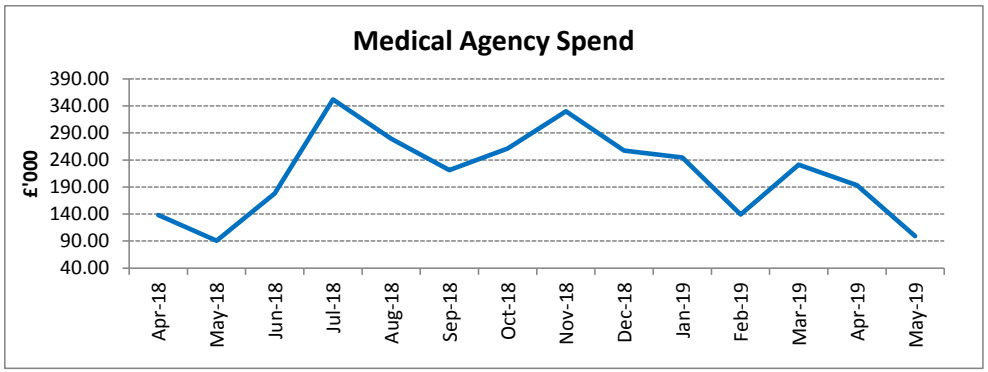
	Registered Nurses				Unregistered Nurses				Overseas Nurses / Nursing Assistants
	Leavers 2018	Starters 2018	% Turnover		Leavers 2018	Starters 2018	% Turnover		
	Headcount	Headcount	Predicted (Based on previous year)	Actual (Headcount)	Headcount	Headcount	Predicted (Based on previous year)	Actual (Headcount)	
January 2018	1	4	0.84%	0.26%	2	8	1.51%	0.53%	
February 2018	2	2	2.15%	0.52%	4	5	1.00%	1.07%	
March 2018	4	6	0.88%	1.03%	5	6	1.04%	1.35%	
April 2018	1	6	0.44%	0.26%	2	8	1.54%	0.54%	
May 2018	2	0	0.67%	0.52%	1	0	0.78%	0.27%	
June 2018	2	2	1.59%	0.53%	3	12	0.26%	0.80%	
July 2018	6	0	1.15%	1.63%	9	8	0.76%	2.39%	3
August 2018	3	1	1.16%	0.85%	1	11	1.02%	0.27%	4
September 2018	3	15	1.14%	1.21%	3	15	1.01%	1.19%	6
October 2018	5	13	0.23%	1.75%	1	19	1.76%	0.34%	9
November 2018	0	5	0.47%	0.00%	3	10	1.02%	1.27%	5
December 2018	3	10	1.43%	1.54%	3	10	2.09%	1.24%	0
January 2019	0	8	0.26%	0.00%	3	6	0.53%	1.08%	4
February 2019	1	2	0.52%	0.44%	1	8	1.07%	0.36%	7
March 2019	3	7	0.88%	1.29%	5	9	1.04%	1.87%	5
April 2019	1	6	0.26%	0.42%	3	9	0.54%	1.12%	1
May 2019	1	4	0.52%	0.43%	2	3	0.27%		10
Totals	28	73			46	147			54

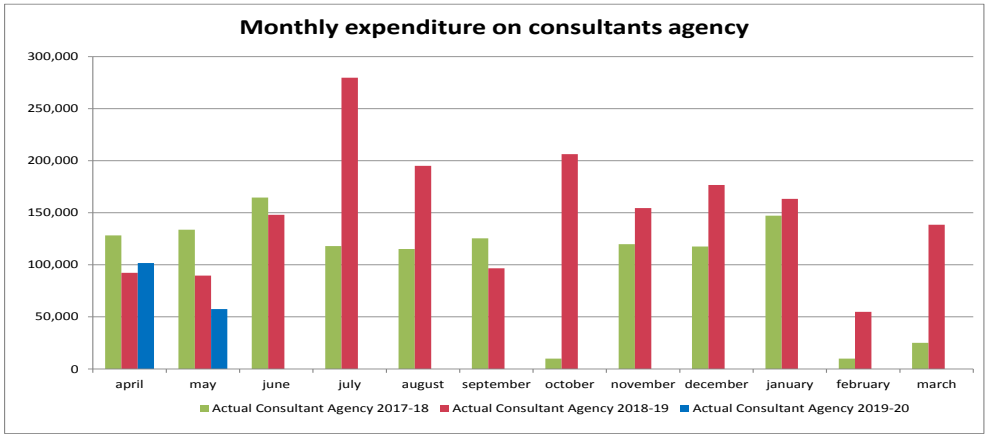
* These figures are related to Ward Based areas only including Glastonbury and Newmarket Rosemary Ward

FINANCE AND WORKFORCE REPORT - MAY 2019









FINANCE AND WORKFORCE REPORT - MAY 2019

Summary by Division

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

DIVISIONAL INCOME AND EXPENDITURE ACCOUNTS	Current Month			Year to date		
	Budget £k	Actual £k	Variance F/(A) £k	Budget £k	Actual £k	Variance F/(A) £k
MEDICINE						
Total Income	(7,711)	(7,887)	177	(14,393)	(14,527)	134
Pay Costs	3,971	3,991	(19)	7,984	8,046	(62)
Non-pay Costs	1,498	1,587	(90)	2,952	3,048	(95)
Operating Expenditure	**5,469**	**5,578**	**(109)**	**10,936**	**11,093**	**(157)**
SURPLUS / (DEFICIT)	**2,242**	**2,310**	**68**	**3,457**	**3,434**	**(23)**
SURGERY						
Total Income	(5,210)	(4,995)	(215)	(10,371)	(10,124)	(247)
Pay Costs	3,072	3,090	(18)	6,152	6,190	(38)
Non-pay Costs	1,141	1,192	(51)	2,291	2,251	41
Operating Expenditure	**4,213**	**4,283**	**(70)**	**8,443**	**8,441**	**3**
SURPLUS / (DEFICIT)	**997**	**713**	**(284)**	**1,928**	**1,683**	**(244)**
WOMENS and CHILDRENS						
Total Income	(1,937)	(1,720)	(217)	(3,791)	(3,570)	(222)
Pay Costs	1,198	1,199	(1)	2,385	2,445	(60)
Non-pay Costs	154	140	14	308	266	42
Operating Expenditure	**1,352**	**1,339**	**13**	**2,693**	**2,711**	**(18)**
SURPLUS / (DEFICIT)	**585**	**380**	**(205)**	**1,098**	**859**	**(239)**
CLINICAL SUPPORT						
Total Income	(864)	(883)	19	(1,650)	(1,705)	55
Pay Costs	1,549	1,439	111	2,994	2,934	60
Non-pay Costs	1,032	1,109	(77)	2,041	2,091	(50)
Operating Expenditure	**2,581**	**2,547**	**34**	**5,035**	**5,025**	**9**
SURPLUS / (DEFICIT)	**(1,718)**	**(1,664)**	**53**	**(3,385)**	**(3,320)**	**64**
COMMUNITY SERVICES						
Total Income	(2,550)	(2,578)	29	(6,203)	(6,164)	(39)
Pay Costs	2,270	2,286	(16)	4,568	4,504	64
Non-pay Costs	913	1,124	(211)	1,888	2,076	(188)
Operating Expenditure	**3,183**	**3,410**	**(227)**	**6,455**	**6,580**	**(124)**
SURPLUS / (DEFICIT)	**(633)**	**(831)**	**(198)**	**(252)**	**(416)**	**(164)**
ESTATES and FACILITIES						
Total Income	(434)	(342)	(92)	(868)	(769)	(99)
Pay Costs	874	852	22	1,748	1,710	38
Non-pay Costs	608	722	(114)	1,066	1,128	(61)
Operating Expenditure	**1,482**	**1,574**	**(92)**	**2,814**	**2,838**	**(24)**
SURPLUS / (DEFICIT)	**(1,048)**	**(1,232)**	**(184)**	**(1,946)**	**(2,069)**	**(122)**
CORPORATE (excl Reserves)						
Total Income	(2,439)	(2,499)	60	(4,831)	(5,269)	438
Pay Costs	1,188	1,039	149	2,374	2,588	(214)
Non-pay Costs (net of Contingency and Reserves)	1,155	1,239	(85)	2,294	2,434	(140)
Finance & Capital	980	854	127	1,961	1,865	95
Operating Expenditure	**3,323**	**3,133**	**191**	**6,628**	**6,887**	**(259)**
SURPLUS / (DEFICIT)	**(884)**	**(634)**	**251**	**(1,797)**	**(1,618)**	**179**
TOTAL						
Total Income	(21,144)	(20,905)	(240)	(42,107)	(42,128)	21
Pay Costs	14,123	13,897	227	28,204	28,417	(213)
Non-pay Costs	6,500	7,113	(613)	12,840	13,292	(453)
Finance & Capital	980	854	127	1,961	1,865	95
Operating Expenditure	**21,603**	**21,863**	**(260)**	**43,004**	**43,574**	**(570)**
SURPLUS / (DEFICIT)	**(459)**	**(959)**	**(500)**	**(897)**	**(1,446)**	**(549)**

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

Medicine (Nicola Cottington)

The division reported a favourable variance of £68k in May (£23k unfavourable variance YTD).

Clinical Income exceeded plan by £205k in month and is largely driven by increased ED attendances and Emergency Inpatients, reflecting continued pressures.

Pay is reported at £19k behind plan in month. Recorded ED activity remained high in May, 2.2% higher than April 19 and 9.4% higher than the same point in 2018. The increase in attendances continued to impact throughout the Trust, with escalation beds on G9 remaining open throughout May, whilst the budget only anticipated its use for 2 weeks. The increase in activity inevitably put pressure on costs with Medical staffing within ED, AMU/EAU over budget through sustained locums and agency usage. These overspends are partly netted by budget phasing issues in both AAU and G3 (£21k & £44k respectively).

The non-pay variance (£90k overspend in Month) is largely driven by an under-accrual in 18/19 on Internal loop recorders and other Cath Lab high cost consumables. The overspend noted in Drugs (£21k YTD) will revert to an underspend of £70k YTD once additional excluded drugs are claimed in June.

The Division has identified £2.4m of CIPS to be delivered in 19/20, achieving the central target with an in-month increase of £10k. The majority of the divisions CIPs are being delivered by schemes already in place with achievement of savings progressing. Mobilising the new schemes in 19/20 continues to be the focus for the division.

Surgery (Simon Taylor)

The division reported an adverse variance of £284k in May (£244k YTD).

Clinical Income has underachieved by £215k. Whilst surgery has overachieved on non-elective activity the division has struggled to achieve elective capacity both in inpatients and outpatients.

Pay reported an £18k overspend in the month and £38k YTD. The main driver of cost has been the use of temporary medical and nursing staff. The nursing

overspend has been caused by winter pressures relating to Surgery supporting escalation beds relating to Medicine patients. The overspend on additional sessions is due to rota gaps and sickness.

Non pay reported a £51k overspend in month and YTD £41k underspent. This relates to drugs and expenditure on non-disposable Medical and Surgical Equipment

Women and Children's (Rose Smith)
The division reported an adverse variance of £205k in May (£239k YTD).

Income reported £217k behind plan in-month and is £222k behind plan YTD. In the month and YTD, the Division experienced lower volumes of neonatal and maternity activity. This underperformance against plan is unlikely to become a trend as outpatient activity is increasing as the Obstetric and Gynaecology service addresses its RTT backlog.

Pay reported a £1k overspend in-month and is £60k overspent YTD. In-month, it was not possible to fully cover the gaps in paediatric medical staffing. Whereas, YTD the Division has experienced cost pressures from both the locum consultant who was employed in Paediatrics and staffing on F1. A business case is being prepared to agree a long term solution to the medical staffing issues experienced in Paediatrics.

Non pay reported a £14k underspend in-month and is £42k underspent YTD. The in-month and YTD underspends have been driven by the lower activity levels as less drugs and consumables have had to be used.

Clinical Support (Rose Smith)
The division reported a favourable variance of £53k in May (£64k YTD).

Income for Clinical Support reported £19k ahead of plan in-month and is £55k ahead of plan YTD. In month, both Radiology outpatient activity and Interventional Radiology activity for inpatients were higher than planned. Year to date, Radiology activity has been above plan for outpatients, interventional procedures and direct access patients.

Pay is £111k underspent in-month and is £60k underspent YTD. In month and YTD, Radiology, Outpatients and Pharmacy have struggled to fill vacancies. The Outpatient staffing review has been concluded and the department is looking to staff to its full responsibilities. The Pharmacy and Radiology services are in the process of advertising and recruiting to the vacant posts.
Non pay reported a £77k overspend in-month and is £50k overspent YTD. In month and YTD, all of the services experienced a number or activity related cost pressures. These may diminish if activity returns to planned levels.

Community Services and Integrated Therapies (Michelle Glass)
The division reported an adverse variance of £198k in May (£164k YTD).

Income reported a £29k over recovery in month, an improvement on prior month levels with a year to data adverse variance of £39k. This is under review to ensure the position continues to improve, with risks addressed within the Division to ensure income is maximised.

An in-month overspend on pay of £16k was realised, primarily as a result of increased levels of spend on agency nursing in May. However, the Division's year to date position remains favourable with a £64k over recovery achieved. This position is net of a Pay CIP and reflects staff turnover levels. As each vacancy arises, the post is reviewed and full consideration of current and expected future business need given, prior to commencing recruitment swiftly in order to avoid agency costs.

Non pay reported an adverse variance of £211k in 2019/20, primarily due to higher than expected monthly spend within the Community Equipment Service. However, using analysis of the profile of prior year expenditure, work is underway to ascertain whether the phasing of expected spend should be updated. In addition higher than expected spend has been incurred this month on dressings to meet service demand and also the purchase of IT Hardware required to support increased mobile working.

The Division is forecasting to deliver £1.1m of CIPS in 2019/20. The Division is focusing on developing proposals for additional schemes for 19/20 in order to address the Divisional gap

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	-25.0	4	4
I&E Margin rating	-3.4%	4	2
I&E Margin Variance rating	-1.1%	3	1
Agency	-14%	1	1
Use of Resources Rating after Overrides		3	3

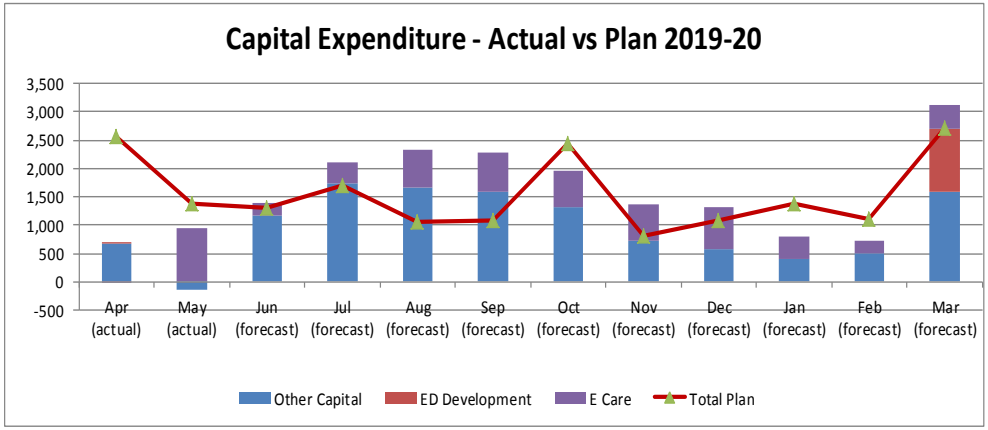
The Trust is scoring an overall UoR of 3 this month, which is consistent with previous months.

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.

FINANCE AND WORKFORCE REPORT - MAY 2019

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Forecast £'000	Jul Forecast £'000	Aug Forecast £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2018-19 £'000
E Care	-5	934	226	386	661	690	641	641	741	386	221	434	5,956
ED Development	0	0	0	0	0	0	0	0	0	0	0	1,100	1,100
Other Schemes	667	-149	1,170	1,731	1,662	1,585	1,314	717	569	414	496	1,593	11,770
Total / Forecast	662	785	1,396	2,117	2,323	2,275	1,955	1,358	1,310	800	717	3,126	18,826
Total Plan	2,560	1,385	1,305	1,710	1,050	1,075	2,434	815	1,075	1,380	1,101	2,702	18,592

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

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

The Trust is awaiting final confirmation of a capital loan to support the capital programme. For this reason many of the estates projects are held awaiting this approval. The forecast assumes that this is received and the schemes will commence in June. Until this loan is approved the minimum level of estates capital to support ongoing projects is being undertaken.

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

Statement of Financial Position at 31st May 2019

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2019 *	Plan 31 March 2020	Plan YTD 31 May 2019	Actual at 31 May 2019	Variance YTD 31 May 2019
	£000	£000	£000	£000	£000
Intangible assets	33,970	35,940	34,583	34,133	(450)
Property, plant and equipment	103,223	115,395	110,338	103,307	(7,031)
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**	**149,346**	**142,494**	**(6,852)**
Inventories	2,698	2,700	2,700	3,002	302
Trade and other receivables	22,119	20,000	20,000	21,534	1,534
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	7,438	5,825	(1,613)
Total current assets	**29,324**	**23,750**	**30,138**	**30,361**	**223**
Trade and other payables	(28,341)	(32,042)	(30,082)	(25,493)	4,589
Borrowing repayable within 1 year	(12,153)	(3,134)	(3,134)	(7,942)	(4,808)
Current Provisions	(47)	(20)	(20)	(47)	(27)
Other liabilities	(1,207)	(992)	(9,334)	(7,737)	1,597
Total current liabilities	**(41,748)**	**(36,188)**	**(42,570)**	**(41,219)**	**1,351**
Total assets less current liabilities	**129,823**	**143,322**	**136,914**	**131,636**	**(5,278)**
Borrowings	(84,956)	(99,186)	(94,706)	(88,216)	6,490
Provisions	(111)	(150)	(150)	(111)	39
Total non-current liabilities	**(85,067)**	**(99,336)**	**(94,856)**	**(88,327)**	**6,529**
Total assets employed	**44,756**	**43,986**	**42,058**	**43,309**	**1,251**
Financed by					
Public dividend capital	69,113	70,430	69,149	69,112	(37)
Revaluation reserve	6,931	9,832	8,021	6,931	(1,090)
Income and expenditure reserve	(31,288)	(36,276)	(35,112)	(32,734)	2,378
Total taxpayers' and others' equity	**44,756**	**43,986**	**42,058**	**43,309**	**1,251**

Non-Current Assets

Net capital investment in intangible assets and property, plant and equipment (PPE) is lower than originally planned due to the phasing of the capital programme starting later than planned during 2019/20.

Trade and Other Receivables

These have increased by £1.7m since April and are £1.5m more than planned at the end of May. Included within the total is £4m of the 2018/19 Provider Sustainability Funding and £2m prepayments for contracts and leases as well as £6m for invoices raised.

Cash

Cash is £1.6m less than plan due to the timing of receipts and the payment run.

Trade and Other Payables

These are £4.6m less than plan at the end of May. This is mainly due to the work completed to improve the Trust's performance against the Better Payment Practice Code, which means that payments are being made quicker to suppliers.

Other Liabilities

This reflects the amount of income received in advance not yet recognised. This is £1.5m less than planned.

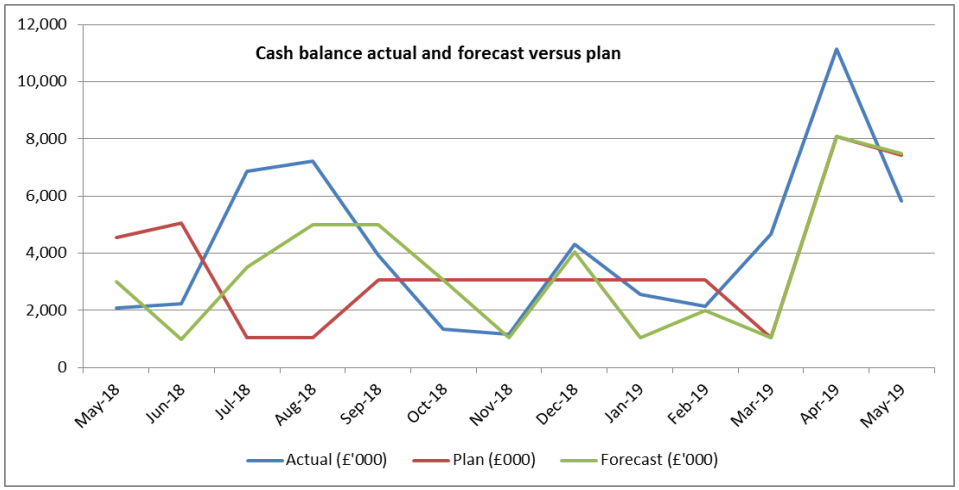
Borrowing

No borrowing was required in April or May so this was not drawn down, but this will be kept under close review. The Trust is required to repay £4.2m of loans by 31 March 2020.

FINANCE AND WORKFORCE REPORT - MAY 2019

Cash Balance Forecast for the year

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

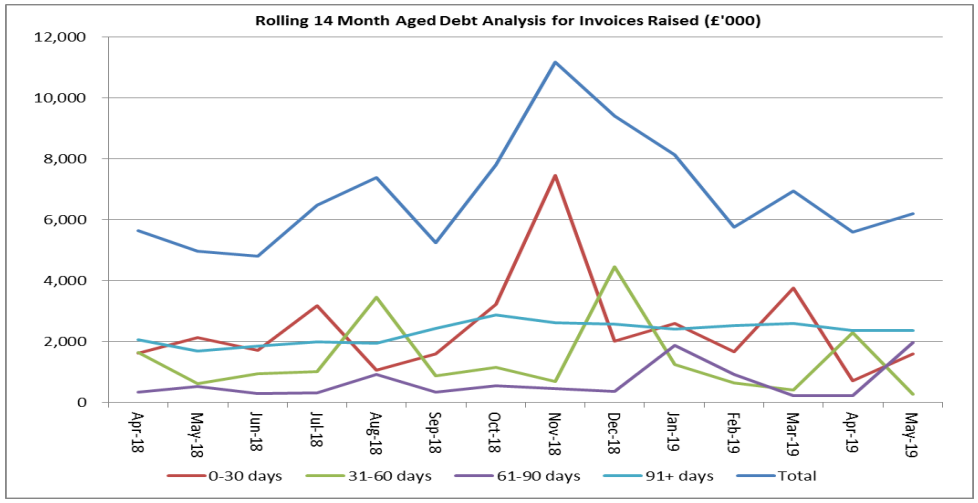


The May 2019 cash position is slightly lower than planned. It has been assumed that the current cash forecast for March – May 2019 is the same as the plan.

The actual cash balance for April was much higher than the current month due to the receipt of upfront funding from the CCGs. The actual cash balance for May is slightly lower than plan due to the timing of receipts and the payment run.

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 £605k since April. There has been a significant increase in 61-90 days, but this is largely off-set by a decrease in 31-60 days.

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

11. Nurse staffing report

To ACCEPT a report on monthly nurse staffing levels

For Report

Presented by Rowan Procter

Trust Board – 28th June 2019

Agenda item:	11			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Rowan Procter, Executive Chief Nurse, and Sinead Collins, Clinical Business Manager			
Date prepared:	24th June 2019			
Subject:	Quality and Workforce Report & Dashboard – Nursing			
Purpose:	X	For information		For approval

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

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

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

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

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

NHSI Safer Staffing - National Quality Board Recommendations

'Developing workforce safeguards – October 2018' document released by NHSI. Multi-disciplinary meeting occurred in June, and agreed that each clinical department will do an annual review process. Task & Finish Group to be set up to get QIA methodology and review process. Also needed is to add outpatients data into this report

Nursing vacancy accuracy position – May figures are over predicted the vacancies and Healthroster accuracy to be looked at again by HR. Updating process of Healthroster to be implemented with a review of time taken to complete this taken to account. Kate Read and Nick McDonald to meet to discuss steps forward.

Healthroster implementation into community – Updating progress has been delayed by CQC Provider Information Request. Newmarket CHT will be the pilot team

Overview of March nurse staffing position

Are we safe?
Across the month of May staff fill rate has been inconsistent and the average fill rate is lower this month than April. Fill rate report to be reviewed alongside template review due to lower fill rate figures

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

Assurance for community staffing has interim measures of daily calls with area leads and the local area managers and nursing leads, however for a more visual and accurate measure they will have to wait till later in year before HealthRoster can start to be implemented.

Are we efficient?
There sickness has increased in individual areas a lot this month (G5, G8, MTU and F10) in comparison to April.

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

CHPPD figures similar to comparable wards in other hospitals. NNU figure however high this month

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

Future planning – Nursing staff

Overseas Nurses/Nursing Assistants

Month	Number of arrivals
Jul-18	3
Aug-18	4
Sep-18	6
Oct-18	9
Nov-18	5
Dec-18	0
Jan-19	4
Feb-19	7
Mar-19	5
Apr-19	0
May-19	10
Jun-19	11
Total	53

Additional Information:
43 overseas nurses have passed their OSCE and are now working as Band 5 Nurses

1 OSCE booked for 19 June 2019

5 OSCE Exams booked for 1st July 2019

5 OSCE exams booked for 3rd July 2019

11 Undertaking OSCE preparation - OSCE to be booked for end of August 2019

9 Nurses due to arrive on 27th June 2019 for July's cohort/Induction

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	May-19		Establishment for the Financial Year 2018/19		Data for May 2019																	
					Workforce													Nursing Sensitive Indicators					
Trust	Ward Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Fill rate Registered %		Fill rate Unregistered %		Bank Use %	Agency use %	Overall Care Hours Per Patient Day	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)	Red Incidents	Complaints	Compliments
			Registered	Unregistered	Day	Night	Day	Night				Registered	Unregistered									
WSFT	ED	Emergency Department	54.91	23.43	91.9%	111.5%	110.4%	135.6%	7.2%	14.1%	N/A			3.00%	13.90%	3.70%	N/A	8	1	1	0	7
WSFT	AAU	Acute Admission Unit	27.30	29.59	68.3%	54.1%	81.6%	114.5%	4.7%	1.0%	10.4			2.80%	13.00%	3.90%	1	3	0	0	0	0
WSFT	F7	Short Stay Ward	22.84	30.94	59.8%	71.0%	106.6%	101.2%	10.7%	3.3%	6.2			5.60%	13.30%	5.90%	0	2	1	0	0	0
WSFT	CCS	Critical Care Services	41.07	1.88	97.8%	82.6%	N/A	N/A	2.1%	3.0%	31.1			3.30%	9.60%	4.60%	1	4	0	0	0	9
WSFT	Theatres	Theatres	61.68	22.27	107.2%	101.1%	N/A	N/A	0.2%	0.0%	N/A			7.90%	12.00%	0.90%	0	0	0	0	0	0
WSFT	Recovery	Theatres	21.23	0.96	144.6%	98.6%	85.0%	N/A	1.4%	0.0%	N/A			1.90%	13.20%	4.40%	0	0	N/A	0	0	0
WSFT	Day Surgery Unit	Theatres	28.43	8.59	53.3%	N/A	104.5%	N/A	0.0%	0.0%	N/A			9.10%	17.40%	0.00%	0	0	0	0	0	4
	Day Surgery Wards		11.76	1.79					9.4%	0.0%				1.90%	14.90%	0.00%						
WSFT	Cardiac Centre	Cardiology	38.14	15.20	70.4%	100.0%	111.4%	91.9%	0.4%	0.4%	4.5			3.20%	14.80%	2.90%	0	1	1	0	0	0
WSFT	G1	Palliative Care	23.96	8.31	71.6%	102.1%	93.7%	N/A	18.2%	2.7%	7.0			9.90%	15.10%	8.30%	0	7	1	0	0	0
WSFT	G3 WEW	Winter Escalation	Not budgeted		101.4%	141.8%	137.5%	116.0%	11.9%	13.9%	5.4			8.80%	11.30%	0.00%	1	5	1	0	0	0
WSFT	G4	Elderly Medicine	19.16	24.36	81.8%	88.3%	102.2%	108.5%	13.4%	4.6%	5.8			10.70%	13.20%	4.40%	5	6	0	0	1	1
WSFT	G5	Elderly Medicine	18.41	22.66	93.7%	95.5%	81.8%	113.0%	14.4%	2.7%	5.5			12.20%	12.70%	2.50%	1	2	0	0	1	0
WSFT	G8	Stroke	23.15	28.87	75.3%	83.3%	95.2%	101.7%	10.3%	4.7%	6.1			2.20%	10.20%	12.40%	1	0	1	0	0	0
WSFT	F1	Paediatrics	18.13	7.16				N/A	15.7%	0.0%	10.1			9.50%	9.90%	0.00%	N/A	1	N/A	0	0	3
WSFT	F3	Trauma and Orthopaedics	19.58	22.27	85.6%	92.7%	87.2%	105.6%	6.0%	4.4%	5.4			5.20%	7.70%	5.00%	3	6	3	0	1	0
WSFT	F4	Trauma and Orthopaedics	12.78	10.59	91.6%	95.4%	95.5%	137.5%	6.5%	7.5%	8.7			2.60%	14.00%	4.40%	0	0	0	0	1	3
WSFT	F5	General Surgery & ENT	19.58	14.51	91.6%	97.9%	91.0%	130.8%	7.0%	1.0%	5.2			6.70%	11.80%	6.00%	0	0	0	0	1	0
WSFT	F6	General Surgery	19.57	14.51	98.1%	84.9%	95.2%	115.3%	3.6%	6.2%	5.0			4.20%	15.80%	0.70%	1	2	1	1	1	0
WSFT	F8	Respiratory	19.90	20.13	101.7%	83.9%	92.2%	96.5%	3.7%	6.1%	6.5			6.60%	10.90%	0.00%	5	1	1	0	0	0
WSFT	F9	Gastroenterology	20.32	22.56	105.8%	95.6%	74.7%	122.1%	17.8%	3.1%	5.3			5.90%	15.10%	3.30%	3	1	1	0	0	0
WSFT	F11	Maternity	49.58	13.89	115.4%	94.6%	81.0%	80.2%	9.7%	0.0%	N/A			5.60%	11.90%	5.90%	0	6	0	0	0	0
WSFT	MLBU	Midwifery Led Birthing Unit															0	0	0	0	0	0
WSFT	Labour Suite	Maternity															0	1	0	1	1	0
WSFT	F12	Infection Control	11.02	5.00	78.0%	101.2%	34.2%	96.6%	6.3%	0.0%	8.9			2.00%	15.90%	0.00%	1	0	1	0	0	0
WSFT	F10	Gynaecology	11.18	1.00	103.3%	105.5%	N/A	N/A	34.6%	2.4%	5.0			10.40%	11.90%	0.00%	0	1	0	0	1	3
WSFT	MTU	Medical Treatment Unit	7.04	1.80	60.8%	N/A	71.5%	N/A	2.3%	0.0%	N/A			15.40%	17.60%	0.00%	0	0	0	0	0	0
WSFT	NNU	Neonatal	20.85	3.64	93.0%	82.9%	53.8%	54.8%	0.6%	0.0%	40.4			0.30%	13.60%	4.30%	N/A	0	N/A	0	0	0
Newmarket	Rosemary Ward	Step - down	12.34	13.47	118.4%	95.0%	109.1%	98.9%	8.4%	17.4%	5.6			9.90%	11.40%	0.00%	0	4	0	0	0	0
Glastonbury Court	Kings Suite	Medically Fit	11.50	12.64	121.0%	101.0%	89.9%	100.0%	7.9%	0.0%	4.7			7.80%	13.30%	0.00%	1	1	1	0	0	0
					91.58% AVG	94.19% AVG	93.25% AVG	108.77% AVG				0.00 TOTAL	0.00 TOTAL	6.24% AVG	13.05% AVG	2.98% AVG	24 TOTAL	62 TOTAL	14 TOTAL	3 TOTAL	8 TOTAL	30 TOTAL

Figures from Healthroster inaccurate

Trust	Team Name	Speciality	Current Funded Total Establishment Registered to Unregistered (WTE)		Patient facing contact (hrs)	Unplanned requests	Vacancies (WTE)		Sickness (%)	Annual Leave (%)	Maternity/Paternity Leave (%)	Pressure Ulcer Incidences (New)	Nursing/Midwifery Administrative Medication Errors	Red Incidents	Missed Visits	Complaints	Compliments
			Registered	Unregistered			Registered	Unregistered									
Community	Bury Town	Community Heath Team	17.59	5.60	1319.32	51	-2.94	0.20	1.45%	Not available comprehensively till Healthroster implemented	Not available this month	11	0	0	0	0	0
Community	Bury Rural	Community Heath Team	10.00	1.20	873.53	26	-0.30	-1.00	5.97%			4	1	0	0	0	0
Community	Mildenhall & Brandon	Community Heath Team	12.59	3.91	910.65	30	-0.60	-0.11	4.65%			7	0	0	0	0	0
Community	Newmarket	Community Heath Team	8.10	2.75	552.92	19	0.00	0.00	4.98%			0	0	0	0	0	0
Community	Sudbury	Community Heath Team	18.03	8.36	1295.92	49	-2.60	0.00	11.06%			3	1	0	0	1	0
Community	Haverhill	Community Heath Team	8.97	4.23	913.48	45	-4.40	0.00	6.21%			4	0	0	0	0	0
Community	Admission Prevention Service	Specialist Services	11.28	3.45	132.52	0	I/D	I/D	16.60%			1	1	0	0	0	0
Community	Children	Community Paediatrics	16.37	15.01	1575.58	1	-2.00	0.00	3.47%			N/A	0	0	0	0	0
					7573.92 TOTAL	221.00 TOTAL	-12.84 TOTAL	-0.91 TOTAL	6.80% AVG	#DIV/0! AVG	#DIV/0! AVG	30 TOTAL	3 TOTAL	0 TOTAL	0 TOTAL	1 TOTAL	0 TOTAL

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

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

12. Medical Revalidation Annual Report

To APPROVE the annual report

For Approval

Presented by Nick Jenkins

Board of Directors – 28 June 2019

ITEM NO:	12
PRESENTED BY:	Dr Nick Jenkins, Medical Director
PREPARED BY:	Paul Molyneux, Deputy Medical Director/Nick Jenkins, Responsible Officer and Medical Director
DATE PREPARED:	June 2019
SUBJECT:	Responsible Officer Annual Report 2019
PURPOSE:	To update the Board on the status of Medical Revalidation and Appraisal, and approve the annual Board Statement of Compliance
STRATEGIC OBJECTIVE:	Invest in quality, staff and clinical leadership

EXECUTIVE SUMMARY:

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

This Annual Report outlines the Trust position as of June 2019, updates the Board on recent developments in appraisal and revalidation and asks for confirmation that it is satisfied the West Suffolk NHS Foundation Trust is compliant with current regulations.

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

The number of doctors with whom the Trust has a prescribed connection as of March 2019 was 262

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

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

Background

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

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

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

Governance Arrangements

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

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

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

Appraisal processes have been well-established for many years. Appraisers are trained and receive top-up training at intervals of at least once a year. This takes the form of an afternoon workshop to highlight key developments in appraisal/revalidation, discuss difficult issues around appraisals and support each other as appraisers. Appraisers also receive individual feedback from each appraisee within three months of the appraisal

The annual appraisal includes:

- Preparation by the doctor which should include reflection on the full scope of their professional activities, not only their clinical work but private practice, voluntary activities, educational

supervisor or appraiser roles and any external professional activities. The doctor must upload a range of suitable supporting evidence applicable to each role.

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

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

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

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

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

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

Responsible Officer

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

Medical Appraisal Lead

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

Progress in 2018-19

a) Continue to monitor appraisal uptake/rates of completion Of the 20 doctors showing as 'non-compliant', 6 had an accepted reason for delay, 8 were 1 month overdue. Efforts are ongoing to ensure the remaining 6 doctors complete their appraisals in the near future. They are sent a formal letter which forms part of their revalidation evidence and must be discussed with their appraiser. If there is no progress, there is now formal process for referral to the General Medical Council to begin the process of non-engagement that ultimately could result in them being removed from the Register

b) Continue to recruit and train new appraisers. A total of 6 new appraisers were recruited and trained. Training was provided by either the Deputy Director of Workforce using a model provided by the University of East Anglia, or an external trainer with more than a decade of experience in appraiser training. We have sufficient experienced appraisers to allow for all doctors requiring an annual appraisal to be appraised

c) Provide appraisers with enhanced training through annual Appraiser Training Workshop. The latest workshops took place in May and June 2019

d) Recognition of Appraiser role through job planning. Appraisers now receive a 0.125 PA allocation in recognition of the work required to be an appraiser. Previously, there was an anomaly whereby the Educational Supervisor role was recognised with a PA allocation but the appraiser role was not. The roles are now both equitably remunerated.

e) The Revalidation Support Group is now fully established and meets every other month. Membership of the Group comprises the Responsible Officer, Lead Appraiser, a non-Executive Director, two senior appraisers and the Executive Director of Workforce and Communications. The Group quality assures previous Appraisals for Doctors approaching revalidation to assist the Responsible Officer in making a recommendation to the GMC. Any issues identified in previous appraisals are also fed back to both appraiser and appraise. Furthermore, the Group also writes a personal e mail to the Doctor confirming successful revalidation, but also identifying, acknowledging and highlighting particular areas of good practice. This has been well received.

Medical Appraisal Activity

262 doctors were appraised during this period.

Delayed appraisals are detailed in the table below.

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

Consultants	Completed	156		
	Approved not submitted	4		
	Unapproved not submitted	7		
			167	
Staff Grades	Completed	18		
	Approved not submitted	1		
	Unapproved not submitted	1		
			20	
Fix term & Locum	Completed	35		
	Approved not submitted	0		
	Unapproved not submitted	1		
			36	
Clinical Fellows & Trust Doctors	Completed	33		
	Approved not submitted	1		
	Unapproved not submitted	5		
			39	
	Total			262

The total number of trained appraisers at 31st March 2019 was 54. At present we have a sufficient number of appraisers.

Revalidation Activity

The number of recommendations made between April 2018 and March 2019 was 49

Positive recommendations	48
Deferrals	1
Non-engagements	0
Late recommendations	0

Development Plan / Issues for 2019-20

1. A key development for 2019-2020 is the move from the current electronic Appraisal System, SARD, to the new System, Allocate. The Allocate system will take over the functions of job planning, appraisal and electronic rostering and the move of appraisal systems is now well underway. Doctors currently completing appraisal up to August 2019

will continue to use the current SARD system, before transitioning to the new system. For those doctors with appraisals due beyond August, their portfolios are currently being transitioned onto Allocate.

2. Appraisers have received training in the use of the new Allocate System and the PMO is aiming to complete the transition to the new system in the next few months. Previous appraisals will remain available for review by the appraise/appraiser and the Revalidation Support Team, to ensure the entire appraisal cycle for each revalidation epoch is accessible

3. The PMO is working with Allocate to finalise details for collation of 360 patient feedback, which is a key component of Appraisal, it is hoped that agreement can be reached on this element in the next three months

4. Given the results of the senior Doctor Burnout Survey last Year, the Better Working Lives Group is exploring how to bring a discussion of wellbeing at work into the Appraisal discussion. One option being is to encourage the appraisee to complete a validated self-administered wellbeing at work survey and bring the results into the appraiser discussion. Appraisers will also be asked to undergo the training in mental health wellbeing at work offered through Suffolk Mind to facilitate any discussion that might arise around the issue of burnout at work

5. The new Allocate System does not offer an opportunity to require uploading of a mandatory training record, unlike the existing SARD which does have this functionality. This means that it will prove challenging to use appraisal as a vehicle for confirming mandatory training is up to date, and this will require alternative mechanisms for monitoring completion of mandatory training.

For approval

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

Attachments:

- Annual Organisational Audit 18-19
- Statement of Compliance

Statement of Compliance 2018-19.(

West Suffolk NHS Foundation Trust_Aoi

13. Seven Day services assurance report

To APPROVE the report

For Approval

Presented by Nick Jenkins

Trust Board – xx xx xx

Agenda item:				
Presented by:	Alex Baldwin, deputy chief operating officer			
Prepared by:	Alex Baldwin, deputy chief operating officer			
Date prepared:	24 June 2019			
Subject:	7 Day Services			
Purpose:		For information	√	For approval

Executive summary:

This paper provides a summary of the spring 2019 7 Day Services (7DS) audit results. It also provides a narrative on the changes to the national reporting requirements and a proposal for bi-annual audit programme supported by detailed analysis consistent with the spring 18 audit.

Appendix one: WSFT seven day services self-assessment assurance framework spring 2019

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

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

Previously considered by:	*n/a*
Risk and assurance:	*n/a*
Legislation, regulatory, equality, diversity and dignity implications	*n/a*

Recommendation:
The Board is asked to note the results of the spring 2019 audit.

1.0 Background

The Seven Day Hospital Services (7DS) Programme was developed to support providers of acute services ('providers') to deliver high quality care and improve outcomes on a seven-day basis for patients admitted to hospital in an emergency.

Ten 7DS clinical standards were originally developed by the NHS Services, Seven Days a Week Forum in 2013. Providers have been working to achieve all these standards, with a focus on four priority standards identified in 2015 with the support of the Academy of Medical Royal Colleges.

The four priority standards were selected to ensure that patients have access to consultant-directed assessment (Clinical Standard 2), diagnostics (Clinical Standard 5), interventions (Clinical Standard 6) and ongoing review (Clinical Standard 8) every day of the week.

To achieve each standard, a provider must be able to meet this level of care for at least 90% of its patients.

It is expected that all Trusts are compliant with the four priority standards by April 2020.

2.0 Spring 2019 audit results

The spring 2019 audit covered the four priority standards.

2.1 Clinical standard 2

The spring 2019 survey reported that the overall proportion of patients seen and assessed by a suitable consultant within 14 hours of admission was **78%.**

Table 1: Time from admission to 1st consultant review by day of the week (based on day of admission)

	Day of admission									
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Weekday	Weekend	Total
Number of patients reviews by a consultant within 14 hours	25	21	22	25	29	17	13	122	30	152
Number of patients reviews by a consultant outside 14 hours	9	6	6	2	12	4	5	35	9	44
Total	34	27	28	27	41	21	18	157	39	196
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	74%	78%	79%	93%	71%	81%	72%	78%	77%	78%

Table 2: Proportion of patients reviewed by a consultant within 14 hours of admission at hospital - survey comparison

	Survey				
	September 2016	March 2017	September 2017	April 2018	May 2019
Proportion of patients reviewed by a consultant within 14 hours of admission at hospital	**72%**	**72%**	**77%**	**79%**	**78%**

Compliance for standard 2 has decreased slightly since April 2018. It is important to note that the difference in performance is the equivalent of three patients receiving consultant review within 14 hours of admission.

It is noteworthy that 90% of patients receive a consultant review within 17 hours of admission to the hospital. This level of performance remains comparable with the April 18 survey.

Table 3: Time to 1st consultant review within 14 hours of admission by admitted specialty

	Within 14 hours	Outside 14 hours	Total	Proportion reviewed within 14 hours
Acute Internal Medicine	69	23	92	75%
Cardiology	5	0	5	100%
Diabetes and Endocrinology	1	2	3	33%
Gastroenterology	1	0	1	100%
General Surgery	26	5	31	84%
Geriatric Medicine	9	1	10	90%
Obstetrics and Gynaecology	3	0	3	100%
Oncology	1	0	1	100%
Paediatric Medicine	8	6	14	57%
Renal Medicine	2	0	2	100%
Respiratory Medicine	0	1	1	0%
Stroke Medicine	6	1	7	86%
Trauma and Orthopaedics	15	3	18	83%
Urology	6	2	8	75%

The Trust's focus should be on consistently meeting the standard across all specialties and there is a requirement for consultant directed review to be clearly documented in e-care.

2.2 Clinical standard 8

There were no patients identified as requiring twice daily audit in the May 2019 survey.

The proportion of patients who required and received a once daily consultant directed review was **89%.**

Table 5: Patients who required once daily consultant reviews and were reviewed

	Day of review

	Mon	Tues	Wed	Thurs	Fri	Sat	Sun	Weekday	Weekend	Total
Once daily review required and received	**69**	**85**	**85**	**69**	**70**	**64**	**59**	**378**	**123**	**501**
Once daily review required and not received	**9**	**1**	**0**	**1**	**3**	**21**	**26**	**14**	**47**	**61**
Excluded from the analysis	**1**	**2**	**0**	**5**	**2**	**3**	**5**	**10**	**8**	**18**

Percentage - receiving required once daily reviews	**88%**	**99%**	**100%**	**99%**	**96%**	**75%**	**69%**	**96%**	**72%**	**89%**

2.3 Summary

In summary the Trust has maintained improvement for standards two, five and six. Standard 8 has deteriorated since April 18 and there is a clear focus on standards of documentation to evidence once daily consultant review.

Table 6: Survey Comparison Autumn 2016- Spring 2019

West Suffolk NHS Foundation Trust	CS2: Time to first consultant review within 14hrs	CS5:Access to diagnostics	CS6: Access to consultant directed interventions	CS8: Ongoing review
Spring 2019	**78%**	**100%**	**100%**	**89%**
Spring 2018	**79%**	**1005**	**100%**	**95%**
Autumn 2017*	**77%**	**N/A**	**N/A**	**N/A**
Spring 2017	**72%**	**100%**	**100%**	**91%**
Autumn 2016	**72%**	**N/A****	**9 out of 9**	**Once daily 87% Twice daily: 5%**

*Autumn 2017 survey only measured clinical standard 2.
** Autumn 2016 survey measured CS2: Access to diagnostics via a survey of consultants

Focus remains on consistent delivery across the seven day period and increasing first consultant review within 14 hours.

3.0 7 Day Services Board Assurance

The 7DS self-assessment process has changed. The online self-assessment survey has been replaced with a 7DS board assurance framework template (appendix one).

The framework template is intended to provide a single, consistent way of recording provider self-assessments of 7DS delivery. The template requires providers to complete all yellow cells either:

- with a free text commentary of performance, covering any gaps to be addressed or
- by selecting a response to questions of compliance from a drop-down list.

The template is used to summarise the headline issues relating to delivery of the 7DS clinical standards as well as providing self-assessment information. It is not a comprehensive picture of the Trust's work on 7DS nor captures the full details of the audit data gathered to support any self-assessments.

In order to provide full assurance the spring 2019 survey replicated the national audit methodology as used for the spring 2018 audit. This allows for accurate comparison with previous audit results. It is expected that the audit will run bi-annually with both the framework template and detailed analysis presented to the board for assurance.

The Trust is required to submit the assurance framework template by 28 June 2019.

West Suffolk NHS FT: 7 Day Hospital Services Self-Assessment - Spring/Summer 2019

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	78% of patients admitted as an emergency had a clinical assessment by a suitbale consultant within 14 hours of admission. 78 % of patients admitted during week days were assessed within 14 hours. 77% of patients admitted during the weekend were assessed within 14 hours. 90% of patients admitted as an emergency were assessed within 17 hours. Overall the Trust has reduced performance from the Spring 18 audit when 79% of patients were assessed within 14 hours. However it is important to note that this is the equivalent of three patients. The percentage of patients who recieve assessment within 17 hours is comparable with the April 18 survey.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	Access to all modalities is avaliable 7 days per week.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Emergency Surgery	Yes available on site	Yes available on site	
	Access to all modalities is avaliable 7 days per week.	Emergency Renal Replacement Therapy	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Urgent Radiotherapy	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Stroke thrombolysis	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Percutaneous Coronary Intervention	Yes available off site via formal arrangement	Yes available off site via formal arrangement	
		Cardiac Pacing	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	The proportion of patients who required and received a once daily consultant directed review was 89%. The proportion of patients who required and received a once daily consultant directed review during the week was 96%. The proportion of patients who required and received a once daily consultant directed reveiw at the weekend was 72%. There were no patients identified as requiring twice daily reveiw in the May 2019 survey The Trust continues to perfrom well on once daily reveiws during the week but has an opportunity to improve the frequency of consultant led reveiw at the weekend.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Performance against the remaining clinical standards as follows: 1. Patient experience - the Trust has robust mechanisms for review of patient experience measures which are reported to and reveiwed at board on a monthly basis. 3. MDT review - the Trust has robust written policies for MDT processes in all specialties which covers appropriate assessment of ongoing or complex needs and integrated management planning (including discharge planning and medicines reconciliation). 4. Shift handovers - the Trust has assurance of robust handover as evidenced by comprehensive board and ward rounds and red 2 green reviews. These are reflected by appropriate hospital policy which is standardised accross seven days. 7. Mental health - The Trust is working hard with the local mental health provider to ensure appropriate availability and response of service 24/7. 9. Transfer to community, primary and social care - the Trust has robust mechanisms for ensuring the next steps in the patient's care pathway is enabled. Evidence includes board and ward rounds, red 2 green reveiws, stranded patient reviews and an engaged and effective discharge planning team. 10. Quality improvement - the Trust has an effective board assured quality improvement strategy which includes mortality reveiws, learning from death panels, length of stay and readmission reveiws etc.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
The Trust is compliant with the standards for services it provides.

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

14. 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

15. Consultant appointment - None to report

16. West Suffolk Alliance Report update

To ACCEPT the report

For Report

Presented by Kate Vaughton

West Suffolk NHS Foundation Trust Board Meeting
28 June 2019

Agenda item:	16			
Presented by:	Kate Vaughton, Director of Integration and Partnerships			
Prepared by:	Jo Cowley, Senior Alliance Development Lead and Dawn Godbold, Associate Director of Integration and Partnerships			
Date prepared:	19/06/19			
Subject:	West Suffolk Alliance Update			
Purpose:	x	For information		For approval

Executive summary:

This paper provides an update to the Board on the progress and development of the West Suffolk Alliance and partnership working in our system.

Main Points:

This paper provides an update on:

- Details on how the alliance is maturing
- Locality development update
- Primary Care Network development
- Community IT update
- Other Transformation activity update
- Social Prescribing update
- Wider partner activity

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*

Putting you first

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

West Suffolk Alliance Update

West Suffolk NHS Foundation Trust Board

28th June 2019

1.0 Introduction

1.1 This paper updates the Board on the progress and development of the West Suffolk Alliance and partnership working in our system.

2.0 Maturing the alliance

2.1 **Workforce** – Workforce is one of our biggest challenges, both in terms of ensuring we have the right skills and numbers as well as making sure that we create an integrated workforce that can provide seamless care for people in West Suffolk.

Up until now, the Integrated Care System (ICS) workforce programme has been led at STP level, through the Local Workforce Action Board established by Health Education England. There has now been recognition that a local group will have more direct influence on getting our workforce programmes progressed across alliance partners based around service need.

In order to facilitate this, a West Suffolk Local Workforce Action Group has been established, to enable more leadership of this agenda at a local level. This will be a regular meeting to support the delivery of workforce and OD transformation as signalled in the alliance strategy.

2.2 **Finance** – As an alliance we have stated that we want to make effective use of our resources. The strategy states "we will use the West Suffolk pound in the best way locally, reducing duplication and waste. All our organisations face challenging finances and if we work together we can use our resources better."[1]

This is a challenge within the ICS as well as the alliances and will be facilitated through the System Finance Committee at alliance level, as well as developments within ICS governance. The West Suffolk and Ipswich and East Suffolk CCG Financial Performance Committees agreed in April to move to a new structure for financial governance, which will operate at the three levels of CCG, WS Alliance and ICS.

The proposal is to move from the current monthly CCG FPC to quarterly and to instigate a system finance committee (working title).

Alliance partners and the CCG have been asked to nominate both a finance and clinical/operational management lead for the new committee. Dates for the new Alliance Finance Committee are being circulated, with the aim of holding meetings in July/August, October/November, January and April. The terms of reference will be agreed at the first meeting.

[1] https://www.healthysuffolk.org.uk/uploads/West_Suffolk_Alliance_Strategy_(002).pdf Page 12.

2.3 **Quality** – To improve the System's approach to quality assurance and improvement, the establishment of a West Suffolk Alliance Quality and Performance Group is to be explored at a workshop planned for 25th June. This piece of work is being led by the CCG Director of Nursing, Lisa Nobes, with clinical leads from across the West Suffolk System.

2.4 **The Programme Delivery Group** – Brings together people engaged in transformation projects, including enabling project leads. The group meets approximately every six weeks, and at their last meeting considered how they support people with dementia and how we can evidence the difference in our way of working for patients and customers. As a result of these discussions a local dementia forum has been established (which will bring together intelligence and action across our organisations to achieve a more system wide approach to this area) and the alliance will start to collect short "vlogs" from the front line with a view to sharing good news stories for staff and patients.

2.5 **Communications and Involvement** – Each organisation controls its own public and internal communications. Together the organisations' network of communications and involvement professionals aim to start communicating with staff first. A general briefing, setting out how impactful examples of joined up care can be has been distributed, which will be followed up with regular bulletins showcasing the changes that are being delivered through alliance working. The next step is for a communications lead to join the Alliance meetings to better advise and link with colleagues. This will mean more practical examples of how working relationships are improving, including "vlogs" with front line staff talking about their experiences.

A twitter handle #TeamWestSuffolk has been created and circulated to partners as part of the drive to build the identity of West Suffolk as a system.

As well as organisational communications, regular joint staff sessions are planned (akin to the wider leadership team meetings that used to be held in community health), where leaders across the system can get together to get updates, work together and strengthen relationships.

3.0 Locality Development

3.1 All six localities continue to mature and strengthen their identity. In addition to the named locality leads, we now have a named engagement lead for all but one locality. These engagement leads have been sourced from the CCG patient engagement forum and their role will support the planning and priorities in each locality ensuring that user voice is heard and acted on.

3.2 The locality engagement leads are:

- Margaret Marks / Mick Simpkin – Haverhill
- Lynne Byrne – Newmarket
- David Dawson – Bury Town
- Graham Norris – Mildenhall and Brandon
- Dave Taylor / Paula Wise – Bury Rural
- Sudbury – still to be agreed

3.3 The development of the Integrated Neighbourhood Teams (INTs) has recently been mapped across a number of key areas and a plan is being developed to mature the team's progress, further building on the successes to date. Mildenhall, Sudbury, and Newmarket Teams are now fully co-located with plans in place for Bury Town and Bury Rural. **Co-location** is viewed as a key enabler to the teams working differently. The biggest gaps identified by the INT leads were joint working with mental health services and information sharing.

3.4 Each locality is now having regular meetings, discussing their priorities and drafting their action plans. The locality leads are also now having regular meetings to ensure consistency and share knowledge.

3.5 The work on the place based needs assessments has commenced and it is hoped to have the first draft of the Mildenhall and Brandon pack by early July. Each profile will contain information on demographics, mortality/morbidity, housing employment, education deprivation and primary care data. Having all this data in one place will be very powerful and will support identification of local priorities for collaborative work, transformation or changes in practice.

3.6 A timeline showing the anticipated locality development milestones is being developed in line with the primary care network maturity matrix. The latest locality map is attached as appendix 2 to this report.

3.7 **Working with the Leisure Sector** – We now have health services such as cardiac rehabilitation provided by our teams in leisure centre settings, rather than traditional health settings. We are currently working out of Newmarket Leisure Centre and Brandon Leisure centre for Cardiac Rehab and are discussing the potential use of Haverhill and Sudbury leisure centres.

By utilising different settings it is hoped to encourage people to attend and continue to use leisure facilities to maintain exercise and a healthy lifestyle post formal rehabilitation course.

The wider estates strategy is supporting this agenda, which is bringing together services to support health and wellbeing in a truly transformational way. The potential is for people accessing physical and mental health services to have some of their treatment in a leisure centre, or be encouraged to make greater use of the centre facilities when they attend health appointments. This is not just about putting facilities next to each other, rather it is about integrating them, so that for instance they share the same lobby, café and information points.

4.0 Primary Care Network Development

PCNs continue to evolve and will be formally established on the 1st July 2019. They have been set up to enable the provision of proactive, accessible, co-ordinated and more integrated primary and community care, improving outcomes for patients. With a recommended network size of between 30,000 and 50,000 population, the networks will be small enough to continue to provide the personal care valued by both patients and GPs, but large enough to have impact through deeper collaboration between practices and others in the local health and social care system. The named accountable clinical director has been identified for each network (see below). The network contract DES (which is an extension to the core GP contract) goes live from 1st July 2019, with a five year funding period.

West Suffolk CCG
Primary Care Networks

Bury St Edmunds PCN		
Practice	**Clinical Director**	**List Size**
Angel Hill	Dr Mark Hunter	13,813
Guildhall		12,046
Mount Farm		13,957
Swan		12,146
Victoria		10,910
Haverhill PCN		
Practice	**Clinical Director**	**List Size**
Clements & Christmas Maltings	Dr Firas Watfeh	17,166
Haverhill Family Practice		15,172
WGGL PCN		
Practice	**Clinical Director**	**List Size**
Glemsford	Dr Christopher Browning	5,127
Guildhall - Clare		5,134
Long Melford		9,214
Wickhambrook		4,885
Sudbury GP Network PCN		
Practice	**Clinical Director**	**List Size**
Hardwicke House	Dr Bob Morgan	23,492
Siam	Dr Bahram Talebpour	10,028
Forest Heath PCN		
Practice	**Clinical Director**	**List Size**
Brandon Medical Practice	Dr Lee Bower Dr Nick Rayner	5,393
Forest Surgery		7,661
Lakenheath		5,239
Market Cross		11,985
Oakfield		7,252
Orchard House		10,774
Reynard		8,643
Rookery		14,132
Blackbourne PCN		
Practice	**Clinical Director**	**List Size**
Botesdale	Dr Richard West Dr Jude Chapman	9,056
Stanton		5,261
Woolpit		13,938

5.0 Community I.T Update

5.1 The governance for decision making related to community I.T has been strengthened by the development of the new Community I.T and SystmOne Digital Strategy Board. This is a new STP wide group chaired by the Director of I.T at ESNEFT. This new group will have a direct link to the WSFT Pillar 3 Community programme group.

5.2 Locally we continue to progress the upgrading of community equipment, as part of the Mobile Phone Smartphone Upgrade Programme we have taken delivery of the first batch of 250 Samsung Xcover handsets. These will be distributed to teams based on the priority list compiled by operational managers.

5.3 **Wi-Fi at Community Sites -** The Council have started to enable WIFI & GOVROAM at Suffolk County Council owned sites, which will allow staff to work more flexibly across local authority sites. GOVROAM is currently being configured by our WSFT internal networks team and we are working closely with other alliance partners on this. All SystmOne units across the community have been enabled to the WSFT HIE.

6.0 Other transformation activity

6.1 The new Suffolk Mental Health Alliance Implementation Group will now oversee the development of the mental health operational model(s), to deliver the future east and west Suffolk mental health and emotional wellbeing services. The Suffolk Mentally Healthy Communities Board has been stepped down during this period.

6.2 Alliance partners have now agreed to utilise all the base information being collected and the draft specification to develop the proposed operational model for mental health services to a greater level of detail and through that also start to make some immediate changes where agreed.

6.3 The specification is based on the four-quadrant model for children and young people and adults as described in the Strategy and NSFT current clinical services are being mapped to each quadrant. It is proposed to use a similar approach to form a number of working groups with an Alliance Senior Responsible Officer for each, alongside a clinical lead and programme manager. Each working group will spend the next four months on the following:

- Building the baseline position for the services within scope including current state, staffing, budget and short, medium and long-term issues.
- Developing through co production what the revised operating model should be, including options for how it could be provided.

6.4 The four key projects are:

i) ***Child and Adolescent Mental Health*** (CAMHS) (including Perinatal and CYP Eating Disorders)

SRO: Allan Cadzow

ii) a) ***Adult Mental Health Access & Community Mental Health Model*** (including early adopter sites)
b) ***IAPT and Wellbeing*** (extension to support Long Term Physical Health Conditions)

SRO(s): Kate Vaughton / Maddie Baker-Woods / Rebecca Pulford

iii) ***Crisis*** including Crisis Resolution and Home Treatment Teams, Psychiatric Liaison, Police Triage and Mental Health Inpatient Wards

SRO(s): Stuart Richardson / Rowan Proctor

iv) ***Learning Disabilities***

SRO: Lisa Nobes

6.5 **Buurtzorg** – System leaders agreed to test the full Dutch Buurtzorg model in west Suffolk to identify whether similar successes could be achieved in the English system as in Holland. The test site commenced in September 2017 in Barrow, with the first individuals being supported by the newly established Neighbourhood Nursing and Care Team in

February 2018. The Kings Fund agreed to evaluate the test site and recognised in their report the highly ambitious project. The learning from the test site and feedback from the Kings Fund have informed the planning for phase two which will aspire to embed the key principles of Buurtzorg. Phase two will focus on adding value to the developing Integrated Neighbourhood Team and Locality approach in Bury Town.

6.6 The opportunities are currently being explored include: coordination / enhancements to Multi-disciplinary Team meetings, with a focus on rising risk individuals; integrated working between the health and social care teams, and exploring options based on person and place releasing time to care, this will include consideration of existing service boundaries and exploring the potential for the teams to move towards a self-management / fellowship style of working.

6.7 **The Responsive Support Service** - developments are progressing towards a single integrated delivery of short-term interventions to people requiring admission avoidance and reablement support. The implementation of this new approach will be phased in from September when the new Locality Home Care Contract goes live on the 16th September.

7.0 Update on social prescribing

7.1 Social prescribing is a coaching resource, which focuses on improved wellbeing and social connection. In addition, it supports a move to prevention and community resilience. GPs, primary and secondary services and supporters / mentors within the community can refer to the service. There is also provision for individuals to self-refer. Participants work on a 1:1 basis with a health coach who supports them in identifying and accessing local services, groups, clubs or activities that can help address social issues or needs. This improves access to appropriate statutory services and the array of support within the voluntary and community sector.

7.2 In West Suffolk, the programme is called LifeLink and it has been initially trialled in Haverhill; with results showing on average a 25% drop in the use of GP appointments over a 6 month period for this group compared to a control group where GP appointment use stayed the same.

7.3 The next steps for LifeLink is to launch in Mildenhall and Brandon in August this year, with other projects likely to be launched later in 2019. There are also on-going discussions with the CCG and PCNs taking place to support social prescribing West Suffolk wide.

HAVERHILL
LifeLink
Linking Lives Together

"Haverhill LifeLink has filled a gap in the support that has been available to a lot of our customers, enabling them to lead independent lives. One of my customers who is lacking in social skills, has been put on an IT course. She is so excited that she now has some focus in her life, she is already looking to the future. She feels more confident know there is support available for her.
Jill Eaton, Legacy Work Coach,
Haverhill Jobcentreplus

8.0 Wider partner activity – including VCS and Districts

8.1 The **Realising Ambitions** funding programme is now open for applications. The fund of around £480K was allocated to the West Suffolk alliance area from the STP / ICS and is managed on behalf of the alliance by the Suffolk Community Foundation. Voluntary and community sector organisations can bid for grants up to £70,000 for projects which support three of the higher ambitions of the STP / ICS: mental health, obesity and loneliness. (These were chosen by the alliance steering group at their meeting in February).

8.2 The closing date for the fund is the 5th August and a panel from across the alliance will meet in late September / early October to review and decide which bids have been successful.

8.3 More information about the fund can be found on the Suffolk Community Foundation website - https://www.suffolkcf.org.uk/grants/

9.0 Conclusion

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

Core Locality Teams (so far)

Bury Town :
PCN Clinical Director: Dr Mark Hunter
Locality Lead: Jane Rooney
Locality Co-ordinator: Anita Kovacs
Transformation Team: Trisha Stevens, Martin Bate, Lesley Standring
Primary Care Lead: Emma Gaskall
Community Team Lead: Julie Harper (acting)
ACS Manager: Teresa Cockette

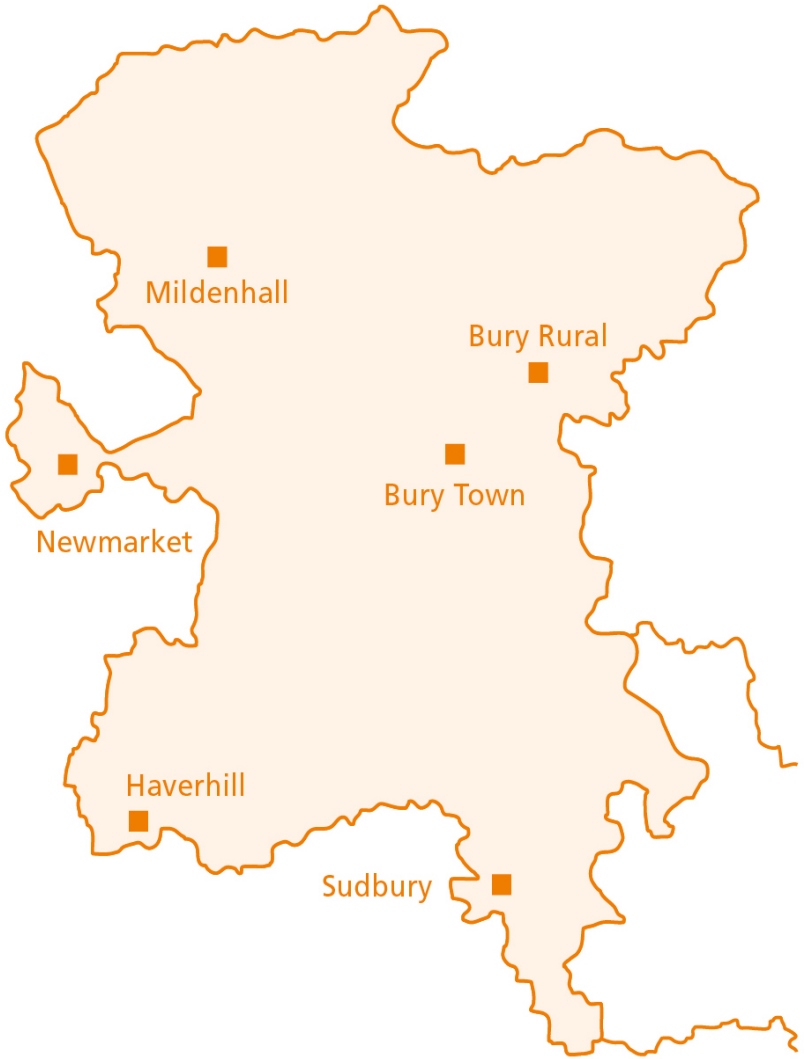
Bury Rural :
PCN Clinical Director: Dr Richard West
Locality Lead: Lucy Petitt
Locality Co-ordinator: TBA
Transformation Team: Janet Watkins, Sarah Hedges
Primary Care Lead: Lois Wreathall
Community Team Lead: Linda Griffiths
ACS Manager: Jo Murray

Haverhill:
PCN Clinical Director: Dr Firas Watfeh
Locality Lead: Lois Wreathall
Locality Co-ordinator: Amanda Webb
Transformation Team: Nicole Smith, Renu Mandel
Primary Care Lead: Lois Wreathall
Community Team Lead: Karen Line
ACS Manager: Gillian Leathers

Sudbury:
PCN Clinical Director (town) Dr Barhram Talebpor, Dr Christopher Browning (rural)
Locality Lead: Rob Kirkpatrick
Locality Co-ordinator: Olivia Rigo
Transformation Team: Kirsty Rawlings
Primary Care Lead: Rachel Seago
Community Team Lead: Jenny McCrory
ACS Manager: Dawn Thompson (acting)

Newmarket:
PCN Clinical Director Dr Nick Rayner
Locality Lead: Sandie Robinson
Locality Co-ordinator: Batsirai Shamuyarira
Transformation Team: Chris Barlow, Tracey Morgan
Primary Care Rep: Rachel Seago
Community Team Lead: Jane Sharland
ACS Manager: Julie Chrisman

Mildenhall & Brandon:
PCN Clinical Director Dr Lee Bower
Locality Lead: Dawn Godbold
Locality Co-ordinator: Leiat Becker
Transformation Team: Hannah Pont, Juliet Estall
Primary Care Rep: Emma Gaskell
Community Team Lead: Heather Male
ACS Manager: Julie Chrisman



#TeamWestSuffolk

ICS Timeline 2019-20

	APR-19	MAY-19	JUN-19	JUL-19	AUG-19	SEP-19	OCT-19	NOV-19	DEC-19	JAN-20	FEB-20	MAR-20
ICS Chair	Recruitment Campaign		Appointment Process	Independent Chair in post								
Governance	Alliance Governance Development Panel Develop draft ICS Board ToR, engagement with regulators, development of scenarios			King's Fund Workshop	Panel continues	King's Fund Workshop	Panel continues	Support to Board induction				
Essex HWBB		HWBB Update on ICS		HWBB outline roles ICS/HWBB ICS Planning		HWBB ToR ICS/HWBB		HWBB plans for joint assembly		HWBB		HWBB
Suffolk HWBB			HWBB outline roles ICS/HWBB ICS Planning			HWBB ToR ICS/HWBB		HWBB plans for joint assembly		HWBB		HWBB
STP Board	Interim chairing by HWBB Chairs				Chairing by ICS Independent Chair			Final STP Board Meeting				
ICS Board								ICS Board Induction Event	First ICS Board		ICS Board	
ICS Planning	Submit ICS Operational Plan	Formal Announcement of ICS	Refresh of ICS Plan			Submit draft ICS Plan	Submit final ICS Plan					
Key Events		Suffolk Show	Wigan Trip	Tendring Show OBA Workshop	OBA Workshop	System Leader's Event					First Joint HWBB Assembly	

Key

Process/Interim Arrangement | Planning | ICS Milestone | Key Event | Board Meeting | Regional Milestone

11:20 GOVERNANCE

17. Trust Executive Group report

To ACCEPT the report

For Report

Presented by Stephen Dunn

Board of Directors – 28 June 2019

Agenda item:	17			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	21 June 2019			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

Executive summary

3 June 2019

Steve Dunn provided an **introduction** to the meeting reflecting on the sustained operational pressure which has resulted in escalation capacity remaining open. The contribution that our overseas nurses continue to make was recognised by TEG. It was noted that the focus of this year's leadership event will include diversity as well as bullying and harassment.

Quality, operational and financial performance was reviewed from the recent Board papers. The focus of quality discussions included RCA actions which are overdue and the importance of providing timely responses to complaints. It was recognised that as we are undertaking testing for new emergency department (ED) standard we are not currently reporting our ED performance locally or national. However, the levels of patient activity seen in ED during April and May have been significantly in excess of levels previously experienced with regular days with in excess of 250 patients attending the department. This is being escalated to the A&E delivery board.

Pressure on the breast cancer pathway was reviewed and it was recognised that this is impacting on 62 day standard performance. Pressure remains on referral to treatment (RTT) performance, which is being impacted on senior doctors' availability for additional sessions. We are working with the CCG to fund and outsource additional activity.

The year-end financial reporting position was noted with a deficit of £6m. This year's target is to break even. This was recognised as challenging, as of April, we were off plan by £50k.

A report was received on **high intensity users project**. The purpose of the project is to establish a multi-disciplinary team (MDT), so that we are working as an interdependent system, providing a person centred, holistic model that enables people to manage their health and well-being, with the required support. The MDT group will be split into CCG locality groups, dependant on the identified high users postcode and GP practice. The MDT aims to agree a co-ordinated and supportive approach to care/plans for intervention for frequent users who impact the urgent care services in the West Suffolk system. The MDT meetings will include a representation from a range of service providers including Primary Care and appropriate voluntary services.

An update was received on **staff support using clinical psychology** this reflected on the current support and proposals going forward. The proposal was welcomed as part of a multidisciplinary service model and this will be developed as a business case.

An update was received on progress and plans to embed **human factors** across the Trust as one of our quality improvement priorities for 2019/20. The programme was structured around training through the

human factors faculty, simulation scenarios within key environments and structured assessment of staff perceptions. The proposed programme was supported by TEG.

17 June 2019

Steve reflected on his attendance, with the other execs, at the volunteers' tea party. The contribution that volunteers make to the delivery of services was recognised and appreciated by the whole of TEG. He also welcomed the appointment of Ed Garrett as the ICS/STP executive lead, replacing Nick Hulme. An update was provided on the local financial support being made available to the Cambridge and Peterborough system. It was noted that the interim NHS people plan was published during June although the content and detailed planning is still in progress.

The **red risk report** was received. There were no new red risks or downgraded red risks. The key strategic risks identified were:

- **System financial and operational sustainability** will impact of the quality of patient services (linked to operational performance and CIP planning and transformation)
- **Winter planning** to ensure safe staffing and capacity for winter.
- **Pathology services** – delivery of pathology services, including MHRA inspection and NEESPS accountability and control. These all have an impact on service delivery and patients services directly impacting of quality and sustainability of services.

It was noted that we have recently received the **CQC provider information request** and can therefore expect a planned CQC inspection during the next six-months. Discussion took place on the plans that are currently in place and the potential focus of the inspection.

A report was received on **sickness absence trends** with a focus on anxiety/stress to be considered by the better working lives group.

An updated was received on the quality priority for 2019/20 relating to **patient flow**. The paper set out the programme of work and a summary of measures that will be used to assess progress and performance. The use of rapid improvement events, which are being supported by the transformation team with ward areas will also support this work.

An update was received on the planned go-live with **Medic Bleep**. It was noted that the app is ready to go, but at the moment we are not in a position to remove the bleeps on 25 June, due to the inconsistently of the Wi-Fi. Discussions are taking place with the Wi-Fi provider and there was indicated that improvements made in recent days and over the weekend seem to have improved performance. .

A guide was received on the proposed **pension withdrawal pilot**. TEG supported the proposal which will allow senior clinicians to deliver additional clinical sessions without the risk of being impacted by tax liabilities.

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

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

Previously considered by:	The Board receives a monthly report from TEG
Risk and assurance:	Failure to effectively communicate or escalate operational concerns.
Legislation, regulatory, equality, diversity and dignity implications	None
Recommendation: The Board note the report	

18. Charitable Funds Committee report (attached)

To ACCEPT the report

For Report

Presented by Gary Norgate

Trust Open Board Meeting – 28th June 2019

Agenda item:	18			
Presented by:	Gary Norgate, Non-Executive Director			
Prepared by:	David Swales, Technical Accountant			
Date prepared:	18 June 2019			
Subject:	Charitable Funds Board Report			
Purpose:	X	For information		For approval

Executive summary:

The Charitable Funds Committee met on 24th May2019. The key issues and actions discussed were:-

- The Legacy officer has been appointed and the Community fundraiser post is currently going through the job evaluation process and will be advertised shortly.
- There has been a lot of fund raising activity in progress and being planned and the Committee were pleased with the progress being made.
- The Committee were updated on the Butterfly Garden project providing a less clinical area for Macmillan patients. It was agreed that there should be an appeal that lasted a year and that at the end of this the Macmillan fund will underwrite any shortfall on the project.
- The Committee agreed that the MyWish website needed updating and approved a budget of £9k for the project.
- The Committee were updated on the disposal of two properties where there Charity is a residual beneficiary. Both properties are proving difficult to sell. It was noted that as part of accounting standards an estimate of the value of the proceeds was included in the accounts. If there was a shortfall then this would be borne by general funds.
- The Committee were updated on the performance on the investments. The investment had performed well in and was showing an overall gain of £46k at the date of the meeting.
- The Committee approved the setting up of a fund for the AAU.
- Inderraj Hanspal presented to the Committee on spending the Ophthalmic fund that had received a large donation. The Committee approved the plan to spend up to £125k on various pieces of equipment. The balance on the fund was £115k and the committee approved the use of the general fund for the balance.
- The fund manager for the Macmillan fund will be asked to provide a formal plan for spending the fund taking into account any shortfall on the Butterfly Garden noted above.
- A “Changing Places” room was discussed and it was agreed that the Charity should support it through an appeal rather than from General funds.

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

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
	X	**X**	**X**	**X**	**X**	**X**	**X**
Previously considered by:	Charitable Funds Committee						
Risk and assurance:	None						
Legislation, regulatory, equality, diversity and dignity implications	None						
Recommendation: The Trust Board is asked to consider the report of the Charitable Funds Committee							

19. Audit Committee report (attached)

To ACCEPT

For Report

Presented by Angus Eaton

Trust Board Meeting – 28 June 2019

Agenda item:	19			
Presented by:	Angus Eaton, NED and Chair of the Audit Committee			
Prepared by:	Richard Jones, Trust Secretary			
Date prepared:	21 June 2019			
Subject:	Audit Committee report - meeting held on 23 May 2019			
Purpose:		For information	X	For approval

Executive summary:

The key issues and actions discussed were:-

- **External Audit report to those charged with governance** - the Committee considered the issues highlighted by the external auditors including:
    1. The 2018/19 Annual Accounts - a number of amendments had been made, none were material
    2. The audited elements of the Annual Report
    3. The Use of Resources review - the auditors issued a qualified except for use of resources conclusion because of the financial sustainability of the Trust
    4. The auditors recommended some improvements that could be made which management and the Committee agreed
- **2018/19 Annual Report** – the Committee reviewed the draft Annual Report and recommended approval to the Trust Board.
- **2018/19 Annual Accounts** – following consideration of the external auditor's report the Committee recommended approval of the accounts to the Trust Board.
- **Quality Report** – the external auditors did not identify any errors in the draft Quality Report but recommended some improvement to processes.
- **Internal Audit** – the final 2018/19 head of internal audit opinion and report was considered and accepted.
- **General Condition 6 and Continuity of Service Certification** – this document was approved.

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

Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	 *Deliver personal care*	 *Deliver safe care*	 *Deliver joined-up care*	 *Support a healthy start*	 *Support a healthy life*	 *Support ageing well*	 *Support all our staff*
	X	X	X				X
Previously considered by:	*This report has been produced for the monthly Trust Board meeting only*						
Risk and assurance:	*None*						
Legislation, regulatory, equality, diversity and dignity implications	*None*						
Recommendation: The Board is asked to note the report.							

20. General Condition 6 & Continuity of Services certificate (attached)

To APPROVE the recommendations

For Approval

Presented by Richard Jones

Board of Directors – 28 June 2019

Agenda item:	20			
Presented by:	Steve Dunn, Chief Executive			
Prepared by:	Richard Jones, trust Secretary & Head of Governance			
Date prepared:	21 June 2019			
Subject:	Certificate for NHS Improvement licencing			
Purpose:		For information	X	For approval

Executive summary:

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

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

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

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

2. **Training of governors - *Confirmed***
   The Board is asked to confirm that it is satisfied that during 2018/19 it provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure governors are equipped with the skills and knowledge they require.

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

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

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

Recommendation:

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

Annex A

Corporate Governance Statement

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

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

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

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

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

Certification on governance and training of governors

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

2 Training of Governors

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

Confirmed

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

Signature		Signature	
Name	Sheila Childerhouse	**Name**	Dr Stephen Dunn
Capacity	Chairman	**Capacity**	Chief Executive
Date	28 June 2019	**Date**	28 June 2019

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

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

Question 1

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

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

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

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

B. For continuity of service – availability of resources

Question 2

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

OR

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

OR

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

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

- Maintaining Care Quality Commission rating of outstanding
- Exceeded the NHSI control total
- Delivery of digital global exemplar objectives

- National recognition for performance in the NHS Staff Survey 2018, including best general acute in the country for giving them control and choice over how they do their work
- Rated as the top hospital in England, Wales and Northern Ireland for meeting best practice criteria for hip fracture treatment by the National Hip Fracture Database
- Scored top in the East of England for doctors' overall training satisfaction in acute trusts, in the General Medical Council's national training survey (2018).

21. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Richard Jones

Board of Directors – 28 June 2019

Agenda item:	21			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	21 June 2019			
Subject:	Items for next meeting			
Purpose:		For information	X	For approval

The attached provides a summary of scheduled items for the next meeting and is drawn from the Board reporting matrix, forward plan and action points.

The final agenda will be drawn-up and approved by the Chair.

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

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

Previously considered by:	The Board receive a monthly report of planned agenda items.
Risk and assurance:	Failure effectively manage the Board agenda or consider matters pertinent to the Board.
Legislation, regulatory, equality, diversity and dignity implications	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.

Recommendation:

To approve the scheduled agenda items for the next meeting

Scheduled draft agenda items for next meeting – 26 July 2019

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient story		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Integrated quality & performance report, including community servcies	✓		Written	Matrix	HB/RP
Alliance partners learning and winter planning report for 2019-20	✓		Written	Matrix	HB
Finance & workforce performance report, including community sickness absence performance and staff recommender scores	✓		Written	Matrix	CB
Transformation report Q1, including Category Towers	✓		Written	Matrix	HB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Nurse staffing report	✓		Written	Matrix	RP
Mandatory training report – Q1	✓		Written	Matrix	KR
"Putting you first award"	✓		Verbal	Matrix	JB
Safe staffing guardian report	✓		Written	Matrix	NJ
Consultant appointment report	✓		Written	Matrix – by exception	JB
R&D annual report	✓		Written	Matrix	NJ
National patient survey report (*if issued*)	✓		Written	Matrix	RP
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
West Suffolk Alliance report	✓		Written	Matrix	KV/HB
Strategic update, including Alliance, System Executive Group and System Transformation Partnership (STP)		✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Quality & Risk Committee report, including Insight report and annual complaints report	✓		Written	Matrix	SC
Digital board report, including community IT update	✓		Written	Matrix	CB
Scrutiny Committee report, including networked pathology strategy		✓	Written	Matrix	GN
Risk management strategy and policy	✓		Written	Matrix	RJ
Confidential staffing matters		✓	Written	Matrix – by exception	JB
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	SC

11:30 ITEMS FOR INFORMATION

22. 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

23. Date of next meeting

To NOTE that the next meeting will be held on Friday, 26th July 2019 at 9:15 am in Quince House, West Suffolk Hospital

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

24. 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