NHS
West Suffolk
NHS Foundation Trust

Board of Directors (In Public)

Schedule	Friday, 2 Nov 2018 9:15 AM — 11:45 AM GMT
Venue	Room F12 & F13, 1st Floor, Sudbury Community Health Centre, Church Field Road, Sudbury CO10 2DZ
Description	A meeting of the Board of Directors will take place on Friday, 2 November 2018 at 9.15 in the Room F12 & F13, 1st Floor, Sudbury Community Health Centre, Church Field Road, Sudbury
Organiser	Karen McHugh

Agenda

AGENDA

Agenda Open Board 2 Nov 2018.docx

9:15 GENERAL BUSINESS

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

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

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

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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 28 September 2018
   For Approval - Presented by Sheila Childerhouse

   Item 5 - Open Board Minutes 2018 09 28 Sept Draft.docx

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

   Item 6 - Action sheet report.doc

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

   Item 7 - Chief Exec Report Nov 18.doc

9:35 DELIVER FOR TODAY

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

   Item 8 - WSFT Board cover sheet Community and alliance update October V1 2018.doc

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

   Item 8 - Appendix 1 Buurtzorg Trial HWS CDO visit 11.9.18 v2.docx

   Item 8 - Appendix 2 PH MH CYP STP CCG Level Data Radars_ (2).xlsx

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

   Item 9 - Integrated Quality & Performance Report_October_2018_Draft_v1.docx

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

Item 10 - Finance and workforce report Cover sheet - M6.docx

Item 10 - Finance Report September 2018 FINAL.docx

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

Item 11 - Transformation Board Report October 18.doc

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

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

Item 12 - Nurse staffing Board Report - September 2018 data.doc

Item 12 - Nurse staffing WSFT Dashboard - Sept 2018.xls

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13. Mandatory training report
To ACCEPT a report
For Report - Presented by Jan Bloomfield

Item 13 - Mandatory Training Trust Board Oct 18.docx

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14. Antenatal and newborn screening annual report 2017-18
To ACCEPT the report
For Report - Presented by Nick Jenkins

Item 14 - ANScreening Annual report Board cover sheet Oct 2018.doc

Item 14 - WSFT ANNB Screening Annual Report Oct 2018.docx

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15. Safe staffing guardian report - Q2
To ACCEPT a report
For Report - Presented by Nick Jenkins

Item 15 - Guardian of safe working report Cover Sheet Oct 2018.doc

Item 15 - Guardian Quarterly Reports July - Sep 18.docx

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

    Item 16 - Consultant appointments Board report - September 2018.doc

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

11:15 BUILD A JOINED-UP FUTURE

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18. Staff Health and Wellbeing programme update
    To ACCEPT the report
    For Report - Presented by Jan Bloomfield

    Item 18 - Staff health and wellbeing programme Board paper - Oct 18.doc

    Item 18 - Appendix One_WSFT Action Framework 2019.docx

    Item 18 - Appendix Three_WSFT SHWB Wellbeing Radar Diagram 2018.docx

    Item 18 - Appendix Two_WSFT Evaluation Framework.docx

11:30 GOVERNANCE

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

    Item 19 - TEG report.doc

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20. Quality & Risk Committee report
    To ACCEPT the report
    For Report - Presented by Sheila Childerhouse

    Item 20 - Q&R Report.doc

    Item 20a - Q&R Minutes - 2018 09 28 Sept.docx

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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

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11:40 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. Board & Sub-committee dates & schedule for 2019/20
To NOTE the dates for information
For Reference - Presented by Sheila Childerhouse

Item 23 - Board Dates 2019-20.doc

24. Date of next meeting
To NOTE that the next meeting will be held on Friday, 30 November 2018 at 9:15 am in Quince House, West Suffolk Hospital.
For Reference - Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

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

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For Approval

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DRAFT

NHS West Suffolk NHS Foundation Trust

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 28 SEPTEMBER 2018

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Sheila Childerhouse	Chair	•	
Helen Beck	Chief Operating Officer	•	
Craig Black	Executive Director of Resources	•	
Jan Bloomfield	Executive Director Workforce & Communications	•	
Richard Davies	Non Executive Director	•	
Steve Dunn	Chief Executive	•	
Angus Eaton	Non Executive Director	•	
Nick Jenkins	Executive Medical Director	•	
Gary Norgate	Non Executive Director	•	
Louisa Pepper	Non Executive Director	•	
Rowan Procter	Executive Chief Nurse	•	
Alan Rose	Non Executive Director	•	
In attendance			
Georgina Holmes	FT Office Manager *(minutes)*		
Richard Jones	Trust Secretary		
Anna Hollis	Communications Manager		
Ivanka Hollis	Assistant Service Manager for Surgery		
Catherine Waller	Intern Non Executive Director		

Action

GENERAL BUSINESS

18/188 INTRODUCTIONS AND APOLOGIES FOR ABSENCE

There were no apologies for absence.

The Chair welcomed everyone to the meeting and introduced and welcomed Louisa Pepper who had recently been appointed as a Non-Executive Director.

She explained that this was Catherine Waller's last board meeting, as her term as an intern Non-Executive Director finished at the end of this month. She thanked her for her contribution to the board and wished her well in the future. Catherine Waller thanked everyone for all the assistance and advice they had given her during the past year, especially Roger Quince, Steve Dunn, Sheila Childerhouse and Alan Rose.

18/189 QUESTIONS FROM THE PUBLIC RELATING TO MATTERS ON THE AGENDA

- Judy Cory congratulated everyone, particularly the speakers, for the success of the recent annual members meeting but was very disappointed to see there was no mention of this in the Bury Free Press.

- John Ellison, a west Suffolk resident, asked if several life lines were needed by the hospital rather urgently so that the situation did not become critical. In particular more generous budgets, easing of conditions outside WSFT's control resulting in high vacancy levels of nursing staff and a positive response to the bid for £15m capital for the emergency department, which he understood was still outstanding.

The Chief Executive acknowledged that the current financial environment was tight and challenging, but the government had announced that it would increase NHS funding by 3.4% over the next five years. As a result there was a NHS long term plan in preparation which would help address the issues that John Ellison referred to.

The emergency department had received some funding to support the completion of the Acute Assessment Unit (AAU) and it was anticipated that the autumn budget might provide clarity on whether the emergency department bid had been successful. Dr Cliff Mann, President of the College of Emergency Medicine, had visited WSFT and acknowledged the need for significant financial investment in the infrastructure of the emergency department. Pauline Philip, National Urgent and Emergency Care Director for NHS England, had also visited the emergency department and agreed with this view.

Despite the financial challenges the Trust had nearly broken event last year and appeared to be delivering against its financial targets this year, even though it still had a deficit.

- Joe Pajak referred to agenda item 6, ref 1613, and the letter from the Secretary of State for Health & Social Care updating all health organisations on preparations leading up to March 2019 in the event of a no deal Brexit scenario, including the continued supply of medical products and business continuity plans. He asked how assured the board was that WSFT was getting the support and information it required from the government to manage any issues that might arise in the event of there being no deal.

  Richard Jones explained that very little information had been received to date. However, one key piece of advice was around medication supplies and that no organisation should start to stockpile. WSFT would be looking at this from a supplier risk point of view, and also emergency planning and resilience.

  Helen Beck reported that information had been received yesterday with a template for all system partnerships re emergency responses and resilience and this was being acted upon.

  The Chief Executive stressed that there was significant uncertainty but the WSFT would be doing everything it could in relation to resilience.

- Jayne Gilbert referred to agenda item 19, estates strategy, and noted that there were no provisional recommendations for the route of travel. The Chair explained that there had been a workshop on estates last night, attended by the board and governors, which had been very helpful and informative about future planning.

  Craig Black explained that this was a five year strategy and structural surveys of the buildings were currently being undertaken. The results should be available in December which would help to establish the timeframe in which a decision would have to be made. The Trust was doing everything it could to manage the estate, as described in the strategy, and when more information was available in December the board would decide the next course of action.

- Liz Steele referred to the Chief Executive's report, page 6, and the statement from NHSI that £480m could be freed up by limiting the use of temporary staffing agencies. She asked for assurance that WSFT was doing this and utilising its own staff as far as possible.

The Chief Executive explained that WSFT was one of the strongest performers in this area. However organisations became increasingly more challenged with winter pressures and recruiting temporary nursing staff was part of the way that escalation areas were staffed during the winter. The Trust was doing a lot to actively manage its workforce.

Jan Bloomfield explained the role of West Suffolk Professionals. This year an individual had been appointed to look at the way the bank operated and they had made a lot of changes and recommendations.

- The Chair explained that Gordon McKay had requested that a question be asked on his behalf. Although this question was not related to a matter on the agenda she had agreed to allow it as it was currently in the news; 'in view of what has happened with in maternity at Shrewsbury and Telford Trust, had WSFT learned any lessons from this?'

  She asked Rowan Procter to refer to this in her report.

18/190 REVIEW OF AGENDA

The agenda was reviewed and there were no issues.

18/191 DECLARATION OF INTERESTS

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

18/192 MINUTES OF THE MEETING HELD ON 27 JULY 2018

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

Page 2, 18/167, 2nd para, 4th sentence to be amended to read, "However, it appeared that there had been some communication issues between NEESPS and the regulators about what had and had not been agreed."

Page 6, 18/173, 5th para, final sentence. It was confirmed that the this was correct; highlighting and question mark to be removed.

18/193 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following issue raised:-

Item 1613 – review Brexit impact as part of the Trust's emergency preparedness. Helen Beck explained that the template she referred to earlier would be used.

The completed actions were reviewed and there were no issues.

18/194 CHIEF EXECUTIVE'S REPORT

The Chief Executive highlighted the focus on winter planning and capacity and the good news that additional funding for the Acute Assessment Unit (AAU) had been received. Additional capacity would be opening but the Trust would need to be able to staff this capacity safely. Work continued in the community to provide additional resilience and the executive team had been out meeting with the teams during the summer.

Recent data showing that west Suffolk was the best performing area in the country for minimising excess bed day was very positive; this was particularly commendable as Suffolk had the second oldest population in the country. It also had the lowest number of delayed transfers of care (DTOC) in the region, which reinforced the success of alliance working.

He referred to the issues around pathology and explained that a meeting had taken place with the NHSI lead for pathology. The Trust was trying to progress with the NEESPS improvements required and the best way to respond to these.

The Chair congratulated the Chief Executive on his selection to be part of the group looking at the future NHS plan.

Gary Norgate referred to the excellent outcome of doctors' training at WSFT, which should assist in attracting new doctors to the Trust. Nick Jenkins noted that the Royal College of Physicians had reported this month that nationally 50% of appointments were not filled. WSFT had recruited a number of specialist consultants in the last few months which were generally very difficult to recruit to. One of the successful candidates interviewed yesterday had been through WSFT training. He said that this was very important in a time when recruitment was so difficult.

The Chair agreed and said that when he met with new consultants they had been very impressed by the level of induction they had received and many of them had undergone training at WSFT and were keen to come back.

Nick Jenkins reported that there continued to be problems with pathology. The new accreditation standards were higher than the previous standards and NEESPS continued to work towards meeting these, but there was still a considerable amount to be done. He explained the current situation and that NEESPS would be voluntarily suspending accreditation until standards had improved.

Significant progress had been made this month with governance and oversight, but there was still work to be done in addressing problems. He was not able to say when recovery would be achieved.

Alan Rose explained that the NEDs would be attempting to put pressure on the NEDs at East Suffolk and North Essex NHS Foundation Trust (ESNEFT) to focus on this and increase the pressure to resolve the NEESPS issue.

The executive team welcomed this suggestion. The Chair and Nick Jenkins explained that there was not the level of concern at ESNEFT as there was at WSFT and WSFT needed to have confidence that its partners were also applying pressure to address the issues.

Alan Rose referred to flu and asked if there would be a major drive for staff to be vaccinated this year. Nick Jenkins explained that there was always a major drive on this. He had spoken to managers at the core brief to raise awareness of the risk of members of staff carrying flu and passing on to patients and most clinical staff understood the necessity for this. The aim was to try to vaccinate people in their work place, rather than having to go to occupational health and each of the wards had a peer vaccinator. Dawn Godbold explained that this year there were more peer vaccinators in the community and there had been more forward planning, with more emphasis on this. Community staff would also be issued with vouchers so that they could go to a pharmacy for their vaccination while they were out and about.

Jan Bloomfield explained that the ambition of the NHS was for 100% of staff to be vaccinated and the aim of WSFT was to achieve this. The Trust had been planning the its flu campaign since April, working with community teams, occupational health teams and the nursing directorate.

Richard Davies noted that there were lots of 'carrots' to encourage staff to be vaccinated; he asked if there were any 'sticks', ie staff not being allowed to work in clinical areas if they had not been vaccinated. Rowan Procter felt this could be counter-productive, however it was confirmed that the executive team would be having this discussion but it would be a challenge.

DELIVER FOR TODAY

18/195 ALLIANCE AND COMMUNITY SERVICES REPORT

Dawn Godbold explained that there were a number of examples in this report of progress and changes in the way of working in community services and the wider system. The creation of the senior matron role, which Amanda Keighley, staff governor, had been appointed to, should start to make a difference to the way of working, with an emphasis on quality and nursing as a profession. The case study in this report demonstrated collaboration and teams working together.

A lot of work was being undertaken on the respiratory pathway and there were now respiratory services with outreach clinics in Sudbury.

Good progress was being made on innovation and IT with a number of ideas being explored.

The development of quality and governance with shared events and joint forums between the hospital and community had been very effective and helped to provide consistency of audits etc.

The delivery plan was work in progress and would be managed through the transformation delivery group and system task and finish group which met weekly. They would be concentrating on delivering programme one and two which were building blocks to allow other programmes to deliver.

Gary Norgate asked about Buurtzorg and when the Trust would be in a position to understand the benefits and how these could be extended in the wider context. Dawn Godbold explained that the Kings Fund had undertaken an initial review and the results should be available at the next board meeting. **D Godbold**

Rowan Procter reported that the Health & Wellbeing board had undertaken some work through questions to patients who had been cared for by the Buurtzorg team and the feedback had been very positive. The local Health & Wellbeing board was also undertaking an evaluation, the results of which should be available by November.

Gary Norgate referred to transformation funding and asked how this worked in relation to transformation funding for the Trust. Dawn Godbold explained that this was one-off money made available from the CCG. There had been 52 bids from across the system and the outcomes would be known shortly. He asked if money received would impact on finances this year. Craig Black explained that this would not be the case.

Alan Rose said that he was very enthusiastic about the volume of activity going on and pleased to see that outcome measures were starting to be shown in this report. However, he was disappointed that there was no baseline material or illustration of trends. He asked for a demonstration of hard outcomes as well.

Dawn Godbold explained that the delivery plan was never meant to be a monitoring report and this was already reported through other measures. Alan Rose requested information on where outcomes could be seen in the report. The Chief Executive suggested showing key KPIs to provide an understanding of where improvements were being made. **D Godbold**

The Chair noted the complexity of community services and said that it was helpful to be able to see the detail on Convene.

Angus Eaton agreed that it was helpful to have all this information but expressed concern that they were trying to do too much and asked about the capacity of the team. Dawn Godbold agreed and explained that that they needed to consider what could be done and who was going to do it. Some of the items in the plan were business as usual.

Catherine Waller referred to child and adult mental health services and asked where the measures for these were. Dawn Godbold explained that there was a strategic alliance group for CAMHS and mental health services and a separate strategy was also being developed around these services.

18/196 INTEGRATED QUALITY & PERFORMANCE REPORT

Helen Beck circulated copies of emergency department's daily performance during August and September. This highlighted a particularly bad Saturday when performance was only 54% which had affected overall performance for the period. The reasons for this were the new junior doctor intake, a significant and sustained increase in demand and no bed capacity.

This information showed that the actions being taken appeared to be having a positive effect and the Trust was managing to maintain capacity despite considerable pressure. Moving GP expected patients to ward F8 had not delivered the planned reduction in ED activity as demand had increased. However, the action that had the biggest impact was that for the majority of the time there were two teams of doctors at night, ie two registrars and two SHOs, which was enabling the team to maintain flow of minors patients through the department more quickly. As a result the Trust was currently on target to achieve 95% for September and 90.5% for the quarter subject to performance over the coming weekend. Achieving this would result in the Trust receiving £250k additional funding.

For the last three weeks WSFT had been second in the country on performance; however the situation still remained very challenging and fragile. She commended the teams in the acute admission ward and emergency department on this achievement, despite the increase in demand. The Chair agreed and asked her to pass on the board's commendation.

Angus Eaton said that the executive team should also be credited for the improvement in this performance as they had worked together to achieve this. The Non-Executive directors agreed.

Rowan Procter reported that there had been a mock unannounced CQC visit to the paediatric area on Tuesday morning. Gary Norgate had been part of this and had been very impressed with the attitude of staff and improvements that had been made. This visit had provided him with a lot of assurance.

Catherine Waller said that she had attended the emergency department twice recently with her daughter and echoed the comments on the quality of care that she had received in the paediatric area.

Helen Beck referred to referral to treatment (RTT) performance which had been disappointing in August. The key areas were high volume specialties, eg ophthalmology (cataracts) where a number of patients had moved from just under 18 weeks to over 18 weeks in the month

There had been a problem with gastroenterology which had been below 92% for the first time ever but this should recover and improve following the appointment of a locum consultant.. Vascular was an area of ongoing concern; this service was provided by Addenbrooke's and the Trust was talking with them about additional manpower. There had also been an issue with dermatology over the summer due to high demand. This was not expected to be resolved quickly but a new Telederm service had been launched with GPs to reduce the demand.

Vascular and ophthalmology were working through a potential outsourcing solution but there would be financial implications which would be discussed by the executive team and the CCG.

The Trust had been on target with five 52 weeks breaches, however this had increased to ten as five patients had been identified as having incorrect coding as a result of human error. Discussions had taken place and the performance and information team was looking at how to address this. All ten patients had or would be treated in September.

The diagnostics six week wait was amber which was a concern as it was normally 100%. The reason for this was the performance of gastroenterology and there had also been a problem with the water supply to the washer disinfectors which had resulted in 75 patients having their endoscopy procedures cancelled. There had also been breaches in MRI. However, Helen Beck explained that performance was 99.5% for September as most of the issues had been resolved.

The cancer two week wait performance was 89.5% due to significant pressure in dermatology. The situation had improved but performance in September and October would still not be where it should be and this would make achievement of the target for the quarter extremely unlikely. However, the actual numbers of diagnoses of cancer was very low and was also delay no in time to treatment; therefore this should not have an impact on the 62 day performance. GPs had been issued with new technology to enable them to photograph patients' lesion and refer to a tele-dermatology service to assist in a reduction in referrals.

Richard Davies noted that August was holiday season and when the intake of new doctors took place, ie predictable issues. This had been discussed previously and he asked if more needed to be done to prepare for August. Helen Beck acknowledged this and said that more could be done in some areas, but there was very little resource of doctors in dermatology. Diagnostics would have seen a small dip but the increase in volume and problems with the water plant had had a significant effect.

Gary Norgate asked about WSFT's use of locum staff and if it was an outlier compared to other trusts. Nick Jenkins said that it was an outlier in a positive sense, ie spending significantly less than other organisations. He explained that there was an agreement between trusts that when they exceeded a certain rate of pay they would inform them and explain why. This rate was reviewed regularly.

Rowan Procter referred to the annual leave seasonal issue and explained that pressure ulcers and falls did not appear to be due to staffing. The majority of falls had taken place at night and the Trust were looking at different ideas to help patients identify where their beds were etc, eg different coloured blankets etc. There was no benchmarking for the number of falls; therefore the Trust has set its own target.

Within 15 minutes of being admitted to a ward a safety checklist was undertaken for every patient, eg if side rails required, water available etc. Rowan Procter had asked procurement to look at a solution to provide every bed with a 'wander guard'.

There were a number of outstanding RCA's in the community and the new senior matron would be looking into these.

An MRSA case had been attributed to WSFT as a patient had come into the emergency department and the appropriate technique had not been followed.

There were no outstanding duties of candour this month.

Gary Norgate commented on the very good transparency in this report. He asked Nick Jenkins to provide an update on discharge summaries. Nick Jenkins explained that work was being undertaken with the CCG to review and revise the criteria for discharge summaries as some of the problems were about what the Trust was required to report. Therefore changes were being made, ie removal of the requirement for every patient discharged from the medical treatment unit to have a discharge summary every time they were discharged. A series of items were being worked through and GPs asked if they required particular information. An education package for F1 doctors has also been implemented in partnership with the Royal College of Physicians. **N Jenkins**

The Chair requested timescales as to when a change/improvement might be seen in discharge performance.

Rowan Procter referred to the question from Gordon McKay about maternity services at Shrewsbury and Telford Trust and explained that a review was being undertaken. When a report was issued WSFT would be going through this and learning from any recommendations. There had only been one neonate death in the last year at WSFT and all incidents such as these were rated as serious incidents and reported to the CQC and CCG.

Angus Eaton noted that refresher training on blood products and transfusion processes had been red all year. Rowan Procter explained that the way of delivering training was being changed, ie on wards and at places of work, which should help to address this. Nick Jenkins explained that the new consultant who had been appointed yesterday would be the transfusion lead which should also assist in improving this.

The Chief Executive commended Cassia Nice and her team on the significant improvement in responses to complaints in the agreed timeframe.

18/197 FINANCE AND WORKFORCE REPORT

Craig Black explained that as there had not been a meeting at the end of August, the finance reports for the past two months were available for today's meeting.

The trend of a slight overspend each month continued, the main reasons for which related to operational pressures described earlier.

Backdated pay was paid in August and despite having been told that organisations would be fully funded, there was a gap of £0.5m for the year. In the first half of the year the Trust had also been trying to deal with the backlog in demand for wheelchairs in the community which had cost £140k up to the end of August. WSFT was currently in discussion with the CCG about both of these costs pressures and the excess activity that it had been delivering this year to date. It was hoped that a satisfactory outcome would be achieved and an update would be provided at the next board meeting. **C Black**

Although the additional cost of winter pressures had been budgeted and planned for, Craig Black was concerned that this could be on the low side taking into account the scale of activity to date.

The level of maternity leave over the last couple of months was higher than previously. He highlighted the staffing plan for winter and the forecasted gap for November due to the opening of the cath lab and the first phase of AAU in December. WSFT had received notification yesterday that the agency was not confident of being able to fulfil the block booking for agency staff over the winter, which could result in financial consequences.

To date the focus on CIPs had been to deliver the 2018/19 programme, and the project management office (PMO) was now focussing on the plan 2019/20.

Currently the cash position was reasonably good, due to payment of sustainability and transformation funding (STF) in July and the capital programme budget not being spent so far this year. However, the cash position remained a concern and would be extremely challenging if the Trust did not receive the loan it had applied for.

Gary Norgate asked about A&E attendance, which suggested less activity. Helen Beck explained that this was the impact of removing GP expected patients.

Gary Norgate noted that there were two spikes in consultant agency spend and asked if this would continue. Craig Black explained that there had been an increase in emergency medicine and additional staff were now working at night which was reflected in the financial figures. He confirmed that this was planned to continue but should be offset by the provider sustainability fund (PSF) money as a result of achieving the A&E target. It had been assumed in the finance report that the Trust would not receive PSF money for quarter two but it was now hoped that it would do.

He stressed that the focus in the organisation was to do the right thing for patients clinically and then deal with the consequences; however it was imperative that the Trust achieved its financial forecast.

Angus Eaton asked about the pay award and if the £0.5m gap had been factored into the financial position. Craig Black explained that this was shown on page 3.

He also asked when the 2019/20 CIP plan would come back to the board. Craig Black explained that the preliminary budget and CIPs would be presented to the board in November.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

18/198 NURSE STAFFING REPORT

Rowan Procter explained that staff were being moved around in order to mitigate risk. There had been a number of medication errors in maternity (F11) due to high vacancy rates but these positions had been filled and performance should improve.

Trusts were required to report when their fill rates for registered nurses fell below 80%. WSFT has set an internal target of 82% for bay based nursing which should assist with quality indicators.

Sudbury had the highest vacancies in the community to recruit to and workshops on staffing, skill mix, training etc were taking place. This approach would then be applied across other community teams.

Gary Norgate asked about the wider strategy for nursing recruitment. He noted that the Trust continued to recruit from overseas, ie Philippines, and asked if this was still effective and if another strategy was required. Jan Bloomfield said that this was the only recruitment strategy as there were no UK nurses available. They were also working on nursing apprenticeships and looking at developing nursing assistants who were registered nurses in their own country in order to utilise their skills as well.

18/199 LEARNING FROM DEATHS

Nick Jenkins explained that this was a quarterly report. Medical reviewers would not be funded by the government after the spring. Despite assurance that there would not be a league table Trusts were measured on preventable deaths, three of which had been identified at WSFT to date.

Richard Davies explained that there had been some debate about whether a death should be classified as preventable when there was a 50:50 split. The decision had been made that in this instance they should be classified as preventable, which reflected the transparency of the organisation.

18/200 QUALITY & LEARNING REPORT

Gary Norgate asked about the implications of the new pressure ulcer scoring and what the board could expect to see. Rowan Procter explained that she would expect to see a reduction.

The board noted the content of the report.

18/201 SAFE STAFFING GUARDIAN REPORT

Nick Jenkins explained that this report should have been presented in July but the guardian was on leave and had since resigned from this role, which meant that the Trust was currently in between guardians.

Alan Rose asked if the number of junior doctor vacancies was a big pressure on the organisation. Nick Jenkins confirmed that this was a pressure and the medical staffing team were trying to address this and was permanently looking for good quality locums. He explained that the numbers had improved since this report.

18/202 EDUCATION REPORT

Jan Bloomfield explained that this was a report for information and that education was one of the strengths of the organisation. This report also included the library annual report.

Richard Davies considered this to be a very good report, however he noted that a lot of the elements were about secondary care and asked if there was scope to extend this to the community and alliance partners.

Jan Bloomfield agreed and said that it was hoped to develop an education programme for the alliance and become more integrated. The 5 o'clock club was already open to alliance partners and the Trust was looking at developing leadership summits for the alliance. Jan Bloomfield would discuss with Dawn Godbold how to report from a community and alliance perspective.. **J Bloomfield / D Godbold**

18/203 ANNUAL REPORTS

i) Equality & diversity

The Chair welcomed and introduced Denise Pora, Deputy Director of Workforce, who explained that this reported provided an update on the Trust's progress with its inclusion strategy and action plan. It also provided assurance that it was meeting the requirements of the NHS standard contract and equalities legislation.

Gary Norgate considered this to be a very good report that provided a lot of assurance.

Angus Eaton referred to disciplinary cases where organisations had a biased towards men and asked for assurance that this was not a risk to WSFT. Denise Pora said that taking into account the number of women employed by the organisation she did not consider this to be a concern.

ii) Safeguarding children

The Chair welcomed and introduced Lisa Sarson, Named Nurse Safeguarding Children.

She explained that recruitment and retention of staff, in particular health visitors and school nurses, was a concern. The other significant issues were an increase in gang activity and an increase in drugs coming from London into some areas.

Richard Davies noted there were key staff who did not have level three training and asked if this being addressed. Lisa Sarson explained that this training had to be renewed on an annual basis and she was confident that this being addressed and achieved.

Rowan Procter reported that the new domestic liaison nurse post had been well received within the organisation and by partner agencies.

Craig Black noted that domestic abuse was one of the County Council's priorities for this year. Staff who were victims of domestic abuse were also supported.

Angus Eaton noted that historically referrals had been higher and asked if there as a metric at which if referrals dropped below a certain level the organisation would investigate the reason. Lisa Sarson explained that the reason why referrals to safeguarding had dropped was due to the establishment of the perinatal mental health service which provided support to individuals.

The Chief Executive considered this to be a very good report and asked about the evolvement of safeguarding arrangements to support safeguarding in the community and the patient pathway. Lisa Sarson explained that there was a named nurse for safeguarding in the community; however the arrangements would be restructured across acute services and the community as a more integrated model.

iii) Infection control

The Chair welcomed Ann How, Lead Infection Prevention Nurse who explained that there had some concerns at the beginning of last year and therefore Dr Debra Adams from NHSI had been invited to visit WSFT. This had been very helpful and positive and she had given very good advice which had been incorporated into this report. At the end of her visit she had rated the WSFT as green which was the first Trust she had given this rating to in ten months.

The challenges of the estate in relation to managing infection control were well documented. Despite this Rowan Procter said that WSFT's infection control measures were very good compared to other Trust's she had visited.

A letter had been received from Ruth May, Executive Director of Nursing NHSI, noting the Trust's reduction in e.coli infections, however Ann How considered improvements could still be made.

Ann How explained that WSFT was very honest and transparent about outbreaks, eg norovirus.

The Chair noted the commitment and awareness of staff to infection control, including volunteers. Helen Beck agreed and said that the commitment and judgement of the infection control team was well respected by staff in the organisation, eg when to close beds and doing what was right for patients.

Alan Rose asked about the feedback from Debra Adams' and her rating the Trust green. Ann How explained that a letter had been received and could be circulated to the board. **R Procter**

18/204 CONSULTANT APPOINTMENT REPORT

The board noted the appointment of the following:-

Dr Emma Gordon – Consultant urology

Dr Roopashree Balasundaram – Consultant emergency medicine

Gary Norgate commented on this positive appointment as it was hard to recruit to A&E but doctors wanted to work at WSFT because of the culture. He also commended Nick Jenkins and the Chief Executive on how they managed the second applicant and their proposal to provide a development plan for the individual.

18/205 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that the award for this month had been received by Harry Rodrigueza, housekeeper, and Amelia Raby, pharmacy recruitment and careers day team.

Harry was nominated by the Quince House tenants' forum for his tireless work to maintain an impressive standard of cleanliness in Quince House. He was always prepared to assist colleagues with requests for additional cleaning support. His work ethic was superb and he did it with a smile on his face.

Amelia had been a member of the pharmacy team since April 2016. The pharmacy department has been carrying a number of vacancies for some time and frequently worked significant overtime, but this was becoming unsustainable. Amelia suggested a

recruitment and careers day, with the aim of recruiting staff to current vacancies and encouraging people to look at pharmacy for their longer-term career prospects. At short notice, she and her team of volunteers from the pharmacy department, HR and the communications team put together an extremely successful day, which it was hoped to repeat in the future .

The board congratulated Harry and Amelia on their commitment to WSFT and support to their colleagues.

BUILD A JOINED UP FUTURE

18/206 ESTATES STRATEGY

Sheila Childerhouse welcomed Jacqui Grimwood, Estates Development Manager, to the meeting, who explained that this was a five year strategy and took into account the latest thinking and recent reviews by Lord Carter and Sir Robert Naylor, as well as strategies of the organisation.

An options review of the estate was currently being undertaken and what this might mean for the organisation.

WSFT was in the top quartile in the country on backlog performance, 69% of which related to the structure of the building. There was constraints in delivering the backlog programme due to working in an operational environment, lack of decant facilities and the level of asbestos in the organisation.

The majority of estate in community services was leasehold, with NHS Property & Estates being the major landlord which WSFT worked closely with to ensure that this estate was compliant. Over the next five years the plan was to move away from NHS Property & Estates and work with the local authority towards the One Public Estate initiative with six hubs in the county.

Space utilisation in the main hospital was good and meeting the Naylor standards; however these were based on the acute background not community services.

Angus Eaton considered this to be a very good document and asked about communications and preparation for what would happen in the future. The Chair explained that the Trust was not yet ready to communicate anything but would be working with partners in the alliance. A shorter version of this document would be produced so that everyone could have access to it. **C Black**

Craig Black explained that in the last ten years a plan/site had been ear marked for a new hospital which was in the public domain. It was also known that there was a finite life for the current building and at some point a decision would need to be made. Jan Bloomfield confirmed that there would be a communication plan around the future of this site.

The Chief Executive referred to 5.6 and highlighted the clinical resilience that had been incorporated into the plan.

The Chair thanked Jacqui Grimwood for a very good and informative report.

18/207 DIGITAL PROGRAMME BOARD REPORT

Craig Black explained that the governance was being broadened to include all digital development in the organisation.

It was noted that M*Modal had been delayed and would now go live mid-November.

GOVERNANCE

18/207 TRUST EXECUTIVE GROUP REPORT

The board noted the receipt of the EPRR core standards submission

18/208 AUDIT COMMITTEE REPORT

Angus Eaton highlighted the proposed amendment to the terms of reference. On Monday Gary Norgate, Craig Black, Angus Eaton and Richard Jones had undertaken an appointment process for internal auditors and it had been agreed to reappoint RSM. He felt assured that this had gone through a rigorous process.

The board agreed the revised terms of reference.

18/209 COUNCIL OF GOVERNORS REPORT

The board received and noted the content of this report.

18/210 USE OF TRUST SEAL

The board noted the use of the Trust seal.

18/211 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were noted.

ITEMS FOR INFORMATION

18/212 ANY OTHER BUSINESS

There was no further business.

18/213 DATE OF NEXT MEETING

The next meeting would take place on Friday 2 November 2018 at 9.15am at Sudbury Health Centre.

RESOLUTION TO MOVE TO CLOSED SESSION

18/214 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

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – 2 November 2018

Agenda item:	6			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	25 October 2018			
Subject:	Matters arising action sheet			
Purpose:		For information	X	For approval

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

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

Actions are RAG rating as follows:

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

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

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

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

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

Ongoing actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1604	Open	29/6/18	Item 24	Report annual governance review findings at the end of September.	Questionnaires issued. Report will be drafted for meeting in November when all responses received.	RJ	30/11/18	Green
1627	Open	28/9/18	Item 8	Schedule the Buurtzorg report be received by the Board at the end of November		DG	30/11/18	Green

Closed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1613	Open	27/7/18	Item 10	Review Brexit impact as part of the Trust's emergency preparedness arrangements (including review of supplier risk). Update to Audit Committee in 2 November 2018	Building into supplier and business continuity plans. **Based on further requests for national reporting it has been agreed that this evolving issue be included in the Scrutiny work plan with monthly reporting as required.**	HB	02/11/18	Complete
1628	Open	28/9/18	Item 8	Within the Alliance and community services report sign-post to key service performance metrics within the IQPR	**Included in monthly report**	DG	02/11/18	Complete
1629	Open	28/9/18	Item 9	Set out improvement trajectory for discharge summary performance	**Included in IQPR**	NJ	02/11/18	Complete
1630	Open	28/9/18	Item 10	Provide an update on discussions with the CCG re financial support in 2018/19, including impact of the high levels of activity being experienced	**Included in Finance Report**	CB	02/11/18	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1631	Open	28/9/18	Item 15	Consider how to strengthen integration of training and education within the Alliance partnership (including the community)	Starting to formalise as part of the Alliance and System Executive Group working. This is an evolving process to enable changes to move away from silo working. This will be reported through the existing Alliance report.	JB / DG	02/11/18	Complete
1632	Open	28/9/18	Item 16.3	In the context of the annual IP report - circulate the feedback letter received in May 2017 from visit by Debra Adam's, Senior Infection Prevention and Control Advisor NHSI	**Circulated by email 11/10/18**	RP	02/11/18	Complete

7. Chief Executive’s report

To ACCEPT a report on current issues from the Chief Executive

For Report

Presented by Stephen Dunn

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – 2 November 2018

Agenda item:	7			
Presented by:	Steve Dunn, Chief Executive Officer			
Prepared by:	Steve Dunn, Chief Executive Officer			
Date prepared:	26 October 2018			
Subject:	Chief Executive's Report			
Purpose:		For information	X	For approval

Executive summary:

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

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

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

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

Recommendation:

To receive the report for information and record the Board's commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated

Chief Executive's Report

Who knew that we have some similarities with the hit TV show Game of Thrones? I confess I've never actually watched the show, but the kids tell me across the dinner table that, in the world of the Seven Kingdoms of Westeros, **'Winter Is Coming'** is the motto of the House of Stark. This year, as the board knows, we started our planning for winter even earlier, way back in January in fact because it was so busy last year. We need to create some additional space if we are to cope and we need extra staff to staff that space safely. As I write this we are on track to open a new acute assessment unit (AAU) in December, which will mean that patients referred in by GPs go straight for assessment in a dedicated and properly equipped facility. We will also open our new cardiac centre at the hospital around the same time, which will mean shorter lengths of stay, better local care as patients will no longer have to go to Papworth for angiograms and pacemakers, and also it will free up another ward!

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

We are also supporting our staff to have flu jabs to protect themselves, their patients and their colleagues. I've had mine! It's not overdramatic to say that it really can be the difference between life and death - flu is a killer. I'm delighted that, at the time of writing, more than 1,767 of our staff have opted to have the **flu vaccination**. That will likely have gone up even further at the time of reading! This is such great news and proves that our staff are dedicated to protecting themselves and those around them. Thank you to each and every one of you! We are committed to achieving the ambition of 100% of front line healthcare workers being vaccinated and appended to this report is our self-assessment against the national best practice management for healthcare worker vaccination.

As part of winter planning and based on predicted peaks in demand, the Trust also recently held a **multi-agency discharge event (MADE)** working with the wider health and social care system to find new ways to both recover and cope with demand. The MADE event took place on 9 and 10 October, with predicted peaks in demand on 7 and 14 October. This was spot on – we saw 241 attendances to the emergency department and 83 admissions to the hospital on Sunday 14 October alone. In addition to managing demand through West Suffolk Hospital we welcomed system partners in to ensure we had a rounded view of the various patient pathways in the west of Suffolk, and to showcase how we are working together across health and social care.

The aim of the MADE event was to: benefit patients, by ensuring care is delivered in the right place at the right time; benefit acute staff to ensure they gain a greater understanding of services available outside of the acute organisation; and benefit wider health and social care system partners to ensure they get a realistic flavour of the demands faced in an acute setting. On 9 and 10 October teams consisting of Trust staff and system partners attended board rounds where redtogreen reviews took place for all patients led by the executive chief nurse. Red reasons were escalated to a team in the hospital control centre and all actions were followed up in the afternoon and reported back. Teams also spoke directly to patients – asking the standard four questions to check if they understood about their stay and discharge plans: Statistically, the MADE contributed to a decrease in breaches and a slight increase in the number of discharges leading up to 14 October. The performance of the hospital would have undoubtedly been much poorer without it. As a result of findings from the day, recommendations have been made about working practices and if any changes are to be implemented, these will be communicated in due course.

Following the successful **West Suffolk Alliance discharge to optimise and assess** pathway 1 workshop held earlier in the summer, acute, community and social services colleagues have been working collaboratively to shape a process that integrates current practices to support and improve patient discharges from hospital. Pathway 1 is for 'medically optimised' patients who can return home with additional support, with all comprehensive assessments undertaken in their own home. Assessments that are completed in a patient's own home will benefit them as they are more relaxed and in an environment that they know well. By removing steps that normally cause a delay in the discharge process, we will ensure we value patients' time and reduce the risk of deconditioning. We are now ready to carry out a test and learn phase on two wards - G5 and F3. Training sessions have been held to inform and support staff during the first stage of implementation. To ensure patients receive the appropriate services in the community, and to support a safe discharge, joint assessments between health and social care teams (occupational therapists and reablement team leads) are planned, to share knowledge and build confidence in trusted assessments. A trusted assessment involves a trusted assessor – someone acting on behalf of, and with, the permission of multiple organisations – carrying out an assessment of health and/or social care needs in a variety of health or social care settings. Joint meetings between acute, community and social services are planned during the test and learn phase to ensure all processes are working as expected. Other wards will be invited to participate as the pathway progresses.

We're absolutely delighted that last month, our **four-hour emergency department (ED) performance** came in at an amazing 95.9%,exceeding the national standard of 95% and making us one of the top performing trusts in the Midlands and East region. This mammoth effort didn't just come into play in September though; for the second quarter of the financial year (July – September), our ED performance has been 90.75%. This means we have beaten our quarterly target and thanks to this achievement we're now set to earn an additional £250,000. These results haven't happened by chance. Teams in ED, acute assessment and patient flow have changed their ways of working to try and make these improvements happen; as well as using the Trust's internal professional standards and escalating quickly, they swapped and worked additional shifts and had a fantastic response from speciality teams in support.

Thank you to everyone who has played a part in this, including those on the wards and in the community who have helped to free up beds for ED patients and generally helped flow across the hospital. Every little piece does make a difference, and whilst time-targets aren't the only indicator of how we're doing as a trust these results do show the very real impact the hard work has. We have also had a quality walkabout in ED from the exec team in the last week, which showed what progress we have made in improving the safety and effectiveness of the care we give to patients. Our challenge now is to try and sustain what we're doing, but I have no doubt that with this dedicated and energetic team we can do it!

In recent months I have been travelling around the county, **meeting community colleagues** at their bases to share information and listen to their views. WSFT community staff work from Woodbridge to Haverhill, from Ipswich to Sudbury and all points in between, so the Trust is providing a truly countywide community service. I was keen to hear first-hand from staff about how the transition had felt, and how things now feel one year in. I was truly heartened to hear that unlike previous transitions this one was felt to have gone smoothly and that staff felt pleased to be part of a local NHS system. A typical session was at Darbishire House in Bury, where I met clinicians and support staff from a range of community services who work in a variety of roles in the towns, villages and remote areas of west Suffolk. A focus of these events has been to update people on the progress of the West Suffolk Alliance, developing the integration of health, social care and other services to benefit local people. The Alliance is an exciting new way of working and I was able to assure colleagues that the community voice was being heard throughout the Trust. It was clear that there has been good progress in building relationships between Trust colleagues based at the hospital and in the community – we are all on the same team. The focus now is to

build resilience into our healthcare system by developing those relationships, and further investing in community services to ensure more people are able to be cared for at home.

One of the reasons we are working in this new alliance way is that we are seeing year on year increases in demand. We have the second oldest population in the country, more homes are being built all the time – and this is not a problem that is going away so we need to work in a different way. This is why our strategy is to invest in community services to shift activity, prevent admission and get people home quickly, supporting them to stay at home. Services – such as the early intervention team – already working in tandem with social and primary care and the voluntary sector; and initiatives such as the neighbourhood nursing team at Barrow (Buurtzorg); and community beds at Glastonbury Court, funded by the Trust are designed to meet the year on year increases in demand. There are also three new beds open at Newmarket Community Hospital. Moreover simple initiatives such as staff rotation across community, council and hospital settings, for example will build expertise, understanding and resilience into the system.

For **September's performance** there were 64 falls and 14 Trust acquired pressure ulcers. There was one C. difficile case in the month. The Trust failed to deliver on the target for 2 week wait for urgent GP referrals, with reported performance at 80.9% and Cancer 62 day GP referral with reported performance 77.4% due to significant increases in demand. The 4 hour wait performance for the emergency department for September was 95.9% with attendances continuing at an increased level year on year level at 11% (adjusted). The quarterly position against the 4 hour standard also achieved the target for Q2 resulting in payment of Provider Transformation Funds (PSF). RTT performance against the 18 week standard has improved in September performance of 89.9%, with two long waiting patients reported for the month.

The **month six financial position** reports a deficit of £7.1m. This is £0.7m worse than planned, partly due to provider sustainability funding (PSF) funding being behind plan as a result of ED performance in Q1 (£0.2m). The Trust has now agreed a control total to make a deficit of £13.8m which will provide PSF of £3.7m should ED and financial targets be met. Therefore the Trust is now planning on a net deficit of £10.1m for 2018-19. In order to achieve the control total the 2018-19 budgets now include a stretch cost improvement programme (CIP) of £2.8m bringing the total CIP plan to £12.2m (5%). The Trust is currently applying for the cash support from the Department of Health (DH) to support this revenue deficit, and also the planned capital programme of £28.1m.

We continue to work with **North East Essex and Suffolk Pathology Services (NEESPS)** and East Suffolk and North Essex Foundation Trust (ESNEFT) to address the deficiencies identified by the MHRA during their unannounced inspection in July 2018. A new governance model has been agreed led by the Strategic Pathology Board which has representation from relevant partner organisations. Based on detailed gap analysis an action plan is being developed to achieve UKAS accreditation and compliance to Blood Safety and Quality (amendment) Regulations (BSQR) standards for blood transfusion for all sites served by the network. We have maintained open communication with the pathology staff on the WSH site to ensure they have visibility of our commitment to the delivery of sustainable laboratory services.

Bullying. Harassment. Discrimination. Intimidation. The words come in many forms, but they all amount to similar things; making someone feel undermined, humiliated, offended, embarrassed, patronised, or even threatened. And they're all something that, unfortunately, most if not all of us will have experienced at some time in our lives – whether at school, at work, in the community, from people we know or from strangers. The common theme is that in all cases, it's unacceptable. We want our 'West Suffolk way' to be a culture of individualism and inclusivity. But, like the rest of the NHS, we know that bullying, harassment or discrimination feature in the working lives of our staff. We are encouraging staff to use the formal and informal ways of speaking up. We can't help unless we know about it, and these kind of behaviours aren't something that we as a Board, or as a Trust, are prepared to stand by and accept.

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

Deliver for today

The Friends of West Suffolk Hospital
Did you know that last year's profits from the Friends' Shop amounted to £21,729? The money raised has allowed them to purchase various items for the benefit of hospital patients, such as six recliner chairs for surgical wards worth £12,000 and a continuous positive airway pressure (CPAP) machine for critical care worth £2,700. Both items have really helped to enhance patient experience here in the hospital. Thank you to the Friends and all those who support them - it is greatly appreciated!

Red bag scheme
The red bag pilot scheme is now being rolled out to all care homes in west Suffolk. The Trust recently held a care home forum which was well attended by care home colleagues, with enthusiastic debate around process improvements between organisations and ways to improve patient care. An initial pilot evaluation carried out with the West Suffolk Clinical Commissioning Group was positive, with care homes involved keen to use the red bags and agreement that fewer patient belongings were going missing as a result. It is hoped that, in addition to reducing length of stay, the scheme will make patients' time with us less stressful. The process involves packing a specially numbered 'red bag' with all the information and personal belongings relevant to a care home resident when they need to go into hospital. The bag contains personal items such as clothes, so that the patient can be dressed whilst with us if possible, glasses, dentures, hearing aid and reading materials, and the patient's notes (the My Care Wishes folder) are inserted into a clear pocket with a handover sheet from the care home. Ambulance staff hand the bag over on arrival at the hospital so that nurses and doctors have up-to-date information about the patient, including current medication, mobility and dietary requirements. This means fewer calls to the care home and easier interaction with the patient. When the patient is ready to leave hospital, their nurse will ensure that all belongings are back in the red bag, and include an update in the My Care Wishes folder.

End stigma and lack of understanding around ADHD
October is Attention Deficit Hyperactivity Disorder (ADHD) awareness month, and colleagues from the integrated community paediatric service (ICPS) are highlighting their work supporting children and young people with a diagnosis of ADHD, and their families. The community paediatricians and ADHD specialist nurses within ICPS, deal with one of the most prevalent childhood behavioural disorders. Between two and five per cent of children under 18 can be affected by this condition, which includes symptoms such as inattentiveness, hyperactivity and impulsiveness that often impacts a child's development, education and family life.

Invest in quality, staff and clinical leadership

Community team rewarded as true gems
Members of the Bury Town community health team have been recognised by a local care home for their hard work and support for the residents. Davers Court in Shakers Lane presented a GEM (going the extra mile) award to members of the team who are aligned with the Mount Farm and Victoria surgeries in Bury.

Creative training
Our clinical skills team recently transformed our skills lab into a patient's living room. The set, complete with an actress as a patient, was used to immerse students from the universities of Suffolk and East Anglia in a realistic palliative care training scenario. That's creative training! One student commented: "It gave a great overview of how to optimise end of life care for patients."

Restart a Heart Day
Members of the community cardiac rehabilitation team marked Restart a Heart Day at Sudbury Health Centre and Newmarket Community Hospital, sharing information and advice. The team is supporting the Nation of Lifesavers campaign, which aims to encourage everyone to learn how to administer bystander CPR, and help save lives.

Mother and daughter duo head to South Africa for archery world championships
Our very own mother and daughter duo Karen and Natasja Pinches are heading out to sunny South Africa to compete together in the International Field Archery Association (IFAA) World Field Archery Championships 2018 from 5 to 13 October 2018. Both Karen, her daughter Natasja, and her husband Charlie are all avid archers, and regularly compete in both European and World Championships. Karen will compete in the female adult barebow category, while Natasja will compete in the female adult freestyle unlimited category, which includes “bows that have all the bells and whistles” according to her mum!

Build a joined-up future

Undergraduate medical education
The new intake of students on the Cambridge Graduate Course in Medicine started at West Suffolk Hospital in September. This year the numbers have increased from 21 to 36. The students will be coming to the hospital for their clinical placements throughout the next four years.

International Physician Associate Week
This month’s International Physician Associate Week has celebrated and promoted the role of physician associates (PAs) - healthcare professionals with a generalist medical education, who work alongside doctors to provide medical care as part of a multidisciplinary team. Physician associates are able to take medical histories from patients, carry out physical examinations and formulate differential diagnoses and management plans. They can also perform diagnostic and therapeutic procedures and request certain tests. The physician associate role in the UK is based on the role of physician assistants, which started in the USA in the 1960s. There are now more than 100,000 PAs in the USA, working as an integral part of their teams across every aspect of medicine. PAs have been practising in the UK since 2005. Currently there are 500 qualified PAs in the UK but this number is set to increase dramatically. There are now over 30 PA courses across the UK, meaning by 2020 there will be 3,000 qualified PAs and a further 1,000 graduating every year after that.

National news

Deliver for today

£240 million social care investment to ease NHS winter pressures
The investment in adult social care this winter will help local authorities reduce pressures on the NHS by getting patients home quicker and freeing up hospital beds across England. The extra funding, announced by Secretary of State for Health and Social Care, Matt Hancock, is aimed at reducing delayed transfers of care and will be allocated to councils based on the adult social care relative needs formula. (Department of Health and Social Care).

Data linkage: joining up the dots to improve patient care
One clinical commissioning group used a survey to ask patients with long-term conditions to assess their confidence in managing their condition, and the results were entered onto their GP record. This information is useful on its own, allowing GPs to tailor care to patients, and refer them to health coaches or peer support initiatives that could improve their confidence. However, once this data was linked up with other records, it became even more powerful.

NHS England strikes deal for ground breaking cancer treatment in a new European first
Adult cancer patients in England will receive a new game-changing therapy treatment under the first negotiated deal of its kind struck in Europe. This is the first time adult NHS patients will have access to CAR-T, and follows a deal NHS England reached last month to make CAR-T available for children and young people with a rare form of leukaemia. The CAR-T therapy – Axicabtagene ciloleucel, also known as Yescarta – offers new hope for adult patients whose large cell lymphoma has returned or has stopped responding to previous treatment. It works by re-programming the patient's own immune system to target their cancer. CAR-T cell treatments mark the beginning of a new era of personalised medicine, and form part of the NHS's long term plan to upgrade cancer services.

NHS to trial tech to cut missed appointments and save up to £20 million
Patients will be able to book and change medical appointments online, receive text reminders and even access maps showing them where in a hospital they need to go through a digital patient tool set to be trialled in ten hospitals. The online portal, DrDoctor, is set to save the NHS tens of millions of pounds by slashing the number of missed appointments as well as making it easier and more convenient for patients to make and manage bookings. Patients can also fill in medical forms before they arrive using the system and receive appointment letters digitally. The tool will be trialled at NHS sites specially selected to test the impact of DrDoctor across a variety of hospitals, from small specialist sites to large inner city hospitals, with plans for the pilot to be in place by March.

Invest in quality, staff and clinical leadership

The spread challenge: how to support uptake of innovations and improvements in health care
This report by the Health Foundation highlights the challenges facing the NHS in improving the uptake of new ideas and practices, and the need for new approaches when developing national and local programmes to support the spread of innovation.

Q: the journey so far
This report by the Health Foundation tracks the progress of the Q Initiative [Q is an initiative connecting people with improvement expertise across the UK, led by the Health Foundation and supported and co-funded by NHS Improvement. Q's mission is to foster continuous and sustainable improvement in health and care.] and focusses on the challenges facing the NHS in improving the uptake of new ideas and practices, and the need for new approaches when developing national and local programmes to support the spread of innovation.

Approaches to better value in the NHS (King's Fund Report)
Like many health care systems, the NHS is increasingly focusing on how it can improve the value of the services it delivers, that is, how it can deliver the highest-quality health outcomes at the lowest possible cost. This requires a change to previous approaches to improvement, which have often reviewed the quality of care and the cost of care separately.

Build a joined-up future

Joined-up listening: integrated care and patient insight
This article articulates the opportunity that integrated care presents for using insight from people and populations to design services that meet their needs and reflect their priorities. This includes breaking down silos within and between organisations to listen to what patients are saying across their entire pathway of care.

Community pharmacies: promoting health and wellbeing

This NICE guidance covers how community pharmacies can help maintain and improve people's physical and mental health and wellbeing, including those with a long-term condition. It aims to encourage more people to use community pharmacies by integrating them within existing health and care pathways, and by ensuring they offer standard services and a consistent approach. This new approach will require a collaborative approach from individual pharmacies and their representatives, local authorities and other commissioners.

Improving people's health: applying behavioural and social sciences to improve population health and wellbeing in England

Academics, public health professionals, and representatives from funders and learned bodies have collaborated to produce this strategy, which will better enable the broad public health system to use behavioural and social sciences to more effectively reduce inequalities and improve the health and wellbeing of the population.

Every NHS hospital in England to cut sugary drinks sales

Every NHS hospital has agreed to cut sales of sugary drinks on their premises as part of NHS England action to curb rising levels of obesity. All 227 trusts across England have pledged to reduce sales of sugar-sweetened drinks to 10% or less of their total drinks sales. The latest data shows that the proportion of drinks sold on NHS premises that contain added sugar has reduced for seven months in a row falling to just 7.4% in participating Trusts in June 2018. Nearly 30 million teaspoons of sugar have now been removed from NHS canteens, shops and vending machines as a result.

Annex A: Best practice management for healthcare worker vaccination - self-assessment

A	Committed leadership (number in brackets relates to references listed below the table)	Trust self-assessment
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	• Board will be informed regularly regarding the progress and percentage of vaccinations. • 2ND November 2018 to record the Board ambition to hit 100% • Board actively involved regarding the flu campaign. Photo campaign • Declaration of decline document available.
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers (1).	YES. They have been ordered and are in use.
A3	Board receive an evaluation of the flu programme 2017-18, including data, successes, challenges and lessons learnt (2,6)	CQUIN report to CCG via Trust board/leadership structures and committees (e.g. H&WB steering group)
A4	Agree on a board champion for flu campaign (3,6)	Yes
A5	Agree how data on uptake and opt-out will be collected and reported	• Using consent forms and Declaration of decline documents, which will be collected in the occupational health (OH) department. • The Occupational Health IT system allows data collection (after the information from the consent forms has been saved). • OH reports on the uptake-opt-out
A6	All board members receive flu vaccination and publicise this (4,6)	Yes
A7	Flu team formed with representatives from all directorates, staff groups and trade union representatives (3,6)	Yes. The Flu team is multidisciplinary and is cooperating with many different departments and directorates (e.g. HR, Chief Nurse & nursing team, community, pharmacy, communication department etc). Trade Unions have been advised on plans
A8	Flu team to meet regularly from August 2018 (4)	Initial meeting included many representatives from deferent departments so as to agree on the general strategy. After that, regular meetings and communication with the core flu team conducted and scheduled.

B	Communications plan	
B1	Rationale for the flu vaccination programme and myth busting to be published – sponsored by senior clinical leaders and trade unions (3,6)	Regular publications for the flu campaign, clinics/times and myth busting. Continuous communication between the occupational health team and the communication team.
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper (4)	Yes
B3	Board and senior managers having their vaccinations to be publicised (4)	Yes
B4	Flu vaccination programme and access to vaccination on induction programmes (4)	Yes
B5	Programme to be publicised on screensavers, posters and social media (3, 5,6)	Yes
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups (3,6)	Yes, by the OH department
C	Flexible accessibility	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered (3,6)	Peer vaccinator team has been formed. Chief nurse has been involved and emphasis has been given in the community peer vaccinator team.
C2	Schedule for easy access drop in clinics agreed (3)	Schedule agreed for drop in clinics. Vaccination vouchers available for the community staff.
C3	Schedule for 24 hour mobile vaccinations to be agreed (3,6)	Main vaccinations conducted by the occupational team (covering from their opening/closing hours) and by local vaccinators, making the vaccine available 24h and at weekends.
D	Incentives	
D1	Board to agree on incentives and how to publicise this (3,6)	Incentives in place and communication team to publish the winners.
D2	Success to be celebrated weekly (3,6)	Informing regularly/weekly about the uptake and discussing results/positive feedback when achieving good results.

9:35 DELIVER FOR TODAY

8. Alliance and community services report

To ACCEPT the report

For Report

Presented by Dawn Godbold

NHS
West Suffolk
NHS Foundation Trust

WSFT Board Meeting - 2 November 2018

Agenda item:	8			
Presented by:	Dawn Godbold, Director of Integration and Community Services			
Prepared by:	Dawn Godbold, Director of Integration and Community Services			
Date prepared:	22/10/2018			
Subject:	Community Services and West Alliance update			
Purpose:	x	For information		For approval

Executive summary:

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

Main Points:

This paper outlines:

- Latest developments with acute and community integration
- An example of quality improvement
- I.T Progress
- Buurtzorg Test and Learn update
- West Suffolk Alliance development
- Transformation funding update
- Latest version of Measures and Metrics

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

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

Putting you first

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

Community Services and Alliance Update

West Suffolk NHS Foundation Trust Board

2 November 2018

1.0 Introduction

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

2.0 Acute and Community Integration

2.1 Relationships continue to strengthen between community and acute staff particularly within the community and integrated services division.

2.2 The lead OT for the division has started a new education committee for **all** West Suffolk occupational therapists, this will be open to OT's from social care, hospice and mental health as well as community and acute based WSFT staff.

2.3 The first meeting was held on the 16th October. This will replace the previous trust 'in-house only OT' service programme.

2.4 The forum will be one centred on the needs of occupational therapists working across West Suffolk as many topics are relevant regardless of settings or organisations. This will benefit the whole range of services we have available across the county and use the experience within our teams/organisations to enable a more diverse learning opportunity whilst also giving us an opportunity to form a close network.

2.5 The forum will also include student updates from UEA/UoE, RCOT guidelines and publications as well as being clinically based with conditions and services updates. It will be designed by clinicians for clinicians

2.6 This will be bi-monthly for senior staff across organisations with monthly relevant training sessions planned for all occupational therapists across West Suffolk.

"Attendees immediately commented about how great it was to come together and share ideas openly which reinforces the benefits of staff coming together from different organisations for the common purpose of developing a profession specific education committee. There is a real sense of therapists feeling they are part of a larger professional group and they have a real thirst for finding out more about the roles and services of the different organisations that occupational therapists are part of".

3.0 Case Example of Quality Improvement

3.1 There was a Datix submitted for a patient who was visited by one of our community nurses who was then subsequently admitted to hospital having been identified as having sepsis.

3.2 Whilst our review of the incident gave us assurance the community assessment had been thorough and appropriate, it did identify an opportunity to share good practice across the community workforce for management of sepsis. Hospital based staff have previously had this training but community staff have not.

3.3 This led to the formation of a team working together to scope what was needed and how the training and education could be delivered in a community setting. The team consisted of a community clinician, manager, practice educator, head of nursing, together with acute colleagues from critical care and infection prevention lead.

3.4 The team also included a district nursing student whose dissertation is on the management of sepsis in the community.

3.5 Actions to date:

- Training needs across community workforce identified
- Training package x1 hour session on deteriorating patient and x1 hour session on sepsis agreed
- These two sessions would be delivered in one 2 hour training session.
- 2 members of the group to deliver the training
- Plan is to deliver these before the end of this year to support winter pressures
- Equipment needs scoped by infection control lead, one tympanic thermometer and one pulse oximeter purchased to trial
- Business case being written to ensure each clinician will have the right equipment
- Correct use of equipment will be part of the training
- We have sourced a National Sepsis tool to use as part of our documentation that will assist with assessment

4.0 I.T Progress

4.1 We have held the first meeting of the community services 'pillar 3' digital group. This newly formed group will ensure that community services IT issues have a clear and direct relationship with the trusts digital transformation programme by having a direct reporting line to the Digital Programme board.

4.2 The group will ensure that IT needs and programmes of work for community services has a logical plan, needs are prioritised and that there is clear senior oversight of any investments and the community services IT contract.

4.3 There will be 5 main work streams:

1. NEL service improvement
2. Systm1 support and optimisation
3. Hardware refresh including smartphones
4. Wi-Fi and Gov.roam at community sites
5. Access to WSFT Cerner HIE through SystmOne

4.4 The Trust has invested with Medequip in a new IT system that was implemented for clinical staff in the wheelchair service on the 1st October. The new system will improve: visibility of the clinical record, management of patient waiting lists, and allow us to change from manual and paper heavy processes to electronic solutions.

4.5 We have begun discussions about how we manage websites as a system in the future. We are focusing on the need for community staff in Suffolk (and Essex) to be able to access what they need on intranet sites; and how to develop public-facing information to help patients and families access what they need. We have agreed an alliance approach, so that we take a whole system view on where information is and how we signpost it, using all the digital platforms we have available across all the providers.

5.0 Buurtzorg Test and Learn Update

5.1 The test and learn is continuing well. We have received confirmation from the CCG that our bid for transformation funding to move to pilot phase early next year has been successful.

5.2 The evaluation from both the Kings Fund and Healthwatch Suffolk has commenced. There is a call organised between the two organisations to compare initial findings. Healthwatch Suffolk has a team of Community Development Officers. One aspect of their role is to meet with and talk to clinicians, staff and patients/carers at GP Practices.

5.3 Earlier this month the Community Development Officer in the West of Suffolk visited the Barrow Surgery to have a chat with the Neighbourhood Nursing & Care Team as well as the practice manager. Attached is a short report at Appendix 1 that offers some interesting early insights.

5.4 The CEO of Healthwatch Suffolk also participated in two visits to the team and he commented 'It is worth noting that the quality of care is rated very highly and early indications tell us that patients can clearly distinguish between care currently, as against care in the past'

5.5 The Health and Social Care Secretary Matthew Hancock made reference to the benefits of the model in an article in the Nursing Times:

https://www.nursingtimes.net/news/community/hancock-talks-up-potential-of-dutch-community-nursing-model/7026404.article

6.0 Contract Update

6.1 The community services equipment contract began a new 3 year contract term on the 1st October retaining the same provider – Medequip.

6.2 The contract for the provision of wheelchairs transferred to a new provider on the 1st October and this transition has gone smoothly with no disruption to service delivery.

7.0 West Suffolk Alliance Development

7.1 The system executive group held a facilitated session to review how integration was progressing 'one year in'. The morning was well attended and all areas of the system were represented.

7.2 The session covered 4 main topics:

- What have we achieved so far?
- What did we do that is working well?
- What did we / I learn?
- What could we do differently going forward?

Then also looked at the coming 12 months and considered:

- What steps, however small, can we try that may change the future – maybe a conversation, a new work stream at a local level?
- What will I commit to doing?
- What will I ask my organisation to commit to?

The group then went on to agree next steps and commitments.

7.3 Initial feedback was that it was a very helpful and productive session. The main points and commitments will be reviewed at the November meeting and actions factored into the Alliance delivery plan.

7.4 The South Norfolk Primary Care Practices have come together to form the Breckland Alliance. WSFT have been invited to be members of this group, and will therefore be able to influence the pathways and interactions between ourselves and the patients from South Norfolk who use our services.

7.5 Colleagues from St Edmundsbury and Forest Health Council together with representatives from WSFT and the whole system held a 'visioning event' in and for Brandon to begin the process of formulating a locality plan for the area. There is an opportunity to integrate services into the current leisure centre and enhance the range of services offered.

8.0 Transformation Funding

8.1 The transformation fund bids listed below have been ratified by the CCG clinical executive group. The projects will be added to the Alliance delivery plan and monitored through the transformation programme delivery group.

Name of bid	Lead organisation	Value
Forest Heath Community Health Care Assistants	Suffolk Primary Care	£70,000
Diagnostic Virtual Ward	West Suffolk Foundation Trust	£57,568
Learning Disabilities Annual Health Checks: Peer Educator Network	ACE Anglia	£15,759
Stand Tall	Suffolk County Council	£70,505
Active Schools Programme	St Edmundsbury District and Borough Council	£15,000
Atrial Fibrillation – Protect and Perfect – GP Education	West Suffolk CCG	£57,000
Atrial Fibrillation – Protect and Perfect – Patient Education	West Suffolk CCG	£16,500
Atrial Fibrillation – reducing strokes with increased detection	West Suffolk CCG	£230,000
HENRY	Suffolk County Council	£30,889
Expansion of social prescribing in West Suffolk	St Edmundsbury District and Borough Council	£164,313
Living Life to the Full – Primary Care based e-cognitive behavioural therapy and life skills course	NSFT	£76,000
Rapid Intervention Vehicle	West Suffolk Foundation Trust / East Anglian Ambulance Trust	£81,500
Whole School approach to emotional wellbeing and mental health	NSFT	£258,000
Speech, Language and Communication pathway	Suffolk County Council / Children's & Young People services	£81,160
Neighbourhood Nursing and Care Team	West Suffolk Foundation Trust / Local Government Association / Suffolk County Council	£200,000
	TOTAL	**£1,424,194**

9.0 Measures and Metrics

9.1 We have continued to work on the measures and metrics required in order that we can demonstrate the impact of the changes we are making. We now have a live data set at CCG and STP level for physical health, mental health and CYP. These can be seen in Appendix 2.

9.2 The measures developed so far are mainly indicators of health; we are doing further work on potential social care metrics. Once the population health analytics work has progressed further we will be able to produce similar charts at locality level, that reflect local priorities.

9.3 We will use the previously developed “I statements” to measure integration successes as well as patient feedback/surveys and case studies to collate quality data.

9.4 There will be a need for the Alliance to determine what information it wants to have at local level for monitoring and planning purposes and what information will be publically available. (Some metrics will be slow to move and may only need to be reported annually or even less often).

9.5 Work to include more of the community contractual and quality indicators into the IQPR continues. It has been agreed to include the CiC measure into the IQPR from next month onwards.

9.6 The community contract transferred with an inherited group of measures and work has been completed jointly between service leads and the CCG to develop a new set of more meaningful data.

9.7 These new measures should start to be reported from January 2019 onwards and will be incorporated where relevant into the IQPR.

10.0 Conclusion

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

healthwatch Suffolk

Healthwatch Suffolk Community Development Officer visit to the Barrow Surgery and Neighbourhood Nursing and Care Team (Buurtzorg type trial)

11 September 2018
Report from Dan Pennock, Healthwatch Suffolk (HWS) Community Development Officer for West Suffolk

A. Meeting with nurses of Neighbourhood Nursing and Care Team (NNCT), Barrow. Theana Warden and two of her colleagues

The team has contact with Ashok Patnaik at HWS and The King's Fund (telephone interviews and focus group). Dan explained HWS's role/remit and that he had been tasked with getting the 'feeling in the area' around the project and what is happening with the team itself. Dan also explained that he would welcome feedback from anyone who had been cared for by them (unlikely as they are mostly housebound) or friends/family of those cared for.

Dan was directed to the local Women's Breakfast Club, Men's Breakfast Club and a Coffee Morning on the 20th of September 2018. Dan was promised the 'Barrow Pack' which is given to all who move to the village (this has subsequently arrived by email). Dan was told of the Homefirst role, medication control, focus on reablement and that their relationship with service users is a very personal one.

The NNCT consider that they provide much reassurance for carers in that they are qualified nurses and involved in more than one aspect of care. They consider that individuals (their service users) are much more likely to accept care/treatment (i.e. be compliant) than with other diverse community practitioners. They either walk or cycle to most of their appointments, they wear logo-ed shirts and are very visible around the village. They are well known and well regarded.

They are trying to put together a social event but are at the early stages. They promised Dan an invitation as and when it happens.

They vocalised frustrations around recruitment, their inability to ever provide the full timetable of work patterns, the boundary difficulties and that there had been no office to work out of in the early stages. IT was only made available four months in.

Dan asked if they enjoyed the role and it was an unequivocal '**yes**'.

B. Meeting with Rebecca Shelley, Practice Manager of Barrow Surgery (part of the Guildhall and Barrow Surgery)

Discussion was about the NNCT trial, its impacts on the surgery and 'thoughts' on the trial: Not confidential but 'sensitive'.

The NNCT are located upstairs in the surgery building so there is considerable interaction, both professional and social, between the two sets of staff. Dan saw this at first hand when one of the NNCT came into the kitchen, where he was meeting Rebecca. Whilst with Rebecca and Dan, the NNCT member invited Dan to visit the Team before he left.

Current status of the Team, as reported by Rebecca: six people in post, five female and one male, vacancies three. Recruitment of nurses is difficult for both the Practice and NNCT but the steadily decreasing length of contract (due to the nature of the trial) on offer is considered to be an extra barrier to recruitment into the Team. Operating times should be 8 till 8 Monday to Friday with Saturday and Sunday working. In reality this pattern has never been achieved because the Team has never been at full complement.

Generally, Rebecca thinks the trial works pretty well for the Practice. The location of NNCT upstairs makes for very good communication and there is always NNCT attendance at MDT meetings, which isn't/hasn't been the case for other community staff.

Identified benefits to the Practice:

i. Taking some of the home visit pressures off the doctors. This is quite significant as the Practice has 'named doctors' for patients and in the case of some more complex patients the doctors have been reticent to cede treatment to community services, but they are more prepared for NNCT to be involved.
ii. Referrals are easy because the Team are just upstairs, communication is more direct so those referring are more certain that the team 'get it' than with solely paper referrals.
iii. NNCT are actively promoting Care Navigation and slowly changing the culture from 'I need a doctor' to 'I need some help'.
iv. It is great for palliative care where the patient may still be mobile enough to leave the house, thus not being eligible for GP home visits; NNCT are available.
v. NNCT can visit and take bloods from those who cannot get to the hospital (physical or mental health barriers).

vi. They can carry out social care elements, which other community practitioners don't do.
vii. The Surgery is open (as a maximum) 8.30 till 6.30, five days a week; NNCT are available for longer.
viii. NNCT can pick up when carers are starting to struggle; this helps avoid the carer becoming unable to provide the family caring function.
ix. The home visit list goes first to NNCT and they pick up what they can help with and thus reduce demand for GP time.
x. Sometimes the Link worker flags up someone with mental health issues (and who are not under any mental health service) and NNCT can get involved. Example given was of an 18-year-old who doesn't qualify for a GP home visit but NNCT can become involved.

Identified drawbacks to the Practice:

i. What is the definition of a ‘social care need’? Barrow is (by and large) an affluent village and there is a slight feeling that this complicates the 'social care need' definition.
ii. Generally, the Practice feel they don't make enough referrals, but this is because there may be any number of 'perfect patients' for referral, albeit they are outside the defined ‘area’ (scope) for the trial. The GP makes calls as far away as Stanton and Great Barton. This is because there is significant patient 'cross over' between Guildhall in Bury and Barrow. Boundaries seem to be a frustration for the Practice and NNCT.
iii. District nurses may still be involved and HCA may still need to take bloods (not a full replacement to existing services).
iv. There are some patients with allocated GPs and those GPs don't want to change the existing historic referrals.
v. The doctors are VERY pro the trial but there is a considerable concern that if the trial doesn't continue, there will be a practical issue with the patients all coming back onto their books, with a significant loss of patient trust in the Practice as a whole. This is because the community sees NNCT as part of the Practice, set up due to their location.

C. NNCT tour of Barrow with Theana Warden

Following the meeting with NNCT, a Team member, Theana, kindly took Dan on a tour of Barrow. Theana showed Dan the location for the two breakfast clubs (The Estate Rooms), took Dan to the coffee shop at Barrow Hall Farm (called 'the Udder Room', because it used to be a cow shed), where the nurses were domiciled prior to getting premises.

Theana introduced Dan to the person who runs Barrow Hall Farm because the local Befriending Group meets there and the coffee shop is shortly going to run Meet up Mondays.

Case study: Theana told Dan of one of the people that she treats/cares for who has a dementia diagnosis. This local resident and patient concerned was housebound, but she said she would like a walk out for a coffee. Theana arranged to walk there with her. Theana also arranged for someone from the community to be available in a car in case the walk proved too much. It didn't, and the trip was a success and has become more regular. During one of the trips the patient expressed an interest in dogs. Theana has since arranged for Our Special Friends (OSF) to call and the patient now goes out with OSF and a dog and very much looks forward to their visits. The dog now has a bowl at her house and there are always treats. I'm told that the patient has grown enormously in confidence and is much happier generally.

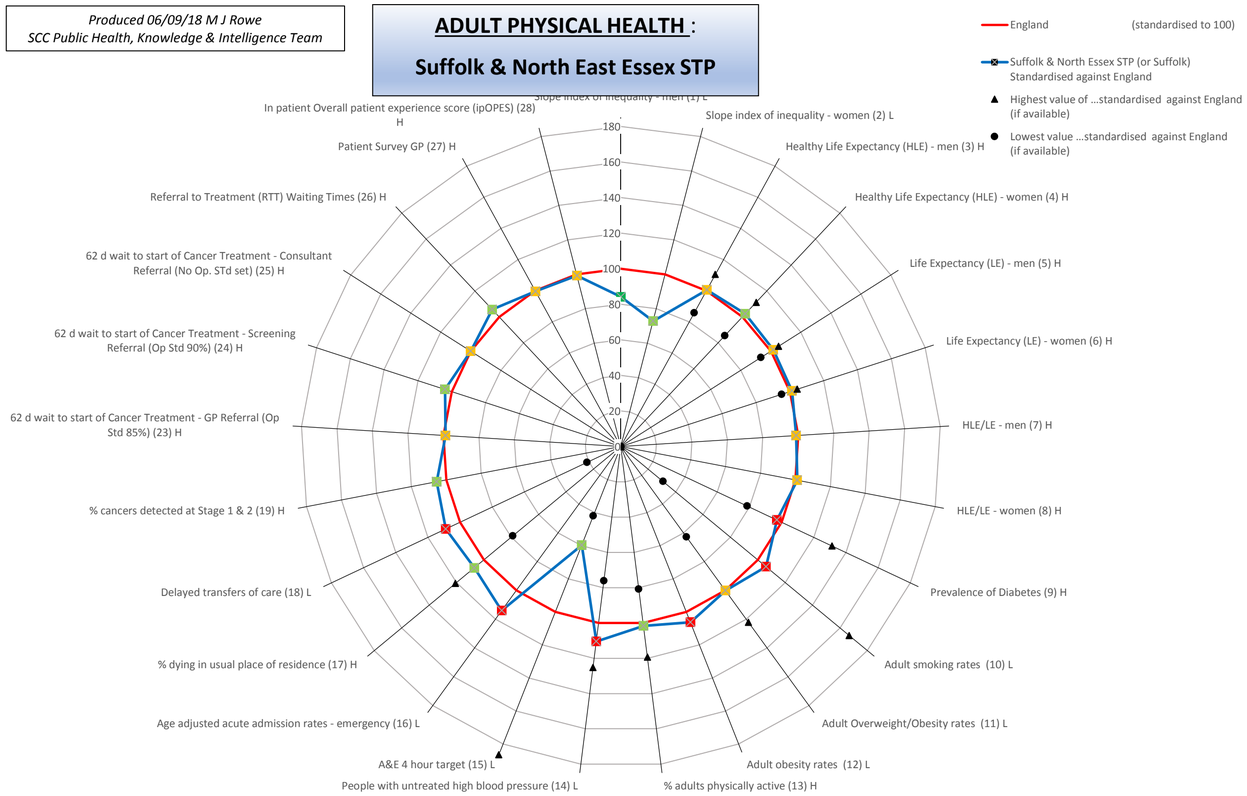
Theana introduced Dan to someone who does small cleaning jobs in the village. She told Dan that there is a village resident who isn't yet in need of NNCT assistance but that she had arranged for the cleaner to pop in and do a bit of cleaning and have a coffee with the person, which is much appreciated. The further benefit of this is that the cleaner 'keeps an eye' on the individual.

Dan believes that it may well only be Theana (of the Team) who goes this 'extra mile', because she lives in the village and is familiar with all the local people, but he was nevertheless impressed by what he saw and heard.

Produced 06/09/18 M J Rowe
SCC Public Health, Knowledge & Intelligence Team

ADULT PHYSICAL HEALTH :

Suffolk & North East Essex STP



Indicators plotted: H Highest is best; ***L*** Lowest is best

Representative STP value is.... .....as against England standardised to 100 — Good — Level — Poor

Compared Inequality in life expectancy at birth Yrs (2012-14) (1) Male (2) Female: Absolute gap in LE between most & least deprived quintiles (Suffolk)

Healthy Life Expectancy (HLE) (2015-16) – (Suffolk) Yrs (3) men
Highest value: Richmond Upon Thames
Lowest value: Manchester
(4) women
Highest value: Wokingham
Lowest value: Manchester

Life Expectancy at birth (LE) (2014-16) - (Suffolk) Yrs (5) men
Highest value: Kensington & Chelsea
Lowest value: Blackpool
(6) women
Highest value: Manchester
Lowest value: Camden

HLE/LE Ratio – (7) men (8) (women)

9) % *Prevalence of Diabetes (2016/17)*
Highest value: The Black Country STP
Lowest value: Hampshire & IoW STP

10) % *Smoking Prevalence in Adults - current smokers (APS) (2017)*
Highest value: Redditch (District)
Lowest value: Christchurch (District)

11) Percentage of adults (aged 18+) classified as overweight or obese (2016/17)
Highest value: Knowsley (District)
Lowest value: City of London (District)

12) % Obesity QOF prevalence (2016/17)
Highest value: NHS Durham Dales, Easington & Sedgefield CCG
Lowest value: NHS Richmond CCG

13) % adults physically active (2016/17)
Highest value: Exeter (District)
Lowest value: Barking & Dagenham (District)

14) % Hypertension: QOF prevalence (all ages) (2016/17)
Highest value: South West London STP
Lowest value: Norfolk & Waveney STP

15) % >4hrs from arrival @ A&E to admission, transfer or discharge (CCG figs are for the appropriate Hospital Trust for that CCG) (Qtr 4 2017/18)
Highest value: Shropshire, Telford & Wrekin STP
Lowest value: Somerset STP

16) Emergency admission for acute conditions that should not normally require hospitalisation per 100,000[1] (2016/17)

17) % dying in usual place of residence (DIUPR) (2016)
Highest value: Devon STP
Lowest value: South East London STP

18) Average daily delayed transfers of care (DToC) per 100,000 (2017/18)
Highest value: Cumbria LA
Lowest value: Barnsley LA (excluding OiSc at 0%)

19) % cancers detected at Stage 1 & 2 (2016)
Highest value: NHS Rushcliffe CCG
Lowest value: NHS Mansfield & Ashfield CCG

20) Under 75 mortality from cancer (2016)
Highest value: NHS Morecambe Bay CCG
Lowest value: NHS North Cumbria CCG

21) Under 75 mortality from cancer - Male (2016)
Highest value: NHS Morecambe Bay CCG
Lowest value: NHS Harrow CCG

22) Under 75 mortality from cancer - Female (2016)
Highest value: NHS Morecambe Bay CCG
Lowest value: *NHS West London CCG*

23) 62 days wait to start of Cancer Treatment - GP Referral (Op Std 85) (Qtr 1 18/19)
Highest value: NHS Canterbury & Coastal CCG
Lowest value: *NHS Richmond CCG*

24) 62 days wait to start of Cancer Treatment - Screening Referral
(Op Std 90%) (Qtr 1 18/19)
Highest value: > 30 CCGs at 100%
Lowest value: *NHS Swale CCG*

25) 62 days wait to start of Cancer Treatment - Consultant Referral
(No Op. Std set) (Qtr 1 18/19)
Highest value: > 20 CCGs
Lowest value: *NHS Newcastle Gateshead CCG*

26) Referral to Treatment (RTT) Waiting Times (26) (June 2018)
Highest value: NHS Rushcliffe CCG
Lowest value: *NHS North Lincolnshire CCG*

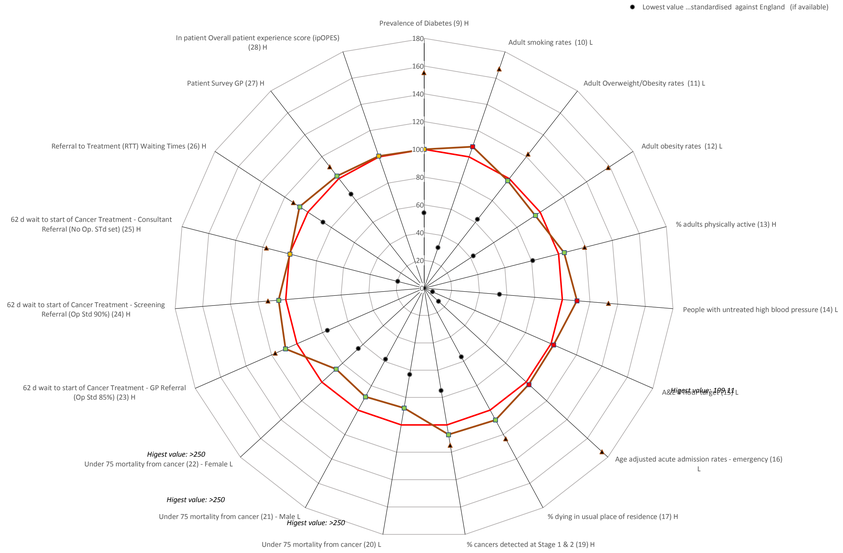
27) Patient Survey GP Overall experience % Good (very or fairly good) (2017-18)

28) In patient Overall patient experience score (ipOPES) (excl. maternity or psychiatric units) at least 1 night in hospital; for STP = average for the three hospitals (2017-18)

Produced 10/10/18 M J Rowe
SCC Public Health, Knowledge & Intelligence Team

ADULT PHYSICAL HEALTH :

West Suffolk CCG



Indicators plotted: H Highest is best; ***L*** Lowest is best

Representative CCG value is.... .....as against England standardised to 100 — Good — Level — Poor

Note: Indicators 1 to 8 and 18 were unavailable at CCG level

9) % *Prevalence of Diabetes (2016/17)*
Highest value: NHS Bradford City CCG
Lowest value: NHS Richmond CCG

10) % *Smoking Prevalence in Adults - current smokers (APS) (2017)*
Highest value: Redditch (District)
Lowest value: Christchurch (District)

11) Percentage of adults (aged 18+) classified as overweight or obese (2016/17)
Highest value: Knowsley (District)
Lowest value: City of London (District)

12) % Obesity QOF prevalence (2016/17)
Highest value: NHS Durham Dales, Eastington & Sedgefield CCG
Lowest value: NHS Richmond CCG

13) % adults physically active (2016/17)
Highest value: Exeter (District)
Lowest value: Barking & Dagenham (District)

14) % Hypertension: QOF prevalence (all ages) (2016/17)
Highest value: NHS West Norfolk CCG
Lowest value: NHS Tower Hamlets CCG

15) % >4hrs from arrival @ A&E to admission, transfer or discharge (CCG figs are for the appropriate Hospital Trust for that CCG) (Qtr 4 2017/18)
Highest value: Stockport NHS Trust
Lowest value: x76 NHS Trusts

16) Emergency admission for acute conditions that should not normally require hospitalisation per 100,000 [1] (2016/17)
Highest value: NHS Bradford City CCG
Lowest value: NHS Crawley CCG

17) % dying in usual place of residence (DiUPR) (2016)
Highest value: NHS South Devon & Torbay CCG
Lowest value: NHS Tower Hamlets

19) % cancers detected at Stage 1 & 2 (2016)
Highest value: NHS Rushcliffe CCG
Lowest value: NHS Mansfield & Ashfield CCG

20) Under 75 mortality from cancer (2016)
Highest value: NHS Morecambe Bay CCG
Lowest value: NHS North Cumbria CCG

21) Under 75 mortality from cancer - Male (2016)
Highest value: NHS Morecambe Bay CCG
Lowest value: NHS Harrow CCG

22) Under 75 mortality from cancer - Female (2016)
Highest value: NHS Morecambe Bay CCG
Lowest value: NHS West London CCG

23) 62 days wait to start of Cancer Treatment - GP Referral (Op Std 85) (Qtr 1 18/19)
Highest value: NHS Canterbury & Coastal CCG
Lowest value: NHS Richmond CCG

24) 62 days wait to start of Cancer Treatment - Screening Referral
(Op Std 90%) (Qtr 1 18/19)
Highest value: > 30 CCGs at 100%
Lowest value: NHS Swale CCG

25) 62 days wait to start of Cancer Treatment - Consultant Referral
(No Op. Std set) (Qtr 1 18/19)
Highest value: > 20 CCGs
Lowest value: NHS Newcastle Gateshead CCG

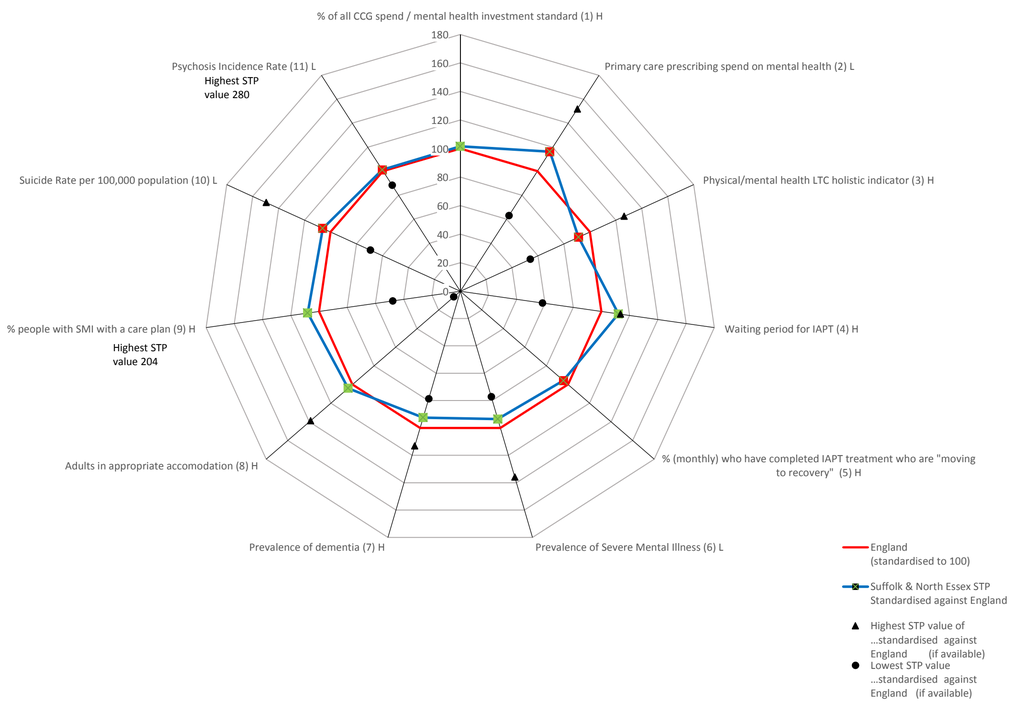
26) Referral to Treatment (RTT) Waiting Times (26) (June 2018)
Highest value: NHS Sheffield CCG
Lowest value: NHS North Lincolnshire CCG

27) Patient Survey GP Overall experience % Good (very or fairly good) (2017-18)
Highest value: NHS Hambleton, Richmondshire & Whitby CCG
Lowest value: NHS Bradford City CCG

28) In patient Overall patient experience score (ipOPES) (excl. maternity or psychiatric units) at least 1 night in hospital; for STP = average for the three hospitals (2017-18)

ADULT MENTAL HEALTH : Suffolk & North East Essex STP

Produced 10/09/18 M J Rowe
SCC Public Health, Knowledge & Intelligence Team



Indicators plotted: H Highest is best; **L** Lowest is best

STP value is ... Good Level Poor .as against England standardised to 100

1) *Mental Health 2016/17 actual spend as a proportion of overall CCG allocation*

2) *Cost of GP prescribing for psychoses and related disorders*
Highest value: Norfolk & Waveney STP
Lowest value: Surrey Heartlands STP

3) *People with SMI who have received the complete physical health check*
Highest value: Northumberland, Tyne and Wear and North Durham STP
Lowest value: Somerset STP

4) *% of referrals that have finished course of treatment waiting <6 weeks for first treatment*
Highest value: Coventry and Warwickshire STP
Lowest value: Leicester, Leicestershire & Rutland STP

5) *% (monthly) who have completed IAPT treatment who are "moving to recovery"*
Highest value: NHS Surry Heath CCG
Lowest value: NHS Wirral CCG

6) *Severe mental illness recorded prevalence (QOF):*
% of practice register (all ages)
Highest value: North Central London STP
Lowest value: Surrey Heartlands STP

7) *Prevalence of dementia (aged 65+)*
Highest value: North Central London STP
Lowest value: Cornwall & Isles of Scilly STP

8) *Stable and appropriate accommodation: % of people on CPA (aged 18-69) (end of quarter snapshot)*
Highest value: Derbyshire STP
Lowest value: Lancashire & Cumbria STP

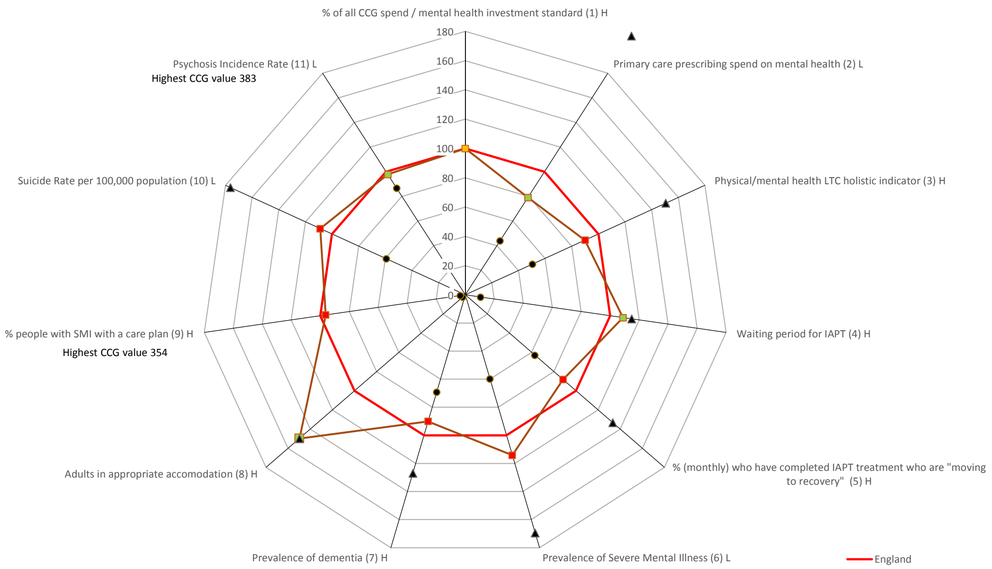
9) *People on Care Programme Approach (CPA)*
Suicide Rate per 100,000 population PHOF 4.10 10+yrs
Highest value: Greater Manchester STP
Lowest value: Hampshire & IoW STP

10) *AS mortality rate from suicide & injury of undetermined intent per 100,000 population*
Highest value: Cornwall & Isles of Scilly STP
Lowest value: Hertfordshire & West Essex STP

11) *New cases of psychosis, estimated incidence rate per 100,000 population age 16-64 yrs*
Highest value: North East London STP
Lowest value: Cornwall & Isles of Scilly STP

ADULT MENTAL HEALTH : West Suffolk CCG

Produced 10/10/18 M J Rowe
SCC Public Health, Knowledge & Intelligence Team



Indicators plotted: H Highest is best; L Lowest is best

CCG value is ... Good Level Poor .....as against England standardised to 100

1) *Mental Health 2016/17 actual spend as a proportion of overall CCG allocation*

2) *Cost of GP prescribing for psychoses and related disorders*
Highest value: NHS Norwich CCG
Lowest value: NHS Bracknell & Ascot CCG

3) *People with SMI who have received the complete physical health check*
Highest value: NHS Halton CCG
Lowest value: NHS Surrey Downs CCG

4) *% of referrals that have finished course of treatment waiting <6 weeks for first treatment*
Highest value: x24 CCGs
Lowest value: NHS Barnet CCG

5) *% (monthly) who have completed IAPT treatment who are "moving to recovery"*
Highest value: NHS Surrey Heath CCG
Lowest value: NHS Wirral CCG

Highest value: NHS Blackpool CCG
Lowest value: NHS Wokingham CCG CCG

7) *Prevalence of dementia (aged 65+)*
Highest value: NHS Salford CCG
Lowest value: NHS Medway CCG

8) *Stable and appropriate accommodation: % of people on CPA (aged 18-69) (end of quarter snapshot)*
Highest value: NHS West Suffolk CCG
Lowest value: NHS Isle of Wight CCG

9) *People on Care Programme Approach (CPA)*
Suicide Rate per 100,000 population PHOF 4.10
10+yrs
Highest value: NHS Bradford CCG
Lowest value: NHS Isle of Wight CCG

10) *AS mortality rate from suicide & injury of undetermined intent per 100,000 population*
Highest value: NHS North Durham CCG
Lowest value: NHS Wokingham CCG

11) *New cases of psychosis, estimated incidence rate*
6) *Severe mental illness recorded prevalence (QOF): % of practice register (all ages) per 100,000 population age 16-64 yrs*

England (standardised to 100)

West Suff CCG Standardised against England

▲ Highest CCG value ...standardised against England (if available)

NHS England and NHS Improvement Eastern

CHILDREN & YOUNG PEOPLE HEALTH

Suffolk & North East Essex CP

NHSE/I Eastern RAG ratings compared to 2019/20 Q4

Red = Worse than 2019/20 Q4 Amber = Not worse than 2019/20 Q4 but not improved Green = Improved

CYP 01 Mental ill health prevalence (mental health support teams)
Source: NHS Digital
Indicator: Prevalence of mental ill health
Source: NHS Digital Mental Health Dashboard
Region: Latest Monthly Data
Sub-region: Latest Monthly Data

CYP 02 Hospital admissions for self-harm in children and young people (5-17 years old)
Source: NHS Digital
Indicator: Hospital admissions for self-harm
Source: NHS Digital Hospital Episode Statistics
Region: Latest Quarterly Data
Sub-region: Latest Quarterly Data

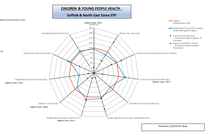
CYP 03 Hospital admissions for mental illness in children and young people (5-17 years old)
Source: NHS Digital
Indicator: Hospital admissions for mental illness
Source: NHS Digital Hospital Episode Statistics
Region: Latest Quarterly Data
Sub-region: Latest Quarterly Data

CYP 04 Eating disorders: Children and young people (0-18 years old)
Source: NHS England
Indicator: Eating disorders
Source: NHS England Mental Health Dashboard
Region: Latest Monthly Data
Sub-region: Latest Monthly Data

CYP 05 Children and young people's access to primary care services
Source: NHS England
Indicator: Access to primary care
Source: NHS England GP Survey
Region: Latest Quarterly Data
Sub-region: Latest Quarterly Data

CYP 06 Children and young people's access to secondary care services
Source: NHS England
Indicator: Access to secondary care
Source: NHS England GP Survey
Region: Latest Quarterly Data
Sub-region: Latest Quarterly Data

CYP 07 Children and young people's access to A&E services
Source: NHS England
Indicator: Access to A&E services
Source: NHS England GP Survey
Region: Latest Quarterly Data
Sub-region: Latest Quarterly Data



Indicator definitions and sources

Ofsted rating

1 - Outstanding 2 - Good 3 - Requires improvement 4 - Inadequate

No. of Ofsted inspections carried out in the previous

Ofsted rating of Youth Offending Service inspection

Ofsted rating of Youth Offending Service inspection

Ofsted rating of Children's Services inspection

Ofsted rating of Children's Services inspection

% of children in poverty (all children aged 0-19 living in families in receipt of benefits)

Source: Local Authority and HM Revenue and Customs

Rate per 10,000 children aged 0-17

Source: Local Authority

Rate per 10,000 children aged 0-17

Source: Local Authority

% of children who have been subject to a child protection plan for a second or subsequent time

Source: Local Authority

% of children who have been looked after continuously for at least 12 months who have had three or more placements

Source: Local Authority

% of children who have been looked after continuously for at least 12 months who have had their current placement for at least two years

Source: Local Authority

% of children who ceased being looked after who were adopted

Source: Local Authority

% of children who ceased being looked after who were aged 0-15 on their last day of care

Source: Local Authority

% of children who ceased being looked after who were aged 0-15 on their last day of care who were adopted

Source: Local Authority

% of children who ceased being looked after who were adopted

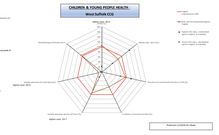
Source: Local Authority

Ofsted rating of Youth Offending Service inspection

Ofsted rating of Youth Offending Service inspection

CHILDREN & YOUNG PEOPLE HEALTH

West Suffolk CCG



Produced 21/03/2013 by Tower

9. Integrated quality and performance report

To ACCEPT the report

For Report

Presented by Rowan Procter and Helen Beck

NHS
West Suffolk
NHS Foundation Trust

Trust Board – October 2018

Agenda item:	9			
Presented by:	Rowan Procter, Executive Chief Nurse Helen Beck, Interim Chief Operating Officer			
Prepared by:	Rowan Procter, Executive Chief Nurse Helen Beck, Chief Operating Officer Joanna Rayner, Head of Performance and Efficiency			
Date prepared:	October 2018			
Subject:	Trust Integrated Quality & Performance Report			
Purpose:	x	For information		For approval
Executive summary:	The attached report provides an overview of the key performance measures for the Trust. A detailed section is included from page 17 onwards.			

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

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

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

Recommendation:
The Trust Board notes the monthly performance report.

1

Putting you first

NHS
West Suffolk
NHS Foundation Trust

Integrated quality and performance report

Month Six: September 2018

2

Putting you first

CONTENTS

EXECUTIVE SUMMARY

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

DETAILED SECTIONS

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1 EXECUTIVE SUMMARY

ARE WE SAFE?

Healthcare associated infections (HCAIs) – There were no MRSA bacteraemia cases in September and 1 case of hospital attributable clostridium difficile. The trust compliance with decolonization decreased in September 2018 to 86%. (Exception report included in the main report, pg 31).

CAS (Central Alerting System) Open (PSAs) – A total of 19 PSAs have been received in 2018/9, with 5 in September 2018. All the alerts have been implemented within timescale to date.

Patient Falls (All patients) - 64 patient falls occurred in September 2018. (*Exception report included in the main report, pg 23*)

Pressure Ulcers- The number of ward acquired pressure ulcers continues to be above the local trust plan of 5 per month. In September 2018, 14 cases occurred with a year to date total of 52. (*Exception report included in the main report, pg 26*)

ARE WE EFFECTIVE?

Cancelled Operations for non-clinical reasons - The rate of cancelled operations for non-clinical reasons was recorded at 1.2% in September 2018. (*Exception report included in the main report pg 40*).

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 90% in September 2018 compared to 91.9% in August 2018. (*Exception report included in the main report pg 41*).

Discharge Summaries- Performance to date, whilst below the 95% target to issue discharge summaries, is showing improvement (inpatients and ED). A&E has achieved a rate of 88.9% in September 2018 whereas inpatient services have achieved a rate of 83.0% (Non-Elective) and 72.0% (Elective.)

ARE WE CARING?

Mixed Sex Accommodation breaches (MSA) – 0 MSA breaches occurred in September 2018.

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

Complaints responded to in time – Note a change in process has resulted in significant positive improvement to Performance. The Quality has also seen positive improvement with second letters at zero for September. (*Exception report included in the main report, pg 47*).

ARE WE RESPONSIVE?

A&E 4 hour waits – September 2018 reported performance at 95.9% with an 11% year on year (Adjusted) increase in attendances. (*Exception report included in the main report, pg 51*).

Cancer – Cancer has experienced significant increases in demand in the last few months. The challenge of demand and capacity continues with two areas failing the target for September. These areas were 2 week wait for urgent GP referrals, with reported performance at 80.9% and Cancer 62 day GP referral with reported performance 77.4%. (*All figures are provisional and exception reports are included in the main report, pg 54-58*).

Referral to Treatment (RTT) - The percentage of patients on an incomplete pathway within 18 weeks for September was 89.89%. The total waiting list is at 18105 in September. In September 2 patients breached the 52 week standard. (*Exception report included in the main report, pg 52-53*).

ARE WE WELL LED?

Appraisal - The appraisal rate for September 2018 is 76.87%. (*Exception report included in the main report, pg 66*).

Sickness Absence – The sickness absence rate has risen this month to 3.86% (*Exception report included in the main report, pg 67*).

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			TRUST TOTAL													
Are we..	Ref.	KPI	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Av/YTD
1. Safe	1.01	CAS (Central Alerting System) Open	1	0	1	0	1	0	0	0	2	5	3	4	5	19
	1.02	CAS (Central Alerting System) Overdue	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	1.03	Emergency C-Section Rate	11.9%	11.2%	9.8%	10.6%	14.1%	10.1%	19.4%	16.4%	11.4%	10.6%	12.4%	9.2%	13.0%	12.2%
	1.04	All relevant inpatients undergoing a VTE Risk assessment	88.0%	94.8%	96.9%	94.7%	96.9%	97.6%	97.3%	98.2%	94.1%	95.1%	93.0%	93.7%	94.0%	94.7%
	1.05	Clostridium Difficile infection - Hospital Attributable	2	6	4	0	1	0	2	1	0	0	1	1	1	4
	1.06	MRSA Bacteraemias - Hospital Attributable	2	0	0	0	0	1	0	0	0	0	0	1	0	1
	1.07	Patient Safety Incidents Reported	467	520	588	479	627	553	535	486	579	465	469	521	488	3008
	1.08	Never Events	0	0	1	0	0	0	0	0	0	0	0	0	0	0
2.Effective	2.02	Canc. Ops - Cancellations for non-clinical reasons	1.0%	1.4%	1.9%	1.3%	0.8%	1.2%	0.9%	0.6%	0.8%	1.5%	1.8%	1.5%	1.2%	1.2%
3. Caring	3.01	Compliments (Logged by Patient Experience)	17	33	87	151	64	20	45	21	93	44	49	33	35	275
	3.02	Formal Complaints	16	17	13	8	12	19	9	13	13	11	20	9	10	76
	3.03	Mixed Sex Accommodation Breaches	0	0	0	1	0	0	1	0	0	1	0	0	0	1
	3.04	IP - Extremely likely or Likely to recommend (FFT)	98.3%	98.6%	96.0%	97.7%	97.1%	98.1%	98.0%	99.0%	99.0%	98.0%	99.0%	99.0%	99.0%	98.8%
	3.05	OP - Extremely likely or Likely to recommend (FFT)	96.0%	95.9%	96.0%	98.6%	95.1%	96.2%	95.0%	97.0%	97.0%	97.0%	97.0%	98.0%	96.0%	97.0%
	3.06	A&E - Extremely likely or Likely to recommend (FFT)	92.3%	94.9%	94.0%	94.0%	96.4%	94.9%	94.0%	94.0%	93.0%	94.0%	96.0%	95.0%	97.0%	94.8%
	3.07	Maternity - Extremely likely or likely to recommend (FFT)	ND	98.8%	100%	97.3%	100%	93.0%	100%	98.0%	99.4%	96.7%	100%	95.0%	92.0%	96.9%
	3.08	Community - Extremely likely or likely to recommend	ND	97.3%	100%	95.7%	95.2%	97.4%	96.0%	94.0%	98.0%	97.0%	90.0%	98.0%	95.0%	95.3%
4. Responsive	4.01	A&E under 4 hr. wait	88.9%	87.4%	90.4%	83.3%	83.8%	85.2%	85.4%	84.9%	93.7%	93.9%	89.0%	88%	95.9%	90.8%
	4.02	RTT: % incomplete pathways within 18 weeks	85.7%	87.0%	88.9%	89.0%	90.2%	89.6%	89.5%	90.4%	92.2%	91.4%	91.4%	89.3%	89.9%	90.8%
	4.03	52 week waiters	29	26	21	15	14	13	24	19	14	10	9	10	2	64
	4.04	Diagnostics within 6 weeks	100%	100%	100%	100%	100%	100%	99%	100%	100%	100%	99.9%	97.6%	99.5%	99.3%
	4.05	Cancer: 2w wait for urgent GP Referrals	91.4%	83.4%	97.9%	97.2%	98.0%	97.5%	94.7%	95.9%	94.9%	91.6%	97.6%	89.5%	80.9%	91.7%
	4.06	Cancer 2w wait breast symptoms	98.3%	100%	100%	99.1%	97.1%	92.9%	86.7%	96.7%	82.6%	84.9%	92.8%	95.9%	93.9%	91.1%
	4.07	Cancer 31 d First Treatment	100%	100%	99%	100%	100%	100%	100%	99.1%	100%	100%	100%	100%	96.9%	99.3%
	4.08	Cancer 31 d Drug Treatment	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.09	Cancer 31 d Surgery	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	4.10	Cancer 62 d GP referral	86.9%	93.9%	89.5%	87.1%	86.6%	79.8%	87.8%	93.3%	85.1%	86.5%	83.4%	88.4%	77.4%	85.7%
	4.11	Cancer 62 d Screening	90.9%	100%	83.3%	100%	93.3%	85.7%	95.5%	72.7%	100%	100%	88.2%	100%	90.5%	91.9%
	4.12	Incomplete 104 day waits	ND	ND	ND	ND	ND	ND	ND	3	1.5	0	1.0	3.0	2.0	10.5

INTEGRATED QUALITY & PERFORMANCE REPORT			TRUST TOTAL													
Are we..	Ref.	KPI	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Av/YTD
5. Well Led	5.01	NHS Staff Survey (Staff Engagement score -Annual)	NA	NA	NA	NA	NA	4.0%	NA	NA	NA	NA	NA	NA	NA	NA
	5.02	Staff F&F Test % Recommended - care (Qrtly)	95.0%	NA	NA	ND	NA	NA	ND	NA	NA	95.0%	NA	95.0%	NA	95%
	5.03	Staff F&F Test % Recommended - place to work (Qrtly)	82.0%	NA	NA	ND	NA	NA	ND	NA	NA	83.0%	NA	82.0%	NA	83%
	5.04	Turnover (Rolling 12 mths)	9.8%	9.0%	9.1%	9.3%	9.3%	8.7%	8.8%	8.4%	8.4%	8.5%	8.6%	8.6%	8.7%	8.5%
	5.05	Sickness Absence	3.5%	3.6%	3.5%	3.5%	3.6%	3.7%	3.7%	3.8%	3.8%	3.7%	3.8%	3.8%	3.90%	3.8%
	5.06	Executive Team Turnover (Trust Management)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	5.07	Agency Spend	150	82	213	245	353	306	373	276	188	330	323	471	521	352
	5.08	Monitor Use of Resources Rating	3	3	3	3	3	3	3	3	3	3	3	3	3	3
6. Productive	6.01	I&E Margin	-3.0%	-2.6%	-2.5%	-2.6%	-2.3%	-2.6%	20.0%	-10.3%	-7.5%	-6.3%	-7.30%	-6.80%	-7.20%	-7.57%
	6.03	Capital service cover	-0.88	-0.32	0.52	0.24	0.38	0.07	0.68	0.48	1.64	-0.80	-0.93	0.87	- 0.92	0.06
	6.04	Liquidity (days)	-12.70	-15.14	9.64	11.39	6.06	6.84	7.86	12.34	16.83	15.36	16.67	14.36	19.19	15.79
	6.05	Long Term Borrowing (£m)	47.6	47.6	56.7	58.7	64.4	64.1	65.4	67.6	69.8	69.0	70.7	74.2	75.3	68.8
	6.06	CIP (Variance YTD £'000s)CIP (Variance YTD £'000s)	-54	-10	-74	-22	-419	-469	-539	-54	-47	-75	-100	-120	-38	-72.3
7.Maternity	7.01	Total number of deliveries (births)	236	205	194	180	199	211	206	198	203	201	172	208	208	1190
	7.02	% of all caesarean sections	18.2%	17.1%	17.0%	18.3%	22.1%	17.1%	30.1%	28.2%	22.4%	18.2%	17.1%	17.0%	22.8%	21.0%
	7.03	Midwife to birth ratio	1.33	1.29	1.28	1.26	1.28	1.29	1.29	1.30	1.30	1.30	1.30	1.30	1.30	1.30
	7.04	Unit Closures	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.05	Completion of WHO checklist	98.0%	98.0%	98.0%	93.0%	93.0%	94.0%	97.0%	86.0%	85.0%	88.0%	94.0%	95.0%	93.0%	90.2%
	7.06	Maternity SIs	1	1	0	1	2	0	1	2	2	0	1	0	0	5
	7.07	Maternity Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	7.08	Breastfeeding Initiation Rates	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	79.0%	76.1%	76.3%	80.7%	85.1%	76.2%	80.2%	79.1%
8. Community	1.32	No of avoidable serious injuries or deaths from falls - Community	0	0	1	0	0	0	0	0	0	0	0	0	0	0
	4.27	RTT 18 weeks Non-Consultant led services - Community	99.4%	93.7%	94.4%	98.4%	98.7%	100%	99.4%	99.2%	97.6%	100%	98.7%	99.0%	99.0%	98.9%
	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community	NA	NA	NA	NA	NA	NA	NA	100%	100%	100%	100%	100%	ND	100%
	4.40	Nursing & therapy Red referrals seen within 4hrs - Community	100%	NA	NA	100%	100%	96.4%	100%	96.4%	100%	100%	98.2%	100%	100%	99.1%
	4.41	Nursing & therapy Amber referrals seen within 72hrs - Community	98.6%	90.9%	96.9%	100%	99.3%	98.0%	97.6%	98.8%	99.4%	99.5%	97.4%	99.4%	99.5%	99.0%
	5.55	Safeguarding Children Mandatory Compliance (Community)	96.8%	95.3%	96.1%	96.0%	95.9%	95.7%	97.0%	98.2%	95.8%	95.3%	94.7%	95.1%	96.2%	95.9%
	5.56	Safeguarding Adults Mandatory Training Compliance (Community)	96.1%	94.3%	95.3%	94.0%	94.1%	93.2%	95.6%	96.0%	95.0%	94.9%	94.3%	94.9%	97.0%	95.4%

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3. IN THIS MONTH – SEPTEMBER 2018, MONTH 6

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

From Month Year	Sep-2018

To Month Year	Sep-2017

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

In this month.... September 2018

Mth We Received.....	Sep-18	Sep-17	Variance	Var. %	Traffic
GP Referrals	5,846	5,697	149	2.6%	⇧
Other Referrals	4,418	4,910	-492	-10.0%	⇩
Ambulance Arrivals	1,678	1,743	-65	-3.7%	⇩
Cancer Referrals*	968	968	0	0.0%	⇨
Urgent Referrals*	2,451	2,378	73	3.1%	⇧

YTD We Received.....	2018	2017	Variance	Var. %	Traffic
GP Referrals	37,761	36,477	1,284	3.5%	⇧
Other Referrals	30,786	30,610	176	0.6%	⇧
Ambulance Arrivals	10,560	10,426	134	1.3%	⇧
Cancer Referrals*	6,299	5,704	595	10.4%	⇧
Urgent Referrals*	15,835	15,002	833	5.6%	⇧

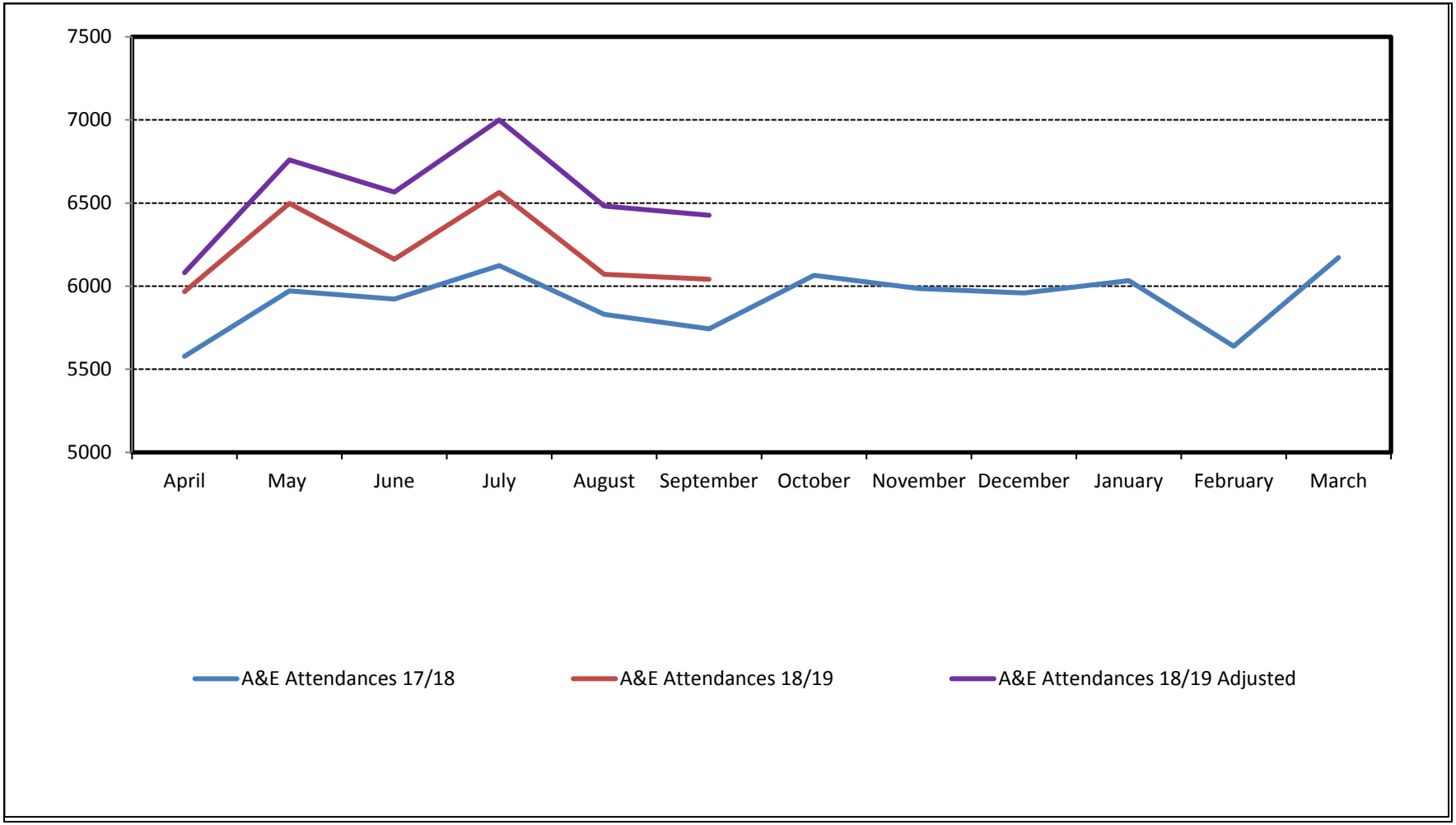
Mth We Delivered.....	Sep-18	Sep-17	Variance	Var. %	Traffic
A&E Attendances	6,042	5,743	299	5.2%	⇧
GP Expected	384	0	384		
**ED Attendances(Adjusted)	6,426	5,743	683	11.9%	⇧
A&E - To IP Admission Ratio	28.3%	30.5%	-2.2%	-2.2%	⇩
Outpatient Attendances	23,392	23,879	-487	-2.0%	⇩
Inpatient Admissions	5,743	5,727	16	0.3%	⇧
Inpatient Discharges	5,718	5,742	-24	-0.4%	⇩
New Births	208	236	-28	-11.9%	⇩
RTT Total Incompletes	18,105	17,236	869	5.0%	⇧

YTD We Delivered.....	2018	2017	Variance	Var. %	Traffic
A&E Attendances	37,304	35,169	2,135	6.1%	⇧
A&E Adjusted Attendances	39,314	35,169	4,145	11.8%	⇧
Outpatient Attendances	141,441	146,052	-4,611	-3.2%	⇩
Inpatient Admissions	34,985	34,001	984	2.9%	⇧
Inpatient Discharges	35,005	34,014	991	2.9%	⇧
New Births	1,190	1,304	-114	-8.7%	⇩

** - Included in Referrals Above

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

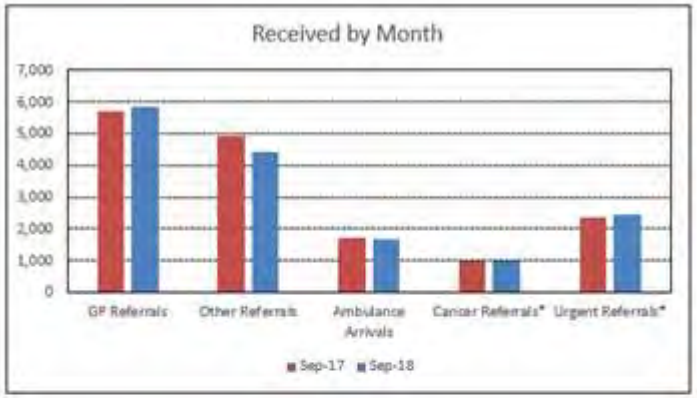
A&E Attendances Year chart (Adjusted)

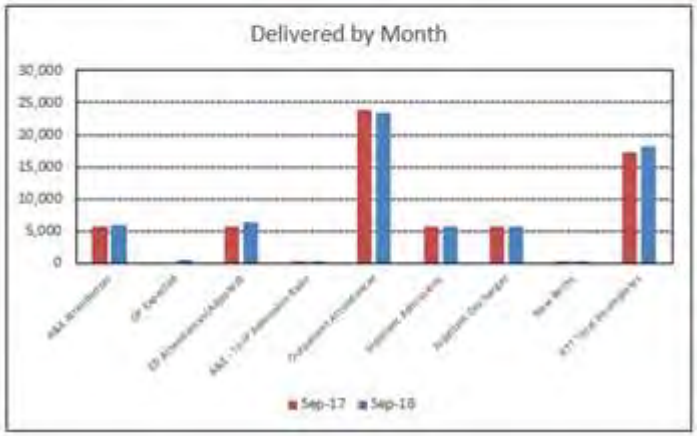


10

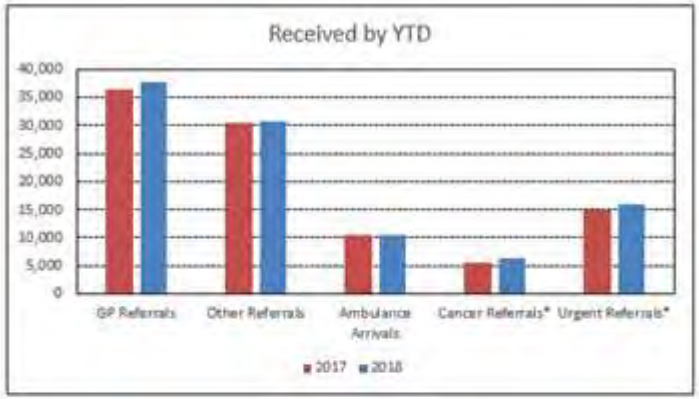
GP and other referrals demonstrate a reduction year on year however cancer referrals are showing signs of increasing. A&E attendances continue to show an increase and incomplete RTT pathways are higher than last year.

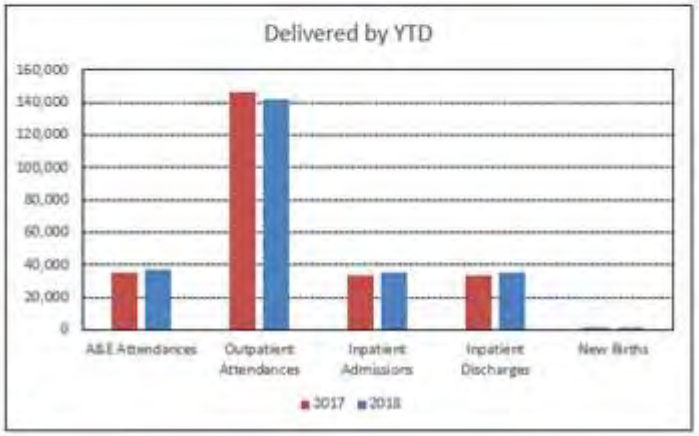
MONTHLY





YEAR TO DATE





DETAILED REPORTS

4. DETAILED SECTIONS – SAFE

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

Are we.		Ref.	KPI	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD(Apr18-Mar19
Safe	HII Compliance	1.09	HII Compliance 1a: Central venous catheter insertion	100%	94.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.10	HII Compliance 1b: Central venous catheter on-going care	100%	100%	100%	100%	100%	100%	100%	100%	100%	95.0%	100%	91.0%	97.0%	95.0%	96.3%
		1.11	HII Compliance 2a: Peripheral cannula insertion	100%	100%	98.0%	97.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.12	HII Compliance 2b: Peripheral cannula on-going	100%	99.0%	99.0%	97.0%	96.0%	99.0%	100%	100%	100%	98.0%	97.0%	98.0%	96.0%	88.0%	96.2%
		1.13	HII Compliance 4a: Preventing surgical site infection preoperative	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.14	HII Compliance 4b: Preventing surgical site infection perioperative	100%	100%	100%	100%	100%	100%	95.0%	100%	100%	100%	100%	100%	100%	100%	100%
		1.15	HII Compliance 5: Ventilator associated pneumonia	100%	100%	100%	78.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	ND	100%
		1.16	HII Compliance 6a: Urinary catheter insertion	100%	100%	78.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		1.17	HII Compliance 6b: Urinary catheter on-going care	100%	97.0%	91.0%	92.0%	95.0%	100%	99.0%	97.0%	100%	95.0%	92.0%	97.0%	97.7%	89.0%	95.1%
	Incidents	1.18	Safety Thermometer: % of patients experiencing new harm-free care-Trust	100%	97.2%	97.6%	98.4%	98.5%	97.9%	97.7%	98.5%	99.2%	97.8%	98.7%	99.2%	88.0%	97.8%	96.8%
		1.19	Safety Thermometer: % of patients experiencing new harm-free care - Community	100%	NA	NA	NA	NA	NA	NA	NA	99.4%	98.1%	99.0%	99.3%	99.1%	97.7%	98.8%
		1.20	No of SIRIs	NT	5	11	14	10	20	11	6	8	11	0	5	6	2	32
		1.21	RIDDOR Reportable Incidents	NT	0	2	0	3	0	2	1	2	4	1	1	1	0	9
		1.22	Total No of E. Coli (Trust level only)	NT	2	1	2	2	2	1	3	1	2	0	1	0	0	4
		1.23	No of Inpatient falls - Trust		44	56	73	69	76	82	72	68	72	62	42	75	64	383
		1.24	No of Inpatient falls - WSH	<48	39	47	56	60	68	74	64	55	61	50	31	63	55	315
		1.25	No of Inpatient falls - Community Hospitals		5	9	17	9	8	8	8	13	11	12	11	12	9	68
		1.26	Falls per 1,000 bed days		3.73	3.93	4.97	5.15	5.56	6.52	5.17	6.13	6.76	4.84	2.82	5.70	5.27	5.25
		1.27	No of Inpatient falls resulting in harm - Trust	NT	10	23	18	23	28	26	20	24	24	22	13	24	12	119
		1.28	No of Inpatient falls resulting in harm - WSH	NT	10	19	15	19	27	25	19	18	19	22	11	20	12	102
		1.29	No of Inpatient falls resulting in harm - Community Hospitals	NT	0	4	3	4	1	1	1	6	5	0	2	4	0	17
		1.30	No of avoidable serious injuries or deaths resulting from falls - Trust	0	0	0	1	0	0	1	0	ND	0	0	0	ND	ND	0
		1.31	No of avoidable serious injuries or deaths resulting from falls - WSH	0	0	0	0	0	0	1	0	ND	0	0	0	ND	ND	0
		1.32	No of avoidable serious injuries or deaths from falls - Community	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0
		1.33	Number of medication errors	NT	69	70	78	63	72	49	76	60	85	43	56	61	63	368
		1.34	No of ward acquired pressure ulcers	NT	14	18	17	12	30	15	9	4	9	9	6	10	14	52
		1.35	No of Community 'In our Care' pressure ulcers	NT	NA	13	14	6	24	15	14	12	19	16	13	20	10	90
		1.36	% of patients with avoidable ward acquired pressure ulcers YTD	<30%	33.0%	32.0%	28.0%	28.0%	29.0%	28.0%	29.0%	29.3%	28.0%	28.0%	29.0%	30.0%	ND	28.9%
		1.37	% of patients with avoidable Community 'In our Care' pressure ulcers		ND	54.0%	56.0%	55.0%	50.0%	47.0%	46.0%	43.0%	ND	ND	ND	ND	ND	43.0%
		1.60	% of patients at risk of falls (with a Falls assessment)		74.1%	73.2%	71.7%	74.3%	73.8%	71.1%	71.7%	71.1%	71.6%	72.2%	74.6%	72.8%	72.0%	72.4%

Are we.			Ref.	KPI	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD(Apr18-Mar19
		Reporting	1.38	MRSA Quarterly Std (including admission and LOS screens)	90%	93.0%	NA	NA	90.0%	NA	NA	92.0%	NA	NA	88.0%	NA	NA	87.0%	87.5%
			1.39	MRSA Bacteraemias - Community Attributable	0	ND	0	0	0	0	0	1	0	0	0	0	0	0	0
			1.40	Clostridium Difficile infection - Community Attributable		1	1	0	0	0	0	2	0	0	1	0	0	0	1
			1.41	MRSA - Decolonisation	95%	91.0%	98.0%	85.0%	91.0%	94.0%	86.0%	95.0%	85.0%	91.0%	90.0%	81.0%	97.0%	86.0%	88.3%
			1.42	MRSA - RCA Reports	NA	0	0	0	0	0	0	0	0	0	0	0	0	0	0
			1.43	MSSA (Hospital)	NT	1	0	1	1	1	0	0	0	2	2	0	0	0	4
			1.44	SIRI final reports due in month submitted beyond 60 working days	0	4	5	4	0	0	1	3	3	3	0	1	0	0	7
			1.45	SIRIs reported >2 working days from identification as red	0	2	3	6	5	7	3	ND	0	1	0	0	0	0	1
			1.46	Green, Amber & Red Active / Accepted risk assessments not in date	0	1	5	0	2	1	4	0	1	3	2	0	3	0	9
			1.47	Datix Risk Register Red / Amber actions overdue	0	0	0	0	0	0	1	3	1	4	3	0	0	0	8
			1.48	Rapid access chest pain clinic access within 2 wks.	100%	97.5%	96.3%	100%	100%	100%	100%	99.1%	57.5%	97.3%	97.3%	96.2%	96.7%	98.6%	90.6%
			1.49	Verbal Duty of Candour outstanding at month-end	0%	0	1	2	0	2	2	1	1	1	2	2	0	0	6
			1.50	Hand Hygiene Audits	95%	98.0%	99.0%	99.0%	99.0%	99.0%	100%	100%	100%	99.0%	99.0%	99.0%	100%	100%	99.5%
			1.51	Quarterly antibiotic audit	98%	93.8%	NA	NA	93.0%	NA	NA	89.0%	NA	NA	92.2%	NA	NA	89.0%	90.6%
			1.52	Serious Incident RCA actions beyond deadline for completion	0	7	2	9	14	9	8	4	9	4	4	7	4	2	30
			1.53	% of Green Patient Safety incidents investigated	NT	58.0%	67.0%	56.0%	55.0%	59.0%	74.0%	68.0%	68.0%	64.0%	61.0%	68.0%	59.0%	63.0%	65.3%
			1.54	Quarterly Environment/Isolation	90%	92.0%	NA	NA	92.0%	NA	NA	91.0%	NA	NA	92.0%	NA	NA	93.0%	92.5%
			1.55	Quarterly VIP score documentation	90%	80.0%	NA	NA	87.0%	NA	NA	80.0%	NA	NA	86.0%	NA	NA	83.0%	84.5%
			1.56	Isolation data (Trust Level only)	95%	88.0%	90.0%	88.0%	88.0%	90.0%	90.0%	89.0%	86.0%	88.0%	87.0%	88.0%	91.0%	91.0%	88.5%
			1.57	Pain Mgt. Quarterly internal report	80%	NA	61.3%	NA	NA	58.8%	NA	NA	NA	NA	NA	86.0%	NA	NA	86.0%
			1.58	Nutrition Risk Assessment	95%	90.0%	89.0%	87.0%	93.0%	92.0%	89.0%	90.0%	90.0%	93.0%	88.0%	91.0%	88.0%	96.0%	91.0%
			1.59	Median NRLS (national reporting & Learning system) upload 6 month rolling average (No. of days)	41	55	48	61	66	75	65	63	26	31	60	59	51	40	45
			1.61	E coli - Hospital Attributable		2	1	2	2	2	1	3	1	2	2	1	1	1	7
			1.62	E coli - Community Attributable		15	12	17	14	7	10	7	14	19	14	13	15	13	75
			1.63	Klebsiella spp. - Hospital Attributable		0	0	1	0	0	0	0	1	0	0	2	0	0	3
			1.64	Klebsiella spp. - Community Attributable		1	1	3	2	2	0	3	4	1	0	3	2	3	23
			1.65	Pseudomonas - Hospital Attributable		0	0	0	0	0	1	0	0	0	0	0	1	0	0
			1.66	Pseudomonas - Community Attributable		1	1	0	0	5	0	1	1	1	0	0	0	1	2

SAFE – DIVISIONAL LEVEL ANALYSIS

Indicator	July			August			September		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
HII compliance 1a: Central venous catheter insertion	100	100		100	100		100	100	
HII compliance 1b: Central venous catheter ongoing care	100	89		100	92		100	92	
HII compliance 2a: Peripheral cannula insertion	100	100	100	100	100	100	100	100	100
HII compliance 2b: Peripheral cannula ongoing	100	100	100	100	94	100	100	81	100
HII compliance 4a: Preventing surgical site infection preoperative	100			100			100		
HII compliance 4b: Preventing surgical site infection perioperative	100			100			100		
HII compliance 5: Ventilator associated pneumonia	100			100			100		
HII compliance 6a: Urinary catheter insertion	100	100		100	100		100	100	
HII compliance 6b: Urinary catheter on-going care	100	96		100	95		100	85	
HII compliance 7: Clostridium Difficile- prevention of spread									
Total no of MRSA bacteraemias: Hospital	0	0	0	0	0	0	0	0	0
Quarterly MRSA (including admission and length of stay screens)							97	76	89
Hand hygiene compliance	99	99	100	100	100	100	100	100	100
Total no of MSSA bacteraemias: Hospital	0	0	0	0	0	0	0	0	0
Total no of C. diff infections: Hospital	1	0	0	0	1	0	0	1	0
Quarterly Antibiotic Audit							86	90	100
Quarterly Environment/Isolation							94	92	94
Quarterly VIP score documentation							81	84	89

Indicator	July			August			September		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
No of Inpatient falls	4	28	0	10	53	0	9	48	0
No of Inpatient falls resulting in harm	1	10	0	3	18	0	2	17	0
No of avoidable serious injuries or deaths resulting from falls	0	0	0	0	0	0	0	0	0
No of ward acquired pressure ulcers	1	6	0	3	7	0	4	10	0
Nutrition: Assessment and monitoring	100.0	89.0	85.0	100.0	82.0	90.0	97.0	96.0	93.0
No of SIRIs	0	2	0	1	4	1	0	1	0
No of medication errors	14	32	3	8	34	8	18	30	8
Cardiac arrests	0	7	0	0	5	0			
Cardiac arrests identified as a SIRI	0	0	0	0	0	0	0	0	0
Pain Management: Quarterly internal report	84.7	90.4	40.3						
VTE: Completed risk assessment (monthly Unify audit)	93.3	92.4	97.7	93.4	93.6	100.0	94.6	93.3	97.7
Quarterly VTE: Prophylaxis compliance									
Safety Thermometer: % of patients experiencing new harm-free care	100.0	98.9	100.0	99.4	99.4	100.0	98.0	97.6	100.0

Indicator	July			August			September		
	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children	Surgery	Medicine	Women & Children
Patient Satisfaction: In-patient overall result	98.0	95.0	98.0	96.0	94.0	96.0	98.0	96.0	99.0
How likely are you to recommend our ward to friends and family if they needed similar care or treatment?	99.0	98.0	95.0	99.0	99.0	100.0	99.0	98.0	100.0
In your opinion, how clean was the hospital room or ward that you were in?	99.0	98.0	98.0	97.0	95.0	97.0	99.0	96.0	100.0
Did you feel you were treated with respect and dignity by staff	100.0	99.0	99.0	100.0	99.0	100.0	100.0	99.0	100.0
Were staff caring and compassionate in their approach?	99.0	99.0	99.0	99.0	98.0	100.0	100.0	100.0	100.0
Did you experience any noise in the night time that you think could have been avoided?	91.0	88.0	98.0	87.0	89.0	87.0	90.0	84.0	100.0
Did you find someone in the hospital staff to talk about your worries and fears?	100.0	96.0	100.0	98.0	99.0	94.0	99.0	97.0	100.0
Were you involved as much as you wanted to be in decisions about your care and treatment?	98.0	93.0	93.0	96.0	93.0	93.0	99.0	94.0	94.0
Did staff talk in front of you as if you were not there?	100.0	96.0	98.0	100.0	95.0	98.0	99.0	97.0	94.0
Were you given enough privacy when discussing your condition or treatment?	100.0	97.0	98.0	100.0	99.0	100.0	100.0	99.0	100.0
Were you given enough privacy when being examined or treated?	100.0	100.0	100.0	100.0	99.0	100.0	100.0	100.0	100.0
Did you get enough help from staff to eat your meals?	98.0	99.0	100.0	97.0	94.0	83.0	98.0	95.0	100.0
How many minutes after you used the call button did it usually take before you got the help you needed?	88.0	83.0	100.0	83.0	74.0	95.0	86.0	87.0	100.0
Number of Inpatient surveys completed	259	221	43	252	177	23	236	198	9
Same sex accommodation: total patients	0	0	0	0	0	0	0	0	0
Complaints	6	7	3	2	5	2	1	4	1
Environment and Cleanliness	93.9	93.2	95.8	93.3	92.8	95.6	93.2	93.2	94.6

5. Exception reports – Safe

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

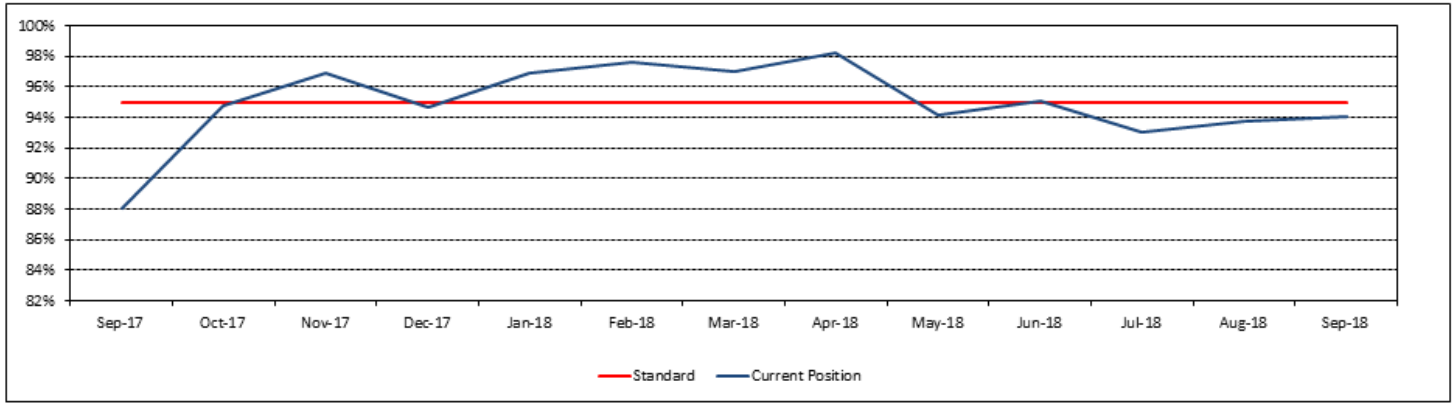
Indicator	All relevant inpatients undergoing a VTE Risk assessment
Standard	95%
Name	Margaret Moody
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Pre Ecare, the day surgical patients (DSU) had a cohort assessment as low risk. Over the last few years the complexity of procedures on DSU has greatly increased. It was agreed in the Spring of 2018 with the clinical director for surgery that the surgical patients on Day Surgery Unit should have an individual assessment. This is still 'bedding in' accounting for the recent dip in performance.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	88.0%	94.8%	96.9%	94.7%	96.9%	97.6%	97.0%	98.2%	94.1%	95.1%	93.0%	93.7%	94.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To improve the percentage of patients in DSU who have an assessment. Continued liaison between information and the thrombosis committee regarding reporting. Continued liaison between the thrombosis committee and the surgical directorate regarding clinical performance. Identifiaction of individual teams where performance is low and more detailed analysis and performance review is needed.	Margaret Moody	Nov-18	Mar-19



18

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	HII Compliance
Standard	100%
Name	Rowan Procter
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

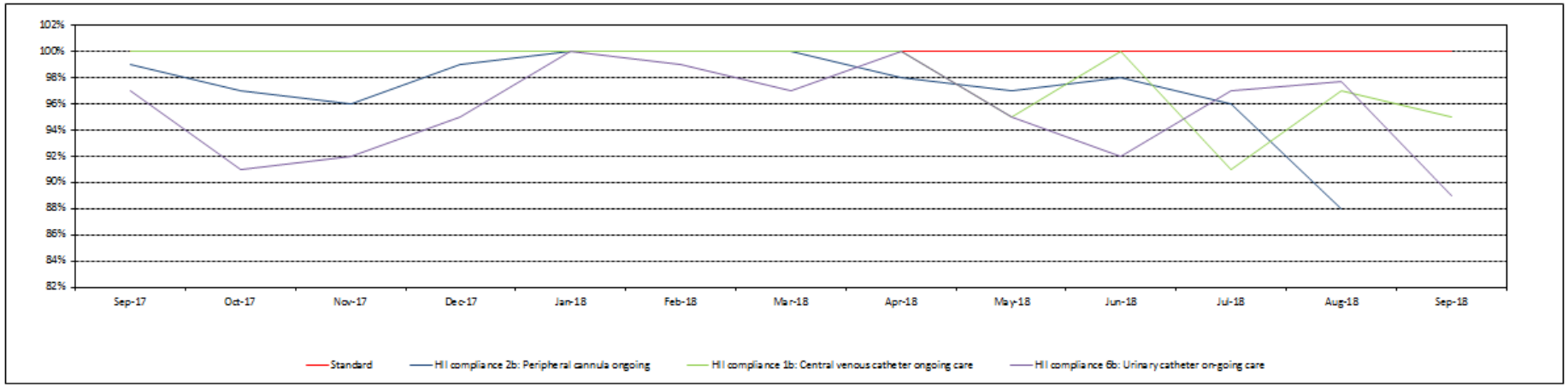
1b: There has been a slight dip in performance in the ongoing care of central venous catheters in September, with a failing in one single ward area. Within this area one patient had a central venous catheter insitu with one element of documentation regarding continuing clinical indication not recorded every shift. The Senior Matron has discussed the documentation elements with the ward staff with an expectation of improvement. All other wards and departments are achieving 100% in this audit

2b: Failings were due to a lack of documentation providing an indication for the continued use of the cannula. The majority of clinical areas have seen an improvement in recording ongoing care. The Matrons and Infection Prevention team continue to monitor compliance and provide support and education to improve care and documentation with this element.

6b: Performance, this month, for the ongoing care of urinary catheters has worsened, with two clinical areas failing in the audit as a result of poor compliance with documenting evidence that the care had been performed. The Senior Matron is providing staff education and support to ensure there are improvements in documentation and evidence of appropriate care delivery. All other wards and departments are achieving 100% in this audit and a clinical area which has recently had poor compliance with this element has also achieved 100% this month.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
HII compliance 1b: Central venous catheter ongoing care	100%	100%	100%	100%	100%	100%	100%	100%	95.0%	100%	91.0%	97.0%	95.0%
HII compliance 2b: Peripheral cannula ongoing	99.0%	99.0%	97.0%	96.0%	99.0%	100%	100%	100%	98.0%	97.0%	98.0%	96.0%	88.0%
HII compliance 6b: Urinary catheter on-going care	97.0%	91.0%	92.0%	95.0%	100%	99.0%	97.0%	100%	95.0%	92.0%	97.0%	97.7%	89.0%

Actions in place to recover the performance		Expected timeframes for improvements	
Description	Owner	Start	End
Pilot on ward to improve the care and documentation of urinary catheters	Infection prevention team	Aug-18	Nov-18
Continue to monitor	Head of Nursing/Matron	Complete	



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Safety Thermometer - Harm-Free Care (New Harms)
Standard	95%
Name	Rowan Proctor
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

The National 'harm free' care composite measure is defined as the proportion of patients without a pressure ulcer (ANY origin, category II-IV), harm from a fall in the last 72 hours, a urinary tract infection (in patients with a urethral urinary catheter) or new VTE treatment. It should be noted that the Safety Thermometer is a spot audit and data is collected on a specific day each month. The SPC chart below shows the Trust Harm free care compared to the national benchmark for the period April 2012 to September 2018 .
The Trust score for September 2018 for new harm free care was 97.76%. The National figure for Harm Free care for September is 97.9% and therefore Red.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	97.2%	97.6%	98.4%	98.5%	97.9%	97.7%	98.5%	99.2%	97.8%	98.7%	99.2%	88.0%	97.8%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To continue to monitor actual harm against national benchmarks.	HB	Sep-18	2018

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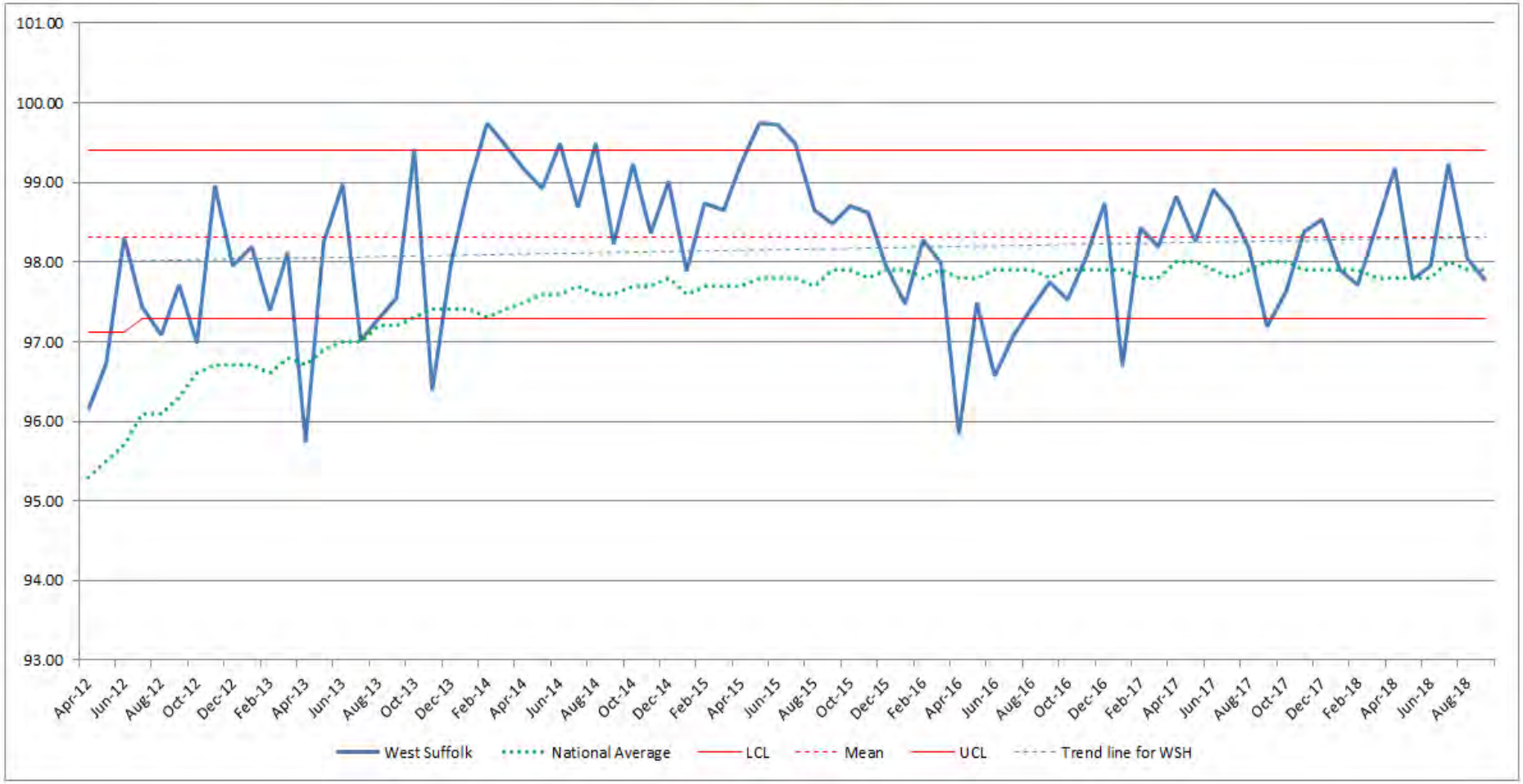
West Suffolk Safety Thermometer Data

April 2012 - September2018



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Falls
Standard	NA
Name	Rowan Procter
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Total number of falls for September in total is 71. Of these falls 64 were recorded as inpatient falls with 7 falls occurring within 'Support to go home' service, Discharge waiting area (DWA), hospital car park, ETC, Physiotherapy and Outpatients and therefore not recorded as 'inpatient' falls. Further breakdown of the 64 inpatient falls reveal that 9 were accounted to the community beds and 55 occurred within the acute trust.
During September we did not achieve our QI target of a 5% reduction in falls, but did meet the CCG target as shown within the SPC chart of falls per 1000 days at 5.27. Unfortunately we had 3 falls in September that resulted in patient harm (all Number of Falls) occurring within DWA, G4 and F6. Full investigations of these incidents of harm are ongoing.
NHSI falls collaborative work continuing with a pilot of new falls symbol being used within G8 and Rosemary Ward NCH. If successful then for roll out over trust and community areas. Development of Falls Champions in all clinical areas and plan for three link study days a year for dissemination of learning.
Community Inpatient areas have seen a reduction in the number of falls sustained by patients during September. Newmarket Hospital is involved in the NHSi Falls Collaborative work and is about to pilot an initiative involving the use of coloured blankets on patients beds, which may help reorientate patients at risk of falls as they return to their bed space, this has been a positive initiative in other parts of the country. We are also purchasing night lights for use in the large bay as most falls occur overnight.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Falls per 1000 bed days (WSH only)	3.73	3.93	4.97	5.15	5.56	6.52	5.17	6.13	6.76	4.84	2.82	7.70	5.27
% of patients at risk of falls (with a Falls assessment)	74.1%	73.2%	71.7%	74.3%	73.8%	71.1%	71.7%	71.1%	71.6%	72.2%	74.6%	72.8%	72.0%

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

Description	Owner	Start	End
The current Slips, Trips and Falls policy to be reviewed and amended to accurately reflect current best practice and support the accurate recording, interventions and investigations in line with the current documentation systems used (eCare / Datix).	Falls Group	Jun-18	Sep-18
The Falls Group and the sub Focus Group are currently exploring the option of the 'Catch a Falling Star' falls study day, focusing on the prevention of falls and appropriate treatment post fall. This has successfully been implemented in a London Trust with good results and could be tailored for the specific purposes of the WSFT. The option of a Falls Prevention video for patients to watch (as used in Michigan - Bronson Healthcare Group) is being explored to try and assist in the reduction of falls. AUG18 Update. the falls group which met on the 28th August felt that this was not the direction to take. It was felt that a complete review was required of the current falls training package delivered which will take place following the completion of the NSHI falls collaborative work. If the business case for a Falls Prevention Nurse is successful then they would lead on this education	Falls Group	May-18	complete
NHS Improvement falls collaborative work re implementation of an improvement project within the trust. July UPDATE. Work continues with NHSI falls collaborative, with aim to reduce the frequent faller cycle of harm with a 10% reduction in falls in patients who have fallen more than twice in an admission period within G8 and Rosemary Ward in Newmarket Hospital.	HoN (Med)	Jun-18	Dec-18
Falls per 1000 bed day data provided as an estimate for two years up to May 2018 will be provided on a monthly basis going forward.	HoN (Med)	Jun-18	complete
Work commencing on improving the training package to staff around falls. This has Physio involvement	HoN (Med)	Jul-18	Nov-18
Trust looking into sourcing improved slipper socks which have grips over whole foot rather than just under foot	HoN	Jul-18	Sep-18
Trust is piloting the use of new symbols for the frequent fallers	HoN	Sep-18	Dec-18
Request for support of a Clinical Nurse Specialist for Older People, to support ensuring that all falls prevention measures are in place	HoN	Sep-18	Dec-18
Newmarket are looking into having different brightly coloured blankets covering the patients beds for those patients that are deemed high risk of falls to allow the patient to recognise their bed spaces. This has been undertaken at Brighton & Sussex University Hospital which has seen an reduction in falls since implementation. If this is a success at Newmarket we would look towards piloting this within the Trust.	HoN (Comm)	Sep-18	Dec-18

SPC chart below has RAG rating based on: Red (Above upper SPC warning line), Amber (above CCG target of 5.6 and below upper SPC warning line), Green (below CCG target). Year end QI target (5% reduction on 2017/18 outturn at year end) shown as purple line on graph below.

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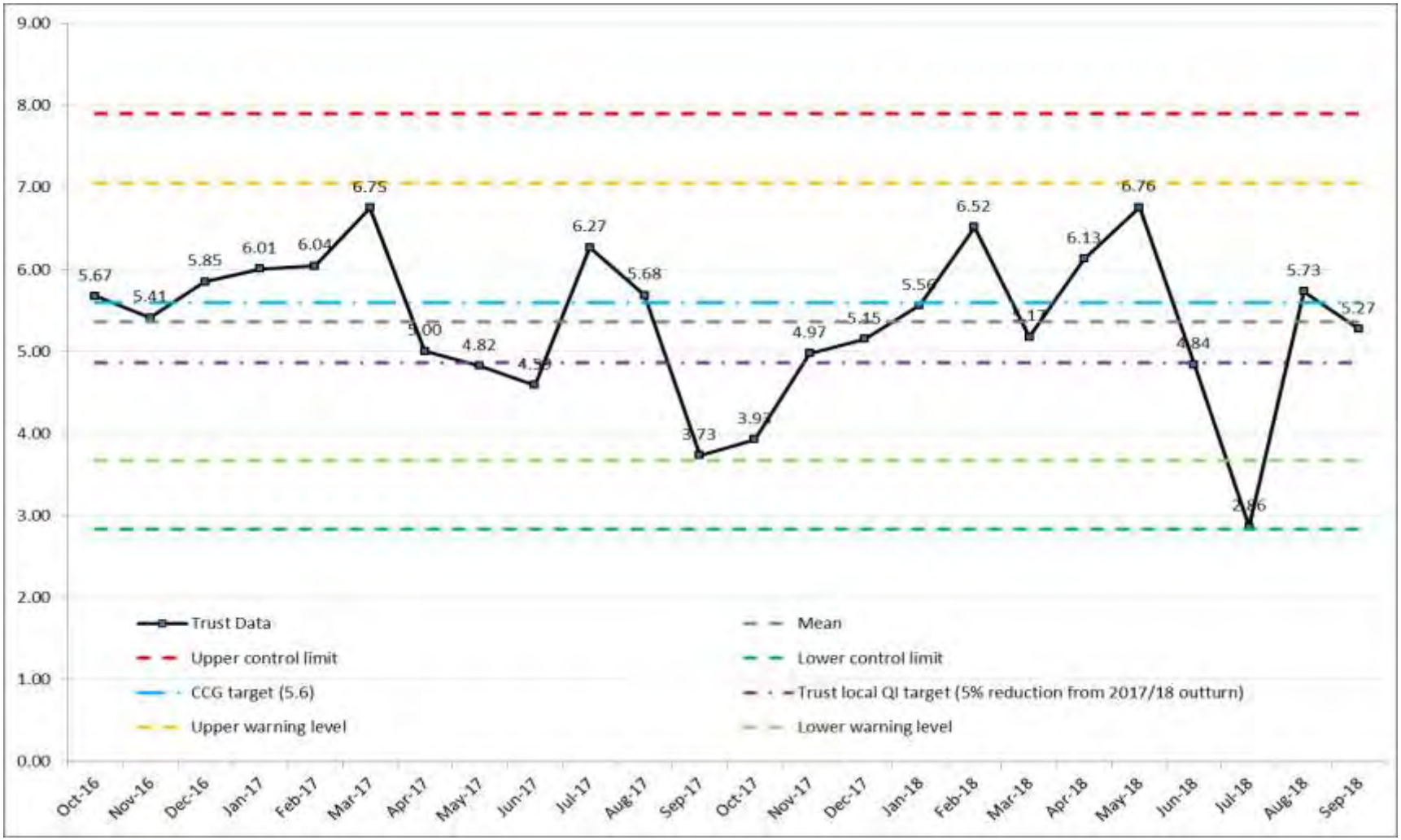
Falls Chart



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

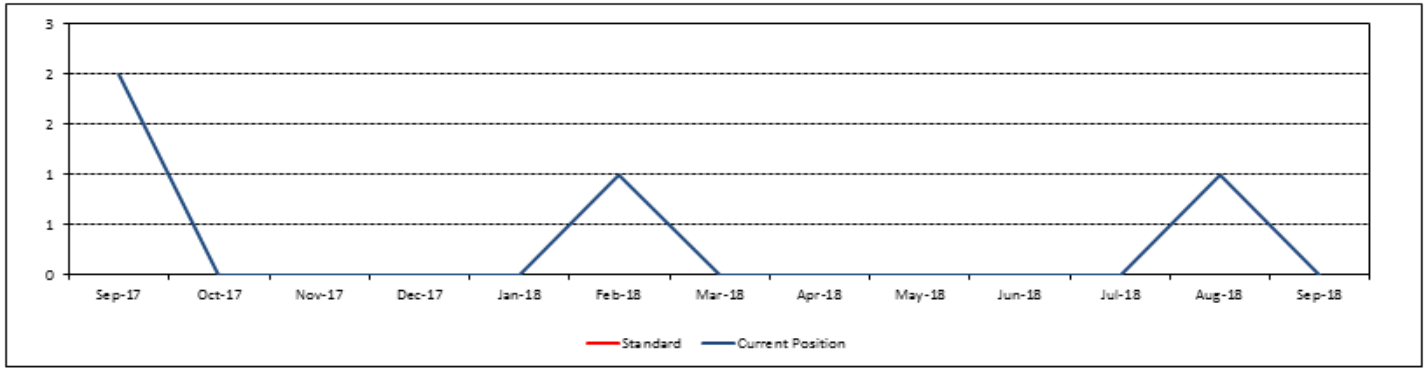
Indicator	MRSA Bacteraemia's - Hospital Attributable
Standard	0
Name	Anne How
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

The Trust recorded one case of MRSA bacteraemia classified as a contaminant in August 2018. The blood cultures were taken in the Emergency Department and had this been an infection it would have been attributed to the CCG. The culture was deemed a contaminant due to the nature of the culture results and because the patient recovered without any MRSA specific antimicrobial therapy. This is documented in the discharge letter. Both NHS England and Improvement deemed these incidences as avoidable and the ruling is that contaminants must sit with the acute Trust. The incidence has been discussed with the Emergency Department an audit of the blood culture procedures will be undertaken. Additional Training for the doctor who obtained the cultures will be arranged should he still be in the Trust.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	2	0	0	0	0	1	0	0	0	0	0	1	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	Pressure Ulcers (Tissue Viability)
Standard	Hospital-Acquired Pressure Ulcers - Below 5 PU pm and <30% avoidable
Name	Rowan Procter
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

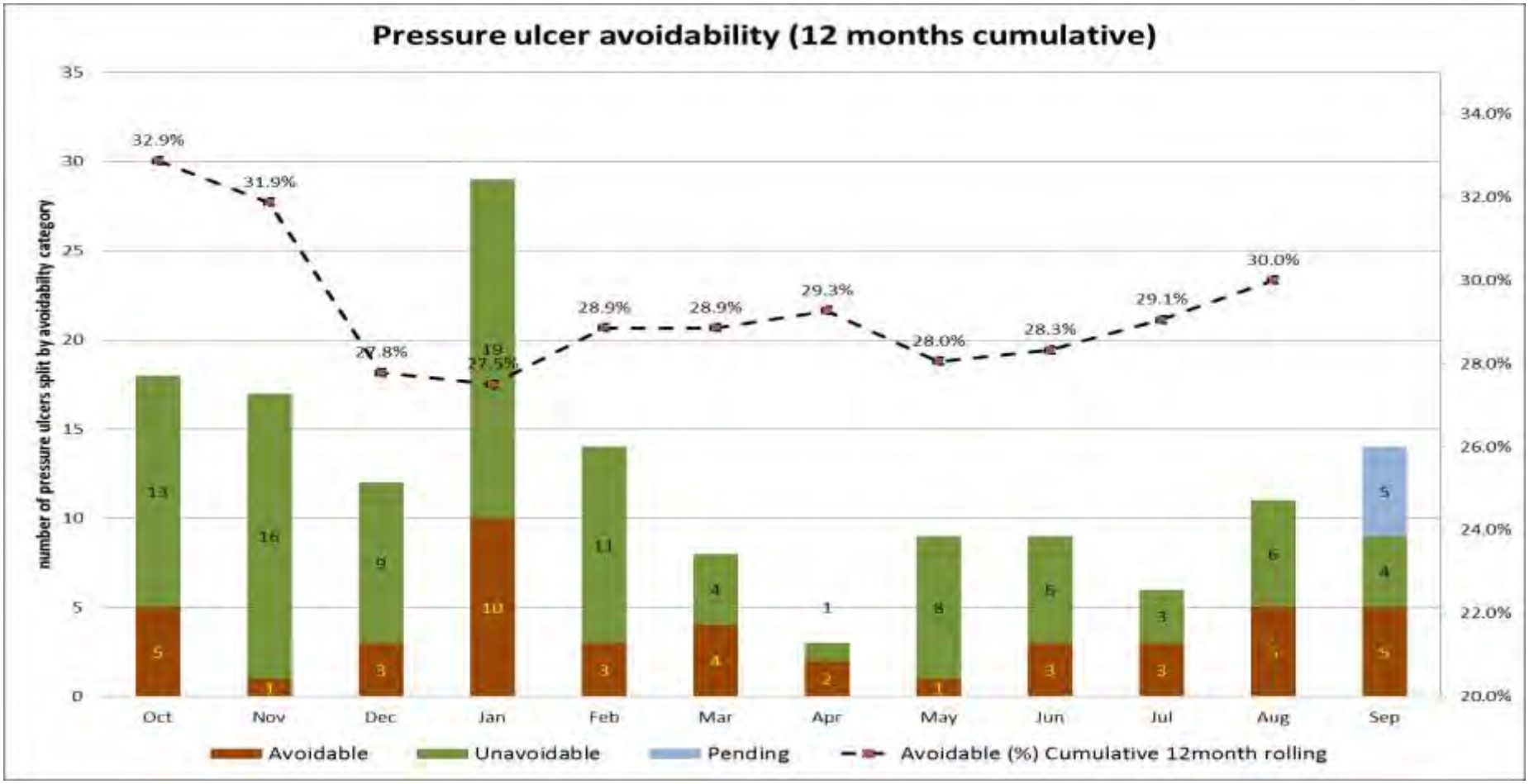
In total, there were fourteen HAPUs in September, an increase from the number reported in August, however, it is noted that two patients had more than one HAPU reported, meaning there were eleven patients affected. Of the fourteen HAPUs, three were defined as Grade 3, with the remainder being Grade 2. There were no Grade 4 HAPUs identified.
The Tissue Viability Teams in the acute and integrated services continue to work with members of the Senior Nursing team on the NHSi Pressure ulcer collaborative. This initiative is focussing on repositioning patients and is just one part of the work the TVNs are doing to promote pressure ulcer prevention across the Trust. Despite an increase in numbers of HAPUs in the past 2 months, overall there has been a reduction this year, testament to the hard work of the TVNs and engagement of the nursing leaders and teams.

	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Target	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%	<30%
Total Pressure Ulcers	15	18	17	12	29	14	8	3	9	9	6	11	14
% of patients with avoidable ward acquired pressure ulcers (YTD 17/18, 12 months cumulative 18/19)	33.0%	32.0%	28.0%	28.0%	29.0%	28.0%	29.0%	29.3%	28.0%	28.3%	29.1%	30.0%	ND

Due to the process required to ascertain whether a pressure ulcer is avoidable or not, there will be a short delay in data being available to allow the full review process to be completed

Due to the process required to ascertain whether a pressure ulcer is avoidable or not, there will be a short delay in data being available to allow the full review process to be completed

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
The trust has been working to develop a tool to ensure consistent classification of avoidable vs non-avoidable. this is due to be trailed over the next few months	Governance	Jun-18	Oct-18
To develop standards for record keeping for nursing staff	HoN	May-18	Aug-18
Review and implementation of the NHSi guidance on classification of pressure damage	HoN	Jul-18	Mar-19
Review of the information within the Patient safety report and Perfect Ward audit to ensure quality improvement and assurance	HoN	Sep-18	Mar-19


Pressure ulcer avoidability (12 months cumulative)
number of pressure ulcers split by avoidability category
35
30
25
20
15
10
5
0
34.0%
32.0%
30.0%
28.0%
26.0%
24.0%
22.0%
20.0%
32.9%
31.9%
27.8%
27.5%
28.9%
28.9%
29.3%
28.0%
28.3%
29.1%
30.0%
13
16
9
19
11
4
1
8
6
3
6
4
5
5
1
3
10
3
4
2
1
3
3
1
5
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Avoidable
Unavoidable
Pending
Avoidable (%) Cumulative 12month rolling

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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Pressure Ulcers (Tissue Viability) Community 'In our care' (IOC)
Standard	TBC
Name	Rowan Procter
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Safe

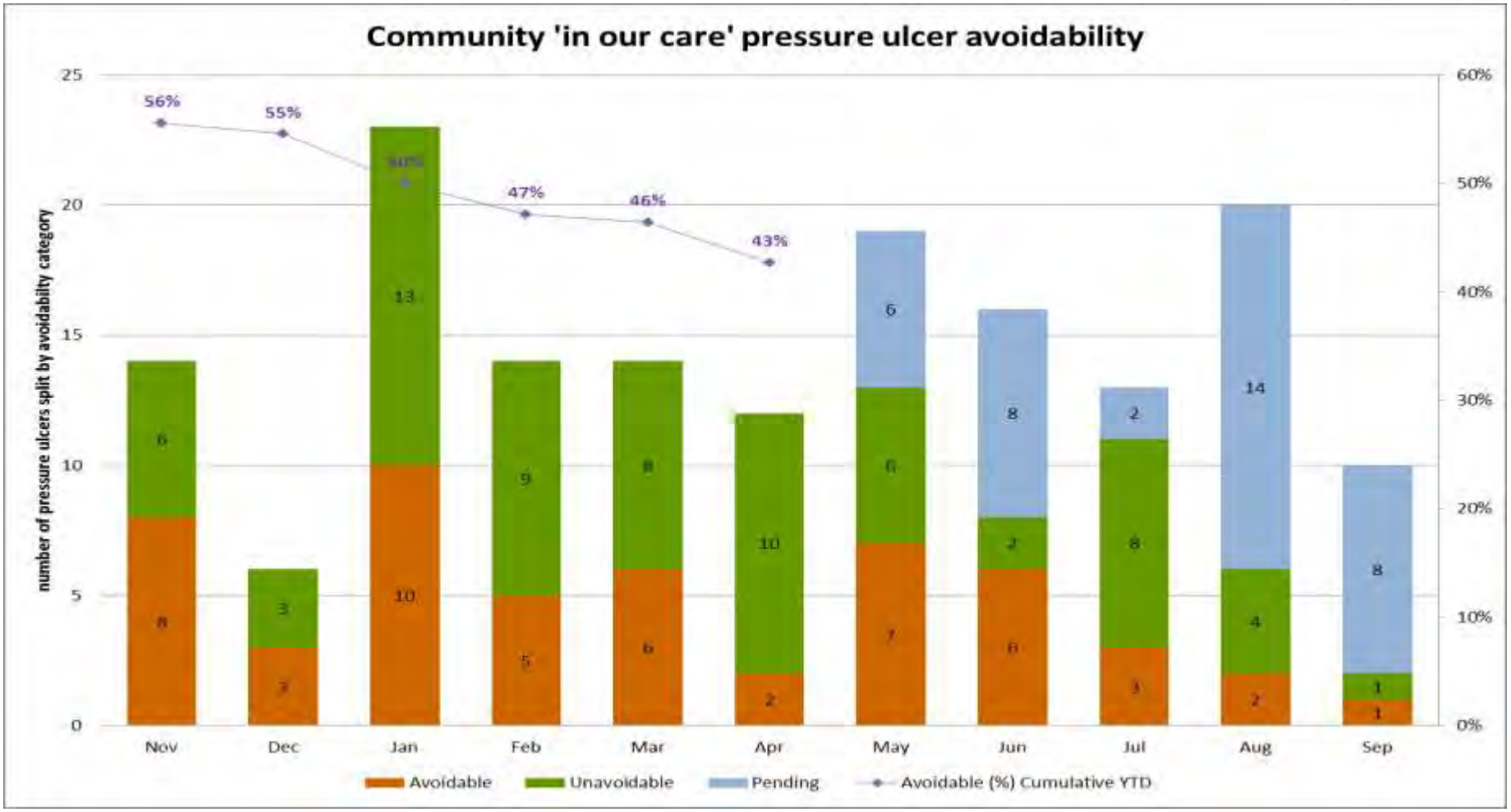
Summary of Current performance & Reasons for under performance

Community Teams saw a slight decrease in the number of reported Pressure Ulcers in Our Care during September, though 2 suspected Deep Tissue Injuries were also reported, which are being reviewed currently. Work continues with Community Teams in terms of the NHSi Pressure Ulcer Collaborative; the MAP system is now available for our use and Repositioning Roadshows will be launched across the Trust on National Stop the Pressure Day, 15th November to provide staff with insight into the impact of even very small changes of position when patients are at rest. Unfortunately there has been some withdrawal of engagement from the Residential Home which has been targeted for this initiative – we continue to work hard to re-engage them.

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Target	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC
Total Pressure Ulcers	13	14	6	24	15	14	12	19	16	13	20	10
% of patients with avoidable IOC pressure ulcers YTD	54.0%	56.0%	55.0%	50.0%	47.0%	46.0%	43.0%	ND	ND	ND	ND	ND

Due to the process required to ascertain whether a pressure ulcer is avoidable or not, there will be a delay in data being available to allow the full review process to be completed

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Review and implementation of the NHSi guidance on classification of pressure damage	HoN	Sep-18	Mar-19
Review of the information within the Patient safety report and Perfect Ward audit to ensure quality improvement and assurance	HoN	Sep-18	Mar-19
Roll out of Repositioning Roadshows.	HoN	Sep-18	Mar-19


Community 'in our care' pressure ulcer avoidability
number of pressure ulcers split by avoidability category
25
20
15
10
5
0
60%
50%
40%
30%
20%
10%
0%
56%
55%
47%
46%
43%
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Avoidable
Unavoidable
Pending
Avoidable (%) Cumulative YTD

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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	MRSA screening (including admission and length of stay screens)
Standard	90%
Name	Anne Howe
Month	01-Sep-18
Data Frequency	Quartley
CQC Area	Safe

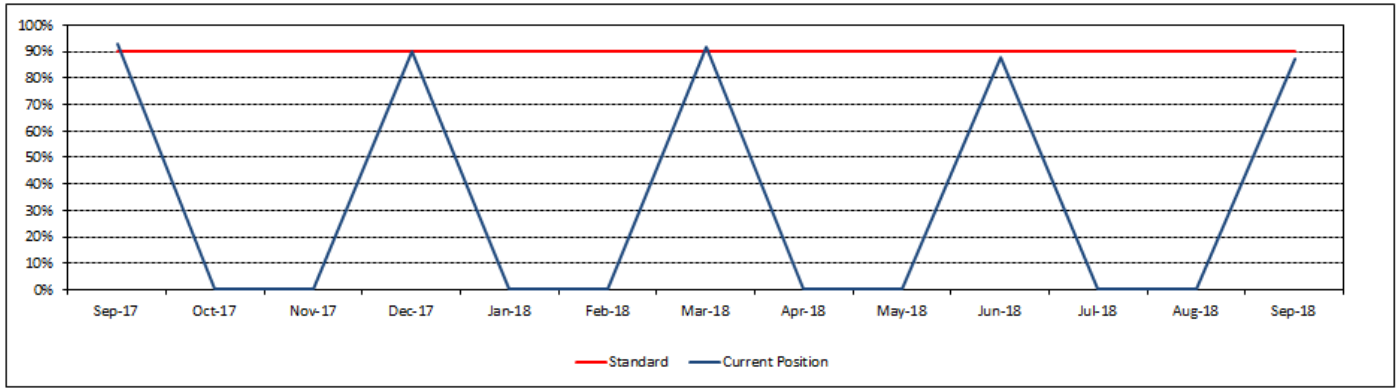
Summary of Current performance & Reasons for under performance

• MRSA screening compliance has decreased from 88% to 87% during Quarter 2. The areas with significant drop in compliance within the Medical Division last quarter have all improved upon the screening compliance this quarter. Work continues to support areas as required.

• The main areas of non-compliance this quarter relate to the post 21 day screens and weekly thereafter. Ad-hoc training continues in relation to the function of requesting MRSA screening for a future date/regular day and the option of adding to 'favourites' on e-Care. Discussions often take place with Ward Managers/Senior Nurses at the time of audit particularly if there is a high rate of non-compliance, including patterns high-lighted and realistic planning of how their ward manage the MRSA screening moving forward.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	93.0%	NA	NA	90.0%	NA	NA	92.0%	NA	NA	88.0%	NA	NA	87.0%

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

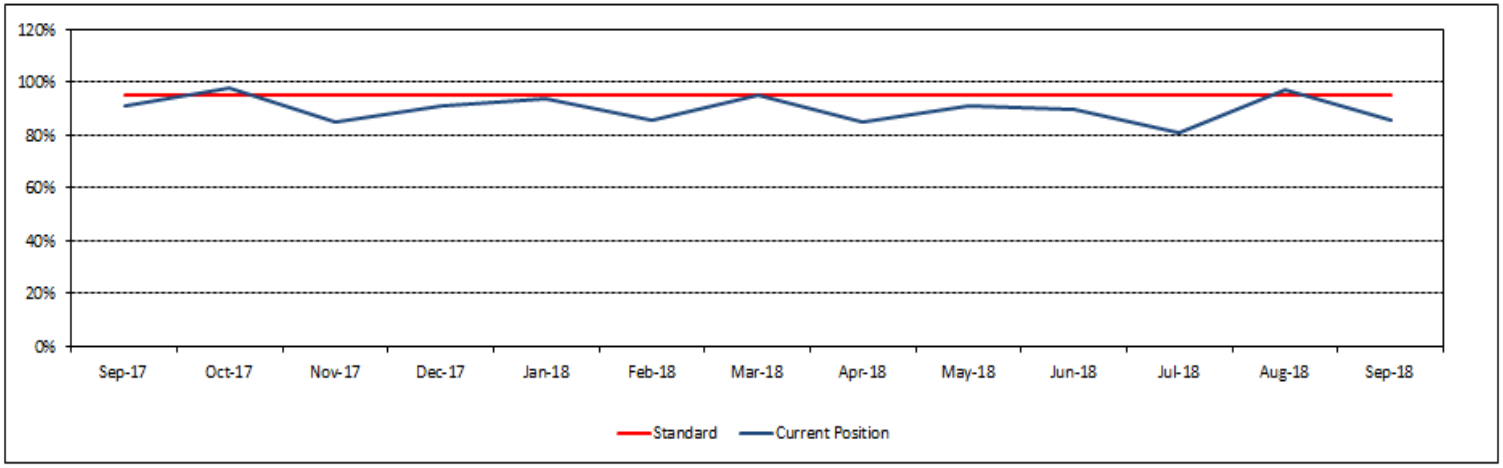
Indicator	MRSA - Decolonisation
Standard	95%
Name	Anne Howe
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

The decolonization compliance decreased in September 2018 which is the last month of the paper prescription. This appears to be due to reduced compliance in the documentation of the regime for two patients on two different wards. A meeting has been held with both wards to highlight this. However from October 2018 the regimen is now an order set on eCare which should address the documentation issues going forward. We will discuss with CCG colleagues how they would like this data to be captured in the future.

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

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

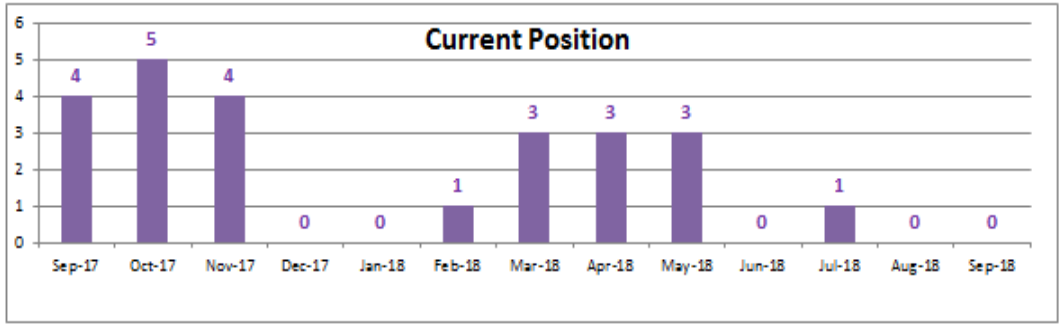
Indicator	Timeliness of SI submission
Standard	0
Name	Rowan Procter
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

All new SIs in September were reported within the two day deadline and there were no final reports due in September.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	4	5	4	0	0	1	3	3	3	0	1	0	0

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to aim for 100% compliance	Governance	Jul-05	Ongoing



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

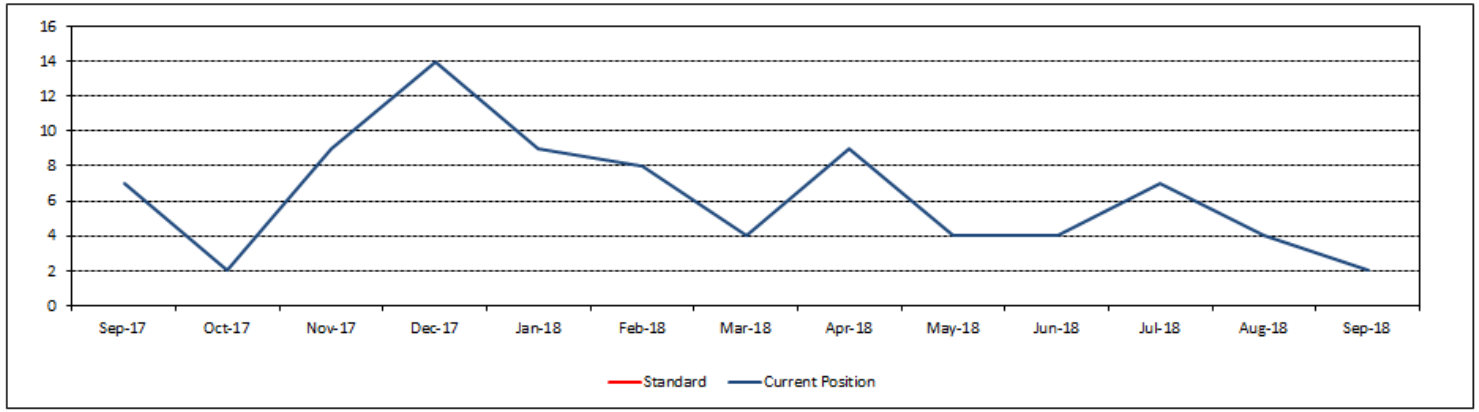
Indicator	Timeliness of RCA action completion
Standard	0
Name	Rowan Procter
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Two actions remain overdue. One relates to functionality within e-Care and has been passed to the e-Care team to discuss the potential options highlighted within the original RCA report. The other is an action requiring feedback to GPs with regard to ensuring that referral pathways for skin lesions are appropriately referred to Dermatology or Plastic surgery rather than initially to General Surgery.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	7	2	9	14	9	8	4	9	4	4	7	4	2

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Clinical Directors meeting have agreed to take greater oversight of RCA action completion	Clinical Directors	Jul-05	Ongoing
Discussion with Senior matrons and Ward Managers at Nursing & Midwifery and Clinical Council (NMCC)	NMCC	Jul-05	Ongoing



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Duty of Candour (DoC)
Standard	0
Name	Rowan Procter
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Safe

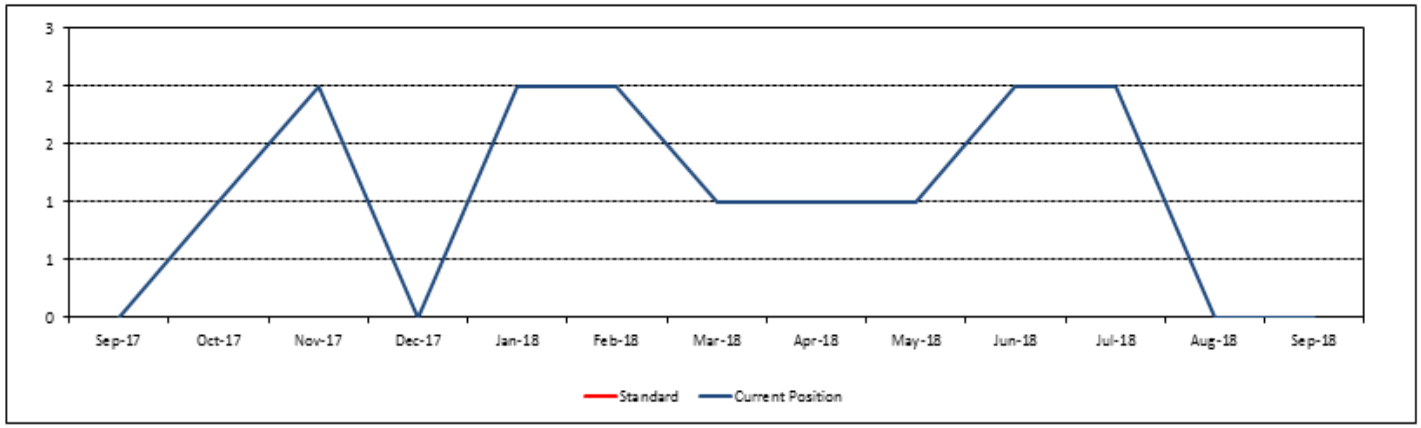
Summary of Current performance & Reasons for under performance

The Trust's policy PP197 Being Open - The Duty of Candour sets out a process to undertake verbal DoC within 10 working days with an accompanying notification letter to follow. The completion of DoC is captured on the Datix incident system and administered by the Nursing & Governance Directorate. The pathway for capturing DoC undertaken by the Community Health teams is now in place and is now included in the data (shown as Trustwide and split by Hospital/community).

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

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

Description	Owner	Start	End
Ongoing follow up of leads for overdue DoC	Governance	2018	2018
The Community teams have been made aware of how to complete DoC on the Datix record. This will be completed prospectively from June with a retrospective review of April and May cases to allow full year reporting. Data will be reported from Q2	LAMS / HoN	Complete	



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Putting you first

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

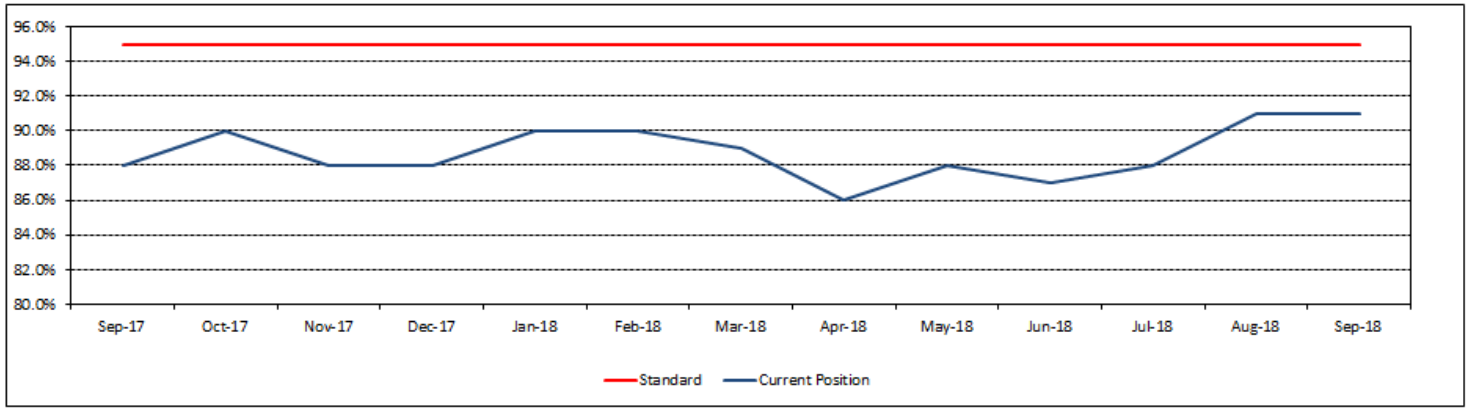
Indicator	Isolation data (Trust Level only)
Standard	95%
Name	Anne Howe
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Compliance with Isolation is at 91%. The side room capacity is monitored daily (Mon to Fri) by the Infection Prevention Nurses(IPN) and occupancy is risk assessed throughout the day, including a daily review of patients on the 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 throughout September to ensure that patients with the highest infection risk are managed there if at all possible including patients with Tuberculosis following the temporary relocation of F10 to G9.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Current Position	88.0%	90.0%	88.0%	88.0%	90.0%	90.0%	89.0%	86.0%	88.0%	87.0%	88.0%	91.0%	91.0%

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	Quarterly Visual Infusion Phlebitis score documentation
Standard	90%
Name	Anne Howe
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

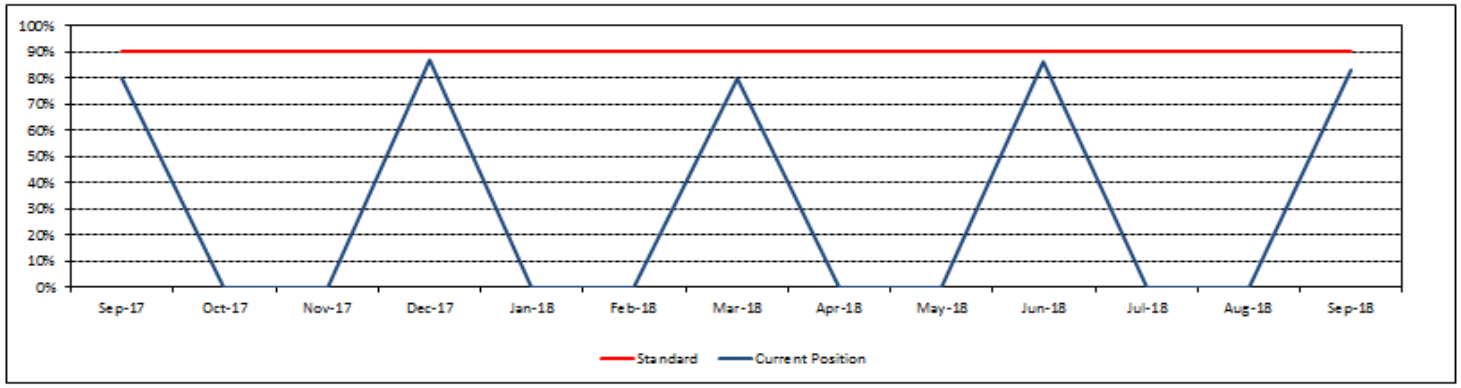
• Visual Infusion Phlebitis score compliance rates have decreased from 86% to 83% this quarter. The timely removal of the intravenous peripheral cannula continues to be audited this quarter, the aim is to reduce the amount of invasive devices in situ which in turn reduces the risk of Patients acquiring Healthcare Associated Infections. Four wards had patients with cannulas in situ that could have been reviewed with a view to removing earlier.

• National Guidance states that care of the intravenous peripheral cannula is documented at least once every shift. Cannula insertions and removal of, should also be documented on e-Care in 'lines, drains & tubes' at the time of occurrence. Ward staff report that cannula insertions are not being documented on e-Care in all cases, this is also evident from the audits. Extensive work by the Audit Team has taken place previously within these areas in an attempt to address and improve this. The Audit Team suggest that if an indwelling cannula has not been documented on e-Care upon transfer to your ward, staff should be encouraged to discuss with the transferring staff member with a request for it to be inserted retrospectively. There is currently a Quality Improvement Project in progress involving care of and documentation of the intravenous peripheral cannula, this is being led by a Junior Doctor within the Trust. As part of this process, the required documentation to complete for 'care if the IV peripheral cannula' is also being reviewed.

• We continue to offer teaching as appropriate in relation to cannula care, and include documentation of insertion, care of and removal of the IV peripheral cannula.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	80.0%	NA	NA	87.0%	NA	NA	80.0%	NA	NA	86.0%	NA	NA	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

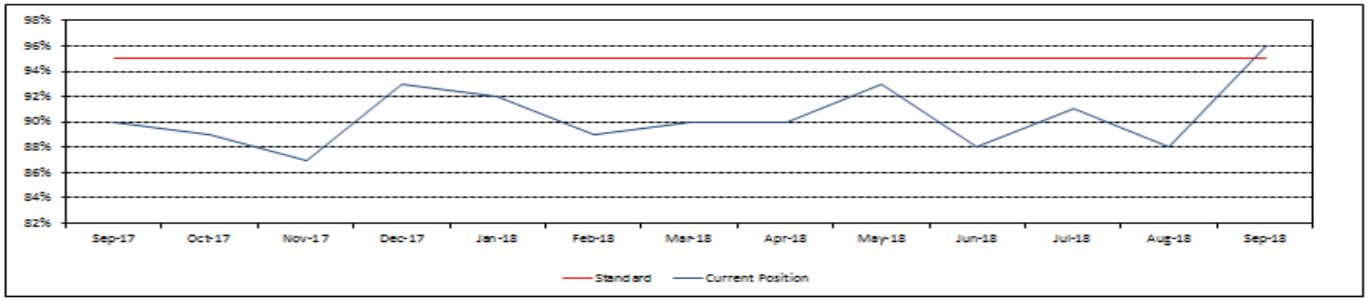
Indicator	Nutrition - Assessment & Monitoring
Standard	95%
Name	Rowan Procter
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

Overall the results for September are encouraging with 96% of patients being assessed within 24hours, but it is recognised that there are still improvements to be made with regard to the completion of risk assessments every seven days and actual weights being recorded.
September saw the introduction of new measurements and reporting to audit compliance with malnutrition risk assessments and weights being recorded. The information captured in this report indicates the percentage of patients who are assessed within 24 hours, the agreed target for malnutrition assessments. This report captures all inpatients, as opposed to, a selection of patients per ward, as previously recorded. However, the Nutrition group are continuing to work with the information team, as it is recognised that currently there is a flaw in this information. The information team are rectifying this issue which will most likely lead to a slight decline in results next month.
This data is part of a three part review of compliance and quality assurance. The 'Perfect Ward' inspections have also been updated to capture and review the quality of risk assessments and accuracy of weights to add some assurance to the process. These inspections are conducted monthly by the Senior Matrons or Ward Managers. The third part of the review is to conduct a quarterly rigorous audit which will capture further information regarding actual weights being recorded, that risk assessments are being repeated appropriately and the accuracy of the assessments. This audit will be conducted by the Senior Matron team and Dietetic team.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	90.0%	89.0%	87.0%	93.0%	92.0%	89.0%	90.0%	90.0%	93.0%	88.0%	91.0%	88.0%	96.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To adjust the Perfect Ward documentation audit to gain assurance that risk assessments are accurate, care is implemented and weights are recorded	HoN	complete	
To redesign a robust quarterly audit which will be conducted by the Senior nursing team in collaboration with Dietetics. This will be presented to the Nutrition Steering group.	HoN	Aug-18	Oct-18
Reform the Nutrition Collaborative team to review the action plan and review key priorities for Acute services and the Community	HoN	Aug-18	Oct-18
Work with the Nursing Assistant Education leads to promote the importance of weighing patients.	HoN	Aug-18	Sep-18
To collate data from the Perfect Ward inspections and share with Ward teams	HoN	Oct-18	
To communicate changes and expectations to Ward Teams	HoN	Oct-18	
To promote the recording of actual weights via the induction of Nursing Assistants	HoN	Oct-18	
Embed and review the new reporting and assurance measures	HoN	Aug-18	Oct-18



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

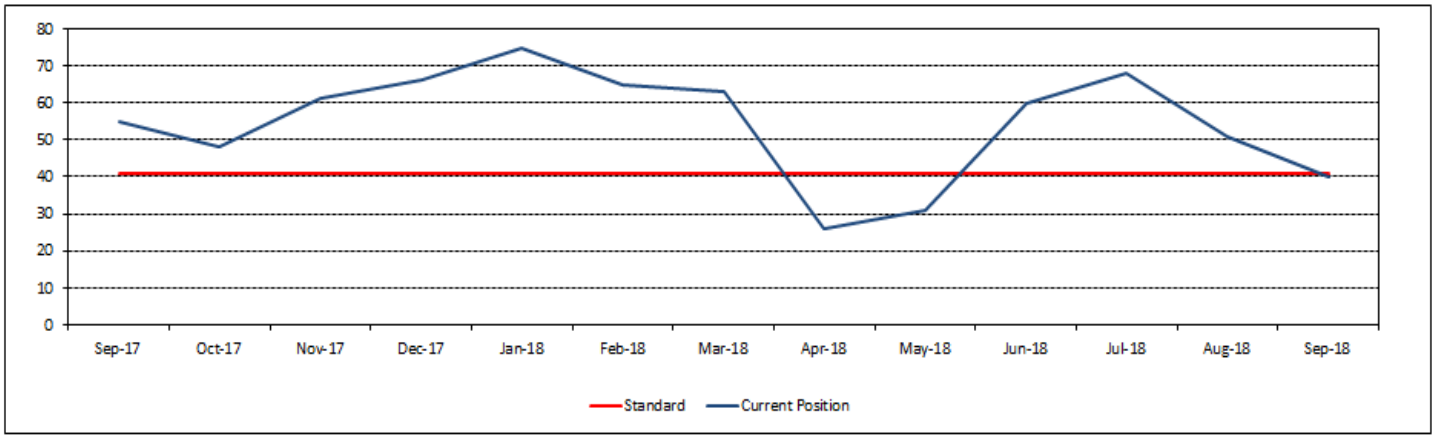
Indicator	Median National Reporting and Learning System upload 6 month rolling average
Standard	41%
Name	Rowan Procter
Month	01-Aug-18
Data Frequency	Monthly
CQC Area	Safe

Summary of Current performance & Reasons for under performance

The timescales for National Reporting and Learning System upload are linked to timely investigation and final approval. There are currently 532 incidents showing as "overdue" on Datix (>12 days) which is a deterioration from last month even though the timeliness of uploading completed investigations has improved. The next NRLS close-down deadline is 30th November and when all incidents from April to September need to have been investigated and uploaded.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	41	41	41	41	41	41	41	41	41	41	41	41	41
Current Position	55	48	61	66	75	65	63	26	31	60	68	51	40

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Targeted follow up with leads (Matrons, CDs)	Governance	ongoing	
Monitor against a peer based comparison (peer group is all non-specialist acute trusts)	Governance	ongoing	



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5. DETAILED REPORTS - EFFECTIVE

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

Are we.		Ref.	KPI	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD(Apr 18-
Effective	Incidents/Reports	2.05	Cardiac arrests	NT	6	4	ND	ND	7	ND	ND	3	4	2	7	3	6	25
		2.06	Cardiac arrests identified as a SIRI	NT	0	0	0	0	0	0	0	1	0	0	0	0	0	1
		2.07	CAS (central alerts system) alerts overdue	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		2.08	% of relevant patients with Personal Health Plan (PHP)	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	ND	100%
		2.09	NICE guidance baseline and risk assessments not completed within 6 months of publication		ND	ND	ND	ND	ND	ND	ND	56	55	48	47	41	49	296
		2.10	WHO Checklist (Qrtly)	100%	99.0%	NA	NA	99.0%	NA	NA	98.0%	NA	NA	99.0%	NA	NA	98.0%	98.5%
		2.11	National clinical audit report baseline & risk assessments not completed within 6 months of publication		ND	ND	ND	ND	ND	ND	ND	22	23	17	18	18	18	116
		2.12	Av. Elective LOS (excl. 0 days)		2.73	2.93	2.85	2.98	3.06	2.27	3.29	3.39	2.8	2.66	2.85	3.29	3.07	3.01
		2.13	Av NEL LOS (excl 0 days)		7.54	8.23	7.66	7.57	8.40	8.13	8.1	8.53	7.93	7.24	7.82	8.00	7.13	7.78
		2.14	% of NEL 0 day LOS		17.5%	18.8%	16.6%	14.7%	13.3%	13.3%	13.7%	13.6%	15.0%	15.7%	15.0%	13.3%	13.9%	14.4%
		2.15	NHS number coding	99%	99.6%	99.6%	99.7%	99.6%	99.7%	99.7%	99.7%	99.7%	99.8%	99.8%	99.8%	99.3%	99.5%	99.7%
		2.16	Fractured Neck of Femur : Surgery in 36 hours	85%	97.0%	96.0%	84.0%	100%	100%	96.0%	93.0%	89.0%	79.0%	100%	94.4%	100%	90.3%	92.1%
		2.17	Discharge Summaries (OP 85% 3d)	85%	55.0%	58.0%	58.0%	58.0%	60.0%	58.0%	56.0%	62.0%	57.0%	63.0%	54.0%	ND	ND	59.0%
		2.18	Discharge Summaries (A&E 95% 1d)	95%	85.9%	83.6%	84.2%	82.6%	84.0%	83.4%	82.3%	81.5%	82.5%	86.1%	86.4%	88.4%	88.9%	85.6%
		2.19	Non-elective Discharge Summaries (IP 95% 1d)	95%	73.0%	73.3%	69.2%	68.9%	70.2%	69.8%	70.8%	73.5%	75.7%	78.1%	76.6%	76.9%	83.0%	77.3%
		2.20	Elective Discharge Summaries (IP 85% 1d)	85%	69.3%	73.3%	68.0%	74.5%	72.8%	71.2%	72.9%	72.1%	71.2%	72.1%	69.5%	70.8%	72.0%	71.3%
		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%	92.0%	84.6%	98.1%	76.7%	94.7%	96.6%	91.7%	85.7%	90.9%	100%	90.0%	91.9%	90.0%	91.4%
		2.23	Canc. Ops. - No. Cancelled for a 2nd time	NT	0	0	0	0	0	0	0	0	0	0	0	0	0	0

EXCEPTION REPORTS – EFFECTIVE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

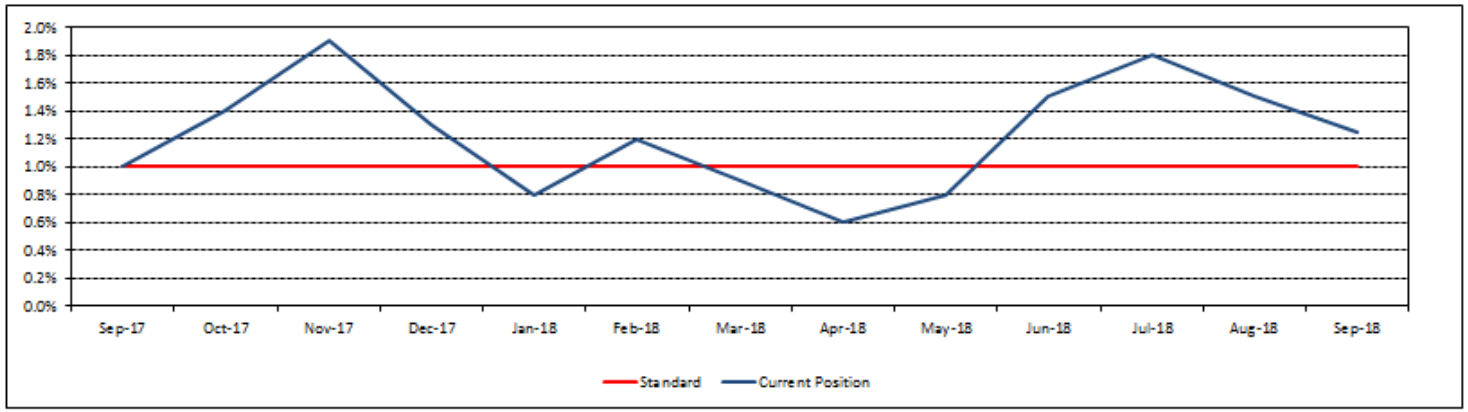
Indicator	Canc. Ops - Cancellations for non-clinical reasons
Standard	1%
Name	Hannah Knights
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

Improved performance from August position. Patients cancelled due to particular issues around anaesthetic cover and some equipment issues in one of the T&O theatres. There were 30 Cancelled Operations for non-clinical reasons.

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

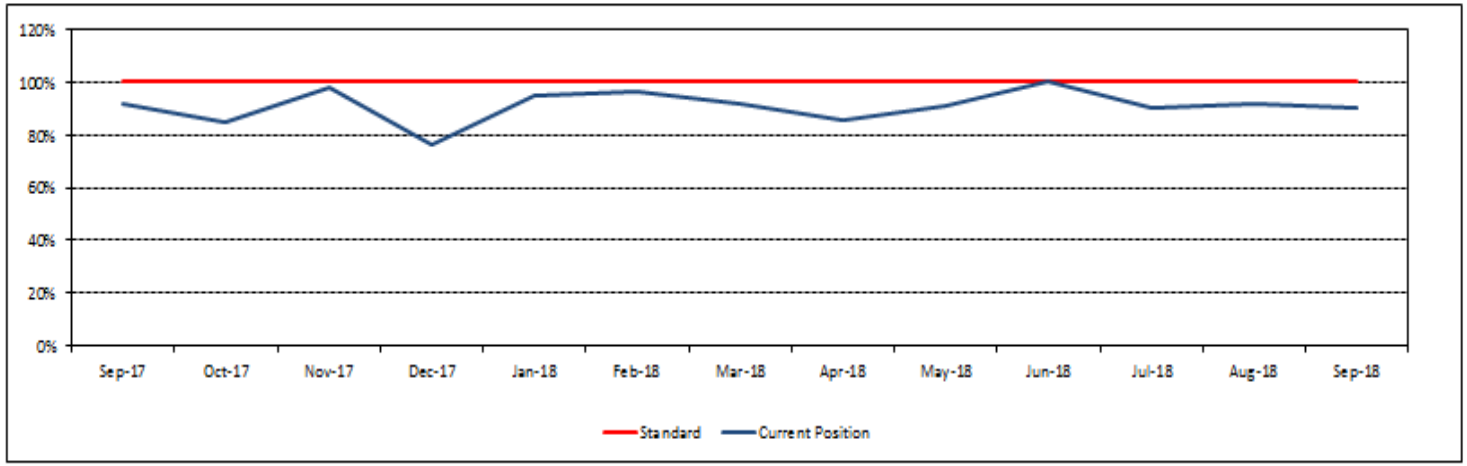
Indicator	Canc. Ops - Patients offered date within 28 days
Standard	100%
Name	Hannah Knights
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Effective

Summary of Current performance & Reasons for under performance

There were 3 patients who were unable to be booked within 28 days, 1 was an Ophthalmology patient who had to be re-booked when someone was available to check their pacemaker prior to surgery. 1 was Orthopaedics, and due to consultant A/L was unable to be rescheduled any sooner and 1 was a Urology patient, who was unable to be re-booked sooner due to capacity constraints driven by rapid access patients.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	92.0%	84.6%	98.1%	76.7%	94.7%	96.6%	91.7%	85.7%	90.9%	100%	90.0%	91.9%	90.0%

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	NICE and AUDIT
Standard	0%
Name	Nick Jenkins
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Effective

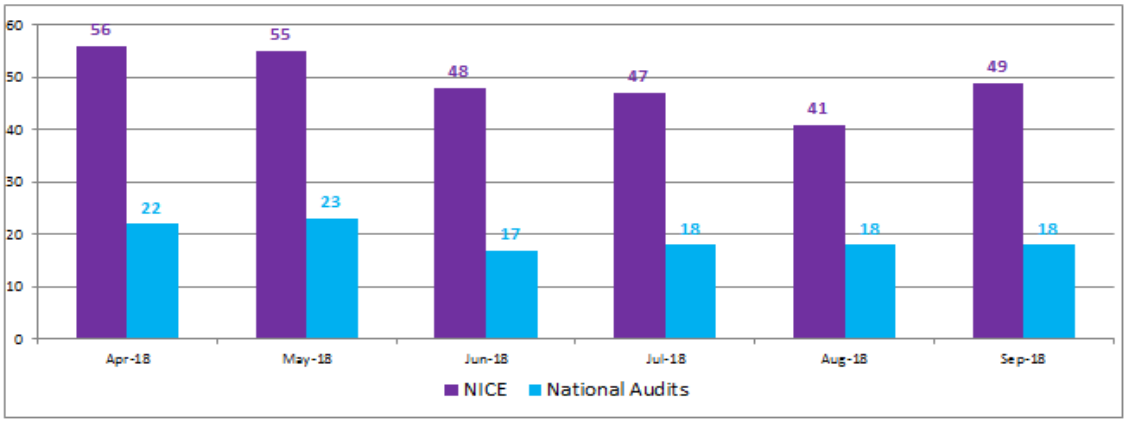
Summary of Current performance & Reasons for under performance

NICE baseline assessments
8 baseline assessments were completed in August 2018 and 2 guidelines were published (six months ago) in February 2018 that require a completed baseline assessment, resulting in a reduction from 47 to 41 baseline assessments not completed within 6 months of publication. This indicator remains AMBER
National clinical audit baseline assessments
0 baseline assessments were completed in September2018 and 0 reports were published (six months ago) in February 2018 that require a completed baseline assessment, resulting in a maintenance of 18 baseline assessments not completed within 6 months of publication. This indicator remains RED.

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

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

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



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6. DETAILED REPORTS - CARING

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

Are we.		Ref.	KPI	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD(Apr 18-Mar19)
3. Caring	Other Friends and Family Test Scores	3.09	IP overall experience result	85%	92.8%	96.0%	96.0%	95.0%	94.0%	95.0%	96.0%	97.0%	97.0%	97.0%	97.0%	95.0%	97.0%	96.7%
		3.10	OP overall experience result	85%	88.6%	95.0%	94.0%	95.0%	96.0%	97.0%	96.0%	97.0%	97.0%	97.0%	97.0%	96.0%	96.0%	96.7%
		3.11	A&E overall experience result	85%	94.0%	93.0%	94.0%	94.0%	94.0%	94.0%	94.0%	94.0%	93.0%	94.0%	95.0%	97.0%	94.0%	94.5%
		3.12	Short-stay overall experience result	85%	98.9%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	100%	99.0%	99.0%	98.0%	99.0%	100%	99.2%
		3.13	Short-stay Extremely likely or Likely to recommend (FFT)	90%	99.0%	99.0%	97.0%	100.0%	99.4%	99.7%	99.0%	100%	99.0%	98.0%	98.0%	99.0%	99.0%	98.8%
		3.14	Maternity - overall experience result	85%	100%	100%	98.0%	95.0%	100%	93.0%	100%	99.0%	95.0%	96.0%	100%	97.0%	94.0%	96.8%
		3.15	Maternity postnatal community - extremely likely or likely to recommend (FFT)	90%	100%	100%	ND	ND	ND	ND	ND	100%	97.0%	96.0%	100%	100%	98.0%	98.5%
		3.16	Maternity birthing unit - extremely likely or likely to recommend (FFT)	90%	100%	100%	100%	ND	100%	100%	ND	100%	ND	ND	100%	100%	100%	100%
		3.17	Maternity antenatal community - extremely likely or likely to recommend (FFT)	90%	100%	96.4%	ND	ND	ND	ND	ND	100%	100%	94.0%	97.0%	100%	100%	98.5%
		3.18	Children's services overall result	85%	ND	ND	ND	ND	ND	ND	ND	97.0%	99.0%	96.0%	95.0%	98.0%	98.0%	97.2%
		3.19	F1 Parent - overall experience result	85%	100%	99.0%	95.0%	98.0%	98.0%	98.0%	98.0%	96.0%	99.0%	96.0%	95.0%	98.0%	95.0%	96.5%
		3.20	F1 - Extremely likely or likely to recommend (FFT)	90%	100%	100%	94.0%	97.0%	100%	100%	100%	92.0%	100%	96.0%	95.0%	94.0%	91.0%	94.7%
		3.21	F1 Children - Overall experience result	85%	ND	ND	ND	ND	ND	ND	ND	85.0%	97.0%	96.0%	99.0%	91.0%	95.0%	93.8%
		3.22	Rosemary ward - extremely likely or likely to recommend (FFT)	90%	ND	100%	100%	100%	78.0%	85.0%	100%	79.0%	100%	88.0%	76.0%	100%	90.0%	88.8%
		3.23	King suite - extremely likely or likely to recommend	90%	ND	100%	100%	94.0%	93.0%	100%	100%	ND	100%	100%	75.0%	100%	100%	95.0%
		3.24	Community paediatrics - extremely likely or likely to recommend (FFT)	90%	ND	96.0%	100%	97.0%	100%	97.0%	95.0%	94.0%	95.0%	100%	100%	100%	94.0%	97.2%
		3.25	Community health teams - extremely likely or likely to recommend (FFT)	90%	ND	100%	100%	100%	90.0%	100%	90.0%	100%	100%	100%	66.0%	89.0%	100%	92.5%
		3.26	Community specialist nursing teams - extremely likely or likely to recommend (FFT)	90%	ND	100%	100%	95.0%	100%	93.0%	100%	92.0%	98.0%	100%	77.0%	90.0%	94.0%	91.8%
		3.27	Stroke Care - Overall Experience Result	85%	99.0%	100%	85.0%	ND	98.0%	95.0%	100%	95.0%	92.0%	100%	100%	100%	90.0%	96.2%
		3.28	Stroke Care - extremely likely or likely to recommend	90%	95.4%	100%	100%	ND	100%	100%	100%	100%	100%	100%	95.0%	100%	100%	99.2%
	Complaint Handling	3.29	Complaints acknowledged within 3 working days	90%	94.0%	100%	100%	87.0%	92.0%	100%	100%	92.0%	100%	100%	100%	88.0%	70.0%	91.7%
		3.30	Complaints responded to within agreed timeframe	90%	67.0%	81.0%	82.0%	50.0%	60.0%	17.0%	54.0%	31.0%	70.0%	50.0%	40.0%	83.0%	100%	62.3%
		3.31	Number of second letters received	1	1	2	0	1	0	0	1	2	2	6	2	1	0	13
		3.32	Ombudsman referrals accepted for investigation	0	0	0	0	1	1	1	0	0	0	0	0	0	1	1
		3.33	No. of complaints to Ombudsman upheld	0	ND	ND	0	0	0	0	0	0	0	0	0	0	0	0
		3.34	No. of PALS contacts	NT	167	190	167	124	161	178	205	183	231	214	275	233	198	1334
		3.35	No. of PALS contacts becoming formal complaints	<=5	2	3	4	1	3	6	1	4	4	4	4	2	2	20

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Putting you first

EXCEPTION REPORTS –CARING

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

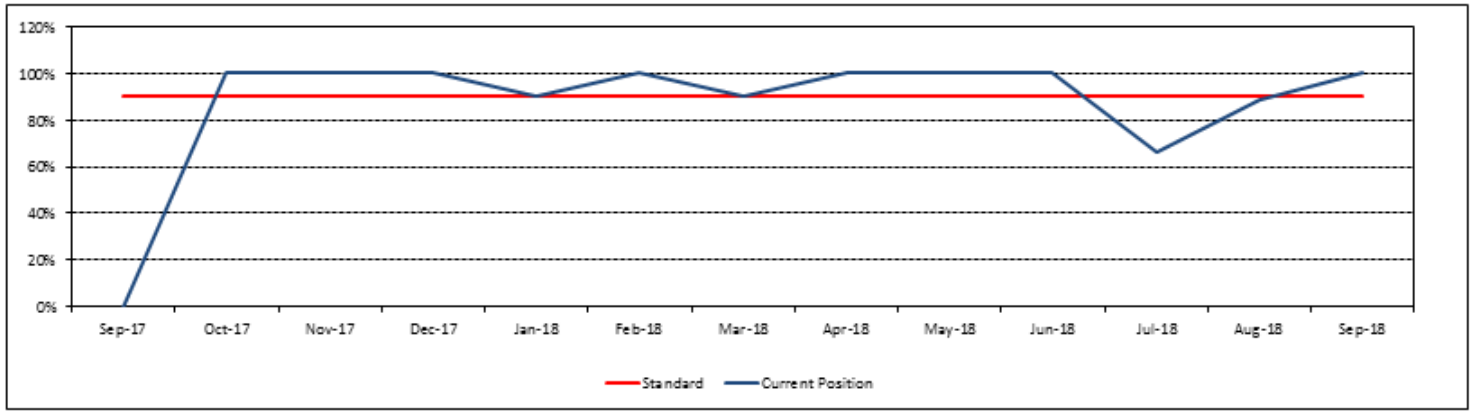
Indicator	Community health teams and Specialist Nursing teams- extremely likely or likely to recommend (FFT)
Standard	90%
Name	Cassia Nice
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

July and August results were due to a poor number of returns. The teams have been reminded again to ensure surveys are given to all patients and this has been escalated to the head of nursing for community and local area managers.
The patient experience team is also exploring using volunteers to conduct telephone surveys for patients in the community who are housebound.
The improved score is due to an increased collection of surveys - giving a more accurate view of the experience.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	ND	100%	100%	100%	90.0%	100.0%	90.0%	100%	100%	100%	66.0%	89.0%	100%

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	King suite - extremely likely or likely to recommend
Standard	90%
Name	Cassia Nice
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Two patients said they were unlikely to recommend King Suite in July. Feedback included comments around the food and one comment that staff were a little strict. Head of Nursing has met with the Home Manager to discuss the food served to patients. King Suite is a re-enablement unit, with a proactive approach, staff are always mindful of patient preference should they decline to participate in activities of daily living.

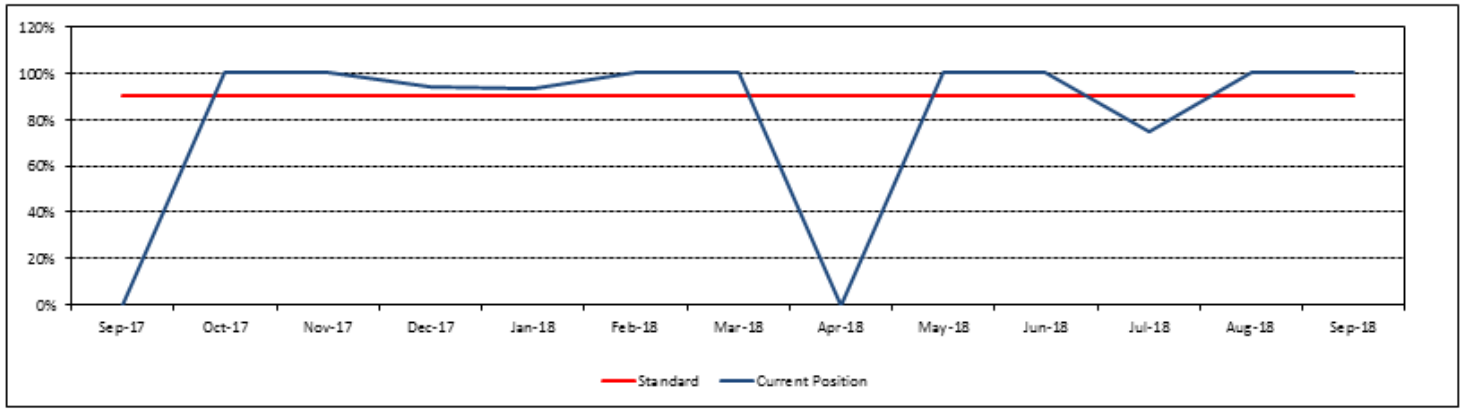
The unit will continue to collect an appropriate number of surveys from patients.

The improved score is due to an increased collection of surveys - giving a more accurate view of the experience.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	ND	100%	100%	94.0%	93.0%	100%	100%	ND	100%	100%	75.0%	100%	100%

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

Description	Owner	Start	End



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

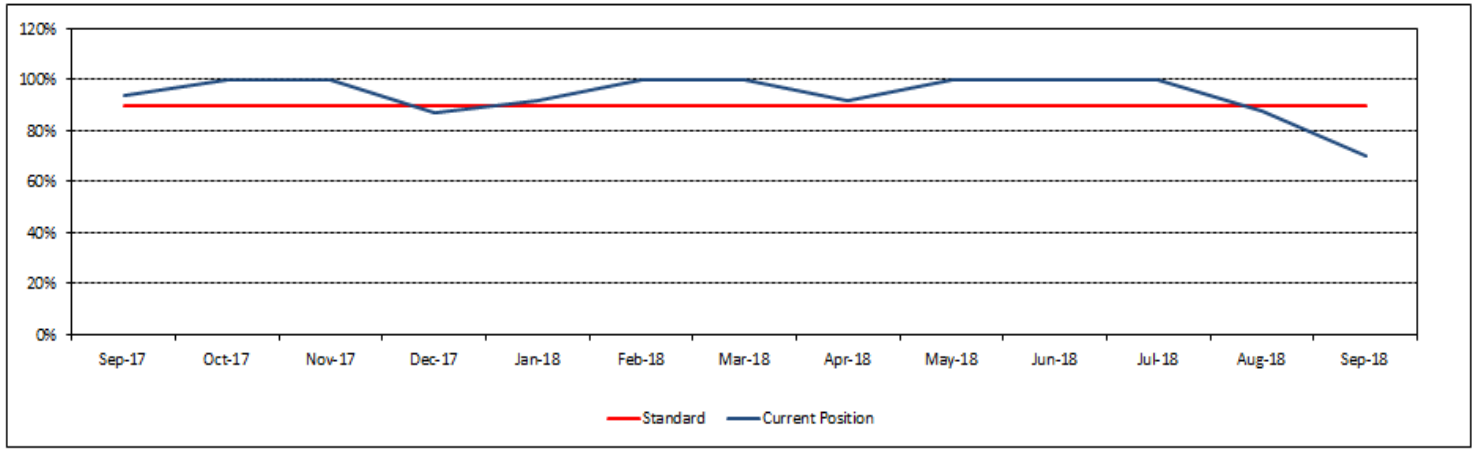
Indicator	Complaints acknowledged within 3 working days
Standard	90%
Name	Cassia Nice
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Administrative error resulting in some acknowledgements being sent out late whilst a member of the team was on annual leave. This has now been rectified with other members of the team trained in this process.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	94.0%	100%	100%	87.0%	92.0%	100%	100%	92.0%	100%	100%	100%	88.0%	70.0%

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

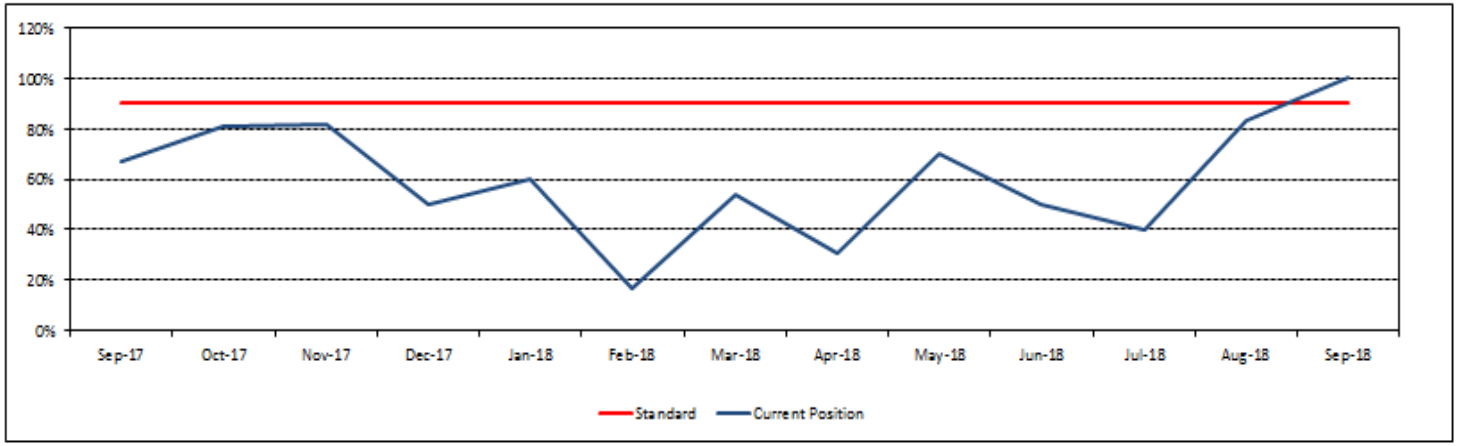
Indicator	Complaints responded to within agreed timeframe
Standard	90%
Name	Cassia Nice
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Caring

Summary of Current performance & Reasons for under performance

Due to a new way of working and an increased number of staff collating complaint investigations, it is hoped that this will continue to improve and consistently meet the target going forward. This is being closely monitored by the patient experience lead and chief nurse with input from a non-executive director.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	67.0%	81.0%	82.0%	50.0%	60.0%	17.0%	54.0%	31.0%	70.0%	50.0%	40.0%	83.0%	100%

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Number of second letters received
Standard	1
Name	Cassia Nice
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Caring

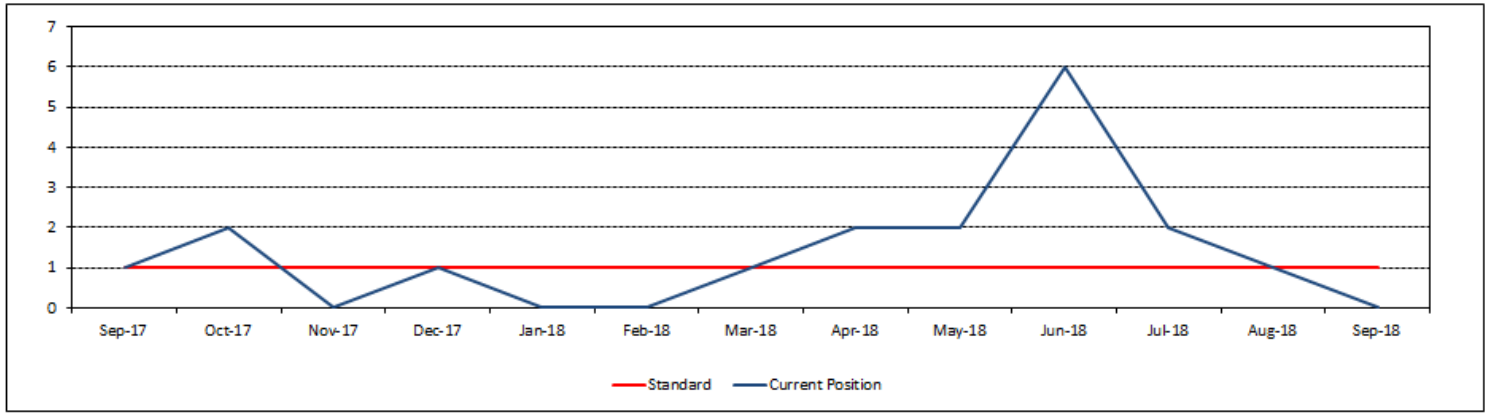
Summary of Current performance & Reasons for under performance

The number of second letters received reduced to zero in September, an improvement from July (2) and August (1). This indicator is now RAG rated Green.

The Patient Experience Lead has trained the team in complaint response writing to ensure investigations are robust and responses of a high standard. Following this change to the way of working there has been a significant improvement in complaints responded to within agreed timeframe (83% in August compared with 40% in July). This will continue to be closely monitored.

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

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



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7. DETAILED REPORTS - RESPONSIVE

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

Are we..		Ref.	KPI	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD(Apr18-Mar19)
4. Responsive	A&E	4.13	Number of Delayed Transfer of Care - (DTOCs)	NT	337	250	279	314	326	393	321	208	206	203	130	242	176	194
		4.14	A&E time to treatment in department (median) for patients arriving by ambulance - CDM	NT	62	59	41	62	57	75	64	70	47	46	41	40	ND	49
		4.15	A&E - Single longest Wait (Admitted & Non-Admitted)	6 hrs.	12.01	15.44	22.04	16.48	18.11	17.18	19.50	18.14	10.30	12.22	14.49	15.54	12.23	13.82
		4.16	A&E -Waits over 12 hours from DTA to Admission	12 Hrs.	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		4.17	A&E - Admission waiting 4-12 hours from dec. to admit		14	10	17	50	122	30	46	17	4	8	15	31	10	85
		4.18	A&E - To inpatient Admission Ratio	27%	30.5%	30.4%	30.0%	32.8%	31.9%	32.1%	29.6%	27.9%	25.8%	25.0%	23.9%	25.7%	28.3%	26.1%
		4.19	A&E Service User Impact (re-attendance in 7 days <5% & time to treat)	1 met	1	1	1	1	1	1	1	1	1	1	1	1	1	1
		4.20	A&E/AMU - Amb. Submit button complete	80%	90.3%	87.7%	88.2%	89.4%	85.7%	89.6%	93.5%	92.7%	94.4%	92.8%	91.3%	90.1%	91.0%	92.1%
		4.21	A&E - Amb. Handover above 30m	0	15	40	84	110	72	87	74	88	84	13	21	24	6	236
		4.22	A&E - Amb. Handover above 60m	0	30	21	46	54	38	30	17	29	3	5	31	16	2	86
	RTT	4.23	RTT - 18w Admitted (Completed)	90%	73.8%	72.0%	70.9%	69.9%	72.6%	73.5%	74.1%	73.4%	71.1%	76.9%	74.7%	74.0%	75.5%	74.3%
		4.24	RTT - 18w Non-admitted (Completed)	95%	87.3%	84.9%	85.8%	90.6%	88.7%	93.9%	93.4%	92.8%	94.5%	93.3%	93.9%	91.0%	88.5%	92.3%
		4.25	RTT waiting List	<15396	17236	16694	16641	16195	15363	15804	15396	16223	16481	16739	16715	16601	18105	16811
		4.26	RTT waiting list over 18 weeks		2467	2171	1843	1775	1504	1650	1614	1560	1294	1443	1433	1775	1830	1556
		4.27	RTT 18 weeks Non-Consultant led services - Community	90%	99.4%	93.7%	94.4%	98.4%	98.7%	100%	99.4%	99.2%	97.6%	100%	98.7%	99.0%	99.0%	98.9%
		4.28	RTT 52 weeks Non-Consultant led services - Community	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Stroke	4.29	Stroke - % Patients scanned within 1 hr.	77%	78.1%	75.7%	74.4%	75.6%	86.7%	76.7%	70.0%	73.7%	63.6%	77.7%	76.3%	84.4%	93.3%	78.2%
		4.30	Stroke - % patients scanned within 12 hrs.	96%	90.2%	97.3%	92.3%	95.6%	98.3%	100%	97.5%	94.7%	97.7%	100%	89.5%	100%	100%	97.0%
		4.31	Stroke - % Patients admitted directly to stroke unit within 4h	75%	82.5%	72.2%	72.5%	60.0%	75.4%	79.3%	72.5%	57.9%	73.2%	84.1%	75.0%	79.6%	82.8%	75.4%
		4.32	Stroke - % greater than 80% of treatment on stroke unit	90%	92.5%	88.9%	92.5%	91.1%	93.0%	96.6%	87.5%	81.6%	82.9%	100%	88.9%	88.6%	96.6%	89.8%
		4.33	Stroke - % of patients treated by the SESDC	48%	51.4%	50.0%	30.8%	32.4%	61.5%	50.0%	51.4%	54.8%	48.7%	58.5%	50.0%	53.9%	69.2%	55.9%
		4.34	Stroke -% of patients assessed by a stroke specialist physician within 24 hrs. of clock start	80%	85.4%	83.3%	82.1%	88.9%	93.3%	83.3%	95.0%	79.0%	81.8%	97.8%	92.1%	97.8%	96.7%	90.9%
		4.35	Stroke -% of patients assessed by nurse & therapist within 24h. All rel. therapists within 72h	75%	92.1%	77.1%	76.3%	77.5%	93.0%	86.2%	86.8%	94.6%	92.5%	88.6%	89.2%	79.6%	86.2%	88.5%
		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%	58.0%	ND	ND	ND	61.0%	ND	ND	ND	57.0%	ND	ND	ND	ND	57.0%
		4.38	Stroke -Provider rating to remain within A-C	C	ND	ND	ND	ND	C	ND	C	C	ND	ND	ND	ND	ND	C

Are we..		Ref.	KPI	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD(Apr18-Mar19)
	Other	4.39	Urgent Referrals for Early Intervention Team (EIT) - Community		ND	ND	ND	ND	ND	ND	ND	100%	100%	100%	100%	100%	ND	100%
		4.40	Nursing & therapy Red referrals seen within 4hrs - Community		100%	NA	NA	100%	100%	96.4%	100%	96.4%	100%	100%	98.2%	100%	100%	99.1%
		4.41	Nursing & therapy Amber referrals seen within 72hrs - Community		98.6%	90.9%	96.9%	100%	99.3%	98.0%	97.6%	98.8%	99.4%	99.5%	97.4%	99.4%	99.5%	99.0%
		4.42	Nursing & therapy Green referrals seen within 18 wks -Community		98.6%	99.3%	97.8%	98.0%	99.8%	99.9%	99.9%	99.3%	99.9%	100%	100%	100%	99.6%	99.8%
		4.43	Wheelchair waiting times – Child (Community)		47.4%	43.8%	75.0%	72.7%	55.6%	61.9%	42.2%	90.9%	100%	95.2%	90.9%	100%	100%	96.2%
		4.44	Wheelchair waiting times - Adult (Community)		70.3%	69.8%	83.5%	70.5%	71.4%	73.6%	72.5%	75.6%	78%	80.0%	54.9%	100%	73.1%	77.0%
		4.45	Sepsis - 1 hr neutropenic sepsis	100%	62.5%	79.0%	73.9%	53.9%	80.0%	75.0%	58.3%	63.6%	80.0%	57.9%	80.0%	72.2%	90.9%	74.1%
		4.46	Percentage of Children in Care initial health assessments completed within 28 calendar days of becoming a child in care	100%	ND	ND	ND	ND	ND	ND	ND	0.0%	4.8%	8.0%	23.1%	31.6%	11.8%	13.2%
		4.47	Percentage of Service Users (children) assessed to be eligible for NHS Continuing Healthcare whose review health assessment is completed annually	80%	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	86.7%	86.7%

EXCEPTION REPORTS – RESPONSIVE

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

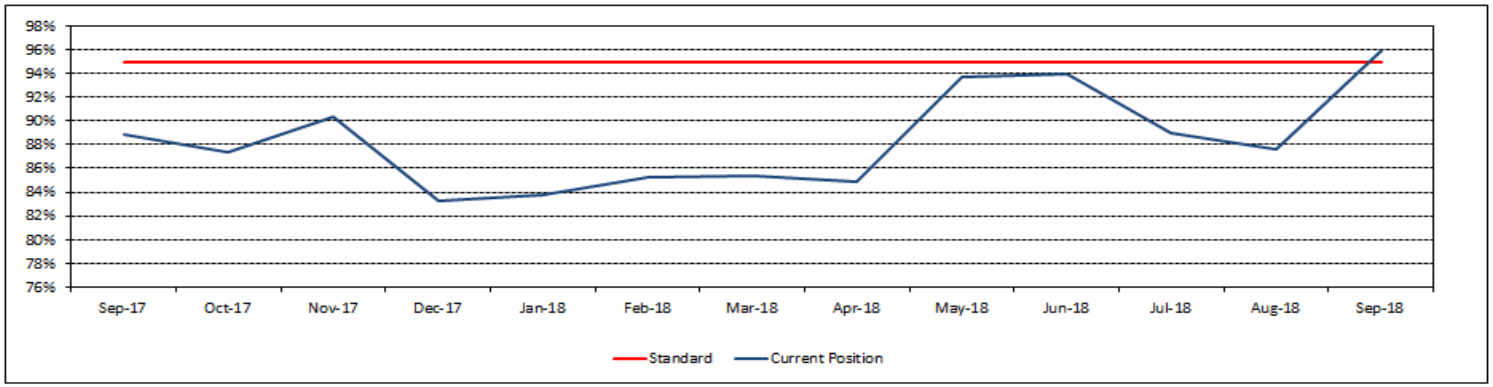
Indicator	A&E 4 hour wait
Standard	95%
Name	Nicola Cottington
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Performance in September was above the standard of 95%

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	88.90%	87.40%	90.40%	83.30%	83.80%	85.20%	85.40%	84.90%	93.70%	93.90%	89.00%	87.60%	95.90%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
A range of improvement actions are incorporated in the ED recovery action plan, and these continue, in order to sustain performance including those below: Medical staffing - new consultant commenced October 18. 2 new registrars recruited, await start date. Increase coverage of vacant night shifts including utilising ACPs to do additional shifts. September. Internal professional standards have been embedded within the department, so any delays from specialities are rapidly escalated and addressed. It will be vital to focus on flow throughout the hospital during Autumn/Winter to maintain performance, a range of actions have been taken including a 2 day Multi Agency Discharge Event planned for October.	NC	Jul-17	TBC



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

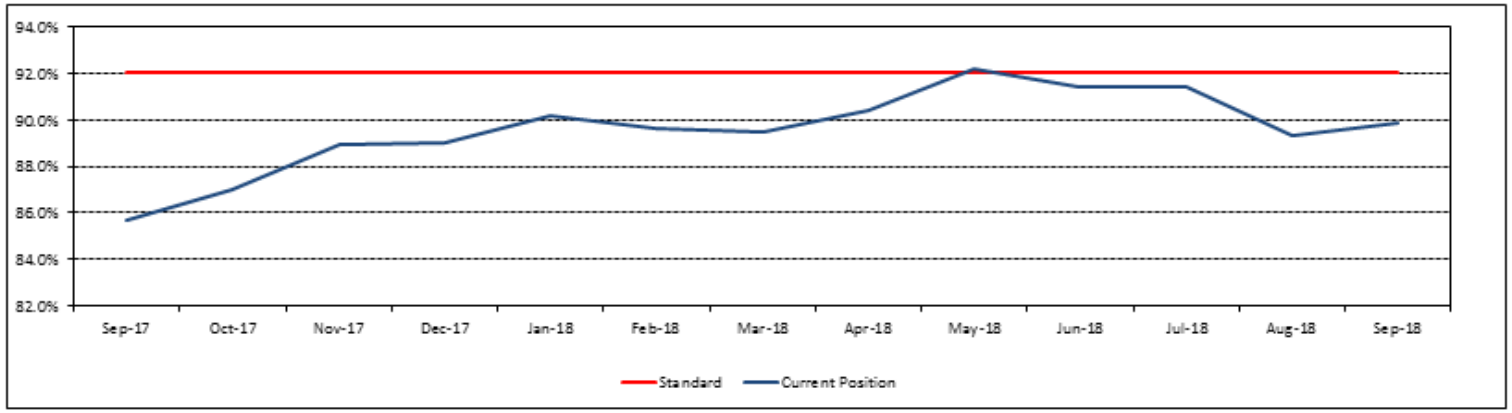
Indicator	RTT: % incomplete pathways within 18 weeks
Standard	92%
Name	Hannah Knights
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

September performance is slightly improved from August from 89.3% to 89.9%. The overall pot size has increased from 16697 to 18105, this is due to adding all the first appointments onto the PTL, which was previously not the case. The amount of patients over 18 weeks has gone from 1779 to 1830. The specialities which failed the 92% target are General Surgery (which includes vascular), Urology, Trauma and Orthopaedics, Ophthalmology, and Gynaecology. Gastroenterology has a much improved performance from 88.3% in August to 91.95% in September.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%
Current Position	85.7%	87.0%	88.9%	89.0%	90.2%	89.6%	89.5%	90.4%	92.2%	91.4%	91.4%	89.3%	89.9%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Targeted work is being undertaken to reduce the back log in challenged specialities. Options to outsource cataracts in Ophthalmology are currently being reviewed with the CCG. Development of a CNS in Vascular is underway, as well as asking other local hospitals if they have any immediate capacity. Urology continues to have pressure particularly around cancer services, which is impacted their ability to meet 18 weeks, new equipment will assist with the delivery of cancer targets and a new consultant in January will support the recovery of 18 weeks. Gynaecology are starting to see some improvement with the new consultants being embedded into clinics and theatre, however still have particular pressure around Uro-gynae.	HB	Jul-17	TBC



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	52 week waiters
Standard	0
Name	Hannah Knights
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Responsive

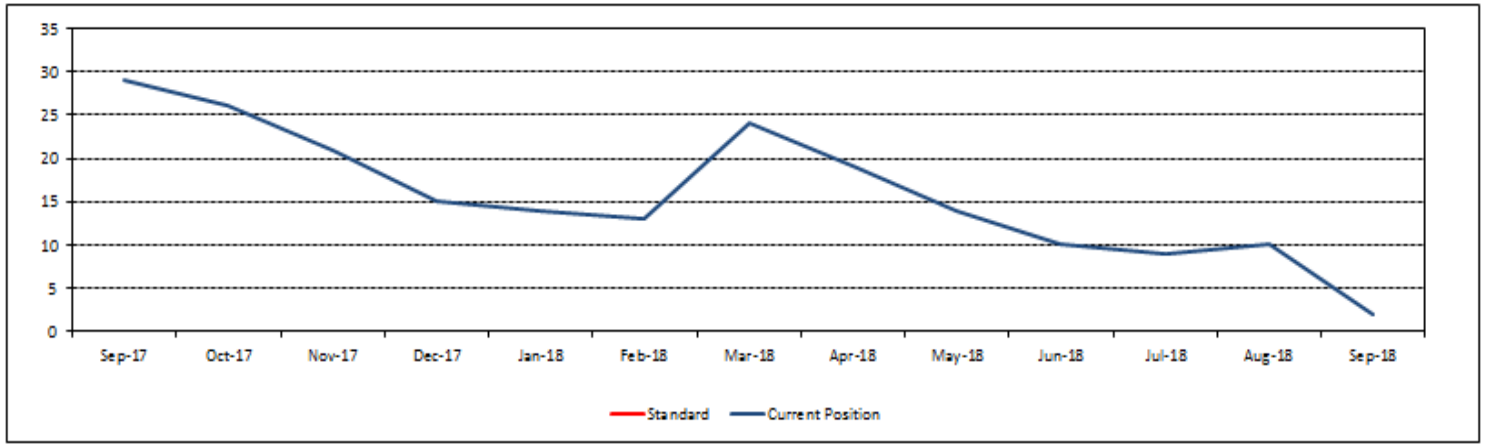
Summary of Current performance & Reasons for under performance

There were 2 patients who breached 52 weeks in September, a much improved position from August. Both were Colorectal patients, one has a TCI of the 14/11/2018 and the other has been returned to their GP.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	29	26	21	15	14	13	24	19	14	10	9	10	2

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

Description	Owner	Start	End
Long waiting patients are monitored on a weekly basis by the senior team to ensure proactive management. A clinical harm review process is in place to provide assurance that long waiting patients are not being exposed to harm. A trust wide RTT training strategy is currently being developed to reduce the risk of pathways being incorrectly coded.	HB	Jul-17	TBC



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancer 62 d GP Referral
Standard	85%
Name	Sam Dhungana
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Responsive

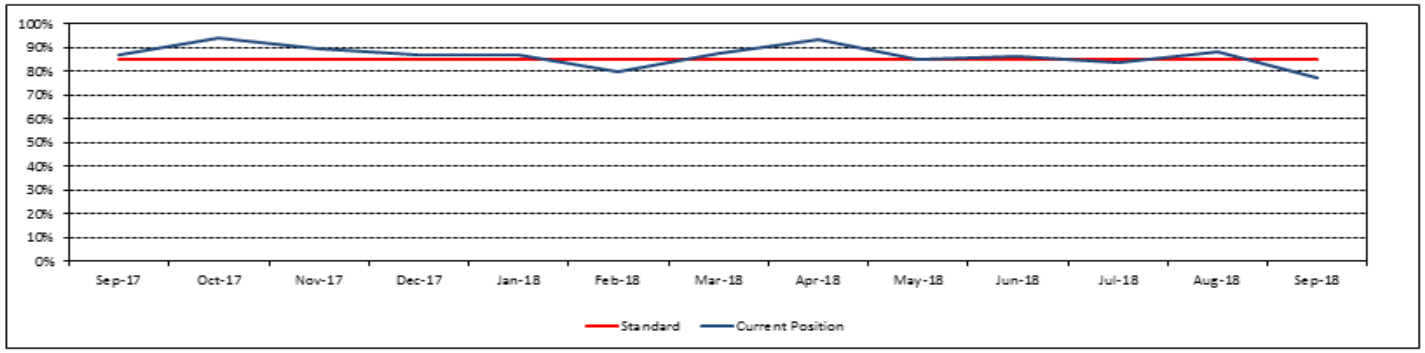
Summary of Current performance & Reasons for under performance

Current Performance: 77.4% September has been the most challenging of the months for the Trust in terms of 62 days cancer waits performance due to unprecedented number of - Urology- 6 local, Colorectal-2, Gynaecology -1 on a local pathway and H/N (ENT)-3, Upper GI -2, Urology-2, Breast-1, Gynaecology (<Colorectal)-1 and Skin >sarcoma -1 on a pathway shared with other providers. Unfortunately the surgery planned for Gynaecology patient was cancelled owing to consultant illness on the day and it happened 8 days past the breach date.

Out of 8 Urology breaches, 7 patients were on prostate pathway and delay was primarily around not result clinics appointment, capacities to book Perineal Template biopsies, getting the tissue diagnosis, organising results clinic to offer treatment options to patient and taking time to consider options and requiring to see different consultants before agreeing to the treatment plan. There patient treated with surgery had in time TCI but moved 2 days past the breach date and they also had acute presentation requiring A&E attendance around that time. Both the Breast and Gynaecology (originally referred as suspected Colorectal ca) patients had very complex presentations requiring multiple MDT/SMDT inputs to confirm diagnosis and stage of the disease to offer best treatment. There was delay in Path TAT to confirm diagnosis and the patient preferred specialist skin ca treatment at Addenbrookes.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%
Current Position	86.9%	93.9%	89.5%	87.1%	86.6%	79.8%	87.8%	93.3%	85.1%	86.5%	83.4%	88.4%	77.4%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Since good recovery in August, the performance has dipped but very significantly this month and a separate recovery plan is being prepared incorporating various actions in particular to improve Urology, Colorectal and ENT diagnostic pathways. Whilst it's in progress, relevant ADOs have received the copies of all recent 62 days RCAs with a view to agree and introduce improvement actions. The Cancer transformation funding to procure Saturation Biopsy Kit to improve Urology diagnostics and Colonoscopies to improve Endoscopy diagnostic for colorectal pathways are both progressing. All 62 days breach RCAs been sent over to the relevant clinicians in the MDT and the services for review and for learning opportunities to prevent future recurrences. There was no clinical harm reported on any of the reviewed pathways.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

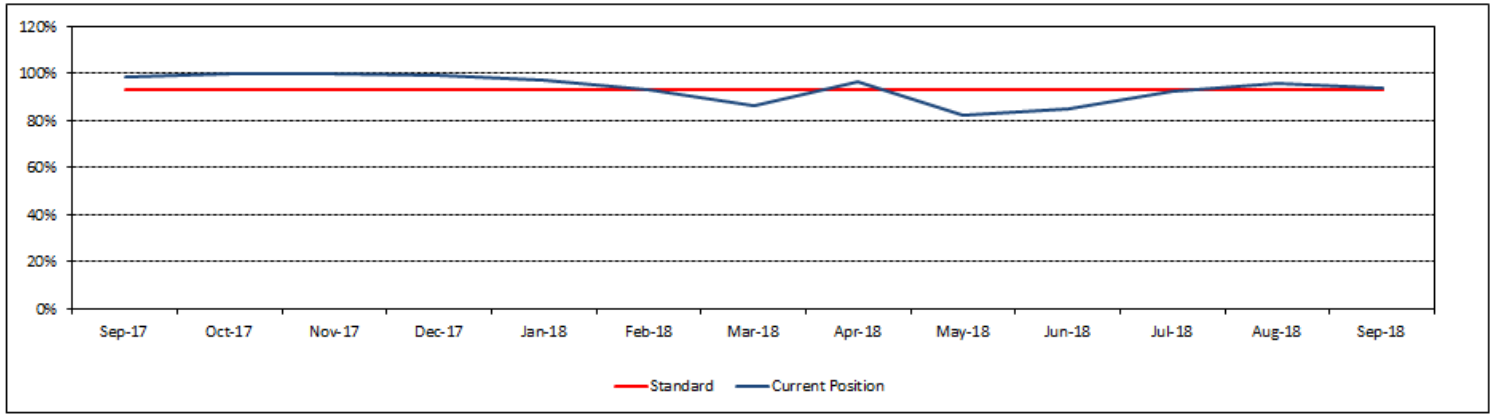
Indicator	Cancer 2w wait breast symptoms
Standard	93%
Name	Sam D
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current Performance- 93.9%. With 5 patients seen past the 14 days standard, this performance is sustained above 93%. All five breaches had one or other patient controlled / choice factors to contribute.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	98.3%	100%	100%	99.1%	97.1%	92.9%	86.7%	96.7%	82.6%	84.9%	92.8%	95.9%	93.9%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
This is a sustained performance. There is very little within the services to influence performance where patients cancel, as not able to attend an earlier appointment.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

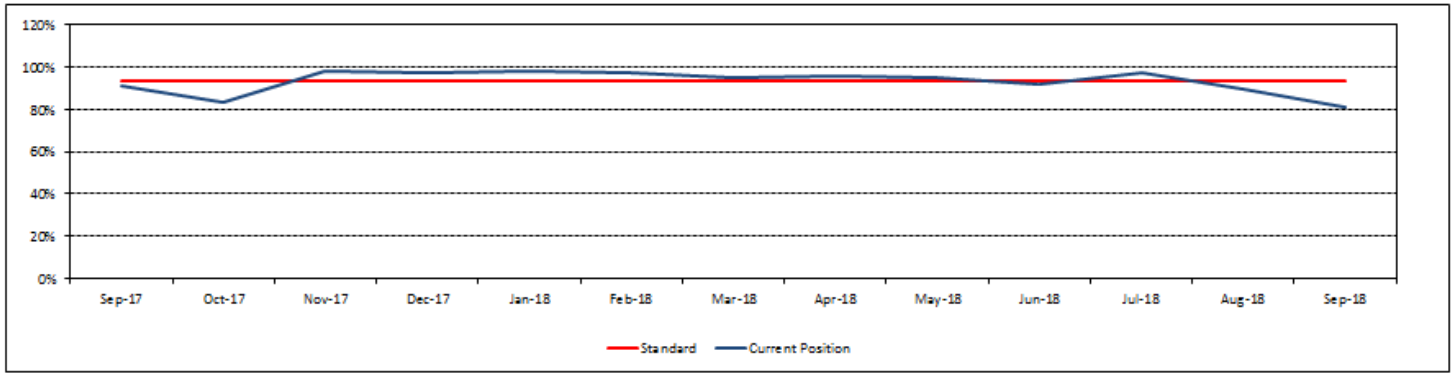
Indicator	Cancer: 2w wait for urgent GP Referrals
Standard	93%
Name	Sam Dhungana
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Current performance 80.9% - The underperformance is largely owing to limited capacity in dermatology services to be able to see patients within 14 days with only 25% of the referrals seen in time. Working with the CCG a new telederm service has been launched which is expected to support this position.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%	93%
Current Position	91.4%	83.4%	97.9%	97.2%	98.0%	97.5%	94.7%	95.9%	94.9%	91.6%	97.6%	89.5%	80.9%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
The Dermatology service were not successful in finding locum cover for either the locum consultant whilst they were away and sick leave. The situation will be reversed following the return of both Consultants and the performance of this service is likely to feature recovery from November. This will be dependent on the numbers of referrals as if they continue to increase it will put the service under more pressure and this will have an adverse effect on the 18 week target as routine patients will not be seen in favour of 2 week waits. As many of the Dermatology 2 week wait referrals received in July and August are booked over 14 days and are counted against September and October breach, there will be an ongoing impact on 2 week wait performance in the first place with added risk to the 62 days performance for the trust. The Dermatology service has reorganised outpatient clinics with theatre lists being taken on by the surgical nurse releasing the consultants to do rapid access clinics and also to utilise the support from other professionals. If appropriate, 2 week wait referrals have been passed directly to Plastic Surgery and it is also hoped to reduce the number of steps within the pathway. Patients have been offered earlier than originally booked out-patient dates in September and October, however patient up take of this offer has been limited so far. The Dermatology service continues to work with the CCG on referral criteria, pathways and GP tele-derm for routine patients. The hope was that these initiatives would help to reduce the number of routine referrals, thus potentially giving us some capacity to meet 2 week wait demand. All these initiatives are yet to be fully launched but expected to be in place by the end of October.	HB	Aug-18	Nov-18



55

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Cancer 62 d Screening
Standard	90%
Name	Sam Dhungana
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Responsive

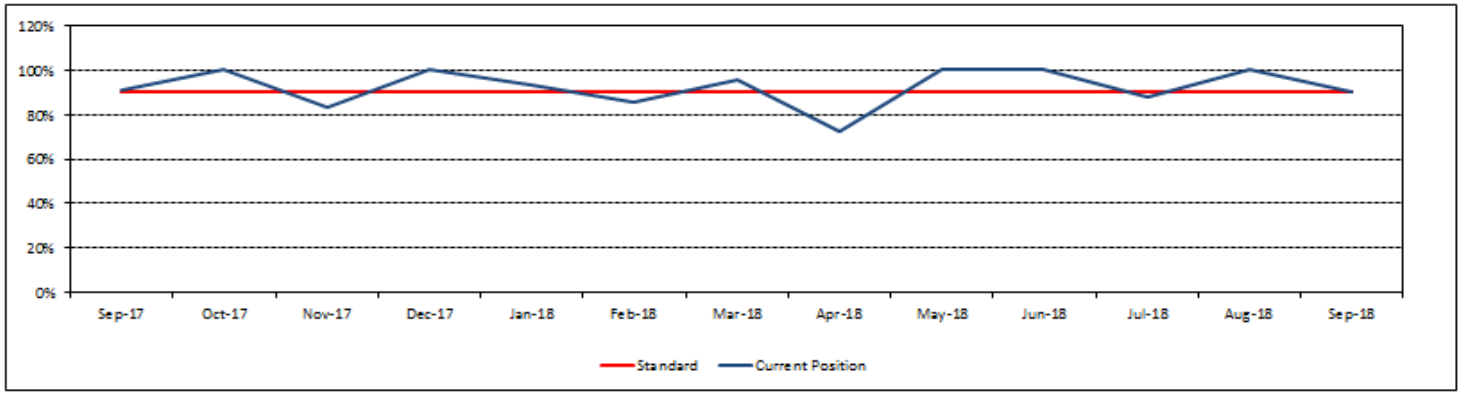
Summary of Current performance & Reasons for under performance

Current Performance 90.5% With one local breach on a Breast cancer Screening patient, the reported position reflects sustained performance above 90%. There was some delay in staging the disease and limited capacity during summer holidays meant patient commenced chemo treatment one day past the target date.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	90.9%	100%	83.3%	100%	93.3%	85.7%	95.5%	72.7%	100%	100%	88.2%	100%	90.5%

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

Description	Owner	Start	End
Performance sustained above 90%. Owing to small number of patients, any factors contributing to the delay in one pathway risks underperformance on this standard. Cancer services keep both the Breast and Colorectal teams well informed of the treatment target date as soon as a screening referral pathway starts and escalate likely delays with diagnostic/staging tests and or start of treatment to the relevant services to help offer an earlier appointment/TCI dates to these patients, where possible.	HB		



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Incomplete 104 day waits
Standard	0
Name	Sam Dhungana
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Responsive

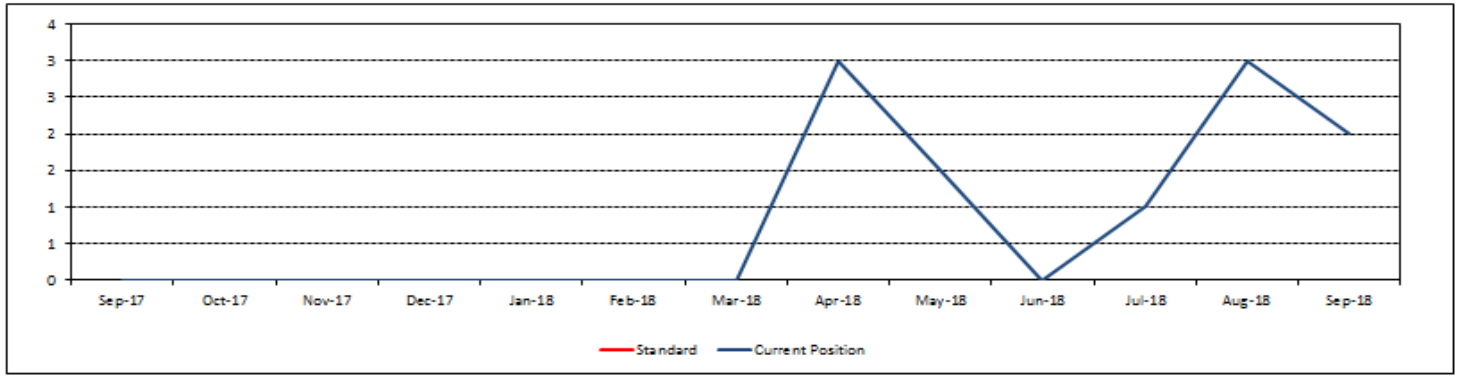
Summary of Current performance & Reasons for under performance

There was a combination of diagnostic and patient choice reasons contributing to long wait for one Colorectal and one Urology patients commencing treatment past 104 days at West Suffolk.
Urology- 113 day there was delay in getting tissue diagnosis and patient wanted to explore all active treatment options at the centre.
RCA review completed and MDT reported no clinical harm to the patient.
Colorectal -111 day Delay in diagnosis as patient cancelled initial diagnostic and subsequent test was non diagnostic requiring further scope and Radiology to confirm and stage and there was delay in surgery.
RCA being reviewed by the team and outcomes is awaited to confirm whether the delay resulted in any harm to the patient or not.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	0	0	0	0	0	0	0	0	0	0	0	0	0
Current Position	ND	ND	ND	ND	ND	ND	ND	3.0	1.5	0	1.0	3.0	2.0

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

Description	Owner	Start	End
Cancer Pathway Coordinator highlight the breach date on all RA patients from the first seen event and continue to escalate potential delays to relevant teams and services involved in the care of patients. Weekly Cancer PTL with pathway tracking comment is distributed to all senior managers across the divisions to inform services and operational managers on current status of all 62 days pathways and for them to offer help to expedite. This is in addition to regular escalation of pathways issues where patient waiting times is long and that risks pathway progress and potential to breach. Clinicians are requested to undertake case review of long waiting patients. Some of the pathways are complex and the wait is medically required. All breach RCAs are sent across to involved clinician and the services to see learning opportunities and also to confirm whether the delay resulted in any harm to patient. They are required to follow the Datix incident reporting system if long wait resulted in causing harm to the patient.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

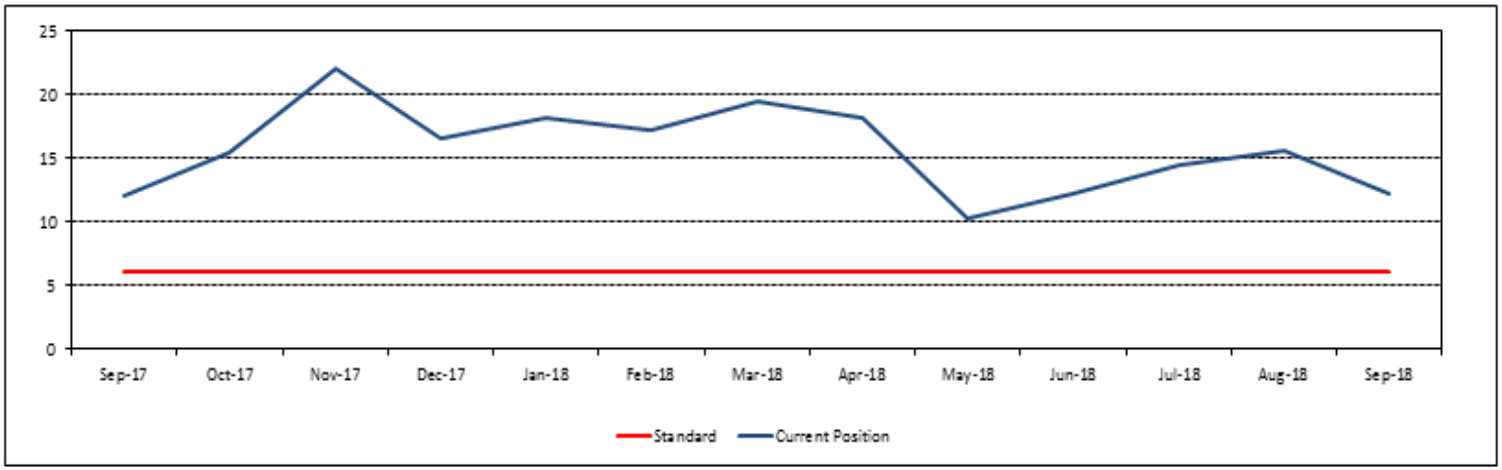
Indicator	A&E - Single longest Wait (Admitted & Non-Admitted)
Standard	6 Hours
Name	Nicola Cottington
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

This patient remained in ED due to clinical reasons.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	6	6	6	6	6	6	6	6	6	6	6	6	6
Current Position	12.01	15.44	22.04	16.48	18.11	17.18	19.50	18.14	10.30	12.22	14.49	15.54	12.23

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Actions in place to recover performance against the 4 hour standard, however due to clinical reasons there will be patients who are in the department for an extended period.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

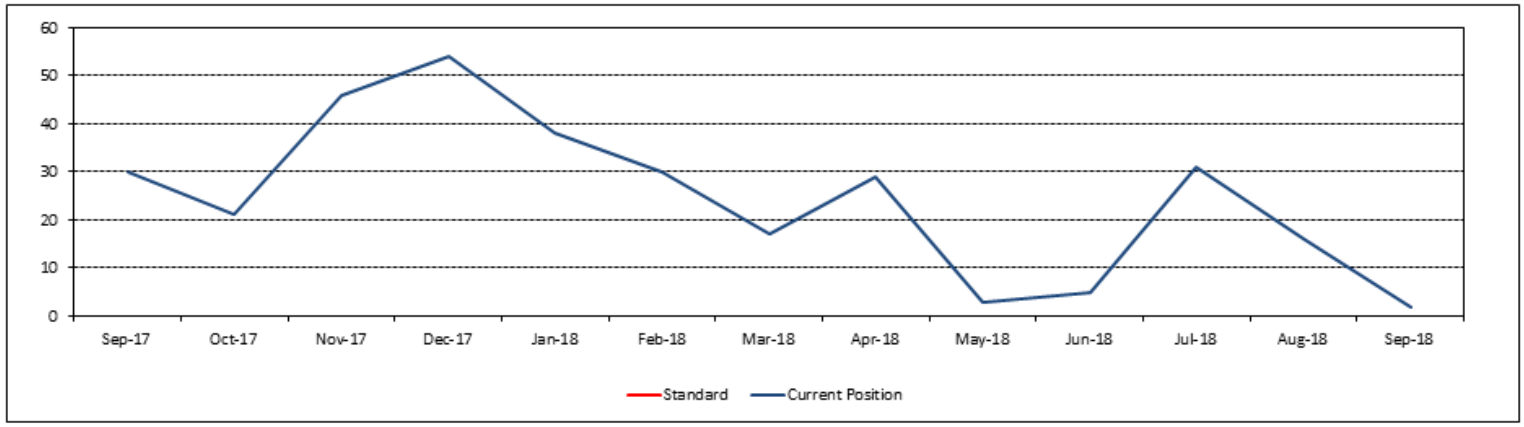
Indicator	A&E - Amb. Handover above 60m
Standard	0
Name	Nicola Cottington
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Responsive

Summary of Current performance & Reasons for under performance

Performance has improved compared to the previous month however there were still 2 delays over 60 minutes in September. Currently the physical space limitations in the Emergency Department mean there is no designated ambulance offload area if a number of ambulances arrive at once and the department is full.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Working closely with HALO to monitor and respond to ambulance demand Planning ambulance escalation area ahead of winter pressures- space to be finalised	NC	Oct-18	tbc



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Stroke - % Patients scanned within 1 hr.
Standard	77%
Name	Jane Allen
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Responsive

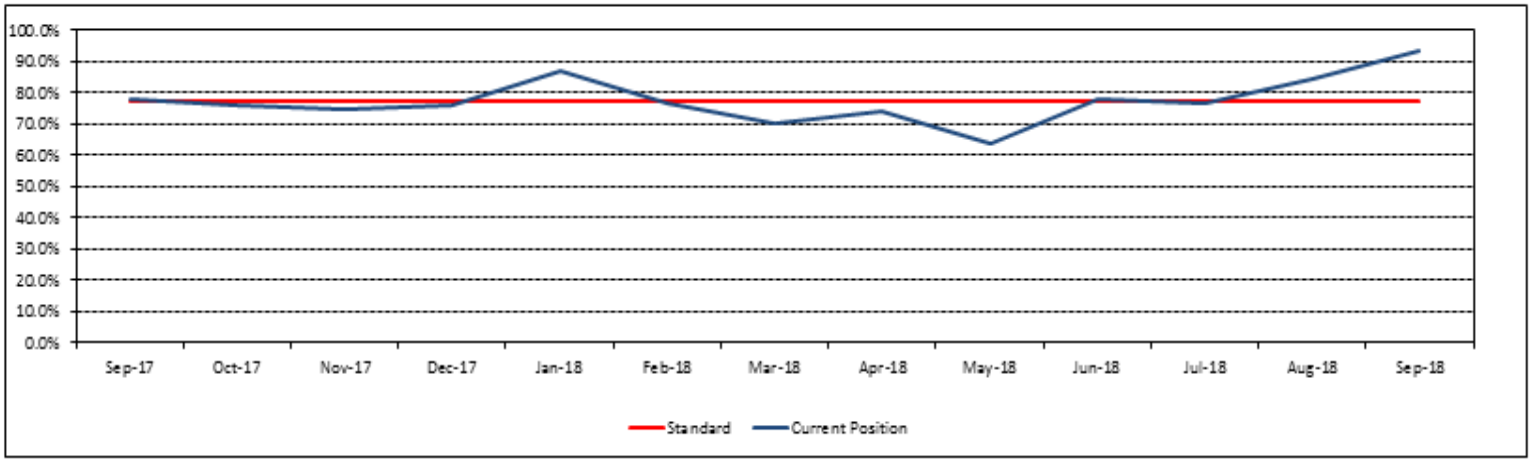
Summary of Current performance & Reasons for under performance

Target met despite a lower number of patients this month. Below actions continue.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%
Current Position	78.1%	75.7%	74.4%	75.6%	86.7%	76.7%	70.0%	73.7%	63.6%	77.7%	76.3%	84.4%	93.3%

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

Description	Owner	Start	End
Monthly breach review meeting with the service manager from ED and ESOT, looking for themes and solutions. Training arranged for triage nurses.	JA	Jul-18	Nov-18



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Stroke - % Patients admitted directly to stroke unit within 12h
Standard	96%
Name	Jane Allen
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Responsive

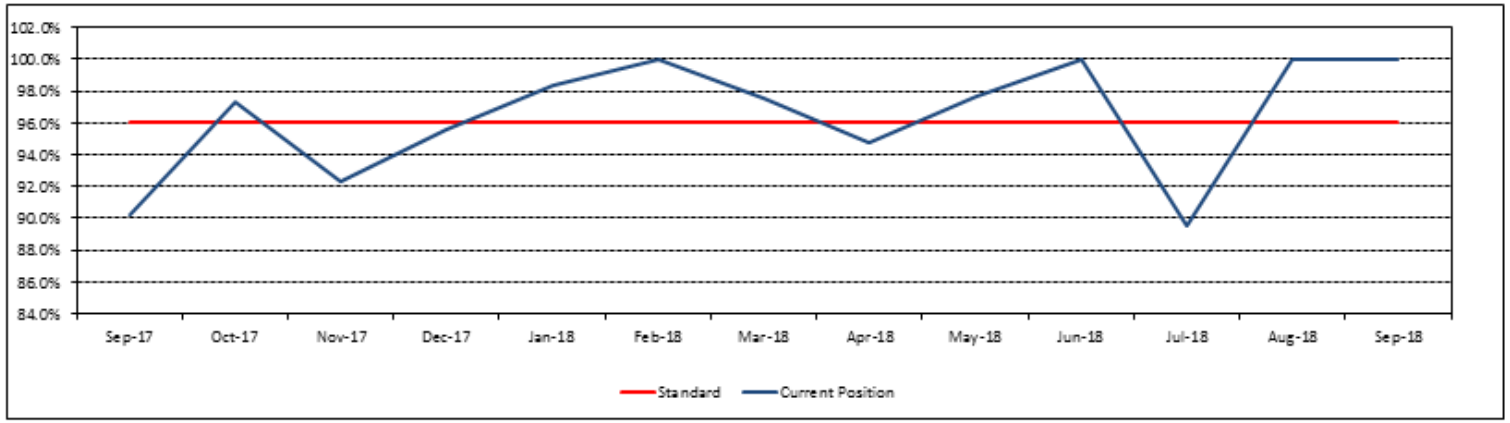
Summary of Current performance & Reasons for under performance

Achieved 100% on a target of 96%. Monthly breach review meetings and education in ED continues.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%
Current Position	90.2%	97.3%	92.3%	95.6%	98.3%	100%	97.5%	94.7%	97.7%	100%	89.5%	100%	100%

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

Description	Owner	Start	End
Monthly breach review meeting with the service manager from ED and ESOT, looking for themes and solutions.	JA	Jul-18	Nov-18



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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	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD(Apr18 Mar19)
	Agency, WTE & vacancies	5.09	Agency Spend Cap		378	378	378	378	378	378	378	ND	ND	ND	ND	ND	ND	ND
		5.10	Bank Spend		1112	1195	1179	1326	1078	1093	996	1340	1361	ND	ND	ND	ND	1351
		5.11	Bank/agency Spend percentage		4.7%	3.8%	4.0%	5.0%	5.7%	ND	6.4%	4.2%	ND	ND	ND	ND	ND	4.2%
		5.12	Proportion of Temporary Staff		10.6%	10.1%	10.9%	8.0%	11.1%	11.3%	11.0%	12.5%	11.9%	9.7%	11.3%	12.7%	12.0%	11.7%
		5.13	Locum and Medical agency spend		270	357	381	508	495	487	468	398	319	468	624	524	523	476
		5.57	Additional sessions		180	198	233	238	136	186	167	253	238	207	161	270	271	233
		5.14	Total Vacancies		7.6%	7.8%	8.0%	8.0%	7.1%	7.9%	ND	8.0%	ND	ND	ND	ND	ND	8.0%
		5.15	Corporate & Admin Costs as %	<7%	9.5%	8.6%	8.6%	11.1%	13.3%	10.7%	ND	9.7%	ND	ND	ND	ND	ND	9.7%
		5.16	% Staff on Maternity/Paternity Leave		2.0%	2.0%	2.0%	2.0%	1.9%	2.0%	1.9%	2.0%	2.3%	2.38%	2.43%	2.60%	2.64%	2.39%
	Other	5.17	Grievance reviews		6	6	6	5	5	5	4	5	4	4	3	3	4	23
		5.18	Recruitment Timescales - Av no. of weeks to recruit	7	6.7	6.9	6.9	6.4	5.4	5.4	5.4	5.4	5.6	5.4	5.4	5.0	6.1	5.5
		5.19	DBS checks	95%	98.5%	97.5%	97.5%	98.5%	98.5%	98.0%	97.0%	98.0%	97.5%	98.0%	98.0%	98.0%	98.0%	97.9%
		5.20	Staff appraisal Rates	90%	53.1%	50.8%	55.8%	62.0%	65.0%	62.3%	63.0%	67.0%	67.3%	69.3%	75.8%	75.2%	76.9%	71.9%
		5.21	Trust Participation in on-going National Audits (Qtrly)	90%	96.0%	NA	NA	96.0%	NA	NA	96.0%	NA	NA	ND	ND	NA	ND	NA

Are we		Ref.	KPI	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD(Apr18 Mar19)
5. Well Led	Training	5.22	Infection Control Training (classroom)	85%	94.5%	94.7%	95.0%	95.0%	94.0%	94.0%	95.0%	94.0%	95.0%	94.0%	95.0%	95.0%	95.0%	94.7%
		5.23	Infection Control Training (eLearning)	85%	83.4%	85.1%	88.0%	88.0%	90.0%	90.0%	90.0%	90.0%	90.0%	91.0%	90.0%	87.0%	90.0%	89.7%
		5.24	Manual Handling Training (Patient)	80%	80.2%	80.4%	84.0%	84.0%	79.0%	79.0%	79.0%	74.0%	76.0%	77.0%	75.0%	79.0%	76.0%	76.2%
		5.25	Manual Handling Training (Non Patient)	80%	85.5%	84.4%	88.0%	88.0%	89.0%	89.0%	88.0%	88.0%	88.0%	83.0%	83.0%	81.0%	85.0%	84.7%
		5.26	Staff Adult Safeguarding Training	80%	89.1%	90.2%	92.0%	92.0%	92.0%	92.0%	92.0%	91.0%	91.0%	92.0%	90.0%	89.0%	91.0%	90.7%
		5.27	Safeguarding Children Level 1	90%	86.5%	88.0%	89.0%	90.0%	91.0%	91.0%	90.0%	90.0%	90.0%	89.0%	89.0%	88.0%	89.0%	89.2%
		5.28	Safeguarding Children Level 2	90%	87.9%	88.6%	90.0%	92.0%	92.0%	92.0%	91.0%	91.0%	90.0%	91.0%	91.0%	89.0%	90.0%	90.3%
		5.29	Safeguarding Children Level 3	90%	73.4%	78.6%	83.0%	86.0%	86.0%	88.0%	83.0%	95.0%	94.0%	94.0%	94.0%	89.0%	91.0%	92.8%
		5.30	Health & Safety Training	80%	89.1%	89.8%	91.0%	91.0%	92.0%	92.0%	91.0%	90.0%	90.0%	91.0%	91.0%	89.0%	90.0%	90.2%
		5.31	Security Awareness Training	80%	88.7%	89.6%	90.0%	91.0%	91.0%	91.0%	90.0%	90.0%	90.0%	91.0%	90.0%	89.0%	89.0%	89.8%
		5.32	Conflict Resolution Training (eLearning)	80%	80.0%	81.4%	82.0%	95.0%	76.0%	85.0%	84.0%	86.0%	87.0%	87.0%	88.0%	82.0%	83.0%	85.5%
		5.33	Conflict Resolution Training	80%	74.5%	76.5%	76.0%	75.0%	88.0%	76.0%	76.0%	69.0%	70.0%	70.0%	71.0%	73.0%	71.0%	70.7%
		5.34	Fire Training (eLearning)	80%	85.0%	85.0%	85.0%	84.0%	84.0%	84.0%	82.0%	80.0%	82.0%	81.0%	81.0%	84.0%	91.0%	83.2%
		5.35	Fire Training (classroom)	80%	89.3%	90.0%	91.0%	91.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	89.0%	90.0%	84.0%	88.8%
		5.36	IG Training	80%	83.6%	87.0%	86.0%	87.0%	84.0%	84.0%	82.0%	86.0%	86.0%	83.0%	84.0%	82.0%	82.0%	83.8%
		5.37	Equality and Diversity	80%	92.3%	93.0%	94.0%	94.0%	88.0%	88.0%	83.0%	81.0%	80.0%	79.0%	79.0%	79.0%	80.0%	79.7%
		5.38	Majax Training	80%	86.5%	88.0%	88.0%	89.0%	90.0%	90.0%	88.0%	88.0%	88.0%	89.0%	88.0%	88.0%	88.0%	88.2%
		5.39	Medicines Management Training	80%	87.1%	86.0%	87.0%	88.0%	89.0%	89.0%	88.0%	87.0%	87.0%	88.0%	89.0%	87.0%	86.0%	87.3%
		5.40	Slips, trips and falls Training	80%	84.9%	86.0%	88.0%	88.0%	87.0%	87.0%	87.0%	85.0%	85.0%	86.0%	86.0%	86.0%	85.0%	85.5%
		5.41	Blood-borne Viruses/Inoculation Incidents	80%	83.8%	85.0%	86.0%	87.0%	86.0%	86.0%	86.0%	85.0%	86.0%	87.0%	88.0%	85.0%	86.0%	86.2%
		5.42	Basic life support training (adult)	80%	81.7%	81.0%	81.0%	82.0%	80.0%	80.0%	78.0%	75.0%	76.0%	76.0%	75.0%	79.0%	79.0%	76.7%
		5.43	Blood Products & Transfusion Processes (Refresher)	80%	79.5%	80.0%	78.0%	80.0%	75.0%	75.0%	72.0%	73.0%	72.0%	73.0%	74.0%	74.0%	73.0%	73.2%
		5.44	Mandatory Training Compliance	90%	NA	86.3%	88.1%	88.7%	84.6%	83.2%	82.8%	83.3%	84.0%	85.0%	84.0%	84.0%	85.0%	84.2%
		5.55	Safeguarding Children Mandatory Compliance (Community)	90%	96.8%	95.3%	96.1%	96.0%	95.9%	95.7%	97.0%	98.2%	95.8%	95.3%	94.7%	95.1%	96.2%	95.9%
		5.56	Safeguarding Adults Mandatory Training Compliance (Comm	90%	96.1%	94.3%	95.3%	94.0%	94.1%	93.2%	95.6%	96.0%	95.0%	94.9%	94.3%	94.9%	97.0%	95.4%

A separate report is being presented on Appraisal to the board in addition to the information above.

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EXCEPTION REPORTS – WELL LED

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

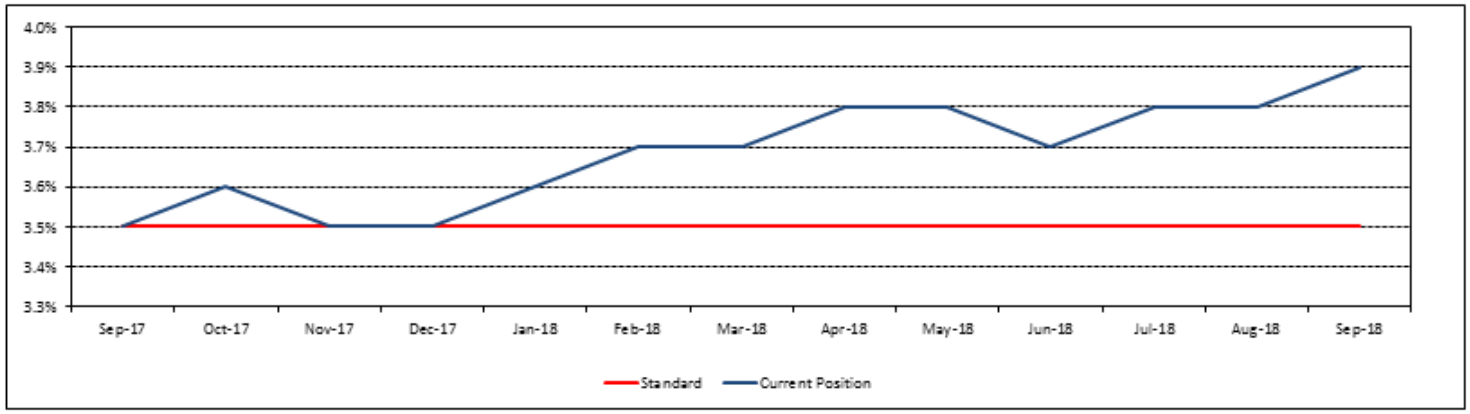
Indicator	Sickness Absence
Standard	3.5%
Name	Denise Needle
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

The sickness absence rate has risen this month to 3.86 %, it is a rise of 0.04%, but is clearly in the wrong direction.
The Trust is actively encouraging all staff to have the flu jab in order to try and minimise any dramatic increases over the winter period.
Other actions remain in place to support managers to manage both short term and long term absence.

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

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



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

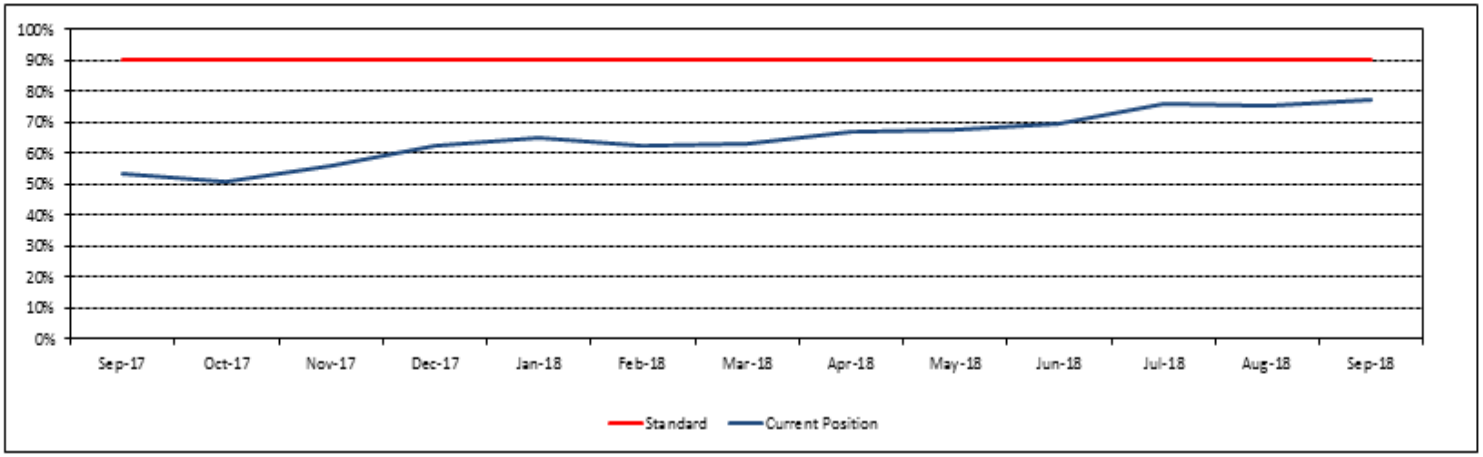
Indicator	Staff appraisal Rates
Standard	90%
Name	Denise Needle
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

The appraisal rate for September 2018 is 76.87%. This shows a steady but increasing level of compliance from September of last year, when a new reporting system was implemented. Further actions to improve compliance, such as targeting those staff who the system shows as having no appraisal on record have been implemented and this is having a slow but positive impact on compliance. The Chief Operating Office is holding monthly meeting with teams to review appraisals via PTL style reports.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Current Position	53.1%	50.8%	55.8%	62.0%	65.0%	62.3%	63.0%	67.0%	67.3%	69.3%	75.8%	75.2%	76.9%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Actions remain in place to support managers to manage both short term and long term absence.	DN		



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

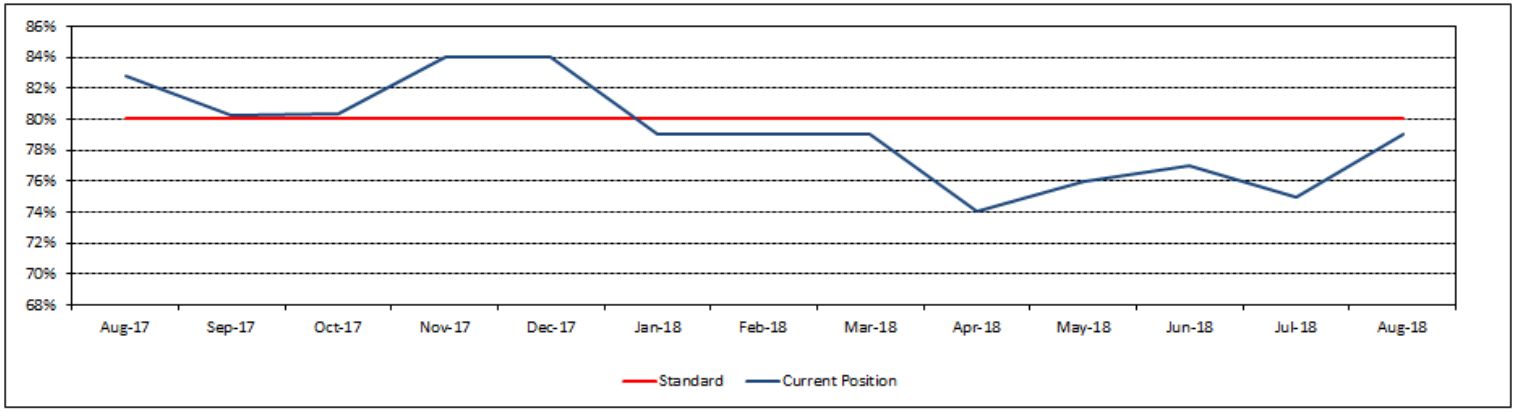
Indicator	Manual Handling Training (Patient)
Standard	80%
Name	Ian Beck
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

The Moving and Handling teams current performance is in line with what it has been for the last 6 years. More training sessions are being provided and we have cancelled no sessions. Since the inheritance of community workforce time to provide extra sessions would be difficult as well as the Moving and Handling team are now providing Display Screen Assessment advice for the acute and the community. The reasons for under performance is the attendance to the sessions which was poor at he beginning of the year. When there is staff shortages on the wards often nurses who are on training are asked to work.

Month	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Current Position	82.8%	80.2%	80.4%	84.0%	84.0%	79.0%	79.0%	79.0%	74.0%	76.0%	77.0%	75.0%	79.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
To continue to provide as many sessions as possible to clinical staff and hope that the trusts latest recruitment drive see staff being released for training. Planning to put together a case to recruit a new member of staff to assist with training and other departmental tasks. This will allow more training sessions to take place.	Neil Herbert	Sep-18	On-going



WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Basic life support training (adult)
Standard	90%
Name	Julie Head
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Well Led

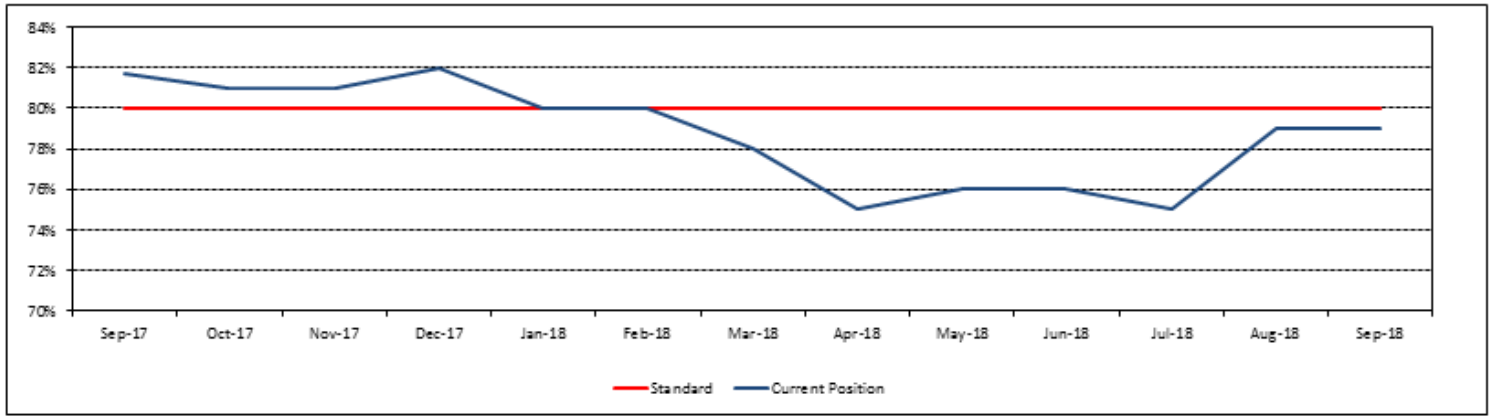
Summary of Current performance & Reasons for under performance

Resuscitation Services are currently in the process of recruiting more band 6 training staff in order to deliver all deteriorating patient education, including basic life support. This extra resource will allow us to deliver basic life support to the wider Trust staff, including community. However, this does not allow for staff training cancellations

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Current Position	81.7%	81.0%	81.0%	82.0%	80.0%	80.0%	78.0%	75.0%	76.0%	76.0%	75.0%	79.0%	79.0%

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

Description	Owner	Start	End
A VAF for a band 6 WTE Resuscitation Trainer has been requested. This is awaiting response	JH & ST	Jul-18	TBA



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

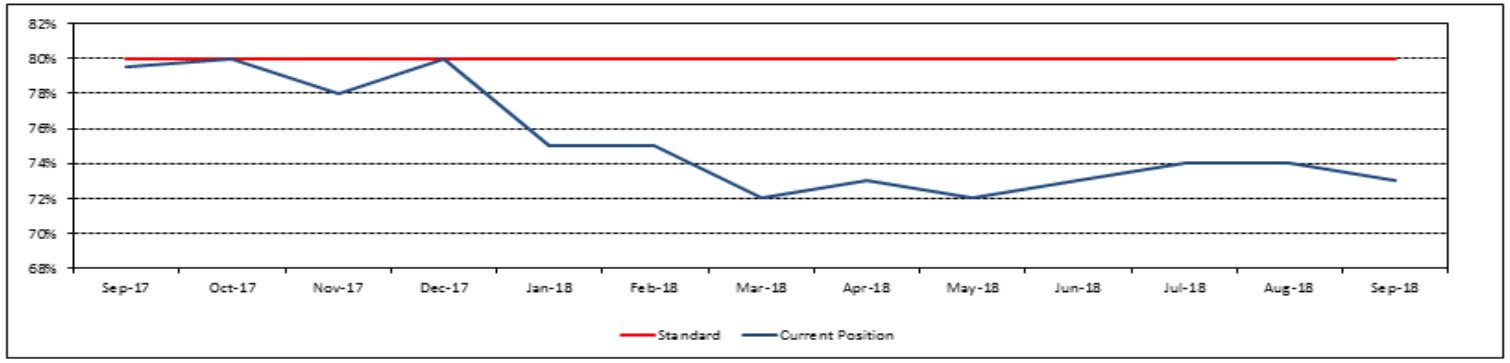
Indicator	Blood Products & Transfusion Processes (Refresher)
Standard	80%
Name	Gilda Bass
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Well Led

Summary of Current performance & Reasons for under performance

Detailed investigations & data analysis have been undertaken to identify the reason for staff non compliance but to date no obvious reason can be found for the continual deterioration in compliance beyond the fact that clinical staff are not completing their e-learning as per Trust policy. The competency matrix review has not been completed due to delay in information from the community being submitted as requested.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Current Position	79.5%	80.0%	78.0%	80.0%	75.0%	75.0%	72.0%	73.0%	72.0%	73.0%	74.0%	74.0%	73.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
1) Review & revise training/competency matrix.	G Bass/J Hoyle	Aug-18	Sep-18
2) Additional face to face updates have been implemented for Theatre staff, Porters, Midwifery, A&E Drs & Paediatric Drs.	G Bass/J Hoyle	Jan-17	Ongoing
3) Monthly reports are sent to CDs & senior managers highlighting staff that are non-compliant.	G Bass/J Hoyle	Oct-10	Ongoing
4) Personalised reports sent to Matrons listing which nursing staff need to complete their mandatory training	G Bass/J Hoyle	Aug-18	Aug-18



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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	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD(Apr18-Mar19)
6. Productive	Activity	6.07	A&E Activity		5743	6065	5985	5959	6033	5639	6172	5967	6498	6161	6564	6072	6072	37334
		6.08	NEL Activity		2466	2586	2491	2528	2539	2406	2557	2273	2474	2471	2475	2372	2359	14424
		6.09	OP - New Appointments		5633	6182	7230	5482	6769	5849	6324	6033	6930	6379	6598	6007	7874	39821
		6.10	OP- Follow-Up Appointments		11116	11815	12668	9769	12673	11103	11609	11142	12248	11520	11750	10929	18327	75916
		6.11	Electives (Incl Daycase)		2786	2868	3157	2545	2841	2632	2871	2665	3019	2799	2871	2788	2739	16881
		6.12	Financial Position (YTD)	Var	-3953	-4114	-5170	-6600	-6525	-6525	-287	-1760	-2793	-3159	-4420	-5641	-7119	-24892
		6.13	Financial Stability Risk Rating	Var	3	3	3	3	3	3	3	3	3	3	3	3	3	18
		6.14	Cash Position (YTD £000s)	Var	4846	2654	3518	4924	6870	3600	3600	5,322	4550	2239	6852	7231	3934	30128

EXCEPTION REPORTS – PRODUCTIVE

The finance report contains full details.

10. DETAILED REPORTS- MATERNITY

		Ref.	KPI	Target	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	YTD(Apr18-Mar19)
Maternity	Safe	7.09	Elective Caesarean Sections	10%	6.4%	5.9%	7.2%	7.8%	8.0%	7.1%	10.7%	11.8%	10.9%	7.6%	4.7%	7.8%	9.6%	8.7%
		7.10	Emergency Caesarean Sections	0-220,224+	11.9%	11.2%	9.8%	10.6%	14.1%	10.1%	19.4%	16.4%	11.4%	10.6%	12.4%	9.2%	13.0%	12.2%
		7.11	Grade 1 Caesarean Section (Decision to delivery time met)	100%	100%	0.0%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		7.12	Grade 2 Caesarean Section (Decision to delivery time met)	80%	82.0%	88.0%	50.0%	80.0%	83.0%	83.0%	81.0%	82.0%	93.0%	90.0%	58.0%	64.0%	82.0%	78.2%
		7.13	Homebirths	2%	2.1%	3.9%	2.6%	3.3%	3.0%	2.4%	0.5%	2.6%	5.0%	1.5%	2.4%	1.5%	3.8%	2.8%
		7.14	Midwifery led birthing unit (MLBU) births	>13%	15.3%	17.1%	16.0%	15.0%	19.1%	18.0%	14.1%	16.4%	11.4%	11.4%	18.8%	17.0%	11.5%	14.4%
		7.15	Labour Suite births	77.5%	82.6%	79.0%	81.4%	81.7%	77.9%	79.6%	85.4%	81.0%	83.0%	86.9%	78.2%	80.6%	83.7%	82.2%
		7.16	Induction of Labour	29.3	34.3%	35.1%	43.8%	43.9%	37.2%	41.2%	37.4%	41.0%	37.8%	40.9%	37.6%	36.4%	34.1%	38.0%
		7.17	Instrument Assisted Deliveries (Forceps & VentoUse)	>14	4.7%	4.2%	7.2%	5.9%	7.0%	7.6%	6.8%	13.0%	9.5%	10.1%	10.0%	12.6%	11.5%	11.1%
		7.18	Critical Care Obstetric Admissions	0	1	0	0	0	2	0	1	1	2	1	0	1	1	6
		7.19	Eclampsia	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Effective	7.20	Shoulder Dystocia	2	7	6	4	5	4	5	8	5	6	8	5	6	9	39
		7.21	Post-partum Hysterectomies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		7.22	Women requiring a blood transfusion of 4 units or more	0	0	0	0	ND	ND	ND	ND	0	0	1	2	0	0	3
		7.23	3rd and 4th degree tears (all deliveries)	12	4	6	3	8	9	7	2	9	4	6	4	7	7	37
	Caring	7.24	Maternal death	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		7.25	Stillbirths	NT	1	2	1	0	2	0	0	1	1	0	1	0	0	3
		7.26	Complaints		0	0	0	1	0	0	1	0	ND	0	3	1	0	4
		7.27	No. of babies admitted to Neonatal Unit (>36+6)	NT	15	15	11	9	8	16	12	18	10	9	7	13	8	65
	Responsive	7.28	No. of babies transferred for therapeutic cooling	0	0	1	0	1	0	0	0	1	0	0	0	0	0	1
		7.29	One to one care in established labour	100%	100%	100%	100%	100%	100%	100%	100%	91.0%	93.0%	92.3%	97.0%	97.0%	100%	95.1%
		7.30	Reported Clinical Incidents	50	52	61	57	49	63	46	48	46	56	48	27	39	44	260
		7.31	Hours of dedicated consultant cover per week	60	99	99	108	90	102	93	93	94	90	93	93	90	87	547
		7.32	Consultant Anaesthetists sessions on Labour Suite	10	10	10	10	10	10	10	10	10	10	10	10	10	10	60
		7.33	OPD cover for Theatre 2	100%	100%	100%	100%	100%	100%	100%	100%	ND	ND	ND	ND	ND	ND	ND
		7.34	No. of women identified as smoking at booking	NT	37	27	28	17	26	21	30	26	31	22	19	21	23	142
		7.35	No. of women identified as smoking at delivery	NT	25	25	24	26	21	22	24	23	26	14	15	27	21	126
		7.36	UNICEF Baby friendly audits	10	10	10	10	10	10	ND	10	ND	ND	10	ND	ND	ND	10
		7.37	Proportion of parents receiving Safer Sleeping Suffolk advic	80%	ND	ND	ND	ND	ND	ND	ND	62.9%	77.8%	81.8%	88.0%	80.0%	96.0%	81.1%
	Other	7.38	No. of bookings (First visit)	NT	265	259	245	193	279	253	274	240	251	237	252	236	231	1447
		7.39	Women booked before 12+6 weeks	95%	92.8%	99.0%	97.0%	97.0%	96.0%	96.0%	ND	95.4%	96.0%	96.6%	94.4%	96.0%	92.0%	95.1%
		7.40	Female Genital Mutilation (FGM)	NT	0	0	0	0	0	1	0	0	0	0	0	0	0	0

EXCEPTION REPORTS – MATERNITY

WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

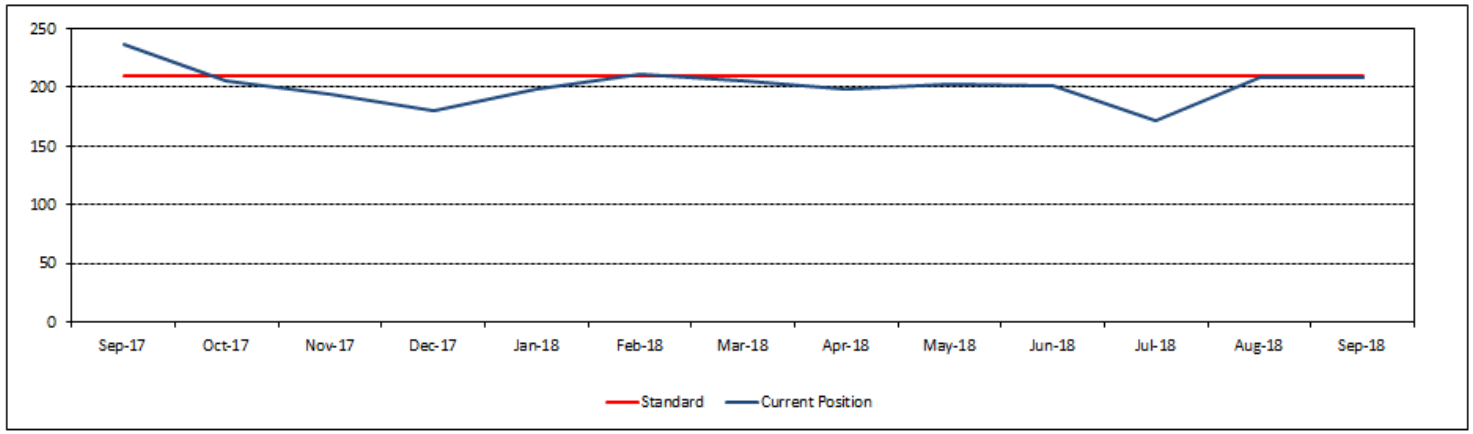
Indicator	Total number of deliveries (births)
Standard	210
Name	Jane Lovedale
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The maternity service is very aware of the reduced number of babies born during the last few months. However there has been an increase in the number of deliveries this month. The service is monitoring this closely and is commencing projects to attract some mothers who currently chose to birth at neighbouring units to West Suffolk Hospital.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	210	210	210	210	210	210	210	210	210	210	210	210	210
Current Position	236	205	194	180	199	211	206	198	203	201	172	208	208

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Close monitoring ongoing.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

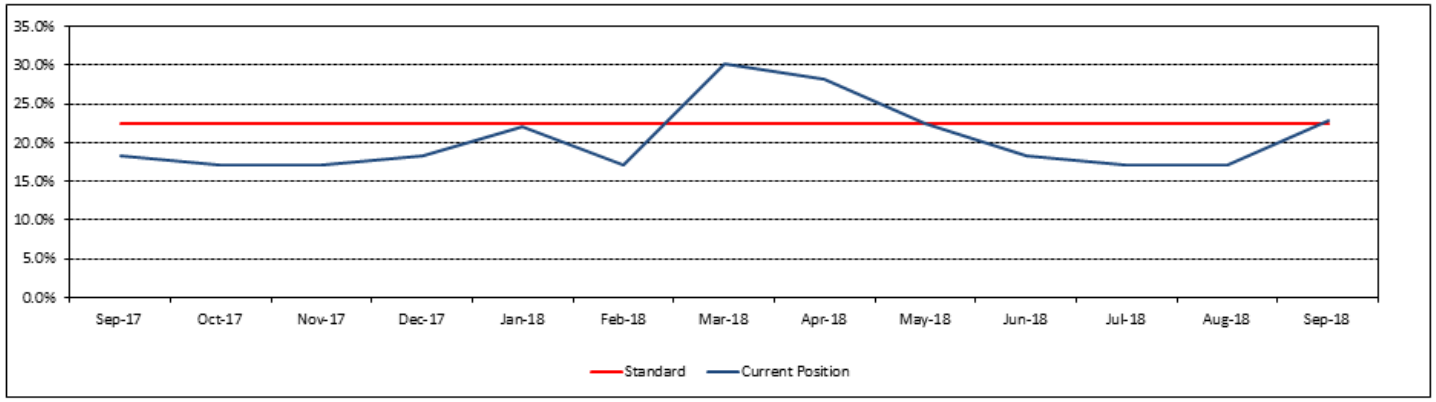
Indicator	% of all caesarean sections
Standard	23%
Name	Jane Lovedale
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

The total number of Caesarean sections this month to 22.8% this is 0.2% above our commissioned rate of 22.6% . The reason for this due to a slight rise in the emergency Caesarean sections rate to 13% (1% higher than the current standard of 12%) The elective Caesarean sections rate remains below the our standard. Caesarean sections should be reviewed together with the rate of instrumental delivery and normal births and this is reflected in the reduced numbers this month of both instrumental delivery and normal vaginal delivery. Where there are concerns with either mother or baby in the first stage of labour Caesarean sections is the only option for delivery. The maternity service monitors all emergency caesarean sections in a multi professional meeting weekly any learning from this is fed back to individuals or published in Risky Business. The rate of Elective Caesarean sections are monitored monthly at the Governance meeting. We will continue to monitor the Caesarean sections rates.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	22.5%	22.5%	22.5%	22.5%	22.5%	22.5%	22.5%	22.5%	22.5%	22.5%	22.5%	22.5%	22.5%
Current Position	18.2%	17.1%	17.0%	18.3%	22.1%	17.1%	30.1%	28.2%	22.4%	18.2%	17.1%	17.0%	22.8%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Monitor if this is a trend or if this is a one off month.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

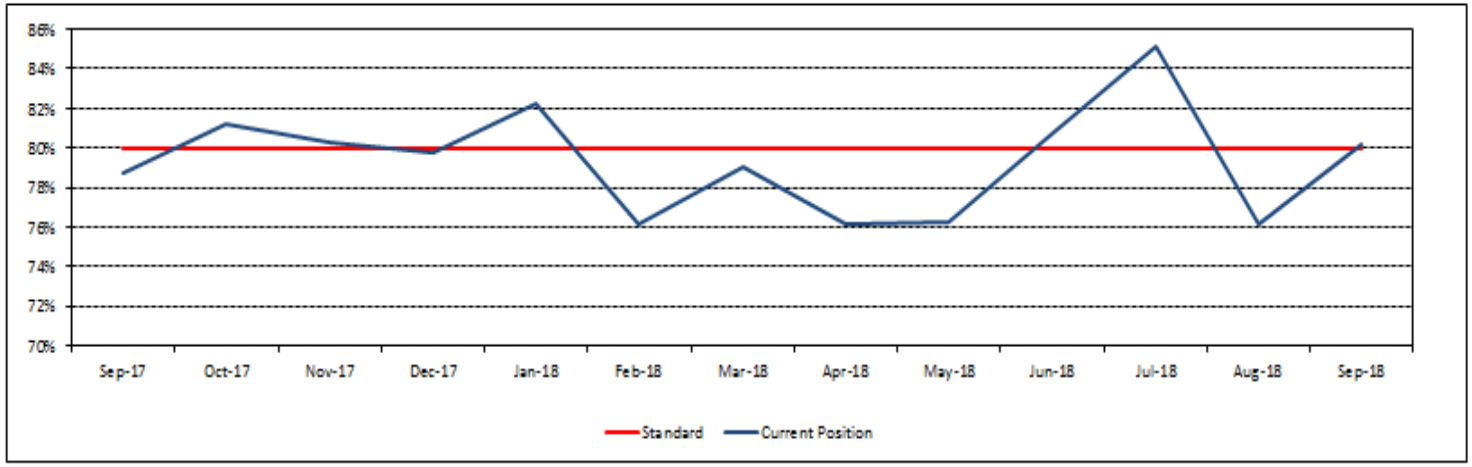
Indicator	Breastfeeding Initiation Rates
Standard	80%
Name	Jane Lovedale
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Breast feeding is associated with significant benefits to both mothers and babies. This month we have achieved over 80% in initiation rate. Staff continue to work hard at promoting breast feeding and supporting women who wish to breast feed . This pleasing result this month will be fed back to staff at our daily Take 5 communication.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Current Position	78.7%	81.2%	80.3%	79.8%	82.2%	76.2%	79.0%	76.1%	76.3%	80.7%	85.1%	76.2%	80.2%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Positive feedback to staff on the Take 5 communication.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

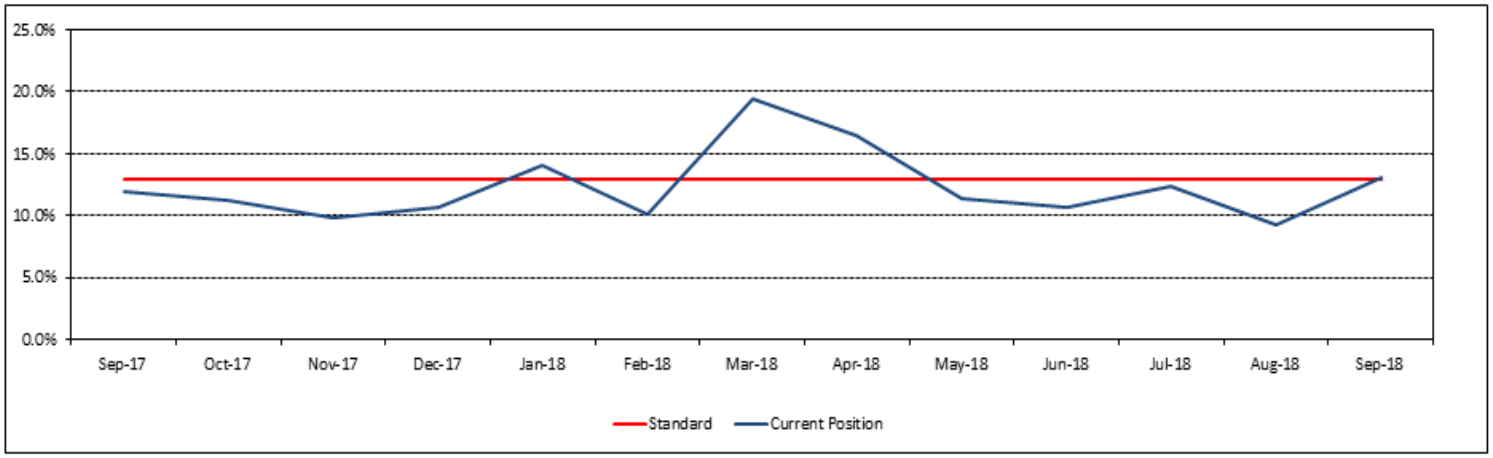
Indicator	Emergency Caesarean Sections
Standard	12.9%
Name	Jane Lovedale
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Where there is compromise in either mother or baby during the first stage of labour Emergency Caesarean Section is the only option. This month the Emergency Caesarean Section rate was 0.1% higher than the standard of at 13%, putting the overall Caesarean Sections rate up to 22.8%, 0.2% higher than the current standard. The previous 4 months the service has achieved a lower rate of between 9 and 12%. The higher rate this month reflects the slight reduction in vaginal and instrumental deliveries and is monitored. The service continues to monitor all Caesarean Sections and weekly learning is fedback to the individual or published on Risky Business if wider learning is required.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	12.9%	12.9%	12.9%	12.9%	12.9%	12.9%	12.9%	12.9%	12.9%	12.9%	12.9%	12.9%	12.9%
Current Position	11.9%	11.2%	9.8%	10.6%	14.1%	10.1%	19.4%	16.4%	11.4%	10.6%	12.4%	9.2%	13.0%

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

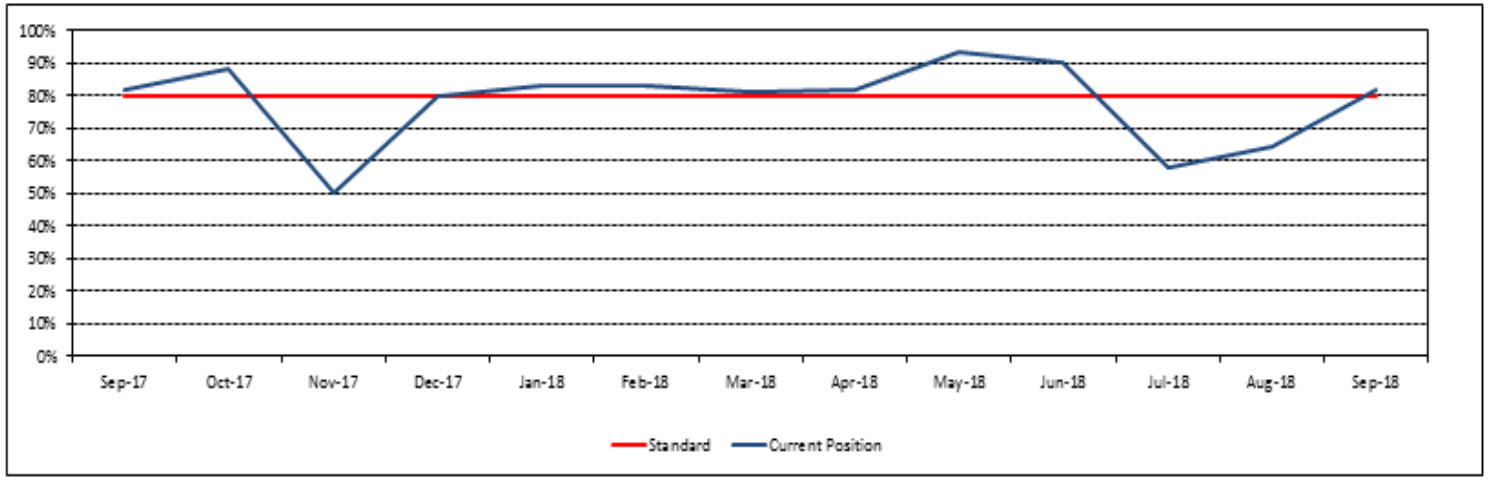
Indicator	Grade 2 Caesarean Section (Decision to delivery time met)
Standard	80%
Name	Jane Lovedale
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

A grade 2 Caesarean Section would be expected to be performed within 75 minutes of the decision. This month we achieved over 80%, an increase from last months rate of 64%. All cases are reviewed on an individual basis and it has been agreed that they will be presented by a consultant obstetrician at the Clinical Governance Steering Group quarterly in order to be able to robustly address trends and themes.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor weekly . Plan to Audit and present 3 monthly at the Clinical Governance steering Group.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

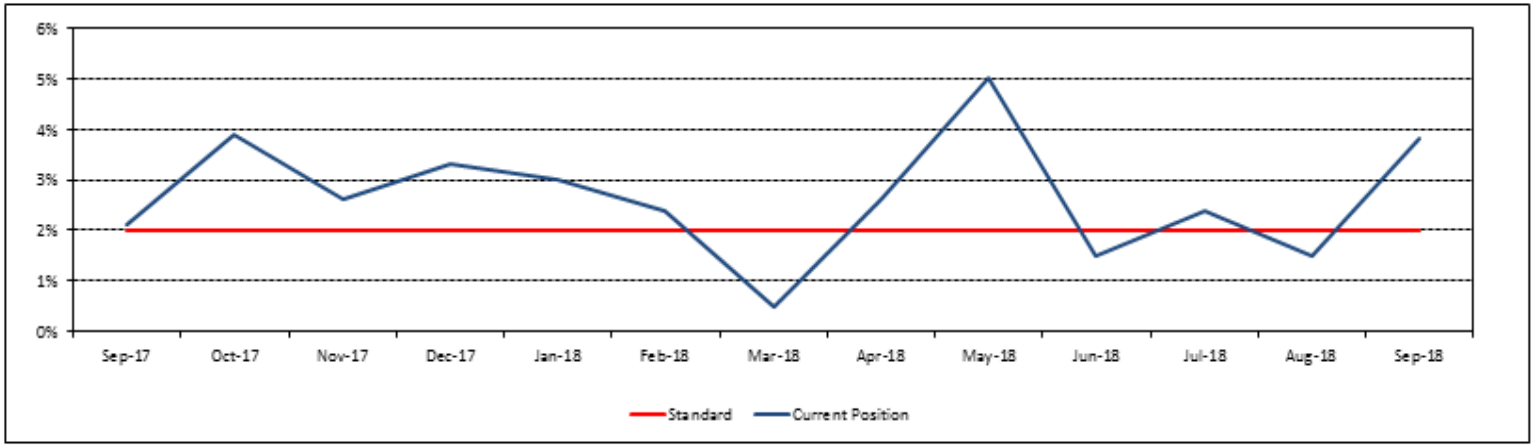
Indicator	Homebirths
Standard	2%
Name	Jane Lovedale
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

All women have a choice in the place of birth. The West Suffolk maternity service has maintained an average of 2.8% per month for the past year. This is significantly higher than the national average of 1.3% in Britain for planned and unplanned (NMPA 2017). This month has seen an increase to 3.8%. There continues to be a month on month variation and we continue to promote choice for women who are low risk and provide a 24 hour service in order for women to achieve this choice of birth.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Current Position	2.1%	3.9%	2.6%	3.3%	3.0%	2.4%	0.5%	2.6%	5.0%	1.5%	2.4%	1.5%	3.8%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to promote homebirths to low risk women.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

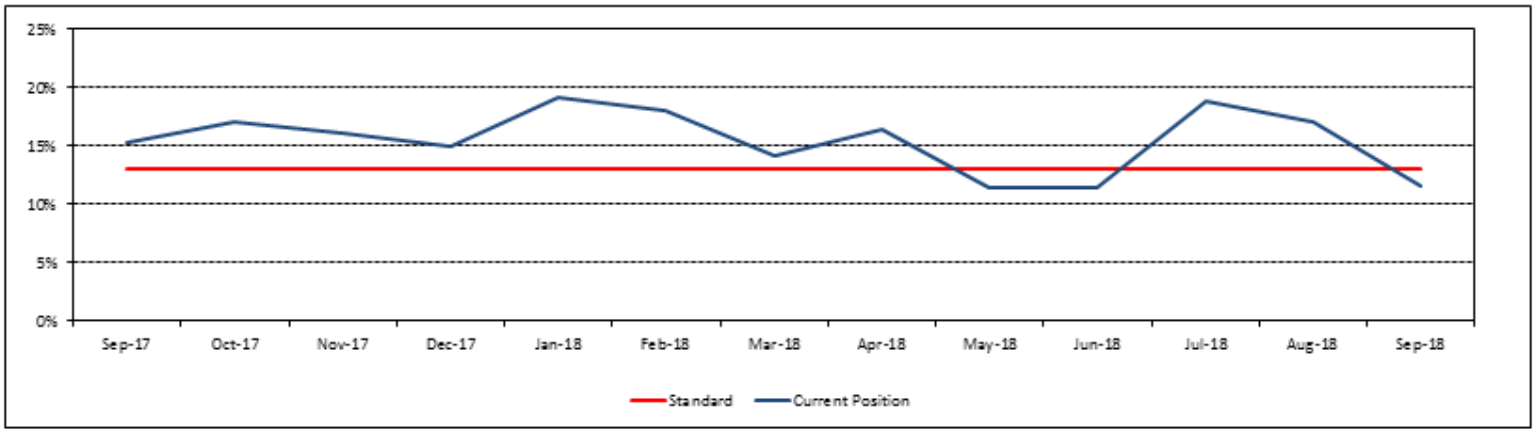
Indicator	Midwifery led birthing unit (MLBU) births
Standard	13%
Name	Jane Lovedale
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

There has been a fall in the number of births in the Midwifery led birthing unit over the last year. One of the reasons for this is thought to be the introduction of Gestation Related Optimal Weight and the increased identification of growth restricted babies and transfer of these women to consultant care. Although there may be other factors. The Birthing Unit has a newly appointed manager with a plan to review the criteria for inclusion for delivery on the birthing unit and this may have an impact on the numbers, although the service is about to undergo refurbishment therefore with the use of Midwifery led birthing unit for high risk women this may not be so clear until this has been completed.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%	13%
Current Position	15.3%	17.1%	16.0%	15.0%	19.1%	18.0%	14.1%	16.4%	11.4%	11.4%	18.8%	17.0%	11.5%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor and review the criteria for inclusion to the Midwifery led birthing unit .			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

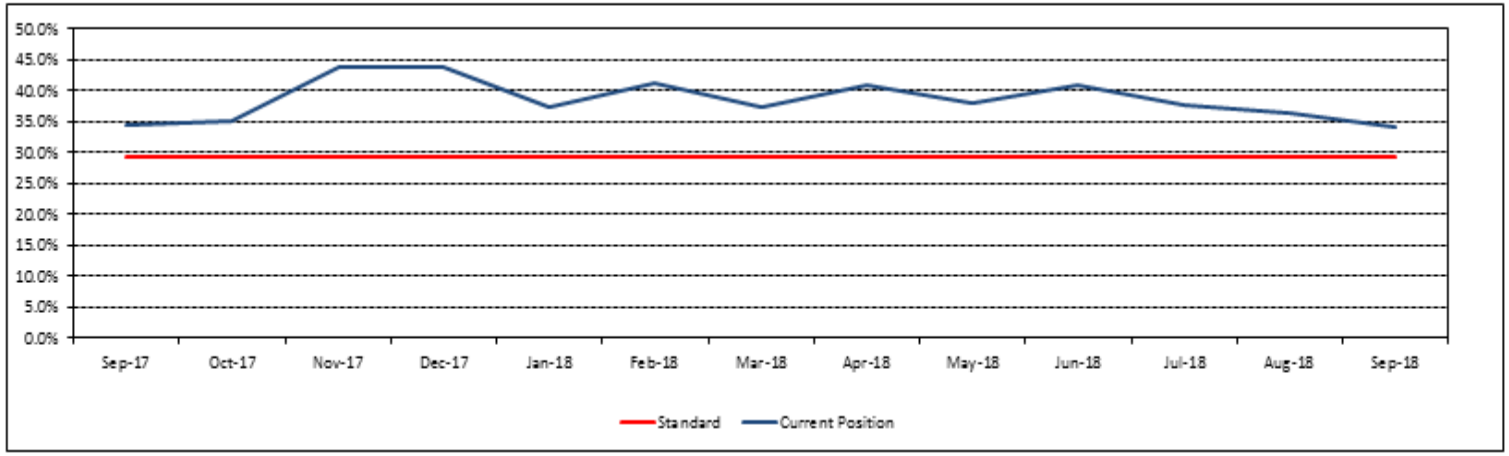
Indicator	Induction of Labour
Standard	29.3%
Name	Jane Lovedale
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Induction of labour has been consistently higher than the standard of 29.3%. Audits have not been found to demonstrate unwarranted inductions. With the introduction of Gestation Related Optimal Weight to identify babies with reduced growth, a significant increase of gestational diabetes requiring induction of labour as well as our rates of offering vaginal birth after caesarean section have all likely had an impact on the induction of labour rates. Although this has been above the standard expected our normal delivery rates remain high therefore this has not increased either our instrumental or Caesarean rates. Induction of labour has been included in the National Maternity and Perinatal Audit due to be published next year. It will be interesting to see if other units have seen an increase in these figures. Following a recent publication of the impact of Saving Babies lives a care bundle 2014 highlighted one of the impacts has seen an increase in the Induction of Labour rate.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%	29.3%
Current Position	34.3%	35.1%	43.8%	43.9%	37.2%	41.2%	37.4%	41.0%	37.8%	40.9%	37.6%	36.4%	34.1%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor monthly. Further audit of the indications for IOL awaited completion.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

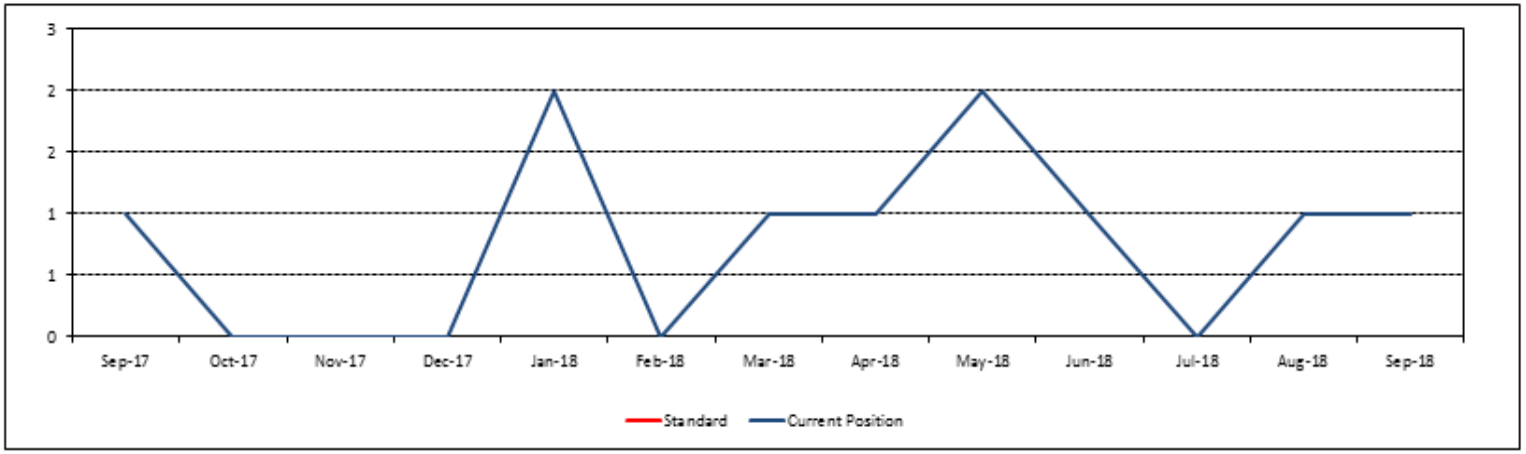
Indicator	Critical Care Obstetric Admissions
Standard	0
Name	Jane Lovedale
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

There are circumstances during pregnancy or following delivery where women require a higher level of care which cannot be achieved either within an acute ward or the maternity department. The maternity service transferred one patient to critical care in September 2018. The maternity service undertakes a clinical review of all cases where critical care is required. Learning that is identified is shared via the maternity services publication Risky Business and if appropriate with individual staff.

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

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



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

Indicator	Shoulder Dystocia
Standard	2
Name	Jane Lovedale
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Maternity

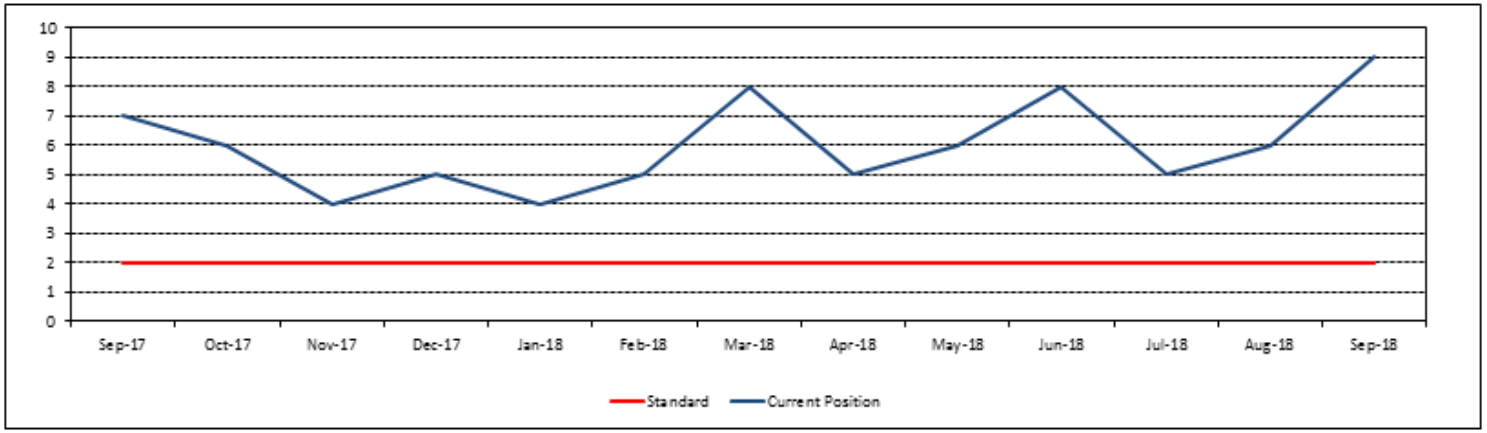
Summary of Current performance & Reasons for under performance

This months figures of 9 reports of shoulder dystocia is an increase from last month. Shoulder dystocia is not included in the national maternity perinatal audit therefore it is difficult to compare with other trusts of a similar size. The Royal college of Obstetricians and Gynaecologist note risk assessments for the prediction of shoulder dystocia are insufficiently predictive to allow prevention in the large majority of cases and therefore the correct management of this obstetric emergency is essential in preventing maternal or fetal injury. However we do as recommended and offer Induction of Labour to all women with diabetes. All cases of shoulder dystocia are reported on Datix and undergo investigation. The current rate was been discussed at Women's Health Governance meeting and a decision made if any further investigation/action is required. An audit has been allocated to one of the junior doctors who will present on completion. It is noted that there were no neonatal or maternal injuries as a result of shoulder dystocia.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	2	2	2	2	2	2	2	2	2	2	2	2	2
Current Position	7	6	4	5	4	5	8	5	6	8	5	6	9

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

Description	Owner	Start	End
Continue with multi-professional training annually for all staff and live drills in the management of shoulder dystocia. For presentation of audit when completed at CGSG.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

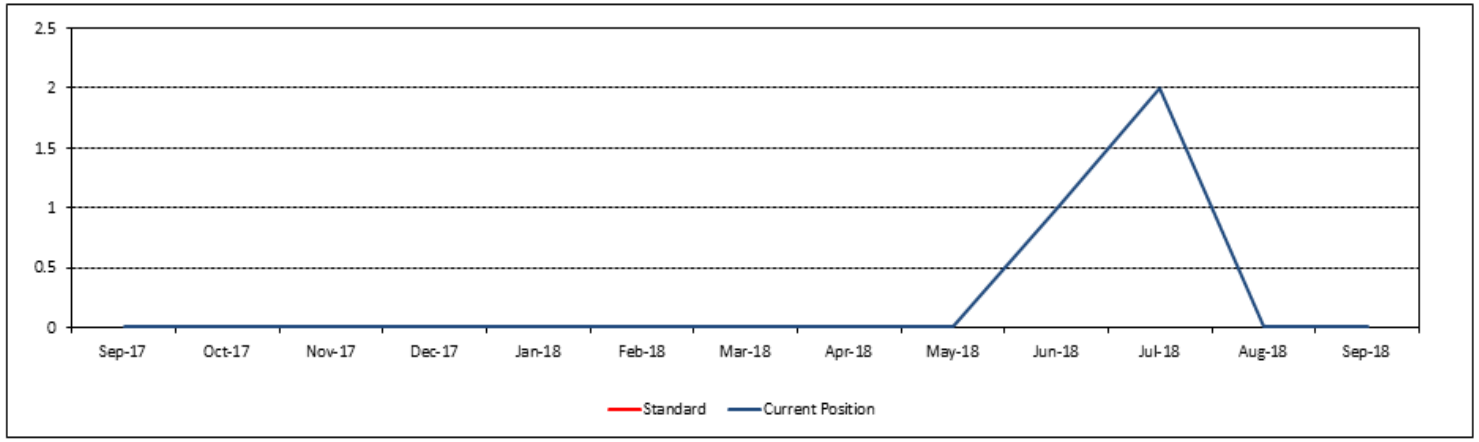
Indicator	Women requiring a blood transfusion of 4 units or more
Standard	0
Name	Jane Lovedale
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Although declining, deaths from obstetric haemorrhage remains a leading cause of direct maternal death. (MBRRACE 2016) Some women are at particular increased risk of major haemorrhage and processes in place are key to good management e.g. appropriate place of delivery, use of prophylactic uterotonics. It is unusual for women to require 4 or more units of blood even in cases of major haemorrhage. Again there were no reported cases this month of women requiring 4 or more unit blood transfusions.

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

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor the management of haemorrhage and ensure any learning identified at the clinical review is addressed.	LS		



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

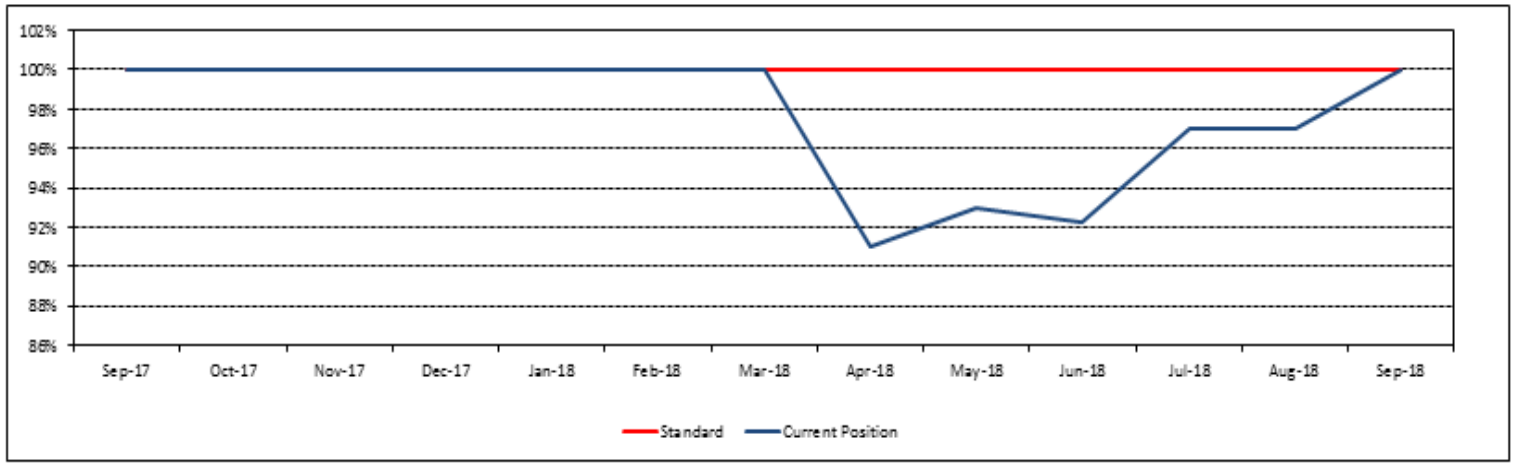
Indicator	One to one care in established labour
Standard	100%
Name	Jane Lovedale
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

There has been a recent change to the way in which data for this indicator has been collected. We have identified some issues with the data entry that results in one to one care not being recorded. September achieved 100% i.e. all women received one to one care in labour. Although there were still some issues around data input with a small number of cases this month which required manual checking of patient records. The error for this anomaly has been identified and has been highlighted to staff.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Current Position	100%	100%	100%	100%	100%	100%	100%	91.0%	93.0%	92.3%	97.0%	97.0%	100%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Continue to monitor the data input of one to one care.			



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WEST SUFFOLK NHS FOUNDATION TRUST INTEGRATED PERFORMANCE - EXCEPTION REPORT

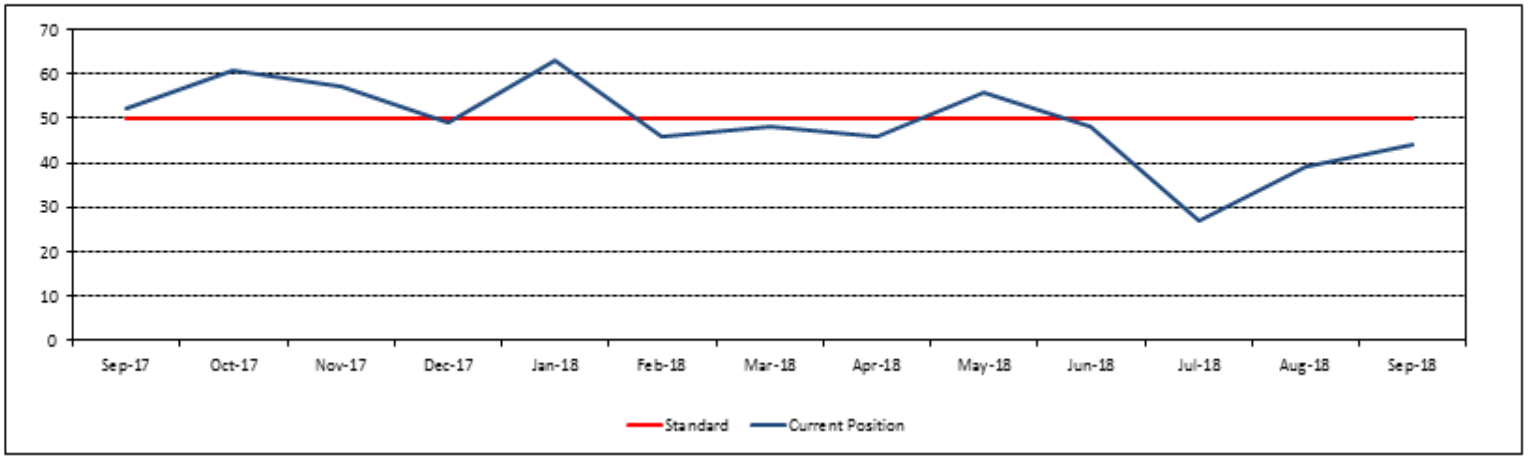
Indicator	Reported Clinical Incidents
Standard	50
Name	Jane Lovedale
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

Over the last two months the maternity service had noted a reduction in the reporting of clinical incidents. Although this month has seen a rise. There have been no significant changes to the service to indicate why this has occurred. Staff in the maternity risk department continue to remind staff of the importance of reporting clinical incidents and support staff in doing them should they so need. At present there is no identified cause for this on going reduction in clinical incident reporting. A staff reminder is to be included in Risky Business this month to remind staff of the displayed trigger in all abreast for risk reporting.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	50	50	50	50	50	50	50	50	50	50	50	50	50
Current Position	52	61	57	49	63	46	48	46	56	48	27	39	44

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

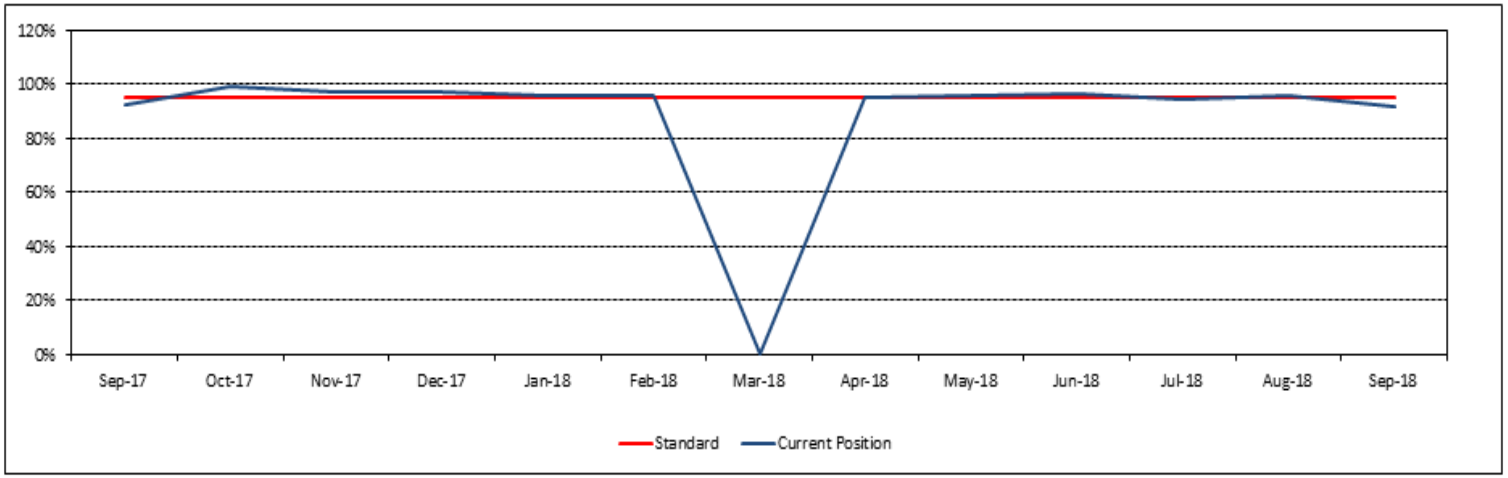
Indicator	Women booked before 12+6 weeks
Standard	95%
Name	Jane Lovedale
Month	01-Sep-18
Data Frequency	Monthly
CQC Area	Maternity

Summary of Current performance & Reasons for under performance

There was a reduction in the number of bookings of women achieved by 12+6. It should be noted that of the 18 which were not booked by the midwife before 12+6 the majority of these had referred late in pregnancy therefore were unavoidable. The reasons for the late referral to be fed back to the Outpatient services manager.

Month	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Standard	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%
Current Position	92.8%	99.0%	97.0%	97.0%	96.0%	96.0%	ND	95.4%	96.0%	96.6%	94.4%	96.0%	92.0%

Actions in place to recover the performance	Expected timeframes for improvements		
Description	Owner	Start	End
Community teams to look more closely at the data to extrapolate the reasons why referral is late.			



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Community Contract Preface

Welcome to the community contract report for September. This month we would like to highlight the following:

- Our FFT for September was 95% from 94 responses
- We received on complaint for Newmarket in-patient unit
- All response times targets for the community health teams were achieved
- The length of stay in our community beds decreased slightly compared to August
- During September we had 24 patients whose discharge was delayed with a loss of 209 bed days, this compares to 18 patients and 159 bed days in August
- Overall face to face activity was down for September, this is being investigated although historically there has been a small decline in activity during September
- The total number of children waiting for SLT in the community clinic service is down for the 12th consecutive month
- The total number of children waiting for SLT in the mainstream schools service has been re-adjusted to reflect the start of the new school year.
- There are less children waiting compared to the start of the new school year in 2017.
- The wheelchair service maintained its performance of 100% for 18 week referral to provision
- There were 4 breaches in the 18 week RTT for consultant paediatrics in the west of the county = 91.53%

10. Finance and workforce report

To ACCEPT the report

For Report

Presented by Craig Black

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – October 2018

Agenda item:	10			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	26th October 2018			
Subject:	Finance and Workforce Board Report – September 2018			
Purpose:	x	For information		For approval

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

The reported I&E for September 2018 is a deficit of £1.465m, against a planned deficit of £1.408m. This results in an adverse variance of £57k in month (£707k YTD). This YTD overspend predominantly relates to

- underperformance against the A&E performance (£165k adverse variance against PSF)
- pay award underfunded (£300k)
- community equipment backlog of wheelchairs (£200k)

Recruitment of ward based registered nurses is behind plan due to a number of withdrawals of newly qualified nurses starting in September (either due to them going elsewhere or failing to meet the required standard). This needs to improve in order to fully staff the capacity being made available to provide additional capacity for winter

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

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FINANCE AND WORKFORCE REPORT
September 2018 (Month 6)

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

Financial Summary

I&E Position YTD	£7.1m	loss
Variance against plan YTD	-£0.7m	adverse
Movement in month against plan	-£0.1m	adverse
EBITDA position YTD	-£3.8m	
EBITDA margin YTD	-41.3%	adverse
Total PSF Received	£1.115m	accrued
Cash at bank	£3,934k	

Executive Summary

- The Trust has agreed a control total of a deficit of £13.8m with NHS Improvement for 2018/19. (£10.2m after PSF).
- The planned deficit for the year to date was £6.4m but the actual deficit was £7.1m, an adverse variance of £0.7m.
- Recruitment of ward based registered nurses is behind plan due to a number of withdrawals of newly qualified nurses starting in September (either due to them going elsewhere or failing to meet the required standard).

Key Risks

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

SUMMARY INCOME AND EXPENDITURE ACCOUNT - September 2018	Sep-18			Year to date			Year end forecast		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget Budget	Actual Actual	Variance Variance F/(A)
NHS Contract Income	15.5	15.4	(0.1)	95.0	95.0	0.1	190.2	191.5	1.3
Other Income	3.1	2.7	(0.4)	18.5	18.4	(0.2)	38.5	38.3	(0.3)
Total Income	18.6	18.1	(0.5)	113.5	113.4	(0.0)	228.8	229.8	1.0
Pay Costs	13.3	13.5	(0.1)	78.8	79.7	(0.9)	157.4	160.4	(3.1)
Non-pay Costs	6.1	5.8	0.3	37.4	37.5	(0.2)	75.8	74.1	1.7
Operating Expenditure	19.5	19.3	0.2	116.2	117.2	(1.1)	233.1	234.5	(1.4)
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	(0.9)	(1.2)	(0.3)	(2.7)	(3.8)	(1.1)	(4.3)	(4.8)	(0.4)
Depreciation	0.5	0.5	(0.0)	3.5	3.1	0.4	6.5	6.5	0.0
Finance costs	0.3	0.3	(0.0)	1.5	1.3	0.2	3.0	2.6	0.4
SURPLUS/(DEFICIT) pre PSF	(1.7)	(2.0)	(0.4)	(7.7)	(8.2)	(0.5)	(13.9)	(13.9)	0.0
Provider Sustainability Funding (PSF)									
PSF - Financial Performance	0.2	0.2	0.0	0.9	0.9	0.0	2.6	2.6	0.0
PSF - A&E Performance	0.1	0.4	0.3	0.4	0.2	(0.2)	1.1	0.9	(0.2)
SURPLUS/(DEFICIT) incl PSF	(1.4)	(1.5)	(0.1)	(6.4)	(7.1)	(0.7)	(10.2)	(10.3)	(0.2)

FINANCE AND WORKFORCE REPORT – September 2018

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Key:

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

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

FINANCE AND WORKFORCE REPORT – September 2018

Income and Expenditure Summary as at September 2018

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

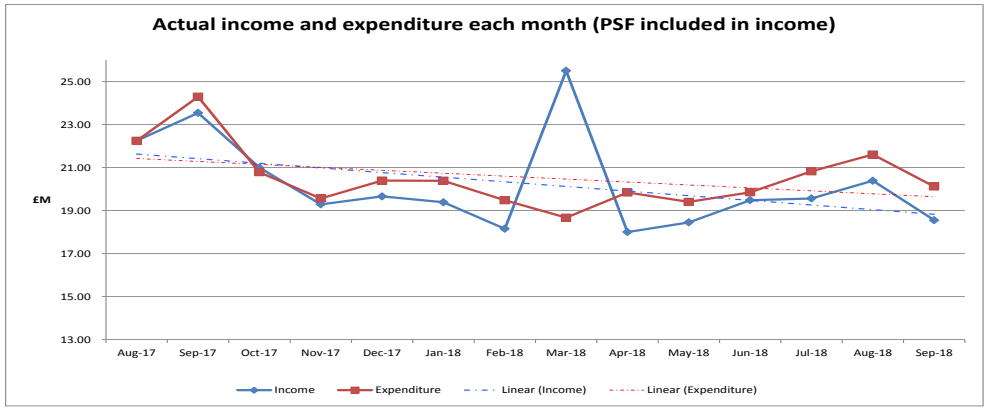
In order to achieve the control total the 2018-19 budgets include a stretch CIP of £2.8m bringing the total CIP plan to £12.2m (5%). We have utilised the 2018-19 contingency of £1.5m in order to meet this stretch CIP.

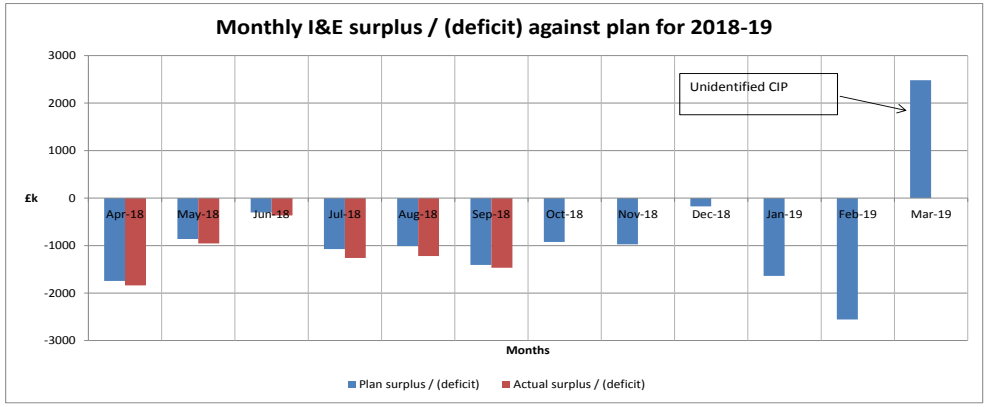
The reported I&E for September 2018 is a deficit of £1.465m, against a planned deficit of £1.408m. This results in an adverse variance of £57k in month (£707k YTD). This YTD overspend predominantly relates to

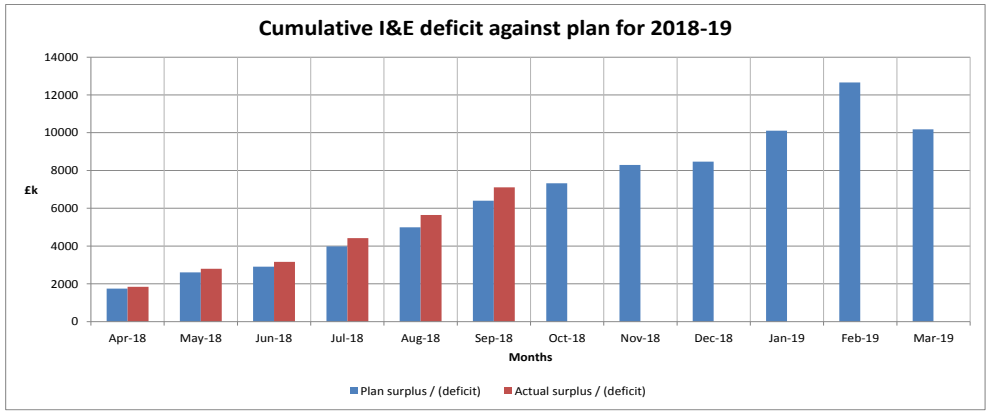
- underperformance against the A&E performance (£165k adverse variance against PSF)
- pay award underfunded (£300k)
- community equipment backlog of wheelchairs (£200k)

Summary of I&E indicators

Income and Expenditure	Plan / target £'000	Actual / forecast £'000	Variance to plan (adv) / fav £'000	Direction of travel (variance)	RAG (report on Red)
In month surplus / (deficit)	(1,408)	(1,465)	(57)		Amber
YTD surplus / (deficit)	(6,398)	(7,106)	(707)		Amber
Forecast surplus / (deficit)	(10,180)	(10,180)	0		Green
EBITDA (excl STF) YTD	(2,661)	(3,811)	(1,150)		Red
EBITDA (%)	(2.3%)	(3.3%)	(1.0%)		Red
Clinical Income YTD	(94,955)	(95,043)	88		Green
Non-Clinical Income YTD	(19,827)	(19,493)	(334)		Red
Pay YTD	78,794	79,708	(914)		Red
Non-Pay YTD	42,386	41,933	453		Green
CIP target YTD	5,431	5,393	(38)		Amber





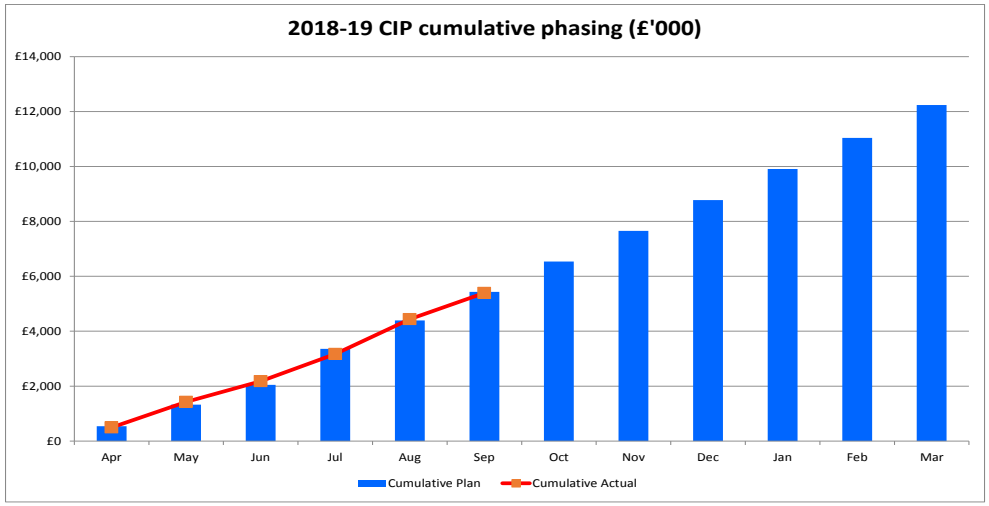


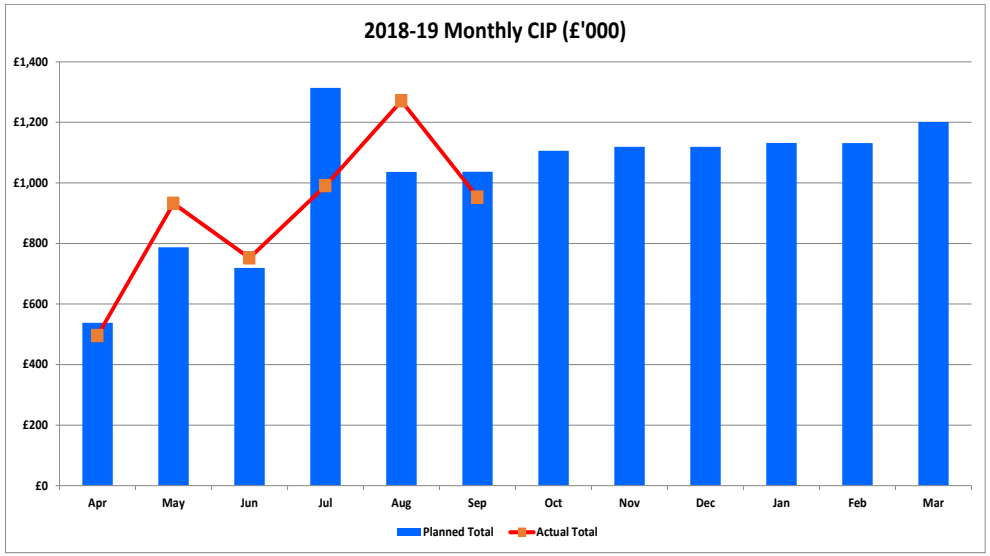
Cost Improvement Programme (CIP) 2018-19

The September position includes a target of £5.43m YTD which represents 44.4% of the 2018-19 plan. There is a shortfall of £38k YTD against this plan.

Recurring/Non Recurring	Summary	2018-19 Annual Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Clinical Income	529	254	127
	Activity growth	234	113	-
	Private Patients	78	39	11
	Other Income	890	300	170
	Consultant Staffing	840	46	9
	Nursing productivity	111	7	-
	Staffing Review	80	421	572
	Additional sessions	58	6	6
	Temporary Pay	712	372	552
	Agency	98	54	88
	Pay controls	-	-	-
	CNST discount	265	132	23
	Community Equipment Service	643	321	320
	Drugs	167	81	130
	Contract renegotiation	69	32	32
	Procurement	840	360	202
	Other	178	42	105
	Service Review	366	122	98
	Patient Flow	629	419	350
	Divisional Cross Cutting allocati	1,880	711	328
	Cancelled CIPs	324	121	-
Recurring Total		**8,989**	**3,956**	**3,124**
Non-Recurring	Capitalisation	1,550	750	750
	Additional sessions	268	20	-
	Contract review	105	41	64
	Non-Specific Divisional savings			712
	Other	1,327	664	744
Non-Recurring Total		**3,250**	**1,475**	**2,270**
Grand Total		**12,239**	**5,431**	**5,393**

In order to deliver the Trust's control target deficit of planned deficit of £13.8m deficit in 2018-19 we need to deliver a CIP of £12.2m (5%).





Cost Improvement Programme (CIP) 2019-20

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

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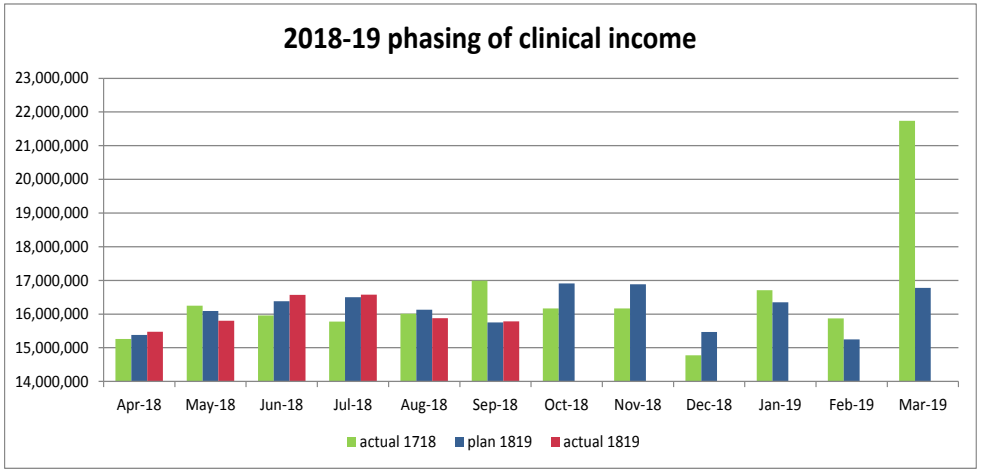
Income Analysis

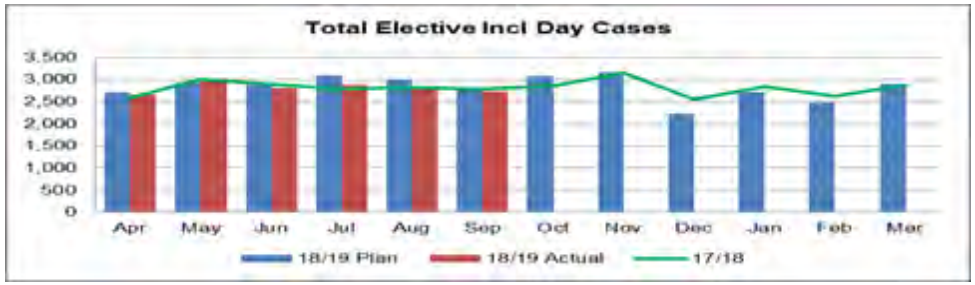
The chart below summarises the phasing of the clinical income plan for 2018-19, including Community Services. This phasing is in line with activity phasing which is how the income is recognised.

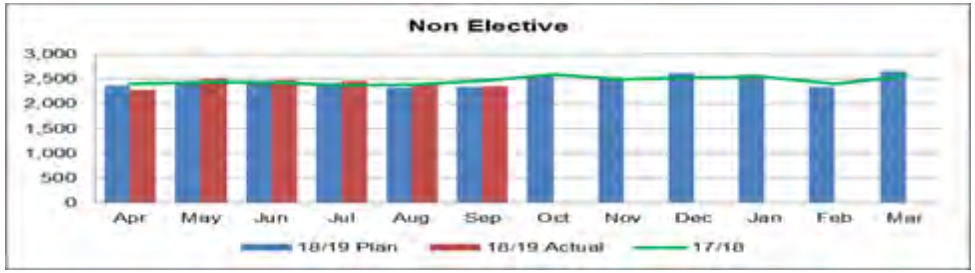


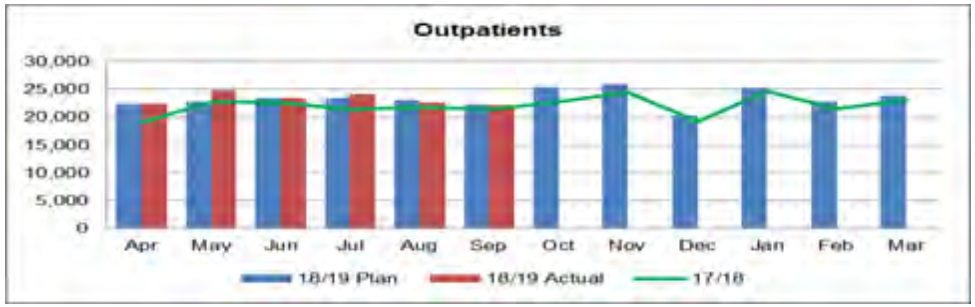
The income position was behind of plan for September. The main area of underperformance against the plan was seen within Elective activity.

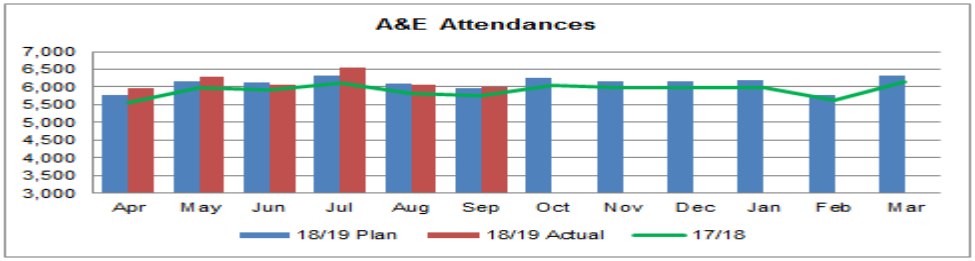
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	689	721	32	4,209	4,464	255
Other Services	1,970	2,068	98	11,766	12,461	696
CQUIN	305	301	(5)	1,886	1,876	(11)
Elective	2,840	2,618	(222)	17,806	16,170	(1,636)
Non Elective	5,224	5,067	(157)	32,011	32,132	121
Emergency Threshold Adjustment	(343)	(341)	1	(2,104)	(2,165)	(60)
Outpatients	2,700	2,865	164	16,664	17,387	723
Community	2,120	2,120	0	12,718	12,718	0
Total	**15,506**	**15,418**	**(89)**	**94,955**	**95,043**	**88**

Activity, by point of delivery

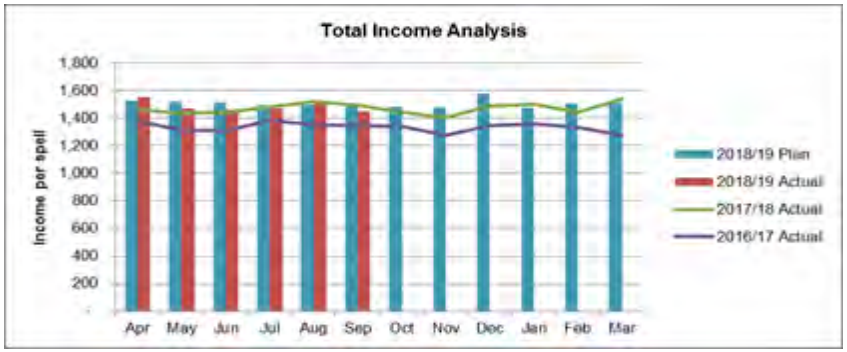


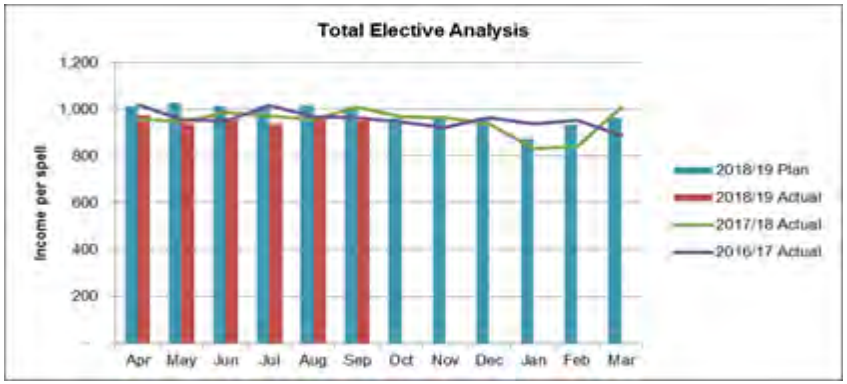


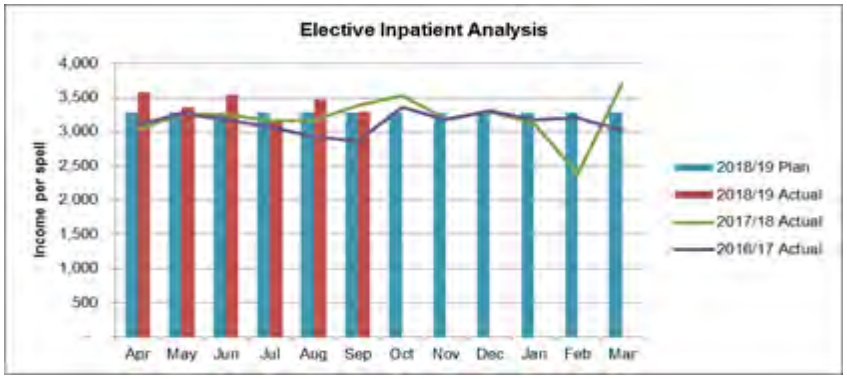


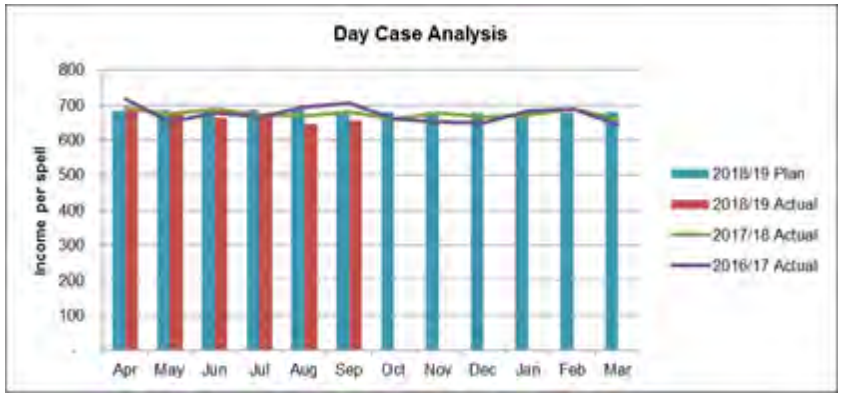


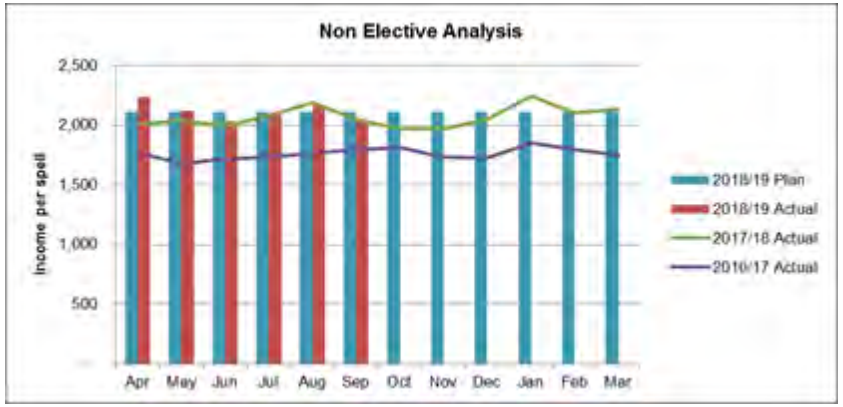
Trends and Analysis

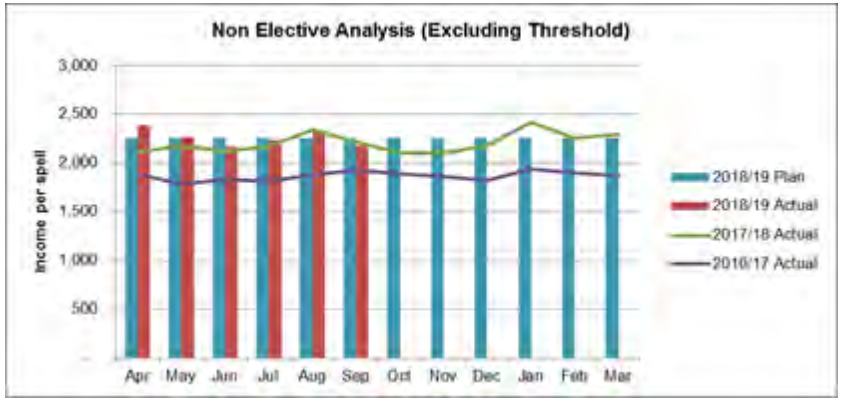












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Workforce

Monthly Expenditure (£) Acute services only				
As at September 2018	Sep-18	Aug-18	Sep-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**11,691**	**12,539**	**10,906**	**69,437**
Substantive Staff	10,452	10,890	9,706	67,248
Medical Agency Staff (includes 'contracted in' staff)	185	268	100	179
Medical Locum Staff	210	241	169	1,067
Additional Medical sessions	248	269	233	384
Nursing Agency Staff	87	125	39	77
Nursing Bank Staff	372	365	247	538
Other Agency Staff	99	39	47	60
Other Bank Staff	150	192	175	296
Overtime	111	121	95	125
On Call	56	61	50	302
Total temporary expenditure	1,518	1,681	1,157	3,028
Total expenditure on pay	**11,970**	**12,571**	**10,862**	**70,276**
Variance (F/(A))	(279)	(31)	44	(839)
Temp Staff costs % of Total Pay	12.7%	13.4%	10.6%	4.3%
Memo : Total agency spend in month	371	431	187	315

Monthly Whole Time Equivalents (WTE) Acute Services only			
As at September 2018	Sep-18	Aug-18	Sep-17
	WTE	WTE	WTE
Budgeted WTE in month	**3,142.7**	**3,141.7**	**3,021.0**
Employed substantive WTE in month	2789.32	2776.83	2748.12
Medical Agency Staff (includes 'contracted in' staff)	16.78	22.09	8.26
Medical Locum	19.15	21.38	14.26
Additional Sessions	21.5	19.4	20.36
Nursing Agency	16.95	24.65	7.94
Nursing Bank	86.1	86.38	78.14
Other Agency	10.9	11.6	16.2
Other Bank	74.58	73.64	87.8
Overtime	31.39	33.03	29.61
On call Worked	6.65	7.21	7.02
Total equivalent temporary WTE	**284.0**	**299.4**	**269.6**
Total equivalent employed WTE	**3,073.3**	**3,076.2**	**3,017.7**
Variance (F/(A))	69.3	65.5	3.3
Temp Staff WTE % of Total Pay	9.2%	9.7%	8.9%
Memo : Total agency WTE in month	44.6	58.3	32.4
Sickness Rates	3.86%	3.83%	2.68%
Mat Leave	2.89%	2.94%	2.3%

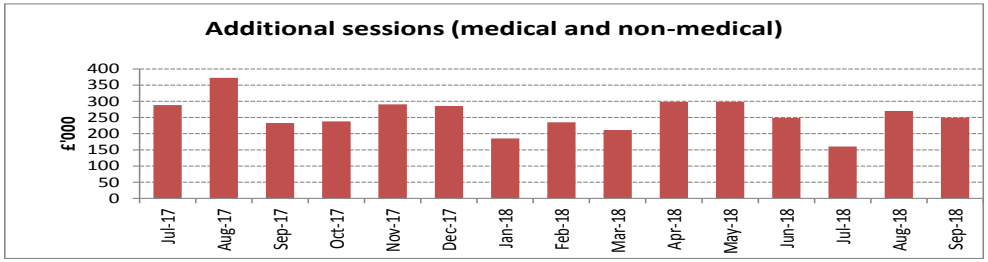
Monthly Whole Time Equivalents (WTE) Community Services Only			
As at September 2018	Sep-18	Aug-18	Sep-17
	WTE	WTE	WTE
Budgeted WTE in month	**486.93**	**486.93**	**377.25**
Employed substantive WTE in month	463.71	468.57	345.6
Medical Agency Staff (includes 'contracted in' staff)	0.92	0.00	0.7
Medical Locum	0.35	0.35	0.4
Additional Sessions	0.00	0.00	0.0
Nursing Agency	1.30	1.88	0.1
Nursing Bank	5.56	5.46	4.8
Other Agency	2.67	4.17	5.6
Other Bank	3.90	2.83	3.5
Overtime	1.94	2.39	1.9
On call Worked	0.00	0.00	0.0
Total equivalent temporary WTE	**16.64**	**17.08**	**16.9**
Total equivalent employed WTE	**480.35**	**485.65**	**362.6**
Variance (F/(A))	6.58	1.28	14.70
Temp Staff WTE % of Total Pay	3.5%	3.5%	4.7%
Memo : Total agency WTE in month	4.9	6.1	6.3
Sickness Rates (Sep / Aug)	3.85%	3.79%	4.32%
Mat Leave	3.38%	2.82%	1.3%

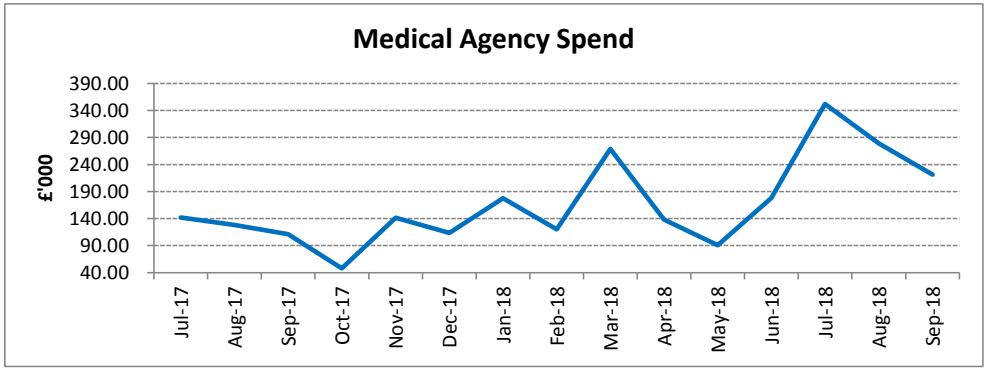
Monthly Expenditure (£) Community Service Only				
As at September 2018	Sep-18	Aug-18	Sep-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,633**	**1,633**	**1,125**	**9,357**
Substantive Staff	1,499	1,615	1,035	9,012
Medical Agency Staff (includes 'contracted in' staff)	14	12	11	70
Medical Locum Staff	3	3	3	18
Additional Medical sessions	1	1	0	3
Nursing Agency Staff	3	12	0	43
Nursing Bank Staff	23	22	15	113
Other Agency Staff	(18)	17	22	56
Other Bank Staff	10	13	12	52
Overtime	7	8	5	46
On Call	3	3	1	18
Total temporary expenditure	47	89	70	420
Total expenditure on pay	**1,545**	**1,704**	**1,104**	**9,432**
Variance (F/(A))	88	(71)	21	(75)
Temp Staff costs % of Total Pay	3.0%	5.2%	6.3%	4.5%
Memo : Total agency spend in month	0	40	33	169

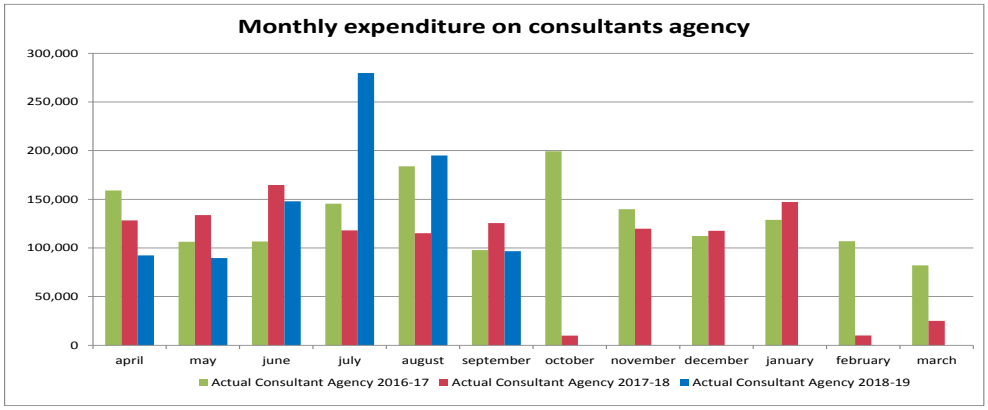
FINANCE AND WORKFORCE REPORT – September 2018

Pay Trends and Analysis

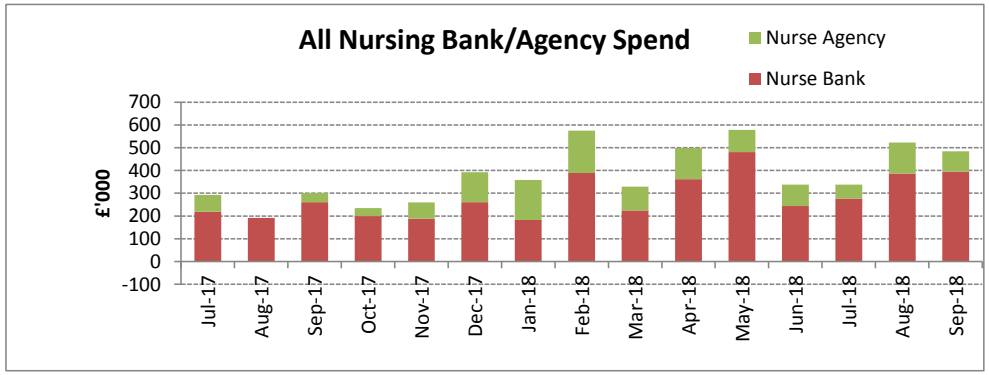
The Trust spent £192k more than budget on pay in September (£914k overspent YTD). This partly reflects the unfunded pay award which is estimated to be a cost pressure of £485k in 2018-19

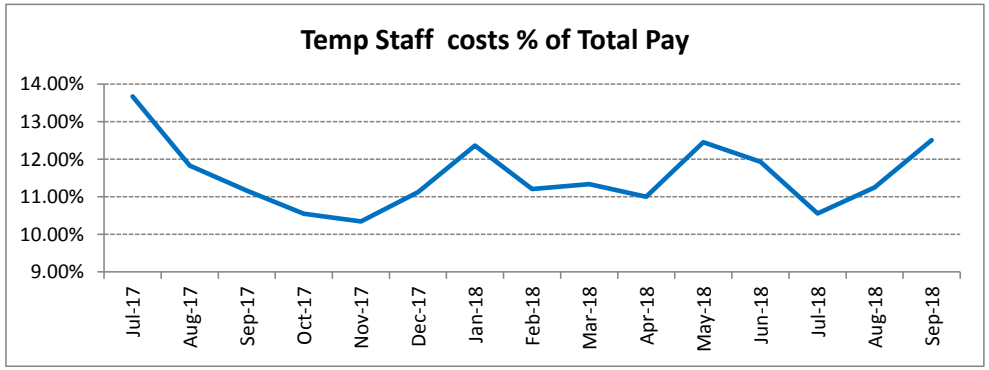




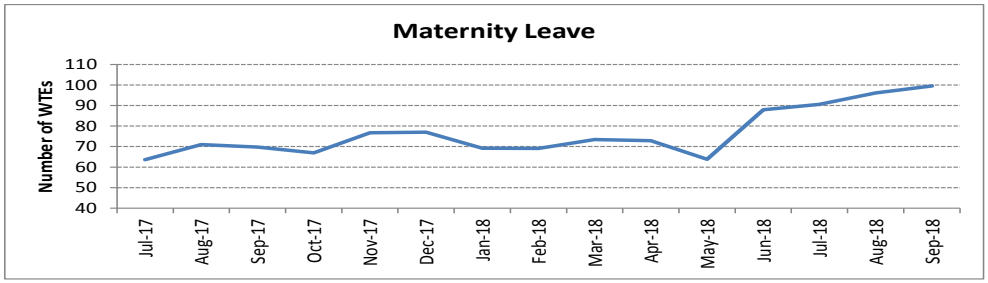


Medical Staff Agency Costs by Speciality	M6 - YTD £'000	M6 £'000
Anaesthetics	225.8	48.2
Urology	213.6	14.0
Xray - Wsh	198.1	33.5
Gastroenterology	185.4	43.5
Medicine - Junior Doctors	152.1	45.9
Clinical Haematology	135.0	(16.3)
Cardiology	126.3	39.0
Medicine - Consultants	112.8	11.5
Eau Medical Staff	110.8	28.4
General Surgery	101.2	14.7
Diabetes	83.7	(7.5)
Ophthalmology	71.6	16.9
Obstetrics	70.6	0.2
Histopathology	63.0	8.8
Chest Medicine	62.9	1.1
E.N.T.	55.7	17.7
Dermatology	54.7	7.6
Plastic Surgery	43.1	17.0
Total	**2,066.5**	**324.1**





FINANCE AND WORKFORCE REPORT – September 2018



Staffing and recruitment

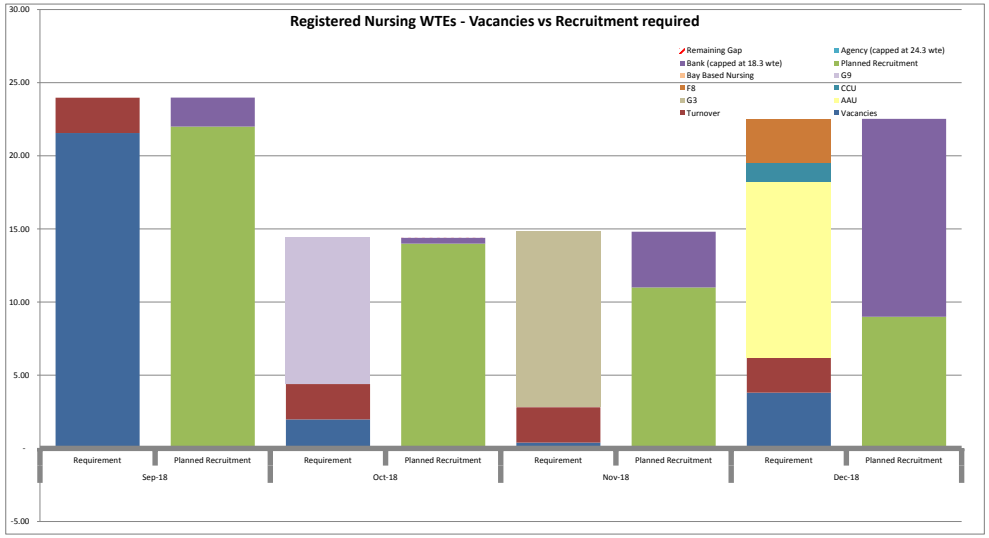
In September the Trust used 44.6 wte of bank/overtime and agency registered nurses, around 20.8 wte more than planned. This was due to a delay in the bay based nursing initiative and recruitment difficulties, as well as an increase in vacancies / maternity leavers beyond plan. Vacancies (including maternity leave) have increased by 27.3 wte between March 2018 and September 2018.

The most significant areas of agency usage were in A&E and on F7 and G8, although A&E dropped significantly during September (8.3 wte to 3.3 wte)

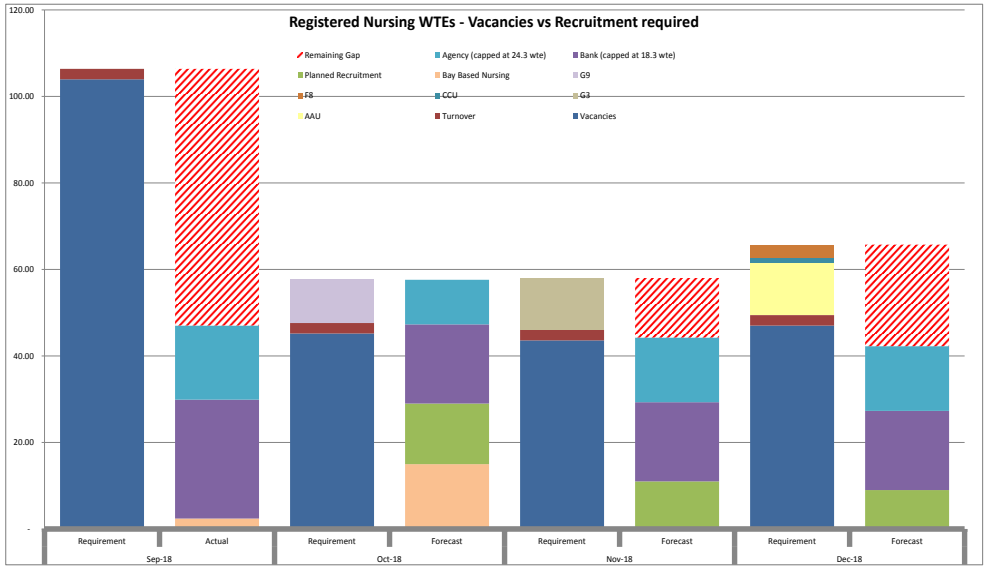
Unfilled posts have increased from 26.2 wte in March to 59.4 wte in September 2018.

Ward	September - Vacancies	September - Bank and overtime	September - Agency	September - Unfilled / (overstaffed)	March - Vacancies	March > September Increase (decrease) in vacancies	March - Unfilled / (overstaffed)
Accident & Emergency	12.62	2.81	3.33	6.48	10.34	2.28	0.62
C.C.U.	2.16	0.82	0.00	1.34	2.21	(0.05)	1.36
Ward F9	9.56	2.27	0.00	7.29	8.30	1.26	5.74
Ward F10	6.27	1.65	0.20	4.42	5.37	0.90	3.84
Ward F12	2.61	0.10	0.14	2.37	2.92	(0.31)	1.56
Ward G1 Hardwick Unit	4.87	0.49	0.00	4.38	2.47	2.40	2.21
Cardiac Ward	1.51	0.50	0.08	0.93	3.24	(1.73)	2.59
Ward G4	3.94	0.52	0.11	3.31	1.87	2.07	1.27
Ward G5	6.50	1.15	0.55	4.80	2.50	4.00	(0.24)
Ward G8	11.51	0.80	3.92	6.79	8.06	3.45	4.49
Ward F1 Paediatrics	7.69	3.71	0.00	3.98	4.85	2.84	1.98
Ward F3	4.59	2.79	1.63	0.17	3.18	1.41	0.05
Ward F4	1.87	0.57	2.24	(0.94)	4.67	(2.80)	3.58
Ward F5	1.33	0.75	0.00	0.58	0.52	0.81	(0.01)
Ward F6	7.71	2.58	1.32	3.81	7.96	(0.25)	5.24
Gynae Ward (On F14)	0.26	0.65	0.00	(0.39)	0.72	(0.46)	0.32
Neonatal Unit	1.89	0.07	0.00	1.82	1.30	0.59	1.16
Ward F8 Ambulatory Core	0.31	2.01	0.77	(2.47)	0.39	(0.08)	(4.03)
Ward F7 Short Stay	11.80	0.43	2.15	9.22	8.01	3.79	1.19
Ward G9 Escalation Ward	1.00	0.00	0.51	0.49	(2.77)	3.77	(5.45)
Community - Glastonbury Court	0.28	0.88	0.20	(0.80)	1.22	(0.94)	0.35
Newmarket Hosp-Rosemary ward	3.69	1.92	0.00	1.77	(0.62)	4.31	(1.54)
Total	**103.97**	**27.47**	**17.15**	**59.35**	**76.71**	**27.26**	**26.28**

Planned staffing and recruitment as at April 2018



Actual and forecast staffing as at September 2018



FINANCE AND WORKFORCE REPORT – September 2018

Summary by Division

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Sep-18 Budget £k	Sep-18 Actual £k	Sep-18 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	(5,564)	(5,587)	23	(34,101)	(34,698)	597
Pay Costs	3,675	3,773	(97)	21,493	22,319	(826)
Non-pay Costs	1,245	1,059	185	8,235	8,178	57
Operating Expenditure	**4,920**	**4,832**	**88**	**29,729**	**30,497**	**(769)**
SURPLUS / (DEFICIT)	**644**	**755**	**111**	**4,372**	**4,201**	**(171)**
SURGERY						
Total Income	(4,966)	(4,694)	(271)	(30,414)	(29,593)	(821)
Pay Costs	3,078	3,027	51	18,023	18,103	(80)
Non-pay Costs	1,122	1,068	54	6,996	6,993	3
Operating Expenditure	**4,200**	**4,095**	**105**	**25,019**	**25,096**	**(77)**
SURPLUS / (DEFICIT)	**765**	**599**	**(166)**	**5,395**	**4,497**	**(898)**
WOMENS and CHILDRENS						
Total Income	(2,063)	(2,077)	14	(12,063)	(11,573)	(489)
Pay Costs	1,180	1,213	(33)	6,816	7,074	(258)
Non-pay Costs	155	140	14	935	955	(19)
Operating Expenditure	**1,334**	**1,353**	**(19)**	**7,752**	**8,029**	**(278)**
SURPLUS / (DEFICIT)	**729**	**724**	**(4)**	**4,311**	**3,544**	**(767)**
CLINICAL SUPPORT						
Total Income	(817)	(831)	14	(4,978)	(5,045)	68
Pay Costs	1,494	1,408	86	8,309	8,206	103
Non-pay Costs	1,029	1,168	(139)	6,238	6,388	(150)
Operating Expenditure	**2,523**	**2,576**	**(53)**	**14,547**	**14,594**	**(47)**
SURPLUS / (DEFICIT)	**(1,706)**	**(1,745)**	**(39)**	**(9,569)**	**(9,549)**	**20**
COMMUNITY SERVICES						
Total Income	(3,079)	(3,195)	116	(18,826)	(18,889)	63
Pay Costs	2,038	2,031	6	12,261	12,306	(45)
Non-pay Costs	993	1,078	(85)	5,706	5,843	(137)
Operating Expenditure	**3,031**	**3,109**	**(78)**	**17,966**	**18,148**	**(182)**
SURPLUS / (DEFICIT)	**48**	**86**	**38**	**859**	**741**	**(118)**
ESTATES and FACILITIES						
Total Income	(382)	(345)	(37)	(2,294)	(2,118)	(175)
Pay Costs	810	808	2	4,743	4,683	59
Non-pay Costs	606	687	(80)	3,452	3,420	32
Operating Expenditure	**1,417**	**1,495**	**(78)**	**8,194**	**8,103**	**92**
SURPLUS / (DEFICIT)	**(1,034)**	**(1,150)**	**(115)**	**(5,901)**	**(5,984)**	**(83)**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	(2,043)	(1,923)	(121)	(12,472)	(12,618)	147
Pay Costs	1,249	1,257	(8)	7,049	7,017	33
Non-pay Costs (net of contingency and reserves)	861	614	248	6,272	5,747	525
Finance & Capital	786	787	(1)	5,018	4,410	607
Operating Expenditure	**2,897**	**2,657**	**239**	**18,339**	**17,174**	**1,165**
SURPLUS / (DEFICIT)	**(853)**	**(735)**	**118**	**(5,867)**	**(4,556)**	**1,310**
TOTAL (including penalties, contingency and reserves)						
Total Income	(18,914)	(18,652)	(262)	(115,147)	(114,536)	(611)
Contract Penalties	0	0	0	0	0	0
Pay Costs	13,524	13,516	8	78,694	79,708	(1,014)
Non-pay Costs	6,011	5,814	196	37,834	37,523	312
Finance & Capital	786	787	(1)	5,018	4,410	607
Operating Expenditure (incl penalties)	**20,321**	**20,117**	**204**	**121,546**	**121,641**	**(95)**
SURPLUS / (DEFICIT)	**(1,408)**	**(1,465)**	**(57)**	**(6,398)**	**(7,106)**	**(707)**

Medicine (Nicola Cottington)

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

Contract income was £43k above plan in the month, with £31k contributed by ED and £78k from outpatients. Despite the high ED attendances – 16% above plan and 4.5% above the same period last year, conversion to admissions was low, resulting in inpatients being £69k below plan.

A combination of reduced length of stay, improved GP Streaming and a concentration to maintain flow, meant that the Trust achieved 95.46% for the ED 4 hour wait in the month, and surpass the target set for the quarter to achieve STF funding for ED. September performance was almost 2% better than all other local Trusts, and saw the Department ranked ninth in the country for Type 1 units.

The over-performance on outpatients and elective inpatients meant that the Division saw an improvement in the Referral to Treatment Time from 95.1% in August to 95.5%, (target 92%), and only one specialty (Gastroenterology – 91.95%) narrowly failing to beat the target. Performance is expected to improve in October.

The expenditure budget was underspent by £68k in the month. Pressure to maintain patient flow and ED performance has meant that there are pressures on staff costs, particularly covering the weekends, to avoid a build up of patients for the start of a new week. The Division benefited from a £206k underspend on drugs - £147k related to a rebate under a Patient Access scheme for a Haematology drug and this is being explored for other such schemes. There were also additional claims on excluded drugs going back to August.

CIPs over performed the target by £36k in the month (£168k versus £132k), primarily due to drugs, Patient Transport and Chemotherapy Income. The new Angio/Pacing unit should help to contribute to CIPs in November, as well as the repatriation of Nephrology outpatients from Addenbrookes. The Division has started to formulate its 2019/20 CIP plan.

Surgery (Simon Taylor)

The division has underperformed by £166k in month (£898k YTD).

The Division has under achieved against plan by £166k in the month on income. This is a combination of clinical income under achieving by £209k whilst outpatient activity over achieved by £92k. Admitted elective care has

underperformed by £276k. Urology was the only speciality to significantly over achieve plan (£37k). Orthopaedics has the largest adverse variance of £144k YTD.

Pay is underspent by £51k. There is a cost pressure relating to temporary medical staffing to support RTT and ward based junior doctors whilst the under spend relates to Nursing and Admin posts.

Non-pay is underspent by £54k. This mainly relates to an under spend on medical and surgical equipment.

Women and Children's (Rose Smith)
In September the division is behind plan by £4k (£767k YTD).

Income reported £14k ahead of plan in-month and is £489k behind plan YTD. In month, neonatal and maternity activity was higher than planned. Year to date, both elective and non-elective inpatient activity has been behind plan which explains the majority of the year to date variance.

Pay reported a £33k overspend in-month and is £258k overspent YTD. In-month, a locum consultant was employed to cover long term sickness in Paediatrics and additional consultant cover was arranged to address some of the RTT pressures in Obstetrics & Gynaecology. Year to date, the medical staffing issues in Obstetrics & Gynaecology have been an issue and the long term consultant sickness has put pressure on the Paediatric budget.

Non pay reported a £14k underspend in-month and is £19k overspent YTD. The in-month underspend was driven by reduced spend on medical and surgical equipment. The YTD overspend has been driven by part-pathway charges for West Suffolk patients who have given birth at other Trusts

Clinical Support (Rose Smith)
In September, the division overspent by £39k (£20k underspent YTD).

Income for Clinical Support reported £14k ahead of plan in-month and is £68k ahead of plan YTD. In month, the Radiology Department saw a higher number of direct access and breast screening patients. This has also dictated the year to date position but it has been supplemented by higher volumes of radiology outpatient activity.

Pay is £86k underspent in-month and is £103k underspent YTD. In month, the majority of the underspend has been driven by both Radiology and Pharmacy being unable to fully backfill their vacancies with bank, agency and overtime. Year to date, the same theme has persisted.

Non pay reported a £139k overspend in-month and is £150k overspent YTD. In-month, the Blood Transfusion Service received a large bill for additional call off orders and the Pharmacy Department generated a large stock adjustment. Year to date, the underlying pressures from the HODS element of the Pathology contract continue to put pressure on the division's budget.

Community Services (Dawn Godbold)
The division reported a £38k underspend in month (£218k overspent YTD).

Income reported a £116k over recovery in month and £63k under recovery YTD. The main reasons for the over-recovery in the month is due to health coaching monies received this month accounting for £34k, covering the first two quarters not previously accrued and community contract income over-recovered by £79k due to a change in contract uplift associated with ESNEFT. There was also additional income accrued to cover the cost of increase staffing within the Paediatric Complex Care Nursing Team, £11k funded by Commissioners.

Pay reported £6k underspent in month and £45k overspend YTD. Main in-month overspends include the vacancy allocation of £22k. Additional recruitment within the Paediatric Complex Nursing Team created an £11k overspend within pay but funded by commissioners so is offset by additional income. This month has also seen a continuation of pay overspends both on Glastonbury Court and Rosemary ward, the majority of spend is on agency to cover gaps in rota's, accounting for an overspend of £4k and £8k respectively. These overspends, have been offset against underspends across the whole of the division due to vacancies.

Non pay reported £85k overspend in month and £137k overspend YTD.
In month overspends include £73k within Central Equipment Service relating to the third quarters reconciliation from Medequip.

For the second month in a row dressings reported an overspend position across the community health teams resulting in a £9k overspend. Commissioned Beds continued to report a £19k overspend in-month. This position will worsen with the new contract price coming into force next month; this impact has been reflected in the divisions forecast position.

Use of Resources (UoR) Rating

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

The key features of the UOR ratings are as follows:

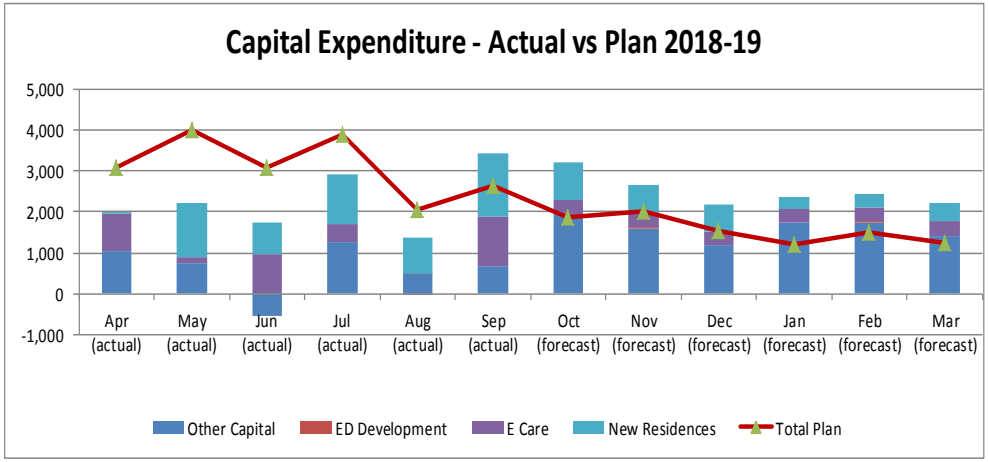
- 1 is the highest score and 4 is the lowest
- The I&E margin ratio is based on a control total basis rather than normalised surplus (deficit).
- The Agency rating measures expenditure on agency staff as a proportion of the ceiling set for agency staff. A positive value indicates an adverse variance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

Metric	Value	Score
Capital Service Capacity rating	-0.920	4
Liquidity rating	-19.185	4
I&E Margin rating	-6.20%	4
I&E Margin Variance rating	0.20%	1
Agency	-24.90%	1
Use of Resources Rating after Overrides		**3**

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

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

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2018-19 £'000
E Care	916	131	975	457	-11	1,217	380	330	330	330	330	364	5,750
ED Development	0	0	0	0	9	0	0	20	0	0	20	0	50
New Residences	37	1,329	773	1,210	903	1,557	910	702	646	302	333	445	9,145
Other Schemes	1,047	760	-555	1,259	471	658	1,912	1,608	1,192	1,727	1,755	1,409	13,241
Total / Forecast	1,999	2,220	1,193	2,926	1,372	3,432	3,202	2,660	2,167	2,359	2,438	2,218	28,186
Total Plan	3,098	4,022	3,098	3,911	2,041	2,638	1,876	2,007	1,551	1,221	1,497	1,226	28,186

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

Expenditure on e-Care for the year to date is £3,686k with a forecast for the year of £5,750k.

The forecast for the year is behind the plan submitted to NHSI so shows a favourable variance. This is because the timing of the implicit finance lease equipment additions in radiology and endoscopy has changed, there is slippage on Residences compared to plan plus most of the MModal (voice recognition) cost was incurred in 2017/18 instead of 2018/19. The next phase of the roof replacement programme commenced slightly later than the original plan forecast.

The forecasts for all projects have been reviewed by the relevant project managers. Since the reforecasting exercise in the previous month there have been no major changes in the forecast expenditure on the schemes.

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

Statement of Financial Position at 30th September 2018

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2018 * £000	Plan 31 March 2019 £000	Plan YTD 30 Sept 2018 £000	Actual at 30 Sept 2018 £000	Variance YTD 30 Sept 2018 £000
Intangible assets	23,852	27,909	26,224	26,490	266
Property, plant and equipment	94,170	111,399	105,510	101,568	(3,942)
Trade and other receivables	3,925	3,925	3,925	3,925	0
Other financial assets	0	0	0	0	0
Total non-current assets	**121,947**	**143,233**	**135,659**	**131,983**	**(3,676)**
Inventories	2,712	2,700	2,750	2,666	(84)
Trade and other receivables	21,413	19,500	19,000	19,676	676
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	3,601	1,050	3,050	3,934	884
Total current assets	**27,726**	**23,250**	**24,800**	**26,276**	**1,476**
Trade and other payables	(26,135)	(27,499)	(26,277)	(23,527)	2,750
Borrowing repayable within 1 year	(3,114)	(3,357)	(3,376)	(3,083)	293
Current ProvisionsProvisions	(94)	(26)	(26)	(94)	(68)
Other liabilities	(963)	(1,000)	(7,000)	(9,198)	(2,198)
Total current liabilities	**(30,306)**	**(31,882)**	**(36,679)**	**(35,902)**	**777**
Total assets less current liabilities	**119,367**	**134,601**	**123,780**	**122,356**	**(1,424)**
Borrowings	(65,391)	(90,471)	(77,011)	(75,285)	1,726
Provisions	(124)	(158)	(158)	(124)	34
Total non-current liabilities	**(65,515)**	**(90,629)**	**(77,169)**	**(75,408)**	**1,761**
Total assets employed	**53,852**	**43,972**	**46,611**	**46,948**	**337**
Financed by					
Public dividend capital	65,803	66,103	65,803	66,008	205
Revaluation reserve	8,021	8,021	8,021	8,021	0
Income and expenditure reserve	(19,974)	(30,152)	(27,213)	(27,080)	133
Total taxpayers' and others' equity	**53,850**	**43,972**	**46,611**	**46,948**	**337**

Non-Current Assets

There is some slippage on the capital programme, mainly on AAU and medical equipment, although GDE is ahead of plan.

Trade and Other Receivables

These have decreased by £0.2m in September but are still £0.7m higher than planned.

Cash

The cash balance is £0.8m higher than plan in September because of slippage on capital. NHSI is being chased urgently for a decision on the capital PDC application.

Trade and Other Payables

This is money owed to other organisations. Payables have decreased by £1.3m since August and are £2.8m less than estimated in the plan for September. This is partly due to slippage on capital and also the clearance of some invoices related to IT capital investment.

Other liabilities

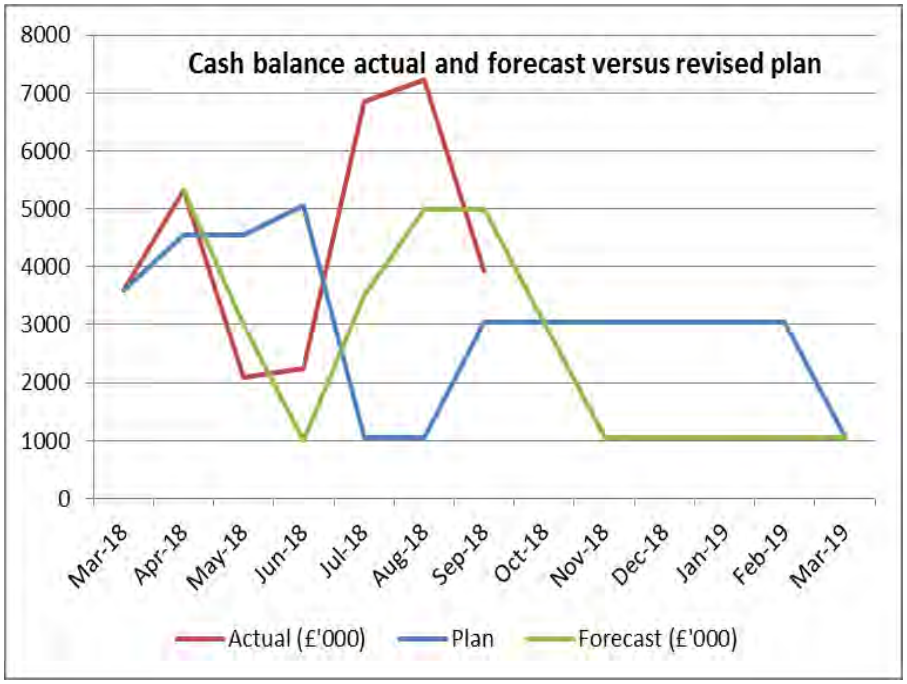
This balance reflects the difference between the income received, mainly for patient care, and the amount that we are able to recognise following the delivery of service. The timing of payments from the CCG was accelerated in August and this balance will start to decrease from October.

Borrowing

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

The Trust has been awarded £2.3 million capital PDC for the first phase of the Acute Assessment Unit expected to open by the end of November 2018. PDC does not have to be repaid but does attract a cash charge of 3.5% per annum. This money has not yet been received and it is not clear when it will be received, this is being chased with NHSI.

Cash Balance Forecast for the year



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

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

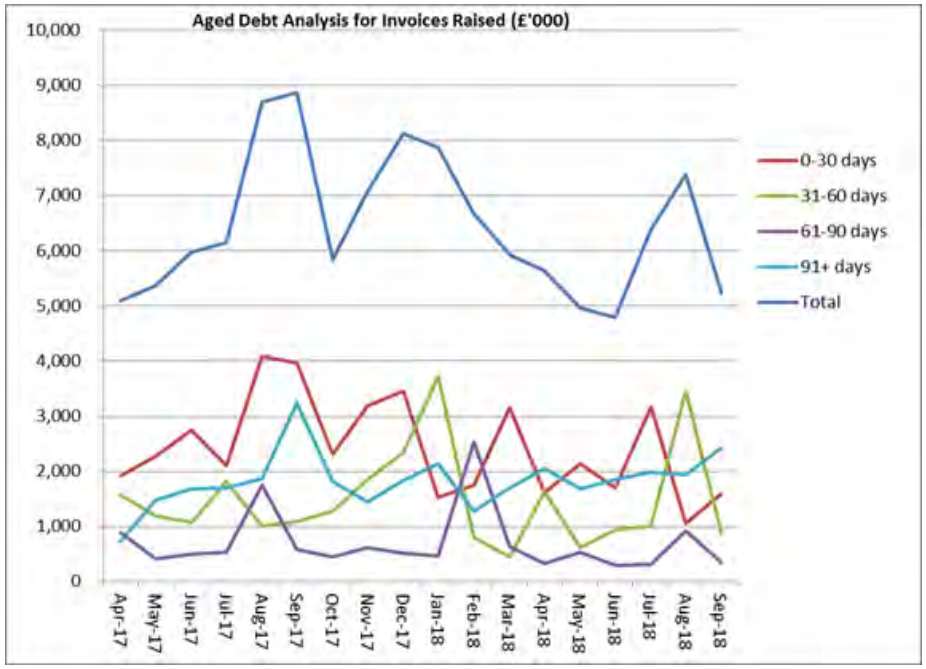
The timing of agreement from DH on the required £8.1m PDC funding or borrowing for the 2018/9 capital programme is still uncertain and is now critical. It is assumed the cash reserves will reduce until the capital loan or PDC funding is received. The timing of the receipt of the £2.3m PDC funding for AAU is also not clear and has been chased. The profiling of the CCG contract payments reduces significantly from October onwards.

The Trust is borrowing cash from DH equivalent to its control total deficit of £10.2m in 2018/19 in addition to capital borrowing. Payments to suppliers may have to be delayed if decisions on PDC are not received soon.

Debt Management

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

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



The overall level of invoices raised but not paid has decreased by £2.1m in September. This is mainly due to outstanding invoices relating to the Cath Lab Managed Service being paid.

25% of the balance due 91+ days relates to Cambridge University Hospital Foundation Trust and a similar amount relates to Ipswich Hospital, both issues are being actively pursued at a senior level. 80% of debt in this category is with NHS organisations.

11. Transformation report

To ACCEPT the report

For Report

Presented by Helen Beck

Trust Board - 2 November 2018

NHS West Suffolk NHS Foundation Trust

Agenda item:	11			
Presented by:	Helen Beck - Chief Operating Officer			
Prepared by:	Lesley Standring – Head of Operational Improvement, WSFT Sandie Robinson - Associate Director of Transformation, CCG Jane Rooney - Head of Planned Care Transformation, CCG John Connelly - Head of PMO, WSFT Sheila Broadfoot - CQUIN Lead, WSFT			
Date prepared:	23 October 2018			
Subject:	Transformation Board Report			
Purpose:	√	For information		For approval

Executive summary:
This report provides an update from the last reporting period and relates to the programs of work being undertaken by the joint transformation teams, the Trust PMO and progress against CQUIN. This month section 2 of the report provides particular detail around the various pieces of work initiated to better understand and manage the continued increased demand in ED attendances.

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:	Planned Care Board A&E Delivery Board
Risk and assurance:	
Legislation, regulatory, equality, diversity and dignity implications	

Recommendation:
The board is asked to note the content of the report and progress in a number in a number of key system wide transformation initiatives

Putting you first

1.0 Update on Hospital Transformation

1.1 Red to Green/SAFER

Board rounds are now supported daily by an operational manager or senior matron, escalating red reasons which cannot be resolved at ward level to the relevant managers of the day and providing a more focused structure to patient flow. Members of the executive team attend a board round once per week to give additional oversight.

1.2 Multi Agency Discharge Event - MADE

The Trust and system partners ran a full MADE event on 9th and 10th October. It is was anticipated that running the event on the 9th and 10th October would help the hospital recover from a predicted peak in demand on the 7th October and put us in a better place to cope with a second peak on the 14th October.
In addition to managing demand the acute hospital welcomed system partners to give a different viewpoint on patients' pathway, and for west Suffolk to showcase how we work together.

Evidence shows that running a MADE gives positive benefits:

- To patients, by ensuring care is delivered in the right place
- To acute staff who gain a greater understanding of services available outside of an acute organisation
- To wider system partners who get a flavour of the demands faced.

Expected outcomes:

- Increased discharges = more beds to allow us to cope with the predicted increase in demand
- Test out a model as an alternative to 'perfect week' to use during the first week of January
- Increased knowledge of the system

Tuesday 9th October

- Teams consisting of WSFT staff and system partners attended each board round
- Ask patients 4 questions about their stay and discharge plans
- 'Red' reasons escalated to a team in the hospital control centre
- A full red to green of all patients was completed led by the executive chief nurse
- All actions followed up in the afternoon and reported back

Wednesday 10 October

- Teams again attended board rounds this time paying particular attention to definite discharges, potential discharges and discharges planned over the next couple of days following the 'why not home? why not today' ethos.

NHSI and ECIST supported the process and were impressed by the processes we have in place to manage flow.

Key findings included positively:

- good attendance at consultant led board rounds
- robust process in place for escalation of barriers to patients' pathways

Requires further work:

- No sense of urgency for TTO writing
- Anxiety frequently reported as a concern for patients about to be discharged

The full findings will be presented to TEG and will help to inform the plan for winter 2018/19

1.3 Diagnostic Virtual Ward

Transformation funding has been agreed in the form of 1.5 wte x band 4 to test out a diagnostic virtual ward model. With the aim of reducing bed days for patients who are awaiting an inpatient investigation prior to discharge

Inclusion Criteria:

- Inpatients identified by consultant in charge of their care
- Awaiting an inpatient investigation (Echocardiogram, Gastroscopy, Sigmoidoscopy, Colonoscopy).
- Planned for discharge after the inpatient investigation (i.e. medically fit for discharge provided the investigation is done in a timely fashion).
- Adults
- Support at home – not 'home alone'
- Easy access back to WSFT/Accident and Emergency
- Contactable by 'phone (preferably mobile)

Plan to recruit to the band 4 post and then test out with patients awaiting ECHO and waiting for Gastroenterology investigations.

1.4 Trustmarque

The Trust commissioned Trustmarque to undertake a data analysis project in ED using the wealth of data pertaining to ED and apply a data driven approach to identify areas for improvement. The data analysis project has delivered some initial findings as well as a live tool which can be used to continue this analysis and to measure the impact of any changes that are tried and implemented.

One of the areas was identifying frequent attenders and the reasons for their attendance. This will allow discussions with relevant partners to ensure these patients are seen in the correct setting by the right professional and seek to reduce repeat visits to ED. Another area of focus is on the reduction of minor and paediatric breaches. Whilst many of the findings are not new, being able to support these views with robust data analysis and measure the impact of changes is very powerful.

The next steps are to further consider the initial findings that were presented and identify some key improvements that can be delivered. Alongside this there will be internal training to understand the data in the analytic tool so this can be used to proactively target areas for improvement and measure the impact of change.

1.5 Appointment of project manager

A band 6 project manager has been recruited to the team she will initially lead on the development of a surgical ambulatory care unit supported by NHS elect.

2.0 Integrated Care Programme Project highlights

2.1 Respiratory

As the model for an integrated respiratory service takes shape the improvements to COPD have now been finalised following a successful recruitment campaign. The service is now working well within the respiratory wards supporting pull based discharge and within the community on admission avoidance. The domiciliary oxygen assessments are now being provided through community clinics with the backlog completely cleared ahead of winter as well as releasing vital clinical capacity. A formal launch of the service is planned for early November.

2.2 A&E Demand Management

The CCG has conducted a review of A&E attendances for the November A&E delivery board. The following is a summary of the headlines and recommendations:

Key summary from CCG sus data:

- The growth in A&E attendances to WSFT comparing **April to August** year on year is 4.6% from WSCCG practices and 5.2% from practices in I&ECCG (against plan of 2.77% growth)
- The growth is NOT specific to in/out of hours or ambulance/walk-ins. The demand is fairly evenly spread
- If we exclude the streamed patients, most practices have reduced ED attendances year on year. However, there are seven practices where ED attends have increased.
- The increase appears to be mainly in adults

Key summary from the Midlands & East region - Analytical Dashboard which provides more recent data:

- A&E demand has been gradually rising (when measured on a rolling basis) since the second week of September but is not statistically unusual on a daily basis.
- The key driver of rising demand appears to be walk-ins (not statistically significant)
- Paediatrics appear to be a key factor in the rise since September (not statistically significant)

Key summary from the CCG Ambulance Dataset:

- 35% of conveyances in the largest growth area of 75s years and over did not result in an admission between April and August. This equates to 885 conveyances, average of 5.8 per day.
- Main reasons identified for the ambulance conveyances are Falls, Health Care Professional (includes GP), 111, Chest Pain and Breathing problems
- 42% of non-admitted conveyances are in-hours equating to 375 conveyance and an average of 2.5 per day.
- Care Homes are 17.5% of this activity, 155 conveyances and an average of 1 per day. (Noting that this data uses the postcode match.)
- The diagnostic has NOT checked for treatments or investigations so patients could have been taken to hospital at the request of the GP, had tests/treatments in A&E or Ambulatory Care and then discharged and therefore an appropriate pathway.

In January 2018 the system undertook a sample review of ED attendances asking people why they chose to attend A&E at WSFT and what alternatives they had or had not considered. The review focussed only on minor attendances including people streamed to GP streaming.

Many attendees reported that confidence levels in 111 and access to a GP appointment were low. 28% claimed they had tried their GP first. Most people (66%) felt A&E was the easiest option to get help and were happy to wait to be seen.

2.3 GP Streaming

The clinical model for GP streaming was refined in August to increase the number of attendances streamed but this has seen little improvement on numbers despite the improved shift fill throughout September and October. A full review of the GP streaming model is planned but is currently on hold pending the mobilisation of the new Integrated Urgent Care (IUC) contract.

2.4 Discussion and recommendations

The diagnostic outlines a number of opportunities for system partners to consider. The table below draws on existing and new demand management initiatives and the potential solutions for consideration.

Diagnostic	Solution in place	Proposed change	Impact	Cost
Conveyances from care homes	Early Intervention Team 24/7 – target of 68% of all refs from community (currently 66%) Geriatrician weekly ward round in 2 care homes GP LES aligned to care homes – weekly ward round and MDT with clinical pharmacy support istumble falls pathway in place Pimp your zimmer in place Red Bag in place Hospice training on frailty and My Care Wishes Trusted Assessor in place	Early Intervention Team Enhanced Proactive Support – The EIT Nursing and Therapy staff will work proactively with the high demand care homes to complement the LES and INTs currently being implemented to develop out of hours assessment of residents; support care homes with certain care management needs i.e. IV therapy and test proactive community input of care within nursing homes. The EIT therapist will support care homes to help manage falls and support manual handling. This will also help promote early reablement and rehabilitation to support residents after illness and falls. The proactive approach will build relationships with care homes, support the appropriate delivery of care, provide training and development to care home staff, and enable residents to remain in their home rather than using urgent care services and being conveyed to acute care. A recent pilot within Ipswich and East Suffolk was held over Easter and May bank holiday weekends. The REACT team proactively worked with five unaligned care homes and provided a first point of contact within the community for any resident who was suffering a decline in their health. 100% of the residents referred to the service were able to remain in their care home, with the Out of Hours service working collaboratively with REACT to prescribe antibiotic treatment. No ambulance call outs were made.	10% reduction in attendances equating to 78 a year	1 Band 6 nurse and Band 6 Therapist £110,000 working with EIT but as part of the locality approach supporting the INTs and Care Home Support Manager

Over 75s conveyances	The Rapid Intervention Vehicle (RIV) comprises of an Emergency Care Practitioner to administer specific medicines (i.e. analgesia, antibiotics, working within pre-determined Patient Group Directives) and a Therapist from the Early Intervention Team. This initiative has been established for a six month period (October – March) to provide an urgent response for patients; currently operating in the Bury Town Bury Rural and Sudbury localities; who may have been conveyed to A&E if not seen and assessed by a healthcare professional. The RIV complements the existing service provided by the Early Intervention Team, seeing patients in a timely manner improving support for frail patients with an urgent health need enabling their needs to be met in their usual place of residence. The service aims to improve patient satisfaction and reduce avoidable non-admitted conveyances. The operational times of the service are currently 1100-1900 Monday – Friday (including Bank Holidays).	Enhance the service to provide weekend cover responding to referrals from all localities in west Suffolk operating between 1000 - 1800. Activity for April - August 2018 inclusive indicates that there were 250 non-admitted conveyances that took place on a Saturday or Sunday. 63 of these non-admitted conveyances were categorised as either a fall or a sick person and going forward could potentially be supported by the RIV.	25 attendances during operational period Nov – end March 2019 equating to 1.6 weekend Savings 25 x £80/ attendance = £2000 Not cost effective based on current modelling but potential to stretch this beyond falls and sick C5 codes if EIT enhanced service outlined above in place	ECP and vehicle £ 12,570 0.58wte B6 EIT Therapist £43,800 **potential duplication with IUC winter proposal to fund a care homes vehicle which will operate over the weekend. Need to explore opportunities to build the proposal together to maximise outcomes*.
Over 75s conveyances	Acute Assessment Unit advice line	Communications to GPs, Paramedics, specialist nurses to promote this service. Add to MyDOS *'The referral line for*		Nil

		medicine on AAU (Acute Assessment Unit) is a multi-purpose line which is used for: *• Senior nurse/ACP/Consultant advice* *• A referral to the Ambulatory Emergency Care Unit* *• A referral to an assessment trolley as a potential admission* *Consultant advice is available to GP's and staff in community and is available on Mon-Friday from 9am to 9pm and weekends and bank holidays from 1pm to 8pm. Tel: 01284-712712'*		
GP + extended hours utilisation	Operational across all of west Suffolk. 63% underutilised	Bury Town population driving largest volume of demand and propose to focus communications 'ask for GP+' campaign localised to BSE to empower patients to ask for GP+ if their practice says they do not have appointments Link communications to top 7 practices Direct booking from IUC	Stretch target to 75% = x attendances	Nil
High Intensity users	Range of independent and poorly coordinated schemes across voluntary and statutory services.	Top 100 patients attending ED equated to 1246 attendances in 2017/18 Aim: to provide a coordinated model to support individuals who are frequent users of urgent care services. Evidence based on Blackpool and NEE models based on a managed *rolling* case load of 50 Proposal to appoint 1 wte coordinator to work with system partners as part of a MDT in each of the 6 localities to identify from urgent care services the top 50 most frequent users. The model adopts a health coaching approach through a named case	174 attendance/year 76 NEL / year Amb conveyance 51/ year	Band 6 £41,113

		coordinator to support delivery of a care and support plan. The model involves identifying the triggers for relapse so early intervention can be made before a crisis occurs.		
Paediatric attendances		Propose deep dive to understand top reasons for attendance and understand alternative options.		
GP streaming	Commissioned Service co-located at WSFT provided by GP Federation to deliver primary care service to ED attendances: M-F – 1100 -2100 S-S – 0900 -2100 BH – 0900 – 2100 Approx. 4 appointments slots /hour **September performance**: Slot availability: 94.6%: Slot utilisation: 55.77% Returned to ED: 1.8%	Appoint a Health Care Assistant from the unfilled slots to increase the number of patients streamed to GP. From 1 December OOHs and GP streaming will be working alongside each other to provide greater flexibility under the winter indemnity scheme in how streaming and direct booking appointments can be managed.	Agree stretch from 1 December to 70% equating to an additional circa 95 ED attendances streamed each month or 3 /day	Nil
NHS 111 Clinical triage	50% of all calls are clinically triaged by a clinical advisor.	1 November launch of the national IUC specification across STP. Shift to **consult and complete** model delivered through a clinical advisory service (CAS) staffed by practitioners across pharmacy, mental health, paediatrics, GP and nurse		Nil
Walk-ins: Public education	**Alternative options for Support Advice – Volunteers in ED** WSFT ED already benefits from the support of Volunteers managed by the West Suffolk Hospital Voluntary Services Team. The Volunteers are located in ED to: •Help and support patients and relatives attending ED making their time	There is potential for these volunteers to also be talking to patients about alternative options for support and where appropriate providing leaflets / information this could include services such as: • 111 • Local pharmacy • GP • GP OOHs Training with regard to appropriate patients / carers to provide	21 attendances/ year	Nil

	as comfortable and stress free as possible •Befriend waiting patients / carers •Ensure that anyone waiting is made comfortable •Help reduce stressful environment	alternative options for support information to and the detail of information to provide would be included in the established induction / training prior to the Volunteer taking up their role. It is anticipated that if individuals are provided with this information in a supportive non-confrontational manner they will consider alternatives to ED in a future situation when they require clinical advice / support There is no financial cost for this initiative but outcomes would be beneficial. If the Volunteers manage to speak to 50% of the patients conveyed but not admitted in a year (based on activity Apr – Aug 2018 extrapolated to full year) and I in 50 patients provided with alternative options to support / advice do not use ED when they next require clinical advise/support, this would reduce the number of non-admitted conveyances by 21 for the year.		
South Norfolk Demand	Maturing relationships are being developed with South Norfolk Alliance and Lead commissioners from S Norfolk CCG.	WSFT to provide details of demand to inform Alliance to Alliance conversations around demand management.		Tbc

2.5 Discharge to Optimise and Assess

Pathway 0 interventions are being progressed as business as usual by the Head of Operational Improvement

Pathway 1 continues to focus on F3 and G5 and although small numbers to date (8) the outcomes have been promising demonstrating a very new way of integrated and flexible working that is shifting recovery and reablement from the hospital to home. The pathway has supported several individuals successfully with progress towards reduction in level of care packages.

The test and learn period has brought both STGH and Homefirst together to deliver a single model of delivery enhanced by a release of 1 wte OT from the acute team to support the process. The plan is to start P1 on the escalation ward (G3) when it opens.

There are two key issues impacting progression:

- Support to Go Home capacity – this is very stretched particularly as key members of the team take annual leave. The acute and community therapists are working through how resilience can be built into this early phase of the pathway until the community teams are fully on board. Going forward delivery of P1 will sit firmly within the localities as part of Responsive Care. STGH are already meeting with the Mildenhall team to understand how this could be tested as a forerunner to joining up the hospital and community teams. Meetings with the other locality teams are currently being organised.
- Trusted Assessment – The cultural shift in how teams come together to deliver P1 is significant. Currently Homefirst and STGH are undertaking joint home visits which in a trusted assessment environment would not be necessary. This will take some time to resolve as the teams learn to work through organisation differences, operational process and have access to information sharing.

Pathway 2 supports patients who cannot be discharged home from the acute trust but have reablement potential, which can be met in a community assessment bed. Glastonbury Court and Newmarket Hospital are providing excellent support to this pathway.

Pathway 3 A protracted Delirium Paper outlining the proposed pathway will be presented at November's transformation delivery group.

2.6 Integrated Urgent Care (IUC)

Mobilisation of this new service has been delayed due to IT issues. Care UK will continue to provide the current service until a revised mobilisation date is agreed.

3.0 Planned Care Programme Project Highlights

3.1 100 Day challenge

Following the success of the NHSE led 100-day challenge; we have now agreed two internal challenges, one for video conferencing and one for the Low Priority procedures. These will commence during quarter 3 and we anticipate strong results as seen with the previous 100-day programme. We are also using a consultant from the 100-day challenge as an advocate to promote the use of this methodology amongst his colleagues

3.2 Right Care Programme – Cardio Vascular Disease (CVD), Respiratory and Neurology

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

A pilot of a new baselining process is taking place, initially looking at opportunities in the low back pain pathway. Whilst the MSK pathway is working well, there is still an opportunity for increasing efficiency in this area.

The remaining Rightcare projects in CVD, respiratory, gastroenterology and Neurology continue to progress. Refreshed plans were submitted at the end of September based on the issue of revised data. Feedback on these plans is now awaited.

3.3 Treatment and Care Funding – Diabetes Management

The diabetes dashboard for Primary care is currently being rolled out across the region and this will be coupled with a drive to increase the number of diabetic patients undertaking structured education.

The Trust supports GP diabetes clinics with education for practice nurses and participation in the clinics themselves. There has been a considerable amount of marketing and communications activity relating to diabetes in the past 2 months and it is hoped that this will improve the uptake of structured education for new and existing diabetics.

3.4 Integrated Pain Management Service (IPMS)

Following the issue of a Prior Information Notice (PIN) earlier this year, it is clear that there is no other provider able to provide an integrated pain service. As such, a Most Capable Provider (MCP) process is taking place to ensure that GP Fed and WSFT are the best and most capable provider.
MCP meetings are being held with an independent committee to ascertain appropriateness and ability. The CCG has funded a project manager to support the process as the contract is due to end on 01/12/18. Approval is being sought to extend the contract to 01/04/19.

3.5 Ophthalmology

Mobilisation of the new triaging service for cataracts continues and issues, primarily relating to IT, are being addressed. Mobilisation is almost complete.

Implementation of the NHSE high impact interventions has continued with full support and joint working between the project team and the clinicians.

A waiting times problem continues for cataract surgery and the Trust is working with the CCG to outsource some of the activity and reduce patient waits. Funding has been agreed with the CCG and currently the operational team is planning for the work to take place. This will alleviate the current pressure on waiting times until a more sustainable solution can be put in place.

3.6 Stroke

Work to review stroke services is being undertaken at STP level with input from all the involved Trusts. The following areas are to be reviewed:

- Provision of speech and language therapy across the STP
- Post stroke rehabilitation – Early Supported Discharge
- Acute care pathway and high acute stroke unit (HASU) review
- Training and education
- Workforce
- Ambulance/ED pathway
- Primary and secondary prevention agenda

The local work on ESD is progressing well with a draft service specification now in place. This is now out for review to all stroke teams. The STP has a mandate from NHSE to commence a review of all ASU/HASU services. A bespoke project manager will now be sourced to undertake this over the next two years.

A business plan to support Atrial Fibrillation (AF) activity has been approved by the Planned Care Board this month and will be presented to the Alliance Steering Group next week. This is to gain support for the programme of prevention, detection and perfection around the AF agenda. The programme is being supported by transformation funding.

3.7 Demand Management

The first demand management project has now been implemented with the relaunch of the Teledermatology service to GPs. This was launched in late September 2018 and the training is taking place at individual practices over the next 6 weeks. We anticipate that this will start to reduce the

number of patients being sent into the Trust almost immediately and result in a better pathway for our patients.

A full service review has commenced within the gynaecology specialty. The lead consultant is engaged in the project and several workshops both clinical and operations have now been scheduled.

We are looking at options for outsourcing some vascular and gynaecology activity as demand in these areas exceeds capacity. Again, outsourcing would allow for some waiting list management whilst a more sustainable solution is found.

Two workshops have taken place to look at the mapping of a revised process for the management of low priority procedures. A national review of these is currently underway but in the meantime the local process needs to reflect our policies. The activity to change the process will take place using 100 day methodology later this year.

3.8 Cancer Care

A new cancer lead has been recruited into the CCG for West Suffolk and is starting to work with the CCG Alliance to develop our Cancer Strategy. Cancer transformation will become an agenda item on the Planned Care Board agenda to ensure that all parties have appropriate oversight.

4.0 PMO Update

4.1 CIP Programme

The 2019/20 CIP Programme build process is underway with divisional CIP workshops in September, October and November 2018 to identify new cost improvement opportunities. A set of 2019/20 cross cutting projects have also been identified. Divisional targets for 2019/20 have been set at 4% of the Trust expenditure budget.

4.2 Medical e-Rostering

The eJobPlan module for consultants is built and now reflects the Trusts operational structure in time for the annual job planning round. Allocate will be supporting the implementation phase of the e-Appraisal module in the last week of October. The implementation of the annual leave modules for consultants and juniors complete by January 2019 with Activity Manager in place by the end of March 2019. The business as usual model has been agreed. A Band 6 Medical Rostering Business Manager in HR will be recruited to achieve the expected benefits from the system.

4.3 Procurement: Category Towers

The following are the category towers contracts:

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

Category Towers (2-6) are in mobilisation. Category Towers (7-11) are in implementation

The Trust is currently awaiting work plans from the LLP to assist with mobilisation so the Trust can link in.

5.0 CQUIN Projects 2018-19

Staff CQUINs title:	Progress	RAG
1a) Staff Health & Wellbeing: Improve two specific results by 5% from 2016 on the national Staff Questionnaire re: H&W provision & MSK & Stress not 'due to work'.	H&W provision – target increase to 45% (2017-8 was 43%). Staff H&W initiatives in place. MSK survey via physio: Aug-Dec MSK – target reduce to 17% (2017-8 was 21%). Stress – target reduce to 28% (2017-8 was 33%). Rely on staff own perception to interpret and decide whether: 'Work was main cause of' Stress or MSK.	Q4 Q4
1b) Food & Drinks sold at WSFT: Continue changes made 2016-7 re: items high in fat, sugar or salt and new targets for 3 changes 2017-8.	All in place including liaison with W H Smith. 10% sales max of sugary drinks (no ban); by March 2019 20% of shelf allowed re: >250kcal sweets & 25% shelf re: >400kcal sandwich/wraps/salads. Submit data for NHS Digital.	
1c) Flu vaccination of staff: 75% uptake by end of February.	2017-8 was WSFT 74% (total incl Community 70.99%). Vaccine started 8/10. 22/10 = 1591 staff = approx. 40%	Q4
Patient CQUINs title:	**Progress**	**RAG**
2a) Sepsis screening of all ED and inpatients. Target 90%	eCare adds symptoms together & prompts 'Suspected Sepsis'. From Q4 (Jan) to use NEWS 2 criteria - eCare updated. Paediatrics yet to have alerts. Q2 audit delay: new list build	
2b) Severe/ High Risk Sepsis treatment ED & Inpatients: IV anti-biotic within 1 hour of diagnosis. Target 90%	Improvements required. Q1 ED 64%, Inpatient 74%. Sepsis/ eCare Group: take forward incl review alerts. Paediatrics yet to have alerts (tbc if alert change). Sepsis Nurse to start re: education & audit. Q2 audit delay: new audit list build.	Q1-4
2c) Severe/ High Risk Sepsis - ED & Inpatients: antibiotic prescription review & assessment. Q4 target 90%	2018-9 – predicted will be met. Note: additional criteria – review within 72 hours & additional documentation & IV to oral switch assessment. Q2 audit delay: new audit list build. Data to be submitted to Public Health England.	
2d) Higher % reduction in 'total all' & Carbapenem Antibiotic use vs 2016. Increase usage within Access group AWaRe (Access, Watch & Reserve).	Note: Total antibiotics & Carbapenems increased 2017-8 re: Tazocin shortage. Challenge to reduce 1% & 2% in 2018-9. New: Increase (for in & outpatients), proportion >55% or by 3% vs 2016 antibiotics within the Access group of AWaRe category.	Q4 Q4
4) Mental Health need in ED – Selected 2 cohorts: reduced ED attendance. Outcomes information. Increased use of MH on ECDS, including audit & improvement plan	NSFT & ED: Maintain reduced attendance of year 1 cohort. Year 2 cohort of frequent attenders, final ID, plans, data: reduce 20%. Use of 'MH diagnosis' to increase. All recorded robustly via ECDS. Audit complete and data quality plan, with goals to be met Q2-4. Data on cohorts to be submitted to NHS Digital. Project evaluation. ED meeting to confirm all goals met.	
6) Advice & Guidance to GP pre referral via eRS. Specialties offering A&G covered at least 75% of referrals received 2016-7 (aim A&G reduce referrals).	Phased monitoring for a total of 20 specialties offering A&G to GPS via eRS. Daily checks on eRS queries in place & reminders sent.7 specialties 2017-8 & 7 in Q1 & Q2 2018-9: varied compliance of 2 day turnaround. Clinician ideally responds direct on eRS: work arounds in place. If GPs do not receive timely response: may refer / complain. CCG – GPs ensure only use facility for A&G (not referral).	
9) Adult Inpatients – preventing ill health (excluding Maternity): Targets By Q4 9a) Tobacco Screening 90% 9b) Tobacco Brief Advice (if yes) 90% 9c) Tobacco Referral and Medication Offer 30% 9d) Alcohol Screening 50% 9e) Alcohol Brief Advice Or Referral (if high score) 80%	Form compliance issue. Stored in 'ad hoc' so all roles can access, rather than a role related task with prompts. eCare change request tbc: increase ADL to capture alcohol levels; plus change Brief Advice, Refer & Prescribe (NRT) to doctor only role: so task prompts improve data recording. Education & communication will then be updated. Part of the Trust's Quality Priorities. Q1 baseline data = 0%. Design & education materials: 'met'. Q2-3 % to improve upon last quarter on: ADL; plus recording 'Yes given' Tobacco Brief Advice, Referrals & noting Alcohol drinking levels. Q4 high national % targets shown opposite.	Q2: 9a, 9d, 9e Q2: tbc 9b, 9c Q3-4
10) STP (Suffolk Transf) Support	Local CQUIN. Predict met re: evidence of meetings.	

10:20 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

12. Nurse staffing report

To ACCEPT a report on monthly nurse staffing levels

For Report

Presented by Rowan Procter

Trust Open Board Meeting – 2nd Nov 2018

West Suffolk NHS Foundation Trust

Agenda item:	12
Presented by:	Rowan Procter, Executive Chief Nurse
Prepared by:	Sinead Collins, Clinical Business Manager
Date prepared:	22 October 2018
Subject:	Quality and Workforce Dashboard – Nursing

Purpose:	X	For information		For approval

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

For in depth review of areas, please inquire for the Matrons' governance reports that are completed monthly for their divisions. Included are any updates in regards to the nursing review

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

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

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

Recommendation:
Observations in September's and progress of nurse staffing review made below.

Observations

Location	Nurse Sensitive Indicators (higher than normal)	Other observations
A&E	5 medication errors	High agency & bank use. High RN & NA vacancy. High amount of overtime. High sickness
F7	4 pressure ulcers, 5 medication errors & 3 falls with harm	High agency & bank use. High RN vacancy. High sickness. High amount of overtime.
F8	6 medication errors	High agency & bank use. High amount of overtime.
CCS	4 medication errors	High RN vacancy
Theatres	-	High bank use & RN vacancy. High amount of sickness. High amount of overtime
DSU	-	High sickness & bank use.
CCU	-	High amount of overtime
G1	5 medication errors	High amount of sickness & overtime. High bank use
G3	-	High bank use & NA vacancy. High amount of overtime
G4	4 falls (with harm)	High bank use. High amount of overtime & sickness. High RN vacancy
G5	-	High agency & bank use. High RN & NA vacancy. High sickness
G8	-	High bank & agency use. High sickness. High RN & NA vacancy.
F1	4 medication errors	High bank use & RN vacancy. High amount of overtime & sickness
F3	4 pressure ulcers & 11 medication errors	High RN vacancy. High amount of overtime. High bank & agency use.
F4	-	High agency & bank use.
F5	-	High bank use.
F6	-	High agency & bank use. High RN vacancy. High amount of overtime. High sickness
F9	-	High bank use. High RN vacancy. High amount of overtime. High sickness.
F10	-	High bank use. High RN vacancy. High sickness.
Maternity	-	High bank use & sickness. High midwife vacancy.
F12	-	High agency & bank use.
F14	-	High amount of overtime & sickness.

NNU	-	High sickness. High bank use & overtime
Kings Suite	-	High bank use. High amount of overtime. High sickness.
Rosemary Ward	-	High agency & bank use. High amount of overtime. High sickness.
Bury Town CHT	3 pressure ulcers (in our care)	High sickness.
Bury Rural CHT	4 pressure ulcers (in our care)	-
Mildenhall & Brandon	-	-
Newmarket CHT	-	High sickness.
Sudbury CHT	-	High RN vacancy. High sickness.
Admission Prevention Service	-	High sickness.
Children CHT	-	High Band 4 vacancy. High sickness.

Vacancies – In West Suffolk Hospital, there are significant vacancies in registered staff, and is -105.06WTE and there is an unregistered vacancy of 26.50WTE. The registered is worse than last month and unregistered figure is better than last month. HR, nursing directorate, comms and operations are developing different methods to recruit and retain nursing staff. Bay base nursing establishment is being implemented by adjusting the rosters in October – this will adjust vacancies. The recruitment of nursing assistants is in progress

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

Roster effectiveness – Out of 27 areas, 26 are over the Trust standard of 20% (Day surgery unit & ward are counted as one area). This is the same as August, which could be explained due annual leave of childless households, continued high sickness and winter period starting. Roster effectiveness is a sum of Sickness (Trust standard <3.5%), Annual leave (Trust Standard 12% - 16%) and Study Leave (Trust Standard 2.5% - 3.5%) – It is not a sum of the maximum % but on average. Roster effectiveness has not been 'drilled' down any further than sickness due to annual & study leave % are based on appropriate management of staff.
We don't collect this information in the community

Sickness – Out of 27 areas, 19 are over the Trust Standard of 3.5% (one less than last month) (Day surgery unit & ward are counted as one area).
In the community, 5 out of the 8 areas are over the Trust Standard (same as last month).

Community Workforce
The workload of the teams has seen a decrease in regards to Patient Facing Contact hrs but Admission Prevention Service as seen an increase due to an increased focus and, as agreed at Trust Board. In general, there has been a slight decrease in unplanned requests.

Updates in September

Oversea nurses numbers
At present 170 conditional offers have been made (this is from the recruitment campaign in December 2017 and June 2018 plus separate Skype interviews).

The arrivals consist of:

- 19th October cohort = 9 confirmed
- End of Nov – To be confirmed

Three of the oversea nurses who started in August passed their OSCEs and are now Band 5 nurses on respective wards. On 25th October, five more booked to take test

Other nursing updates
Seven Welcome payments were given this month to new nurses starting.
Recent NA job advert raised 25 interested applicants and now being shortlisted

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Sep-18			Establishment for the Financial Year 2017/18						Data for September 2018													
										Workforce											Nursing Sensitive Indicators		
Trust	Ward Name	Speciality	Current Funded Beds/Chairs Trolleys	Current Funded Establishment (WTE)	Current Funded Total Establishment Registered to Unregistered (%)		SCNT Establishment (WTE) (Feb 2017)	Number of patients per RN/Midwife (not including unit manager)		Fill rate Registered %		Fill rate Unregistered %		Bank staff use %	Agency staff use %	Overtime (Hrs)	Vacancies (WTE)		Sickness (%)	Overall Care Hours Per Patient Day	Roster Effectiveness - Total Non Productive Time (% excl maternity)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)
					Registered	Unregistered		Day	Night	Day	Night	Day	Night				Registered	Unregistered						
WSFT	ED	Emergency Department	21 trollies and 30 chairs	81.79	70.47%	29.53%	N/A	1 - 4	1 - 5	77.5%	95.2%	78.6%	109.8%	8.18%	10.93%	317	-7.97	-5.20	8.30%	N/A	26.40%	N/A	5	1
WSFT	F7	Short Stay Ward	34	55.20	52.00%	48.00%	42.65	6	9	59.1%	73.1%	96.6%	101.5%	11.79%	5.98%	224	-11.20	-0.97	6.40%	6.4	28.30%	4	5	3
WSFT	F8	Acute Medical Unit	12 beds, 10 trollies and 4 chairs	27.79	56.00%	44.00%	I/D	6	N/A	100.5%	98.9%	130.0%	116.3%	14.28%	1.23%	349	-0.40	1.48	1.90%	10.9	23.60%	0	6	1
WSFT	CCS	Critical Care Services	9	51.53	96.14%	3.86%	N/A	1 -2	1 -2	87.4%	83.8%	N/A	N/A	1.26%	0.00%	78	-0.60	-0.70	6.20%	29.6	24.10%	0	4	0
WSFT	Theatres	Theatres	8 theatres	88.38	74.00%	26.00%	N/A	1/3	(1/3)	105.0%	100.0%	N/A	N/A	4.17%	0.00%	178	-5.44	0.40	5.90%	N/A	21.60%	0	0	N/A
WSFT	Recovery	Theatres	11 spaces	22.31	96.00%	4.00%	N/A	1 -2	1 -2	147.2%	88.4%	61.5%	N/A	2.07%	0.00%	0	-0.90	-0.10	3.00%	N/A	21.80%	0	1	N/A
WSFT	Day Surgery Unit	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC ward	52.06	78.00%	22.00%	N/A	1 - 1.5	N/A	59.7%	N/A	91.4%	N/A	0.11%	0.00%	0	-1.30	-1.20	3.40%	N/A	22.10%	0	0	0
	Day Surgery Wards													10.60%	0.00%	7	0.30	0.00	9.20%		24.90%			
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	13.32	2 - 3	2 - 3	102.0%	88.5%	34.9%	N/A	3.52%	0.00%	179	-0.60	-0.70	0.40%	13.0	27.90%	0	2	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	18.32	4	6	88.2%	104.2%	113.5%	N/A	8.88%	0.00%	124	-2.42	1.00	5.20%	8.0	28.80%	0	5	1
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	45.57	6	10	86.0%	84.7%	76.4%	107.0%	15.48%	0.75%	187	-1.08	-5.67	3.80%	5.0	24.80%	1	0	1
WSFT	G4	Elderly Medicine	32	44.80	48.00%	52.00%	44.78	6	10	82.8%	73.5%	114.4%	110.8%	15.16%	0.00%	427	-4.70	-2.97	5.10%	5.9	25.30%	1	0	4
WSFT	G5	Elderly Medicine	33	42.22	51.00%	49.00%	50.52	6	11	69.7%	92.4%	90.3%	99.1%	21.52%	4.37%	79	-6.48	-5.18	8.00%	4.8	24.40%	0	1	2
WSFT	G8	Stroke	32	49.35	54.31%	45.69%	42.26	5	8	68.9%	76.1%	94.3%	103.3%	19.75%	13.70%	71	-12.34	-3.84	10.90%	5.9	32.20%	1	0	2
WSFT	F1	Paediatrics	15 - 20	26.31	68.64%	31.36%	N/A	6	9	116.5%	119.7%	100.0%	N/A	22.44%	0.00%	215	-5.98	1.50	5.20%	10.5	24.60%	N/A	4	N/A
WSFT	F3	Trauma and Orthopaedics	34	40.47	59.07%	40.93%	48.48	7	11	83.5%	88.6%	140.3%	104.2%	4.85%	1.19%	252	-4.60	-0.70	2.00%	5.3	20.60%	4	11	0
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	21.71	8	16	84.5%	90.0%	94.5%	179.3%	7.59%	6.05%	88	-2.90	-0.90	2.60%	10.6	22.50%	0	0	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	40.19	7	11	92.4%	96.8%	96.7%	106.9%	8.28%	0.00%	42	-1.38	-1.15	3.20%	6.4	22.00%	0	1	1
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	47.91	7	11	63.6%	72.1%	124.6%	135.3%	8.16%	2.70%	314	-4.10	-1.16	7.40%	4.8	21.30%	0	0	1
WSFT	F9	Gastroenterology	33	42.63	52.34%	47.66%	48.16	7	11	73.9%	84.1%	79.8%	114.5%	21.02%	0.76%	253	-9.60	-2.60	11.30%	4.8	33.20%	1	2	1
WSFT	F10	Respiratory	25	40.75	56.58%	43.42%	40.62	6	6	78.7%	73.6%	98.8%	99.9%	8.70%	0.26%	93	-7.30	2.40	6.70%	7.0	25.70%	1	3	0
WSFT	F11	Maternity	29	61.55	72.14%	27.86%	N/A	7.25	14.5	114.1%	91.0%	74.0%	63.5%	7.48%	0.00%	22	-5.67	0.60	6.90%	N/A	23.30%	0	2	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms					1	1													0	0	0
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre					1 - 2	1 - 2													0	1	0
WSFT	F12	Infection Control	8	16.42	68.59%	31.41%	9.61	4	4	86.2%	79.3%	35.3%	117.0%	18.73%	1.19%	0	-2.60	-0.54	0.90%	9.5	29.20%	1	1	0
WSFT	F14	Gynaecology	8	12.58	96.55%	3.45%	I/D	4	4	96.3%	99.2%	N/A	N/A	1.42%	0.00%	195	-0.30	-0.40	9.70%	16.5	25.90%	0	0	0
WSFT	MTU	Medical Treatment Unit	9 trollies and 8 chairs	9.00	80.00%	20.00%	N/A	5 - 8	N/A	95.4%	N/A	85.7%	N/A	0.00%	0.00%	0	-0.20	0.00	0.70%	N/A	17.90%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.24	85.14%	14.86%	N/A	2 - 4	2 - 4	87.3%	92.2%	39.0%	26.7%	4.73%	0.00%	144	-1.30	0.80	13.60%	21.2	36.00%	N/A	0	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	N/A	8	8	277.9%	89.6%	171.9%	110.0%	9.66%	6.41%	117	-2.70	-1.50	6.70%	5.8	24.10%	0	2	0
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	N/A	6.6	10	117.4%	99.6%	107.4%	100.0%	4.49%	0.72%	196	-1.30	0.80	6.50%	5.0	22.70%	0	0	1
										96.36%	89.39%	92.92%	105.84%	9.44%	2.01%	4151	-105.06	-26.50	5.75%		25.19%	*Trust standard is 20%*		
										AVG	**AVG**	**AVG**	**AVG**	**AVG**	**AVG**	**TOTAL**	**TOTAL**	**TOTAL**	**AVG**		**AVG**			

Trust	Team Name	Speciality	Current Funded Beds/Chairs Trolleys	Current Funded Establishment (WTE)	Current Funded Total Establishment Registered to Unregistered (%)		SCNT Establishment (WTE) (Feb 2017)	Number of patients per RN/Midwife (not including unit manager)		Patient facing contact (hrs)	Another method workload measurement to be determined	Bank staff use %	Agency staff use %	Overtime (Hrs)	Vacancies (WTE)		Sickness (%)	Overall Care Hours Per Patient Day (June 2017)	Unplanned requests	Pressure Ulcer Incidences (In our care)	Nursing/Midwifery Administrative Medication Errors	Missed visits
					Registered	Unregistered		Day	Night						Registered	Unregistered						
Community	Bury Town	Community Heath Team	No community equivalent	21.59	25.94%	74.06%	No equivalent tool for community nurses	No specific number		1240.12		We are unable to collect this information this month		To be confirmed if can measure	-1.80	-1.00	9.00%	No equivalent tool for community nurses	56	3	0	0
Community	Bury Rural	Community Heath Team		11.20	10.71%	89.29%				602.30					-0.20	-0.50	1.21%		22	4	0	0
Community	Mildenhall & Brandon	Community Heath Team		14.50	20.07%	79.93%				769.43					-1.60	-0.09	2.89%		32	0	0	1
Community	Newmarket	Community Heath Team		11.25	28.00%	72.00%				458.28					0.00	0.00	9.16%		24	1	0	0
Community	Sudbury	Community Heath Team		25.92	32.25%	67.75%				1029.40					-4.20	0.00	7.14%		45	1	0	1
Community	Haverhill	Community Heath Team		13.20	32.05%	67.95%				770.25					-1.84	0.00	0.00%		25	0	0	0
Community	Admission Prevention Service	Specialist Services		13.73	25.13%	74.87%				68.80					-1.42	0.00	5.52%		0	0	0	0
Community	Children	Community Paediatrics		32.89	47.07%	52.93%				1198.05					-0.86	-3.00	10.16%		0	N/A	0	0
										6136.63		#DIV/0!	#DIV/0!		-11.92	-4.59	5.64%		204			
										TOTAL		**AVG**	**AVG**		**TOTAL**	**TOTAL**	**AVG**		**TOTAL**			
																	Target - 3.5%					

Explanations

WSFT have some significant environmental layout challenges and additional activity that are not reflected in the SNCT(F14/G1/G8/F12/CCU/NCH)
Fill Rate is an indication of patient safety - national target 80% (less than = red), Trust internal target 85% (equal and greater than = green)
Medication errors are not always down to nursing and can be pharmacist or medical staff as well
In vacancy column: - means vacancy and + means overestablished.
Roster effectiveness is a sum of Sickness (<3.5%), Annual leave (12% - 16%) and Study Leave (2.5% - 3.5%)
DSU has been split into ward and unit only by HR, that is why only a section has been split in this dashboard
G9 - Closed during April
Pressure Ulcer Incidences (In our care) - includes DTI's

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

13. Mandatory training report

To ACCEPT a report

For Report

Presented by Jan Bloomfield

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – 2 November 2018

Agenda item:	13
Presented by:	Jan Bloomfield, Executive Director Workforce & Communications
Prepared by:	Rebecca Rutterford, Workforce Development Manager
Date prepared:	15th October 2018
Subject:	Mandatory Training

Purpose:		For information	☑	For approval

Executive summary:
Appendix A is the October 2018 Mandatory Training Report, this represents data taken from the system on 10th July 2018.
Appendix B The Recovery Plan outlines the actions currently in place to improve take up of mandatory training across the Trust in those areas below the relevant target.
Appendix C provides performance impact assessments for those areas below target, compiled by the subject matter experts for each area.
Appendix D The National CQUIN 2015-6 target for Dementia staff training states that the Trust should include quarterly reports to Provider Boards of:
• Numbers of staff who have completed the training;
• Overall percentage of staff training within each provider'.
Appendix E shows mandatory training figures for SCH Community staff. SCH Community currently records training in a system called Staff Pathways.

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

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Increase in target

Subjects which previously met the 80% target have not been included in the action plan; this will be reviewed once the community data merges with our acute data at the beginning of 2019. At which point the size of the compliance gap and how to achieve the revised target will be assessed with the subject leads.

IT

Internet Explorer 11 (IE11) has been released to the majority of computers within the Trust which has resolved some performance issues.

Following a meeting with the OLM account Manager and IT, it has been identified that the remaining issues around eLearning performance are due to the unsuitability of our existing server to host eLearning. IT is currently investigating costs for a more suitable server.

Compliance

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

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Appendix A

Subject Matter - High Level Mandatory Training Analysis October 2018

Competence Name	Trust Target	Expired	In Date	Total	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	90% Stretch Target agreed for all subjects apart from IG which has a national 95% target
179|LOCAL|Infection Control - Classroom|	90%	84	1317	1401	95%	95%	94%	94%	95%	94%	95%	94%	95%	95%	95%	94%	
NHS|CSTF|Preventing Radicalisation - Levels 1 & 2 (Basic Prevent Awareness) - 3 Years|	90%	273	2816	3089	N/A	N/A	N/A	84%	86%	87%	88%	90%	90%	90%	91%	91%	
179|LOCAL|Safeguarding Adults|	90%	288	2801	3089	91%	92%	92%	92%	92%	91%	91%	92%	91%	90%	91%	91%	
179|LOCAL|Safeguarding Children Level 2|	90%	171	1528	1699	90%	92%	92%	92%	91%	91%	90%	91%	91%	89%	90%	90%	
NHS|MAND|Safeguarding Children Level 3 - 1 Year|	90%	26	275	301	83%	86%	86%	88%	83%	95%	94%	94%	94%	89%	91%	91%	
NHS|MAND|Safeguarding Children Level 1 - 3 Years|	90%	334	2755	3089	89%	90%	90%	91%	90%	90%	90%	89%	89%	88%	89%	89%	
179|LOCAL|Infection Control - eLearning|	90%	183	1481	1664	87%	88%	90%	90%	90%	90%	90%	91%	90%	87%	90%	89%	
179|LOCAL|Health & Safety / Risk Management|	90%	340	2749	3089	91%	91%	92%	92%	91%	90%	90%	91%	91%	89%	90%	89%	
179|LOCAL|Fire Safety Training - Classroom|	90%	351	2738	3089	91%	91%	91%	90%	90%	90%	90%	90%	89%	90%	91%	89%	
179|LOCAL|MAJAX|	90%	354	2736	3090	88%	89%	89%	90%	88%	88%	88%	89%	88%	88%	88%	89%	
179|LOCAL|Security Awareness|	90%	572	4149	4721	90%	91%	91%	91%	90%	90%	90%	91%	90%	89%	89%	88%	
179|LOCAL|Blood Bourn Viruses/Inoculation Incidents|	90%	244	1632	1876	86%	87%	87%	86%	86%	85%	86%	87%	88%	85%	86%	87%	
179|LOCAL|Medicine Management (Refresher)|	90%	210	1374	1584	87%	88%	89%	89%	88%	87%	87%	88%	89%	87%	86%	87%	
179|LOCAL|Slips Trips Falls|	90%	352	2247	2599	88%	88%	88%	87%	87%	85%	85%	86%	86%	86%	85%	86%	
179|LOCAL|Conflict Resolution - elearning|	90%	122	615	737	82%	85%	87%	85%	84%	86%	87%	87%	88%	82%	83%	83%	
179|LOCAL|Fire Safety Training - eLearning|	90%	520	2569	3089	85%	84%	85%	84%	82%	80%	82%	81%	81%	84%	84%	83%	
179|LOCAL|Moving and Handling Non Clinical Load Handler|	90%	75	348	423	84%	88%	88%	89%	88%	88%	88%	83%	83%	81%	85%	82%	
179|LOCAL|Equality and Diversity|	90%	599	2490	3089	94%	94%	94%	88%	83%	81%	80%	79%	79%	79%	80%	81%	
179|LOCAL|Information Governance|	95%	604	2485	3089	86%	87%	85%	84%	82%	86%	86%	83%	84%	82%	82%	80%	
179|LOCAL|Basic Life Support - Adult|	90%	453	1704	2157	81%	82%	82%	80%	78%	75%	76%	76%	75%	79%	79%	79%	
179|LOCAL|Moving and Handling - Clinical|	90%	348	1184	1532	80%	84%	82%	79%	79%	74%	76%	77%	75%	79%	76%	77%	
179|LOCAL|Moving & Handling - elearning|	90%	237	757	994	76%	75%	77%	77%	78%	75%	76%	79%	80%	76%	77%	76%	
179|LOCAL|Blood Products & Transfusion Processes (Refresher)|	90%	365	1062	1427	78%	80%	77%	75%	72%	73%	72%	73%	74%	74%	73%	74%	
179|LOCAL|Conflict Resolution|	90%	366	803	1169	76%	75%	77%	76%	76%	69%	70%	70%	71%	73%	71%	69%	
NHS|CSTF|Preventing Radicalisation - Levels 3, 4 & 5 (Prevent Awareness) - No Specified Renewal|	90%	798	1190	1988	N/A	N/A	N/A	4%	9%	17%	26%	36%	44%	51%	55%	60%	

July 18 new starters	Attended	Not Attended	Grand Total	% Compliance
179|LOCAL|Trust Induction|	35	4	39	90%

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Mandatory Training Recovery Plan Oct 2018 **Appendix B**

Subject	Jul 2018 %	Method	Actions	Completion date	Responsibility	Progress
Information Governance	80%	E-learning	IG team to target non-compliant staff directly with the training slides and compliance test. An additional face to face session per month to be offered.	Jan 2019	Sara Ames	• The IG team continue to offer one off training sessions to departments that require it and offer alternative training media/sessions for those who can't access the online module. • Sickness in the team has resulted in less face to face sessions in the last quarter but the team are now back to capacity. • An additional face to face session is being offered to staff per month.
Equality & Diversity	81%	E-learning	Equality & Diversity was introduced as a mandatory training subject in May 2015, with a three yearly renewal. As the three yearly renewal is now upon us, a large number of staff are all becoming non-compliant. This has resulted in a substantial dip in compliance. Investigation and targeted emails to be sent to managers.	Jan 2019	Denise Pora	• The Equality & Diversity package is now working as expected and staff are able to complete their training. • Workforce Development Manager has sent a detailed compliance report to the lead showing the least compliant areas. • Equality, Diversity and Inclusion Mandatory Training will be provided at Trust Induction from November 2018 and it is expected this will have a positive impact on compliance.
Basic Life Support	79%	Face to face	Identify trends or key areas where compliance has dropped.	Jan 2019	Julie Head	• List of non-compliant staff have been provided for the BLS trainers to target. • Drop in sessions in timeout have been offered to try and capture additional staff • Identified the need for an increase in educational resources – band 6 WTE VAF approved. Awaiting successful interviews and appointment
Moving & Handling–e-learning	76%	E-learning	Manual Handling Advisor to email managers encouraging staff to be compliant and complete the eLearning package.	Jan 2019	Neil Herbert	• Manual Handling Advisor has targeted all non-compliant staff.

Subject	Jul 2018 %	Method	Actions	Completion date	Responsibility	Progress
Moving & Handling - Clinical	77%	Face to face	All mandatory training dates are decided at the beginning of year. The Moving and Handling Team ensure that all sessions are covered by either the service lead or Advisor/Trainer. Some departments use their key workers to update supporting the Moving and Handling Team	Jan 2019	Neil Herbert	• Sufficient courses have been provided to cover staff requirements but the impact of cancelling some mandatory training sessions and courses not being fully attended have had an impact on compliance. • More staff have been trained this year than by the same point last year and more sessions have been provided.
Blood Products and Transfusion Processes	74%		The Blood Transfusion Nurse Specialists have sought to understand the deteriorating compliance since figures started to drop in Autumn 2017. During 2017/18 20 additional face: face transfusion updates were provided to Theatre registered practitioners & midwives. Additional face: face training sessions for Paediatric doctors, A&E doctors, general & theatre Porters were introduced in January 2018.	Jan 2019	Gilda Bass/Joanne Hoyle	• Sufficient access to e-learning or face: face training is provided • HTT/HTC to consider utilising 2 yearly national learn Blood e-learning modules • Information from Community Matron still awaited to enable completion of competency matrix review
Conflict Resolution	69%	Face to Face	A proposal was agreed at TEG to amend our current Conflict Resolution training to Managing Challenging Behaviour (MCB) which incorporates the main learning outcomes of Conflict Resolution, ensuring we remain compliant with the Core Skills Training Framework learning outcomes, but also techniques and skills of breakaway.	Jan 2019	Darren Cooksey	• The project plans to transition Conflict Resolution to Managing Challenging Behaviour has begun, including: finalising the program, bringing the training in house and ensuring we have sufficient cover to provide the training required, reviewing the training requirements and booking the courses. This is currently on hold whilst we wait for feedback from the subject lead.
Prevent WRAP (Workshop to raise awareness of Prevent)	60%	Face to Face	A national target of 85% to be reached by March 2018 has been set for all staff who are involved in assessing patients. Restrictions with trainer requirements and a vacancy for the subject lead post has resulted in a delay in rolling out a training package.	Jan 2019	Sara Taylor	• Training courses have been organised and advertised in the Green Sheet and extra courses provided where there was demand. At least 19 sessions provided last quarter. • On 23rd November, another Train the trainer session has been organised to increase the amount of trainers • Keeping CCG updated with progress

Subject	Jul 2018 %	Method	Actions	Completion date	Responsibility	Progress
						• Attendance at EOE NHSE PREVENT FORUM • WRAP has been added to Registered and Non-Registered inductions. • An eLearning package has been made available to support staff to fit the training into their role. • Prevent trainers are targeting existing meetings to offer training to the attendees. • WRAP training has been put on doctors mandatory e-learning completion list

Performance impact assessments

Appendix C

Subject	Issues	Performance Concerns	Lead
179|LOCAL|Moving and Handling –e-learning	• Poor uptake	• Potential staff injury • Financial implication such as sick pay, staff cover, court costs, compensation.	Moving and Handling Advisor
179|LOCAL|Moving and Handling - Clinical|	• Mandatory Training being cancelled due to demands on wards • Release of staff on clinical areas	• Potential staff injury resulting in RIDDOR absenteeism. • Financial implication such as sick pay, staff cover, court costs, compensation. • Inability to discuss both new techniques and remind staff of current best practise	Moving and Handling Advisor
179|LOCAL|Basic Life Support - Adult|	• Mandatory Training being cancelled due to demands on wards • Release of staff on clinical areas	• Staff not updated in essential skills & changes in resuscitation guidelines • The potential that patients may not receive correct treatment during emergency • Trust reputation / poor press if patients do not receive BLS / treatment appropriate for them	Resuscitation Lead
179|LOCAL| Conflict Resolution|	• Staffing levels and the Ward/ Departments ability to backfill will affect the numbers attending • Release of staff on clinical areas.	• Failure to recognise body language indications of possible aggression. • Failure to recognise warning signs when an aggressor is agitated or distressed. • Failure to recognise danger signs which may indicate imminent attack. • Failure to employ applicable communication skills • Litigation consequences • Potential staff injuries resulting in RIDDOR absenteeism. • Poor staff morale	Portering and Security manager
179|LOCAL|Information Governance|	• Annual training replaced 3 yearly training in 2014 • 95% compliance target explicit in 2015/16 IG toolkit	• Increased risk of IG breaches and vulnerability to ICO fine if staff awareness of IG is poor. • IG toolkit compliance will be unsatisfactory (level 1 only) if we cannot demonstrate achievement of 95% target.	IG Manager

Subject	Issues	Performance Concerns	Lead
179|LOCAL|Equality and Diversity|	• Large number of staff have reached their three yearly renewal at the same point. • Technical OLM system issues prevented staff from completed the eLearning course for a month. • Increase of target from 80% to 90%	• Failure to meet public sector equality duty and requirements of 2010 Equality Act. Risk of unlawful practices by staff resulting in litigation • Discrimination by/against staff and service users resulting in reduced quality of care, poor impact on staff motivation, failure to retain staff, reputational damage resulting in failure to recruit staff and impact on community confidence in Trust.	Deputy Director or Workforce (Organisation Development)
NHS|CSTF|Preventing Radicalisation - Levels 3, 4 & 5 (Prevent Awareness) - No Specified Renewal|	• Only reported as a mandatory requirement 3 months ago. • Been a lack of trainers still recently	• Not being aware of all the ways in which your organisation may be vulnerable to its learners becoming radicalised • Not identifying the levels of risk proportionate to your organisation • Not ensuring that all relevant policies and procedures are in place to mitigate that risk Not regularly reviewing these risks and checking to ensure relevant procedures are being carried out.	Prevent Lead
179|LOCAL| Blood Products & Transfusion Processes (Refresher)|	• Failure of staff to use on line training package provided • Not clear of process within Trust to ensure mandatory training is complied with and consequences	• Staff unaware of updated national/local guidelines to minimise the risks of transfusion. • Potential "never event" of ABO incompatible transfusion resulting in patient harm • Potential Litigation • Non-compliance with DoH circular 'Better Blood Transfusion'.	Blood Transfusion Committee

Appendix D – Dementia Training Figures

2018/19

Month	Number require training	Total number trained	% Compliance
April	759	715	94.20%
May	751	703	93.61%
June	741	694	93.66%
Q1.	**2251**	**2112**	**93.82%**
July	795	839	94.76%
Aug	785	828	94.81%
Sep	799	846	94.44%
Q2.	**2379**	**2513**	**94.67%**

1045

Appendix E – SCH Community
Mandatory Training – as at September 2018

West Suffolk	September-2018							
Topic	All			Enabling**	Operations*	Facilities	Paediatrics	Wheelchairs
	Compliant	NonCompliant	% Compliancy					
Conflict Resolution	459	46	90.89%	100.00%	85.37%	95.24%	97.73%	69.23%
Dementia Compliance	481	24	95.25%	100.00%	93.09%	95.24%	99.09%	69.23%
Equality and Diversity	481	24	95.25%	100.00%	94.72%	95.24%	97.73%	61.54%
Fire	445	60	88.12%	100.00%	84.55%	61.90%	96.36%	53.85%
Health & Safety	478	27	94.65%	100.00%	92.68%	90.48%	98.18%	76.92%
Infection Control	442	63	87.52%	100.00%	84.55%	76.19%	93.18%	61.54%
Information Governance	462	43	91.49%	100.00%	87.80%	85.71%	95.91%	92.31%
Learning Disabilities	460	45	91.09%	100.00%	87.40%	90.48%	96.36%	69.23%
Life Support	349	65	84.30%	N/A	79.04%	N/A	91.48%	77.78%
Mental Capacity	127	42	75.15%	100.00%	75.63%	N/A	N/A	62.50%
Moving and Handling	432	73	85.54%	100.00%	82.93%	85.71%	89.55%	61.54%
Safeguarding Adults	490	15	97.03%	100.00%	96.75%	100.00%	98.64%	69.23%
Safeguarding Children	486	19	96.24%	100.00%	97.15%	95.24%	96.82%	69.23%
Overall % for all topics	**5592**	**546**	**91.10%**	**100.00%**	**88.21%**	**88.31%**	**95.99%**	68.75%
*** Enabling = Informatics, Business support, Quality,*								
** Operations = Newmarket Hospital, Specialist nurses & CHT Teams*								

14. Antenatal and newborn screening annual report 2017-18

To ACCEPT the report

For Report

Presented by Nick Jenkins

West Suffolk NHS Foundation Trust

Trust Board – 2 November 2018

Agenda item:	14			
Presented by:	Dr Nick Jenkins			
Prepared by:	Rachael Clarke Screening Coordinator & Lynne Saunders Head of Midwifery			
Date prepared:	October 2018			
Subject:	Screening Annual Report			
Purpose:	x	For information		For approval

Executive summary:
The purpose of this annual report is to provide a concise narrative of the West Suffolk NHS Foundation Trust's Antenatal and Newborn Screening Services activities. This report covers the period from August 2017 to September 2018 and includes summarised tables of our KPI's (Tables 1 and 2).

The report highlights the 7 areas included in the Antenatal and Newborn Screening programme and gives a brief overview of the performance of each.

Sickle Cell Testing: WSH books women earlier in pregnancy than the national average 75.6% (national 55.6%. It now offers partner testing at the booking appointment where women have a known heamoglobinopathy.
Infectious Diseases in Pregnancy Screening: Changes this year to the notification of infectious diseases, now only notified when confirmed by the reference laboratory.
Fetal Anomaly Screening Programme: The sonography service now reports fetal anomalies to NCARDRS. Additionally a failsafe has been put in place to reduce the number of rejected blood samples and reduce the need for repeat testing.
Newborn Blood Spot: This year there has been a sustained reduction in the number of these tests that needed to be repeated, reducing the need for newborn babies to have a second blood test.
Newborn Hearing Screening Programme: The service has achieved a coverage for completed hearing screens by four weeks of age in the last quarter is 99.2%
Newborn Infant Physical Examination: Additional update training for midwives undertaking this examination has been put in place this year.
Diabetic eye screening in pregnancy: In conjunction with the medical obstetric clinic all women with diabetes are reminded to participate in eye screening in pregnancy.

These programmes are provided by a number of services at WSH who work together to ensure that a quality service is provided and KPIs set by PHE are achieved. These include maternity services, sonography, laboratory services and hearing screeners. The report give detail of feedback from patients, 2 patient satisfaction surveys, by sonography and hearing screening, both of which give a positive view of these services and a number of individual pieces of feedback received from families who have had fetal anomaly screening, also positive.

The report describes the local and regional screening meetings and committees and the governance structure for the service within WSH. It includes a section on incidents that have occurred within the screening programmes, the investigations and any subsequent actions.

Additionally this report included details of the PHE QA visit in April 2018, which was successful, the subsequent report outlines the achievement and actions to address areas where it was felt further improvement could be achieved.
This action plan will be monitored locally via the governance structures in place and also by PHE.

The report concludes with some areas for escalation including the failsafe data base currently in use,

further reporting to NCARDRS and the national introduction of NIPT testing. These are also priories set for the coming year, Improve training log for sonographers to alert when training is due, Embed hearing screening audits and user feedback into our governance process and regularly present findings at the Clinical Governance Steering Group. Incorporate an IT system that will protect against missed screening incidents and decrease time spent manually inputting data. Undertaking user feedback audits of the antenatal and newborn screening pathway							
Trust priorities	**Deliver for today**			**Invest in quality, staff and clinical leadership**		**Build a joined-up future**	
	x						
Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	x	x	x	x	x		x
Previously considered by:	Circulated to internal stakeholders						
Risk and assurance:	Includes the action plan following PHE QA visit in April 2018						
Legislation, regulatory, equality, diversity and dignity implications	Expected by PHE as part of the Antenatal and Newborn Screening programme						
Recommendation: The Board is asked to note this report and approve delegation of future reports to the Clinical Safety and Effectiveness Committee for noting and approval.							

NHS
West Suffolk
NHS Foundation Trust

Antenatal and Newborn Screening Annual Report

August 2017 to September 2018

Author:

Rachael Clarke Antenatal and Newborn Screening Coordinator

October 2018

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1) INTRODUCTION

West Suffolk NHS Foundation Trust is the provider of antenatal and newborn screening services to the women who chose to birth at West Suffolk Hospital. This report is an overview of that service and the programmes provided between August 2017 and September 2018.

During this year the service has received a planned quality visit from Public Health England, the commissioner of services, and the subsequent report outlines the achievement and actions to address areas where it was felt further improvement could be achieved. (Appendix 1)

2) OVERVIEW OF THE ANTENATAL SCREENING SERVICE

A number of professionals and departments work together to achieve the requirements of the screening programmes, these include:

- The maternity services
- Obstetric ultrasound department
- Newborn Hearing Screening department
- Blood sciences microbiology and haematology are provided in house and services provided for Trisomy screening are provided by The Department of Prenatal Screening at Addenbrookes Cambridge.

3) PROGAMME UPDATES

Sickle Cell Testing (SCT)

This year the maternity service has focused on obtaining rapid partner testing and onward referrals for any who screen positive. Team midwives now offer partner testing at booking if the woman is already aware that she has a haemoglobinopathy or carrier status. The maternity service are exceptional at booking (first appointment) women by 10^{+0} weeks' gestation achieving this in 75.68% of cases above the national average of 55.68% of cases.

Infectious Diseases in Pregnancy Screening (IDPS)

This year there has been a change to the notification of suspected positive infectious disease results. In line with national guidance we are only informed of those results that have been confirmed by the Reference Laboratory.

Fetal Anomaly Screening Programme (FASP)

From April 2017 most structural abnormalities, including those required by FASP, have been reported to the National Congenital Anomaly & Rare Disease Registration Service (NCARDRS). This is completed by a designated sonographer.

In response to an 'unacceptable' KPI of at/below 97.0% FA1 in Quarter 1 of 2017/18 (April-June 2017) see Table 1 in Appendix 2, first and second trimester blood forms and samples now have a second visual check before leaving the department. Following the implementation of this checking process all the quarters (four in total, up to and including September 2018) have been within the 'acceptable' see Table 2 in Appendix 3.

Newborn Blood Spot (NBS)

During the time of this report there has been a focused and ongoing piece of work to improve our unnecessary blood spot repeat rate from 3% Quarter 4 in 2016 to 1% Quarter 1 2018, reducing the number of babies in whom a second sample needs to be taken. For the first time, the maternity service has achieved a green KPI for this. The maternity services is able to demonstrate a consistent and sustained improvement achieving a KPI of 1.1%, in the preceding reporting periods This was achieved by creating screening champions in both the community midwifery team and the hospital (F11 ward, neonatal unit and Rainbow ward). There have been regular meetings (of the screening champions) and the creation of a weekly league table.

Newborn Hearing Screening Programme (NHSP)

The ongoing issue of USAF Lakenheath babies being incorrectly mapped to West Suffolk has been remedied. A new site has been created in Smart4Hearing for these babies. This is now operational and the KPI reports for West Suffolk now accurately reflect our eligible population. Coverage for completed hearing screens by four weeks of age in the last quarter is 99.2% (the remaining 0.8% are babies that were not brought to an appointment within the time scale).

Newborn Infant Physical Examination (NIPE)

There have been ongoing developments of this service during the year with the first joint NIPE examiner meeting, with a plan for there to be an annual joint update. The Practice Development Midwife (PDM) will lead on the clinical update/teaching/learning component of this. The screening midwife co-ordinator will be responsible for feedback and updates on screening related items.

Diabetic eye screening in pregnancy

All pregnant women with diabetes have regular appointments in the Medical Obstetric Clinic. This clinic adheres to NICE guidance for the care of this group of women. The Medical obstetric clinic is working with the Diabetic Eye screening programme and since the last reporting period now ensure that the woman are given the national leaflet 'Screening for eye problems for pregnant women with diabetes' to encourage them to participate in this screening, this is hoped that this will support an improved uptake in this important screening.

4) ANTENATAL AND NEWBORN SCREENING LOCAL OPERATIONAL GROUP

The ANNB local operational group, known at West Suffolk Hospital as the Screening Steering Group, is now firmly embedded within maternity service's governance structures. It has agreed purpose and multidisciplinary representation. The quarterly KPIs report is reviewed here before submission to Public Health England (PHE) The meeting gives an opportunity for all areas involved in the delivery of the screening programme to meet and discuss all aspects of the service provision including screening incidents, At present the action plan following the Quality Assurance visit in April 2018 is reviewed and updated here.

There are terms of reference with a required representation; the meeting is recorded in minutes that are circulated.

Our Terms of Reference state that, to be quorate, at least half the total number of the members of the Group must be present for some or all of the meeting. Three of our last four meetings have been quorate.

Members are required to attend at least half of the meetings in any one year and a record of attendance via the minutes. Attendance will be reviewed every fourth meeting in order to update the membership/circulation list. The circulation list was discussed at the September 2018 meeting with a plan to formally review at the next meeting in December 2018.

5) ACHIEVEMENTS IN LAST 12 MONTHS

As a service we have worked hard to maintain and improve standards achieved in our screening programme. Some of these achievements are listed below:

Reduction in the repeat newborn bloodspot rate from 3% to 1.0%. This has in part been achieved by the creation of our bloodspot champions who are now more generally our screening champions. They have taken full ownership of this project and provided leadership within their teams or clinical areas and driven quality improvements and maintenance.

Screening has become embedded in the maternity governance structure in a more effective manner.

Incidents are reduced with less Serious Incident Assessment Forms (SIAF) than in the last reporting period.

There is a general and significant improvement in the communication and information sharing between departments and Trust and an overwhelming sense of effective multidisciplinary care.

Systems and follow-up procedures have been implemented for those who have ended their pregnancies following a screen positive result. Collaborative working with the Bereavement Midwife has seen the development of a robust and valued service for all woman and their families who sadly have been faced with the complexities and sadness associated with ending their pregnancies.

We were responsive when we unexpectedly needed to facilitate the care of 77 mothers and babies from USAF Lakenheath following the temporary closure of its birthing facilities. We ensured that women/babies were screened and results both actioned and available as appropriate.

We have continued the internal recording of fetal abnormalities and the Sonography Department is now externally (antenatal) reporting to NCARDRS. We have produced an annual audit (1 April 2017- 31 March 2018) showing compliance with detecting eleven auditable conditions as required by FASP (Section 5.6, NHS Fetal Anomaly Screening Programme; June 2015).

6) AUDITS

Screening programme audit

NHS Screening Programmes standards/service specifications state that antenatal and newborn screening tests should be offered to all individuals. The appropriate pre-test information, consent obtained, relevant tests performed in a timely manner and subsequent

results are discussed with each individual. Appropriate management in line with standards in the case of screen positive results was also included in the audit.

The WSH meets the required standard in a number of areas of the antenatal and newborn screening programmes, for example newborn examinations and anomaly screening at 20 weeks, completion of the Family Origin Questionnaire and acceptance and declining of tests offered.

However, the required standard was not met in several areas of the programmes including documentation and signing of results on the designated page in the notes. In particular those women who require a Quadruple (QUAD) test.

Newborn hearing screening service are considering how it is to achieve discussion and offering of hearing screening. Although the child health book is completed by the screener, they should also consider signing the newborn health records so there is documentation in the hospital record.

Standards were achieved within the hospital for screen positive results. Where there was non-compliance these related to other disciplines or other hospitals breaching the agreed timeframe.

For the time period of this audit the WSH were using a local maternity records. In April 2017 the WSH introduced the Perinatal Institute notes which is hoped will improve compliance as they more easily reflect the NHS standards within the text. There is a plan to re-audit using the same criteria with the new notes in October 2018.

Image quality audit

This audit shows compliance with recording six anatomical images during the 18- 20^{+6} week anomaly scan (Section 5.6: NHS Fetal Anomaly Screening Programme; June 2015).

Sonographers Individual Quality Audit

Six-monthly Down's syndrome Quality Assurance Support Service (DQASS) audit shows compliance with all sonographers, either green or amber bias. All sonographers score good or acceptable in the quarterly internal image audit.

The National Pregnancy in Diabetes Audit (NPID) has been completed by antenatal clinic staff. The results of this audit are published in the national audit.

7) INEQUALITIES

The antenatal and newborn screening programme strives to ensure that all women receive the same standards of care and have the same opportunities for screening in their pregnancy. This year the service has identified two areas where it is felt improvement could be made.

Women who book late in pregnancy

Women who book late or who transfers in under 20 weeks (outside the combined screening window $<14^{+2}$) were not always being identified as being eligible for second trimester screening. It seemed the primary focus for these women was the optimum timeframe for the anomaly scan. Any late bookers or transfers in are now highlighted at the earliest opportunity to the screening team by both the community midwife and the ultrasound team.

The ultrasound administrator does a weekly cross-reference of the upcoming anomaly scans and whether they have had a dating scan here. This extrapolates our “at risk” of omission population, so screening can then be arranged if required within the remaining timeframe. Late booking has been identified as a significant risk factor for maternal mortality and morbidity for all women, and particularly black and minority ethnic women.

Women who live outside of our geographical boundaries

We have noted that women who live outside of our geographical boundaries, referred to as cross-border women are more likely to suffer gaps in their screening pathway. The service has met and scheduled a further meeting with the community midwifery team that refers and cares for this group of women which equates to approximately 10% of WSH total delivered population in order to address this. We have encouraged them to create a specific NHS Team mail so that we could communicate much more efficiently and effectively. This is now operational and appears successful in its aim.

8) EDUCATION AND TRAINING

Ultrasound Scanning Department

Ultrasound staff training is monitored at appraisal, but it is felt that there needs to be a more robust method of timely monitoring. There is a plan to investigate other methods to highlight training deficits and to discuss the formulation of a training matrix with the Practice Development Midwife, who has one in place for the maternity service.

Maternity Services

The Maternity Service provides eight mandatory training days per year for midwives. Antenatal and Newborn screening is a component of these sessions. Of the last nine scheduled sessions (this incorporates the extra timeframe that this report covers) one session was cancelled due to staffing issues. Antenatal Screening update has been included in three sessions with a further session utilised for the Non Invasive Prenatal Testing (NIPT) rollout, which has subsequently been delayed nationally. This reduction in the number of update sessions in 2017/18 was due to the requirement to provide all midwives with training on perinatal mental health to coincide with the implementation of a countywide Perinatal Mental health Service.

New midwives joining the Trust have a scheduled session with the Screening Co-ordinator Midwife as part of their induction, to discuss any training needs. Internal monitoring identifies practitioners with any specific training requirements. These are detected through bloodspot repeats, screening blood errors, missed scheduling of appointments, conversation and email enquiries and documentation omissions or errors.

9) LEARNING FROM INCIDENTS OVER LAST 12 MONTHS

During the period of this report there have been 7 cases of RCAs or SIAFs. One SIAF was being undertaken at the time of last year’s report and has been included in this report.

The aforementioned incident was a cross-border delayed bloodspot testing issue. This was caused by a lack of adequate fact finding and information sharing between community, hospital and Trusts. The bloodspot was obtained and results given.

One incident was a missed/late bloodspot due to a failure in the hospital's discharge process. Community staff became aware that the patient was at home when we notified them that a sample had not yet been received by the laboratory. Patient testing then occurred.

Two incidents were women who transferred into WSH later in pregnancy having not received antenatal care in the United Kingdom and were eligible for second trimester screening. This screening was either no offered or not followed up appropriately. These incidents are actions discussed in our inequalities section above.

All unnecessary repeat newborn bloodspots, repeat maternal (none clinically required) blood samples and RED (over 72 hours) NIPEs are reported internally via our Datix reporting system. The overarching issue is attention to detail: in relation to samples this has been partially addressed with second checking processes. Practitioners with reoccurring sampling issues have been offered individual support and training.

Two incidents occurred in the laboratories. One was 15 infectious diseases samples that required retesting. The other incident was the omission in detection of abnormal haemoglobin peaks that would indicate further investigation and also warrant partner testing. All affected parties and processes have been identified, tested, results obtained and amended.

One NHSP screening incident where one baby was commenced screened with the wrong NHS number recorded. This was rectified immediately and the baby re-screened with the correct NHS number. Screeners have been reminded to check the demographic details in front of them with the parents at the bedside.

10) USER FEEDBACK

Newborn Hearing Screening

The hearing screening service gathered user feedback regarding the effectiveness of text messaging parents to remind them of their baby's screening appointment. The general consensus from the screening team was that text messages were useful to remind new parents of their appointments. It was felt that the results generally could have been better and had been adversely influenced by external factors such as setting up a new clinic in Newmarket.

The hearing screening service performs an annual patient satisfaction survey that has been acknowledged locally but has not been discussed in any detail. Copy of the last survey is included in Appendix 4.

Ultrasound Department

The sonography department completes regular user satisfaction surveys that encompass all of imaging. A summary of their Patient Information and Staff Audit for April to June 2018 has been included in Appendix 2.

Antenatal and Newborn Screening

The screening office regularly receives direct user feedback from patients who have had have ended their pregnancies following a positive testing result initiated through the screening pathways:

"*I cannot tell you how much of a difference you have made in the most heartbreaking situation. You have been such a significant part of our journey. I suppose that we would have got through regardless and we have had no choice, but your input and support has been unwavering and it has made the most significant impact."*

"Essentially you are - or at least were - a stranger and yet to feel as though you genuinely care is worth so much. You have made all the difference. Somehow knowing that you were there made the whole situation bearable. I instantly trusted you and felt the most amazing sense of reassurance knowing that you were there."

"I spend much of my life being the supporter or carer and do not find it easy to lean on others or ask for help. But I haven't needed to ask for anything. At every turn, you have instinctively known what to say or where to point us next. At each stage, you have just got it right."

"Not only are you an utter professional, but you also have the most compassionate and non-judgemental manner and that combination is inspirational."

"The bottom line is that you have metaphorically held my hand throughout the whole process. The whole thing is unimaginable until you actually face it and nothing can prepare you for how you will feel. I feel so lucky to have had the support from someone like you and despite the devastating situation, I cannot begin to express the gratitude I feel and the positivity of how we have been treated and cared for."

"A piece of me was shattered irreparably on Friday when I had to walk away and leave our precious baby. It will be a very long time before we get to a place where things are 'normal' again - whatever that is! But amidst all of the pain, I can honestly say that my faith in human nature has been confirmed. The kindness, respect and support that we have received is something that I will never forget. In the bleakest of situations, I have been utterly overwhelmed by such wonderful people."

"I will write properly to all those concerned in time, but for now, please know that you have made a very special difference".

The screening team have received feedback of this nature on many occasions. This following testimony demonstrates the effectiveness of the whole team:

"*We were so impressed by the level of care received from everyone - sonographer lady, midwives, Dr …. Their kindness, understanding and tactfulness were second to none"*.

At present a user survey of the antenatal screening service has not been completed.

11) QUALITY ASSURANCE AUDIT VISIT ACTION PLAN

We prepared for a QA visit in the year prior to the visit taking place in April 2018, this was QA's second visit to the Trust and it was felt that this visit was a success We were thought of as being a safe, proactive and effective provider of the antenatal and newborn screening programmes. The final report is dated 15/06/2018. The action plan developed in response to this report is included in Appendix 1.

The action plan is being reviewed at the Screening Steering Group and completion will be monitored at Women's Health Governance until it is completed.

12) RISK REGISTER

At each meeting of the Screening Steering Group risk as considered for entry or removal from the divisional risk register. The following was included on the risk register until September 208 when it was closed.

Non-compliant with UKAS (UK Accreditation Service). As of 30/08/18 "d*iscussed at Women's Health Governance Meeting on 30/08/2018. As the antenatal QA visit has now taken place and report received and this has not affected this accreditation to be closed".*

13) ISSUES FOR ESCALATION

Failsafe system

Our IT systems have little or no interface with the data we require for tracking purposes. We are completely reliant upon manual data entry which can and has been problematic. There is no alert system to warn us of women who fall outside our normal parameters. Our daily checks are time consuming and laborious and undertaken across several different computer programmes. We need a system that is self-populating at point of referral and fit for purpose. This has been included in the consideration of Cerner's Maternity system (the Trust's provider of electronic patient records) we have also made enquiries, in house, regarding creation of a system that would fulfil our requirements. This was paused whilst we considered our option with Cerner.

NCARDRS

We are not fully reporting to NCARDRS. This is a project requiring a full structured launch so that clinicians know exactly what, where and when to report.

Consultant with special interest in antenatal screening.

As a maternity service we would benefit greatly from a consultant who had a special interest in our more complex screen positive cases. This would provide continuity of care for the women, a consistent point of contact for the screening midwife co-ordinator and a reduction in the number of referrals and cases managed at a tertiary unit, it is hope that the recent appointment of an additional consultant will address this.

Private Provision of NIPT (outside of WSH)

The private provision of NIPT is out-of-step with the national screening programme for Downs, Edwards and Pataus Syndromes. We are in a position where women are ahead of us as a service provider, and accessing this test prior to their dating scan and without an initial screen positive result (this will be the point when we will offer a funded NIPT). There is no clarity or direction around how we best address this gap and as a consequence counsel women and manage their care when complexities arise.

NIPE Examinations

The NIPE examination should occur within 72 hours of birth. Although our KPIs are classed as 'achievable' we know that our 'post 72 hours when screened babies' are predominantly care of the neonatal unit. These babies are, by definition of where they are, our unwell/requiring treatment babies. As they are under the care of doctors not midwives they are exempt from a midwife performed NIPE. There is a definite issue around prioritising the babies amongst this cohort who are actually well enough to have their NIPE performed

within the timeframe (there are rare exceptions where babies are too ill). Further discussions need to occur with senior doctors as unnecessary resources are expended by the screening team contacting and reminding doctors that the NIPE is required or even overdue. This action was added to our local Screening Steering Group action plan in September 2018.

14) PLANNED RECONFIGURATION / RE-PROCUREMENT OF SERVICES

The maternity service will be moving forward with the maternity electronic patient records as mentioned above.

At the time of writing this report we are unable to comment on exactly what (if any) reconfiguring of our blood sciences laboratories is likely to occur and how this may affect our screening service.

15) PRIORITIES FOR NEXT 12 MONTHS

Ultrasound: Improve training log for sonographers to alert when training is due.

Embed hearing screening audits and user feedback into our governance process and regularly present findings at the Clinical Governance Steering Group.

Incorporate an IT system that will protect against missed screening incidents and decrease time spent manually inputting data.

Undertaking user feedback audits of the antenatal and newborn screening pathway.

APPENDIX 1

Action Plan in response to the Screening Quality Assurance Visit Report – NHS Antenatal and Newborn Screening Programmes.

No	Recommendation	Evidence required	Due	Responsibility	Status	Progress
1.	Strengthen internal risk and governance processes to make sure there is regular monitoring of the quality and integrity of antenatal and newborn screening programmes	Terms of reference for the operational screening group with reporting arrangements demonstrating board level oversight. (Maternity department, obstetric radiography department and newborn hearing screening service) Improved governance process demonstrating appropriate level sign off of the quarterly key performance indicators, annual data returns and annual report Include the screening champion role in governance processes	December 2018	R Clarke J Marling R Segar	In progress	**September 2018** Evidence 1, terms of reference included. Agenda from Steering Group Meeting included. Minutes from Steering Group and Clinical Governance meeting to be added when completed which include reference to the screening champion's role.
2.	Update the risk management strategy and local screening guidelines to reference "Managing Safety Incidents in NHS Screening Programmes"	Evidence that screening guidelines and local maternity risk management strategy contain the PHE screening incident guidance and have been and ratified through the trust framework.	June 2019	L Saunders	Not started	**September 2018** To be updated when strategy is updated.
3.	To provide assurance that there are safe arrangements for newborn hearing screening staff to carry out home visits	Lone worker risk assessment completed in line with the Suffolk Community Healthcare lone worker policy	September 2018	R Segar	Closed.	**September 2018:** This team do not undertake lone working therefore this recommendation is not relevant. Closed

4.	To develop a newborn hearing screening guideline for the deceased baby pathway	Local guideline that is ratified through the organisation's governance framework Evidence of dissemination to staff	September 2018	R Segar	In progress	**September 2018:** Pathway included in Evidence 4 – awaiting ratification (confirming process).
5.	Update screening guidelines, operational policies and standard operating procedures (SOP) to reflect programme standards for: infectious diseases screening sickle cell and thalassemia screening fetal anomaly screening newborn hearing screening newborn blood spot screening newborn and infant physical examination	Updated and published documents to: include the information women / parents should receive to give informed consent include screening pathways detail the support for non-English speaking people including interpreting services include failsafe processes in SOPs be recorded in the programme board minutes as published governance framework that includes annual update of guidelines in line with screening service specifications Evidence of approval through local governance structure	June 2019	R Clarke R Segar/J Phillpot (NHSP)	Not started	**September 2018:** Not yet commenced.
6.	Include antenatal and newborn screening in the programme of audits and develop a process for feeding back findings and actions.	Audit report and related action plan Copies of minutes of local operational meetings to evidence monitoring Programme board minutes demonstrating escalation	June 2019	R Clarke & J Lovedale	Not started	**September 2018:** Audit timetable to be developed.

7.	To improve processes to make sure audiology and national newborn hearing screening data reports are: ▯ followed up in line with the screening programme operational guidance ▯ used to improve the newborn hearing screening service	Standard operating procedure describing the required actions in response to audiology and NHSP data reports with evidence of monitoring through local governance structure Audit reports to evidence quality of screening service and improvements plans Evidence of monitoring through local governance structure Actions recorded in: ▯ minutes of local hearing screening	December 2018	R Segar/J Phillpot	Not started	**September 2018**: No update.
8.	Formalise the deputy screening coordinator role	Deputy screening midwife job description Documented in minutes of local governance meetings and programme board	September 2018	R Clarke	Not Started	**September 2018:** Discussed at the Steering Group and included in those minutes that a separate JD will not be completed for the Deputy Screening Midwife as they do not fulfil the role in its entirety. It was agreed that an SoP will be created that lists the activities and functions of anyone deputising in that role.
9.	Strengthen the functions of the Screening Support Sonographer (SSS)	Revised job description that is consistent with national guidance Evidence of approval through local governance structure	December 2018	J Marling	In progress	**September 2018**:Evidence 9: Scanned copy of draft JD
10.	To update the job description for the hearing screening manager to reflect current processes	Revised job description that is consistent with national guidance. Evidence of approval through local governance structure	June 2019	J Phillpot	Not started	**September 2018:** No update.

11.	Improve the quality of screening updates and training by: ▯ using resources provided by the screening programmes ▯ making sure midwives who perform NIPE screening receive updates and training to give assurance of competency	Training slides and resources NIPE midwives included in the training needs analysis Evidence of approval through local governance structure	September 2018	R Clarke	On going	**September 2018:** Had NIPE meeting 08/08/18. Minutes requested from H. McBride 19/09/18. Request to J.S re what exact training material is recommended, no specific material but presentation being updated in line with new service specification. NIPE meeting completed and plan for ongoing updating made. To be added to TNA when updated in Feb 2019.
12.	To strengthen the newborn hearing screening service to make sure training for new hearing screeners is facilitated.	Evidence that the local manager or deputy is completing the Certificate in Assessing Vocational Achievement (CAVA) course or evidence of formalised arrangements for assessment support Information recorded in minutes from local screening steering group and programme board	June 2019	J Phillpot	Not started	**September 2018:** On appointment of new local manager CAVA will be completed.
13.	Improve the screen positive pathway to make sure women are offered pre-natal diagnosis by 12+6 weeks	Updated and ratified screening guidelines Evidence of approval through local governance structure	December 2018	R Clarke	In progress.	**September 2018:** Partner testing now offered to all known carriers at booking. Guideline to be updated.
14.	Make sure women who miscarry or terminate their pregnancy following antenatal screening are informed of the outcome of their screening tests	Updated and published infectious diseases screening guidelines. Evidence of approval through local governance structure	December 2018	R Clarke	In progress	**September 2018:** To be discussed and clarified at Maternity Voices Partnership meeting.

15.	Implement a process to record outcomes for all screened conditions. This should be is recorded electronically on the NIPE Smart IT system	Updated standard operating procedure Evidence of change via local governance structure	December 2018	R Clarke	In progress	**September 2018:** Discussed at NIPE meeting in August 2018. Role to be included with ANNSC roles and responsibilities.
16.	Produce and implement an action plan to meet programme standards 3, 5 and 6	Action plan and minutes from screening steering group meeting. Quarterly newborn bloodspot laboratory report monitoring: standard 3: use of NHS number standard 5: timely sample receipt standard 6: bloodspot quality; avoidable repeat rate Evidence of monitoring through local governance structure	December 2018	R Clarke	Completed.	**September 2018:** Action plan following high repeat rate: included. Minutes and terms of reference from Screening Champions included this meeting is then mentioned at Steering Group. Evidence of KPIs. ALL ACTIONS IN THIS SECTION COMPLETED CLOSED

APPENDIX 2:
Table 1: April 17-March

KPI	Description	Threshold		Q1	Q2	Q3	Q4
ID1	Antenatal infectious disease screening - HIV coverage	Acceptable ≥ 95.0%	Achievable ≥ 99.0%	100%	100%	99.7%	99.7%
ID2	Antenatal infectious disease screening - timely assessment of women with hepatitis B	Acceptable ≥ 70.0%	Achievable ≥ 90.0%	100%	N/A	0%	50%
ID3	Hepatitis B coverage	Acceptable ≥ 95.0%	Achievable ≥ 99.0%	100%	100%	99.7%	99.7%
ID4	Syphilis coverage	Acceptable ≥ 95.0%	Achievable ≥ 99.0%	100%	100%	99.7%	99.7%
FA1	Fetal anomaly screening - completion of laboratory request forms *Comment: screening champs to help drive improvements 21/12/2017*	Acceptable ≥ 97.0%	Achievable = 100%	95.8%	98.4%	97%	98.2%
FA2	Fetal anomaly screening (18+0 to 20+6 fetal anomaly ultrasound) – coverage	Acceptable ≥ 90.0%	Achievable ≥ 95.0%	100%	99.8%	100%	100%
ST1	Antenatal sickle cell and thalassaemia screening – coverage	Acceptable ≥ 95.0%	Achievable ≥ 99.0%	100%	100%	99.7%	99.7%
ST2	Antenatal sickle cell and thalassaemia screening - timeliness of test	Acceptable ≥ 50.0%	Achievable ≥ 75.0%	74.1%	70.2%	75%	83.8%
ST3	Antenatal sickle cell and thalassaemia screening - completion of FOQ *Comment: screening champs to help drive improvements 21/12/2017*	Acceptable ≥ 95.0%	Achievable ≥ 99.0%	97.8%	98.4%	97.4%	98.4%
NP1	Newborn and infant physical examination - coverage (newborn)	Acceptable ≥ 95.0%	Achievable ≥ 99.5%	99.5%	99.9%	99.5%	99.8%
NP2	Newborn and infant physical examination – timely assessment of developmental dysplasia of the hip (DDH)	Acceptable ≥ 95.0%	Achievable = 100.0%	100%	N/A	0%	100%
NB2	Newborn blood spot screening - avoidable repeat tests	Acceptable ≤ 2.0%	Achievable ≤ 1.0%	2.0%	1.5%	1.1%	1.1%

APPENDIX 3
Table 2 April 18-September 18

KPI	Description	Threshold		Q1
ID1	Antenatal infectious disease screening - HIV coverage	Acceptable ≥ 95.0%	Achievable ≥ 99.0%	99.7%
ID2	Antenatal infectious disease screening - timely assessment of women with hepatitis B	Acceptable ≥ 70.0%	Achievable ≥ 90.0%	N/A
ID3	Hepatitis B coverage	Acceptable ≥ 95.0%	Achievable ≥ 99.0%	99.8%
ID4	Syphilis coverage	Acceptable ≥ 95.0%	Achievable ≥ 99.0%	99.8%
FA1	Fetal anomaly screening - completion of laboratory request forms *Comment: screening champs to help drive improvements 21/12/2017*	Acceptable ≥ 97.0%	Achievable = 100%	98.1%
FA2	Fetal anomaly screening (18+0 to 20+6 fetal anomaly ultrasound) – coverage	Acceptable ≥ 90.0%	Achievable ≥ 95.0%	99.8%
ST1	Antenatal sickle cell and thalassaemia screening – coverage	Acceptable ≥ 95.0%	Achievable ≥ 99.0%	99.8%
ST2	Antenatal sickle cell and thalassaemia screening - timeliness of test	Acceptable ≥ 50.0%	Achievable ≥ 75.0%	75.3%
ST3	Antenatal sickle cell and thalassaemia screening - completion of FOQ *Comment: screening champs to help drive improvements 21/12/2017*	Acceptable ≥ 95.0%	Achievable ≥ 99.0%	99.0%
ST4a	ST4a - timely offer of PND to women at risk of having an affected infant To be set	1 mum at risk of baby affected by sickle cell. Declined PND, mum screened, partner tested and from mum's result to partner testing with result within 10 working days and all completed by 12+3		0
ST4b	ST4b - timely offer of PND to couples at risk of having an affected infant To be set	1 couple at risk of baby affected by sickle cell. Declined PND, mum screened, partner tested and from mum's result to partner testing with result within 10 working days and all completed by 12+3		0
NP1	Newborn and infant physical examination - coverage (newborn)	Acceptable ≥ 95.0%	Achievable ≥ 99.5%	99.5%
NP2	Newborn and infant physical examination – timely assessment of developmental dysplasia of the hip (DDH)	Acceptable ≥ 95.0%	Achievable = 100.0%	100%
NB2	Newborn blood spot screening - avoidable repeat tests	Acceptable ≤ 2.0%	Achievable ≤ 1.0%	0.9%

APPENDIX 4:
Newborn Hearing Screening Programme (NHSP) Survey Screening Test

OUTCOME

54 survey sheets were returned, 50 were used to calculate the results as 4 were not filled in.

		No	%
1. Were you informed about ante-natal and newborn screening programmes before the hearing screening test:	***Yes***	***48***	***96***
	No	***0***	***0***
	Unsure / can't remember	***2***	***4***
2. Did the screener explain to you what would happen during the hearing test?	***Yes, completely***	***50***	***100***
	Yes, to some extent	***0***	***0***
	No	***0***	***0***
	Unsure / can't remember	***0***	***0***
3. Did the explanation include why the screening might not be successful, including Hearing Loss as one of the possible reasons?	***Yes***	***49***	***98***
	No	***0***	***0***
	Didn't respond	***1***	***1***

4. Was the result of the test clearly explained to you?

Yes, it was clearly explained	***50***	***100***
The result was explained, but it was not clear	***0***	***0***
The result was not explained to me	***0***	***0***

Referral for further testing

5. Was your baby referred to the Audiology Department for further testing?

Yes	***0***	***0***
No	***100***	***100***

Other

6. Did you need the services of an interpreter?

Yes	***0***	***0***
No	***100***	***100***

7. Was an interpreter made available to you in an appropriate language?

Yes	***0***	***0***
No	***0***	***0***

8. Were you satisfied with the interpreting service you received?

Yes, completely	***0***	***0***
To some extent	***0***	***0***
No	***0***	***0***

*Please comment ……

……

9. Please expand on any of your answers, or make any other comments about the Newborn Hearing Screening Programme (e.g. do you feel you were fully supported throughout the process)?

    - Great that it was done before we went home

    - Felt fully informed and supported throughout the whole process that was short and not disruptive to the baby

Thank you for completing this questionnaire.

Please return in the enclosed envelope to Newborn Hearing Screening

…….

Or place in the survey box on the ward.

APPENDIX 5:

Patient Information and Staff Audit Summer 2018

Background/Rationale

Patient satisfaction is important in all aspects of the service that we offer as an imaging department.

We aim to keep the patient information that we send, display or give verbally to our patients as up to date as possible to reflect any changes in practise. All patient information leaflets have a review date on them to ensure that they are reviewed regularly. Any verbal information that is given to patients is current and given by practitioners who are experts in their field.

Aim

We aim for 100% satisfaction from our patients.

Conclusions

The results of this audit were very positive. Our patients are feeling well informed prior to their appointment and feel that the information that they are being sent is comprehensive. There were no issues with the way that staff came across to our patients and all patients felt happy with their practitioner and the way that they were treated and verbally addressed at their attendance.

In comparing the results from 2018 with those received in 2017, we received no negative responses in 2017, but a small percentage in 2018. These have been highlighted in red on the results table.

7. Satisfaction with the opening hours of the department (Newmarket)
8. How I will get my results (Newmarket & Nuc Med)
10. Aware of who to contact if experienced any problems (Newmarket)
11. Satisfied with the time waiting for my appointment in the department (Newmarket)
12. Satisfaction between the referral and imaging (Newmarket & Gynae & U/S)

In looking back at the source data behind the table the negative responses relate to 2 patients that attended Newmarket Hospital

Recommendations/Action Plan

With regards to the above negative comments, we need to look at the communication on offer around advising patients how they will get their results. The practitioner is responsible for advising the patient of this after their examination.

With regards to the Newmarket patient who was unaware of who to contact if they experienced problems, we need to check whether Newmarket are displaying the same posters in their waiting room as those used at WSH.

The opening hours at Newmarket are restricted to a 9-5, Monday to Friday service currently, but the West Suffolk is able to offer more flexibility if required. Opening hours are constantly being discussed, with the restriction being staff availability.

15. Safe staffing guardian report - Q2

To ACCEPT a report

For Report

Presented by Nick Jenkins

NHS
West Suffolk
NHS Foundation Trust

Trust Open Board Report – 2 November 2018

Agenda item:	15			
Presented by:	Nick Jenkins, Executive Medical Director			
Prepared by:	Helen Kroon, HR			
Date prepared:	October 2018			
Subject:	Guardian of safe working report			
Purpose:	X	For information		For approval

Executive summary:

This is the seventh report produced since the introduction of the 2016 Terms and Conditions of Service (TCS) for Doctor and Dentists in Training by NHS Employers. Full details of this contract are to be found here: http://www.nhsemployers.org/your-workforce/need-to-know/junior-doctors-2016-contract

The report is compiled by the Guardian of Safe Working Hours (GOSW), a role appointed as part of the new contract. The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A system of Exception Reporting is in place, which replaces monitoring of working hours. This is done using Allocate software, a system already in place at West Suffolk, but extended for this purpose.

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:	-
Risk and assurance:	-
Legislation, regulatory, equality, diversity and dignity implications	-
Recommendation: *To accept report*	

QUARTERLY REPORT ON SAFE WORKING HOURS
DOCTORS AND DENTISTS IN TRAINING
1st July 2018 – 30th September 2018
Executive Summary

Introduction

On this occasion the report has been compiled by the Medical Staffing Manager, whilst the Trust is recruiting a new Guardian of Safe Working.

The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A system of Exception Reporting is in place, which replaces monitoring of working hours. This is done using Allocate software, a system already in place at West Suffolk, but extended for this purpose. This report covers the three month period (1st July 2018 – 30th September 2018 inclusive).

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

All trainees taking up appointments are on the New Contract. Trust grade positions are on contracts that mirror the new Contract.

Summary data

Number of doctors in training on 2016 TCS (total):	136 (includes p/t trainees)
Amount of time available in job plan for guardian to do the role: per week	1 PAs / 4 hours
Admin support provided to the guardian (if any):	0.5WTE
Amount of job-planned time for educational supervisors: trainee[1]	0.125 PAs per
Amount of job-planned time for Clinical Supervisors:	0, included in 1.5 SPA time[1]

1. Exception reporting: 1st July – 30th September 2018

a) Exception reports (with regard to working hours)

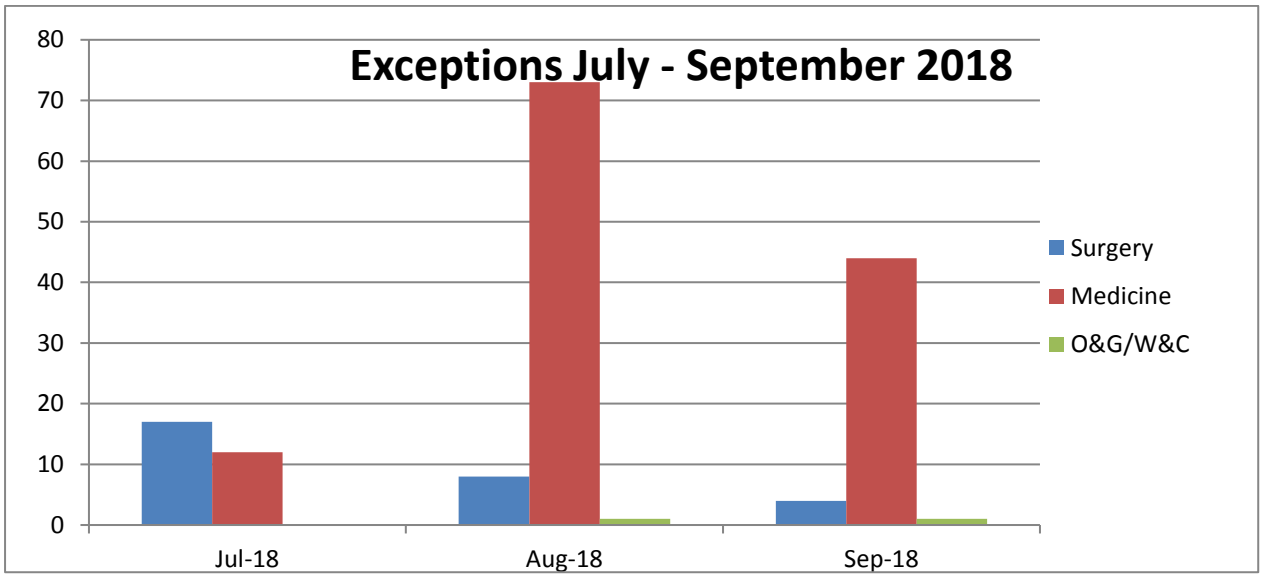
The purpose of exception reporting is to ensure prompt resolution and/or remedial action to ensure that safe working hours are maintained. If there are consistent problems a work schedule review should be carried out. A process is in place on Allocate for the Junior Doctors to fill in the report, which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

Exception Reports by EXCEPTION TYPE AND OVERTIME HOURS CLAIMED						
Department	Grade	Pattern of Hours worked	Educational Opportunities or available Support	Support available during Service Commitments	Hours of Work	Total overtime hours claimed
Surgery	F1	0	0	0	11	20.00
	F2	0	0	0	1	3.50
	GPST/ ST1	8	0	0	4	7.75
	TR F2/ CST/ STR	0	1	0	4	4.25
Medicine	F1	0	0	2	80	113.75
	F2	0	0	0	40	56.00
	CMT/StR	0	0	0	7	15.25
Woman & Child	F2	0	0	0	1	1.25
	GPST	0	0	0	1	1.75
Total		**8**	**1**	**2**	**149**	**223.50**

Exception Reports by DEPARTMENT				
Department	No. exceptions carried over from before 30th June 18	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Surgery	0	29	29	0
Medicine	1	129	127	2
Woman&Child/Paeds	0	2	2	0
Clinical Support	0	0	0	0
Total	**1**	**160**	**158**	**2**

Exception reports by SPECIALTY & GRADE					
Department	Grade	Exceptions carried over from before 30th June 18	Exceptions raised	Exceptions closed	Exceptions outstanding
Surgery	F1	0	11	11	0
	F2	0	1	1	0
	GPST/ ST1	0	12	12	0
	TR F2/ CST/ STR	0	5	5	0
Medicine	F1	0	82	82	0
	F2	0	40	40	0
	CMT/StR	1	7	5	2
Woman & Child	F2	0	1	1	0
	GPST	0	1	1	0
Total		**1**	**160**	**158**	**2**

Exception reports – RESPONSE TIME			
Department	Addressed within 48 hrs	Addressed within 7 days	Addressed in longer than 7 days
Surgery	11	10	8
Medicine	22	60	47
Woman & Child	0	0	2
Total	**33**	**70**	**57**



b) Work schedule reviews for period 1st July 2018 – 30th September 2018

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

2. Locum Bookings: 1st July – 30th September 2018

TABLE 1: Shifts requested between 1st July and 30th September 2018 by 'reason requested'

Locum bookings – by REASON REQUESTED						
Department	Extra/Rota Compliance/ Induction Cover	Leave (ie Annual/Study/ Interview)	Maternity Leave	Sickness/ Reduced Duties	Vacancy	Grand Total
A&E	44	69		23	479	**615**
Anaesthetics	4		6	4	18	**32**
Cardiology	55					**55**
Community Paediatrics					44	**44**
Dermatology	0				37	**37**
ENT				1	9	**10**
General Surgery	40	1		2	69	**112**
Haematology				16		**16**
ITU	15				33	**48**
Medicine	281	34		35	420	**770**
O&G	6		12		47	**65**
Ophthalmology					15	**15**
Paediatrics	14			66	18	**98**
Radiology					123	**123**
T&O	2		1	2	51	**56**
Urology	7				58	**65**
Grand Total	**468**	**104**	**19**	**149**	**1421**	**2161**

TABLE 2: Shifts requested between 1st July and 30th September 2018 by 'Agency / In house fill'

Locum bookings – by AGENCY															
Department	A&E Agecy	Athona	IDM	Interact Med	Locum Pople	Locum Vision	National Locums	NC Healthcare	NHS	Pertemps	Promedical	RM Medics	Total Assist	Unfilled shift	Grand Total
A&E	13				116	4			271		50			161	615
Anaesthetics									32						32
Cardiology			55												55
Community Paediatrics	44														44
Dermatology									37					0	37
ENT									10						10
General Surgery									99					13	112
Haematology										16					16
ITU									48						48
Medicine	5		15	46				20	469	66	5	40		104	770
O&G									65						65
Ophthalmology									15						15
Paediatrics									33				55	10	98
Radiology		60							63						123
T&O							3		22				20	11	56
Urology	20								10	35					65
Grand Total	**82**	**60**	**70**	**46**	**116**	**4**	**3**	**20**	**1174**	**117**	**55**	**40**	**75**	**299**	**2161**

TABLE 3: Shifts requested between 1st July and 30th September 2018 filled 'In house only by grade'

Locum bookings – by GRADE IN HOUSE						
Department	Cons	F1	F2/ST	SAS	SpR	Grand Total
A&E	13		37		221	271
Anaesthetics					32	32
Dermatology				37		37
ENT					10	10
General Surgery		2	57		40	99
ITU			1		47	48
Medicine	285		170		14	469
O&G	17		2		46	65
Ophthalmology					15	15
Paediatrics			7		26	33
Radiology	63					63
T&O			14		8	22
Urology			3		7	10
Grand Total	**378**	**2**	**291**	**37**	**466**	**1174**

3. Vacancies - 1st July – 30th September 2018

HR have provided details of current junior doctor vacancies:

Department	Grade	July 18	Aug 18	Sept 18
A&E	ST3+	4	4	4
	GP/ ST1-2	1	2	2
Anaesthetics	ST3+	1	2	1
	ACCS/CT	1	1	0
Medicine	ST1-2	0	4	1
	ST3+	2	1	2
Obs & Gynae	ST3+	2	0	0
T&O	ST3+	0	1	2
Pediatrics	ST4+	0	0	1.2
Total		**11**	**15**	**13.2**

4. Fines - 1st July – 30th September 2018

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

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

This quarter there was one instance where a fine has been made, in the department of medicine. This information has been fed back to the Medical Directorate.

Doctors	Ward	Date Range (Occurrence)	Breach details	Notes	Total hourly (x4) figure (cost to the Trust)	Hrly Penalty rate paid to doctor	Amount already paid	Amount remaining to Dr	Amount to Guardian fund
Doctor A	G5	20/08/18 - 26/08/18	72 hrs	Worked 75 Hours (3 hours over 72 limit)	£153.15	£70.11	£38.28	£31.83	£83.04

Total breach fines paid by the Trust from August 2017 to date are £8,439.09 and the Guardian Fund currently stands at £4,585.59.

16. Consultant appointment report

To RECEIVE the report

For Report

Presented by Jan Bloomfield

BOARD OF DIRECTORS – 2 November 18

NHS West Suffolk NHS Foundation Trust

Agenda item:	16			
Presented by:	Jan Bloomfield, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	Monday 22nd October 2018			
Subject:	Consultant Appointments			
Purpose:	X	For information		For approval

Executive summary:

Please find attached confirmation of Consultant appointments

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

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

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

Recommendation:

For information only

POST:	Consultant Haematology
DATE OF INTERVIEW:	Thursday 27th September 2018
REASON FOR VACANCY:	Replacement – Cynthia Beatty
CANDIDATE APPOINTED:	Dr Isabel Lentell
START DATE:	14th January 2019
PREVIOUS EMPLOYMENT:	December 2016 - Present – Haematology ST7 – East of England Deanery (LTFT)- Addenbrookes Hospital December 2015 – November 2016 – Haematology ST6 – West Suffolk Hospital August 2014 – March 2015 – Haematology ST6 – Western General Hospital, Edinburgh February 2014 – August 2014 Haematology ST5– St John's Hospital Livingston August 2013 – February 2014 – Haematology ST5 – Royal Hospital for Sick children, Edinburgh August 2012 – August 2013 – Haematology ST4 – South east Deanery – Royal Infirmary of Edinburgh, Western General Hospital August 2011 – July 2012 – Haematology ST3 – South East Deanery – Royal Infirmary of Edinburgh August 2009 – August 2011 – Core Medical Training , Northern Deanery, James Cook University Hospital, University Hospital of North Tees, and University Hospital of North Tees August 2007- August 2009 – FY1 and FY2, Northern Deanery , Sunderland NHS Foundation Trust
QUALIFICATIONS:	• June 2007 - MBBS with distinction - Newcastle University • May 2009 – MRCP (UK) – Part 1 • June 2010 - MRCP (UK) – Part 2 (Written) • November 2010 - MRCP (UK) PACES • November 2013 – FRCPath Part 1 • October 2017 – FRCPath Part 2
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	2 2 2

POST:	Consultant Otolaryngologist
DATE OF INTERVIEW:	Thursday 11th October 2018
REASON FOR VACANCY:	Replacement – Laith Tapponi
CANDIDATE APPOINTED:	Mr Robin Youngs
START DATE:	18th February 2019
PREVIOUS EMPLOYMENT:	December 1999 - Present – Consultant Otolaryngologist – Gloucestershire Hospitals NHS Foundation Trust November 1989 – November 1999 - Consultant Otolaryngologist – West Suffolk Foundation Trust November 1985 – March 1989 – Senior Registrar in Otolaryngology – Saint Bartholomew's Hospital Rotation, London July 1987 – December 1987 – TWJ Research Fellow – University of Toronto October 1983 – October 1985 - Registrar in Otolaryngology – St Marys Hospital London November 1982 – October 1983 – Senior House Officer in Otolaryngology and Plastic surgery – Kings College Hospital, London May 1982 – November 1982 – Senior House officer in Neurosurgery – South East Thames regional Neurosurgery Unit Brook Hospital, London September 1981- February 1982 – Senior House Officer in Accident and Emergency, Queens Mary Hospital Roehampton, London February 1981 – July 1981 – House Physician, Essex County Hospital August 1980- January 1981 – House Surgeon, Queens Mary's Hospital, Roehampton, London
QUALIFICATIONS:	• June 2018 – MBBS (University of London) • April 1980 –MRCS LRCP (London) • October 1984 –FRCS (Otolaryngology- England) • December 1993 – MD (University of London) • August 2016 – PG Certificate (University of London)
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	6 2 2

17. Putting you first award

To NOTE a verbal report of this month’s winner

For Report

Presented by Jan Bloomfield

11:15 BUILD A JOINED-UP FUTURE

18. Staff Health and Wellbeing programme update

To ACCEPT the report

For Report

Presented by Jan Bloomfield

NHS
West Suffolk
NHS Foundation Trust

Trust Board – 2 November 2018

Agenda item:	18			
Presented by:	Jan Bloomfield, Director of Workforce and Organisational Development			
Prepared by:	Dr Molly Thomas-Meyer, Public Health Registrar*			
Date prepared:	15 October 2018			
Subject:	Staff health and wellbeing programme			
Purpose:	X	For information		For approval

Executive summary:

Our staff is one of West Suffolk NHS Foundation Trust's greatest assets. We have long recognised the importance of promoting their health and wellbeing as a marker of a good employer, but also as a way to support them in delivering excellent patient care for our community.

In 2016, a staff health and wellbeing strategy was introduced which built on the interventions previously in place. This raised the profile and importance of this as a priority across the organisation. Last year, good mental health was added to the areas the programme covers, which has led to a culture of increased openness and recognition of its importance for staff resilience. Similarly the programme now covers areas such as finance in recognition that health can be affected by a range of issues.

At the beginning of 2018 Cambridge Health at Work (now *oh: Occupational Health and Wellbeing*) came on board to oversee the staff occupational health programme and to bring their experience from working with other trusts. They have employed a coordinator to oversee and facilitate work with staff on health and wellbeing initiatives directly on site. They work with our comms and public health teams, as well as local partners such as *OneLife Suffolk*, to deliver and promote evidence based interventions.

This year we have consolidated and built these relationships, and now have a holistic wellbeing framework which covers the key factors for supporting our staff. Within the framework we have mapped the work being done, and outlined specific actions which will take place in the short and long term. All this has been done with minimal cost, and often using existing resources and assets within the trust. We have similarly built on the previous evaluation framework to show uptake and progress across the organisation.

We are encouraged to see that despite many pressures on our organisation and staff, WSFT continues to have a high level of staff who are engaged with the organisation, and the NHS Staff Survey reported an increase in the number of staff who recognise the priority that this has been given within the trust.

Our ambition for the current year is to ensure that new interventions become established and that having consolidated and introduced the framework, we can turn our attention to identifying

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further gaps that may need a specific or targeted approach.

**Many thanks to Giles Wright and Caroline Porter from oh: Occupational Health and Wellbeing contributing to this 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			x		X

Previously considered by:	None
Risk and assurance:	Financial risk if investment in staff health and wellbeing do not produce a financial return in reduced sickness absence or reduced staff turnover. This risk is mitigated by mobilising existing resources as far as possible; the amount of new investment required so far is low.
Legislation, regulatory, equality, diversity and dignity implications	The trust is required to take action to reduce staff sickness. National guidance (eg NICE, the Health & Safety Executive) recommends organisations have robust and holistic policies for supporting staff health and wellbeing.

Recommendation:

- To receive the report on the organisation's current approach to promote and improve staff health and wellbeing through a mix of individualised and population wide interventions, recognising the benefits that a healthy and resilient staff will bring to patient care and the wider community.
- To support the ongoing work for addressing issues that can affect staff's physical and mental health.

Introduction

Our organisation has long recognised the importance of a happy and health workforce to maintain its ability to deliver first class care for our patients across the community. The trust has a health and wellbeing policy[1] and in 2016 a three-year strategy (2016-19) was adopted to ensure that intentions turned into actions and progress is monitored. The programme is led by the health and wellbeing steering group which meets quarterly and is chaired by the Director of Workforce and Organisational Development. The work is completed by many individual staff members coordinated by our OH partner *oh:Occupational Health and Wellbeing*, with clinical input from the public health team.

It is important to highlight that the vast majority of the improvements made have been at no financial cost to the trust. By working with community organisations and mobilising existing resources, the programme has been expanded in a highly cost-effective manner. The total cash investment in 2017/18 will be approximately £10,000.

This paper looks at the work following on from the last board update in January 2018 and describes and evaluates the progress, as well as outlining the strategic steps we have taken this year.

Nationally recognised priority

There is increasing recognition of the benefits to employers of adopting and supporting health and wellbeing policies for their workforce. As a result it is named as a priority in the Five Year Forward View, and NHS England began incentivising structured programmes in the 2016/17 CQUIN. This has since been extended. The National Institute for Health and Clinical Excellence[2] . provides guidance which involves a series of specific actions that should be taken for both physical and mental wellbeing of staff.

Population health benefit

The trust employs 4000 people and we therefore play a role in influencing the wellbeing of more than 1% of the West Suffolk population. This effect is increased with the additional benefits that come through indirectly influencing the children and family of the staff.

Development of the staff health and wellbeing programme to date

In 2016 the public health team at WSFT completed a SWOT analysis of the current provision of health and wellbeing for staff. The results founded the basis for the 3-year strategy, and the trust executive group accepted eight recommendations to increase uptake of those services and develop the offer further. All of the actions related to those

[1] www.wsh.nhs.uk/CMS-Documents?Trust-policies/251-300/PP(15)288Healthandwellbeingatwork.pdf
[2] https://www.nice.org.uk/guidance/ng13

were completed by the beginning of 2018. One of the major areas of expansion was to look at ways to support mental health amongst the staff, focussing on prevention of ill health and ways to provide avenues of support for existing issues.

Development of the staff health and wellbeing programme this year

The current year has involved building on this earlier mapping and gap analysis work, and establishing our new partner on staff wellbeing, *oh: Occupational Health and Wellbeing*. Our aim has been to make the health and wellbeing programme more holistic and sustainable, while maintaining an asset based and evidence based approach.

Firstly the focus this year has been directing energies on integrating staff from *oh: Occupational Health and Wellbeing*, and fostering relationships between the two organisations. This has been achieved with oversight from the public health team to identify priorities and establish stakeholder expectations. Links have now been successfully established and relationships developed to help deliver the programme via many targeted and group wide interventions.

There has been pleasing levels of support from all levels within the trust, and noticeable Executive and non- Executive Board member encouragement. We have expanded the range and amount of communications of specific and general health and wellbeing initiatives using a number of media channels. We have also aimed to amplify the partnerships with local groups who provide services which will be of benefit to our staff -- such as *OneLife Suffolk* and *Suffolk MIND.* We have been able to continue and embed all the interventions started in the previous year, and have found that the support has translated into sustainability -- through recruiting new volunteers and resources.

Secondly, we have developed a Health & Wellbeing action framework that has two major aims:

- to capture the many smaller interventions that are on offer throughout the trust -- often by individuals who donate their time. This helps monitor the breadth of effort going on in our organisation but also helps us to signpost those who are looking for help or support on particular topics.
- to extend the ambition of the health and wellbeing programme to all areas which are recognised as affecting the health and wellbeing of individuals, as well as the organisation -- in order to identify gaps and actions to consider.

It includes the requirements of the trust's strategy, NHS Workforce Health and Wellbeing Framework, and the national Workplace Wellbeing Charter (for which we have now started gathering evidence to meet its criteria.)

The 2019 Action Framework is attached as an appendix (one).

The framework is intended to be a 'live' document which can be used for both identifying gaps, collecting evidence of progress and planning future efforts.

Lastly, we have embarked up on some new areas for interventions. For example, we conducted a survey of burnout amongst our senior staff. We have found a burnout rate which is significant enough to warrant a strategy which will encompass organisational and individual focussed actions, to include all employees eventually. The aim is to have a positive, practical and proactive response to protecting our most valuable asset: our staff. We have communicated the findings to our staff, and are now in the process of putting the strategy together – looking to build our response on the existing interventions available. We have had good levels of senior support for this and interest from *NHS Improvement* about our approach.

In all areas we continue to develop the H&WB programme using an asset based approach when helps increase levels of community support and requires modest financial investment.

Evidence of impact

An evaluation framework has been devised with a mix of structural, process and outcome indicators. As well as this report, progress is reported quarterly by *oh: Occupational Health and Wellbeing* to the Health and Wellbeing Steering Group .

The following information is correct as at 15 October 2018 and is presented as an appendix (two).

Headlines:

- 2017/18 flu campaign had an uptake of 74.7% amongst staff, an increase on the previous year. The 2018/19 campaign is now underway and progressing well.
- The NHS Staff survey for 2017 reported WSFT was in the top 20% of trusts for levels of staff who felt their organisation takes positive action on health and wellbeing. This was a 6% increase on the baseline (2015), and also therefore met a CQUIN target
- The number of staff who completed Britain's Healthiest Workplace survey was over 5% -- this exceeded the target set and shows positive engagement.
- The Suffolk MIND pilot was completed over 3 months– nearly 40 line managers have benefited and the evaluation was extremely positive.
- Workplace Wellbeing Charter now has overseer to collect evidence and facilitate securing this accreditation
- 3 CQUIN wellbeing targets for 2017/18 were met.
- We were shortlisted for the most Active Workplace award as part of the 2018 West Suffolk Sports Awards organised by Abbey Croft Leisure.
- Despite the national trend in work pressures, WSFT was the joint top performing trust in the county for staff who recommended their trust as a place to work or receive treatment (NHS Staff Survey 2017)

For the Board's interest the 2016 baseline data presented in January 2018, using the radar format, has been updated with more recent figures, to give a snapshot overview of changes over the period. Success is indicated by a larger area under the polygon created.

The purpose of this is to show change over time, but also to reflect the idea that health and wellbeing is made up of many different and varied factors.

The diagram is presented as an appendix (three).

Going forwards

Following the period of change and integration, we are ready for the next stage of expanding the scope of the programme and building on the range of interventions available to staff.

- To identify specific needs of community teams for health and wellbeing and how they can participate equitably from the programme.
- To continue to collect evidence for the Workplace Wellbeing Charter and submit it for accreditation with a view to reach the Excellence level in 2019/20.
- To conduct a flu campaign for 2018/19 across the main hospital and community to ensure staff receive immunisations.
- To develop individual and organisational approaches to burnout amongst staff using a collaborative strategy to be launched in late 2018.
- To offer advice and self care sessions on specific topics such as menopause – to be delivered by trust and local primary care specialists.
- To establish a student volunteer programme in collaboration with West Suffolk College, in order to expand the volunteer programme to our community settings and increase alliances with local partners
- To increase the number and availability of Making Every Contact Count training sessions to all staff.
- To increase collaboration with our community partners such as *OneLife Suffolk* to increase health and wellbeing prevention and supportive intervention opportunities for our staff.

APPENDIX ONE

APPENDIX TWO

RADAR CHART

APPENDIX THREE

EVALUATION AND DATA

West Suffolk Wellbeing Action Plan 2019

Leadership

Trust ambition 7 *Support all our staff.*

West Suffolk Foundation Trust Leadership Team encourages a consistent and positive approach to employee wellbeing throughout the organisation. They recognise and reward good work, one example being the Annual Shining Light awards for staff members who exceed their roles.
The organisation is aware of its responsibilities adhering to all relevant legislation.
WSFT has a Health, Work and Wellbeing strategy in place. They have a Quarterly Steering Group including Board engagement/reporting.

CURRENT WORK	FUTURE PLAN (Quarterly)	
	2018>On-going	2019/20
Employees complete Personal and Development Plans to maximise their potential. Line managers have relevant leadership and management training. Care First provided awareness workshops during Mental Health Awareness Week in May. MIND training - Mental Health Training for Line Managers. Shining Light Awards	Continually process to maintain and build on professional portfolios. Promote personal stories of self-improvement following MECC training. Awards held annually in March.	Further MIND training for managers to be scheduled. Providing resources to managers with guidance on supporting colleagues and sign posting to services.

West Suffolk Wellbeing Action Plan 2019

Mental Health

Trust Ambition 5 *Support a healthy life.* **Trust ambition 7** *Support all our staff.*

WSFT is mindful their workforce is aware of mental health and mental wellbeing and that they have access to support and information as required.

Employees are able to contact **Care First** which is an employee assistance programme, with opportunity to refer access to free counseling and information. Information and support is available 24 hours every day online and by telephone.

"Being in good mental health brings resilience to cope with difficulties, have good relationships with others and an ability to think clearly, participate in decision making, and have optimism, sense of control and self-efficacy. These are important for staying healthy." www.gov.uk ; Wellbeing and mental health; applying all our health (Feb 2018).

CURRENT WORK	FUTURE PLAN	
	2018>On-going	2019/20
Evaluation of MIND training - (Mental Health Training for Line Managers) completed. We have Care first in place at WSFT, We receive reports quarterly regarding activity of the service. Care First provided awareness workshop's during Mental Health Awareness Week in May. Considering extending to quarterly sessions. Stress Workshops provided by OH x2 yearly. Library/Education Centre provide resources for mental wellbeing, including Mood Boosting books for their uplifting qualities, Books on Prescription providing self help techniques, Colouring materials for	Positive evaluation of MIND training for managers. Plan to re-commission and expand 2018/19. Hard copy Information booklets to be made available in OH. Intranet links to be set up to access additional MH websites and digital booklets. Workshops to be reviewed. Mindfulness Workshop> opportunity for workshop to be held during Leadership Summit. Bully and Harassment launched October via HR	Plan to increase workshops to quarterly and expand roll out. Provide Resilience Training. Provide Mindfulness Workshops for all staff. Plan to convene burnout taskforce to look at issue amongst clinical staff and to look at organisational

West Suffolk Wellbeing Action Plan 2019

	Mindfulness. Freedom to Speak Up Guardian in place since 2017 Tea and Empathy – rota of staff who answer bleep if someone needs to unburden themselves and is in need of a friendly listener.	team. Burnout amongst senior doctors survey completed March 2018.	approach to all staff groups.

Life Style

Trust Ambition 5 *Support a healthy life.* **Trust ambition 7** *Support all our staff.*

WSFT aims to support people through all individual lifestyle choices, habits and behaviour which in turn impact on their wellbeing.

"Physical and mental health are related, with one affecting the other. Preventing, treating and managing physical health conditions also require improving mental health and wellbeing. Equally, preventing, treating and managing mental health problems require addressing physical health. Both of these aspects are addressed here." www.gov.uk ; Wellbeing and mental health; applying all our health (Feb 2018).

	CURRENT WORK	FUTURE PLAN	
		2018>On-going	**2019/20**
	WSH Smoke Free Environment. One Life run Stop Smoking Clinics on site weekly. NHS Health Checks. One Life Suffolk provide free health checks for staff aged between 40-74. Physical activity- Some of our WSFT Staff currently run Circuit Exercise and Tae Kwando classes on site aiming for ease of access to staff members and encourage physical activity. Active travel. One element is the national Cycle-to-Work scheme, purchasing cycling goods tax-free. Healthy Eating. Hospital canteen provides healthy choices, they have won Eat Out, Eat Well award.	Continuing to promote the service. **Stoptober**- promotional push for support. Health Checks to also be provided at Community location. Health Walks. Abbeycroft or Onelife Suffolk to initially support prior to group independently managing. Reduced local Gym membership available. Review MECC training, to expand and include additional staff, not just medical.	MECC Training to raise awareness of One Life Suffolk support services. To roll out weight management courses/ workshops at WSH. To increase presence of OneLife Suffolk staff and services across the

West Suffolk Wellbeing Action Plan 2019

	Obesity – One Life offer a Weight Management Course.	Champion stories. Staff incorporating a Healthy Living life style success stories. Those that may have been as a result of attending MECC training.	trust. Considering piloting: health check machine for staff and patients.

Focus on: MSK – Musculoskeletal

Trust Ambition 5 *Support a healthy life.* **Trust ambition 7** *Support all our staff.*

"Musculoskeletal conditions affect the joints, bones and muscles, and also include rarer autoimmune diseases and back pain. More years are lived with musculoskeletal disability than any other long term condition." www.england.nhs.uk
WSFT aim to support their workforce in preventing MSK injury through various methods including education, providing equipment and moving and handling techniques. They also provide assistance to help staff return to work. Self-care is encouraged and sign posting to occupational physiotherapy service provided.

	CURRENT WORK	FUTURE PLAN	
		2018>On-going	2019/20
	Specialist Physiotherapy self-referral service for staff. (ongoing) Moving and Handling Service.	Continuing to promote service. Desk exercise booklet to be made available in OH.	Link to digital copy.

Focus on: Preventing Flu

Trust Ambition 5 *Support a healthy life.*

Throughout the flu season we offer and provide our staff with the Flu vaccination. The campaign includes a large promotional crusade and for 2018/19 we are incorporating the NHS Employers Flu Fighters materials. We provide advice, myth busting and also a great team workforce ethos with Flu Champions assisting the Occupational Health Team to complete vaccinations across the Trust.

	CURRENT WORK	FUTURE PLAN

West Suffolk Wellbeing Action Plan 2019

	2018>On-going	2019/20
Flu Strategy>2018/19 Flu Fighter Campaign.	Flu campaign underway. Evaluating and will act on data as we are aware of prevalence, or news of pathway issues. Will follow NHS checklist for best practice management checklist for public assurance via trust boards, December 2018.	Early planning, using learning points from 2018/19 Schedule meetings/book rooms.

Life Experiences and Ill Health

Trust Ambition 5 *Support a healthy life.* **Trust ambition 7** *Support all our staff.*

Life experiences and Ill health is a huge topic and will have a completely different meaning to each individual employee. WSFT aims to holistically support their employees through generalised life events (ie Menopause) as well as specific health conditions (ie Diabetes).

CURRENT WORK	FUTURE PLAN	
	2018>On-going	2019/20

	Menopause Workshop and policy review planned. Health and Wellbeing Focus Group led quarterly. Carers Support for patients and visitors.	Workshop planned in late 2018. Being supported by Trust specialist Consultant and GP. Develop Trust policy to support staff and enhance a healthy workplace culture. Develop staff support to be more prominent and easily accessible. Carers Week- June – programme of awareness raising activities and education.	On-going regular support workshops to be scheduled. Liaise with Carer Support Services at WSH to plan for Carers Week. Plan/commission Family Carer Workshops for those caring for Elderly friends or relatives.

Financial Wellbeing

Trust ambition 7 *Support all our staff.*

Various studies have been completed regarding finances and how they affect individuals/employees. One outcome suggested that employees who were troubled by their financial situation were twice as likely to be in poor health as those who were not. There appears to be a link between financial worries and stress, absence and engagement.

WSFT are aware of the impact and implications that negative financial situations can have on their staff and is something that is all too often experienced. To assist and offer support employees can self-refer to Neyber, financial wellbeing service. Neyber offers access to free financial education and insights, and affordable loans which you can repay straight from your salary.

"……financial well-being—or a lack of it—regardless of income. It's a highly personal state, not fully described by objective financial measures. Instead, well-being is defined as having financial security and financial freedom of choice, in the present and in the future.

Financial behaviour is also guided by personality, attitudes, knowledge, and skills. The actions consumers take, within the options available

to them, create their level of financial well-being. " consumerfinance.gov/reports/financial-well-being

CURRENT WORK	FUTURE PLAN	
	2018>On-going	2019/20
Neyber, financial wellbeing service. Organisation is invited to attend various team meetings and trust inductions to promote the service and enable staff to view information and be supported as required.	Continuing to promote service and sign posting for information.	Links to website easily accessible.

Absence Management

Trust ambition 7 *Support all our staff.*

At WSFT an attendance management policy is in place, with procedures and information accessible to staff; Improving Employee Health, Wellbeing and Attendance Policy. Return to work interviews are able to be monitored through the Staff Friends and Family Survey. This identifies staff groups and will highlight who is not receiving interviews and follow up accordingly. WSFT has a proactive approach to reasonable adjustments assisting staff to get back to work.

The staff Physio Service works in partnership with the trusts Moving and Handling Service to help identify risk, aiming to help reduce and alleviate workforce MSK injury's.

Working to recognise and support workforce Mental Health wellbeing, stress management workshops available, further support and training under review for future implementation.

West Suffolk Wellbeing Action Plan 2019

	CURRENT WORK	FUTURE PLAN 2018>On-going
	The Improving Employee Health, Wellbeing and Attendance Policy is currently being reviewed, with phased returns being an element of focus. Absence Management Training is held x4 yearly, is also available ad-hoc on request. Bradford Factor scores used for absences. Appraisals completed. Return to work interviews conducted, appropriate support provided alongside specific risk assessments taking into an individual's health status. Reasonable adjustments are available to employees in line with recommendations for relevant professionals.	Procedures followed and completed accordingly. Completed annually for each member of staff. Policies and procedures followed. In addition to Lifestyle, One Life Suffolk will be demonstrating a Health Check kiosk for staff to use in November. Demonstration with a view to having one in the trust> positive workforce approach.

Safe Environments **Trust Ambition 5** *Support a healthy life.* **Trust ambition 7** *Support all our staff.*

West Suffolk Wellbeing Action Plan 2019

WSFT have all required Health and Safety policies and procedures in place and are able to demonstrate compliance with Health and Safety Legislation. PP(17)018 – Health, Safety & Welfare Policy; PP(17)132 – Risk assessment policy & procedure.

They have a Health, Safety and Risk Manager in post to provide information, support and advice as necessary to employees/our workforce.

The Trust has a competent advisor (Mike Dixon, Health, Safety & Risk Manager) who holds a Nebosh Diploma and a Risk Officer in post who has recently undergone Nebosh training to assist the Health, Safety & Risk Manager.

The Trust has a Health & Safety committee, whom we report to and who meet on a quarterly basis. Minutes of these meetings are disseminated to h/s Link staff and printed & displayed on the H/S notice board.

Workplace inspections are carried out throughout the Trust and the community to identify any health & safety issues for staff and patients/visitors. These are typically carried out by the Health & Safety Link staff (We currently have around 168 trained link staff) but are also carried out by the Health, Safety & Risk Office.

All areas/departments of the hospital are required to have a Health & Safety Link person; part of their role is to ensure that their areas have suitable & sufficient risk assessments and workplace inspections and that they have an up to date h/s folder with all relevant information, risk assessments. The Health, Safety & Risk Office offer constant support and advice.

A Health & Safety Noticeboard is displayed in the main hospital with information, advice and other relevant information/contact details. Any other ad-hoc information regarding health & safety, that we require to be disseminated to staff can be done by making use of the Trust Green Sheet and via emails to link staff (as well as managers) and through our Communications team, who also send out information via email.

All staff are inducted at the start of employment. This covers health & safety; our duties to them as an employee and their duties as part of the HSAWA 1974 and other legislation. Ad-hoc training can be provided as required and there is an online learning platform for staff to make use of.

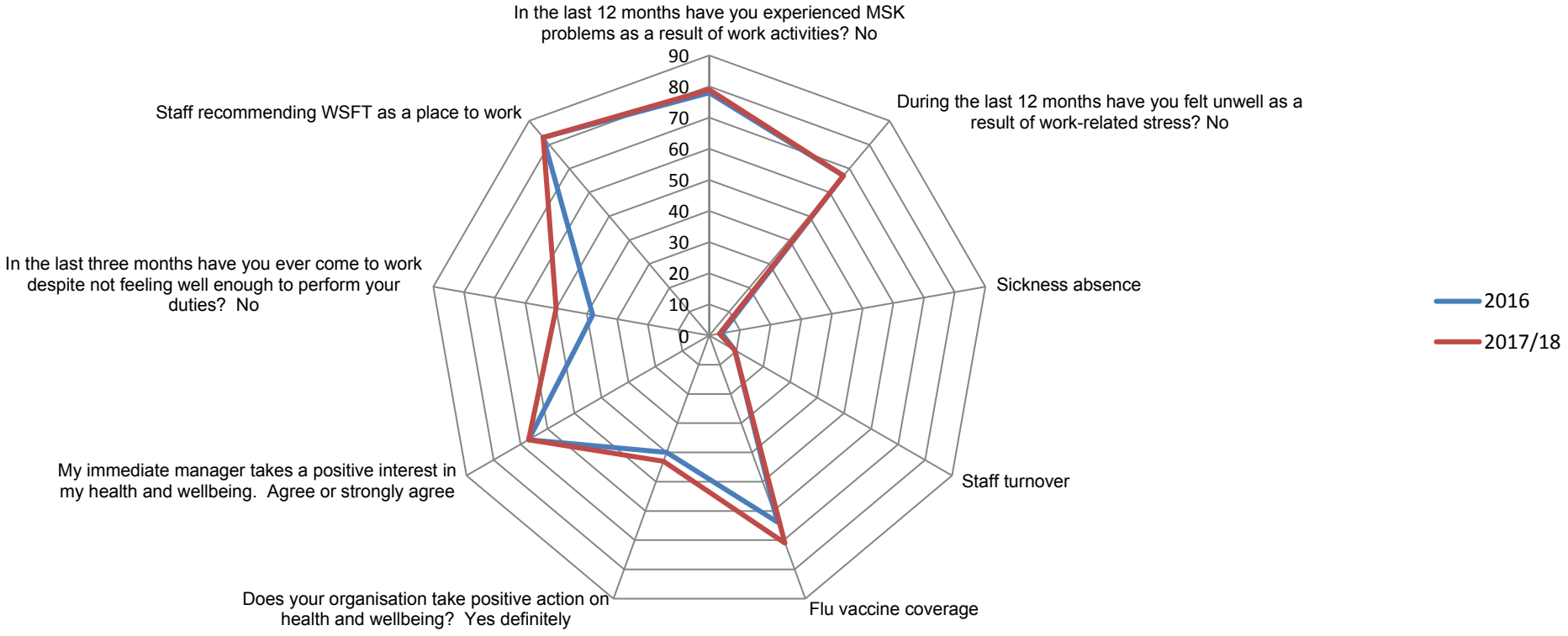
There is an online learning platform which also covers health & safety and staff are required to undergo this training as part of their ongoing mandatory training.

	CURRENT WORK	FUTURE PLAN
		On-going

West Suffolk Wellbeing Action Plan 2019

	Health and Safety training provided to all staff relevant to their role. **Management of Violence and Aggression Policy** The West Suffolk NHS Foundation Trust has a statutory obligation to ensure as is reasonably practicable, a safe and secure environment for its staff. Violent, abusive behaviour and criminal acts will not be tolerated. Health & Safety committee, report to and meet on a quarterly basis. All areas/departments of the hospital are required to have a Health & Safety Link person	Mandatory training. All staff are inducted at the start of employment Monitoring/review of policy as necessary. Workplace inspections are carried out throughout the Trust and the community.

WSFT Staff Health and Wellbeing Outcome Framework Radar Diagram 2018



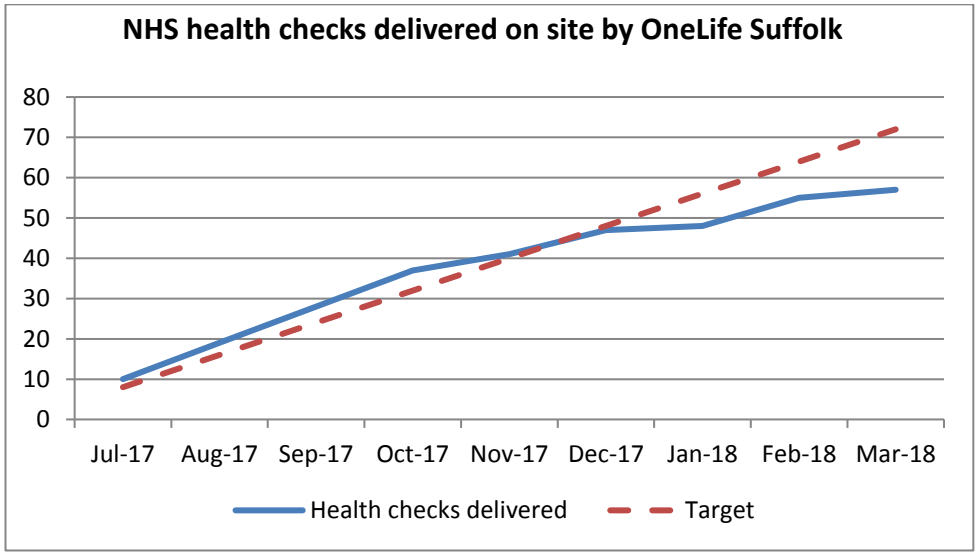
Staff health and wellbeing evaluation framework and dashboard

Structures	Processes	Outputs	Outcomes
Physical wellbeing			
	NHS health checks delivered	Staff set quit dates with on-site stop smoking service Achievement of healthy food CQUIN Flu vaccine coverage	NHS Staff survey - % experiencing work-related MSK problems
Mental wellbeing			
Tea & Empathy rota established Rota coordinator identified		Uptake of Care First Line managers attended full MIND training	NHS staff survey - % experiencing work-related stress
Overall			
Quarterly staff focus groups established Greensheet monthly focus published Ongoing coordination of programme secured Staff led initiatives enabled	Staff webpages hits	NHS staff survey - % reporting organisation definitely takes interest in H&W Achievement of Workplace Wellbeing Charter standards Staff webpage click throughs	Sickness absence rate • Total • 0-3 days • % declared stress, anxiety, depression Staff turnover rate NHS staff survey - % coming to work despite not feeling well enough • Of those - % felt pressure from manager • % felt pressure from colleagues • % felt pressure from themselves NHS staff survey - % agree or strongly agree immediate manager takes interest in health and wellbeing Staff F&F test - % recommend as place to work

Quantitative indicators

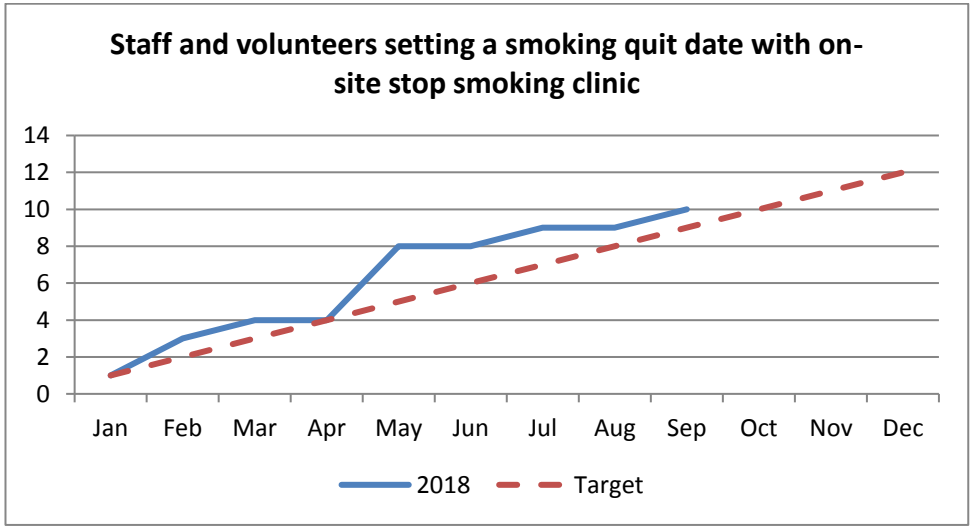
NHS health checks delivered on-site to staff and volunteers

Source	Frequency	Target/notes
OneLife Suffolk	Quarterly	Target = 10 clinics per annum, 8 out of 10 slots per clinic filled = 80 per annum Clinics are promoted to staff and volunteers of WSFT From January 2018 also promoted to NSFT Wedgwood House staff and volunteers



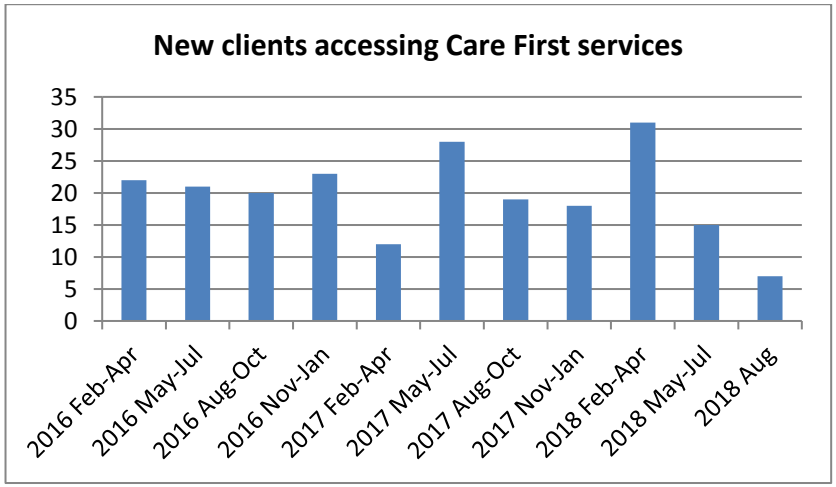
Staff and volunteers setting smoking quit dates with on-site clinic

Source	Frequency	Target/notes
OneLife Suffolk	Quarterly	Baseline being established Clinic to move to antenatal clinic and extend hours to Mondays 8am-1pm Accessible by staff, volunteers, patients and relatives/carers Data being collected from Jan 2018



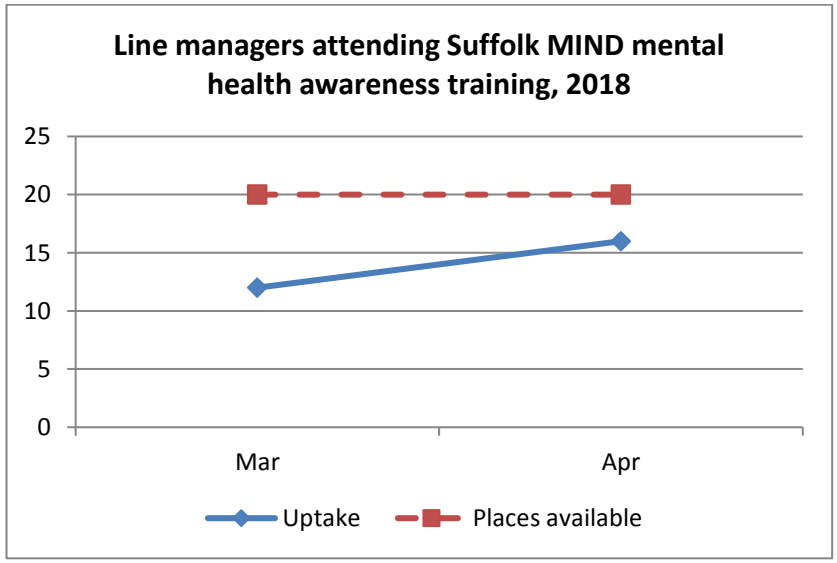
Uptake of Care First

Source	Frequency	Target/notes
Care First	Quarterly	Care First reported 'It is great to see a sustained high level of usage of the EAP, which is testament to the proactive role Occupational Health play in referring staff to Care first.



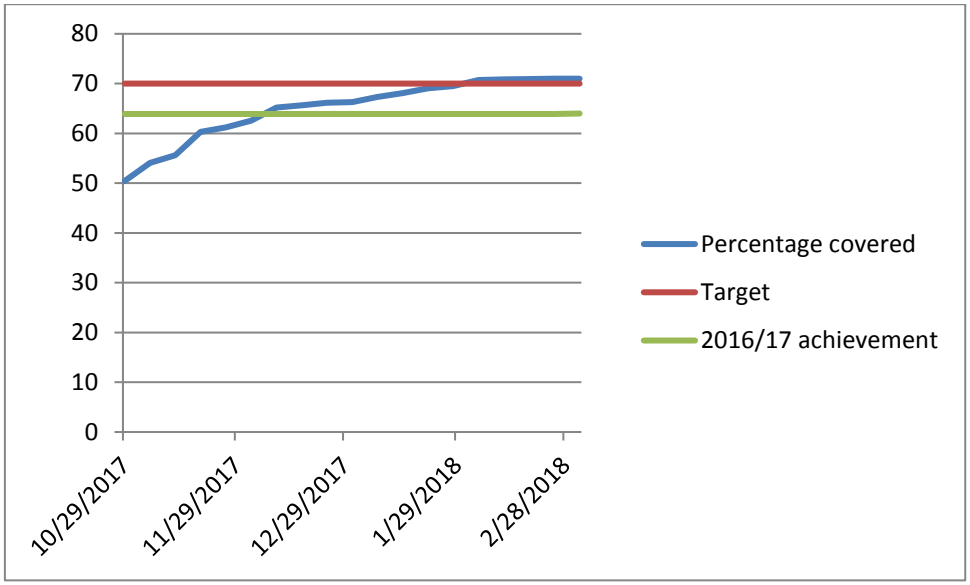
Line managers attending MIND training

Source	Frequency	Target/notes
Suffolk MIND	Monthly	Courses are 2 x 1 day, 2 weeks apart Starting in February 2018 and running monthly, piloting 3 months at first Capacity is 20 per course, the uptakehas been 9-16 attendees. Following on from very positive evaluation, recommendation is to commiisssion a series of these sessions for 2018/19- once evry two months for one year.



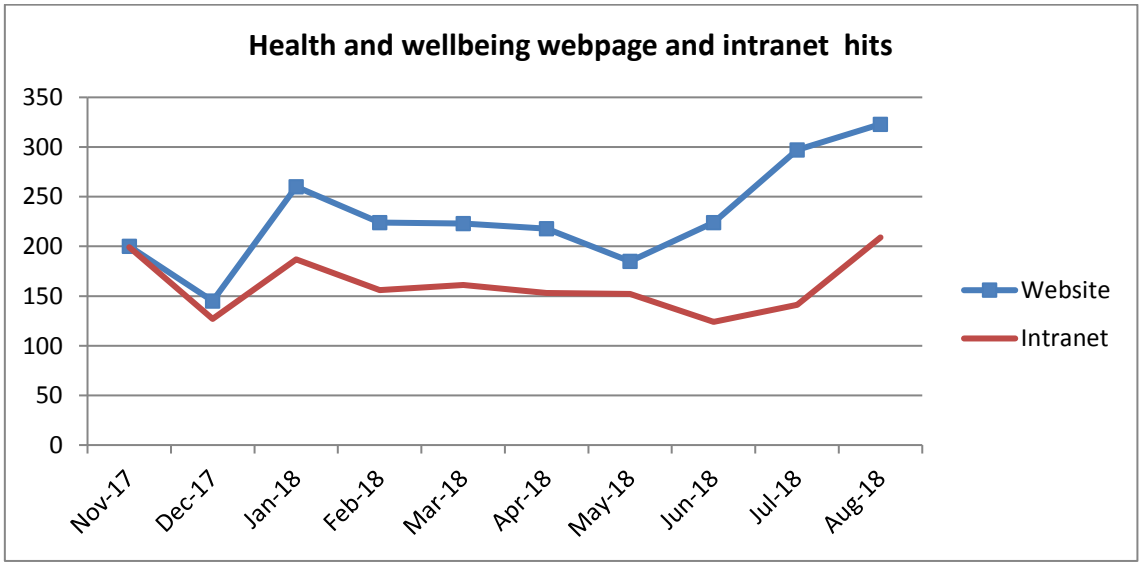
Flu vaccine coverage 2017/18

Source	Frequency	Target/notes
Oh *Occupational Health and Wellbeing*	Weekly during flu season	Target is 70% of eligible staff Season runs October to February



Health and wellbeing webpages hits

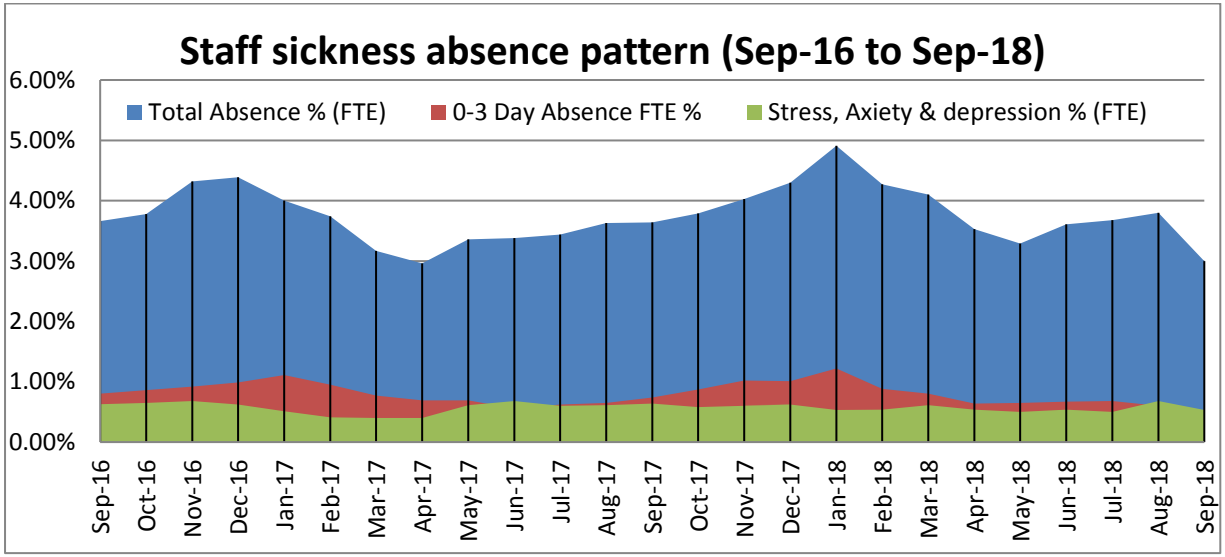
Source	Frequency	Target/notes
Communications	Monthly	Links for click through include to external site and internal information pages.

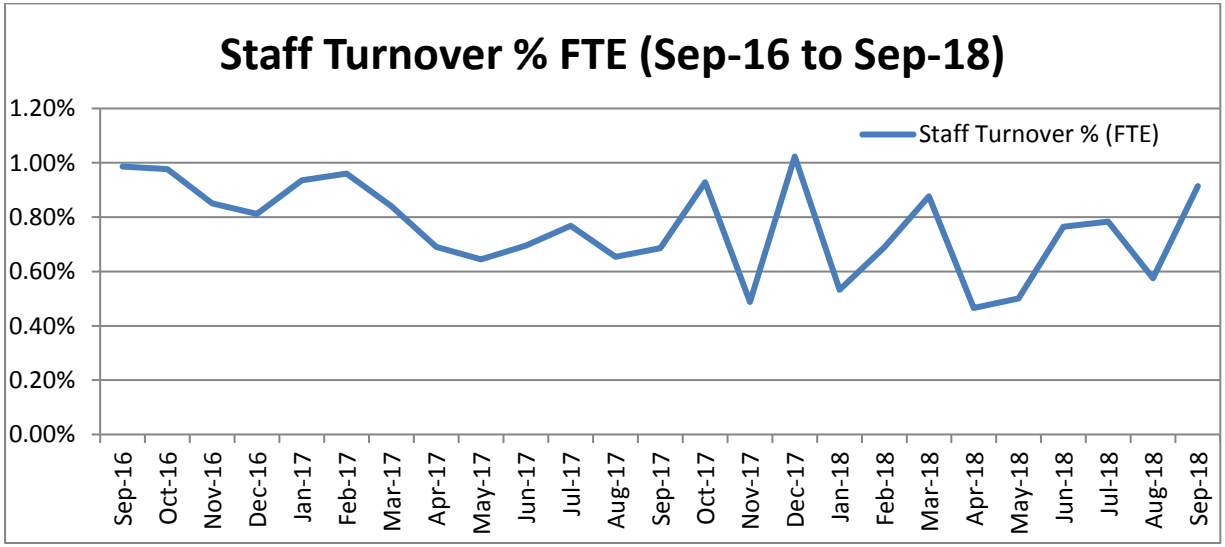


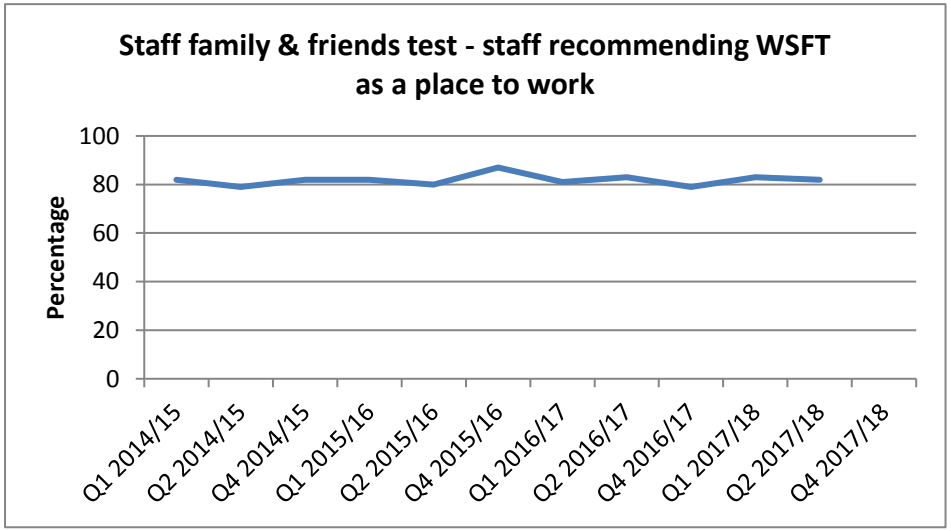
Qualitative indicators

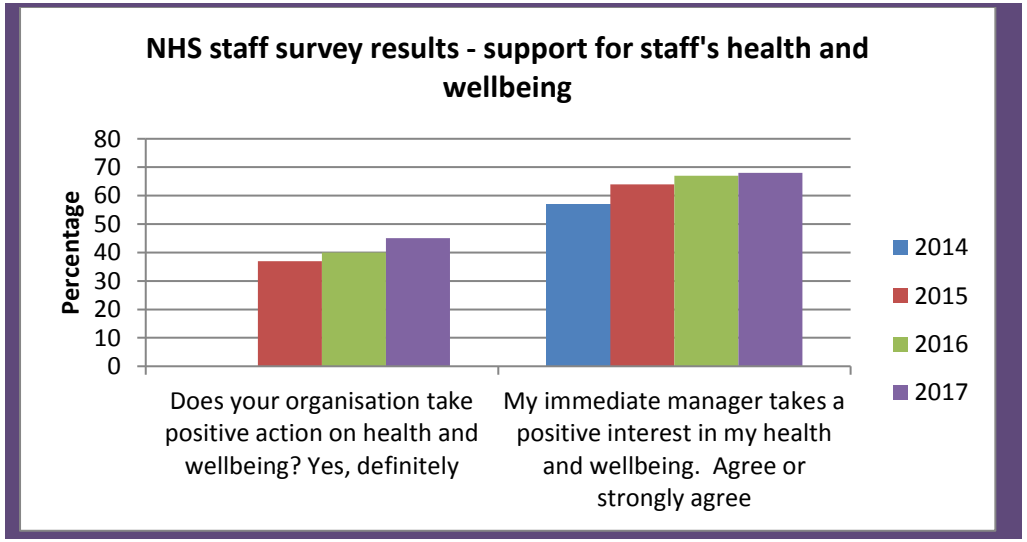
	Source	Notes	On track?
Achievement of healthy food CQUIN	Transformation	Milestones reported quarterly to CCG	Yes
Tea & Empathy rota established	Public health	Rota began in May 2017	Complete
T&E rota coordinator identified	Public health	Administrator to Guardian of Safe Working	Complete
Quarterly focus groups	Communications	Requirement = 4 per year	Complete in 2017/18
Greensheet monthly focus published	Communications	Requirement = 12 per year, began Jul 2017	Yes – 7 by Jan 18
Ongoing coordination of programme secured	Public health	Occupational Health and Wellbeing contract extended from 01 April 2017	Complete
Achievement of Workplace Wellbeing Charter standards	OH	Goals set out in H&W strategy: • 'Commitment' met by end 2016 • 'Achievement' met by end 2018 • 'Excellence' met by end 2019/20	Behind – 'Commitment' not yet met at Sep 2018 – outstanding some evidence

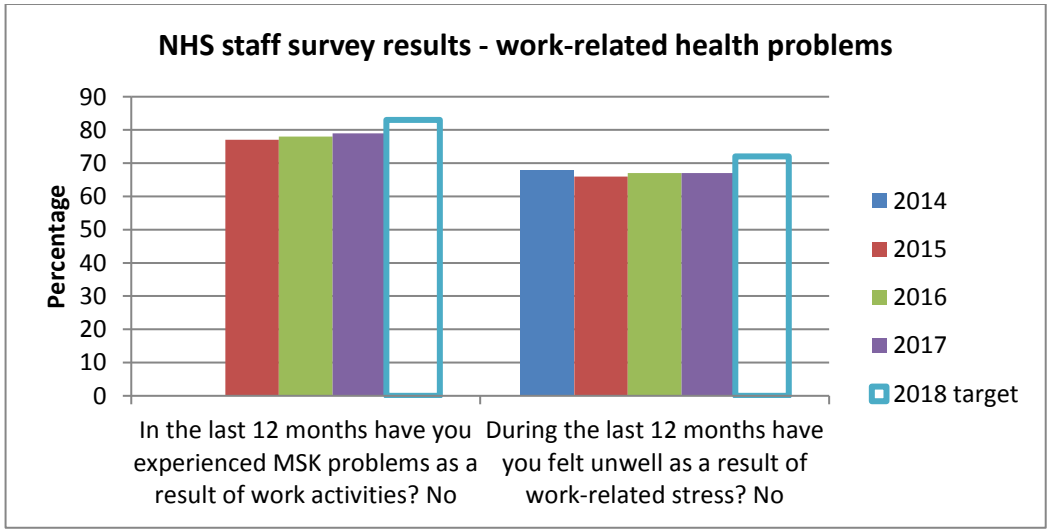
Outcomes indicators

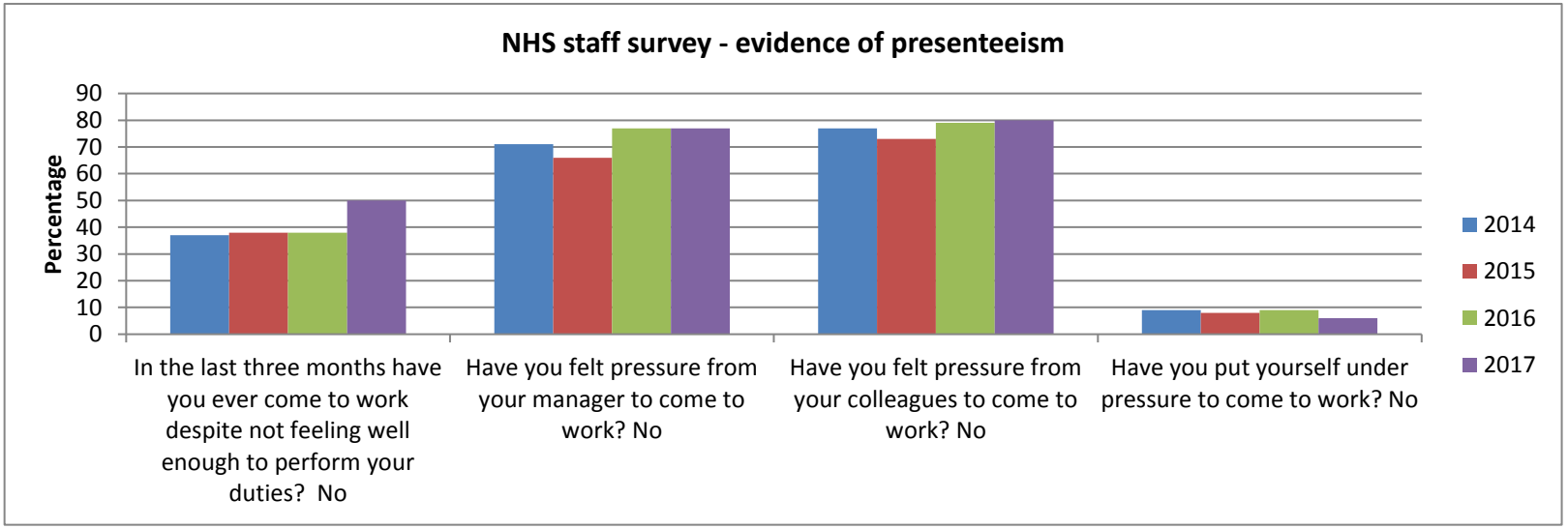





Staff family & friends test - staff recommending WSFT as a place to work
Percentage
100
80
60
40
20
0
Q1 2014/15
Q2 2014/15
Q4 2014/15
Q1 2015/16
Q2 2015/16
Q4 2015/16
Q1 2016/17
Q2 2016/17
Q4 2016/17
Q1 2017/18
Q2 2017/18
Q4 2017/18

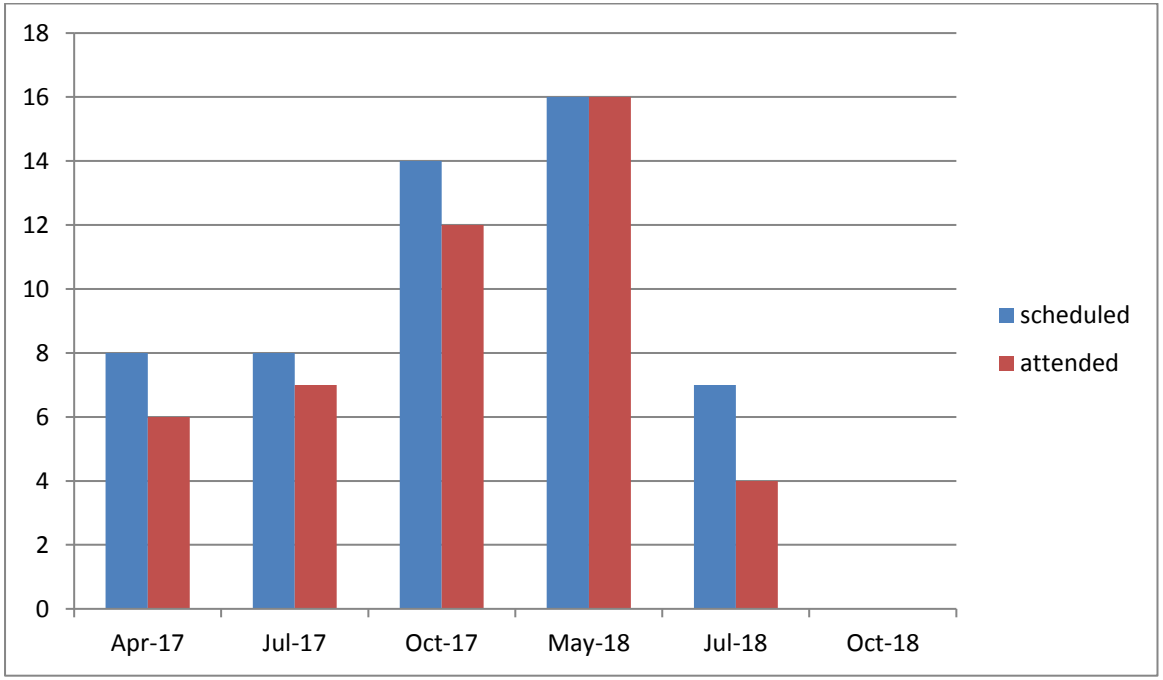

NHS staff survey results - support for staff's health and wellbeing
Percentage
80
70
60
50
40
30
20
10
0
Does your organisation take positive action on health and wellbeing? Yes, definitely
My immediate manager takes a positive interest in my health and wellbeing. Agree or strongly agree
2014
2015
2016
2017


NHS staff survey results - work-related health problems
Percentage
90
80
70
60
50
40
30
20
10
0
In the last 12 months have you experienced MSK problems as a result of work activities? No
During the last 12 months have you felt unwell as a result of work-related stress? No
2014
2015
2016
2017
2018 target



Note: 2018 staff survey results are due for publication in March 2019

Focus Group Meetings



Source	Frequency	Target/notes
Oh *Occupational Health and Wellbeing Team* Communications Team	Quaterly	An exercise /fitness club has started as a result of the focus group. This is run by a Physio based in the Community. Peak numbers saw 18 attend the Monday night session. Levels dropped as expected over summer but opportunity to expand if numbers rise again. Plan for a feedback/evelauation form to be rolled out at the end og each session (2019 owards) to ascertain further thoughts not discussed in group and to enable data collection and reporting as appropriate.

11:30 GOVERNANCE

19. Trust Executive Group report

To ACCEPT a report

For Report

Presented by Stephen Dunn

Board of Directors – 2 November 2018

Agenda item:	19			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	25 October 2018			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

Executive summary

Steve Dunn provided an introduction to the meeting and recognised the significant improvement in **ED performance** over the last week, month and quarter. The Q2 performance had secured additional provider sustainability funding (PSF).

Discussion took place regarding ongoing **preparation for winter**, including the impact on these plans of offers from other trusts in the wider system to agencies for staffing. In this context recruitment of nursing assistants remained good, but registered nurse recruitment remained challenging.

Improved performance in staff appraisal was recognised and emphasis was given to the importance of promoting uptake of **flu vaccinations** to protect patients and staff.

The **integrated quality and performance report** (IQPR) was reviewed. It was noted that a number of improvements had been delivered: infection prevents, ED 4 hour wait, complaint response times and duty of candour. The RRT position had deteriorated in August; review took place of the underlying specialties driving this challenge. The plan remains to achieve zero 52 week breaches by the end of October. It was noted that delivery of diagnostic services was impacting on cancer performance.

The proposed project plan for the planned **ED development** was reviewed. While the national funding decision is pending it was agreed to progress key elements of this programme to ensure we are able to deliver the improvements as soon as possible when a funding decision is taken.

The **education and library annual report** was received.

Relevant **policy documents**:

a) Emergency Preparedness, Resilience and Recovery **(EPRR) strategy and C3 plan** was circulated to TEG for 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	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							

20. Quality & Risk Committee report

To ACCEPT the report

For Report

Presented by Sheila Childerhouse

NHS West Suffolk NHS Foundation Trust

Board of Directors – 2 November 2018

Agenda item:	20			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Ruth Williamson, PA			
Date prepared:	24th October, 2018			
Subject:	Quality & Risk Committee Report			
Purpose:	X	For information		For approval

Executive summary:

This report provides a summary of the Quality & Risk Committee meeting that took place on 28 September, 2018, including a summary of the subcommittees held during quarter 3.

The meeting received a presentation on community services integration, one year on, with the committee passing on their grateful thanks to the leadership and teams which had enabled this integration to go so well.

(a) **Clinical Safety & Effectiveness Committee (10/9/18)**
Noted Point of Care Testing and issues concerning progress have been escalated to the executive team, together with a plan of work and detail of resources required to rectify.

(b) **Corporate Risk Committee (17/08/18)**
Health & Safety assurance has been reviewed in light of departure of fire safety officer.
Assurance given that the top three risks highlighted in the Risk Register analysis and review had been sufficiently defined within the BAF in order to address.

(c) **Patient Experience Committee (14/9/18)**
Format of future meetings is under consideration.

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*
		X	X				

Previously considered by:	-
Risk and assurance:	-

Legislation, regulatory, equality, diversity and dignity implications	-
Recommendation: To accept the report.	

QUALITY & RISK COMMITTEE
Minutes of the meeting held on Friday 28 September, 2018,
Commencing at 2.00 p.m. in the Northgate Meeting Room, Quince House, WSFT

COMMITTEE MEMBER		Attendance	Apologies
Sheila Childerhouse **(SC)**	Chair (Chair)	X	
Stephen Dunn **(SD)**	Chief Executive	X	
Craig Black **(CB)**	Director of Resources	X	
Nick Jenkins **(NJ)**	Medical Director	X	
Helen Beck **(HB)**	Interim Chief Operating Officer		X
Jan Bloomfield **(JBI)**	Director of Workforce & Communications	X	
Rowan Procter **(RP)**	Chief Nurse	X	
Dawn Godbold **(DG)**	Director of Integration & Community Services	X	
Gary Norgate **(GN)**	Non-Executive Director		X
Richard Davies **(RD)**	Non-Executive Director	X	
Richard Jones **(RJ)**	Trust Secretary & Head of Governance	X	
Alan Rose **(AR)**	Non-Executive Director	X	
Angus Eaton **(AE)**	Non-Executive Director	X	
Louisa Pepper **(LP)**	Non-Executive Director	X	
Catherine Waller **(CW)**	Honorary Non-Executive Director		X
In attendance			
Ruth Williamson	PA to Medical Director (Minutes)		
Peter Adler	Governor – Presentation only		

Action

Community Services – One Year On

DG presented a review of the service, a year after integration with the trust. It was agreed that DG would supply a copy of this presentation to all those present. **DG**

AR referred to provision of mental health services and DG advised that plans were being formulated to enable joint working in Newmarket and Sudbury. RJ enquired at what point joint working and co-location transformed to a more "Buurtzorg" inspired system. DG responded that Buurtzorg was still in the test and learn phase. Phase 1 would be looking at broadening the catchment area, with referrals now being taken from GPs outside of Barrow. However it should be noted that Buurtzorg's needs differed from the community caseload and consideration will need to be given to how the models merge. Initial thoughts are a hybrid of the two. RP advised that the Trust would struggle to recruit solely to the Buurtzorg model; a pragmatic approach was required.

SD asked whether Buurtzorg should be reserved for complex cases or targeting the groups it serves best. RP stated that Buurtzorg was about the community and knowing the neighbourhood. If changed to suit a patient's complexity it would not work as effectively or efficiently. Buurtzorg concentrated on self-empowerment.

SD said that the empowerment of staff had been impressive, particularly in relation to speech and language. **RJ**

AR asked if integrated neighbourhood teams were in place. DG advised that some were whilst others were a work in progress. The components were in place, but not yet not fully integrated. AR asked what was needed to effect this integration. CB responded that the service would need to come under one organisation or alliance which, if working properly, would ensure that clinical decisions were taken without pause as to the effect on the differing organisations. He advised that that there were audit issues in allowing other organisations to spend your money. It was easy to put a block in place and required effort and willingness to overcome.

KA advised of the contribution to people with medical conditions wellbeing from good neighbourhood schemes in the community.

AE was pleased at the level of take up on staff rotation. DG advised that this was a rolling programme and the norm for all the areas.

JBI referred to the joint harmonisation project in respect of staff terms and conditions, with the first policies about to go to the Trust Council. All those previously on SERCO spine points were now on Agenda for Change. Meetings with the unions had been very helpful.

AR asked if social care staff would be integrated. JBI advised of good secondment arrangements between health and social care, but full integration was difficult to arrange. AE asked whether collaboration with primary care should include the Trust. RP stated that we were all West Suffolk NHS Foundation Trust and not the hospital or the community.

SC congratulated the leadership who had enabled this integration to go so well.

1. **Apologies for Absence**

Apologies received as detailed above.

2. **Minutes of Previous Meeting**

The minutes of the meeting held on 29 June, 2018 were accepted as a true and accurate reflection of the meeting.

3. **Matters Arising Action Sheet**

Action Ref 41 - Patient Experience Committee - (PEC) – (15 June, 2018) - Meeting in progress. Update to be provided at next meeting.

Completion of matters arising reference 42 was duly noted.

4. **Reports from Sub-Committees**

a. ***Clinical Safety & Effectiveness Committee (CSEC) - (10 September, 2018)***

RJ referred to ***Item 3.1 - Action Ref 371 – Point of Care Testing*** and advised of lengthy discussions that had taken place. The lack of progress had been noted and escalated to the executive team, together with a plan of work and detail of resources required.

b. ***Corporate Risk Committee (CRC) - (17 August, 2018)***

Item 4.1 - Health and Safety Committee Report – NJ reported that health and safety assurance had been reviewed in light of departure of fire safety officer.

AE referred to ***Item 5.3 - Risk Register Analysis and Review*** and the reference to the top 3 risks:

1. system/financial/operational sustainability,
2. winter planning and pathology services,
3. system financial operational ability

and asked if they had been sufficiently defined in order to address. RJ advised that the issues had been set out in the BAF. AE asked for the BAF to be placed as a reference document in the library section of Convene. RJ to action. **RJ**

c. ***Patient Experience Committee - (PEC) – (14 September, 2018)***

RP, JBL, RJ and AR are to meet to look at how the committee works in the future. RJ advised that reports to the last meeting were much improved. Structural changes to the patient journey and elements from this have helped with assurance.

5. **Quality Group Report**

Noted three areas requiring improvement from the last CQC visit which are anticipated to be covered at the next (critical care, maternity and ED). RP asked if any of the non-executive directors would like to be involved in the mock visits being arranged in this regard and if so that they email her direct.

AR asked if the CQC could shut down the service in respect of NEESPS and whether work was required in this regard. RP did not believe additional work was required. The CQC would want to see that this was being well led, issues articulated and any concerns escalated. AR asked if there was any protection under well led. RP advised there was an audit trail and this could be evidenced. However, she was unsure if this would be sufficient.

NJ said it would be difficult to produce such a document, as the CQC would want to reassure themselves rather than derive comfort from a document produced by the Trust. RP reported there were sufficient minutes to demonstrate stress testing of decisions taken.

AE stated that the CQC ED pre-visit had been good as those attending were detached from the department. He asked who would do this for NEESPS. NJ advised that NHS Improvement had been invited to visit the Trust and had done so this week.

6. **Any Other Business**

No further business was noted.

7. **Reflection on Meeting and Identify Any Issues for Escalation or Capture/Review on the Risk Register**

Noted challenges around partnership working with NEESPs in sharp contrast to the incredible partnership working with alliance and community integration colleagues.

8. **Date and Time of Next Meeting**

Please note the meeting will start at 14:00 in the Northgate Meeting Room, Quince House, WSFT.

Date of meeting may change, but will be confirmed by email.

Please note this meeting has been confirmed for 14 December at 2 pm, Northgate Meeting Room.

The meeting closed at 3.20 p.m.

DRAFT

21. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Richard Jones

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – 2 November 2018

Agenda item:	25			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	20 September 2018			
Subject:	Items for next meeting			
Purpose:		For information	X	For approval

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

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

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

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

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

Recommendation:

To approve the scheduled agenda items for the next meeting

Putting you first

Scheduled draft agenda items for next meeting – 30 November 2018

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient story		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Alliance and community services report, including Buurtzorg evaluation	✓		Written	Matrix	DG
Integrated quality & performance report, including: - staff recommender scores - pressure ulcer update on acute/community improvement and Alliance working (including nursing homes)	✓		Written	Matrix	HB/RP
Finance & workforce performance report	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Nurse staffing report	✓		Written	Matrix	RP
Freedom to speak up guardian	✓		Written	Matrix	JB (Nick Finch)
Quality and learning report – including quality priorities	✓		Written	Matrix	RP
Learning from death report – Q2	✓		Written	Matrix	NJ
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
WSFT Digital Board report	✓		Written	Matrix	CB
Strategic update, including Alliance, System Executive Group and System Transformation Partnership (STP)		✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Audit Committee report , including agreeing delegated authority for approval of the Charitable funds annual accounts	✓		Written	Matrix	AE
Charitable Funds Committee report	✓		Written	Matrix	GN
Scrutiny Committee report		✓	Written	Matrix	GN
Board Assurance Framework (BAF) report	✓		Written	Matrix	RJ
Annual governance review report		✓	Written	Action point	RJ
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	RQ

11:40 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. Board & Sub-committee dates & schedule for 2019/20

To NOTE the dates for information

For Reference

Presented by Sheila Childerhouse

NHS
West Suffolk
NHS Foundation Trust

TRUST BOARD MEETING DATES

2019/20

Open (Public) Session commences 9.15am – 11.15am
Closed (Private) Session commences 11.30am – 1.00pm

Friday 25 January

Friday 1 March

Friday 29 March

Friday 26 April

Friday 24 May

Friday 28 June

Friday 26 July

No meeting in August

AMM - 17 September

Friday 27 September

Friday 1 November

Friday 29 November

No meeting in December

Friday 31 January

Friday 28 February

Board meetings are normally held in the Northgate Room, Quince House, WSH,Hardwick Lane, IP33 2QZ.

Please check the website for location prior to the meeting.

24. Date of next meeting

To NOTE that the next meeting will be held on Friday, 30 November 2018 at 9:15 am in Quince House, West Suffolk Hospital.

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

25. The Trust Board is invited to adopt the following resolution:

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

Presented by Sheila Childerhouse