West Suffolk NHS
NHS Foundation Trust

Council of Governors Meeting

There will be a meeting of the **COUNCIL OF GOVERNORS** of West Suffolk NHS Foundation Trust on Thursday **10 August 2017 at 17.30** in the Education Centre, West Suffolk Hospital

Roger Quince, Chairman

Agenda

General duties/Statutory role
(a) To hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. (b) To represent the interests of the members of the corporation as a whole and the interests of the public. The Council is involved in strategic discussions, appoints the Chairman and Non-Executive Directors, external auditors and assures itself that Trust performance is at the required standard.

17.30	**GENERAL BUSINESS**	
1.	**Apologies for absence** To receive any apologies for the meeting	Roger Quince
2.	**Welcome and introductions** To welcome governors and attendees to the meeting. To note the resignation of Ian Collyer and confirm that he will not be replaced prior to the elections.	Roger Quince
3.	**Declaration of interests for items on the agenda** To receive any declarations of interest for items on the agenda	Roger Quince
4.	**Minutes of the meeting of 11 May 2017** (enclosed) To approve the minutes of the meeting held on 11 May 2017	Roger Quince
5.	**Matters arising action sheet** (enclosed) To note updates on actions not covered elsewhere on the agenda	Roger Quince
6.	**Chairman's update** (verbal) To receive an update from the Chairman, including the appointment of a Senior Independent Director	Roger Quince
7.	**Chief Executive's report** (enclosed) To note a report on operational and strategic matters	Helen Beck
8.	**Governor issues** To note the issues raised and receive any agenda items from Governors for future meetings	June Carpenter
18.00	**DELIVER FOR TODAY**	
9.	**Summary Quality & Performance Report** (enclosed) To note the summary report	Richard Davies
10.	**Summary Finance & Workforce Report** (enclosed) To note the summary report	Alan Rose

18.20	**INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP**	
11.	**Non-Executive Director Presentation** To receive a presentation from Richard Davies	Richard Davies
18.35	**BUILD A JOINED UP FUTURE**	
12.	**Pathology services** *(*enclosed*)* To receive a report setting out the governance arrangements for NEESPS	Helen Beck
13.	**e-Care update** (enclosed) To receive a report on phase 2 and progress with reporting	Helen Beck
14.	**Annual Report & Accounts 2016/17** (on Trust website or hard copy on request) To receive the Annual Report & Accounts for 2016/17 http://www.wsh.nhs.uk/CMS-Documents/Trust-Publications/Annual-reports/Annual-report-2016-17.pdf	Richard Jones
15.	**Annual Audit Letter and Quality Report limited assurance review** (enclosed) To receive the audit reports from BDO, External Auditors	Lisa Clampin, BDO
16.	**Annual external audit review** (enclosed) To receive a report and recommendation from the Audit Committee on the Trust's External Auditors BDO from the Chair of the Audit Committee	Richard Jones
19.10	**GOVERNANCE**	
17.	**Equality & Diversity Action Plan** (enclosed) To receive the updated report and action plan.	Denise Pora
18.	**Appointment of Deputy Lead Governor** (enclosed) To appoint a deputy Lead Governor	Richard Jones
19.	**Lead Governor report** (enclosed) To receive a report from the Lead Governor.	June Carpenter
20.	**Staff Governor report** (enclosed) To receive a report from a Staff Governor	Nick Finch
19.30	**ITEMS FOR INFORMATION**	
21.	**Dates for meetings for 2018** To note the meetings dates for 2018 Wednesday 21 February Thursday 17 May Thursday 9 August Wednesday 14 November Annual Members Meeting Tuesday 11 September 2018 - tbc	Roger Quince
22.	**Reflections on meeting** To consider whether the right balance has been achieved in terms of information received and questions for assurance versus operational delivery	Roger Quince
23.	**Dates of meetings for 2017** Thursday 16 November Tuesday 12 September– Annual Members Meeting (Apex, Bury St Edmunds)	Roger Quince
19.35	**CLOSE**	

West Suffolk NHS
NHS Foundation Trust

REPORT TO:	Council of Governors
MEETING DATE:	10 August 2017
SUBJECT:	Draft Minutes of the Council of Governors Meeting held on 11 May 2017
AGENDA ITEM:	4
PRESENTED BY:	Roger Quince, Chair
FOR:	Approval

West Suffolk NHS
NHS Foundation Trust

DRAFT

MINUTES OF THE COUNCIL OF GOVERNORS' MEETING
HELD ON THURSDAY 11 MAY 2017 AT 17.30
IN THE EDUCATION CENTRE AT WEST SUFFOLK NHS FOUNDATION TRUST

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Roger Quince	Chairman	•	
Mary Allan	Public Governor	•	
June Carpenter	Public Governor	•	
Jane Chilvers	Staff Governor	•	
Ian Collyer	Public Governor		•
Justine Corney	Public Governor	•	
Judy Cory	Partner Governor	•	
Nick Finch	Staff Governor	•	
David Frape	Public Governor	•	
Jayne Gilbert	Public Governor	•	
Mark Gurnell	Partner Governor	•	
Peter Harris	Public Governor		
Beccy Hopfensperger	Partner Governor	**N/A**	
Jenny McCaughan	Staff Governor		•
Sara Mildmay-White	Partner Governor	•	
Laraine Moody	Partner Governor	•	
Barry Moult	Public Governor	•	
Janice Osborne	Public Governor	•	
Joe Pajak	Public Governor	•	
Lindsay Pike	Staff Governor	•	
Margaret Rutter	Public Governor		•
Mick Smith	Public Governor	•	
Liz Steele	Public Governor	•	
Stuart Woodhead	Public Governor	•	
In attendance			
Richard Davies	Non Executive Director		
Georgina Holmes	FT Office Manager *(minutes)*		
Neville Hounsome	Non Executive Director		
Richard Jones	Trust Secretary & Head of Governance		
Gary Norgate	Non Executive Director		
Alan Rose	Non Executive Director		
Helen Jopling	Public Health Registrar – *item 11*		

Action

GENERAL BUSINESS

17/23 APOLOGIES

Apologies for absence were noted as above.

Richard Jones explained that although Rebecca Hopfensperger had been re-elected on 4 May, she had not yet been re-appointed as the Governor representative for the County Council. Therefore her absence at this meeting would not count as a non-attendance.

17/24 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting and introduced Richard Davies, the new Non Executive for Cambridge University and Alan Rose, who had replaced Rosie Varley.

17/25 DECLARATIONS OF INTEREST

There were no declarations of interest.

17/26 MINUTES OF THE COUNCIL OF GOVERNORS MEETING HELD ON 8 FEBRUARY 2017

The minutes of the meeting held on 8 February 2017 were approved as a true and accurate record subject to the following amendment:-

Page 3, item 17/08 6 (typo), Moreton Hall.

17/27 MATTERS ARISING ACTION SHEET

There were no ongoing actions. The completed action, Item 144, was noted, ie provide an update on reporting by e-Care to a future meeting.

Neville Hounsome reported that a discussion had taken place on TPP and the MHRA audit at the closed session of this meeting and there were some concerns from Governors about this.

17/28 CHAIRMAN'S UPDATE

The Chairman said that he was proud to report that the Trust's Chief Operating Officer, Jon Green, had left to become Chief Executive of Queen Elizabeth Hospital, Kings Lynn. Helen Beck had therefore been appointed as Interim Chief Operating Officer for six months, prior to an open competitive process for a substantive Chief Operating Officer. This interim appointment would help with continuity.

The Trust's provisional financial position at the end of the year was a deficit of £5.1m, which meant that the control total had been achieved. As a result WSFT was awarded additional money, which improved the year-end result to a deficit of £3.4m.

It was confirmed that TPP losses were not included in this figure and did not count towards the control total.

Last week Simon Stevens, his executive team and regional directors had visited WSFT. This had begun with a discussion about STP, which was followed by an executive meeting. A question and answer session with staff then followed lunch. It was considered to have been a very positive day and the NHS executive team had said that it had been a pleasure to visit a Trust where people were not complaining. This reflected the results of the staff survey which showed WSFT as the top Trust in England.

Neville Hounsome reported that he had attended the Shining Lights event earlier today, where there had been 220 nominations. This was an example of people taking pride in what they did.

Alan Rose asked if there was a Council of Governors nomination for a Shining Lights award. It was confirmed that this was not the case but agreed that this was a good idea and would be followed up. **R Jones**

It was reported that at the closed session of this meeting, the Council of Governors had supported Alan Rose's nomination as the Trust's Senior Independent Director.

17/29 CHIEF EXECUTIVE'S REPORT

June Carpenter asked about patients waiting for over 52 weeks and if this was being addressed.

The Chairman explained that this was well on the way to being addressed, although ENT remained a challenge.

Richard Jones explained that the list of patients who had waited over 52 weeks was being tested and validated. The patient tracking list (PTL) validation had identified an error in the way in which patient waiting had been counted. Until this process had been completed it could not be confirmed when this would be resolved. Validation was being prioritised in ENT.

Joe Pajak referred to oral surgery and said that he was concerned that current patients were not being given the correct message. They were being told that it was not known what was happening; therefore they could not make an appointment for completion of their treatment. It was confirmed that this would be followed up with Helen Beck. **R Jones**

Liz Steele referred to Red2Green board rounds and asked where the social worker who took part in these was based, ie in the hospital. It was confirmed that this was the case.

June Carpenter asked if e-Care Ordercomms was still going live this month. The Chairman confirmed that this was currently the plan. Gary Norgate explained that vigorous testing was ongoing and it was intended to proceed with this unless a defect was identified during testing.

17/30 GOVERNOR ISSUES

There were no issues.

DELIVER FOR TODAY

17/31 SUMMARY QUALITY & PERFORMANCE REPORT

Neville Hounsome reported that there was a varied picture, with some areas of improvement and some ongoing concerns. There had been a better performance in terms of A&E as a result of Red2Green, the Flow action group and Glastonbury Court. Although the Trust had not achieved the national target, progress in this area was encouraging had enabled G9 to close earlier than anticipated.

Referral to treatment (RTT) was still work in progress and data was being validated.

Work on reducing the number of pressure ulcers had resulted in an improvement but falls and noise at night were ongoing issues.

The biggest issue was the MHRA audit on the TPP laboratory. This had identified a number of record keeping issues which could cause potential harm to patients but there was no evidence that this was the case. This meant that MHRA could issue a ‘case and desist’ notice which would have a dramatic effect on WSFT’s ability to remain operational.

The Trust had been open and transparent about actions being taken to address the issues. However, it was very disappointing that when MHRA came back in March they found that actions that the management of TPP had said had been completed had not been. WSFT accepted that it should have been more robust in the management of this situation and had now recruited someone to assist with this.

Stuart Woodhead asked if a further visit from MHRA was expected and how confident the Trust was that an improvement would be shown.

Neville Hounsome confirmed that a further visit would take place and the Trust was now confident that it was aware of the areas that had not yet been addressed.

Stuart Woodhead was very concerned at how serious the situation had become, considering that in February the Trust knew that TPP was a serious issue but six weeks later the situation was far from ideal and there was the threat of a 'cease and desist' order.

The Chairman explained that this was a TPP issue and they had originally told the Trust that they were addressing it. In February the Trust was only peripherally involved. However, when WSFT became aware that TPP had not taken the actions they said they had, the Trust stepped in to manage the situation. He explained that it would be more of a risk to close the hospital than to allow it to remain open.

Joe Pajak said that this should be a learning curve. Alan Rose agreed that this could be learned from with the new structure of TPP to ensure greater management and tighter governance of its operations.

Gary Norgate also agreed that there were a number of lessons to be learned and that WSFT had put too much trust in what it was being told by TPP.

Stuart Woodhead requested that at the next CoG meeting there should be an update report on the new TPP structure and assurance that the same situation would not occur. This would help to provide some confidence to Governors that this was being managed in a more effective way. **R Jones**

Alan Rose stressed that this situation would not be resolved immediately as there were still losses to bear from the previous structure.

Judy Cory said that she was very pleased to see that the forms for chaperoning had been changed. However, she expressed concern about locum consultants and doctors and their training on e-Care, which meant that letters with results were being delayed. The Chairman confirmed that locums received e-Care training and asked Judy Cory to speak to PALs or make a formal complaint about the issue she was referring to.

Barry Moult noted that there was no information on sepsis in this report and asked if there any issues relating to this. The Chairman explained that as far as he was aware there were no issues. Richard Jones said that he would confirm this. **R Jones**

Mick Smith referred to the table on page 5 and suggested that there was an error, as 85.91% should not be green. Richard Jones agreed that this should not be showing as green.

17/32 SUMMARY FINANCE & WORKFORCE REPORT

Gary Norgate reported that income was slightly better than planned in March due to phasing. Pay costs were also better than planned, which resulted in a monthly surplus which was also ahead of forecast. WSFT therefore finished the year with a loss of £10.5m which was better than the agreed control. As a result £6.3m of sustainability and transformation funding was released, which reduced this to a £4.3m loss. This then resulted in additional funding of £900k, giving a final deficit figure of £3.4m.

However, he stressed that WSFT had not achieved its stretch cost improvement plan (CIP) and had achieved its final position through non-recurrent adjustments.

The TPP impairment referred to investments made in TPP which had been re-valued and were effectively a write-off. This would not affect the control total.

A new way of looking a financial performance had been introduced, ie use of resources rated 1-4; 1 being good and 4 being poor. WSFT had a rating of 3 and was held back by two measures, liquidity and capital services capability. However it scored better for financial efficiency and use of agency, which had improved significantly.

Next year would be a major challenge with a CIP of £13.3m required to achieve the control total. Plans to achieve this were in place but the Trust would not compromise on quality. It was also getting support from KPMG and would need to contain demand and continue with initiatives such as Red2Green.

Stuart Woodhead noted that savings next year were very challenging. He suggested that it might be better to set a more achievable target, and asked if WSFT had committed to these savings which could be unrealistic. Gary Norgate explained that targets were held by the divisions and these plans had been developed by those who would be delivering them.

Joe Pajak referred to the I&E headlines for 2016/17 and noted that there was a difference with the table. It was explained that the table was produced before the additional funding was received.

Jan Osborne suggested that sustainability and transformation funding should be used to deliver prevention methods rather than balancing the books. Gary Norgate explained that the organisation had to balance income to enable it to deliver services and this money had been spent in order to do this.

June Carpenter asked about CIPs and how these plans would be met. Gary Norgate explained that there were detailed CIPs that were seen and reviewed by the Board.

Mary Allan asked about agency staff and if this was progressing, as she noted that this was still not green. Neville Hounsome explained that WSFT was employing considerably fewer agency nurses than other organisations. This had been achieved by retaining and recruiting substantive staff. The plan was to continue to recruit more substantive staff and this was being focussed on by the executive team.

Justine Cory asked about wards G6 and G7 and if people working in these areas would be re-located. It was confirmed that this would be the case.

Barry Moult asked about the Global Digital Exemplar (GDE) funding and the Trust was confident that this would be awarded. It was explained that it had been confirmed that this had been signed off by the Secretary of State and should be received eventually.

The Chairman explained that KPMG's support was being funding by NHSI, not WSFT.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

17/33 QUALITY PRESENTATION – AGEING WELL

The Chairman introduced Dr Helena Jopling, Public Health Registrar, who was working with WSFT until December and leading on work in encouraging healthy living.

Helena Jopling explained that on the whole West Suffolk was ageing well and she would be talking about the advice she would be giving on how older people could continue to age well.

This related to a number of factors, including individual lifestyle; social and community networks; and general socio-economic, cultural and environment conditions, which included living and working conditions. Her presentation included a number of short video clips that illustrated ways in which people benefited from remaining active both socially and mentally.

The benefits of giving up smoking could be seen very quickly, with improvement in circulation and lung function within three months and the risk of coronary heart disease being halved after a year. The benefits continued up to 15 years when the risk of coronary heart disease would be the same as a non-smoker. The low risk alcohol guidelines and Eatwell Guide were also highlighted, together with the benefits of exercise.

The importance of social contact was explained, with ten top tips to help people feel less lonely. These included groups and activities that people could become involved in, eg volunteering for organisations such as Community Action Suffolk or the Suffolk Wildlife Trust and taking part in health walks.

Housing and living conditions were also very important and people needed to be aware of home assistance grants and ways in which they could ensure that their house was kept warm, dry and safe.

The Chairman thanked Helena for a very interesting and informative presentation.

`17/34 NON-EXECUTIVE DIRECTOR PRESENTATION

Alan Rose explained that this would be a short presentation on his background and experience.

He spent a number years working in the private sector, before being treated for cancer and moving to Yorkshire. He then set up his own landscape gardening business and became a NED and then Chairman of York hospital. Following the end of his term at York hospital he became Chairman of Colchester hospital, supporting an initiative to form a partnership with Ipswich hospital. The result of this was a decision that the Board should be run from Ipswich hospital and as he stepped down as Chairman.

In 2016 he joined the Board of Governors at Anglia Ruskin University.

He explained that he wanted to join the Board of WSFT as he was keen to support its focus on quality and engagement and collaboration with the local health system.

As a Non-Executive Director he would bring an independent view and he had considerable and varying experience of working with NHS Trusts and Governors over the last ten years

He was patient-focused and particularly interested in support organisations, volunteers, friends and others who provided care in a variety of different ways.

He explained that he was the NED lead on the Patient Experience Committee and outlined his role as Senior Independent Director.

The Chairman thanked Alan and said that he would be valuable in giving guidance to the new Chair when he or she was appointed.

BUILD A JOINED UP FUTURE

Covered elsewhere on agenda

GOVERNANCE

17/35 ANNUAL QUALITY REPORT

The commentary from the Governors for inclusion in the quality report was approved.

Richard Jones thanked June Carpenter, Liz Steele and Stuart Woodhead for their assistance in the preparation of this.

17/36 CHAIRMAN AND NED APPRAISALS

It was noted that the new NEDs, Richard Davies and Alan Rose, would not be included in this process. However, the Chairman's appraisal would be undertaken as usual, as his term of office did not end until 31 December 2017.

Jayne Gilbert, Liz Steele, Justine Corney, June Carpenter, Jane Chilvers, Barry Moult and Stuart Woodhead volunteered to participate in this process.

17/37 APPOINTMENT OF DEPUTY LEAD GOVERNOR

Richard Jones referred to the recent amendment to the Constitution which made provision for a deputy Lead Governor role. He stressed that this would not be a shadow role, but only to deputise if the Lead Governor was not available for a period of time.

The role specification of the Lead Governor was attached to this report and the process for nominations would take place prior to the next CoG meeting in August, when a deputy Lead Governor would be elected.

It was noted that one of the responsibilities of the Lead Governor was to take part in the annual appraisal meeting of the Chairman, in conjunction with the Senior Independent Director. It was agreed that the role specification should be amended to reflect this. **R Jones**

The Council of Governors approved the process for the appointment of a deputy Lead Governor.

17/38 ENGAGEMENT COMMITTEE

Jan Osborne stressed that this committee was key in delivering the Trust's engagement strategy. A work plan was attached to this report and more members of the committee were required to assist in the delivery of this. The work of this committee had also helped to establish links between the Governor role and patient experience work.

Liz Steele volunteered to become a member of this committee.

The Chairman asked other Governors to consider becoming members of this committee and let Georgina Holmes know if they were interested.

17/39 LEAD GOVERNOR REPORT

June Carpenter reported that there had been a very good training and development session for Governors since the last meeting. She encouraged Governors to try to attend these in the future.

Visits to the pharmacy department and new physiotherapy practice had also been arranged for Governors, and these had been very interesting and informative. Again she encouraged Governors to attend these where possible.

ITEMS FOR INFORMATION

17/40 REFLECTIONS ON MEETING

Judy Cory was very pleased that Alan Rose was interested in the volunteers. She reported that the Friends of West Suffolk Hospital had recently given nearly £28k to purchase equipment for various areas across the organisation. She encouraged Governors to become Friends.

June Carpenter said that it had been very useful to have had a presentation at this meeting. The Chairman agreed that the presentation had been very good and was central to what WSFT was trying to achieve.

Jan Osborne reflected on Alan Rose's comments about the importance of working with the community and other organisations across the region, eg STP. She stressed the importance of the availability of the right type of housing in the right place for the right people.

17/41 DATES OF COUNCIL OF GOVERNORS MEETING FOR 2017

Thursday 10 August 2017
Tuesday 12 September 2017 - Annual Members Meeting
Thursday 16 November 2017

West Suffolk NHS
NHS Foundation Trust

REPORT TO:	Council of Governors
MEETING DATE:	10 August 2017
SUBJECT:	Matters Arising Action Sheet from Council of Governors Meeting of 11 May 2017
AGENDA ITEM:	5
PRESENTED BY:	Roger Quince, Chair
FOR:	Information

The attached details action agreed at previous Council of Governor 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.

Ongoing action points
No outstanding actions.

Completed action points

Ref.	Date of Meeting	Item	Action	Action taken	**Action By**	Completion date
145	11 May 2017	17/28	Follow up proposal that there should be a Council of Governors nomination for a Shining Lights award	Email sent to Jan Bloomfield with proposal and response received that this would be implemented for next year.	R Jones	5 June 17
146	11 May 2017	17/29	Follow up concerns that oral surgery patients were being given incorrect information about continuity of treatment.	Update provided in CEO report	G Holmes	10 August 17
147	11 May 2017	17/31	Update on the new TPP structure to provide assurance that the same situation would not occur and help to provide some confidence to Governors that this is being managed in a more effective way.	Agenda item	R Jones	10 August 17
148	11 May 2017	17/31	Confirm that there have been no issues relating to sepsis over the past three months (no information provided in Performance & Quality summary report)	Update provided in summary quality report	R Jones	10 August 17
149	11 May 2107	17/37	Amend Lead Governor role specification to reflect that one of responsibilities was to take part in the annual appraisal meeting of the Chairman, in conjunction with the Senior Independent Director.	Added additional responsibility to role: 5. With the Senior Independent Director to take part in the Chair's annual appraisal meeting.	R Jones	10 August 17

West Suffolk NHS
NHS Foundation Trust

Council of Governors – 10 August 2017

AGENDA ITEM:	7
PRESENTED BY:	Helen Beck, Interim Executive Chief Operating Officer
PREPARED BY:	Steve Dunn, Chief Executive Officer
DATE PREPARED:	21 July 2017
SUBJECT:	Chief Executive's Report
PURPOSE:	Information

I have been saddened in the last few months to reflect on acts of terrorism in our country. The shocking attacks in Manchester and London were reminders of the responsibility we have to care for our community, and the challenges the NHS faces, when major incidents occur. I am proud to be part of the NHS, the fast and effective response to those affected was exemplary. The UK threat level remains at severe, and we are on standby to support any major incident should we be called upon.

The Grenfell Tower fire has been a further shocking event which has shaken all of us and my deepest sympathy goes to all of those affected. We are responding with Suffolk Fire and Rescue Service as part of a nationally assessment of fire prevention and risk assessment.

I am conscious of the Governors' role in contributing to strategic decisions of the organisation and in doing this representing the interests of our Members as a whole and the interests of the public. Within this report I have reflected some of the key messages from my report to the Board of Directors but framed to highlight some of the key strategic issues and challenges that the organisation is addressing. I was conscious in preparing this report that some of the information feels relatively 'old news' but I wanted to ensure that you receive a full briefing on what has been a very busy few months since your last meeting. A key challenge in the coming weeks is to maintain the momentum for the transition of community services in the west of Suffolk ahead of the 1 October contract.

Despite soaring patient numbers and one of the busiest days that the emergency department has ever recorded, the Trust has exceeded the national 95% **four-hour A&E standard** for the first quarter of this year. In the April to June quarter the emergency department saw 17,471 patients, with 95.12% being seen within four hours and exceeding the national emergency access standard (95%). This is despite an increase of 3,476 patients compared to the same period in 2016. I am exceptionally proud of our whole hospital team for this fantastic achievement. It is not just our emergency team who contribute, but the coordination of everyone from across the hospital helps to make this happen. For the same period in 2016 we were achieving 85.9% at this stage of the year, which shows the incredible commitment to quality care and the drive of our staff to deliver the very best for patients under sustained pressure.

During July the **Emergency Care Intensive Support Team** visited our emergency department (ED). The formal report from the visit is pending but feedback from the day was positive about the performance being delivered within the limits of the ED physical environment. To improve patient experience, help us better manage the flow of patients and address some of the issues raised with ECIST we are embarking on a redesign of our ED. Initial development work started on 14 July, with the hope that it will be fully completed by the end of October.

June's **performance** pack shows that we have maintained operational performance for emergency flow reflecting the focus on red2green – achieving 95.53% for Q1. 18 week referral to treatment (RTT) performance in June is 83.36% for patients on an incomplete pathway against a standard of 92%. Whilst this is still below the standard of 92% it is a significant improvement from the previously reported May position of 79.71%. I regret that this month we have reported 15 patients breaching 52 weeks. The majority of these are within ENT reflecting the significant capacity issues within this specialty, with patient choice being a significant factor in the remaining breaches. We did not achieve the 62 day cancer standard with a performance of 84.76% against a standard of 85% but recovered our previous performance for the two week wait standard with a performance of 96.59% against a standard of 93%.

I understand the concerns raised regarding the closure of our **orthodontics and oral surgery** service. This is not a decision that we have taken lightly; growing demand for these services, which were being run two-days-a-week, was resulting in patients waiting longer than we would like for treatment. This, combined with the need to replace significant amounts of equipment, meant that we weren't providing the quality of service that we or our patients expect. All oral surgery patients were offered dates for treatment, those unable to accept these dates will be referred to the new provider which NHS England has now announced is Blue Sky Dental in Newmarket. Orthodontics patients are expected to be transferred to a new provider imminently. We will be communicating with all orthodontics patients in the next few weeks, via a joint letter from ourselves, NHS England and the new provider.

In May we were visited by the **intensive support team (IST)** regarding RTT procedures. In summary the IST found that the Trust has an effective understanding of the data quality issues and there is clear evidence of a well-considered and logical approach to data quality. They also identified that the trust was able to articulate a clear and appropriate onward plan for improving data quality. There are areas for improvement and the report is considered in more detail within the Quality & Performance report.

We are continuing to work with our digital partner, Cerner, to implement a medium term solution for identified inaccuracies around information contained within some **discharge summary letters** issued to GPs. At the point the issue was identified we immediately implemented a manual process to ensure the correct information was being sent to GPs. A medium term solution is being implemented to allow us to further improve the information sent to GPs in the coming weeks.

On Friday 5 May, our pathology service transferred from the Pathology Partnership (tPP) to **North East Essex and Suffolk Pathology Services (NEESPS)**. This is a partnership of Ipswich, Colchester and West Suffolk hospitals and our vision is to deliver innovative high-performing pathology services that are clinically-led and responsive to the needs of our patients. It is business as usual in our laboratories, however staff in this service are transferring to Colchester Hospital University NHS Foundation Trust (CHUFT) as their new employer. Colchester is the host of the new service, which is designed to deliver the benefits of scale of three hospitals working together while being close enough to clinical services and patients to provide an excellent service to our customers. My thanks, as ever, to all of you who work in this service or support it, for your patience and ongoing hard work as we go through this change.

The **Medicine Healthcare Regulatory Authority** (MHRA) visited the Trust during June. The inspector recognised improvements made but we remain non-compliant. The visit included new areas of assessment and identified two major concerns (staffing and fridge validation) and four other areas for improvement. Based on the improvements seen the inspector recommended moving from weekly to monthly monitoring updates.

The **month 3 financial position** reports a deficit of £809k for June which is worse than plan by £74k.The reported cumulative position is therefore £6k better than plan. The 2017-18 budgets include a CIP of £13.3m of which £2,664k has been achieved by the end of June (20%). Delivering the control total will ensure the Trust receives Sustainability and Transformation Funding (S&TF) of £5.2m, resulting in a year end net deficit of £5.9m. We continue to work with KPMG through the financial improvement programme (FIP) for 2017/18 and beyond. The primary focus is to ensure that robust CIPs are in place to deliver the control total for 2017/18 and a CIP pipeline is available to deliver financial sustainability going forward.

The Future Operating Model (FOM) for the NHS Supply Chain is organised into eleven '**Category Towers**', covering medical, capital and non-medical areas of the procurement spend. In collaboration with three NHS providers who also host procurement hubs we submitted six bids for the Medical Category Towers on 12 May 2017. The bids are currently being evaluated by the Department of Health. The outcome of the bids will be known on 14 August 2017 with a maximum award of three Category Towers to any single provider. The WSFT procurement hub is engaging with the other partners to provide in-depth analysis about specific opportunities and risks. Gary Norgate and Steve Turpie are working with the hub staff to provide an effective challenge to the assessment and decision making. Craig Black is the lead executive director. Following notification of success at the award stage, a process of due diligence will be undertaken and a report prepared for each host trust's board outlining the contract, risks and obligations. This report would be available for the WSFT Board meeting scheduled for 29 September 2017.

We went live with **OrderComms** on 3 June 2017, a slight delay from the original go live date. Overall the technical implementation has been very successful with minimal issues identified. We continue to support users in understanding and adhering to the new workflows with floorwalker support continuing until 30 June. This includes supporting juniors and consultants with the new endorsing workflows. Sepsis/Acute Kidney Injury (AKI) live reporting was launched on Monday 19 June and has been a success to date. These changes will allow us to start to delivery patient safety improvements through our benefits realisation plans.

Thankfully Trust was not affected by the **ransomware cyber-attack** which took hold of the NHS in May. All our clinical patient services were running as normal. As a precautionary measure we temporarily shut down some systems and put restrictions in place for some email traffic. Our IT team have been phenomenal since the attack took place. They pulled out all the stops and worked solidly over the weekend, to ensure our systems continue to be protected. This included installing security updates to over 2,500 PCs and all servers. They deserve a huge thank you for all their efforts.

We have an exciting new project for **West Suffolk Hospital volunteer service - Helpforce!** We are extremely excited to be one of five hospitals in the country to pilot this new initiative. HelpForce will provide the NHS with additional support through greater use of volunteers, volunteer led initiatives and the voluntary sector—integrated with health and social care systems and staff. With Helpforce we will look to:

- support our discharge and early intervention teams by creating new volunteer roles to help patients' discharge home and intervention regarding unnecessary admission to hospital.
- push the boundaries to create new roles to fit volunteers and to develop existing roles too
- support our patients at home and coordinate signposting on for further help.
- promote physical and mental health and wellbeing in volunteers and their value.

We look forward to working in partnership with our community to achieve these aims.

In July I attended Suffolk Health & Wellbeing Board and presented our health and wellbeing strategy - **Protecting and improving your health and wellbeing, together**. In our five year strategy this makes a clear and substantial commitment to make the prevention of ill health a core part of everything we do. As part of this work the Trust Executive Group (TEG) this month supported a proposal to invest in on-going coordination of staff health and wellbeing initiatives and line manager training for mental wellbeing.

NSHI started publishing monthly data on the numbers of **patient safety incidents reported** to the NRLS in the last 12 months by each NHS trust and foundation trust in England. The data is broken down by month reported and degree of harm, and is refreshed and updated on a monthly basis. The publication provides timely organisational data on reporting to the NRLS, promotes data transparency, encourages more consistency in NRLS reporting patterns, and supports organisations to monitor potential under-reporting of incidents. We will use this data in future Board reports to monitor performance regarding incident reporting.

The Trust has hosted the latest of its **leadership events**, this month opening the session to wider system leaders to support the establishment of the West Suffolk integrated care system. Bringing

together our own leaders, as well as representatives from our clinical commissioning groups (CCGs) and GPs. The day focused on digital advancements in the NHS, with a number of expert guest speakers from across the country and was a real success allowing leaders from across the system to share ideas and break down barriers to joint working.

I am delighted that our endoscopy unit has been **accredited by the joint advisory group** for GI endoscopy (JAG). The JAG assessment ensure the quality of patient care in endoscopy through the accreditation of services by defining and maintaining the standards by which endoscopy is practised, and is hosted by the Royal College of Physicians.

It was a pleasure to host NHS England's **NHS England's executive group meeting**. I was able to tell them about all the great work and high quality services our amazing staff deliver, and some of you were part of a lively debate, which covered many topics. I also showed Simon Stevens around the hospital, where he viewed our wonderful dementia friendly memory walk, and learned about our e-Care system and how it underpins our ambition to further improve our quality. Trust staff also participated in a Q&A with NHS England executives Simon Stevens, chief executive, Jane Cummings, chief nurse and Professor Sir Bruce Keogh, medical director.

Finally I am delighted that we have been named as one of the country's top hospitals once more. This is a direct result of our fantastic clinical outcomes and patient care. The accolade is a testament to the consistent hard work and dedication of our staff over the years, who are committed to making sure all of our patients have the best experience they can when using the hospital. Received for the third year running, the award recognises the safe, effective and high quality care we provide. The hospital was one of 40 from across the country to receive the accolade from independent healthcare intelligence company Caspe Healthcare Knowledge Systems (CHKS) during its top hospitals 2017 awards ceremony in London on Wednesday 10 May. The CHKS top hospitals award recognises and rewards the best performing client trusts across the UK, following the evaluation of over 22 key performance indicators covering safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. The indicators are revised annually to take into account any newly-available performance information.

Chief Executive blog
http://staff.wsha.local/Blog/Tacklingviolencetowardsstaff.aspx

DELIVER FOR TODAY

Exceptional stroke care being delivered in Suffolk
The radical turnaround of stroke services across east and west Suffolk has been recognised with a national award. Earlier this month, NHS Ipswich and East Suffolk and NHS West Suffolk clinical commissioning groups (the CCGs) scooped the Healthcare Transformation Award for Innovation in Improving Outcomes and Reducing Variation. Dr Anne Nicolson, stroke services lead at West Suffolk NHS Foundation Trust and Suffolk stroke services, said: "This collaboration continues to improve stroke care for all patients and carers in Suffolk. Working closely with the CCGs and Ipswich Hospital, seven-day-a-week working has become normal practice in the acute hospitals for multiple disciplines including physiotherapy, occupational therapy and stroke medicine. The early supported discharge service has also been embedded to provide ongoing stroke therapy at home for patients after discharge." Suffolk now has the lowest level of premature stroke mortality compared to similar areas in the country. Please see the Public Health England Healthier Lives website for more information.

New cardiology lab
The Trust's planning application for a new single-storey cardiac catheterisation and pacing suite continues. Dr Pegah Salahshouri, lead consultant cardiologist at the West Suffolk NHS Foundation Trust, explained: "The proposed build will allow cardiology services to be developed at the Trust, allowing more complex procedures to take place. For example, we will be able to fit pacemakers and expand the current coronary catheterisation. Patients who currently have to be transferred elsewhere for these procedures will be able to have all of their care here at West Suffolk."

New mothers mental health clinic
A new perinatal service is being launched this summer to treat pregnant women and new mothers suffering from mental health problems, with patients able to get appointments at West Suffolk NHS Foundation Trust and Ipswich Hospital NHS Trust. The clinic has been created by Norfolk and Suffolk NHS Foundation Trust (NSFT), with funding from West Suffolk and Ipswich and East Suffolk NHS Clinical Commissioning Groups (CCG). The NSFT team will work closely with midwifery staff at both trusts, as well as health visitors and social services, in order to provide women with joined-up care when they are at their most vulnerable. The service will offer around 750 appointments each year.

Digital Dave
The Trust supported Dementia Awareness Week including the latest dementia friendly initiative, Dave, a state-of-the-art digital reminiscence therapy system. Dave helps patients with dementia and elderly inpatients to have a more comfortable stay by providing access to archives of historic photos, music, games and even by allowing patients to take their own photos.

Community hospital opens new look café
Visitors to Newmarket Community Hospital found its popular restaurant had had a makeover in May. The White Lodge Café re-opened on 3 May with new décor and furniture including comfortable sofas and armchairs. The café offers light meals and snacks from breakfast to afternoon tea, including daily specials, fresh salads, and homemade soup. New to the menu is freshly-brewed coffee, a greater variety of hot and cold drinks, 'grab and go' meals, and other sweet and savoury items. Improvements to the café, which is open Monday to Friday, 8.00am - 4.00pm, have been made by the Suffolk community facilities team and their colleagues, and will benefit staff, patients and visitors using this important community hub.

Artist donates mural
The day surgery unit has been transformed with an aquatic mural splashed across windows and walls. Donated by local born artist Amanda Turner, the bright scene is a welcome distraction for patients who come to the unit for treatment. The digital piece of art spans six internal windows and is printed on transparent film, so that it acts like a stained glass window, with the natural light shining through and changing the effects throughout the day.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

'I am proud to work here' – staff praise hospital in latest survey
Staff have heaped praise on the Trust in the latest Staff Friends and Family Test survey, with more than 95% saying they would recommend it as a place to receive care or treatment. More than 870 people across the Trust responded to the questionnaire, which asked colleagues to think about their experience of the hospital from April to June this year (Q1). Staff reported that the Trust was a "high standard hospital", saying that "staff go the extra mile to care for their patients", and that WSFT is "a caring, professional organisation with patient care its top priority". One colleague simply put: "I am proud to work here." The Staff Friends and Family Test is a national initiative introduced by NHS England to help improve patient experience.

'Every Heart Matters' appeal
A £500,000 appeal has been launched to support the build of a brand new cardiac centre. The My WiSH Charity's 'Every Heart Matters' appeal was officially launched yesterday (24 July) by renowned Newmarket jockey Frankie Dettori, in front of hospital staff, charity members and patients. The hospital's cardiology department has seen a significant increase in patient demand over the last five years, and is now on a mission to transform and improve the care patients with heart conditions receive. We are investing £5.2m in developing a state of the art cardiac suite that will provide quicker access to more treatments, but the £500,000 My WiSH is hoping to raise will lead to the whole unit, which is currently fragmented on different floors, being brought together in one purpose-built centre. With the cardiac suite allowing procedures like angiography and pacemakers to be fitted on site for the first time ever, the appeal funds will mean that diagnostic tests such as heart scans, treadmill testing and cardiac rhythm monitoring can also be done in the same place – rather than two floors above in the current unit.

High visibility for infection prevention and control team
Hospital acquired infections are a huge risk to patients' recovery. To raise the profile of the infection prevention and control team, they are now wearing bright red uniforms, so they are more visible than ever for staff and visitors. Anne How, infection prevention control lead, said: "The team are delighted with the new uniforms, and we take a lot of pride in supporting our patients and the clinical teams across our hospitals. By being more visible in clinical areas we hope people will take the opportunity to stop and ask us what we can do to help. We've already seen an increase of questions from staff, so the uniforms are a definite success! This will also help us control an area in times of an outbreak, as it will be clear who we are and where we are for both staff and patients."

Record-breaking volunteers
This year over 400 volunteers were celebrated at the annual volunteers' tea party, with a record-breaking total of 47,358 hours of time given to the hospital last year. 49 long service awards were handed out by Trust chairman Roger Quince, to volunteers who, between them, have given 530 years of service, and around 30 students completed the Trust's six month student volunteer programme last year.

New freedom to speak up guardian
The Trust has appointed Nick Finch who works in the purchasing department and is also a staff governor as its freedom to speak up guardian. The appointment of a national guardian for speaking up freely and safely, and freedom to speak up guardians in NHS trusts were recommended by Sir Robert Francis, following his review and subsequent report into the failings in Mid Staffordshire.

Quince House – next set of tenants
All executive directors, their 'direct report'* managers, and the Trust office administration team moved into their new offices in Quince House along with the HR and finance teams. They join the estates and facilities team who had already moved over to the new building. It's an open door building and during office hours you can enter Quince House to speak with any of the teams. With the teams moving to the new building, we will be able to create a new, and vital clinical acute assessment unit (AAU) which will have six functions:

- An acute assessment unit
- Same-day ambulatory emergency care
- Rapid assessment triage
- Short-stay clinical unit
- Surgical assessment
- Discharge area

As AAU will vacate its current location, this will also free up space which can be used for patients when work is undertaken in other wards. For example, with space to move patients around, more work can be done to the wards that need roof repairs and asbestos removal, work which will increase the lifespan of our wards by 20+ years.

Anaesthetic team shortlisted for award
The anaesthetic team at West Suffolk NHS Foundation Trust (WSFT) was shortlisted for Anaesthesia Team of the Year in the British Medical Journal (BMJ) awards 2017, an award sponsored by the Royal College of Anaesthetists (RCoA). The 9th annual BMJ awards, they recognise and celebrate the inspirational work of healthcare teams across the country. The anaesthetic team at the hospital is driving quality improvement across the Trust by introducing new ways of working. Anaesthetists now play a lead clinical role in every area where surgical patients' care is designed and managed.

International Nurses Day
Executive chief nurse Rowan Procter was interviewed on BBC Radio Suffolk's breakfast show about international nurses' day. Rowan gave a positive account of what it's like to be a modern day nurse at WSFT and highlighted what opportunities are available locally to get into nursing.

Shining Lights
The annual 'Shining Lights' staff awards were held on 11 May, celebrating the achievements of staff over the past year. With a record 220 nominations received from hospital staff and the public, the awards were given to individuals or teams who have shown particularly outstanding dedication and excellence in the care of their patients, or the initiative to drive through service improvements in the hospital or out in the community. The awards were held in a spruced up Time Out. In total 17 awards were up for grabs, including employee of the year, clinical team of the year, inspirational leadership, rising star, My WiSH Charity star and volunteer of the year.

Charge nurse Will Ferreira was crowned employee of the year following his drive of an innovative project to improve patient safety and raise awareness of ways staff can help minimise the chance of patients developing pressure ulcers. Colleagues said of Will: "Will has shown great enthusiasm when educating ward staff to recognise and care for patients with pressure ulcers. He really is someone to aspire to". The clinical team of the year went to the community diabetes nurse team, who are supporting practice nurses working in GP surgeries to provide the most up-to-date advice and treatments choices for people with diabetes. As a result of the hard work and dedication of those involved in the partnership, West Suffolk Clinical Commissioning Group has risen from 209th to 81st in the country for the support given to patients with diabetes in just two years.

BUILD A JOINED-UP FUTURE

Taking strides towards paper-free care
The Trust's Global Digital Exemplar (GDE) journey continues, as it received the first portion of funding from NHS England for digital developments. The hospital was given GDE status last year, after bidding for a share of the central £100million NHS England put forward for the initiative. Awarded to hospitals considered to be the most advanced technologically, the Trust has already begun putting its portion of the funds to good use. Dermot O'Riordan, chief clinical information officer and consultant surgeon, said: "The possibilities as a Global Digital Exemplar are vast and very exciting. Our latest development has been programming our computers with automatic alerts, calculated from a patient's symptoms, for conditions like sepsis and acute kidney injury. These conditions can be life-threatening, and these digital advancements are helping our staff detect these issues as early as possible. Further investment over time will enable us to gain more clinical information out of the system, to identify areas where we can improve the quality of patient care." Earlier this month the Trust received £3.3million of the total £10million it will get from NHS England to make the developments.

We are recruiting to our first **Buurtzorg team** to test a Dutch model of integrated health and personal care delivered by small teams of self-managed nurses working in the community. Buurtzorg, which in English means 'neighbourhood care', advocates the use of highly qualified nurses to deliver dedicated personal and health care to patients in a neighbourhood area. The nurses work in small self-managed teams to deliver holistic care, working closely alongside their formal and informal networks to allow individuals to stay in their homes and communities for as long as possible. WSFT, NHS West Suffolk Clinical Commissioning Group, Suffolk County Council and West Suffolk councils, with the support of the East of England Local Government Association, are seeking enthusiastic nurses and nursing assistants with community experience to join west Suffolk's first Buurtzorg team to test this new community model of care at home. This is a really exciting opportunity for community nursing in west Suffolk. The Buurtzorg model has the potential to help us meet our ambition to keep people healthy and living independently for longer. We know many people would prefer to remain in their own familiar environment when unwell or managing a health condition and through this model we can help coach individuals and families to maintain their health and wellbeing.

Sharing patient records pilot scheme
A pilot project in Sudbury enabling GPs and hospital clinicians to securely view each other's patient records is to be rolled out across west Suffolk. The information-sharing scheme has been road-tested by patient volunteers at a surgery in Sudbury for the past 12 months, proving so effective it will be introduced at ten other practices in the west of the county. It increases efficiency and improves healthcare by speeding up treatment times and significantly reducing the number of wasted or cancelled appointments. Dr Dermot O'Riordan, chief clinical information officer, said the

scheme would benefit patients hugely: “The scheme enables GPs and hospital clinicians to access the most up-to-date data held on an individual. This information is only used for direct patient care. If a confused patient is admitted to hospital overnight we can access their GP records to see what medication they’re on and what allergies they might have. We can also check if they have underlying chronic health problems.”

Fast follower nominated
The Trust announced that as a global digital exemplar it had nominated Milton Keynes University Hospital NHS Foundation Trust for the fast follower scheme, intended to provide evidence that the blueprinting process is suitable for the other sites across the NHS. This is another step on the ten-year digitisation programme, which begun with the e-Care go live in May 2016.

Sugary drinks ban
The Trust responded to NHS England’s sugary drinks ban at hospitals. Dr Helena Jopling, public health registrar, set out how the Trust has already implemented restrictions on the sale of sugary drinks in our retail outlets and cafes, and banned the promotion of such items across the Trust. Helena also featured on BBC Radio Suffolk’s Breakfast Show, and discussed national eat what you want day, providing a health perspective on the issue and encouraged a sensible approach to diet and nutrition.

West Suffolk NHS
NHS Foundation Trust

REPORT TO:	Council of Governors
MEETING DATE:	10 August 2017
SUBJECT:	Governor issues
AGENDA ITEM:	8
PREPARED BY:	June Carpenter, Lead Governor Richard Jones, Trust Secretary & Head of Governance
PRESENTED BY:	June Carpenter, Lead Governor
FOR:	Information

Response to feedback from June Carpenter, following informal Governors meeting on 25 July 2017.

1. **Feedback to Governors following Quality Walkabouts**
   A summary from quality walkabouts is captured as part of the visit and used to ensure learning is actioned within the area as well as thematically across the Trust. A process will be put in place from August to ensure that the summary is systematically shared with those that took part in the walkabout.

2. **Are there any trends in the complaints to the trust and what are we learning from them? Is there adequate feedback to any staff mentioned in them?**
   Due to the reduction in formal complaints there have been fewer clear themes. Subjects of concerns tend to be unrelated across different areas of the hospital. The most recent theme identified was with one of our surgical wards (F6) in early/mid quarter 1. The subject of these complaints related to poor communication with patients and relatives resulting in concerns about nursing care. The ward manager and senior matron have worked hard to address these issues through education with staff and increased visibility of the ward manager which has had a noticeable positive impact. We have not received any further complaints about this area since May.

3. **Update on the Discharge Summary problem**
   Update in the CEO report.

4. **Update on the Category Towers bid**
   Update in the CEO report.

5. **Is there any governor training scheduled or will this recommence after the elections?**
   No further training planned prior to elections. Following elections a Trust induction programme will be offered in late Jan/early Feb 2018. This will be supplemented with governor training by external lead in March/April 2018.

Recommendation:

To note issues raised and responses.

West Suffolk NHS
NHS Foundation Trust

REPORT TO:	Council of Governors
MEETING DATE:	10 August 2017
SUBJECT:	Summary quality & performance report
AGENDA ITEM:	9
PREPARED BY:	Helen Beck, Interim Chief Operating Officer Rowan Procter, Chief Nurse Richard Jones, Trust Secretary & Head of Governance
PRESENTED BY:	Richard Davies - Non-Executive Director
FOR:	Information - To update the Council of Governors on quality and operational performance

The performance for Q1 demonstrates overall **good performance achieving the key national targets** defined by NHS Improvement's (NHSI) Single Oversight Framework with the exception of some key areas. Performance shows the pressure the Trust has been under operationally; in addition we are still facing issues with e-Care and our ability to accurately report performance – this has impacted on our referral to treatment (RTT) performance. We stopped reporting estimated RTT performance in June and remain in regular contact with the CCG and NHS Improvement over our performance.

Despite high patient numbers and one of the busiest days that the emergency department has ever recorded, the Trust exceeded the national 95% **four-hour A&E standard** for Q1. In the April to June quarter the emergency department saw 17,471 patients, with 95.12% being seen within four hours.

1. Performance against local targets and measures

(a) Patient safety dashboard

Within the **patient safety dashboard** 17/36 indicators for which data was available were reported as 'green' throughout Q1, including:

- Infection prevention indicators - Central venous catheter insertion and ongoing care, Preventing surgical site infection pre-operative, ventilator associated pneumonia, urinary catheter insertion, Clostridium Difficile- prevention of spread, MRSA bacteraemias, and MRSA - admission and length of stay screens.
- Quarterly Standard principle compliance, Environment/Isolation
- Avoidable serious injuries or deaths resulting from falls and falls per 1000 bed days (total and with moderate/severe harm)
- RCA actions beyond deadline for completion
- Incident reporting and management: SIRIs reported within 2 working days
- Active risk assessments in date and Outstanding actions in date for Red / Amber entries on Datix risk register

Due to reporting limitations we remain unable to report compliance for MRSA screening. Falls per 1000 Beds days and Falls with moderate/severe harm/death per 1000 bed days which had not been previously available from e-Care have been provided as a working estimate for Jan-May17 with an aim to provide final figures for reporting from Q2 2016/17 onwards. A new VTE report has been built and is now available.

The maternity and community dashboards are also reported to the board as part of the monthly quality and performance report. This includes more than ~100 indicators cover activity, booking clinical outcomes, workforce, risk and patient experience.

The Trust continued to rate the number of **patient falls** as red. In Q1 there were 156 patient falls a reduction compared to each of the last four quarters - 187 in Q4, 194 in Q3, 178 in Q2 and 166 in Q1. When benchmarked the number of falls in April and May was below the national average of 6.63 falls per thousand bed days (Royal College of Physicians 2015) with a working estimate of 5.1 and 4.5 respectively.

The Matron Team are leading on a Trust-wide falls group to address the high number of falls, this will include ward level involvement along with the relevant specialist nurses and allied health professionals. This will promote sharing of best practice, learning from incidents and outcomes. The group is planning to commence this approach from September with quarterly meetings thereafter with agreed actions for wards to develop and implement. The Trust has taken part in the National Falls Audit and we anticipate results to be available later in the year.

The Trust saw a small increase in the number of **hospital acquired pressure ulcers (HAPU)** in Q1 (35) compared with 33 in Q4, 58 in Q3, 38 in Q2 and 51 in Q1. Although the numbers of HAPU remains high, the number deemed avoidable is significantly lower - 37% of HAPUs deemed avoidable year to date.

There has been an increase in reported grade 2 and grade 3 HAPUs in June despite the continued work of the 'React to Red' programme. It is probable this has been exacerbated by an increased demand for services and a prolonged period of high temperatures in June resulting in an increase in associated risk factors. There has been a heightened focus on ensuring patients are appropriately hydrated on admission and during their inpatient stay. Early review of the incidents indicates many of those affected by pressure damage were in the last days of life. This can be as a result of tissue failure or planned changes to the delivery of care e.g. less frequent turning. This increase of reported damage will be continued to be monitored to ensure there is not a continued upward trend.

The 'React to Red' project is currently focussing on preventing heel damage by identifying prevention champions on each ward, 'Heel Heroes'. Staff training is being delivered and there continues to be a strategy of raising awareness amongst the nursing teams, promoting the use of pressure damage prevention strategies and accurate risk assessment. The Tissue Viability team has been restructured and continues to work in conjunction with the Matrons and Ward Managers to maintain the profile of pressure ulcer prevention.

The Heads of Nursing and Matrons are also planning focussed sessions for the nursing teams on pressure ulcer prevention, falls prevention and maintaining adequate nutrition. These groups will be support joint working with Allied Health Professionals and Specialist Nurses to ensure practice is safe, current and evidence based.

Q1 performance for **sepsis screening** achieved the 90% compliance target. This is a measure of appropriate investigation for patients identified as being at risk of sepsis. Compliance with treatment with antibiotics within 60 minutes of diagnosis improved in Q1 – 75% in ED and for 87.5% inpatients*. In June sepsis alerting went live on e-Care. This means that patients at risk of sepsis are automatically flagged with the clinical teams to support timely intervention.
** April and May data only*

(b) Patient experience dashboard

Within the **patient experience dashboard** 20/26 indicators for which data was available were reported as 'green' throughout Q1.

All recommender indicators were rated as green for each month in the quarter – inpatient, outpatients, short stay, A&E, A&E children, birthing unit, F1 (parent and young person) and stroke.

We have maintained the **reduction in the number of complaints** with 30 in Q1 2017-18 compared to 41 in Q4, 42 in Q3, 74 in Q2 and 77 in Q1 in 2016-17.

Disturbance from other patients continues to be identified by patients as the most common reason for **noise at night**. Ward managers have been reminded to continue to offer ear plugs wherever possible and Senior Matrons are prioritising the replacement of soft closing bins for which the mechanism has failed.

The outpatient department continues to increase the number of patient surveys collected which show information about communication in **delays in being seen** needed to improve within colposcopy, fracture clinic and neurology. This has been fed back to the areas concerned to raise awareness and ensure outpatient staff are kept informed of delays and communicate this to patients. Twenty new patient pagers have been ordered to allow patients to leave the department where there are significant delays – these are due to be delivered at the beginning of August.

The question regarding being **offered a chaperone** has been altered for August data capture with language which is clearer and allows patients to indicate if they did not wish a chaperone to be present.

(c) Clinical effectiveness dashboard

Within the **clinical effectiveness dashboard** 5/6 indicators for which data was available were reported as 'green' for each month in Q1.

The Trust's overall reported **SHMI** (summary hospital-level mortality indicator) and **HSMR** (hospital standardised mortality ratio) for the latest reported period are both statistically below the expected levels (90.0 and 90.5 respectively).

During 2017/18, trusts will be required to collect and publish specified information on deaths. This will be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards). Changes to the Quality Accounts regulations will require that the data we publish be summarised in Quality Accounts from June 2018, including evidence of learning and action as a result of this information and an assessment of the impact of actions that a provider has taken. An important part of this work will be improving how we engage relatives of deceased patients in these reviews.

(d) Other targets and indicators

Table 1: Performance against national targets

Target or Indicator (per Risk Assessment Framework)	Target	Q1	Q4	Q1	Q2
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	81.77%*	95.2%*	96.8%*	93%*
RTT waiter over 52 weeks for incomplete pathway	0	44	-	-	-
A&E Clinical Quality - Total Time in A&E under 4 hours	95%	95.12%	91.5%	86.0%	87.3%
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	85.79%	87.0%	85.9%	90.4%
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	97.56%	94.2%	100%	97.5%
Cancer 31 day wait for second or subsequent treatment - surgery	94%	100%	100%	100%	100.0%
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	100%	99.5%	100%	100.0%
Cancer 31 day wait from diagnosis to first treatment	96%	100%	100%	100%	100.0%
Cancer 2 week (all cancers)	93%	94.2%	98.9%	91.4%	94.9%
Cancer 2 week (breast symptoms)	93%	94.5%	96.7%	85.3%	77.8%
C.Diff due to lapses in care (YTD)	16	3	9	1	3

***** Estimated data due to reporting issues

The launch of e-Care in May 2016 had an expected impact on our ability to report performance against a number of quality standards, including the **referral to treatment** (18 week) standard. During 2016/17 reporting against this standard has been based on estimates as we have been unable to accurately track activity at the patient level. We now have a functional patient tracking list (PTL) within e-Care and working with our digital partner, Cerner, we have made significant progress to improve reporting - since June we have been reporting actual rather than estimated performance.

Detailed action plans for each of the all specialties with RTT and capacity issues have been developed and further validation work of the new PTL continues in all areas. Recruitment is underway for an access manager to cover RTT, cancer and diagnostic performance standards. An initial meeting with the national Intensive Support Team (IST) has been held from which a plan is being developed to address capacity and demand analysis and also undertake a sustainability assessment addressing organisational capability.

Recommendation:

To note the summary report.

West Suffolk NHS
NHS Foundation Trust

REPORT TO:	Council of Governors
MEETING DATE:	10 August 2017
SUBJECT:	Summary Finance Report
AGENDA ITEM:	10
PREPARED BY:	Nick Macdonald, Deputy Director of Finance
PRESENTED BY:	Alan Rose - Non-Executive Director
FOR:	Information - To update the Council of Governors on Financial Performance

EXECUTIVE SUMMARY:

This report provides an overview of key issues during Q1 and highlights any specific issues where performance fell short of the target values as well as areas of improvement. The format of this report is intended to highlight the key elements of the monthly Board Report.

- The Q1 position reports a loss of £2.8m, against a planned loss of £2.8m.
- This position includes STF funding of £0.8m.We have forecast STF funding of £5.2m for the year.
- The Use of Resources Rating (UoR) is 3 YTD (1 being highest, 4 being lowest)
- The cost improvement programme has a target of £2.7m in Q1 and there is currently a shortfall of £26k against this. This target represents 20% of the full year CIP.

Key risks

- Delivering the 2017-18 Cost Improvement Programme of £13.3m
- Containing the increase in demand to that included in the plan (2.5%).
- We are in arbitration with NHSPS regarding property charges for Community Services dating back to October 2015.
- Receiving Sustainability and Transformation Funding – dependent on Financial and Operational performance
- Working across the system to minimise delays in discharge

I&E headlines for June 2017

The reported I&E for June 2017 is a deficit of £809k against a planned deficit of £735k. This results in an adverse variance of £74k (favourable variance of £6k YTD).

1. Use of Resources (UoR) Rating

Providers' financial performance is formally assessed via five "Use of Resources (UoR) Metrics. The highest score is a 1 and 4 is the lowest. Under the UoR we score a 3 cumulatively to June 2017.

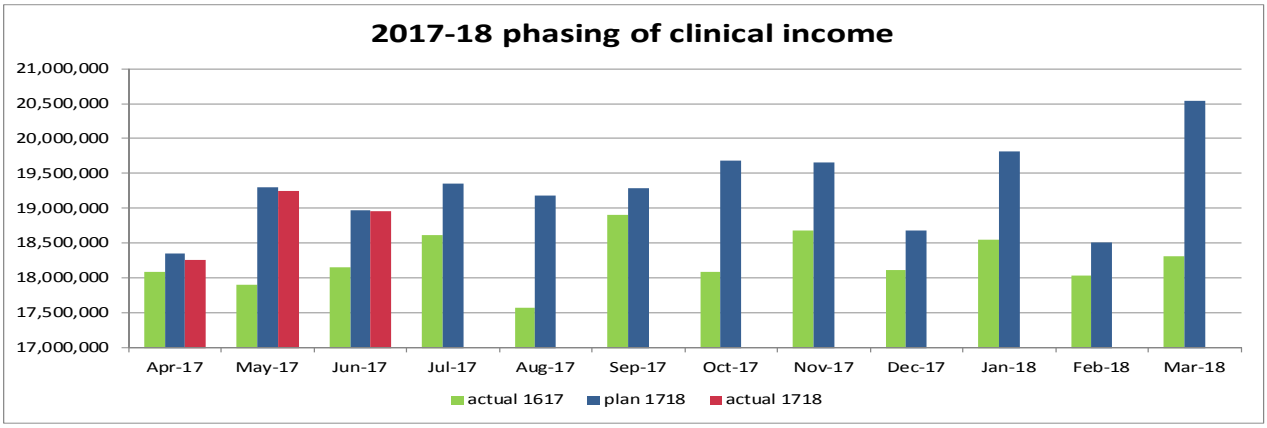
Metric	Value	Score
Capital Service Capacity rating	-2.501	4
Liquidity rating	-15.723	4
I&E Margin rating	-4.30%	4
I&E Margin Variance rating	0.40%	1
Agency	-42.50%	1
Use of Resources Rating after Overrides		3

2. Performance against I & E plan

SUMMARY INCOME AND EXPENDITURE ACCOUNT - June 2017	Jun-17 Budget £m	Jun-17 Actual £m	Jun-17 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m	Year end forecast Budget £m	Year end forecast Actual £m	Year end forecast Variance £m
NHS Contract Income	19.1	19.1	(0.0)	55.9	55.7	(0.1)	226.2	225.7	(0.4)
Other Income	2.3	2.6	0.2	6.3	6.9	0.6	25.3	26.6	1.3
Total Income	**21.4**	**21.6**	**0.2**	**62.1**	**62.6**	**0.5**	**251.4**	**252.3**	**0.9**
Pay Costs	12.3	12.2	0.1	36.5	36.1	0.4	145.3	145.3	0.0
Non-pay Costs	9.3	9.6	(0.3)	27.7	28.5	(0.8)	108.7	109.6	(0.9)
Operating Expenditure	**21.6**	**21.8**	**(0.2)**	**64.2**	**64.6**	**(0.4)**	**253.9**	**254.8**	**(0.9)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	2.5	2.5	0.0
EBITDA	**(0.2)**	**(0.2)**	**0.0**	**(2.1)**	**(2.0)**	**0.1**	**(5.0)**	**(5.0)**	**(0.0)**
EBITDA margin	(1.3%)	(1.2%)	0.1%	(2.1%)	(1.9%)	0.1%	0.1%	0.1%	(0.0%)
Depreciation	0.3	0.4	(0.0)	1.1	1.2	(0.1)	4.7	4.7	0.0
Finance costs	0.1	0.1	(0.0)	0.4	0.4	0.0	1.4	1.4	0.0
SURPLUS/(DEFICIT) pre S&TF	**(0.6)**	**(0.7)**	**(0.1)**	**(3.6)**	**(3.6)**	**0.0**	**(11.1)**	**(11.1)**	**(0.0)**
S&T funding - Financial Performance	(0.1)	(0.1)	(0.0)	0.5	0.5	0.0	3.6	3.6	0.0
S&T funding - A&E Performance	(0.0)	(0.0)	(0.0)	0.2	0.2	0.0	1.6	1.6	0.0
SURPLUS/(DEFICIT) incl S&TF	**(0.7)**	**(0.8)**	**(0.1)**	**(2.8)**	**(2.8)**	**0.0**	**(5.9)**	**(5.9)**	**(0.0)**

Performance against Income plan

The chart below summarises the phasing of the clinical income plan for 2017-18, including Suffolk Community Health. This phasing is in line with activity phasing and does not take into account the block payment.



	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	687	744	57	2,042	2,096	53
Other Services	2,294	2,156	(138)	7,089	6,699	(390)
CQUIN	307	303	(4)	890	889	(1)
Elective	2,723	2,884	161	7,551	8,235	683
Non Elective	5,067	5,120	53	15,318	15,357	39
Emergency Threshold Adjustment	(284)	(387)	(103)	(861)	(1,099)	(238)
Outpatients	2,865	2,686	(179)	7,987	7,706	(281)
Community	5,379	5,379	0	10,759	10,759	0
Total	**19,038**	**18,885**	**(153)**	**50,776**	**50,641**	**(135)**

3. Performance against Expenditure plan - Workforce

Monthly Expenditure Acute services only				
As at June 2017	Jun-17	May-17	Jun-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**11,151**	**10,798**	**10,885**	**33,106**
Substantive Staff	9,935	9,692	9,313	29,169
Medical Agency Staff (includes 'contracted in' staff)	132	136	157	411
Medical Locum Staff	229	231	112	626
Additional Medical sessions	230	263	244	725
Nursing Agency Staff	81	66	182	219
Nursing Bank Staff	162	154	248	545
Other Agency Staff	49	76	367	167
Other Bank Staff	120	133	114	406
Overtime	88	89	63	287
On Call	55	59	41	161
Total temporary expenditure	1,147	1,208	1,528	3,546
Total expenditure on pay	**11,083**	**10,900**	**10,841**	**32,715**
Variance (F/(A))	68	(102)	44	391
Temp Staff costs % of Total Pay	10.4%	11.1%	14.1%	10.8%
Memo : Total agency spend in month	262	278	706	796

Monthly whole time equivalents (WTE) Acute Services only			
As at June 2017	Jun-17	May-17	Jun-16
	WTE	WTE	WTE
Budgeted WTE in month	**2,980.9**	**2,945.0**	**3,037.7**
Employed substantive WTE in month	**2724.3**	**2725.03**	**2,669.5**
Medical Agency Staff (includes 'contracted in' staff)	11.13	14.74	8.8
Medical Locum	16.46	18.06	14.0
Additional Sessions	18.21	21.85	21.2
Nursing Agency	12.5	10.26	23.1
Nursing Bank	52.86	50.16	76.2
Other Agency	16.41	20.29	38.0
Other Bank	57.73	60.75	56.2
Overtime	40.19	40.99	43.2
On call Worked	8.42	11.23	10.4
Total equivalent temporary WTE	**233.9**	**248.3**	**291.1**
Total equivalent employed WTE	**2,958.2**	**2,973.4**	**2,960.6**
Variance (F/(A))	22.7	(28.3)	77.2
Temp Staff WTE % of Total Pay	7.9%	8.4%	9.8%
Memo : Total agency WTE in month	40.0	45.3	69.9
Sickness Rates (May/April)	3.61%	3.62%	3.76%
Mat Leave	1.8%	2.1%	2.1%

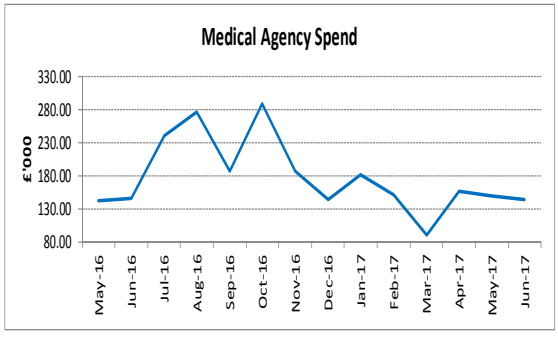
Monthly Expenditure Community Service				
As at June 2017	Jun-17	May-17	Jun-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,123**	**1,129**	**1,007**	**3,365**
Substantive Staff	1,056	1,049	949	3,162
Medical Agency Staff (includes 'contracted in' staff)	13	14	0	41
Medical Locum Staff	4	3	10	10
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	0	0	2	2
Nursing Bank Staff	11	16	5	42
Other Agency Staff	15	24	25	73
Other Bank Staff	9	7	7	28
Overtime	4	5	4	13
On Call	1	1	1	4
Total temporary expenditure	57	70	54	212
Total expenditure on pay	**1,114**	**1,120**	**1,003**	**3,374**
Variance (F/(A))	9	9	(6)	(9)
Temp Staff costs % of Total Pay	5.1%	6.3%	5.4%	6.3%
Memo : Total agency spend in month	28	38	27	116

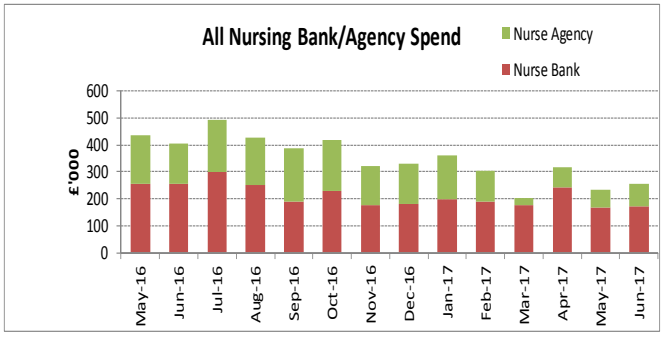
Monthly whole time equivalents (WTE) Community Services			
As at June 2017	Jun-17	May-17	Jun-16
	WTE	WTE	WTE
Budgeted WTE in month	**380.57**	**380.57**	**334.3**
Employed substantive WTE in month	**344.1**	**343.1**	**313.6**
Medical Agency Staff (includes 'contracted in' staff)	1.0	1.5	0.0
Medical Locum	0.4	0.4	0.5
Additional Sessions	0.0	0.0	0.0
Nursing Agency	0.0	0.1	0.4
Nursing Bank	3.8	5.1	1.5
Other Agency	5.4	9.9	6.5
Other Bank	2.3	2.2	2.8
Overtime	2.1	2.5	2.2
On call Worked	0.0	0.0	(0.7)
Total equivalent temporary WTE	**14.9**	**21.5**	**13.2**
Total equivalent employed WTE	**359.0**	**364.6**	**326.7**
Variance (F/(A))	21.6	16.0	7.6
Temp Staff WTE % of Total Pay	4.2%	5.9%	4.0%
Memo : Total agency WTE in month	6.4	11.4	6.9
Sickness Rates (May/April)	3.55%	3.80%	3.63%
Mat Leave	1.1%	1.1%	1.4%

The overall WTE variance for Acute services is now 22.7 WTE below establishment. There are 2.4 WTE fewer WTE than in June 2016, although this includes an increase of 55 substantive WTEs.

The monthly cost of additional sessions decreased by £33k to £230k. These costs are for both Medical and Non-Medical staff

Suffolk Community Services staff numbers have decreased by 5.6 WTE during March.



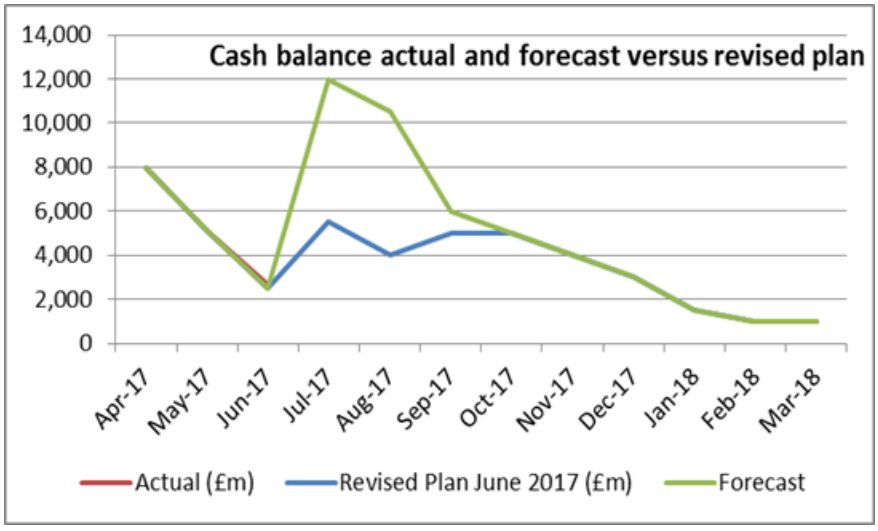


4. Balance Sheet

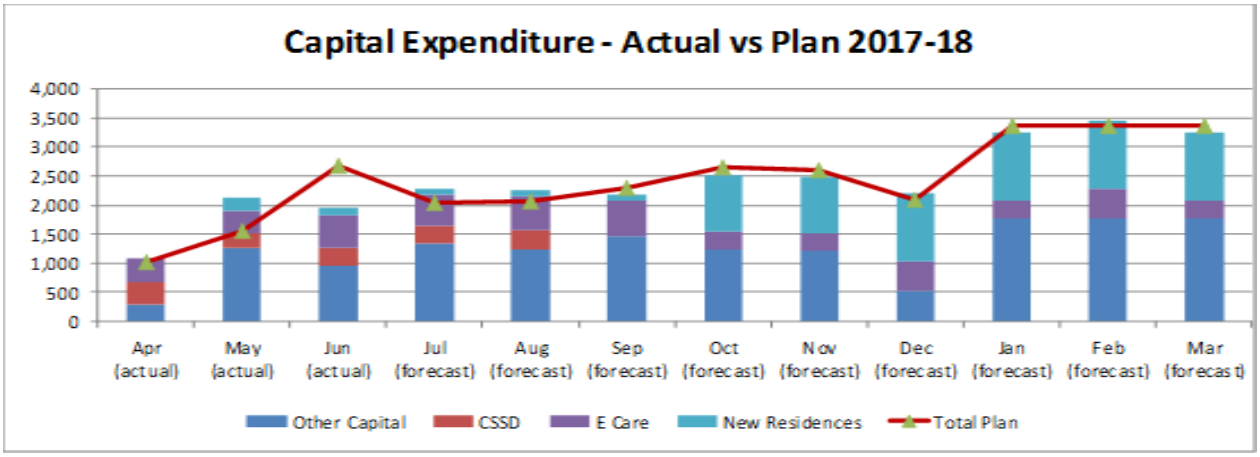
STATEMENT OF FINANCIAL POSITION	As at 1 April 2017 £000	Plan 31 March 2018 £000	Plan YTD 30 June 2017 £000	As at 30 June 2017 £000	Variance YTD 30 June 2017 £000
Intangible assets	15,611	19,711	17,142	16,658	(484)
Property, plant and equipment	74,053	94,189	76,970	76,996	26
Trade and other receivables	0	0	0	0	0
Other financial assets	0	0	0	0	0
Total non-current assets	**89,664**	**113,900**	**94,112**	**93,654**	**(458)**
Inventories	2,693	2,600	2,700	2,678	(22)
Trade and other receivables	18,345	11,700	17,011	19,434	2,423
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	1,352	1,000	2,500	2,689	189
Total current assets	**22,390**	**15,300**	**22,211**	**24,801**	**2,590**
Trade and other payables	(23,434)	(28,196)	(22,000)	(24,165)	(2,165)
Borrowing repayable within 1 year	(534)	(1,796)	(2,299)	(2,302)	(3)
Current ProvisionsProvisions	(61)	(61)	(84)	(89)	(5)
Other liabilities	(1,325)	(295)	(6,000)	(6,726)	(726)
Total current liabilities	**(25,354)**	**(30,347)**	**(30,383)**	**(33,282)**	**(2,899)**
Total assets less current liabilities	**86,700**	**98,853**	**85,940**	**85,174**	**(766)**
Borrowings	(44,375)	(55,951)	(45,668)	(45,704)	(36)
Provisions	(181)	(158)	(163)	(168)	(5)
Total non-current liabilities	**(44,556)**	**(56,109)**	**(45,831)**	**(45,872)**	**(41)**
Total assets employed	**42,144**	**42,744**	**40,109**	**39,302**	**(807)**
Financed by					
Public dividend capital	59,232	65,732	59,232	59,232	(0)
Revaluation reserve	3,621	3,621	3,621	3,621	(0)
Income and expenditure reserve	(20,709)	(26,609)	(22,744)	(23,551)	(807)
Total taxpayers' and others' equity	**42,144**	**42,744**	**40,109**	**39,302**	**(807)**

The cash at bank as at the end of June 2017 is £2.7m.

5. Cashflow forecast for the year



6. Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Forecast £'000	Aug Forecast £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2017-18 £'000
E Care	415	381	567	533	585	625	305	305	505	305	505	305	5,333
CSSD	384	260	300	322	323	0	0	0	0	0	0	0	1,589
New Residences	0	246	128	97	97	97	974	974	1,174	1,174	1,174	1,174	7,310
Other Schemes	296	1,253	952	1,336	1,248	1,461	1,242	1,220	520	1,782	1,782	1,768	14,858
Total forecast / Forecast	1,096	2,140	1,947	2,288	2,253	2,183	2,520	2,499	2,198	3,260	3,460	3,246	29,090
Total Plan	1,012	1,568	2,673	2,034	2,058	2,283	2,643	2,612	2,103	3,365	3,365	3,363	29,082

The capital programme for the year is shown in the graph above.

The capital budget for the year was approved by the Trust Board in March 2017 at £28,082k. Following the bid for ED Primary Care Streaming this has been increased by £1m (the value of the bid). The balance of this scheme is being funded from the capital contingency fund. The £1m PDC funding for the ED Primary Care has been received in July.

The CSSD build is nearing completion and is forecast to be in line with its budget of £1.6m for the year. The final expenditure for this project (except for retentions) will be paid in August.

Expenditure on e-Care for the year to date is £1,363k and this is in line with the budget for the same period. The E-Care programme budget reflects the increased scope associated with the Global Digital Excellence (GDE) funding. The first tranche of this funding £3.3m was received in July. Initial indications are that the second tranche of funding will be received in December 2017, however past history would indicate that this timing is not guaranteed.

The forecasts for all projects have been reviewed by the relevant project managers. There are no significant financial risks to the budgets reported. Year to date the overall expenditure of £5,182k is slightly below the plan of £5,253k.

Recommendation:

To note the summary report.

NHS
West Suffolk
NHS Foundation Trust

REPORT TO:	Council of Governors
MEETING DATE:	10 August 2017
SUBJECT:	Pathology services
AGENDA ITEM:	12
PRESENTED BY:	Prepared by Nick Jenkins, Executive Medical Director Presented by Helen Beck, Interim Executive Chief Operating Office
DATE PREPARED:	31 July 2017
FOR:	Information

1. Introduction

The following is extracted from North East Essex & Suffolk Pathology Services (NEESPS) report to the closed Board. To promote openness and transparency it is the intention that, with agreement of partners, these reports will be received in the public Board meeting. I am working closely with clinical leads to ensure that the structures and processes put in place effectively engagement with clinicians within the service and address or escalate concerns in a timely manner.

Delivery of an effective governance framework will be test the ability to address escalate concerns in a timely manner as part of process which effectively reviews a range of quality indicators for service performance and outcomes. Annex A sets out the original governance structure approved by the Board and any variation from this model, as part of the NEESPS operationalisation, will again be carefully considered.

2. Background

Pathology is one of the most highly regulated and scrutinised services within the healthcare arena. There are several Quality standards and regulatory statutes that govern the overall compliance of Pathology Services.

It is fair to say that tPP did not necessarily give this the attention and focus required. This has resulted in the Transfusion Laboratory at West Suffolk Hospital being put under threat of a ‘cease and desist’ notice from the MHRA and overall there have been concerns from staff in terms of compliance with the required standards. Health and Safety has not been robustly managed and monitored and the training function is not unified in terms of focus and function.

The intent is to implement means to address the above, that will deliver a focused and robust approach to quality, compliance and regulatory affairs for the business overall.

3. Progress and operationalisation

A business governance workstream is already established. Functions from the previous business structure have been drawn into an integrated Pathology Divisional Board meeting, which covers:

- Operational matters - reports from speciality groups, other speciality and site issues
- Financial matters
- Quality matters - incidents, complaints, accreditation
- IT - again speciality and site specific matters
- HR - speciality and site specific issues

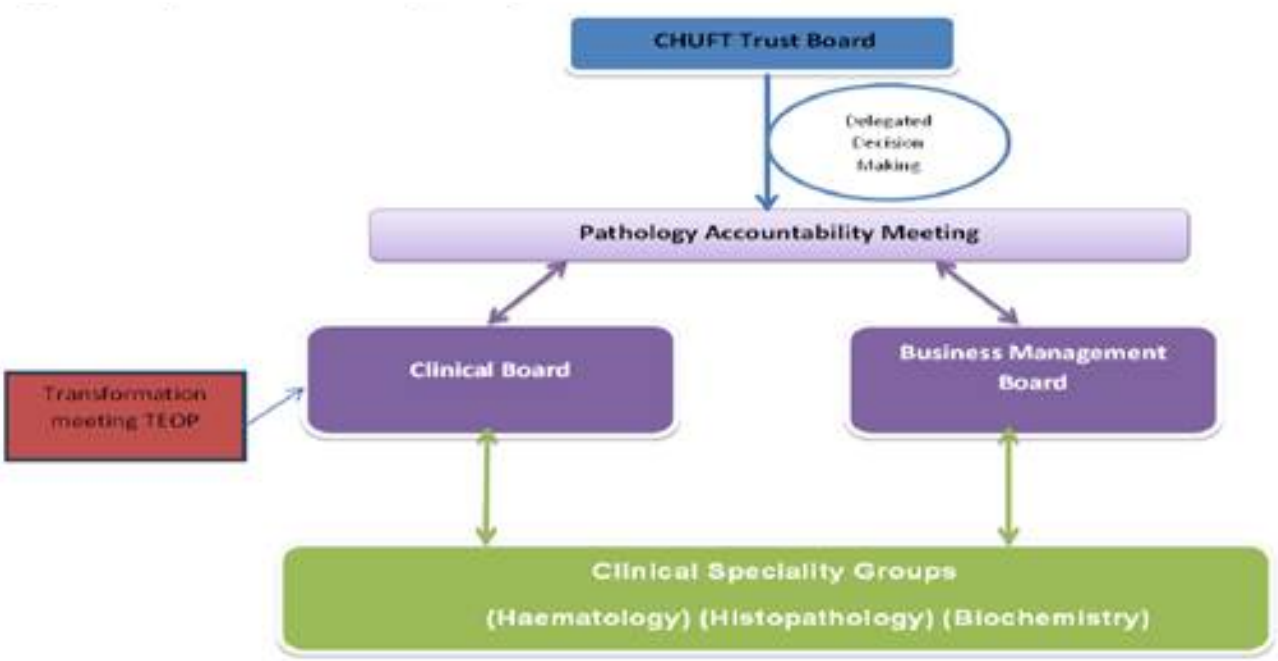
As for other divisional meetings, reports will be made to management and board committees of the NEESPS host organisation. Reports to management committees will be circulated to partner trusts to ensure all owners have access to the same information at the same time.

The sequence of meetings established is Speciality Groups leading to Pathology Board leading to the accountability meeting with partner/owner trusts.

The first Pathology Board meeting was held on Thursday, 20 July 2017 and was well attended. There have been two Pathology Divisional Integrated Performance meetings to date, with the 3rd to take place on Thursday, 3 August 2017. The purpose of these meetings is for the partner trusts to hold the clinical leads and management of NEESPS to account for performance as per the governance framework.

Overall the governance framework is beginning to “bed in” and over the coming months the teams will become used to the timing and functionality of these arrangements.

Annex A: NEESPS governance structure (approved by partner Board April 2017)



West Suffolk NHS
NHS Foundation Trust

REPORT TO:	Council of Governors
MEETING DATE:	10 August 2017
SUBJECT:	To receive update on e-Care implementation and Global Digital Excellence (GDE) programme
AGENDA ITEM:	13
PRESENTED BY:	Helen Beck, Interim Executive Chief Operating Officer
FOR:	Information

1	**Purpose**
1.1	This paper provides the Council of Governors with an update on the current status of the e-Care and Global Digital Excellence (GDE) programmes. The Council is asked to note the report.
2	**Background**
2.1	The organisation has committed to a ten year programme of major transformation around digitising the organisation. The first major part of this programme was the original go live of e-Care in May 2016. This initial go live included a replacement PAS, FirstNet (within emergency department), clinical documents and electronic medicines management. In addition some limited components of OrderComms were introduced. Pathology OrderComms and Sepsis/AKI alerting was successfully implemented in June 2017.
2.2	The organisation now continues with phase 2 of the e-Care programme and delivering GDE commitments with full updates provided below.
3	**Phase 2 e-Care Programme Summary**
3.1	There were three original planned drops for the e-Care phase 2 programme as shown below. At the e-Care Programme Board it was agreed to combine drops 2 and 3 with a go live date of 30th October. This would ensure the least disruption to staff and support the domain strategy. On this basis the revised Phase 2 plan is shown below

Drop	Original dates	Covers
Drop 1	20 May 2017	• OrderComms Pathology • Sepsis and Acute Kidney Infection (AKI) alerting
Drop 2	30 October 2017	• Patient portal • Patient Flow/Capacity management • Diabetic order set • Paediatrics • Dynamic documentation • Suite of nursing care plans • 5 new care pathways

3.2	***Drop 1*** As reported previously we went live with Order Comms pathology on 03 June 2017. Sepsis/AKI went live on Monday 19th June. Both have been successful technically. We continue to support staff in adapting to new workflows.

3.3	***Drop 2*** We are currently reviewing whether to postpone implementation of patient portal due to its current limited functionality and await the updated Cerner offer. We are also exploring other options on the market. All other projects are progressing and are on target for implementation on 30th October. Engagement and training plans are being finalised.
3.4	In addition to the above planned drops we are also working with Cerner to implement Medical Transcription Management (MTM) module which would improve the current secretarial workflow.
3	**GDE update**
3.1	The Trust had a very successful go live for phase 1 and as such, was one of 26 Trusts asked to bid for national Global Digital Excellence status. In September 2016, it was confirmed that the Trust had been successful in securing £10m funding, as part of an initial tranche of 12 Trusts. The Global Digital Excellence (GDE) programme is a 2-year programme that commenced in November 2016.
3.2	Our GDE programme covers four main pillars: **Pillar 1** — **Digital acute trust** — Completing the internal journey of digitisation **Pillar 2** — **Supporting the ICO** — Creating the digital infrastructure that will support the ambitions of the Sustainability and Transformation Plan **Pillar 3** — **Exemplar digital community** — Building the organisation into a centre of digital excellence and acting as mentor and guide for other developing organisations **Pillar 4** — **Hardware and infrastructure** — Ensuring that we have a robust and compliant infrastructure at the foundation of the programme. To date our main focus has been on pillar four as this is the critical infrastructure that supports delivery of all other components.
4	**Pillar 1 – Digital Acute Trust**
4.1	We are engaging departments with a view to producing outline business cases for all potential GDE opportunities. This will identify benefits, risks and resource implications for each potential project. We will then use an agreed criteria to review each application which in turn will confirm the final content of the GDE pillar 1 programme.
5	**Pillar 2 – Supporting the Integrated Care Organisation**
5.1	• We received a demonstration of the Cerner HealtheIntent population health solution and are currently in the process of organising a further demonstration for system partners and trust clinicians. • The trust hosted a system leadership event on 05 July with dedicated focus on pillar two opportunities. This was well attended with representatives from across the health and social care system. • We have now connected 12 EMIS GP practises to Health Information Exchange. This provides the GPs with view only access to the e-Care electronic patient record. This has been well received to date and a full benefits analysis will be undertaken later this year. Early testing of the network links for SystmOne GP Surgeries has now commenced in anticipation of the SystmOne HIE software coming in September.
6	**Pillar 3 – Exemplar Digital Community**
6.1	• We continue to work with Milton Keynes University Hospital NHS Foundation Trust to progress the bid for them to become our fast followers.

	• We are also considering our requirements from an international partnership. • We are currently organising our first GDE event to showcase our Allied Health Professional (AHP) content. This will be held in September.
7	**Pillar 4 – hardware and infrastructure**
7.1	• Progress continues to be made in 2017 on the Trust technical infrastructure in support of our e-Care and GDE programmes. • Work on the upgrade of the Trust e-mail system is progressing and the new hardware is now on site. The new build should be complete by mid-August (@ 16/08) at which time new mailboxes for meeting room and resource will be created. User mailbox migration will commence w/c 21/08 and will take around 2 months to complete. A more detailed briefing will be provided once the migration plan is complete. • The new firewall has arrived, the kick off has been held; however implementation will not start until 21/08 as key personnel are away at present. It is expected to take around a month to complete the install and a further month to migrate connections from the old to the new. • The remote access upgrade has started with the kick off meeting and a further technical meeting to agree configuration will follow. However after that the project will halt as it is dependent on the proposed SAN upgrade which remains in procurement as options for a managed service are concluded. Once the delivery date for the SAN is confirm the project will restart. • Planning work to migrate EDM (Evolve) and Theatres (Opera) from Windows 2003 to Windows 2008 are well advanced. Business cases for both are expected in September as these migrations facilitate the upgrade of Microsoft AD, which is a key part of the Trust Cyber plan. • New Mobile Device Management software is also being tested as the current "Good" software expires at the end of September. The new product will be deployed on the 300 existing mobile devices (laptops and tablets) providing improved security and better access. In summary the infrastructure work is progressing well and is largely on target for the objectives agree at the start of the project.
8	**Reporting**
8.1	We continue to work on improvements with reporting. We are now able to produce a reliable VTE report. In addition we have built and successfully tested a falls and nutrition report which will be launched imminently. EPARs reporting is also in hand and again will be ready to be launched to the organisation within the next few weeks. We continue to work closely with Cerner to produce a robust bed occupancy report which is proving to be more challenging.
9	**Recommendations**
9.1	The Council is asked; • To note the general progress

ITEM 15

WEST SUFFOLK NHS FOUNDATION TRUST

ANNUAL AUDIT LETTER

Audit for the year ended 31 March 2017
14 July 2017

BDO

EXECUTIVE SUMMARY

PURPOSE OF THE LETTER

This report to the Council of Governors summarises the key issues arising from the work that we have carried out in respect of the year ended 31 Mach 2017. It is addressed to the Trust but is also intended to communicate the key findings we have identified to key external stakeholders and members of the public.

RESPONSIBILITIES OF AUDITORS AND THE TRUST

It is the responsibility of the Trust to ensure that proper arrangements are in place for the conduct of its business and that public money is safeguarded and properly accounted for.

Our responsibility is to plan and carry out an audit that meets the requirements of the National Audit Office's (NAO's) Code of Audit Practice (the Code), and to review and report on:

- The Trust's financial statements
- Whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are also required to review and report on the annual report, annual governance statement, remuneration and staff report and the foundation trust consolidation schedules.

We also undertake a review of the Trust's quality report, to confirm that it has been prepared in line with requirements and to test three performance indicators, two mandated by NHS Improvement and one selected by the Governors.

We recognise the value of your co-operation and support and would like to take this opportunity to express our appreciation for the assistance and co-operation provided during the audit.

BDO LLP
14 July 2017

AUDIT CONCLUSIONS

FINANCIAL STATEMENTS

We issued our unmodified true and fair opinion on the financial statements on 31 May 2017.

We reported our detailed findings to the Audit Committee on 26 May 2017. We reported on uncorrected misstatements which management and the Audit Committee concluded were immaterial.

USE OF RESOURCES

We issued our qualified "except for" conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources on 31 May 2017.

The exception reported was in relation to the Trust's sustainable resource deployment.

QUALITY REPORT

We issued our qualified limited assurance report on the quality report on 31 May 2017.

We reported our detailed findings in a separate report on 25 May 2017.

The qualification is in relation to the reporting of the Referral to Treatment (RTT) performance indicator only.

FINANCIAL STATEMENTS

OPINION We issued our unmodified true and fair opinion on the financial statements on 31 May 2017.

SCOPE OF THE AUDIT OF THE FINANCIAL STATEMENTS

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that they are free from material misstatement, whether caused by fraud or error.

This includes an assessment of whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed the reasonableness of significant accounting estimates, and the overall presentation of the financial statements.

OUR ASSESSMENT OF RISKS OF MATERIAL MISSTATEMENT

Our audit was scoped by obtaining an understanding of the Trust and its environment, including the system of internal control, and assessing the risks of material misstatement in the financial statements.

We set out below the risks that had the greatest effect on our audit strategy, the allocation of resources in the audit, and the direction of the efforts of the audit team.

RISK DESCRIPTION	HOW RISK WAS ADDRESSED BY OUR AUDIT AND AUDIT FINDINGS	CONCLUSION
Management override of controls Auditing standards presume that a risk of management override of controls is present in all entities and require us to respond to this risk by testing the appropriateness of accounting journals and other adjustments to the financial statements, reviewing accounting estimates for possible bias and obtaining an understanding of the business rationale of significant transactions that appear to be unusual. At the year-end we became aware that the Trust was able to meet its control total, which it previously predicted that it would not achieve. As a result the Trust received additional monies from the Sustainability and Transformation Fund (STF) which has enabled it to over- achieve its predicted deficit. There is a heightened audit risk of management bias in estimates as a result of the Trust's unpredicted ability to achieve its control total and receive the additional STF.	We tested the appropriateness of journal entries recorded in the general ledger and other adjustments made in the preparation of the financial statements We reviewed accounting estimates (in particular, the accounting estimate in relation to the Community services equipment) for biases and evaluated whether the circumstances producing the bias, if any, represent a risk of material misstatement due to fraud We obtained an understanding of the business rationale for significant transactions that are outside the normal course of business for the entity or that otherwise appeared to be unusual. No issues were identified in our review of the appropriateness of journal entries and other adjustments made to the financial statements. We identified one non-material unadjusted audit difference of £391k in relation to the calculation of the accounting estimate for the Community services equipment accrual. We did not consider this to be as a result of bias. A non-material unadjusted audit difference was raised in respect of this. If this adjustment had been made, it would improve the deficit position. We also identified that no prior period amount was recorded in respect of the community services equipment accrual. We considered the best estimate of this figure to be £654k. This was not material but resulted in the deficit in this year's financial statements being understated by £654k.	We reported the identified error of £391k as an unadjusted audit difference. We also reported the projected error of £654k as an unadjusted audit difference.

RISK DESCRIPTION	HOW RISK WAS ADDRESSED BY OUR AUDIT AND AUDIT FINDINGS	CONCLUSION
Revenue recognition Under auditing standards there is a presumption that income recognition presents a fraud risk. This risk is in respect of the existence and accuracy of material income streams including: - patient care - education and training - non-patient care services to other bodies.	We responded to this risk by carrying out audit procedures to gain an understanding of the Trust's internal control environment for the significant income streams, including how this operates to prevent loss of income and ensure that income is recognised in the correct accounting period We substantively tested an extended sample, compared to non-risk areas, of material non-NHS income streams to supporting documentation to confirm that income has been accurately recorded and earned in the year. We reviewed the process for resolving discrepancies between the Trust and other NHS bodies through the agreement of balances process, and management's estimate of amounts receivable where there are contract disputes, subsequently investigating all discrepancies and disputed amounts above £250k. This tolerable variance was lowered in response to the significant audit risk identified. We agreed a sample of income with other NHS bodies back to contract amounts. We ensured that all income items tested had been accounted for in line with the Trust's revenue recognition policy. No non-trivial issues were identified by our testing of material revenue streams.	No issues to report.
Valuation of land and buildings A full revaluation of the Trust's land and buildings for 2016/17 was completed. These are valued on a depreciated replacement cost (DRC) basis; as such regard is required, amongst other factors, to current land values, building tender indices and the condition of the Trust's buildings. The reliance on judgements and assumptions as part of valuation processes results in a high level of estimation uncertainty associated with the balance. As a result there is a risk of material misstatement if inappropriate or inaccurate estimates or assumptions are used in the review of these fair values.	We responded to this risk by reviewing the instructions provided to the valuer and reviewed the valuer's skills and expertise in order to determine that we could rely on the management expert. We concluded that we were able to rely on the Trust's management expert. We confirmed that the basis of valuation for assets valued in year is appropriate based on their usage. We reviewed the methodology applied by the valuers and concluded on the appropriateness of the valuations applied. We reviewed valuation movements against indices of price movements for similar classes of assets and concluded all movements to be in line with these indices. We were satisfied that property valuations are materially correct and the basis of valuation for assets valued in the year was appropriate.	No issues to report.

RISK DESCRIPTION	HOW RISK WAS ADDRESSED BY OUR AUDIT AND AUDIT FINDINGS	CONCLUSION
Accounting for the finanicial position and results of the transforming Pathology Partnership (tPP) The Trust entered into a partnership with a number of other NHS and Foundation Trusts to provide pathology services. The tPP has made losses and there are governance concerns. The future of the operation of the partnership is also uncertain. At the year end the Trust impaired its investment in tPP by £5m. Any changes to the structure of the organisation may have a material impact on corresponding transactions and balances recognised in the financial statements, in particular the valuation of the investment and the impairment estimate. There is a risk that such transactions and balances are not accounted for correctly.	We reviewed the Trust's calculation of the impairment provided and its accounting treatment of this impairment against the requirements of the Group Accounting Manual (GAM) and underlying international financial reporting standards. We considered the supporting evidence, including financial forecasts provided by tPP. We reviewed the associated transactions and their recognition and presentation in the financial statements. We considered the future arrangements of the partnership and the impact that this may have on the underlying valuation of the investment. We were satisfied that the valuation of the investment was materially correct. We identified that a transfer of inventory of £222k previously made to the tPP had been incorrectly capitalised as part of the investment. This resulted in overstatement of the impairment provided against the investment. We did not consider this to be as a result of bias. This was adjusted for in the final financial statements. Last year we identified the need for an immaterial impairment adjustment of £690k, which the Trust did not amend for. This led to the overstatement of the impairment recognised as at 31/03/2017. We were satisfied that the accounting treatment of the impairment was consistent with the requirements of the GAM.	Management corrected the £222k misstatement. We reported the projected error of £690k as an unadjusted audit difference.
Costs of e-Care Implementation The costs capitalised in the implementation of e-Care during 2016/17 were significantly higher than the costs budgeted as at 31/03/2016. As a result, there is a risk of material misstatement if items have been inappropriately capitalised.	We substantively tested an extended sample of intangible asset additions to supporting documentation to confirm that the costs associated with e-Care were appropriately capitalised. No issues were identified from our testing, with all additions confirmed to have been appropriately capitalised.	No issues to report.

OUR APPLICATION OF MATERIALITY

We apply the concept of materiality both in planning and performing our audit and in evaluating the effect of misstatements.

We consider materiality to be the magnitude by which misstatements, including omissions, could influence the economic decisions of reasonably knowledgeable users that are taken on the basis of the financial statements.

Importantly, misstatements below these levels will not necessarily be evaluated as immaterial as we also take account of the nature of identified misstatements, and the particular circumstances of their occurrence, when evaluating their effect on the financial statements as a whole.

The materiality for the financial statements as a whole was set at £4.5 million. This was determined with reference to a benchmark of gross expenditure (of which it represents 1.75 per cent) which we consider to be one of the principal considerations for the Trust in assessing the financial performance.

We agreed with the Audit Committee that we would report all individual audit differences in excess of £180,000.

AUDIT DIFFERENCES

Our audit did not identify any material audit differences.

We found 5 audit differences not corrected in the final financial statements as follows:

- £0.690 million which is the current year impact of our estimated impairment for tPP for 2015/16 (projected). If the impairment had been recorded in the prior year, the value of the current year impairment would have been lower by the above amount. This would therefore have no impact on the retained deficit position cumulatively
- £0.391 million which is the adjustment for the understatement of the deposit accrual (factual)
- £0.654 million which is the brought forward uncorrected audit difference to recognise the deposits accrual (projected)
- £0.345 million which is the extrapolated element of overstatement of other costs due to expenses relating to the prior period being recognised in the current year, as they were not accrued for in the prior period (projected). This has no impact on the cumulative retained deficit as the expenditure should have been included in the prior year
- £0.630 million which is the adjustment to add two finance leases that were incorrectly accounted for as operating leases to property, plant and equipment (factual). The impact of accounting for these leases as finance leases would be a reduction in the deficit for the year of £0.030 million.

Correcting for these remaining misstatements would have resulted in the Trust reporting a £0.802 million lower deficit for the year. We consider that these misstatements did not have a material impact on our opinion on the financial statements.

FOUNDATION TRUST CONSOLIDATION SCHEDULES

We are required to provide an opinion to the Trust to confirm that the financial information included in the foundation trust consolidation schedules (and used in the preparation of the Group consolidation) is consistent with the audited financial statements.

We reported the foundation trust consolidation schedules were consistent with the financial statements.

NAO GROUP ASSURANCE REVIEW

The Trust was selected as one of sixty three sampled NHS foundation trusts by the NAO for full group audit review by the component auditor of the foundation trust consolidation schedules, including testing of reported counter-party transactions and balances.

Our work did not result in any exceptions being reported to the NAO.

ANNUAL REPORT

Other information in the annual report was not inconsistent or misleading with the financial statements or with our knowledge acquired in the course of our audit.

ANNUAL GOVERNANCE STATEMENT

The annual governance statement was not inconsistent or misleading with other information we were aware of from our audit of the financial statements, the evidence provided in the Trust's review of effectiveness and our knowledge of the Trust.

REMUNERATION AND STAFF REPORTS

The auditable parts of the remuneration and staff reports were found to have been properly prepared in accordance with the requirements directed by the Secretary of State.

INTERNAL CONTROLS

We did not find any significant deficiencies in internal controls during the course of our audit. A number of other areas for improvement were identified which we have discussed with management.

USE OF RESOURCES

CONCLUSION	We issued a modified conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources on 31 May 2017.

SCOPE OF THE AUDIT OF USE OF RESOURCES

We are required to be satisfied that proper arrangements have been made to secure economy, efficiency and effectiveness in the use of resources based on the following reporting criterion:

In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

As part of reaching our overall conclusion we consider the following sub criteria in our work: informed decision making, sustainable resource deployment, and working with partners and other third parties.

OUR ASSESSMENT OF SIGNIFICANT RISKS

Our audit was scoped by our cumulative knowledge brought forward from previous audits, relevant findings from work undertaken in support of the opinion on financial statements, reports from the Trust including internal audit, information disclosed or available to support the governance statement and annual report, and information available from the risk registers and supporting arrangements.

We set out below the risks that had the greatest effect on our audit strategy, the allocation of resources in the audit, and direction of the efforts of the audit team.

RISK DESCRIPTION	HOW RISK WAS ADDRESSED BY OUR AUDIT AND AUDIT FINDINGS	CONCLUSION
Financial position (sustainable resource deployment) The Trust recorded a deficit of £8.1m for the year ended 31 March 2017, and has forecast a deficit of £5.9m for the year ending 31 March 2018 and £2.5m deficit for the year ending 31 March 2019. The Trust's Cost Improvement Programme savings requirement increases from £12.5m to £13.3m then £18.3m respectively over the three years. The Trust is currently scored by NHS Improvement as presenting the second highest level of financial risk in its grading system for Foundation Trusts. There is a significant risk to the Trust's ability to achieve financial sustainability in the medium term.	In response to this audit risk we: • Considered the Trust's financial performance in the year to 31 March 2017, and achievement of control totals and planned Cost Improvement Programme schemes. • Reviewed the Trust's arrangements for financial and Cost Improvement Programme performance management for the year ended 31 March 2017. • Considered the feasibility of the operational plan and the reasonableness of the assumptions used in developing the Trust's medium term financial plans, specifically for the years ending 31 March 2018 and 31 March 2019. For the year ended 31 March 2017 the Trust reported a deficit of £8.1m after receiving £7.1m of Sustainability and Transformation Funding (STF) and incurring £5m of impairments. The underlying and comparable financial deficit for 2016/17 is, therefore, £10.2m compared to £9.8m deficit in 2015/16 and a control total of £11.1m deficit for 2016/17. This deficit was after achievement of £12.5m of Cost Improvement Programme (CIP) savings in 2016/17 (2015/16: £9.8m). The Trust is forecasting a deficit for 2017/18 of £11.1m before receipt of £5.2m of STF and after assumed achievement of an increased target of £13.3m CIP savings. This is a deterioration compared to 2016/17. After risk assessing its 2017/18 potential CIP schemes, the Trust determined a £1.8m shortfall against the £13.3m requirement, adding further pressure to the underlying position. The Trust is forecasting a deficit for 2018/19 of £7.7m before receipt of £5.2m of STF and after assuming achievement of a notably increased target of £18.3m CIP savings. This deficit is an improvement compared to 2016/17 and 2017/18 but the level of CIP savings required to achieve this outcome is 59% higher than the risk-assessed £11.5m currently anticipated for 2017/18 and is consequently judged to be of a transformational level. The Trust recognises this challenge and is actively working with KPMG, commissioned by NHS Improvement, to assist the Trust in developing and implementing a Financial Improvement Programme designed to secure financial sustainability in the medium term. However, there are still significant risks regarding the sufficiency of resource capacity and capability within the Trust to secure the necessary change to achieve financial sustainability in the medium term and current forecasts through to 2018/19 do not bring the Trust back to breakeven. NHS Improvement's Single Oversight Framework rates Trusts in a number of areas including finance and use of resources, scoring providers 1 (best) to 4 against each metric. The Trust's Financial Reporting risk rating is 3 and is expected to remain at this level for 2017/18 and 2018/19. The Trust has a clear strategy and commitment amongst its leadership to deliver the necessary action to improve its underlying deficit position and is taking action designed to achieve this, in particular through strengthening its CIP management arrangements. However, whilst the Trust considers that arrangements sufficient to address the increased CIP challenges in 2017/18 and 2018/19 will be put in place, as at 31 March 2017 the implementation of these actions was at an early stage and significant uncertainties remained regarding the Trust's resource capacity and capability to deliver the necessary actions and achieve financial sustainability in the medium term.	We were unable to conclude that there was sufficient evidence that the Trust's arrangements for 2016/17 supported, in all significant respects, its ability to achieve planned and sustainable financial stability. We consulted with NHS Improvement in forming our conclusion.

RISK DESCRIPTION	HOW RISK WAS ADDRESSED BY OUR AUDIT AND AUDIT FINDINGS	CONCLUSION
e-Care (informed decision making) There are known data quality issues with the e-Care system, which was implemented in 2016. The most notable issues are in relation to the data used for the referral to treatment time (RTT) 18 week target, which is currently estimated. Some data used in the performance dashboard is also unavailable. Although the Trust, CCG and NHSI are fully aware of the issues with the e-Care system, the problems with the quality of the data cast doubt over the Trust's ability to make properly informed decisions using the data available.	As part of our audit we considered the impact on the Trust's performance and ability to accurately report data. We reviewed the clarity of reporting on matters where data is obtained from e-Care. We reviewed the adequacy of the action plan in place to ensure that the issue with data quality is rectified in a timely manner. On the implementation of e-Care in May 2016, some issues arose with the Trust's ability to report some performance indicators. The most notable issues were: • Referral to treatment time (RTT): The data used for this indicator was estimated during the year. • VTE: The Trust was unable to report against this indicator because the manual audits on the required VTE assessments undertaken by the Trust are not recorded on e-Care. NHSI has confirmed that do not have a concern that the data quality issues have impacted on the Trust's finances. To establish whether the data quality issues with e-Care impacted on the Trust's ability to make informed decisions, we sought feedback from a sample of the Trust's non- executive directors regarding e-Care. The feedback highlighted that they were satisfied with the action being taken to rectify the issues with e-Care and their view was that the data quality issues did not inhibit their ability to make informed decisions. They considered that the Executives at the Trust had been transparent with reporting the issues identified although they would have liked more timely communication on the extent of the implementation issues encountered.	Overall we were satisfied that the data quality issues with e-Care did not impact on the Trust's ability to make informed decisions. We had no issues to report by exception.

RISK DESCRIPTION	HOW RISK WAS ADDRESSED BY OUR AUDIT AND AUDIT FINDINGS	CONCLUSION
The Pathology Partnership (Working with partners and other third parties) We are required to consider the arrangements in place against all of the use of resources sub-criteria. This includes completing a refresh on our overall risk assessment. No further significant risks were identified, however we did focus our work on considering the value for money of the Pathology Partnership (tPP).	The Trust continued to work appropriately in partnership with a number of organisations during the year. The Trust started to consider the arrangements in place for tPP and whether the partnership remained viable. The tPP arrangement is loss making and forecasts show that tPP is expected to remain a loss making entity until 2021/22. The Trust Board received an options appraisal regarding the future of the pathology service and it was concluded that total dissolution was not an option given that the set-up was as a result of the Carter review and NHSI had requested that the partnership remain. Financially, the best option was to set-up two east/west hubs and this was done after the year end. Further to the considerations made by the Trust on the future of tPP, a review was undertaken by the Medicines & Healthcare Products Regulatory Authority (MHRA) on 26 January 2017 of the blood products service provided by tPP to the Trust. The inspection findings indicated that there were serious deficiencies in the delivery of safe blood transfusion services, particularly with the Management System used for the service and the workforce deficits. The Trust took immediate action to rectify the issues identified and worked closely with MHRA to satisfy them sufficiently to withhold a cease and desist notice, providing weekly updates. There is a detailed action plan in place And MHRA is expected to complete a follow-up review in due course.	We had no issues to report by exception.

QUALITY REPORT

CONCLUSION	We issued an unqualified assurance report on the quality report on 31 May 2017.

SCOPE OF THE REVIEW OF THE QUALITY REPORT

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The quality report is not prepared in line with the guidance issued by NHS Improvement
- The quality report is not consistent with the sources specified in NHS Improvement's detailed guidance for external assurance on quality reports 2016/17
- the two performance indicators subject of limited assurance review are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the guidance.

SPECIFIED INDICATORS FOR TESTING

We are required to test two mandated performance indicators, from a suite of four indicators, chosen in the order of priority required by NHS Improvement:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period (also known as the referral to treatment indicator)
- Percentage of patients with a total time in A&E of four hours or less from arrival to arrival, admission, transfer of discharge
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers
- Emergency readmissions within 28 days of discharge from hospital.

We tested the first two on the list, as well as "Working with Suffolk County Council and clinical commissioning group partners to improve patient access to paediatric speech and language services compared with October 2015 (Start of Community Project)" chosen by the Governors. The results of this audit are outside the scope of our limited assurance report.

REQUIREMENTS	RESPONSE	FINDINGS
Review the content of the report and consistency with specified documents.	We reviewed the contents of the quality report and compared this to the guidance and Regulations issued by the Department of Health. We read the information included in the quality report and considered whether it was materially inconsistent with the: • Board minutes and papers relating to quality reported to the Board • Feedback from Commissioners, Local Healthwatch and Overview and Scrutiny Committee • The Trust's complaints report • Latest national patient survey and staff survey • Head of Internal Audit's annual opinion over the Trust's control environment • Annual governance statement • Care Quality Commission's quality and risk profiles • Results of the latest Payment by Results coding review.	The quality report was prepared in line with the Regulations. We reported to management where there were omissions or where additional information and disclosure was required to comply with the guidance issued by NHS Improvement. These amendments were made to the final published version. The quality report was not materially inconsistent with our review of the information we were required to consider.
Testing of the 18 week referral to treatment (RTT) Indicator The Trust reported performance of 91.75% in respect of the RTT indicator, against a target of 92% in the quality report.	With the installation of e-Care, the Trust's patient administration system, in May 2016, significant issues occurred with the data warehouse resulting in the Trust being unable to report the performance indicator. There were also issues with the quality of data input. As a result the performance indicator was being estimated and there was no patient level data supporting the indicator being reported.	As a result of us not being able to perform testing on this performance indicator due to the absence of patient level data, we were unable to conclude that it was reasonably stated in all material respects.

REQUIREMENTS	RESPONSE	FINDINGS
Testing of the A&E Indicator The Trust reported performance of 86.89% in respect of the A&E indicator, against a target of 95% in the quality report.	We undertook testing to: • Confirm the definition and guidance used by the Trust to calculate the indicator • Document and walk through the Trust's systems used to produce the indicator • Undertake substantive testing on the underlying data against six specified data quality dimensions.	No issues to report.
Testing of the local Indicator Working with Suffolk County Council and Clinical Commissioning Group partners to improve patient access to paediatric speech and language services compared with October 2015 (Start of Community Project).	We undertook testing to: • Confirm the definition and guidance used by the Trust to calculate the indicator • Document and walk through the Trust's systems used to produce the indicator • Undertake substantive testing on the underlying data against six specified data quality dimensions.	Our work on this indicator found that the Trust's measurement of the nine month waiting period is not measured to the specific date of access but to the month of access, whereas this is not made clear in the Quality Report. Our testing of the underlying data identified some minor errors with the utilisation of the system used to prepare the reported indicator.

APPENDIX

REPORTS ISSUED

We issued the following reports in respect of the 2016/17 financial year.

REPORT	DATE
Planning report	20 April 2017
Audit completion report	31 May 2017
Report on the quality report	25 May 2017
Annual Audit Letter	14 July 2017

FEES

We reported our original fee proposals in our planning report. We have not had to amend our planned fees.

AUDIT AREA	FINAL FEES £	PLANNED FEES £
Audit Fee	44,000	44,000
Total audit	**44,000**	**44,000**
Fees for audit related services - Quality report	5,000	5,000
Total assurance services	**49,000**	**49,000**

FOR MORE INFORMATION:

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The matters raised in our report prepared in connection with the audit are those we believe should be brought to the attention of the organisation. They do not purport to be a complete record of all matters arising. No responsibility to any third party is accepted.

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Item 15b

WEST SUFFOLK NHS FOUNDATION TRUST

QUALITY REPORT 2016/17

LIMITED ASSURANCE REVIEW

Report to the Council of Governors

May 2017

CONTENTS

EXECUTIVE SUMMARY
Significant audit findings

This report covers the findings of our review of West Suffolk NHS Foundation Trust's Quality Report for the year ended 31 March 2017, which is included within the Trust's Annual Report. The scope of the limited assurance review includes checking the contents of the quality review against guidance issued by NHS Improvement, considering its consistency with other specified information and spot checks of a sample of reported performance indicators.

AREA OF AUDIT	SUMMARY
Content of the report	We are satisfied that, after some minor amendments made in response to audit findings, the Quality Report is compliant with the guidance issued by NHS Improvement.
Consistency checks with specified documents	We have read the draft Quality Report and conclude that it is not materially inconsistent with our review of the information we are required to consider as set out in NHS Improvement's detailed guidance for external assurance on Quality Reports 2016/17. At the time of writing this report we have not yet reviewed the stakeholder statements.
Mandated indicator 1: Percentage of patients taking less than 18 weeks from referral to treatment (Incomplete pathway)	The Trust reported performance of 91.75% in respect of the Percentage of Patients taking less than 18 weeks from referral to treatment indicator, against a target of 92% in the draft Quality Report. The Trust is currently estimating the data that is being reported. With the installation of e-Care, the Trust's patient administration system, in May 2016, significant issues occurred with the data warehouse resulting in the Trust being unable to report the performance indicator. There are also issues with the quality of data input. As a result the performance indicator is being estimated and there is no patient level data supporting the indicator being reported. As a result of us not being able to perform testing on this performance indicator due to the absence of patient level data, we cannot gain assurance that it is reasonably stated in all material respects. Consequently, we anticipate issuing a modified limited assurance opinion in respect of this indicator.
Mandated indicator 2: 4 hour A&E waiting times	The Trust has reported performance of 86.89% in respect of the maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge indicator, against a target of 95% in the draft Quality Report. Testing confirmed that the compliance rate was 86.89%. There are adequate data capture arrangements for the initiation, system processing and reporting of this indicator. Our testing of a sample of 15 cases included checks on A&E attendees from throughout the 2016/17 year, confirming that all had been correctly recorded as meeting/exceeding the 4 hour target where applicable. All were concluded to have been accurately recorded. On the implementation of e-Care in May 2016, the Trust was unable to report on this indicator for a 2 week period. We have considered whether the missing two weeks data could have had a material impact on the indicator figure reported based on average numbers of A&E attendances each week, for which we concluded that they would not have a material impact. Therefore, as a result of additional information provided by the Trust, and audit work performed, we have been able to conclude that this performance indicator is reasonably stated in all material respects.

AREA OF AUDIT	SUMMARY
Local indicator (not covered by our assurance report):	The Trust has reported the number of patients who receive access to paediatric speech and language services within less than 9 months. The Trust aims to improve the number of patients waiting less than 9 months compared to October 2015 when the Community Contract commenced. The Trust has reported performance of 91.4%, with a total of 4,738 out of 5,185 patients reported in the draft Quality Report as having received access within 9 months.
Working with Suffolk County Council and Clinical Commissioning Group partners to improve patient access to paediatric speech and language services compared with October 2015 (Start of Community Project)	We re-calculated the compliance rate using the data held on the Trust's S1 system and found this to be incorrectly calculated. The compliance rate was re-calculated as 89%. The reported performance is, therefore, overstated. We tested 30 patients selected at random from the data used to calculate the indicator, to ensure the results recorded in respect of each patient agreed to the patient records. Four errors were identified from our testing. We have raised a number of recommendations relating to this indicator, which we have set out in appendix I.
Limited assurance opinion	We have read the draft Quality Report and conclude that it is not materially inconsistent with our review of the information we are required to read as set out in NHS Improvement's detailed guidance for external assurance on quality reports 2016/17. We conclude that the content of the Quality Report is in line with the NHS Foundation Trust Annual Reporting Manual 2016/17 and supporting guidance and that the reported 4 hour A&E waiting times performance indicator is reasonably stated in all material respects. We have been unable to conclude that the percentage of patients taking less than 18 weeks from referral to treatment (incomplete pathway) performance indicator is reasonably stated in all material respects and therefore we anticipate issuing a modified limited assurance opinion in respect of this indicator.

We would like to thank staff for their co-operation and assistance during the audit.

AUDIT SCOPE AND OBJECTIVES

Requirement to publish a Quality Report

QUALITY ACCOUNT

All trusts are required under statute to publish a Quality Account which must include prescribed information as required by the NHS Act 2009 and in the terms set out in the NHS (Quality Account) Regulations 2010 as amended by the NHS (Quality Account) Amendments Regulations 2011 and NHS (Quality Account) Amendments Regulations 2012 (collectively "the Quality Accounts Regulations").

For 2016-17, there is no significant change in the arrangements for producing quality accounts. NHS England and NHS Improvement wrote to all trust chief executives in January 2017 to confirm this.

QUALITY REPORT

NHS Improvement requires Foundation Trusts to include a Quality Report in their Annual Report.

NHS Improvement's detailed requirements for Quality Reports for 2016/17 document confirms that their requirements for the Quality Report incorporates all the requirements of the Quality Account Regulations, as well as a number of additional reporting requirements set by NHS Improvement.

AUDIT SCOPE AND OBJECTIVES
Limited assurance audit review

SCOPE AND OBJECTIVES

NHS Improvement requires that NHS Foundation Trusts obtain external assurance from auditors for the Quality Report to include:

1. A review of the content of the quality report against NHS Improvement's detailed requirements for quality reports 2016/17.
2. A review of the content of the quality report for consistency against the other information sources as directed by NHS Improvement.
3. Testing of mandated performance indicators (and one indicator selected by Governors), to assess whether these have been reasonably stated in all material respects.

MANDATED INDICATORS

We are required to test two mandated performance indicators, from a suite of four indicators, chosen in the order of priority required by NHS Improvement:

1. Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
2. Percentage of patients with a total time in A%E of four hours or less from arrival to arrival, admission, transfer of discharge
3. Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers
4. Emergency readmissions within 28 days of discharge from hospital.

The results of this review are reported in our limited assurance report in the quality report.

As the trust reports all of the indicators in monitor's list we have reviewed the following two indicators:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- Percentage of patients with a total time in A&E of four hours or less from arrival to arrival, admission, transfer of discharge.

OTHER INDICATORS

The Trust is also required to obtain external assurance over one local indicator included in the Quality Report, as selected by the Council of Governors of the Trust.

We are not required to provide any assurance over this indicator.

Governors selected the following local indicator for external review:

- Working with Suffolk County Council and Clinical Commissioning Group partners to improve patient access to paediatric speech and language services compared with October 2015 (Start of Community Project).

COMMUNICATIONS

The required outcomes of this review are:

- Limited assurance report on the Quality Report
- Detailed report on the findings and recommendations for improvements, including the additional indicator, addressed to the Council of Governors.

The content of this report has been discussed and agreed with the Trust Secretary.

DETAILED FINDINGS
Review of the quality report

CONTENT OF THE REPORT	CONCLUSIONS AND AUDIT ISSUES
We reviewed the Quality Report against the requirements set out in NHS Improvement's detailed requirements for Quality Reports for 2016/17.	We reviewed the draft quality report and have reported to management where there were some minor omissions that were required to comply with the guidance issued by NHS Improvement. The Trust has amended the Quality Report to reflect our recommended changes to ensure that the report is compliant with the guidance issued by NHS Improvement.

CONSISTENCY CHECKS	CONCLUSIONS AND AUDIT ISSUES
We read the Quality Report to assess if it is materially inconsistent with any of the following documents, as directed by NHS Improvement: • Board minutes for the period April 2016 to May 2017 • Papers relating to quality reported to the Board over the period April 2016 to May 2017 • Feedback from Governors • Feedback from Commissioners, Health watch organisations and the Overview and Scrutiny Committee • The Trust's complaints report to be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 • Feedback from other named stakeholders involved in the sign off of the quality report • Latest national and local patient survey dated June 2016 and September 2016 respectively • Latest National Staff Survey for 2016/17. • Head of Internal Audit's annual opinion for 2016/17 • Care Quality Commission Inspection Report dated August 2016.	We have read the draft quality report and conclude that it is not materially inconsistent with our review of the information we are required to read as set out in NHS Improvement's detailed guidance for external assurance on Quality Reports 2016/17. At the time of writing this report we have not yet reviewed the stakeholder statements.

DETAILED FINDINGS
Mandated indicator testing

PERCENTAGE OF PATIENTS UNDER 18 WEEKS	AUDIT ISSUES AND IMPACT ON ASSURANCE REPORT
The Referral to Treatment (RTT) operational standards are that 90% of admitted and 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral. In order to sustain delivery of these standards, 92% of patients who have not yet started treatment should have been waiting no more than 18 weeks. The Trust is required to report the percentage of pathways incomplete within 18 weeks for patients that remain on incomplete pathways at the end of each month. The reported figure being the average of the 12 monthly positions across the whole year. The Trust has reported performance of 91.75% of incomplete pathways being below 18 weeks for patients on incomplete pathways at the end of the reporting period (as an average across the 2016/17 financial year), against a target of 92% in the quality report. The data used to report this indicator is estimated.	The Trust has reported performance of 91.75% in respect of the Percentage of Patients taking less than 18 weeks from referral to treatment indicator, against a target of 92% in the draft Quality Report. The Trust is currently estimating the data that is being reported. With the installation of e-Care, the Trust's patient administration system, in May 2016, significant issues occurred with the data warehouse resulting in the Trust being unable to report the performance indicator. There are also issues with the quality of data input. As a result the performance indicator is being estimated and there is no patient level data supporting the indicator being reported. Therefore we were not able to perform testing on the data behind the reported indicator figure. We have recommended that, in order to ensure transparency of this matter, a narrative statement below the reported figures for the mandated indicators is included, explaining that e-Care implementation has led to the figures for this particular indicator being estimated. As a result of us not being able to perform testing on this performance indicator, we cannot gain assurance that this indicator is reasonably stated in all material respects in the Quality Report. Consequently, we anticipate issuing a modified limited assurance opinion in respect of this particular indicator.

4 HOUR A&E WAITING TIMES	AUDIT ISSUES AND IMPACT ON ASSURANCE REPORT
The Trust is required to report the percentage of patients who are admitted, discharged or transferred within 4 hours of arrival at A&E. The Trust has reported performance of 86.89% of patients being admitted, discharged or transferred within 4 hours of arrival at A&E, against a target of 95% in the quality report.	The Trust has reported performance of 86.89% in respect of the maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge indicator, against a target of 95% in the draft Quality Report. Testing confirmed that the compliance rate was 86.89%. There are adequate data capture arrangements for the initiation, system processing and reporting of this indicator. Our testing of a sample of 15 cases included checks on A&E attendees from throughout the 2016/17 year, confirming that all had been correctly recorded as meeting/exceeding the 4 hour target where applicable. All were concluded to have been accurately recorded. It should be noted that the e-Care integrated electronic patient record system, which went live in May 2016, was designed in a way that would assist with the production of this performance indicator in future periods. As explained in the above Indicator, there were implementation issues with this system, which, for the A&E indicator, meant that there were issues with the integrity of the data for the first two weeks in May 2016, where the system was not recording the data needed to report on this indicator. Therefore the figure in the Quality Report covers a 50 week period, omitting these two weeks. We considered whether the missing two weeks' data could have had a material impact on the indicator figure reported based on average numbers of A&E attendances each week, and concluded that they would not have a material impact. The Trust has been transparent with the users of the accounts by adding in a statement to explain that the percentage has been calculated based on 50 weeks of the year, due to the un-reportable two weeks in May. We have concluded that this performance indicator is reasonably stated in all material respects.

DETAILED FINDINGS
Local indicator testing

Local Indicator	AUDIT ISSUES AND IMPACT ON ASSURANCE REPORT
Working with Suffolk County Council and Clinical Commissioning Group partners to improve patient access to paediatric speech and language services compared with October 2015 (Start of Community Project). The Trust reported the Number of children waiting to receive Speech and Language therapy treatment during the 2016/17 year, highlighting the number of children who had been waiting in on the clinic and schools waiting list for over and under 9 months.	The Trust has reported the number of patients who receive access to paediatric speech and language services within less than 9 months. The Trust aims to improve the number of patients waiting less than 9 months compared to October 2015 when the Community Contract commenced. The Trust has reported performance of 91.4%, with a total of 4,738 out of 5,185 patients reported in the draft Quality Report as having received access within 9 months. We re-calculated the compliance rate using the data held on the Trust's S1 system. From this we have concluded the compliance rates to have been incorrectly calculated. The compliance rate was re-calculated as 89% with the reported figure found to be overstated, as there were actually 123 additional fails which were not identified in the Trust's calculation. We have tested 30 patients selected at random from the data used to calculate the indicator, to ensure the results recorded in respect of each patient agreed to the patient records. Four errors were identified from our testing. Two of the patients were recorded as waiting Less than 9 Months when they were actually waiting for greater than 9 months. A further 2 of the patients were recorded as waiting for greater than 9 months who were actually waiting for less than 9 months. We identified: - The data analysts were not using the correct date for the "initial assessment", due to the therapist not pressing the correct button on the S1 system when uploading the information from the assessment, meaning the analyst had, in one case, picked up the referral to treatment date instead. - Five cases where the analysts were picking up "record keeping" inputs to the system, as opposed to the actual initial assessment date, meaning that they were not calculating the waiting time correctly. - One case where the therapist had selected the correct button when uploading the initial assessment detail, however, this was missed by the data analysts and the case was reported based on the initial referral to treatment date, despite there being an initial assessment date on the case file for the patient tested. - One case where the analysts had picked up the date the patient had moved onto the "working with" list, having received their first treatment, as the "initial assessment" date. Therefore, this patient was recorded as a fail in the tested month, whereas they should not have even been a part of the data having already received some care. - Two cases where, due to an issue with the calculation used to derive the number of months the patients had been waiting, they were recorded as waiting less than 9 months, when actually they were both waiting for over 9 months, based on the total number of days waiting divided by the average days per month. This meant that they were included as passes (less than 9 months), when they were actually fails. From reviewing the entire population, we identified 123 cases where the same had happened, and the formulae used meant that they were recorded as waiting less than 9 months when the patients were actually waiting for more than 9 months. - The report for April 2016 for the clinic waiting list had not been produced in the same way as the other months. This report did not contain the supporting data for all of the cases reported on, and did not have an evaluation showing the

Local Indicator	AUDIT ISSUES AND IMPACT ON ASSURANCE REPORT
	waiting bands for the patients. We were unable to test the completeness of the data as the data processing team were not able to produce a report of only those cases where the patients have had their initial assessment (Clock Starts) but then dropped out before receiving any treatment (Clock Ends). We have raised a number of recommendations in relation to this performance indicator, which can be seen in appendix I.

APPENDICES

APPENDIX I: RECOMMENDATIONS AND ACTION PLAN

CONCLUSIONS FROM WORK	RECOMMENDATIONS	MANAGEMENT RESPONSE	RESPONSIBILITY	TIMING
REVIEW OF THE QUALITY ACCOUNT				
PERFORMANCE INDICATORS				
Access to Paediatric Speech and Language PI Our testing identified errors with the calculation used to identify the waiting time for patients as over/under 9 Months.	Revisit the calculation used to report the figures in the quality report for the access to paediatric speech and language performance indicator.			
Access to Paediatric Speech and Language PI Our testing identified a number of cases where the Therapists, particularly Locums, had not entered information onto the system correctly, and the data processing team had not identified the correct dates for the indicator reporting.	Implement a regular review process (monthly), where an experienced member of the therapy team reviews the data uploaded and ensures the details/results are input to the system correctly. This will help to ensure that the initial assessment date is accurately recorded. Therapists, in particular the Locums, should be thoroughly trained on how to document the details of their assessments in S1. Introduce procedure notes on how information should be added to S1.			
Access to Paediatric Speech and Language PI Our testing identified that the Trust is not able to run appropriate reports to show all details of every discharge from the waiting list, between initial assessment and receipt of treatment.	Retain records of all patients who are discharged from the waiting list. This will show those patients who have started to receive a package of care, and also those who are discharged without receiving any care, and detail the reasons for discharge.			

APPENDIX II: STATUS OF PRIOR YEAR RECOMMENDATIONS

RECOMMENDATIONS	MANAGEMENT RESPONSE	RESPONSIBILITY	PRIORITY & TIMING	PROGRESS
PERFORMANCE INDICATORS				
WHO Checklist Observation Audit Perform the observation audit every month in every theatre on the allocated date	Theatre staff will be made aware they should stick to the audit timetable and provide cover to coordinate the audit if on annual leave	Irene Fretwell	June 2016 (Complete)	
WHO Checklist Observation Audit Rotate the Operational Department Practitioner on occasion so that they observe a different department to the one they normally work within. There are potential further benefits of such rotation from the sharing of best practice between the departments.	This is not considered achievable as the ODP auditors are part of the theatre team for the procedure. Consider and agree possible alternative actions: • Further consideration of other staff groups to audit WHO checklist in theatre. • Governance manager for Surgery to spot check on audit days. • Possible annual peer review audit with another Trust.	Surgical Clinical Directors	September 2016	
WHO Checklist Observation Audit Provide training to all Operational Department Practitioners performing the audits to minimise incorrectly completed audit forms. Include the number of incorrectly completed forms as part of the indicator's reporting.	Provide training from Governance on the Safer Surgery Audit tools. This information will be included into future reporting within the Quality Report.	Irene Fretwell/ Governance Manager (Surgery) Governance Manager (Surgery)	August 2016 May 2017	
WHO Checklist Observation Audit Consider redefining the indicator to show the percentage of patients that were fully compliant with all 3/5 stages of the WHO checklist.	Reporting the number of patients meeting all of the 3/5 stages of the checklist will be trialled and if this adds values to interpreting and learning from the audits will be adopted.	Governance Manager (Surgery)	October 2016	

The matters raised in our report prepared in connection with the audit are those we believe should be brought to your attention. They do not purport to be a complete record of all matters arising. This report is prepared solely for the use of the company and may not be quoted nor copied without our prior written consent. No responsibility to any third party is accepted.

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West Suffolk NHS
NHS Foundation Trust

REPORT TO:	Council of Governors
MEETING DATE:	10 August 2017
SUBJECT:	External Audit performance – report from Audit Committee
AGENDA ITEM:	16
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	18 July 2017
FOR:	Approval

1. Background

The NHS Foundation Trust Code of Governance document, issued by NHS Improvement, includes guidance to the Council of Governors relating to assessing the performance of the external auditors:

C.3.4. The Audit Committee should make a report to the Council of Governors in relation to the performance of the external auditor, including details such as the quality and value of the work and the timeliness of reporting and fees, to enable to Council of Governors to consider whether or not to re-appoint them. The Audit Committee should also make recommendation to the Council of Governors about the appointment, re-appointment and removal of the external auditor and approve the remuneration and terms of engagement of the external auditor."

2. Performance of the External Auditors

The Audit Committee met on the 28 July 2017, at this meeting the performance of the Trust's external auditors was considered, in particular the:

- Timeliness of reporting
- Quality of work
- Audit fees

2.1. **Timeliness of reporting**

The Audit Committee agreed that the Trust had a good working relationship with BDO and deadlines were always met. BDO responded to the vast majority of queries raised in 2017/18 promptly.

Audit Reports have always been received to enable the Trust to meet the Annual Reports and Accounts external filing deadlines although in 2017/18 there was additional pressure due to extenuating circumstances with the audit team and also because the Trust challenged the Use of Resources conclusion.

2.2. **Quality of Work**

The Audit Committee considers that it has received good quality reports from BDO that communicate any significant findings arising from their audit. The reports have been helpful in assisting the Audit Committee in discharging its governance duties. They work effectively with Internal Audit ensuring that sharing of information provides a cost effective method of ensuring all audit requirements and risks can be met.

The quality of BDO's audit work is assessed by Financial Reporting Council (FRC) on an annual basis. The report covers all of their audit work and not just their NHS clients.

The following section in an extract from the report which identified areas for improvement. These matters were not considered significant enough to warrant sanctions as allowed for by the FRC. The content of the FRC report is focussed on the matters where they believe improvements are required and the report is not intended to provide a balanced scorecard.

"Our key findings in the current year requiring action by the firm, which are elaborated further in section 2 together with the firm's actions to address them, are that the firm should:
Individual audit reviews
– Improve the quality of information provided and the communication with Audit Committees in areas of judgment.
– Improve the quality of audit evidence and challenge to management in relation to the audit of provisions.
– Ensure that improvements to substantive analytical review procedures are embedded in the audit of revenue.
– Improve the extent of corroborative evidence in the testing of journals.
Review of firm-wide procedures
– Ensure the Ethics Partner is always consulted on independence matter s when required."

The other firms subject to this scrutiny generally had similar issues raised. A copy of those reports can be found here

https://www.frc.org.uk/Our-Work/Audit-and-Actuarial-Regulation/Audit-Quality-Review/Audit-firm-specific-reports/Audit-firm-specific-reports-2017.aspx

2.3. Audit Fees

The Trust carried out a competitive external audit tender exercise and BDO were successfully re-appointed as appointed as external auditor for three years from 2017/18. This external audit tender exercise should provide the Council of Governors with a level of assurance that the fees have been market tested and therefore fees offer good value for money.

For the 2016/17 financial year the summary of fees is as follows:

	£
Statutory audit fee	44,000
Quality Report	5,000
Total	**49,000**

3. Recommendation

The Council of Governors is asked to consider the feedback from the Audit Committee on the performance of the Trust's external auditors. This should provide sufficient assurance to the Council of Governors that BDO has provided a quality, timely and cost effective external audit service. The Audit Committee recommends that BDO should remain in appointment as the Trust's external auditors until their current contract ends.

West Suffolk NHS
NHS Foundation Trust

REPORT TO:	Council of Governors
MEETING DATE:	10 August 2017
SUBJECT:	Equality and Diversity Objectives and Action Plan
AGENDA ITEM:	17
PRESENTED BY:	Denise Pora, Workforce Development Manager
FOR:	Information

1. Background and Introduction

Equality and diversity are at the heart of our continued ambition to become the employer of choice and our vision to deliver the best quality and safest care for our community. We are also fully committed to complying with the 2010 Equality Act and our public sector equality duty (PSED).

The purpose of this report is to update and seek the views of the Council of Governors on the assessments made of the equality and diversity priorities for the Trust and the draft objectives and action plan developed to address these.

2. Draft Equality Objectives and Action Plan

A single comprehensive draft action plan has been developed for the trust covering the Workforce Race Equality Standard (WRES), the Equality Delivery Scheme 2 (EDS2), equality and diversity issues arising from the national staff survey 2016 and the Social Partnership Forum collective call to action on tackling bullying in the NHS.

Six equality and diversity objectives have been identified. Staff and the local community are being consulted on these and their associated actions. The objectives are:

- Improve the patient experience and care of older age patients (including those with dementia)
- Promote and support inclusive leadership at all levels of the trust
- Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours
- Embed equality and diversity in mainstream business processes
- Improve information and data collected, in respect of protected characteristics
- Ensure that the recruitment interview process is bias free

The draft Trust Equality and Diversity Action Plan setting out the action to be taken to make progress towards achieving these objectives is attached as **appendix A**.

3. Equality Delivery System 2 (EDS2)

Implementation of the EDS2 is a requirement on both NHS commissioners and NHS providers. At the heart of the EDS2 is a set of 18 outcomes grouped into 4 goals. These focus on the issues of most concern to patients, carers, communities, NHS staff and Boards of Directors.

The four goals are:

- Better health outcomes
- Improved patient access and experience
- A representative and supported workforce
- Inclusive leadership

A copy of the draft EDS2 template proposing ratings and giving evidence for those ratings can be found at http://www.wsh.nhs.uk/Corporate-information/Information-we-publish/Equality-and-diversity-share-your-views.aspx

4. Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) is included in the NHS standard contract and its main purpose is:

- To help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators.
- Produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff and
- To improve BME representation at the Board level of the organisation.

A copy of the Trust's WRES template can also be found at http://www.wsh.nhs.uk/Corporate-information/Information-we-publish/Equality-and-diversity-share-your-views.aspx. This document provides context for the Trust's equality and diversity objectives and action plan.

5. Questions for the Council of Governors

Feedback from Council of Governors members is requested on:

Draft Equality and Diversity objectives and action plan: *Are the draft objectives the right areas for the Trust to focus on? And are the proposed actions the right ones?*

EDS2: *Are the proposed ratings against the outcomes correct?*

Equality and Diversity Action Plan 2017 to 2019

Equality and Diversity Objective	Action – by 31/8/19	Lead	Supports
Improve the patient experience and care of older age patients (including those with dementia).	• Cognitive screening – review dementia screening within eCare; process to include single question and request for review/referral for memory assessment services via GP • Add delirium screening to eCare • Train volunteers to become 'Ward Companions' to offer comfort, compassion and company for patients at the ends of their lives and their families.	Lead Nurse Dementia & Frail Elderly Voluntary Services Manager	• EDS Goals: better health outcomes, improved patient access and experience • Strategic Framework Ambitions: 1,6
Promote and support inclusive leadership at all levels of the Trust.	• Include cultural competence in 2030 Leaders Programme and evaluate the impact. • Improve the understanding and recognition of managers and leaders of hidden and unconscious bias and its potential impact on patient care. • Increase target for compliance with mandatory Equality and Diversity training from 80% to 90% by 1.4.18 and review with a view to increasing to 95% by 1.1.19	Workforce Development Manager	• EDS Goal: inclusive leadership • Strategic Framework Ambition: 7

Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours.	• Promote 'Freedom to Speak Up, Freedom to Improve' campaign to all staff. • Support and develop the roles of Freedom to Speak-Up Guardian and Guardian of Safe Working.	Executive Director of Workforce and Communications	• EDS Goal: representative and supported workforce • Strategic Framework Ambition: 7 • Social Partnership Forum: Tackling Bullying in the NHS – A collective call to action
Embed equality and diversity in mainstream business processes	• Explore the potential of recruiting and training cultural ambassadors to support mediation processes • Include equality impact assessment as part of the standard business planning template • Ensure impact on equality is considered appropriately in all reports put before the Trust Board and Trust Executive Group	Workforce Development Manager	• EDS Goal: inclusive leadership • Strategic Framework Ambition: 1 • Public Sector Equality Duty
Improve information and data collected, in respect of protected characteristics, to ensure that the right services are delivered, and in order to improve patient experience and staff satisfaction.	• Review how we analyse and use complaints data relating to protected characteristics • Work towards 100% workforce sample for the NHS staff survey with particular concerted focus on BME staff who are generally less likely to complete the exercise • Review results of gender pay gap reporting and identify action	Workforce Development Manager Deputy Director of HR (Workforce) Workforce Development Manager	• EDS Goals: representative and supported workforce and improved patient access and experience • Workforce Race Equality Scheme • Strategic Framework Ambition 1

	• Identify potential for additional patient data collection on protected characteristics via e-Care • Roll out ESR self-service giving all staff access to update their personal details (including protected characteristics) and promote to staff. Campaign will focus on BME staff and those with a disability.	Workforce Development Manager Deputy Director of HR (Workforce)	
Ensure that the recruitment interview process is bias free	• Internal audit of recruitment interview process to seek to identify reason(s) for the reduced likelihood of shortlisted BME candidates being appointed by comparison to shortlisted white candidates. Identify action as appropriate. • Explore the potential of recruiting and training cultural ambassadors to support the selection process.	Workforce Development Manager	• Workforce Race Equality Scheme • Public Sector Equality Duty • EDS Goal: Fair NHS recruitment and selection processes lead to a more representative workforce at all levels

West Suffolk NHS
NHS Foundation Trust

REPORT TO:	Council of Governors
MEETING DATE:	10 August 2017
SUBJECT:	Appointment of Deputy Lead Governor
AGENDA ITEM:	18
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
FOR:	Approval

1. Background

It was agreed at the Council of Governors meeting on 11 May 2017, that the election of a Deputy Lead Governor would take place at the meeting on 10 August 2017.

In accordance with the process agreed at that meeting nominations were invited from the Public Governors for the role, the closing date for these being 1 August 2017.

2. Nominations

Only one nomination was received from Liz Steele and her supporting statement is provided below:

I have been a governor for 2 years and understand the role fully. I attend all meetings and training and support the Trust at events. I contribute to Council and Governor meetings when necessary. I was a head teacher for 20 years and so have experience of leadership.

I have a loyalty towards the hospital but I challenge when appropriate. I have the time to spend on the role of Governor and Deputy Lead if needed. I live locally and am always available at short notice and quickly.

I recently was involved in the selection process for a new chairman.

3. Recommendation

Governors are asked to approve the appointment of Liz Steele as Deputy Lead Governor for the remainder of the vacant term (until November 2018). This is subject to the incumbent governor standing and being re-elected as a public governor in November 2017.

West Suffolk NHS
NHS Foundation Trust

REPORT TO:	Council of Governors
MEETING DATE:	10 August 2017
SUBJECT:	Report from Lead Governor
AGENDA ITEM:	19
PRESENTED BY:	June Carpenter, Lead Governor
FOR:	Information

As I reflect on the 3 months since the last CoG in May there are several changes. The Trust offices have moved to Quince House, the Nominations Committee have interviewed for a new Chair without success and we head towards the elections for Governors forming a new CoG.

Attending the Trust board meetings has helped us understand the continuing challenges that the Trust faces. Some Governors have completed the appraisals for the NEDs something one can only do if you observe them at work. We have met with the NEDs at a joint meeting, always useful and informative and helps to clarify any queries one might have. Quality Walkabouts and sessions in the Courtyard Cafe add to one's knowledge of the workings of the Trust.

To be an informed and effective Governor personally I believe that attending these events is a time commitment but essential and should be considered before standing as a governor again.

West Suffolk NHS
NHS Foundation Trust

REPORT TO:	Council of Governors
MEETING DATE:	10 August 2017
SUBJECT:	Staff Governor Report
AGENDA ITEM:	20
PRESENTED BY:	Nick Finch, Staff Governor
FOR:	Information

Over the past couple of months I have continued to meet with the staff I represent by attending departmental meetings both on formal and on an ad-hoc basis.

I have received same interesting feedback both positive and negative which has been handed to the relevant managers to address.

Along with the Public Governors I have sat on the nominations committee and have been part of the appointment process for a new Chairman.

During the next couple of weeks I will be actively looking for candidates who are interested and would be prepared to stand as a Staff Governor in the elections later this year.