Council of Governors Meeting

There will be a meeting of the **COUNCIL OF GOVERNORS** of West Suffolk NHS Foundation Trust on Wednesday **21 February 2018 at 17.30** in the Education Centre, West Suffolk Hospital

Sheila Childerhouse, Chair

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's focus in holding the Board to account is on strategy, control, accountability and culture.

17.30	**GENERAL BUSINESS**	
1.	**Apologies for absence** To receive any apologies for the meeting	Sheila Childerhouse
2.	**Welcome and introductions** To welcome governors and attendees to the meeting.	Sheila Childerhouse
3.	**Declaration of interests for items on the agenda** To receive any declarations of interest for items on the agenda	Sheila Childerhouse
4.	**Minutes of the meeting of 16 November 2017** (enclosed) To approve the minutes of the meeting held on 16 November 2017	Sheila Childerhouse
5.	**Matters arising action sheet** (enclosed) To note updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
6.	**Chair's update** (enclosed) To receive an update from the Chair	Sheila Childerhouse
7.	**Chief executive's report** (enclosed) To note a report on operational and strategic matters	Stephen Dunn
8.	**Governor issues** To note the issues raised and receive any agenda items from Governors for future meetings	June Carpenter
18.15	**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
18.35	**INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP**	
11.	**e-Care update** (enclosed) To receive a report on on the implementation of e-Care and Global Digital Exemplar programme	Dermot O'Riordan
18.55	**BUILD A JOINED UP FUTURE**	
12.	**Annual quality report and operational plan** (enclosed) To approve the quality indicator to be tested by the external auditors and invite nominations from governors to act as readers for the annual quality report and operational plan.	Richard Jones
19.05	**GOVERNANCE**	
13.	**Register of interests** (enclosed) To review the register of governors' interests	Richard Jones
14.	**Subcommittees of the Council of Governors** (enclosed) To approve/elect membership of sub-committees: a) **Engagement Committee** – minimum 5 governors plus lead governor b) **Nominations Committee** – Chair, 3 public governors, lead governor, 1 staff governor and 1 partner governor	Sheila Childerhouse / Richard Jones
15.	**Lead Governor report** (enclosed) To receive a report from the Lead Governor.	June Carpenter
16.	**Election of NHS Providers Governor Advisory Committee** (enclosed) To note the election and process for governors to vote	Richard Jones
19.20	**ITEMS FOR INFORMATION**	
17.	**Dates for meetings for 2018** Thursday 17 May Thursday 9 August Wednesday 14 November Annual Members Meeting Tuesday 11 September	
18.	**Reflections on meeting** To consider whether the right balance has been achieved in terms of information received and questions for assurance versus operational delivery	Sheila Childerhouse
19.30	**CLOSE**	

REPORT TO:	Council of Governors
MEETING DATE:	21 February 2018
SUBJECT:	Draft Minutes of the Council of Governors Meeting held on 16 November 2017
AGENDA ITEM:	4
PRESENTED BY:	Sheila Childerhouse, Chair
FOR:	Approval

DRAFT

MINUTES OF THE COUNCIL OF GOVERNORS' MEETING
HELD ON THURSDAY 16 NOVEMBER 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	•	
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		•
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		
Catherine Waller	Intern Non-Executive Director		

Action

GENERAL BUSINESS

17/65 APOLOGIES

Apologies for absence were noted as above.

It was noted that the Chief Executive and Alan Rose had also sent their apologies.

17/66 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting and introduced Catherine Waller, intern Non-Executive Director. He explained that she was taking part in a programme developed by NHSI to give people experience of the Non-Executive Director role, with the intention that they would be more able to apply for a Non-Executive Director position in the future.

The Chairman also introduced Dr Kate Honnor, Histopathology Registrar, who was shadowing Nick Jenkins for the day.

It was noted that Charles Nevitt had resigned as a public Governor and confirmed that he would not be replaced prior to the elections.

17/67 DECLARATIONS OF INTEREST

There were no declarations of interest.

17/68 MINUTES OF THE COUNCIL OF GOVERNORS MEETING HELD ON 10 AUGUST 2017

The minutes of the meeting held on 10 August 2017 were approved as a true and accurate record.

17/69 MATTERS ARISING ACTION SHEET

There were no ongoing actions. The two completed actions were items on the agenda for today's meeting.

17/70 CHAIRMAN'S UPDATE

The Chairman said that it had been a great experience to be Chair of WSFT and of the Council of Governors. He thanked the Governors for all their work and asked those that were re-elected to carry on with this work.

He reported that the CQC had come into the Trust last Wednesday afternoon to give a briefing on what the inspection process would involve, including an unannounced visit in January and a well led review at the beginning of December. However, they then made an unannounced visit last Thursday and Friday. The feedback they had given was very positive; there had been one issue where they found a bottle of out of date nail varnish remover in a drugs cupboard. Nick Jenkins explained that all drugs/items in a drugs cupboard must be in date. They had also looked at end of life care and outpatients.

There had been a lot of positive comments and the lead inspector had indicated that the CQC would not be coming back, apart from the well led review. Following this they would produce a draft report which would be sent to the Trust approximately six weeks later. WSFT would have ten working days to respond to any matters of factual accuracy. The CQC would then publish the final report on their website.

The Chairman considered the feedback to be a very good result overall.

The CQC had not commented on the mandatory training rate but this needed to be addressed. Mark Gurnell confirmed that Addenbrooke's was very rigorous in enforcing this.

The Chairman referred to the Governor elections; there would be a new Council of Governors from 1 December 2017 and a number of current Governors were standing again. He reminded those who were re-elected that part of their job would be to bring on/mentor new colleagues. He also suggested that the Lead Governor needed to make it clear to new public Governors from day one what the expectations were. June Carpenter explained that she would be inviting new Governors to meet for coffee before the Governor training day on 3 February 2018.

17/71 CHIEF EXECUTIVE'S REPORT

Judy Cory expressed her concern about the front of hospital concourse. She had met with Richard Jones to discuss this and would be meeting with pharmacy about who would be selling which items.

The Chairman reminded Governors that the hospital provided services to patients and was not a money making venture. He stressed that a range of items needed to be provided, such as newspapers, and this was a valuable service to patients.

Nick Jenkins agreed that there was a need to ensure that patients and visitors were able to obtain everything they needed in the main entrance area. He explained that the plan was for this to be discussed further and also to consult with patients and visitors about what they would like. It was suggested that this should be one of the questions asked in the Courtyard Café sessions. **R Jones / G Holmes**

Joe Pajak asked what the timeline for this was and suggested that the consultation should be put on the website. Stuart Woodhead said that as a public Governor, representing the public and people attending the hospital, he considered that the front entrance was a very important part of the experience that people had when they attended the hospital, apart from the medical treatment they received.

Jan Osborne referred to the Sustainability and Transformation Funding (STF) of £5.2m and asked about the gap and the risk of not achieving the cost improvement plan. It was explained that this would be discussed under the finance and performance report.

Jan Osnorne also referred to 'caring for carers' and asked for clarification about how carers were made aware of this initiative when a loved one went into hospital. It was explained that this initiative was currently not across the whole hospital but the intention was for it to be. Nick Jenkins said that he would look into how this was communicated to carers and report back to the next meeting. **N Jenkins**

June Carpenter asked about the number of staff who had had flu jabs. Nick Jenkins said that this was still very disappointing as approximately only 50% of staff had been vaccinated to date.

Peter Harris noted that nurses were going out into the hospital with trolleys and attending meetings and appeared to be trying to encourage as many staff as possible to have a flu jab. Nick Jenkins considered that they could still try harder, including aiming for staff who worked nights and early mornings.

Joe Pajak said that he had heard that 40% of people considered flu jabs to be a negative.

Nick Jenkins explained that he had written to NHS England proposing that this should become mandatory for all staff. He had also raised this with the Department of Health but they did not have the appetite to mandate this. The Chairman said that WSFT needed to learn from what Addenbrooke's had done and increase its attempt to get more staff vaccinated.

Sara Mildmay-White said that she was very pleased to see that assessments for NHS Continuing Healthcare would not be part of the discharge process, and asked when and where this would be done. Nick Jenkins explained that this would be completed soon after discharge at wherever the patient was discharged to.

June Carpenter referred to the recent Strategic Transformation Partnership (STP) event for Non-Executive Directors and Governors, and that in the brochure that had been produced all the examples were from Essex. There had been very few attendees and very little input from the Suffolk area. Nick Jenkins explained that various Executive Directors from WSFT sat on committees within the STP.

Justine Corney said that the whole system appeared to be focussed on Ipswich and Colchester hospitals.

The Chairman explained that the major event within the STP was the merger of the two hospitals, also that each system was going down the integrated care route, and this was where WSFT was focussing its efforts.

Nick Jenkins referred to preparations for winter. He explained that in January 2017 a process started which had been rolled out nationwide to make inpatient ward care as efficient as possible. This included discussions about patients every weekday, led by a consultant, to support the flow of patients through the hospital as soon as possible.

WSFT was now able to identify and report the benefits of this initiative. The average length of stay had reduced by just over half a day. There was also a range of other initiatives, including the support to go home service. He explained how this worked, the benefits and the difference it was making.

17/72 GOVERNOR ISSUES

The responses to the Governor issues were noted.

June Carpenter explained that she was expecting that quarterly feedback from the quality walkabouts would be reported at this meeting. However, Richard Jones had confirmed that in future a quarterly report would be going to the Board and included as part of the summary quality and performance report to the Council of Governors.

The Chairman explained about the new phone auditing tool that could now be used when undertaken quality walkabouts.

It was noted that the Board meeting on 29 March 2018 was a Thursday, due to 30 March being Good Friday.

DELIVER FOR TODAY

17/73 SUMMARY QUALITY & PERFORMANCE REPORT

Gary Norgate explained that several initiatives were driving improvements in performance but the NEDs still had some concerns in a number of areas, eg pressure ulcers and falls. Pressure ulcers had been discussed at the Board meeting and a good explanation had been provided by the executive team, but this would continue to be focussed on. There had been reporting issues around falls and actions were being implemented to improve this.

Performance of the emergency department continued to be an issue and a number of actions had been put in place to improve the situation.

The other issue was referral to treatment (RTT) which was behind target. It was now possible to report this accurately, rather than forecasting and now that it was known what the problem was this could start to be addressed.

Gary Norgate highlighted the strong performance in nutrition where there had been two or three months of improvement.

Mary Allan asked how performance on pressure ulcers compared with other hospitals. The Chairman explained that this was measured within the safety thermometer and WSFT performed strongly compared to the national average.

Nick Jenkins explained that F5 had had over 500 days without a pressure ulcer and the learning from this was being taken to other areas of the organisation.

David Frape asked about the use of water beds. It was explained that the Trust used air beds which were more effective.

He also asked about sepsis during surgery and understanding what caused this. Nick Jenkins confirmed that the Trust always tried to understand what caused an infection.

June Carpenter asked about learning from deaths and if this this was fed back to the family/relatives. Nick Jenkins confirmed that information was fed back, ie duty of candour. Information was also fed back to all teams across the organisation.

17/74 SUMMARY FINANCE & WORKFORCE REPORT

Neville Hounsome explained that this report looked at the financial position at half year. The Trust was currently on target to achieve the year-end forecast. It was positive that 45% of the cost improvement programme (CIP) had already been delivered which was considerable progress compared to the last two years. If all CIPs were achieved the Trust would achieve its year-end target which meant that it would receive STF funding. However, if it did not achieve its target it would not receive this funding.

The Non-Executive Directors had asked the executive team about winter pressures and if this would impact on the Trust's finances and use up the contingency.

The main cause for concern was Women & Children, which had performed well while Lakenheath had not been able to accommodate pregnant mothers. However, performance could now be challenging as WSFT was no longer treating Lakenheath these patients.

May Allan asked if the good financial performance was due to better budgeting and forecasting than previous years. Neville Hounsome explained that CIPs were better this year and phased more accurately.

Neville Hounsome referred to 2018/19 and explained that the main issue was the target of a CIP of £18.3m, which was 8% of revenue. This was the largest saving that the Trust had ever been asked to make. The executive team were focussed on this and KPMG had been assisting. The Non-Executive Directors had asked the executive team to consider earlier rather than later if this figure was deliverable or not. He explained that funding for Glastonbury Court was not guaranteed for future years and without it achieving the CIP would be more difficult.

It was noted that slippage in the capital programme would not affect I&E (Income & Expenditure account)

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

17/75 PATHOLOGY SERVICES

Nick Jenkins updated the Council of Governors on pathology and explained that in April this had moved from the Pathology Partnership (TPP) to North East Essex and Suffolk Pathology Services (NEESPS). The majority of the same staff were in the laboratories but there was a different management team, which had been an improvement as far as communication and discussions were concerned. Although services were not yet good enough they had developed a plan to get back on track.

The only option for a 'plan B' was to bring everything back in-house, which was in direct opposition to the Department of Health's (DH) plans for partnership working. Another solution would be to find a different partner to work with who could provide the services required. However, the organisation that had previously been considered was now experiencing the same problems that had been experienced by TPP. This meant that there was currently no other partner to go to who would be able to provide any more assurance than NEESPS.

In order to provide assurance that safe services could be provided WSFT had retained its own consultants in the laboratories and they were accountable to Nick Jenkins. However, there was still not a reliable quality governance system which could provide assurance that the processes the laboratories should have were in existence and being adhered to. Although this was a problem he felt that the situation was improving and he did not think that the laboratory was unsafe, or not providing the services that it should be providing for patients.

Stuart Woodhead agreed that the governance and organisation of TPP was flawed right from the beginning. His concern was that NEEPS appeared to have serious governance issues which needed to be addressed, or it would be in a similar situation to TPP. If there was no obvious alternative provider he proposed looking at the range of pathology services required by the hospital and for a series of solutions.

Nick Jenkins assured Stuart Woodhead that the Trust was seriously looking for a 'plan B'. However, NEESPS recognised that its governance was inadequate and were working to improve this.

Neville Hounsome explained that the fact Nick Jenkins attended meetings with NEESPS provided a degree of assurance.

Joe Pajak asked if there was evidence across the country that this was not working everywhere and if anyone had spoken to the DH about this, or if some areas were able to work in this way and WSFT could learn from this. The Chairman confirmed that WSFT had responded to the DH and said that mergers were unsettling for staff and could result in good people being lost. Also that organisations did not all have the management capacity and experience to manage an operation of this type.

Mary Allan asked Nick Jenkins if he was not confident that NEESPS would work. Nick Jenkins said that although he was not confident, he thought that it could well work but there was no guarantee. Whereas he never thought that TPP would work.

The Chairman stressed that a lot of people were working very hard on this and NEESPS needed to be given time, although at the same time alternatives should continue to be explored.

BUILD A JOINED UP FUTURE

17/76 e-CARE UPDATE

Gary Norgate reminded Governors of the background and history of moving to e-Care and the decision taken by the Trust to work with Cerner. He explained that e-Care was an ongoing journey of up to ten years and even then it would be changing and improving. He stressed that it was not a technology project, but a people project, helping people to work in a different ways facilitated by technology.

He explained the content of phase 1, which went live in May 2016, and that by 2017 full OrderComms had been introduced. Phase 2 had recently gone live and this had gone very smoothly, but there was more work required to encourage people to engage with and use the new system.

Phase 3 would be the main part of the Global Digital Exemplar (GDE) funding and he explained the four different pillars in this phase. The Non-Executive Directors were focussing on four things, one of which was 'is it safe?'. They had been assured by the fact that go-live had been delayed when there had been concerns. They were also focussing on benefits realisation and interoperability across the system and its potential to support the Integrated Care Organisation strategy, as well as commercial performance of the contract, ie whether it was value for money.

June Carpenter asked what the timescale was. Gary Norgate explained that this was a ten year journey and phase 3 would go-live gradually from 2018.

Joe Pajak asked about commercial performance and how value for money of the contract could be tested. Gary Norgate explained that it was also in Cerner's interests to demonstrate value for money in order to ensure they obtained further business throughout the NHS.

David Frape asked if GPs were integrated with this system and if there was any resistance from GPs getting involved. Gary Norgate explained that twelve GPs were currently trialling this and GPs had been involved throughout the e-Care process, as well as the CCG. There had been good collaboration and issues with interoperability had been overcome.

Richard Davies explained that GPs had been using electronic care for a long time and the advantages of interoperability were considerable.

Gary Norgate stressed that security was key; therefore before anything was released it was ensured that the correct firewalls and access control were in place.

GOVERNANCE

17/77 PROPOSED AMENDMENT TO CONSTITUTION

Richard Jones explained that this started to look at moving governance structures towards representing the change of emphasis and working across the system. Therefore the proposal was for there to be two primary care nominated partner Governors. It was proposed to replace the vacant Community Action Suffolk position with a primary care nominated partner, as local voluntary services would have a strong voice within the Alliance model. There would also be a new seat for an additional representative from primary care.

Liz Steele asked about the requirement for partner Governors to be involved in the activities of the Council of Governors and attend meetings. Richard Jones confirmed that partner Governors were required to attend meetings and encouraged to take part in other activities. As with all Governors if they missed three meetings in succession this would be reviewed in line with the Constitution.

Joe Pajak asked about this review and the need to attend meetings and if this was a national recommendation. Richard Jones confirmed that this requirement had been re-visited previously as part of the review of WSFT's constitution.

Joe Pajak asked if there should be a nominated partner Governor from Health and Wellbeing. The Chairman explained that this was included under Council representatives.

Sara Mildmay-White asked if this additional position would be for a patient representative or a GP. Richard Jones confirmed that this would be a representative from primary care.

The Council of Governors approved the proposed constitutional change to establish two primary care representatives on the Council of Governors as partner Governors.

It was noted that this recommendation also required the approval of the Trust Board.

17/78 REPORT FROM NOMINATIONS COMMITTEE

The Chairman reported that mid-year 360◦ appraisals had been undertaken for Richard Davies and Alan Rose. He reminded the Council of Governors of the process for this and thanked those who had taken part.

A Nominations Committee meeting had taken place earlier this afternoon and the key messages were agreed that would be fed back to the two individuals. The Chairman would be meeting with Richard Davies and Alan Rose and undertaking their appraisals within the next two weeks.

17/79 LEAD GOVERNOR REPORT

This report was received and the content noted.

17/80 STAFF GOVERNOR REPORT

This report was received and the content noted.

ITEMS FOR INFORMATION

17/81 DATES FOR MEETINGS FOR 2018

The dates for meetings for 2018 were received and noted as follows:-

Wednesday 21 February
Thursday 17 May
Thursday 9 August
Wednesday 14 November
Annual Members Meeting Tuesday 11 September 2018

17/82 REFLECTIONS ON MEETING

This was the final meeting for the Chairman and the current Council of Governors. The Chairman thanked the Governors for all their hard work and Neville Hounsome for all his work as a Non-Executive Director.

REPORT TO:	Council of Governors
MEETING DATE:	21 February 2018
SUBJECT:	Matters Arising Action Sheet from Council of Governors Meeting of 16 November 2017
AGENDA ITEM:	5
PRESENTED BY:	Sheila Childerhouse, 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
152	16 November 2017	17/66	Incorporate questions relating to main entrance area in Courtyard Café questionnaire	Questionnaire amended by patient experience manager to include questions and used in December Courtyard Café session.	G Holmes	5 Dec 17
153	16 November 2017	17/54	Confirm how carers made aware of 'caring for cares' initiative when a loved one admitted to hospital.	We use a variety of ways to advertise the support we offer to family carers Ideally family carers should be identified by ward staff on admission and given the carers pack with badge, but this can happen at any stage during an admission. Each ward has a supply of carer's packs and a list to record when they have been given out. There is a carers page on the trust website containing information that is included in the packs: http://www.wsh.nhs.uk/Patients-and-visitors/Information-for-carers.aspx There is a carers' display board in the main hospital foyer and in the main corridor and there are posters at the entrance to each ward advertising the support available and the carers packs. We have envelopes for family carers in the outpatients dept. containing a 'helpful organisations leaflet' and a slip that tells the carer if the person they care for is admitted to WSH to ask for a family carers pack from the ward.	N Jenkins	21 Feb 18

REPORT TO:	Council of Governors
MEETING DATE:	21 February 2018
SUBJECT:	Chair's report to Council of Governors
AGENDA ITEM:	6
PREPARED BY:	Sheila Childerhouse, Chair
PRESENTED BY:	Sheila Childerhouse, Chair
FOR:	Information

I intend to use this as a regular report to the Council of Governors to provide a summary of the key activities that I have been involved in.

Prior to taking up post in January I sought to meet with and engage with a number of staff within the Trust as well as external partners. I am most grateful to Roger Quince who as part of a structured handover provided insight to the strengths and challenges facing the Trust.

As part of my programme of activities I will endeavour to maintain a balance between my internal focus on our hospital and community services and my engagement with external partners.

I wish to pass on my thanks to all those who have welcomed me so warmly to the Trust both within the hospital but also the community. I was delighted to be invited to the first informal meeting of the newly elected Governors which provided an excellent way for me to start to get to know our Governors.

In addition to the meetings and events set out I have weekly meetings with Steve Dunn. I also meet regularly with all directors including Craig Black, Richard Jones and Georgina Holmes.

Date	Meetings and events (1/1/18 until 9/2/18)
4/1/18	Steve Turpie, NED – introductory meeting
5/1/18	Steve Dunn, CEO – introductory meeting
9/1/18	Quality walkabout – visiting ward F10
9/1/18	Alan Rose, NED – introductory meeting
9/1/18	Catherine Waller, Intern NED – introductory meeting
10/1/18	Scrutiny Committee – monthly meeting
10/1/18	Tara Rose and Sue Smith – communications and charity
10/1/18	Rowan Procter, Executive Chief Nurse – introductory meeting
12/1/18	STP Board meeting
16/1/18	David Swales, Assistant Director of Finance to discuss Charitable Funds Committee
16/1/18	Craig Black, Director of Finance and Deputy CEO – introductory meeting
16/1/18	Helen Beck, Chief Operating Office – introductory meeting
18/1/18	Meeting with Staff Governors
18/1/18	Informal meeting with Governors
19/1/18	Susannah Howard, STP Programme Director – discuss STP chairs agenda

Date	Meetings and events (1/1/18 until 9/2/18)
19/1/18	Richard Davies, NED – introductory meeting
19/1/18	Gary Norgate, NED – introductory meeting
22/1/18	Claire Lea, Richard Jones and Georgina Holmes – agenda for Governor induction event on 3 February
22/1/18	Clinical Directors meeting – introductory meeting
23/1/18	Quality walkabout - visiting the pharmacy department
23/1/18	NHS Improvement and executive team – regular performance review meeting
26/1/18	All NEDs - Board pre-meeting
26/1/18	Audit Committee – approve charitable funds accounts
26/1/18	Trust Board meeting
26/1/18	Quality & Risk Committee meeting – including Buurtzorg presentation
26/1/18	Charitable Funds Committee – regular meeting
30/1/18	Quality walkabout - visiting the pre-assessment unit (PAU)
30/1/18	Meeting with Sue Smith, Fundraising Manager and Charity Team (My Wish)
30/1/18	Paul Morris – tour of hospital
30/1/18	Mark Shenton, Chair Ipswich and East Suffolk CCG
3/2/18	Governor training day facilitated by Claire Lea
6/2/18	'People we care for' - voluntary sector event in Cambridge
7/2/18	Trust induction
7/2/18	Bury Free Press interview
8/2/18	Pam Donnelly, Strategic Director of Customer & Relationships at Colchester Borough Council
8/2/18	Suffolk & North East Essex STP Chairs Group
8/2/18	Gary Page, chairman of the Norfolk and Suffolk NHS Foundation Trust
9/2/18	STP Board meeting

Recommendation

Governors are asked to note the report for information.

Council of Governors – 21 February 2018

AGENDA ITEM:	7
PRESENTED BY:	Steve Dunn, Chief Executive Officer
PREPARED BY:	Steve Dunn, Chief Executive Officer
DATE PREPARED:	5 February 2018
SUBJECT:	Chief Executive's Report
PURPOSE:	Information

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 aimed to highlight some of the key strategic issues and challenges that the organisation is addressing.

I am delighted to welcome **Sheila Childerhouse** as our new chair. Sheila has vast experience of both the public and voluntary sector having served on various local and regional health bodies since 1984 in non-executive and chair roles, most recently at the East of England Ambulance Service NHS Trust (EEAST) and Anglian Community Enterprise. Sheila brings a wealth of expertise to the position and I am confident that the Trust will benefit hugely from her extensive experience and expertise.

I felt immensely proud for all our staff when we received the highest rating**, 'outstanding', from the Care Quality Commission (CQC)** – one of just seven general hospitals in England, and the only one in the Midlands and East region, to hold the accolade.

Inspectors said WSFT staff 'truly respected and valued patients and individuals and empowered them as partners in their care, practically and emotionally, by offering an exceptional and distinctive service.' They also said: 'On all the wards we visited, staff displayed a culture of compassion and positivity, and had a genuine desire to want to provide the best possible care to patients'. The Care Quality Commission visited the Trust in November last year, inspecting its end-of-life and outpatient services and reviewing how well-led the organisation was. The Trust was rated outstanding for being caring, effective and well-led, and good for being safe and responsive.

This is a testament to everyone's hard work and unwavering commitment. I am privileged to see the incredible care our staff provide 24/7, 365 days a year, and I'm delighted that their efforts have been recognised by the CQC. I am particularly proud that our end-of-life service has moved from having one requires improvement rating in our last inspection, to outstanding. Good end of life care is tailored to the person who needs it, and this report shows that our staff go above and beyond to ensure comfort, dignity and kindness is at the heart of what they do.

Since we last met we have been putting in place detailed plans to respond to winter pressures. A core part of this has been our focus on ensuring that we make sure every day that a patient spends in our hospital is a 'green' day. In addition to previous schemes which I have mentioned in previous reports we have put in place a series of further initiatives to help our patients get fit and well as soon as possible and ensure that they get back to where they want and need to be:

- Sally Lawrence and Jenny McCaughan have set up a weekly multi-disciplinary team (MDT) review of **stranded patients** (inpatients that have been in hospital for seven days or more), and those patients with the longest length of stay (31 days or more). This is part of a wider programme of work to ensure that the care we provide to patients is as coordinated and efficient as possible, to avoid unnecessary delays for inpatients, and helping us to provide emergency department (ED) and inpatient services safely over winter and beyond.

  Regular reviews take place and are attended by nursing, care coordinators, discharge planning team, therapies, social services, the CCG and a senior manager. The group identifies patient delays and communicates these delays to the services who can resolve them. The reviews also provide a forum for communication for all staff involved in complex discharge planning (e.g. social services, discharge planning team, therapies) to ensure the whole MDT is working in parallel towards each patient's discharge.

- Our **'Support to go home'** initiative is supporting complex discharges. It is a care-bridging service we are hosting in partnership with Suffolk County Council, which helps patients get home more quickly and saves bed days in the hospital. Since its launch in September, the 'support to go home' service has so far helped 151 patients to get home more quickly, and saved 763 bed days in the hospital. The team aims to make sure patients can still be discharged home if there's a delayed start date for their out-of-hospital package of care. Care is provided seven days a week, in a patient's home by a WSFT team, which support patients with washing, dressing, medication prompts and meal preparation. We're really seeing a positive impact as a result of this service, and our team of reablement support workers are doing a fantastic job enhancing the recovery of patients in their own home.

- A new **discharge waiting area** (DWA) has been developed to provide a safe and comfortable environment for patients to wait for the final step of their discharge to be completed e.g. TTOs and transport. The DWA supports patient flow by enabling beds to be freed up earlier in the day, this in turn ensures we treat the right patient, in the right place, first time. Staff are asked to:

  - Identify suitable patients, ideally the day before and on the day
  - Have patients ready to go to the DWA as early as possible
  - View the DWA as an integral part of the patient pathway.

- The Trust has an aspiration and ambition for each ward to discharge at least two **'golden' patients** out of their total daily discharges before 10.00am each day. Patients should be discharged either out of hospital or to the discharge waiting area.

- I was very proud to take part in the launch of a fantastic joint-initiative to help care home residents receive quicker and more effective care should they need to come into hospital. Care home residents in east and west Suffolk are now benefitting from the new **'Red Bag' scheme**; the bag contains important medical information, medication and personal items packed by care home staff, and transferred to the hospital via ambulance colleagues. The red bag keeps all the patient's important information in one place with the aim of speeding up the handover time between ambulance and hospital and providing a smoother and less stressful experience for the patient. It means that nurses and doctors have timely information about the patient, resulting in fewer calls to the care home and easier interaction. The initiative is a partnership between ourselves, 20 local care homes, NHS Ipswich and East Suffolk and NHS West Suffolk clinical commissioning groups, Ipswich Hospital NHS Trust and the East of England Ambulance Service NHS Trust.

- As part of our winter planning, the Trust ran a '**perfect week'** exercise across West Suffolk Hospital from 2 – 9 January. This is because every year, after Christmas and New Year, the NHS experiences higher levels of patient demand. The week saw staff from both clinical and non-clinical areas pull together to focus on supporting patient flow throughout the hospital, in order to maintain high quality standards of care and positive patient experience.

Notwithstanding all our preparations, the Trust has seen its busiest winter ever. Since Christmas the Trust has seen **sustained winter pressure**, with high numbers of attendances and admissions of very sick patients. In response we opened our planned escalation beds, but due to the significantly higher than expected numbers of admissions, we have also had to open additional surge beds. This was required to ensure that we had capacity to appropriately care for patients. We have struggled to get additional temporary staff to nurse these additional beds despite increasing pay to substantive, bank and agency nurses. We have had to mitigate this risk across the organisation, which has unfortunately resulted in areas working with staffing levels which are below our core numbers. We take this issue seriously, and our staffing plans have been reviewed at regular intervals each day by a senior matron, including weekends. Appropriate mitigations are put in place to maintain safety.

In December we experienced more than 6% additional admissions to the hospital than the same period in 2016 - with emergency attendances hitting 230 on one day, compared to 178 for the same period the previous year. Emergency department (ED) performance deteriorated to 83% for December, with some exceptionally challenging days. Over the last six months we have worked to reduce the number of 'stranded patients' (inpatients that have been in hospital for seven days or more). Through initiatives such as 'red to green' we have exceed our target of 160 and regularly achieved numbers as low as 140. At this level the hospital is able to run, achieving good patient flow. In the first few weeks after Christmas however, the number of stranded patients rose to as high as 208 and remained high. This reflects the high acuity of patients admitted to the hospital and some social care delays following the Christmas and New Year bank holiday period. Our partners in social care have worked hard to address this issue and have provided additional social worker capacity as well as purchasing additional care. As a result stranded patient numbers have dropped but remain above our target of 160.

The sustained pressure and decisions we have had to take have impacted on performance in a number of areas but the priority as always was patient safety. It also means that we have had to make some difficult decisions:

- Cancelling routine elective activity, as per recommendations from the National Emergency Pressures Panel (NEPP) – we have continued to provide urgent elective surgery, including cancer treatment
- Temporarily using the area that we established as our discharge waiting area (DWA) to create 13 additional inpatient beds
- Opening our ultraclean elective F4 ward to selected emergency surgical patients. The emergency patients admitted to F4 have been carefully chosen to reduce the impact and allow the ward to be returned to its intended purpose as soon as possible
- For a short period (48 hours) we admitted female surgical patients to our maternity beds, again we selected these patients carefully to minimise the risk to mothers and babies on the ward and we provided nursing support to work alongside our midwives
- Working sensitively with patients and families to support suitable placement in the community pending their destination of choice becoming available.

It is hugely disappointing that we have had to cancel some patient admissions for planned operations due to winter pressures. We recognise the impact this has on patients and their families but also our staff. Staff have worked incredibly hard to improve the Trust's referral to treatment (RTT) time and we have seen improved performance against the RTT target and fewer 52 week wait breaches. These measures will deteriorate while we respond to the current levels of demand. Patients whose operations are cancelled will be rebooked as soon as possible, but with limited capacity to provide the surgery this will likely impact on our activity and performance for some time. It is estimated that the additional sessions required to undertake this work will create a cost pressure of £340k.

Throughout this period our staff have once again gone above and beyond. I was in every day between Christmas day and the end of January and saw our hospital and community staff pull together time and time again. I would like thank them all for their professionalism and commitment. We will continue to respond to the high levels of demand and are working with colleagues across the health and care system to look after members of our community.

Although our **vacancy levels** are no higher than they were last year, it's felt like a really tough few months for our staff in terms of capacity. We aren't alone in feeling this way; NHS Providers, which represents health chiefs, has recently published information saying that for two thirds of trust leaders, recruitment and staff numbers are more of a concern for them than the money. We're endeavouring to try and fill as many registered nurse vacancies as possible, whether through substantive recruitment, bank, or agency staff.

The Trust is in the progress of pulling together a workforce and capacity plan which will drive the longer term nursing recruitment plan. In the meantime that Trust has had a successful recruitment trip to Phillipines and made 55 appointments – it is now about taking them through the rigorous migration process. The HR department has restructured in order to appoint a nursing workforce lead whose main focus will be recruitment and retention of nurses. A nursing apprenticeship plan is being pulled together with the intention of presenting this to the Board soon. In the short term, the Trust has introduced a bonus scheme to encourage more substantive and bank staff to work more shifts until the end of March (20 bank staff are signed up with another 10 in the pipeline). In addition we are introducing, where possible, more flexible working in order to retain and attract nurses back to the Trust.

December's performance shows we reported no C. difficile cases, and continue to focus on reducing patient falls and pressure ulcers, with 69 falls and 13 pressure ulcers reported in December. Referral to treatment (RTT) performance for patients on an incomplete pathway is 89% against the target of 92%, although due to the pressures seen in January and referred to above, this is likely to deteriorate. Unfortunately we have reported 15 patients breaching 52 weeks. RTT remains the most significant performance challenge facing the Trust and we are working with KPMG and the intensive support Tteam to support performance improvement. Cancer performance improved during December, with all targets being achieved. The Trust achieved the 62-day wait for first treatment from NHS Cancer Screening Service referral target in December, with performance of 100% against a target of 90%. The year to date performance for all cancer targets is ahead of the national threshold.

The **month nine financial position** reports a deficit of £734k for December which is worse than plan by £889k.The reported cumulative position is therefore £1,079k worse than plan. There has been an increase in our costs relating to escalation capacity during December, and since our use of escalation capacity has been significant in January this expenditure pattern is likely to continue but without any further funding. STF is dependent upon achieving financial and performance targets and our Q4 plan is reliant on achieving £1.8m STF income. The 2017-18 budgets include a cost improvement plan (CIP) of £14.4m, of which £9.7m had been achieved by the end of December (67%).

We continue to work with **North East Essex and Suffolk Pathology Services (NEESPS)** to address regulatory and accreditation concerns. The MHRA undertook a wide ranging inspection of the blood transfusion service on 18 and 19 January 2018. While the visit recognised that improvements have been made it identified that further work is required to address staffing and validation of IT/equipment.

Chief executive blog
As the year came to a close, like many others I stopped and reflected on the last 12 months; and what a 12 months it's been for us here at West Suffolk NHS Foundation Trust (WSFT).

http://www.wsh.nhs.uk/News-room/news-posts/To-2017-and-beyond.aspx

Deliver for today

The **National Emergency Pressures Panel** (NEPP) met at the start of the month, chaired by Professor Sir Bruce Keogh, to discuss the pressure NHS trusts have been facing.

The panel noted that the NHS has been under sustained pressure over the Christmas period with high levels of respiratory illness, bed occupancy levels giving limited capacity to deal with demand surges, early indications of increasing flu prevalence and some reports suggesting a rise in the severity of illness among patients arriving at A&Es. Amongst other recommendations, the panel took the step to urge health trusts to delay non-urgent operations until at least the end of the month. Officials said up to 55,000 operations could be deferred.

As well as all the work going on in the hospital and community, our clinical teams got out and about hitting the streets of Bury in the name of public health this month. To support **World Diabetes Day** (14 November), a group of diabetes nurses and dieticians manned a stand at the Arc shopping centre with our My Wish Charity. They met with more than 100 members of the public, answering any diabetes-related questions that they had, and even met patients and their families that had visited our hospital diabetes clinic that morning! Our diabetes and endocrinology consultant, Nilu Hewapathirana, also did an interview on BBC Radio Suffolk to help spread awareness of the condition, with a particular focus on pregnant women and gestational diabetes. It was great to see, and these simple steps to help support our public health agenda really can make all the difference.

Eight **ward volunteer companions** are now available to sit with patients in the last days of life. They are also able to support families and carers who need to leave their loved-one for a while, or who are struggling and need someone to sit with them for a couple of hours. This service is available for all adult services, and Macmillan educator Michelle Buono is visiting all clinical areas to raise awareness of the service and a quick reference guide for referral is available. It is initiatives like these that show how our end-of-life care services have come on leaps and bounds – a fact reflected in our latest CQC report.

Invest in quality, staff and clinical leadership

We're delighted to be one of just 12 acute NHS hospital trusts **working with HelpForce**, an organisation set up to accelerate improvements in the involvement of volunteers in the NHS, to develop new volunteer roles and create a best practice model for volunteering. HelpForce is starting with a focus on critical moments in hospitals where staff and patients would benefit from additional support, for example at meal times or discharge from hospital. It is also prioritising volunteer help for patients who do not have their own family or wider support network. We are so proud to have more than 400 volunteers who dedicate their tireless energy to helping both our patients and our staff have the best experience they can, and hope our collaboration with HelpForce will allow us to implement new innovations and integrate our volunteers even further.

We're very proud to have received the prestigious, internationally recognised **Baby Friendly Award** – an accreditation set up by Unicef and the World Health Organisation. The Baby Friendly Initiative is a global programme which provides a practical and effective way for health services to improve the care provided for all mothers and babies. In the United Kingdom the initiative works with public services to protect, promote, and support breastfeeding, and to strengthen mother-baby and family relationships. Achieving full accreditation involved a series of three stage assessment visits to ensure that recognised best practice standards are in place. The assessment report said: 'Mothers reported that the whole atmosphere at West Suffolk was calm and friendly. The team were very welcoming and all mothers reported that staff were kind and considerate, and that they were very happy with their care. The team achieved exceptional scores in this area.'
We're delighted that our maternity teams have been recognised in this way.

Specialist nurses in the integrated community paediatric service (ICPS) are working with colleagues to ensure that the **voice of the child** is heard and recorded. Jo Hutchings, named nurse for safeguarding children in community services, and Teresa Mann, specialist nurse for children in care, are training all their ICPS colleagues on ways to capture the voice of the child in records. Since the training started the team has seen real results in the reports prepared by staff, who are thinking outside the box to hear and capture the thoughts of the children they see.
More than 140 staff have already done the training, with Jo and Teresa being asked for more dates.

European Union citizens who have made their lives in the UK have made a huge contribution to our country, and to our NHS, and we want them to stay. The UK government has now reached an agreement with the EU to safeguard citizens' rights. The agreement will provide EU citizens and their family members living in the UK certainty about their rights after we leave the EU and most importantly, allow them to stay here.

No EU citizen currently living here lawfully will have to leave the UK when we leave the EU. There will be plenty of time for people to apply for, and receive, their new residence status after the UK leaves the EU. EU citizens who arrive by 29 March, 2019, and have lived in the UK for five years will be able to apply to stay indefinitely by getting 'settled status'. People who won't have been here for five years when we leave, but arrive here by 29 March, 2019, will be able to apply for permission to stay on until they reach the five-year threshold. They can then also apply for settled status.

Following consultation, a revised version of the **never events policy and framework** and updated never events list have been published. This list now includes two additional types of never event. These aim to provide clarity for staff providing services who may be involved in identifying, investigating or managing never events and ensuring there is a focus on learning and improvement.

Health Education England (HEE) has published a draft **health and care workforce strategy for England to 2027** - facing the facts, shaping the future. The draft workforce strategy sets out the national strategy for recruiting, training and supporting the largest workforce in the country. It is currently out for consultation, with the publication date of July 2018. The document is deliberately broad in its inclusiveness, covering all staff groups, including the adult social care workforce. It tells the story of the last five years, lays out where we are now and looks forward, using both the Five Year Forward View frame and a more aspirational 10 year timescale. The Trust will be discussing and responding to the draft strategy initially through the Clinical Workforce Strategy Group, all comments received will be collated and feedback to HEE by the 23 March 2018.

Nursing teams have gone digital with a new app to make ward inspections quicker, easier and more effective - **Perfect Ward** is a smart app to support ward inspections, so those completing audits can now score questions, capture photos and write free-text comments straight into the app, meaning information is quick to record and up-to-date. Information is stored in the app rather than on the phone used, so it's always secure. Capturing the information directly on phones or tablets also means there's no longer a need to write up and send reports afterwards, saving valuable time. As soon as an inspection is complete, everyone with the app can be alerted and see the results. With automated reporting, it's also much easier to compare performance and track improvements at ward level. There are five different audits available in the app; documentation, observation, patient experience, staff and infection prevention and control. Matrons, ward managers, service managers, general managers, pharmacy, executive directors and the infection prevention team all have access to Perfect Ward, and will be using it to complete ward audits going forward. It will be used on all wards at the West Suffolk Hospital, as well as Rosemary Ward in Newmarket Hospital, and the Kings Suite at Glastonbury Court.

The **outpatients department**, in collaboration with voluntary services, has begun a new initiative to improve the experience of patients in the minor operations lists. After a patient has had their procedure, they are taken to a quiet recovery area before going home, where they're given tea, coffee and biscuits by one of our lovely volunteers. Early feedback has been very positive, with all patients rating the volunteer service they received as excellent. It's a simple innovation, but a great example of how our clinical and voluntary teams can work together to improve patient experience. We are hoping to roll this scheme out in Newmarket Community Hospital too in the near future.

Our **staff choir, Lift**, hosted its first ever concert at St Mary's Church, Bury St Edmunds on Thursday 30 November to help raise funds for the hospital's palliative care services. Dr Phillippa Lawson, respiratory consultant, founded the choir in March 2017, as a way of helping staff to de-stress and support their health and wellbeing. It currently has more than 40 members who regularly attend weekly choir sessions held in the hospital chapel.

Our first cohort of staff completed the new Trust-developed multi-professional **preceptorship programme** in November. Staff from varied disciplines, including nurses, midwives, occupational therapists, physiotherapists, clinical psychologists, community speech and language therapists, and community nurses, came together to receive their certificates after 10-12 months of study and training. The programme helps staff to develop their confidence as an autonomous professional, refine their clinical skills, values and behaviours and to continue their journey of life-long learning. There are six separate study days throughout the year, which each cover a specific subject such as professionalism, resilience, and integration.

Sarah Gull, consultant obstetrician and gynaecologist, has been appointed as the **first guardian for safe working** to support junior doctors in their new contract. The main purpose of this role is to promote safety for patients and their doctors. We all want a good working environment, where staff do not get overtired and feel valued and listened to.
With OneLife Suffolk we are offering **free health checks for staff** aged between 40-74. These assess general health, and in particular, the risk of cardiovascular disease.

Build a joined-up future

New cardiac build underway
The first piece of ground has been broken in preparation for the build of our new £5.2 million state-of-the-art cardiac catheterisation and pacing suite. We're hugely excited about this clinical build, which is set to transform and improve the scope and quality of care that our cardiology patients will receive. The new cardiac suite will mean quicker access to investigations and treatments and will enable angiography and pacemakers to be fitted on site, significantly reducing length of stay for patients, and improving patient experience.

Our My WiSH Charity is also doing its bit to support the suite and help create a fully-integrated cardiac centre; the latest appeal, Every Heart Matters, is looking to raise an extra £500,000 to move cardiac diagnostic functions from the first floor of the hospital onto the ground floor with the new suite. It has currently raised more than £125,000 towards the project.

New sterile services department opens
Our new purpose-built premises to bring the cleaning and sterilising of medical equipment on site at West Suffolk Hospital has been officially opened. The new sterile services department is now fully operational after moving from the Hospital Road site, where it has been based since 1971, to the new purpose-built premises. Sterile services plays a vital role in cleaning and sterilising medical and surgical equipment. It processes an average of 96,000 sets of equipment each year, serving West Suffolk Hospital's wards, clinics and operating theatres, Newmarket Community Hospital and local GPs. With staff no longer influenced by delivery times and couriers, the service is much more efficient and can react to the demands of the busy hospital and external services.

We are working in collaboration with the West Suffolk Clinical Commissioning Group (WSCCG) over the next six months to investigate and implement changes to **prescribing practices** across the Trust, and enhance changes already occurring in primary care. The project aims to reduce both the prescribing and supply of items at discharge from hospital that are used for the treatment of minor/short-term conditions, and that can be purchased 'over the counter'. It also aims to support and enhance the polypharmacy medication review and de-prescribing work that is already being undertaken in both primary and secondary care. These changes will improve the quality of patient care and are expected to result in cost-savings to both WSFT and WSCCG.

Following on from World Mental Health Day, we have been promoting ways staff can access **support for mental wellbeing**. For clinical staff, lots of people who have done health coaching training say it has had a big effect on their resilience by giving them a fresh approach to their work, and a better sense of how they can share responsibility with their patients. The benefits of physical activity for mental wellbeing are also being promoted – a brisk walk, a swim, or even a couple of circuits of the corridors looking at the paintings on display will help keep you cheerful.

And finally, recognising the importance of our staff's mental wellbeing for good quality patient care, the Trust is going to work with Suffolk MIND over the next 12-18 months to provide line manager training in how to create a mentally healthy workspace.

Work has started on the site for three new **staff accommodation blocks** to replace the existing 40-year-old residences. The facility is planned to be in use by May 2019.

REPORT TO:	Council of Governors
MEETING DATE:	21 February 2018
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 6 February 2018.

1. **Could we have Governors lanyards - helpful for the public and staff to know who we are.**

   We will order lanyards and these will be available for all Governors. Timings will be confirmed once ordered.

2. **Governor training**

   (a) Could we have a repeat of Craig's finance training including an overview of how the funding in the bigger Picture works

   We will include this in the next phase of the Governors induction programme and these will take place prior to the May meeting of the Council of Governors.

   (b) Nick Finch would like to do a repeat of his procurement explanation and the value of his new role as freedom to speak up guardian (FTSUG), possibly at an informal Governors meeting.

   We fully support the proposed use of the informal Governors meeting for this kind of session/communication. The Staff Governors will receive briefings on the FTSUG role and other staff engagement approaches are part of their planned quarterly meeting with Jan Bloomfield, Director of Human Resources and Communications.

   (c) A short presentation on My WISH

   We would be happy to present at an informal Governors meeting. Jan Bloomfield, Director of Human Resources and Communications with Sue Smith, Fundraising Manager have agreed to do this.

   (d) Talk from the learning difficulties nurse and one on how dementia is tackled in the trust

   Julie Fountain, Lead Nurse, Dementia & Frail Elderly Care would be happy to present at an informal Governors meeting.

3. Visits

As reported at the last Governors meeting we will continue to offer these visits, although historically uptake has been relatively poor. The target for the visits has been support services/departments, such as pharmacy and radiology.

The emergency department, Newmarket Hospital, children's services and Glastonbury Court are active clinical areas and therefore visits by groups are not appropriate. However, these areas will be included in future quality walkabouts when a governor is in attendance. This will allow the experience of the governor present to be shared with others. Governors also have the opportunity to take part in environmental walkabouts which focus more on general public areas (waiting rooms, corridors, outpatients, courtyards) to support the department managers in ensuring that the Trust's corporate identity and values are represented accurately.

(a) Pharmacy

We will arrange visits to the department (four governors at a time) during May and the dates will be communicated to Governors.

(b) Sterile service department

Dates for visits during March/April have been circulated to governors.

(c) A presentation on how the appointments and W/L offices work

It is proposed that this area is included in the programme of visits for a small group of Governors. This will allow the Governors who attend to feedback to the other Governors. This will be arranged by Georgina Holmes through Angela Price, Service Manager Surgical Division.

4. Queries / Suggestions

(a) Shining Lights - is there to be a Governors shining light

A Governor will be included on the judging panel for Shinning Lights to sit alongside Steve Dunn, Chief Executive, Jan Bloomfield, Director of Workforce & Communications and Gary Norgate, Non-Executive Director.

This year there are fourteen awards categories available for nomination, which represent all areas of the Trust, from frontline staff to people who have made an impact in other ways such as training and innovation:

- Volunteer of the year
- Clinical team of the year
- Non-clinical team of the year
- Community team of the year
- Rising star
- Outstanding contribution to education
- Service improvement award
- Inspirational leadership
- The innovation award
- Excellent contribution in a non-clinical area
- Living our values
- Outstanding contribution to quality of care
- Lifetime achievement
- Employee of the year.

(b) Should the EIT, Buurtzorg and good neighbour scheme be linked together

The EIT service, Buurtzorg test and learn and good neighbour scheme do have some common elements and need to complement one another, but are essentially separate services targeting a different group of patients. Through the good neighbour discussions we are exploring what type of a good neighbour role we could develop that would support both EIT and Burrtzorg.

(c) Time Out - clearer clarification of who should sit where

Jacqui Grimwood, Estates & Facilities Development Manager will discuss with Brod Pooley, Catering Manager if this appears to be an issue. However, no feedback regarding this has been received from any other parties.

(d) Courtyard Cafe - could the sign informing people where the money from car parking goes be enlarged and actually say it funds a ward. A press release saying that the funds have been used for such and without them what the implication would be

Changing the posters is not felt to be the most effective approach. Communication with staff, public and press will take place as part of any future review of car parking charges.

(e) The rubbish bins at the front of the hospital have been noted to be overflowing.

This feedback has been highlighted to the team who will monitor the situation and if required increase the frequency of bin emptying. There have recently been staffing issues in the estates team, but emptying bins is a priority.

(f) An update on the situation regarding the cancellation of elective surgery, is there a communication that goes to patients?

An update is provided in the CEO and quality and performance reports. All cancelled patients are spoken with personally by a member of the waiting list team and any specific concerns are escalated through the Service Manager or PALs. A standard letting explaining the Trust's position is also sent to all patients cancelled as a result of winter pressure.

(g) Chaperone / friend has this been added to appointment letters?

It has been raised that including this language in the OPD appointment letter could unnecessarily raise patient anxiety about the messages to be communicated in a clinic. All surgical clinics have a nurse available to act as a chaperone and in the medical clinics the clinicians ask the nurse running their clinic to act as a chaperone. Posters promoting the chaperone role within outpatients have been prepared and are being reviewed prior to printing.

(h) Community staff feel that the winter pressure monies have gone to hospital staff and not them. When are they going to get IT that links up with the trust and not just system 1

The new combined Trust was formed on 1st October 2017 and the need for a new Information Management and Technology strategy was raised both before and after the formation of the revised Trust.

Prior to Christmas time was spent in a stakeholder engagement exercise and this has led to the development of a new draft IM&T strategy that includes Community Health Services.

Currently the draft Strategy is going through its final reviews prior to being presented to the Trust Executive Group (TEG) on 19 February 2018. Community Health Services are represented at TEG and have received copies of the draft as part of the consultation process. If TEG are happy with the draft Strategy it will be presented to Trust Board for formal approval in March 2018.

(i) Mental Health - what training is there for staff to help them with this group of patients?

Rowan Procter, Chief Nurse confirmed that all nurses have a level of generic training during their full nurse training course. They spend time in paediatrics, learning disabilities, adult and mental health placements. In key areas the Mental Health Psychiatric liaison service provides bespoke training for staff, such as in ED.

(j) What staff feedback is there from Newmarket and community services?

Part of annual NHS staff survey and local staff survey in the Spring. Also scheduling exec directors meetings around the area. These will be followed by a Q&A session for staff – Newmarket and Sudbury will be the first sessions.

(k) What is happening to land belonging to the Trust in Sudbury?

Please see attached briefing (Appendix 1).

(l) Query raised about the lack of privacy when checking in at the MRI desk when you are asked to repeat all your personal details which all the waiting room can here. Also on leaving the department the exit button is very close to the fire alarm

This has been forwarded to the manager and will be discussed with estates ie. moving the exit button away from the fire alarm and looking at ways to support privacy around the reception area.

Recommendation:

To note issues raised and responses.

NHS
West Suffolk
NHS Foundation Trust

FAO: WSFT governors
Subject: Church Field Road site

Date: February 2018

Four sites owned by the West Suffolk NHS Foundation Trust in the Sudbury area were deemed surplus to NHS requirement. These sites comprised of: Harp Close Meadow; Walnuttree and St Leonards hospitals; and a small remaining portion of land (approximately 4.5 acres) on Church Field Road.

In 2012, the Trust launched a formal public consultation around its intentions for these four sites to be potentially marketed for sale.

On 3 May, 2012, a public meeting took place in Sudbury Town Hall, where the Trust's disposal plans were presented. The formal consultation also included: an information website; public exhibitions for each site as they went through the planning consultation process; and an information leaflet, which was printed and distributed to 6,000 homes in the surrounding area. Electronic copies of the public display boards and leaflet, which reference the remaining portion of land on Church Field Road specifically, are attached as Appendices A and B.

A local liaison forum was also established, with formal terms of reference, to keep partner organisations and stakeholders involved in the developments around these four sites. This ran for a year after the formal consultation took place.

Plans specifically relating to the remaining portion of the Church Field Road site were discussed during the formal consultation. These included a number of land allocation options, and the possibility of reconsidering land allocation through the Local Development Framework.

It was communicated at the time that Church Field Road would be the last of the four sites under consideration. It was anticipated that it would be some years before a decision on the site was considered (originally estimated 2014).

The Trust has now reached that point in time, and as per our local plan we are looking at planning options available to us for this piece of land. No formal decisions have been taken; we are exploring the possibility of reallocating the land for housing use, and as such, are looking at whether such planning application for a residential-led scheme can be facilitated.

We intend to make a pre-application to Babergh District Council; following feedback, we will then commence local public engagement with the Sudbury community prior to submitting any formal planning application, to ensure the community has an opportunity to comment on and feed into the decision-making process.

We understand Sudbury community concerns, and their commitment to local healthcare - the new Sudbury Community Health Centre, also on Church Field Road, was officially opened in 2015. However, the NHS has a duty to look at whether it can make its land and buildings work better, as unfortunately unused land costs the Trust money to hold and maintain. Selling or generating income from surplus property that is not being used for patient care creates funds that we can invest to improve healthcare services.

This followed recommendations by the Department of Health, and remains in line with Government targets, reinforced by the publication of the Naylor Review in 2017. In turn, any capital receipt from the sale of sites is

reinvested into meeting the healthcare needs of people living in the communities served by West Suffolk NHS Foundation Trust.

The Sudbury community will have the opportunity to engage with us, and provide feedback on, this issue prior to any formal planning application being submitted.

Please do not hesitate to contact me should you require any further information at this stage.

Stephen Dunn
Chief executive

West Suffolk NHS Foundation Trust

REPORT TO:	Council of Governors
MEETING DATE:	21 February 2018
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 Q3 demonstrates overall **good performance achieving the majority of local and national targets** (defined by NHS Improvement's (NHSI) Single Oversight Framework).

This report describes performance against these targets aligned to the care quality commission's (CQC) five key questions. This include a summary against identfied areas for improvement.

CQC's five key questions

Are we safe?	You are protected from abuse and avoidable harm.
Are we effective?	Your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.
Are we caring?	Staff involve and treat you with compassion, kindness, dignity and respect.
Are we responsive?	Services are organised so that they meet your needs.
Are we well-led?	The leadership, management and governance of the organisation make sure it's providing high-quality care that's based around your individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.

Recommendation:

To note the summary report.

Summary quality & performance report

Are we safe?

Within the **safety dashboard** 10/38 indicators for which data was available were reported as 'green' throughout Q3, including:

- Response to patient safety alerts (2)
- Infection prevention indicators – MRSA, central venous catheter insertion and ongoing care, preventing surgical site infection pre-operative and perioperative care
- Avoidable serious injuries or deaths resulting from falls
- Risk register red/amber risks action completion
- Quarterly environmental isolation.

Areas for improvement

- Whilst the Trust was under trajectory for **Clostridium *difficile*** in the first two quarters, the first two months of Q3 have been over trajectory with a total of 10 cases. Whilst there were no cases in December 2017 the Trust is over trajectory for Q3. As previously acknowledged this may reflect the global shortage of Tazocin which has required the use of antibiotics associated with a higher risk of Clostridium *difficile* infection. The December position reflection availability of Tazocin improving
- The Tissue Viability team continue to maintain excellent visibility and support for ward teams, promoting **pressure ulcer prevention** via bite size teaching sessions, one to one education and promoting awareness and improvement of staff knowledge and practice in promoting skin health and integrity. The Head of Nursing for Surgery and the Tissue Viability team are supporting the wards to achieve more timely completion of investigations. Datix has been updated to reduce the burden of investigation for grade 2 ulcers whilst still capturing the key points of information to allow learning
- The **Falls Focus Group** continues to meet on a bi-monthly basis. Work is ongoing to update the current Datix and e-Care systems to ensure that they are reflective of current recognised best and local practice and to ensure that they are responsive in tackling the issue of patients falling. It is planned that a lying and standing blood pressure task will be set for all patients admitted to the Trust who are over 65 years of age as per NICE guidance
- The Trust has a target for timely reporting and investigation of cases reported as a **Serious incident (SIs).** These are national targets and are monitored by the CCG. Recent changes in reporting requirements associated with the community teams and pressures of work in the wards have led to some delays around reporting and investigation primarily of pressure ulcers over the Christmas period.

The Trust reported a **never event** in October 2017 relating to the administration of methotrexate. The investigation report is being finalised but identified human error as the root cause as the prescription details were entered on the GP electronic health record system as a repeatable oral methotrexate prescription. A joint investigation has been undertaken and learning identified. Action includes establishing a single set of shared care agreements and standard operating procedures across hospital and primary care. This would ensure that the risks of duplicate prescribing is minimised through the use of existing and well established safety controls within GP electronic health record systems. We have written to all GPs with patients receiving subcutaneous methotrexate to ensure that this mode of delivery is accurately reflected in the patients primary care record.

Are we effective?

Within the **effective dashboard** 5/9 indicators for which data was available were reported as 'green' for each month in Q3, including:

- Management of the central alerts system (CAS)
- WHO checklist compliance
- Choose and book available slots
- Cancer two week wait services available on choose and book
- Operations cancelled for the second time.

Areas for improvement

- Clear and complete documentation in a patient's health record is directly linked to the quality of care they receive. Around 40% of **discharge summaries** relate to patients that have been referred to other specialities and so should be completed by them (i.e. Surgery, Medical teams, O&G etc). There are also plans to improving automatic completion of discharge summaries as part of the emergency department (ED) optimisation project over the next few months
- We continue to struggle to offer patients appoints following a **cancelled operation within 28 days**.

Are we caring?

Within the **caring dashboard** 21/26 indicators for which data was available were reported as 'green' throughout Q3.

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.

Areas for improvement

- **Complaints responses times** dropped in December with 7 of the 14 responses due in the month being sent late. This reflects the operation pressures during this period.

Are we responsive?

The table sets out performance against the national service standards. Six of the 11 standards have been met.

Target or Indicator (per Risk Assessment Framework)	Target	Q3	Q2	Q1	Q4
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	92%	88.32%	85.85%	81.77%*	95.2%*
RTT waiter over 52 weeks for incomplete pathway	0	62	90	44	-
A&E Clinical Quality - Total Time in A&E under 4 hours	95%	87.02%	90.54%	95.12%	91.5%
Cancer 62 Day Waits for first treatment (from urgent GP referral)	85%	89.28%	85.41%	85.79%	87.0%
Cancer 62 Day Waits for first treatment (from NHS Cancer Screening Service referral)	90%	94.44%	96.23%	97.56%	94.2%
Cancer 31 day wait for second or subsequent treatment - surgery	94%	100%	100%	100%	100%
Cancer 31 day wait for second or subsequent treatment - drug treatments	98%	100%	100%	100%	99.5%
Cancer 31 day wait from diagnosis to first treatment	96%	99.75%	100%	100%	100%
Cancer 2 week (all cancers)	93%	92.79%	94.12	94.2%	98.9%
Cancer 2 week (breast symptoms)	93%	99.71%	98.81	94.5%	96.7%
C. *diff* due to lapses in care (YTD)	16	10	3	3	9

***** Estimated data due to reporting issues

Areas for improvement

- Delays in being seen by a clinical decision maker (CDM) continues to be the main reason with a majority of the delays being out of hours. Gaps in the medical workforce continue at middle grade and junior doctor level and despite locum requests and increased hourly rates of pay, there continue to be gaps on a frequent basis. There has been agreement for additional consultant support during weekend days and additional locum consultant cover which will provide additional support overall. Bed availability continues to be challenging - additional initiatives have commenced which have had a positive impact. However, the number of speciality expected patients being seen in ED has adversely affected our capacity and ability to manage ED patients in a timely manner
- The percentage of patients on an incomplete pathway within 18 weeks is below the national target of 92%, with performance in December of 89%. Data quality issues and validation of the list continue. The total waiting list has reduced to 16,195 in December. In December, 15 patients breached the 52-week standard, with YTD total of 196. RTT remains the most significant performance challenge facing the Trust and we are working with KPMG and the Intensive Support Team to support performance improvement
- Cancer performance (provisional figures) improved during December, with achieving all the targets. The Trust achieved the 62-day wait for first treatment from NHS Cancer Screening Service referral target in December with performance of 100% against a target of 90%. The YTD performance for all cancer targets is ahead of the national threshold. To improve performance for 'cancer two week wait for urgent GP referrals' we have engaged with the CCG at various levels to improve demand management. Following significant efforts from clinicians and all involved in this

service, they have recovered the situation in November 2017, with December figure of 97%

- The percentage of **stroke patients** scanned within 1 hour of clock start is the of work for the emergency stroke outreach team (ESOT) who continue to work with ED staff in stroke recognition and the importance of referring to ESOT immediately a stroke is suspected.

Are we well-led?

Within the **well-led dashboard** 24/34 indicators for which data was available were reported as 'green' throughout Q3, including:

- Turnover (Rolling 12 mths)
- Executive Team Turnover (Trust Management)
- Agency Spend
- Proportion of Temporary Staff
- Vacancies (2 indicators)
- DBS checks
- Trust Participation in on-going National Audits (Qtrly)
- 14 of the 21 mandatory training requirements

Areas for improvement

- All Staff to have an **appraisal** - The appraisal compliance percentage (62.64% in December) has risen significantly since moving to the new process of recording. The Trust has seen an 11.81% improvement in that time.

REPORT TO:	Council of Governors
MEETING DATE:	21 February 2018
SUBJECT:	Summary Finance Report
AGENDA ITEM:	10
PREPARED BY:	Nick Macdonald, Deputy Director of Finance
PRESENTED BY:	Alan Rose - Non-Executive Director
FOR:	Information - update on Financial Performance

EXECUTIVE SUMMARY:

This report provides an overview of key issues during Q3 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 Q3 position reports a YTD loss of £4.8m, against a planned loss of £3.8m.
- This position includes STF funding of £2.9m.We have forecast STF funding of £4.7m for the year.
- The Use of Resources Rating (UoR) is 3 YTD (1 being highest, 4 being lowest)
- The December position includes a target of £9,928k YTD which represents 69% of the 2017-18 plan. There is currently a shortfall of £218k YTD against this plan.

Key risks

- Delivering the cost improvement programme.
- Containing the increase in demand to that included in the plan (2.5%).
- Our current Q3 A&E performance is below the 90% target for the receipt of Sustainability and Transformation Funding.
- Working across the system to minimise delays in discharge and requirement for escalation beds

I&E headlines for December 2017

The reported I&E for December 2017 YTD is a deficit of £4,849k, against a planned deficit of £3,293k. This results in an adverse variance of £1,556 YTD.

The monthly adverse variance is £889k which is after receiving winter pressure funding of £537k. This is due to unfunded cost pressures relating to:

- recognition of failure to meet A&E target and therefore drop in STF funding (£468k)
- remaining KPMG invoices (£388k) which may be mitigated by further CIP schemes delivering savings during Q4
- overspend on medical and surgical expenditure in December (£300k)
- overspend on pay relating to escalation capacity (£250k)

Given the use of escalation capacity has been significant in January the expenditure pattern in December is likely to continue but without any further funding. We are therefore concerned that our 17-18 control total may not be met, which would impact on our Q4 STF relating to financial performance .Early indications suggest we are unlikely to receive A&E performance STF in Q4.

This year's contingency has been largely deployed against costs relating to RTT, Pathology Services, NHSPS settlement and the SCH community contract.

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 September 2017.

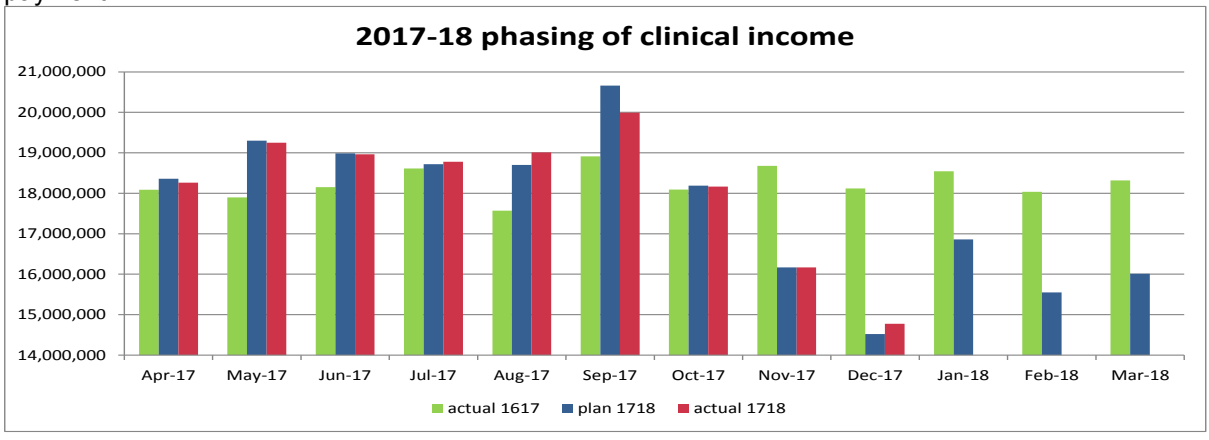
Metric	Value	Score
Capital Service Capacity rating	0.160	4
Liquidity rating	-12.858	3
I&E Margin rating	-2.60%	4
I&E Margin Variance rating	-0.03%	2
Agency	-42.06%	1
Use of Resources Rating after Overrides		**3**

2. Performance against I & E plan

SUMMARY INCOME AND EXPENDITURE ACCOUNT - December 2017	Dec-17			Year to date			Year end forecast		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	14.0	14.7	0.7	160.2	160.4	0.2	206.8	206.7	(0.1)
Other Income	5.2	4.9	(0.3)	25.9	27.1	1.2	33.5	35.2	1.7
Total Income	**19.2**	**19.6**	**0.5**	**186.1**	**187.5**	**1.4**	**240.3**	**241.9**	**1.6**
Pay Costs	12.5	12.7	(0.3)	109.8	109.8	0.0	147.3	147.3	0.0
Non-pay Costs	3.3	4.6	(1.3)	76.0	78.3	(2.3)	94.7	96.7	(2.0)
Operating Expenditure	**15.8**	**17.3**	**(1.6)**	**185.8**	**188.1**	**(2.2)**	**242.0**	**244.0**	**(2.0)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**3.4**	**2.3**	**(1.1)**	**0.2**	**(0.6)**	**(0.8)**	**(1.7)**	**(2.1)**	**(0.4)**
EBITDA margin	20.4%	11.9%	(8.5%)	1.9%	1.2%	(0.7%)	1.5%	1.1%	(0.4%)
Depreciation	2.2	2.2	0.0	5.0	5.1	(0.1)	6.7	6.7	0.0
Finance costs	0.9	0.9	0.0	1.9	2.1	(0.2)	2.2	1.8	0.4
SURPLUS/(DEFICIT) pre S&TF	**0.3**	**(0.8)**	**(1.1)**	**(6.7)**	**(7.8)**	**(1.1)**	**(10.6)**	**(10.6)**	**0.0**
S&T funding - Financial Performance	0.4	0.4	0.0	2.4	2.4	0.0	3.6	3.6	0.0
S&T funding - A&E Performance	0.2	(0.3)	(0.5)	1.0	0.5	(0.5)	1.6	1.1	(0.5)
SURPLUS/(DEFICIT) incl S&TF	**0.8**	**(0.7)**	**(1.5)**	**(3.3)**	**(4.8)**	**(1.6)**	**(5.4)**	**(5.9)**	**(0.5)**

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	668	695	27	6,131	6,471	341
Other Services	1,653	1,625	(27)	21,607	19,239	(2,368)
CQUIN	289	289	(0)	2,696	2,728	32
Elective	2,293	2,405	112	23,479	24,796	1,317
Non Elective	5,351	5,431	80	45,645	47,190	1,545
Emergency Threshold Adjustment	(293)	(382)	(89)	(2,602)	(3,400)	(798)
Outpatients	2,406	2,355	(51)	24,352	23,726	(626)
Community	1,633	2,307	674	38,911	39,660	749
Total	**14,000**	**14,725**	**725**	**160,219**	**160,410**	**191**

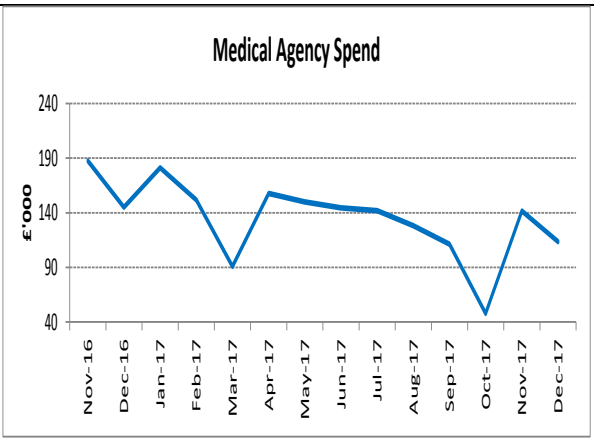
3. Performance against Expenditure plan - Workforce

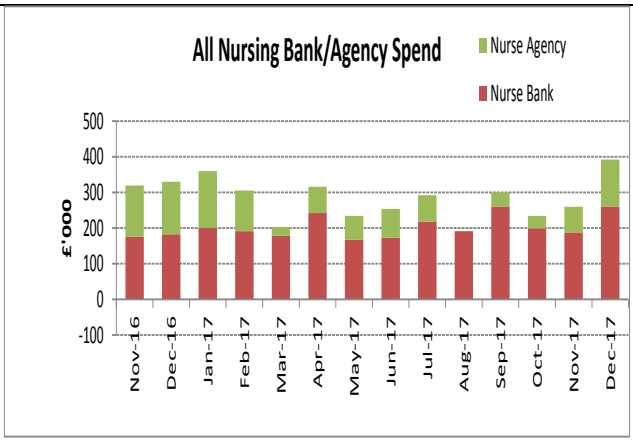
Monthly Expenditure Acute services only				
As at December 2017	Dec-17	Nov-17	Dec-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	10,920	10,968	10,710	98,438
Substantive Staff	9,753	9,765	9,522	87,419
Medical Agency Staff (includes 'contracted in' staff)	102	129	160	1,023
Medical Locum Staff	391	236	163	2,213
Additional Medical sessions	286	290	238	2,433
Nursing Agency Staff	123	72	143	569
Nursing Bank Staff	245	176	175	1,779
Other Agency Staff	47	91	92	619
Other Bank Staff	135	141	127	1,281
Overtime	128	120	78	918
On Call	51	55	47	473
Total temporary expenditure	1,509	1,309	1,222	11,307
Total expenditure on pay	11,262	11,074	10,743	98,726
Variance (F/(A))	(343)	(107)	(33)	(288)
Temp Staff costs % of Total Pay	13.4%	11.8%	11.4%	11.5%
Memo : Total agency spend in month	273	291	394	2,211

Monthly whole time equivalents (WTE) Acute Services only			
As at December 2017	Dec-17	Nov-17	Dec-16
	WTE	WTE	WTE
Budgeted WTE in month	2,931.4	2,981.4	3,016.6
Employed substantive WTE in month	2745.58	2747.66	2,730.6
Medical Agency Staff (includes 'contracted in' staff)	8.44	13.15	12.1
Medical Locum	21.64	13.72	15.8
Additional Sessions	22.21	22.52	22.1
Nursing Agency	24.31	14.23	22.1
Nursing Bank	76.63	57.52	58.0
Other Agency	12.17	22.27	27.0
Other Bank	67.16	59.28	63.7
Overtime	35.42	35.82	36.1
On call Worked	6.64	7.28	8.5
Total equivalent temporary WTE	274.6	245.8	265.4
Total equivalent employed WTE	3,020.2	2,993.5	2,996.0
Variance (F/(A))	(88.8)	(12.0)	20.6
Temp Staff WTE % of Total Pay	9.1%	8.2%	8.9%
Memo : Total agency WTE in month	44.9	49.7	61.3
Sickness Rates (Dec/Nov)	3.51%	3.53%	3.93%
Mat Leave	1.3%	2.4%	2.1%

Monthly Expenditure Community Service				
As at November 2017	Dec-17	Nov-17	Dec-16	YTD 2017-18
	£'000	£'000	£'000	£'000
Budgeted costs in month	1,528	1,530	1,080	11,037
Substantive Staff	1,397	1,387	1,011	10,445
Medical Agency Staff (includes 'contracted in' staff)	12	13	(15)	109
Medical Locum Staff	3	3	3	30
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	8	0	5	1
Nursing Bank Staff	16	12	8	128
Other Agency Staff	5	12	38	187
Other Bank Staff	2	2	11	74
Overtime	4	4	4	42
On Call	2	5	3	15
Total temporary expenditure	53	51	57	585
Total expenditure on pay	1,449	1,438	1,068	11,030
Variance (F/(A))	79	92	11	7
Temp Staff costs % of Total Pay	3.6%	3.5%	5.4%	5.3%
Memo : Total agency spend in month	25	25	28	297

Monthly whole time equivalents (WTE) Community Services			
As at November 2017	Dec-17	Nov-17	Dec-16
	WTE	WTE	WTE
Budgeted WTE in month	497.6	494.6	359.1
Employed substantive WTE in month	447.8	442.0	337.8
Medical Agency Staff (includes 'contracted in' staff)	0.7	0.8	0.0
Medical Locum	0.4	0.4	0.4
Additional Sessions	0.0	0.0	0.0
Nursing Agency	1.3	0.0	0.7
Nursing Bank	4.6	3.8	2.7
Other Agency	1.4	4.6	9.4
Other Bank	0.7	0.4	3.2
Overtime	1.4	1.4	2.2
On call Worked	0.0	0.0	0.9
Total equivalent temporary WTE	10.5	11.3	19.5
Total equivalent employed WTE	458.3	453.3	357.3
Variance (F/(A))	39.3	41.3	1.8
Temp Staff WTE % of Total Pay	2.3%	2.5%	5.5%
Memo : Total agency WTE in month	3.4	5.5	10.1
Sickness Rates (Nov /Oct)	3.55%	3.42%	3.96%
Mat Leave	2.1%	2.1%	1.7%





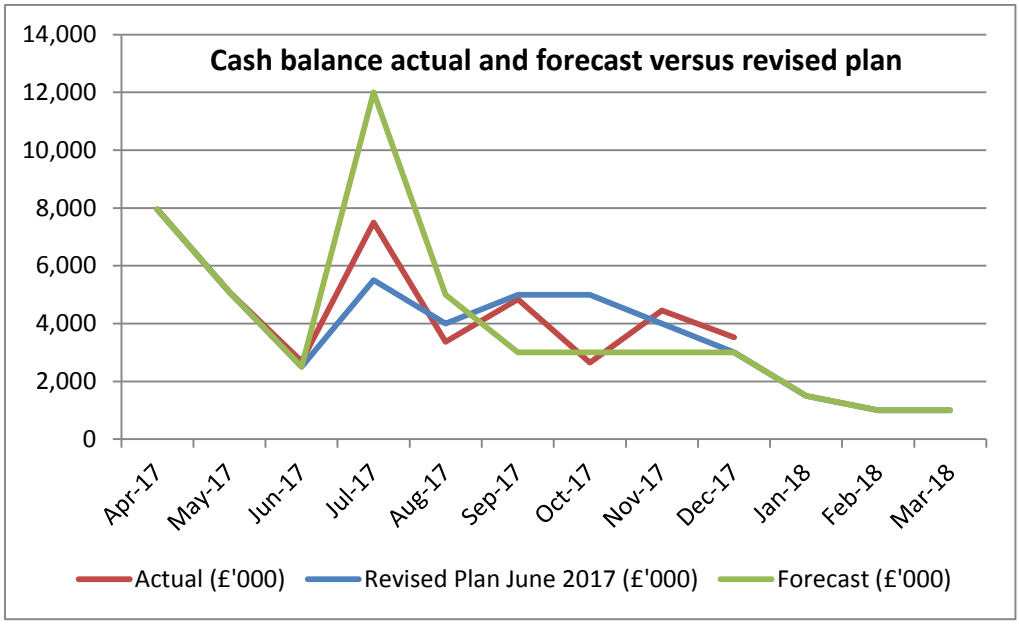
4. Balance Sheet

STATEMENT OF FINANCIAL POSITION

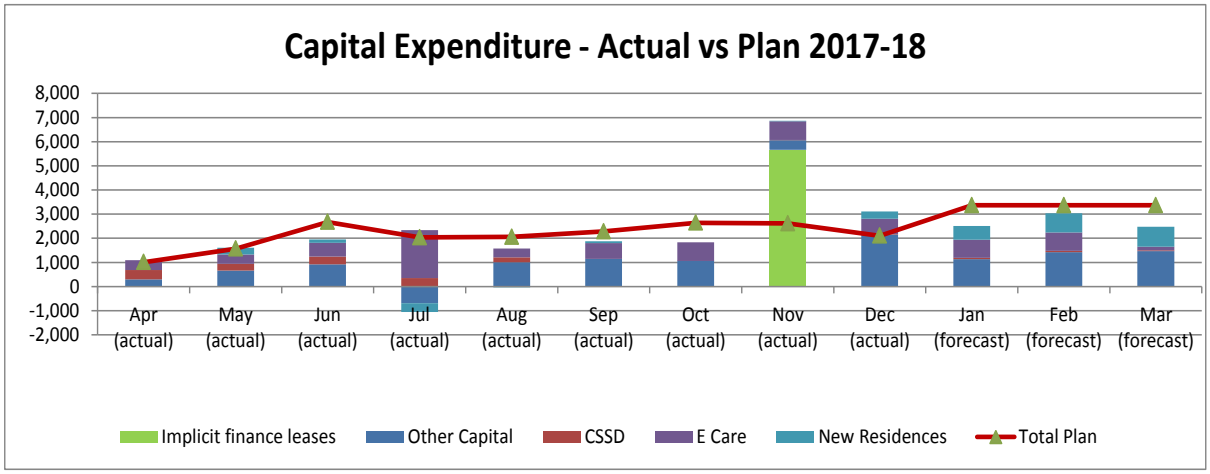
	As at 1 April 2017 * £000	Plan 31 March 2018 £000	Plan YTD 31 Dec 2017 £000	As at 31 Dec 2017 £000	Variance YTD 31 Dec 2017 £000
Intangible assets	15,611	19,711	18,945	19,905	960
Property, plant and equipment	74,053	94,189	86,301	85,750	(551)
Trade and other receivables	0	0	0	0	0
Other financial assets	0	0	0	0	0
Total non-current assets	**89,664**	**113,900**	**105,246**	**105,655**	**408**
Inventories	2,693	2,600	2,700	3,145	445
Trade and other receivables	18,345	11,700	15,796	20,938	5,142
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	1,352	1,000	3,000	3,518	518
Total current assets	**22,390**	**15,300**	**21,496**	**27,601**	**6,105**
Trade and other payables	(23,434)	(28,195)	(25,419)	(25,364)	55
Borrowing repayable within 1 year	(534)	(1,796)	(2,049)	(2,440)	(391)
Current ProvisionsProvisions	(61)	(61)	(84)	(89)	(5)
Other liabilities	(1,325)	(295)	(2,500)	(4,890)	(2,390)
Total current liabilities	**(25,354)**	**(30,347)**	**(30,052)**	**(32,783)**	**(2,731)**
Total assets less current liabilities	**86,700**	**98,853**	**96,690**	**100,474**	**3,783**
Borrowings	(44,375)	(55,951)	(52,189)	(58,653)	(6,464)
Provisions	(181)	(158)	(163)	(192)	(29)
Total non-current liabilities	**(44,556)**	**(56,109)**	**(52,352)**	**(58,846)**	**(6,494)**
Total assets employed	**42,144**	**42,744**	**44,338**	**41,628**	**(2,711)**
Financed by					
Public dividend capital	59,232	65,732	65,732	63,565	(2,167)
Revaluation reserve	3,621	3,621	3,621	3,621	(0)
Income and expenditure reserve	(20,709)	(26,609)	(25,015)	(25,558)	(543)
Total taxpayers' and others' equity	**42,144**	**42,744**	**44,338**	**41,628**	**(2,710)**

The cash at bank as at the end of December 2017 is £3.5m.

5. Cash flow forecast for the year



6. Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Actual £'000	Dec Actual £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2017-18 £'000
E Care	415	382	567	1,990	369	654	769	764	629	752	760	152	8,202
CSSD	384	283	319	352	197	-10	8	12	26	60	50	25	1,707
New Residences	0	284	140	-373	-33	68	-9	26	300	566	800	830	2,599
Implicit finance leases	0	0	0	0	0	0	0	5,667	0	0	0	0	5,667
Other Schemes	296	665	922	-684	1,009	1,150	1,057	397	2,154	1,133	1,427	1,471	10,997
Total forecast / Forecast	1,095	1,613	1,947	1,285	1,542	1,862	1,826	6,866	3,109	2,511	3,037	2,478	29,172
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 was received during July.

The CSSD build is now complete with the forecast build cost of £1.6m for the year. The delay in the implementation has meant that the value of interest capitalised has increased. Once the CSSD is in operation this will revert to a revenue cost. The final expenditure on this project relate to the payment of retentions and some monies withheld pending satisfactory completion of minor works.

Expenditure on e-Care for the year to date is £6,539k and is in line with the revised E-Care budget. 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. The second tranche of GDE funding has not been received and there are no indications of when this will be received.

The forecasts for all projects have been reviewed by the relevant project managers. The expenditure profiles of these schemes have been rephased. There are no significant financial risks to the budgets reported. Year to date the overall expenditure of £21,069 is above the plan of £18,988k. This is as a result of the implicit finance lease review (noted below) and slippage on a number of key projects:

- Fire compartmentation £647k
- Residences £3,885k
- Main entrance concourse £650k
- Ambulatory Assessment Unit £625k
- Labour suite refurbishment £594k

These have been rephased into future years.

As reported in the October report all significant managed service agreements have been reviewed to ensure the correct accounting treatment is being applied to any embedded leases. As a result of this a total of £5.7m of finance leases have been identified. This does not have an impact on cash but increases our capital assets and associated borrowing. This is shown in the graph with the spike in expenditure in the current month. The managed services reviewed include MRI, Radiology and Endoscopy. Early discussions with our auditors indicate acceptance of the principles involved and that our proposed treatment of this as a prior period adjustment is a sensible approach to take.

Recommendation:

To note the summary report.

NHS
West Suffolk
NHS Foundation Trust

REPORT TO:	Council of Governors
MEETING DATE:	21 February 2018
SUBJECT:	To receive a report on the implementation of e-Care and Global Digital Exemplar programme
AGENDA ITEM:	11
PRESENTED BY:	Dermot O'Riordan, Chief Clinical Information Officer (CCIO)
FOR:	Information

1.	**Purpose**
1.1	This paper provides the Council of Governors with an update on progress with e-Care implementation and the Global Digital Exemplar (GDE) programme to date and plans for next phase of development. The council is asked to note the report.
2.	**The journey to date**
2.1	Most NHS organisations are implementing electronic patient records (EPRs). This takes away the old paper charts and folders that traditionally sat at the end of the bed and uses computer programmes to record all information about the care of the patient. The trust board decided to move to an EPR system in April 2013 and after a procurement exercise we selected Cerner Millennium as our preferred supplier. We therefore started a major programme of change to introduce this new system. Locally we call this programme e-Care.
2.2	We introduced the first components of e-Care in May 2016. At that time we went live with: • Replacement of the Patient Administration System (PAS). A PAS is the underlying 'engine' of the hospital that keeps track of all patient appointments and admissions. • A new system called FirstNet for the emergency department • Introduction of electronic medicines management (EPMA) • Clinical documentation such as letters, documents and clinical notes • The requesting and reporting of some tests (radiology and cardiology).
2.3	In June 2017 we built on these initial foundations by adding all laboratory requesting and reporting and introducing alerts for sepsis and acute kidney infection (AKI) alerting.
2.4	Phase two of implementation was launched on 29 October 2017 during which we brought paediatrics on line with e-Care and launched new functionality called patient flow which will transform how we manage beds in the hospital.

In addition we introduced a range of new documentation, care plans and care pathways which will improve how we care for our patients. We also introduced some medication enhancements such as a new alert for duplicate paracetamol prescribing, a new and more intuitive workflow for creating discharge summaries and a new diabetic care plan.

3. Global digital excellence

3.1 The West Suffolk NHS Foundation Trust (WSFT) is one of 16 chosen hospitals in the country to become a flagship Global Digital Exemplar (GDE). The purpose of the GDE programme is that hospitals that are considered to be more advanced digitally should support other trusts to reach the same achievements. This is from a combination of trying new things on behalf of others and through sharing our learning with other organisations. We were awarded £10million to support us in delivering our GDE programme.

3.2 Our GDE programme covers four main areas:

Pillar 1	Digital acute trust	We will be continuing to roll out new parts of e-Care to other departments in the trust. This includes maternity, surgery, anaesthetics and ophthalmology. In addition we will be rolling out new observations machines.
Pillar 2	Supporting the establishment of an integrated care organisation	Introducing a new patient portal which will people with access to their own health records. We will also be working with other providers to try and create a single care record that all clinicians can see and contribute to. We will also introduce a new initiative called population health which is where we use sophisticated tools to analyse data from across many organisations enabling us to design the most suitable models of care.
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.

4. The reason for this journey

4.1 The trust has made significant investment around digitisation and it is helpful to consider what we are ultimately hoping to achieve. It should be noted that this is a ten year transformational programme and therefore some of these benefits may take many years to become a reality. In addition being a GDE site enables us to explore emerging innovations and to try new things, which means some of these benefits may be more challenging to achieve. Any of course, many new opportunities will become available as technology develops further. The end picture may therefore change over time. However the potential described here gives a good indication of where our ambitions lie and why are pursuing these goals.

	Imagine if …… we could prevent citizens from becoming unwell and needing hospital care • Citizens will be taking much greater responsibility for their own health utilising a range of self-care technological solutions. This could be as simple as a downloadable 'app' which offers advice and support on a long term condition right up to wearable devices that could transmit readings and information directly into the patient record. • We will be using the multitude of data that will be available from all health and social care partners to underpin a risk stratification model whereby we can identify those citizens that require a much greater degree of support and intervention. Services will be prioritised to these individuals with a view to keeping them healthy and well and therefore out of hospital. We will also use this data to provide a rich platform for research and general improvements to health outcomes. • We will have lots of different ways that citizens could engage with hospital clinicians without needing to physically attend the hospital. This might be using the patient portal to send messages to the consultants or using Voice Over Internet Provider (VoIP) solutions to hold teleconsultations with clinicians.
	Imagine if …… all organisations involved in the care of our citizens were using a single shared personal record • The GP and community teams would know immediately if one of their patients has been admitted to the hospital, the reasons why and what we are doing to treat them. They could write directly into the shared record to support the care of the patient whilst in the hospital and would know in real time what treatment is being provided – therefore being better prepared to wrap the right care around the patient when they return home. • We would no longer need to ask the patient for information when admitting them to hospital. Relevant and accurate clinical information (such as current medication and long term problems) would be immediately available within the shared record and would automatically pull through into e-Care. This would be particularly helpful if the patient arrives as an emergency and is unable to provide this information.
	Imagine if …….. we were delivering the highest possible levels of safety for our patients • We are already using functionality within e-Care to drive down the number of adverse drug events. New functionality such as dose range checking, duplicate prescribing alerts, drug allergies and wrist band scanning on administration are already working within the system. Moving forward we will reduce the risks even further by introducing closed loop medication (where all parts of the medications management are supported electronically i.e. ordering, verifying, preparing and administering medications). • We are already using the system to identify deteriorating patients (for sepsis and acute kidney injury) and the system guides the clinician to enact the appropriate response. We now need to work with clinicians to agree an appropriate and effective level of alerting and decision support to guide the highest levels of quality. • We will shortly be introducing new Vital Signs technology where nursing staff will use new devices to take observations that will then be automatically uploaded into the e-Care patient record in real time, thereby avoiding any transcription errors and enabling faster and easier identification of trends.

	Imagine if …… there were no clinical variation • Patients will follow standardised care pathways for the majority of conditions and treatments ensuring optimal levels of care and reducing the length of stay required. We have recently launched three new care pathways and will look to extend this much further as part of the e-Care programme. • We will develop our clinical informatics capability enabling us to report on and identify variation in care delivered so that we can support all teams and clinicians to perform at the highest level standards.
	Imagine if …… we were working as efficiently and effectively as we could • Our staff are already telling us of the benefits of having up to date information, available whenever and wherever they need up – no more wasted time waiting for paper notes that another clinician may be using. • We will shortly be making the patient record available to clinicians on their mobile devices giving them even greater accessibility in real time. Eventually clinicians will be able to dictate directly into these devices and this information will automatically be inserted into the correct place in the patient record, including the ability to create letters and notes. • We will aim to eradicate waste. We already have alerts in the system that signal to staff if they are ordering tests that have already been ordered by another member of staff. This will avoid the wastage of unnecessary duplicate tests. • Patients will eventually be able to manage their own appointments through the patient portal which will reduce 'did not attends'. • Patients will use the portal to complete questionnaires prior to attending the hospital therefore streamlining the clerking process and ensuring that the clinicians have all relevant information at the point they are seeing the patient.
5.	**Recommendations**
5.1	The council of governors is asked to note progress with e-Care and GDE programme and the potential benefits to be achieved.

Sarah Jane Relf
12 February 2018

REPORT TO:	Council of Governors
MEETING DATE:	21 February 2018
SUBJECT:	Operational Plan and Annual Quality Report proposal
AGENDA ITEM:	12
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
FOR:	Agreement

1. Introduction

This report asks the Council of Governors to make decisions of three matters:

a) Identify Governors to act as readers for the Operational Plan and put in place a process to engage Governors in the refreshed plan
b) Identify Governors as readers for the Annual Quality Report
c) To agree a locally defined quality indicator to be tested by our external auditors as part of their limited assurance review of the Annual Quality Report.

2. Proposal

(a) Governor readers and engagement for the Operational Plan

The guidance from NHSI to refresh operational plans for 2018-19 was issued on 2 February 2018. This included tight timescales to submit draft and final versions of the operational plan by 8 March 2018 and 30 April 2018 respectively.

Work has started to refresh the operational plan in accordance with the guidance but recognising the importance of engaging the Governors it is proposed that:

(i) A joint board and governor workshop to review the operational plan is scheduled for Tuesday 27 March 2018. The purpose of this session will be to ensure that there is a shared understanding of the proposed plan and seek the views of Governors on the Trust's operational strategy.

(ii) Up to three Governors are identified as readers for the draft operational plan. This will be to ensure that the document the context of the plan, while complying with the requirements of the guidance, remains accessible for the public in terms of its language and the explanation of proposals.

Readers will receive the draft plan for comment late-March. The document is likely to be no more than 40 pages in length and it would be expected that comments will be provided within two weeks to allow the submission of the final plan to the Board by 20 April 2018.

(b) Readers for the Annual Quality Report

A key document that the Trust produces each year is the Annual Quality Report. This sits within the Trust's Annual Report but is also a standalone document available to the public on the NHS Choices website.

Up to three Governors are identified as readers for the draft Annual Quality Report. This will be to ensure that the report, while complying with the requirements of national guidance, remains accessible for the public in terms of its language.

Readers will receive the draft Annual Quality Report for comment late-April. The document is likely to be approximately 75 pages in length and it would be expected that comments will be received within two weeks to allow the submission of the final report to the Board by 18 May 2018.

(c) Testing for the limited assurance report of the Trust's Annual Quality Report

The audit guidance from NHSI requires our External Audit to provide a limited assurance report of the Trust's Annual Quality Report. This assurance report is comprised two elements of indicator testing based on two nationally defined indicators and one local indicator identified by Governors.

The two national indicators that the auditors are mandated to review this year are:

1. Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge
2. Summary Hospital-level Mortality Indicator

The approach followed to identify the locally defined indicator for testing has been for the governors to identify an indicator from the quality priorities for the year (**Annex)**. It is proposed to follow a similar approach for the 2017/18 limited assurance report.

It is important to note that the focus of the audit will be to test the reliability of the data and reporting of the indicator by the Trust, not to assess or comment in its effectiveness in improving the quality of patient care. As such the executive team has considered the priorities and feel that testing would be most useful in terms of adding value to the Trust's understanding for the indicator relating to local methodology for gathering data on the Friends and Family Test. The focus of this will be to both test the accuracy of the data but more importantly to assess the methodology to gather to the data to ensure that it provides patients and carers with the opportunity to openly feedback their views and experiences.

3. Recommendation

1. Governors note the planned joint Board and Governor workshop to be scheduled to consider the refreshed operational plan
2. Governors seek nominations for up to three governors to act as readers of the draft operational plan
3. Governors seek nominations for up to three governors to act as readers of the Annual Quality Report
4. Governors agree the recommendation to test the Trust's local Friends and Family data as part of the external auditor's limited assurance report of the Annual Quality Report.

Annex – Quality priorities for 2017-18

Deliver personal care

Deliver measurable improvements in the patient experience

1. Sustain and improve Friends and Family Test performance ensuring we consistently achieve 90% of patients recommending our services to their friends and family
2. Improve performance against the baseline of 2016 for the following questions from the national patient survey:
    - Doctors and nurses talking in front of patients as if they were not there
    - Patients being asked to give their views on quality of care
3. Improve patient experience of access to surgery against the baseline of 2016/17, as measured by 18 week target performance.

Deliver safe care

Reduce the incidence of hospital-associated harm on inpatient wards

4. Ensure that there are no more than 16 avoidable hospital-associated C. *difficile* infection cases during 2017/18
5. Reduce the incidence of avoidable pressure ulcers below the baseline for 2016/17
6. Implement the programme of work to improve our ward environments during 2017/18

Consistently deliver improvements in the care we provide to our patients

7. Improve reliability of AKI diagnosis, treatment and monitoring for inpatients – during the year improving performance against the baseline of 2016/17
8. Improve reliability of sepsis screening and treatment for emergency admissions – improving performance during 2017/18
9. Demonstrate a systematic approach to identifying inpatient deaths which may have been caused by a problem in care. Demonstrate that learning has resulted and that the actions taken in response have had a measurable impact on quality or safety

REPORT TO:	Council of Governors
MEETING DATE:	21 February 2018
SUBJECT:	Register of Governors' Interests
AGENDA ITEM:	13
PREPARED BY:	Georgina Holmes, FT Office Manager
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
FOR:	Information

1. Introduction

The Register of Governors' Interests should be formally reviewed and updated on an annual basis.

At each Council of Governors meeting declarations are also received for items to be considered as part of the agenda.

2. Recommendation

The Council of Governors receives and notes the updated Register of Governors' Interests.

Individual Governors are reminded of their responsibility to inform the Chairman or Trust Secretary of any changes to their defined interests.

REGISTER OF GOVERNORS' INTERESTS SUMMARY

The register of governors' interests is constructed and maintained pursuant to the National Health Service Act 2006. All governors should declare relevant and material interests. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring.

Signed copies of individual governor's declarations are held by the Foundation Trust office.
Interests which should be regarded as "relevant and material" are:

1. Directorships, including Non Executive Directorships held in private companies or public limited companies (with the exception of those of dormant companies).
2. Ownership, part-ownership or Directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.
3. Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
4. A position of trust in a charity or voluntary organisation in the field of health and social care
5. Any connection with a voluntary or other organisation contracting for NHS services
6. To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the NHS Foundation Trust, including but not limited to, lenders or banks.
7. Any other commercial interest in the decision before the meeting

Supplementary Information:
In the case of spouses and cohabiting partners the interest of the spouse/partner shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

	Declared Interest	Date Reviewed
Trust Chair		
Sheila Childerhouse	Trustee of the East Anglia's Children's Hospices	21 February 2018
Staff Governors		
Peta Cook	Nil	21 February 2018
Javed Imam	Nil	21 February 2018

	Declared Interest	Date Reviewed
Amanda Keighley	Chairperson of Brockley Community Council – funds developed for the benefit of the community of Brockley, individuals or groups. Not specifically in the field of health and social care. Husband is a full time officer of UNISON.	21 February 2018
Garry Sharp	Member of Suffolk Accident Rescue Service	21 February 2018
Martin Wood	Private practice admitting rights at BMI Bury St Edmunds Hospital Treat NHS carpal tunnel patients under BMI NHS choose & book contract	21 February 2018
Nominated Partner Governors		
Judy Cory	Vice Chairman, Friends of West Suffolk Hospital	21 February 2018
Dr Mark Gurnell	Council member – UK Society for Endocrinology	21 February 2018
Cllr Rebecca Hopfensperger	A Cabinet Member for Adult Care for Suffolk County Council, directly responsible for adult social care. A Suffolk County Councillor for Suffolk County Council, hold the position of cabinet member for adult care. Suffolk County Council commission and work with the NHS.	21 February 2018
Laraine Moody	Bury St Edmunds Chamber of Commerce Board	21 February 2018
Cllr Sara Mildmay-White	St Edmundsbury Borough Councillor	21 February 2018
Public Governors		
Peter Alder	Chair of good neighbour scheme in Barton Mills	21 February 2018
Mary Allan	Nil	21 February 2018
Florence Bevan	Director: Pentland Consulting Ltd, Grange House, Bennett Avenue, Elmswell IP30 9GY	21 February 2018
June Carpenter	Nil	21 February 2018
Justine Corney	Director of Lavenham Community Council	21 February 2018
Jayne Gilbert	Nil	21 February 2018

	Declared Interest	Date Reviewed
Gordon McKay	Committee member of St Edmundsbury Newstalk Volunteer at West Suffolk Hospital (x-ray department)	21 February 2018
Barry Moult	Director Grace Baptist Trust (East Anglia) Employee of Colchester Hospital, on secondment to STP until 1 October 2018	21 February 2018
Jayne Neal	Nil	21 February 2018
Adrian Osborne	Sudbury Town Councillor Babergh District Councillor	21 February 2018
Joe Pajak	I am a Director of Flexpace Limited – which provides education leadership and governance consultancy and advice to charities, schools, colleges and local authorities. I act as an education leadership and governance adviser/consultant and currently have a professional relationship with Livability (a national disability charity)	21 February 2018
Margaret Rutter	Nil	21 February 2018
Jane Skinner	Nil	21 February 2018
Liz Steele	Nil	21 February 2018

REPORT TO:	Council of Governors
MEETING DATE:	21 February 2018
SUBJECT:	Sub-Committees of the Council of Governors
AGENDA ITEM:	14
PREPARED BY:	Georgina Holmes, FT Office Manager
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
FOR:	Approval

1. Background

The Council of Governors has two established sub-committees to support its processes and decision making:

- Engagement Committee; and
- Nominations Committee.

Following the election to the Council of Governors it is appropriate to re-establish the membership of these committees based on the newly elected governing body.

2. Nominations for committees

On 5 February governors were invited to self-nominate to join one/both of these committees, providing a short paragraph explaining why they would like to become a member of the committee. The closing date for nominations was 12 February 2018.

(a) Nominations Committee

This Committee supports the Council of Governors in decisions regarding the appointment, appraisal and remuneration of Non-executive Directors.

The composition of the Committee is drawn from the Public, Staff and Partner Governors. This ensures input from across the Council's composition.

- Chair of the Trust (Chair)
- Four Public Governors (one of whom should be the Lead Governor)
- One Staff Governor
- One Partner Governor

The following nominations have been received within each of these groups:

- Public – five nominations for three seats. Therefore an anonymous ballot takes place using **Ballot Form – Public Ballot** (attached)

- Staff – Martin Wood

- Partner – Sara Mildmay-White

Ballot process

All Governors present at the Council of Governors meeting are entitled to vote for the candidates they feel should take up the positions on the Committee. Governors are asked to complete the attached ballot form and bring to the meeting on 21 February 2018.

The completed ballot forms will be collected at the start of the meeting. The results will be given as part of the discussion of the agenda item. In the event of a tie names will be drawn from the nominations with the same number of votes for the available number of seats.

(b) Engagement Committee

This Committee plays an important role in structuring and delivering the Trust's public engagement strategy.

The membership of the committee comprises at least six Governors, including the lead governor.

The following nominations have been received. There will be no ballot for the Engagement Committee.

Peter Alder (Public)
Florence Bevan (Public)
Peta Cook (Staff)
Jayne Gilbert (Public)
Gordon McKay (Public)

3. Recommendation

(i) The Council of Governors is asked to elect three public governors to join the Nominations Committee.

(ii) The Council of Governors is asked to note the nominations for the Engagement Committee.

NHS
West Suffolk
NHS Foundation Trust

Council of Governors meeting – 21 February 2018
Nominations Committee ballot paper

Public ballot – three seats available

As there are three available seats you can place up to **THREE** crosses ("X") in the box(es) next to the names of Public Governors you would like to elect to this Committee.

Justine Corney As staff partner in an accountancy practice and as a Trustee of various charities I have been actively involved in the recruitment and employment of staff since 1987. This involved job descriptions and skills assessment, appraisals, setting targets and work and training programs and reviewing duties and salaries. I have also served previously on this subcommittee and was involved in all aspects of its work.	
Jayne Gilbert I have been on this committee before so have experience. I would be willing to mentor any new governors who wish to be considered.	
Barry Moult Having been on the nominations committee previously, I believe I would be best using my previous experience serving on this committee. I was previously on an interview panel for the recruitment of a non-executive board member and more recently the appointment of the Chair of the Board. I understand the need for a balance of non-executives to challenge the Trust Board in different areas of expertise. Being elected would bring continuity to this committee.	
Margaret Rutter I worked for the MOD in the HR Office for Senior Professional Technical Officers. This was high level specialist staff. My job entailed obtaining details of the vacancy, trawling vacancy notices, and acknowledging applications. The setting up of the interview board and providing the board members with the candidate's staff record, references, and other relevant documents. After the interviews I would inform the candidates the results of their interview. On occasions I would have to send the successful candidate's details to security clearance for a up-grade. This meant that I had to delay issuing the results without allowing the candidates to know why there was a delay. I feel this experience would help me to be a successful member of the Nominations Committee.	
Liz Steele I feel that my experience gained from my time as a governor and my participation in the appraisal of the NEDS, has given me the skills and understanding of this role. I have experience of selection and interviewing in other settings. I was part of the group of governors that formed the panels for selection of a new Chair for West Suffolk Foundation Trust.	

REPORT TO:	Council of Governors
MEETING DATE:	21 February 2018
SUBJECT:	Report from Lead Governor
AGENDA ITEM:	15
PRESENTED BY:	June Carpenter, Lead Governor
FOR:	Information

Since the last report we have said goodbye to Roger Quince the previous chairman and welcomed Sheila Childerhouse to this position who comes with a wealth of experience.

We also have a new CoG with some re-elected governors and many new ones. It is reassuring to see the enthusiasm they are bringing to the role. Many of them have already attended a Trust board, a governor training day, an informal governors meeting , quality qalkabouts and a session in the Courtyard Cafe. These are very important ways to learn how the Trust works and serves the public thus helping one to gain knowledge and making the council stronger.

I look forward to working with everyone.

June Carpenter
Lead Governor

REPORT TO:	Council of Governors
MEETING DATE:	21 February 2018
SUBJECT:	Election of NHS Providers' Governor Advisory Committee
AGENDA ITEM:	16
PREPARED BY:	Georgina Holmes, FT Office Manager
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
FOR:	Information and approval

1. Background

NHS Providers is the membership organisation and trade association for the NHS hospital, mental health, community and ambulance services that treat patients and service users in the NHS. It helps NHS foundation trusts and trusts to deliver high-quality, patient-focused care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate. 98% of all trusts are members of this organisation.

Their Governor Advisory Committee is comprised of eight governors elected by member trusts, and two chairs who are NHS Providers board members. The committee oversees the governor support work and provides advice on governor-specific issues.

WSFT's council of governors, as a whole, is entitled to vote in the forthcoming election of eight governors to this committee. Voting will be conducted by single transferable vote and the council of governors is collectively asked to rank candidates in order of preference.

2. Proposal

In order to give all governors a chance to submit their preference, details of candidates together with a voting preference form will be circulated at the Council of Governors meeting on 21 February 2018. Following the meeting, an electronic copy of this information will also be emailed out to governors.

Governors are asked to return their completed forms, either by post or electronically to Georgina Holmes by Friday 9 March. Individual returns will then be collated and a collective vote submitted to NHS Providers on behalf of the Council.

3. Recommendation

The Council of Governors is asked to approve the proposed process for governors to vote for members of NHS Providers' Governor Advisory Committee.