COUNCIL OF GOVERNORS MEETING

Tuesday 6 August 2019, 17.30

Northgate Room, 2nd Floor, Quince House, West Suffolk Hospital

AGENDA

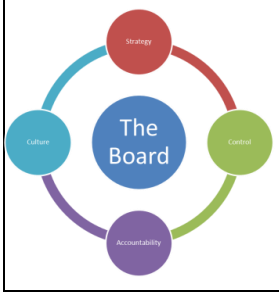
Council of Governors Meeting

There will be a meeting of the **COUNCIL OF GOVERNORS** of West Suffolk NHS Foundation Trust on Tuesday, **6 August 2019 at 17.30** in the Northgate Room, Quince House, 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: Mary Allan, Stephen Dunn, Andrew Hassan. To note the resignation of Garry Sharp, staff governor and that Dr Vinod Shenoy has been invited to join the Council of Governors as the next highest polling candidate.	Sheila Childerhouse
2.	**Welcome and introductions** To request mobile phones be switched to silent.	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 previous meeting** (enclosed) To approve the minutes of the meeting held on 13 May 2019	Sheila Childerhouse
5.	**Matters arising action sheet** (enclosed) To note updates on actions not covered elsewhere on the agenda	Sheila Childerhouse
6.	**Chair's report** (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	Nick Jenkins
8.	**Governor issues** (enclosed) To note the issues raised and receive any agenda items from Governors for future meetings	Liz Steele
18.00	**DELIVER FOR TODAY**	
9.	**Summary finance & workforce report** (enclosed) To note the summary report	Louisa Pepper
10.	**Summary quality & performance report** (enclosed) To note the summary report	Richard Davies

18.20	**INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP**	
11.	**Trust Inclusion Objectives** (enclosed) To receive an update	Denise Pora
12.	**Pathology services** (enclosed) To receive an update	Nick Jenkins
18.40	**BUILD A JOINED UP FUTURE**	
13.	**Alliance update** (enclosed) To note the report	Sheila Childerhouse
14.	**Annual Report & Accounts 2018/19** (on Trust website or hard copy on request) To receive the Annual Report & Accounts for 2018/19	Richard Jones
15.	**Annual Audit Letter and Quality Report limited assurance review** (enclosed) To receive the audit reports from BDO, External Auditors	Matthew Weller, BDO
16.	**Annual external audit review** (enclosed) To receive a report and recommendation from the Audit Committee on the Trust's External Auditors BDO	Alan Rose
19.00	**GOVERNANCE**	
17.	**Report from Nominations Committee** (enclosed) To note a report from the Nominations Committee meeting of 5 June 2019	Sheila Childerhouse
18.	**Report from Engagement Committee** (enclosed) To receive the minutes of the meeting of 16 July 2019	Florence Bevan
19.	**Lead Governor report** (enclosed) To receive a report from the Lead Governor.	Liz Steele
20.	**Staff Governors report** (enclosed) To receive a report from the Staff Governors	Martin Wood
19.30	**ITEMS FOR INFORMATION**	
21.	**Urgent items of any other business** To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency	Sheila Childerhouse
22.	**Dates for meetings for 2019** Tuesday 17 September - Annual members meeting (Apex) Wednesday 13 November **To note dates for 2020:** Tuesday 11 February Wednesday 6 May Tuesday 11 August Tuesday 22 September - Annual members meeting (Apex) Wednesday 11 November	Sheila Childerhouse
23.	**Reflections on meeting** To consider whether the right balance has been achieved in terms of information received and questions for assurance and the Trust's values and behaviours observed.	Sheila Childerhouse
19.35	**CLOSE**	

1. Apologies for absence

To receive any apologies for the meeting: Mary Allan, Stephen Dunn, Andrew Hassan.

To note the resignation of Garry Sharp, staff governor and that Dr Vinod Shenoy has been invited to join the Council of Governors as the next highest polling candidate.

For Reference

Presented by Sheila Childerhouse

2. Welcome and introductions

To request mobile phones be switched to silent.

For Reference

Presented by Sheila Childerhouse

3. Declaration of interests for items on the agenda

To receive any declarations of interest for items on the agenda

For Reference

Presented by Sheila Childerhouse

4. Minutes of the previous meeting (enclosed)

To approve the minutes of the meeting held on 13 May 2019

For Approval

Presented by Sheila Childerhouse

REPORT TO:	Council of Governors
MEETING DATE:	6 August 2019
SUBJECT:	Draft Minutes of the Council of Governors Meeting held on 13 May 2019
AGENDA ITEM:	4
PRESENTED BY:	Sheila Childerhouse, Chair
FOR:	Approval

DRAFT

MINUTES OF THE COUNCIL OF GOVERNORS' MEETING
HELD ON MONDAY 13 MAY AT 5.30pm
IN THE NORTHGATE ROOM AT WEST SUFFOLK NHS FOUNDATION TRUST

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Sheila Childerhouse	Chair	•	
Peter Alder	Public Governor	•	
Mary Allan	Public Governor	•	
Florence Bevan	Public Governor	•	
June Carpenter	Public Governor	•	
Peta Cook	Staff Governor	•	
Justine Corney	Public Governor	•	
Judy Cory	Partner Governor	•	
Jayne Gilbert	Public Governor	•	
Mark Gurnell	Partner Governor		•
Andrew Hassan	Partner Governor	•	
Rebecca Hopfensperger	Partner Governor	•	
Robin Howe	Public Governor	•	
Javed Imam	Staff Governor	•	
Amanda Keighley	Staff Governor	•	
Gordon McKay	Public Governor	•	
Sara Mildmay-White	Partner Governor	•	
Laraine Moody	Partner Governor	•	
Barry Moult	Public Governor		•
Jayne Neal	Public Governor	•	
Adrian Osborne	Public Governor	•	
Joe Pajak	Public Governor	•	
Gary Sharp	Staff Governor	•	
Jane Skinner	Public Governor	•	
Liz Steele	Public Governor	•	
Martin Wood	Staff Governor	•	
In attendance			
Craig Black	Director of Resources		
Georgina Holmes	FT Office Manager *(minutes)*		
Stephen Dunn	Chief Executive		
Richard Davies	Non-Executive Director		
Gary Norgate	Non-Executive Director		
Louisa Pepper	Non-Executive Director		
Alan Rose	Non-Executive Director		

Action

GENERAL BUSINESS

19/21 APOLOGIES

Apologies for absence were noted as above. Richard Jones had also given his apologies.

19/22 WELCOME AND INTRODUCTIONS

The Chair welcomed everyone to the meeting and thanked governors for such good attendance.

19/23 DECLARATIONS OF INTEREST

There were no declarations of interest relating to items on the agenda.

19/24 MINUTES OF THE COUNCIL OF GOVERNORS MEETING HELD ON 12 FEBRUARY 2019

The minutes of the meeting held on 12 February 2019 were approved as a true and accurate record.

19/25 MATTERS ARISING ACTION SHEET

The ongoing actions were reviewed and the following update provided:-

Item 174; Follow up with Peta Cook re IT issues in the community and report back to a future meeting. Gary Norgate reported that Mike Bone, Chief Information Officer (CIO) for WSFT, had met with the CIO for ESNEFT and had agreed to look at what it would mean to move away from the existing contract. They were working towards a date of approximately September 2019 to give notice. Six months after this they could move to a wholly owned service that they would be responsible for.

The Chair considered this to be very good progress.

19/26 CHAIR'S REPORT

The governors noted the content of this report.

19/27 CHIEF EXECUTIVE'S REPORT

The Chief Executive reported that it had been a very busy winter and this had continued into spring with all escalation and surge areas still open which was significant for this time of year. Recent board reports showed a 10% increase in emergency department attendance and 7% increase year to date in non-elective admissions which was way above the local and national planning assumption. The reasons for this and lessons learned were being looked at and lessons that could be learned and applied for next year.

Staff were under a lot of pressure, particularly nurses and had been moved around both in the hospital and community to ensure that the Trust continued to provide safe care. Although the new cardiac unit and first phase of the acute admissions unit (AAU) were now open and provided additional capacity the escalation areas were still required.

Approximately ten Filipino nurses per month were arriving at the hospital, and a further 30 were due to arrive in September which would assist in filling the 85 vacancies for registered nurses. However, they would not be fully operational in this role for at least three months after their arrival at WSFT.

Despite the additional pressures performance had been better than a year ago which was very positive. The quality and performance report highlighted the challenges for quality indicators through the winter and spring period. The focus was now on leadership and planning for next year and phase two of the AAU would be opening later this year which should help. The rapid intervention vehicle (RIV) which had been very successful in avoiding admissions would continue and further initiatives within the community were also being implemented.

All through the year demand had tracked the bed model, but peaks had been slightly higher than anticipated. However, over the last few weeks the Trust had been very busy and demand had not tracked the model. This appeared to be a regional issue across Norfolk, Suffolk and Cambridge which could be partly linked to an ageing population.

The discharge waiting area had been a real asset. The Trust had also developed a good relationship with RAF Lakenheath and the local armed forces, with their nurses working in the hospital in a non-registered capacity to give them greater experience and training. This had also been beneficial in helping out WSFT's nurses.

The Chief Executive was very pleased to report that the Trust had delivered its financial plan which was a great achievement.

Work on addressing the issues within pathology continued and there was now greater engagement from ENSEFT and its board.

Despite the pressures the Trust was still achieving outstanding staff survey results with good achievement from a number of teams, eg orthopaedics.

The new accommodation was now open and governors had been given the opportunity to have a tour of this. It was agreed that this was an excellent facility which should assist in recruiting and retaining staff.

The Chair referred to the Chief Executive's appointment to the NHS Assembly which was very significant and would give Suffolk a strong voice on this group. She also congratulated him on his positon of third in the HSJ's list of top NHS Chief Executives in the country. The Council of Governors commended him for this achievement.

The Chief Executive explained that the NHS Assembly and long term plan were about closer working. WSFT was already on the right direction of travel, working closely with its partners, the alliance and mental health. The aim was to dismantle the 'competition architecture' of the NHS and develop greater collaboration of the health and social care system. This would also result in changes in financial flows.

The HSJ had defined WSFT as one of the best small hospitals the country which was a testament to the commitment of staff and the quality of care they provided. However, he said that there were still improvements to be made as not everyone had a good experience at the hospital and all staff needed to remain aware of this and not become complacent.

June Carpenter referred to NEESPS and that governors should be receiving regular updates on this. The Chair explained that there was an agreement that governors of both Trusts should receive the same update, ie a joint publication. Gary Norgate reported that there had been a very good meeting with the Chief Executive and accountable officer from ESNEFT where the strategy was presented together with the progress that was being made. It was agreed that the strategy be shared with governors after it had been communicated to pathology staff.

G Norgate / R Jones

The Chair considered that NEESPS was now a focus of the ESNEFT executive team. She stressed the need to make sure that both sets of governors received the same briefing and information.

Gordon McKay asked if the board was aware of the increase in the local population and the large number of homes being built, eg Morton Hall and surrounding areas. The Chair assured governors that the board and system were very aware of this and the CCG and alliance were taking this into account in their forward planning.

The Chief Executive explained that new homes tended to bring in young families which put pressure on related services but not so much on inpatient areas which was more a reflection of an ageing population. Additional growth in population was subject to national funding which meant that the system could receive further funding. However this was age adjusted and related to deprivation, therefore there was not likely to be a significant increase in funding.

Sara Mildmay-White asked about emergency admissions and how this had impacted on elective work. The Chief Executive explained that there had been some challenges around elective care in some areas, but throughout the winter the elective programme was managed so that it focussed on priority areas with relevant areas ring fenced. This year the elective programme had been stronger despite additional pressures. Martin Wood agreed and confirmed that the team had been able to continue with elective orthopaedics.

Judy Cory thanked the Chief Executive for including information on capital projects/estate works in his report which had been very helpful.

June Carpenter asked if there was any progress or further information on a new hospital. The Chief Executive said that some of this reflected the national funding issue and it had not yet been clarified what the plans were for a new hospital. WSFT had done very well recently in terms of receiving a considerable amount of additional funding for capital projects. He assured governors that the board and executive team had not lost sight of this but as part of the STP it would require their support and to consider it a priority in the national capital plan. Matt Hancock had visited the hospital and new facilities and he continued to discuss this with him.

Andrew Hassan referred to the funding formula and explained that the CCG had received 1.5% below what the formula suggested it should receive. There was also a risk that the neighbouring systems which was in difficult financial circumstances might be bailed out by the local system and this had not been factored into the budget setting of the CCG. The Chair confirmed that the board and STP were very aware and concerned about this. The new regional lead was visiting WSFT tomorrow and this was likely to be a topic of conversation.

19/28 GOVERNOR ISSUES

The Chair considered these to be very good, well thought out strategic questions and thanked Liz Steele and governors for this.

Joe Pajak referred to question 2; 'does the Action Plan within the Board papers demonstrate a credible strategy to deliver high quality care?'. He said that governors felt that it would be helpful if the action plan from the Council of Governors meeting was in the same format as the action plan from board meetings, ie uniform layout with colour coding. The Chair proposed that she should discuss this with Liz Steele and Richard Jones.

S Childerhouse / R Jones / L Steele

He also noted that actions from the board meetings were showing as completed when this was not the case. The Chair acknowledged this and confirmed that the issue of governors receiving joint pathology updates had been discussed at the board and would remain open. It was confirmed that as well as green, actions could also be amber or red rated (RAG rating), depending on their progress against timescales.

Liz Steele referred to question 4; 'is there a rationale for some items/data not to be recorded in the IQPR report?' She said that governors were very pleased that there would be a presentation at the meeting.

DELIVER FOR TODAY

19/29 SUMMARY FINANCE & WORKFORCE REPORT

Alan Rose said that from a board point of view 2018/19 had been a very good year financially and the Trust had achieved its plan for nearly every criteria related to finance and slightly exceeded it in some areas.

Income and expenditure had met the plan with a deficit of £6m which was ahead of the plan set by the system. 11% of staff pay was spent on temporary staff, ie nurses and medical workforce; this was a key area that could affect an organisation's financial performance and team had done very well in controlling this.

There had been a cost improvement programme (CIP) to save approximately 5% (£12m) of and £1m had been saved on drug procurement. Recurring savings, which were the best type of savings, made up 55% of CIPs. Non-recurring CIPs saved money for the year, but not necessarily for future years. All CIP initiatives went through a quality assurance process and were signed off by Nick Jenkins and Rowan Procter to ensure that the savings programme would not adversely affect quality or safety and was not finance driven.

The Trust had spent £30m on capital projects this year, including the accommodation block. Of this £30m, £12m had been spent on IT which was helping to make WSFT a leading Trust.

The management of cash was an ongoing issue for the finance team to ensure that it remained solvent.

He explained that moving into 2019/20 there had been a national re-setting of NHS money to try to ensure that Trust would breakeven for next year. This would require a challenging 4%/£9m CIP for WSFT to ensure that this it achieved the control total of zero and plans were in place for the majority of this £9m saving.

The capital plan for the year was forecast to be £19m and included the second phase of AAU and the start of the emergency department, as well as other ongoing projects to maintain the building and infrastructure.

The governors agreed that it was a great credit to staff that the financial plan for last year had been achieved whilst maintaining the quality of care.

Florence Bevan referred to the capacity of the electricity supply into the hospital that had been discussed last year at the joint board and governor workshop on the estates strategy and asked if this would still be an issue. Alan Rose explained that this would become an issue sometime over the next two years depending on the increase in demand during this period. Craig Black confirmed that this was the case and that long term an increase in capacity would be required with more than one input to the site; there was a programme of work to look at the options.

The Chair thanked Alan Rose for a very clear explanation of the finances of the Trust.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

19/30 QUALITY PRESENTATION – SPC CHARTS, 'PLOT THE DOTS'

The Chair explained that this new way of reporting would make it easier to interpret data and thanked Jo Rayner for attending the meeting today.

Jo Rayner introduced herself and apologised for the incorrect date on the front of the copy of the presentation that had been circulated. She had been working with the board to look a performance reports and how data was presented. She had also been working with NHSI on this initiative, ie statistical process control (SPC), 'plot the dots', charts.

She explained that the numbers in this presentation were fictional and that the median was derived from the most recent 15 or more points of data. Reporting data in this way helped to understand a variation within a process and variations could be positive of negative, and a common cause variation or special cause variation.

Common cause variation was a normal, natural variation that could be expected. Special cause variation was caused by something that was not normally part of the process and should result in asking further questions.

She explained the SPC rules and shift of data; a positive shift was shown in blue and a negative shift in amber. Anything for six or more points in a row would signify a trend and would warrant investigation.

A new report would be produced for May to run alongside the current integrated quality and performance report (IQPR) and she advised governors to use the guide that had been included in the papers for the meeting today (item 10) when looking at this. RAG rated data would continue to be used for the time being for some areas, eg appraisals, caesarean section rates. This would be a developing process with a gradual changeover.

The Chair thanked her for a very succinct presentation and agreed that the guide was a great help in interpreting these charts.

Liz Steele referred to the issue of there regularly being no data in the RAG charts; she assumed that this would not continue to be the case for the new reporting system. It was explained that non-availability of data was often due to timing issues or changes in a process for reporting data. Jo Rayner explained that if no data was available for a significant amount of time it was probably not required anymore and should be removed from the report. The new style of reporting would be more targeted to give a greater insight into areas that required focus. With the SPC charts where there was no data available this would not be included.

Jayne Gilbert asked if the governors could be reassured that this would not enable things to be hidden. Louisa Pepper confirmed, on behalf of the NEDs, that governors could be assured that reporting would be more dynamic and easier to interpret and this would focus attention on trends that were both positive and negative. The Chair agreed that it would help to focus on key issues and questions.

It was noted that this was being driven and encouraged by NHSI and the plan was that this should be a universal standards across all organisations. All the data in the current IQPR would still be available as an electronic dashboard.

Amanda Keighley noted that these charts were critical to the development of the quality improvement programme. The Chief Executive agreed and said that this data made it very easy to understand what should be focussed on.

The Chair proposed that a further session should take place with governors once this had been and developed further and used for a while.

S Childerhouse / R Jones

19/31 SUMMARY QUALITY & PERFORMANCE REPORT

Louisa Pepper explained that WSFT had delivered against a number of local and national targets. The NEDs needed to ensure that they focussed on areas that required improvement and one of the areas that underpinned how they focussed on quality was through the quality walkabouts. She highlighted areas that had been visited and explained that the Trust was now looking at how to move this into the community setting.

She assured governors that staff were committed to delivering high quality patient care. An example of this was demonstrated on a recent quality walkabout to the Kings Suite when a newly placed student had been very pro-active and engaged with everyone, even though it was only their second day.

As previously reported, the Trust had experienced very high demand both in the hospital and community and escalation and surge areas still remained open. The board was very focussed on how this was being managed and holding the executives to account for planning for next year.

The number of safety indicators that were green had decreased but there were also some areas that had performed well, eg falls in the community. Pressure ulcers continued to require improvement and this was an ongoing focus of the organisation. Governors had been invited to a very good presentation at a recent Quality and Risk Committee meeting, where the complex nature of this was explained. There were a number of innovative projects/initiatives including new training and technology and working with care homes on preventative measures.

The outstanding risk assessments were being progressed and external resources had been bought in to support this work to ensure completion by August.

Nutrition assessments continued to be a concern and the NEDs has been focussing on this with the executive team at board meetings. Rowan Procter had agreed to look into this further with a deep dive into areas that were under performing so that the reasons for this could be understood and appropriate support/training provided.

With regard to effectiveness, there were a number of indicators that had delivered exceptional performance. However, discharge assessments still required improvement and this had been discussed at length by the board. Elective discharge summaries were now improving and Helen Beck would be undertaking a deep dive into non-elective and emergency department discharge summaries.

The dashboard for caring indicators was very positive for inpatient and outpatient areas and complaints responses performance was good.

The four hour wait target in the emergency department was an ongoing area of concern. WSFT had been selected to be one of the pilot hospitals for the new emergency performance measures but would also continue to focus on the four hour wait.

Referral to treatment times also continued to be an area of focus and the NEDs were assured that the executive team were working hard on this, including the data quality issue. Patients who had waited over 52 weeks were all individuals with complex needs.

Performance against cancer standards was always discussed at board meetings. The two week wait for breast cancer was an issue and the Trust was looking at innovative ways of working differently, eg ‘one stop shop’ where an individual had all their tests and a diagnosis on one visit, rather than having to attend a number of appointments. However this required additional the appointment of additional radiologists to effectively implement this.

Work continued on completing appraisals; the new HR director should assist with this as he had a background in delivering effective performance in this area, as well as a focus on mandatory training.

Liz Steele referred to the quality walkabout summary report from Paul Morris and explained that there was an inconsistent approach to follow up communication to governors who had taken part; with a copy of the action plan not always being received. It was agreed that a consistent approach was required and this would be followed up with Paul Morris.

S Childerhouse / R Jones

Joe Pajak referred to the announcement by NHSI that a pathology quality assurance dashboard was due to be released and asked if the Trust was aware of this. The Chair and Chief Executive were not aware of this and requested that he forward further details. **J Pajak**

BUILD A JOINED UP FUTURE

19/32 ALLIANCE UPDATE, INCLUDING MENTAL HEALTH

The Chief Executive explained that the west Suffolk alliance was meeting on a regular basis through the system executive group (SEG) and was becoming stronger and stronger. The alliance's strategy focussed on bringing teams together across public services and health and care services. Six localities had now been set up, ie Forest Health, Newmarket, Haverhill, Bury Town, Bury Rural and Sudbury, with integrated neighbourhood teams working out of these localities. They also linked across the primary network teams that had been established. Appendix C of this report gave details of the six localities, the leads and GP practice links with each one.

Appendices A and B gave details of case studies which illustrated the integration that was now taking place. Case study one was a particularly good example of alliance working with the lymphoedema team. Amanda Keighley said that bringing the lymphoedema team into the alliance had meant that this service was now much more streamlined and available. A presentation was taking place on 25 June with further case studies on working across the different services.

She noted that there were still some key leadership vacancies eg IT. The Chief Executive confirmed that funding had been set aside for this. He explained that the discharge to optimise and assess initiative in the community and care homes was a good a good example of cross organisation funding.

Peta Cook agreed that the case studies were a very good way of illustrating alliance working but said that it would be helpful to have examples of paediatrics in the community as well. The Chief Executive agreed and explained that this was now being focussed on in the integrated performance and quality report. **P Cook / R Jones**

Alan Rose asked Andrew Hassan about his view of the development of the primary care network and localities. Andrew Hassan explained that there were varying views of GPs from different areas and there were some concerns about the capacity of GPs who also had to continue to do their day job. He said the East Anglia had the largest deficit of GPs than anywhere else in the country. It was explained that almost all localities now had a GP lead.

June Carpenter asked about the RIV and if there were any plans to increase this service as it had been so successful. Andrew Hassan explained that this was run by the ambulance service and was being enhanced across communities.

Beccy Hopfensperger noted that the discharge to optimise and assess initiative was working very well and this meant that the alliance was top in the region compared to its neighbours and in the top quartile nationally. This showed how well the integrated teams were working with very good results. She said that the alliance was further ahead of the game than of lot of other areas and they should be proud of this.

The Chair reported that from April the strategic transformation partnership (STP) was an integrated care system (ICS) and an operational plan had been produced. The ICS was currently recruiting an independent chair which would be a key role within the organisation. This would require an individual with a breadth of experience as they would need to work at local and national level with politicians etc. There had been some positive interest and interviews were scheduled to take place in late June. It was hoped to have someone in post fairly soon after this, depending on their availability.

GOVERNANCE

19/33 GOVERNOR COMMENTARY IN THE ANNUAL QUALITY REPORT 2018-19

Liz Steele thanked the governors who had acted as readers and drafted the commentary for this report.

She reported that it was considered that the content of this report was still too acute and it was hoped that it would be more focussed on the community for next year.

The Council of Governors reviewed and approved the draft commentary for inclusion in WSFT's Annual Quality Report.

The Chair also thanked those governors who had contributed to this report.

19/34 REPORT FROM ENGAGEMENT COMMITTEE

a) To receive the minutes from the meeting of 30 April 2019

Liz Steele explained that governors continued to engage with the public and recruit new members wherever possible. There were a number of opportunities to attend events with the MyWish team and she encouraged governors to take part in these.

It was suggested that attending patient involvement group meetings at GP surgeries could be a good method of engagement.

b) To approve the revised Engagement Strategy for 1 April 2019-31 March 2021

The Council of Governors reviewed and approved the proposed amendments to the Engagement Strategy for 1 April 2019 to 31 March 2021.

c) To approve the terms of reference for the Engagement Committee

The Council of Governors noted and approved the terms of reference for the Engagement Committee.

19/35 LEAD GOVERNOR REPORT

Liz Steele thanked governors who had attended and supported the engagement events.

She reported that she and Javed Imam had attended an NHS Providers/GovernWell event last week. This had been very good from a networking point of view and feedback of ideas. A number of organisations were not as far forward as WSFT with integration and there were a number with very large financial deficits.

One of the issues raised was that there had been a suggestion about the future role of governors and whether this would change/develop. It was reported that the CQC was looking at the way inspections took place and if governors could become more accountable and involved in the inspection process.

There was also reference to staff and issues with the workforce, which was common across all organisations, and looking at streamlining staff across hospitals and communities.

There had also been a proposal to look at a more integrated approach with other organisations for overseas recruitment. The Chief Executive explained that there had been article in the Times about this but WSFT's recruitment of nurses from the Philippines appear to be very successful and therefore it was not likely to be part of this.

He explained the proposals for the implementation of the NHS long term plan and that there were no plans to remove governors, however there would be some curtailing of the freedom of Foundation Trusts.

The Chair said that she thought that the role of governors could become more complex as work across larger systems developed; however the Council of Governors' role was to focus on WSFT.

19/36 STAFF GOVERNORS REPORT

Amanda Keighley highlighted the staff supporter report which provided details of the various services that were available for staff at all levels in the organisation.

The Chair referred to the commitment and engagement of the current staff governors which was a great asset to the Council of Governors and organisation as a whole.

ITEMS FOR INFORMATION

19/37 URGENT ITEMS OF ANY OTHER BUSINESS

Gordon McKay asked about the rumour he had heard about the recruitment of nurses who could speak sign language and their being paid £50 per hour. Martin Wood said that he had also heard a similar rumour. The Chair, Chief Executive and Craig Black said that they were not aware of this.

19/38 DATES FOR COUNCIL OF GOVERNOR MEETINGS FOR 2019

Future dates for meetings for 2019 were noted as follows:-

Tuesday 6 August
Wednesday 13 November
Annual Members Meeting Tuesday 17 September 2019

19/39 REFLECTIONS ON MEETING

No comments received.

5. Matters arising action sheet (enclosed)

To note updates on actions not covered elsewhere on the agenda

For Reference

Presented by Sheila Childerhouse

REPORT TO:	Council of Governors
MEETING DATE:	6 August 2019
SUBJECT:	Matters Arising Action Sheet from Council of Governors Meeting of 13 May 2019
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
None

Completed action points

Ref.	Date of Meeting	Item	Action	Action taken	**Lead**	**Target date**	**RAG rating for delivery**
174	12/2/19	19/07	Follow up with Peta Cook re IT issues in the community and report back to a future meeting.	Concerns regarding community IT raised at Board on 1 March 2019. The outcome of the escalation meeting with the CCG will be followed-up by Board on 24 May. The issue has been captured on the Trust's risk register. Updated included in Governor issues report and has been scheduled to be included in the CEO report going forward.	G Norgate	6/8/19	Complete
181	13/5/19	19/27	Circulate pathology strategy to CoG once it has been shared with pathology staff.	Draft strategy circulated with briefing by email 29 June 2019.	R Jones	29/6/19	Complete
182	13/5/19	19/28	Proposal that action plan from CoG minutes should replicate format of action plan from Board minutes, i.e. RAG rating.	The format of the action points has been updated to mirror the RAG rating used by the Board.	R Jones	6/8/19	Complete
183	13/5/19	19/30	Arrange a further training session on 'plot the dots' once this has been developed and used for a while.	Reviewed with Jo Rayner, Head of Performance and Efficiency who is the lead for this project. She advised that training be scheduled for spring 2020 and this has been incorporated into the CoG work plan.	R Jones	6/8/19	Complete
184	13/5/19	19/31	Follow up with Paul Morris re approach to feedback on quality walkabouts, ie governors do not always receive a copy of the action plan.	Feedback now provided in CoG papers on a quarterly basis. As well as a narrative summary of visits during the quarter this will detail the number and status of actions identified from the walkabouts. The summary reports from the individual walkabouts and shared with the area and relevant managers. There is communication with the walkabout membership, including a briefing and debriefing at the time of the visit which informs this report.	R Jones	6/8/19	Complete

Ref.	Date of Meeting	Item	Action	Action taken	**Lead**	**Target date**	**RAG rating for delivery**
185	13/5/19	19/31	Further details on NHSI pathology assurance dashboard to be forwarded to the Chair and Chief Executive.	This was raised at the Board of Directors and it was agreed would be managed through business as usual as part of the Trust's Getting It Right First Time pathology review (noted that this is not currently scheduled)	J Pajak	6/8/19	Complete
186	13/5/19	19/32	Include examples of case studies of paediatrics in the community in the Alliance update.	Peta Cook asked to provide information to Kate Vaughton for her report to next CoG meeting (email 30 May 19)	P Cook	6/8/19	Complete

6. Chair’s report (enclosed)

To receive an update from the Chair

For Reference

Presented by Sheila Childerhouse

REPORT TO:	Council of Governors
MEETING DATE:	6 August 2019
SUBJECT:	Chair's report to Council of Governors
AGENDA ITEM:	6
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 focus of the meetings and activities I have been involved in. I am continuing to maintain a balance between internally focused activities for the hospital and community services and the external partners that we work with.

Meetings/calls with the new regional director, Ann Radmore:
Both Steve and myself have taken time to develop our relationship with the regional teams and in particular the director. Ann has visited the Trust and is keen for us to share our journey to outstanding and the learning from this. She has drawn on my current and past experience and we have discussed a number of potential NED and chair candidates. In particular we have had significant discussions in relation to the appointment of the STP independent Chair.

Regional ICS development event/STP board:
The development of the ICS continues to be a focus for me as chair of chairs. The Board is working well and has warmly welcomed the appointment of Ed Garrett as accountable officer for the ICS. The integrated design panel meets virtually once a week and has taken on the responsibility for developing the future governance and development program for the partnership. As chair of chairs I chaired the stakeholder day which formed part of the selection process for the independent chair. I am grateful to Gary Norgate for substituting for me at the final interview panel, however, I was able to be part of the final confirmation meeting. I have worked with a preferred candidate and believe that he will be an excellent appointment.

Rural services network:
This is a network that the Trust has recently joined. It is a coming together of leaders from rural authorities and organisations. The NHS and local government are particularly well represented as well as the voluntary sector. I was asked to speak at the recent event and focused on some of the challenges for West Suffolk as a rural area and some of the initiatives of which we can be proud. They were particularly interested in some of the ways in which we have integrated community and acute services as well as the opportunities that integration within the Alliance can bring. As ever with conferences it is some of the contacts that you make that are the most valuable outcome of the day.

Quality walkabouts
I'm extremely pleased that these continue to bring insight to the Trust. The small focused group is able in a relatively short time to really gain an appreciation of a ward, a service or an area. I am grateful to Governors for their continued support for these and for the contribution they make. I am also pleased that non-execs are now participating fully in these visits - bringing challenge and insight. It's also very welcome that more of the executive directors are participating in the walkabouts. They are always valuable and certainly significant in our CQC preparation. It has been particularly encouraging lately to revisit wards and get a real sense of change and improvement since the previous visit.

Recommendation
Governors are asked to note the report for information.

Annex A: List of meetings attended

Date	Meetings and events (1/5/19 until 31/7/19)
02/05/2019	Integrated Care Design Panel tele-conference with Susannah Howard
07/05/2019	1:1 with Steve Dunn
07/05/2019	Suffolk & North East Essex STP Chairs' Group
08/05/2019	Scrutiny Committee Meeting
08/05/2019	Induction meeting with Dr Isobel Lentell
08/05/2019	1:1 with Liz Steele
08/05/2019	Telephone call with Ann Radmore
08/05/2019	Induction meeting with Dr James Heathcote
08/05/2019	Monthly NED Catch Up Call
09/05/2019	Integrated Care Design Panel tele-conference with Susannah Howard
09/05/2019	Suffolk County Council Chairman's Reception
10/05/2019	Suffolk and North East Essex STP Board Meeting
13/05/2019	NHS Retirement Fellowship meeting
13/05/2019	1:1 with Steve Dunn
13/05/2019	1:1 with Tara Rose Head of Communications
13/05/2019	Tour of new staff accommodation
13/05/2019	Council of Governors meeting
14/05/2019	Quality walkabout – Theatres
14/05/2019	Ann Radmore meeting and visiting WSFT
14/05/2019	Catch up with Catherine Waller
16/05/2019	Integrated Care Design Panel tele-conference with Susannah Howard
17/05/2019	Regional ICS Development Event
21/05/2019	Quality walkabout – radiology
21/05/2019	1:1 with Kate Vaughton
21/05/2019	Guided walk with the Guide Dogs Association
21/05/2019	Meeting with ICS Comms, Simon Morgan
21/05/2019	Meeting with Dr Christopher Browning
22/05/2019	1:1 with Steve Dunn
22/05/2019	Teleconference with recruitment agency for ICS Chair position
22/05/2019	Shining Lights event
23/05/2019	Prep meeting for Annual members meeting 2019
23/05/2019	Audit committee meeting – annual report sign office
23/05/2019	Board development session
24/05/2019	Trust Board meeting
24/05/2019	Charitable funds committee meeting
30/05/2019	Telephone call with prospective candidate ICS Chair role
31/05/2019	Teleconference on ICS chair applicants with Susannah Howard
03/06/2019	Teleconference on ICS chair applicants with Susannah Howard
04/06/2019	1:1 with Steve Dunn
04/06/2019	1:1 with Tara Rose Head of Communications
05/06/2019	NHSI PRM meeting
05/06/2019	Meeting with Barry Moult
05/06/2019	Nominations committee meeting
06/06/2019	Parliamentary Inquiry Rural health & Social Care 2019
06/06/2019	Integrated Care Design Panel tele-conference with Susannah Howard
11/06/2019	1:1 with Steve Dunn
12/06/2019	Scrutiny Committee Meeting
12/06/2019	1:1 with Liz Steele
12/06/2019	NHS Provider Digital interview
12/06/2019	Prep meeting for Annual members meeting 2019
13/06/2019	Integrated Care Design Panel tele-conference with Susannah Howard
14/06/2019	ICS Independent Chair Panel interviews
17/06/2019	Friends trustee meeting

Date	Meetings and events (1/5/19 until 31/7/19)
18/06/2019	Quality walkabout – F9
18/06/2019	1:1 with Kate Vaughton
18/06/2019	Suffolk & North East Essex STP Chairs' Group
19/06/2019	WSFT Leadership summit 2019
20/06/2019	1:1 with Louisa Pepper, NED
20/06/2019	NED dinner
21/06/2019	Suffolk and North East Essex STP Board Meeting
24/06/2019	Sheila's appraisal with Liz Steele & Gary Norgate
25/06/2019	Prep meeting for Annual members meeting 2019
25/06/2019	1:1 with Steve Dunn
28/06/2019	Trust Board meeting
28/06/2019	Telephone call with Ann Radmore
28/06/2019	Quality and Risk committee meeting
16/07/2019	Quality walkabout – G8
16/07/2019	Meeting with Anna Hollis, Communications
16/07/2019	Appraisal with Richard Davies
16/07/2019	Meeting with Joe Hawes, Dean of St Edmundsbury
17/07/2019	Appraisal with Alan Rose
17/07/2019	Appraisal with Gary Norgate
17/07/2019	Meeting with Richard Jones
18/07/2019	Monthly NED Catch Up Call
19/07/2019	Appraisal with Angus Eaton
22/07/2019	ICS Independent chair interview
24/07/2019	Appraisal with Louisa Pepper
24/07/2019	NHS Providers Dinner with Baroness Dido Harding
30/07/2019	Quality walkabout
30/07/2019	1:1 Liz Steele
30/07/2019	1:1 Ruth Williamson, Trust Office Manager
30/07/2019	Meeting with Nick Finch
30/07/2019	NED Dinner
31/07/2019	Rural Services Network – East Midlands Regional Seminar

7. Chief executive’s report (enclosed)

To note a report on operational and strategic matters

For Reference

Presented by Nick Jenkins

Council of Governors – 6 August 2019

AGENDA ITEM:	7
PRESENTED BY:	Nick Jenkins, Executive Medical Director
PREPARED BY:	Steve Dunn, Chief Executive Officer
DATE PREPARED:	31 July 2019
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 aim to highlight some of the key strategic issues and challenges that the organisation is addressing.

July has seen us wish another very **happy birthday to the NHS**, as it turned the ripe old age of 71. We were delighted to see the RT Hon Matt Hancock MP, who dropped by the West Suffolk Hospital and attended an afternoon tea hosted by local NHS Retirement Fellowship branches to celebrate with staff past and present. The NHS's first ever patient was 13-year-old Sylvia Diggory, who I believe had a very serious liver condition called acute nephritis; I'm pleased to say the NHS started as it meant to go on, and Sylvia led a very long life and went on to have children and grandchildren thanks to the care of the NHS – literally from day-one. How far we have all come since the birth of the NHS; Sylvia Diggory may have been the first NHS patient, but I very much hope we won't ever see a last. To the next 71 years!

We often talk about the '**West Suffolk way'** here, which is just as much about doing the little things as the big things to improve what we do for patients. If you have visited the West Suffolk Hospital in Bury St Edmunds recently, you may have noticed that there are flowers blooming and bees buzzing! This is down to the hard work of some of our Trust's estates team and volunteers who have made it their mission to ensure the hospital supports the town with its Bury in Bloom credentials. We always try to ensure the hospital is clean, tidy and attractive for patients, visitors and staff, but I'm particularly proud of our hardworking team and volunteers this year for providing such a calming and pleasant environment for our patients and staff. These small things really do make a difference.

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

I was delighted to announce the appointment of **Jeremy Over** to the role of executive director of workforce and communications earlier this month. Jeremy, who has worked in the NHS for 19 years, is an experienced HR and workforce director and a Fellow of the Chartered Institute of Personnel and Development. Having worked in NHS trusts in both London and East Anglia, most recently at the Norfolk and Norwich University Hospitals NHS Foundation Trust which he joined in 2014, Jeremy brings a wealth of expertise and local knowledge to the position. I know that he will be exceptionally well-placed to help carry the Trust forward and continue to make our organisation a great place to work. Jeremy will join the Trust in November, replacing much-respected director Jan Bloomfield who is kindly staying with the organisation for two days a week until Jeremy takes up the position.

For any organisation, but especially one that cares for its community, ensuring the wellbeing of its staff is vitally important. Our Trust is an **inclusive employer** that values its people above all else, wants to ensure equal access and opportunities and for no one to experience discrimination or intolerance. The new Workforce Disability Equality Standard (WDES) aims to help NHS organisations improve the working lives of disabled people. At WSFT, we are encouraging disabled people amongst our staff, and any colleagues who want to get involved, to help develop the ways we support everyone who works with us. We know this is an area where we need to improve. There is evidence both nationally and locally that disabled people may have a poorer experience at work than those who do not have a disability. For example, they are more likely to experience bullying and harassment and less likely to believe they have equal opportunities for career progression or promotion.

The **Trusted Partners initiative** is one of the ways WSFT shows its commitment to supporting its most valued asset - our staff. Colleagues from across the Trust offer a variety of life experience, and a willingness to share a safe, non-judgemental, confidential and supportive response to anyone who needs it. They are there to listen, talk through issues and problems, and where appropriate, signpost people to more formal sources of support. While staff can approach the Partners for anything where you feel a listening ear would help, if they believe they are being bullied or discriminated against because of your gender, orientation, race or culture, we really want to hear from them.

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

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

- I had the absolute privilege to be a part of our **annual volunteer thank you event** a few weeks ago, where we take the time to rightly celebrate the generosity of our wonderful NHS volunteers. I presented a staggering 45 volunteer awards, to volunteers who had clocked up 415 years of service between them! One volunteer, Christine Hinchley, from Bury St Edmunds, was thanked for giving an incredible 30 years of service to West Suffolk Hospital as a volunteer in the Friends Shop. Our volunteers are the icing on the cake at our hospital, and truly make such a difference to improve the experience of our patients and staff. The impact our volunteers have on patient care cannot be underestimated; they collectively gave nearly 50,000 hours of time to our Trust last year – what a heroic achievement! Thank you to you all.

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

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

In the meantime, we plough on with **our developments**; not just the new emergency department, but a new acute assessment unit and new labour delivery suite are also under build. I've often said that the West Suffolk NHS Foundation Trust (WSFT) never rests on its laurels, and that's certainly been the case in 2019! Colleagues have been working hard to keep our patients cared for and things running smoothly across the hospital and in the community, but we've also been pushing on with some great new developments.

Those of you who have visited West Suffolk Hospital recently might have spotted our new **staff and student accommodation blocks** at the back of the site. The Rt Hon Jo Churchill MP kindly joined us to formally open those a few weeks ago, and they're already being well used! The scheme replaces the previous 40-year-old hospital residences with three modern, five-story buildings, providing 160 en-suite bedrooms complete with communal kitchen and living areas. We are so proud to have built these stunning accommodation blocks as part of our estates investment plan. I'd like to formally thank colleagues, the architects and contractors for their hard work and collaboration on this exciting development; it looks fantastic, and is another example of how we're making our Trust a great place to work.

Another example is the go-live of **Medic Bleep**, the new communication tool we'll be using to replace non-emergency bleeps. I hope to write more about this next month, but the journey here has been a long one with huge amounts of effort from both the WSFT Medic Bleep project team, and Medic Creations as the team behind the app, to get us to this point. This is another huge step on our digital agenda and, most importantly, it will give our staff more time back to do what they do best – care for patients. Because after all, our patients are what it's all about! I would like to say a huge thank you for everyone's support following our go-live with Medic Bleep in July. We know that any system change takes some getting used to, and the patience, understanding and willingness to support we have seen from staff has been so appreciated.

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

One crucial development to add to the list is that the Department of Health and Social Care has provided approval in principle for the ownership of **Newmarket's community hospital** to be transferred to us from NHS Property Services. We are already doing so much on site to integrate primary, community, outpatient, social work and mental health teams; I look forward to working in partnership with our staff, other tenants, alliance members, patients and our communities to develop and expand services in the future.

A newly developed policy has enabled NHS trusts to apply for ownership of buildings on their estate, which are currently owned by NHS Property Services and Community Health Partnerships. Transfer will be finalised on the completion of a series of conditions applied to the business case, so watch this space.

As part of an imaginative initiative our **therapists have been sharing best practice** with care home chefs. Chefs from care homes across west Suffolk have been supported to improve care for people with dysphagia at a study day hosted by WSFT community speech and language therapists. The Chefs' Day, which was held in March, offered two half-day sessions focused on managing patients in the community who have difficulties swallowing, with talks and demonstrations, practical advice and information. The event was organised to complement training delivered to care homes locally on the recent introduction of the International Dysphagia Diet Standardisation Initiative (IDDSI) and Nutilis Clear products, which are now standard in Suffolk. The day was also open to nurses and managers, and aimed to share the skills and knowledge to ensure they offer meals that are IDDSI compliant and suitable for residents' needs. It also focused on making mealtime a more enjoyable experience for care home residents, where often up to 75% of people have dysphagia.

I am so proud that two of our clinicians who offer a **west Suffolk integrated community service** to patients who have had a fragility fracture are among the speakers at a national conference in London. Ann Hunt and Nicola Burrows, fracture and falls prevention specialist nurses, have been invited to talk about their work in the West Suffolk Fracture Liaison Service at next month's event, Setting up and developing effective fracture liaison services – improving secondary fracture prevention. They will be focusing on how they deliver falls and bone health assessment in patients' own homes; developing effective links with primary care, secondary and social care and the voluntary sector, and evaluating the impact of service change.

Overall in terms of June's **quality and performance** there were 61 falls and 31 Trust acquired pressure ulcers, both show a reduction from May. There was one case of C. difficile. We failed to deliver on the cancer targets for three areas: 2 week wait breast symptoms (90.9%), Cancer 62 day GP referral (67.2%) and incomplete 104 days wait with five breaches reported in June 2019. Referral to treatment performance for June was 85.4%, with four patients waiting longer than 52 weeks for treatment. The Trust is part of a pilot scheme trialling a number of new metrics for ED performance. These new metrics have replaced the longstanding 4-hour waits performance metric, so this has therefore been removed from this month's report. When the new metrics have been agreed nationally they will be included for monitoring.

The Trust is continuing to experience **high levels of emergency attendances** and admit high numbers of very unwell patients, putting significant pressure on the hospital and staff. We have put actions in place and available escalation beds have remained open. Planning and learning is already being put in place for next winter with patient flow identified as one of our three quality improvement priorities for the year.

The month three **financial position** reports a deficit of £2.4m which is £0.8m worse than plan. We agreed a control total to breakeven which means we need to deliver a cost improvement programme of £8.9m. We continue to forecast to meet our plan to break even in 2019-20. However, this requires a recovery plan to reduce the current rate of expenditure by around £4m, as well as escalation costs to fund winter pressures of around £1m. Across the STP we have also been asked to reduce our capital programme by 20% - a reduction in the Trust's capital programme of £3.7m.

Assessment of the risk register has identified the following as the **top risks** to the organisation:

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

As you may already be aware, the **Care Quality Commission (CQC)** will be inspecting us sometime between 26 August and 28 October. The inspection is run 'unannounced', meaning that the inspectors could arrive on site anytime between these dates. It doesn't feel like a long time since the CQC was last here. But this isn't unusual; the CQC has changed how it inspects services and the majority of trusts will have an inspection every year. So, we need to be ready and all on the 'front foot', in both our acute and community services. To showcase the things we're really proud of, we need to make sure that we all get the basics right. The CQC will wish to meet and speak with Governors as part of the well-led element of the inspection. When we receive details of the timing of the well-led inspection we will contact Governors.

The results of the **General Medical Council's latest doctors in training survey** have been issued and I am delighted to say that we are once again ranked as the number one acute trust in the east of England in terms of overall satisfaction – moving up three percentage points to 82%. The survey asks doctors in training, from foundation doctors to specialists, questions based on a number of criteria, including clinical supervision, educational supervision, induction, teamwork and supportive environment.

In the **National Institute for Health Research** 2018/19 league tables, our research team have come top of the Eastern region for the largest increase in people participating in NHS research, with a 126% increase compared to the previous year! That comes to more than 1,500 participants. We're very proud of our amazing research team who are supporting research to improve patient treatment and care in the future. Keep up the good work, guys!

I was truly humbled earlier this month when alongside the **Guide Dog Association** and Jen Bacon Trust eye clinic liaison officer, I was guided with Trust chair Sheila Childerhouse around the hospital. We were wearing simulation-specs and using canes and really got to feel what it might be like to be visually impaired and have to navigate a hospital independently, but it also helped to raise awareness with staff about sight loss within our healthcare setting. Helen Sismore, community engagement for guide dogs East Anglia, and Geraldine McKeag and her guide dog Quinter, wanted to join the group too, to review how easy our NHS facilities are to access independently for people with sight impairment and to look at both clinic and corridor accessibility.

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

We know that sometimes the **smallest things can make the biggest difference** to our patients and visitors. Our catering staff at the West Suffolk Hospital have gone the extra mile for patients, visitors and staff by starting to offer a traditional afternoon tea for just £6.50 per person that can be ordered by anyone, for any occasion, for up to six people. It might sound like an odd thing to provide in a hospital, but sometimes families want to celebrate a new birth, or perhaps the end of some difficult treatment, or even an all clear. Patients may be unable to go home to celebrate straight away, but they are able to visit our staff restaurant with their family in a more relaxed setting and have a special treat. Patients have already started using it, with one of our neonatal babies making her very first outing for an afternoon tea with mum, dad and family earlier in the month. These small things are really what makes WSFT a special trust. And we're also trying to improve patient experience by making life easier for our community; passengers with concessionary bus passes are now able to travel free on the pre-bookable bus service connecting Haverhill and its surrounding villages to West Suffolk Hospital. Until recently, senior citizens, students and the disabled with concessionary passes were not able to use them on the service, which is operated by The Voluntary Network. But now they are able to travel for free, thanks to their fares being funded by the West Suffolk Alliance. This is great news, and show that by working together, we can really make a difference!

Many people ask me what it's like to be the chief executive of an NHS trust so I decided reflect on that, and set out my first few years in my new book '**An NHS baptism of fire: My first years as an NHS chief executive'**. I hope it conveys my experiences, the highs and the lows, and my thoughts on whether small hospitals can have a bright future – a topic that remains under much national debate. The Kindle edition of the book costs £3.99, with all royalties going to the WSFT's My WiSH Charity.

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

Deliver for today

Diabetes is focus for community study day
Our community diabetes team recently organised a successful West Suffolk diabetes study day for 50 GPs and practice nurses at the British Racing School in Newmarket. The team worked with Astra Zeneca to secure excellent speakers for the event. Most were home-grown, including Jessie Wright, one of the diabetes specialist dietitians at WSH, who talked about diabetes, liver disease and diet.

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

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

Emergency access standards
We are one of the trusts across England to take part in the testing of the proposed new urgent and emergency care standards, which will help the NHS to understand the impact they have on clinical care, patient experience and the management of services, compared to the current single four-hour access standard in A&E. That work has largely been completed and we are ready to start testing of some of these standards, for an initial period of six to eight weeks. We expect that a second period of testing covering all the standards will follow shortly after. Once testing is completed, the NHS nationally will analyse the data to track results, with the learning from here and the other participating trusts informing any final recommendations from the review later in the year.

Invest in quality, staff and clinical leadership

What does the EBME team do?
Absolutely vital to the running of the Trust, some of you may never have heard of this brilliant team, comprising of two managers and seven technicians. The electro-biomedical engineering (EBME) department and medical equipment library services team manage, maintain, loan and purchase the majority of medical devices in the Trust.

Chief resident programme prize-winners
Specialist registrars Dr Adam Devany (trauma and orthopaedics) and Dr Chrishan Gunasekera (ophthalmology), were hailed as joint first prize-winners at this year's Chief Resident Clinical Leadership and Management Development Programme. Run jointly by The Judge Business School, Cambridge University, and Cambridge University Hospital's post-graduate medical centre, and sponsored by the East of England Deanery, the one-year programme is aimed at doctors in their final training years prior to taking up consultant roles, and general practitioners seeking leadership roles within commissioning.

Royal College of Physicians' Eastern Update in Medicine conference
Congratulations to Dr Chris Paisey, foundation year two (FY2) trainee doctor, on winning first prize at the Royal College of Physicians' Eastern Update in Medicine conference for his poster presentation, 'Large scale retrospective mortality analysis in patients who develop acute kidney injury in a district general hospital'. The poster detailed a quality improvement project that Dr Paisey, Dr David Chapman (FY1) and consultant nephrologist Vivian Yiu undertook using e-Care. Due to the availability of electronic medical records, they were able to run a report looking at more than 4,000 patients who were admitted over a two-year period with acute kidney injury.

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

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

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

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

Experience of Care Week
This is an international initiative which happens on an annual basis across health and social care, celebrating work that takes place to improve the experience of patients, families, carers and staff. Our patient experience team were excited to share details of events taking place to celebrate Experience of Care Week and let staff know how they could get involved, whether in the hospital or out in the community.

Stroke research: second highest recruiter in the region
Over the last year the Trust's stroke research team has successfully recruited 58 patients to their stroke studies, which has placed us as the second highest recruiter in the eastern region for stroke specialty studies, just behind Addenbrooke's. This is an amazing achievement for a team which is made up of only three members of staff: lead stroke consultant Dr Abul Azim; stroke specialist research nurse Lisa Wood and superintendent radiographer Claire Moore, who manages the imaging elements associated with research.

Build a joined-up future

Car park improvements
Please be aware that from July the Trust will be making improvements to car park A at the front of the site. The improvements include resurfacing and new lighting, following feedback from our patients. This will mean there will temporarily be slightly fewer spaces available for patients and visitors to park (30% reduction in car park A). Car park C at the top of St Nicholas Way, which is usually staff only, will be signposted as also available for patients while works are ongoing. The Trust is also providing information for patients about the works through appointment letters and on our Trust website. Thank you for your patience.

Video consultations
In line with our digital ambitions to utilise technology for our patients, we've been running a pilot in paediatrics where we've been using video consultations for follow up appointments. The pilot has been a great success, and we are now exploring what other areas of the Trust might benefit from video consultations.

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

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

Team's work highlighted in prestigious journal
Members of the WSFT's community child and family clinical psychology team have had an article about their work published in the March Clinical Psychology Forum from the British Psychological Society. My child won't sleep: A psychotherapeutic approach to sleep problems in children with complex neurodevelopmental needs was written by clinical psychologists Dr Sally Moore and Dr Mariana Giurgiu, Emma Gammons, child and family practitioner and Harriet Wickson, assistant psychologist.

8. Governor issues (enclosed)

To note the issues raised and receive any agenda items from Governors for future meetings

For Reference

Presented by Liz Steele

REPORT TO:	Council of Governors
MEETING DATE:	6 August 2019
SUBJECT:	Governor issues
AGENDA ITEM:	8
PREPARED BY:	Liz Steele, Lead Governor Richard Jones, Trust Secretary & Head of Governance
PRESENTED BY:	Liz Steele, Lead Governor
FOR:	Information

Response to feedback from Liz Steele, following informal Governors meeting on 23 July 2019.

1. **How many incidents. Near misses, have been reported in a management reporting system, related to Pathology incidents. This in light of recent events at another trust where incorrect test results related to unnecessary surgery and treatment on patients**

   Datix enables us to capture incidents that relate to pathology adverse events. In 2019, to date 178 such incidents have been reported of which 14 indicated some degree of harm to the patient - 13 minor and one moderate harm. The moderate harm incident resulted in a delay in the patient receiving treatment where a sample was categorised as routine not urgent due to a communication error however, aside from the emotional impact on the patient there was no long term harm. Analysis of trust-wide incident data for the same period has not identified any incidents of 'inappropriate or incorrect treatment or procedure' relating to pathology.

2. **How are the inefficiencies in the patient transport being addressed? If they are not meeting their KPIs - what progress is in place to manage the risks and additional cost to WSFT?**

   The contract for non-urgent patient transport is held by the CCG. We are working closely with them to manage and address this issue. The CCG has issued a contract performance notice which has a detail remedial action plan. The next steps would be for the CCG to issue financial penalties against E-Zec. The Trust is being reimbursed for additional transport costs that it incurs e.g. private ambulances booking.

   The KPI performance for July is currently being reviewed with the CCG and e-Zec to determine next steps. A workshop is planned for 2 August to support this review process.

3. **With the CQC visit due here are we with IT in the community and what plan is in place to ensure it is fit for purpose? What is the plan for the roll out of a new IT provider for the Community? Can we be assured that there will be an efficient and effective IT for Community staff once the NEL contract ceases?**

   Following the decision by the Trust Board to work up a plan to exit the NEL CSU Community IT contract considerable work has been undertaken by WSFT working in co-operation with ESNEFT. It starts with the formation of a Community IT and System One Digital Board (CS1DB) that will set and manage the programme of work to complete the transition of services. This board is chaired by Mike Meers, ICT Director at ESNEFT with support from Mike Bone, CIO at WSFT. Board membership includes senior community leads and IT staff. Working to the board are three sub groups:

- System One (S1) Management Group - focussed on driving improvement to the S1 community system to maximise the quality and value of the data
- Clinical Assurance Group (CIAG) - oversees security and information governance
- IT Technical Group - dealing with changes to infrastructure.

Terms of reference and initial membership of the board and all groups has been created and the CS1DB has its first meeting scheduled for 2nd August 2019. In the meantime MLL Limited who provide the Suffolk Cloud network have been working with the technical group to provide a costed proposal to update and manage the whole community network and this is to be presented to the IT Technical Group (and fed upwards into the CS1DB) during August.

4. What feedback do you get from the staff, GPs, WSFT, patients, using the digital dictation system and how are you monitoring quality. How are you responding to feedback from the staff that the quality is unacceptable? We have an example of the mistakes being made.

Sarah Jane Relf, e-Care/GDE Operational Lead provided the following response:

Thank you for taking an interest in the MMODAL project. To answer your specific questions regarding feedback and quality assurance it is important to give you some background information so that you can see we are being very cautious in rolling this out.

- The project is only at pilot stage currently and will not progress further until we are confident that issues around workflow and quality of voice recognition are resolved. There are four services currently using it
- We were aware of the issue regarding the two letters that you presented to us. I hope this assures you that we are monitoring the pilot closely. I can confirm that these should not have been sent as they were. Either the clinicians should be making corrections (some of our specialist nurses are doing this) or the letter should have gone to the secretary for them to undertake the corrections before distribution. On this occasion the consultant accidently pressed send rather than send to secretary. We have helped this consultant and we are looking at changing the colours of the buttons within MMODAL so that we can try and make this easier for others as well
- We have been working closely with the pilot users throughout and therefore we are very active in receiving feedback from both the dictators and the secretaries. The workflows are being changed to respond to their requests and concerns. Please be assured therefore that we are very actively listening to staff concerns. Indeed we have recently pulled the full wider roll out because we were not satisfied with the feedback from our pilot users as we felt that the pilot could not be classed as successful at this stage
- We have formally raised our concerns regarding quality of the output of voice recognition for MMODAL and they are currently running analysis on sample users. We are also speaking to Great Ormond Street (who also use MMODAL) to understand how we compare against another trust and also speaking to Homerton who use Nuance (a direct competitor of MMODAL).

I hope this answers the questions raised and provides some assurance about how we are managing the project.

5. With the national increase in sepsis:

a. What assurance can you give that WSFT are well prepared for any increase that might occur across the trust

Over the last six months a range of interventions have been put in place. The WSFT has employed a full time Sepsis and AKI Project Nurse; their primary aim is to improve recognition and prompt treatment of sepsis within the Trust. Training sessions are delivered in both the hospital and community settings with relevant guidance is being updated and e-Care alerts now optimised to support timely intervention and escalation.

The Sepsis and AKI Project Nurse reviews the e-Care real time alerts and shares learning from this twice weekly. During the same period, neutropenic sepsis compliance has consistently improved - achieving 100% compliance in April.

b. Is the indiscriminate use of antibiotics in the community hiding cases of sepsis, in particular the on-site GP service?

Sue Partridge, consultant microbiologist provided the following response:

My view is that much of the national increase in sepsis is actually due to more effective capture of data, as well as some improvement in detection with the various tools and systems that are in use. So not necessarily more patients with sepsis, but perhaps more being identified and certainly more systematic recording of the diagnosis of sepsis.

While I would always be concerned about the indiscriminate use of antibiotics, I am not sure that this would hide cases of sepsis. Sepsis is a clinical diagnosis, being a severe manifestation of infection. While there are certain clinical observations/test results that suggest sepsis, the final diagnosis is a clinical one. As the prescription of antibiotics is done by an appropriately trained clinician, I would expect that part of their assessment of the patient would include:

- Is there evidence of infection?
- Is there evidence of severe infection (sepsis)?

This would determine whether the patients received antibiotics, and whether they needed to be admitted for treatment of severe infection/sepsis. My view is that early administration of (appropriate) antibiotics can prevent an infection progressing and the patient developing sepsis.

6. What is the process for ensuring/supporting patients who have no fixed address, in leaving the hospital in a timely manner?

We work very closely with social services who are based within the hospital with the discharge planning team. This is challenging, particularly for those with ongoing health and care needs. For some individuals transport is arranged from the hospital to West Suffolk House to enable them to present to the housing team.

7. We are aware that the major incident plan has been updated, can you explain what the monitoring/testing plan is?

The major incident plan and patient flow escalation plan have been replaced by the Command Control and Coordination (c3) Plan and the Mass Casualty/Fatalities tactical plan. The c3 Plan was tested pre-adoption in April 2018, and is currently used for business as usual, patient escalation and incident response. The next major exercise formal test is planned for June 2020. This is a year earlier that NHSE mandate, but is seen as necessary as to leave it to the 3-year point will result in unnecessary corporate skill fade, and will further allow practice in new and revised linked regional plans. All incidents are debriefed and the impact on the c3 Plan and other tactical plans are documented and implemented where appropriate.

8. Outline the process for communicating with patients concerning cancelled clinics and cancelled operations and how this is recorded and audited

<u>Cancelled clinics</u>
The process for cancellations in advance (more than a week) is that letters are sent from e-Care and these are recorded against the patients record on the system as hospital cancellations. Short notice cancellations are made by phone, recognising the time delay for post. But are recorded in the same way on e-Care. Service managers review cancellations due to consultant leave (for which six weeks' notice is required).

A new activity manager module of Allocate (a system that supports job planning, appraisal and rostering) will provide greater visibility of cancelled sessions. Individual patient pathways are monitored through the access meeting and this would highlight prolonged pathways for patients and any impact as a result of multiple cancellations.

Cancelled operations

All theatre bookings and cancellations are managed through telephone conversations with patients. We would only use letters to communication if we have failed on multiple attempts to contact a patient directly. Cancellations on the day are always a last resort but are sometimes inevitable, for example short notice staff sickness (surgeons/anaesthetists), equipment failure and in rare circumstances bed capacity. These cancelations are monitored as part of the Board performance pack. We are monitored against rebooking within 28 days of on the day cancellations (also in the Board pack with good performance). Other cancellations on operations are monitored by the surgical management team.

Recommendation:
To note the response to the issues raised.

9. Summary finance & workforce report (enclosed)

To note the summary report

For Reference

Presented by Louisa Pepper

REPORT TO:	Council of Governors
MEETING DATE:	6 August 2019
SUBJECT:	Summary Finance & Workforce Report
AGENDA ITEM:	9
PREPARED BY:	Nick Macdonald, Deputy Director of Finance
PRESENTED BY:	Louisa Pepper, Non-Executive Director
FOR:	Information - update on Financial Performance

EXECUTIVE SUMMARY:

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

- The planned YTD deficit was £1.6m but the actual deficit was £2.4m, an adverse variance of £0.8m.
- We continue to forecast to meet our plan to break even in 2019-20. However, this requires a recovery plan to reduce the current rate of expenditure by around £4m, as well as escalation costs to fund winter pressures of around £1m.
- The reported forecast assumes we deliver this recovery plan and will therefore receive all our PSF.
- Across the STP we have been asked to reduce our capital programme by 20% - ie a reduction in the Trusts capital programme of £3.7m
- The Use of Resources Rating (UoR) is 3 YTD (1 being highest, 4 being lowest)

Income and Expenditure Summary as at June 2019

The Trust agreed a control total to break even in 2019-20 which enabled Provider Sustainability Funding (PSF) of £10.1m. In order to deliver the Trust's control target in 2019-20 we needed to deliver a CIP of £8.9m (4%). In June we planned to achieve £2,341k (26.4% of the annual plan) but achieved £2,295k (£46k behind plan).

We are planning to break even in 2019-20, but the current position indicates a deficit of £4m plus costs associated with additional winter capacity (c. £1m).

The YTD variance relates to demand being significantly higher than planned and the costs of extra capacity to meet this demand being beyond that funded by around £200k per month. The Trust has also incurred non-recurring costs relating to overseas recruitment (£200k) and community equipment (£150k).

Failing to meet our financial control total would have a detrimental impact on our PSF since £6.0m of our PSF relates to financial performance. The reported forecast assumes we enact a recovery plan that will ensure we meet our break even control total by the year end.

Each Division is preparing a recovery plan in order to deliver the funded activity within their 2019-20 budget. These will be discussed and prioritised in order to compile a Trust wide recovery plan.

Use of Resources (UoR) Rating

Providers' financial performance is formally assessed via five "Use of Resources (UoR) Metrics. The highest score is a 1 and 4 is the lowest. Under the UoR we score a 3 cumulatively to June 2019.

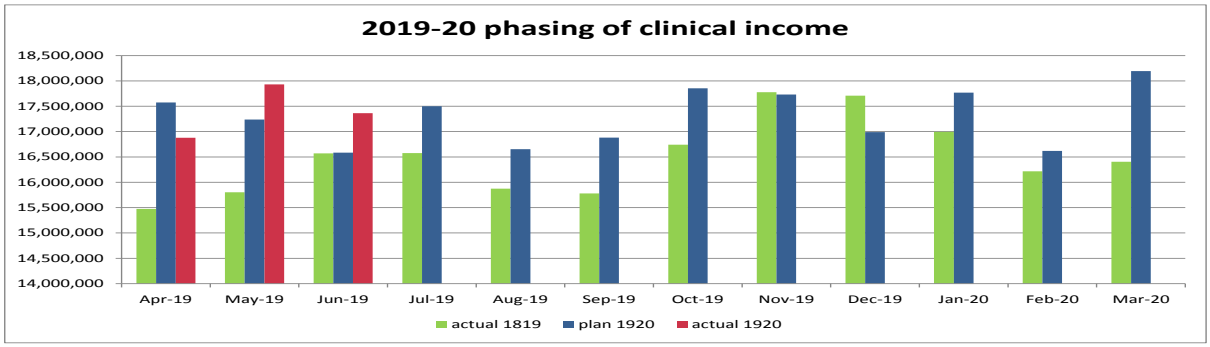
Metric	Value	Score	Plan
Capital Service Capacity rating	-0.1	4	4
Liquidity rating	-22.9	4	4
I&E Margin rating	-5.2%	4	2
I&E Margin Variance rating	-2.7%	4	1
Agency	-8%	1	1
Use of Resources Rating after Overrides		3	3

Performance against I & E plan

SUMMARY INCOME AND EXPENDITURE ACCOUNT - June 2019	Jun-19 Budget £m	Jun-19 Actual £m	Jun-19 Variance F/(A) £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance F/(A) £m	Year end forecast Budget £m	Year end forecast Actual £m	Year end forecast Variance F/(A) £m
NHS Contract Income	17.1	17.4	0.3	51.9	52.4	0.5	209.6	212.1	2.5
Other Income	3.1	2.8	(0.3)	9.1	8.7	(0.4)	37.4	36.1	(1.3)
Total Income	**20.2**	**20.2**	**(0.0)**	**61.0**	**61.1**	**0.1**	**247.0**	**248.2**	**1.2**
Pay Costs	14.1	14.3	(0.2)	42.3	42.8	(0.4)	170.0	170.8	(0.8)
Non-pay Costs	6.4	6.5	(0.2)	19.3	19.8	(0.6)	75.3	76.5	(1.2)
Operating Expenditure	**20.5**	**20.8**	**(0.4)**	**61.6**	**62.6**	**(1.0)**	**245.4**	**247.3**	**(2.0)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**(0.3)**	**(0.6)**	**(0.4)**	**(0.6)**	**(1.5)**	**(0.9)**	**1.7**	**0.9**	**(0.7)**
Depreciation	0.7	0.6	0.1	2.0	1.8	0.2	7.9	7.4	0.5
Finance costs	0.3	0.4	(0.0)	1.0	1.0	(0.1)	3.9	3.7	0.2
SURPLUS/(DEFICIT)	**(1.3)**	**(1.6)**	**(0.3)**	**(3.5)**	**(4.3)**	**(0.8)**	**(10.1)**	**(10.1)**	**(0.0)**
Provider Sustainability Funding (PSF)									
PSF - Financial Performance	0.6	0.6	0.0	1.9	1.9	0.0	10.1	10.1	0.0
SURPLUS/(DEFICIT) incl PSF	**(0.6)**	**(1.0)**	**(0.3)**	**(1.6)**	**(2.4)**	**(0.8)**	**0.0**	**(0.0)**	**(0.0)**

Performance against Income plan

The chart below summarises the phasing of the clinical income plan for 2019-20, including Suffolk Community Health. This phasing is in line with activity phasing and does not take into account the block payment but does include Provider Sustainability Funding (PSF.



	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	904	954	51	2,693	2,904	211
Other Services	1,512	1,725	213	4,683	5,011	327
CQUIN	166	168	3	503	506	3
Elective	2,568	2,730	162	8,087	7,998	(89)
Non Elective	6,133	5,972	(162)	18,174	18,184	10
EmergencyThreshold Adjustment	(341)	(341)	0	(1,009)	(1,009)	0
Outpatients	2,930	3,000	70	9,113	9,117	3
Community	3,221	3,215	(6)	9,663	9,645	(18)
Total	17,093	17,423	330	51,908	52,355	447

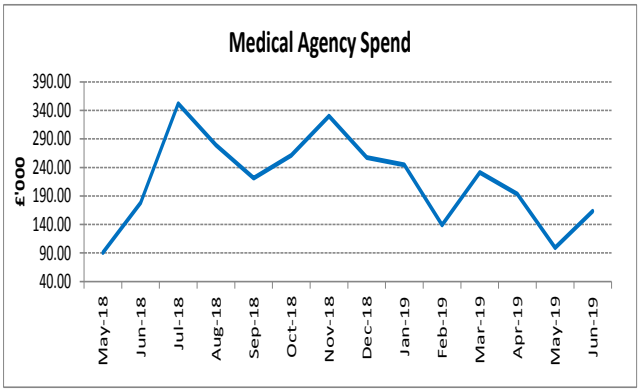
Performance against Expenditure plan - Workforce

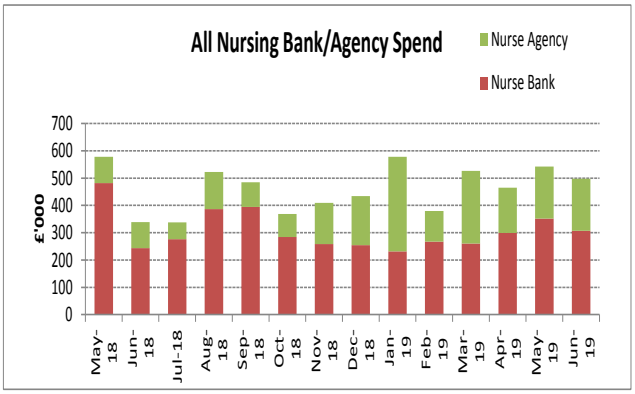
Monthly Expenditure (£) Acute services only				
As at June 2019	Jun-19	May-19	Jun-18	YTD 2019/20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**12,396**	**12,437**	**11,092**	**37,195**
Substantive Staff	11,116	10,777	9,943	33,092
Medical Agency Staff (includes 'contracted in' staff)	150	92	167	424
Medical Locum Staff	240	134	224	660
Additional Medical sessions	213	313	248	835
Nursing Agency Staff	181	160	89	495
Nursing Bank Staff	282	318	231	863
Other Agency Staff	107	48	20	192
Other Bank Staff	135	118	117	404
Overtime	167	179	102	567
On Call	71	66	60	204
Total temporary expenditure	1,546	1,428	1,259	4,643
Total expenditure on pay	**12,662**	**12,205**	**11,201**	**37,735**
Variance (F/(A))	(266)	232	(110)	(540)
Temp Staff costs % of Total Pay	12.2%	11.7%	11.2%	12.3%
Memo : Total agency spend in month	438	300	276	1,111

Monthly Whole Time Equivalents (WTE) Acute Services only			
As at June 2019	Jun-19	May-19	Jun-18
	WTE	WTE	WTE
Budgeted WTE in month	**3,323.6**	**3,400.3**	**3,130.9**
Employed substantive WTE in month	2956.93	2927.92	2771.73
Medical Agency Staff (includes 'contracted in' staff)	10.94	7.79	11.48
Medical Locum	17.94	12.77	20.84
Additional Sessions	16.22	21.05	17.79
Nursing Agency	26.07	22.41	17.55
Nursing Bank	79.3	81.85	73.62
Other Agency	10.1	6.42	5.71
Other Bank	59.51	56.37	56.46
Overtime	46.93	47.76	30.59
On call Worked	6.82	6.38	7.33
Total equivalent temporary WTE	**273.8**	**262.8**	**241.4**
Total equivalent employed WTE	**3,230.8**	**3,190.7**	**3,013.1**
Variance (F/(A))	92.9	209.6	117.8
Temp Staff WTE % of Total Pay	8.5%	8.2%	8.0%
Memo : Total agency WTE in month	47.1	36.6	34.7
Sickness Rates (May / Apr)	3.55%	3.39%	3.79%
Mat Leave	2.73%	3.01%	2.56%

Monthly Expenditure (£) Community Service Only				
As at June 2019	Jun-19	May-19	Jun-18	YTD 2019-20
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,703**	**1,687**	**1,516**	**5,108**
Substantive Staff	1,563	1,595	1,473	4,716
Medical Agency Staff (includes 'contracted in' staff)	13	7	12	32
Medical Locum Staff	4	5	3	17
Additional Medical sessions	4	0	1	5
Nursing Agency Staff	10	30	6	51
Nursing Bank Staff	25	35	12	96
Other Agency Staff	(12)	5	13	(0)
Other Bank Staff	3	8	8	17
Overtime	9	5	6	21
On Call	4	3	3	11
Total temporary expenditure	60	97	63	250
Total expenditure on pay	**1,623**	**1,692**	**1,536**	**4,966**
Variance (F/(A))	80	(5)	(20)	141
Temp Staff costs % of Total Pay	3.7%	5.7%	4.1%	5.0%
Memo : Total agency spend in month	11	42	30	82

Monthly Whole Time Equivalents (WTE) Community Services Only			
As at June 2019	Jun-19	May-19	Jun-18
	WTE	WTE	WTE
Budgeted WTE in month	**528.62**	**531.17**	**485.56**
Employed substantive WTE in month	476.72	478.09	473.95
Medical Agency Staff (includes 'contracted in' staff)	0.85	0.44	0.74
Medical Locum	0.35	0.35	0.35
Additional Sessions	0.00	0.00	0.00
Nursing Agency	1.53	4.19	1.01
Nursing Bank	6.91	8.88	3.78
Other Agency	2.23	1.58	4.41
Other Bank	0.68	1.46	3.02
Overtime	2.62	1.68	2.02
On call Worked	0.00	0.00	0.04
Total equivalent temporary WTE	**15.2**	**18.6**	**15.4**
Total equivalent employed WTE	**491.9**	**496.7**	**489.32**
Variance (F/(A))	36.73	34.50	(3.76)
Temp Staff WTE % of Total Pay	3.1%	3.7%	3.1%
Memo : Total agency WTE in month	4.6	6.2	6.2
Sickness Rates (May /April)	4.29%	4.13%	3.67%
Mat Leave	2.55%	2.81%	3.11%





Recruitment – Ward Based Registered Nurses

Whilst there are currently 83 WTE vacancies for registered nurses on ward based areas we also have a pipeline of 74 WTE nurses who will become available over the coming months.

Since winter escalation plans assume another 50 beds are opened, at a ratio of 0.63 registered nurses per bed 32 further WTE registered nurses will also be needed, as well as replacing staff who leave at a rate of around 2 per month.

The following table gives a trajectory from June 2019 – June 2020 for filling these posts. This trajectory, including winter planning, is across

- Medical and Surgical Wards and Gynaecology,
- Rosemary Ward and Glastonbury Court,
- AAU and A&E,

but excludes Critical Care Service, Theatre staff, Discharge Waiting Area, Paediatrics, Neonates, Maternity and Community Teams.

Registered Nursing - Wards (WTEs)

	Actual	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Funded vacancies b'f	91.6	92.8	79.8	72.2	62.4	33.4	12.8	33.0	25.4	18.6	11.0	3.4	(4.2)
leavers	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
maternity leave commenced	0.0	0.0	2.0	0.0	0.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
increased establishment :													
winter : G3 (already staffed)	10.0												
winter : G9							16.0						
winter : F10							16.0						
quality													
other developments													
new staff													
new starters (from below)	(10.0)	(15.0)	(10.0)	(11.0)	(31.0)	(23.0)	(15.0)	(10.0)	(10.0)	(10.0)	(10.0)	(10.0)	(10.0)
return from maternity leave (assume average drop to 0.8)	(0.8)		(1.6)	(0.8)		(1.6)	(0.8)	(1.6)	(0.8)	(1.6)	(1.6)	(1.6)	(1.6)
Total vacancies c 'fwd	92.8	79.8	72.2	62.4	33.4	12.8	33.0	25.4	18.6	11.0	3.4	(4.2)	(11.8)
filled by temporary staff :													
bank	11.7	11.7	30.0	30.0	20.0	0.0	10.0	5.0	0.0				
agency	26.3	26.3	10.0										
overtime	29.0	29.0	0.0										
Providing staffing to fill vacant posts	**66.9**	**66.9**	**40.0**	**30.0**	**20.0**	**0.0**	**10.0**	**5.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Net vacancies in month (average c. 40 before BBN)	25.9	12.9	32.2	32.4	13.4	12.8	23.0	20.4	18.6	11.0	3.4	(4.2)	(11.8)

Analysis of offered posts (pipeline)	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Offered but not yet available b'fwd	73.0	74.0	77.0	81.0	95.0	55.0	43.0	38.0	33.0	23.0	13.0	3.0	(7.0)
new starter onto B5 Ward rota (incl transfer from B3)	(10.0)	(15.0)	(10.0)	(11.0)	(31.0)	(23.0)	(15.0)	(10.0)	(10.0)	(10.0)	(10.0)	(10.0)	(10.0)
On site but working as B3 (monthly movement, incl transfer to B5)	0.0	(2.0)	4.0	15.0	(19.0)	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Offers made in month but not yet available for B3 or B5	11.0	20.0	10.0	10.0	10.0	10.0	10.0	5.0	0.0	0.0	0.0	0.0	5.0
Offered but not yet available c'fwd ('pipeline' of qualified nurses)	74.0	77.0	81.0	95.0	55.0	43.0	38.0	33.0	23.0	13.0	3.0	(7.0)	(12.0)

June 19 - June 20	WTE
B'f vacancies	91.6
Turnover	26.0
Net Maternity leavers	3.6
Additional capacity requirement	42.0
Total Recruitment required	163.2
Nurses in pipeline not yet in post b'f	73.0
Nurses in pipeline not yet in post c'f	12.0
Planned recruitment	91.0
	176.0
Over recruitment	12.8

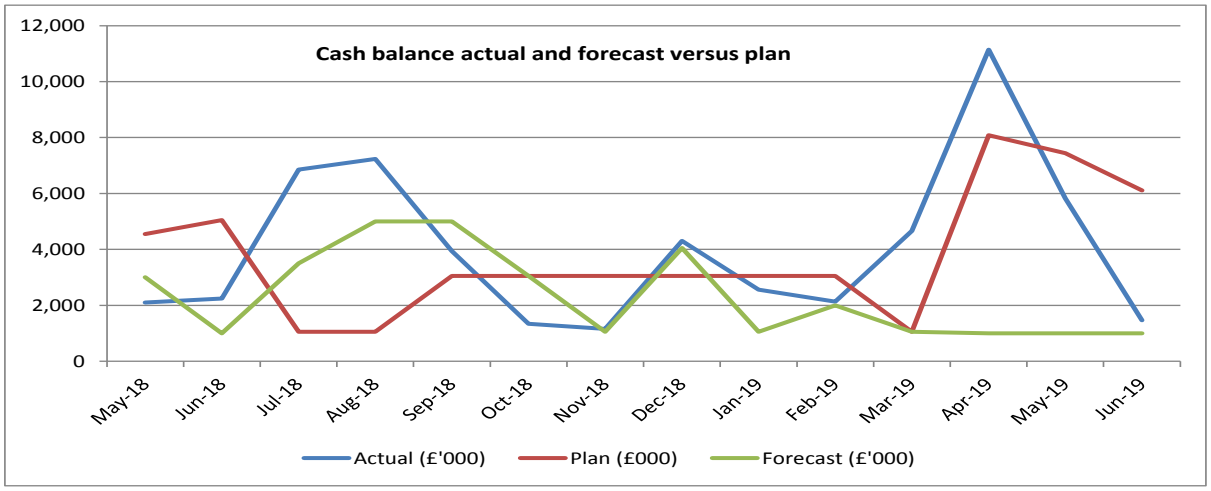
Balance Sheet

STATEMENT OF FINANCIAL POSITION

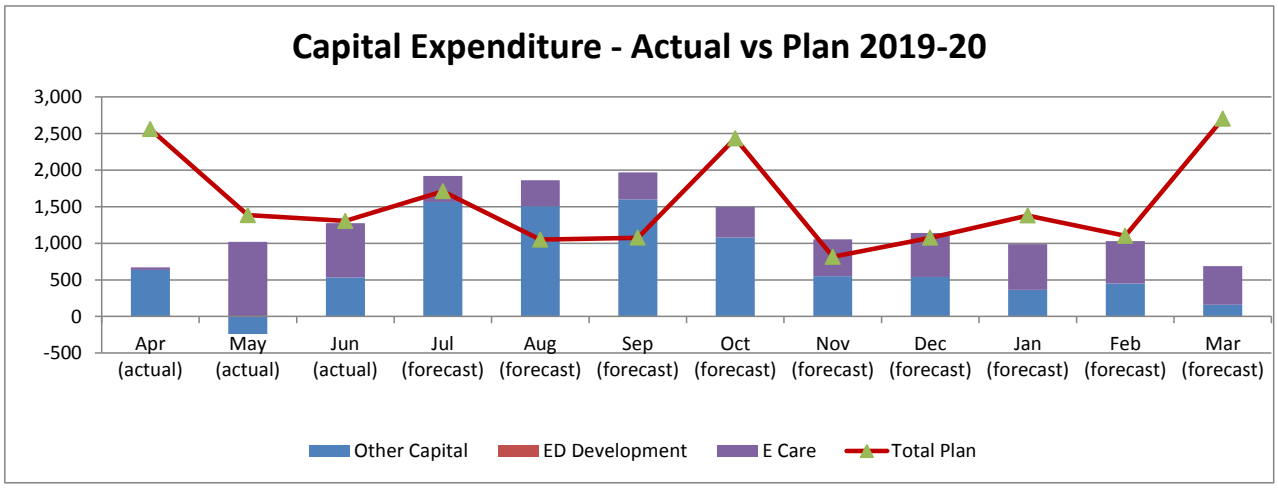
	As at 1 April 2019	Plan 31 March 2020	Plan YTD 30 June 2019	Actual at 30 June 2019	Variance YTD 30 June 2019
	£000	£000	£000	£000	£000
Intangible assets	33,970	35,940	34,675	34,218	(457)
Property, plant and equipment	103,223	115,395	110,948	103,888	(7,060)
Trade and other receivables	5,054	4,425	4,425	5,054	629
Other financial assets	0	0	0	0	0
Total non-current assets	**142,247**	**155,760**	**150,048**	**143,160**	**(6,888)**
Inventories	2,698	2,700	2,700	2,820	120
Trade and other receivables	22,119	20,000	20,000	24,054	4,054
Other financial assets	0	0	0	0	0
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	4,507	1,050	6,106	1,467	(4,639)
Total current assets	**29,324**	**23,750**	**28,806**	**28,341**	**(465)**
Trade and other payables	(28,341)	(32,042)	(30,082)	(26,932)	3,150
Borrowing repayable within 1 year	(12,153)	(3,134)	(3,134)	(7,564)	(4,430)
Current Provisions	(47)	(20)	(20)	(47)	(27)
Other liabilities	(1,207)	(992)	(8,481)	(6,714)	1,767
Total current liabilities	**(41,748)**	**(36,188)**	**(41,717)**	**(41,257)**	**460**
Total assets less current liabilities	**129,823**	**143,322**	**137,137**	**130,244**	**(6,893)**
Borrowings	(84,956)	(99,186)	(95,514)	(88,216)	7,298
Provisions	(111)	(150)	(150)	(111)	39
Total non-current liabilities	**(85,067)**	**(99,336)**	**(95,664)**	**(88,327)**	**7,337**
Total assets employed	**44,756**	**43,986**	**41,473**	**41,917**	**444**
Financed by					
Public dividend capital	69,113	70,430	69,167	69,112	(55)
Revaluation reserve	6,931	9,832	8,021	6,451	(1,570)
Income and expenditure reserve	(31,288)	(36,276)	(35,715)	(33,646)	2,069
Total taxpayers' and others' equity	**44,756**	**43,986**	**41,473**	**41,917**	**444**

The cash at bank as at the end of June 2019 is £1.5m.

Cash flow forecast for the year compared to actual



Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Forecast £'000	Aug Forecast £'000	Sep Forecast £'000	Oct Forecast £'000	Nov Forecast £'000	Dec Forecast £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2019-20 £'000
E Care	34	1,019	743	357	356	371	415	504	601	626	579	529	6,133
ED Development	0	0	-0	0	0	0	0	0	0	0	0	0	0
Other Schemes	636	-242	534	1,564	1,506	1,599	1,080	550	538	363	451	161	8,741
Total / Forecast	**670**	**777**	**1,276**	**1,921**	**1,862**	**1,970**	**1,495**	**1,054**	**1,139**	**989**	**1,030**	**689**	**14,874**
Total Plan	**2,560**	**1,385**	**1,305**	**1,710**	**1,050**	**1,075**	**2,434**	**815**	**1,075**	**1,380**	**1,101**	**2,702**	**18,592**

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

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

We have prepared a Capital Programme totalling £18.6m expenditure in 2019-20. This is underpinned by around £10.5m of further PDC (subject to approval). However, the NHS Capital Budget is insufficient to fund all capital programmes and across our STP we have been asked to reduce our Capital programme by 20%. This has resulted in WSFT proposing a reduction to our programme of £3.7m (to £14.9m).

Our Capital programme has already prioritised those schemes that improve patient safety and we are contractually committed to many of them. Therefore we feel there is little room to reduce the programme although there is always likely to be slippage against some schemes. We would propose that any delay is merely into the very early part of 2020-21 and whilst this may have implications on patient safety the Trust will do everything possible to mitigate these risks.

Recommendation:
To note the summary report.

10. Summary quality & performance report (enclosed)

To note the summary report

For Reference

Presented by Richard Davies

REPORT TO:	Council of Governors
MEETING DATE:	6 August 2019
SUBJECT:	Summary quality & performance report
AGENDA ITEM:	10
PREPARED BY:	Helen Beck, 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 Q4 demonstrates overall **good performance achieving 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 includes a summary against identified 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.

Quality walkabout summary - Q1 2019/20
Report from Paul Morris, Deputy Chief Nurse

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

There have been many highlights including examples of positive nursing leadership on F7 and F9 leading to a reduction in incidents and negative patient experience, and the introduction of a falls board on F6 in response to a serious incident.

Some areas for improvement have also been highlighted including the revamp of ward boards for displaying quality information which is inconsistent across the Trust. This is currently being actioned by the Matrons and ward boards are updated as ward refurbishment programmes take place. The changing of curtains to lighten areas which previously felt dark and staffing reviews to ensure service delivery meets the acuity of the patient base.

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

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

Recommendation:

To note the summary report.

Summary quality & performance report

Are we safe?

Within the **safety dashboard** 8 of 38 indicators for which data was available were reported as 'green' throughout Q1 (an increase from 7 in Q4 2018/19). These included:

- Infection prevention indicators – central venous catheter insertion, preventing surgical site infection pre- and peri- operatively; urinary catheter insertion, MSRA bacteraemia - community attributable
- Serious harm as a result of falls in the community
- Timely reporting of serious incidents (2 working days) and submission of final reports (60 working days)
- Pain management performance

Areas for improvement

- There were a total of 179 **inpatient falls** during Q1 (compared to 150, 135 and 149 in the previous three quarters respectively). Over the last year there is no discernible trend in numbers against the mean falls per 1000 beds days (an indicator which takes account of variable activity). There is an ongoing work plan and quality improvement initiatives in this area. These are informed by a range of activities including the contacts made through the regional falls collaborative. From August there will be dedicated matron hours focussing on falls training and quality improvement activities.

- There were a total of 127 **pressure ulcers** during Q1 (compared to 104, 90 and 73 in the previous three quarters respectively). After what appeared as an upward trajectory since November 2018 it was pleasing to see a reduction in pressure ulcers in June (31) compared with May (54). This trend will be kept under review. The proactive approach to reducing incidences of new pressure ulcers continues and includes nutritional assessment and interventions for which improvement is expected by September.

- The number of out of date **risk assessments and actions** remains red. This is as a result of the recording of all fire risk assessments centrally. A prioritised programme to update these assessments has been agreed with external support to complete the work and update the central records by the end of September.

- We have seen a deterioration in performance for **overdue RCA actions** since December '18. A process to review progress with investigation report actions after three months has been introduced (starting Aug '19) and we expect to see improvement over the next three months.

- The performance indicator for **patients with nutrition assessment within 24 hrs** was clarified in September 2018. Since this time performance has remained at about 80% against a target of 95%. Following completion of the NHSI nutrition collaborative work continues to improve nutritional assessments, referrals and care planning, as well as supporting protected meal-times. A streamlining exercise is also underway for the range of data and metrics associated with food, fluid and nutrition. Progress will be reported in detail to the Trust's Clinical Safety & Effectiveness Committee in September.

Are we effective?

Within the **effective dashboard** 5 of 11 indicators for which data was available were reported as 'green' for each month in Q1, including:

- Management of the central alerts system (CAS)
- NHS number coding
- Fractured neck of femur surgery within 36 hours
- Cancer two week wait services available on choose and book
- Operations cancelled for the second time.

It has been recognised that significant improvement has been achieved for overdue NICE baseline assessments – reducing from 49 in September 2018 to 17 in Jun 2019.

Areas for improvement

- Emergency department (ED) and non-elective **discharge summary** performance remained challenging. Timely electronic capture and reporting has been introduced to support improvement. Training for junior doctors on high-quality and timely production of discharge summaries has been delivered in the last month. The sessions received positive evaluation and will be repeated to the new intake juniors starting in August.

Are we caring?

Within the **caring dashboard** 15 of 22 indicators for which data was available were reported as 'green' throughout Q1.

The following **recommender indicators were rated as green** for each month in the quarter – inpatient; outpatients; short stay; maternity – postnatal community, F1 (parent and extremely likely to recommend); Kings suite, community paeds, community teams and stroke.

Are we responsive?

Within the **responsive dashboard** 18 of 29 indicators for which data was available were reported as 'green' throughout Q1.

Areas for improvement

- We are currently piloting new metrics to measure **emergency department** performance which we are not able to report publically during the pilot phase

- **Ambulance handovers** – we are consistently seeing more than 40 ambulance handovers over 30 minutes. A comprehensive action plan has been agreed with East of England Ambulance Service NHS Trust (EEAST) and presented to the system's A&E delivery board.

- **18-week maximum wait** from point of referral to treatment (RTT). While some improvements have been achieved in RTT performance the waiting list is growing. Work is ongoing within the divisions to test and challenge capacity and demand analysis.

This work is currently being finalised to support the RTT improvement plans for waiting times for first appointments as well as surgery. Options for outsourcing activity are being considered.

- **Children in care assessments** – during Q1 we started to monitor the percentage of initial assessments completed within 15 working days of receiving all of the relevant paperwork. Delivery of this target has not been at the level expected despite being in the Trust's control – at the July Board it was agreed to undertake a more detailed review in this area to inform the Trust's improvement plan.

Are we well-led?

Within the **well-led dashboard** 5 of 28 indicators for which data was available were reported as 'green' throughout Q1.

Areas for improvement

- All staff to have an **appraisal** – year-on-year reported performance has improved from 69% to 81%. The focus of HR continues to work with managers to ensure effective action is taken to complete and record appraisals, including the planned role of managers self-serve in the electronic staff record.
- Compliance with **mandatory training** improved during the quarter. Improvements are being made to e-learning access and reporting for hospital and community staff.

11. Trust Inclusion Objectives (enclosed)

To receive an update

For Reference

Presented by Denise Pora

Council of Governors Meeting – 6 August 2019

Agenda item:	11			
Presented by:	Denise Pora, Deputy Director of Workforce (Organisation Development)			
Prepared by:	Denise Pora, Deputy Director of Workforce (Organisation Development)			
Date prepared:	24 July 2019			
Subject:	Trust Inclusion Objectives			
Purpose:		For information	X	For approval

Executive summary:

The purpose of our inclusion strategy is to ensure the WSFT has a culture where everyone is confident and comfortable being their authentic and whole self at the Trust, whether as a member of staff, volunteer, patient, service user or visitor and no-one experiences intolerance or discrimination.

A formal review and updating of the inclusion strategy's supporting objectives is carried out every two years. The purpose of this report is to seek the views of the Council of Governors on the assessments made of the priorities for the Trust and the draft inclusion objectives developed to address these. This is part of a process of internal and external consultation. The draft objectives are:

For patients, service users and carers

- Improve the experience and care of patients and service users experiencing mental distress those with learning disabilities and neurodiversity
- Improve the experience and care of people who are lesbian, gay, bisexual, trans and all other sexualities and gender identities

For staff

- Promote and support inclusive leadership at all levels of the trust
- Ensure the recruitment interview process is bias free
- Facilitate the voices of all staff, providing forums for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the trust on issues of equality, diversity and inclusion
- Take action to support the mental health wellbeing of all staff

For patients, service users, carers and staff

- Promote a culture of inclusion in delivery of care to all patients and staff
- Improve information and data collected, in respect of protected characteristics in order to understand what action may be required
- Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours

In addition to consultation with stakeholders, the updated objectives reflect a review of Trust performance against the NHS Equality Delivery System (EDS2) and a range of other indicators. Governors' views on our assessment against the outcomes of EDS2 are also welcomed. These can be found at https://www.wsh.nhs.uk/Corporate-information/Information-we-publish/Equality-diversity-and-inclusion.aspx

<table>
<tr><td rowspan="2">Trust priorities

[Please indicate Trust priorities relevant to the subject of the report]</td><td colspan="2">Deliver for today</td><td colspan="2">Invest in quality, staff and clinical leadership</td><td colspan="3">Build a joined-up future</td></tr>
<tr><td colspan="2">X</td><td colspan="2">X</td><td colspan="3"></td></tr>
<tr><td rowspan="2">Trust ambitions

[Please indicate ambitions relevant to the subject of the report]</td><td>Deliver personal care</td><td>Deliver safe care</td><td>Deliver joined-up care</td><td>Support a healthy start</td><td>Support a healthy life</td><td>Support ageing well</td><td>Support all our staff</td></tr>
<tr><td>X</td><td></td><td></td><td></td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Previously considered by:</td><td colspan="7">WSFT Equality, Diversity and Inclusion Steering Group</td></tr>
<tr><td>Risk and assurance:</td><td colspan="7">Equality monitoring processes within Workforce and Communications Directorate</td></tr>
<tr><td>Legislation, regulatory, equality, diversity and dignity implications</td><td colspan="7">• Compliance with the 2010 Equality Act and Public Sector Equality Duty
• Workforce Race Equality Standard and Workforce Disability Equality Standard included in NHS standard contract and CQC well-led domain
• Annual Gender Pay Gap reporting is a legal requirement</td></tr>
<tr><td colspan="8">Recommendation:
Governors are invited to comment on the Trust draft inclusion objectives and the ratings made against the outcomes of the Equality Delivery System (EDS2).</td></tr>
</table>

Trust inclusion strategy and objectives 2019 - 21

Background and Introduction

The purpose of this report is to seek the views of the Council of Governors on the assessments made of the equality and diversity priorities for the Trust and the draft inclusion objectives developed to address these. This is part of a process of internal and external consultation on our inclusion objectives 2019 to 2021.

The purpose of our inclusion strategy is to ensure the WSFT has a culture where everyone is confident and comfortable being their authentic and whole self at the Trust, whether as a member of staff, volunteer, patient, service user or visitor and no-one experiences intolerance or discrimination.

Specifically, we aim:

- To embrace all people irrespective of, for example, race, religion or belief, gender identity or expression, sexual orientation, age, marital status, pregnancy, maternity or disability.
- To give equal access and opportunities to all, and get rid of discrimination and intolerance.

We will do this both as an employer and as a service provider.

Our inclusion strategy supports our commitment to the provision of high quality, safe care for all members of the communities we serve and our ambition to support all our staff as set out in our strategic framework Our patients, our hospital, our future, together'.

Draft inclusion objectives 2019 to 2021

Our draft inclusion objectives have been drawn from: consultation with staff and service users, a review of our performance against the Workforce Race Equality Standard indicators (2019 data), the Workforce Disability Equality Standard (2019 data), our 2018 staff survey results, our 2018 Gender Pay Gap Report, the NHS Equality Delivery System (EDS2)*, the Trust's Strategic Framework 'Our patients, our hospital, our future, together' and the requirements of the Equality Act (2010) including the Public Sector Equality Duty (PSED).

We strive to take an inclusive approach to all people at all times and, in addition, our inclusion objectives around specific protected characteristics provide a focus for two years. Governors may remember that our patient, service user and carer specific objectives 2017 to 2019 focussed on patient experience and care of older age patients (including those with dementia). Having been reviewed, it is proposed that some of the objectives of the previous period are carried forward as work remains work to be done.

The draft objectives for 2019 to 2021 are:

For patients, service users and carers

- Improve the experience and care of patients and service users experiencing mental distress those with learning disabilities and neurodiversity**
- Improve the experience and care of people who are lesbian, gay, bisexual, trans and all other sexualities and gender identities

For staff

- Promote and support inclusive leadership at all levels of the trust
- Ensure the recruitment interview process is bias free
- Facilitate the voices of all staff, providing forums for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the trust on issues of equality, diversity and inclusion
- Take action to support the mental health wellbeing of all staff

For patients, service users, carers and staff

- Promote a culture of inclusion in delivery of care to all patients and staff
- Improve information and data collected, in respect of protected characteristics in order to understand what action may be required
- Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours

***Equality Delivery System 2 (EDS2)**

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

The four goals are:

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

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

**Neurodiversity – neurological difference is recognised and respected as any other human variation. Neurological differences can include dyspraxia, dyslexia, attention deficit hyperactivity disorder, autistic spectrum, Tourette syndrome.

Questions for the Council of Governors

Feedback from Council of Governors members is requested on:

- The Trust draft inclusion objectives and
- The ratings made against the outcomes of the Equality Delivery System (EDS2).

12. Pathology services (enclosed)

To receive an update

For Reference

Presented by Nick Jenkins

REPORT TO:	Council of Governors
MEETING DATE:	6 August 2019
SUBJECT:	Pathology services
AGENDA ITEM:	12
PREPARED BY:	Nick Jenkins, Executive Medical Director
PRESENTED BY:	Nick Jenkins, Executive Medical Director
FOR:	Information

The North East Essex and Suffolk Pathology Service (NEESPS) developed a five-year strategy that it asked staff for their views on. The Trust was conscious that, despite the phenomenal efforts of the consultants, scientists, and support staff in our pathology teams, the pathology service has been challenged since it transferred to the Transforming Pathology Partnership (TPP) and then to NEESPS – with an often inconsistent service received by clinical staff.

Because this is a service that impacts a lot of people, we sought feedback from a wide range of views on whether the new proposed strategy would meet the needs of patients in our services. The engagement exercise closed on Monday, 15 July.

The pathology strategy is attached to this cover sheet and an update will be provided on the feedback and next steps.

Recommendation:

To receive an update on the pathology service strategy engagement exercise

Pathology Services – Vision and Strategy

This draft paper has been prepared for the NEESPS Strategic Board by the Pathology Strategy Advisory Group in consultation with the pathology teams. The scope is limited to the strategy and vision for the future delivery of pathology services across the Suffolk and North East Essex Integrated Care System in the context of the wider transformation programme and reconfiguration of other services expected to take place over the next five years. The document will be modified as wider stakeholder feedback is received.

1. Introduction and Background

1.1 Pathology services may be considered to consist of analytical disciplines (Clinical Biochemistry, Haematology and Microbiology) and anatomical disciplines (Histology (histopathology), Cytology (both gynae and non-gynae) and Morbid Anatomy). For the purposes of this paper, options for the future of pathology services have been considered under the headings of Microbiology, Blood Sciences, and Cellular Pathology; however, Clinical Haematology is out of scope and remains a medical/oncology service matter. Detailed appraisals prepared by the clinical teams may be found at Annexes A, B and C.

1.2 **Pathology Services Consolidation.** The NHS East of England Strategic Health Authority's Strategic Projects Team proposed a competitive bid process for pathology services across the region as part of a Pathology Transformation Project launched in 2010. The aims of this project were to drive up consistency and quality while creating medium to long term economic sustainability for pathology services through economies of scale delivered via the consolidation of pathology in line with the recommendations of the Carter Report (Review of NHS Pathology Services in England) [1,2].

1.3 **The Pathology Partnership.** The region's NHS Trusts were required to form their own pathology Joint Venture arrangements. The Strategic Projects Team employed KPMG to facilitate the process and the Pathology Partnership, whose name at that time was "Transforming Pathology Partnership" (TPP), employed PricewaterhouseCoopers (PWC) to facilitate their contract bids for the provision of general practice pathology results and clinical advice across the region. TPP was a consortium of six NHS trusts: West Suffolk FT (WSFT); Ipswich Hospital Trust (IHT); Cambridge University Hospitals FT (CUHFT); Hinchingbrooke Hospital; Colchester Hospital University FT (CHUFT); and, Mid Essex Hospital Trust (MEHT). When MEHT withdrew, East and North Hertfordshire (ENH) joined the consortium which was re-branded as the Pathology Partnership (tPP) and established in May 2014[3].

1.4 **Employment Structure.** CUHFT (Cambridge) was the host Trust and the region's pathology laboratory staff were required to re-apply for their current positions in tPP where the staffing structures had been streamlined to reduce costs (before there had been any transfer of work). Those staff members who were successful underwent contractual transfer to CUHFT, under the Transfer of Undertakings (Protection of Employment) Regulations 2006 (TUPE). Microbiology Services were simultaneously sub-contracted to Public Health England (PHE) and microbiology laboratory staff were TUPE transferred to PHE. During this contractual transfer period, many existing laboratory staff were made redundant and many others chose to leave. The consultant

[1] "Independent Review of NHS Pathology Services". Department of Health. August 2006.
[2] "Report of the Second Phase of the Review of NHS Pathology Services in England: Chaired by Lord Carter of Coles". 2008.
[3] "Major pathology reorganisation to go ahead after OFT all clear". Health Service Journal. 28 March 2014.

pathologists' contracts of employment remained with their original NHS trusts. CUHFT and IHT were designated as the two hubs for pathology in the region. ENH, Hinchingbrooke Hospital, CHUFT and WSFT retained host satellite laboratories with the intention that they would only perform urgent work although this change was never fully implemented.

1.5 **Break up of tPP.** The six Partner Trusts were both owners and customers under the joint venture arrangement; therefore, the Pathology Partnership's Executive Board was both an autonomous entity and accountable to the Executive Boards of the Partner Trusts which is not considered best practice. During its 3-year existence tPP experienced a high turnover of senior staff, including three Chief Executive Officers and four Chief Operating Officers. In its first year, it emerged that tPP was forecasting a £4.5m deficit for 2014-15 on budgeted income of £67.8m. The following year, in 2015-16, CUHFT (as host to 800 pathology staff) announced its intention to withdraw[4] from tPP after it incurred a £15 million deficit. The Pathology Partnership was formally dissolved at the end of April 2017 with an initial stated debt of £25 million (£20 million of which was attributable to non-payments to PHE) but it was later calculated that the total debt was nearer to £70 million.

1.6 **Creation of NEESPS.** Following the withdrawal of CUHFT, ENH and Hinchingbrooke Hospital and the dissolution of tPP, the remaining pathology laboratory staff were transferred to CHUFT on 5 May 2017 as the new host Trust for a partnership between CHUFT, IHT and WSFT to be called North East Essex and Suffolk Pathology Services (NEESPS). In 2017/18, NEESPS had a turnover of £35m which placed it in the upper quartile nationally and it conducted 22.23m tests which made it the 10th largest service in the NHS. The merger of CHUFT and IHT in July 2018 to form East Suffolk and North Essex NHS Foundation Trust (ESNEFT) resulted in the transfer of pathology staff to ESNEFT as new host Trust. For many pathology staff this was the third staff consultation and TUPE transfer they had experienced within four years.

1.7 **Current Pathology Services.** NEESPS delivers pathology testing support to three acute hospitals (Ipswich, Colchester and West Suffolk) and GP surgeries along with phlebotomy collections at Sudbury, Riverside (Ipswich) and outpatient clinics on the three acute sites. NEESPS provides four laboratories at each acute hospital site (blood sciences, blood transfusion, cellular pathology and microbiology) conducting a repertoire of laboratory tests (performed on a very wide variety of specimen types), which support diagnosis and treatment of a broad range of conditions. Delivery of gynae cytology is expected to change from July 2019 when a new NHSE contract will come into effect. Separately from NEESPS, the partners deliver additional pathology services in the form of anticoagulant monitoring, Point of Care Testing, Mortuary and Bereavement Services, and their consultant-delivered service including the infection control service, the antibiotic stewardship service, the 24/7 clinical advisory service, and the diagnostic service. Further information about the health economy and the organisations that comprise NEESPS may be found at Annex D.

1.8 **Impact on Staff of Transformation.** The impact on staff of attempts to transform pathology across the East of England since 2010 should not be underestimated, with many feeling their professional advice concerning the potential risks of consolidation, and, more importantly, the approach to be adopted had been ignored. Subsequent events with the creation and break-up of tPP (which has become a case study in the NHS of how not to implement the transformation of pathology) helps to explain the reluctance of some staff who experienced it to welcome the prospect of further change. The impact on staff appears to have been most profound in those units originally

[4] "Host trust quits financially 'fragile' NHS pathology venture". Health Service Journal. 1 July 2016.

designated to become 'spoke' laboratories under tPP and, at WSFT, this appears to have been exacerbated during the creation of NEESPS and the merger of the other partners to form ESNEFT.

1.9 ***That said, a clear vision and strategy for the future of pathology services is now required to remove the negative effect that uncertainty can have on the morale, retention and recruitment of staff and, ultimately, on their ability to deliver resilient, efficient, high quality services.***

2. Drivers of safety and sustainability for district general hospitals

2.1 The Integrated Care System's (ICS) clinical vision outlines a continuum of care from self-help and independence through community-based care to hospital care, with an intention to shift care away from hospitals into the community. Therefore, there will be an increasing focus in hospitals on more complex and emergency work requiring 24/7 levels of expertise to maintain consistent, safe services. For the immediate future, the district general hospital model is likely to remain at the core of the provision of acute hospital services; however, the longer-term sustainability of this model of providing services is being questioned as a consequence of a number of factors, including:

- **The lack of clinical viability for small and low volume services.** Where the local catchment population does not generate sufficient demand to support the number of clinical experts required to sustain 24/7 services, patients (or samples) have to travel to larger, more distant centres for some procedures (and tests). The alternative is that the local hospital may have to provide speciality cover at sub-optimal scale in order to maintain provision of 7-day cover which is likely to be both financially inefficient and clinically unsustainable.
- **The difficulty attracting the right quality of staff to sustain services.**
- **The development of increasing sub-specialisation.** Where sub-specialisation is delivered with a move away from 'generalist' services, there is less ability for specialists to cross-cover and take part in shared rotas to provide care for emergency patients. This can be mitigated if clinicians are able to maintain generalist skills in addition to an area of sub-specialisation.
- **Economies of learning.** Evidence regarding improved clinical outcomes with increased scale (cf. Improving Outcomes Guidance and GIRFT) can lead to smaller units being unable to meet new national standards for minimum numbers. The theory is that for specialised procedures and tests, larger centres undertaking high numbers will have better, more reliable outcomes.
- **Economies of scale.** The increasing use of high cost capital assets in the delivery of specialist diagnostics and treatments means the economics of capital investment and return are only worthwhile if larger catchment populations are involved. This has to be balanced against the practicalities and costs of transporting (sometimes fragile) specimens with the delays resulting from transport schedules, potential batching for processing and receipt of reports.
- **The need to change the way services are provided to meet the needs of local people.** This may involve delivering services closer to where people live, or in alternative settings. Digital connectivity has the potential to enable this change and could remove the limitations of size and geography; however, a functioning common Laboratory Information Management System (LIMS) combined with reliable communication from the computer systems at each site are essential pre-requisites and these are unlikely to be available across the ICS before 2021.

2.2 As a result of these factors, clinical and diagnostic services, such as pathology, need to be at sufficient scale to sustain a range of sub-specialist expertise, staff rotas, support services and to

invest in modern facilities and equipment. In the long-term, whilst the forecast growth in the population of the catchment served by the ICS is significant, in the context of the other drivers, the model of provincial hospital sites operating in relative isolation whilst able to provide the full range of clinical and diagnostic services is not likely to be sustainable, economically viable or able to deliver consistent high quality care. Therefore, an integrated, network solution is likely to be required in order to deliver safe, sustainable pathology services in the future.

3. Strategic drivers for pathology services

3.1 The Carter reports[5] into pathology optimisation recommended the consolidation of pathology laboratories to maximise existing capacity and savings from economies of scale. This recommendation has been endorsed by international and NHS evidence that the sustainable pathology services resulting from consolidation and modernisation increase both quality of service for patients and efficiency. NHSI is looking for an increase in the ambition behind and speed of consolidation of pathology services across the NHS. The Carter reports proposed consolidation by the introduction of a 'hub and spoke' model whereby high volume, non-urgent work would be transferred to a central laboratory to maximise benefits through economies of scale (although a clinical advisory service would still be required). Spoke laboratories, referred to as 'essential service laboratories' (ESL), then provide (relatively) low volume, urgent testing close to patients[6].

3.2 NHSI also requires providers and commissioners to work together to plan for the delivery over the next five years of clinically and financially sustainable solutions for the provision of pathology services within STP/ICS boundaries. As part of this plan, the reconfiguration of pathology services needs to accelerate to realise the efficiencies from increasing the capability and capacity of laboratories and adopting world-class technology, and from better support for preventative medicine, management of long-term conditions and management of patients in primary care[7]. However, NHSI is aware that one size does not fit all and will support a network that works locally.

3.3 Commissioners have adopted a partnership approach with providers as part of the ICS to share aims, visions and risks to achieve the best level of affordable service for users and patients. This involves the adoption of a whole system approach to the provision of healthcare ensuring that services to patients are integrated to provide high standards at affordable cost. The aim is to achieve optimum value for money by striking a balance between efficacy of the service and cost.

3.4 Provider trusts are aware that service demand is increasing year on year because of changing demographics and long-term conditions and laboratories need to be optimised to be able to do more with the same or even less. All departments need to be able to contribute towards improving financial sustainability at a time when access to capital for refurbishment or new builds is severely restricted. Overall, provider trusts want to improve the quality, efficiency and effectiveness of pathology leading to better patient care and believe this can be achieved through:

- Better training and development opportunities for all staff and improved recruitment and retention in a reducing labour market with an ageing workforce;

[5] "Review of NHS Pathology Services in England": DH, 2006; Second Phase of the Review of NHS Pathology Services in England": DH 2008; Operational productivity and performance in English NHS acute hospitals: Unwarranted variations": DH 2016.
[6] "Consolidated pathology network – Structural, commercial and regulatory issues to address in business cases": NHSI April 2018.
[7] "Pathology collaboration full business case': NHSI Model Case, 2017.

- Improved quality standards to produce distributed Centres of Excellence for pathology with an increased pool of consultant expertise available across sites;
- Reduced unit costs through economies of scale and allowing income to be maximised whilst retaining defined laboratory services on acute sites;
- More efficient utilisation of facilities and equipment with rapidly changing technology; and
- Increased volume and range of specialist services locally to maximise economies of scale.

4. Key strategic issues for NEESPS

4.1 **Network Legacy.** NEESPS inherited a number of significant difficulties from its predecessor tPP:

- An effective Laboratory Information Management System (LIMS) has not been rolled out to all labs and, where a new LIMS had been introduced, it had not been subject to appropriate computer system validation which is a regulatory requirement for both UKAS Accreditation and for Blood Transfusion (to show no patient harm caused through the supply of blood).
- The Quality Management System (QMS) implemented by tPP had different software products and different operating arrangements on each acute site;
- Analytical equipment was inherited with different models on different sites[8] with different contract renewal dates and no rolling schedule of contract update in place (most on a 'reagent rental' or 'cost per reportable' basis); moreover, there is no planned replacement programme for equipment purchased from capital funds (mainly in Cellular Pathology);
- There are too few staff in all technical disciplines and high use of agency biomedical scientists;
- Laboratory staff for microbiology are employed by PHE on different terms and conditions; and,
- The 'hollowing out' under tPP reduced the quality and training functions resulting in poor regulatory compliance and large gaps in activity to support the ongoing accreditation of labs.

4.2 **Achievement of Accreditation.** Since the closure of Clinical Pathology Accreditation Ltd (CPA), the only option for the accreditation of a pathology service is the Medical Laboratories International Standard ISO 15189 which is technically more demanding than CPA used to be with the requirement to provide considerable evidence of conformity to the United Kingdom Accreditation Service (UKAS). To be accredited by the UKAS the organisation must be a defined legal entity (such as a limited company, limited liability partnership or an NHS Foundation Trust). While operating a non-accredited laboratory is not prohibited as long as users are aware that it is not accredited, other laboratory service providers are using accreditation as a market differentiator and NHSI has explicitly stated that all NHS pathology laboratories must be accredited. Importantly, accreditation is a contractual requirement for a range of existing pathology services including all CCG contracts and NHSE-funded screening activity (although the contract for NHS screening activity is not at risk). The CCG contracts for primary care pathology services are due for renewal in April 2019 and any lack of accreditation may mean that a contract award without a competitive tender exercise could be subject to challenge. Primary care pathology services comprise around 50% of all activity undertaken by the laboratories and, were these CCG contracts to be lost, the negative impact on

[8] For example, biochemistry equipment: Ipswich - Roche Cobas 8000 series; Colchester - 6000 series (slower, different reagent packs and inability to create network-wide SOPs); West Suffolk – older 6000 series (now unreliable and the oldest in the NHS and negotiations are at an advanced stage to replace this equipment at West Suffolk).

the pathology services to the acute hospitals across the ICS cannot be overstated. The Institute of Bio-Medical Scientists (IBMS) also requires that all professional training is undertaken at an accredited laboratory; therefore, all NEESPS training is currently coordinated through Ipswich as the only NEESPS laboratory remaining with accreditation. ***NHS pathology services must achieve and maintain laboratory accreditation.***

4.3 **Achievement of Regulatory Compliance.** There is a requirement for all hospital blood banks to demonstrate compliance with the Blood Safety & Quality Regulations (2005) to the Medicines and Healthcare products Regulatory Agency (MHRA). The incomplete LIMS computer system validation (CSV) and insufficient supporting quality work in Blood Transfusion at WSFT under tPP has led to a high level of regulatory scrutiny by the Medicines and Healthcare products Regulatory Agency (MHRA) of the hospital blood bank. ***NHS pathology services must achieve and maintain regulatory compliance.***

4.4 **Adoption of an appropriate Commercial Structure.** The current commercial structure for NEESPS is a hybrid of those suggested by NHSI in its recent guide to commercial structures available for a consolidated pathology network[9]. To be accredited a pathology service must have a legal entity and this may come from the individual (foundation) trusts in a collaboration, an alliance contract, a single host trust or a specially created legal entity. NEESPS's commercial structure is currently closest to a '*unit organisation hosted by one trust*'; however, no partnership agreement or joint venture has been established. This means that whilst all contracts, finance systems, liabilities and responsibilities have transferred to the host trust there is currently no equitable basis agreed for them to be shared by the partners. ***NHSI has identified that a partnership agreement that reflects the current Trust structures is key in ensuring that the network is able to function properly.***

4.5 **Installation and validation of a common Laboratory Information Management System (LIMS).** ***A fully functioning, validated common LIMS system combined with reliable communication with hospital computer systems at each main site is an essential pre-requisite for effective delivery of a distributed network and this is unlikely to be available much before 2021.***

4.6 **Establishment of appropriate, standardised equipment and managed service contracts.** The equipment on each site is different, even when produced by the same manufacturer, with different contract renewal dates and much of it is now in need of replacement. Standardisation will be needed for the development of network SOPs and to permit the flexible use of network resources in the future. ***Standardisation of equipment is also essential to achieve efficiencies in equipment procurement, maintenance and, in some cases, the purchase of reagents.***

4.7 **Review of estate.** The pathology services estate on each site should be reviewed to inform future decision making, with a focus on quality, location, access and potential room for expansion.

4.8 **Future collaboration with other networks.** Consideration should be given to the potential for collaboration with other networks in the future (such as the Eastern Pathology Alliance) to gain scale and to deliver efficiencies in procurement, managed equipment contracts and logistics.

[9] "Consolidated pathology network – Commercial structure and operational guide" NHSI, February 2018.

5. Vision for pathology services

5.1 The ambition is **to improve the quality and efficiency of pathology services leading to delivery of the best care and experience for patients.** To achieve this, we will:

- **Keep people in control of their health.** People play the leading role in staying healthy, recovery from ill health and living well with long-term illness and will have access to their records and test results via their own online health portal or on personal digital devices. Pathology will be at the centre of this, working directly with patients and alongside other health professionals to support them through screening, diagnosis and monitoring of health and disease[10].
- **Lead the integration of care.** People want to receive care, support and advice from one system. The complex network of organisations involved can lead to this feeling very fragmented. We will take a lead in the integration of services to deliver a more seamless experience and better outcomes giving multi-disciplinary teams timely information and specialist advice to enable better treatment planning. Shared electronic care records will provide an end-to-end view of patients' health and care with standardised pathology terminology. Fundamental to the integration of care will be the development of an integrated IT system and transport network.
- **Develop centres of excellence.** We will organise our service in ways which give the best quality, access and experience of care. We will build on our strengths to develop a dispersed model by discipline with provision of some specialised tests from a single laboratory in the network (not necessarily the same for all tests) to allow for appropriate equipment and technical expertise. At the same time, we will retain defined laboratory services on all sites and seek to offer access to specialist services locally with the benefits, costs, risks and opportunities shared on an equitable basis[11].
- **Support and develop our staff.** We depend on our highly skilled staff to be able to offer excellent services. We will offer the best opportunities for personal development (through education, training and research), strong team development and a supportive environment in which to grow and develop careers.
- **Drive technology enabled care.** New technology can revolutionise the quality, speed and experience of care. Our teams will be supported to drive in the introduction of new diagnostic and information technology, to offer the best care and experience. Pathology services will be reconfigured to provide the most appropriate structure to deal with commoditised and more specialist testing, including prevention and diagnostics. Digital connectivity will enable this move and remove the limitations of size and geography from providing the most appropriate services to clinicians and to patients and should enable procurement and collaboration across network and geographical boundaries[12].

[10] National Pathology Programme. Digital First: Clinical Transformation through Pathology Innovation. 2018
[11] Improving services for patients through pathology networks. Dr Ian Fry. 2018
[12] National Pathology Programme. Ibid.

6. Pathology Strategy Recommendations.

6.1 In light of the issues, drivers and vision set out above, strategic options appraisals have been carried out by the teams in each pathology discipline which can be found at Annexes A, B and C. Each clinical team has decided that the development of a distributed network under direct NHS management and governance within an agreed commercial structure offers the best way ahead for their service. The clinical recommendations from the detailed options appraisals may be summarised as follows:

6.2 **Microbiology.** Bring microbiology services 'in house' (ie. ending the sub-contract of laboratory services to PHE) to create a single Microbiology/Pathology service with a distributed network under direct NHS management and governance. Once under single NHS management, within an agreed commercial structure, the detailed clinically-led assessment of the testing services needed for each of the laboratory sites (including molecular, rapid and POCT tests) can be agreed with the focus on clinical need and delivery by an accredited, high-quality service which has 24/7 access to a networked LIMS to achieve agreed turnaround times. Once a sustainable service is in place there can be active consideration of extending the size of the network with appropriate partners to deliver the quality and financial benefits from increased scale with appropriate levels of scientific and clinical staff.

6.3 **Blood Sciences.** Proceed with implementation of a distributed network model for the provision of Blood Sciences under direct NHS management and governance within an agreed commercial model. This will ensure provision of a quality accredited service with the optimum utilisation of advanced LIMS and analytical systems supported by a skilled and experienced workforce which is sustainable with the increasing patient demand and complexity and growing expectations from service users in the community and primary care sectors. This option will ensure the network has the critical core capacity and capability needed to support emerging diagnostic tests (eg. molecular and genomics) so that patients can have timely access to key tests on a consistent 24/7 basis.

6.4 **Cellular Pathology.** Implement a consolidated Cellular Pathology service utilising a distributed network under direct NHS management and governance within an agreed commercial model. This will ensure provision of a high-quality, accredited service with the optimum utilisation of advanced LIMS and analytical systems supported by a skilled and experienced workforce which is sustainable with increased patient demand and complexity and with growing expectations from service users in the community and primary care sectors. This network model would be unlikely to result in significant change in the short term but would ensure that the network has the critical core capacity and capability to support developing diagnostic tests (eg. digital, molecular and genomics) so that patients may have timely access to the accredited network service.

6.5 **Guiding Principles.** In the process of developing the options appraisals, a broad consensus emerged that we should operate in a pathology network because it offers benefits for patients, and that the following principles should guide the future development of our pathology services:

- Test results should be delivered when they are needed, and scale efficiencies should always be sought in the design of networked services;
- Pathology services should be clinically-led and clinical advice taken on all major network decisions;
- Work should be repatriated whenever it can be demonstrated to offer clinical benefit; and,
- The network should develop the clinical/technical expertise and capacity to enable the above.

Microbiology

Current Service Description

Microbiology is a branch of medical science concerned with the prevention, diagnosis and treatment of infectious diseases. Common tests are culture techniques for samples from a wide variety of specimen types. Microbiology includes different branches of work including Bacteriology; Virology; Mycology; and, Parasitology.

Colchester, Ipswich and West Suffolk hospitals, as the three NEESPS main hospital sites, all have large emergency departments, and all currently have microbiology laboratories. These laboratories process samples from acute hospitals, general practices and community providers within Ipswich & East Suffolk, West Suffolk and North East Essex CCGs as well as for parts of Mid Essex CCG. The population served is just under one million.

The Microbiology laboratory service across the NEESPS network of hospitals is sub-contracted to Public Health England (PHE) although the medical staff have remained NHS employees employed by the NHS Trust where they work. PHE was awarded the service contract via the Pathology Partnership (tPP) in 2014. The agreement between Cambridge University Hospitals NHS FT on behalf of tPP and PHE was for a 10-year term (until 2024) with various termination clauses including failure to renew the CCG Commissioning Contract for community pathology services (including microbiology) due in April 2019. PHE is contractually obliged to maintain accreditation in all of the laboratory sites throughout the contract period.

The tPP strategy for microbiology service delivery envisaged PHE providing a centralised microbiology service model based on two hubs one at Cambridge (Addenbrookes Hospital) which included all specialist testing and a second hub at Ipswich Hospital. There was to be no microbiology laboratory presence at West Suffolk Hospital or Colchester Hospital. The break-up of tPP in 2017 left the service fragmented and in need of a new service model which this document seeks to address. The separation of the laboratory staff (PHE employed) and their operational performance management from the consultant microbiologists (host trust employed) who provide clinical interpretation of results and related advice on diagnosis, treatment and patient management is an important issue for both integrated governance, service accreditation and accountability. The lack of an overarching integrated governance structure is a cause of anxiety for service users and clinicians alike.

There has been a significant loss of experienced staff compromising day-to-day service provision, maintenance of quality and development of the service. For microbiology, as a major clinical discipline within pathology, there have been consistent and significant challenges in achieving UKAS accreditation. None of the three laboratories is currently accredited. The staffing challenge has resulted in concerns about the quality and safety of the required 24/7 access to Microbiology for all clinical areas including the Emergency Department (ED), Neonatal Unit, Coronary Care, Cancer Services, etc. There is a related issue regarding the value for money of the service provided by PHE, as the sub-contracted provider, which costs NEESPS ~£7.2 million per year. The PHE service is not accredited by UKAS in spite of their contractual commitment and lacks a single, integrated Laboratory Information Management System (LIMS) for order comms and links to other clinical information systems (such as PAS, EMIS and ICE) for key users.

For the delivery and alignment of the microbiology and pathology strategies it is of crucial importance that all interested parties, both internally and externally, recognise that pathology is a heterogeneous and complex set of inter-related disciplines. Consolidation options for microbiology, often considered as a non-urgent service (where urgent is defined as requiring a test result in less than 2 hours), can be significantly different from disciplines such as biochemistry and haematology. However, timeliness of microbiology results is a significant challenge for appropriate patient care. Delays to diagnosis result in patients being over treated and broad-spectrum antibiotics being used where narrower spectrum agents would suffice. Currently the service provision is reliant on traditional microbiology techniques and methods which are not always optimal for patient management. There has been little service development or modernisation developing molecular diagnostics, which are now becoming commonplace in diagnostic pathology laboratories. Consolidating services for microbiology adds delays transporting and processing samples and can affect the viability of some organisms leading to false negative results. Logistic challenges and the need to batch some types of samples can add days to the turnaround time, reducing the quality of the service we provide to patients.

To achieve UKAS accreditation and optimum use of skills and equipment within budget, a key task is to agree which microbiology tests need to be on which site for explicit clinical reasons within a single managed network. This process will need active consultation and patient-based evidence to inform the decisions made by the clinically-led microbiology/wider pathology team and relevant clinicians from areas such as ED, ITU, NICU, Maternity, CCU, Surgery and Medicine. Since all pathology services, including Microbiology, are expected to be re-designed in line with NHSI

guidance the importance of pathology as a partner in key clinical pathways for surgery, medicine and cancer services will have to be considered.

It has been noted that the corporate culture, values and priorities of PHE as a National organisation are diverging from those of NEESPS and its partner Trusts as the providers of local health and care. PHE has a role focused on major population centres (logical under tPP with a specialist hub at Cambridge and a much larger population for their work on outbreaks, epidemiology, major incidents and population-wide information on infectious disease trends). NEESPS consists of three medium sized acute hospitals. When clinical pressures and developments are being discussed the ability of pathology to speak with a single voice to ensure patient focused decisions is a key benefit and will provide certainty when planning for future opportunities for the service in Pathology and the Trusts front-line clinical services.

NEESPS requires a strategy consistent with the clinical need of the population. This flexible approach requires active consultation with hospital clinicians and GPs to ensure patient needs and expectations are met now and in the future.

If the preferred strategy is to end the contractual relationship with PHE and transfer relevant staff to NHS Pathology, then agreement will need to include the future of equipment and assets including IT and the Kiestra TLA track.

Strategic Drivers

Strengths (Internal)

- Core of skilled and committed staff remain working on all three sites to deliver the day-to-day service.
- All three laboratories are still operational so there is some service resilience.

Weaknesses (Internal)

- Concerns about insufficient staff and technology at each site to cope with the volume and complexity of patient samples with growing clinical acuity and clinical expectations.
- Risk of loss of skilled and qualified laboratory staff and difficulty in recruiting due to staff uncertainty which has resulted in a heavy reliance on locum/agency staff.
- Serious issues with management of contract performance and overall service delivery by PHE including the loss of accreditation.
- Each of the three laboratories is working in relative managerial, clinical and geographical isolation with different LIMS, equipment, SOPs and QMS.

Opportunities (External)

- Negotiating an end to the increasingly out of date contract with PHE so that the changing needs of the acute Trusts and their respective patients, CCGs/GPs and the local population may be better served.
- Development of a molecular service (currently provided by Addenbrooke's Hospital) to gain control of the test repertoire turnaround times (TATs).
- PHE equipment procurement relies mainly on capital purchase which restricts ability to keep equipment in line with changing service expectations and within constrained budgets (eg. use of POCT, rapid PCR, etc.) when compared to managed service contracts.

Threats (External)

- Loss of accreditation in September 2018 – UKAS application withdrawn as ISO standards could not be met across the three microbiology laboratory sites.
- Overnight urgent samples from WSFT are sent to Addenbrooke's (complex pathway with multiple risk factors involving junior doctors and switchboard staff).
- PHE maintains separation of employer between consultant pathologists and BMS/laboratory staff and the rest of the pathology staff within NEESPS.

Vision for the Discipline in 2024

Service to be UKAS accredited and clinically-led with all staff in microbiology under NHS management. Clinical leadership to ensure oversight of service performance and efficiency. Formal corporate and clinical governance structures to reflect a clear line of sight from top to bottom and show how consultant oversight of the service is effective for patient care pathways under a Laboratory Director.

The depth and breadth of Microbiology laboratory testing on each site assessed against clinical need focused on when results and information is required rather than where the tests are undertaken. A key step to developing a formal network will be to agree the test repertoire by site in consultation with front-line services and TATs for delivery of results for acute services to ensure there is no inconsistency due to IT issues or delays in transporting specimens off-site.

Develop the service to meet the needs of patients locally. This will require the introduction of technology that will improve the turnaround time (TAT) (eg. molecular testing for influenza, can produce results that are available in hours rather than days. This allows for correct early diagnosis which in turn will improve antibiotic husbandry, support GIRFT, permit appropriate use of isolation facilities and assist with bed management within each Trust.

Laboratory supervision will be required on each site once the strategy and test repertoire have been agreed. All sites will need access to a Containment Level 3 (CL3) laboratory for clinically relevant samples and laboratory processes within an agreed timeframe. UKAS compliant roles at Pathology Directorate level including Quality Manager(s), H&S officer, service development team and other support roles to be identified once the strategy is confirmed. Service responsive to the needs of the hospitals, primary care, and the community on an equitable basis and services to be available 24/7 where clinically required linked to agreed TAT per test for given clinical symptoms/patient presentation. A fully integrated laboratory network with a fully operational interconnected LIMS (to support cross-site working from a distance) with a single set of SOPs within a common QMS/LIMS database (eg. Q-Pulse, Datix). Robust, reliable transport methods with clear definition of responsibilities and accountability for real-time sample tracking. Molecular technology to be part of the strategy to ensure access to a service repertoire available or accessible from all three sites and responsive to the needs of patients and to revolutionise microbiological diagnosis in terms of TAT and sensitivity.

The future vision would be for an overall service with staff integration to develop the clinical team across the three sites. A Laboratory Director would sit above all three sites for both laboratory and clinical accountability. This structure would allow provision of an integrated clinical service and is dependent on a fully functioning, interconnected LIMS. For resource efficiency reasons each site may undertake some specialist work for all 3 networked sites:

- Virology hub with a wider panel of molecular work and consideration to appointing a consultant virologist;
- Centralised TB work where the central site would have additional facilities including rapid diagnostic ability;
- Centralised Chlamydia and other genitourinary pathogen testing;
- Mycology (fungal diseases); and,
- Parasitology.

Once a single service strategy is agreed, investment will be required in appropriate equipment and linked to a workforce strategy for each site. Ensure equity of access to a responsive service for the wider NEESPS population and ensure no site disadvantaged compared to other sites. Each of the three sites to be mapped to clinical/patient need with input from front line services (eg. ED, ICU, Cancer). Introduce rotation of staff to specialist areas to develop BMS staff and provide professional challenge and variety to enhance learning and development opportunities including consideration of Advanced Practitioners and reporting competencies generally. Shared on-call is reliant on real time access to all results via LIMS. Options to take account of staff views to avoid recruitment, morale, training and retention issues.

Preferred Service Options

Bring services 'in house' under NHS management in a distributed network

Bring microbiology services 'in house' (ie. ending the sub-contract of microbiology laboratory services to PHE) to create a single Microbiology/Pathology service with a distributed network under direct NHS management and governance. Once under single NHS management, within an agreed commercial structure, the detailed, clinically-led assessment of the testing services needed for each of the laboratory sites (including molecular, rapid and POCT tests) can be agreed with the focus on clinical need and delivery by an accredited, high-quality service which has 24/7 access to a networked LIMS to achieve agreed turnaround times. Once a sustainable service is in place there can be active consideration of extending the size of the network with appropriate partners to deliver the quality and financial benefits from increased scale with appropriate levels of scientific and clinical staff.

Bring services 'in house' to achieve a single Microbiology/Pathology service network under direct NHS management and governance. The depth and breadth of Microbiology laboratory testing on each site assessed against clinical need focused on when results and information is required rather than where the tests are undertaken.

Strengths (Internal)

- Ensures common governance structures for pathology and NEESPS network.
- Integrates medical staff with laboratory staff for shared ownership of service with shared priorities.
- Potentially enables flexible, cross-discipline working with integrated planning and governance responsive to local needs within ICS planning environment.
- Consistent oversight of services and accountability for performance with internal and external requesters.
- Responsive local support structures (eg. HR and OH).
- Network resilience with three laboratories providing options for business continuity and disaster recovery.

Weaknesses (Internal)

- Limited resources (esp. capital) with related revenue pressures including significant CIP expectations.
- NHS system undergoing radical change with ICS model replacing market model for NHS planning.
- Network management at embryonic level following major failure of pre-cursor network (tPP).
- NHS network governance not yet in place so accountabilities unclear and time required to embed integrated governance and risk structures.
- Legacy IT systems need fundamental reconfiguration to establish integrated information systems to allow movement of work/specialities to improve quality,

• Familiarity with shared IT and analytical equipment and staff with improved patient and clinical interpretation.	asset utilisation, use of automated technology and staff capacity and capability with resulting improvements in 24/7 service resilience.
Opportunities (External) • Investment in automation technology on a shared network basis (eg. track, IT support, sample reception, quality management, transport). • Build common values and culture of NHS ownership with wide range of acute services (eg. Bone Marrow Transplant, cancer, cystic fibrosis and transplant care) from a local system where pathology is seen as an integral part of clinical service delivery.	**Threats (External)** • Service experiences significant unfunded volume growth with higher expectations of quality & response. • Resources required are not prioritised in competition with other clinical areas (eg. ICU, surgery, NNU). • Risk of constant restructuring with fragmentation or outsourcing if performance seen as unacceptable or too costly due to rapid technology cost pressures.

Consider extending Pathology Network

Form a larger Microbiology/Pathology network (eg. NHSI supports a network approach for population of 1.5m – 2m).

Strengths (Internal) • Shared skills, training, depth and breadth of expertise, and responsiveness to wider population initiatives (eg. POCT, genomics, HPV, molecular). • Attracts staff due to variety and depth of work including sub-specialisms, etc. • Accords with national policy and direction (eg. Carter 2006, 2008 and 2017 and NHSI 2017, 2018). • Economies of scale with improved value for money during a period of rapidly changing technology and equipment sophistication and capacity. • Service flexibility improved with some scope to move work and staff to respond to 24/7 surges and dips enhances quality management and resilience. • Lower indirect, management and overhead costs due to potential economies of scale.	**Weaknesses (Internal)** • Potential risk of loss of detailed attention to services and governance across multiple sites. • Requires significant investment in IT, logistics and network infrastructure and overheads. • Risk of loss of local understanding of specific service needs and ability to plan/invest appropriately (including in local staff) with related impact on cost control. • Management of large networks can create layers of cost and bureaucracy introducing communication issues from user/bench level to senior management. • Different priorities from network partners impacts on clear understanding of service strategy, focus and priorities (including staff and equipment investment). • Reliance on logistics (IT and transport) requiring good continuity and disaster recovery planning.
Opportunities (External) • Well-led and governed networks with inclusive teams and excellent communications can thrive because they can share diverse opportunities for clinical, scientific and personal/professional growth. • Regional/patch networks can provide access to a depth and breadth of experience, training, development, research and personal/professional development that small labs/networks cannot provide. • Drives development of centres of excellence in specialist areas with ability to invest in technology and skills to improve patient outcomes and support clinical networks (e.g. Cancer and hyper-acute areas).	**Threats (External)** • Loss of focus on individual sites and staff making them feel part of an unresponsive monolith with little say in resource allocation and financial investment plans. • Loss of control by senior medical and scientific staff resulting in loss of key staff and problems of recruitment and retention due to low morale, damaged network reputation and poor service quality. • Potential to become detached from operational needs and realities of hospital clinicians and their patients. • Failure to understand the local need to manage and support urgent pressures and developments due to different focus and priorities.

Blood Sciences

Current Service Description

Blood Sciences is a term used for laboratories providing Biochemistry, Haematology and Blood Transfusion services (and it can also include Immunology and Molecular Pathology services). This paper considers how to achieve the optimum quality accredited service for blood sciences sample processing and testing (including clinical interpretation and advice) with the aim of network development taking into account access to a common LIMS, robotic and analytical track systems with sufficient skilled and experienced scientific and clinical staff to cope with increasing volume and complexity of demand. However, Clinical Haematology is considered to be out of scope for the development of the pathology laboratory network arrangements. Hospital patient services involving Clinical Haematology will remain a matter for medical/oncology service discussions. As part of Pathology Network discussions, the views and needs of the Clinical Haematologists, who ensure the Haematology laboratory service is clinically-led, will be actively considered to ensure a seamless quality accredited and integrated laboratory/clinical Haematology service.

Examples of common laboratory tests in a Blood Sciences laboratory include Blood Grouping and Cross Matching (Blood Transfusion), Full Blood Counts and Blood Film analysis (Haematology) and Urea and Electrolytes, Liver Function and tests for renal and cardiac functions (Biochemistry). Haematology is the branch of medicine concerned with the study of the cause, prognosis, treatment, and prevention of diseases related to blood. Biochemistry tests are used to explore the chemical processes within the body. As a laboratory-based science it brings together biology and chemistry by using chemical knowledge and sophisticated techniques and analysers to assist with the diagnosis and management of patients. NEESPS Blood Sciences comprises the following departments on all three sites (Ipswich, Colchester and West Suffolk Hospitals): Phlebotomy/POCT; Specimen Reception; Clinical Biochemistry; Immunology; Haematology; and, Blood Transfusion.

Blood Sciences is a highly automated, high-volume service with significant urgent clinical demand where turnaround times (TATs) are often measured in minutes rather than hours. This is particularly relevant in ED and intensive care settings such as ITU, Neonatal Unit, Coronary Care Unit where urgent tests may include Urea and Electrolytes, Liver and Renal function tests, and Troponins. The efficiency of time management from decision to request to the result reported relies on timely access to phlebotomy (often by medical or nursing staff) followed by direct vacuum driven air tube from the department to Pathology where a 24/7 service is aware of the urgent nature of the sample(s) due to alert via the LIMS system via the order comms module.

Blood Sciences all share the same strategy which is to provide a seamless service to service users so that wherever samples are drawn from patients the same analytical service will be supplied to the same high standard so that the test results can aid patient diagnostic pathways. The ultimate aim of the networked service is to have compatible analytical equipment on each site, using the same interconnected LIMS, delivering a robust service which can react to changing demand without degrading the service. The Blood Transfusion service will achieve MHRA compliance and UKAS ISO15189 accreditation over the next two years so that patient safety can be assured to users, clinicians and patients.

Blood Sciences provides a clinically-led service recognising the advantage this offers at the clinical interface by enabling the early identification of changing needs from clinicians to ensure the service remains clinically relevant.

The service comprises a mixture of HCPC state registered and non-registered staff, the skill-mix is constantly changing as staff are trained and the needs of patients and service users are reviewed. Within the NEESPS developing network there is a constant search to deliver improvements to the overall service so that it is easy to use and accessible to users and patients alike by:

- Providing a booking system that allows patient choice of bleed site from 7 bleed areas without long waits.
- Assessing the balance of volume and urgency of work across the laboratories to make the best of NEESPS's geographical spread using an interconnected LIMs, and transport system in key areas including GP centres. The network aim is to agree a hub/spoke service configuration with the hub facility at a site best able to fulfil the role with the space and equipment to provide a safe, high quality working environment for staff. The hub lab with spokes at the other sites will ensure the smaller labs can react to changes in sample volume and acuity and provide support as part of any business continuity plans.
- A central user accessible helpdesk is planned to provide a single point of contact for information for clinicians and patients in the community, from the booking of blood tests and ordering consumables to result enquiries. The plan is to have a central helpdesk and service management team co-located with a community phlebotomy site in one location acting as the NEESPS operations base.

The Blood Sciences service aims to work with service users to provide an efficient cost-effective service by:

- Continue to develop clinical pathways that include the tests appropriate to clinical presentation and symptoms;
- Repatriate work over time linked to available clinical expertise and financial viability.
- Identify partners to plan for future service provision recognising that NHSI guidance suggests fewer networks.
- Ensure reported incidents and near misses are used to improve services and control risks to avoid patient harm.
- Work with relevant trusts to drive change within pathology and the network to ensure each lab provides a relevant clinical service on each site that is accredited, effective and efficient (eg. Model Hospital data benchmarking).
- Continue to review and implement new technologies and tests as appropriate, affordable and clinically required.

Strategic Drivers

Leadership

- Blood Sciences requires a single clinical and management network lead to deliver network-wide accreditation, coordinate the service and ensure the correct configuration for site and patient needs.
- A better structure is needed for integrated governance with clear lines for responsibilities, accountabilities and reporting purposes.
- A network secretariat is required to ensure effective management of the governance arrangements and to ensure timely availability of key information including risk and quality dashboards.

Workforce

- The configuration of the laboratories will need clear information on expected future demand to enable the development of a workforce plan to identify any gaps prior to implementation of the hub/spoke model.
- Modern expectations of a safe, high quality working environment will need to be taken into account when assessing the space and estate infrastructure available.
- Early development of a recruitment and retention policy will be important for maintaining adequate staffing for 24/7 rotas which are fundamental to an operationally resilient Blood Science service.

Commercial

- The NHS operates in a mixed market and regular reporting of performance, productivity and financial performance will need to be embedded with the operational management team.
- Resource constraints can make commercial options attractive which include the use of managed service contracts and estate leasing to ensure a quality service may be provided that represents good value for money.

Quality

- NHS Commissioning guidance includes strong expectation of the Barnes QA scheme allied to UKAS ISO 15189 accreditation.
- Professional and accreditation bodies will require evidence of appropriate training standards and the availability of relevant resources as part of being able to demonstrate that a high-quality service is being delivered which should be supported by them (eg. RCPath, ACB, IBMS).

Vision for the Discipline in 2024

- An integrated, NHS singly managed Hub and Spoke model in line with NHSI guidance.
- A UKAS accredited, networked and consolidated service with RCPath, IBMS, ACB training organisation on all sites.
- A clinical-led service with agreed quality and risk dashboard linked to a single integrated governance structure.
- Consistently deliver an efficient, effective consolidated service to contribute to the overall success of the NEESPS network which is recognised by its users and peers as a high quality and high performing patient focused service.
- Developing cutting-edge services in partnership with key commercial and university partners through contracts to ensure new technology and analytical equipment is available for staff to utilise for patient benefit.

The creation of a Pathology Network with a Blood Sciences service utilising a hub/spoke model will support an ICS-based strategy ensuring support for keeping the population health or providing early intervention in primary/community setting to assist with diagnosis and treatment. This model provides a key benefit of helping to keep patients out of hospital where possible but ready to support the clinical community should patients require Blood Sciences to provide accessible and responsive services in secondary or tertiary environments.

The use of area-wide Blood Sciences network controls management and service costs in a clinically-led service and when combined with use of a QA dashboard will deliver an efficient service that represents value for money.

The scarce specialised skills and experience in key posts including BMS, Clinical Scientist and Consultant level requires a formal network approach to protect the quality and safety of services and ensure users and patients receive a consistent, timely and high-quality service.

Preferred Service Option

Integrate Blood Sciences as a distributed network under NHS management

Proceed with implementation of a distributed network model for the provision of Blood Sciences under direct NHS management and governance within an agreed commercial model. This will ensure provision of a quality accredited service with the optimum utilisation of advanced LIMS and analytical systems supported by a skilled and experienced scientific and clinical workforce which is sustainable with the increasing patient demand and complexity and growing expectations from service users in the community and primary care sectors. This option will ensure the network has the critical core capacity and capability needed to support emerging diagnostic tests (eg. molecular and genomics) so that patients can have timely access to key tests on a consistent 24/7 basis.

The national strategy is to establish pathology networks, with particular opportunities for Blood Sciences and Microbiology to provide more responsive, high quality and efficient services as initially envisaged by the Carter Reports of 2006 and 2008. Consolidating Blood Sciences and other disciplines under this Hub/ESL model configured for local network and population needs would allow for the most consistent, clinically appropriate turnaround times delivering the right test at the right time. This option also makes better use of the highly skilled workforce to deliver improved, earlier diagnostic services supporting better patient outcomes. Taking a hub and spoke approach to Blood Sciences/Pathology consolidation gives the NEESPS network the ability to ensure an appropriate critical mass to support specialist diagnostics, so that patients have equal access to key tests and services that are sustainable. In 2017/18, trusts self-reported £33.6m of pathology cost improvement with a further £30m of savings identified in trust plans for 2018/19.

Strengths (Internal)

- Optimises the use of skills, expertise and equipment and optimises productivity and value for money.
- Ensures 24/7 service with sufficient staff to work safely in good working conditions and to provide the service utilising automated, sophisticated analytical platforms.
- Releases time and money for savings or reinvestment in new equipment with the potential to repatriate tests.
- A standardised approach across the network will assist the service to provide a safe, high quality system which meets the requirements of regulators.

Weaknesses (Internal)

- Requires robust and resilient network infrastructure with specific requirements for interconnected IT systems enabling the LIMS to link to PAS, ICE and other information systems to ensure an end-to-end quality system to ensure patients and users receive a responsive, timely and accurate service which is clinically-led.
- Transition phases require adequate planning and resources to make implementation of change successful while continuing to deliver a safe, high quality service.

Opportunities (External)

- Well-structured business cases for the development of an integrated Blood Sciences network may attract significant financial support from NHSI.
- Network expansion can occur once infrastructure is in place to meet the needs of a larger population and provide further professional development opportunities.
- A successful network would promote improved recruitment and retention as well as service and staff stability with improved staff morale. A successful network with strong development plans will attract quality candidates for all posts and grades/professions.
- Consolidated test volumes will improve affordability of commercial managed service contracts to ensure the service keeps up with the best equipment to provide new tests and technologies for patient benefit.
- Networking enables the development of an area-wide POCT and rapid testing service to keep patients out of hospital and make maximum benefit to GIRT initiatives for clinical pathways with early use of Pathology to improve outcomes and the patient experience as well as the service reputation with its users including GPs.

Threats (External)

- Hub and spoke model requires a radical challenge to working habits which have been in place for decades and can result in major destabilisation of key people and services if not sensitively managed and communicated via an agreed engagement and consultation exercise.
- Transformational change requires significant access to time, money and programme management skills and training which is not readily available in resource constrained environment.
- Transition phases can take significant time and effort from already busy and limited staff and the potential for stress and ‘change fatigue’ needs to be a key part of network planning of this model.
- Finance pressures are inevitable due to ‘double running of services while required checks are made that new services are robust and ready to become the new BAU.
- Change in working conditions and location may be an expectation of the new Hub/Spoke model which needs sensitive handling to avoid industrial relations challenges and potential loss of valued staff just when the new service model needs them the most.

Cellular Pathology

Current Service Description

Cellular Pathology is the study of disease in organs, tissues and cells. Histopathology and cytopathology are key diagnostic departments performing critical tests for the initial detection and diagnosis of cancer and other diseases supported by microscopy, immunohistochemistry and modern molecular techniques. Histopathology and cytopathology also detect and confirm recurrence of cancers, give details of cancer grade, extent, provide information for treatment and prognosis and also provide vital evidence for targeted oncological treatment.

The tPP strategy was to leave Histopathology as it was. All three NEESPS main hospital sites (West Suffolk, Ipswich and Colchester) currently still have comprehensive Cellular Pathology laboratories processing pathology samples from the hospitals, general practices and community providers within Ipswich & East Suffolk, West Suffolk and North East Essex CCGs as well as parts of Mid Essex CCG. The population served is just under one million. The service is managed across the three sites by a Histopathology Service Manager and clinically led by a Histopathology Clinical Lead (currently vacant). That said, a key integrated governance and accountability issue is the standalone nature of the Cellular Pathology services at each site where the consultant Pathologists provide clinical interpretation of results and related advice on diagnosis, treatment and patient management in relative isolation.

The Cellular Pathology service across the NEESPS network of hospitals is provided solely by NHS staff. The break-up of tPP in 2017 left the service fragmented so the pathology laboratories were restructured with North East Essex and Suffolk pathology services and staff transferred from tPP to NEESPS in May 2017 hosted by Colchester Hospital University NHS Foundation Trust on behalf of the network. The staff were then transferred to ESNEFT as the new host trust when it was formed from the merger of Colchester and Ipswich Hospital Trusts on 1 July 2018 (except for the consultant histologists and secretarial staff who remain employed by their respective trusts). Although all the staff are employed by the NHS, it has been noted that there is no overall clinical governance and leadership. One option for consideration is to create a NEESPS Network Pathology Director role, with a Royal College of Pathologists approved job description, to include clear managerial and clinical leadership arrangements. The lack of an integrated governance structure is a cause of concern for service users and clinicians and has been an obstacle to implementing an overall service strategy that will meet the expectations of all stakeholders including the Pathology UK Accreditation Service (UKAS).

For Cellular Pathology, as a major clinical discipline within pathology, there have been significant challenges in achieving and then maintaining UKAS accreditation including provision of adequate staffing levels. The staffing challenge has resulted in consistent concerns about the quality and safety of Cellular Pathology including meeting key turnaround targets for samples particularly for suspected cancer. The service lacks a single, integrated Laboratory Information Management System (LIMS) for order comms with links to other clinical information systems (such as PAS, EMIS, ICE) for key users including GPs and Oncology resulting in potential risks to patient outcomes.

For the delivery and alignment of the Cellular Pathology and pathology strategies it is of crucial importance that all interested parties, both internally and externally, recognise that pathology is a heterogeneous and complex set of sub-specialist disciplines. Consolidation options for Cellular Pathology, as a mainly non-urgent service (excluding unplanned frozen sections), can be significantly different from disciplines such as biochemistry and haematology. Nevertheless, Cellular Pathology still needs to be explicitly matched to the urgent / non-urgent nature of the clinical / laboratory service and to the clinical and operational requirements of each hospital site. To achieve and maintain UKAS accreditation with the optimum use of skills and equipment within budget, a key task will be to agree which Cellular Pathology processes from: macro examination; cut-up; sample preparation/processing; staining and clinical review (including at MDTs) and the reporting step need to be on which site and for what clinical reasons. NEESPS needs a strategy aligned to the wider NHS national strategy for pathology services with Cellular Pathology integrated with the rest of pathology. This flexible approach will require active consultation with hospital clinicians (especially from Cancer Services and Surgery) and GPs to ensure patient needs and expectations are met on a consistent basis.

Cellular Pathology, as with the other pathology disciplines, needs to contribute to continuous improvement initiatives and cost improvement programmes to cope with growing clinical pressures and developments. The NEESPS Network will need to ensure that the overall service issues are being discussed in the context of pathology ensuring the delivery of effective and efficient patient focused decisions. Pathology needs to be recognised across the Trusts as a key partner in delivering successful patient and clinical pathways from Pathology supporting early and accurate diagnoses and treatment plans. Pathology needs to be closely involved in planning for future opportunities for service provision across the Trusts front-line clinical services

Strategic Drivers

Strengths (Internal)

- Each of the three laboratories is working in relative managerial, clinical and geographical isolation with different LIMS, equipment, SOPs and QMS.
- West Suffolk has a full complement of Consultant staff while other sites are working to attract new staff to ensure workload can be dealt with to meet TATs.
- Excellent clinical engagement on all sites and a clear desire to make services as good as they can be.

Weaknesses (Internal)

- Staff numbers and grades at each site to cope with the volume and complexity of patient samples and growing clinical acuity and clinical expectations.
- Risk of loss of skilled and qualified laboratory staff and difficulty in recruiting due to staff uncertainty which has resulted in heavy reliance on locum/agency staff.
- Lack of NEESPS-wide UKAS accreditation at WSFT is a major concern with no agree timeline for resolution.

Opportunities (External)

- Central NHS funding may be made available in the near future for cross-network proposals to adopt Digital Pathology.
- Development of a Molecular service (currently provided by specialist centres) to gain control of the test repertoire turnaround times (TATs).

Threats (External)

- Regional specialisation in key sub-specialties and the growing expectation of HPV centres for Cytology plus the inevitable digitisation of Histology could result in loss of workload especially in complex clinical areas.
- University based FTs may create Centres of Excellence to attract experienced staff and significant R&D funding to support the acute diagnostic services.

Vision for the Discipline in 2024

Service to achieve network-wide UKAS accreditation and to be clinically-led along with all disciplines under NEESPS NHS management. Clinical leadership and service governance to ensure all disciplines are actively involved in overseeing performance and efficiency as the requirement for MDTs grows in number and complexity. Governance structures have effective consultant oversight of the service for patient care and pathways under a Network Director.

The extent of Cellular Pathology laboratory testing on each site needs to be forecast against clinical need focused on when results and information will be required rather than where the tests are undertaken. It may be possible to develop Associate Practitioners and to centralise some aspects of cut-up and/or sample processing. A key step to developing a formal network will be to agree the test repertoire by site in consultation with front-line services (eg. Oncology, Surgery and sub-speciality areas including Breast, Liver, etc). There is a need to recognise the relative TATs for delivery of results for urgent cancer referrals and the expectation nationally of a move to digital histology (as seen in Leeds) and to ensure there is no inconsistency in quality due to IT and staffing issues or delay in transporting specimens off-site.

Laboratory supervision will be required on each site once the strategy and test repertoire have been agreed. UKAS compliant roles at Pathology Directorate level including Quality Manager(s), H&S officer, service development team and other support roles will need to be identified once the strategy is confirmed. Services responsive to the needs of the hospitals, primary care, and the community on an equitable basis will be required where clinically justified linked to agreed TATs per test for given clinical symptoms/patient presentation. Provision of services must include a business continuity plan for unplanned frozen sections by agreeing SOPs should samples need to be taken off-site for preparation and reporting. Development of a fully integrated laboratory network with a fully operational interconnected LIMS (to support cross-site working from a distance) with a single set of SOPs within a common QMS/LIMS database (eg. Q-Pulse, Datix) will be needed. The network will also require reliable sample transport with clear definition of responsibilities and accountability for real-time sample tracking. Molecular and digital technology needs to be part of the strategy to ensure access to a service repertoire accessible from all sites.

Overall service and staff to integrate to develop a single clinical team across the three sites. For example, one overall Laboratory Director sitting above all three sites for both laboratory and clinical accountability. This structure, together with an interconnected LIMS, would allow provision of robust cross cover arrangements for MDT duties and urgent clinical requests for advice. For resource efficiency reasons each site may undertake some specialist work for all 3 networked sites (eg. sub-specialty samples including breast, skin, liver, intestinal, etc).

Subject to an agreed single service strategy, investment will be needed in the appropriate equipment linked to a workforce strategy for each site to ensure equity of access to a responsive service for the wider NEESPS population. Each of the three sites will require mapping to clinical/patient need with input from front-line services (eg. Cancer Services, cardiac/thoracic surgery). For the workforce the introduction of staff rotation through specialist areas will be essential to develop Consultant and BMS staff to enhance learning and development opportunities including consideration of Advanced Practitioners and reporting competencies generally. Service options need to take staff views into account to avoid problems with staff recruitment and retention.

Preferred Service Option

Integrate Cellular Pathology as a distributed network under NHS management

Integrate services to achieve NEESPS single Cellular Pathology services with a distributed local network under NHS direct management and governance (NHS hosted). Implement a consolidated Cellular Pathology service utilising a distributed network under direct NHS management and governance within an agreed commercial model. This will ensure provision of a high-quality, accredited service with the optimum utilisation of advanced LIMS and analytical systems supported by a skilled and experienced workforce which is sustainable with increased patient demand and complexity and with growing expectations from service users in the community and primary care sectors. This will also ensure that the network has the critical core capacity and capability to support developing diagnostic tests (eg. digital, molecular and genomics) so that patients may have timely access to the accredited network service.

Strengths (Internal)

- Ensures common governance structure for Cellular Pathology and NEESPS network under an agreed Clinical Lead.
- Enables flexible, cross-discipline and MDT working with integrated planning and governance.
- Attracts staff due to variety and depth of work including sub-specialisms (in addition to generalist work), etc.
- Integrates medical staff and laboratory staff for shared ownership of service with shared priorities and values.
- Responsive to local acute needs within a developing ICS planning environment.
- Consistent oversight of services and accountability for performance with internal and external requesters.
- Consultants remain employed by local NHS trust with honorary contract and indemnity via NEESPS.
- Network resilience with three laboratories providing processing options for business continuity.
- Familiarity with shared IT and analytical equipment and staff with improved working options across sites and consistent quality of patient and clinical service.

Weaknesses (Internal)

- Limited resources (esp. capital) with related revenue pressures including significant CIP expectations.
- NHS system undergoing radical change with ICS model replacing market model for NHS planning.
- Network management at embryonic level following loss of tPP.
- NHS network governance not yet in place so responsibilities and accountabilities unclear. Time required to embed integrated governance and risk structures.
- Legacy IT systems need fundamental reconfiguration to establish integrated information systems to allow movement of work/specialities to improve quality, asset utilisation, use of automated technology and staff capacity and capability with resulting improvements in NEESPS service resilience.
- A functioning validated common LIMS system and reliable communication with hospital computer systems at each site are essential pre-requisites unlikely to be available before 2021.

Opportunities (External)

- Investment in larger scale laboratory space, modern automation and technology on a shared network basis (eg. Digital Pathology, sample reception, quality management, transport, IT support).
- Build common values and culture of NHS ownership for larger population/patient base with wide range of acute and hyper-acute services from a local NHS system where Cellular Pathology is seen as a valued and integral part of clinical service delivery particularly in relation to early cancer detection and management.

Threats (External)

- Service gets ‘lost’ in the scale of a developing ICS model but experiences significant volume growth in key areas allied to higher expectations of service quality and response.
- Resources required are not prioritised when in competition with other areas (eg. ICU, surgery, NNU).
- Risk of constant restructuring with fragmentation or outsourcing if performance seen as unacceptable or too costly due to rapid technology cost pressures.

Organisational Information

Suffolk and North East Essex Integrated Care System

In April 2019, Suffolk and North East Essex became an Integrated Care System (ICS), hosting three Alliances of provider organisations. These Alliances are committed to working together to integrate care and to create one clinical community. The scale of the new ICS is significant:

- 953,000 residents in 2 counties (7 districts & boroughs);
- 3 acute hospitals, 8 community hospitals, 104 GP practices, 2 mental health trusts;
- Rapidly growing & ageing population with significant health inequalities (8 years of life); and,
- £2,400,000,000 (2.4bn) public service turnover annually (2016 figure).

The STP's (pre-cursor of the ICS) objective is to achieve viable acute hospitals across the system through the redesign of clinical pathways around outcomes, underpinned by innovation. Analysis undertaken during the development of the proposed approach to hospital services showed that:

- The local population is changing and there is a widening health and wellbeing gap;
- There are significant care and quality issues and increasing demand for services;
- It is becoming increasingly difficult to recruit and retain staff; and,
- Provider trusts are financially unsustainable – reflecting the finance and efficiency gap.

Suffolk and North Essex - Integrated Care System			
NHS Foundation Trust	East Suffolk and North Essex		West Suffolk
Local catchment	800,000		280,000
Turnover (2017/18)	£ 661,000,000		£ 253,000,000
Employees (Headcount)	9,500		3,800
	Colchester	**Ipswich**	**West Suffolk**
Bed numbers	560	541	460
Elective admissions	46,000	51,000	35,000
Emergency admissions	48,000	44,000	32,500
A&E attendances	89,000	90,000	71,000
Outpatient attendances	415,000	866,000	250,000

East Suffolk and North Essex NHS Foundation Trust

The formation of ESNEFT in July 2018 is the most important transformation programme in the Suffolk and North East Essex STP plan creating sustainable, high quality acute and community healthcare for the population in an area which has had long-standing instability. The merger created a platform for transformation with the extended clinical teams able to offer services at scale, enabling significant improvements in quality of care, better access to clinical trials, help to address staff shortages and delivery of greater efficiency[13] with patient volumes exceeding those of many tertiary centres.

West Suffolk NHS Foundation Trust

WSFT achieved foundation status in 2011 and is a medium acute general hospital delivering acute and community healthcare and one of the few hospital trusts assessed by the CQC as 'outstanding'.

[13] Monitor/Boston Consulting Group (2012), "Economies of Scale and Scope"

13. Alliance update (enclosed)

To note the report

For Reference

Presented by Sheila Childerhouse

REPORT TO:	Council of Governors
MEETING DATE:	6 August 2019
SUBJECT:	West Suffolk Alliance update
AGENDA ITEM:	13
PRESENTED BY:	Sheila Childerhouse, Chair
FOR:	Information

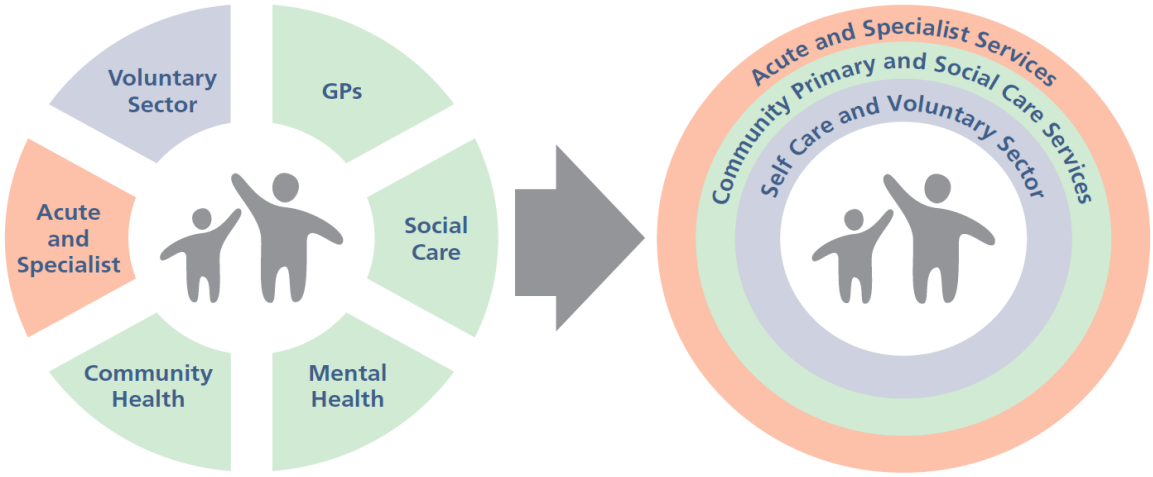
1. Background

The health and care partnership, which makes up the West Suffolk Alliance began to deliver community services within our geographical footprint in October 2017 and has been more broadly working together to improve the service offer to the population of West Suffolk since this point.

Along with the other Alliances within the Suffolk and North East Essex Sustainability and Transformation Partnership (SNEE STP), West Suffolk was asked to produce a strategy by June 2018. The delivery of the West Suffolk Alliance strategy is a critical element of the wider SNEE STP Plan as it provides the detail on the local delivery model and the development of a new way of working in partnership at a locality level.

Our focus within West Suffolk Alliance is on people and places and the strategy sets out the commitment of all partners to move from working as individual organisations towards being a fully integrated single system based around the individual. To achieve this shared vision, clear local priorities have been agreed to provide an improved service for people in West Suffolk and to tackle the sustainability issues faced by the system together.

Co-ordinating services around the individual - so that if feels like one service



The strategy was co-developed by all key partners and reflected the feedback previously given by patients, the public and people who use our services. As per the below diagram the document is part of a wider network of plans and strategies and builds on these to show how we will add value through Alliance working.

2. Area of focus and development

- **Locality development** – whilst the direction of travel for our localities has been agreed, getting pace on transformation can be difficult with front line teams managing business as usual, increased demand and pressures on recruitment to vacancies. Named locality leads continue to work with front line team leads, GPs and wider partners to develop shared priorities, along with action plans, for their localities.

  An example of partnership working in the localities is the development of six additional Health Care Assistants (HCAs) in the Mildenhall, Brandon, Newmarket and Haverhill localities to work with housebound patients including those in residential and nursing care. This group of people is particularly vulnerable to poor health outcomes and acute exacerbations of illness and frailty.

- **Primary Care Network Development** (PCNs) – The development of PCNs is an important component of our locality development. Each PCN is now meeting regularly and starting to agree the practicalities of operating as a network, how they might share staff and work with others around the social prescribing and other opportunities. Four of our PCNs are working with LifeLink (the current social prescribing programme), with the final two yet to determine their delivery model.

- **Working together to improve services** – a range of quality improvements come direct from clinical and professional leads spotting an issue and working together to fix it. Two examples illustrate this approach:

  - **Paediatrics** – Dr Lakshman (Consultant Paediatrician at West Suffolk Foundation Trust) and Dr Emma Ayers (a GP in Mildenhall) have joined forces to produce advice for GPs and patients around some common childhood problems. Topics covered so far include eczema, cows' milk protein allergy, hernias and toddler diarrhoea. GP practices have been asked to name Paediatric champions and a WhatsApp group has been set up to share regular updates, tips and advice. Patient information leaflets are being developed and the options for making this a web-based resource is currently being looked into.

  - **Wound care in Primary Care** – Emma Williamson a Practice Nurse from Angel Hill GP Practice has developed a holistic wound care clinic with the aim of having "all patients with below-the-knee wounds healed within 12 weeks."

- **Wider Partnership Activity** – through the Alliance's system executive group (SEG) we continue to focus on innovative partnership and influences for health and wellbeing. Examples in quarter 1 include: Abbeycroft Leisure with West Suffolk Councils and other partners allowing them to develop new leisure premises that work hand in glove with other services including health and care; LifeLink who are delivering social prescribing in Haverhill; and St Nicholas Hospice as part of a system strategy for end of life care.

- **Mental Health Transformation** - Work is ongoing to operationalise mental health and wellbeing strategy for Suffolk. The immediate priority is to improve the care that people receive. We must ensure the safety of services; regain the confidence of service users, families and carers; and support Norfolk and Suffolk Foundation Trust (NSFT), its new leadership team and its hard-working and dedicated staff to ensure this happens as quickly as possible.

  The Alliance continues to work with co-production partners to ensure we continue to hear the voice of staff and service users, their families and carers to continue to shape this work. To support this the Alliance have developed a proposal to bring together a small implementation team seconded from within alliance organisations lead by a full time Programme Director, who came into post at the beginning of July. An agreed timetable seeks to transition to the new mental health model as set out within the strategy from September 2020. To enable this to happen there are three distinct phases:

- ***June to end of September 2019***: further development of the mental health operational model and the base case information
- ***October 2019 to end of January 2020:*** due diligence process with the Alliances based on a series of half day meetings around themes.
- ***February 2019 to end of September 2020:*** further development of the operational model and transition planning to new arrangement to go live end of September 2020.

- **Governance review** - the Alliance is reviewing some aspects of its governance. In part as a response to the development of the Integrated Care System (ICS), but also as a regular assurance process that the governance is fit for purpose for the Alliance as it moves forward.

14. Annual Report & Accounts 2018/19 (on Trust website or hard copy on request)

To receive the Annual Report & Accounts for 2018/19

For Reference

Presented by Richard Jones

REPORT TO:	Council of Governors
MEETING DATE:	6 August 2019
SUBJECT:	Governor issues
AGENDA ITEM:	14
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
FOR:	Information

The Council of Governors is asked to receive the annual report and accounts in public session.

The report was approved by the Board in closed session in May but could not be reported publically until it had been laid before Parliament – this took place on 4 July 2019.

The full document is available via the link below:

https://www.wsh.nhs.uk/CMS-Documents/Trust-Publications/Annual-reports/Annual-report-2018-19.pdf

Recommendation:

To receive the annual report and accounts.

15. Annual Audit Letter and Quality Report limited assurance review (enclosed)

To receive the audit reports from BDO, External Auditors

For Reference

Presented by Matthew Weller, BDO

WEST SUFFOLK NHS FOUNDATION TRUST

Annual Audit Letter

Year ended 31 March 2019

IDEAS | PEOPLE | TRUST

BDO

EXECUTIVE SUMMARY

Purpose of the Annual Audit Letter

This Annual Audit Letter summarises the key issues arising from the work that we have carried out in respect of the year ended 31 March 2019.

It is addressed to the Trust but is also intended to communicate the key findings we have identified to key external stakeholders and members of the public.

Responsibilities of auditors and the Trust

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

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

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

We are also required to review and report on the Annual Report, Annual Governance Statement and the Trust Accounts Consolidation schedules.

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

BDO LLP

14 July 2019

Audit conclusions

Audit area	Conclusion
Financial statements	Unqualified opinion
Use of resources	Qualified 'except for' opinion in respect of the Trust's arrangements for securing economy, efficiency and effectiveness
Quality Report	Unqualified limited assurance report
Trust accounts consolidation schedules	Consistent with the financial statements
NAO group assurance review	No exceptions reported
Annual Report	Not inconsistent or misleading with the financial statements
Annual Governance statement	Complianct with NHS Improvement's guidance
Remuneration and staff report	Auditable parts found to be properly prepared

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

FINANCIAL STATEMENTS

Audit conclusion

We issued an unqualified audit opinion on the financial statements.

Final materiality

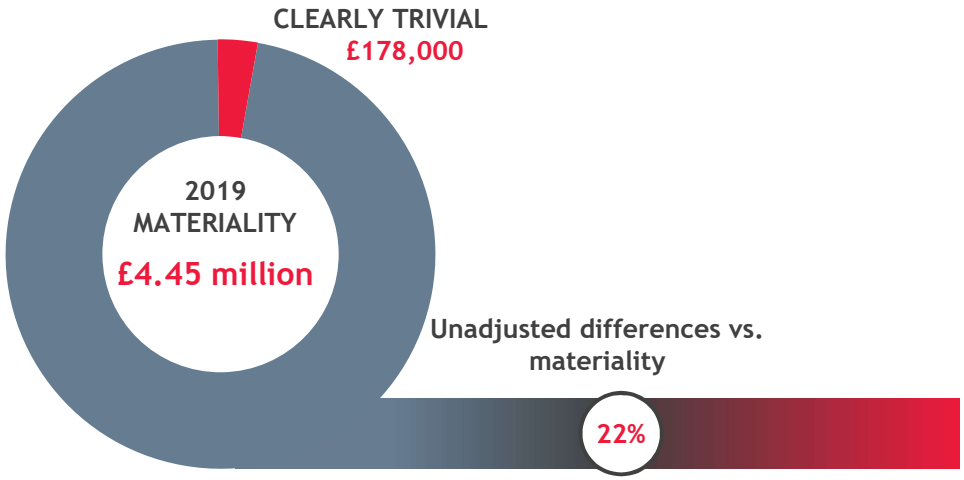
Materiality was calculated at £4.45 million based on a benchmark of 1.75% of gross expenditure.

Material misstatements

We did not identify any material misstatements.

Unadjusted audit differences

We identified audit adjustments that, if posted, would increase the deficit for the year by £0.992 million.



FINANCIAL STATEMENTS

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

Risk description	How the risk was addressed by our audit	Results
Management override of controls	We carried out the following planned audit procedures: • Determined key risk characteristics to filter the population of journals, using our IT team to assist with the journal extraction; • Reviewed and verified unusual journal entries made in the year, agreeing the journals to supporting documentation; • Reviewed estimates and judgements applied by Management in the financial statements to assess their appropriateness and the existence of any systematic bias; and • Reviewed unadjusted audit differences for indications of bias or deliberate misstatement, or where they appeared to be solely to deliver agreed control total to receive the additional Provider Sustainability Funding.	No issues were identified in our testing of the appropriateness of journal entries and other adjustments made to the financial statements. We identified a non-material unadjusted audit difference of £0.652 million in relation to the calculation of the accounting estimate for the Community service equipment accrual in the prior year. If this adjustment was made, it would have reduced the prior year deficit and increased the current year deficit. No issues have been identified with the calculation of this accrual in the current year.

FINANCIAL STATEMENTS

Risk description	How the risk was addressed by our audit	Results
Revenue recognition	At the planning stage we carried out audit procedures to update our understanding of the Trust's internal control environment for the significant income streams, including how this operates to prevent loss of income and ensure that income is recognised in the correct accounting period. We continued to refresh our understanding throughout the audit process. We reviewed a sample of contracts with NHS commissioners, and compared amounts billed under these contracts to underlying supporting data. We reviewed correspondence between the Trust and commissioners, together with the minutes from contract challenge meetings, to obtain further evidence to corroborate or challenge the Trust's position. We reviewed the year-end NHS Agreement of Balances process and mismatches report provided by the Department of Health and Social Care, with a particular focus on income and receivables amounts which are subject to adjustments or disputes by the counter-party, or where significant mismatches with counter-party returns are identified.	In the 2017/18 audit we identified that the Trust did not accrue for income of £0.340 million from Guy's and St Thomas NHS Foundation Trust relating to the 2017/18 year. This was an isolated issue which was left unadjusted in 2017/18 on the grounds of immateriality but was corrected in 2018/19, so causing 2018/19 income to be overstated by £0.340 million. Our testing did not identify any other issues in respect of revenue recognition.

FINANCIAL STATEMENTS

Risk description	How the risk was addressed by our audit	Results
Fair value of Property, Plant and Equipment (PPE)	We carried out the following planned audit procedures: • Reviewed the instructions provided to the valuer and reviewed the valuer's skills and expertise in order to determine if we can rely on the management expert; • Reviewed the source data used in determining the valuation and confirmed its accuracy; • Confirmed that the basis of valuation for assets valued in year is appropriate based on their usage; and • Reviewed valuation movements against indices of price movements for similar classes of assets and followed up valuation movements that appeared unusual against indices.	We confirmed that the property valuations are materially correct and the basis of valuation for assets valued in the year is appropriate. We confirmed that the source data provided to the valuer was in line with our expectations. We concluded that we were able to rely on the valuer (who is considered to be a "management expert"). We identified that the Trust had incorrectly recorded a capital receivable as a PPE addition as at 31 March 2019, thus overstating the value of PPE prior to valuation adjustments by £0.500 million. The valuation decrease recorded was therefore understated by £0.500 million. The Trust adjusted for this misstatement in the final financial statements. We also identified that the Trust had calculated accumulated depreciation to be added back on valuation incorrectly by £0.055 million. The Trust also adjusted for this misstatement in the final financial statements. Finally, a number of classification issues were identified which were all adjusted in the final financial statements.

USE OF RESOURCES

Audit conclusion

We issued a qualified 'except for' use of resources conclusion, referring to the weaknesses in the arrangements for securing economy, efficiency and effectiveness in respect of the Trust's use of resources.

We set out below the risks that had the greatest effect on our audit strategy.

Risk description	How the risk was addressed by our audit
Financial position	We reviewed the Trust's in year budget monitoring processes, and the completeness and accuracy of management information reported for decision making purposes. We reviewed the Trust's medium term financial plan and annual budgets submitted to NHS Improvement, including the reasonableness of the underlying assumptions made by management and the consideration of risks to sustainable deployment of resources. We reviewed progress against the Trust's Cost Improvement Programme (CIP) savings targets and arrangements to ensure that future targets are realistic and achievable, including how the Trust works with commissioners and other third parties to develop required savings schemes.

USE OF RESOURCES

Risk description	Results
Financial position	We found that: • The Trust set an original budget for 2018/19 of a £13.8m deficit, reducing to a deficit of £10.1m after taking account of anticipated Provider Sustainability Funding (PSF). After excluding an impairment of PPE of £5.5m (which was not expected but is allowed to be excluded from financial performance measures), the net effect of donated assets of £0.4m, the PSF incentive of £3.7m and also a bonus of £3.3m at the year-end, the level of which was greater than expected, the Trust achieved a deficit of £13.5m, thus improving on the forecast deficit by £0.3m. The final outturn for 2018/19 was a deficit of £11.6m, increasing the cumulative deficit to £31.3m (2017/18: £20.0m), after allowing for a transfer to the revaluation reserve. • During 2018/19, the Trust delivered all of the £12.2m CIP, which played a significant part in the Trust achieving its overall financial plan. • The final underlying deficit achieved of £13.1m (after excluding PSF and impairments) is a deterioration on the prior period equivalent deficit of £9.9m (excluding sustainability and transformation funding). There was also a deterioration in operating profitability, achieving an operating deficit of £3.957m compared to an operating profit of £1.914m in 2017/18. • The planned deficit control total set by NHSI for 2019/20 is £10.1m. If achieved, this would give the Trust access to £10.1m of additional funding, achieving a breakeven position. Delivery of the Trust's current 2019/20 plan requires a further £8.9m of CIP savings, which is less than the £12.2m delivered in 2018/19, but nonetheless still a significant challenge. • Although a breakeven for 2019/20 would be a notably positive achievement, there would remain significant cumulative deficits and borrowing levels to address. As at 31 March 2019, the Trust has £97.1m of borrowing, of which £12.2m is required to be repaid in 2019/20, with the only viable plan to re-pay this amount being to take out further borrowings. The Trust also has a significant capital programme planned for 2019/20 and beyond which requires £15.5m of cash in 2019/20 and therefore further borrowings. The cash balance as at 31 March 2019 is £4.5m, which is insufficient to get the Trust through 2019/20. The Trust is currently budgeting a requirement of an additional £7.8m of borrowing in 2019/20. • Notwithstanding the achievements in 2018/19 and the planned breakeven after PSF for 2019/20, there remain significant issues to be addressed in terms of cumulative deficits, borrowing and cash flows. We therefore concluded that there is insufficient evidence that the Trust's arrangements support, in all significant respects, its ability to achieve planned and sustainable financial stability and modified our opinion in this respect.

QUALITY REPORT

Audit conclusion

We issued an unqualified assurance report on the quality report.

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

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

We tested the first two on the list, as well as the learning from deaths indicator, as chosen by the Governors. The results of this audit are outside the scope of our limited assurance report.

Requirements	Response	Findings
Review the content of the report and consistency with specified documents.	We reviewed the contents of the Quality Report and compared this to the guidance and Regulations issued by NHS Improvement. We read the information included in the Quality Report and considered whether it was materially inconsistent with: • Board minutes and papers relating to quality reported to the Board. • Feedback from Commissioners, Governors, Local Healthwatch, the Overview and Scrutiny Committee and other named stakeholders. • The Trust's complaints report. • Latest national and local patient survey. • Latest national and local staff survey. • Head of Internal Audit's annual opinion over the Trust's control environment. • Care Quality Commission's inspection report.	The Quality Report has been prepared in line with the Regulations. We reported to management where there are omissions or where additional information and disclosure is required to comply with the guidance issued by NHS Improvement. These amendments were made to the final published version. The Quality Report is not materially inconsistent with our review of the information we are required to consider.

QUALITY REPORT

Requirements	Response	Findings
Testing of 4 hour A&E waiting times The Trust reported performance of 90.7% in respect of the 4 hour A&E waiting times indicator, against a target of 95% in the Quality Report.	We undertook testing to: • Confirm the definition and guidance used by the Trust to calculate the indicator. • Document and walk through the Trust's systems used to produce the indicator. • Undertake substantive testing on the underlying data against six specified data quality dimensions. We tested of a sample of 30 cases included in the reported performance for data validity, consisting of 15 patients who met the performance target and 15 breaches.	We were able to conclude that this performance indicator is reasonably stated in all material respects.
Testing of 62 day cancer waiting times The Trust reported performance of 84.6% in respect of the 62 day cancer waiting times indicator, against a target of 85% in the Quality Report.	We undertook testing to: • Confirm the definition and guidance used by the Trust to calculate the indicator. • Document and walk through the Trust's systems used to produce the indicator. • Undertake substantive testing on the underlying data against six specified data quality dimensions. We tested a sample of 30 cases included in the reported performance for data validity, consisting of 15 patients who met the performance target and 15 breaches. We also tested 15 cases for data completeness.	We were able to conclude that this performance indicator is reasonably stated in all material respects.
Testing of learning from deaths indicator The Trust reported performance of 774 case reviews in respect of the 900 deaths at the Trust during the year.	We undertook testing to: • Confirm the definition and guidance used by the Trust to calculate the indicator. • Document and walk through the Trust's systems used to produce the indicator. • Undertake substantive testing on the underlying data against six specified data quality dimensions. We tested a sample of 15 cases included in the reported performance for data validity. We also tested 15 cases for data completeness.	We were able to conclude that this performance indicator is reasonably stated in all material respects.

REPORTS ISSUED AND FEES

Fees summary

	2018/19 £	2017/18 £
Audit fee		
• Trust financial statements and use of resources	45,225	45,225
Non-audit assurance services		
• Fees for audit related services: Quality Report	4,295	4,295
Total fees	**49,520**	**49,520**

Communication

Communication	Date (to be) communicated	To whom
Audit Planning Report	January 2019	Audit Committee
Audit progress report	April 2019	Audit Committee
Audit completion report	May 2019	Audit Committee
Report on the Quality Report	May 2019	Audit Committee
Annual Audit Letter	July 2019	Audit Committee

FOR MORE INFORMATION:

David Eagles
e: david.eagles@bdo.co.uk

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

BDO is an award winning UK member firm of BDO International, the world's fifth largest accountancy network, with more than 1,000 offices in more than 100 countries.

BDO LLP is a corporate establishment under the Limited Liability Partnership Act 2000 and a UK Member Firm of BDO International. BDO Northern Ireland, a separate partnership, operates under a licence agreement. BDO LLP and BDO Northern Ireland are both separately authorised and regulated by the Financial Conduct Authority to conduct investment business.

www.bdo.co.uk

Report to the Audit Committee

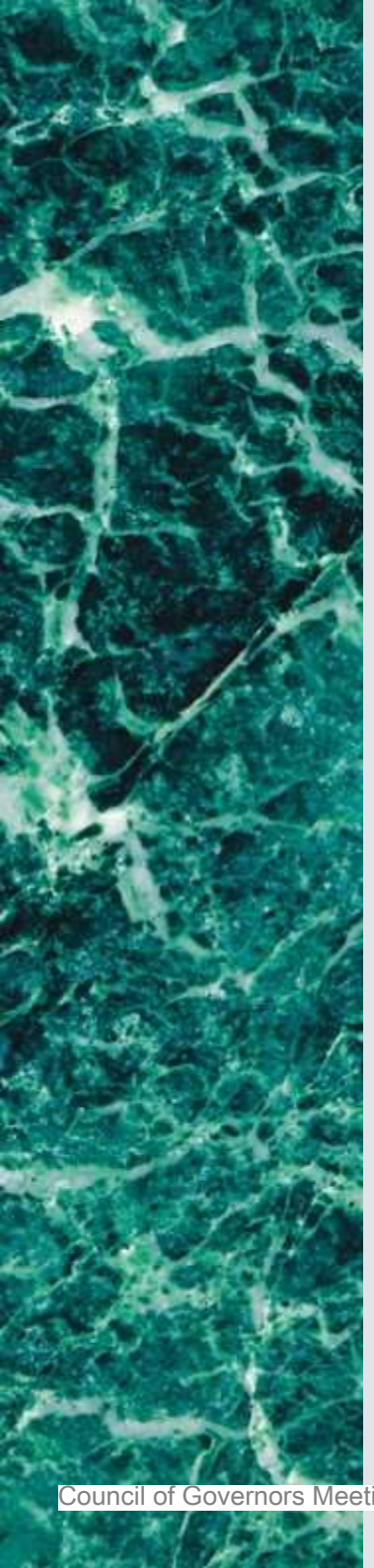
WEST SUFFOLK NHS FOUNDATION TRUST

LIMITED ASSURANCE REVIEW ON THE QUALITY REPORT 2018/19

20 May 2019

IDEAS | PEOPLE | TRUST

BDO



CONTENTS

SIGNIFICANT REVIEW FINDINGS

Executive Summary

This report covers the findings of our review of West Suffolk NHS Foundation Trust's (the Trust) Quality Report for the year ended 31 March 2019, which is included within the Trust's Annual Report. The scope of the limited assurance review includes checking the contents of the quality review against guidance issued by NHS Improvement, considering its consistency with other specified information and spot checks of a sample of reported performance indicators.

AREA OF REVIEW	SUMMARY
Content of the report	We have reviewed the draft Quality Report and we have reported to management where there are omissions or where additional information and disclosure is required to comply with the guidance issued by NHS Improvement. The Trust has amended the Quality Report to reflect our recommended changes and we conclude that the content of the report is compliant with the guidance issued by NHS Improvement.
Consistency checks with specified documents	We have read the draft Quality Report and conclude that it is not materially inconsistent with our review of the information we are required to consider as set out in the NHS Improvement's detailed guidance for external assurance on Quality Reports 2018/19.
Mandated indicator 1: 4 hour A&E waiting times	The Trust has reported performance of 90.7% in respect of the 4 hour A&E waiting times indicator, against a target of 95% in the draft Quality Report. Our testing of a sample of cases included checks to ensure that the correct information had been entered onto the system used for the indicator calculation. It was identified that cases can be manually amended on the e-Care system after they have been input, which is usually appropriate. We were unable to verify the appropriateness of these adjustments and recommend that a clear audit trail is maintained of all adjustments made. We did not find any other issues arising as a result of all the testing performed over this indicator. Therefore we have been able to conclude that this performance indicator is reasonably stated in all material respects.
Mandated indicator 2: 62 day cancer waiting times	The Trust has reported performance of 84.6% in respect of the 62 day cancer waiting times indicator, against a target of 85% in the draft Quality Report. Our testing of a sample of cases included checks to ensure that the correct information had been entered onto the system used for the indicator calculation. We did not find any issues arising as a result of all the testing performed over this indicator. Therefore we have been able to conclude that this performance indicator is reasonably stated in all material respects.

SIGNIFICANT REVIEW FINDINGS

Executive Summary

AREA OF AUDIT	SUMMARY
Local indicator	The Trust reported performance of 774 case reviews in respect of the 900 inpatient deaths at the Trust during the year.
(not covered by our assurance report):	Our testing of a sample of cases included checks to ensure that the correct information had been entered onto the system used for the indicator calculation.
Learning from deaths	It was identified that the initial patient deaths data includes both patients who died in the emergency department (ED) and patients who died after admission. ED deaths are excluded from the e-Care report. A small number of reported deaths are removed from the learning from deaths information system as they have been reported in error. No clear audit trail is however maintained of this process and there is a risk that the incorrect patients could be removed. We recommend that a process of maintaining a clear audit trail of these amendments is implemented. Therefore we have been able to conclude that this performance indicator is reasonably stated in all material respects.
Limited assurance opinion	We have read the draft Quality Report and conclude that it is not materially inconsistent with our review of the information we are required to read as set out in the NHS Improvement's detailed guidance for external assurance on quality reports 2018/19. We conclude that the content of the Quality Report is in line with the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance and that the reported 4 hour A&E waiting time and 62 day cancer waiting time performance indicators are reasonably stated in all material respects.

We would like to take this opportunity to thank the management and staff of the Trust for the co-operation and assistance provided during the limited assurance review.

REQUIREMENT TO PUBLISH A QUALITY REPORT

Review Scope and Objectives

Quality Account

All trusts are required under statute to publish a Quality Account which must include prescribed information as required by the NHS Act 2009 and in the terms set out in the NHS (Quality Account) Regulations 2010 as amended by the NHS (Quality Account) Amendment Regulations 2011, the NHS (Quality Account) Amendment Regulations 2012 and the NHS (Quality Account) Amendment Regulations 2017 (collectively "the Quality Accounts Regulations").

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added new mandatory disclosure requirements relating to 'Learning from Deaths' to quality accounts from 2017/18 onwards. The providers are expected to report their progress in using learning from deaths to inform their quality improvement plans during the year ended 31 March 2019.

Quality Report

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

NHS Improvement's detailed requirements for Quality Reports for 2018/19 document confirms that their requirements for the Quality Report incorporates all the requirements of the Quality Account Regulations, as well as a number of additional reporting requirements set by NHS Improvement.

LIMITED ASSURANCE REVIEW

Review Scope and Objectives

SCOPE AND OBJECTIVES

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

1	**A review of the content of the quality report against NHS Improvement's detailed requirements for quality reports 2018/19.**
2	**A review of the content of the quality report for consistency against the other information sources as directed by NHS Improvement.**
3	**Testing of mandated performance indicators (and one indicator selected by Governors), to assess whether these have been reasonably stated in all material respects.**

MANDATED INDICATORS

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

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

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

As the Trust reports all of the indicators in NHS Improvement's list, we have reviewed the following two indicators:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer of discharge
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

OTHER INDICATORS

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

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

Governors selected the following local indicator for external review:

- Learning from deaths.

LIMITED ASSURANCE REVIEW
Review Scope and Objectives

Communications

The required outcomes of this review are:

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

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

REVIEW OF THE QUALITY REPORT
Detailed Findings

CONTENT OF THE REPORT	FINDINGS, ISSUES IDENTIFIED AND CONCLUSIONS
We reviewed the Quality Report against the requirements set out in the NHS Improvement's detailed requirements for Quality Reports for 2018/19.	We reviewed the draft quality report and have reported to management where there are omissions or where additional information and disclosure is required to comply with the guidance issued by NHS Improvement. The Trust has amended the Quality Report to reflect our recommended changes and we conclude that the content of the report is compliant with the guidance issued by NHS Improvement.

CONSISTENCY CHECKS	FINDINGS, ISSUES IDENTIFIED AND CONCLUSIONS
We read the Quality Report to assess if it is materially inconsistent with any of the following documents, as directed by NHS Improvement: • Board minutes for the period April 2018 to May 2019 • Papers relating to quality reported to the Board over the period April 2018 to May 2019 • Feedback from Governors dated May 2019 • Feedback from Commissioners, Health watch organisations and the Overview and Scrutiny Committee dated May 2019 • The Trust's complaints report to be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 • Feedback from other named stakeholders involved in the sign off of the quality report • Latest national and local patient survey dated June 2018 • Latest national and local staff survey dated 2018 • Head of Internal Audit's annual opinion for 2018/19 • Care Quality Commission Inspection Report.	We conclude that it is not materially inconsistent with our review of the information we are required to read as set out in the NHS Improvement's detailed guidance for external assurance on Quality Report 2018/19.

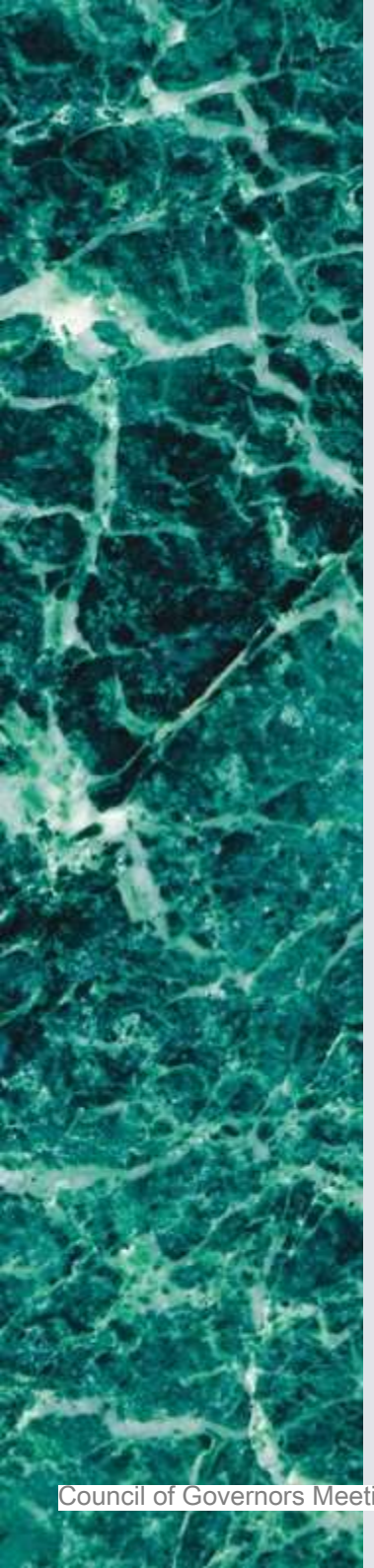
MANDATED INDICATOR TESTING
Detailed Findings

4 HOUR A&E WAITING TIMES INDICATOR	FINDINGS, ISSUES IDENTIFIED AND CONCLUSIONS
The Trust is required to report the percentage of patients who are admitted, discharged or transferred within 4 hours of arrival at A&E. The Trust has reported performance of 90.7% of patients being admitted, discharged or transferred within 4 hours of arrival at A&E, against a target of 95% in the quality report.	Our testing of a sample of 30 cases for patients included checks on A&E attendees from throughout the 2018/19 year, confirming that all had been correctly recorded as meeting the 4 hour target where applicable. This sample consisted of 15 patients who met the performance target and 15 breaches. All were concluded to have been accurately recorded. We also reviewed the general control environment around the compilation of the indicator data. It was identified that cases can be manually amended on the e-Care system after they have been input, which is usually appropriate. We were unable to verify the appropriateness of these adjustments and recommend that a clear audit trail is maintained of all adjustments made. As a result of the audit work performed, we have been able to conclude that this performance indicator is reasonably stated in all material respects.

62 DAY CANCER WAITING TIMES INDICATOR	FINDINGS, ISSUES IDENTIFIED AND CONCLUSIONS
The Trust is required to report the percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer. The Government's Cancer Reform Strategy, which was published in December 2007, outlined a significant programme to improve cancer services and in particular to ensure that more patients benefited from the success of the existing cancer waiting times standards. The Trust is required to meet the 85% national target for this indicator and performance against this target will be considered as part of Monitor's risk assessment of governance at the Trust. The Trust has reported expected performance of 84.6% patients achieving the 62 day wait cancer care pathway.	We have tested 30 cases to ensure the cancer referral to treatment period start date was the date the acute provider received an urgent (two week wait priority) referral for suspected cancer from a GP and that the treatment start date was the date first definitive treatment commenced if the patient was subsequently diagnosed by checking the dates reported on Somerset back to the patient's notes. This sample consisted of 15 patients who met the performance target and 15 breaches. We have also tested a sample of 15 patients for which a GP referral was received, but were not included within the indicator because no cancer was detected. We also reviewed the general control environment around the compilation of the indicator data. No deficiencies in control were identified. We did not find any issues arising as a result of all the testing performed over this indicator. Therefore we have concluded that the performance is reasonably stated in all material respects.

LOCAL INDICATOR TESTING
Detailed Findings

LEARNING FROM DEATHS INDICATOR	FINDINGS, ISSUES IDENTIFIED AND CONCLUSIONS
The Trust has reported the number of case record reviews and investigations carried out in respect of inpatients who have died at the Trust during the year. Of the 900 inpatient deaths recorded in total, The Trust is reporting 749 case record reviews and 31 investigations have taken place.	We have tested 15 patients selected at random from the learning from deaths information system (Rhapsody), from the population of patients who died at the Trust during the year, confirming that a case record review has been performed where applicable. This sample consisted of 13 patients for whom the case record review was performed and 2 patients for whom the review was not performed. All were concluded to have been accurately recorded. We have also selected a sample of 15 inpatients who died during the year as recorded on the e-Care system in order to confirm the consistency of the data recorded on the two systems. No issues were identified. We also reviewed the general control environment around the compilation of the indicator data. It was identified that the initial patient deaths data includes both patients who died in the emergency department (ED) and patients who died after admission. ED deaths are excluded from the e-Care report. **A small number of deaths are removed from the Rhapsody system as they have been reported in error.** No clear audit trail is however maintained of this process and there is a risk that the incorrect patients could be removed. We recommend that a process of maintaining a clear audit trail of these amendments is implemented. Therefore we have been able to conclude that this performance indicator is reasonably stated in all material respects.



APPENDICES

APPENDIX I: RECOMMENDATIONS AND ACTION PLAN

CONCLUSIONS FROM WORK	RECOMMENDATIONS	MANAGEMENT RESPONSE	RESPONSIBILITY	TIMING
PERFORMANCE INDICATORS				
A&E Indicator Amendments to E-Care are identifiable from each daily breach report but evidence for the change and details of when E-care was changed can't be acquired. As such, the E-Care data may not be valid. This is an inherent weakness of the validators process which is to review all breaches to confirm they actually exceeded the 4 hour target.	Ensure the E-Care system is able to support the creation of an audit trail when amendments are made to the A&E waiting time. This will allow all changes to be validated as appropriate.	It has been confirmed through conversation with ED (Donna Romaine) and IT (Karen Leggett) that anything changed in e-Care can be audited and that this was always the case. This recommendation can therefore be closed	IT leads for ED data	
Learning from Deaths Indicator Both Emergency Department (ED) deaths and admitted deaths are recorded within Rhapsody. A small number of deaths are removed from the Rhapsody system as they have been reported in error. This process of removal is not documented and there is no audit trail to identify what patient was removed and for what reason. This increases the risk that the data set used to determine the Learning from Death indicator is not complete, as we are unable to validate if the deaths which have been removed from the system have been done for appropriate reasons, per the guidance.	Keep a comprehensive record of all changes and amendments made to the data held within Rhapsody in relation to the Emergency Department deaths.	It has been confirmed through conversation with ED (Donna Romaine) and IT (Karen Leggett) that anything changed in e-Care can be audited and that this was always the case. This recommendation can therefore be closed	LfD Manager	

FOR MORE INFORMATION:

David Eagles
Partner

t: 01473 320728
m: 07967 203431
e: David.Eagles@bdo.co.uk

16. Annual external audit review (enclosed)

To receive a report and recommendation from the Audit Committee on the Trust's External Auditors BDO

For Reference

Presented by Alan Rose

Council of Governors – 6 August 2019

Agenda item:	16			
Presented by:	Alan Rose, Non-Executive Director			
Prepared by:	Liana Nicholson, Assistant Director of Finance			
Date prepared:	26 July 2019			
Subject:	External Audit report to Governors from the Audit Committee			
Purpose:		For information	✓	For approval

Executive summary:

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

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

The attached draft report to the Council of Governors outlines the External Auditors performance for the 2018/19 financial year and recommends the continued use of BDO as External Audit provider.

The Audit Committee agreed this report at its meeting on 26 July 2019.

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

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

Previously considered by:	N/A
Risk and assurance:	BDO is subject to review by the Financial Reporting Council. No issues have been noted from the reviews completed.

Legislation, regulatory, equality, diversity and dignity implications	International Standards of Auditing

Recommendation:

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

It is also recommended by the Audit Committee that BDO's contract is extended for one further year at the same price (ending in 2020/21). After this a re-tendering exercise will be undertaken (starting July 2020).

1. Background

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

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

2. Performance of the External Auditors

The Audit Committee met on the 26 July 2019, at this meeting the performance of the Trust's external auditors was considered, in particular the:

- Timeliness of reporting
- Quality of work
- Audit fees

2.1. Timeliness of reporting

The Audit Committee agreed that the Trust had a good working relationship with BDO and deadlines were always met. BDO responded to queries raised in 2018/19 promptly.

Audit Reports have always been received to enable the Trust to meet the Annual Report and Accounts external filing deadlines.

2.2. Quality of Work

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

Access to senior members of the Audit Team has been satisfactory during 2018/19. The Audit Committee also takes comfort on how BDO compares the Trust to other Trusts in specific areas, showing an effective use of benchmarking.

The quality of BDO's audit work is assessed by Financial Reporting Council (FRC) on an annual basis. The last report issued by FRC was in June 2018 and was considered at the Audit Committee in July 2018. No significant issues were identified by the FRC.

It was noted by the Audit Committee that there have been occasion when representatives from BDO had been unable to attend scheduled meetings. This will be flagged with the partner to consider and address.

2.3. Audit Fees

The Trust carried out a competitive external audit tender exercise and BDO were successfully re-appointed as appointed as external auditor for 3 years from 2017/18. This external audit tender exercise should provide the Council of Governors with a level of assurance that the fees have been market tested and therefore fees offer good value for money.

The contract with BDO will end following the 2019/20 audit and therefore the Trust will need to consider a re-tender exercise or to extend the contract for another one year.

For the 2018/19 financial year the summary of fees excluding VAT is as follows:

	£'000
Statutory audit fee	45
Quality Report	4
Total	**49**

The fees are the same as those charged in 2017/18 and are in line with the fees proposed during the tender exercise.

3. Recommendation

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

It is also recommended by the Audit Committee that BDO's contract is extended for one further year at the same price (ending in 2020/21). After this a re-tendering exercise will be undertaken (starting July 2020).

17. Report from Nominations Committee (enclosed)

To note a report from the Nominations Committee meeting of 5 June 2019

For Reference

Presented by Sheila Childerhouse

REPORT TO:	Council of Governors
MEETING DATE:	6 August 2019
SUBJECT:	Report from the Nominations Committee meeting held on 5 June 2019
AGENDA ITEM:	17
PRESENTED BY:	Sheila Childerhouse, Chair
FOR:	Information

The following summarises discussions that took place at the Nominations Committee meeting on 5 June 2019

- The terms of office for the NEDs were reviewed and it was noted that there were a number of NEDs whose current terms of office ended in 2020. These would be discussed at the next meeting of the nominations committee, with a recommendation taken to the Council of Governors meeting on 13 November 2019.

- The 360° feedback summaries for Angus Eaton, Richard Davies, Gary Norgate, Louisa Pepper (mid-term) and Alan Rose were reviewed. The committee agreed key strengths and areas for development for discussion in their appraisal meetings.

- The Chair left the meeting and her 360° feedback summary was reviewed. The key strengths and areas for development for discussion at her appraisal meeting were agreed.

18. Report from Engagement Committee (enclosed)

To receive the minutes of the meeting of 16 July 2019

For Reference

Presented by Florence Bevan

REPORT TO:	Council of Governors
MEETING DATE:	6 August 2019
SUBJECT:	Report from Engagement Committee meeting held on 16 July 2019
AGENDA ITEM:	18
PRESENTED BY:	Florence Bevan, Chair of Engagement Committee
FOR:	Information

The attached minutes summarise discussions that took place at the Engagement Committee meeting on 16 July 2019.

There was one item for escalation to the Council of Governors as a result of the change to the choice of food available in the Courtyard Café. This has been followed up with the catering manager and a response is appended to the minutes. The response is helpful and it is reassuring that no formal complaints have been received on this matter. Further work is being undertaken to extend the range of food within the Courtyard Café, including engaging with patients, visitors and staff to seek their views. The outcome of this work will be reported to the Engagement Committee.

Recommendation

Governors receive the minutes for information.

DRAFT

MINUTES OF THE COUNCIL OF GOVERNORS ENGAGEMENT COMMITTEE

HELD ON TUESDAY 16 JULY 2019, 4.30pm

IN THE WESTGATE ROOM AT WEST SUFFOLK HOSPITAL

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Peter Alder	Public Governor	•	
Florence Bevan	Public Governor	•	
June Carpenter	Public Governor	•	
Peta Cook	Staff Governor	•	
Jayne Gilbert	Public Governor	•	
Gordon McKay	Public Governor	•	
Liz Steele	Public Governor (Lead Governor)	•	
In attendance			
Georgina Holmes	FT Office Manager		
Richard Jones	Trust Secretary / Head of Governance		
Cassia Nice	Patient Experience Lead		
Sue Smith	Fundraising Manager		

Action

19/21 APOLOGIES

There were no apologies for absence.

19/22 MINUTES OF MEETING HELD ON 17 JANUARY 2019

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

Jayne Gilbert asked for an update/clarification on the following:

Item 19/14, Experience of Care – the use of iPads for area observations. Cassia Nice explained that the patient experience team did not have iPads but governors were welcome to use their own if they wished.

Item 19/15, Charitable Funds Briefing. She noted that all of the courtyard gardens were currently locked and there was no information on the doors as to how they could be accessed. It was explained that some were locked due to construction work that was being undertaken on the adjacent building, however the others were now all unlocked.

Item 19/8, Courtyard Café Feedback. She was concerned about the reduction in the choice of food offered in the Courtyard Café which had become more of a coffee shop with very few hot options. The café staff were not aware of the reason for this and did not appear to have been engaged in or consulted about this change. This was causing a problem with patients/visitors and there was no sign to tell them that they could go up to Time Out. Georgina Holmes would email Brod Pooley and ask about the rationale behind this. **G Holmes**

19/23 MATTERS ARISING ACTION SHEET

The ongoing action was reviewed and there were no issues.

The completed actions were reviewed and the following issue raised:

Item 25, consider arranging a quality walkabout in phlebotomy. It was noted that it had been decided that area observations would be more beneficial than a quality walkabout. Liz Steele reported that she had recently undertaken an area observation in phlebotomy and fed back to the manager. A further observation had been arranged for early December.

19/24 EXPERIENCE OF CARE

To receive an update on engagement activities including area observations

Area observations had been scheduled for the remainder of the year, including a number in the community. Governors reported that they had found these very interesting. Cassia Nice explained that following feedback to the department manager an action plan was drawn up. This was reviewed with the manager a month later to ensure that actions had been followed up.

Liz Steele and Jayne Gilbert reported that the fracture clinic had improved considerably since the area observations that they had undertaken.

It was agreed that a summary of area observations and actions completed etc would be produced for each engagement committee meeting. **C Nice**

To review further opportunities for governor engagement

It was agreed that governors were already taking part in a number of engagement activities; therefore no further opportunities were currently required.

To receive feedback on the Voice meeting, 10 July 2019

Cassia Nice reported that the Voice group was going from strength to strength and was working on several different projects. One of these was around improving the experience of families of patients who were dying in hospital. They were also involved in outpatient transformation work which was a five year county wide project and taking part in a research study hosted by the University of East Anglia for people who would like to stop smoking or drinking.

Peta Cook reported that community paediatrics was looking at setting up its own Voice group and was working with Cassia Nice on this.

19/25 CHARITABLE FUNDS BRIEFING

To review future activities and potential for governor engagement

Dates from the borough councils for AliveCor were still awaited.

MyWish had recently been chosen as Marks & Spencer's (Bury St Edmunds) charity for the year, therefore there could be opportunities for governor involvement in this. MyWish was also the Arc's charity again for this year. Sue Smith would send Georgina Holmes details of any events that were being arranged with both these organisations. **S Smith**

To receive an update on the Butterfly Appeal

There had been an issue with the courtyard that had been chosen for the location of this facility as it was required for another service.

The MyWish team had undertaken some research on footfall in the different corridors in the hospital and the results had confirmed that the courtyard that had been chosen was in the most appropriate place as it was very quiet. It was hoped that the issue with this courtyard could be resolved and confirmed by estates within the next month so that the appeal could be launched. Sue Smith would forward further details as soon as possible. **S Smith**

She reported that the Trust had applied for a grant to build a changing places bathroom and MyWish would match this figure. Currently the nearest facility was in Stowmarket.

Peter Alder suggested that MyWish car stickers should be produced but it was explained that there would be a cost issue.

19/26 CONSIDERATION OF ENGAGEMENT PLAN FOR 2019-20

26.1 Engagement plan 2019-20

The engagement plan was reviewed and Richard Jones explained that the subject for the Annual Members Meeting (AMM) would be diabetes. There would be a trial run of this in Sudbury on Friday 30 August as a lot of these patients came from Sudbury and were less likely to travel to the AMM. It was hoped to hold a similar event in another location later in the year.

It was considered that the engagement sessions in Newmarket Café were worth doing as they give an insight into the community.

Jayne Gilbert and June Carpenter volunteered to do additional sessions in Courtyard Café and would forward available dates to Georgina Holmes who would confirm with the catering manager. **G Holmes**

26.2 Membership Numbers

The membership numbers were reviewed; the total was currently 5981 versus a target of 6000. Members under 50 years of age were 1137 versus the target of 1250. The total number of members recruited to date was 170.

19/27 FEEDBACK REPORTS

Courtyard & Newmarket Café feedback

Peta Cook noted that feedback from the recent session at Newmarket had been received from 12 patients/visitors; she considered this to be good taking into account its size and compared to feedback numbers in the Courtyard Café.

It was noted that WSFT was still considered to be a small, friendly hospital with a nice atmosphere and that appointments ran to time.

Jayne Gilbert referred to the amount of paper that was being used when sending out patient letters, ie only one line on the second page. Cassia Nice explained that this was being addressed for the most commonly used letters; however there were over 800 templates therefore it would be very labour intensive to do this for all letters.

It was agreed that the following actions should be taken in response to comments received from the Courtyard Café:- **G Holmes**

- Find out from Lynne Saunders why WSFT doesn't use a milk bank.
- Ask estates what seats were available around the lower car park for patients waiting to be picked up.
- Feedback comments on the trollies (wheels) in the Courtyard café being very noisy.

19/28 ISSUES FOR ESCALATION TO THE COUNCIL OF GOVERNORS

It was agreed that the change to the choice food available in the Courtyard Café should be escalated to the Council of Governors.

19/29 DATE OF FUTURE MEETINGS

Tuesday 15 October, 4.30pm

Response to changes made in Courtyard Café
Provide by Brod Pooley, Facilities Manager for Catering and Community

The reasons for the change were:

Food Hygiene

- After our last visit from the local environmental health office (EHO) we were awarded a 5*rating however the inspector, catering manager and myself identified a risk due to the size of the kitchen area and the storage, handling and cooking of high risk protein items. This did not stop us from being awarded the highest standard however, even though we comply with all the food separation and cross contamination legislation this risk was something we needed to investigate and to improve on.

Equipment/area

- The age of the equipment within the area meant that we were unable to source parts easily
- The amount of heat that the ovens produced was detrimental to the area especially during the hotter spring and summer seasons when the staff found the working conditions unpleasant, as did customers while waiting in at the counter. The added heat also caused the refrigeration equipment to fail on a regular basis
- With the removing of major cooking within the area the smell of cooking has been removed which has improved the area.

Duplication of service

- The Timeout Restaurant offers freshly cooked food items for sale which was a duplication of service however, within this area there is the advantage of a staff discount for members of the Trust but there is a more extensive offer giving you a greater choice of fresh and healthy products.

Going forward

- We will be extending our range of freshly prepared salads and introducing a new range of filled wraps
- There will be greater choice within the out of hours vendors within the courtyard for patients, visitors and staff - something I am sure you and the Board will be pleased to hear.

Engagement

- As a big part of the reasoning behind this change was food hygiene related the catering management team needed to have a plan in place which could discussed with the team
- The staff working within the area have taken this initial plan and run with it as they appreciate the benefits of the change for their wellbeing.

Finance

- Even though the takings have not increased as a result of the changes we needed to make, the profit margin from the new items introduced has increased to mitigate the changes.

19. Lead Governor report (enclosed)

To receive a report from the Lead Governor

For Reference

Presented by Liz Steele

REPORT TO:	Council of Governors
MEETING DATE:	6 August 2019
SUBJECT:	Report from Lead Governor
AGENDA ITEM:	19
PRESENTED BY:	Liz Steele, Lead Governor
FOR:	Information

The governors continue to undertake the tasks expected of them.

- The weekly Quality Walkabouts not only give governors the opportunity to visit different parts of the hospital but also to be a new set of eyes to see areas/issues that may be familiar to staff members.

- The area observations have been a very valuable activity for the Patient Experience team. We have covered several areas, some more than once. Please remember if you undertake one of these to take an iPad or puzzle book so that you do not attract attention to yourself. You can write notes rather than using a clip board and then when feeding back the action plan will be undertaken by the staff.

- Governors continue to attend the monthly board meetings and continue to ask questions related to the agenda and items within it. If for any reason issues are not included in the agenda that you wish assurance of then please email me as I have a monthly meeting with Sheila.

- The meeting with the NEDs is an excellent time to ask, off the agenda, questions to our representatives. They find this meeting very useful also.

- The informal Governors meeting prior to our meetings are well attended and produce a good cross section of questions that are then answered within our papers. If you are unable to attend, then please do send me your questions so that the governors can discuss and word them in the appropriate way.

- We are all asked to engage with the public and encourage membership. If you have opportunities to do this then you can always get application forms from George. We are trying to expand on the places we meet people but the Courtyard café is still our main focus for engagement.

- Some governors attended the Shining Light Awards. This was a very inspiring occasion with staff going the extra mile for their patients. Congratulations to all the winners but congratulations to all staff who continue to work so hard.

- The Five O'Clock club continues to be an inspiring insight into different subjects. Thank you to all those who manage to attend.

Thank you to all the Governors who continue to give such a lot of their time to carry out all our responsibilities

Liz Steele
Lead Governor

20. Staff Governors report (enclosed)

To receive a report from the Staff Governors

For Reference

Presented by Martin Wood

REPORT TO:	Council of Governors
MEETING DATE:	6 August 2019
SUBJECT:	Report from Staff Governors
AGENDA ITEM:	20
PRESENTED BY:	Martin Wood, Staff Governor
FOR:	Information

Issues raised by staff governors were reviewed at the recent quarterly staff governor meeting with Kate Read, Richard Jones and Georgina Holmes.

It was noted that Garry Sharp had resigned as a staff governor. Dr Vinod Shenoy, who was the next highest polling candidate at the staff governor elections in 2017, had been invited to join the Council of Governors

- The board meeting at the beginning of November would take place in Mildenhall. The plan was for at least two of the ten board meetings per year to take place in the community. The executive team were currently visiting teams in the community in order to maintain their visibility.

- The transportation of flu vaccines had been discussed by the Health & Safety Committee. Once a vaccine had been removed from the main fridge it could not be used after a number of hours, therefore it was important to establish the quantity required for any location on a certain date. The issue of who was able to transport vaccines (ie registered nurses) and who could administer the vaccine was being followed up.

- There appeared to be an issue around what nurses were now allowed to do in terms of their grade, regardless of their competency and the fact that they had been doing something for a number of years. It was confirmed that this was being followed up and a group was being set up to look at sign off for competencies.

- The previous situation that had occurred at the mandatory training day was being addressed and the organisers would be ensure that there was somewhere for people to have their lunch if they did not have time to go to Time Out.

  Feedback from the mandatory training days had been very positive as these were now specifically tailored for community staff. Induction days had also improved and were more relevant to community staff.

  The issue with new community staff not being given their ESR log-in in time was also being addressed and newly recruited staff were being encouraged to complete their mandatory training before they joined the Trust.

- Staff were now aware of the different support services available and where they could go if they had an problem or needed advice. It was agreed that it would be helpful if this was promoted on a regular basis, eg in the Green Sheet etc. The proposed schedule for this would be followed up.

- The Medical Staffing Committee was being reinstated. This was considered to be very positive as a number of consultants felt that they were not being consulted about changes that were being made. There were also issues in pathology with staff feeling that they were not being kept informed and that they were not seeing changes that they would like to see. It was explained that there was currently a consultation process around the pathology strategy for both the clinical structure and ownership model. The above comments would be fed back to the executive team to ensure that staff were engaged with if any major changes were planned.

- Two issues that were frustrating staff in the community were IT and estates. It was agreed that a further community IT newsletter needed to be produced and the schedule for the production of future updates confirmed.

21. Urgent items of any other business

To consider any matters which, in the opinion of the Chair, should be considered as a matter of urgency

For Reference

Presented by Sheila Childerhouse

22. Dates for meetings for 2019

Tuesday 17 September - Annual members meeting (Apex)

Wednesday 13 November

To note dates for 2020:

Tuesday 11 February

Wednesday 6 May

Tuesday 11 August

Tuesday 22 September - Annual members meeting (Apex)

Wednesday 11 November

For Reference

Presented by Sheila Childerhouse

23. Reflections on meeting

To consider whether the right balance has been achieved in terms of information received and questions for assurance and the Trust's values and behaviours observed

For Discussion

Presented by Sheila Childerhouse