West Suffolk NHS
NHS Foundation Trust

Board of Directors

A meeting of the Board of Directors will take place on Friday, **27 January 2017 at 9.15** in the Committee Room, at West Suffolk Hospital

Roger Quince
Chairman

Agenda (in Public)

9:15 GENERAL BUSINESS		
1.	**Apologies for absence** To note any apologies for the meeting.	Roger Quince
2.	**Questions from the Public relating to matters on the agenda** (verbal) To receive questions from members of the public of information or clarification relating only to matters on the agenda	Roger Quince
3.	**Review of agenda** To agree any alterations to the timing of the agenda	Roger Quince
4.	**Declaration of interests for items on the agenda** To note any declarations of interest for items on the agenda	Roger Quince
5.	**Minutes of the previous meeting (attached)** To approve the minutes of the meeting held on 25 November 2016	Roger Quince
6.	**Matters arising action sheet (attached)** To accept updates on actions not covered elsewhere on the agenda	Roger Quince
7.	**Chief Executive's report (attached)** To accept a report on current issues from the Chief Executive	Steve Dunn
9:35 DELIVER FOR TODAY		
8.	**Quality & Performance reports (attached)** To receive the report	Jon Green / Rowan Procter
9.	**Finance & Workforce Performance report (attached)** To accept the monthly Finance & Workforce report	Craig Black
10.	**Transformation report – Q3 (attached)** To receive a report	Jon Green
11.	**Community services report (attached)** To receive a report from the Provider Management Group	Jon Green
10:10 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP		
12.	**Aggregated quality report (attached)** To accept the aggregated analysis including serious incidents, red complaints and PALs enquiries	Rowan Procter / Nick Jenkins
13.	**Nurse staffing report (attached)** To accept a report on monthly nurse staffing levels	Rowan Procter

14.	**Staff car parking tariff (attached)** To receive the final arrangements	Jan Bloomfield
15.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Jan Bloomfield
10:30 BUILD A JOINED-UP FUTURE		
16.	**e-Care report (verbal update)** To receive an update on e-Care	Jon Green / Craig Black
10:40 GOVERNANCE		
17.	**Review of the Trust's constitution (attached)** To approve amendments to the Trust's constitution	Richard Jones
18.	**Trust Executive Group report (attached)** To receive a report of meetings held during the month	Steve Dunn
19.	**Council of Governors report (attached)** To receive a report of meeting held on 16 November	Roger Quince
20.	**Charitable Funds Committee report (attached)** To receive a report of meeting held on 25 November	Roger Quince
21.	**Register of interests report (attached)** To receive the updated register	Richard Jones
22.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:00 ITEMS FOR INFORMATION		
23.	**Any other business** To consider any matters which, in the opinion of the Chairman, should be considered as a matter of urgency	Roger Quince
24.	**Date of next meeting** To note that the next meeting will be held on Friday, 3 March 2017 at 9:15 am in the Committee Room.	Roger Quince
RESOLUTION TO MOVE TO CLOSED SESSION		
25.	The Trust Board is invited to adopt the following resolution: "That representatives of the press, and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1 (2), Public Bodies (Admission to Meetings) Act l960	Roger Quince

DRAFT

West Suffolk NHS
NHS Foundation Trust

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 25 NOVEMBER 2016

COMMITTEE MEMBERS			
		Attendance	**Apologies**
Roger Quince	Chairman	•	
John Benson	Non Executive Director	•	
Craig Black	Executive Director of Resources	•	
Jan Bloomfield	Executive Director Workforce & Communications	•	
Steve Dunn	Chief Executive	•	
Jon Green	Executive Chief Operating Officer	•	
Neville Hounsome	Non Executive Director	•	
Nick Jenkins	Executive Medical Director	•	
Gary Norgate	Non Executive Director	•	
Rowan Procter	Executive Chief Nurse	•	
Steven Turpie	Non Executive Director	•	
Rosie Varley	Non Executive Director	•	
In attendance			
Georgina Holmes	FT Office Manager *(minutes)*		
Richard Jones	Trust Secretary		

Action

GENERAL BUSINESS

16/221 APOLOGIES FOR ABSENCE

There were no apologies for absence.

16/222 QUESTIONS FROM THE PUBLIC

June Carpenter referred to waiting times for ENT and Oral surgery and the increase in waiting times for Ophthalmology. It was confirmed that this would be discussed under item 9, Quality & Performance report.

16/223 REVIEW OF AGENDA

The agenda was reviewed and the Chairman noted that sufficient time needed to be allowed for item 14, Car Parking strategy.

16/224 DECLARATION OF INTERESTS

There were no declarations of interest.

16/225 MINUTES OF THE MEETING HELD ON 28 OCTOBER 2016

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

Item 16/203, page 6, para 3 – correction to second sentence; “Good, accurate literature was available to show that stroke support was poor when people left hospital.”

16/226 MATTERS ARISING ACTION SHEET

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

Ref 1344 - research proposal for use of video in theatres – Gary Norgate asked that that a lay member should be included as part of the group involved in this project. It was agreed that this would be useful.

Nick Jenkins reported that further work had been undertaken since the last meeting and several organisations had been identified.in the US who had installed cameras in theatres.

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

Ref 1332 - provide a steer to the Board as to whether noise at night is something we can do something about – the Chairman noted that noise at night continued to be a problem. He said that it should not be assumed that this was all due to other patients or staff. People needed to be aware of environmental factors, eg squeaky doors that staff who worked within the area failed to notice. Rowan Procter explained that reasons for noise at night were being looked at it in more details.

16/227 CHIEF EXECUTIVE'S REPORT

The Chief Executive highlighted the following issues in his report:-

- Regrettably there had been a further never event during November. Fortunately the patient had not suffered any harm. An investigation would be undertaken and lessons learned would be fed back across the organisation.

- The organisation remained under pressure which continued to have a negative effect on the Trust's financial position.

- A flow action group had been set up, chaired by Nick Jenkins and attended by Jon Green and Rowan Procter as vice-chairs. The first meeting would be taking place today and relevant staff had been told that they must attend.

- Escalation beds were fully open across the hospital. This was particularly challenging and staff on the wards were working very hard and already feeling the pressure. It would not be possible to sustain this throughout the winter, therefore there was a need to look at working differently, ie focus on discharges 'home for lunch'.

- Sustainability & Transformation Plans (STP) across the NHS had been released. Major changes were now being proposed around hospitals in South Essex.

- The Chief Executive, Craig Black, Helen Beck, Dermot O'Riordan and Sarah Judge had attended the Cerner Health Conference in Kansas last week, together with staff from a number of other global digital exemplar sites. This underscored WSFT's decision to move to a Cerner system and the Trust now needed to fully exploit its benefits and functionality. However, ongoing challenges such as those being experienced by medical secretaries also needed to be addressed.

Neville Hounsome asked about the Single Oversight Framework. The Chief Executive explained that this was about Monitor and the TDA (Trust Development Authority), who had now combined to become NHS Improvement (NHSI), updating their framework and incorporating other regulators.

The issue around implementation was organisations being in the right band/category (1-4). WSFT had been put into category 2, therefore it needed to continue to report and sign off statements etc for submission. It was also very important to discuss financial challenges and be open and transparent with regulators.

Jon Green explained that if the Trust was in a lower category intervention would be mandated for significant concerns, eg A&E. However whilst it was in category 2 it was currently difficult to get external support.

Gary Norgate congratulated Nick Jenkins on his article in the Green Sheet on the importance of staff having their flu vaccination and the implications of not doing so. He asked if anything else could be done to increase numbers. Nick Jenkins explained that a number of other actions were being taken; Rowan Procter had send out an additional communication and staff were going around the organisation giving flu jabs. He would like to look at making this mandatory for next year, but was not sure if this was possible.

16/228 QUALITY PRESENTATION – NATIONAL HIP FRACTURE DATABASE 2016

Mr Sam Parsons, Orthopaedics Consultant, introduced himself and his colleagues in the Trauma & Orthopaedics team. He explained that they worked as a unit and a large part of their work was looking after elderly patients with hip fractures.

WSFT was the best performing hospital in the region and sixth best in the country for providing hip fracture care.

The National Hip Fracture Database (NHFD) had been set up to look at ways to improve management of fragility fractures. This involved a national clinical audit which aimed to collect data to help improve care for these patients. The results enabled organisations to compare themselves with others. It had also allowed the introduction of a Best Practice Tariff (BPT) which was worth £1300 per patient and included seven standards of care.

It was very important that patients received prompt surgery, ie within 36 hours. E-care had enabled WSFT to introduce a pathway for hip fractures and Sam Parsons explained the importance of receiving prompt treatment. The mortality rate of hip fracture patients was 7-8% and others suffered a loss of independence, which resulted in their requiring support from the social care system.

The care and treatment given to every patient was recorded and the team met at least fortnightly. RCAs were now being undertaken for every patient whose care did not meet best practice.

WSFT met 85.1% of BPT criteria, against a national average of 65.6% and an East of England average of 66%. Sam Parson stressed that it was not always possible to compare data as there was some query about the accuracy of data submitted by some organisations. The definition of mobilisation was also not defined across the system.

88.2% of WSFT patients received surgery on the day or day after admission. 96.2% of final discharge destinations were documented. It was explained that organisations were expected to follow patients for 120 days following discharge.

The Chairman asked how many hip fracture patients did not return to their own home. Sam Parsons explained that the national figure was one in four patients, but the outcome was better at WSFT.

Rowan Procter noted that the number of cases submitted looked inequitable compared to the size of organisations. It was explained that this could be due to a number of factors, ie some areas had a younger/fitter population.

Sam Parsons explained there was a proposed plan for post hospital care to be provided by WSFT rather than Social Services. However, this would be very difficult due to workload and resources etc; it highlighted the need for an integrated care organisation. John Benson agreed that this would be a great advantage but it would need to be part of the Accountable Care Organisation (ACO).

It was explained that this was already being done in the community in some areas, ie fragility clinics and looking at realistic rehabilitation goals when patients were discharged to their own home.

Nick Jenkins asked how WSFT could improve on its position as sixth best in the country. Jon Green explained that WSFT was in the process of discussions around an ACO and working with the community. He proposed that this should be included as part of this proposal and members of this team should also be included and look at developing a further pathway. Nick Jenkins confirmed that this had been discussed by the Shadow ACO Board this week.

J Green / N Jenkins

Sam Parsons explained that there was a multi-disciplinary team (MDT) meeting every week. This looked at the future care requirements of individual patients, in advance of their being ready to be discharged. The purpose was to ensure that they received appropriate equipment and care when leaving hospital.

Rowan Procter referred to the 60% of patients who were admitted to F3 within four hours. She asked if there was any data on outcomes of patients who were operated on earlier, and those who were not operated on within the required timescale. Sam Parsons explained that this often related to the co-morbidity of patients; however it was known that early surgery did give better results. He stressed that it was very important to operate on patients with co-morbidities as soon as possible for the best outcome.

Future risks to providing the best possible care and outcomes for these patients were theatre capacity, staffing on F3, safe discharge and out of hours physiotherapy cover. There was also an ageing population and a decreasing tariff. The future of the block contract and BPT was also a risk.

Sam Parsons considered that the BPT was a driver for quality improvement and patients receiving the best care. Craig Black agreed and explained that best care was often the cheapest care.

The Chairman assured Sam Parsons and his team that this was not about finance and that the Board would always give priority to patient care over money. A system approach was now being looked at which would be much better for patients but would also save money.

Sam Parsons suggested that one way to move improve performance was a real time countdown using e-Care. Craig Black said that this should be possible and he would follow this up.

Other proposals for improvement included weekend trauma lists, although there could be an issue where they conflicted with other specialties; longer trauma list times during the week, ie until 6.30pm; the reinstatement of the trauma assessment room on F3 and identifying the first patient for the next morning. It was explained that was already being done, but it could be a real challenge as patients were often admitted out of hours.

It was suggested that in order to avoid patients breaching the possibility of bypassing the Emergency Department, particularly during out of hours, should be looked into.

The Chairman proposed that Nick Jenkins should work with the team and consider how they could advance and improve performance and outcomes for patients even further.

DELIVER FOR TODAY

16/229 QUALITY & PERFORMANCE REPORT

Jon Green explained that it had not be possible to include information on paediatric SALT recovery as there had been problems with obtaining data. However, this was broadly in line with trajectory but there were still some issues with finance and there was only £50k currently available.

The diagnostic target was still not being achieved but there had been significant progress this month, particularly around ultrasound. This was now ahead of trajectory and should be back on target in November, which was a month ahead of plan.

All cancer targets had been achieved for the month; therefore last month was a one-off problem.

Referral to treatment (RTT) information was included in the report this month; however this was an estimate as accurate figures were still not available. Jon Green said that he was fairly confident about these figures. He explained that there had been problems for at least two years with oral surgery due to the high number of referrals and limited capacity. As a consequence the Trust had served notice that it we be withdrawing from oral surgery and would not be taking new referrals from 1 April 2017.

ENT was experiencing problems, as were most areas in the country. This was due to high activity, particularly major ear surgery. The Trust was currently running two waiting lists but would move to only electronic referral into ENT services, which would help with the management of this.

Performance in ophthalmology deviated and there was still an issue with e-Care, however Jon Green was confident that this on trajectory to recover.

Delivering the A&E target continued to be a challenge. The main reason was a flow issue through the organisation, rather than a process issue in the A&E department, which was a shift compared to earlier in the year. There were now delays in bed availability. Earlier in the month a ward had also been closed due to norovirus. This month (November) the Trust was where it planned to be in terms of the number of escalation beds that were open.

A&E performance at the beginning of this week had been very poor but had recovered. F7/F8 now needed to be used properly to enable effective flow through the organisation.

Rowan Procter referred to falls and pressure ulcers. Falls were being reviewed and any resulting in harm were escalated to the CCG. A more in depth analysis of pressure ulcers had been undertaken and these were no higher than last year. Grade three pressure ulcers were now being reported as serious incidents. There were fewer avoidable pressure ulcers than previously, which was an improvement.

Of the eight RCA actions overdue, six were due to be completed in October. Four of these were in maternity services and it was hoped that these would be closed in December. The three outstanding duty of candour had also been closed.

John Benson referred to the patient experience dashboard and noted the poor performance in outpatients on "where you informed of any delays in being seen?" and suggested that this needed to be kept an eye on. He welcomed the increase in people being offered a chaperone.

He also referred to the poor performance on completion of initial health assessments for children in care. Rowan Procter explained that there were significant issues with Social Care providing all the paperwork when a child went into care. She had asked Pam Chappell to put together an SLA with the local authority on the length of time to complete the paperwork in order to meet a child's needs. She also explained that 25% of capacity was lost due to DNAs and this had been discussed a yesterday's meeting. This was often due to the inability of carers to take children to assessments, or carers not complying with this requirement.

Jon Green said that he would provide more detail on issues that were not the fault of WSFT. **J Green**

Neville Hounsome referred to the recommended actions for incidents with investigation overdue. He asked if these were last month's actions and if they were now in place. It was confirmed that this was the case and they were now all in place.

He also asked about the A&E action plan that was presented to the Board three months ago and if there was anything outstanding from this plan which had not been delivered. Jon Green explained that the major outstanding element was building work around paediatrics; all other actions had been progressed.

Gary Norgate referred to A&E and special measures and was pleased that a flow action group had been set up. He asked at what point WSFT would trigger a request for special support. Jon Green explained that the Trust was currently in category 2 and special measures were initiated at the lower end of category 4. He had specifically asked for support from the Emergency Care Intensive Support Team (ECIST) and a representative would be attending the flow action meeting today. They would also be attending a specific event on 6 December.

WSFT was currently a fair way from receiving further support as this was based on national performance and the Trust was still in the top half.

The Chief Executive assured the Board that this was the organisation's biggest priority and it was pushing for central support.

The Chairman proposed that there should be a report/presentation in January on the progress of the flow action group. **N Jenkins**

Nick Jenkins stressed that this was not about the four hour emergency access target, but about flow through the organisation. The focus was now very different and was on patient flow, not issues within A&E. He said that the Trust had asked for and been given some support from the CCG; internal people had also been freed up to focus on this. ECIST would be helping and advising but were not able to come into the Trust on a regular basis due to workload.

Steve Turpie asked about pressure ulcers and referred to a 'back to the floor' on G5 that he had been on. Nurses on this ward had commented that they did not have enough nursing assistants to change patients, particularly in the morning and at lunchtime. He asked Rowan Procter if she was assured that there were enough staff to change patients and if this was one of the root causes of pressure ulcers. Rowan Procter explained that G5 was an escalation ward at the time he had done his 'back to the floor'. Part of the review/analysis of pressure ulcers looked at staffing as well as other factors.

16/230 FINANCE AND WORKFORCE REPORT

Craig Black reported that the overspend continued to be the same amount every month. In October the plan had changed to take account of the fact that for the last six months of the year the Trust needed to save £650k per month in order to achieve the stretch CIP and therefore the control total. This meant that this month WSFT was £850k off plan.

Spend on medical and nursing staff had increased in the month, in particular medical agency staff. A CIP was targeted at reducing these numbers but they remained persistent. The issues that had been referred to in the performance report were the main reason for this, ie medical agency staff in A&E and AMU, and agency nursing staff covering escalation capacity.

Nursing staff had not reduced in October as it was not known what the bed number would be and staffing decisions were made based on the fact that this could be high. Confidence needed to be gained within the organisation that it could manage to the projected bed number and staff accordingly. However, it was not expected that nursing staff would reduce significantly.

A consequence of the financial position would be cash and future decisions would need to be made about capital investment.

Craig Black confirmed that a message had gone out into the organisation about how critical it was to achieve financial targets. The presentation this morning had given him confidence that this was being taken seriously. It was important to ensure that change in clinical performance was focussed on, as this was what would alter the financial position.

Gary Norgate referred to the need for the organisation to gain the confidence to operate with fewer beds. He asked how this change of approach was being driven and if staff understood the need to change the way in which they worked. Rowan Procter explained that at each bed meeting there was a list of where there were vacant shifts. This was reviewed with ward staff to see if they could manage, and vacancies were not automatically filled with agency staff. A risk assessment was also undertaken as to whether a shift needed to be filled.

Jon Green explained that the need for agency staff was escalated to executive level and they were now only booked two days ahead, rather than for the week. However, the challenge was when there was a variation in the number of admissions. Gary Norgate said that he felt more assured as decisions were being made at executive level.

The Chief Executive said that the executive team had made sure that everyone understood that they could contribute and help and that this would be achieved through addressing patient flow.

16/231 COMMUNITY SERVICES REPORT

The Board noted the content of this report.

The Chairman reported that Community Services had made a good contribution to plans being developed around the ACO.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

16/232 AGGREGATED QUALITY REPORT

Rowan Procter highlighted the issues around pressure ulcers which had already been discussed.

16/233 NURSE STAFFING REPORT

Rowan Procter explained that this report was a result of working with finance and the quality team to look at where the issues were.

F3 was a very busy ward with a high mix of patients. She was working with F3 to look at recruiting more nursing assistants as there were a high number of nursing sensitive indicators.

Vacancies for registered and unregistered nurses were high and HR was looking at recruitment of these staff.

The Chairman asked for an introductory summary/narrative in this report, similar to other reports. Apart from this the Board considered this to be a great improvement with a good level of detail. **R Procter**

16/234 CAR PARKING STRATEGY

The Chairman explained that this had been discussed in a number of contexts. He stressed that the Board was being asked to approve a set of proposals and this is what they needed to focus on today.

Jan Bloomfield reminded everyone that car parking had been a challenge for many years, including issues around disabled access, capacity and the capital to enable investment in further spaces. Last year the decision was made to make a substantial investment to expand and improve car parking, which would result in an additional 400 spaces by the end of January 2017. The configuration of the car parks had also been looked at to try to address some of the issues that had been fed back. As a result further disabled spaces had been created in car park A with directions to the disabled access. Wheel chair assisted car parking had also been introduced.

Due to this investment, it was considered that it was important to look at the current tariffs, which had been not increased for the past three years. A great deal of time had been spent looking at tariffs and the final recommendations were detailed in the paper that had been submitted to the Board today.

A very positive meeting had taken place with patient groups on 10 December; their main concern was about capacity and access for disabled patients and visitors. This paper had taken account of these views.

An equality impact assessment had also been undertaken, particularly around blue badge holders. The outcome of this had been the need to treat everyone equally and there had been nothing about the ability of blue badge holders to be able to pay. Therefore, because of the concessions that WSFT offered, including the NHS travel scheme, it was felt that there was no reason to give concessions to blue badge holders. There had been three blue badge holders at the meeting with the patient group and they had had no issue around charges; their issues had been around access.

It was noted that there was already a 20 minutes free of charge allowance, which was particularly beneficial to people who were dropping off/waiting for patients or having a blood test. It was proposed to also introduce a one hour tariff.

The proposals had been talked through with the local Suffolk County Councillor, who also represented local residents. They had been very pleased with the investment in the additional capacity. Discussions had also been had with the local MP who recognised the reasons for this.

Rosie Varley thanked the executive team for this paper and acknowledged that this was a very controversial issue. She was broadly in favour with the direction of this review; however she said that it was important that it was recognised that WSFT was one of the most expensive hospitals in the country for parking.

She referred to the 20 minute free of charge allowance and proposed that this should be extended to 30 minutes, as it was not always possible to drop of people with mobility issues within 20 minutes. She also had reservations about charging people with disabilities, but accepted the proposal and the consultation that had taken place.

It was confirmed that dispensation was available for individuals with lower incomes from the General Office. It was agreed that this needed to be made clearer to people.

Rosie Varley thanked the Governors for insisting that signs were put up to say that money from car parking went back into the hospital.

Nick Jenkins said that a lot of money had been invested in car parking. If money for this investment was not coming back into the organisation through parking charges, it would come of out of patient care.

Steve Turpie asked if other options had been considered for additional spaces for blue badge holders and to make it easier for them to access the hospital. Jan Bloomfield agreed that the whole of the site needed to be looked at, ie Macmillan Unit. There were already spaces at the back and front of the site and she stressed that this was very much about improving access for disabled people.

Neville Hounsome said that if the charges were going to be high, the Trust must be able to provide spaces.

The Chief Executive explained that it had been difficult to come to the conclusion to charge blue badge holders; therefore he agreed that it was important to improve access for these people and this needed to be looked at further.

One of the issues regularly fed back had been the need for a one hour charge and this was being addressed in the proposal. However, he agreed with Nick Jenkins that it was important that car parking was not funded out of patient care. TEG had discussed this in detail and on Monday had come to a unified agreement about the proposals.

The Chairman proposed that the Board should accept the proposals, but the executive team should look at further improvements around disabled access and report back to the Board. **J Bloomfield / C Black**

The proposal to move from 20 minutes to 30 minutes free of charge was referred to. Craig Black explained that currently people were told that they had 20 minutes, although they were not actually charged until after 30 minutes. Jean Le Fleming explained that the additional 10 minutes was to allow time to get in and out of the site. She felt that this would be resolved by introducing a one hour charge.

Craig Black explained that if 30 minutes, was extended to 40 minutes, this would have a significant cost implication, ie equivalent to four nurses a year.

The Chairman suggested looking into this further, ie if more than 20 minutes was needed to drop off a disabled patient.

Nick Jenkins noted that this had been discussed with patient groups and other parties, and no one had said that 20 minutes was a problem. John Benson proposed leaving the current 20 minutes free of charge period but if it caused issues it should be reviewed further.

Jan Bloomfield confirmed that the new tariff would be implemented from 1 February 2017, in order to coincide with the new car parks. Craig Black questioned whether this should be from 1 January from a financial point of view.

Jan Bloomfield explained that staff charges were also being reviewed and requested that the Scrutiny Committee be delegated responsibility for of these. The Board agreed to this request.

The Board agreed to the revised tariffs proposed for patients and visitors, including blue badge holders, subject to a further review of improving disabled access.

16/235 CONSULTANT APPOINTMENT REPORT

The Board noted the following appointment:-

Dr Barka Sinha – Consultant in Obstetrics and Gynaecology

It was explained that his previous position at WSFT as a Hybrid Consultant included covering some of the responsibilities of a Registrar, ie at night.

16/236 PUTTING YOU FIRST AWARD

The Chief Executive read out a citation from a patient who had been involved in an accident. Rowan Procter had stopped at the scene to assist when she was on her way home from work and had then visited him whilst he was in hospital. The patient and his wife wished to thank her for going beyond the call of duty and had asked that she be recognised for this. The Board congratulated Rowan Procter and commended her for her actions.

Jan Bloomfield reported that the following team and individuals had received a Putting You First Award this month:-

A team from Trauma & Orthopaedics (AMU F8), Maxine Cook, Ian Proctor and Christine George, had provided adult colouring and puzzle books for patients and relatives waiting in ambulatory care.

This helped to distract people and keep their spirits up while waiting for tests and treatment.

Dr Andrew Stevens, FY1 doctor on ward F9, Following an increased incidence of *c.difficile* infection on F9, the ward was under additional scrutiny for a period of weeks, including the antibiotic prescribing practices of the ward doctors. Dr Stevens had developed a template to support his colleagues in their antibiotic reviews on ward rounds. This template had now been developed in to an e-Care auto-text for use across the organisation. This demonstrated junior doctor engagement with e-Care.

Becky Smith, a sister on Sister, ward G4 had been Nominated by Sharon Basson, senior matron. She was aware that one of her patients was distressed as they had learned that their beloved dog had become very unwell and was likely to have to be put to sleep. She found out what time the vet was due to be at the patient's home to attend the dog and she transported the patient home in her own car to say goodbye and hold his dog. She then returned the patient to G4.

The Board congratulated the above individuals for their innovation and commitment to patient care.

BUILD A JOINED UP FUTURE

16/237 e-CARE REPORT

The Chief Executive reported that he had attended the last Programme Board meeting. The issues being experienced by medical secretaries still needed to be resolved and people needed to start using the data that was now being generated by e-Care.

Some of the reporting issues had been sorted out but these needed to be refined further.

John Benson reported that at the recent Council of Governors meeting there had been a discussion about the issues around reporting. He asked if any progress was being seen in improving reporting and data quality issues. Craig Black confirmed that data quality was being worked on and was progressing. Eventually more data would be available before.

16/238 SUSTAINABILITY ANNUAL REPORT

The Chairman considered this to be a very positive report and asked Jan Bloomfield to pass his thanks back to those involved.

The Chief Executive noted the low emissions, despite the Trust's infrastructure.

GOVERNANCE

16/239 TRUST EXECUTIVE GROUP REPORT

The Board noted the content of this report.

16/240 AUDIT COMMITTEE REPORT

The Chairman noted the good work on internal and clinical audit and the helpful support that had been provided by others.

Steve Turpie reported that there had been an excellent presentation on TPP and noted the ongoing concerns around assurance on the operational quality of TPP. He said that it was important that these were addressed. Rowan Procter confirmed that progress was being made and the situation was improving. A follow up meeting was taking place on Tuesday, 29 November.

Nick Jenkins felt that currently quality did not appear to have improved. However, there was more engagement and intention to improve. There was a better process that might lead to this but the benefits were not yet being seen.

The Board approved the extension of the Standing Orders, Reservation & Delegation of Powers and Standing Financial Instructions Policy.

16/241 ANNUAL GOVERNANCE REVIEW

The Board approved the recommendations in this report:-

1. The proposal for the annual governance self-assessment approach to be administered through a questionnaire to directors

2. Begin the process to appoint an appropriate independent organisation to undertake the required well-led review, while engaging in the national consultation on development of the review requirements

3. In February 2017 the Board receives a report of the self-assessment and updates on appointment of an independent reviewer and national developments regarding the national well-led assessment framework

Richard Jones explained that members of the national group were meeting in December. He would send out the questionnaire following this meeting.

16/242 MEDICAL DIRECTOR RESPONSIBLE OFFICER APPOINTMENT

The Board approved the appointment of Dr Nicholas Jenkins, Medical Director, as Responsible Officer for the Trust in accordance with the Medical Profession (Responsible Officer) Amendment) Regulations 2013

16/243 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were noted.

The Chairman proposed that there should not be a presentation for the next few months and the Board should concentrate on business. If necessary there could be a very short presentation, eg A&E/patient flow, followed by a discussion. **R Jones**

ITEMS FOR INFORMATION

16/244 ANY OTHER BUSINESS

There was no further business.

16/245 DATE OF NEXT MEETING

The next meeting would take place on Friday 27 January 2017 at 9.15am in the Committee Room.

RESOLUTION TO MOVE TO CLOSED SESSION

16/246 RESOLUTION

The Trust Board agreed to adopt the following resolution:-

"That members of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" Section 1(2) Public Bodies (Admission to Meetings) Act 1960.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 27 January 2017

AGENDA ITEM:	Item 6
PRESENTED BY:	Roger Quince, Chairman
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	19 January 2017
SUBJECT:	Matters arising action sheet
PURPOSE:	Approval

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

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

Actions are RAG rating as follows:

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

Linked Strategic objective (link to website)	6. To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by: (e.g. committees or forums)	The Board received a monthly report of new, ongoing and closed actions.
Risk description: (including reference Risk Register and BAF if applicable)	Failure effectively implement action agreed by the Board
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Report provides audit trail between minutes and action points, with status tracking. Action not removed from action log until accepted as closed by the Board.
Legislation / Regulatory requirements:	
Other key issues:	

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

Ongoing actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1330	Open	30/9/16	Item 8	Confirm online audit system is live for staff	Testing complete and final system changes being made. Migration to live server has taken place and scheduled for go live by 1 February 2017.	RJ	03/03/2017	Green
1331	Open	30/9/16	Item 9	Provide Board with a stroke services option appraisal and sustainability report	Following discussion in October Board meeting it was agreed that this should consider the provision of care out of hospital. An initial review was considered by the executive team on 16 Nov. Based on this discussion a full option appraisal to be considered by the Board in Feb '17.	JG	03/03/2017	Green
1344	Open	28/10/16	Item 16	Based on report received regarding the use of video in theatre it was agreed to consider a research proposal in the area	**FOR APPROVAL** Board to consider proposal that the focus at this stage to mitigate the never event risk is through the development of effective human factors interventions. The internal audit programme for 2017/18 to include review of action/progress in this area with the medical director identified as the executive lead. Review of the audit finding (est. Q4) will assess progress and requirement for further mitigation.	NJ	27/01/2017	Green
1353	Open	25/11/16	Item 9	28 day pathway for looked after children - provide level of detail in the report to demonstrate performance when all relevant information is received from referring agency	Report being developed to include not only overall performance, but performance for when all relevant information for referral has been received. This will be included in future Board reports.	JG	27/01/2016	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1354	Open	25/11/16	Item 9	As presentation in January receive a report from the newly formed Flow Action Group (FLAG)	Scheduled for next meeting	NJ	03/03/2017	Green
1356	Open	25/11/16	Item 14	Report on the planned site reconfiguration for car parking, including provision for disabled parking	New car park on schedule to be completed on western boundary by 31.01.17 (extra 400 spaces). This will allow patient parking to be provided near the Macmillan Unit and in front of the Education Centre (approx.100 spaces) by 01.02.17. This will ease pressure on car park A at front of hospital and allow provision of dedicated blue badge bays in car park A (36) to be provided by 06.02.17.	JB/CB	03/03/2017	Green
1357	Open	25/11/16	Item 23	Review the use of presentations to the Board, with focus of issues relevant to Board priorities and agenda	**FOR APPROVAL** Following discussion with Chairman and executives it is proposed to re-establish the Q&RC with a specific remit of picking up quality and divisional presentation as well as receiving patient stories. The agenda format will mirror the Audit Committee with a concise section for routine business followed by 'deep dive/presentation'. The committee will retain its overview responsibility for the three subcommittees and aspects of quality - terms of reference to be agreed in March '17. The arrangement to be reviewed in a year.	RJ	27/01/2016	Green

Completed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1341	Open	28/10/16	Item 9	Through the e-Care Programme Board develop a system based performance report/dashboard. This will support direction of ACO development	Dashboard to support FLAG has been developed. This will be used as the basis for further development.	CB	27/01/2017	Complete
1352	Open	25/11/16	Item 8	Consider use of the fractured neck of femur pathway to support community/ACO integration (links with ED)	Agreed to form part of the clinical pathways which are under development as part of Alliance/ACO discussions.	NJ/JG	27/01/2017	Complete
1355	Open	25/11/16	Item 13	New nurse staffing report welcomed but to requested include introductory / summary narrative as part of the covering page.	**AGENDA ITEM**	RP	27/01/2017	Complete

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 27 January 2017

AGENDA ITEM:	Item 7
PRESENTED BY:	Steve Dunn, Chief Executive Officer
PREPARED BY:	Steve Dunn, Chief Executive Officer
DATE PREPARED:	20 January 2017
SUBJECT:	Chief Executive's Report
PURPOSE:	Information

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

The Christmas period and January has been difficult at the hospital with unprecedented pressure on our services. First of all I would like to **thank all staff for everything you have done** to pull together as a team and make sure we put patients first. Some of you have gone above and beyond, working overtime during anti-social hours and being willing to do whatever it takes to keep our hospital and patients safe. I know many of you are exhausted and mentally drained by the effort it has taken to get this far.

Go Green – why it's important for patients
Go **Green** this Winter is encouraging us to adapt and change the way we work in order to identify from within where unnecessary patient waiting occurs. We have launched it as a Trust wide campaign because we must do all we can to reduce patients' length of stay and improve processes for discharging them. Patient flow is one of our biggest challenges and when patients don't flow effectively through the hospital we have to manage it.

It is helpful at this stage, as we continue refining our early morning board rounds, identifying **red** and **green** actions for our patients and using the SAFER patient flow bundle as a set of simple rules to support an improvement in patient flow, to remind ourselves who this is ultimately for - our patients. We know unnecessary waiting causes harm to our patients and we recognise that our actions as we care for them must support their journey with us in a value added way. Our job is to make them all well enough to go home as quickly and safely as possible.

We must ensure that every day a patient is in hospital is a **green** day where actions are taken to actively manage and advance their care and treatment. We want to reduce our **red** days where nothing of value happens to the patient. Our goal is to make every day a **green** day for every patient. We are dealing with the needs of an elderly population, people come into our care because they need our support, but hospital is not always the best place to be. Indeed, if you had 1,000 days left to live, how many would you choose to spend in hospital?

The approach is all about creating and delivering expectation for our patients and our colleagues. **Red** to **green** aims to ensure that everyone, especially the person receiving care, knows what the next steps are and knows that the system of care is ensuring there is no waste of their, often precious, time.

When patients remain with us, what happens to them? Studies have found that:

- 10 days in hospital leads to the equivalent of 10 years ageing in the muscles of people over 80 and reconditioning takes twice as long as this de-conditioning
- One week of bed rest equates to 10% loss in strength, and for an older person who is at threshold strength for climbing the stairs at home, getting out of bed or even standing up from the toilet, a 10% loss of strength may make the difference between dependence and independence
- 48% of people over 85 die within one year of hospital admission

I am delighted to say that our commissioners have agreed to support an alliance of organisations in east and west Suffolk as the 'Most Capable Provider' of **community health services**. The decision means that we now have the opportunity to develop a model for providing these services by October 2017 when the current contract ends. I believe this approach is a positive development for staff and patients in west Suffolk because it aims to avoid another fully competitive tender process.

The East and West Suffolk Alliance includes Suffolk GP Federation, Norfolk and Suffolk NHS Foundation Trust, West Suffolk NHS Foundation Trust, The Ipswich Hospital NHS Trust and Suffolk County Council. It is intended that the alliances drive even closer integration of acute, primary care, social care, mental health and community services.

This month's **performance pack** not only reflects the pressure that are being felt through the hospital and the emergency flow in the run up to the Christmas period but also other operational pressures. As well as failing the A&E 4 hour standard the trust suffered a sharp deterioration in echocardiology 6 week performance that resulted in an overall failure of the diagnostic target after successful delivery in November. Additionally the draft 62 day cancer performance for December is indicating a fail after the November performance was confirmed at 84.7% against the 85% target. We are still facing issues with e-Care and our ability to accurately report data. We are working with Cerner to resolve the technical reporting issues and this will be underpinned by robust procedures to ensure accurate data capture.

The **month 9 financial position** is behind plan by £5.4m year to date which is largely due to increased expenditure on escalation capacity and our failure to achieve our stretch CIP of £2m YTD. Consequently we will only receive £2.9m of the £6.1m Sustainability and Transformation funding we had anticipated in 2016-17, and therefore £1.6m of this shortfall is reflected in the YTD position.

Action within the Trust to increase the number of discharges and make those discharges that do take place earlier in the day is key to delivering both the operational and financial plan. Our future sustainability is dependent on this action, as well as reducing the overall volume of activity, in line with STP plans. The Patient Flow Group, chaired by the medical director, continues to focus on defined workstreams to ensure timely assessment, review and discharge planning for patients in the hospital.

The year-end forecast will not be achieved without considerable remedial action. This will require the delivery of those schemes currently identified along with further initiatives to reduce expenditure. The risks around our I&E position could have a detrimental effect on our cash position. The Trust has in place financing arrangements which mean there is no urgent requirement for cash. However, the requirement to fund the deficit could result in the need to review and potentially reduce the future capital programme.

The challenging financial environment has underpinned our need to increase patient and staff parking charges, at a time when we have made a £2m investment to provide 400 additional car parking spaces on the hospital site.

Quarterly performance of the NHS provider sector was discussed at the NHS Improvement Board meeting on 24 November 2016:

- The Q2 net deficit for the sector is £648m, compared to £461m at Q1. This is £968m better than at Q2 2015/16 and £18m worse than at the same time of 2014/15.
- Including the £1.8 billion of sustainability and transformation funding (STF), the sector has forecast to end the year with a deficit of £669m, £89m worse than plan.

- Against forecast, the aggregate deficit at month six is marginally over plan by £22 million. The sector was £5m ahead of plan at Q1. 71 providers reported an adverse variance against plan at Q2. The overall net adverse variance was largely driven by:
    - Cost Improvement Plans that were £92m under forecast delivery
    - Bed days lost due to delayed transfers of care rising by 35% compared to Q2 last year
    - Agency costs exceeding plan by almost 16%
    - Adverse variance of £195 million for non-pay items. In particular, costs of drugs and clinical supplies significantly exceeded plan.

NHS Improvement and the Care Quality Commission (CQC) continue to align their approaches to overseeing providers and understanding where support is needed. As part of this work they are consulting on a new **use of resources assessment** and a new **well-led framework.**

CQC and NHS Improvement have agreed that NHS Improvement will undertake the use of resources assessment in line with an agreed methodology and propose a rating. NHS Improvement will carry out an assessment to determine how effectively providers are using their resources to deliver high quality, including safe, efficient and sustainable care for patients. It will do this by assessing how well they are meeting financial controls, how financially sustainable they are, and how efficiently they use their resources more broadly while still delivering high quality care to patients. NHS Improvement will use this assessment to inform its oversight of trusts.

As part of the further development and alignment of the respective oversight and regulatory regimes, CQC and NHS Improvement have been working on a new well-led framework for trusts, which builds on CQC's current well-led assessment and Monitor's previous well-led framework for governance reviews. The revised approach to well-led for trusts will bring together the existing aligned well-led framework published by CQC, the NHS Trust Development Authority and Monitor in 2015 into a common structure.

The **CQC is also consulting on a new model of inspection** - "Our *next phase of regulation. A more targeted, responsive and collaborative approach*". The changes aim to provide:

- More integrated approach (flexible and responsive to changes in care provision)
- Targeted approach (areas of greatest concern and where there have been improvements in quality
- Greater emphasis on leadership, including at the level of overall accountability for quality of care
- Closer working and alignment with NHS Improvement / other partners (therefore less duplication)

Key changes include:

- Reduction in the burden of on-site inspection:
    - at least one core area (unannounced)
    - 'Well-led' (announced)
- Provider information request not as detailed
- Some amendments / additions to the prompts within the key lines of enquiry
- Intelligent monitoring replaced with new Insight model
- Strengthened in year relationship management not just around inspection time
- Removal of some elements from definition of 'core services' (Diagnostic imaging and Gynaecology)
- Effective use of accreditation schemes

The document also identifies the need to keep the CQC apprised of any changes to organisational service provision such as changing models of care and complex providers through sustainability and transformation plans, devolution and the new care models programme. The timeframe for implementation of the revised assessment frameworks is April 2017.

Chief Executive blog
http://staff.wsha.local/Blog/Hospitalunderhighestlevelofpressure%e2%80%93messagefromSteveDunn,chiefexecutive.aspx

DELIVER FOR TODAY

Speedy fix for patients as Trust develops innovative trauma service
Patients attending West Suffolk NHS Foundation Trust with a trauma now benefit from rapid access to day surgery as part of an innovative service. The day surgery trauma list, a new concept in the UK, has been designed to improve the experience of patients who need to have surgery quickly, but who don't need to wait in a hospital bed while they are being scheduled for their operation. The service is helping to manage demand on emergency services, reduce costs, and improve patient experience. When patients attend the emergency department with a trauma and are assessed as needing low-risk surgery as soon as possible they are now scheduled into West Suffolk Hospital's day surgery unit instead of the main operating theatre. This means they can go home rather than wait for their surgery in a hospital bed and are discharged home again on the same day as they have their operation.

Healthcare options this festive season
With winter upon us local people are being reminded of the healthcare options available. Jon Green, chief operating officer at West Suffolk NHS Foundation Trust, said: "Emergency departments come under increasing pressure, particularly over the winter period. It's important that as far as possible we make sure that the people who visit the department really need to be there. There are other services that provide urgent advice and assistance and we are working to encourage local people to use these services when appropriate. Pharmacists, GPs and the 111 telephone service are all geared up to help people who need support, but whose condition is not serious and life-threatening."

Trust tackles mounting car parking issues at West Suffolk Hospital
West Suffolk NHS Foundation Trust has taken steps to address a number of issues with the availability of car parking at its West Suffolk Hospital site. It is due to open an additional 400 spaces at the hospital in early 2017 after making a £2 million investment in this and a range of improvement works.

After liaising with patient representatives, the Trust is amended the tariff for parking in the New Year to make a modest contribution towards the investment that has been made. It is also addressing a regular complaint from patients that short-stay visits are charged at an excessively high rate by introducing a new tariff for a one hour stay. Additional spaces for disabled drivers who carry a Blue Badge are being created, along with specially-designated wheelchair-supported access spaces that provide better access for those unable to walk.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

West Suffolk top in the east of England for hip fracture care
The National Hip Fracture Database rates West Suffolk NHS Foundation Trust (WSFT) as top in the east of England for the care patients receive when attending with a hip fracture, and sixth nationally, up three places from last year. Hip fracture is the most common serious injury in older people, often resulting in lengthy hospital stays with only a minority of patients regaining their previous abilities and often needing long-term care. An integrated staff team, including specialists from the emergency department, orthopaedics, elderly medicine and physiotherapy, work hard to deliver against best clinical practice guidelines. The team has introduced regular virtual fracture clinics at West Suffolk Hospital, a key part of the care given to patients attending with musculoskeletal injuries, where they assess patient needs together to identify immediate care needs and ensure they see the right specialist at the earliest opportunity.

WSFT achieved 85.1% in the best practice tariff, the highest in the east region, against a national average of 65.6%. Records show that:

- 100% of patients received a bone health assessment (national average 97.2%)
- 88.2% of patients had surgery on the day of, or day after, admission (national average 71.5%)
- 80.2% of patients were mobilised out of bed on the day after surgery (national average 76.1%)
- The average overall length of stay in days was 17 (national average 21.1 days)

Group exercise fun for children with disabilities
An innovative sports health partnership, piloted to offer children with disabilities the chance to exercise together and socialise, has been so successful there are calls for further exercise classes to be established. The partnership, between the children's community physiotherapy team from Suffolk Community Healthcare, Abbeycroft Leisure and Ipswich Borough Council, was developed to bring together the knowledge and expertise of local physiotherapists with the enthusiasm and skill of sports centre staff. Instead of children having to do their exercises on their own in a clinical setting, they have been able to use gym facilities alongside their peers, guided by both physiotherapists and gym staff collaboratively. The piloted sessions were based around strengthening exercises in the gym for children living with developmental conditions such as cerebral palsy, or for those recovering from effects of brain surgery. Exercise and physical therapy is such an important aspect of the rehabilitation of these children with the goal being to maximise control of the body; build strength and improve balance; increase flexibility and, ultimately, independence.

Improved diabetes care in West Suffolk
Partnership working between healthcare professionals has delivered significant improvements to Type 2 diabetes care in west Suffolk. New figures show that more patients than ever before are getting the support they need to control their blood pressure, blood sugar and cholesterol levels. These are the three key indicators measured by the national NHS Quality and Outcomes Framework to identify local levels of diabetes care.

The improvement follows the introduction of a community diabetes service, which sees specialist hospital diabetes nurses working alongside general practice nurses in 19 west Suffolk GP practices to provide enhanced diabetes care to patients closer to home. The service, commissioned by NHS West Suffolk Clinical Commissioning Group (WSCCG), is delivered in partnership with West Suffolk NHS Foundation Trust. The west Suffolk area is now ranked at 81 out of 209 CCGs for diabetes care, with 61% of patients receiving the support they need, a figure which is now higher than the national average of 60%.

BUILD A JOINED-UP FUTURE

Christmas was business as usual for Suffolk healthcare workers
The Early Intervention Team at West Suffolk NHS Foundation Trust worked throughout Christmas to help keep patients at home with their friends and families throughout the west of Suffolk. A multidisciplinary team of support workers, occupational therapists, physiotherapists, nurses and social workers all play a role in assessing and caring for patients in their homes, helping them to maintain their independence rather than come into hospital when it is unnecessary. Hosted by the Trust, this service is delivered in partnership with Suffolk Community Healthcare, Suffolk County Council, Age UK Suffolk, and Suffolk Family Carers. For the first time this year, occupational therapists and physiotherapists in the Early Intervention Team worked throughout Christmas Day to ensure patient care is not interrupted over the holiday season.

NATIONAL NEWS

DELIVER FOR TODAY

The challenge and potential of whole system flow
Improving the flow of patients, service users, information and resources within and between health and social care organisations can have a crucial role to play in coordinating care around the needs of patients and service users, and driving up service quality and productivity. This report outlines an organising framework and tested methods that local health and social care leaders can use to improve whole system flow. It draws on case studies and other examples of work in this area from across the UK and internationally.

State of the NHS Provider sector
NHS Providers has produced, for the first time, a view of how the sector is performing, identifying the challenges it faces and the successes we should be celebrating while also setting out what more

support is needed. This is intended to be a regular publication. (NHS Providers, November 2016)

The frontline battle: an inquiry into the impact of alcohol on emergency services

The report reveals the full extent of the pressures and dangers that alcohol related problems place on emergency services. It discusses the impact on staff, the impact on service provisions and the effect on time and resources. It makes recommendations to reduce the demand on emergency services including greater partnership working, price limits on alcohol and greater public education on alcohol harm.

Individual care plans reduce falls and broken hips in New Zealand hospitals

New Zealand is believed to be the first country in the world to achieve a national reduction in the number of in-hospital falls that result in a broken hip, a paper published in the *New Zealand Medical Journal* shows. (BMJ, 2016;355:i6490, December 2016) Note: You will need your Athens ID to access the full article at https://www.ncbi.nlm.nih.gov/pubmed/27906924

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

Helping parents spot the signs of sepsis

The UK Sepsis Trust estimates that there are more than 120,000 cases of sepsis and around 37,000 deaths each year in England. A nationwide campaign, launched by Health Secretary Jeremy Hunt, will help parents spot the symptoms of sepsis to protect young children and save lives.

The digital patient: transforming primary care?

This report argues that digital technology for patients and staff in primary care holds great potential for the NHS but that the impact of this new digital capability is far from certain. It reviews the evidence on digital technology and its impact on patients and finds that patient-facing technology is already showing promise, particularly for people with long-term conditions. The report warns that policy-makers and politicians should avoid assuming that self-care enabling technology will produce significant savings, at least in the short term. (Nuffield Trust, November 2016)

Multimorbidity – the biggest clinical challenge facing the NHS?

Around one in four of us have two or more long-term conditions (LTCs), often known as 'multimorbidity' and this rises to two thirds of people aged 65 years or over. In this joint blog, Dawn Moody and David Bramley argue multimorbidity is therefore becoming the norm. They take a look at the adverse impact this can have upon individual quality of life and examine its association with higher mortality, adverse drug events and greater use unplanned care.

A seat at the table: the views of people living with HIV

The King's Fund is committed to listening to people with lived experience of our health care system. We have been reviewing HIV services in England to develop policy and planning recommendations for the next 5 to 10 years. It is common practice for our reviews to involve a broad range of stakeholders. It is less common – but no less important – for us to directly involve people with lived experiences in the design of our research and in influencing how services may need to change. This article asks three people living with HIV why the experiences of patients should be used to develop policy and planning recommendations.

BUILD A JOINED-UP FUTURE

Use of electronic cigarettes in pregnancy

A guide for midwives and other healthcare professionals.

E-cigarettes in pregnancy infographic

Changes in the behaviour and health of 40 to 60 year olds

These reports, produced by Public Health England, present the results of analysis of health-related questions on obesity, smoking, drinking and general health conditions from the Health Survey for England. The reports show how the behaviour and health of people aged between 40 and 60 has changed over the past 20 years.

No one should have no one: working to end loneliness amongst older people
This report warns that loneliness leads to an increased demand on health services, partly because isolated people are more likely to develop health conditions, such as heart problems, depression and dementia. The report also outlines the early findings of a pilot programme that takes a community-based approach to tackling loneliness

Beyond Brexit: Assessing key risks to the nursing workforce in England
This analysis considers how two key factors, Brexit and population growth, could impact the NHS. See page 11for a graphical illustration of where WSFT sits in relation to all other trusts in England.

Swimming Together or Sinking Alone: health care and the art of systems leadership
A report from the Institute of Healthcare Management based on revealing interviews with senior leaders in health and local government on what is really happening as managers grapple with the Sustainability and Transformation Plan (STP) process.

Realising the value: ten actions to put people and communities at the heart of health and wellbeing
This is the final report of the *Realising the value* programme, an 18-month programme funded by NHS England in support of the NHS Five Year Forward View vision to develop a new relationship with people and communities. The report sets out ten key actions on what should be done and how people need to work differently to put people and communities at the heart of health and wellbeing.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – January 2017

AGENDA ITEM:	Item 8
PRESENTED BY:	JON GREEN, CHIEF OPERATING OFFICER AND ROWAN PROCTER, EXECUTIVE CHIEF NURSE
PREPARED BY:	JON GREEN, CHIEF OPERATING OFFICER AND ROWAN PROCTER, EXECUTIVE CHIEF NURSE
DATE PREPARED:	18 JANUARY 2017
SUBJECT:	TRUST QUALITY & PERFORMANCE REPORT
PURPOSE:	TO UPDATE THE BOARD ON CURRENT QUALITY ISSUES AND CURRENT PERFORMANCE AGAINST TARGETS

EXECUTIVE SUMMARY:

This commentary provides an overview of key issues during the month and highlights where performance fell short of the target values as well as areas of improvement and noticeable good performance.

- This month the Trust had 2 C diff (3 in November) - however we have had 8 cases quarter to date against a threshold of 4 and have already failed the year threshold of 16 with 21 instances. Falls for the month were 65 (62 in December) and 14 pressure ulcers (19 in December) - pages 6, 7 & 8.
- Looked after Children performance is 14.29% against a 100% target with one out of 7 initial health assessments completed within 28 days. However, 100% achieved for an appointment offered within 28 days of all paperwork being received - page 34
- RCA actions overdue are 15 - page 11.
- Duty of Candour cases outstanding are 3 - page 11

This month's performance pack continues to reflect the challenges of e-Care implementation between systems. The Trust has been in regular contact with both the CCG and NHSI over our reporting status.

- The Trust reported A&E performance of 86.50% for December; an improvement on November but still well below the national target. The Flow Action Group continues to work across all wards in the support of the overall system A&E plan - page 22.
- Stroke performance achieved all targets with the exception of patients spending 90% of their time on a Stroke Unit - page 26.
- The Cancer target for 62-day wait for first treatment has a draft performance of 83.84% against the 85% target, but remains on target to achieve the quarter - page 23.
- The 6 week diagnostic target was missed with 94.83% against a 99% target; this was a result of a rapid and sharp deterioration in Cardiac diagnostic performance - page 27.
- The Trust had no 52-week breaches of the 18 week target and achieved all other access and Cancer targets - page 22.

Linked Strategic objective (link to website)	
Issue previously considered by: (e.g. committees or forums)	

Risk description: (including reference Risk Register and BAF if applicable)	
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	
Legislation / Regulatory requirements:	
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	

Recommendation:

The Board is asked to note the Trust Quality & Performance Report and agree the implementation of actions as outlined.

1. CLINICAL QUALITY

This section identifies those areas that are breaching or at risk of breaching the Clinical Quality Indicators, with the main reasons and mitigating actions.

Patient Safety Dashboard

Indicator	Target	Red	Amber	Green	Oct	Nov	Dec
HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	100	100	100
HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	100	86	100
HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	100	100	100
HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	93	96	99
HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100	100	100	95
HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100	100	87	100
HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	100	100	100
HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	90	85	93
HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<85	85-99	= 100	100	100	100
Total no of MRSA bacteraemias: Hospital	= 0 per yr	> 0	No Target	= 0	0	0	0
Total no of MRSA bacteraemias: Community acquired (Trust level only)	No Target	No Target	No Target	No Target	1	0	0
Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	NA	NA	89
MRSA decolonisation (treatment and post screening) (Trust Level only)	= 90%	<80	80-94	95-100	92	95	96
MRSA Elective screening (Trust level only)	= 100%	<80	80-99	= 100	ND	ND	ND
MRSA Emergency screening (Trust level only)	= 100%	<80	80-99	= 100	ND	ND	ND
Hand hygiene compliance	= 95%	<85	85-99	= 100	100	99	100
Total no of MSSA bacteraemias: Hospital	No Target	No Target	No Target	No Target	0	1	0
Quarterly Standard principle compliance	90%	<80	80-90%	90-100	NA	NA	93
Total no of C. diff infections: Hospital	= 16 per yr	No Target	No Target	No Target	3	3	2
Total no of C.diff infections: Community acquired (Trust Level only)	No Target	No Target	No Target	No Target	2	4	0
Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	NA	NA	92
Total no of E Coli (Trust level only)	No Target	No Target	No Target	No Target	15	16	
Isolation data (Trust level only)	= 95%	<85	85-94	95-100	92	95	93
Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	NA	NA	93
Quarterly VIP score documentation	= 90%	<80	80-89	90-100	NA	NA	83
MEWS documentation and escalation compliance	= 100%	<80	80-99	= 100	ND	ND	ND
PEWS documentation and escalation compliance	= 100%	<80	80-99	= 100	100	100	100
No of patient falls	= 48	>=48	No Target	<48	67	62	65
Falls per 1,000 bed days (Trust and Divisional levels only)	= 5.6	>5.8	5.6-5.8	<5.6	ND	ND	ND
No of patient falls resulting in harm	No Target	No Target	No Target	No Target	19	18	19
No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	ND	0	ND
Falls with moderate/severe harm/death per 1000 bed days (Trust and Divisional levels only)	= <0.19	>0.19	No Target	= <0.19	ND	ND	ND
No of patients with ward acquired pressure ulcers	< 5	>=5	No Target	<5	24	22	14
No of patients with avoidable ward acquired pressure ulcers	= 0	>0	No Target	= 0	7	ND	ND
Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	80.77	83.87	83.44
No of SIRIs	No Target	No Target	No Target	No Target	9	11	11
No of medication errors	No Target	No Target	No Target	No Target	68	47	57
Cardiac arrests	No Target	No Target	No Target	No Target	5	6	7
Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	0	0	1
Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	71	NA	NA
VTE: Completed risk assessment (monthly Unify audit)	> 98%	< 98	No Target	> 98	ND	ND	ND
Quarterly VTE: Prophylaxis compliance	= 100%	<95	95-99	= 100	NA	NA	87
Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	97.53	98.03	98.73
RCA Actions beyond deadline for completion	0	>=10	5 - 9	0 - 4	8	11	15
% of 'Green' PSI incidents investigated	TBC	TBC	TBC	TBC	62	59	60
Median NRLS upload	26days	>48	27-47	0-26	52	ND	ND
SIRIs reported > 2 working days from identification as red	0	>1	1	0	1	0	0
SIRI final reports due in month submitted beyond 60 working days	0	>1	1	0	0	0	0
Number of SIRI reports open on STEIS more than 60 days after initial notification – Total	No Target	No Target	No Target	No Target	0	0	0
Number of SIRI reports open on STEIS more than 60 days after initial notification– Sitting with WSFT (excludes 'stop the clock')	0	>6	4-6	0-3	0	0	0
Active risk assessments in date	100%	<75%	75 – 94%	>=95%	100	100	100

Indicator	Target	Red	Amber	Green	Oct	Nov	Dec
Outstanding actions in date for Red / Amber entries on Datix risk register	100%	<75%	75 – 94%	>=95%	100	100	100
Non-compliance with Duty of Candour requirements	0	>3	1 - 3	0	1	1	1

Exception reporting for indicators in the Patient Safety Dashboard

All indicators in the Patient Safety dashboard which are red, amber for two consecutive months or are an amber quarterly indicator will have narrative below.

Data notes:

Please note December audit data for *MEWS* is incomplete.

In addition data items *Falls per 1000 Beds days Falls with moderate/severe harm/death per 1000 bed days*, *VTE: Completed risk assessment* and *Gynaecology (F14) 30-day readmissions* have not been possible to collate due to the transfer over to e-Care. The Information team are exploring ways to ensure this data is provided for future months.

Data items *Elective MRSA screening* and *MRSA Emergency Screening* information currently cannot be supplied following the implementation of Clinisys laboratory system. (Until Nov15 elective screening had been above 98%). We are awaiting an update from tPP on their development of a replacement search function. This acknowledged risk was upgraded to 'red' on the risk register in February, the meeting to assess the risk held in accordance with policy, has re-graded it as Amber, but at the top of the scale with controls in place. Ongoing review of the risk and progress towards a solution continue; testing of the proposed solution has not so far proved successful

There are a number of indicators for F3 which are red and amber RAG rated, F3 has experienced high levels of sickness and vacancy during the past few months however, vacancies are being managed and staffing numbers are due to increase over the next few weeks and months.

1.1 HII compliance 2b: Peripheral cannula ongoing

a) Current Position

A score of 99 in December was higher than November (96) and was amber RAG rated for the sixth month in a row. This was based on 6 episodes of non-compliance; where there were two episodes of no documentation of VIP score on G4, and one on F4, and one episode of no ongoing indication for the cannula on F4.

b) Recommended action

Continued support from ward manager and matron to ensure that all staff are aware of VIP checks to include continuing indication for the cannula and the age of the equipment. Matrons are checking weekly to ensure an improvement on compliance.

1.2 HII compliance 6b: Urinary catheter on-going care

a) Current Position

A score of 93 in December was higher than November (85) and was amber RAG rated for the sixth month in a row. This was based on 5 episodes of non-compliance; where there were two episodes of no documentation of care on G5, one each on G4 and G9 and one episode of no continued indication for the catheter on F12

b) Recommended action

Continued support from Ecare team and matron team to ensure staff are aware of how to record care given on eCare. Matrons will be checking weekly to ensure an improvement on compliance.

1.3 Quarterly MRSA (including admission and length of stay screens)

a) Current Position

This quarter compliance has risen slightly from 91% to 93%. Common non-compliance issues include: equipment that has been decontaminated is not being labelled with a green 'I am clean' label, boxes of equipment/IV fluids stored on floor in store rooms, sharps bins do not have the temporary closure mechanism applied when not in use and hand gels missing from the end of patient beds

b) Recommended action

The quarterly audit results are sent out to all clinical areas and disseminated to ensure staff are aware of this & change practice to improve compliance.

1.4 Quarterly Antibiotic Audit

a) Current Position

In Quarter Three, the Trust overall achieved 92% compliance against a target of 98%, down from 93% in Quarter Two. The audit nurses have provided education about how to update the review dates to junior doctors on all wards this quarter, however compliance with this remains poor. A report is now provided to all wards on a daily basis with details of all patients on antibiotics with their review dates highlighted, to help improve practice with this important aspect of antimicrobial prescribing.

b) Recommended action

Actions in place to achieve best prescribing practice include:

- Antibiotic Audit Nurses document in patients notes where non-compliance with any of the standards are identified. Where able, Audit Nurse will contact prescribers to discuss issues with prescribing, particularly when the antibiotic prescribed is outside of Trust guidelines.
- An individual prescriber feedback form has been developed and will be issued to prescribers where issues of non-compliance are identified, however IPTI continue to speak directly to prescribers and provide face-to-face education where able.
- The ward consultants, ward managers and matrons receive their antibiotic report specifying their compliances and non-compliances in a timely manner post audit.
- The mobile phone application ‘Microguide’, continues to receive good response.
- An educational programme based upon the Department of Health and Public Health England’s Antimicrobial Prescribing and Stewardship Competencies was launched in August 2015 with the junior doctors. This programme is mandatory for all junior doctors to support them with antimicrobial prescribing.
- The nurse mandatory session has been updated to include more information relating to antimicrobial stewardship.
- The weekly Microbiology ward round continues on F7, with great feedback from the ward doctors.
- World Antibiotic Awareness Week activities took place again this year from 14th – 18th November to raise awareness of antibiotic management within the Trust.

1.5 Quarterly VIP score documentation

a) Current Position

VIP score compliance results have continued to increase, rising from 81% in quarter two to 83% this quarter, which is back to the last pre- e-Care result. However this still remains below target. The Audit Team continue to provide ad-hoc training to ward staff on how to complete cannula insertions and document VIP scores on e-Care, and have offered more formal training as required.

b) Recommended action

The quarterly audit results are sent out to all clinical areas and disseminated to ensure staff are aware of this & change practice to improve compliance. In particular staff are directed to be aware that when inserting a cannula that it is appropriately documented on e-Care. When a patient is transferred to the ward, staff should check that if they have a cannula in-situ that the insertion has been recorded and ensure that VIP scores are documented daily.

A number of wards have introduced a daily ‘VIP round’ to ensure that the recording of VIP scores becomes an established part of practice on the ward.

1.6 Nutrition: Assessment and monitoring

a) Current Position

A score of 83.44 in December was lower than November (83.87) failures on ward F7, G9, F10, G8, F3, G1 and F14 were mainly - not weighed on admission x 14, reweighed at 7 days x 2, no nutritional screen on admission x 13.

b) Recommended action

Matrons are redesigning the audit form which currently does not reflect the documentation now on e-Care, it is hoped that this will better reflect the recorded data

We continue to raise awareness of importance of these parameters and will revisit at the next ward managers' meetings in February.

1.7 Quarterly VTE: Prophylaxis compliance

a) Current Position

A score of 87 for Q3 is lower than Q2 (95). There has been a decline in VTE assessment on admission and re-assessment within 24 hours across all divisions. Medical and Women & Children Divisions report improvement in all other aspects of VTE prophylaxis, whereas Surgical Division reports a decrease leading to a dramatic decline in the percentage of high risk patients receiving the required prophylaxis.

b) Recommended action

Results discussed in Surgical Governance Steering Group and consultant reports that some junior doctors incorrectly recorded that patients were not wearing anti-embolic stockings when they were removed for bathing (an agreed exception), which may have contributed to low compliance with high risk patients receiving the required prophylaxis. A re-audit is planned for the Surgical Division.

1.8 Total no of C. difficile infections: Hospital

a) Current Position

Performance against trajectory is as follows:

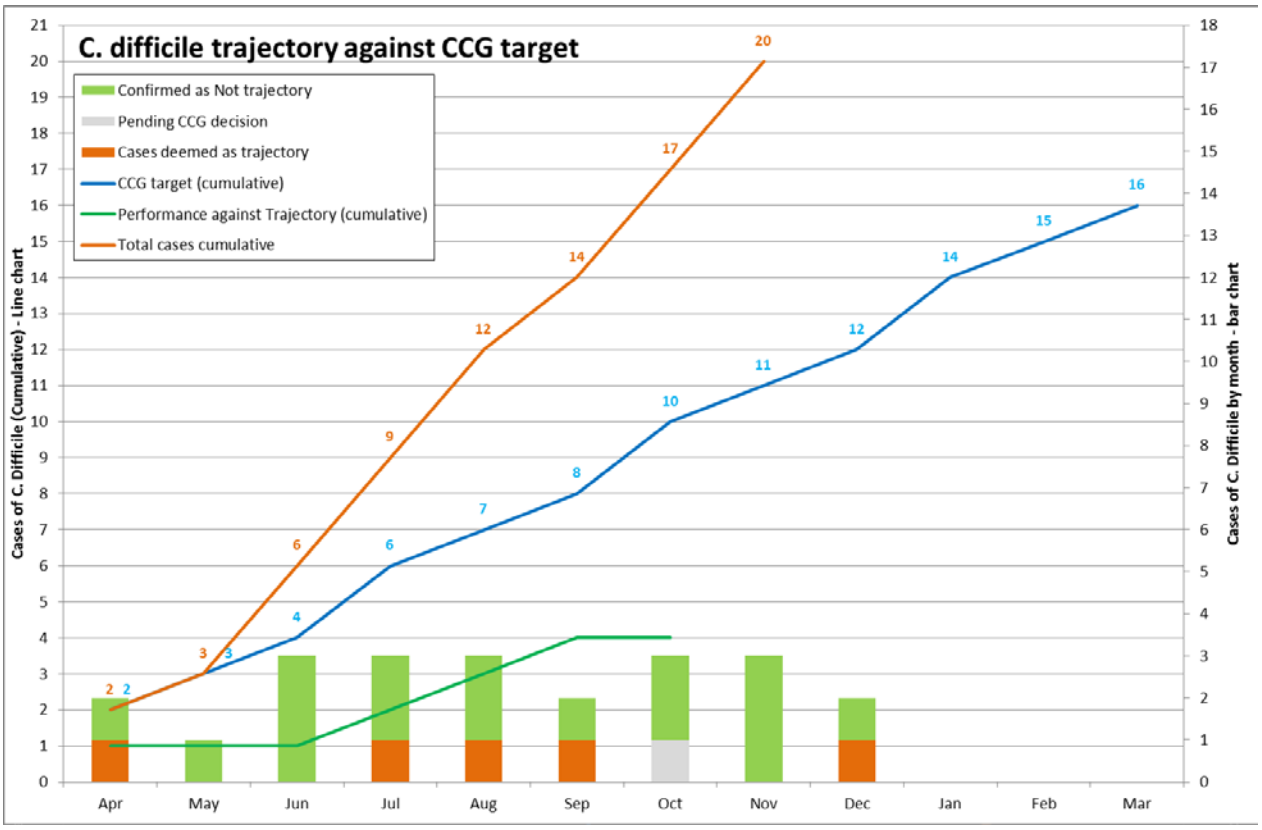
There were two cases of Hospital attributable CDT in December which occurred on wards F3 and G1 (although this G1 case reflects relapse from the original infection in October 2016). Both incidences have been agreed as Non trajectory.

At the end of December the Trust had reported a total of 22 reported cases against a final total of no more than 16 trajectory cases for 2016-2017. Of the 22 cases; 16 have been deemed non trajectory by our commissioners (no lapses of care) whereby they will not accrue a penalty, there are five trajectory cases (with 1 of those cases submitted for appeal and reconsideration to our commissioners) and the remainder are awaited.

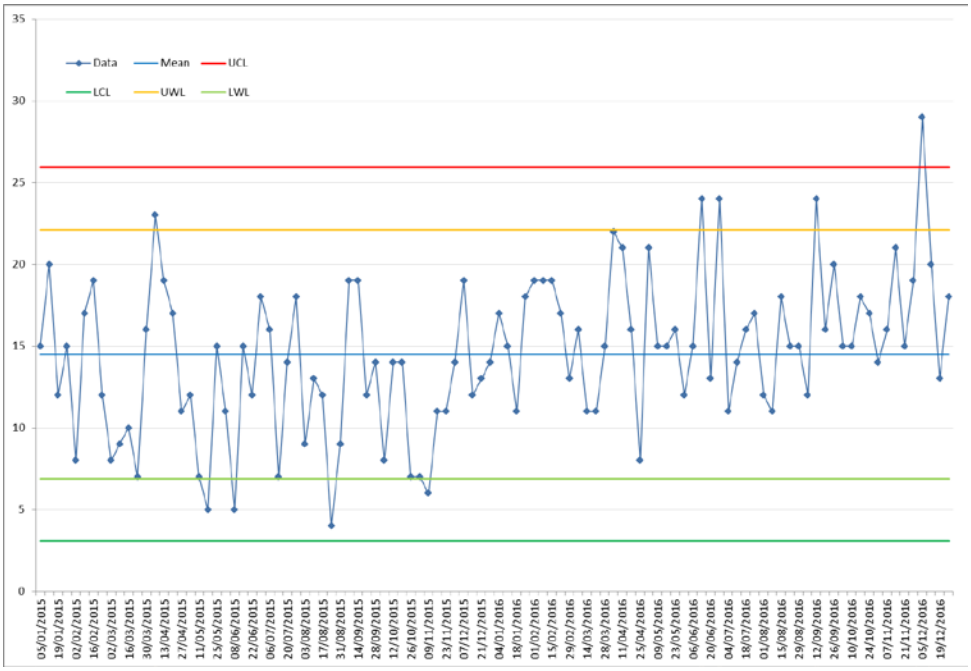
The graph below has been updated to demonstrate the Trust performance against the trajectory target set by the CCG.

b) Recommended Action

To continue with vigilance to identify symptoms of C difficile for early identification and testing.



1.9 No of Patient Falls & No of Patient Falls Resulting In Harm or Serious Injury



The SPC chart above shows a data point above the Upper confidence limit for the w/c 5th December. This related to 29 incidents and included one patient who fell four times and one who fell three times in that week.

There were 65 falls in December (62 in November), none with major harm, 3 patients were assisted to the floor (3 in November) preventing them from falling.

Data items: Falls per 1000 beds days and falls with moderate/severe harm/death per 1000 bed days have not been possible to collate due to the transfer over to e-Care. The Information team are exploring ways to ensure this data is provided in the future

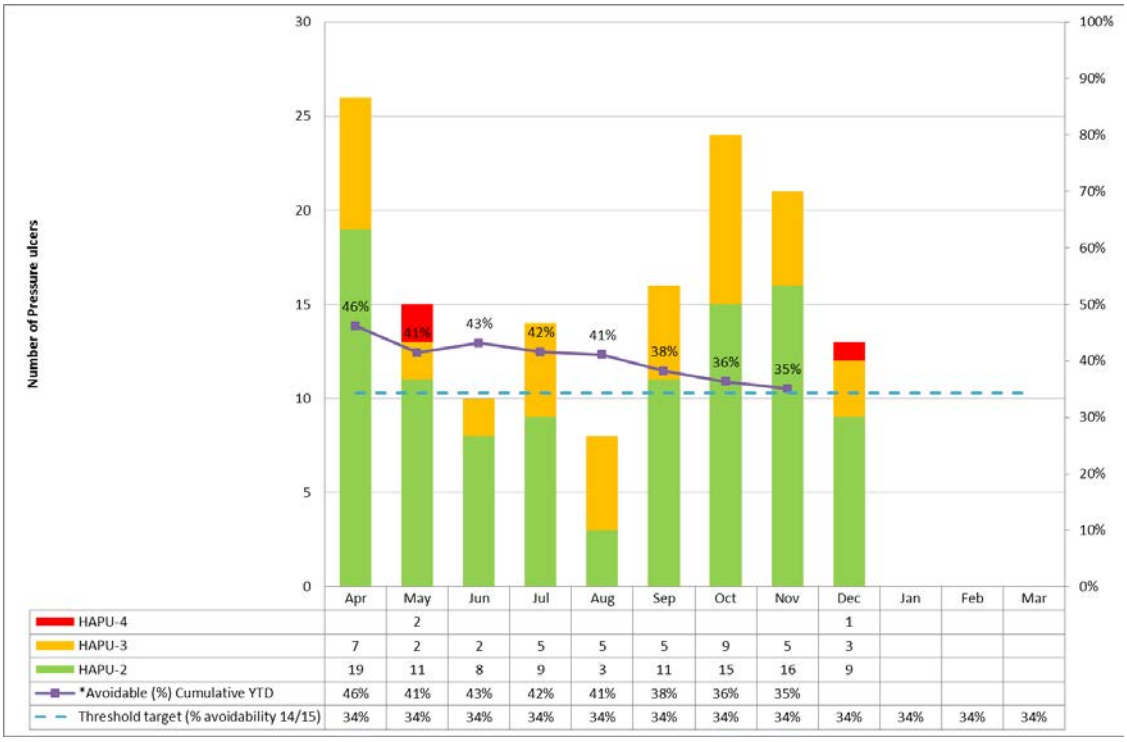
Patients who fell more than twice in the last three months at their usual place of residence and prior to admission have not been possible to collate due to the transfer over to e-Care. The Information Team are exploring ways to ensure this data is provided for future months.

In April we reported 64 falls which was 5.06 falls per 1000 beds day, if we are to assume similar numbers of bed days this month our overall number of falls per thousand bed days will have reduced.

Three patients fell more than twice in their inpatient stay this month, two in November.

Seven patients fell at Newmarket Hospital (3 in November), 12 patients fell at Glastonbury Court including one patient who sustained a fractured neck of femur, these falls are reported separately.

1.10 No of Patient with Ward Acquired Grade 2/3/4 Pressure Ulcers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
HAPU-4		2							1			
HAPU-3	7	2	2	5	5	5	9	5	3			
HAPU-2	19	11	8	9	3	11	15	16	9			
*Avoidable (%) Cumulative YTD	46%	41%	43%	42%	41%	38%	36%	35%				
Threshold target (% avoidability 14/15)	34%	34%	34%	34%	34%	34%	34%	34%	34%	34%	34%	34%

Judged as Avoidable following clinical review by Matron or TVN

Grade 2 / 3 / 4 Pressure Ulcers / Deep Tissue Injury (DTI)

There were 10 HAPU-2 in December. F3 had three ulcers, G9 and F9 had two each. F12 and F7 had one ulcer each.

There were three HAPU-3 in December. Critical Care, G9 and G5 had one ulcer each.

There was one HAPU-4 in December. This was an expected deterioration of an earlier reported HAPU-3 which relates to a patient who was on an End of Life pathway and declined all pressure ulcer preventative care in their last days. The patient was provided with best supportive care and passed away.

There were six DTI reported in December.

There has been a flag raised for F10 due to the number of HAPU reported in the period Apr-Nov and 24 HAPU have been reported during this time and detailed investigation is underway to determine further information. F10 respiratory patients do need, and prefer, to sit upright to assist breathing and are therefore reluctant to change position putting extra strain on sacrum elbows and heels, also prolonged wearing of oxygen tubes can cause pressure damage on particularly frail patients.

HAPU-3 have been automatically reportable as an SI from October 2016. A pathway to ensure timely investigation, review and submission has been agreed by Tissue Viability and the Matrons.

Avoidable harm

The Trust target for avoidable pressure ulcers is defined in the quality priority *Maintain the incidence of avoidable pressure ulcers, avoidable inpatient falls and hospital acquired VTE below the baseline for 2014/15.* The target is therefore to ensure the percentage of total pressure ulcers deemed avoidable does not exceed the 2014/15 level (34%) by the end of March 2017.

At the end of December there had been 147 HAPU 2, 3 or 4 reported and currently 47 of these have been classified as avoidable, 90 as unavoidable with another 10 pending confirmation of grading. This puts the Trust currently just above the threshold (at 35%) although it has fallen since the beginning of the year and is anticipated to further improve once December's data is complete.

The increase in staff recognising and reporting pressure ulcers (see graph below demonstrating numbers of the period Apr14-Nov16) together with the 'React to Red' campaign to ensure timely recognition of deep tissue injury is expected to reduce the percentage to below the target before the year end.

Benchmarking

The Trust has agreed to provide data on numbers and avoidability to another trust who are coordinating an informal benchmarking exercise following a notable rise in the number of reported pressure ulcers at their trust.

Pressure ulcer prevention

Since the launch of the React to Red Campaign we saw our Hospital Acquired Pressure incidents fall from 30 in the month of April to 16 in September however it has risen again in October/November. Weekly ward walks are being undertaken by Matron lead for PU and the Tissue Viability Lead to educate and support staff. Since October short competency packs have been rolled, out a ward at a time, targeting high incidence areas first. These give staff the skills to grade and treat pressure ulcers appropriately.

1.11 Safety Thermometer: % of patients experiencing harm-free care

a) Current Position

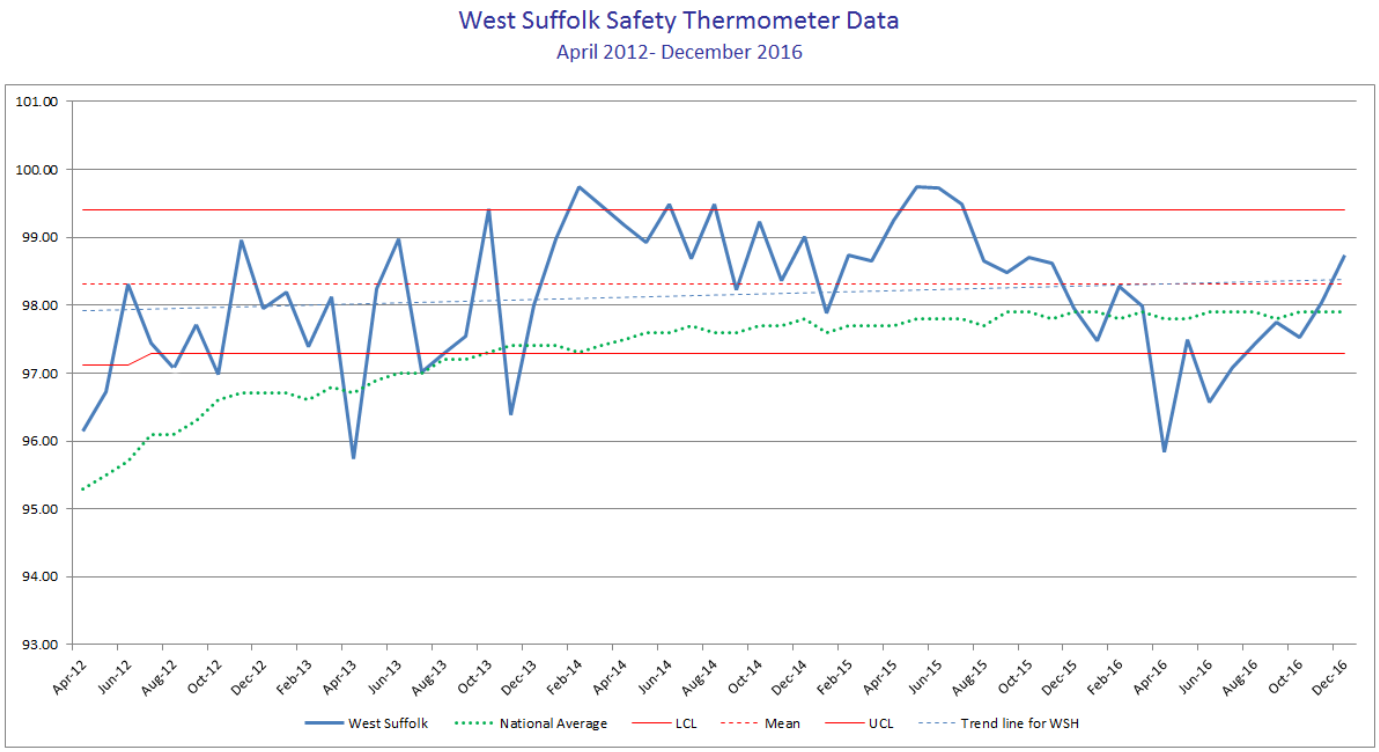
The National 'harm free' care composite measure is defined as the proportion of patients without a pressure ulcer (ANY origin, category II-IV), harm from a fall in the last 72 hours, a urinary tract infection (in patients with a urethral urinary catheter) or new VTE treatment.

	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec -16
Harm Free	93.38	91.94	95.30	93.95	91.43	94.97	93.63	92.31	92.25	92.71	92.31	92.61	93.16
Pressure Ulcers – All	4.07	4.28	3.47	4.79	4.68	3.27	3.43	5.31	3.88	5.03	5.49	5.67	3.80
Pressure Ulcers - New	1.02	1.01	0.99	1.51	2.34	1.26	1.47	1.06	1.29	1.01	1.65	1.23	0.51
Falls with Harm	0.00	0.50	0.25	0.25	1.30	0.50	0.49	0.53	0.00	0.75	0.55	0.49	0.76
Catheters & UTIs	2.54	3.53	0.99	1.26	2.86	1.26	1.96	2.12	3.62	1.51	2.20	1.23	2.28
Catheters & New UTIs	1.02	0.76	0.50	0.00	0.78	0.50	0.98	0.53	0.78	0.50	0.00	0.25	0.00
New VTEs	0.00	0.25	0.00	0.25	0.00	0.25	0.49	0.80	0.52	0.00	0.27	0.00	0.00
All Harms	6.62	8.06	4.70	6.05	8.57	5.03	6.37	7.69	7.75	7.29	7.69	7.39	6.84
New Harms	2.04	2.52	1.73	2.02	4.16	2.51	3.43	2.92	2.58	2.26	2.47	1.97	1.27
Sample	393	397	404	397	3.85	398	408	377	387	398	364	406	395
Surveys	18	18	18	18	18	18	18	18	18	18	17	18	18

The data can be manipulated to just look at "new harm" (harm that occurred within our care) and with this parameter, our Trust score for December 2016 is **1.27 %** therefore, our new harm free care is **98.73%** The National new harm for December 2016 is **2.1%** or (**97.9**%).

It should be noted that the Safety Thermometer is a spot audit and data is collected on a specific day each month.

The SPC chart below shows the Trust Harm free care compared to the national benchmark for the period April 2012 to December 2016. The Trust figures have remained above the National average.



b) Recommended Actions

To continue to monitor actual harm against national benchmarks

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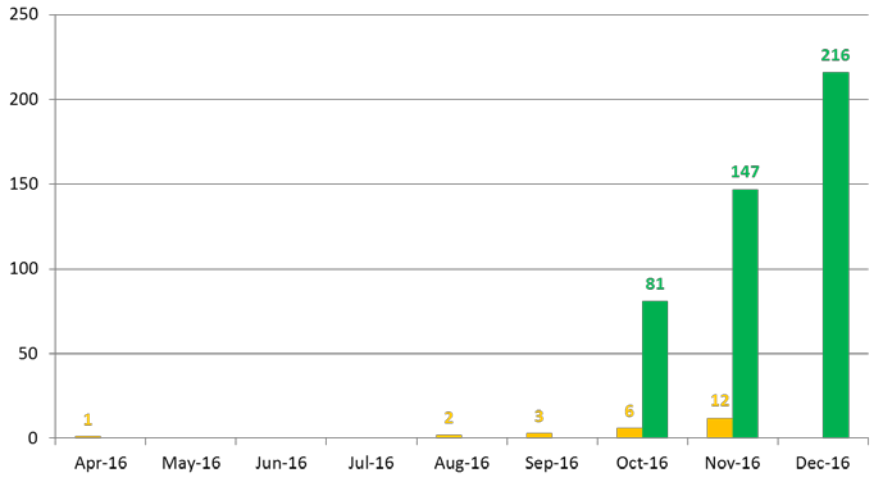
1.12 Incidents with investigation overdue

a) Current Position

Graph: Green and Amber incidents overdue* by month.



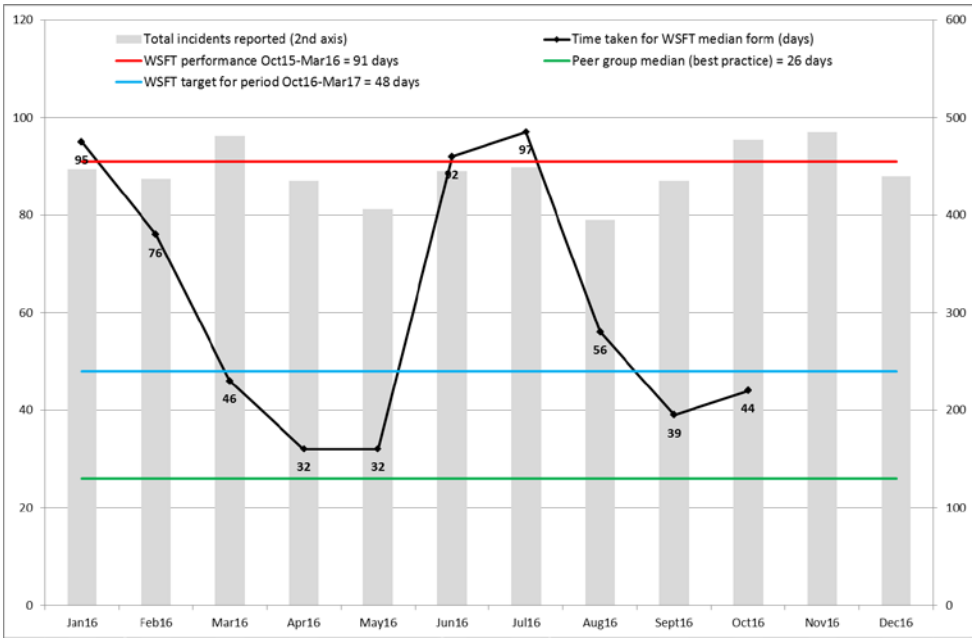
*Overdue - Amber incidents for current reporting month are still within 30 day deadline so are not included on the graph

The graph above shows the number of green and amber incidents that are still awaiting investigation. The majority of overdue incident investigations fall within the month of November and December. NB: All green incidents up to September 2016 were closed off as part of the six monthly NRLS submission deadline.

251 (60%) of the December green incidents had been investigated at the time of this report compared to (59%) last month.

The indicator 50% of patient safety incidents uploaded to the NRLS has been added as a new KPI with 26 days (peer group median) as a best practice (green) and <48 days (threshold for the lower quartile in the most recent NRLS benchmark) as an in-year target (blue). The red line (91 days) is the last published WSFT data for the period Oct-Mar 2016.

November and December have not yet met the threshold for 50% of incidents uploaded and therefore no data is shown.



1.13 RCA Actions beyond deadline for completion

a) Current Position

There are currently 15 RCA actions showing as overdue on Datix. Eight of these have a due date prior to December 2016.

b) Recommended Action

The individual staff members have been contacted to get a position update on each action and an estimated completion date.

1.14 Duty of Candour outstanding

c) Current Position

There are currently three cases requiring verbal Duty of Candour which are reported as being overdue.

d) Recommended Action

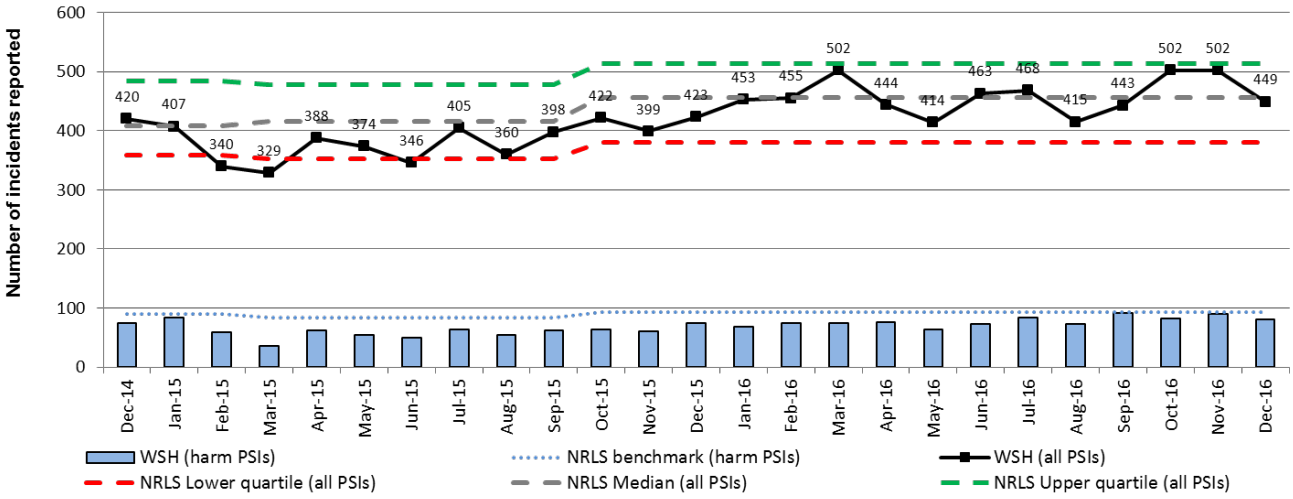
The individuals responsible for providing Duty of Candour have been contacted. Non-compliance with Duty of Candour is escalated to the Clinical Directors.

1.15 Patient Safety Incidents reported

The rate of PSIs is a nationally mandated item for inclusion in the Quality Accounts. The NRLS target lines shows how many patient safety incidents WSH would have to report to fall into the upper / median and lower quartiles for the peer group. The most recent benchmark issued is for the period Oct15 – Mar16.

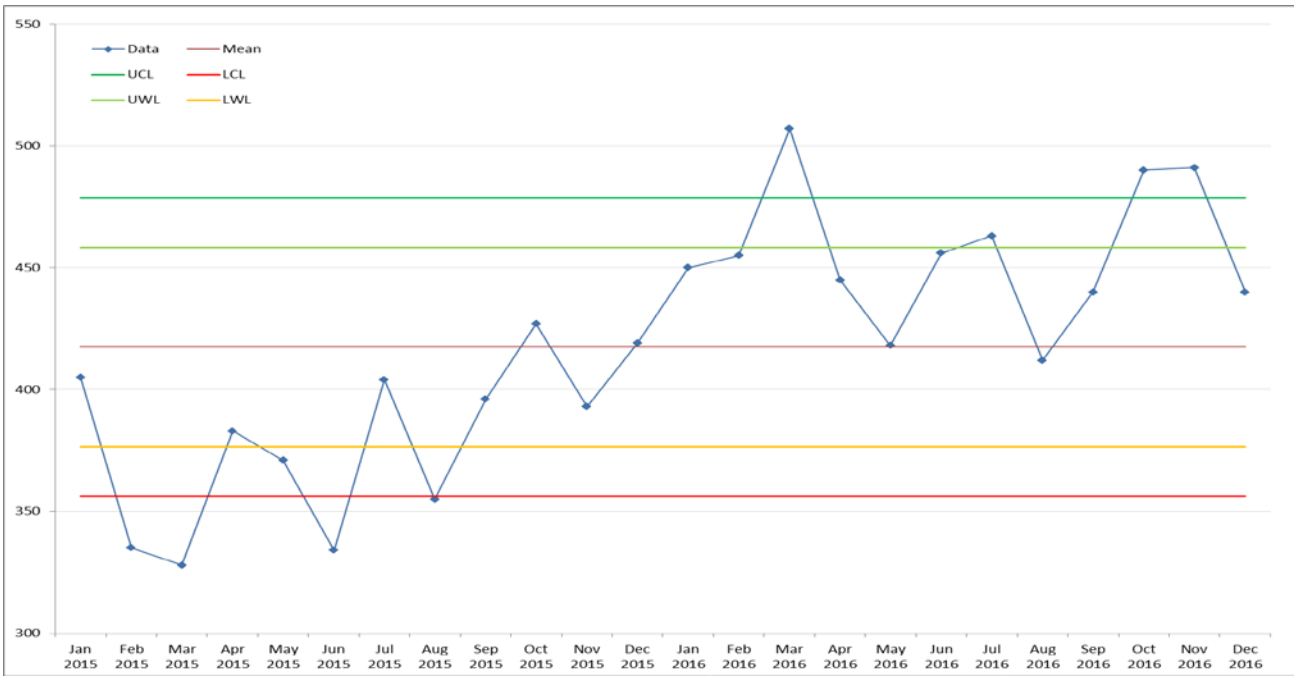
There were 555 incidents reported in December including 449 patient safety incidents (PSIs). This was lower than October / November and similar to earlier month and is just below the median threshold for the peer group. Community incidents are now being captured through Datix e-reporting as of the 1st August 2016.

Graph: Patient Safety Incidents reported



The SPC chart below plots all PSIs reported over a two year period.

Graph: Patient Safety Incidents reported over two years



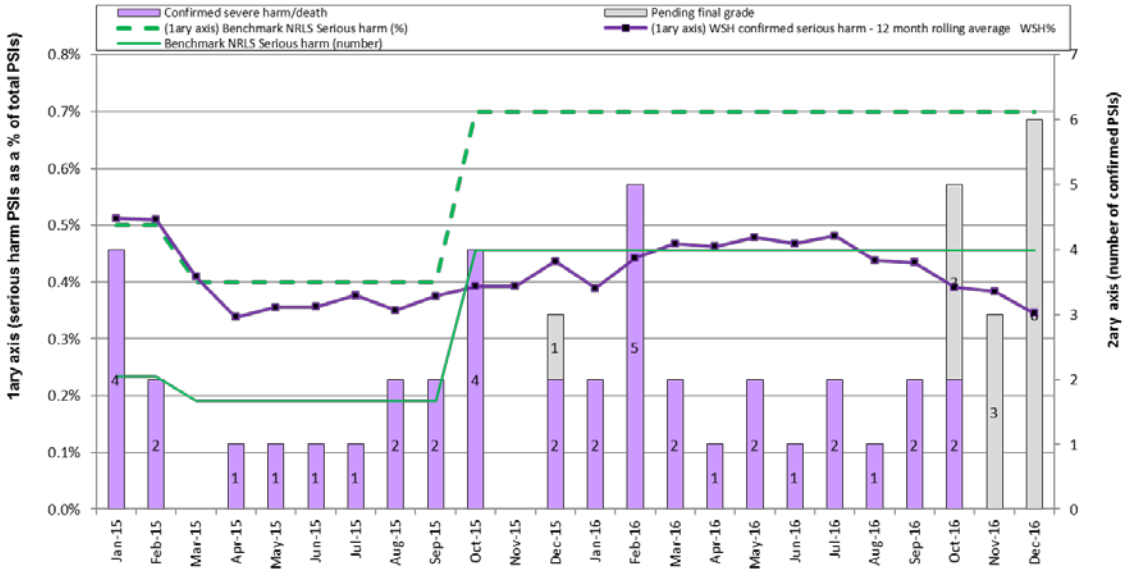
1.16 Patient Safety Incidents (Severe harm or death)

The percentage of PSIs resulting in severe harm or death is a nationally mandated item for inclusion in the Quality Accounts. The peer group average (serious PSIs as a percentage of total PSIs) is from the NRLS period Oct15 - Mar16. This demonstrated an increase in the percentage of incidents resulting in serious harm across the peer group. The benchmark line applies the peer group percentage serious harm to the peer group median total PSIs to give a comparison with the Trust's monthly figures. The WSH percentage data is plotted as a line which shows the rolling average over a twelve month period.

The Trust percentage sits below the NRLS average. The number of serious PSIs (confirmed and unconfirmed) is plotted as a column on the secondary axis.

In December there were six cases reported: three Intrauterine deaths, one fall resulting in a fractured femur, one cardiac arrest and one delay in diagnosis all of which are awaiting RCA to confirm harm grading. The seven incidents from previous months still awaiting confirmation of harm include one misdiagnosis in the emergency department, one delay in escalation one mental health inquest case, one fall with a head injury, one delay in diagnosis one cardiac arrest and one post-operative complication which are still under investigation and therefore awaiting RCA to confirm harm grading.

Graph: Patient Safety Incidents (Severe harm or death)



Please note this graph shows the incidents according to the month the incident occurred in. The incident may have been reported as a SIRI in a different month especially if the case was identified retrospectively e.g. through a complaint or inquest notification.

Patient Experience Dashboard

In line with national reporting (on NHS choices via UNIFY) the scoring for the Friends and Family test changed from April 2015. It is now scored & reported as a % of patients recommending the service i.e. answering extremely likely or likely to the question "How likely is it that you would recommend the service to friends and family?"

A target of 90% of patients recommending the service has been set.

Indicator	Target	Red	Amber	Green	Oct	Nov	Dec
Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	92	83	91
(In-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	98	97	95
Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	66	69	73
Timely call bell response	= 85%	<75	75-84	85-100	86	83	82
Patient Satisfaction: outpatient overall result	= 85%	<75	75-84	85-100	93	92	91
(Out-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	98	97	97
Were you informed of any delays in being seen?	= 85%	<75	75-84	85-100	68	66	67
Were you offered the company of a chaperone whilst you were being examined?	= 85%	<75	75-84	85-100	81	79	76
Patient Satisfaction: short-stay overall result	= 85%	<75	75-84	85-100	99	99	99
(Short-stay) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	99	98	100
Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	94	93	95
(A&E) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	80	85	95
Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	98	98	97
How likely is it that you would recommend the post-natal ward to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	95	90
How likely are you to recommend our labour suite to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	100	100
How likely are you to recommend our antenatal department to friends and family?	= 90%	<80	70-89	90-100	100	99	100
How likely are you to recommend our post-natal care to friends and family?	= 90%	<80	70-89	90-100	100	93	98
How likely is it that you would recommend the birthing unit to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	100	100	100
Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	96	97	93
(Young children) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	97	100	96
Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	100	ND	98
(F1 Parent) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	97	ND	96
Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	95	96	93
(Stroke) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	100	100	100
Have you been involved in planning your recovery / rehabilitation?	= 85%	<75	75-84	85-100	73	89	88

Additional Patient Experience indicators

Indicator	Target	Red	Amber	Green	Oct	Nov	Dec
Response within 25 working days or negotiated timescale with complainant	100%	<75%	75 – 89%	>=90%	81	88	100
Number of second letters received	0	>6	2 - 6	0 - 1	3	3	2
Health Service Referrals accepted by Ombudsman	0	>=2	1	0	1	0	0
Red complaints actions beyond deadline for completion	0	>=5	1 - 4	0	0	0	0
Number of PALS contacts becoming formal complaints	0	>=10	6 - 9	<=5	0	0	2

Exception reporting for indicators in the Patient Experience Dashboard

All indicators in the Patient Experience dashboard which are red or amber for two consecutive months will have narrative below.

1.17 Inpatient: Noise at night

a) Current Position

This score has risen to 73 compared to the high 60s in the previous two months.

a) Recommended Action

Staff are continuing to offer RoseVital trays to patients to aid their sleeping. A task and finish group has been organised in January to review all patient surveys and wording of questions ahead of the new financial year. There is a proposal to reword this question.

1.18 Out-patient: Were you informed of any delays in being seen?

a) Current Position

Of the patients that experienced a delay, 33% of Fracture Clinic patients report not having been kept informed of delays and 42% in the Eye Treatment Centre.

However the overall percentage of patients experiencing a delay continues to decrease, with around 40% of patients reporting no delays in outpatient clinics.

b) Recommended Action

Staff have been reminded to ensure patients are being kept informed of delays. We are continuing to explore alternative ways of obtaining feedback in outpatient areas which will assist in understanding the extent of the issue and how to satisfactorily rectify.

1.19 Out-patient: Offered the company of a chaperone whilst being examined?

a) Current Position

There has been an improvement on the score for this question since September when it was highlighted as a red area. It is now amber (76) although clinics report a chaperone is always present throughout consultations and the score is likely to relate to understanding of the question.

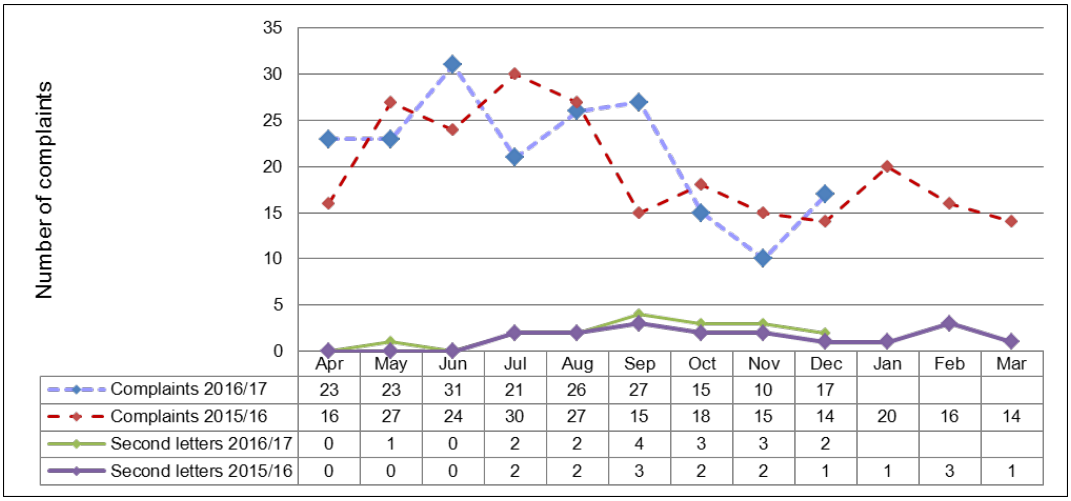
b) Recommended Action

The wording of this question is due to be changed in the new financial year. It is hoped greater clarity around the meaning of chaperone will give truer results.

1.21 Complaints

17 complaints were received in December, an increase compared to October/November. 100% of complaints were responded to in December within of the Trust's preferred timeframe. The breakdown of the complaints received in December is as follows by Primary Division: Medical (7), Surgical (7), Women & Children's Health (1) and Estates and Facilities (2). Trust-wide the top three most common problem areas are as below:

Patient Care – including Nutrition/Hydration	8
Values & Behaviours (Staff)	5
Clinical Treatment – General Medicine Group	4



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Complaints 2016/17	23	23	31	21	26	27	15	10	17			
Complaints 2015/16	16	27	24	30	27	15	18	15	14	20	16	14
Second letters 2016/17	0	1	0	2	2	4	3	3	2			
Second letters 2015/16	0	0	0	2	2	3	2	2	1	1	3	1

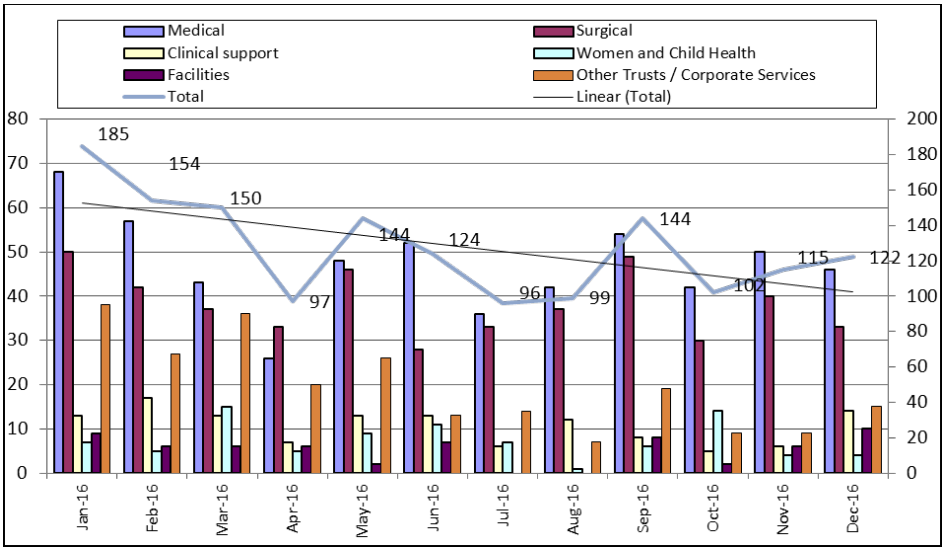
1.22 PALS

In December 2016 there were 122 recorded PALS contacts. This number denotes initial contacts and not the number of actual communications between the patient/visitor which can, in some particular cases, be multiple.

A breakdown of contacts by Directorate from Jan 16 – Dec 16 is given in the chart and a synopsis of enquiries received for the same period is given below. Total for each month is shown as a line on a second axis. Trust-wide the most common three reasons for contacts are shown as follows:

Queries, advice & requests for information	25
Appointments – including delays and cancellations	24
Communications	13

The category of 'Queries, advice & request for information' appeared as the top issues in December, the main theme in this data was the location of a patient. There were no identifiable themes for Appointments and Communications. Concerns relating to Ear, Nose and Throat Services have decreased throughout December. Four contacts throughout December were felt to have been of complex nature and ten contacts were non-routine, the remainder being classed as routine enquiries.



Clinical Effectiveness Dashboard

All indicators in the Clinical Effectiveness dashboard which are red or amber for two consecutive months will have narrative below.

Indicator	Target	Red	Amber	Green	Oct	Nov	Dec
TA (Technology appraisal) business case beyond agreed deadline	0	>9	4 – 9	0 – 3	0	0	0
WHO checklist (Quarterly)	100%	<90	90 – 94	>=95	NA	NA	97
Trust participation in relevant ongoing National audits (Quarterly)	100%	<75	75 – 89	>=90	NA	NA	100
Gynaecology (F14) 30 day readmissions	No target	No target	No target	No target	ND	ND	ND
Babies admitted to NNU with normal temperature on arrival (term)	100%	<50%	50-80%	>80%	100	100	100
12 month Mortality standardised rate (Dr Foster)	100%	>100	90-100	<90	83.31	82.57	84.13
CAS (central alerting system) alerts overdue	0	>=1	No target	0	0	0	0

Maternity dashboard

Following a presentation to the Board in October it was agreed to receive more information within the performance pack on activities within the W&C division. This was very much about ensuring that the board maintains awareness of what is happening rather than any underlying concerns. The dashboard is reproduced in full below and elements already reported in the main quality report dashboard have been removed to prevent duplicate reporting.

	Red	Amber	Green	Oct-16	Nov-16	Dec-16
ACTIVITY – Births						
Total Women Delivered	> 250 or < 2 00	>216 or <208	>208 or <216	215	192	231
Total Number of Babies born at WSH	> 250 or < 2 00	>216 or <208	>208 or <216	219	195	234
Twins	No target	No target	No target	4	3	3
Homebirths	< 1%	2% or less	2.5%	2.7%	3.6%	ND
Midwifery Led Birthing Unit (MLBU) Births	<=10%	13% or less	20%	17.7%	17.2%	20.8%
Labour Suite Births	<=64%	69% to 74%	75%	79.5%	79.2%	76.2%
BBAs	No target	No target	No target	2	2	5
Normal Vaginal deliveries	No target	No target	No target	149	133	167
Vaginal Breech deliveries	No target	No target	No target	1	1	0
Non operative vaginal deliveries	No target	No target	No target	149	134	
Water births	No target	No target	No target	13	11	21
Total Caesarean Sections	> 22.6%	No target	<22.6%	20.5%	17.7%	19%
Total Elective Caesarean Sections	>=13%	11 - 12%	10%	5.1%	5.7%	6.9%
Total Emergency Caesarean Sections	>=15%	13 - 14%	12%	15.3%	12%	12.1%
Second stage caesarean sections	No target	No target	No target	4	6	6
Forceps Deliveries	No target	No target	No target	3.7%	7.8%	3.5%
Ventouse Deliveries	No target	No target	No target	6%	4.7%	5.2%
Inductions of Labour	No target	No target	No target	36.7%	34.4%	34.2%
Failed Instrumental Delivery	No target	No target	No target	0	1	1
Unsuccessful Trial of Instrumental Delivery	No target	No target	No target	1	2	1
Use of sequential instruments	No target	No target	No target	ND	ND	ND
Grade 1 Caesarean Section (Decision to Delivery Time met)	<=95%	96 - 99%	100%	100%	100%	100
Grade 2 Caesarean Section (Decision to delivery time met)	<=75%	76 - 79%	80%	90%	93%	81
Total no. of women eligible for Vaginal Birth after Caesarean Section (VBAC)	No target	No target	No target	18	21	24
Number of women presenting in labour for VBAC against number achieved.	No target	No target	No target	5	10	8
ACTIVITY – Bookings						
Number of Bookings (1st visit)	No target	No target	No target	254	255	226
Women booked before 12+6 weeks	<=90%	91 - 94%	95%	97%	97%	95%
CLINICAL OUTCOMES - Maternal						
Postpartum Haemorrhage 1000 - 2000mls	No target	No target	No target	16	11	15
Postpartum Haemorrhage 2,000 - 2,499mls	No target	No target	No target	2	3	0
Postpartum Haemorrhage 2,500mls+	No target	No target	No target	3	0	4
Post-partum Hysterectomies	1	1	0	0	0	0
Women requiring a blood transfusion of 4 units or more	1	1	0	ND	ND	ND
Critical Care Obstetric Admissions	1	1	0	0	0	0
Eclampsia	1	1	0	1	0	0
Shoulders Dystocia	5 or more	3-4	2	6	5	7
3rd and 4th degree tears (All vaginal deliveries)	No target	No target	No target	9	7	4

	Red	Amber	Green	Oct-16	Nov-16	Dec-16
3rd and 4th degree tears (Spontaneous Vaginal Deliveries)	10	7-9	6	7	5	3
3rd and 4th degree tears (Instrumental Deliveries)				2	2	1
Maternal Sepsis	No target	No target	No target	ND	ND	ND
Maternal death	No target	No target	No target	0	0	0
Female Genital Mutilation (FGM)	No target	No target	No target	0	0	0
Clinical Outcomes –Neonatal						
Number of babies admitted to Neonatal Unit (>36+6)	No target	No target	No target	12	16	20
Number of babies with Apgars of <7 at 5 mins at term (37 weeks or more)	No target	No target	No target	4	3	5
Number of Babies transferred for therapeutic cooling	1	No target	0	0	1	0
Cases of Meconium aspiration	No target	No target	No target	2	0	0
Cases of hypoxia	No target	No target	No target	0	0	0
Cases of Encephalopathy (grades 2 and 3)	No target	No target	No target	0	0	0
Stillbirths	No target	No target	No target	2	0	3
Postnatal activity						
Total women delivered who breastfed babies within first 48 hours	<75%	75-80%	>80%	82.6%	80.5%	80.1%
Return of women with perineal problems, up to 6 weeks postnatally	No target	No target	No target	ND	ND	ND
Workforce						
Weekly hours of dedicated consultant cover on Labour Suite	<=55 hrs	56-59	60hrs or >	60	60	75
Midwife/birth ratio	>=1:32	No target	1:30	1:29	1:28	
Supervisor to Midwife Ratio	No target	No target	No target	1:19	1:19	1.:19
Consultant Anaesthetists sessions on Labour Suite	< 8 sessions	8-9 sessions	10 sessions	10	10	10
ODP cover for Theatre 2	80%	90%	100%	100%	100%	100%
Anaesthetist response to request for epidural for pain relief within 30 mins	< 70%	70 - 79%	>=80%	ND	ND	ND
Risk incidents/complaints/patient satisfaction						
Reported clinical Incidents	>40	40-59	60 and above	68	54	48
Serious incidents	No target	No target	No target	2	0	3
Never events	No target	No target	No target	0	1	0
Complaints	No target	No target	No target	0	0	1
1 to 1 Care in Labour	<=95%	96 - 99%	100%	100%	100%	100%
Unit closures	No target	No target	No target	0	0	0
Massive Obstetric Haemorrhage protocol	No target	No target	No target	ND	ND	ND
Maternal Postnatal readmissions	No target	No target	No target	ND	ND	ND
Completion of WHO Checklist	80%	90%	100%	95%	82%	96%
Babies assessed as needing BCG vaccine	No target	No target	No target	16	12	ND
Babies who receive BCG vaccine following assessment	No target	No target	No target	7	6	ND
UNICEF Baby Friendly Audits	No target	No target	No target	24	**26**	10
Proportion of parents receiving a Safer Sleeping Suffolk Thermometer.	No target	No target	No target	49	108	ND

<u>Exception reporting for red indicators in the Clinical Effectiveness Dashboard</u>

1.23 Maternity - Total Women Delivered and Number of Babies born at WSH

The total number of deliveries and babies born at WSH varies from month to month, The maternity service delivered 231 babies in December, this is reflected in the midwives to birth ratio of 1:30 being reported in the Performance section of this report. It is not planned to take any action on this.

1.24 Maternity - Shoulders Dystocia

There has been a continued trend of incidents of shoulder dystocia above the predicted level. Each case is reviewed to ensure that appropriate care is provided; increased training has heightened awareness of this risk and has possibly led to earlier use of drills to expedite delivery. There were no incidents reported of brachial plexus injury

1.26 Maternity - Reported clinical Incidents

Noted trend of reduced level of reporting incidents, to monitor only at present.

1.27 Maternity - Completion of WHO Checklist

Compliance improved to 96% this month, and whilst still RAG rated as amber this is a considerable improvement from November's 82%. Work will continue to improve performance.

The Ward Analysis Report for all Clinical Quality Indicators is provided at Appendix 1.

2. MORTALITY DATA

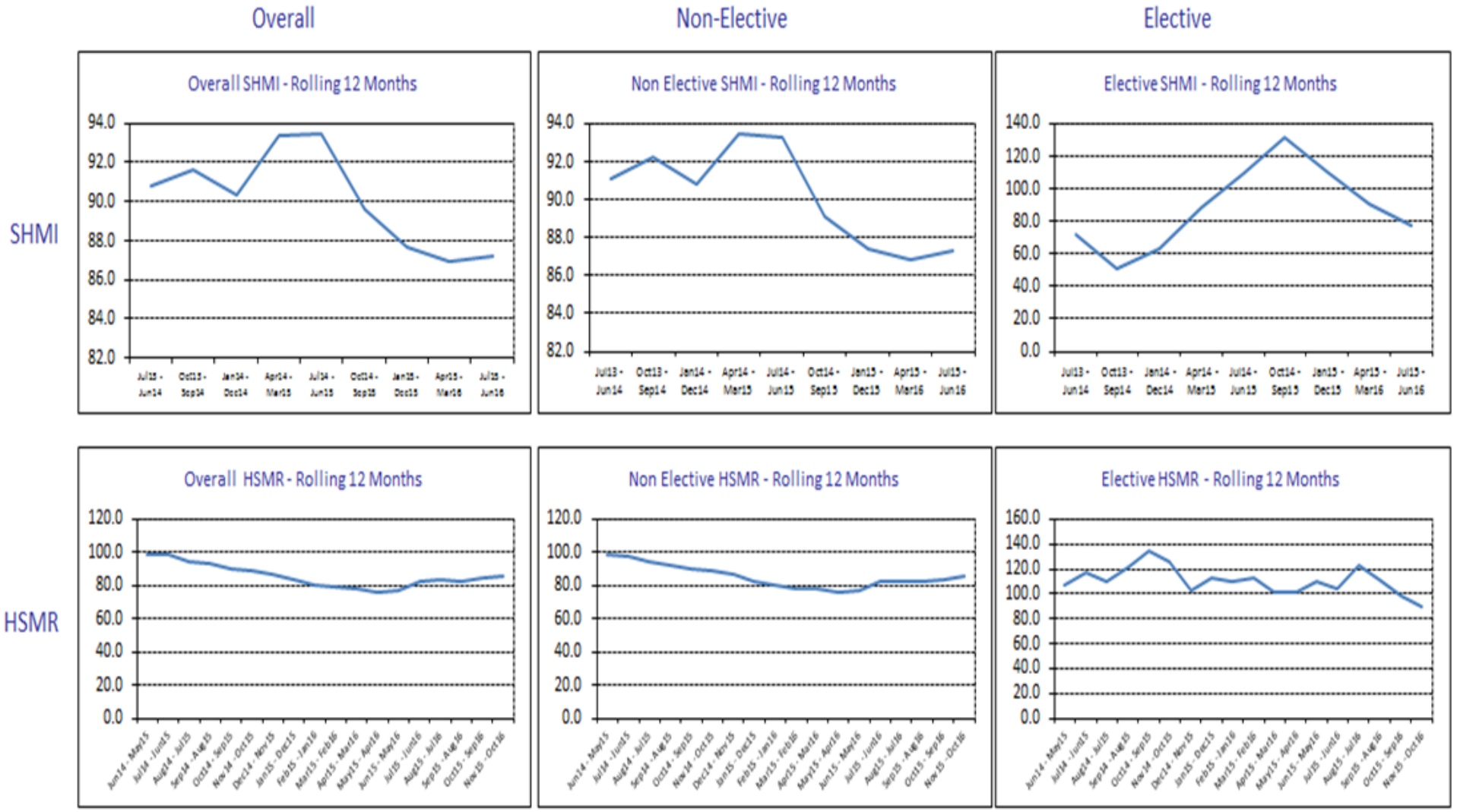
Mortality HSMR and SHMI Data

Mortality (Individual Months)	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
No of Deaths	77	55	72	85	78	77	69	80	122	134	105	84
No of Discharges	5,153	5,026	5,072	5,493	4,921	5,298	5,642	5,269	5,313	5,311	4,838	5,360
% Deaths	1.49%	1.09%	1.42%	1.55%	1.59%	1.45%	1.22%	1.52%	2.30%	2.52%	2.17%	1.57%
HSMR*	82.1	71.1	83.4	107.2	106.7	94.9	78.1	94.4	104.9	106.5	108.6	86.7
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
No of Deaths	79	73	70	55	70	52	67	73	78	109	91	84
No of Discharges	5,032	5209	5273	5730	5188	5483	5637	5568	5402	5375	5439	5725
% Deaths	1.57%	1.40%	1.33%	0.96%	1.35%	0.95%	1.19%	1.31%	1.44%	2.03%	1.67%	1.47%
HSMR*	89.5	75.3	86.5	62.4	86.1	63.5	66.8	74.2	71.9	87.4	91.0	
	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
No of Deaths	71	87	71	58	74	82	83	98	102			
No of Discharges	5,321	5427	5691	5410	5400	5674	5733	5950	5401			
% Deaths	1.33%	1.60%	1.25%	1.07%	1.37%	1.45%	1.45%	1.65%	1.89%			
HSMR*												

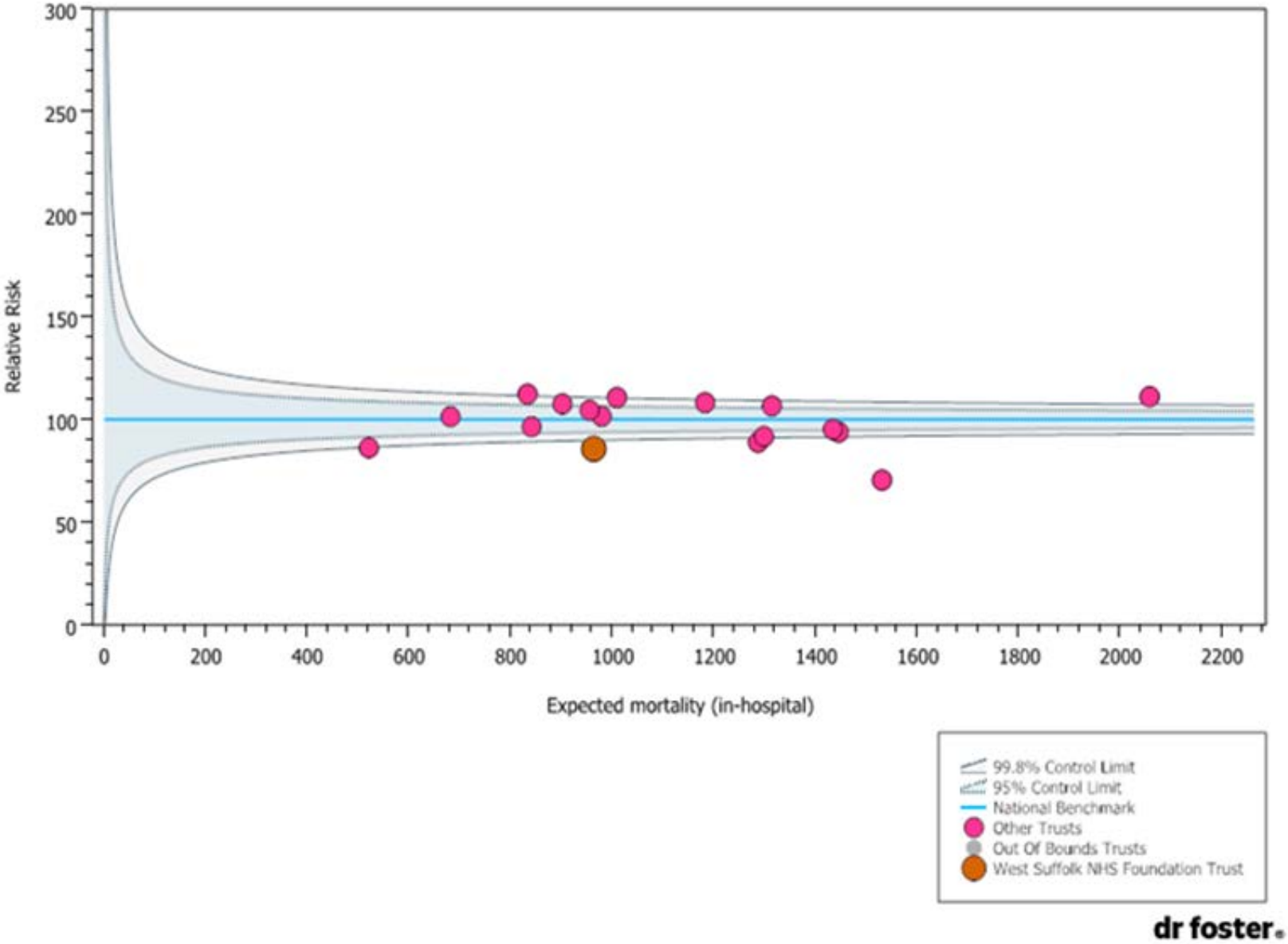
HSMR BENCHMARK IS USING FY 15 -16

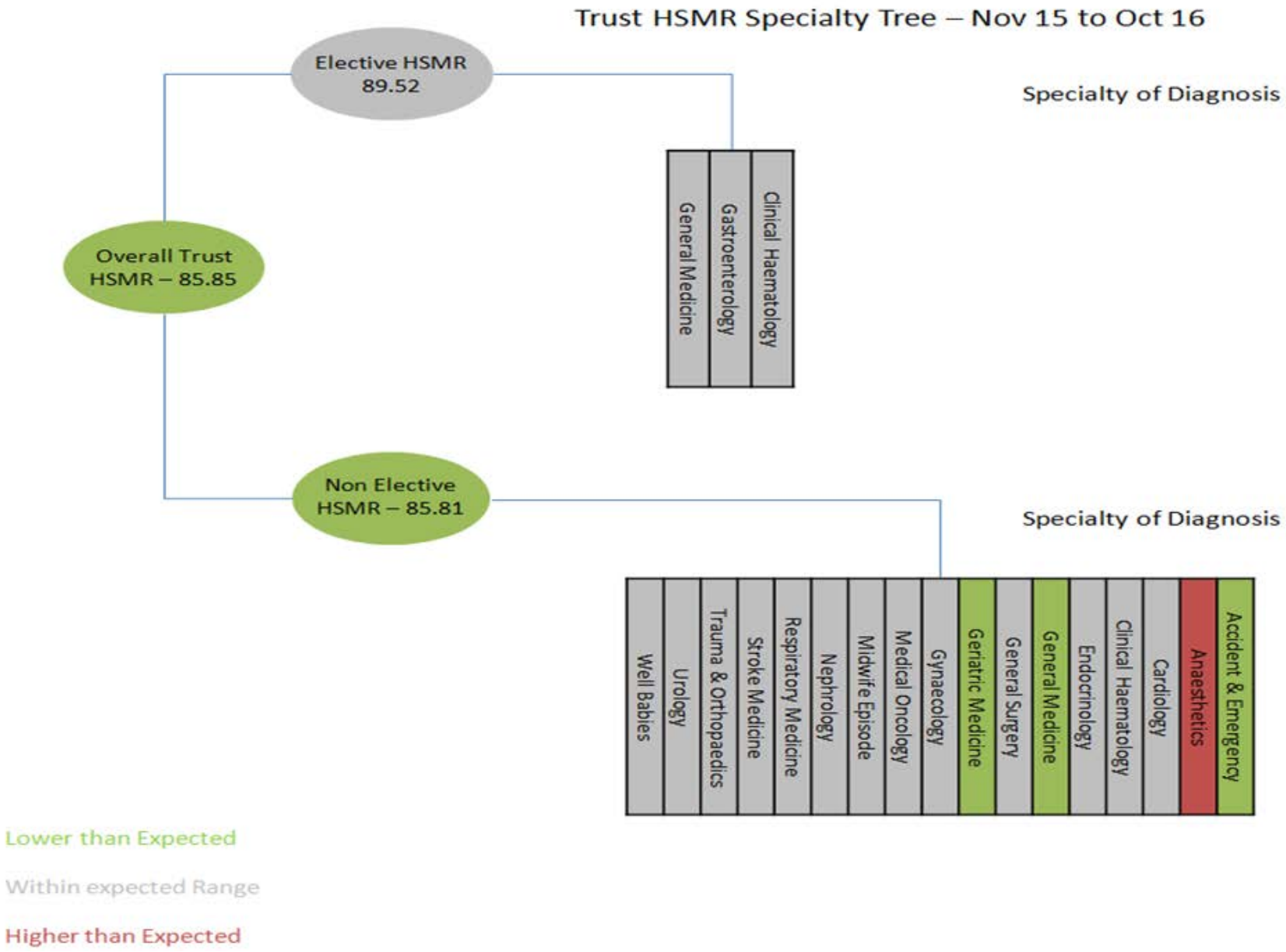
SHMI - Rolling 12 Months (Quarterly)	Apr12 - Mar13	Jul12 - Jun13	Oct12 - Sep13	Jan13 - Dec13	Apr13 - Mar14	Jul13 - Jun14	Oct13 - Sep14	Jan14 - Dec14	Apr14 - Mar15	Jul14 - Jun15	Oct14 - Sep15	Jan15 - Dec15
Overall Observed Deaths	1254	1275	1328	1349	1281	1264	1292	1316	1439	1461	1401	1361
Overall Expected Deaths	1403	1420	1424	1418	1396	1392	1410	1456	1541	1562	1563	1553
Overall SHMI	89.4	89.8	93.2	95.1	91.8	90.8	91.6	90.3	93.4	93.5	89.6	87.7
Non Elective SHMI	89.8	90.2	93.9	95.4	92.1	91.1	92.2	90.8	93.4	93.3	89.1	87.4
Elective SHMI	67.2	63.4	49.2	71.7	68.8	71.5	50.8	63.2	88.4	109.7	131.5	110.9
	Apr15 - Mar16	Jul15 - Jun16	Oct15 - Sep16	Jan16 - Dec16	Apr16 - Mar17	Jul16 - Jun17	Oct16 - Sep17	Jan17 - Dec17	Apr17 - Mar18	Jul17 - Jun18	Oct17 - Sep18	Jan18 - Dec18
Overall Observed Deaths	1334	1337										
Overall Expected Deaths	1535	1533										
Overall SHMI	86.9	87.2										
Non Elective SHMI	86.9	87.3										
Elective SHMI	90.1	77.2										

HSMR - Rolling 12 Months	Jun13 - May14	Jul13 - Jun14	Aug13 - Jul14	Sep13 - Aug14	Oct13 - Sep14	Nov13 - Oct14	Dec13 - Nov14	Jan14 - Dec14	Feb14 - Jan15	Mar14 - Feb15	Apr14 - Mar15	May14 - Apr15
Overall Observed Deaths	755	758	779	798	804	792	803	842	902	934	938	946
Overall Expected Deaths	883	894	902	898	913	916	926	910	971	985	992	958
Overall HSMR	85.4	84.7	86.3	88.8	88.0	86.4	86.7	92.5	92.8	94.8	94.5	98.7
Non Elective HSMR	85.6	84.9	86.6	89.2	88.5	86.7	86.3	92.6	94.0	95.8	94.5	98.6
Elective HSMR	65.7	66.8	56.7	55.4	42.0	60.4	75.2	77.6	82.1	102.1	103.8	112.2
	Jun14 - May15	Jul14 - Jun15	Aug14 - Jul15	Sep14 - Aug15	Oct14 - Sep15	Nov14 - Oct15	Dec14 - Nov15	Jan15 - Dec15	Feb15 - Jan16	Mar15 - Feb16	Apr15 - Mar16	May15 - Apr16
Overall Observed Deaths	954	956	925	913	892	886	876	836	812	784	785	766
Overall Expected Deaths	968	974	980	984	991	996	1009	1005	1004	996	1006	1011
Overall HSMR	98.5	98.1	94.4	92.8	90.0	88.9	86.8	83.2	80.8	78.7	78.0	75.8
Non Elective HSMR	98.4	97.9	94.2	92.5	89.5	88.5	86.8	82.9	80.8	78.4	77.8	75.5
Elective HSMR	107.4	117.4	110.6	122.1	134.6	125.6	102.9	112.9	109.5	112.5	100.8	100.9
	Jun15 - May16	Jul15 - Jun16	Aug15 - Jul16	Sep15 - Aug16	Oct15 - Sep16	Nov15 - Oct16	Dec15 - Nov16	Jan16 - Dec16	Feb16 - Jan17	Mar16 - Feb17	Apr16 - Mar17	May16 - Apr17
Overall Observed Deaths	786	781	791	793	812	832						
Overall Expected Deaths	1020	948	949	960	965	916						
Overall HSMR	77.1	82.4	83.3	82.6	84.1	85.3						
Non Elective HSMR	76.8	82.2	83.0	82.4	84.0	85.8						
Elective HSMR	109.8	104.4	122.4	111.3	99.2	89.8						


Overall
Non-Elective
Elective
SHMI
HSMR
Overall SHMI - Rolling 12 Months
Non Elective SHMI - Rolling 12 Months
Elective SHMI - Rolling 12 Months
Overall HSMR - Rolling 12 Months
Non Elective HSMR - Rolling 12 Months
Elective HSMR - Rolling 12 Months

West Suffolk NHS Foundation Trust v Other Acute providers in East of England




Trust HSMR Specialty Tree – Nov 15 to Oct 16
Elective HSMR 89.52
Specialty of Diagnosis
Clinical Haematology
Gastroenterology
General Medicine
Overall Trust HSMR – 85.85
Non Elective HSMR – 85.81
Specialty of Diagnosis
Accident & Emergency
Anaesthetics
Cardiology
Clinical Haematology
Endocrinology
General Medicine
General Surgery
Geriatric Medicine
Gynaecology
Medical Oncology
Midwife Episode
Nephrology
Respiratory Medicine
Stroke Medicine
Trauma & Orthopaedics
Urology
Well Babies
Lower than Expected
Within expected Range
Higher than Expected

3. MONITOR ASSURANCE FRAMEWORK

The Governance Rating table shows no failures of the governance rating against Monitor's Risk Assessment Framework.

Monitor Compliance Framework						April	May	June	July	August	September	October	November	December
Performance Indicator	Threshold	Month	QTD	Weighting	Lead Exec									
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	92.03%	92.13%	1.0	Jon Green	95.61%	95.69%	96.75%	93.25%	92.93%	92.16%	92.16%	92.09%	92.03%
Number of RTT Waits over 52 weeks for incomplete pathways	0	0	1	-	Jon Green	1	1	1	0	0	0	1	0	0
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	86.50%	85.36%	1.0	Jon Green	90.62%	82.26%	83.56%	85.20%	88.59%	88.21%	86.14%	84.51%	86.50%
All cancers: 62-day wait for first treatment (5) from:Urgent GP referral for suspected cancer - **See Further detail below**	85%	83.84%	85.70%	1.0	Jon Green	86.10%	86.80%	90.80%	100.00%	87.40%	83.80%	88.14%	84.31%	83.84%
All cancers: 62-day wait for first treatment (5) from: NHS Cancer Screening Service referral	90%	96.15%	100.00%		Jon Green	100.00%	100.00%	100.00%	100.00%	92.60%	100.00%	100.00%	100.00%	96.15%
All cancers: 31-day wait for second or subsequent treatment, comprising: Surgery	94%	100.00%	100.00%	1.0	Jon Green	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
All cancers: 31-day wait for second or subsequent treatment, comprising: anti-cancer drug treatments	98%	100.00%	100.00%		Jon Green	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
All cancers: 31-day wait for second or subsequent treatment, comprising: radiotherapy - Not applicable to WSFT														
All cancers: 31-day wait from diagnosis to first treatment	96%	100.00%	99.50%	0.5	Jon Green	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Cancer: two week wait from referral to date first seen (8), comprising: all urgent referrals (cancer suspected)	93%	97.46%	97.19%	0.5	Jon Green	99.00%	95.90%	81.00%	97.30%	93.00%	94.30%	97.05%	97.48%	97.46%
Cancer: two week wait from referral to date first seen (8), comprising: for symptomatic breast patients (cancer not initially suspected)	93%	93.23%	98.17%		Jon Green	99.20%	91.00%	64.30%	76.50%	57.90%	99.00%	98.31%	99.17%	93.23%
Outcomes:														
Clostridium (C.) difficile - meeting the C.difficile objective - MONTH	2	2			Rowan Proctor	1	1	3	3	3	2	3	3	2
Clostridium (C.) difficile - meeting the C.difficile objective - QUARTER	4		8	1.0	Rowan Proctor									
Clostridium (C.) difficile - meeting the C.difficile objective - ANNUALLY	16		21		Rowan Proctor									
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	N/A	-	-	0.5	Rowan Proctor									

Governance Rating	3.0

West Suffolk NHS Foundation Trust Cancer Waits Performance Report - November 2017					
GP Suspected Cancer, Cancer Screening Referral Receipt to Start of 1st Treatment: 62 Days Waiting Times Standard 85%				Performance %	
Cancer Type	<62 days	>62 days	Total	Trust	England~
Breast	10		10	100	94.7
Gynae	1+3x.5	1x.5	3	83.3	76.1
Haem	4		4	100	78.1
Head & Neck	1+1x.5	2x.5	2.5	75	75.6
Lower GI	8	4+2x.5	13	64	70.1
Lung	1+2x.5		2	100	69
Other	1	1	2	50	71.2
Skin	17	4	21	80	95.2
Upper GI	3		3	100	76.4
Urology	15+1x.5	1x.5	16	96.9	77.5
Total	61+7x.5	9+5x.5	76.5	84.3	82.1

Governance Rating	Rated Green if no issues are identified and Red where monitor are taking enforcement action. *Where Monitor have identified a concern at a trust but not yet taken action, they provide a written description stating the issue at hand and the action they are considering.*

3.1 A&E: Maximum waiting time of four hours from admission/transfer/discharge

a) Current Position

86.50% against a threshold of 95%

b) Recommended Action

The Trust has continued to experience significant demand. This demand has increased in both volume and acuity with the onset of the colder weather. The majority of the Emergency Care Group work streams have now been implemented which has seen a shift in reason for breach from ED attributable to flow/capacity limitations. As a result the trust has established the Flow Action Group which brings colleagues from around the trust together to tackle limitations to flow and discharge. The most significant project which is being implemented is the 'Red to Green' which highlights all patients who are not progressing in their care pathway whilst actively planning for discharge and involving them in the care

plans. This is being rolled out across the hospital by the Transformation Team. The ED Demand Management Group continues to meet to ensure a system wide approach is adopted to tackling the rising demand seen by our ED. With these work streams continuing we anticipate an upward trend in performance.

3.2 All cancers: 62-day wait for first treatment (5) from Urgent GP referral for suspected cancer

a) Current Position
83.84% against a threshold of 85%

b) Recommended Action
There are significantly high numbers of incoming 2 WW referrals resulting into delay in diagnostics and treatment plans. In some instances patient choice has also been responsible for the delay in timely diagnosis restricting the Trust's ability to expedite timely treatment.
All potential breaches on 62 days pathways were escalated to the appropriate MDT clinicians and the services during the time of pathway tracking.
The number of bank holidays during December also restricted our ability open up additional/extra capacity by the services.
Haem - This was a complex pathway starting originally with H/N, had a long wait for tissue diagnosis. It required full staging and cross MDT referral to Haem team for proper treatment plan following repeated discussion with the SMDT before referral.
Colorectal - One Colorectal patient had significant comorbidities and multiple cancellations of diagnostic appointments resulting in a long wait for tissue diagnosis and staging, and another patient also had a long wait for diagnostic, but they also required cross MDT referral to assess and determine no spread of disease before surgery. Owing to complex pathways there was delay in treatment within target. Both RCAs being reviewed by the team including clinical harm review in one case.
Skin - There was inadequate capacity to offer an earlier TCI for the planned procedures to two skin patients. All RCAs are being reviewed by the clinicians involved with a view to preventing these from happening again. RCAs being reviewed by the team including clinical harm in one case for breach above 104 days wait.
The small step change actions have been brought in to the Outpatients with a few open slots for plastic consultation during parallel running clinics. This is aimed to help reduce the diagnostic delay and also to combine diagnostic/treatment procedure where clinically appropriate and improve 62 days pathways. Unfortunately, the Surgical Nurse Practitioner post was not taken up by the successful candidate and now needs to be re advertised.
Upper GI - One original H/N referral had an Upper GI ca requiring cross MDT referral and SMDT inputs, resulting in late referral to Addenbrookes.
Urology - One Urology patient underwent multiple diagnostics following inconclusive TRUSS findings and a long wait for Template biopsy and staging before commencing on hormones.
There was a delay due to MDT and SMDT inputs to 2 patients and planned surgery at Addenbrookes was moved to West Suffolk lately in one case and other was a timely referral but breached at Addenbrookes.
All breach pathway RCAs are being reviewed by the clinicians in the teams involved including the clinical harm review for 104 days plus breach (Colo, Skin, Urology) to bring improvement measures where possible.

3.3 Clostridium (C.) difficile – meeting the C.difficile objective – MONTH/QUARTER

a) Current Position
2 for month against a threshold of 2
8 for QTD against a threshold of 4

b) Recommended Action
See page 5 of the report.

4. CONTRACTUAL AND KEY PERFORMANCE INDICATORS

This section identifies those area that are breaching or at risk of breaching the Key Performance Indicators, with the main reasons and mitigating actions.

Performance Indicator	Threshold	In Month Performance	YTD	Comments	Lead Exec	Sep	Oct	Nov	Dec	Change mth on mth	On Plan To Achieve	Area of Concern	Forecast to Breach
A&E						Sep	Oct	Nov	Dec				
A&E Time to treatment in department (median) for patients arriving by ambulance - CDM	Median time to treatment above 60 minutes	56	67		Jon Green	61	58	46	56	↘			
A&E - Single longest total time spent by patients in the A&E department, for admitted and non-admitted patients	Should not exceed 6 hours	17:28	17:28	**Delay due to Mental Health being required to see the patient**	Jon Green	12:47	12:25	15:00	17:28	↘			
A&E Trolley Waits not longer than 12 hours	0 Patients waiting over 12 hours from DTA to Admission	0	0		Jon Green	0	0	0	0	↔			
A&E - Threshold for admission via A&E	i) if the monthly ratio is above the corresponding 2012/13 monthly ratio for two month in a six month period ii) if year end is greater than 27%	34.02%	31.44%		Jon Green	31.89%	32.30%	33.73%	34.02%	↘			
A&E - Service User Impact Indicators	To satisfy at least one of the following Service User Impact Indicators: 1. Unplanned Reattendances within 7 days below 5% (Reattendances for the same condition) 2. Time to treatment in department (median) for all Service Users arriving by ambulance.	ONE MET	ONE MET		Jon Green	ONE MET	ONE MET	ONE MET	ONE MET	↔			
A&E & AMU - Ambulance submit button complete	80%	90.46%	83.72%		Jon Green	87.90%	91.57%	88.38%	90.46%	↗			
A&E - Ambulance Handovers above 30 minutes	0 handovers over 30 minutes - £200 per breach	ND	193	**Unvalidated data until March; validated thereafter**	Jon Green	20	45	33	ND				
A&E - Ambulance Handovers above 60 minutes	0 handovers over 60 minutes - £1000 per breach	ND	43		Jon Green	3	7	13	ND				
Percentage of patients presenting at type 1 and 2 (major) A & E sites in certain high risk categories who are reviewed by an emergency medicine consultant before being discharged	14.00%	93.55%	78.71%		Jon Green	79.17%	86.21%	83.33%	93.55%	↗			
RTT													
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway under 26 weeks	99.00%	97.15%	98.09%		Jon Green	97.82%	98.01%	97.94%	97.15%	↘			
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90.00%	70.60%	74.90%		Jon Green	68.55%	68.28%	70.34%	70.60%	↗			
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95.00%	89.37%	92.61%		Jon Green	92.17%	87.61%	86.35%	89.37%	↗			
Stroke													
% of patients scanned within 1 hour of clock start	77% (Contract) 57.5% (Upper Quartile)	80.56%	75.28%		Jon Green	84.38%	77.50%	77.78%	80.56%	↗			
% of patients scanned within 12 hours of clock start	96% (Contract) 96% (Upper Quartile)	97.22%	97.43%		Jon Green	100.00%	100.00%	100.00%	97.22%	↘			
% of patients admitted directly to Stroke Unit within 4 hours of clock start	75% (Contract) 70% (Upper Quartile)	77.14%	74.23%		Jon Green	81.25%	76.32%	84.00%	77.14%	↘			
>80% treated on a stroke unit >90% of their stay	90%	88.57%	88.03%		Jon Green	93.75%	92.11%	83.33%	88.57%	↗			
% of patients treated by a stroke skilled early supported discharge team	48% (Contract) 48% (Upper Quartile)	68.18%	43.96%		Jon Green	31.03%	40.74%	47.37%	68.18%	↗			
% of patients assessed by a stroke specialist consultant physician within 24 hours of clock start.	80% (Contract) 79% (Upper Quartile)	86.11%	85.61%		Jon Green	87.50%	92.50%	92.59%	86.11%	↘			
% of applicable patients who are assessed by a nurse and at least one therapist within 24 hours, all relevant therapists within 72 hours and have rehabilitation goals agreed within 5 days of clock start.	75% (Contract) 70.5% (Upper Quartile)	88.89%	76.69%		Jon Green	80.00%	87.50%	86.96%	88.89%	↗			
% of eligible service users given thrombolysis	100% (RCA to be provided for breaches)	100.00%	30.26%		Jon Green	100.00%	100.00%	100.00%	100.00%	↔			
All stroke survivors to have a 6 month follow up assessment.	50%	ND	65.18%		Jon Green					-			
Provider rating to remain between A-C in each of the 9 domains covered in SSNAP where the Provider is at this level. For the one domain (SaLT) where the Provider is at level E, this will be improved to level to C by March 2017.	To remain at or above: National average or current performance (A-C) Improve performance to level C by end of the year (SaLT)	ND	D	Reports are generated by SSNAP every 4 months - this is as at July 2016, reported for October Board	Jon Green					-			
Discharge Summaries													
Discharge Summaries - Outpatients	85% sent to GP's within 3 days	ND			Pam Chrispin	ND	ND	ND	ND	-			
Discharge Summaries - A&E	95% of A&E Discharge Summaries to be sent to GPs within one working day	98.85%	97.69%		Pam Chrispin	97.19%	97.41%	95.26%	98.85%	↗			
Discharge Summaries - Inpatients	95% sent to GP's within 1 day	92.28%	91.94%		Pam Chrispin	93.32%	93.39%	92.96%	92.28%	↘			
Choose & Book													
Provider failure to ensure that "sufficient appointment slots" are made available on the Choose and Book system	A maximum of 3% slots unavailable (£50 per appointment over 5%. Threshold applied over monthly figures)	ND			Jon Green	ND	ND	ND	ND	-			
All 2 Week Wait services delivered by the Provider shall be available via Choose & Book (subject to any exclusions approved by NHS East of England)	100%	100.00%	100.00%		Jon Green	100.00%	100.00%	100.00%	100.00%	↔			
Cancelled Operations													
Provider cancellation of Elective Care operation for non-clinical reasons either before or after Patient admission	i) 1% of all elective procedures	1.28%	0.83%		Jon Green	0.89%	1.30%	0.83%	1.28%	↘			
Patients offered date within 28 days of cancelled operation	100%	89.66%	94.68%		Jon Green	90.91%	94.29%	100.00%	89.66%	↘			
No urgent operation should be cancelled for a second time	0 2nd Urgent Cancellations	0			Jon Green	0	0	0	0	↔			
Maternity													
Access to Maternity services (VSB06)	90% of women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 completed weeks of pregnancy.	95.13%	95.92%		Rowan Proctor	94.12%	97.24%	97.25%	95.13%	↘			
Maintain maternity 1:30 ratio	1:30	01:30	01:29		Rowan Proctor	01:29	01:29	01:28	01:30	↘			
Pledge 1.4: 1:1 care in established labour	1:1	100.00%	99.94%		Rowan Proctor	99.50%	100.00%	100.00%	100.00%	↔			
Breastfeeding initiation rates.	80%	79.65%	78.04%		Rowan Proctor	80.36%	82.41%	80.00%	79.65%	↘			
Reduction in the proportion of births that are undertaken as caesarean sections.	22.70%	19.05%	19.15%		Rowan Proctor	23.08%	20.37%	17.44%	19.0%	↘			

Other contract / National targets													
Mixed Sex Accomodation breaches	0 Breaches	0	5		Jon Green	2	0	0	0	↔			
Consultant to Consultant referral	Commisioner to audit if concern about levels of consultant referrals	ND		Due to data quality issues with eCare we are unable to report on referrals at this time	Jon Green	ND	ND	ND	ND	-			
MRSA - emergency screening	100% Screened within 24 hours	TBC	TBC	Figures currently unavailable due to issues with TPP providing us with the data required	Rowan Proctor	TBC	TBC	TBC	TBC	-			
MRSA - Elective screening	100% Screened prior to admission		TBC		Rowan Proctor	TBC	TBC	TBC	TBC	-			
Rapid access - chest pain clinic	100% of patients should have a maximum wait of two weeks	87.50%	79.56%		Jon Green	97.44%	94.34%	73.44%	87.50%	↗			
Acute oncology service: 1 hour to needle from diagnosis of neutropenic sepsis	100%	100.00%	98.48%	MacMillan	Jon Green	100.00%	100.00%	100.00%	100.00%	↔			
		80.00%	78.81%	ED	Jon Green	78.95%	82.35%	83.33%	80.00%	↘			
		90.48%	94.57%	Overall Trust (Inc AMU)	Jon Green	84.00%	88.00%	88.24%	90.48%	↗			
New to Follow up	Thresholds set at each speciality - overall Trust Threshold is 1.9	2.15	1.98		Jon Green	1.98	2.08	2.01	2.15	↗			
Patients receiving primary diagnostic test within 6 weeks of referral for diagnostic test	99%	94.83%	95.77%		Jon Green	91.78%	96.40%	99.40%	94.83%	↘			
All relevant inpatients undergoing a VTE Risk assessment	95%	TBC			Jon Green	TBC	TBC	TBC	TBC	-			

Key: ↗ performance improving, ↘ performing deteriorating, ↔ performance remains the same.

4.1 A&E - Single longest total time spent by patients in the A&E department, for admitted and non-admitted patients

a) Current Position

The Trust remained outside the contractual target.

b) Recommended Action

This time is one of isolation and was the case of a psychiatric patient for which a serious case review has taken place. Recommendations are due to follow after a number of failings by NSFT. There has however been cases which have exceeded the 6hrs in the context of significant capacity issues. The demand has increased in both volume and acuity with the onset of the colder weather. The majority of the Emergency Care Group work streams have now been implemented which has seen a shift in reason for breach from ED attributable to flow/capacity limitations. As a result the trust has established the Flow Action Group which brings colleagues from around the trust together to tackle limitations to flow and discharge. The most significant project which is being implemented is the 'Red to Green' which highlights all patients who are not progressing in their care pathway whilst actively planning for discharge and involving them in the care plans. This is being rolled out across the hospital by the Transformation Team. With this improvement in flow we anticipate the maximum waiting time in ED will decrease.

4.2 A&E – threshold for admission via A&E

a) Current Position

34.02% against a threshold of 27%.

b) Recommended Action

The Trust has continued to experience significant demand. This demand has increased in both volume and acuity with the onset of the colder weather. As a result 'sicker' patients are presenting to our hospital requiring a more intense or prolonged period of therapy. Active challenge within the department is now common place to ensure patients are not unnecessarily admitted to wards. The revised CDU policy is promoting a more 'appropriate' cohort of patients being admitted in. This is demonstrating a higher turnover therefore allowing for more admissions into CDU. This alone will significantly add to this figure.

4.3 Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway under 26 weeks

a) Current Position

97.15% against a threshold of 99%.

b) Recommended Action

Wait times for first appointment within ENT at around 30-32 weeks. Oral Surgery wait times in excess of 26 weeks for first appointment. Patients are waiting over 26 weeks for Urology surgery, due to pressures within the service and multiple cancelled lists due to sickness. Patients waiting over 26 weeks for Vascular surgery

and follow up appointments (whilst still on an active pathway), due to their refusal to do any additional lists at standard rates.

4.4 Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted

a) Current Position
70.60% against a threshold of 90%.

b) Recommended Action
Patients waiting 45-50 weeks for major ear surgery within ENT. Additional sessions completed in Oral Surgery and Ophthalmology to try and reduce the backlog, which has had an impact on the admitted performance. Clinic capacity issues within Dermatology, causing delays to treatment. Increase in referrals within Urology and demand on cancer services. Escalated trauma patients within Orthopaedics has led to electives being delayed.

4.5 Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted

a) Current Position
89.37% against a threshold of 95%.

b) Recommended Action
Large volume of additional clinics performed in Oral Surgery to reduce the backlog. Increase in referrals for 2WW patients in Dermatology, Colorectal and Urology, pushing out waiting times for routine. Lack of consultants in Cardiology to cover chest pain clinics – once locum cover was arranged patients breaching. Known capacity issues within ENT.

4.6 Stroke - >80% treated on a stroke unit >90% of their stay

a) Current Position
88.57% against a threshold of 90%.

b) Recommended Action
Four out of 35 patients breached. For two of these, there were no stroke unit beds available. One patient suffered an inpatient stroke and it was deemed best for the patient to leave them on their base ward where they later passed away. The fourth was another inpatient stroke, where there was late notification to the stroke team.

4.7 Discharge Summaries – Inpatients

a) Current Position

92.28% against a target of 95% sent to GPs within 1 day

b) Recommended Action
The Trust is reviewing the ability of e-Care to produce a cut down version of the discharge summary for daycase patients, as many of the data items are not required, which will improve completion of the discharge summaries further. The Trust is creating some additional reporting on compliance to the standard at a more frequent interval to drive up performance.

4.8 Breastfeeding initiation rates

a) Current Position

79.65%% against a threshold of 80%

b) Recommended Action
After several months of good breastfeeding initiation rates there was unfortunately a reduction in December 2016. It is unclear at present why this occurred however the maternity service continues to work toward achieving high levels of breast feeding initiation. The service is preparing for a planned Baby Friendly Initiative (BFI) assessment in the summer and is undertaking both staff and patient audits to establish where any deficits may be found which it is hoped would support an increase in breastfeeding initiation.

4.9 Rapid access - chest pain clinic

a) Current Position
87.50% against a threshold of 100%

b) Recommended Action
Demand for rapid access continues to remain high. For the month of December we did not have a locum to assist with clinics. We now have a locum to replace our vacant post plus a second one providing daily clinics.

4.10 Acute Oncology Service: 1 hour to needle from diagnosis of neutropenic sepsis

a) Current Position
Macmillan - 100%
ED - 80.00%
Overall Trust figure (including AMU) of 90.48% against a threshold of 100%

a) Recommended Action
There was one case that did not achieve the Neutropenic Sepsis 1 hour door to needle time. The case related to a patient within the Emergency Department. Following review if was found access to the patient's PICC line was the cause of the delay in administering antibiotics. Staff Nurse PICC line competences are monitored through the Neutropenic Sepsis Group.

4.11 Patients receiving primary diagnostic test within 6 weeks of referral for diagnostic test

a) Current Position
94.83% against a threshold of 99%

b) Recommended Action
There continues to be improvements in diagnostic waiting times for the majority of diagnostic tests. However, December saw an unprecedented increase in the number of patients where the Echocardiography diagnostic breached the 99% threshold. The position worsened considerably as a consequence of the following issues:

1. An increase in rapid access referrals for patients on the two week pathway. As a consequence of NICE recommendations these patients are given priority for the test. In addition, the Trust agreed to take on CUHFT activity as they were unable to manage demand
2. Competing demands for the diagnostic, for example; in May 2016 there were around 700 patients awaiting a follow-up outpatient appointment. The department also provides the test for in-patients, often to facilitate discharge and due to Red to Green initiative, patient requests are now timely. This has had a significant impact on demand.
3. There is on average 350 slots available each month. Demand (including New & Rapid Access) is approximately 400 per month. In additional there are on average 330 Follow-up and 150 in-patients tests to do resulting in a monthly demand of approximately 550. Current workforce are working overtime to rectify this.
4. E-Care allows any clinician to request the test – this has had an impact on number of referrals

In order to recover this unacceptable position, further work is being undertaken - see table 1.

Table 1.

Recovery Action Plan			
Item	**Issue / Constraint**	**Action**	**Timeframe**
1	Increased number of referrals requiring echo	Gather data to understand specific GP practice referral rates which are leading to the increase in demand	24.01.17
2	Workforce	a) Immediate request to secure a locum Physiologist b) Review current Physiologist establishments in line with activity demand & forecasts	In post by 30.01.17 06.02.17
3	Equipment	Fast track the leasing of an additional Echo machine through procurement	25.01.17
4	In sufficient space within the department	Secure a room to enable diagnostics to perform additional test	Complete
5	Advanced performance notice to improve activity monitoring	Create a weekly performance report; manage 6 week diagnostic demand in line with targets and proactively manage against other scan requirements	24.01.17

5. WORKFORCE

This section identifies those areas that are breaching or at risk of breaching the Workforce Indicators, with the main reasons and mitigating actions.

Performance Indicator	Threshold	YTD	Comments
Workforce			
Sickness absence rate	<3.5%	3.93%	
Turnover	<10%	10.17%	
Reviews	Grievance/Banding reviews	4	
Recruitment Timescales	Average number of weeks to recruit = 7	6	
DBS Checks	To complete 95% of required DBS checks	98.50%	
All Staff to have an appraisal	Both general and consultant staff each have a target of 90% to have had an appraisal within the previous 12 months. Appraisal is a rolling programme	92.00%	

5.1 Sickness Absence Rate

a) Current Position

3.93% against a threshold of <3.5%.

b) Recommended Action

Noroviris on wards has contributed to this slight rise on last month. Support continues to be offered to managers and staff.

5.2 Turnover

a) Current Position
10.17% against a threshold of <10%.

b) Recommended Action
This is an improvement from last month and is the result of the work undertaken by the workforce team in resignations and dismissals.

6. RECOMMENDATION

The Board is asked to note the Trust Quality & Performance Report and agree the implementation of actions as outlined.

Appendix A – Community Data

Adult KPI's									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Dec 2016**	**Method of measurement**	**December Comments / Queries 2016**	**Oct 2016**	**Nov 2016**
SCH		D4-qoc1	Number and % of service users who rated the service as 'good' or 'better'.	85%		Quarterly		98.23%	
SCH		D4-qoc2	Number and % of service users who responded that they felt 'better'.	85%		Quarterly		95.03%	
SCH		D4-qoc2	Number and % of service users who responded that they felt 'well informed'.	85%		Quarterly		94.28%	
SCH		D5-acc4	18 week referral to treatment for non-Consultant led services 15 services: Paed OT, PT, SALT, Adult, Wheelchairs, Podiatry, Biomechanics, Stoma nurses, Neuro nurses, Parkinson's, SCARC, Environmental, H Failure, Hand Therapy & Continence	95% patients treated within 18 weeks	99.92%	Monthly		99.71%	100.00%
SCH		D5-acc8	18 week referral to treatment for Consultant led services Inpatient rules - Foot and Ankle Outpatient rules - Paediatrics (E&W)	95% patients to be treated within 18 weeks	92.94%	Monthly	F&A are compliant to the 18week RTT. All the breaches are in the Paediatric service	86.16%	87.28%
SCH		PU-001-a PU-001-b	No increase in the number of Grade 2 and Grade 3 pressure ulcers (as per agreed definition), developed post 72 hours admission into SCH care, compared to 12/13 outturn. This measure includes patients in in - patient and other community based settings.	No increase in 12/13 outturn. Zero	0	Monthly		0	0
SCH	Dementia	c-gen4	All community clinical staff to receive relevant dementia awareness training	95%	94.10%	Monthly	This slight downturn is due to a significant number of staff caming back to work after long term sick. We expect this compliance to improve in January.	96.30%	94.62%
SCH	Canc by Prov	c-gen7	% of clinics cancelled by the Provider		0.12%	Quarterly			.
SCH	Safeguarding - children	c-safe1	% eligible staff who have completed level 1 training	98%	97.12%	Monthly	This slight downturn is due to a significant number of staff caming back to work after long term sick. We expect this compliance to improve in January.	96.81%	97.52%
SCH	Safeguarding - adults	c-safe2	% eligible staff who have completed level 1 training	98%	96.94%	Monthly		96.45%	97.25%
SCH	Disch summ	dis summ-CQUIN	% of discharge summaries from the following services; Community Hospital, Adult SaLT, Community Intervention & Leg ulcer service, that are provided to GP practices within 3 days of discharge from the service (previously within 1 day of discharge).	95%	98.00%	Monthly		100.00%	100.00%
InPt		D3-str3	% of patients requiring a joint community rehabilitation Care Plan have one in place ahead of discharge from acute hospital.	75%	100.00%	Monthly		100.00%	100.00%
InPt		D3-str4	% of appropriate stroke survivors whose community rehabilitation treatment programme started within 7 days of leaving acute hospital, or ESD, where agreed as part of the care plan (SSNAP). The definition of 'Appropriate Patients' is - all patients requiring continued therapy input.	75%	100.00%	Monthly		100.00%	100.00%
InPt	MRSA	c-inf1	Number of cases	No cases	0	Monthly		0	0
InPt	MRSA	c-inf2	Completed RCAs on all community cases of MRSA	100%	N/A	Monthly		N/A	N/A
InPt	C-Diff	c-inf4	Completed RCAs on all community hospital outbreaks of C difficile	100%	N/A	Monthly		N/A	N/A
InPt	Comm Hosp	s-ip7	Number of inpatient falls resulting in moderate or significant harm	No more than 1.25 per month (15 per annum) falls/1000bed days	0.58	Monthly		0.43	0
InPt	IDPT	s-disch4	Transfer from acute hospital to community based provision from receipt of referral within a timescale not exceeding 48 hours providing the Service User is medically and physically fit for discharge	80% of Service Users medically and physically fit for discharge	Service no longer supports this KPI - as agreed with CCG Oct 2016	Monthly		94.12%	100.00%
InPt	Step Up Adm Prevention Comm Beds	s-apcb1	The community beds will be available for access across the 24 hour 7 days a week	100%	100.00%	Monthly		100.00%	100.00%
InPt	Step Up Adm Prevention Comm Beds	s-apcb6	All Service Users will have a management plan agreed with them and their family/carer where applicable within 24 hours from arrival.	98%	100.00%	Monthly		100.00%	100.00%
IHT		D2-ltc4	% of people with COPD who accept a referral to a pulmonary rehabilitation programme who complete the prescribed course and are discharged within 18 weeks of initial referral by a GP/health professional.	95%	100.00%	Monthly		100.00%	100.00%
IHT	CCC	D4-int1	Care coordination centre - % of telephone calls answered within 60 seconds	95% in 60secs	93.75%	Monthly	# of calls handled: 16,108 # of calls answered in 0-60 seconds: 15,101 % 0-60 seconds: 93.75% Number of abandoned calls: 406 Abandoned calls %: 2.46% Average Wait Time: 16 seconds Average Wait Time: 16 seconds	91.67%	93.12%

Host	Service	Technical Reference	Quality Requirement	Threshold	Dec 2016	Method of measurement	December Comments / Queries 2016	Oct 2016	Nov 2016
IHT		D4-ccc6	% of responders (to include referrers, carers and service users) who rate the CCC as good or above. The definition of referrers will need to be defined/agreed.	85%	97.00%	Quarterly			
IHT	Card Rehab	s-card5	Number of service users successfully discharged from phase 3.	600 per annum: (trajectory of 50 Service Users in total per month)	no longer reporting as of July 16	Monthly		no longer reporting as of July 16	no longer reporting as of July 16
IHT	COPD	s-copd4	Number of pulmonary rehab courses offered	At least 500 courses offered per year	39 offered	Monthly		48 offered	58 offered
IHT	COPD	s-copd4	Number of pulmonary rehab courses completed	At least 250 courses completed per year	48 completed	Monthly		39 completed	10 completed
IHT	COPD	s-copd5	Community pulmonary rehabilitation - review offered 6 months after completing the course	95%	100.00%	Monthly		100.00%	100.00%
IHT	Comm Continence	s-cc3	% of Service Users re-assessed at 6 weeks	98%	no longer reporting as of November 16	Monthly		98.47%	no longer reporting
IHT	Comm Continence	s-cc4	% of Service Users re-assessed at 12 monthly intervals (previously 6 monthly intervals)	98%	100.00%	Monthly		100.00%	100.00%
IHT	H Failure	s-hf4	% of Service Users seen within 14 days of receipt of referral	85% within 14 days referral	no longer reporting as of July 16	Monthly		no longer reporting as of July 16	no longer reporting as of July 16
IHT	MIU	s-miu3	Timeliness Indicators: 1) Total time spent in A& E department 2) Time to initial assessment (95th percentile) 3) Time to treatment in department (median) 1) 95% of Service Users waiting less than 4 hours 2) 95th percentile time to assessment above 15 minutes 3) median time to treatment above 60 minutes		#1 = 100%	Monthly		#1 = 100%	#1 = 100%
IHT	MIU	s-miu4	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who rated the service as "good" or better	85%		Quarterly			
IHT	MIU	s-miu4	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who responded that they felt "supported".	85%		Quarterly			
IHT	MIU	s-miu4	A+E Service experience: Quarterly Service User satisfaction surveys Number and % of service users who responded that they felt "well informed".	85%		Quarterly			
IHT	MIU	s-miu5	Total time spent in A+E department 95% of Service Users waiting less than 4 hours for admitted Service Users and with the same threshold for non-admitted measured over each Quarter rather than monthly (or, where the Quarter does not begin on 1 July, measured over each three-month period beginning on 1 July)	95%	100.00%	Monthly		100.00%	100.00%
Mede	CES	c-gen8	Response times from receipt of referral: Within 4 hours – Service Users at end of life (GSF prognostic indicator)	98% for all standards	96.95% (191/197)	Monthly	Relates to 6 items. All items were delivered within 5 hours of the request	85.92% (122/142)	97.12% (135/139)
Mede	CES	c-gen8	Same Working day - Urgent equipment	98.00%		Monthly			
Mede	CES	c-gen8	Next Working day - Urgent equipment	98.00%	99.74% (754/756)	Monthly		95.83% (661/693)	98.31% (758/771)
Mede	CES	c-gen8	Within 2 working days - to support hospital discharge or prevent admission	98.00%		Monthly			
Mede	CES	c-gen8	Within 3 working days - to support hospital discharge or prevent admission	98.00%		Monthly			
Mede	CES	c-gen8	Within 5 working days - to support hospital discharge or prevent admission	98.00%		Monthly			
Mede	CES	c-gen8	Within 7 working days - to support hospital discharge or prevent admission		99.74% (1939/1944)	Monthly		98.67% (2076/2104	99.45% (2175/2187
Mede	CES	c-gen8	Within 10 working days - to support hospital discharge or prevent admission	98.00%	99.81% (526/527)	Monthly		95.56% (581/608)	96.38% (559/580)
Mede	CES	c-gen9	Collection times: % of urgent next day collections for deceased Service Users	98% for all standards	99.16% (354/357)	Monthly		97.39% (298/306)	100% (137/137)
Mede	CES	c-gen9	% of urgent collections within 2 working days	98.00%		Monthly			
Mede	CES	c-gen9	% of urgent collections within 3 working days	98.00%	99.53% (213/214)	Monthly		98.75% (948/960)	99.07% (425/429)
Mede	CES	c-gen9	% of urgent collections within 5 working days	98.00%		Monthly			
Mede	CES	c-gen9	% of collections within 10 working days	98.00%	99.38% (4456/4484)	Monthly		96.90% (4096/4227	98.52% (4799/4871
Mede	Ass Tech	s-at2	All long term service users to have a minimum annual review	100%	100.00%	Monthly		100.00%	100.00%
Mede	Ass Tech	s-at4	Delivery of equipment within agreed time frames	95%	100.00%	Monthly		100.00%	100.00%
Mede	Wheelchair	s-wchair1	All Service Users have a first appointment/contact seen after initial response time according to priority / need: High Priority	within 6 weeks 100%	N/A	Monthly		N/A	N/A
Mede	Wheelchair	s-wchair1	Medium Priority	within 12 weeks	N/A	Monthly		N/A	N/A
Mede	Wheelchair	s-wchair1	Low Priority	within 18 weeks	100.00%	Monthly		88.89%	88.89%

Host	Service	Technical Reference	Quality Requirement	Threshold	Dec 2016	Method of measurement	December Comments / Queries 2016	Oct 2016	Nov 2016
NCHC		D2-ltc2-a	% of people that have been identified by case finding, (using risk stratification, or other means), and deemed suitable for intervention by the MDT, and referred to SCH, that have a care lead.	95%	100.00%	Monthly		100.00%	100.00%
NCHC		D2-ltc2-b	% of people identified via case finding, that have a care plan (including self-care) that has been shared with the GP practice within two weeks of the patient coming onto the caseload. The GP practice will require a copy of the care plan, and the information will be shared with the MDT, which includes a GP. For clarity, the definition of an MDT is; 'A virtual or real team of health and care practitioners, who could be, or are involved in patient's care. An MDT does not necessarily mean a physical meeting.'	95%	100.00%	Monthly		100.00%	100.00%
NCHC		D5-ccc7	% of referrals seen following triage; Emergency - 2 hrs	Emergency - 100%	100.00%	Monthly		100.00%	100.00%
NCHC		D5-ccc7	Urgent 4 hrs	Urgent - 95%	97.36%	Monthly		99.16%	98.56%
NCHC		D5-ccc7	Intermediate - 72 hrs	Intermediate - 95%	98.81%	Monthly		98.12%	98.14%
NCHC		D5-ccc7	18 weeks	18 weeks - 95%	98.88%	Monthly		99.43%	99.28%
NCHC		D4-int1	Community Health Team Leads and/or Local Area Managers to work with GP practices and establish direct working relationships that aid mutual understanding and aim to improve the quality of services to patients. A schedule of face to face meetings is to be agreed and adhered to by both parties and a joint action plan is to be produced that shall be regularly reviewed. % of link GP practices and Community Health Team Leads who feel that they have a 'positive working relationship' with each other. A joint action plan is expected to be maintained All link GP Practices and respective CHT leads to be surveyed quarterly, moving to six monthly at an agreed point	80%		Quarterly			
NCHC	PHP	c-php1	Number of Service Users with the following Long term conditions with a Personal Health plan (Parkinson's Disease, Multiple sclerosis, Muscular Dystrophy, Chronic Obstructive Pulmonary Disease, all other chronic respiratory diseases, Coronary Heart Disease, Heart Failure).	80% completed	96.00%	Monthly		96.67%	96.55%
NCHC	IDPT	s-disch1	Triage and assessment of referrals within 1 Operational Day	98%	Service no longer supports this KPI - as agreed with CCG Oct 2016	Monthly		98.44%	100.00%
NCHC	IDPT	s-disch2	Urgent discharge achieved (<24 hours from referral to the team) for Service Users terminally ill and wishing to die at home	85%	0.00%	Monthly	6 patients referred: 2 patients omitted from the data as still inpatients, of the remaining 4: 2 patients awaited care packages 2 patients deischarged at 27hours and 24hrs 20 mins	100.00%	N/A
NCHC	EAU CIS	eau-cis-IHT	% of patients seen within 2 hrs. of initial referral. The Senior Nurse (part of the CIS) allocated to the EAU at IHT will begin patient assessment within 2 hrs of consultant referral.	98%	N/A	Monthly		N/A	N/A
NCHC	Verification of expected death training	c-gen2	Number of qualified nursing staff trained in Service User areas, community nursing teams and local Healthcare teams (to include all clinical staff from within planned care, urgent care, & intensive case management as the integrated service model is implemented)	90%		Monthly			
WSH	Adult SALT	s-salt1	All new referrals are triaged within 5 Operating Days of receipt of referral;	98%	98.80%	Monthly		98.55%	97.74%
WSH	Adult SALT	s-salt2	Service Users seen within the following timescales after triage: Priority 1 within 10 Operating Days	Priority 1 - 100%	100.00%	Monthly		90.00%	90.91%
WSH	Adult SALT	s-salt2	Priority 2 within 20 Operating Days	Priority 2 - 95%	99.00%	Monthly		99.00%	98.51%
WSH	Adult SALT	s-salt2	Priority 3 within 18 weeks	Priority 3 - 95%	100.00%	Monthly		100.00%	100.00%
WSH	Medical Appliances	s-ma1	% of appointments available within 6 weeks	95%	100.00%	Monthly		100.00%	100.00%
WSH	Medical Appliances	s-ma2	% of urgent cases seen within one working day	100%	No Urgent referrals received	Monthly		No Urgent referrals received	No Urgent referrals received
WSH	Parkinson's Disease	s-pd2	% service users on caseload who have an annual specialist review	95%	100.00%	Monthly		100.00%	100.00%

Children's Services KPIs									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Dec 2016**	**Method of Measurement**	**Nov Comments/ Queries 2016**	**Oct 2016**	**Nov 2016**
WSH	All Paediatric Services	GP-1	18 week RTT for Consultant led services	95%	80.00%	Monthly	12 (all East)treated breaches out of 83. There is an element of patient choice, vulnerable families and service capacity affecting this performance. An action plan is being submitted.	75.00%	73.49%
WSH	All Paediatric Services	GP-1	18 week RTT for non-Consultant led services	95%	100.00%	Monthly		98.56%	100.00%
WSH	All Paediatric Services	PaedSLT-4	All Children to have a Personal Health plan completed where required.	100% Service Users offered a PHP	100.00%	Monthly		100.00%	100.00%
WSH	All Paediatric Services	GP-6	Safeguarding - % eligible staff who have completed level 1 training	98%	99.53%	Monthly			100.00%
WSH	All Paediatric Services	GP-9 PDL-01	Discharge Letters - to be sent within 24 hours of discharge from a community hospital and 72 hours of discharge from all other caseloads (all discharge letters whether electronic/non electronic to clearly state date dictated, date signed and date sent)	95%	100.00%	Monthly		97.14%	100.00%
WSH	All Paediatric Services	PaedSLT-5	Personalised Care Planning - Percentage of Transition (to adults) Care Plans completed	From Q4 2012/13 no deterioration on baseline		Annual	Annual Report		
WSH	Newborn Hearing Screening Service (West)	NBHS-2	Timely screening – where consented screens to be completed by four weeks of age	95%	99.62%	Monthly		98.12%	99.15%
WSH	Newborn Hearing Screening Service (West)	NBHS-3	Screening outcomes set within 3 months	≥99%	99.65%	Monthly		98.03%	99.54%
WSH	Community Children's Nursing	CCN-14 cps-ip02	% of children identified as having high level needs being actively case managed.	Q3 2012/13 establish baseline Q4 2012/13 onwards >75%	100.00%	Monthly		100.00%	100.00%
WSH	Leapfrog Therapeutic Service	Leap-8	Outcomes achieved for children utilising the services	Annual report produced		Annual	Annual report		
WSH	Therapy Focus Suffolk	TFS-6	All relevant staff that have been 'Bobath' update trained	100%		Annual	Annual report		
WSH	Access	cps-a02	Children/young people in special schools receive speech and language interventions	100%	100.00% 117 contacts	Monthly		100.00% 259 contacts	100.00% 273 contacts
WSH	Access	ots-a02	Children/young people in special schools receive OT interventions	100%	100.00% 143 contacts	Monthly		100.00% 155 contacts	225 contacts
WSH	Children in Care	CiC-001a	The Provider will aim to achieve 100% compliance with the guidance to ensure that all CiC will have a Specific, Measurable, Achievable, Realistic and Time-scaled (SMART) health care plan completed within 28 days of a child becoming looked after. All initial health assessments and SMART care plans are shared with appropriate parties.	100% in 28 days	14.29%	Monthly	1 out of 7 IHAs were completed wthin 28 days of the child being placed in care 6 out of 7 IHAs were completed wthin 28 days of the service being notified of the child The 7th child declined 2 offered appointments and was seen on day 30 The service continues to improve on the IHAs completed within 28 days of being notified	25.00%	10.00%
WSH	Children in Care	CiC-001b	Initial Health Assessments that are completed within 28 days of receiving ALL relevant paperwork	100% in 28 days	85.71%	Monthly		62.50%	80.00%
WSH	Children in Care	CiC-001c	Initial Health Assessment appointments that are OFFERED within 28 days of receiving ALL relevant paperwork	100% in 28 days	100.00%	Monthly		62.50%	90.00%

1 18 week referral to treatment for Consultant led services – Paediatrics (E&W)

a) Current Position
92.94% against a 95% target
All 12 breaches are in the East Service.
The service currently has 0.6 and 0.4wte vacancies in the East and West of the county respectively.

b) Recommended Action
- Continued focus on recruitment to the 0.4 and 0.6 wte vacancies in the East and West of the service. Vacancy is out to advertisement and interview date set for early March.
- Complete a "deep dive" review of referrals and pathway in January.
- Ensure clinical prioritisation of caseloads as part of above review.
- Review the current service referral criteria and benchmark with neighbouring paediatric services, recommendations to follow.
- Review clinical priority of children on follow up caseload.

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2 Dementia Awareness Training for clinical staff – All community clinical staff to receive relevant dementia awareness training

a) Current Position
Currently 94.10% against 95% target. This slight decrease is due to several staff coming back from long term sick and being out of date with their mandatory training due to the length of time they have been absent.

b) Recommended Action
- All service leaders and team leads have received emails detailing which of their staff are out of date.
- Additional sessions provided.

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3 Adult & Children Safeguarding Training – All providers - % eligible staff who have completed level 1 training

a) Current Position
Currently 96.94% and 97.12% for Adult and Children Safeguarding training against 98% target. Trajectory target for December was 98%. SCH is awaiting confirmation from the CCG that the target will be reduced to 95% in line with other Suffolk providers. This slight decrease in compliance is due to several staff coming back from long term sick and being out of date with their mandatory training.

	Adult Safeguarding	Children Safeguarding
IHT	95.79%	95.33%
NCHC	97.09%	97.29%
WSH	97.38%	97.90%

b) Recommended Action
- SCH has produced a trajectory to return to 98% compliance.
- Continued focus on identifying out of date staff.
- Sending reminders to staff and managers before they come out of date.

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4 Care coordination centre - IHT- % of telephone calls answered within 60 seconds

a) Current Position
93.75% against 95% target.

This met the revised RAP target of 93% for December but is below the 95% KPI target.

The CCG have kept the RAP open for a further month.

b) Recommended Action

- A remedial action plan has been agreed with the Commissioners.
- Continue working through the actions identified in the remedial action plan.
- Weekly monitoring in place.
- Continued focus on recruitment, currently 7 vacancies of which 5 have been recruited to with start dates during February and March.

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5 Community Equipment Services – Medequip – Next Working day delivery and urgent collections within 3 working days

a) Current Position

96.95% against 98% target – Delivery within 4 hours, 191 out of 197 deliveries made within time
This relates to 1 delivery of 6 items to the same patient. The 6 items were delivered within 5 hours.

b) Recommended Action

- The service is actively working with the requestors to ensure items are requested for appropriate delivery times.
- Communication sent out to referrers to remind of appropriate use of 4 hour request slots.
- Review of items available for 4 hour delivery being undertaken.
- Request action plan for improved compliance through contract meetings.

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6 Discharge Planning - s-disch2 – Urgent discharge of terminally ill patients within 24hours for service users who wish to die at home

a) Current Position

0% against 100% target.
6 patients referred to the service. 2 were omitted from the data as they needed to remain acute inpatients, of the remaining 4:
2 were delayed due to awaiting care packages
2 were discharged at 27 hours and 24 hours 20mins.

b) Recommended Action

- Service capacity is currently under review jointly with commissioners. A new service specification is being considered that would potentially broaden the scope of the service, with additional resources recognised as being needed.
- Opportunities for integration between community and acute teams being explored that would improve service efficiencies and create capacity.

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7 CIC-001a&b Children in Care – WSH – Children in Care receiving a completed Initial Health Assessment within 28 days of becoming looked after and receiving a completed IHA within 28 days of SCH receiving ALL relevant paperwork

a) Current Position

CiC-001a –14.29% against a 100% target
CiC-001b – 85.71% against a 100% target
CiC -001c – 100.00% against a 100% target

7 Initial Health Assessments were completed in December. 1 was completed within 28 days of becoming CiC, 6 were completed within 28 days of the service receiving ALL the paperwork.

All 7 families had been offered appointments within 28 days of the service receiving their information. The family of the child that was seen outside of 28 days declined 2 appointment offers within 28 days and was seen on day 30.

b) Recommended Action

- The service is continuing to monitor the capacity provided by the new pathway, which currently is sufficient to provide the correct number of appointments.
- The DNA rates of agreed Initial Health Assessments has been reviewed and escalated to Suffolk County Council.
- A meeting with the Local Authority Safeguarding manager has been arranged to discuss foster carers responsibilities for the booking and agreeing timely Initial Health Assessments.

	Units	Target	Red	Amber	Green	Jul	Aug	Sep	Oct	Nov	Dec
Patient Experience											
Service users who rated the service as 'good' or 'better' (Quarterly)	Nos.	No Target						1557			
	%	85%	<80%	80%-85%	>=85%			98.23%			
Service users who responded that they felt 'better'	Nos.	No Target				157	100	106	159	179	115
	%	85%	<80%	80%-85%	>=85%	92%	95%	98%	94%	94%	94%
Service users who felt 'well informed'	Nos.	No Target				270	165	133	187	190	144
	%	85%	<80%	80%-85%	>=85%	93%	96%	94%	93%	90%	96%
10% of long term condition patients feel "better supported" to self manage their conditions (Quarterly)	Nos.	No Target						119			
	%	No Target						100%			
Falls (Inpatient Units)											
Total numbers of inpatient falls (includes rolls and slips)	Nos.	No Target				34	34	47	26	59	60
Rolls out of Bed		No Target				2	4	1	1	1	5
Slip out of chair		No Target				1	3	2	0	3	3
Assisted Falls/ near misses		No Target				4	6	5	4	0	1
% of total falls resulting in harm	%	No Target				21%	32%	19%	15%	29%	22%
Numbers of falls resulting in moderate harm	Nos.	No Target				1	0	1	0	0	0
Numbers of falls resulting in severe harm	Nos.	No Target				0	1	0	0	0	2
Numbers of patients who have had repeat falls	Nos.	No Target				6	8	8	6	10	13
% of RCA reports for repeat fallers	%	100%	90%-95%	95%-100%	=100%	100%	100%	100%	100%	100%	100%
Numbers of falls per 1000 bed days (* from Oct 2015 includes commissioned bed numbers)		<1.25/1000 beddays	>1.50	1.25-1.50	<=1.25	11.71	12.5	13.3	7.6	17.3	17.4
Pressure Ulcers											
Pressure Ulcers – In Our Care Community											
Grade 2		100 pa	>110	100-110	<=100	13	6	13	18	13	19
Grade 3		26 pa	>30	27-29	<=26	2	4	5	10	10	6
Grade 4		0 pa	>1	1	0	1	0	0	0	0	1
Pressure Ulcers – In our care In-patient											
Grade 2		13 pa	>17	13-17	<=13	1	0	2	2	4	5
Grade 3		2 pa	>4	02-Apr	<=2	0	1	0	1	2	0
Grade 4		0 pa	>1	1	0	0	0	0	0	0	1
Safeguarding People Who Use Our Services From Abuse											
Number of adult safeguarding referrals made		No Target				2	5	1	5	3	5
Satisfaction of the providers obligation eliminating mixed sex accomodation		No Target				100%	100%	100%	100%	100%	100%

	Units	Target	Red	Amber	Green	Jul	Aug	Sep	Oct	Nov	Dec
MRSA											
Bacteraemia – Number of cases		0	>2	>0 to 2	=0	0	0	0	0	0	0
MRSA RCA reports		100%	<95%	95%-100%	=100 %	0	0	0	0	0	0
Clostridium Difficile											
C.Diff number of cases		4 for 6 months	>4 YTD		<=4 YTD	c	0	1	0	0	0
C.Diff associated diseases (CDAD) RCA reports		100%	<95%	95%-100%	=100 %	N/A	N/A	100%	N/A	N/A	N/A
Infection Control											
Infection control training		100%	<83%	83%-100%	=100 %	83.45%	88.34%	88.82%	88.39%	90.17%	91.00%
Essential Steps Care Bundles Including Hand Hygiene											
Hand hygiene audit results - 5 moments SCH overall compliance.	Yes	100%	<95%	95%-100%	=100 %	98.00%	98.00%	99.00%	99.00%	98.00%	99.00%
Isolation room audit		100%	<95%	95%-100%	=100 %	100%	100%	100%	100%	100%	100%
Management of Medication -SCH NRLS Reportable Incidents											
Total number of medication incidents in month		No Target				10	13	8	4	9	16
Level of **actual** patient harm resulting from medication incidents	No harm	No Target				7	10	5	4	8	15
(also includes those not attributed to SCH management)	Low harm	No Target				3	3	3	0	1	1
Number of medication incidents involving Controlled Drugs		No Target				0	3	1	1	1	0

Incidents											
NRLS (i.e. patient safety) reportable incidents in month		No Target				120	145	165	160	191	178
Number of Never Events in month		No Target				0	0	0	0	0	0
Number of Serious Incidents (SIs) that occurred in month		No Target				0	1	0	11	12	9
Number of SIs reported to CCG in month		No Target				0	1	0	11	10	9
Percentage of SI reports submitted to CCG on time in month		No Target				N/A	100%	N/A	0%	100%	100%
Duty of Candour Applicable Incidents		No Target				5	7	7	11	9	10

Severity of NPSA Reportable Incidents											
None		No Target				75	97	115	117	125	119
Low		No Target				40	39	43	32	54	50
Moderate		No Target				4	8	7	11	12	6
Major		No Target				1	1	0	0	0	3
Catastrophic		No Target				0	0	0	0	0	0

Training Compliance											
Adult Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	89.45%	92.31%	92.96%	96.45%	97.25%	96.94%
Children Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	91.50%	91.61%	94.28%	96.81%	97.52%	97.12%
Dementia Care – Mandatory Training Compliance		95%	<90%	90%-95%	>95%	92.50%	93.88%	95.60%	96.30%	94.62%	94.10%
WRAP									35.50%	44.48%	44.47%
MCA / DoLs- Training compliance									64.80%	71.46%	70.97%

Total Compliments	21	61	47	47	52	21	33	19	46	21	38	28	36	27
Total SCH Complaints	3	2	5	4	3	4	2	6	7	5	1	1	2	2
Acknowledged within 3 days	100%	50%	80%	100%	100%	60%	100%	50%	83%	100%	100%	50%	50%	100%
%of Responses within 25 days	100%	100%	20%	50%	66%	25%	50%	33%	71%	TBC	0%	100%	50%	-
Responded to within 25 days	3	0	1	2	2	1	1	2	5	TBC	0	1	1	-
Responded to after 25 days	0	0	4	2	1	3	1	4	2	TBC	1	0	1	-
Average response time (days)	13	26	30	23	29	31	33	30	24	TBC	31	19	TBC	-

Progress on Paediatric SLT Service Variation monies.

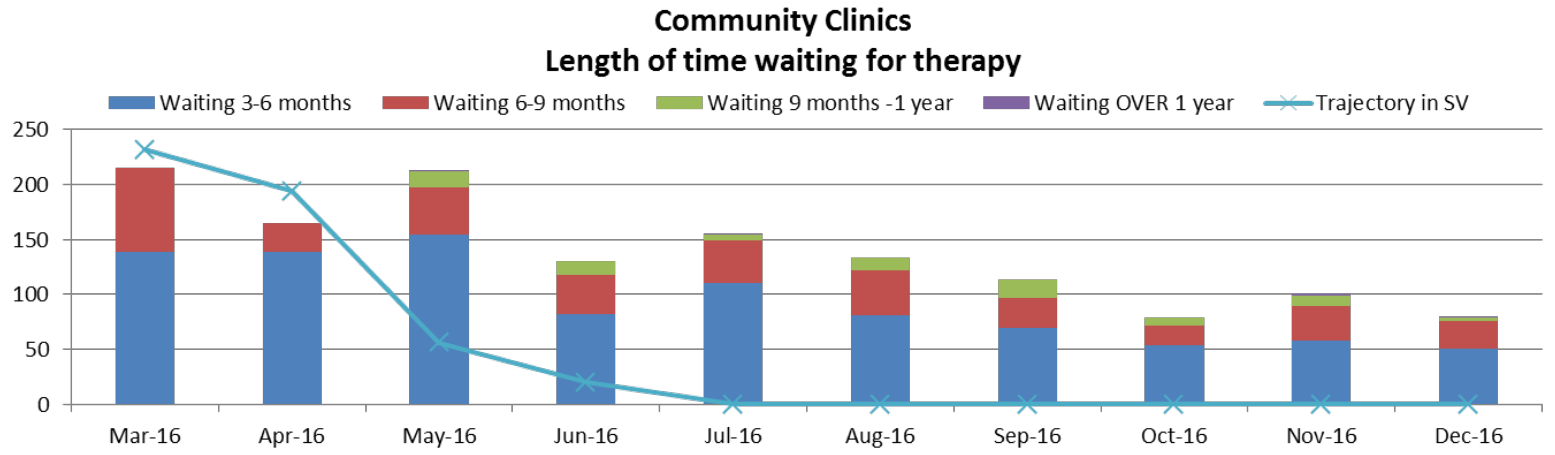
- There has been agreement to fund an extra £50k investment in the service to cover until end of March.
- There is continuing advertising for the vacant posts.
- The service redesign is on hold whilst the CCG liaise with the local authority requiring future commissioning.
- There has been a loss of 2 staff members and a higher than usual number of referrals in October that have both contributed to the slight increase in waiting times for November

Community Clinic

Clinic Waiting lists

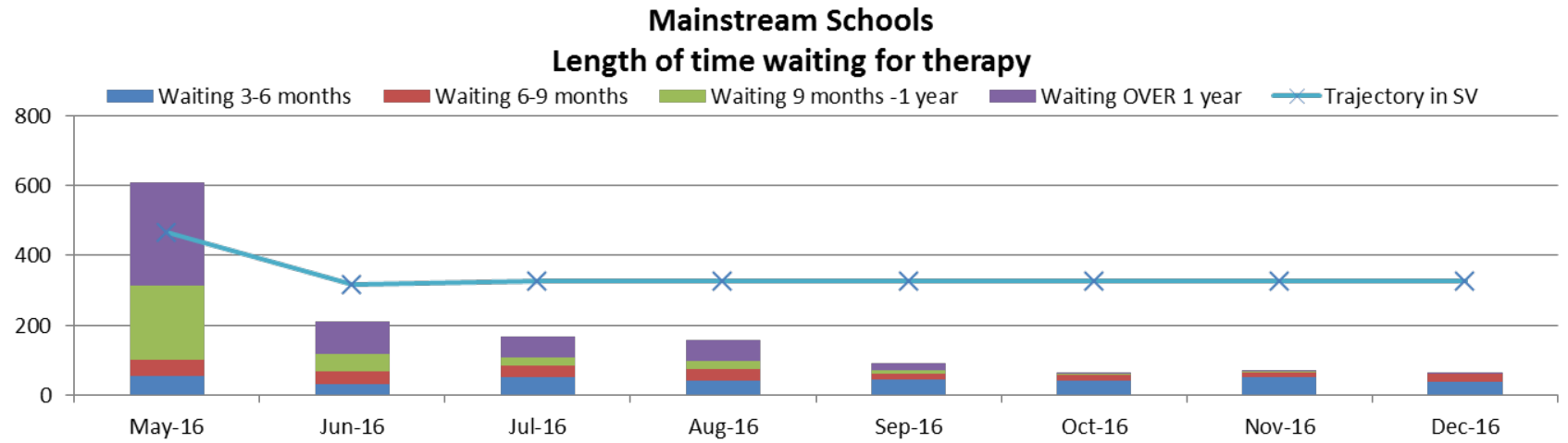
Reports run 03/01/2017

Length of wait Community Clinics *(pre-school caseload)*	**No. of children waiting July 2015**	**No. of children waiting March 2016**	**No. of children waiting April 2016**	**No. of children waiting May 2016**	**No. of children waiting June 2016**	**No. of children waiting July 2016**	**No. of children waiting August 2016**	**No. of children waiting September 2016**	**No. of children waiting October 2016**	**No. of children waiting November 2016**	**No. of children waiting December 2016**
Waiting up to 3 months	139	193	206	135	191	167	150	156	151	176	158
Waiting 3-6 months	139	139	139	154	82	110	81	70	54	58	51
Waiting 6-9 months	151	76	26	43	36	39	41	27	18	31	25
Waiting 9 months -1 year	106	0	0	15	12	6	12	17	7	10	3
Waiting OVER 1 year	0	0	0	1	0	1	0	0	0	2	1
Caseload waiting for therapy *(Excluding patients who already had a package of care)*	**535**	**408**	**371**	**348**	**321**	**323**	**284**	**270**	**230**	**277**	**238**
Already had PoC		62	78	70	66	119	97	72	75	67	75
Total waiting ***(Including patients who have already receive 1 POC and are waiting for another)***		**470**	**449**	**418**	**387**	**442**	**381**	**342**	**305**	**344**	**313**



Mainstream Schools

Schools Waiting lists											
No waiting data by months prior to May											
Length of wait Mainstream Schools *(pre-school caseload)*	**No. of children waiting July 2015**	**No. of children waiting March 2016**	**No. of children waiting April 2016**	**No. of children waiting May 2016**	**No. of children waiting June 2016**	**No. of children waiting July 2016**	**No. of children waiting August 2016**	**No. of children waiting September 2016**	**No. of children waiting October 2016**	**No. of children waiting November 2016**	**No. of children waiting December 2016**
Waiting up to 3 months				142	126	117	119	88	72	68	60
Waiting 3-6 months				54	32	50	41	44	42	51	37
Waiting 6-9 months				46	36	33	33	18	16	13	22
Waiting 9 months -1 year				212	48	23	23	10	3	2	0
Waiting OVER 1 year				298	95	60	61	17	3	2	2
Caseload waiting for therapy *(Excluding patients who already had a package of care)*				**752**	**337**	**283**	**277**	**177**	**136**	**136**	**121**
Already had PoC				*unavailable*	264	356	396	395	377	392	332
Total waiting ***(Including patients who have already receive 1 POC and are waiting for another)***				**752**	**601**	**639**	**673**	**572**	**513**	**528**	**453**



							Surgery								Medicine															Women & Children			
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED	CCU	OLD G5	Glastonbury Court	F9	F10	G1	G3	G4	G8	MTU	F12	G5 - Ward (OLD G9)	WEW – G9	F7	F8	F1	F11	F14	MLBU
Patient Safety	QR-PS-10	HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	100	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-20	HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	100	No Data	100	100	100	NA	NA	NA	NA	No Data	No Data	No Data	100	100	100	100	No Data	No Data	NA	No Data	No Data	100	No Data	NA	NA	NA	No Data	NA
	QR-PS-30	HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	No Data	NA	NA	No Data	NA	NA	NA	NA	NA	NA	NA	NA	NA	100	NA	NA	NA	NA	No Data	100	NA	NA	NA
	QR-PS-40	HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	100	80	100	100	100	NA	NA	NA	NA	No Data	No Data	No Data	100	100	100	100	60	100	NA	100	100	100	NA	NA	100	NA	100	NA
	QR-PS-50	HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	NA	100	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-60	HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	NA	100	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-90	HII compliance 5: Ventilator associated pneumonia	= 100%	<85	85-99	= 100	NA	NA	NA	NA	80	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-100	HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	NA	NA	NA	NA	NA	100	NA	NA	No Data	NA	NA	NA	NA	NA	No Data	NA	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	NA	NA
	QR-PS-110	HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	100	100	100	100	NA	NA	NA	NA	NA	No Data	No Data	No Data	100	100	No Data	100	83	100	NA	67	75	50	NA	NA	NA	NA	100	NA
	QR-PS-111	HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<80	80-99	= 100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	No Data	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-220	Total no of MRSA bacteraemias: Hospital	= 0 per yr	> 0	No Target	= 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PS-112	Total no of MRSA bacteraemias: Community acquired (Trust level only)	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-400	Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	91	100	39	92	100	No Data	No Data	No Data	No Data	100	NA	NA	94	80	90	67	87	89	NA	100	93	No Data	100	100	No Data	50	100	NA
	QR-PS-410	MRSA decolonisation (treatment and post screening) (Trust Level only)	= 90%	<80	80-94	95-100	NA	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na
	QR-PS-115	MRSA Elective screening (Trust level only)	= 100%	<80	80-99	= 100	NA	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na
	QR-PS-116	MRSA Emergency screening (Trust level only)	= 100%	<80	80-99	= 100	NA	NA	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na	na
	QR-PS-250	Hand hygiene compliance	= 95%	<85	85-99	= 100	100	100	100	100	100	NA	100	100	100	100	NA	NA	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	NA
	QR-PS-230	Total no of MSSA bacteraemias: Hospital	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PS-117	Quarterly Standard principle compliance	90%	<80	80-90%	90-100	86	93	93	95	86	No Data	No Data	No Data	100	100	NA	NA	86	86	97	95	90	84	NA	95	90	No Data	98	100	93	98	96	NA
	QR-PS-240	Total no of C. diff infections: Hospital	= 16 per year	No Target	No Target	No Target	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PS-420	Total no of C.diff infections: Community acquired (Trust Level only)	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PS-290	Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	86	No Data	97	92	NA	NA	NA	NA	NA	No Data	NA	NA	99	87	96	84	85	90	NA	86	97	No Data	97	100	90	No Data	100	NA
	QR-PS-114	Total no of E Coli (Trust level only)	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PS-430	Isolation data (Trust level only)	= 95%	<85	85-94	95-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PS-440	Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	90	91	94	93	92	95	96	92	88	95	NA	NA	89	84	92	92	95	92	NA	96	94	No Data	93	98	93	98	96	NA
	QR-PS-450	Quarterly VIP score documentation	= 90%	<80	80-89	90-100	43	77	78	83	100	No Data	No Data	No Data	25	100	NA	NA	93	100	33	100	81	88	NA	50	80	No Data	50	60	100	100	33	na
	QR-PS-312	MEWS documentation and escalation compliance (hide)	= 100%	<80	80-99	= 100	No Data	No Data	No Data	No Data	NA	NA	NA	NA	NA	No Data	No Data	check	No Data	No Data	No Data	No Data	No Data	No Data	NA	No Data	check	No Data	No Data	No Data	NA	NA	No Data	NA
	QR-PS-120	No of patient falls	= 48	>=48	No Target	<48	6	3	2	4	0	NA	NA	NA	1	0	0	0	3	3	2	4	3	8	0	2	12	5	7	0	NA	0	0	NA
	QR-PS-121	Falls per 1,000 bed days (Trust and Divisional levels only)	= 5.6	>5.8	5.6-5.8	<5.6	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PS-130	No of patient falls resulting in harm	No Target	No Target	No Target	No Target	4	0	0	3	0	NA	NA	NA	0	0	NA	NA	1	2	0	0	1	2	0	0	4	1	1	0	NA	0	0	NA
	QR-PS-140	No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-141	Falls with moderate/severe harm/death per 1000 bed days (Trust and Divisional levels only)	= <0.19	>0.19	No Target	= <0.19	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-470	No of patients with ward acquired pressure ulcers	No Target	No Target	No Target	No Target	4	0	0	0	1	NA	NA	NA	NA	0	0	0	2	0	0	0	0	0	0	2	1	3	1	0	NA	0	0	NA
	QR-PS-480	No of patients with avoidable ward acquired pressure ulcers	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-190	Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	90	100	100	100	100	NA	NA	NA	NA	No Data	No Data	No Data	100	90	60	100	70	60	NA	100	100	80	No Data	No Data	NA	NA	60	NA
	QR-PS-210	Hydration: Patients with appropriate fluid balance management (hide)	= 95%	<85	85-94	95-100	No Data	No Data	No Data	No Data	NA	NA	NA	NA	NA	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	NA	No Data	No Data	No Data	No Data	No Data	NA	NA	No Data	NA
	QR-PS-260	No of SIRIs	No Target	No Target	No Target	No Target	0	0	0	0	1	0	0	0	1	0	0	1	0	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	QR-PS-500	No of medication errors	No Target	No Target	No Target	No Target	2	1	4	4	2	0	0	0	6	0	0	1	0	1	4	2	2	3	0	0	5	1	4	1	0	2	0	0
	QR-PS-300	Cardiac arrests	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1	1	1	0	0	1	0	2	0	0	0	0	0
	QR-PS-490	Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
	QR-PS-340	Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	0.0	0.0	0.0	0.0	NA	NA	NA	NA	NA	NA	0.0	NA	0.0	0.0	0.0	0.0	0.0	0.0	NA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	NA
	QR-PS-370	VTE: Completed risk assessment (monthly Unify audit)	> 98%	< 98	No Target	> 98	No Data	No Data	No Data	No Data	No Data	na	na	No Data	na	No Data	No Data	No Data	No Data	No Data	na	No Data	No Data	No Data	na	No Data	No Data	na	No Data	No Data	na	No Data	No Data	No Data
	QR-PS-380	Quarterly VTE: Prophylaxis compliance	= 100%	<95	95-99	= 100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	QR-PS-390	Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	93.75	100	100	100	100	No Data	No Data	No Data	No Data	100	No Data	No Data	96.88	100	No Data	96.77	100	100	No Data	No Data	100	100	100	No Data	No Data	100	No Data	No Data
	QR-PEI-10	Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	73	99	95	96	NA	NA	NA	NA	NA	97	No Data	No Data	87	97	96	89	85	NA	NA	na	99	92	87	94	NA	NA	93	NA
	QR-PEI-180	(In-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	64.15	100	98.53	95.65	NA	NA	NA	NA	NA	100	No Data	No Data	100	100	100	100	96.15	NA	NA	na	100	100	90.63	95	NA	NA	100	NA
	QR-PEI-20	In your opinion, how clean was the hospital room or ward that you are in?	= 85%	<75	75-84	85-100	91	100	99	99	NA	NA	NA	NA	NA	100	No Data	No Data	100	100	96	94	96	NA	NA	na	100	100	96	95	NA	NA	97	NA
	QR-PEI-340	Did you feel you were treated with respect and dignity by staff?	= 85%	<75	75-84	85-100	82	100	100	98	NA	NA	NA	NA	NA	100	No Data	No Data	98	100	100	98	96	NA	NA	na	100	98	99	100	NA	NA	98	NA
	QR-PEI-330	Were Staff caring and compassionate in their approach?	= 85%	<75	75-84	85-100	82	100	99	98	NA	NA	NA	NA	NA	100	No Data	No Data	94	100	100	98	96	NA	NA	na	100	98	98	95	NA	NA	100	NA
	QR-PEI-30	Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	34	99	62	87	NA	NA	NA	NA	NA	79	No Data	No Data	42	70	100	71	50	NA	NA	na	88	69	44	85	NA	NA	87	NA

							Surgery								Medicine														Women & Children			
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED	CCU	OLD G5	Glastonbury Court	F9	F10	G1	G3	G4	G8	MTU	F12	G5 - Ward (OLD G9)	WEW – G9	F7	F8	F1	F11	F14	MLBU
Patient Experience: in-patient	QR-PEI-70	(In-patient) Did you find someone on the hospital staff to talk to about your worries and fears?	= 85%	<75	75-84	85-100	69	100	98	95	NA	NA	NA	NA	NA	100	No Data	No Data	88	100	94	79	76	NA	NA	na	100	98	89	93	NA	NA	90	NA
	QR-PEI-80	Were you involved as much as you wanted to be in decisions about your condition and treatment?	= 85%	<75	75-84	85-100	80	100	97	98	NA	NA	NA	NA	NA	100	No Data	No Data	89	100	94	81	83	NA	NA	na	100	90	88	86	NA	NA	88	NA
	QR-PEI-90	Were you given enough privacy when discussing your care?	= 85%	<75	75-84	85-100	79	100	99	96	NA	NA	NA	NA	NA	100	No Data	No Data	94	100	100	88	100	NA	NA	na	100	100	95	100	NA	NA	88	NA
	QR-PEI-350	Did you get enough help from staff to eat your meals?	= 85%	<75	75-84	85-100	84	100	99	100	NA	NA	NA	NA	NA	100	No Data	No Data	100	100	100	88	81	NA	NA	na	100	92	95	89	NA	NA	86	NA
	QR-PEI-100	(In-patient) Were you given enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	82	100	100	98	NA	NA	NA	NA	NA	100	No Data	No Data	100	100	100	95	100	NA	NA	na	100	100	100	100	NA	NA	98	NA
	QR-PEI-150	Timely call bell response	= 85%	<75	75-84	85-100	43	93	97	100	NA	NA	NA	NA	NA	93	No Data	No Data	64	100	78	95	62	NA	NA	na	100	70	59	80	NA	NA	96	NA
	QR-PEI-290	Same sex accommodation: total patients	= 0	>2	1-2	= 0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PEI-300	Complaints	= 0	>2	1-2	= 0	3	0	0	0	0	0	0	0	0	0	1	0	0	0	1	0	0	1	0	0	0	0	0	1	0	0	0	0
	QR-PEI-310	Environment and Cleanliness	= 90%	<80	80-89	90-100	No Data	No Data	90	No Data	96	No Data	96	No Data	84	No Data	No Data	No Data	No Data	80	No Data	No Data	No Data	No Data	No Data	94	No Data	No Data	No Data	89	No Data	No Data	90	94
Patient Experience: short-stay	QR-PES-10	Patient Satisfaction: short-stay overall result	= 85%	<75	75-84	85-100	NA	99	NA	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0	NA	NA	NA	NA
	QR-PES-60	(Short-stay) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	NA	100	NA	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0	NA	NA	NA	NA
	QR-PES-20	(Short-stay) Were you given enough privacy when being examined and treated?	= 85%	<75	75-84	85-100	NA	100	NA	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0	NA	NA	NA	NA
	QR-PES-30	(Short-stay) Were staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	NA	100	NA	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0	NA	NA	NA	NA
	QR-PES-40	Were you told who to contact if you were worried after leaving hospital?	= 85%	<75	75-84	85-100	NA	100	NA	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0	NA	NA	NA	NA
	QR-PES-50	(Short-stay) Overall how would you rate the care you received in the department?	= 85%	<75	75-84	85-100	NA	98	NA	NA	NA	NA	NA	100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0	NA	NA	NA	NA
	QR-PES-70	Number of short stay surveys completed	No Target	No Target	No Target	No Target	NA	110	NA	NA	NA	NA	NA	26	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	0	0	NA	NA	NA	NA
Patient Experience: A&E	QR-PEA-10	Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	95	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEA-100	(A&E) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	NA	NA	NA	NA	NA	NA	NA	NA	95.11	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEA-30	Were A&E staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	98	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEA-110	Were you given enough privacy when discussing your condition at reception?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	95	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEA-120	Did Doctors and Nurses listen to what you had to say?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	98	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEA-130	Did staff tell you who to contact if you were worried about your condition after leaving A&E?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	91	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEA-80	Did a member of staff tell you what danger signs to watch for when going home?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	93	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEA-140	Number of A&E surveys completed	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	517	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
Patient Experience: A&E (Children questions)	QR-PEAC-70	Patient Satisfaction: A&E Children questions overall result	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	na	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEAC-80	(A&E Children) How likely are you to recommend our A&E department to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	NA	NA	NA	NA	NA	NA	NA	NA	na	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEAC-90	Did the Doctor or Nurse listen to what you had to say?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	na	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEAC-100	Were staff friendly and kind to you and your family?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	na	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEAC-50	Did we help with your pain?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	na	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEAC-60	Did staff explain the care you need at home?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	na	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEAC-130	Number of A&E children surveys completed	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	na	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	NA
Patient Experience: Maternity	QR-PEM-10	Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	97	NA	NA
	QR-PEM-120	How likely is it that you would recommend the post-natal ward to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	90	NA	NA
	QR-PEM-130	How likely are you to recommend our labour suite to friends and family if they needed similar care or treatment?	= 75%	<70	70-74	75-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	100	NA	NA
	QR-PEM-135	How likely are you to recommend our antenatal department to friends and family?	= 75%	<70	70-74	75-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	100	NA	NA
	QR-PEM-140	How likely are you to recommend our post-natal care to friends and family?	= 75%	<70	70-74	75-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	98.25	NA	NA
	QR-PEM-30	(Maternity) Were staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	98	NA	NA
	QR-PEM-40	(Maternity) Did you find someone on the hospital staff to talk to about your worries and fears?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	94	NA	NA
	QR-PEM-50	Were you involved as much as you wanted to be in decisions about your care and treatment?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	96	NA	NA
	QR-PEM-60	(Maternity) Were you given enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	96	NA	NA
	QR-PEM-70	Did you hold your baby in skin to skin contact after the birth (baby naked apart from the nappy and a hat, lying on your chest)?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	96	NA	NA
	QR-PEM-80	Were you given adequate help and support to feed your baby whilst in hospital?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	96	NA	NA
	QR-PEM-90	How many minutes after you used the call button did it usually take before you got the help you needed?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	97	NA	NA
	QR-PEM-100	Has a member of staff told you about medication side effects to watch for when you go home?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	95	NA	NA
	QR-PEM-110	Have hospital staff told you who to contact if you are worried about your condition after you leave hospital?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	100	NA	NA
	QR-PEM-20	In your opinion, how clean was the hospital room or ward that you were in?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	98	NA	NA
	QR-PEM-121	Number of maternity surveys completed	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	220	NA	NA
	QR-PEBU-10	How likely is it that you would recommend the birthing unit to friends and family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	100
	QR-PEBU-20	Did you feel that your community midwife gave you sufficient information about the birthing unit prior to you being referred?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	93

							Surgery								Medicine														Women & Children			
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED	CCU	OLD G5	Glastonbury Court	F9	F10	G1	G3	G4	G8	MTU	F12	G5 - Ward (OLD G9)	WEW – G9	F7	F8	F1	F11	F14	MLBU
Patient Experience: Birthing Unit	QR-PEBU-40	If you phoned for advice prior to admission to the birthing unit did you feel that the advice given to you was useful and appropriate?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	94
	QR-PEBU-50	Do you feel that the 'home from home' environment had a positive effect on your birthing experience?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	98
	QR-PEBU-60	Did you have confidence and trust in the midwives caring for you during labour?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	100
	QR-PEBU-70	Were your birthing partners made to feel welcome by the midwives on the birthing unit?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	100
	QR-PEBU-80	Were you at any time left alone by your midwife at a time when you felt worried?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	96
	QR-PEBU-90	Thinking about your care during labour and birth, were you involved in the decisions about your care?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	98
	QR-PEBU-100	Overall how would you rate the care you received on the MLBU during your labour and birth?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	99
	QR-PEBU-110	Number of birthing unit surveys completed	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	NA	NA	NA	27
Patient Satisfaction: Young Children	QR-PEYC-120	Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	93	NA	NA	NA
	QR-PEYC-110	(Young children) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	95.45	NA	NA	NA
	QR-PEYC-20	Did you understand the information given to you regarding your treatment and care?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	100	NA	NA	NA
	QR-PEYC-10	Were you as involved as you wanted to be in decisions about your care and treatment?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	100	NA	NA	NA
	QR-PEYC-140	Did the Doctor or Nurses explain what they were doing in a way that you could understand?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	94	NA	NA	NA
	QR-PEYC-40	Were you offered age/need appropriate activities?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	80	NA	NA	NA
	QR-PEYC-60	Was your experience in other hospital departments (i.e. X-ray department, out-patient department, theatre) satisfactory?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	86	NA	NA	NA
	QR-PEYC-70	Was your experience during procedures/investigations (i.e.blood tests, X-rays) managed sensitively?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	100	NA	NA	NA
	QR-PEYC-150	If you were in pain, did the Doctor or Nurse do everything they could to help with the pain?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	75	NA	NA	NA
	QR-PEYC-160	Were staff kind and caring towards you?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	100	NA	NA	NA
	QR-PEYC-90	Is the environment child - friendly?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	100	NA	NA	NA
	QR-PEYC-100	Overall, how would you rate your experience in the Paediatric Unit?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	88	NA	NA	NA
	QR-PEYC-130	Number of young children surveys completed	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	8	NA	NA	NA
F1 Parent	QR-PEF1-120	Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	98	NA	NA	NA
	QR-PEF1-110	(F1 Parent) How likely are you to recommend our ward to friends & family if they needed similar care or treatment?	= 90%	<80	70-89	90-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	95.45	NA	NA	NA
	QR-PEF1-20	Did you understand the information given to you regarding your child's treatment and care?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	100	NA	NA	NA
	QR-PEF1-10	Were you and your child as involved as you wanted to be in decisions about care and treatment?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	100	NA	NA	NA
	QR-PEF1-130	Did the Doctor or Nurses explain what they were doing in a way that your child could understand?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	95	NA	NA	NA
	QR-PEF1-40	Were there appropriate play activities for your child (such as toys, games and books)?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	89	NA	NA	NA
	QR-PEF1-60	Was your child's experience in other hospital departments (i.e. X-ray department, out-patient department, theatre) satisfactory?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	100	NA	NA	NA
	QR-PEF1-70	Was your child's experience during procedures/investigations (i.e.blood tests, X-rays) managed sensitively?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	100	NA	NA	NA
	QR-PEF1-150	If your child was in pain, did the doctor or nurse do everything they could to help with the pain?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	96	NA	NA	NA
	QR-PEF1-140	Were staff kind and caring towards your child?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	100	NA	NA	NA
	QR-PEF1-90	Is the environment child-friendly?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	100	NA	NA	NA
	QR-PEF1-100	Overall, how would you rate your experience in the Children's Unit?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	93	NA	NA	NA
	QR-PEF1-160	Number of F1 parent surveys completed	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	na	na	14	NA	NA	NA
Patient Experience: Stroke	QR-PEST-10	Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEST-80	(Stroke) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEST-20	Have you been told you have had a stroke, which lead to your admission to hospital?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	88	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEST-30	Have you been involved in planning your recovery / rehabilitation?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	88	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEST-40	While you were in the Stroke Department how much information about your condition or treatment was given to you?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	93	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEST-50	Have you received the help you require while eating?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEST-60	Do you feel cared for?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	100	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEST-70	Were you given enough privacy when being examined or treated or when your care was discussed with you?	= 85%	<75	75-84	85-100	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	97	NA	NA	NA	NA	na	na	NA	NA	NA	NA
	QR-PEST-90	Number of stroke surveys completed	No Target	No Target	No Target	No Target	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	16	NA	NA	NA	NA	na	na	NA	NA	NA	NA

West Suffolk NHS
NHS Foundation Trust

Item 8c Board of Directors (Public) – 17th January 2017

PRESENTED BY:	Jan Bloomfield, Executive Director Workforce & Communications
PREPARED BY:	Karen Margetts, Training Improvement Manager
DATE PREPARED:	17th January 2017
SUBJECT:	Mandatory Training
PURPOSE:	For information and update
STRATEGIC OBJECTIVE:	To continue to secure, motivate, educate and develop a committed workforce providing high quality patient focused services

EXECUTIVE SUMMARY:

Appendix A is the December 2016 Mandatory Training Report, this represents data taken from the system on 10th December 2016. It has been noted that compliance for Safeguarding Children (Levels 1, 2 and 3), Information Governance and Manual Handling remains lower than we had hoped and therefore we are requesting for the Subject Matter leads to complete recovery plans. Information Governance are already contacting individuals via email to ensure compliance levels increase.

Appendix B outlines the actions currently in place to improve take up of mandatory training across the Trust in those areas below 80% compliance, 90% for Safeguarding Children and 95% for Information Governance.

Appendix C provides a risk assessment for those areas below the relevant target, compiled by the subject matter experts for each area.

Appendix D The National CQUIN 2015-6 target for **Dementia** staff training states that the Trust should include quarterly reports to Provider Boards of:
• Numbers of staff who have completed the training;
• Overall percentage of staff training within each provider'.
During Q3 there were 3,079 that required training and the total number trained were 2,819 which equates to 91.56%.

Appendix E shows mandatory training and induction figures for SCH Community staff. SCH Community currently records training in a system called Staff Pathways. Mental capacity has now been included as a mandatory requirement and is currently targeted at all Band 5 and above clinical roles. The overall compliance level for all mandatory topics is 92.42% for December 2016. There was 100% compliance for induction in this quarter.

Prevent is part of the Government's counter-terrorism strategy CONTEST and aims to stop people becoming terrorists or supporting terrorism. There are 2 forms of Prevent training:

- Basic awareness which has been added to our Safeguarding Adults training packages which all staff are required to complete
- Prevent classroom training called WRAP (workshop to raise awareness of prevent) is required for all clinical patient facing staff. Classroom WRAP courses have been

added to the training prospectus.

The Mandatory Training Steering Group are pulling together a plan to implement PREVENT and to embed the new subject into the current training matrix with as minimal operational impact as possible. A lead for this subject has now been appointed and we are therefore looking at how this training will be rolled out to the organisation.

Matters resulting from recommendations in this report	**Present**	**Considered**
Financial Implications	yes	no
Workforce Implications	yes	yes
Impact on Equality and Diversity	yes	yes
Legislation, Regulations and other external directives	yes	yes
Internal policy or procedural issues	yes	yes
Risk Implications for West Suffolk Hospital (including any clinical and financial consequences): Risk to patient safety due to untrained staff.	**Mitigating Actions** Mandatory Training action plan (attached) and risk assessment	
Level of Assurance that can be given to the Committee from the report based on the evidence [significant, sufficient, limited, none]: Sufficient		
Recommendation to the Board of Directors: Acceptance of the action plan to further improve compliance		

Appendix A

Subject Matter - High Level Mandatory Training Analysis December 2016

Competence Name	Trust Target	Does not meet requirement	Meets Requirement	Grand Total	May-16	Jun-16	Jul-17	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
179|LOCAL|Infection Control - Classroom|	80%	93	1423	1516	95%	94%	95%	95%	95%	94%	94%	94%
179|LOCAL|Equality and Diversity|	80%	279	2926	3205	89%	90%	91%	90%	90%	90%	91%	91%
179|LOCAL|Fire Safety Training - Classroom|	80%	367	2838	3205	89%	88%	89%	87%	88%	88%	88%	89%
179|LOCAL|Security Awareness|	80%	407	2798	3205	91%	90%	90%	87%	87%	86%	87%	87%
179|LOCAL|Infection Control - eLearning|	80%	194	1326	1520	90%	91%	91%	88%	87%	86%	87%	87%
179|LOCAL|Safeguarding Adults|	80%	417	2788	3205	90%	90%	91%	89%	87%	87%	87%	87%
179|LOCAL|Health & Safety / Risk Management|	80%	421	2784	3205	89%	89%	89%	88%	86%	86%	86%	87%
NHS|MAND|Safeguarding Children Level 1 - 3 Years|	90%	431	2774	3205	90%	90%	90%	88%	87%	87%	86%	87%
179|LOCAL|Fire Safety Training - eLearning|	80%	432	2773	3205	89%	89%	90%	88%	87%	86%	87%	87%
179|LOCAL|Moving and Handling Non Clinical Load Handler|	80%	54	337	391	66%	67%	70%	66%	69%	71%	75%	86%
179|LOCAL|Safeguarding Children Level 2|	90%	218	1325	1543	90%	90%	90%	87%	86%	86%	85%	86%
179|LOCAL|MAJAX|	80%	465	2740	3205	87%	86%	87%	85%	84%	85%	85%	85%
179|LOCAL|Medicine Management (Refresher)|	80%	228	1301	1529	89%	89%	90%	86%	86%	86%	85%	85%
179|LOCAL|Slips Trips Falls|	80%	358	1767	2125	87%	86%	86%	84%	84%	83%	83%	83%
179|LOCAL|Information Governance|	95%	565	2640	3205	87%	85%	85%	84%	82%	80%	81%	82%
179|LOCAL|Blood Bourn Viruses/Inoculation Incidents|	80%	338	1574	1912	86%	85%	85%	83%	82%	82%	82%	82%
179|LOCAL|Basic Life Support - Adult|	80%	397	1688	2085	79%	75%	77%	76%	76%	78%	78%	81%
NHS|MAND|Safeguarding Children Level 3 - 1 Year|	90%	61	256	317	85%	80%	84%	86%	81%	80%	83%	81%
179|LOCAL|Moving and Handling - Clinical|	80%	348	1371	1719	80%	75%	77%	78%	78%	77%	78%	80%
179|LOCAL|Blood Products & Transfusion Processes (Refresher)|	80%	354	1206	1560	80%	76%	77%	74%	75%	75%	77%	77%
179|LOCAL|Moving & Handling - elearning|	80%	216	725	941	79%	80%	80%	74%	75%	76%	77%	77%
179|LOCAL|Conflict Resolution - elearning|	80%	176	562	738	78%	80%	82%	74%	76%	76%	77%	76%
179|LOCAL|Conflict Resolution|	80%	333	957	1290	77%	76%	75%	75%	75%	73%	73%	74%

Oct 2016 New Starters % Compliance – Trust	Total
No	4
Yes	33
Grand Total	37
% Compliance	89%

	Apr %	Method	Actions	Completion date	Responsibility	Progress
National requirements		E-learning	The region has signed up to a Streamlining project which includes statutory and mandatory training, recruitment, medical staffing and occupational health. The project should see a reduction in duplication of paperwork and training for staff and reduce the hire time and cost for Trusts.	On-going	Rebecca Rutterford	The region has agreed to align their training to the 10 subjects within the Core Skills Training Framework (CSTF). Target date of Oct 15 for all organisations to have aligned their training to the set learning outcomes. West Suffolk currently has 9 out of 10 aligned. With the inclusion of Prevent as part of the project, this now makes 11 subjects to align to. As from January 2017 the new training programme for Infection Control will commence and we are currently in the process of aligning to the CSTF competency on ESR/OLM and submitting the declaration to Skills for Health. We are already accepting training from other Trusts within the region with the aim to reduce the duplication of training, however the Streamlining project is currently investigating why activity seems to be slow paced.
e-Care			Consider the implication of e-Care training on existing education programmes.	Complete	MTSG	The impact on mandatory training compliance due to e-Care training was being monitored – appendix A. The cancellation of all training, including mandatory training for a 4 week period over e-Care go live was likely to have an impact on compliance. The Education Team booked two additional dates to support staff in remaining compliant. These dates are 30th September 2016 and 4th November 2016. Induction was not affected and continued as normal.
Conflict Resolution e-learning	82.03%	E-learning	Emails to mangers encouraging staff to be compliant and complete the eLearning package.	Complete	Darren Cooksey	Targeted emails to staff reminding them to complete training. 3.22% Increase seen since the last Board report and now compliance is over 80%
Safeguarding Children level 3	83.71%	Face to face	To improve Safeguarding Children level 3 compliance to 90%	Jul 2016	Lisa Sarson	At the end of Q3, compliance for Safeguarding Children level 3 is reported at 81%.
Moving & Handling–e-learning	80.43%	E-learning	Manual Handling Advisor e-mailing mangers encouraging staff to be compliant and complete the eLearning package.	Complete	Neil Herbert	Target now met
Basic Life Support	80.97%	Face to face	Reliance on bank and reduced staffing due to sickness has had an impact on figures.	Complete	Julie Head	Target now met
Information Governance	85.09%	E-learning	Staff who are out of date with IG training are being targeted directly with the training slides and compliance test.	Jul 2016	Sara Ames	Will continue to offer one off training sessions to departments that require it. At the end of Q3 compliance is reported at 82%. Compliance rise is likely to be slower

	Apr %	Method	Actions	Completion date	Responsibility	Progress
						than others as it's a yearly requirement for all staff.
Conflict Resolution	75.32%	Face to Face	Training sessions have been fully booked due to bank staff being encouraged to book onto courses.	Oct 2016	Darren Cooksey	At the end of Q3 compliance is reported at 74%. April's course was cancelled due to e-Care go live. An additional morning course was arranged in June, but unfortunately there wasn't much take up.

Risk Assessments

Appendix C

Subject	Issues	Risks	Description of Action	Lead	Status *
179|LOCAL| Moving and Handling –e-learning	• Poor uptake	• Potential staff injury • Financial implication such as sick pay, staff cover, court costs, compensation.	• Reminders to be sent to those who are non-compliant	Moving and Handling Advisor	Low
179|LOCAL| Conflict Resolution|	• Staffing levels and the Ward/ Departments ability to backfill will affect the numbers attending • Release of staff on clinical areas.	• Failure to recognise body language indications of possible aggression. • Failure to recognise warning signs when an aggressor is agitated or distressed. • Failure to recognise danger signs which may indicate imminent attack. • Failure to employ applicable communication skills • Litigation consequences • Potential staff injuries resulting in RIDDOR absenteeism. • Poor staff morale	• Training compacted to four hours to enable staff attendance. • LSMS and Portering can be called to via 2222 to assist staff in managing difficult situations • Police assistance can be summoned. • Restrictive Physical Intervention team may be employed when managing clinically confused patients. • Refresher sessions for staff who have expired, lasting 2 hours. • Discussion taking place to incorporate conflict resolution, dementia awareness and break away training into one package	Portering and Security manager	Low
179|LOCAL| Conflict Resolution –elearning|	•	• Failure to recognise body language indications of possible aggression. • Failure to recognise warning signs when an aggressor is agitated or distressed. • Failure to recognise danger signs which may indicate imminent attack. • Failure to employ applicable communication skills • Litigation consequences • Potential staff injuries resulting in RIDDOR absenteeism. • Poor staff morale	• Communication has gone out to all staff to advertise the new training package. • Targeted communication has been sent to specific staff groups and managers that require the new training package. • LSMS to enlist support from security management director and non-executive member of the board responsible for security.	Portering and Security manager	Low

Subject	Issues	Risks	Description of Action	Lead	Status *
179|LOCAL|Information Governance|	• Annual training replaced 3 yearly training in 2014 • 95% compliance target explicit in 2015/16 IG toolkit	• Increased risk of IG breaches and vulnerability to ICO fine if staff awareness of IG is poor. • IG toolkit compliance will be unsatisfactory (level 1 only) if we cannot demonstrate achievement of 95% target.	• Outstanding staff are contacted on a monthly basis to update training. • Training materials and test attached to email to facilitate a quick and convenient way to carry out training.	IG Manager	Medium
NHS|MAND| Safeguarding Children Level 3 - 1 Year|	• Poor uptake • Specialised face to face learning • Annual dates for departmental sessions scheduled past staff expiry dates	• Failure to recognise signs & symptoms of abuse in a child • Failure to recognise parental factors that predispose a child to significant harm • Failure to understand how to report concerns for child • Failure to recognise and act upon more specialised areas of child protection	• Paediatric, neonatal and midwifery level 3 training offered over a number of dates throughout the year. • Extra training sessions advertised • Three sessions per year open to all Trust employees and partner agencies presenting a range of topics • Unit managers for areas with high contact with children and young people also receive lists of non-compliant staff. • Emails of those non-compliant sent to managers and risk assessments requested.	Named Nurse Safeguarding children	Medium

Appendix D – Dementia Training Figures

Month	Number require training	Total number trained	% Compliance
April	1023	877	85.75%
May	1079	917	84.99%
June	1065	918	86.20%
Q1.	**3167**	**2712**	**85.63%**
July	1053	906	86.04%
Aug	1033	908	87.90%
Sep	1064	956	89.85%
Q2.	**3150**	**2770**	**87.94%**
Oct	1041	944	90.68%
Nov	1020	935	91.67%
Dec	1018	940	92.34%
Q3.	**3079**	**2819**	**91.56%**
Jan	993	863	86.91%
Feb	985	860	87.31%
March	1011	874	86.45%
Q4.	**2989**	**2597**	**86.89%**

Appendix E – SCH Community

Mandatory Training – as at December 2016

Topic	All			Enabling**	Workforce	Leadership	Operations*	Quality and Governance	Paediatrics
	Compliant	NonCompliant	% Compliancy						
Conflict Resolution	349	32	91.60%	92.22%	N/A	100.00%	91.78%	100.00%	90.87%
Dementia Compliance	354	27	92.91%	96.67%	N/A	100.00%	86.30%	100.00%	93.27%
Equality and Diversity	370	11	97.11%	94.44%	N/A	100.00%	95.89%	100.00%	98.56%
Fire	333	48	87.40%	83.33%	N/A	50.00%	91.78%	87.50%	87.98%
Health & Safety	375	6	98.43%	98.89%	N/A	100.00%	97.26%	100.00%	98.56%
Infection Control	346	35	90.81%	77.78%	N/A	100.00%	89.04%	100.00%	96.63%
Information Governance	355	26	93.18%	88.89%	N/A	100.00%	91.78%	100.00%	95.19%
Learning Disabilities	326	55	85.56%	77.78%	N/A	100.00%	73.97%	87.50%	92.79%
Life Support	198	33	85.71%	N/A	N/A	N/A	70.77%	100.00%	91.36%
Mental Capacity	25	11	69.44%	N/A	N/A	N/A	68.57%	100.00%	N/A
Moving and Handling	345	36	90.55%	96.67%	N/A	100.00%	87.67%	100.00%	88.46%
Safeguarding Adults	371	10	97.38%	95.56%	N/A	100.00%	94.52%	100.00%	99.04%
Safeguarding Children	373	8	97.90%	94.44%	N/A	100.00%	98.63%	100.00%	99.04%
Overall % for all topics	**4120**	**338**	**92.42%**	**90.61%**	**N/A**	**95.45%**	**88.48%**	**97.85%**	**94.37%**
*** Enabling = Facilities, Finance & Informatics*									
*** Operations = Newmarket Hospital, Epilepsy, Neurology, Parkinsons, Adult SLT*									

SCH Induction

New Starters % Compliance	Q3 Oct-Dec 2016
No	0
Yes	14
Grand Total	14
% Compliance	100%

West Suffolk NHS
NHS Foundation Trust

Board of Directors - January 2017

AGENDA ITEM:	Item 9
PRESENTED BY:	Nick Macdonald, Deputy Director of Finance
PREPARED BY:	Nick Macdonald, Deputy Director of Finance
DATE PREPARED:	23 January 2017
SUBJECT:	December Board report
PURPOSE:	Review

EXECUTIVE SUMMARY:

The December position includes a reforecast to a deficit of £12.1m, reflecting the Trusts failure to achieve any of the stretch CIP (£3.9m) in 2016-17. This forecast also recognises that the Trust will only receive £2.9m of Sustainability and Transformation funding against the £6.1m that would have been received if the Trust met the control total and all operational performance targets.

The deterioration in the Trusts YTD adverse variance is largely due to the phasing of the stretch CIP, being £650k per month since October (£1.95m YTD). Since the costs associated with escalation beds, pressures in A&E and Midwifery will exhaust our contingency by the year end the failure to achieve the stretch CIP impacts our bottom line completely.

During December we have recognised the financial consequences of failing to achieve the A&E target for Q2 (£191k) as well as failed financial performance for Q3 (£1.5m).

We have also included a 'below the line' adjustment to our forecast to take into account WSFT loss on investment in tPP, being 12.5% of tPP cumulative losses (£5.2m). This increases our total forecast deficit to £17.3m in 2016-17.

Linked Strategic objective (link to website)	**To provide value for money for the taxpayer and to maintain a financially sound organisation**
Issue previously considered by: (e.g. committees or forums)	
Risk description: (including reference Risk Register and BAF if applicable)	
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	
Legislation / Regulatory requirements:	
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	None

Recommendation:

The Board is asked to review this report

West Suffolk NHS
NHS Foundation Trust

FINANCE AND WORKFORCE REPORT
December 2016 (Month 9)

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

Financial Summary

I&E Position YTD	£9.2m	loss
Variance against plan YTD	£5,432k	adverse
Movement in month against plan	£2,581k	adverse
EBITDA position YTD	£3,458k	loss
EBITDA margin YTD	-1.80%	loss
Cash at bank	£3,678k	
Use of Resources Rating (UoR)	4	

Executive Summary

- The Month 9 YTD position is behind plan by £5,432k.
- The Use of Resources Rating (UoR) (previously Financial Sustainability Risk Rating), is 4 YTD (1 being highest, 4 being lowest)
- The Trust is forecasting an annual deficit of £12.1m before accounting for writing off the tPP investment.

Key Risks

- Delivering the cost improvement programme
- Containing the increase in demand to that included in the plan (2.5%).
- Receiving Sustainability and Transformation Funding – dependent on Financial and Operational performance
- Working across the system to minimise delays in discharge and requirement for escalation beds

SUMMARY INCOME AND EXPENDITURE ACCOUNT - December 2016	Dec-16			Year to date			Year end forecast		
	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
NHS Contract Income	18.0	18.3	0.3	163.9	164.1	0.2	219.7	220.0	0.3
Other Income	3.4	1.3	(2.1)	26.3	23.1	(3.2)	33.8	32.3	(1.5)
Total Income	**21.4**	**19.6**	**(1.8)**	**190.2**	**187.2**	**(3.0)**	**253.5**	**252.4**	**(1.1)**
Pay Costs	11.8	11.8	(0.0)	105.7	106.6	(1.0)	141.4	142.7	(1.3)
Non-pay Costs	9.8	10.5	(0.7)	82.7	84.1	(1.4)	106.1	110.0	(3.8)
Operating Expenditure	**21.6**	**22.3**	**(0.7)**	**188.3**	**190.7**	**(2.4)**	**247.5**	**252.7**	**(5.1)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	2.5	0.0	2.5
EBITDA	**(0.2)**	**(2.7)**	**(2.5)**	**1.9**	**(3.5)**	**(5.3)**	**3.5**	**(0.3)**	**(3.8)**
EBITDA margin	(0.9%)	(13.7%)	(12.8%)	1.0%	(1.8%)	(2.8%)	1.4%	1.4%	0.0%
Depreciation	0.6	0.7	(0.1)	4.4	4.5	(0.1)	6.7	6.8	(0.1)
Finance costs	0.1	0.1	(0.0)	1.3	1.3	0.0	1.7	1.7	0.0
SURPLUS/(DEFICIT)	**(1.0)**	**(3.5)**	**(2.6)**	**(3.8)**	**(9.2)**	**(5.4)**	**(5.0)**	**(8.9)**	**(3.9)**
S&T funding included in Other Income forecast above that is at risk							0.0	(3.2)	(3.2)
Possible SURPLUS / (DEFICIT)							**(5.0)**	**(12.1)**	**(7.2)**
tPP investment write off							0.0	(5.2)	(5.2)
Final SURPLUS / (DEFICIT)							**(5.0)**	**(17.3)**	**(12.3)**

FINANCE AND WORKFORCE REPORT – December 2016

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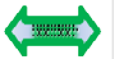
- Income and Expenditure Summary Page 3
- I&E indicators and trends Page 4
- Income Analysis Page 5
- Workforce Analysis Page 7
- Directorate Summary and Analysis Page 11
- Cost Improvement Programme (CIP) Page 13
- Capital Page 14
- Use of Resources (UoR) Risk Rating Page 15
- Balance Sheet Page 16
- Cash Flow Page 17

Key:

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

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

Income and Expenditure summary as at December 2016

The reported I&E for December 2016 is a deficit of £3,541k, against a planned deficit of £960k. This results in an adverse variance of £2,581k (£5,432k YTD) which is predominantly due to the stretch CIP and lost Sustainability and Transformation funding.

A significant cause of the deterioration in plan over the last 3 months relates to the underachievement of the stretch CIP, being £650k per month (£1.95m YTD).

As a result of our failure to meet the Q3 financial plan we are not eligible for any Sustainability and Transformation funding in Q3 (£1.525m) and this is reflected in the December position. Furthermore we lost our appeal against our failure to meet the A&E performance target for Q2, which resulted in a further £191k S&T funding being removed this month.

CIP
The December position includes a YTD CIP target of £8.0m of which £5.5m has been achieved. The shortfall largely relates to stretch CIP (£1.95m) and DTOCs (£0.3m). The CIP target is £12.5m for the full year.

Forecast
The forecast has been revised to reflect the performance against the stretch CIP target (£3.9m) and lost Sustainability and Transformation funding (£3.2m) and as a result we now forecast a deficit of £12.1m.

TPP investment
On advice from our auditors, and consistent with the treatment of other shareholding Trusts our forecast now also includes the loss on our investment.

Since we own 12.5% of tPP we forecast this loss to be 12.5% of tPP cumulative losses since they started trading in May 2014. The reported losses have been :

- 2014-15 £4.9m
- 2015-16 £15.1m
- 2016-17 forecast loss of £21.2m.

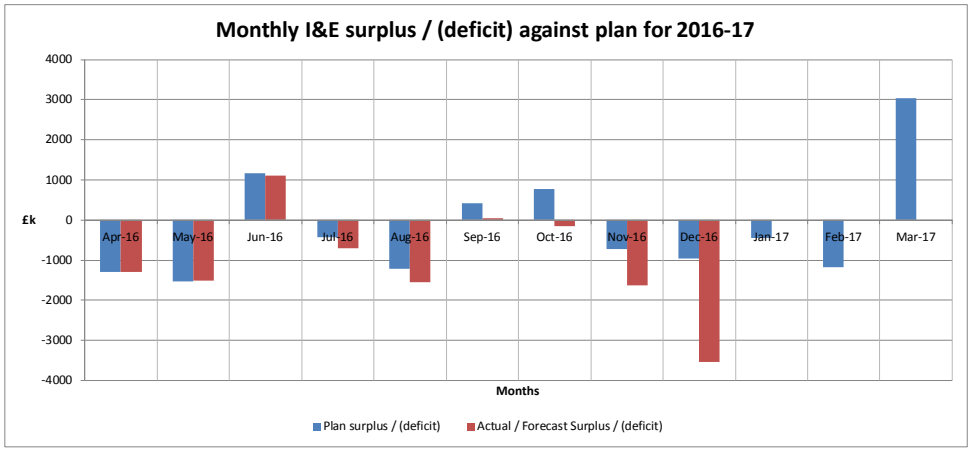
Therefore in total WSFT share of the tPP loss is 12.5% of £41.2m, being £5.15m. This is now included in the forecast as a ‘below the line’ adjustment.

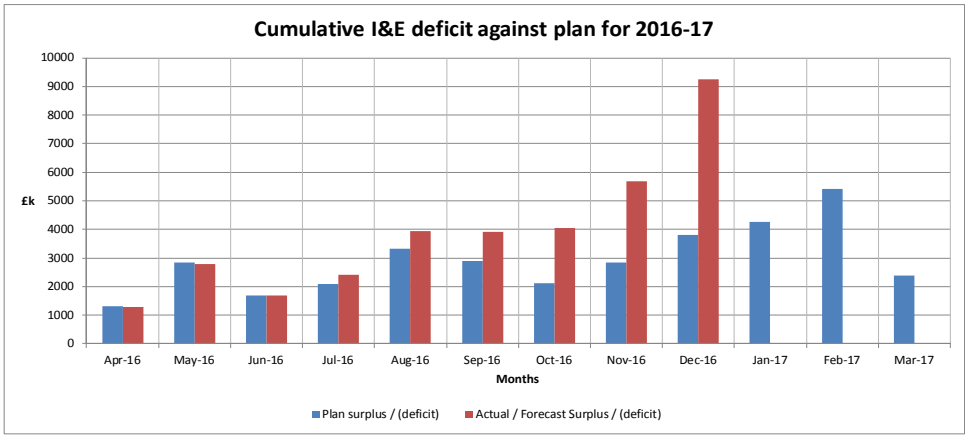
The tPP write off will therefore increase WSFT loss in 2016-17 to £17.3m

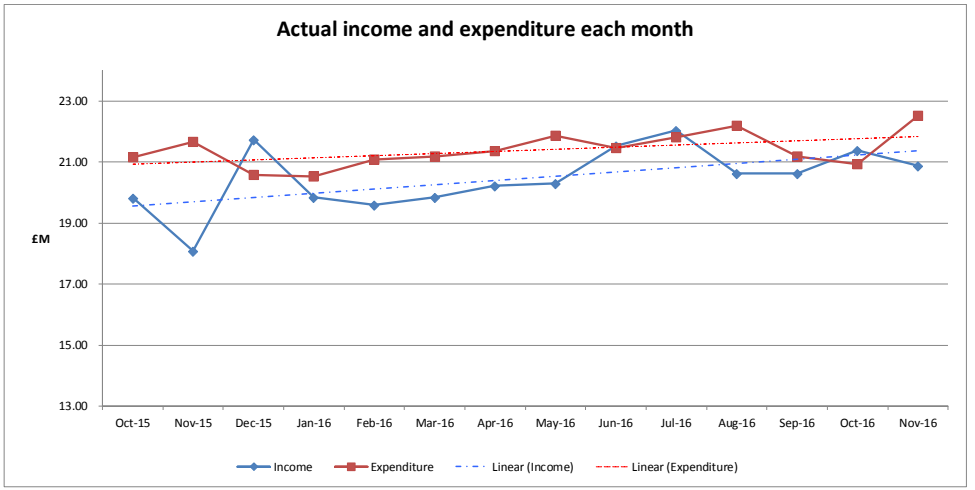
FINANCE AND WORKFORCE REPORT – December 2016

Summary of I&E indicators

Income and Expenditure	Plan / target £'000	Actual / forecast £'000	Variance to plan (adv) / fav £'000	Direction of travel (variance)	RAG (report on Red)
In month surplus / (deficit)	(960)	(3,541)	(2,581)	↑	Red
YTD surplus / (deficit)	(3,796)	(9,228)	(5,432)	↑	Red
Forecast surplus / (deficit)	(5,000)	(12,100)	(7,100)	↑	Red
EBITDA YTD	1,880	(3,458)	(5,338)	↑	Red
EBITDA (%)	1.0%	(1.8%)	(2.8%)	↑	Red
Use of Resources (UoR) Rating fav / (adv)	3	4	1	↑	Amber
Clinical Income YTD	(163,932)	(164,129)	197	↑	Amber
Non-Clinical Income YTD	(26,274)	(23,112)	(3,162)	↑	Red
Pay YTD	105,661	106,633	(973)	↑	Red
Non-Pay YTD	88,342	89,835	(1,494)	↑	Red
CIP target YTD	(8,019)	(5,469)	(2,550)	↑	Red

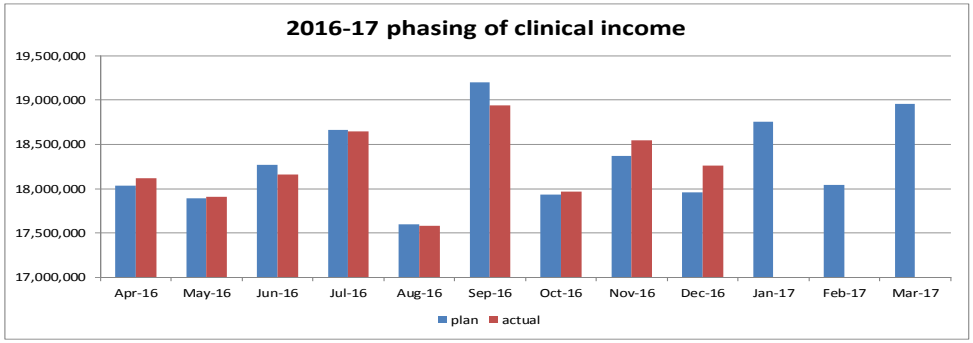






Income Analysis

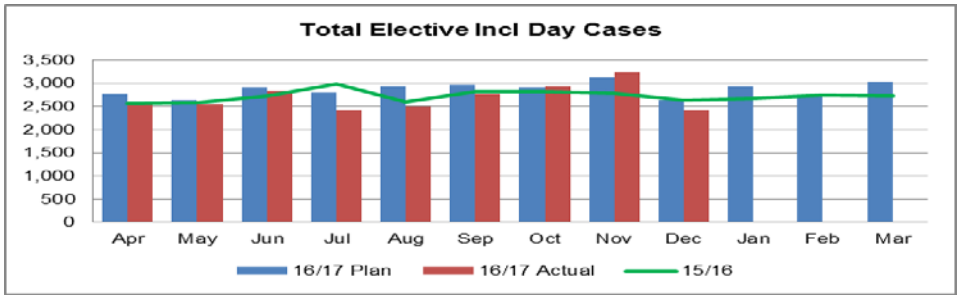
The chart below summarises the phasing of the clinical income plan for 2016-17, including Suffolk Community Health. This phasing is in line with activity phasing and does not take into account the block payment.

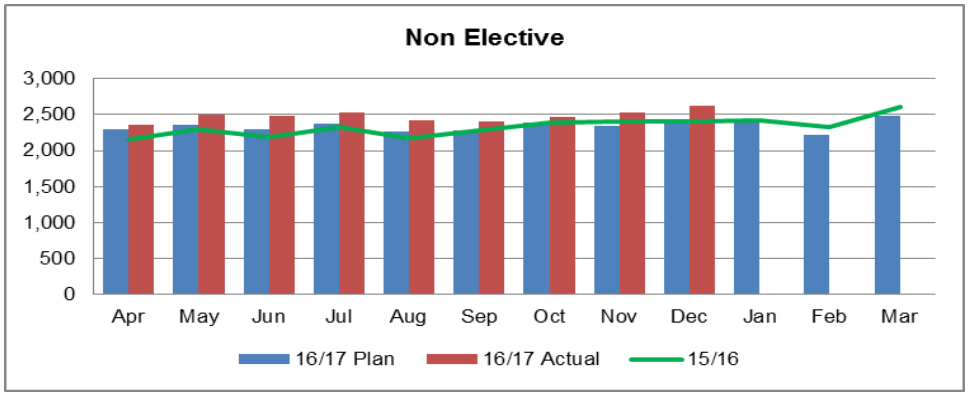


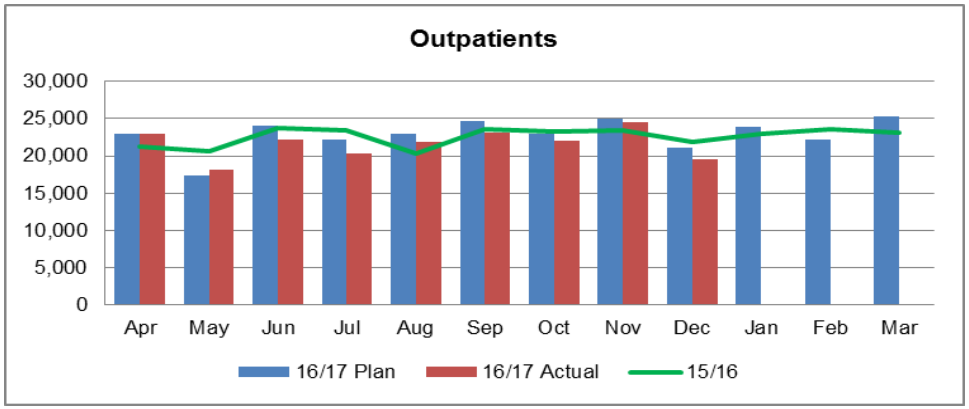
The income position was behind plan in December. Elective and Outpatients were the main areas behind plan within the month and have been consistently throughout the year.

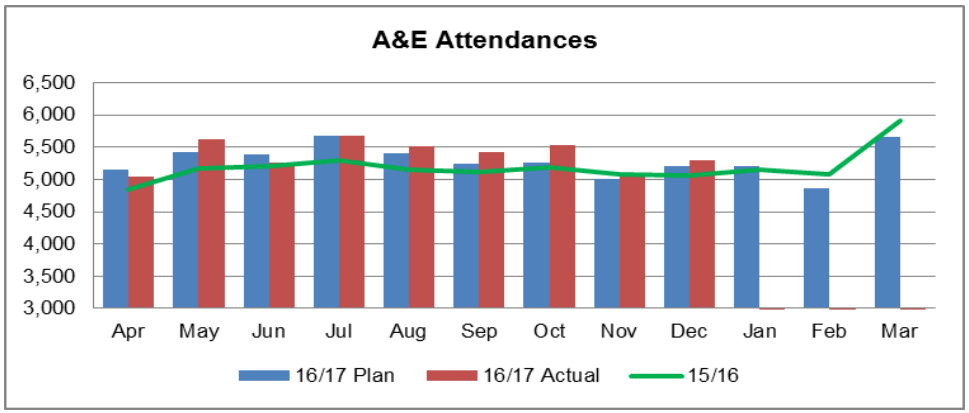
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	608	593	(15)	5,575	5,465	(110)
Other Services	2,142	2,882	740	19,260	23,239	3,979
CQUIN	298	283	(15)	2,743	2,638	(104)
Elective	2,706	2,460	(245)	26,254	23,763	(2,492)
Non Elective	4,761	4,823	62	41,298	42,267	970
Emergency Threshold Adjustment	(236)	(250)	(14)	(2,088)	(2,352)	(264)
Outpatients	2,740	2,525	(215)	26,415	24,634	(1,781)
Community	4,942	4,942	0	44,475	44,475	0
Total	**17,960**	**18,257**	**297**	**163,932**	**164,129**	**197**

Activity, by point of delivery

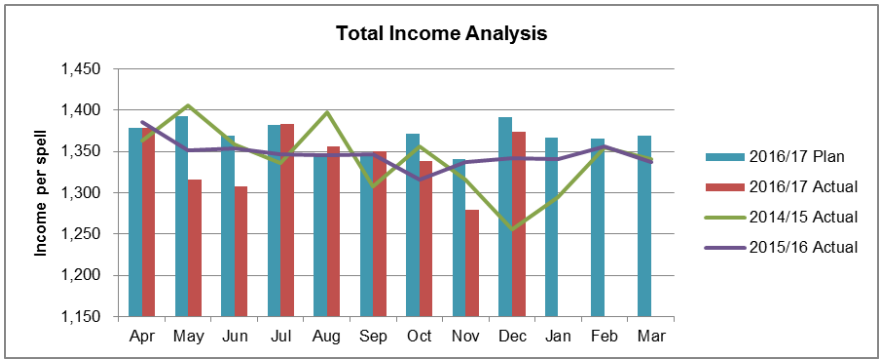


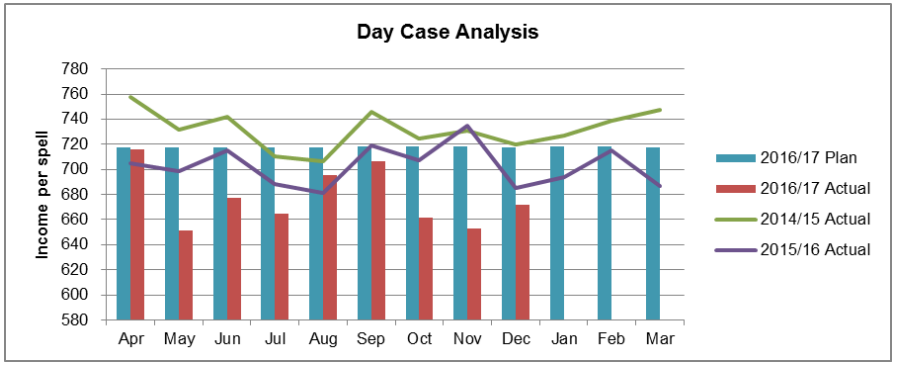


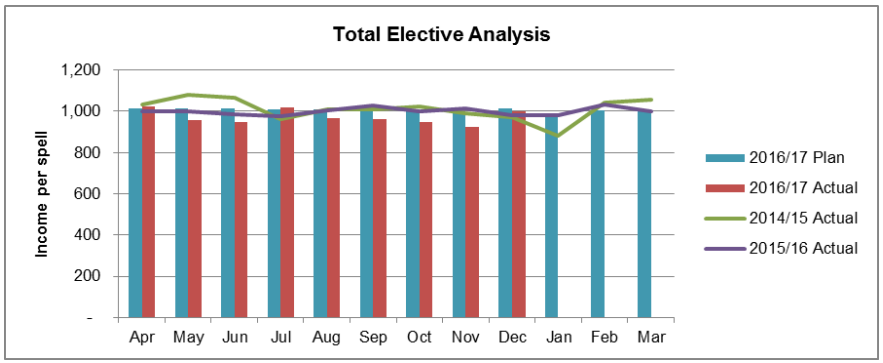


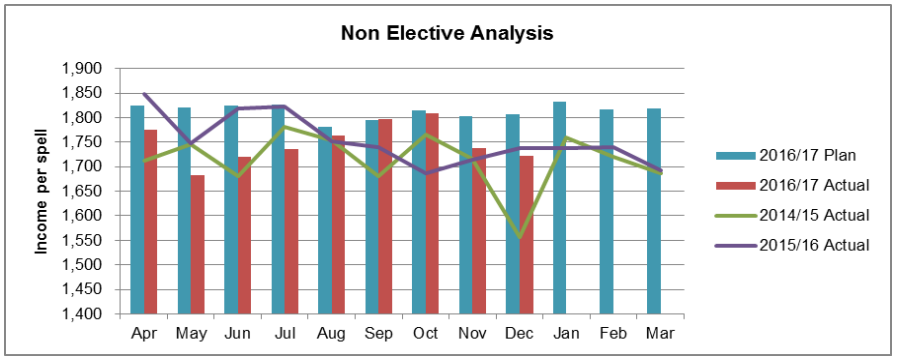


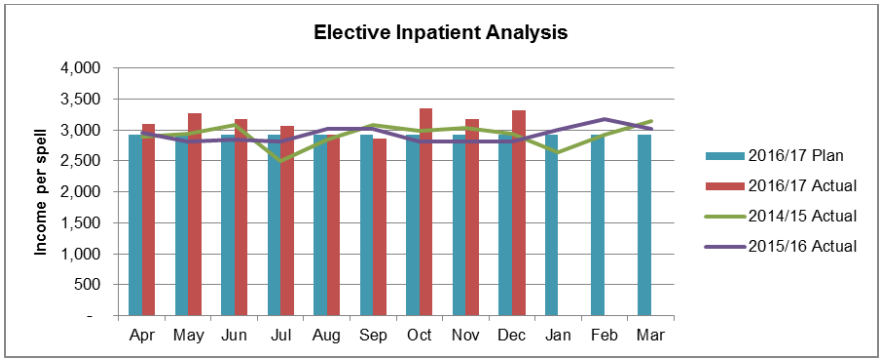
Trends and Analysis

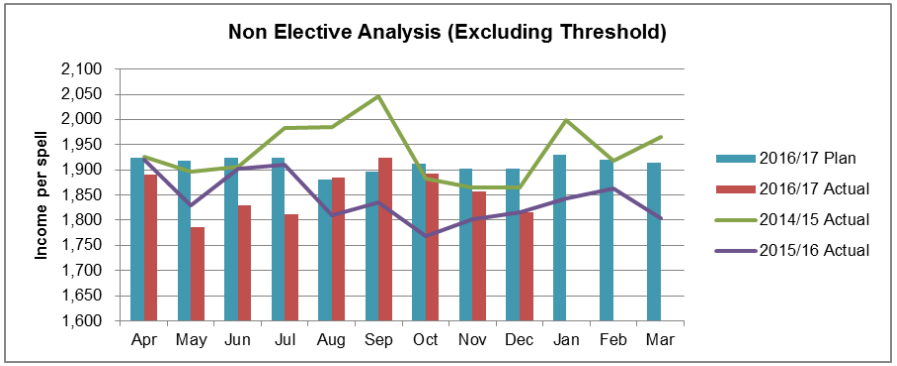












FINANCE AND WORKFORCE REPORT – December 2016

Workforce

Monthly Expenditure Acute services only				
As at December 2016	Dec-16	Nov-16	Dec-15	YTD 2016-17
	£'000	£'000	£'000	£'000
Budgeted costs in month	**10,710**	**10,635**	**10,067**	**96,411**
Substantive Staff	9,522	9,561	9,071	84,995
Medical Agency Staff (includes 'contracted in' staff)	160	187	153	1,863
Medical Locum Staff	163	139	87	1,358
Additional Medical sessions	238	249	153	2,147
Nursing Agency Staff	143	139	45	1,479
Nursing Bank Staff	175	167	266	2,095
Other Agency Staff	92	101	93	1,071
Other Bank Staff	127	124	110	1,214
Overtime	78	79	64	691
On Call	47	53	46	448
Total temporary expenditure	1,222	1,239	1,018	12,367
Total expenditure on pay	**10,743**	**10,799**	**10,089**	**97,362**
Variance (F/(A))	(33)	(165)	(21)	(952)
Temp Staff costs % of Total Pay	11.4%	11.5%	10.1%	12.7%
Memo : Total agency spend in month	394	427	291	4,413

Monthly Expenditure Community Service				
As at December 2016	Dec-16	Nov-16	Dec-15	YTD 2016-17
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,080**	**1,085**	**969**	**9,250**
Substantive Staff	1,011	1,043	931	8,684
Medical Agency Staff (includes 'contracted in' staff)	(15)	0	17	(15)
Medical Locum Staff	3	3	6	41
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	5	5	0	30
Nursing Bank Staff	8	9	4	52
Other Agency Staff	38	44	3	320
Other Bank Staff	11	14	10	109
Overtime	4	6	2	38
On Call	3	1	1	12
Total temporary expenditure	57	82	44	586
Total expenditure on pay	**1,068**	**1,125**	**975**	**9,271**
Variance (F/(A))	11	(39)	(6)	(21)
Temp Staff costs % of Total Pay	5.4%	7.3%	4.5%	6.3%
Memo : Total agency spend in month	28	49	20	335

Monthly whole time equivalents (WTE) Acute Services only			
As at December 2016	Dec-16	Nov-16	Dec-15
	WTE	WTE	WTE
Budgeted WTE in month	**3,016.6**	**3,012.5**	**2,925.3**
Employed substantive WTE in month	**2,730.6**	**2,713.4**	**2,677.5**
Medical Agency Staff (includes 'contracted in' staff)	12.1	13.0	19.1
Medical Locum	15.8	12.4	13.3
Additional Sessions	22.1	24.4	21.7
Nursing Agency	22.1	21.6	14.8
Nursing Bank	58.0	56.8	91.4
Other Agency	27.0	20.2	24.4
Other Bank	63.7	60.3	58.5
Overtime	36.1	36.9	29.5
On call Worked	8.5	9.2	8.6
Total equivalent temporary WTE	**265.4**	**254.7**	**281.3**
Total equivalent employed WTE	**2,996.0**	**2,968.1**	**2,958.8**
Variance (F/(A))	20.6	44.4	(33.6)
Temp Staff WTE % of Total Pay	8.9%	8.6%	9.5%
Memo : Total agency WTE in month	61.3	54.8	58.3
Sickness Rates (October / September)	3.88%	3.88%	3.6%
Mat Leave	2.0%	2.0%	1.9%

Monthly whole time equivalents (WTE) Community Services			
As at December 2016	Dec-16	Nov-16	Dec-15
	WTE	WTE	WTE
Budgeted WTE in month	**359.1**	**359.2**	**327.2**
Employed substantive WTE in month	**337.8**	**342.9**	**319.1**
Medical Agency Staff (includes 'contracted in' staff)	0.0	0.0	0.7
Medical Locum	0.4	0.4	0.8
Additional Sessions	0.0	0.0	0.0
Nursing Agency	0.7	0.8	0.1
Nursing Bank	2.7	2.7	1.3
Other Agency	9.4	11.6	1.9
Other Bank	3.2	3.9	2.8
Overtime	2.2	3.6	1.2
On call Worked	0.9	(1.0)	0.4
Total equivalent temporary WTE	**19.5**	**22.0**	**9.1**
Total equivalent employed WTE	**357.3**	**364.8**	**328.2**
Variance (F/(A))	1.8	(5.6)	(0.9)
Temp Staff WTE % of Total Pay	5.5%	6.0%	2.8%
Memo : Total agency WTE in month	10.1	12.4	2.7
Sickness Rates (October / September)	4.26%	4.26%	
Mat Leave	1.5%	1.5%	

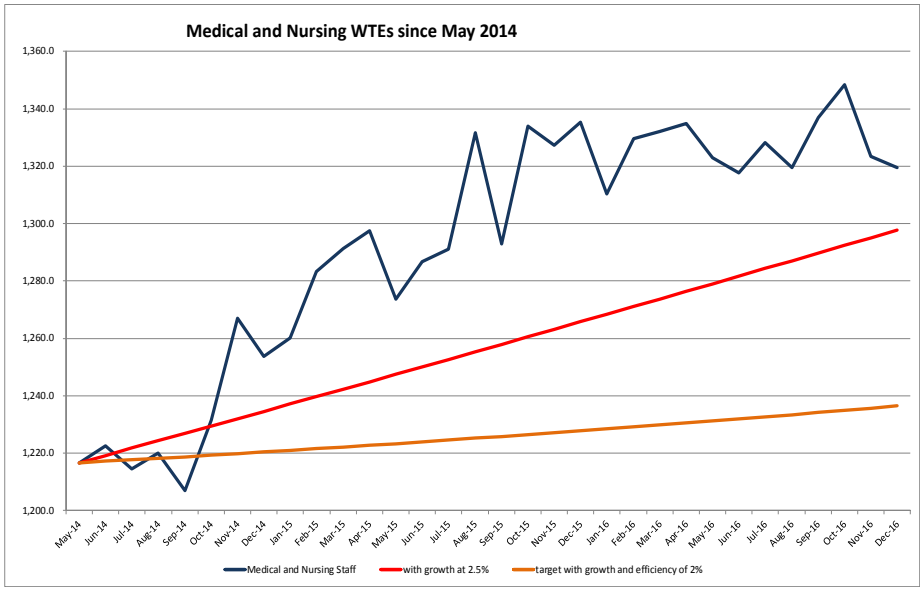
* Note the Acute tables includes Collaborative Procurement Hub staff on WSH Contracts

* Note that pay costs and WTE are gross, ie do not net off income or WTE relating to salary costs recharged to other organisations.

Staffing levels

The Trust overspent pay budgets by £21k in December, with £14k being in Nursing (£961k YTD). Costs have reduced significantly over the last two months due to closing escalation beds.

The chart below shows the growth in Medical and Nursing WTEs since May 2014 of around 103 WTEs (blue line). There has been a reduction of 4 WTE during December.



Medical staffing have increased by 6 WTE since April 2016, largely as the result of increases in medical agency staff.

If our medical and nursing staffing levels had increased in line with our growth in activity of broadly 2.5% we would currently be employing 22 fewer staff (red line).

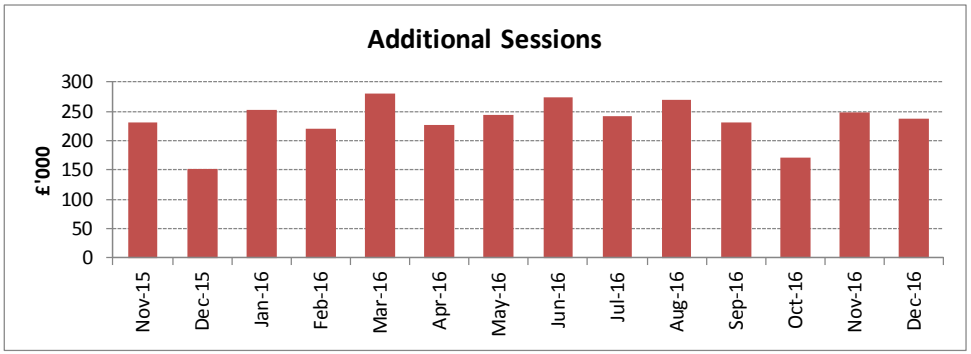
In order to achieve our 2% productivity target we should be staffing at the orange line, which is around 83 WTE fewer than we were at December 2016.

Over the last 12 months the Trust has spent an average of £1.15m per month (£13.8m since January 2016) on the following non-substantive payments. Average monthly expenditure:

- Medical agency £218k
- Medical locums £151k
- Nursing agency £165k
- Nursing bank £245k
- Additional sessions £242k
- Overtime £78k
- On-call £51k

Pay Trends and Analysis

The monthly cost of additional sessions decreased by £11k to £238k. These costs are for both Medical and Non-Medical staff. However, Medical Agency staffing costs decreased by £42k, being £145k in December (£187k in November), the lowest since May 2016.



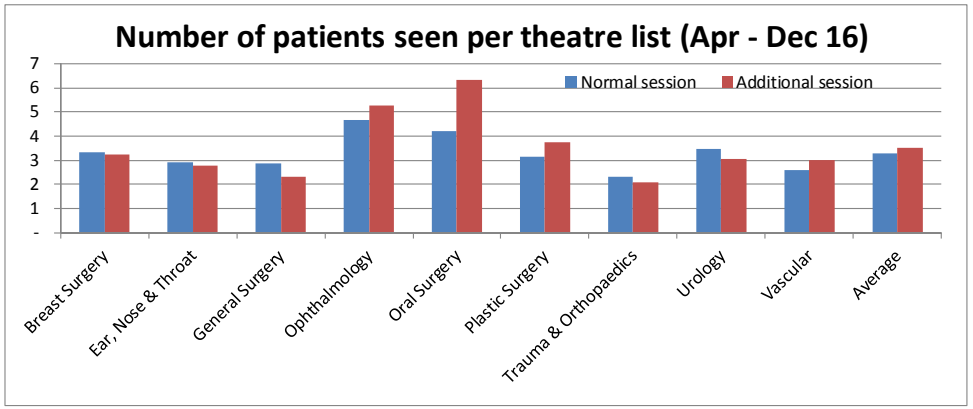
Efficiency of additional sessions against 'normal' sessions

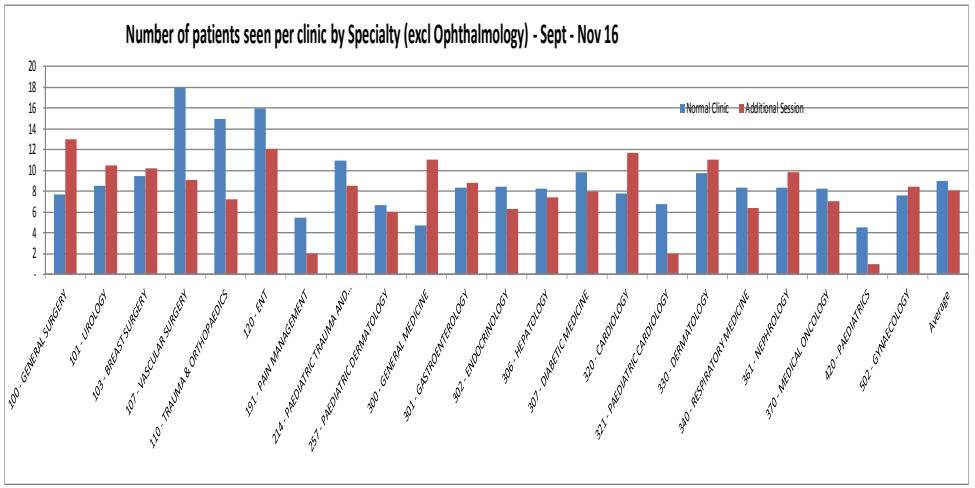
There has been concern over the efficiency of additional sessions which are provided either at weekends, evenings or during SPA time. The charts below show the average number of patients seen per theatre session or outpatient clinic by speciality, during 'normal' sessions against additional sessions

Whilst on average Theatre sessions appear a little more efficient within additional sessions, outpatients appear less so.

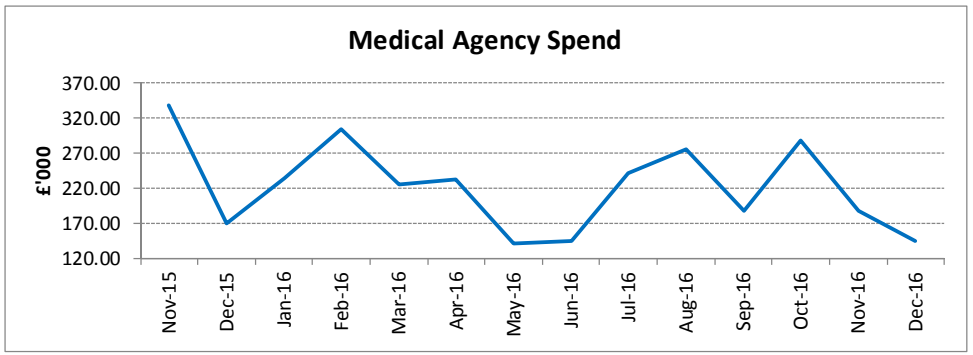
However, there are nuances within each speciality and across the types of patients seen during the normal working week as opposed to those seen in additional sessions which needs further analysis.

FINANCE AND WORKFORCE REPORT – December 2016

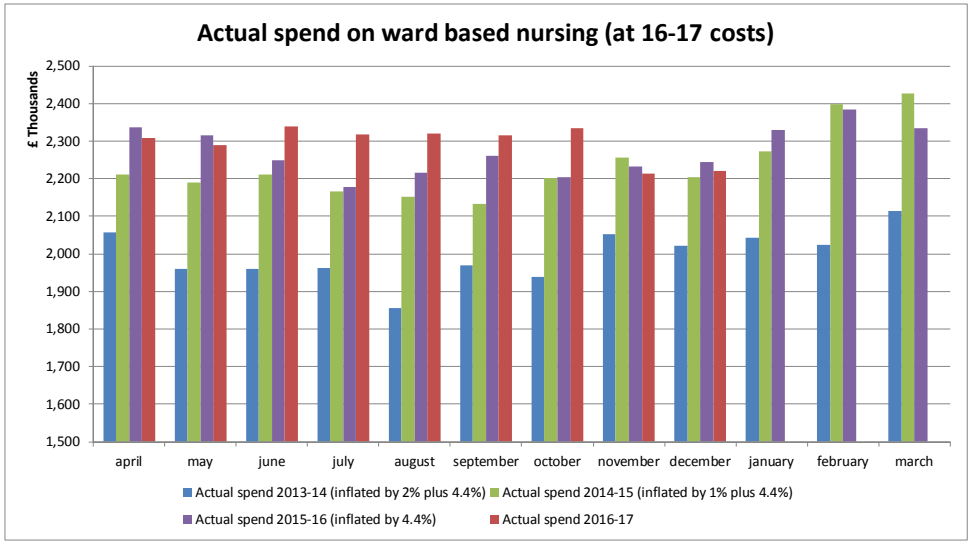




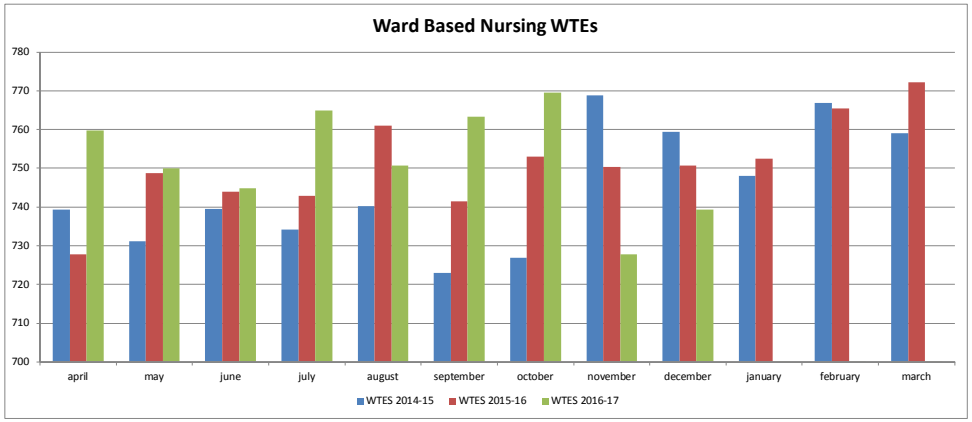
Note : Ophthalmology has been removed as the data looked strange and threw the scale of the chart.



Ward Based Nursing



Ward based nursing costs remained at £2.21m in December, which includes a reduction of around £80k relating to the planned reductions around escalation bed closures



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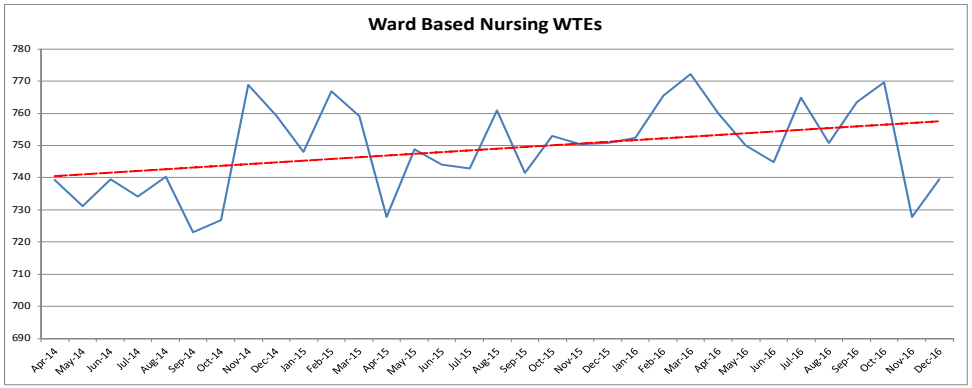
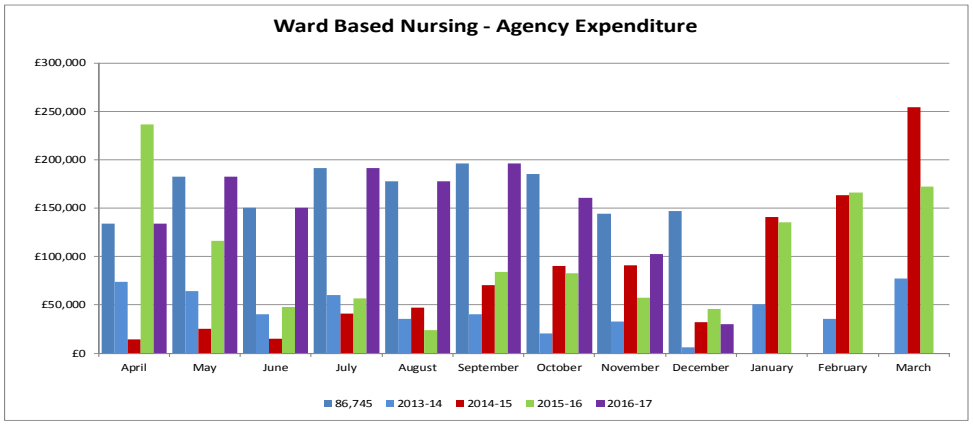
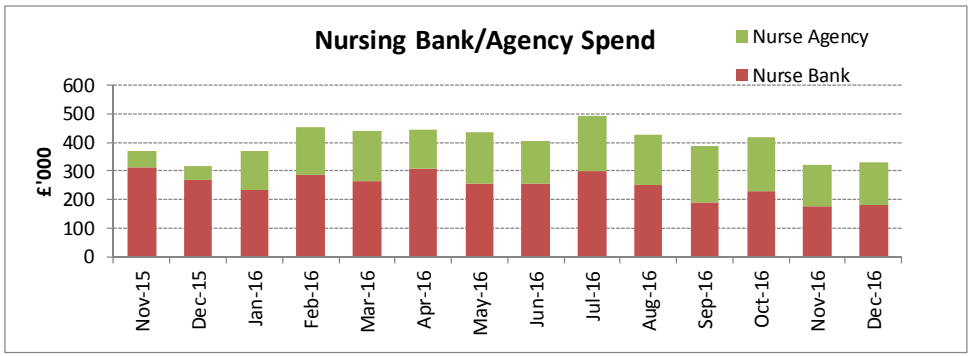




All Nursing



Comparing variance against ceiling for agency costs

Our proportion of agency costs against our total pay costs are the lowest for any DGH in the Midlands and East

Midlands and East of England Acute Trusts

Acute Only			
Midlands and East Region - monthly agency performance repc	(Underspend)/ overspend ppn against ceiling	Rank by underspend ppn against ceiling	Rank by expenditure ppn of total pay
Birmingham Women's NHS Foundation Trust	-48%	1	3
Birmingham Children's Hospital NHS Foundation Trust	-38%	2	1
Cambridge University Hospitals NHS Foundation Trust	-36%	3	2
Heart Of England NHS Foundation Trust	-20%	4	12
Bedford Hospital NHS Trust	-13%	5	17
Worcestershire Acute Hospitals NHS Trust	-11%	6	34
South Warwickshire NHS Foundation Trust	-11%	7	6
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS FT	-10%	8	4
Colchester Hospital University NHS Foundation Trust	-4%	9	43
University Hospitals Of North Midlands NHS Trust	-2%	10	21
Peterborough and Stamford Hospitals NHS Foundation Trust	1%	11	27
Mid Essex Hospital Services NHS Trust	2%	12	32
Derby Teaching Hospitals NHS Foundation Trust	3%	13	5
Worcestershire Health and Care NHS Trust	3%	14	14
James Paget University Hospitals NHS Foundation Trust	4%	15	25
United Lincolnshire Hospitals NHS Trust	4%	16	30
West Suffolk NHS Foundation Trust	6%	17	11
West Hertfordshire Hospitals NHS Trust	10%	21	44
University Hospitals Coventry and Warwickshire NHS Trust	10%	22	31
Milton Keynes Hospital NHS Foundation Trust	11%	23	42
The Princess Alexandra Hospital NHS Trust	12%	24	38
Nottingham University Hospitals NHS Trust	13%	25	8
The Royal Orthopaedic Hospital NHS Foundation Trust	15%	26	35
University Hospitals Of Leicester NHS Trust	15%	27	9
Hinchingbrooke Health Care NHS Trust	16%	28	40
Chesterfield Royal Hospital NHS Foundation Trust	18%	29	36
Shrewsbury and Telford Hospital NHS Trust	26%	30	15
South Staffordshire and Shropshire Healthcare NHS FT	28%	31	18
Ipswich Hospital NHS Trust	28%	32	16
The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust	30%	33	39
Papworth Hospital NHS Foundation Trust	31%	34	7
Norfolk and Norwich University Hospitals NHS Foundation Trust	31%	36	29
Burton Hospitals NHS Foundation Trust	32%	37	20
Luton and Dunstable University Hospital NHS Foundation Trust	32%	38	26
Northampton General Hospital NHS Trust	36%	39	28
University Hospitals Birmingham NHS Foundation Trust	41%	40	10
Basildon and Thurrock University Hospitals NHS Foundation	45%	42	33
Southend University Hospital NHS Foundation Trust	55%	43	37
East and North Hertfordshire NHS Trust	57%	44	41
Kettering General Hospital NHS Foundation Trust	59%	45	45
Sherwood Forest Hospitals NHS Foundation Trust	61%	46	46
The Royal Wolverhampton NHS Trust	62%	47	13
North Staffordshire Combined Healthcare NHS Trust	68%	50	19
Sandwell and West Birmingham Hospitals NHS Trust	87%	51	24
The Dudley Group NHS Foundation Trust	115%	52	23
Walsall Healthcare NHS Trust	122%	53	22

FINANCE AND WORKFORCE REPORT – December 2016

Summary by Directorate

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Dec-16 Budget £k	Dec-16 Actual £k	Dec-16 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	(5,164)	(5,102)	(62)	(46,753)	(47,195)	442
Pay Costs	3,435	3,347	88	30,300	30,820	(520)
Non-pay Costs	1,225	1,266	(42)	11,843	12,041	(197)
Operating Expenditure	**4,660**	**4,613**	**46**	**42,144**	**42,861**	**(717)**
SURPLUS / (DEFICIT)	**504**	**489**	**(16)**	**4,609**	**4,334**	**(275)**
SURGERY						
Total Income	(4,952)	(4,727)	(225)	(46,246)	(44,679)	(1,567)
Pay Costs	2,977	2,900	77	26,881	26,657	224
Non-pay Costs	1,084	1,120	(36)	9,566	9,468	98
Operating Expenditure	**4,061**	**4,020**	**40**	**36,447**	**36,124**	**322**
SURPLUS / (DEFICIT)	**891**	**706**	**(185)**	**9,800**	**8,555**	**(1,245)**
WOMENS and CHILDRENS						
Total Income	(1,690)	(1,647)	(42)	(16,486)	(16,043)	(443)
Pay Costs	1,096	1,096	(0)	9,819	9,961	(142)
Non-pay Costs	140	146	(7)	1,257	1,335	(78)
Operating Expenditure	**1,236**	**1,243**	**(7)**	**11,077**	**11,296**	**(219)**
SURPLUS / (DEFICIT)	**454**	**405**	**(49)**	**5,410**	**4,747**	**(663)**
CLINICAL SUPPORT						
Total Income	(1,001)	(888)	(113)	(9,303)	(8,861)	(442)
Pay Costs	1,604	1,674	(69)	14,447	14,635	(188)
Non-pay Costs	1,007	1,005	1	9,377	9,080	296
Operating Expenditure	**2,611**	**2,679**	**(68)**	**23,824**	**23,715**	**109**
SURPLUS / (DEFICIT)	**(1,609)**	**(1,791)**	**(182)**	**(14,522)**	**(14,854)**	**(333)**
COMMUNITY SERVICES						
Total Income	(5,132)	(4,893)	(239)	(46,263)	(45,813)	(450)
Pay Costs	1,080	1,068	11	9,250	9,280	(30)
Non-pay Costs	4,618	4,409	210	37,330	36,940	390
Operating Expenditure	**5,698**	**5,477**	**221**	**46,579**	**46,220**	**360**
SURPLUS / (DEFICIT)	**(566)**	**(584)**	**(18)**	**(316)**	**(406)**	**(90)**
ESTATES and FACILITIES						
Total Income	(345)	(316)	(29)	(3,107)	(2,855)	(253)
Pay Costs	727	717	10	6,543	6,555	(12)
Non-pay Costs	641	657	(17)	5,474	5,466	8
Operating Expenditure	**1,368**	**1,375**	**(6)**	**12,016**	**12,021**	**(4)**
SURPLUS / (DEFICIT)	**(1,023)**	**(1,059)**	**(36)**	**(8,909)**	**(9,166)**	**(257)**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	(3,835)	(2,010)	(1,825)	(22,202)	(20,507)	(1,695)
Pay Costs	871	1,004	(133)	8,420	8,836	(415)
Non-pay Costs (net of contingency and reserves)	1,811	1,849	(38)	7,974	8,338	(364)
Finance & Capital	764	864	(100)	5,676	5,770	(94)
Operating Expenditure	**3,446**	**3,717**	**(271)**	**22,070**	**22,944**	**(873)**
SURPLUS / (DEFICIT)	**389**	**(1,707)**	**(2,096)**	**132**	**(2,437)**	**(2,568)**
TOTAL (including penalties, contingency and reserves)						
Total Income	(22,118)	(19,582)	(2,536)	(190,361)	(185,952)	(4,408)
Contract Penalties	0	0	0	0	0	0
Pay Costs	11,790	11,807	(17)	105,661	106,743	(1,082)
Non-pay Costs	10,524	10,452	72	82,821	82,667	153
Finance & Capital	764	864	(100)	5,676	5,770	(94)
Operating Expenditure (incl penalties)	**23,079**	**23,123**	**(45)**	**194,157**	**195,180**	**(1,023)**
SURPLUS / (DEFICIT)	**(960)**	**(3,541)**	**(2,581)**	**(3,796)**	**(9,228)**	**(5,432)**

Medicine (Annie Campbell)

The Division under performed by £16k in December, (under performed by £275k YTD).

Contract income was £72k behind plan in the month. This was driven by ED attendance income (due to the case mix - attendances were above plan) and outpatients (due to e-Care issues). The Division's initiative to review individual clinicians use of e-care has been in place since the beginning of January, and appears to be making an improvement. Finance identified an area in ED where cannulas were not being recorded correctly and the action taken should improve income by approximately £15k per month.

With the indications from January, and the initiatives in place, it is expected that January income should be above plan

Net expenditure was £54k better than budget. The last two months have seen reductions in nurse agency and these are expected to further decrease through to February, although both norovirus and ED pressures have may prevent these decreases being fully realised. Medical agency was also reduced, but there are some vacancies that may see these costs increase slightly.

Non-pay continues to be an issue. Patient transport, security costs, drugs and MSE, all contributed. Drugs are a result of NHSE tightening the criteria on excluded drugs, and together with MSE symptomatic of increased inpatient activity. Patient transport has been discussed with the CCG and may result in a tendering exercise in the short term. This should reduce significantly once the new pacing suite is implemented.

The Division have complied with the Directors request to keep expenditure in line with budgets for the last five months. The cumulative effect of November and December being a £22k underspend.

CIPs were on target for the month although there may be a slight drift towards the end of the year due to a VAT issue, not being satisfactorily being resolved.

Surgery (Simon Taylor)

The Division has underperformed by £185k in December (£1,245k YTD).

Surgical activity is below plan in both admitted care and outpatients.

The Division has struggled this month due to winter pressures and closure of DSU over Christmas. However critical care was very busy. Action has been taken to improve performance in January.

Three specialities are significantly struggling to meet their outpatient plan, Orthopaedics, General Surgery & Urology. However, it ids thought this may be due to data quality and recording within eCare.

Pay is underspent by £77k. The division is still covering shifts with agency, and this is likely to continue in some areas with vacancies and long term sickness impacting on safe staffing levels. The favourable variance is due to a non-recurring adjustment.

Non-pay is overspent by £42k which includes £30k of non-recurring expenditure

In relation to CIP's Surgery has underachieved by £13k YTD. The variance is due to overspend on orthotics but the division is still forecasting to achieve its CIP plan by year end.

Women and Children's (Rose Smith)

In December the Division reported an under performance of £49k (£663k YTD).

Clinical income reported was £28k behind plan in-month and £380k behind plan YTD. This is mainly due to an in-month under performance within Neonatology Critical Care and Gynaecology admitted patient care in elective day cases.

Other Income is £14k behind plan in-month and £63k YTD, mainly due to private patient income as well as a decrease in deanery training income.

Pay reported a break even position in December and £142k overspend YTD. As in prior months, there have been overspends with Hospital and Community Midwifery, offset against underspends across the rest of the division. The midwifery consultation has been completed and is expected to be implemented during January 2017.

Non pay reported £7k overspend in-month and £78k YTD.

Clinical Support (Rose Smith)

The Division under performed by £182k in-month and (£333k YTD).

Clinical income for Clinical Support was £69k behind plan in-month and £151k behind plan YTD, mainly due to in-month underperformance within Diagnostic Imaging and Interventional Radiology admitted patient care.

Income was £44k behind plan in-month and £291k behind plan YTD. This is primarily due to Private Physiotherapy Service £15k (though income is increasing since the service went live in October), Integrated Therapies Recharges £10k, and decrease in patient income for Radiology £9k.

Clinical Support pay reported a £69k overspend in-month, £188k YTD. The main overspends are within Radiology due to agency and additional sessions resulting in overspends of £25k and £20k respectively. There is also a £19k overspend within Pharmacy due additional hours required post e-care.

Non pay reported a £1k underspend in-month and £231k underspend YTD.

Community Services (Dawn Godbold)

Community Services reported an £18k under performance in-month and £90k YTD.

Contract Income reported £239k under recovery in-month, and £450k under recovery YTD. This under recovery relates to an adjustment to the recharges to Suffolk County Council for community equipment.

Pay reported an £11k underspend in-month and £30k overspend YTD. In month underspends mainly within Paediatrics offset against overspends in both Glastonbury Court and Adult SALT.

Non pay reported a £210k underspend in-month (£390k underspent YTD) due to Estates, Central Equipment Store and Paediatrics.

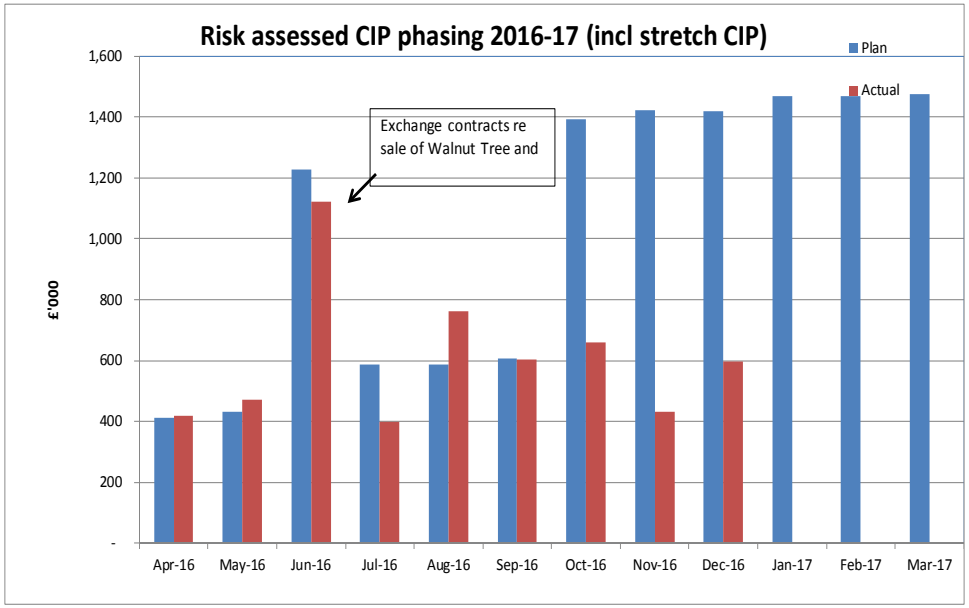
Whilst community services remain on plan there are significant risks around the costs associated with :

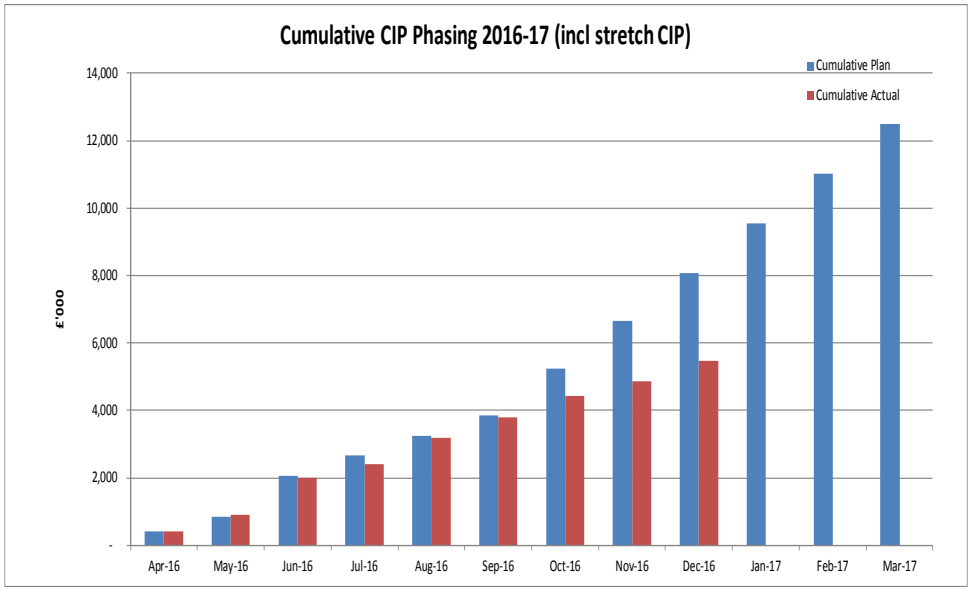
- recharging Suffolk County Council for additional community equipment
- NHS Property Services. We are now actively discussing the disputed charges and are hopeful a resolution can be reported at the next Board.

Corporate Services

This position includes the stretch CIP and Sustainability and Transformation funding.

Cost Improvement Programme (CIP)





Summary of year to date performance against CIP target

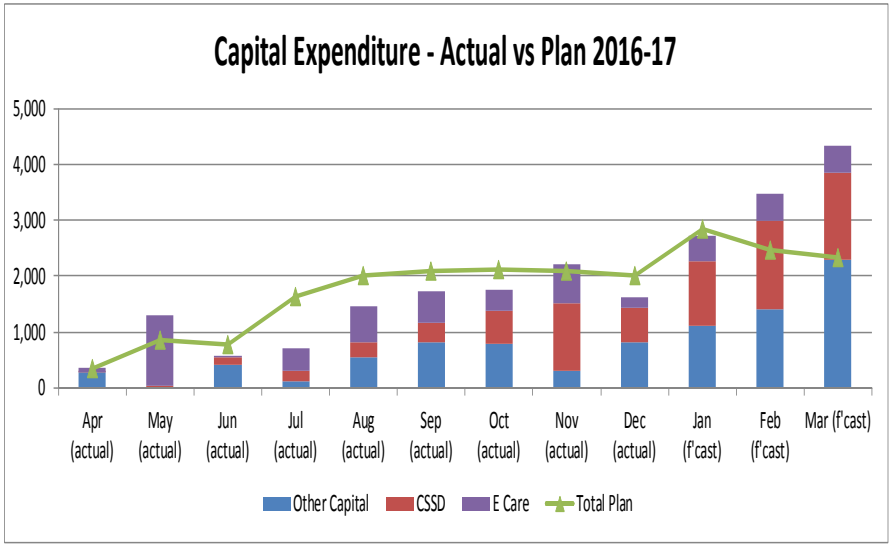
CIP schemes	Annual Plan	Plan YTD	Actual YTD	Forecast
	£'000	£'000	£'000	£'000
Activity growth	1,634	1,226	1,145	1,527
PCP	138	103	139	186
Price rise	31	23	15	50
Car parking	210	126	110	250
Staff review	552	394	381	507
Additional sessions	551	311	65	250
Agency reduction	405	127	-	250
Drugs	81	61	79	105
Pathology volume	68	47	-	-
Estates	375	216	106	400
DTOCs	540	300	-	240
Non-pay	407	324	202	448
Other	1,108	815	816	1,087
Non-recurring	2,500	2,063	2,013	2,500
Stretch CIP	3,900	1,884	-	-
New schemes	-	-	400	800
Grand Total	**12,500**	**8,019**	**5,469**	**8,600**

The impact of the stretch CIP can be seen over the last 3 months, as well as the planned savings in delayed transfers of care. However, since no savings have been identified against these schemes, we have failed our CIP plans significantly since October, and in total YTD by £2,550k (£1,826k as at November).

We are forecasting to achieve our original CIP of £8.6m

FINANCE AND WORKFORCE REPORT – December 2016

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Actual £'000	Dec Actual £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2016-17 £'000
E Care	94	1,262	19	412	625	561	378	705	198	473	473	473	5,672
CSSD	11	37	130	176	281	365	580	1,221	603	1,135	1,577	1,556	7,671
Other Schemes	270	15	426	124	548	806	793	299	819	1,125	1,419	2,300	8,944
Total Actual / Forecast	375	1,313	574	713	1,454	1,732	1,751	2,225	1,620	2,732	3,469	4,329	22,286
Total Plan	359	864	770	1,628	2,012	2,104	2,124	2,101	2,009	2,834	2,459	2,327	21,590

The capital programme for the year is shown in the graph above. The CSSD and E-Care schemes are shown separately.

Overall the slippage on the 2016-17 Capital Programme is £2.2 million to the end of December. This is mainly due to re-phasing of larger projects such as the CSSD building and the Cath Lab. Whilst these are forecast to continue to underspend in 2016-17 the overall capital programme is forecast to overspend by £0.7m due to increasing expenditure on e-Care.

The CSSD build has commenced and will incorporate two additional floors to facilitate future clinical development in the hospital core. Expenditure is £0.4 million behind plan in December and £3 million behind plan YTD.

Slippage on the Cath Lab in 2016-17 is anticipated to be £2.256 million by the end of the year and largely relates to a delay with the Mortuary move. Enabling works have been identified for G6 and F12 and are due to commence in mid-February. Build works have also been tendered with commencement due in mid-March.

Phase 1 E-Care went live at the beginning of May and the Capital Programme assumes Phase 2 of the original business case will be completed within this financial year. Expenditure on e-Care is £4.253 million at the end of December, (against a total plan for 2016-17 of £3.44 million.)

The outcome of the Global Digital Excellence (GDE) bid has not been taken into consideration in the M9 forecast since it is yet to be determined when the funding will arrive and it is still subject to formal Treasury sign-off. However, the E-Care programme budget is currently being reviewed to take account of the increased scope associated with this funding.

Use of Resources (UoR) Rating

(previously the Financial Sustainability Risk Rating)

Following implementation of the Single Oversight Framework (SOF), providers' financial performance will now be formally assessed via five "Use of Resources (UoR) Metrics.

The key features of the UOR ratings are as follows:

- The scoring has reversed (compared with the FSRR ratings) so that 1 is now the highest score and 4 is now the lowest
- The liquidity ratio and the capital servicing capacity ratios are identical (except for the scoring) to those that were included within the FSRR
- The I&E margin ratio and the distance from plan ratio is similar to those used in the FSRR except that the calculation is based on a control total basis rather than normalised surplus (deficit). Note that these are not applied to plan data as control totals were not in use prior to 2016/17.
- A new metric has been introduced to measure expenditure on agency staff as a proportion of the ceiling for agency staff. A positive value indicates an adverse variance above the ceiling.
- The overall metric is calculated by attaching a 20% weighting to each category. The score may then be limited if any of the individual scores are 4, if the control total was not accepted, or is planned / forecast to be overspent or if the trust is in special measures.

Metric	Value	Score
Capital Service Capacity rating	-2.594	4
Liquidity rating	-16.455	4
I&E Margin rating	-4.93%	4
I&E Margin Variance rating	-2.12%	4
Agency	5.22%	2
Use of Resources Rating after Overrides		4

The Trust is now scoring an overall UoR of **4**, but within this score the I & E margin variance rating score has decreased from 1 to 2 reflecting the deterioration in the I & E position. If this rating value decreases to between -1% and -2% the score will deteriorate to 3 and less than -2% will mean a score of 4. Agency would need to be 25% or more away from the agency ceiling for the score to deteriorate.

We have suggested to NHSI that our working capital facility should be included in our liquidity calculation, which would improve our UoR to a 3. They are reviewing this issue, but are unable to provide a positive response in time for this report.

Statement of Financial Position at 31st December 2016

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2016 £000	Plan 31 March 2017 £000	Plan YTD 31 Dec 2016 £000	As at 31 Dec 2016 £000	Variance YTD 31 Dec 2016 £000
Intangible assets	10,876	13,487	13,072	15,059	1,987
Property, plant and equipment	61,923	74,893	69,620	65,345	(4,275)
Trade and other receivables	273	340	340	340	0
Other financial assets	1,688	2,409	2,259	1,909	(350)
Total non-current assets	**74,760**	**91,129**	**85,292**	**82,653**	**(2,638)**
Inventories	2,825	2,850	2,950	2,778	(172)
Trade and other receivables	11,191	9,230	9,380	13,130	3,750
Non-current assets for sale	1,400	0	0	0	0
Cash and cash equivalents	2,601	3,007	3,678	4,302	624
Total current assets	**18,017**	**15,087**	**16,008**	**20,211**	**4,203**
Trade and other payables	(21,692)	(20,686)	(17,660)	(27,899)	(10,239)
Borrowings	(130)	(130)	(130)	(130)	0
Provisions	(84)	(84)	(84)	(84)	0
Other liabilities	(1,892)	(295)	(476)	(942)	(466)
Total current liabilities	**(23,798)**	**(21,195)**	**(18,350)**	**(29,055)**	**(10,705)**
Total assets less current liabilities	**68,979**	**85,021**	**82,949**	**73,809**	**(9,141)**
Trade and other payables - Non current	(912)	(1,083)	(1,083)	(1,111)	(28)
Borrowings	(18,205)	(39,075)	(35,640)	(32,064)	3,576
Provisions	(202)	(203)	(211)	(202)	9
Total non-current liabilities	**(19,319)**	**(40,361)**	**(36,934)**	**(33,377)**	**3,557**
Total assets employed	**49,660**	**44,660**	**46,015**	**40,432**	**(5,584)**
Financed by					
Public dividend capital	59,232	59,232	59,232	59,232	(0)
Revaluation reserve	2,151	2,151	2,151	2,151	0
Income and expenditure reserve	(11,723)	(16,723)	(15,368)	(20,951)	(5,583)
Total taxpayers' and others' equity	**49,660**	**44,660**	**46,015**	**40,432**	**(5,583)**

Intangible Assets and Property Plant and Equipment:

The £2.0m variance on Intangible Assets is due to E-care . The planned expenditure for E-Care is currently under review following the Digital Excellence Award.

The variance on Property, Plant and Equipment is due to slippage, mainly on CSSD, but is expected to catch up with plan as the year progresses.

The adverse variance on E-Care will need to be funded either from slippage on the PPE programme or from the Digital Excellence Award funding which is expected to be received in Quarter 4.

Other financial assets:
This investment relates to the Pathology Partnership (tPP) joint venture. The Trust is planning to increase its investment with tPP by £0.6 million in Quarter 4. The associated risk since CUHFT has announced its withdrawal from the partnership continues to be reviewed regularly and discussed with regulatory partners.

Trade and other receivables:
These continue to be higher than planned and additional steps are being taken in January to reduce the amount owed to the Trust, including weekly payments from tPP.

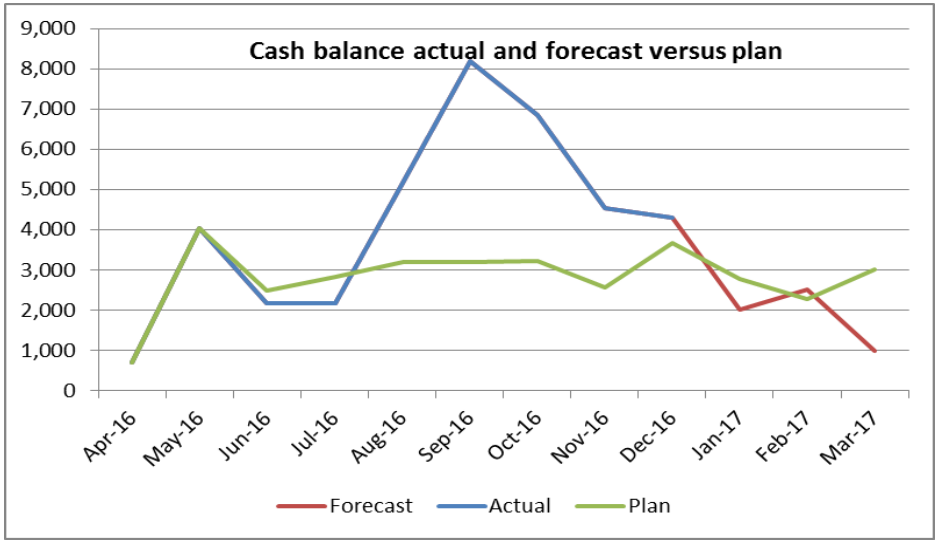
Cash:
Cash is higher than planned and forecast a month ago because the NCHC community contract invoice was not received in December but was paid as soon as it was received in January.

Trade and other payables:
Current payables have increased significantly since November. A significant cause of the increase is the NCHC contract for Community Services being paid in January rather than in month (see above). In addition there was an unplanned reduction in payments processed in month due to staffing issues but this is expected to return to normal levels in the coming weeks. Payables will decrease further as issues are resolved with TPP and progress has already been made on this in January.

Borrowing:
Borrowing is less than planned at the end of December because the working capital facility has not been utilised as planned to support the deficit because of slippage on the capital programme. It is expected that the working capital facility will be drawn down in quarter 4 as capital slippage reduces and because the profiling of cash payments from the CCG is lower in Quarter 4.

FINANCE AND WORKFORCE REPORT – December 2016

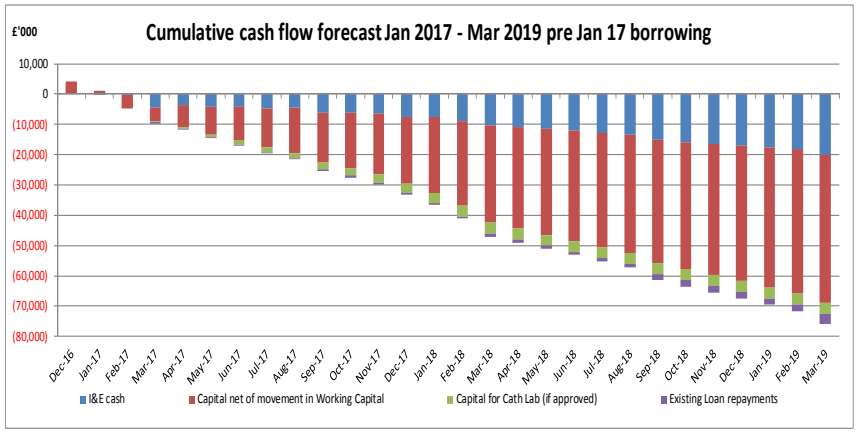
Cash Balance Forecast for the year



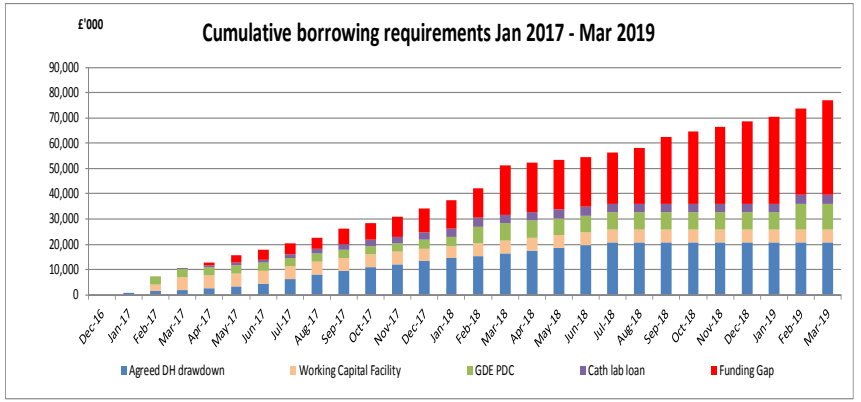
The graph illustrates the cash trajectory year to date, plan and revised forecast. It also assumes receipt of £3.3 million cash in February for the Global Digital Excellence Bid which was previously assumed to be received in January.

Cash forecast in line with Operational Plans

The Trusts cash position deteriorates over the next two years as a result of the I&E forecast and capital programme included in our 2017-18 to 2018-19 Operational Plan.



In order to maintain a cash balance of £1m we forecast a funding gap of £1.3m from April 2017, rising to £38m by March 2019. We will therefore require distressed funding in order to meet our Operational Plans.



West Suffolk NHS
NHS Foundation Trust

Board of Directors – 27January 2017

AGENDA ITEM:	Item 10
PRESENTED BY:	JON GREEN
PREPARED BY:	HELEN BECK, LESLEY STANDRING, DEBS CRELLY & STEVE DAVIES
DATE PREPARED:	20 JANUARY 2017
SUBJECT:	TRUST TRANSFORMATION BOARD REPORT
PURPOSE:	INFORMATION

Executive Summary

This report provides an update to the board on the range of joint projects being managed by the PMO and progressed jointly by the Trust and the CCG along with a number of internal Transformation projects being managed by the Trust.

STP Supported Projects/System Wide Projects
The Service Transformation Programme is a joint activity between the WSCCG and WSFT and comprises projects which will deliver benefits across the West Suffolk health system. Acting as "one organisation" – with a joint Executive, this programme manages projects which deliver benefits across Primary Care/ Acute or Community settings.

Integration Work
A business case is in development for the New Carer Reablement Service, now called 'Support To Get Home.'

7 Day Services
Following the initial data collection audit by NHSI our results place us in the middle of the range. A further national collection of data is to take place. The data collection period is a chosen week between 15th March and 12th April. The submission date is the 24th May and analysis will be available to NHS Improvement and NHS England on 7th June. This collection is again on the 4 priority standards, national leads have indicated that there will be no Consultant survey this time. A nurse to complete the audit for the duration has already been identified and the audit has been planned. 7DS leads have monthly teleconferences with national leads and take part in webinars with other Trusts to ensure the team are fully informed. Meetings are taking place with eCare leads to gain clarity in data recording which will be communicated well in advanced.

FLAG
Patient flow is the number one priority for the organisation to support improvements in patient care and reduce costs through a reduction in escalation capacity requirements. A new group has been established chaired by the medical director and the to manage the various programmes of work under this initiative.

With long arm support from ECIST - Implementation of SAFER has been agreed as the Trust main priority to support improved patient flow. The programme includes 8.30am Consultant/registrar led board rounds on all wards. All patients start the day with a red status and have to meet certain criteria to move to green. This includes having a planned discharge date and clinical criteria for discharge which they and their family are aware of as well as a clear plan to progress their diagnosis and recovery. Internal professional standards are currently being developed.

Ambulatory Emergency Care
Dr Liz Hamilton has been appointed as the new clinical lead for Ambulatory Care and the team have support from Dr Simon Arthur as GP/CCG Lead. Pilots are planned to increase the take to a target 30%.

e-Care
A diagnostic review of the benefits within the e Care business case is underway and it is expected that a summary report will be available for the next board paper. Early indications are that it is currently too early to identify significant benefits due to the delay in the launch of the order communications module into the system.

National CQUINs
An update is provided for the national CQUIN's and the local CQUIN focusing on frailty. National schemes for 2017/18 Now have leads identified and are in the planning phase.

Linked Strategic objective (link to website)	
Issue previously considered by: (e.g. committees or forums)	
Risk description: (including reference Risk Register and BAF if applicable)	
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	
Legislation / Regulatory requirements:	
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	

Recommendation:

The Board is asked to note the Trust Transformation Report

Project	Objective	End Date	Value	Risks	Benefits	Update
PMO	**Agency project** 1) Improve control and planning of workforce. 2) Implementation of Agency control new framework.	April 17	£500k	Implementation and coordination of new framework with regional partners	Reduced costs of Agency staffing	This project has delivered savings on Nursing of 12%, but little progress on Doctors rates. The project is still ongoing and continuing to progress.
	E rostering Project Improved workforce: - Additional session payment and planning - Improved theatre utilisation and outpatients - Accuracy of enhanced/ overtime payments	Oct 17	£397k	Identification of suitable rostering system for the additional staff groups not currently using an erostering platform (i.e. Medical). Organisational culture change	Reduced Workforce Costs	This project has been re scoped, and the business case was presented to TEG on 16th January 2017. This was given the approval to proceed to the next stage, which is full clinical engagement and systems evaluation.
	Medical Products usage To maximize the use of Alternative medical products to generate a saving of £ 224k.	April 17	£224k	Clinical objections to suitable alternatives	£224K	Initial products phase completed - exam gloves and other products will be completed by April '17.
	Medicines Optimisation Project To maximize the use of Bio Similar "generic" Pharmaceutical products for complex drugs.	Jan 17	£247k		£80k	On track – will increase Financial benefit as other bio-similar drugs have been identified.
	New Reablement Service To discharge medically fit patients who require short term care packages, unblocking 12 beds.	Jan 17	£224k	Winter pressures will not release the closure of 12 beds	Potential Cost savings of escalation capacity	Business case presented to Executives who requested more financial information.

PMO	**Transformation / Integration** To improve health care outcomes for a targeted cohort of patients by moving care into their home Reducing acute hospital length of stay - TBA with WSFT.	Mar 16	TBC	Working with all parts of the health system to enact changes to operations	Improved health outcomes Cost savings	Now considered to be an STP project and not in scope.
	Community Service Out of Hospital Beds 1) To ensure the best use of facilities within NHS run community Hospitals. 2) To generate £150k of short term savings (already submitted as part of Community CIP)	Dec 16	£150k			Completed – a paper on the viability of the Community Hospital sites being prepared by the CCG, hence no further actions needed.
	Theatre Productivity In order to reduce the waiting list, and to potentially repatriate elective work, there is a need to improve theatre utilisation. Over the 5 week schedule, there are currently 111 surgical sessions without a theatre slot. There is also an opportunity to review which surgical procedures that could be undertaken in an alternative environment e.g. moving main theatre procedures to Day Surgery, Day Surgery to Outpatients, Hysteroscopy to Gynae Outpatients.	Dec 16	£158k	Engagement with clinicians and theatre team. System inefficiencies as theatres not on e-Care leading to dual entry of data and lack of co-ordination	Improved efficiency	Successful increase in theatre utilisation has created savings, further work still to be completed as BAU. Planning to deploy theatres and Anaesthetics in phase 2 of eCare
	Digital Optimisation Implementation of an appropriate technological solution to enable improved efficiency within the medical secretariat.	Jan 17	£80k	Identification of appropriate digital solution Engagement with medical secretaries Engagement with clinical workforce	Improved Efficiency	Re-scoped project - revisit project plan by end of January.
	Newmarket Coffee Shop To provide an updated catering facility which will generate revenue and profitability?	Dec 16	£25k	None	Income for WSFT	Completed - business case approved, operation will start 1 April ’17.

PMO	**MSK Service SPOA** To design and implement a single point of access MSK service taking a "teams without walls" approach. This project will reduce the number of acute first outpatient appointments by 13% and reduction in Orthopedic Clinical threshold procedures.	Dec 16	£115k	Increase in cost of AHPS MSK Contract due to increased activity. Mitigated by contractual conversations in context of agreements already made on reduction of contract value. The ability of WSFT to work in partnership with AHPS on the proposed model within the timeframes. As a new project it will need a 'team without walls' approach to mitigate any issues.	Improved health outcomes Costs Savings	Started to change pathway, significant progress made. Project now completed, with savings being delivered at a lower level
	Outpatients Efficiency Project To generate an annual saving of £331,500 by increasing utilisation to 75% (Upper quartile) to reduce additional Clinics and an annual saving in postage of £16,104 by reducing Clinic cancellations by 50%.	Feb 17	£330k	Consultant reaction to change.	Improved utilisation of Clinics Improved Patient service	Significant progress made, email system ready to go live, redesign of Additional and Cancellation of clinics management process underway. E job planning included in the e rostering project, programme of Clinic audits commences in Feb '17.
	Nursing & Midwifery Review This project will lay the foundation for the development of a more systematic and standardized approach to nursing and midwifery workforce planning & management to succeed the current	Feb 17	£330k	Winter pressures will effect delivery for results / efficiency savings Clinical objections to plans to relocate specialities.	Cost savings £330k	Not on track - options appraisal paper delayed.

PMO	methodology that will assure the Trust and all external interested parties, of a proactive drive to ensure the co-operative association with nursing/midwifery workforce, quality, finance, clinical outcomes and realize operational excellence.					
	Teledermatology To have WSFT consultants undertake the review that is currently outsourced to Vantage	Nov 16	£29k	None	Cost savings £74k	Completed – Vantage contract terminated and WSFT now undertaking work. Reduced savings
	NOTE: Additional projects updates 1. Community Pain Services – Single model of operation under the Alliance now under development, for implementation April / may 2. Dental – service de commissioned Now approved. 3. Audiology – Rejected proposal due to clinical concerns. No further work. 4. Follow up appointments – PID to be presented Feb TPG 5. Dialysis – commissioning of service to WSFT - subject to more detailed business paper, presented to TPS Jan, further clinical assessment is required prior to decision					
	FINANCIAL SUMMARY OF SERVICE TRANSFORMATION PROJECTS : 16/17 ACTUAL = £434K 17/18 FULL YEAR EFFECT = £1.320K 17/18 PROJECTION (if 3 other projects get delivered) = £2.236k ADDITIONAL PROJECTS STILL BEING PROGRESSED = £538K					

Integration	**Support to Get Home (Formerly New Carer Reablement Service)** To design a care team who can operate at pace to support reablement and care for selected patients: A. End of Life B. Support short term reablement C. Provide a 'bridge' until care available D. Support Discharge to assess	Mar 17	**16/17** Savings - £159 Costs - £140 **17/18** Savings - £637 Costs - £415	SCC – Home first service not supportive Carers not available Recruitment Savings not realised	Able to discharge medically fit patients earlier Able to close 12 beds Support to discharge to assess roll out	Funding streams in development with 2 options – Option 1 - pay as you go with each hour of direct care paid by ACS set up costs required by WSFT Option 2 - pump prime by ACS
	Connect/Integrated Neighbourhood Teams/Frailty A collaborative programme of work that supports system integration to manage complex needs away from the acute hospital looking initially at the following 3 areas: 1. High demand patients who are over 75 and live in Bury town 2. Implementation of a frailty pathway 3. Implementation of integrated reablement	Mar 17	£596	Resources and system funding pressures Releasing capacity within teams to deliver change whilst managing day to day demands Lack of engagement / pace Lack of clinical leadership	More people supported through case management delivered in community settings Reduction in admissions More efficient use of community beds Increased efficiency of workforce	System wide involvement Locality profile for BSE being developed Action plan developed Focus on Bury town

Integration	**ED Demand Management** This project is PMO supported. The emergency department demand management group will review the following areas to ensure that efficient pathways and service provision is in place to reduce demand on the emergency department: 1. Early Intervention Team and wider Reactive Care implementation 2. High demand pathways such as activity from care homes and high referral practice populations (including mental health frequent attenders) 3. GP plus and Out of Hours primary care 4. 111 5. Ambulance conveyances 6. Communications planning	Mar 17	TBC	Working with all parts of the health system to enact changes to operations	Improved health outcomes	The EIT service is being promoted with GP's and linking with the 111 service to ensure awareness and appropriate referrals. A skills audit is taking place with EIT and SCH to identify and address any gaps. Work regarding frequent attenders now with ED sustainability group who will be organizing analysis, MDT's and area wide communication.

Local/ National	**7 Day Services – NHSI/NHSE** • To comply with the 4 priority standards according to national timescales • To gain complex data for national submission • To embed standards and opportunities to gain consistent recording via e-Care • To plan for next data submission • To work towards the 10 7DS standards	Awaiting details of 2nd tranche Complete Ongoing	£0	If WSFT are in second tranche, full compliance of 4 standards by end of 2018. Cost: Initial scoping has demonstrated a cost of 3 million to achieve the 4 priority standards. Recruitment would be a high risk.	The national data regarding mortality rates has since been discounted. There are no early adopters with full compliance however the suggestion is that discharges would be more evenly distributed throughout the week and LoS may be reduced.	A nurse to complete the audit for the duration has already been identified and the audit has been planned. 7DS leads have monthly teleconferences with national leads and take part in webinars with other Trusts to ensure the team are fully informed. Meetings are taking place with eCare Leads to gain clarity in data recording which will be communicated well in advance The AEC pathway within eCare is being facilitated and should make data collection easier,

FLAG	Implementation of the SAFER bundles and the Red to Green initiative Implementation of early board rounds across all adult inpatient areas excluding Maternity to improve patient flow	Ongoing		Lack of engagement from Clinicians	Earlier in the day discharge Every patient has a plan which they and their family know about Every patient knows their planned discharge date	Launched on the 3rd January across 14 inpatient wards – early reports show full uptake with variability in consultant attendance depending on the day Changes to ecare whiteboard to support the board round in place by 10th February Plan in place to support the roll out of SAFER by the end March 2017 which includes changes to ward rounds.

Local/ National	**National CQUIN's** See Appendix A.					Update on red rated schemes: Flu Vaccinations: The campaign continues however the target set is very high (75% staff) Reduction in antibiotics: This is unlikely to be achieved due to the control data being taken at a time of very low use. Schemes 2017/18 There is a continued focus on staff health and wellbeing and antibiotic reduction and new focuses on emergency mental health needs and e-referrals. Schemes are being scoped but detail is likely to be subject to change at this stage.
e-Care	**Benefits Realisation** Following phase one implementation and stabilisation development of a robust project management framework to ensure realisation of the identified benefits.	7 years in line with revised BC phasing	£20m	Business case review has identified deficit in identified benefits. Other opportunities being explored to close gap	GoGDE funding creates opportunity to progress at pace Enabler to deliver improved quality and	Benefits realisation programme following PMO methodology

	Review and update of original business case undertaken to reflect impact of material changes to the delivery timelines Benefits delivery period reduced from 8 to 7 years due to delays in implementation			Resources required to improved adoption to deliver benefits Potential for overlap and double counting with other	Financial performance	

Appendix A - CQUINS

West Suffolk NHS
NHS Foundation Trust

2016-7 – Total Value £3,443,256 for 8 projects	Q1	Q2	Q3	Q4
NATIONAL				
1a) Staff Health & Wellbeing:	**FULL £344,326**			
Activity, Stress, MSK. Introduce a full range of health & wellbeing initiatives covering: physical activity, mental health and improving access to physiotherapy for MSK issues.	£68,865: for Action Plan	£ N/A – continue delivery	£ N/A – continue delivery	£275,461: Deliver plan
1b) Healthy food for staff, visitors and patients	**FULL £344,326**			
Part a: Health of food offered on premises: Items high in fat, sugar & salt, ban on: **1)** price promotions, 2) advertising & 3) items at checkouts; **4)** healthy options available incl. at night. **Issue: 1) with W H Smith; 4) install vending: staff at night**	£ N/A – prep.	£ N/A – progress	£ N/A – progress	£68,865 per each complete = £275,461 **2 issues**
Part b: Submit national data collection returns Q1 based on existing contracts with food and drink suppliers.	£68,865	N/A		
1c) Frontline staff – flu vaccinations:	**TARGET %**			
Achieving an uptake of flu vaccinations by frontline staff of 75% by 31/12/2016. Data monthly over 4 months (Sept-Dec). **Risk was:** very high target noting 2015-6 = 53% to Feb. Resource invested (£12.7k). Status as at 19/1 = 64.60%.	Prep	Progress	**75**	N/A
	FULL £344,326			
	N/A	N/A	55%-64% = £120,514 **Achieved 64-74% = £172,163** 75% = £344,326	
2a) ED - Sepsis	**TARGET %**			
Screening: via local protocol. Note new NICE guide July. Q1-4 top £ for 90%. Stepped payment available. Red Flag Sepsis: anti-biotic in 1 hour of presenting & anti-biotic review within 3 days. Locally agree target Q2-4. **Issue:** Q2-Q4: e-Care delay on Sepsis ID may affect %. **Risks:** CCG to agree Treat target Q2 & 3.	**90** Screen % Treat	**90** Screen TBC % Treat	**90** Screen TBC % Treat	**90** Screen TBC % Treat
	FULL £172,163			
	Screen: £17,216	Screen: £17,216	Screen: £17,216	Screen: £17,216
	Treat: £25,825	Treat: £25,825	Treat: £25,825	Treat: £25,824
2b) Inpatients - Sepsis	**TARGET %**			
Screening: via local protocol. Note new NICE guide July. Red Flag Sepsis: i) New patient - anti-biotic in 1 hour of ID & anti-biotic review within 3 days. ii) Existing patient – anti-biotic in 90 minutes of ID & anti-biotic review within 3 days. **Issue:** Q2-Q4: e-Care delay on Sepsis ID may affect %. **Risks:** CCG to agree treat target Q2 & 3. Q4 National Treat target of 90%. Stepped payment available.	Baselines x 3	TBC % Screen TBC % Treat	TBC % Screen TBC % Treat	**90** Screen **90** Treat
	FULL £172,163			
	Screen £17,216	Screen £17,216	Screen £17,216	Screen £17,216
	Treat £25,825	Treat £25,825	Treat £25,825	Treat £25,824 Part payments available
3a) 1% reduction (from 2013-4) in antibiotic consumption per 1,000 admissions (Defined Daily Doses) by end Q4: 1. Total antibiotic consumption 2. Total consumption of carbapenem 3. Total consumption of piperacillin-tazobactam **Risk:** major challenge to reduce from a low base. 4. Supply consumption data 2014-5 & 2015-6.	**TARGET %**			
	Prep	Progress	Progress	**<1%**
	FULL £275,460			
	£ N/A 4. Target met.	£ N/A	£ N/A	£68,865 per each of 4 = £275,460.
3b) Empiric review of antibiotic prescriptions. % of antibiotic prescriptions reviewed within 72 hours. Audit of 50 prescriptions per month.	**TARGET %**			
	25	**50**	**75**	**90**
	FULL £68,865			
	£17,216	£17,216	£17,216	£17,216
LOCAL	**FULL £1,721,628**			
4) Frailty. Multi-organisational. Action Plan, system vision, data dashboard. KPI's. Quarterly report to SWF Group: CCG requested more information, now sent & will roll Q1 £ to Q2.	Q1 rolled over to Q2	£430,407 Q1 £430,407	£430,407	£430,407

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 27th January 2017

AGENDA ITEM:	Item 11
PRESENTED BY:	Jon Green Executive Chief Operating Officer
PREPARED BY:	Dawn Godbold, Director of Community Services and Pamela Chappell Director of Nursing, Therapies and Governance
DATE PREPARED:	20/1/2017
SUBJECT:	Provider Management Group report – December meeting 2016
PURPOSE:	Information

EXECUTIVE SUMMARY:

The following provides a summary of the meeting.

1. Contract Performance KPI Summary:

- FFT score for November was 96%, from a total of 504 responses.
- There were 2 formal complaints received in November; 1 for the wheelchair service and 1 for the leg ulcer service. Both complaints relate to clinical aspects of treatment.
- All response time targets were met in November.
- There were 48 Delayed Transfers of Care (DTOC) in November, compared to 30 in September. This equates to 673 bed days being lost during the month. The position is becoming steadily worse. PMG are to receive a paper at Februaries meeting detailing all the actions that are currently being undertaken to improve this.
- Paediatric SLT waiting lists for community clinics increased slightly due to the loss of 2 staff members and a higher than usual referral rate in October.
- The Care Co-ordination Centre achieved 93.12% for speed of answer. This remains below the contractual targets of 95% but ahead of the improvement trajectory set in the remedial action plan.
- The community equipment service improved its performance against all KPI's when compared to October.
- Mandatory training for children's safeguarding compliance continues to improve to 97.52% for children's, adult safeguarding training compliance is 97.25%.
- There were 22 breaches out of 83 in the 18-week pathway for Consultant Paediatrician's.
- The Children in Care 28 day compliance has improved again in November with 80% of children being seen within 28 days of receiving all paperwork.

2. Provider updates

West Suffolk Foundation Trust
Main areas of note are the improved position with paediatric SLT waiting times and children in care assessments.
Discussions are continuing with NHS Prop-Co regarding rental prices and ongoing maintenance/statutory compliance.

The Space Utilisation study has identified a lot of voids in usage, this now needs to be aligned with the plans to change where and how services are provided clinically.

Ipswich Hospital Trust
CCC performance and number of DTOC's are the main areas of focus. CCG, the remedial action plan for the CCC will remain open for a further month during January, there continues to be 7 vacancies although some of the 7 posts should be filled during January.
IHT have requested that Ian Strurgess do a review of the patients in the community hospitals to determine if the 'type' of patient placed is linked to the rise in DTOC numbers.

NCH&C
13 band 3 support workers to commence with the community teams in January. Continue to roll out the changes to the clinical triage process in the community health teams. Still in dispute over the funding of the First Dressing Initiative – PMG agreed that nan escalation meeting between the CEO's of NCHC and the CCG was needed to resolve this issue.

Medequip
Improved position against all KPI's compared to October. Have seen a reduction of 8% in activity due to the loss of the Great Yarmouth and Waveney contract. The programme of planned preventative maintenance continues. PMG agreed to move ahead with serving notice on the Ipswich depot to move to the single site solution as part of a cost improvement initiative.

3. Risk Report
The risk report was received, following discussion PMG agreed to add a risk of/maintaining BAU during contract transition, and 1 relating to moving to a single site depot for CES.

4. CIP/SIP update – The programme of both cost and service improvement projects was reviewed. It was agreed that a re-work of some of the financial predictions was needed and the phase 2 projects also needed financials attached. The first of the joint consortium/CCG cost improvements meetings has taken place.

5. Buurtzorg Presentation – PMG received a presentation from representatives of the East of England Local Government Association and Public World consultants. A brief overview of the Buurtzorg model was given and a discussion on a possible test site in Suffolk followed. A business case for a test site is to be presented to the January Health and Wellbeing Board. If this gets approval there will need to be a locally agreed framework for the testing.

Linked Strategic objective (link to website)	
Issue previously considered by: (e.g. committees or forums)	
Risk description:	
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	
Legislation / Regulatory requirements:	
Other key issues:	

Recommendation:
The Board notes the report and the issues for escalation

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 27th January, 2017

AGENDA ITEM:	Item 12
PRESENTED BY:	Rowan Procter , Executive Chief Nurse Sandy Lewis, Associate Chief Nurse, Head of Patient Safety
PREPARED BY:	Rebecca Gibson, Compliance Manager Cassia Nice, Patient Experience Manager
DATE PREPARED:	January 2017
SUBJECT:	Aggregated Quality Report
PURPOSE:	Information

EXECUTIVE SUMMARY

- This report will be reflective of the data from December 2016
- In December there were 449 Patients Safety Incidents (PSI) reported, a decrease from November.
- Level of harm in proportion to overall Patient Safety Incidents reported:
  - 82% (82% November) no harm (Green)
  - 13% (14% November) minor harm (Green)
  - 2% (4% November) moderate harm (Amber)
  - 1.1% (0.2% November) major harm (Red)
  - 0.7% (0.4% November) catastrophic harm (Red)
- In relation to type of incidents reported in December the highest areas of reporting related to Pressure ulcers, Slips Trips & Falls, and Discharge , Transfer and Follow up.
- 17 Complaints were received in December compared to 10 in November
- 122 PALS contacts were recorded in December compared to 115 in November.

Linked Strategic objective (link to website)	To demonstrate first class corporate, financial and clinical governance to maintain a financially sound business
Issue previously considered by: (e.g. committees or forums)	Clinical Safety & Effectiveness Committee Clinical Governance Steering Groups
Risk description: (including reference Risk Register and BAF if applicable)	Failure to effectively triangulate internal and external intelligence on quality themes or areas of poor performance
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Monthly quality reporting to the Board strengthened aggregated analysis. Quality walkabouts and feedback from staff, patients and visitors.
Legislation / Regulatory requirements:	NHS Improvement Quality Governance requirements. CQC Registration and Key Lines of Enquiry (KLOE)
Other key issues:	
Recommendation: **To note the report**	

Table 1: Aggregated Patient Experience Report

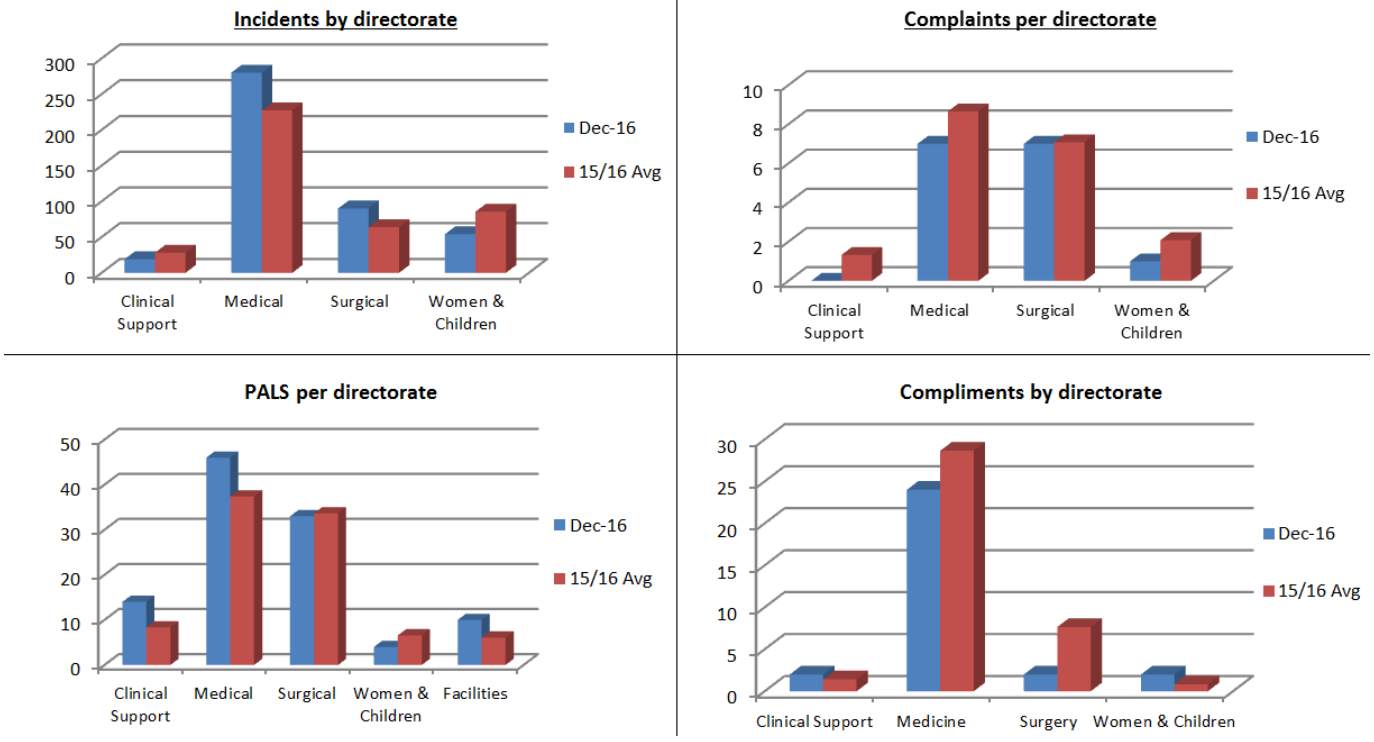


Table 2: PSIs reported by month (24 months)

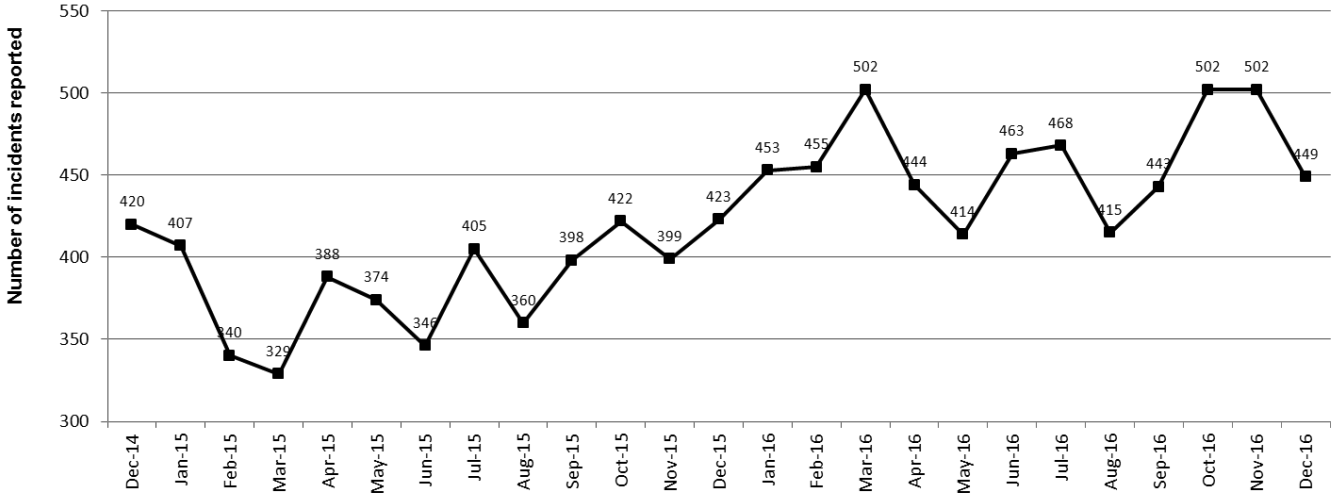
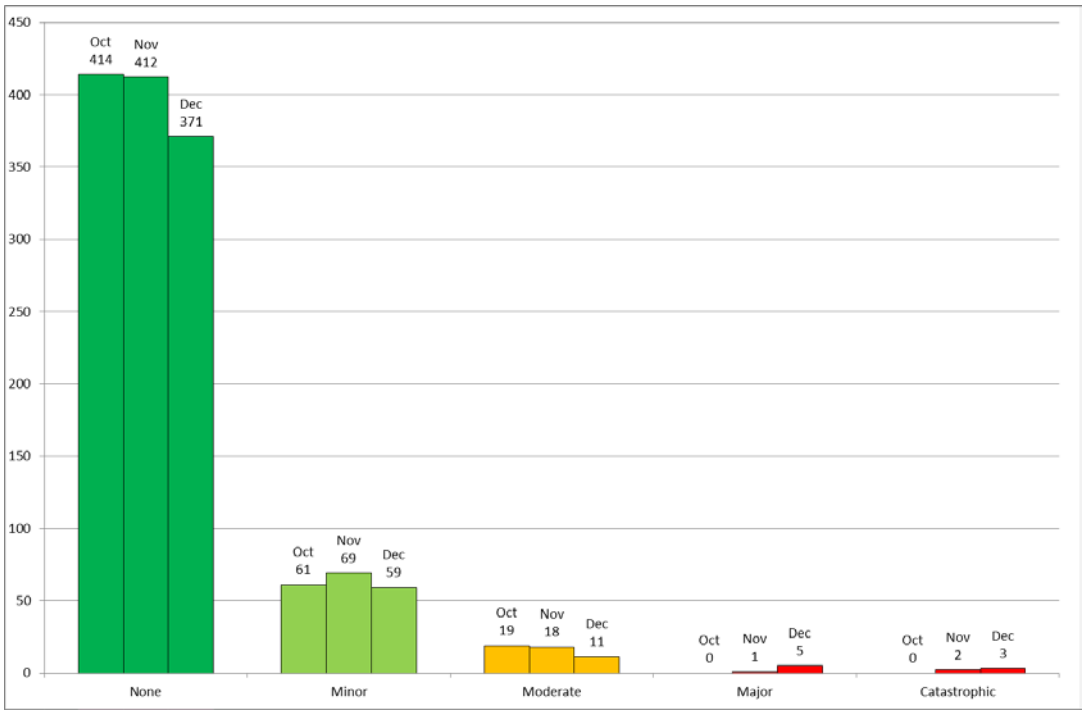


Table 3: Incidents reported by severity



Within Table 2 (above) the chart reflects incidents in relation to harm grading colour coded by grade (for example the dark green columns reflect incidents which resulted in no harm over the last 3 months).

Within December (8) there has been a significant increase in incidents categorised as major or catastrophic harm in comparison to October (0), November (3). Five of the incidents relate to quality of care provided to patients.

The eight Catastrophic / Major harm (red) incidents are as follows:

- Three Intrauterine deaths
- One Grade 4 hospital acquired pressure ulcer in Medicine
- One Organisational Red relating to the care of Trauma patients in the Emergency Department
- One cardiac arrest following a Pulmonary Emboli on Ward F7
- One missed fracture in the Emergency Department

The 11 moderate harm incidents relate to:

Medicine (7)

- Two Hospital acquired Grade 3 pressure ulcers
- One Fall
- Three Delay in treatment incidents
- One related to reduced staffing

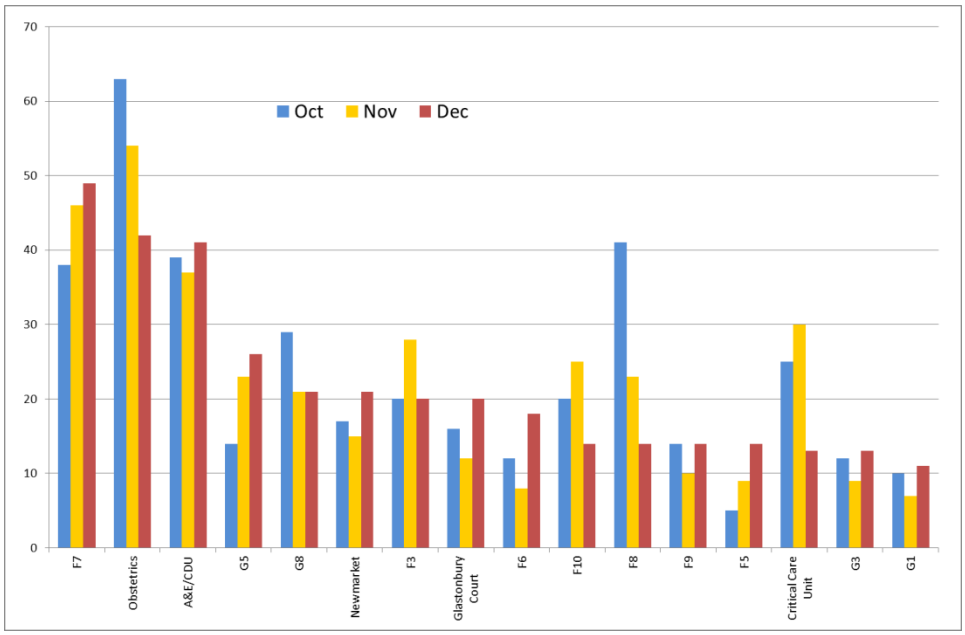
Surgical (3)

- One Hospital acquired Grade 3 pressure ulcer
- One C. difficile infection
- One Fall

Women & Children (1)

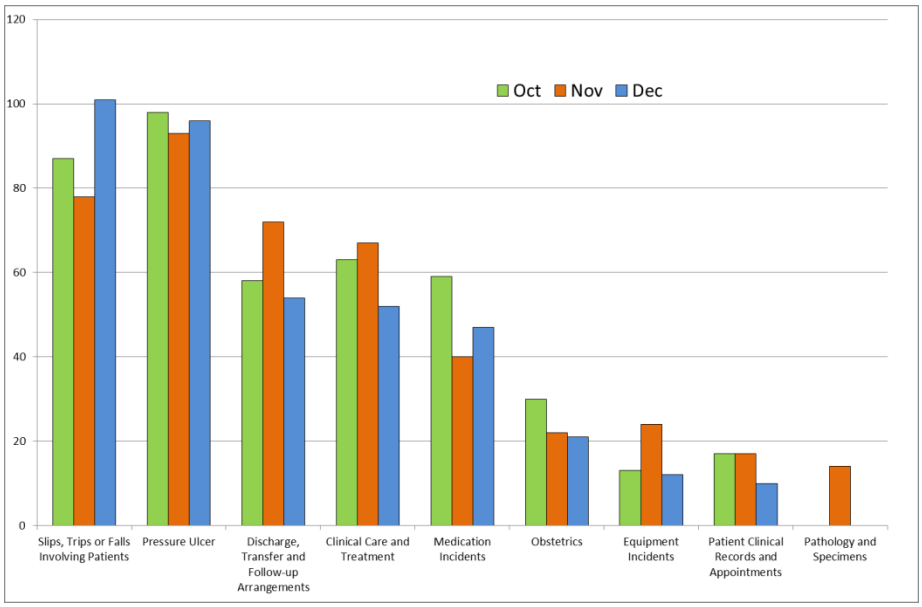
- One Violence & Agression incident

Table 4: High reporting areas (n >10 incidents per month)



During December there were a a reduction in incident reporting across the Trust, There was a slight increase in some of the high reporting areas. However a significant reduction in Obstetrics, F8, F10 and Critical Care.

Table 5: High reporting incident types (n >10 incidents per month)



Slips, Trips & Falls, Pressure ulcers, and Discharge, Transfer & Follow up incidents account for the highest number of incidents reported. In relation to falls the incidents relate to predominantly none and minor harm, with one relating to major harm (# NOF) and two moderate harms (Head injury and laceration to shin).

Of the reported pressure ulcers, fourteen relate to hospital acquired , a reduction from November where 22 were reported. One is identified as a Grade 3 that has deteriorated into a Grade 4 and is currently under investigation. Three are identified as hospital acquired Grade 3 and therefore also under investigation.

Incidents relating to discharge, transfer and follow identified the following issues.Delay or failure of discharge and transfer relating to patients being discharged home or to another ward. The issues identified related to transport , beds not available, TTO's ,change in patients condition and care packages. There were a number of unanticipated transfers relating to obstetris services. The other area identified related to

patients transferred back from Glastonbury Court or Newmarket due to a change in medical condition.

Complaints

17 complaints were received in December, an increase compared to October/November. 100% of complaints were responded to in December within of the Trust's preferred timeframe. The breakdown of the complaints received in December is as follows by Primary Division: Medical (7), Surgical (7), Women & Children's Health (1) and Estates and Facilities (2).

Table 6: Complaints by location

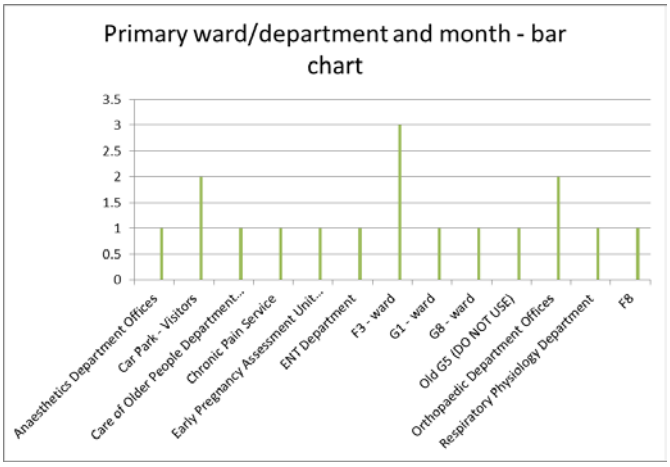
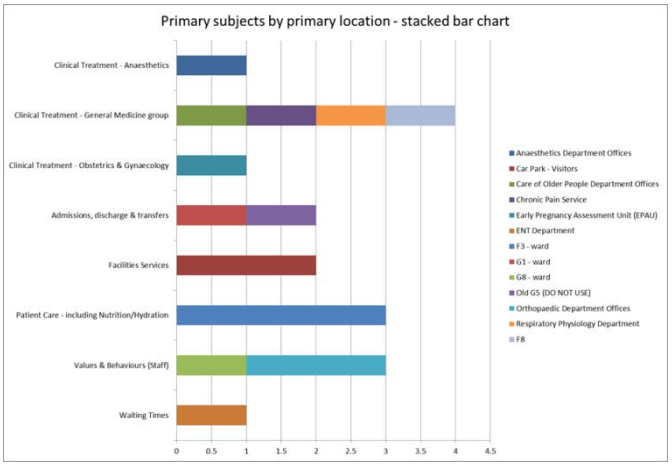


Table 7: Complaints by type



Patient Experience Themes

Area	*Analysis*	*RAG rating*
Car Park	Visitors continued to complain about lack of parking throughout December, in particular blue badge spaces.	Amber
Ward F3	Three complaints were received relating to Ward F3 in December which is higher than usual. There was also a decrease in patients recommending the ward; 64% of 53 patients surveyed said they would recommend the ward which is lower than the Trust target of =<90%. The complaints related to general nursing care needs not being adequately met.	Amber
Ward F9	A patient raised concerns with PALS about the way patients with dementia were treated on the ward. Dementia specialist nurses are planning dementia training on the ward.	Amber

Red rating = area for concern for >=3 months
Amber rating = area for concern for 1-2 months
Green rating = highlighted as a high performing area with regards to governance functions

West Suffolk NHS
NHS Foundation Trust

Trust Board – 25 November 2016

AGENDA ITEM:	Item 13
PRESENTED BY:	Rowan Procter, Executive Chief Nurse
PREPARED BY:	Sinead Collins, Clinical Business Manager
DATE PREPARED:	27th January 2017
SUBJECT:	Quality and Workforce Dashboard – Nursing
PURPOSE:	For Information

EXECUTIVE SUMMARY:

The aim of the Quality and Workforce Dashboard is to enhance the understanding ward and theatre staff have of the service they deliver, identify variation in practice, investigate and correct unwarranted variation and lead change to demonstrate value. This dashboard has been created instead of the ward profiles to give the Trust Board a quick overview staff levels and quality indicators of areas within the trust. It also complies with national expectation to show staffing levels within Open Trust Board Papers

There are still are areas that we need to improve the collection of data and the Business Manager is working with the relevant people to complete this. Also will develop with HR/Finance and Nursing to agree ranges that appropriate so can introduce conditional formatting to this dashboard. For in depth review of areas, please inquire for the Matrons' governance reports that are completed monthly for their divisions.

Additionally we will be including any updates in regards to the nursing review below

Linked Strategic objective (link to website)	1. To be the healthcare provider of first choice by providing excellent quality, safe, effective and caring services;
Issue previously considered by: (e.g. committees or forums)	-
Risk description: (including reference Risk Register and BAF if applicable)	-
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	-
Legislation / Regulatoryrequirements:	-
Other key issues: (e.g. finance, workforce, policy implications, sustainability&communication)	-

Recommendation:

For information, note that in December the dashboard has four red columns. This is due a HR reporting system creating incorrect information and has not been able to be corrected in time

Observations are made below

Observations

November

ED – 6 medication errors due to higher flow of patients and pressures and temporary staff use
F7 – Few pressure ulcers and five medication errors due to high vacancies and temporary staff use
F3 – Four medication errors and pressure ulcers but good staffing and slightly above recognised sickness and vacancies
F10 – Four pressure ulcers and 3 falls due to below 90% fill rate on nursing assistants
G1 – high medication errors but staff level of nursing below 90%
G5 – Four pressure ulcers and falls but staffing levels good, however had just change location from G9
G9 – High falls but the staff fill rate is low

High Vacancies – F7, AMU, F1, Theatres
High sickness – DSU, MTU, ED, Kings Suite

December

ED – 6 medication errors due to higher flow of patients and pressures and temporary staff use
F7 – Few medication errors due to high vacancies, low fill rate of RNs and temporary staff use
F3 – Four medication errors and pressure ulcers due to low fill rate of RNs and raised vacancies
G1 – High medication errors but staff level of nursing below 90%
G5 – High pressure ulcers and falls
G9 – Few pressure ulcers but high vacancies and sickness

High Vacancies – F7, AMU, G9, Theatres, F3

Update on progress of Nurse Staffing Review

Since end of November, Executive Chief Nurse met with all the General Managers to discuss the recommendations of the last nurse review paper sent to Trust Board. The steps taken were for General Managers to do a deeper review of their Nurse Specialist and send reports back to Executive Chief Nurse. Still waiting on Surgery and F14 to send their reports. It was also agreed that a repeat SCNT review of wards done, this commences in February.

Outpatients, Radiology and Pharmacy already have done internal reviews and Executive Chief Nurse is satisfied or escalated where appropriate.

Theatres, Critical Care, Paediatrics are still requiring review. Paediatrics was started at end of November and lead by General Manager; however no update has been given. Theatres and Critical Care have started this month.

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Dec-16			Establishment for the Financial Year 2016/17						Data for December 2016													
										Workforce											Nursing Sensitive Indicators		
Trust	Ward Name	Speciality	Current Funded Beds/Chairs Trolleys	Current Funded Establishment (WTE)	Current Funded Total Establishment Registered to Unregistered (%)		SCNT Establishment (June 2016 data) (WTE)	Number of patients per RN/Midwife (not including unit manager)		Fill rate Registered %		Fill rate Unregistered %		Bank staff use %	Agency staff use %	Vacancies (WTE)		Sickness (%)	Overall Care Hours Per Patient Day (Nov 2016)	Roster Effectiveness - Total Non Productive Time (% excl maternity)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)
					Registered	Unregistered		Day	Night	Day	Night	Day	Night			Registered	Unregistered						
WSFT	ED	Emergency Department	21 trollies and 30 chairs	65.24	77.64%	22.36%	N/A	1 - 4	1 - 5	116.6%	110.5%	108.4%	108.5%			-4.60	3.42		N/A		N/A	6	0
WSFT	F7	Short Stay Ward	34	78.04	53.99%	46.01%	N/A	6	9	76.4%	97.9%	84.4%	83.9%			-8.98	14.80		8.37		1	4	1
WSFT	AMU	Acute Medical Unit	12 beds, 10 trollies and 4 chairs				N/A	6	N/A										N/A		0	1	0
WSFT	CCS	Critical Care Services	9	48.69	96.14%	3.86%	N/A	1 -2	1 -2	101.7%	99.7%	0.0%	0.0%			-2.50	-0.90		21.70		1	2	0
WSFT	Theatres	Theatres	8 theatres	87.84	74.00%	26.00%	N/A	1/3	(1/3)	101.2%	101.1%	N/A	N/A			11.86	-7.60		N/A		N/A	1	N/A
WSFT	Recovery	Theatres	11 spaces	22.56	96.00%	4.00%	N/A	1 -2	1 -2	131.5%	99.9%	70.9%	0.0%			-0.62	0.00		N/A		N/A	0	N/A
WSFT	DSU	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC ward area	51.15	78.00%	22.00%	N/A	1 - 1.5	N/A	68.2%	N/A	105.2%	N/A			0.00	0.10		N/A		N/A	0	N/A
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	11.19	2 - 3	2 - 3	101.3%	93.4%	57.4%	0.0%			-2.10	-0.40		12.69		0	0	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	6.88	4	6	85.9%	100.0%	102.4%	0.0%			-1.45	-1.70		8.21		0	4	0
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	39.77	6	10	94.8%	97.9%	71.8%	93.3%			2.85	3.00		5.52		0	2	0
WSFT	G4	Elderly Medicine	32	48.04	50.06%	49.94%	31.67	6	10	93.0%	100.1%	87.5%	80.7%			1.55	3.42		6.25		0	2	1
WSFT	G5	Elderly Medicine	33	Waiting on Finance	Waiting on Finance	Waiting on Finance	41.35	6	11	92.0%	96.8%	85.6%	91.5%			1.24	0.05		5.13		1	5	4
WSFT	G8	Stroke	32	48.42	54.31%	45.69%	34.53	5	8	86.9%	93.7%	84.6%	84.6%			2.30	5.60		6.56		0	3	2
WSFT	G9	Winter Escalation	30	Waiting on Finance	Waiting on Finance	Waiting on Finance	Available Feb	6	10	90.0%	134.9%	84.1%	78.5%			10.40	8.80		N/A		3	1	1
WSFT	F1	Paediatrics	15 - 20	29.85	68.64%	31.36%	N/A	6	9	78.6%	129.6%	125.8%	0.0%			1.82	0.00		N/A		N/A	0	N/A
WSFT	F3	Trauma and Orthopaedics	33	37.89	59.07%	40.93%	33.35	7	11	84.5%	97.3%	123.4%	98.6%			4.50	-2.30		5.27		4	2	4
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	19.73	8	16	83.9%	90.3%	87.8%	176.3%			2.70	3.30		6.55		0	1	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	37.58	7	11	90.4%	94.6%	88.6%	108.5%			-1.22	0.50		5.53		0	4	0
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	46.28	7	11	78.6%	95.8%	94.8%	95.3%			-0.30	3.70		7.95		0	4	3
WSFT	F9	Gastroenterology	33	43.77	52.34%	47.66%	49.42	7	11	101.9%	100.4%	73.9%	97.0%			2.00	0.11		5.08		2	0	1
WSFT	F10	Respiratory	25	40.76	56.58%	43.42%	39.10	6	6	110.6%	92.2%	114.7%	91.0%			2.10	4.40		7.25		0	1	2
WSFT	F11	Maternity	29	54.71	72.14%	27.86%	N/A	7.25	14.5	120.8%	99.4%	83.6%	58.0%			-2.10	3.00		N/A		0	2	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms					1	1												N/A	0	N/A
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre recovery area, bereavement suite					1 - 2	1 - 2												N/A	1	N/A
WSFT	F12	Infection Control	8	16.43	68.59%	31.41%	10.49	4	4	99.7%	92.6%	93.6%	100.1%			2.12	0.20		9.71		2	0	0
WSFT	F14	Gynaecology	8	11.58	96.55%	3.45%	6.49	4	4	101.2%	98.6%	0.0%	0.0%			0.70	0.40		N/A		0	0	0
WSFT	MTU	Medical Treatment Unit	9 trollies and 8 chairs	8.73	82.47%	17.53%	N/A	5 - 8	N/A	74.4%	0.0%	50.0%	0.0%			0.20	-0.30		N/A		0	0	0
WSFT	NNU	Neonatal	12 cots	24.69	85.14%	14.86%	N/A	2 - 4	2 - 4	103.0%	92.5%	30.8%	51.6%			-3.65	1.70		N/A		N/A	0	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	10.28	8	8	94.4%	103.3%	93.9%	100.0%	7.45%	1.4%	1.66	2.19	0.72%	6.80	N/A	0	0	0
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	35.75	6.6	10	77.1%	100.0%	92.1%	95.5%			Over	3.60		5.70		0	1	4
																20.48	49.09	Target - 3%		Trust standard is 20%			

Key findings	
	WSFT have some significant environmental layout challenges and additional activity that are not reflected in the SNCT(F14/G1/G8/F12/CCU/NCH)
	SNCT review to be repeated (Jan 2017)
	Theatres and DSU establishment includes ODPs and non-nursing professionals and thus fill rate is not included
	Theatres have had an increase in capacity recently
	Some units do not use electronic rostering therefore there is no data for those units
	G9 - changed just after beginning of November so can not get true figures for vacancies, etc

Key	
N/A	Not applicable or no data
ETC	Eye Treatment Centre

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Nov-16			Establishment for the Financial Year 2016/17						Data for November 2016												
										Workforce											Nursing Sensitive Indicators		
Trust	Ward Name	Speciality	Current Funded Beds/Chairs Trolleys	Current Funded Establishment (WTE)	Current Funded Total Establishment Registered to Unregistered (%)		SCNT Establishment (June 2016 data) (WTE)	Number of patients per RN/Midwife (not including unit manager)		Fill rate Registered %		Fill rate Unregistered %		Bank staff use %	Agency staff use %	Vacancies (WTE)		Sickness (%)	Overall Care Hours Per Patient Day (Nov 2016)	Roster Effectiveness - Total Non Productive Time (% excl maternity)	Pressure Ulcer Incidences (Hospital Acquired)	Nursing/Midwifery Administrative Medication Errors	Falls (with Harm)
					Registered	Unregistered		Day	Night	Day	Night	Day	Night			Registered	Unregistered						
WSFT	ED	Emergency Department	21 trollies and 30 chairs	65.24	77.64%	22.36%	N/A	1 - 4	1 - 5	109.7%	111.4%	98.1%	94.3%	6.60%	15.60%	-0.37	2.70	11.20%	N/A	23.9%	N/A	6	0
WSFT	F7	Short Stay Ward	34	78.04	53.99%	46.01%	N/A	6	9	89.3%	99.9%	101.5%	94.1%	6.30%	5.80%	26.94	18.75	6.10%	8.41	14.0%	3	5	0
WSFT	AMU	Acute Medical Unit	12 beds, 10 trollies and 4 chairs				N/A	6	N/A					5.90%	12.10%			3.20%	N/A	14.1%	0	2	1
WSFT	CCS	Critical Care Services	9	48.69	96.14%	3.86%	N/A	1 -2	1 -2	100.4%	93.5%	0.0%	0.0%	3.30%	0.00%	-0.89	-0.90	4.90%	17.14	17.2%	1	1	0
WSFT	Theatres	Theatres	8 theatres	87.84	74.00%	26.00%	N/A	1/3	(1/3)	N/A	N/A	N/A	N/A	0.50%	0.00%	13.03	-6.60	6.50%	N/A	18.7%	N/A	0	N/A
WSFT	Recovery	Theatres	11 spaces	22.56	96.00%	4.00%	N/A	1 -2	1 -2	141.8%	95.1%	100.0%	0.0%	0.20%	0.00%	0.48	0.00	1.80%	N/A	11.5%	N/A	1	N/A
WSFT	DSU	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC ward area	51.15	78.00%	22.00%	N/A	1 - 1.5	N/A	N/A	N/A	N/A	N/A	3.40%	0.00%	0.00	0.10	11.60%	N/A	23.8%	N/A	0	N/A
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	11.19	2 - 3	2 - 3	100.9%	100.0%	81.8%	0.0%	0.90%	0.00%	-1.90	-0.40	2.00%	12.82	16.3%	0	0	1
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	6.88	4	6	83.0%	100.2%	95.0%	0.0%	5.50%	0.00%	1.68	-1.70	4.60%	8.36	14.7%	0	6	0
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	39.77	6	10	104.8%	98.8%	92.8%	107.4%	11.20%	0.90%	3.23	2.10	5.70%	6.08	16.0%	1	1	0
WSFT	G4	Elderly Medicine	32	48.04	50.06%	49.94%	31.67	6	10	94.4%	92.3%	88.9%	98.5%	11.60%	0.60%	3.53	3.45	6.80%	6.90	22.7%	1	1	2
WSFT	G5	Elderly Medicine	33	Collect Dec	Collect Dec	Collect Dec	41.35	6	11	99.4%	101.1%	99.8%	102.8%	8.40%	0.60%	2.13	0.95	5.30%	5.52	17.8%	4	2	4
WSFT	G8	Stroke	32	48.42	54.31%	45.69%	34.53	5	8	95.7%	100.7%	94.9%	96.7%	8.80%	0.40%	0.30	5.00	4.40%	7.11	19.6%	1	0	0
WSFT	G9	Winter Escalation	30	Collect Dec	Collect Dec	Collect Dec	Available Feb	6	10	71.5%	110.0%	78.1%	73.0%	Collect Dec	Collect Dec	Collect Dec	Collect Dec	Collect Dec	N/A	Collect Dec	1	1	6
WSFT	F1	Paediatrics	15 - 20	29.85	68.64%	31.36%	N/A	6	9	89.9%	97.4%	73.3%	0.0%	16.70%	0.00%	4.80	0.00	6.60%	N/A	22.8%	N/A	3	N/A
WSFT	F3	Trauma and Orthopaedics	33	37.89	59.07%	40.93%	33.35	7	11	94.6%	98.5%	138.6%	100.5%	2.30%	2.90%	3.90	-2.30	5.60%	5.56	14.7%	4	4	1
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	19.73	8	16	90.9%	95.0%	89.3%	162.7%	10.80%	1.70%	2.70	1.30	6.00%	6.48	19.4%	0	1	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	37.58	7	11	96.4%	101.1%	94.1%	112.7%	4.80%	0.80%	0.24	0.50	2.60%	5.15	21.5%	1	1	0
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	46.28	7	11	83.4%	92.4%	109.0%	108.7%	0.80%	4.20%	2.85	1.00	6.40%	7.45	16.5%	1	2	2
WSFT	F9	Gastroenterology	33	43.77	52.34%	47.66%	49.42	7	11	103.6%	97.8%	88.8%	103.4%	13.20%	0.00%	2.84	3.23	5.20%	5.43	15.4%	0	1	2
WSFT	F10	Respiratory	25	40.76	56.58%	43.42%	39.10	6	6	111.6%	83.3%	113.0%	92.2%	6.10%	0.00%	1.30	3.40	8.40%	6.98	22.2%	4	0	3
WSFT	F11	Maternity	29	54.71	72.14%	27.86%	N/A	7.25	14.5	116.6%	99.3%	88.9%	65.4%	11.30%	0.00%	1.85	2.40	7.80%	N/A	20.3%	0	0	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms					1	1												N/A	0	N/A
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre recovery area, bereavement suite					1 - 2	1 - 2												N/A	1	N/A
WSFT	F12	Infection Control	8	16.43	68.59%	31.41%	10.49	4	4	93.3%	97.6%	93.3%	88.0%	8.10%	4.70%	3.14	0.10	6.00%	8.28	22.8%	0	1	0
WSFT	F14	Gynaecology	8	11.58	96.55%	3.45%	6.49	4	4	98.7%	98.3%	0.0%	0.0%	3.00%	0.00%	1.10	0.40	5.60%	N/A	21.3%	0	0	0
WSFT	MTU	Medical Treatment Unit	9 trollies and 8 chairs	8.73	82.47%	17.53%	N/A	5 - 8	N/A	86.5%	0.0%	88.6%	0.0%	0.00%	0.00%	0.20	-0.30	13.30%	N/A	24.7%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.69	85.14%	14.86%	N/A	2 - 4	2 - 4	97.2%	86.7%	21.7%	56.7%	3.60%	0.00%	0.22	1.70	5.40%	N/A	20.2%	N/A	0	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	10.28	8	8	97.1%	100.0%	91.6%	100.0%	5.12%	2.77%	2.66	2.19	2.93%	6.60	N/A	2	2	4
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	35.75	6.6	10	87.2%	100.0%	96.7%	95.0%	7.40%	3.2%	Over	3.60	13.5%	9.10	18.3%	1	1	4
																75.96	40.67	Target - 3%		Trust standard is 20%			

Key findings	
	WSFT have some significant environmental layout challenges and additional activity that are not reflected in the SNCT(F14/G1/G8/F12/CCU/NCH)
	SNCT review to be repeated (Jan 2017)
	Theatres and DSU establishment includes ODPs and non-nursing professionals and thus fill rate is not included
	Theatres have had an increase in capacity recently
	Some units do not use electronic rostering therefore there is no data for those units
	G9 - changed just after beginning of November so can not get true figures for vacancies, etc

Key	
N/A	Not applicable or no data
ETC	Eye Treatment Centre

West Suffolk NHS
NHS Foundation Trust

TRUST BOARD OF DIRECTORS – 27th January 2017

AGENDA ITEM:	Item 14
PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce and Communications
PREPARED BY:	Jean Le Fleming, Administration Manager, Facilities
DATE PREPARED:	19th January 2017
SUBJECT:	Car Parking – Staff Tariff Review
PURPOSE:	Annual review of staff car parking charges

EXECUTIVE SUMMARY:

Management of the car parks on the West Suffolk Hospital site was transferred to OCS/Legion Parking in June 2013. There have been no increased charges since that time, pending a review of capacity issues and income, following the introduction of more stringent barrier control at both the front and rear of the hospital.

Monthly car park charges for staff were considerably reduced to facilitate access via the barrier system in September 2014. It was agreed at that time that no changes to the rates would be made for at least two years i.e. September 2016.

Comprehensive data is now available from the barrier system to confirm staff compliance with Trust policy and income generated from more stringent control of access to the site.

This allows the Trust to review tariffs taking account of comments from all users of the site, with the aim of maintaining or increasing income, to assist in improving facilities on site as well as adhering to the Trust's Travel Plan.

A number of options have been considered by the Trust's Executive Team, Scrutiny Committee, Travel Plan Steering Group and Trust Council. In addition, an Equality Impact Assessment has been undertaken to ensure a fair and equitable charging system is in place for staff wishing to park on the hospital site when an additional 400 spaces have been opened on the western boundary.

It is anticipated that the agreed method of payment will be implemented with effect from 1st February 2017 (to coincide with the opening of the new park) and reviewed annually prior to each new financial year thereafter.

Linked Strategic objective (link to website)	To provide value for money for the taxpayer and to maintain a financially sound organisation.
Issue previously considered by: (e.g. committees or forums)	Travel Plan Steering Group Trust Council Scrutiny Committee Executive Directors and Trust Executive Group
Risk description: (including reference Risk Register and BAF if applicable)	Uncertainty of car parking income Staff morale
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Easily identified car parks for staff use Fair and equitable tariffs Clear policy for management of car parking across the site
Legislation/Regulatory requirements:	British Parking Association and NHS guidelines on car parking charges
Other key issues: (e.g. finance, workforce, policy implications, sustainability and communication)	As set out in the report
Recommendation: To agree the revised tariffs proposed for staff, as recommended by the Scrutiny Committee, to be effective from 1st February 2017.	

Car Parking – Staff Tariff Review 2017

1. Introduction

It is now well established that income from car parking charges is essential to contribute to the running of a busy acute hospital. The Trust nevertheless acknowledges that there continues to be some opposition to charging for parking and it therefore aims (in line with its car parking strategy) to provide adequate, safe and accessible car parks for all users of the site at reasonable and equitable rates.

The Trust Board at its meeting on 25th November 2016 agreed the schedule of charges for patients and visitors, including blue badge holders. It was agreed at that meeting the Scrutiny Committee would be asked to review the options for staff charges on 14th December 2016.

The aim is to implement all new charging tariffs with effect from 1st February 2017 to coincide with the opening of a new car park on the western boundary (additional 400 spaces), reconfiguration of existing car parks to increase parking provision for patients and visitors at the rear of the site, and provision of additional blue badge holder bays in car park A at the front of the hospital.

2. Background

The management of the car park contract was transferred to OCS/Legion Parking in 2013 when a new barrier controlled system was introduced.

No changes were made to the charges until September 2014 when the rates were reduced considerably to encourage more staff to pay by salary deduction and gain access to the site by automatic number plate recognition.

It was agreed that there would be no increase in salary deductions for at least two years i.e. until September 2016.

However, recognising the problems staff have experienced with capacity issues, the Trust postponed any changes in car park charges until the new car park (an additional 400 spaces) and reconfiguration of all other car parks was complete. This is anticipated to be 1st February 2017.

The provision of an additional 400 spaces on the western boundary by early 2017 and reconfiguration of all other car parks will assist in improving the parking experience for all users of the site.

This will not however reduce the need to monitor and rigorously control access to the site. The Trust will continue to provide off-site parking and a shuttle bus to the hospital, as well as provide additional secure storage for bicycles. In addition to encouraging staff to cycle to work, the Trust will shortly relaunch the benefits of car sharing and provide dedicated car sharers spaces in the new car park R as well as in the existing car park C.

To support these schemes, ensure the Trust meets its Travel Plan targets and can provide routine maintenance and repairs to the estate, it is necessary to obtain income from car parking.

3. Current position

The current tariff based on contractual hours was considered by staff in 2007 to be the most favourable method of payment. The site has evolved since then with improved barrier controlled access. This method of charging is still considered reasonable for most users of the site although it does not address the problem of staff not following the Trust's car free day policy meticulously.

A number of options were therefore considered by the Trust's Executive Team, prior to submission to the Travel Plan Steering Group and Trust Council.

In line with the review of patients and visitors charges, an Equality Impact Assessment was also undertaken of the proposals for staff charging.

The Equality Impact Assessment clarified that charges for car parking could not be linked to pay bands.

4. Final Proposal

As a consequence of the EIA, only one proposal was submitted to Trust Council on 1st December 2016. The basis of this option is set out below.

a. Charges based on contractual hours

This is a slight variation on the current charging arrangements, with two minor modifications:

- Up to 22 hrs amended to 22.5 hours which is beneficial to staff working three days
- Reintroduction of fourth band i.e. over 30 hours (this was unintentionally removed in 2014)

The benefits of this option are:

- Staff are familiar with this system
- Staff will not need to re-register
- Payroll can automatically adjust the charges for salary deduction according to staff's contractual hours
- Administration required to adopt this option will be minimal
- Some staff may wish to change from salary deduction to paying daily or vice versa but that will not be problematical

The disadvantage of this option:

It does not address the issue that only 10% of staff currently adopt the Trust's car free day policy, which has contributed to the capacity problems on site.

Even with the provision of additional spaces and reconfiguration of existing car parks, the Trust will still need to manage the volume of traffic entering and leaving the site daily.

b. Proposed new rates:

Staff currently pay according to contractual hours and it is proposed to increase these as follows:

Contracted hours	**Current rates **(discounted)**		**Rates 2013/14**	**Proposed new rates**	
	£		**£**		**£**
Up to 15 hours	6.00		6.55	Up to 15 hours	8.00
Up to 22 hours	12.00		13.56	15 – 22.5 hours	16.00
Over 22 hours	18.00		19.48	23 – 30 hours	24.00
		Over 30 hrs	25.86	Over 30 hours	30.00
*** these rates were reduced considerably in September 2014 to encourage access to the site by automatic number plate/salary deduction – fixed rate for min. two years*					
Daily rate	1.60		1.60		2.00

Staff will still be required to adhere to the Trust's car free day policy when adopting this option.

The income generated from these increases (subject to the existing staff profile remaining the same) is £18,000 per month.

c. Implementation date

It is proposed to implement new charges to coincide with the opening of the new car park (1st February 2017), subject to no delay with the overall implementation and reconfiguration of all other car parks.

d. Senior staff car park

In conjunction with the reconfiguration of the car parks at the rear of the site, the location of the senior staff car park was reviewed. Consideration was therefore given separately to the charges for this car park dependent on the agreed location.

The feasibility of moving the senior car park to a secure barrier controlled area within the new car park on the western boundary was cost prohibitive. The preferred option was for minor adjustments to be undertaken to fencing within the existing location which it is anticipated will provide an additional 30 spaces.

The monthly charge for use of this extended car park from 1st February 2017 will be £60, pro rata for part-time staff.

5. General Information

Other factors to be taken into account when considering the options for car parking charges.

- The Trust is required to adhere to its 2014 Travel Plan and separate discussions on a car sharing scheme will offset any staff concerns on increased charges (sharing can reduce costs by 50%). Also, car sharing can offset any concerns about more vehicles being brought onto site.

- The Trust is providing a secure storage unit for 60 bicycles to encourage more staff to cycle to work. This too can assist staff who find car park charges prohibitive and/or help the Trust with its health and well-being objectives.

- New members of staff are required to pay by salary deduction

- New members of staff will not automatically be given access to site (pending review of capacity following reconfiguration of the site)

- The Rugby Club and shuttle bus will continue to be free of charge

- The number of people paying daily will be restricted (wherever possible) to those who do not get paid through the Trust's payroll

- All tariffs will continue to be reviewed annually

- The Trust has the right to review charges at any other time

6. Recommendation

Taking into account the benefits, disadvantages and general information provided, the Scrutiny Committee recommends that the Board of Directors ratifies the proposed staff car parking charges set out above.

The Board of Directors is also asked to support the implementation of these new rates from 1st February 2017.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 27 January 2017

AGENDA ITEM:	Item 17
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	19 January 2017
SUBJECT:	Review of the Trust's constitution
PURPOSE:	Approval

EXECUTIVE SUMMARY:

At its meeting on 30 September 2016 the Board of Directors agreed to the principle of extending the Trust's membership area to include the east of the county. As part of the constitutional review to enact this change a small working group including Governors was established and has made the following recommendations for updates to the constitution:

1. Extend **public membership area** to include whole of Suffolk – enacted through change in Annex 1, page 26

2. Update **quorate definition for Council of Governors** - a less prescriptive form of words is proposed '*one-third of the whole number of the Governors are present, the majority of whom from the public constituency*' (Annex 7, para 3.34 page 87)

3. Make provision for **remote attendance at Board of directors** meetings - it would not be expected that this provision would often be implemented but may be useful in exceptional circumstances. This provision means that if a Director attends a meeting remotely that they are considered to be included in the quorum and therefore are entitled to vote (Annex 8 para 3.19 pages 101)

4. Make provision for a **Deputy lead governor** position - enacted through change which indicates that the deputy only takes-up function in absence of lead governor (Annex 7, para 9 page 91)

5. **Situational conflicts** for directors - legal advice indicated that the constitution did not adequately cater for conflicts of interest and this has caused some difficulties for FTs elsewhere (para 34.2.2). Appropriate wording has been included in the constitution to manage 'situational conflicts' for circumstances such as joint ventures or other vehicles which place the directors of WSFT on another legal entity.

The full constitution with tracked changes is attached for approval by the Board. Following approval the amendments will be recommended for approval by the Council of Governors at their meeting on 8 February 2017. Following these approvals the amendments to the constitution are effective immediately and the updated constitution will be submitted to NHSI for information.

Linked Strategic objective (link to website)	6. To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by: (e.g. committees or forums)	Board of Directors (September 2016) Council of Governors (November 2016)
Risk description:	
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Legal opinion from Bevan Brittan confirms that changes and updated constitution are legal and valid against the relevant Acts
Legislation / Regulatory requirements:	Compliance with National Health Service Act 2006 and Health and Social Care Act 2012.
Other key issues:	
Recommendation: The Board approves the recommended changes to the constitution and submission to the Council of Governors.	

Item 17

West Suffolk NHS Foundation Trust

Constitution

February 2017

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1. Name

The name of the foundation trust is West Suffolk NHS Foundation Trust (the trust).

2. Principal purpose

2.1 The principal purpose of the trust is the provision of goods and services for the purposes of the health service in England.

2.2 The trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3. Other purposes and powers

3.1 The trust may provide goods and services for any purposes related to:

3.1.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.1.2 the promotion and protection of public health.

3.2 The trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

3.3 The powers of the trust are set out in the 2006 Act.

3.4 All the powers of the trust shall be exercised by the Board of Directors on behalf of the trust.

3.5 Any of these powers may be delegated to a committee of Directors or to an Executive Director.

4. Membership and constituencies

The trust shall have members, each of whom shall be a member of one of the following constituencies:

4.1 the public constituency or

4.2 the staff constituency

5. Application for membership

An individual who is eligible to become a Member of the trust may do so on application to the trust.

6. Public Constituency

6.1 An individual who lives in the area specified in Annex 1 as the area for a public constituency may become or continue as a Member of the trust.

6.2 Those individuals who live in the area specified for a public constituency are referred to collectively as the Public Constituency.

6.3 The minimum number of Members in the Public Constituency is specified in Annex 1.

7. Staff Constituency

7.1 An individual who is employed by the trust under a contract of employment with the trust may become or continue as a member of the trust provided:

7.1.1 he is employed by the trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

7.1.2 he has been continuously employed by the trust under a contract of employment for at least 12 months.

7.2 Individuals who exercise functions for the purposes of the trust, otherwise than under a contract of employment with the trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For clarity this does not include individuals who exercise functions for the purposes of the trust on a voluntary basis.

7.3 The Trust Secretary must have regard to Chapter 1 of Part 14 of the Employment Rights Act 1996 for the purposes of determining whether an individual has been continuously employed by the Trust, or has continuously exercised functions for the purposes of the Trust.

7.4 Those individuals who are eligible for membership of the trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

7.5 The minimum number of members in the Staff Constituency is specified in Annex 2.

Automatic membership by default – staff

7.6 An individual who is:

7.6.1 eligible to become a Member of the Staff Constituency, and

7.6.2 invited by the trust to become a Member of the Staff Constituency,

shall become a Member of the trust as a Member of the Staff Constituency without an application being made, unless he informs the trust that he does not wish to do so.

8. Restriction on membership

8.1 An individual who is a Member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a Member of any other constituency or class.

8.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

8.3 An individual must be at least 16 years old to become a member of the trust.

8.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the trust are set out in Annex 10 – Further Provisions.

9. Annual Members' Meeting

9.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

10. Council of Governors – composition

10.1 The trust is to have a Council of Governors, which shall comprise both elected and appointed Governors.

10.2 The composition of the Council of Governors is specified in Annex 3.

10.3 The aggregate number of public Governors is to be more than half the total membership of the Council of Governors.

10.4 The members of the Council of Governors, other than the appointed members, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3.

11. Council of Governors – election of governors

11.1 Elections for elected members of the Council of Governors shall be conducted in accordance with the Model ~~Election~~ Rules for Elections.

11.2 The Model ~~Election~~ Rules for Elections as published from time to time by the Department of Health form part of this Constitution. The Model ~~Election~~ Rules for Elections current at the date ~~of the trust's Licence~~ this constitution is approved are attached at Annex 4. Elections for elected members of the Council of Governors shall be conducted using the first past the post system. Thus, where appropriate, the alternative rules marked "FPP" (First Past the Post) should be used.

11.3 A subsequent variation of the Model ~~Election~~ Rules for Elections by the Department of Health shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 46 of the Constitution (amendment of the constitution).

11.4 An election, if contested, shall be by secret ballot.

11.5 Where a vacancy arises for an elected Governor the trust may, instead of holding a by-election, fill the vacancy by appointing the highest polling unsuccessful candidate at the most recent election of governors for the constituency or class in respect of which the vacancy has arisen. Any person so appointed shall hold office for the unexpired term of office of the retiring Governor.

12. Council of Governors - tenure

12.1 An elected Governor may hold office for a period of up to 3 years.

12.2 An elected Governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected.

12.3 Subject to Paragraph 12.4 below, an elected Governor shall be eligible for re-election at the end of his term.

12.4 An elected Governor may not hold office for longer than 9 years or be re-elected if, by virtue of this paragraph 12.4, he would not be able to remain in office for the full three year period.

12.5 An appointed Governor may hold office for a period of up to 3 years.

12.6 An appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him.

12.7 An appointed Governor shall be eligible for re-appointment at the end of his term, but may not hold office for more than nine years.

13. Council of Governors – disqualification and removal

13.1 The following may not become or continue as a member of the Council of Governors:

13.1.1 a person who has been ~~adjudged~~ made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

13.1.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

13.1.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

13.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

13.3 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Council of Governors are set out in Annex 5.

14. Council of Governors – Termination of tenure

14.1 A Governor may resign from that office at any time during the term of that office by giving notice in writing to the Secretary to the trust.

14.2 If a Governor fails to attend any meeting of the Council of Governors, for a period of one year or three consecutive meetings (whichever is the shorter) his tenure of office is to be immediately terminated unless the other Governors agree by a majority vote that:

14.2.1 the absence was due to a reasonable cause; and

14.2.2 he will be able to start attending meetings of the Council of Governors again within such a period as they consider reasonable.

14.3 Where a person has been elected or appointed to be a Governor and he becomes disqualified for appointment under paragraph 13, he shall notify the Secretary in writing of such disqualification.

14.4 If it comes to the notice of the Secretary at the time of his appointment or later that the Governor is so disqualified, he shall immediately declare that the person in question is disqualified and notify him in writing to that effect.

14.5 Upon receipt of any such notification, that person's tenure of office, if any, shall be terminated and he shall cease to act as a governor.

15. Council of Governors – Vacancies

Where membership of the Council of Governors ceases, Public and Staff Governors shall be replaced in accordance with paragraph 11.5, and appointed Governors shall be replaced in accordance with processes agreed with their appointers.

16. Council of Governors – duties of governors

16.1 The general duties of the Council of Governors are –

16.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

16.1.2 to represent the interests of the members of the trust as a whole and the interests of the public.

16.2 The Trust must take steps to secure that the governors are equipped with the skills and knowledge they require in their capacity as such.

17. Council of Governors – meetings of governors

17.1 The Chairman of the trust (i.e. the Chairman of the Board of Directors, appointed in accordance with the provisions of paragraph 26.1 or paragraph 27.1 below) or, in his absence the Deputy Chairman (appointed in accordance with the provisions of paragraph 28 below), shall preside at meetings of the Council of Governors.

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons. The Chairman may also exclude any member of the public from a meeting of the Council of Governors if he is interfering with or preventing the proper conduct of the meeting.

17.3 For the purposes of obtaining information about the trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the trust's or

Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

18. Council of Governors – standing orders

The standing orders for the practice and procedure of the Council of Governors, as may be varied from time to time in accordance with paragraph 46, are attached at Annex 7.

19. Council of Governors – referral to the Panel

19.1 In this paragraph, the Panel means a panel of persons appointed by Monitor to which a governor of an NHS foundation trust may refer a question as to whether the trust has failed or is failing—

19.1.1 to act in accordance with its Constitution, or

19.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

19.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

20. Council of Governors - conflicts of interest of governors

If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21. Council of Governors – travel expenses

The trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the trust.

22. Council of Governors – further provisions

Further provisions with respect to the Council of Governors are set out in Annex 5 and Annex 10.

23. Board of Directors – composition

23.1 The trust is to have a Board of Directors, which shall comprise both Executive Directors and Non-Executive Directors.

23.2 The Board of Directors is to comprise:

23.2.1 a Non-Executive Chairman;

23.2.2 5 other Non-Executive Directors; and

23.2.3 5 Executive Directors.

23.3 One of the Executive Directors shall be the Chief Executive.

23.4 The Chief Executive shall be the Accounting Officer.

23.5 One of the Executive Directors shall be the Finance Director.

23.6 One of the Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

23.7 One of the Executive Directors is to be a registered nurse or a registered midwife.

24. Board of Directors – general duty

The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the trust as a whole and for the public.

25. Board of Directors – qualification for appointment as a non-executive director

A person may be appointed as a Non-Executive Director only if –

25.1 he is a member of the Public Constituency, or

25.2 where any of the trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university, and

25.3 he is not disqualified by virtue of paragraph 31 below.

26. Board of Directors – appointment and removal of chairman and other non-executive directors

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Chairman of the trust and the other Non-Executive Directors.

26.2 Removal of the Chairman or another Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

26.3 The initial Chairman and the initial Non-Executive Directors are to be appointed in accordance with paragraph 27 below.

27. Board of Directors – appointment of initial chairman and initial other non-executive directors

27.1 The Council of Governors shall appoint the chairman of the applicant NHS Trust as the initial Chairman of the trust if he wishes to be appointed.

27.2 The power of the Council of Governors to appoint the other Non-Executive Directors of the trust is to be exercised, so far as possible, by appointing as the initial Non-Executive Directors of the trust any of the Non-Executive Directors of the applicant NHS Trust (other than the Chairman) who wish to be appointed.

27.3 The criteria for qualification for appointment as a Non-Executive Director set out in paragraph 25 above (other than disqualification by virtue of paragraph 31 below) do not apply to the appointment of the initial Chairman and the initial other Non-Executive Directors in accordance with the procedures set out in this paragraph.

27.4 An individual appointed as the initial Chairman or as an initial Non-Executive Director in accordance with the provisions of this paragraph shall be appointed for the unexpired period of his term of office as chairman or (as the case may be) non-executive director of the applicant NHS Trust; but if, on appointment, that period is less than 12 months, he shall be appointed for 12 months.

28. Board of Directors – appointment of deputy chairman

The Council of Governors at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as a Deputy Chairman.

29. Board of Directors - appointment and removal of the Chief Executive and other executive directors

29.1 The Non-Executive Directors shall appoint or remove the Chief Executive.

29.2 The appointment of the Chief Executive shall require the approval of the Council of Governors.

29.3 The initial Chief Executive is to be appointed in accordance with paragraph 30 below.

29.4 A committee consisting of the Chairman, the Chief Executive and the other Non-Executive Directors shall appoint or remove the other Executive Directors.

30. Board of Directors – appointment and removal of initial Chief Executive

30.1 The chief officer of the applicant NHS Trust shall be appointed as the initial Chief Executive of the trust if he wishes to be appointed.

30.2 The appointment of the chief officer of the applicant NHS trust as the initial Chief Executive of the trust shall not require the approval of the Council of Governors.

31. Board of Directors – disqualification

The following may not become or continue as a member of the Board of Directors:

31.1 a person who has been ~~adjudged~~ made bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

31.2 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

31.3 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

31.4 a person who, in the case of a Non-Executive Director other than the initial Non-Executive Directors, no longer satisfies paragraph 25.1 or 25.2 (if applicable).

31.5 a person whose tenure of office as a chairman or as a member or director of a national health service body has been terminated on the grounds that his appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest.

31.6 a person who has had his name removed from a list maintained under regulations pursuant to sections 91, 106, 123, or 146 of the 2006 Act, by a direction or has otherwise been disqualified or suspended from any healthcare profession, and has not subsequently has his name included in such a list or had his qualification re-instated or suspension lifted (as applicable).

31.7 a person who has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a national health service body.

31.8 a person who has failed to agree (or having agreed, fails) to abide by the value of the trust's principles as set out in Annex 9.

31.9 a person does not meet the criteria set out in Regulation 5(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (including any modification or re-enactment).

32. Board of Directors – meetings

32.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

32.2 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

33. Board of Directors – standing orders

The standing orders for the practice and procedure of the Board of Directors, as may be varied from time to time in accordance with paragraph 46, are attached at Annex 8.

34. Board of Directors - conflicts of interest of directors

34.1 The duties that a Director of the trust has by virtue of being a Director include in particular –

34.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the trust (a "Conflict").

34.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

34.2 The duty referred to in sub-paragraph 34.1.1 is not infringed if –

34.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

34.2.2 The matter has been authorised in accordance with the Constitution.

34.3 The duty referred to in sub-paragraph 34.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

34.4 In sub-paragraph 34.1.2, "third party" means a person other than –

34.4.1 The trust, or

34.4.2 A person acting on its behalf.

34.5 If a Director of the trust has in any way a direct of indirect interest in a proposed transaction or arrangement with the trust, the Director must declare the nature and extent of that interest to the other Directors.

34.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

34.7 Any declaration required by this paragraph must be made before the trust enters into the transaction or arrangement.

34.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

34.9 A Director need not declare an interest –

34.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

34.9.2 If, or to the extent that, the Directors are already aware of it;

34.9.3 If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered –

34.9.3.1 By a meeting of the Board of Directors, or

34.9.3.2 By a committee of the Directors appointed for the purpose under the Constitution.

34.10 A matter shall have been authorised for the purposes of paragraph 34.2.2 above if:

34.10.1 The Directors, in accordance with the requirements set out in this paragraph 34.10, authorise any matter or situation proposed to them by any Director which would, if not authorised, involve a Director (an "Interested Director") breaching his duty under paragraph 34.1.1 above to avoid Conflicts:

34.10.1.1 the matter in question shall have been proposed by any Director for consideration in the same way that any other matter may be proposed to the Directors under the provisions of this Constitution;

34.10.1.2 any requirement as to the quorum for consideration of the relevant matter is met without counting the Interested Director or any other Interest Director; and

34.10.1.3 the matter was agreed to without the Interested Director voting or would have been agreed to if the Interested Director's and any other Interested Director's vote had not been counted.

34.10.2 Any authorisation of a Conflict under this paragraph 34.10 may (whether at the time of giving the authorisation or subsequently):

34.10.2.1 extend to any actual or potential conflict of interest which may reasonably be expected to arise out of the Conflict so authorised;

34.10.2.2 provide that the Interested Director be excluded from the receipt of documents and information and the participation in discussions (whether at meetings of the Directors or otherwise) related to the Conflict;

34.10.2.3 impose upon the Interested Director such other terms for the purposes of dealing with the Conflict as the Directors think fit;

34.10.2.4 provide that, where the Interested Director obtains, or has obtained (through his involvement in the Conflict and otherwise than through his position as a Director of the Trust) information that is confidential to a third party, he will not be obliged to disclose that information to the Board of Directors, or to use it in relation to the Trust's affairs where to do so would amount to a breach of that confidence; and

34.10.2.5 permit the Interested Director to absent himself from the discussion of matters relating to the Conflict at any meeting of the Directors and be excused from reviewing papers prepared by, or for, the Directors to the extent they relate to such matters.

34.11 Where the Directors authorise a Conflict, the Interested Director will be obliged to conduct himself in accordance with any terms imposed by the Directors in relation to the Conflict.

34.12 The Directors may revoke or vary such authorisation at any time, but this will not affect anything done by the Interested Director, prior to such revocation or variation in accordance with the terms of such authorisation.

34.13 A Director is not required, by reason of being a Director, to account to the Trust for any remuneration, profit or other benefit which he derives from or in connection with a relationship involving a Conflict which has been authorised by the Directors (subject in each case to any terms, limits or conditions attaching to that authorisation) and no contract shall be liable to be avoided on such grounds.

~~34.10~~34.14

35. Board of Directors – remuneration and terms of office

35.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Chairman and the other Non-Executive Directors.

35.2 The trust shall establish a committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Chief Executive and other Executive Directors; (or, pending the establishment of such a committee, in accordance with the terms and conditions decided by the remuneration committee of the applicant NHS Trust).

36. Registers

The trust shall have:

36.1 a register of Members showing, in respect of each Member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

36.2 a register of members of the Council of Governors;

36.3 a register of interests of Governors;

36.4 a register of Directors; and

36.5 a register of interests of the Directors.

37. Registers – inspection and copies

37.1 The trust shall make the registers specified in paragraph 36 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations.

37.2 The trust shall not make any part of its registers available for inspection by members of the public which shows details of any Member of the trust, if the Member so requests.

37.3 So far as the registers are required to be made available:

37.3.1 they are to be available for inspection free of charge at all reasonable times; and

37.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

37.4 If the person requesting a copy or extract is not a Member of the trust, the trust may impose a reasonable charge for doing so.

38. Documents available for public inspection

38.1 The trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

38.1.1 a copy of the current Constitution;

38.1.2 a copy of the latest annual accounts and any report of the auditor on them; and

38.1.3 a copy of the latest annual report;

38.2 The trust shall also make the following documents relating to a special administration of the trust available for inspection by members of the public free of charge at all reasonable times:

38.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(trusts coming out of administration) or 65LA (trusts to be dissolved) of the 2006 Act.

38.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

38.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

38.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

38.2.5 a copy of any statement provided under section 65F(administrator's draft report) of the 2006 Act.

38.2.6 a copy of any notice published under section 65F(administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA(Monitor's decision), 65KB (Secretary of State's response to Monitor's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

38.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

38.2.8 a copy of any final report published under section 65I (administrator's final report),

38.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

38.2.10 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

38.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy.

38.4 If the person requesting a copy or extract is not a member of the trust, the trust may impose a reasonable charge for doing so.

39. Auditor

39.1 The trust shall have an auditor.

39.2 The Council of Governors shall appoint or remove the auditor at a general meeting of the Council of Governors.

40. Audit committee

The trust shall establish a committee of Non-Executive Directors as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

41. Accounts

41.1 The trust must keep proper accounts and proper records in relation to the accounts.

41.2 Monitor may with the approval of the Secretary of State give directions to the trust as to the content and form of its accounts.

41.3 The accounts are to be audited by the trust's auditor.

41.4 The trust shall prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Secretary of State direct.

41.5 The functions of the trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

42. Annual report, forward plans and non-NHS work

42.1 The trust shall prepare an annual report and send it to Monitor.

42.2 The trust shall give information as to its forward planning in respect of each financial year to Monitor.

42.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.

42.4 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

42.5 Each forward plan must include information about:

42.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the trust proposes to carry on, and

42.5.2 the income it expects to receive from doing so.

42.6 Where a forward plan contains a proposal that the trust carry on an activity of a kind mentioned in sub-paragraph 42.5.1 the Council of Governors must:

42.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the trust of its principal purpose or the performance of its other functions, and

42.6.2 notify the Directors of the trust of its determination.

42.7 A trust which proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of health service in England may implement the proposal only if more than half of the members of Council of Governors of the trust voting approve its implementation.

43. Presentation of the annual accounts and reports to the Governors and Members

43.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

43.1.1 the annual accounts

43.1.2 any report of the auditor on them

43.1.3 the annual report.

43.2 The documents shall also be presented to the Members of the trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

43.3 The trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 43.1 with the Annual Members' Meeting.

44. Indemnity

The Secretary of the trust and members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their functions, save where they have acted recklessly, and the trust may also take out and maintain at its own cost insurance against such risks, both for its own benefit and for the benefit of such persons.

45. Instruments

45.1 The trust shall have a seal.

45.2 The seal shall not be affixed except under the authority of the Board of Directors.

46. Amendment of the constitution

46.1 The trust may make amendments of its Constitution only if:

46.1.1 More than half of the members of the Council of Governors of the trust voting approve the amendments, and

46.1.2 More than half of the members of the Board of Directors of the trust voting approve the amendments.

46.2 Amendments made under paragraph 46.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act

46.3 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the trust):

46.3.1 At least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment, and

46.3.2 The trust must give the Members an opportunity to vote on whether they approve the amendment.

46.4 If more than half of the Members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the trust must take such steps as are necessary as a result.

46.5 Amendments by the trust of its Constitution are to be notified to Monitor. For the avoidance of doubt, Monitor's functions do not include a power or duty to determine whether or not the constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

47. Mergers etc. and significant transactions

47.1 The trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

47.2 The trust may enter into a significant transaction only if more than half of the members of the Council of Governors of the trust voting approve entering into the transaction.

47.3 "Significant transaction" means a transaction which meets the definition set out in Table 1 below:

Table 1: Significant transaction

Ratio	Description	Significant
Assets	The gross assets* subject to the transaction, divided by the gross assets of the trust	>25%

Income	The income attributable to assets or contract associated with the transaction, divided by the income of the trust	>25%
Consideration to total NHS foundation trust capital	The gross capital** of the company or business being acquired/divested, divided by the total capital*** of the trust following completion or the effects on the total capital of the trust resulting from a transaction	>25%

* Gross assets is the total of fixed assets and current assets

** Gross capital equals the market value of the target's shares and debt securities, plus the excess of current liabilities over current assets

*** Total capital of the foundation trust equals taxpayers' equity

48. Interpretation and definitions

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the National Health Service Act 2006 as amended by the Health and Social Care Act 2012.

References to statutory provisions shall be deemed to include references to any provision amending, re-enacting or replacing them and to such provisions as amended from time to time.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

the 2006 Act is the National Health Service Act 2006.

the 2012 Act is the Health and Social Care Act 2012.

Accounting Officer means the Officer responsible and accountable for discharging the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act, which shall be the Chief Executive.

Adviser means a person formally appointed by resolution of the Council of Governors to advise the Council of Governors at meetings of the Council of Governors in an advisory and non-voting capacity.

Annual Members Meeting is defined in paragraph 9 of the constitution.

Audit Committee means a committee whose functions are concerned with the arrangements for providing the Board with an independent and objective review on its financial and risk systems, financial information and compliance with laws, guidance, and regulations governing the NHS and with the arrangements for the

monitoring and improving the quality of healthcare for which the trust has responsibility.

Board of Directors ("the Board") means the Executive and Non-Executive Directors including the Chairman as constituted in accordance with the Constitution as the Board of Directors.

Chairman is the person appointed by the Council of Governors to lead the Council of Governors and Board of Directors and to ensure that they successfully discharge their overall responsibility for the trust as a whole. The expression "the Chairman of the trust" shall be deemed to include the Deputy Chairman of the trust if the Chairman is absent from the meeting or is otherwise unavailable.

Chief Executive means the accounting officer of the trust.

Committee members means in the context of a Committee persons formally appointed by the Council of Governors or Board of Directors to be members of the Committee.

Council of Governors means the elected and appointed Governors of the trust collectively as a body, as constituted in accordance with the Constitution.

Constitution means this constitution and all annexes to it.

Deputy Chairman means the Non Executive Director appointed by the Council of Governors to take on the Chairman duties if the Chairman is absent for any reason.

Director means a Member of the Board.

Executive Director means a Member of the Board who holds an executive office of the trust.

Finance Director means the Chief Financial Officer of the trust.

Governor means a person who is a member of the Council of Governors.

Licence issued by Monitor the Licence sets out a range of conditions that the Trust must meet.

Member means any person registered as a member of the trust, and authorised to vote in elections to select Governors.

Monitor is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act.

Motion means a formal proposition to be discussed and voted on during the course of a meeting.

Non Executive Director means a member of the Board of Directors who is not an

Executive Director of the trust.

Officer means employee of the trust or any other person holding a paid appointment or office with the trust.

Secretary means a person who may be appointed to act independently of the Council of Governors to provide advice on corporate governance issues to the Council of Governors, and the Chairman and monitor the trust's compliance with the law, Standing Orders and guidance of the Monitor.

SFIs means Standing Financial Instructions.

SOs mean Standing Orders.

Voluntary Organisation is a body, other than a public or local authority, the activities of which are not carried on for profit.

ANNEX 1 – THE PUBLIC CONSTITUENCY

The trust shall have a single Public Constituency. The area of the Public Constituency will be made up of the wards specified below and the minimum number of Members in the Public Constituency shall be 100.

Babergh:	Alton, Berners, Boxford, Brett Vale, Brook, Bures St Mary, Chadacre, Dodnash, Glemsford and Stanstead, Great Cornard (North Ward), Great Cornard (South Ward), Hadleigh (North Ward), Hadleigh (South Ward), Holbrook, Lavenham, Leavenheath, Long Melford, Lower Brett, Mid Samford, Nayland, North Cosford, Pinewood, South Cosford, Sudbury (East Ward), Sudbury (North Ward), Sudbury (South Ward), Waldingfield.
Braintree:	Bumpstead, Hedingham and Maplestead, Stour Valley North, Stour Valley South, Upper Colne, ~~and~~ Yeldham
Breckland:	Conifer, East Guiltcross, Harling and Heathlands, Mid Forest, Thetford-Abbey, Thetford-Castle, Thetford-Guildhall, Thetford-Saxon, Watton, Wayland, Weeting, ~~and~~ West Guiltcross
East Cambridgeshire:	Bottisham, Burwell, Cheveley, Dullingham Villages, Fordham Villages, Isleham, Soham North, Soham South, ~~and~~ The Swaffhams
Forest Heath:	All Saints, Brandon East, Brandon West, Eriswell & the Rows, Exning, Great Heath, Iceni, Lakenheath, Manor, Market, Red Lodge, St Marys, Severals, South.
Ipswich	Alexandra, Bixley, Bridge, Castle Hill, Gainsborough, Gipping, Holywells, Priory Heath, Rushmere, St John's, St Margaret's, Sprites, Stoke Park, Westgate, Whitehouse, Whitton.
King's Lynn and West Norfolk:	Denton
Mid Suffolk:	Bacton & Old Newton, Badwell Ash, Barking & Somersham, Bramford & Blakenham, Claydon & Barham, Debenham, Elmswell & Norton, Eye, Fressingfield, Gislingham, Haughley & Wetherden, Helmingham & Coddenham, Hoxne, Mendlesham, Needham Market, Onehouse, Palgrave, Rattlesden, Rickinghall & Walsham, Ringshall, Stowmarket Central, Stowmarket North, Stowmarket South, Stowupland, Stradbroke & Laxfield, The Stonhams, Thurston & Hessett, Wetheringsett, Woolpit, Worlingworth.

South Norfolk:	Bressingham and Burston, Diss and Roydon
St Edmundsbury:	Abbeygate, Bardwell, Barningham, Barrow, Cavendish, Chedburgh, Clare, Eastgate, Fornham, Great Barton, Haverhill East, Haverhill North, Haverhill South, Haverhill West, Horringer and Whelnetham, Hundon, Ixworth, Kedington, Minden, Moreton Hall, Northgate, Pakenham, Risby, Risbygate, Rougham, Southgate, St Olaves, Stanton, Westgate, Wickhambrook, ~~and~~ Withersfield
Suffolk Coastal	Aldeburgh, Deben, Felixstowe East, Felixstowe North, Felixstowe South, Felixstowe West, Framlingham, Fynn Valley, Grundisburgh, Hacheston, Kesgrave East, Kesgrave West, Kirton, Leiston, Martlesham, Melton, Nacton & Purdis Farm, Orford & Eyke, Peasenhall & Yoxford, Rendlesham, Saxmundham, The Trimleys, Tower, Wenhaston & Westleton, Wickham Market, Woodbridge.
Waveney	Beccles North, Beccles South, Blything, Bungay, Carlton, Carlton Colville, Gunton & Corton, Halesworth, Harbour, Kessingland, Kirkley, Lothingland, Normanston, Oulton, Oulton Broad, Pakefield, Southwold & Reydon, St Margaret's, The Saints, Wainford, Whitton, Worlingham, Wrentham.

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The Staff Constituency will comprise a single class. The minimum number of Members in the Staff Constituency shall be 100.

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C. Appointed Governors:	
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i. Suffolk County Council	1
ii. St Edmundsbury Council in consultation with Babergh, Braintree, Breckland, East Cambridgeshire, Forest Heath, Ipswich, King's Lynn and West Norfolk, Mid Suffolk, ~~and~~ South Norfolk, Suffolk Coastal and Waveney councils	1
(b) University of Cambridge Governor	1
(c) Other appointing organisations: (specified for the purposes of sub-paragraph 9(7) of Schedule 7 of the 2006 Act)	
i. Friends of West Suffolk Hospital	1
ii. Community Action Suffolk	1
iii. University Campus Suffolk (UCS) in consultation with West Suffolk College	1
Or in each case such other organisations as may be the successors to their functions.	

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PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires:

"*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution;

"*council of governors*" means the council of governors of the corporation;

"*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message;

"*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b)

"*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2;

"*telephone voting record*" has the meaning set out in rule 26.5 (d);

"*text message voting facility*" has the meaning set out in rule 26.3;

"*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

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8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be

obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency, or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party,

and if the candidate has no such interests, the paper must include a

statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a member of the council of governors by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and

date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it, and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing,

as given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e-voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e-voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after

any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,

("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (url) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope;

("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election,

pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate,
(d) contact details of the returning officer,

("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election then

the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as "the telephone voting facility").

26.3 If text message voting is a method of polling for the relevant election then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as "the text message voting facility").

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the url of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet,

and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X",

"*non-transferable vote*" means a ballot document:

(a) on which no second or subsequent preference is recorded for

a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,

(b) the transfer of a surplus of a candidate deemed to be elected, or

(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in

accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:

(i) the use of such software for the purpose of counting votes in the relevant election, and

(ii) a policy governing the use of such software, and

(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:

(iii) ballot papers that have been returned; and

(iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and

(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub-paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word "rejected" on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words "rejected in part" on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP448 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels

according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate, and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or

more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or

STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV9.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer

value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV9.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been

ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records,

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them

to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued,

the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chair by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records,

telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage,

by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the

election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet(or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions,

as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

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66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor for the

purpose of seeking a referral to the independent election arbitration panel (IEAP).

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as the independent panel may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election. Monitor will refer the application to the independent election arbitration panel appointed by Monitor.

66.6 If the independent election arbitration panel requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the IEAP shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 The IEAP may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

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67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.

ANNEX 5 – ADDITIONAL PROVISIONS – COUNCIL OF GOVERNORS

A person may not become or continue as a Governor of the trust if –

(a) he, in the case of a staff Governor or public Governor, ceases to be a Member of the constituency he represents;

(b) he, in the case of a appointed Governor, has his sponsorship withdrawn by their sponsoring organisation;

(c) he has within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with a national health service body;

(d) his tenure of office as the chairman or as a member or director of a national health service body has been terminated on the grounds that his appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

(e) he is an Executive Director or Non-Executive Director of the trust, or a governor, non executive director, chairman, chief executive officer of an organisation the nature of whose business is to give rise to potential conflicts of interest of a personal or prejudicial nature to such a degree as to prevent the person from the proper exercise of their duties as a Governor of this Trust. This may include other NHS Foundation Trusts;

(f) a person who has had his name removed from a list maintained under regulations pursuant to sections 91, 106, 123, or 146 of the 2006 Act, by a direction or has otherwise been disqualified or suspended from any healthcare profession, and has not subsequently has his name included in such a list or had his qualification re-instated or suspension lifted (as applicable).

(g) he is incapable by reason of mental disorder, illness or injury of managing and/or administering his property and/or affairs;

(h) he has been declared, by a sub-committee of the Council of Governors, to be a vexatious complainant; or

(i) he has failed to agree (or having agreed, fails) to abide by the Code of Conduct for Governors as set out in Annex 6 and the value of the trust's Principles as set out in Annex 9.

ANNEX 6 - CODE OF CONDUCT FOR GOVERNORS

Introduction

1 This Code seeks to outline appropriate conduct for Governor, and addresses both the requirements of office and their personal behaviour. Ideally any penalties for non-compliance would never need to be applied; however a Code is considered an essential guide for Governors, particularly those who are newly elected.

2 The Code seeks to expand on or complement the Constitution. Copies will be made available for the information of all Governors and for those considering seeking election to the Council of Governors.

Qualifications for office

4 Members of the Council of Governors must continue to comply with the qualifications required to hold elected office throughout their period of tenure as defined in the Constitution. The Secretary should be advised of any changes in circumstances, which disqualify the Governor from continuing in office. An example of this would be a public Governor becoming an employee of the trust, given that the number of employees sitting on the trust's elected bodies is limited.

Role and functions

5 Governors should:

a) adhere to the trust's rules and policies and support its objectives, in particular those of retaining Foundation Trust status and developing a successful trust.

b) act in the best interests of the trust at all times.

c) contribute to the workings of their Council of Governors in order for it to fulfill its role and functions.

d) recognise that their role is a collective one. They exercise collective decision making in the meeting room, which is recorded in the minutes. Outside the meeting room a Governor has no more rights and privileges than any other member.

e) note that the functions allotted to the Council of Governors are not of a managerial nature.

Confidentiality

6 All Governors are required to respect the confidentiality of the information they are made privy to as a result of their membership of the Council of Governors.

Conflict of interests

7 Governors should act with the utmost integrity and objectivity and in the best interests of the trust in performing their duties. They should not use their position for personal advantage or seek to gain preferential treatment. Any Governor who has a material interest in a matter as defined by the Constitution, shall declare such interest to the Council of Governors and:

- shall not vote on any such matters.

- Shall not be present except with the permission of the Council of Governors in any discussion of the matter.

If in any doubt they should seek advice from the Secretary. It is important that conflicts of interest are addressed and are seen to be actioned in the interests of the trust and all individuals concerned.

8 Any Governor who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so be a majority of the remaining Governors.

Council of Governors meetings

9 Governors have a responsibility to attend meetings of the Council of Governors. When this is not possible they should submit an apology to the Secretary in advance of the meeting.

10 In accordance with the Constitution, absence from the Council of Governors meetings without good reason established to the satisfaction of the Council of Governors is grounds for disqualification. If a Governor fails to attend for a period of one year or three consecutive meetings (whichever is the shorter) of the Council of Governors, his tenure of office is to be immediately terminated unless the other Governors are satisfied that the absence was due to a reasonable cause and he will be able to start attending meetings of the trust again within such a period as they consider reasonable.

11 Governors are expected to attend for the duration of the meeting.

Personal conduct

12 Governors are required to adhere to the highest standards of conduct in the performance of their duties. In respect of their interaction with others, they are required to:

a) adhere to good practice in respect of the conduct of meetings and respect the views of their fellow elected governors

b) be mindful of conduct which could be deemed to be unfair or discriminatory

c) treat the trust's executives and other employees with respect and in accordance with the trust's policy

d) recognise that the Council of Governors and management have a common purpose, i.e. promote the success of the trust, and adopt a team approach

e) Governors should conduct themselves in such a manner as to reflect positively on the trust. When attending external meetings or any other events at which they are present, it is important for Governors to be ambassadors for the trust.

Accountability

13 Governors are accountable to the membership and should demonstrate this by attending Members' meetings and other key events, which provide opportunities to interface with their electorate in order to best understand their views.

Induction and development

14 Training is essential for Governors, in respect of the effective performance of their current role. Governors are required to adhere to the trust's policies in all respects and undertake identified training and develop to allow them to effectively undertake their role.

Visits to trust Premises

15 Where Governors wish to visit the premises of the trust in a formal capacity as opposed to individuals in a personal capacity, the Council of Governors should liaise with the Secretary to make the necessary arrangements.

Non-compliance with the Code of Conduct

16 Non-compliance with the Code may result in action being taken as follows:-

a) Where misconduct takes place, the Chairman shall be authorised to take such action as may be immediately required, including the exclusion of the person concerned from a meeting.

b) Where such misconduct is alleged, it shall be open to the Council of Governors to decide, by simple majority of those in attendance, to lay a formal charge of misconduct.

c) notifying the Governor in writing of the charge/s, detailing the specific behaviour, which is considered to be detrimental to the trust, and inviting and considering their response within a defined timescale.

d) inviting the Governor to address the Council of Governors in person if the matter cannot be resolved satisfactorily through correspondence;

e) deciding, by simple majority of those present and voting, whether to uphold the charge of conduct detrimental to the trust;

f) imposing such sanctions as shall be deemed appropriate. Such sanctions will range from the issuing of a written warning as to the member's future conduct and consequences, non-payment of expenses to the removal of the Governor from office.

17 A Governor may be removed from the Council of Governors for non-compliance with the Code of Conduct by a resolution approved by not less than two-thirds of the remaining Governors present and voting at a general meeting of the Council of Governors.

18 This Code of Conduct does not limit or invalidate the right of the Governors or the trust to act under the Constitution.

ANNEX 7 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE COUNCIL OF GOVERNORS

1. INTERPRETATION

1.1 Save as otherwise permitted by law, at any meeting the Chairman of the trust shall be the final authority on the interpretation of Standing Orders (of which he should be advised by the Chief Executive or Secretary).

1.2 Any expression to which a meaning is given in the National Health Service Act 2006 ("2006 Act") or in the Constitution shall have the same meaning in these Standing Orders.

2. THE COUNCIL OF GOVERNORS

2.1 **Composition of the Council of Governors -** The composition of the Council of Governors shall be in accordance with the Constitution.

2.2 **Appointment of the Chairman and members –** The Chairman is appointed by the Council of Governors, as set out in the Constitution.

2.3 **Terms of Office of the Chairman and members-** The regulations setting out the period of tenure of office of the Chairman and members and for the termination or suspension of office of the Chairman and members are contained in the Constitution.

2.4 **Appointment and Powers of Deputy Chairman –** subject to Standing Order 2.5 below; members of the Council of Governors may appoint one of the Non-Executive Directors, to be Deputy Chairman for such period, not exceeding the remainder of his term as a Non-Executive Director of the trust, as they may specify on appointing him.

2.5 Any Non-Executive Director so appointed may at any time resign from the office of Deputy Chairman and the Council of Governors may thereupon appoint another Non Executive Director as Deputy Chairman in accordance with the provisions of Standing Order 2.4.

2.6 Where the Chairman of the trust has died or has ceased to hold office or where he has been unable to perform his duties as Chairman owing to illness or any other cause, the Deputy Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes his duties, as the case may be, and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform his duties, be taken to include references to the Deputy Chairman.

3. MEETINGS OF THE COUNCIL OF GOVERNORS

3.1 *Admission of the Public and the Press* – The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Council of Governors but shall be required to withdraw upon the Council of Governors (including a majority of the public Governors present at the meeting) resolving as follows:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest"

3.2 The Chairman (or Deputy Chairman) shall give such directions as he thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the trust's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Council of Governors (including a majority of the public Governors present at the meeting) resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Council of Governors to complete business without the presence of the public"

3.3 Nothing in these Standing Orders shall require the trust to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without the prior agreement of the Council of Governors.

3.4 **Calling Meetings** – Meetings of the Council of Governors shall be held at such times and places as the Council of Governors may determine.

3.5 The Council of Governors will hold at least four meetings each year, one of which is the Annual Members Meeting.

3.6 The Chairman of the trust may call a meeting of the Council of Governors at any time. If the Chairman refuses to call a meeting after a requisition for that purpose, signed by at least one-third of the whole number of members of the Council of Governors, has been presented to him or her, or if, without so refusing, the Chairman does not call a meeting within seven days after such requisition has been presented to him at the trust's headquarters, such one-third or more members may forthwith call a meeting.

3.7 **Notice of Meetings** - Before each meeting of the Council of Governors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Chairman or by an officer authorised by the Chairman to sign on his behalf shall be delivered to every Governor, or sent by post to the usual place of residence of each Governor, so as to be available to him at least three days before the meeting.

3.8 Want of service of the notice on any Governor shall not affect the validity of a meeting.

3.9 In the case of a meeting called by Governors in default of the Chairman, the notice shall be signed by those Governors and no business shall be transacted at the meeting other than that specified in the notice.

3.10 Agendas will be sent to Governors five days[2] before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be

[2] See 3.7 the Notice should be sent before the Agenda.

dispatched no later than three days before the meeting, save in emergency. A notice shall be presumed to have been served one day after posting.

3.11 Before each meeting of the Council of Governors a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the trust's office at least three days before the meeting.

3.12 **Setting the Agenda** - The Council of Governors may determine that certain matters shall appear on every agenda for a meeting and shall be addressed prior to any other business being conducted. (Such matters may be identified within these Standing Orders or following subsequent resolution shall be listed in an Appendix to the Standing Orders).

3.13 A Governor desiring a matter to be included on an agenda shall make his request in writing to the Chairman at least ten clear days before the meeting. The request should state whether the item of business is proposed to be transacted in the presence of the public and should include appropriate supporting information. Requests made less than ten days before a meeting may be included on the agenda at the discretion of the Chairman.

3.14 **Petitions** - where a petition has been received by the trust the Chairman of the Council of Governors shall include the petition as an item for the agenda of the next Council of Governors meeting.

3.15 **Chairman of Meeting** - At any meeting of the Council of Governors, the Chairman, if present, shall preside. If the Chairman is absent from the meeting the Deputy Chairman, if there is one and he is present, shall preside. If the Chairman and Deputy Chairman are absent another Non Executive Director as the members present shall choose who shall preside.

3.16 If the Chairman is absent temporarily on the grounds of a declared conflict of interest the Deputy Chairman, if present, shall preside. If the Chairman and Deputy Chairman are disqualified from participating, such Governor from the Public Constituency as the Governors present shall choose by majority vote who shall preside.

3.17 **Notices of Motion** – A member of the Council of Governors desiring to move or amend a Motion shall send a written notice thereof at least ten clear days before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any Motion being moved during the meeting, without notice on any business mentioned on the agenda.

3.18 **Withdrawal of Motion or Amendments –** A Motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and consent of the Chairman.

3.19 **Motion to Rescind a Resolution –** Notice of Motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the member who gives it and also the signature of four other Governors. When any such Motion has been disposed of by the Council of Governors, it shall not be competent for any Governor other than the Chairman to propose a Motion to the same effect within six months however the Chairman may do so if he considers it appropriate.

3.20 **Motions -** The mover of a Motion shall have a right of reply at the close of any discussion on the Motion or any amendment thereto.

3.21 When a Motion is under discussion or immediately prior to discussion it shall be open to a member to move:

- An amendment to the Motion,
- The adjournment of the discussion or the meeting
- That the meeting proceed to the next business (*)
- The appointment of an ad hoc committee to deal with a specific item of business
- That the Motion be now put (*)
- A Motion resolving to exclude the public (including the press).

* In the case of sub-paragraphs denoted by (*) above to ensure objectivity Motions may only be put by a member who has not previously taken part in the debate and who is eligible to vote.

No amendment to the Motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the Motion.

3.22 **Chairman's Ruling -** Statements of members of the Council of Governors made at meetings of the Council of Governors shall be relevant to matter under discussion at the material time and the decision of the Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

3.23 **Voting -** every question at a meeting shall be determined by either a majority of the votes of the Governors present, qualified to vote on the issue and voting on the question unless the Constitution requires otherwise. In the case of the number of votes for and against a Motion being equal, the Chairman of the meeting, or the person presiding over that issue if the Chairman is absent, shall have a second or casting vote.

3.24 All questions put to the vote shall, at the discretion of the Chairman of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Governors present so request.

3.25 If at least one-third of the Governors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each governor voted or abstained.

3.26 If a Governor so requests, his or her vote shall be recorded by name upon any vote (other than by paper ballot).

3.27 In no circumstances may an absent Governor vote by proxy. Absence is defined as being absent at the time of the vote.

3.28 A person attending the Council of Governors to represent a Governor during a period of incapacity or temporary absence without formal appointment as a Governor may not exercise the voting rights of the Governor. A person's status when attending a meeting shall be recorded in the minutes.

3.29 **Minutes -** The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

3.30 No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

3.31 Minutes shall be circulated in accordance with Governors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public as required by Code of Practice on Openness in the NHS.

3.32 **Variation and Amendment of Standing Orders –** will be undertaken in accordance with paragraph 46 of the Constitution.

3.33 **Record of Attendance –** the names of the Chairman and Governors present at the meeting shall be recorded in the minutes.

3.34 **Quorum –** No business shall be transacted at a meeting unless at least one third of the whole number of the Governors are present, the majority of whom are from the public constituency.~~, including at least five Public Governors, two Staff Governors and two appointed Governors~~. If at any meeting there is no quorum within 30 minutes of the time fixed for the start of the meeting, the meeting shall stand adjourned for 7 days and upon reconvening, those present shall constitute a quorum.

3.35 If the Chairman or Governor has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see Standing Orders 6 or 7) he shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. The meeting must then proceed to the next business.

4. ARRANGEMENTS FOR DELEGATION

4.1 **Committees –** The Council of Governors shall agree from time to time to the delegation of matters for consideration by committee, or sub-committees which it has formally constituted in accordance with the Constitution. The constitution and terms of reference of these committees or sub-committees and their specific powers shall be approved by the Council of Governors. Such committees and subcommittees shall be advisory only and not decision-making.

4.2 **Overriding Standing Orders –** If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Council of Governors for action or ratification. All members of the Council of Governors and staff have a duty to disclose any non-compliance with these Standing Orders to the Chairman as soon as possible.

5. COMMITTEES

5.1 Subject to any guidance or best practice advice as may be issued by Monitor, the Council of Governors may and, if directed by Monitor, shall appoint committees of

the Council of Governors to assist it in the proper performance of its functions, consisting wholly or partly of the Chair, Governors, and others, including Advisers.

5.2 A committee appointed under Standing Order 5.1 may, subject to such directions as may be given by the Council of Governors, appoint sub-committees consisting wholly or partly of members of the committee.

5.3 These Standing Orders, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Council of Governors with the terms “Chairman” to be read as a reference to the Chairman of the committee, and the term “Governor” to be read as a reference to a member of the committee as the context permits. There is no requirement to hold meetings of committees, established by the Council of Governors in public.

5.4 Each such committee shall have such terms of reference and powers and be subject to such conditions as the Council of Governors shall decide and shall be in accordance with the 2006 Act, the Constitution, and any best practice advice and/or guidance issued by Monitor, but the Council of Governors shall not delegate to any committee any of the powers or responsibilities which are to be exercised by the Council of Governors at a formal meeting.

5.5 Where committees are authorised to establish sub-committees they may not delegate their powers to the sub-committee unless expressly authorised by the Council of Governors.

5.6 Any committee or sub-committee established under this Standing Order 5.1 may call upon outside advisers to assist them with their tasks including any Advisers, subject to the advance agreement of the Board of Directors.

5.7 The Council of Governors shall approve the appointments to each of the committees which it has formally constituted.

5.8 Where the Council of Governors is required to appoint persons to a committee to undertake statutory functions, and where such appointments are to operate independently of the Council of Governors, such appointments shall be made in accordance with applicable statute and regulations and with best practice advice and/or guidance issued by Monitor.

5.9 Where the Council of Governors determines that persons who are neither Governors, nor Directors or Officers of the Trust, shall be appointed to a committee, the terms of such appointment shall be determined by the Council of Governors subject to the payment of travelling expenses and other allowances being in accordance with such sum as may be determined by the Board of Directors.

5.10 The Council of Governors may appoint members to serve on joint committees with the Board of Directors or committees of the Board of Directors on the request of the Chair.

5.11 The Secretary or his deputy will attend all meetings of the Committees in support of them.

6. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

6.1 **Declaration of interests –** The Constitution and the trust's Code of Conduct requires Governors to declare interests which are relevant and material to the Council of Governors of which they are a member. All existing Governors should declare such interests. Any Governors appointed subsequently should do so on appointment.

6.2 Interests which should be regarded as "relevant and material" are:

6.2.1 Directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies).

6.2.2 Ownership, part-ownership or directorship of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.

6.2.3 Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.

6.2.4 A position of trust in a charity or Voluntary Organisation in the field of health and social care

6.2.5 Any connection with a voluntary or other organisation contracting for NHS services

6.2.6 To the extent not covered above, any connection with an organisation, entity or company considering entering into or having entered into a financial agreement with the NHS Foundation Trust, including but not limited to, lenders or banks.

6.2.7 Any other commercial interest in the decision before the meeting

6.3 At the time Governors' interests are declared, they should be recorded in the Council of Governors minutes. Any changes in interests should be declared at the next Council of Governors meeting following the change occurring.

6.4 Governors' directorships of companies likely or possibly seeking to do business with the trust should be published in the Council of Governors Annual Report. The information should be kept up to date for inclusion in succeeding annual reports.

6.5 During the course of a Council of Governors meeting, if a conflict of interest is established, the member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

6.6 There is no requirement in the Code of Conduct for the interests of Governors' spouses or partners to be declared. However Standing Order 7 requires that the interest of members' spouses, if living together, in contracts should be declared. Therefore the interests of Governors' spouses and cohabiting partners should also be regarded as relevant.

6.7 If Governors have any doubt about the relevance of an interest, this should be discussed with the Chairman. Financial Reporting Standard No 8 (issued by the Accounting Standards Council) specifies that influence rather than the immediacy

of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

6.8 **Register of Interests –** The Secretary will ensure that a register of interests is established to record formally declarations of interests of members. In particular the register will include details of all directorships and other relevant and material interests which have been declared by both elected and appointed members.

6.9 These details will be kept up to date by means of an annual review of the register in which any changes to interests declared during the preceding twelve months will be incorporated.

6.10 The register will be available to the public and the Secretary will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

7. DISABILITY OF CHAIRMAN AND MEMBERS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

7.1 Subject to the following provisions of this Standing Orders, if the Chairman or a Governor has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the trust at which the contract or other matter is the subject of consideration, he shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

7.2 The Council of Governors may exclude the Chairman or a member of the Council of Governors from a meeting of the Council of Governors while any contract, proposed contract to other matter in which he has a pecuniary interest, is under consideration.

7.3 Any remuneration compensation or allowances payable to the Chairman or a member of the Council of Governors by virtue of the Constitution shall not be treated as a pecuniary interest for the purpose of this Standing Order.

7.4 For the purpose of this Standing Order the Chairman or a member of the Council of Governors shall be treated as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

a. He, or a nominee of his, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

b. He is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

And in the case of married persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

7.5 The Chairman or a member shall not be treated as having a pecuniary interest in any contract, proposed contract or any other matter by reason only:

a. of his membership of a company or other body, if he has no beneficial interest in any securities of that company or other body; or

b. of an interest in any company, body or person with which he is connected which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a member in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

7.6 Where the Chairman or a member of the Council of Governors has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and the total nominal value of these securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company body, whichever is the less, and if the share capital is of more than one class, the total nominal value of shares of any one class in which he has beneficial interest does not exceed one-hundredth of the total issued share capital of that class, this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his duty to disclose his interest.

7.7 The Standing Order applies to a committee or sub-committee as it applies to the trust.

8. SENIOR INDEPENDENT DIRECTOR

8.1 The Council of Governors is entitled to be consulted by the Board of Directors on the appointment of the Trust's Senior Independent Director.

8.2 The role of the Senior Independent Director is as set out in the Trust's "Senior Independent Director Role Specification" as amended from time to time. For the avoidance of doubt the "Senior Independent Director Role Specification" does not form part of the Constitution.

9. LEAD GOVERNOR AND DEPUTY LEAD GOVERNOR

~~9.1 The Council of Governors will appoint a public Governor as the Lead Governor.~~

9.1 The appointment of the Lead Governor and Deputy Lead Governor will be made from those Governors who have been elected as Governors from the Public Constituency.

9.2 The role of the Lead Governor is as set out in the Trust's "Lead Governor Role Specification" as amended from time to time. For the avoidance of doubt the "Lead Governor Role Specification" does not form part of the Constitution.

9.3 The Deputy Lead Governor will take up the role and responsibilities of the Lead Governor on a temporary basis, in the event the Lead Governor is absent for any reason.

ANNEX 8 – STANDING ORDERS FOR THE PRACTICE AND PROCEDURE OF THE BOARD OF DIRECTORS

SECTION A

INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

SECTION B – STANDING ORDERS

1. INTRODUCTION

2. THE BOARD

3. MEETINGS OF THE TRUST

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

5. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

7. DUTIES AND OBLIGATIONS OF DIRECTORS UNDER THE STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

SECTION A

1. INTERPRETATION AND DEFINITIONS FOR STANDING ORDERS AND STANDING FINANCIAL INSTRUCTIONS

1.1 Save as otherwise permitted by law, at any meeting the Chairman of the trust shall be the final authority on the interpretation of Standing Orders (on which they should be advised by the Chief Executive or Secretary to the Board).

1.2 All references in these Standing Orders to the masculine gender shall be read as equally applicable to the feminine gender and vice-versa.

SECTION B – STANDING ORDERS

1. INTRODUCTION

1.1 Statutory Framework

The trust is a public benefit corporation which was established under the 2006 Act on 1 March 2009.

1.1.1 The powers of the trust are set out in the 2006 Act subject to any restrictions in the Constitution or the License.

1.1.2 The Constitution requires the Board to adopt Standing Orders for the regulation of its proceedings and business. The trust must also adopt Standing Financial Instruction (SFIs) as an integral part of Standing Orders setting out the responsibility of individuals.

1.1.3 The trust will also be bound by such other statute, legal provisions and binding guidance from Monitor which governs the conduct of its affairs.

1.1.4 As a statutory body, the trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable.

1.2 Delegation of Powers

1.2.1 The powers of the trust shall be exercised by the Board of Directors on behalf of the trust.

1.2.2 Any of those powers may be delegated to a committee of Directors or to an Executive Director. The Standing Orders set out the detail of these arrangements. Under the Standing Order relating to the Arrangements for the Exercise of Functions (SO 5) the trust is given powers to "make arrangements for the exercise, on behalf of the trust of any of their functions by a committee or subcommittee, or by an Officer of the trust, in each case subject to such restrictions and conditions as the trust thinks fit. Delegated Powers are covered in a separate document (Reservation of Powers to the Board and Delegation of Powers). This document has effect as if incorporated into the Standing Orders. Delegated Powers are covered in a separate document entitled – 'Schedule of Matters reserved to the Board and Scheme of Delegation' and have effect as if incorporated into the Standing Orders and Standing Financial Instructions.

2. THE BOARD

2.1 Composition of the Board

The composition of the Board shall be in accordance with the Constitution.

2.2 Appointment and Powers of Deputy Chairman

2.2.1 In accordance with paragraph 28 of the Constitution and subject to Standing Order 2.2.2 below, the Council of Governors may appoint a Non Executive Director, to be Deputy Chairman, for such period, not exceeding the remainder of his term as a member of the Board, as they may specify on appointing him.

2.2.2 Any Non Executive Director so appointed may at any time resign from the office of Deputy Chairman by giving notice in writing to the Chairman (in the Chairman's capacity as Chairman of the Board and the Council of Governors). The Council of Governors may thereupon appoint another Non Executive Director as Chairman in accordance with the provisions of Standing Order 2.2.1.

2.2.3 Where the Chairman of the trust has died or has ceased to hold office, or where they have been unable to perform their duties as Chairman owing to illness or any other cause, the Deputy Chairman shall act as Chairman until a new Chairman is appointed or the existing Chairman resumes their duties, as the case may be; and references to the Chairman in these Standing Orders shall, so long as there is no Chairman able to perform those duties, be taken to include references to the Deputy Chairman.

2.3 Appointment and Powers of Senior Independent Director

2.3.1 Subject to Standing Order 2.3.2 below, the Board of Directors (in consultation with the Council of Governors) may appoint any Member of the Board, who is also a Non Executive Director, to be the Senior Independent Director, for such period, not exceeding the remainder of his term as a Member of the Board, as they may specify on appointing him. The Senior Independent Director shall perform the role set out in the Trust's "Senior Independent Director Role Description", as amended from time to time by resolution of the Board.

2.3.2 Any Non-Executive Director so appointed may at any time resign from the office of Senior Independent Director by giving notice in writing to the Chairman. The Chairman (in consultation with the other Non Executive Directors and the Council of Governors) may thereupon appoint another member of the Board as Senior Independent Director in accordance with the provisions of Standing Order 2.3.1.

2.4 Appointment and Powers of Deputy Chief Executive

The Chairman and Chief Executive may jointly appoint or remove one of the Executive Directors as the deputy chief Executive. The powers of the Deputy chief executive are defined in the Board's Scheme of Delegation.

2.5 Role of Directors

The Board will function as a corporate decision making body and Non Executive and Executive Directors will be full and equal Board members. Their role as members of the Board will be to consider the key strategic and managerial issues facing the trust in carrying out its statutory and other functions. In exercising these functions, the Board will consider guidance from Monitor "The NHS Foundation Trust Code of Governance" as amended from time to time.

2.6 Corporate role of the Board

2.6.1 All business conducted by the trust shall be conducted in the name of the trust.

2.6.2 All funds received in trust shall be held in the name of the trust as corporate trustee.

2.6.3 The powers of the trust established under statute subject to the License shall be exercised by the Board in private session except as otherwise provided for in Standing Order 3.

2.7 Schedule of Matters reserved to the Board and Scheme of Delegation

2.7.1 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These powers and decisions are set out in the 'Schedule of Matters Reserved to the Board' and shall have effect as if incorporated into the Standing Orders. Those powers which it has delegated to Officers and other bodies are contained in the Scheme of Delegation.

2.8 Lead Roles for Directors

2.8.1 The Chairman will ensure that the designation of Lead roles as set out in any statutory or other guidance will be made in accordance with that guidance or statutory requirement (e.g. appointing a Lead Board Director with responsibilities for Infection Control or Child Protection Services etc).

3. MEETINGS OF THE TRUST

3.1 Calling meetings

3.1.1 Meetings of the Board shall be held at regular intervals at such times and places as the Board may determine.

3.1.2 The Chairman may call a meeting of the Board at any time.

3.1.3 One third or more Directors of the Board may requisition a meeting in writing. If the Chairman refuses, or fails, to call a meeting within seven days of a requisition being presented, the Directors signing the requisition may forthwith call a meeting.

3.2 Notice of Meetings and the Business to be transacted

3.2.1 Before each meeting of the Board a written notice specifying the business proposed to be transacted shall be delivered to every Director, or sent by

post to the usual place of residence of each Director, so as to be available to Directors at least three days before the meeting. The notice shall be signed by the Chairman or by an Officer authorised by the Chairman to sign on their behalf. Want of service of such a notice on any Director shall not affect the validity of a meeting.

3.2.2 In the case of a meeting called by Directors in default of the Chairman calling the meeting, the notice shall be signed by those Directors.

3.2.3 No business shall be transacted at the meeting other than that specified on the agenda, or emergency Motions allowed under Standing Order 3.6.

3.2.4 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chairman at least 15 days before the meeting. The request should include appropriate supporting information. Requests made less than 15 days before a meeting may be included on the agenda at the discretion of the Chairman.

3.2.5 In the event that a meeting of the Board is to be held in public pursuant to paragraph 3.17.1, a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the trust's principal offices at least three days before the meeting.

3.3 Agenda and Supporting Papers

3.3.1 The Agenda will be sent to Directors five days[3] before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be dispatched no later than three days before the meeting, save in emergency.

3.4 Petitions

Where a petition has been received by the trust the Chairman shall include the petition as an item for the agenda of the next meeting.

3.5 Notice of Motion

3.5.1 Subject to the provision of Standing Orders 3.7 'Motions: Procedure at and during a meeting' and 3.8 'Motions to rescind a resolution', a Director of the Board wishing to move a Motion shall send a written notice to the Chief Executive who will ensure that it is brought to the immediate attention of the Chairman.

3.5.2 The notice shall be delivered at least 10 clear days before the meeting. The Chief Executive shall include in the agenda for the meeting all notices so received that are in order and permissible under governing regulations. This Standing Order shall not prevent any Motion being withdrawn or moved without notice on any business mentioned on the agenda for the meeting.

[3] See SO 3.2.1 and 3.2.5; the Notice should precede the Agenda.

3.6 Emergency Motions

3.6.1 Subject to the agreement of the Chairman, and subject also to the provision of Standing Order 3.7 'Motions: Procedure at and during a meeting', a Director of the Board may give written notice of an emergency Motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the trust Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairman's decision to include the item shall be final.

3.7 Motions: Procedure at and during a meeting

3.7.1 Who may propose

A Motion may be proposed by the Chairman of the meeting or any Director present. It must also be seconded by another Director.

3.7.2 Contents of Motions

The Chairman may exclude from the debate at their discretion any such Motion of which notice was not given on the notice summoning the meeting other than a Motion relating to:

- the reception of a report;
- consideration of any item of business before the trust Board;
- the accuracy of minutes;
- that the Board proceed to next business;
- that the Board adjourn;
- that the question be now put.

3.7.3 Amendments to Motions

A Motion for amendment shall not be discussed unless it has been proposed and seconded.

Amendments to Motions shall be moved relevant to the Motion, and shall not have the effect of negating the Motion before the Board.

If there are a number of amendments, they shall be considered one at a time. When a Motion has been amended, the amended Motion shall become the substantive Motion before the meeting, upon which any further amendment may be moved.

3.7.4 Rights of reply to Motions

a) Amendments

The mover of an amendment may reply to the debate on their amendment immediately prior to the mover of the original Motion, who shall have the right of reply at the close of debate on the amendment, but may not otherwise speak on it.

b) Substantive/original Motion

The Director who proposed the substantive Motion shall have a right of reply at the close of any debate on the Motion.

3.7.5 Withdrawing a Motion

A Motion, or an amendment to a Motion, may be withdrawn.

3.7.6 Motions once under debate

When a Motion is under debate, no Motion may be moved other than:

- an amendment to the Motion;
- the adjournment of the discussion, or the meeting;
- that the meeting proceed to the next business;
- that the question should be now put;
- the appointment of an 'ad hoc' committee to deal with a specific item of business;
- that Director be not further heard;

In those cases where the Motion is either that the meeting proceeds to the 'next business' or 'that the question be now put' in the interests of objectivity these should only be put forward by a Director of the Board who has not taken part in the debate and who is eligible to vote.

If a Motion to proceed to the next business or that the question be now put, is carried, the Chairman should give the mover of the substantive Motion under debate a right of reply, if not already exercised. The matter should then be put to the vote.

3.8 Motion to Rescind a Resolution

3.8.1 Notice of Motion to rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of three other Directors, and before considering any such Motion of which notice shall have been given, the trust Board may refer the matter to any appropriate Committee or the Chief Executive for recommendation.

3.8.2 When any such Motion has been dealt with by the trust Board it shall not be competent for any Director other than the Chairman to propose a Motion to the same effect within six months. This Standing Order shall not apply to Motions moved in pursuance of a report or recommendations of a Committee or the Chief Executive.

3.9 Chairman of meeting

3.9.1 At any meeting of the trust Board the Chairman, if present, shall preside. If the Chairman is absent from the meeting, the Deputy Chairman (if the Board has appointed one), if present, shall preside.

3.9.2 If the Chairman and Deputy Chairman are absent, such Director (who is not also an Executive Director of the trust) as the Directors present shall choose shall preside.

3.10 Chairman's ruling

The decision of the Chairman of the meeting on questions of order, relevancy and regularity (including procedure on handling Motions) and their interpretation of the Standing Orders and Standing Financial Instructions, at the meeting, shall be final.

3.11 Quorum

3.11.1 No business shall be transacted at a meeting unless at least one-third of the whole number of the Chairman and Directors (including at least one Executive Director and one Non Executive Director) is present.

3.11.2 An Officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

3.11.3 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of a declaration of a conflict of interest (see Standing Order 7) that person shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

3.12 Voting

3.12.1 Save as provided in Standing Orders 3.l3 - Suspension of Standing Orders and 3.l4 - Variation and Amendment of Standing Orders, every question put to a vote at a meeting shall be determined by a majority of the votes of Directors present and voting on the question. In the case of an equal vote, the person presiding (i.e.: the Chairman of the meeting) shall have a second, and casting vote.

3.12.2 At the discretion of the Chairman all questions put to the vote shall be determined by oral expression or by a show of hands, unless the Chairman directs otherwise, or it is proposed, seconded and carried that a vote be taken by paper ballot.

3.12.3 If at least one third of the Directors present so request, the voting on any question may be recorded so as to show how each Director present voted or did not vote (except when conducted by paper ballot).

3.12.4 If a Director so requests, their vote shall be recorded by name.

3.12.5 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

3.12.6 A manager who has been formally appointed by the Board to act up for a Director during a period of incapacity or temporarily to fill a Director vacancy as an Acting Director or Interim Director under paragraph 4 and 5 respectively of Annex 10 of the constitution shall be entitled to exercise the voting rights of the Director.

3.12.7 A manager attending the Board meeting to represent a Director during a period of incapacity or temporary absence who is not an acting Director or an interim Director for the purposes of the Constitution may not exercise the voting rights of the Director. An Officer's status when attending a meeting shall be recorded in the minutes.

3.13 Suspension of Standing Orders

3.13.1 Except where this would contravene any provision in the Constitution, the License, any statutory provision, any binding guidance issued by Monitor, or the rules relating to the Quorum (Standing Order 3.11), any one or more of the Standing Orders may be waived at any meeting, provided that at least two-thirds of the whole number of the Directors are present (including at least one Executive Director and one Non Executive Director) and that at least two-thirds of those Directors present signify their agreement to such suspension. The reason for and decision to waive shall be recorded in the trust Board's minutes.

3.13.2 A separate record of matters discussed during the waiver of Standing Orders shall be made and shall be available to the Chairman and Directors of the trust.

3.13.3 The Audit Committee shall review every decision to suspend Standing Orders.

3.14 Variation and amendment of Standing Orders

3.14.1 These Standing Orders shall only be varied in accordance with paragraph 46 of the Constitution.

3.15 Record of Attendance

The names of the Chairman and Directors present at the meeting shall be recorded.

3.16 Minutes

The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they shall be signed by the person presiding at it.

No discussion shall take place upon the minutes except upon their accuracy or where the Chairman considers discussion appropriate.

3.17 Admission of public and the press

3.17.1 Board meetings shall be held in public but the whole or any part of a meeting may be held in private if the Board so resolves.

3.17.2 In that event members of the public and the press will be excluded from all or part of a Board meeting.

3.17.3 General disturbances

In the event that the public and press are admitted to all or part of a Board meeting pursuant to paragraph 3.17.1 and 3.17.2 above, the Chairman (or Deputy Chairman if one has been appointed) or the person presiding over the meeting shall give such directions as he thinks fit with regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the trust's business shall be conducted without interruption and disruption and, the public and/or press maybe required to withdraw from a Board meeting at any time and for any reason whatsoever.

3.17.4 Use of Mechanical or Electrical Equipment for Recording or Transmission of Meetings

Nothing in these Standing Orders shall be construed as permitting the introduction by the public, or press representatives, of recording, transmitting, video or similar apparatus into meetings of the trust or Committee thereof. Such permission shall be granted only upon resolution of the trust.

3.18 Observers at trust meetings

The trust will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the trust Board's meetings and may change, alter or vary these terms and conditions as it deems fit.

3.19 Meetings: electronic communication

3.19.1 In this SO, "electronic communication" means a communication transmitted (whether from one person to another, from one device to another or from a person to a device or vice versa): (a) by means of an electronic communications network; or (b) by other means but while in an electronic form.

3.19.2 A Director in electronic communication with the Chairman and all other parties to a meeting of the Board of Directors or of a committee or sub-committee of the Directors shall be regarded for all purposes as personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

3.19.3 A meeting at which one or more of the Directors attends by way of electronic communication is deemed to be held at such a place as the Directors shall at the said meeting resolve. In the absence of such a

resolution, the meeting shall be deemed to be held at the place (if any) where a majority of the Directors attending the meeting are physically present, or in default of such a majority, the place at which the Chairman of the meeting is physically present.

3.19.4 Meetings held in accordance with this SO are subject to SO 3.11 (Quorum). For such a meeting to be valid, a quorum must be present and maintained throughout the meeting.

3.19.5 The minutes of a meeting held in this way must state that it was held by electronic communication and that the Directors were all able to hear each other and were present throughout the meeting.

4. APPOINTMENT OF COMMITTEES AND SUB-COMMITTEES

4.1 Subject to the Constitution, the Board shall appoint committees of the Board, consisting wholly of Directors.

4.2 Appointment of Committees

Subject to the Constitution, the trust Board may appoint committees of the trust.

The trust shall determine the membership and terms of reference of committees and sub-committees and shall if it requires to, receive and consider reports of such committees.

4.3 Applicability of Standing Orders and Standing Financial Instructions to Committees

The Standing Orders and Standing Financial Instructions of the trust, as far as they are applicable, shall as appropriate apply to meetings and any committees established by the trust. In which case the term “Chairman” is to be read as a reference to the Chairman of other committee as the context permits, and the term “member” is to be read as a reference to a member of other committee also as the context permits. (There is no requirement to hold meetings of committees established by the trust in public.)

4.4 Terms of Reference

Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide and shall be in accordance with any legislation. Such terms of reference shall have effect as if incorporated into the Standing Orders.

4.5 Delegation of powers by Committees to Sub-Committees

Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board.

4.6 Approval of Appointments to Committees

The Board shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that

persons, who are neither members nor Officers, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board. The Board shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

4.7 Committees established by the trust Board

The committees and sub-committees established by the Board may vary from time to time as per operational requirements, legislation and best practice. Their terms of reference may be obtained from the Secretary to the trust.

4.8 The Board of Directors may appoint persons to serve as members on joint committees with the Council of Governors or committees of the Council of Governors on the request of the Chairman.

5. ARRANGEMENTS FOR THE EXERCISE OF TRUST FUNCTIONS BY DELEGATION

5.1 Delegation of Functions to Committees, Officers or other bodies

Subject to the Constitution and License and such guidance as may be given by Monitor, the Board may make arrangements for the exercise, on behalf of the Board, of any of its functions by a committee, sub-committee appointed by virtue of Standing Order 4, or by an Officer of the trust, in each case subject to such restrictions and conditions as the trust thinks fit.

5.2 Emergency Powers and urgent decisions

The powers which the Board has reserved to itself within these Standing Orders (see Standing Order 2.7) may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two non-Executive Directors. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the trust Board for noting.

5.3 Delegation to Committees

The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or subcommittees, which it has formally constituted in accordance with the Constitution, the License, binding guidance issued by Monitor and the 2006 Act. The Constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board in respect of its sub-committees.

5.4 Delegation to Officers

5.4.1 Those functions of the trust which have not been retained as reserved by the Board or delegated to other committee or sub-committee or joint-committee shall be exercised on behalf of the trust by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate Officers to undertake the remaining functions for which he/she will still retain accountability to the trust.

5.4.2 The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Finance Director to provide information and advise the Board in accordance with the Constitution, License and any statutory requirements, or provisions required by Monitor.

5.5 Schedule of Matters Reserved to the trust and Scheme of Delegation of powers

The arrangements made by the Board as set out in the "Scheme of Reservation and Delegation" of powers shall have effect as if incorporated in these Standing Orders.

5.6 Duty to report non-compliance with Standing Orders and Standing Financial Instructions

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board for action or ratification. All Directors of the trust Board and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

6. OVERLAP WITH OTHER TRUST POLICY STATEMENTS/PROCEDURES, REGULATIONS AND THE STANDING FINANCIAL INSTRUCTIONS

6.1 Policy statements: general principles

The trust Board will from time to time agree and approve Policy statements/ procedures which will apply to all or specific groups of staff employed by the trust. The decisions to approve such policies and procedures will be recorded in an appropriate trust Board minute and will be deemed where appropriate to be an integral part of the trust's Standing Orders and Standing Financial Instructions.

6.2 Specific Policy statements

Notwithstanding the application of Standing Order 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following Policy statements:

- the Standards of Business Conduct policy for trust staff;

- the staff Disciplinary and Appeals Procedures adopted by the trust both of which shall have effect as if incorporated in these Standing Orders.

6.3 Standing Financial Instructions

Standing Financial Instructions adopted by the trust Board in accordance with the Financial Regulations shall have effect as if incorporated in these Standing Orders.

6.4 Specific guidance

Notwithstanding the application of Standing Order 6.1 above, these Standing Orders and Standing Financial Instructions must be read in conjunction with the following guidance and any other binding guidance issued by Monitor:

- Caldicott Guardian 1997;
- Human Rights Act 1998;
- Freedom of Information Act 2000.

7. DUTIES AND OBLIGATIONS OF DIRECTORS UNDER THESE STANDING ORDERS

7.1 Declaration of Interests

7.1.1 Requirements for Declaring Interests and applicability to Board Directors

(a) All existing Board Directors should declare any relevant and material interests. Any Director appointed subsequently should do so on appointment.

7.1.2 Interests which are relevant and material

(a) Interests which should be regarded as "relevant and material" are defined under paragraph 34 of the Constitution.

(b) Any Director who comes to know that the trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in Standing Order 7.3 below and elsewhere) has any pecuniary interest, direct or indirect, the Director shall declare his/her interest by giving notice in writing of such fact to the trust as soon as practicable.

7.1.3 Advice on Interests

If Board Directors have any doubt about the relevance of an interest, this should be discussed with the Chairman or with the Secretary.

Financial Reporting Standard No 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of an interest. The interests of partners in professional partnerships including general practitioners should also be considered.

7.1.4 Recording of Interests in trust Board minutes

At the time Directors' interests are declared, they should be recorded in the trust Board minutes.

Any changes in interests should be declared at the next trust Board meeting following the change occurring and recorded in the minutes of that meeting.

7.1.5 Publication of declared interests in Annual Report

Board Directors' Directorships of companies likely or possibly seeking to do business with the NHS should be published in the trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

7.1.6 Conflicts of interest which arise during the course of a meeting

During the course of a Board meeting, if a conflict of interest is established, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

7.2 Register of Interests

7.2.1 The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board or Committee Directors. In particular the Register will include details of all directorships and other relevant and material interests (as defined in SO 7.1.2) which have been declared by both executive and non-executive trust Board Directors.

7.2.2 These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

7.2.3 The Register will be available to the public and the Chief Executive will take reasonable steps to bring the existence of the Register to the attention of local residents and to publicise arrangements for viewing it.

7.3 Exclusion of Chairman and Directors in proceedings on account of pecuniary interest

7.3.1 Definition of terms used in interpreting 'Pecuniary' interest

For the sake of clarity, the following definition of terms is to be used in interpreting this Standing Order:

(a) "spouse" shall include any person who lives with another person in the same household (and any pecuniary interest of one spouse shall, if known to the other spouse, be deemed to be an interest of that other spouse);

(b) "contract" shall include any proposed contract or other course of dealing.

(c) "Pecuniary interest"

Subject to the exceptions set out in this Standing Order, a person shall be treated as having an indirect pecuniary interest in a contract if:-

(i) he/she, or a nominee of his/her, is a member of a company or other body (not being a public body), with which the contract is made, or to be made or which has a direct pecuniary interest in the same, or

(ii) he/she is a partner, associate or employee of any person with whom the contract is made or to be made or who has a direct pecuniary interest in the same.

(d) Exception to Pecuniary interests

A person shall not be regarded as having a pecuniary interest in any contract if:-

(i) neither he/she or any person connected with him/her has any beneficial interest in the securities of a company of which he/she or such person appears as a member, or

(ii) any interest that he/she or any person connected with him/her may have in the contract is so remote or insignificant that it cannot reasonably be regarded as likely to influence him/her in relation to considering or voting on that contract, or

(iii) those securities of any company in which he/she (or any person connected with him/her) has a beneficial interest do not exceed £5,000 in nominal value or one per cent of the total issued share capital of the company or of the relevant class of such capital, whichever is the less.

Provided however, that where paragraph (iii) above applies the person shall nevertheless be obliged to disclose/declare their interest in accordance with Standing Order 7.1.2 (ii).

7.3.2 Exclusion in proceedings of the trust Board

(a) Subject to the following provisions of this Standing Order, if a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board at which the contract or other matter is the subject of consideration, they shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

(b) The Board may exclude a Director from a meeting of the Board while any contract, proposed contract or other matter in which he has a pecuniary interest is under consideration.

(c) Any remuneration, compensation or allowance payable to a Director.

(d) This Standing Order applies to a committee or subcommittee as it applies to the trust.

7.4 Standards of Business Conduct

7.4.1 Trust Policy

All trust staff and Directors must comply with the trust's Standards of Business Conduct Policy. This section of standing orders shall be read in conjunction with this document.

7.4.2 Interest of Officers in Contracts

(a) Any Officer or employee of the trust who comes to know that the trust has entered into or proposes to enter into a contract in which he/she or any person connected with him/her (as defined in SO 7.3) has any pecuniary interest, direct or indirect, the Officer shall declare their interest by giving notice in writing of such fact to the Chief Executive or trust's Secretary as soon as practicable.

(b) An Officer should also declare to the Chief Executive any other employment or business or other relationship of his/her, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the trust.

(c) The trust will require interests, employment or relationships so declared to be entered in a register of interests of staff.

7.4.3 Canvassing of and Recommendations by Directors in Relation to Appointments

(a) Canvassing of Directors or of any Committee of the trust directly or indirectly for any appointment under the trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

(b) Directors shall not solicit for any person any appointment under the trust or recommend any person for such appointment; but this paragraph of this Standing Order shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the trust.

7.4.4 Relatives of Directors or Officers

(a) Candidates for any staff appointment under the trust shall, when making an application, disclose in writing to the trust whether they are related to any Director or the holder of any office under the trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him liable to instant dismissal.

(b) The Chairman and every Director and Officer of the trust shall disclose to the Board any relationship between himself and a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the trust Board any such disclosure made.

(c) On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the trust whether they are related to any other Director or holder of any office under the trust.

(d) Where the relationship to a Director/Officer of the Trust is disclosed, the Standing Order headed 'Disability of Chairman and Directors in proceedings on account of pecuniary interest' (Standing Order 7) shall apply.

8. CUSTODY OF SEAL, SEALING OF DOCUMENTS AND SIGNATURE OF DOCUMENTS

8.1 Custody of Seal

The common seal of the trust shall be kept by the Chief Executive or a nominated Officer by him/her in a secure place.

8.2 Sealing of Documents

Where it is necessary that a document shall be sealed, the seal shall be affixed in the presence of two Directors or a Director and the Secretary duly authorised by the Board.

8.3 Register of Sealing

The Chief Executive shall keep a register in which he/she, or another manager of the Authority authorised by him/her, shall enter a record of the sealing of every document.

8.4 Signature of documents

Where any document will be a necessary step in legal proceedings on behalf of the trust, it shall, unless any enactment otherwise requires or authorises, be signed by the Chief Executive or any Executive Director.

In land transactions, the signing of certain supporting documents will be delegated to Officers and set out clearly in the Scheme of Delegation but will not include the main or principal documents effecting the transfer (e.g. sale/purchase agreement, lease, contracts for construction works and main warranty agreements or any document which is required to be executed as a deed).

ANNEX 9 – STATEMENT OF TRUST PRINCIPLES

The West Suffolk NHS Foundation Trust will operate within a governance framework which reflects best practice within the NHS. In particular it will adopt the seven principles of public life, determined by the Nolan Report. It will also from time to time develop mission statements, corporate values, codes of conduct and other governance statements.

Nolan Principles: - the seven principles of public life

1. **Selflessness**: Holders of public office should take decisions solely in terms of the public interest. They should not do so to gain financial or other material benefit for themselves, their family or their friends.

2. **Integrity**: Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might influence them in the performance of their official duties.

3. **Objectivity**: In carrying out public business, including making public appointments, awarding contracts or recommending individuals for rewards and benefits, holders of public office should make choice on merit.

4. **Accountability**: Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

5. **Openness**: Holders of public office should be as open as possible about all the decisions and actions they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

6. **Honesty**: Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

7. **Leadership**: Holders of public office should promote and support these principles by leadership and example.

ANNEX 10 – FURTHER PROVISIONS

1. Trust Secretary

1.1 The trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Chief Executive or the Finance Director.

1.2 Minutes of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept by the Secretary.

1.3 The Secretary is to be appointed and removed by the Chairman and Chief Executive acting jointly.

2. Vacancy of Governor or Director position

2.1 The validity of any act of the trust is not affected by any vacancy among the Directors or the Governors or by any defect in the appointment of any Director or governor.

3. Absent Director

3.1 If:

3.1.1 an Executive Director is temporarily unable to perform his/her duties due to illness or some other reason (the "Absent Director"); and

3.1.2 the Board of Directors agree that the duties of the Absent Director need to be carried out;

then the Chairman (if the Absent Director is the Chief Executive) or the Chief Executive (in any other case) may appoint an acting Director as an additional Director to carry out the Absent Director's duties temporarily.

3.2 For the purposes of paragraph 3.1 of this Annex, the number of Directors appointed under paragraph 23.2.3 of the Constitution shall be relaxed accordingly.

3.3 The acting Director will vacate office as soon as the Absent Director returns to office or, if earlier, the date on which the person entitled to appoint him under this paragraph notifies him that he is no longer to act as an acting Director.

3.4 The acting Director shall be an Executive Director for the purposes of the 2006 Act. He shall be responsible for his/her own acts and defaults and he shall not be deemed to be the agent of the Absent Director.

4. Vacant Positions

4.1 If:

4.1.1 an Executive Director post is vacant ("Vacant Position"); and

4.1.2 the Board of Directors agree that the Vacant Position needs to be filled by an interim postholder pending appointment of a permanent postholder, then the Chairman (if the Vacant Position is the Chief Executive) or the

Chief Executive (in any other case) may appoint a Director as an interim Director ("Interim Director") to fill the Vacant Position pending appointment of a permanent postholder.

4.2 The Interim Director will vacate office on the appointment of a permanent postholder or, if earlier, the date on which the persons entitled to appoint him under this paragraph notifies him that he is no longer to act as an Interim Director.

4.3 The Interim Director shall be an Executive Director for the purposes of the 2006 Act.

5. Title of "Director"

5.1 The trust may confer on senior staff the title "Director" as an indication of their corporate responsibility within the trust but such persons will not be Directors of the trust for the purposes of the 2006 Act ("statutory Directors") unless their title includes the title "Chief" or "Executive" or "Non Executive Director" or "Chair" or "Chairman" and will not have the voting rights of statutory Directors or any power to bind the trust.

6. Disqualification of membership

6.1 An individual may not become or continue as a member of the Trust if:

6.1.1 the individual has been specifically excluded in writing from any of the Trust's premises or other facilities in whole or in part following a decision of the Board of Directors that such a course of action is necessary because, for example, the individual concerned has been violent, aggressive or has committed an act of gross misconduct; or

6.1.2 the Board of Directors considers that an individual has or is likely to cause harm or detriment to the Trust and after the Trust has consulted with or made reasonable efforts to consult with the individual about the concerns of the Board and the Board notifies the individual about his disqualification accordingly.

6.2 Notwithstanding anything contained in this Constitution, no person who ceases to be a member of the Trust pursuant to paragraph 6.1.1 or 6.1.2 above shall be re-admitted to membership except by a decision of the Board of Directors.

6.3 It is the responsibility of Members to ensure their eligibility and not the trust, but if the trust is on notice that a Member may be disqualified from membership, they shall carry out all reasonable enquiries to establish if this is the case.

7. Termination of membership

7.1 A member shall cease to be a member if that member:

7.1.1 resigns by notice to the Secretary or the Chief Executive;

7.1.2 ceases to fulfill the requirements of paragraph 6 or 7 of the Constitution;

7.1.3 is disqualified under any other provision of this constitution;

7.1.4 dies; or

7.1.5 the Council of Governors, having made reasonable enquiries, determines that the member no longer wishes to be a member or he ceases to be eligible as a member for whatever reason.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 27 January 2017

AGENDA ITEM:	Item 18
PRESENTED BY:	Dr Stephen Dunn, Chief Executive
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	20 January 2017
SUBJECT:	Trust Executive Group (TEG) report
PURPOSE:	Information

EXECUTIVE SUMMARY:

16 January 2017

Steve Dunn provided an update including a reflection on the intense **operational pressure** during Christmas and January and the excellent response from staff to respond to the 20% increase in activity compared to the same period last year. TEG considered key short term priorities to be addressed including: improving red-to-green compliance and patient flow (with impact on quality, operational and financial performance); controlling agency spend; and managing nurse vacancies.

Jon Green reported on the **4 hour wait performance** within the Trust and comparison within the region. While our performance had been below expectation (mid 80%) this had been better than many other trusts who had been forced to escalate into areas not usually used for acute inpatient beds. It was noted that there had been considerable national press coverage on this issues and performance.

A report was received from the **Flow Action Group (FLAG)** emphasis remained on Red to Green Board Rounds and ensuring these take place each day in all areas. Super users are being used to support effective roll out of board rounds. Progress in other areas was reviewed and updates received.

Craig Black gave an update on the **financial position**. It had highlighted that we have failed to achieve the required cost improvement programme to achieve the year end forecast and as a result we would not now receive all of the transformation funding. A meeting has been scheduled for early February with NHSI to review the Trust's position and year end forecast this could result in the Trust being placed in the 'distressed financial regime', impacting on the capital programme and funding.

A review of the **staff escalation policy** was received which had been updated to for staff at Newmarket and Glastonbury court.

TEG approved in principle the recommendation to developed electronic **clinical activity management, e-rostering and e-job planning**. It was agreed that the proposal be brought back to TEG for a clinically and administratively led case to support the benefits realisation and procurement.

The action plan in response to the **trauma peer review** were received. Nick Jenkins confirmed that he would chair the trauma group in the future. Issues identified in the review would inform the theatre capacity review which is current being undertaken.

Annie Campbell confirmed that the executive directors had approved the business case to improve staffing and the environment for the care of **paediatric patients** within the Emergency Department.

Ali Bailey presented the draft **communications strategy** for review and comment. The communications team will be working with divisions to support delivery of the plan and campaigns for the year.

Linked Strategic objective (link to website)	To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by:	N/A
Risk description: (including reference Risk Register and BAF if applicable)	N/A
Description of assurances:	N/A
Legislation / Regulatory requirements:	N/A
Other key issues:	None
Recommendation: To note the report	

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 27 January 2017

AGENDA ITEM:	Item 19
PRESENTED BY:	Roger Quince, Chairman
PREPARED BY:	Georgina Holmes, Foundation Trust Office Manager
SUBJECT:	Council of Governors report – 16 November 2016
PURPOSE:	Information

EXECUTIVE SUMMARY:

This report provides a summary of the business considered at the Council of Governors meeting held on 16 November 2016. The report is presented to the Board of Directors for information to provide insight into these activities. Key points from the meeting were:

- Charles Nevitt was welcomed as a new Public Governor and Nick Jenkins as the new Medical Director for the Trust.
- The Chief Executive provided an update on the challenges facing the Trust and recent achievements.
- Responses to the issues raised by Governors were noted. A proposal for Governor training/development was agreed.
- The quality and performance and finance reports were reviewed and questions asked on areas of challenge.
- A presentation was received from Nick Jenkins, Medical Director on his background and experience and his aspirations in his new role.
- The CQC inspection report and action plan was noted and accepted.
- An update was given on STP and the ACO from Richard Watson, Chief Redesign Officer for the CGG and Dawn Godbold, Director of Operations for Community Services.
- The NHSI Planning Guidance was noted and two Governors volunteered to act as readers and comment on the final plan.
- A report on the review of the constitution and role of the Lead Governor was received. The recommendations were approved, subject to further discussions on the role of the Lead Governor at the informal Governors meeting on 26 January 2017.
- It was noted that the election for a Lead Governor would take place at the Council of Governors meeting on 8 February 2017.
- Reports from the Engagement Committee and Staff Governors were received.

Linked Strategic objective (link to website)	6. To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by: (e.g. committees or forums)	Report received by the Board of Directors for information to provide insight into the activities and discussions taking place at the governor meetings.
Risk description:	Failure of Directors and Governors to work together effectively.

Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Representation of Directors at Council of Governor meeting and vice versa. Joint workshop and development sessions. Workshop in September to consider future working between NEDs and Governors.
Legislation / Regulatory requirements:	Health & Social Care Act 2012. Monitor's Code of Governance.
Other key issues:	
Recommendation: The Board is asked to receive the above report for information	

ITEM 20

MINUTES OF THE CHARITABLE FUNDS COMMITTEE

Held on Friday 25 November, 2016,
Commencing at 2.00 p.m. in the Committee Room,
West Suffolk NHS Foundation Trust

COMMITTEE MEMBERS				
			Attendance	**Apologies**
Roger Quince (Chair)	**(RQ)**	Chairman	X	
Craig Black	**(CB)**	Executive Director of Resources	X	
Jon Green	**(JG)**	Chief Operating Officer		X
Gary Norgate	**(GN)**	Non-Executive Director	X	
Jan Bloomfield	**(JB)**	Executive Director Workforce & Communications	X	
In attendance				
Steve Dunn	**(SD)**	Chief Executive Officer	X	
David Swales	**(DS)**	Assistant Director of Finance		X
Louise Wishart	**(LW)**	Assistant Director of Finance, Acting	X	
Margaret Pawsey	**(MP)**	Charitable Funds Accountant/Administrator	X	
Sue Smith	**(SS)**	Fundraising Manager	X	
Sally Daniels	**(SDa)**	Fundraising Officer		X
Ali Bailey	**(AB)**	Communications Manager	X	
Elaine Phillips	**(EP)**	Temporary PA, Trust Office	X	

ACTION

1. **Apologies**

Apologies as detailed above.

2. **Minutes of the Previous Meeting**

The Minutes of the meeting held on 26 August, 2016 were accepted as a true and accurate record, subject to inclusion, under attendees, of SD.

3. **Matters Arising Action Sheet**

CB had not spoken to Black Rock, but intending to very shortly. Need to get an external view on where the market is, so that was the final action point regarding strategy on liquidating our investments. CB to report back at next meeting. If there is anything that comes out of that discussion, before our next meeting, Craig will circulate by email. **CB**

4. **Fundraising Report**

RQ commented that we had just received interesting update news. LW advised that since the legacies report was written, we have received three legacies:
Joan Aldous £7,145.94
Thelma Harries £161, 744.02
Philip Bowers £360,424.55.
These come under general purpose.

All agreed this was brilliant news. SD asked if we can publicise the generosity.

JB advised that we would go back to the Estate and talk through with them how they wish to handle. RQ asked if this was not possible, could a general legacy with three amounts be lumped together? Confirmed this would be possible.

SD suggested that we use the human interest story of what care was received, the reasons for the donation and how we use the money. Bring to the attention of others via Bury Free Press and local outlets for getting the message out and continue why it is important to do this.

JB commented that the most important thing to look at is what we substantially spend to make a link as to what the legacy did. There is a tendency with the General trust fund to be frittered. RQ asked if we can look at what we are spending money on. CB can provide details and then ask AB to construct comms line. **CB/AB**

AB commented on her experiences at Southampton, which had more legacies than us and had a long running legacies campaign with the actress Susan George. Legacies tend to withstand economic crises better than fundraising. JB commented that perhaps we could use Laura Wright, who she says, the hospital saved when she was 6. She is the official songstress for rugby and also does a lot of impressive events.

It was noted that all the plans, apart from the Charity Auction, were all health related and added that we need to do more so with Occupational Health team, so we can promote the benefits.

There was a discussion regarding the marathon which has not been done in Bury before, so well done to Sue for getting in early. It will be part of the Festival of Sport and split with us and Town Pastors. There will be a family run, a 10k, half and full marathon, all on the same day. Was all under the Town Pastors, but we managed to convince them to split. SS advised that there is no financial obligation to us.

It was asked if we can brand – sold as the Great East Run. We as the charity noted this project was too big for us. Sally and Sue have no experience, whereas this way it is all organised for us. AB commented that the Great Run Series is a big exercise and would be surprised if no copyright. SD asked if we could find out quickly. CB advised that there is a Great Eastern Run in Peterborough.

LW asked how the marathon will be administered. She understood that the auction has been previously administered by us and we pay out share at the end, however this year someone else will administer and we will get our share. How do we know we have received what we should have done? SS advised that the organiser has set out a contract, he has an account and we will see a copy of the bank accounts. JB to audit auction and something similar will be in place for marathon, audited by BDO, although as we are not putting anything in for the marathon, it will also protect our name, should anything go wrong.

SD questioned if we were still having the It's a Bury knockout. The feedback was that people love it and so is still going ahead.

RQ asked if we were doing anything with the Christmas Fayre. JB commented that only one charity are allowed to hold buckets. St Edmundsbury are the organisers. SD suggested that we start conversations early for next year, so that we can promote the legacy and the charity. JB advised that we have been bucket holders before. It will be good to promote the charity and also the legacies.

SS advised that we have been nominated for a Health Business Award in London on Tuesday 29th November for the NHS publicity campaign, which was for the Memory Walk.

Actions

1	We are planning to investigate publicity around recent legacies, whether tied to individuals or in general, yet to be determined.	**SS**
2	Investigate whether we can persuade St Edmundsbury for priority on buckets for next year's fayre.	**SS**
3	SD asked if thank you letter to Nikkos could be written. SS advised that letters to come from Chairman and Chief Executive for major donor category were already planned.	**SS**

5. **Financial Report Period Ending 30 September, 2016**

Taken as read

GN asked if we could look at cash and whether a better option. CB to discuss with Black Rock. If advised to do something quickly, will email committee if that is the course of action. Item 3 of today's meeting refers. **CB**

6. **Investment Report as at 30 September, 2016**

Nil to report.

7. **New Fund Applications**

LW advised that she has been contacted by some Orthopedic consultants who are involved in the East Anglian Orthopedic Club. They are considering if they want to come in as a trust fund rather than a club. No further update, as they haven't made a final decision.

SD raised that we have £1.6m in cash and potentially c£500k extra with no bids against these funds and asked if we are clear on what we want to spend money on? Do we deplete the fund or spend? CB commented that most of the funds are not held as general, particularly oncology and maternity. We encourage them to spend as quickly as possible, as people don't donate money for it to sit in a bank account. We need to consider what to do with the funding.

RQ advised that on the Quality walkabout in Rainbow Ward (F002) on Tuesday,

although they have lots of dedicated money, it looks tattered and cluttered. Several pushchairs were up and taking up all the space. When asked if they could be moved, they were advised there was no space. They have £26,000 which could be spent.

An interesting debate followed with regards to sign off of funds. JB stated that people genuinely think they revere their trust fund and that it has to be special to spend money. There is no harm sitting with the manager to discuss how to spend the money. People think that trust funds should go on items the NHS shouldn't pay for. We mustn't alienate the people working in these areas, as these are the people who make the donations happen.

SD advised that we need rules as trustees on how we spend money to assure spend in accordance with process. LW commented that as there have been legal challenges, it does have to be charitable and something over and above what the NHS would pay for.

SD asked if we can have a process and discussion with fund holders. We can invite them to be party to the decision. If we had a collective discussion with fund holders, we could come to a considered view. We don't need to impose, but make sure money is used.

SS advised that they speak to donors many times a week before donating. Ward managers are contacted every week and we rarely get feedback to what they need. Staff don't engage us enough to sell back to the donors.

A proposal was put forward by SD to address issues, which may be the way forward. This should be noted in the Charity Strategy and perhaps Charity Stars can help us prioritise? SD to action. **SS**

AB suggested that we could have £100k of legacy money to put up bids for staff to find a panel of people. JB suggested writing to General Managers because the Friends have £41k and want bids of up to £5k. SS to action. AB suggested we could also fund match. **SS**

8. **Funds Closed**

Nil.

9. **Trust Fund Bids**

LW advised that she had a VAF form for the yearly renewal of a Cancer counsellor (currently in post). This will be using McMillan monies, whereby it was previously paid by trust fund, although the Bobby Robson funds have now dried up. There was some confusion if one or two posts, but confirmed and supported in the meeting that it was one post.

10. **Current Fund Balances**

Nothing to report

11. **Approval Arrangements for 2015/16 Annual Report & Statement of Accounts**

LW advised that we are trying to involve fundraising more this year in the drafting of the annual report before it comes for approval. There is a new SORP (Statement of Recommended Practice). We are audited and approval is by the end of January. The work is done virtually and sent round electronically. We use the trust auditors, we don't need a full audit, but we do need to produce a full set of accounts as we are considered a larger charity. The cost of audit is c£6k.

12. **Any Other Business**

JB had already mentioned that the Friends have opened up £41k to enable bids by February. They have just invested in another paid member of staff in the shop, because they are gearing themselves up to WH Smiths eventually going. They gave us £37k last year. We don't charge them rent and it is run by volunteers, but there is a paid Manager and Assistant. They get lots of small legacies and have historically been the main recipient of legacies.

The fundraising strategy paper as presented by AB was discussed in depth.

AB advised that the document has not changed from the last meeting. There is at least a doubling or trebling of income based on the investment in 2 people working full time in fundraising. They have paid back cost from 2012/13 onwards.

PEST analysis / SWOT analysis

No comments

Competitor analysis

SD was surprised that we are bigger than Ipswich, but dwarfed by St Nicholas, EACH and Addenbrookes. RQ commented that it was all a question of image and brands.

A patient, whom RQ knew, was in F8 and F7 and his family were very impressed with the care the healthcare assistant showed to him and family. At the funeral, there was a note with a request for no flowers, but donations to McMillan (who visited him once) and St Nicholas, with whom they had no contact.

St Nicholas's care is 75% funded by the state. They only have 12 beds with limited use. The hospice have 12 charity staff.

Addenbrookes figures are quite inflated in terms of their income as they lease their scanners. The Charity buys them and lease back to hospital, which is nearly half the income. They put a lot of R&D through the charity. They have 22 charity staff.

Vision

SS advised of a major plan to start building from low donors to mid donors to become our legacy, which will have a huge impact in future.

RQ asked if legacies have proved to be quite a big element, why don't we have a target including legacies?

CB advised that whatever target we would have set, we have hit today. Discussions we have had in the past is that we do need to do something in order to target future legacies, but when we've assessed the effectiveness of the investment in fundraising team, it has been looking at growth in donations, which has in fact doubled since taking on extra staff.

SS advised that as a fundraising team, the only way to increase major donors, grants and legacies is to get more staff. We physically do not have enough manpower to concentrate on one specific area. Donors need to have had a care plan and we need to nurture donors. We therefore need resource and physical hours to focus.

CB asked what they had spent most time on in the last 3 months. We make choices on time allocation. Judgement as to the best use of that time and it may be Major donors would be a better use of time. AB added that we should be targeting £100k plus donations. You need to run an appeal of £500k for those amounts. The Trust has to work closely with charity. JB commented that the hospice do community stuff to keep their name out there, as well as targeting major donors. You have to do both.

RQ suggested coming back with a proposal for increasing staff. We need to know what they are doing, what their targets are and what they are aiming to achieve. SS to action. **SS**

Strategic Objective 1

JB commented that the aim is to come back with a properly costed and targeted plan, so that we will raise that amount.

JB added that for governance, there needs to be a connection between Finance and the fundraising team to encourage more donations. LW has spoken to AB and SS this week. There has been a lack of information flow, but this is easy to remedy.

Objectives:

1. Increase money in funding target
2. Raise profile
3. Engage staff

SD summarised that this is an aspiration for our charity to communicate with local community and donors. We need to ask for detail on actions on a costed basis coming through the charity committee, which then becomes the work programme to take forward. We can then tie that into a possible investment in team. SS to action. **SS**

SD suggested that we agree the Charities next three capital appeals with the Charitable Funds Committee. RQ added that there is a very clear steer to the Cath Lab. If you put a particular cardiologist on the TV, money would flow in. We would do the capital works and the equipment would be funded by the charity. The rule of thumb is 10-20%. SD added we need to prioritise and asked what is the fundraising approach to the Cath lab? SS to action in time for next meeting. **SS**

SD asked if we need naming rights for the new building. Do we sell the name for the new building? A discussion then followed and it was felt that this needed to be a separate discussion.

Objective 2

RQ stated that he would prefer there to be a figure and a date by, rather than a % figure.

AB advised that community fundraising is a low return compared to capital appeal for the investment in staff. 5% is to grow community fundraising, based on the current staff we have, which is a fair challenge for team. Had we invested in staff earlier, it might not have been so bad. If an appeal is brought in, a capital appeal generates so much publicity and increases revenue for charity for years and years.

Proposal accepted, but subsequent submissions needed for capital programmes.

AB said we haven't had enough detailed information on targeting. Do we have clear targets for every event? Major donors want to know what you are spending on. We have had no monitoring. LW said systems are in place, but communication is needed. RQ said we have been very coy on admitting how much we are spending. Will now be showing what we are spending in the accounts.

JB asked from a governance perspective, as we have agreed the strategy, should it go to closed board? As all board members are trustees. RQ happy to circulate to all board members by email saying the strategy has been agreed by charitable funds committee.

Action to bring back work plan – AB **AB**

AB asked if we can add an agenda item to next meeting that we review recent changes to regulation of fundraising. **RW**

13. Reflection on Meeting

No reflections were noted.

14. Dates of Future Meetings

3rd March – 3.00 – 4.30
26th May – 2.00 – 4.00
29th September – 2.00 – 4.00
24th November – 2.00 – 4.00

The meeting closed at 3.23pm

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 27 January 2017

ITEM NO:	Item 20
PRESENTED BY:	Craig Black, Executive Director of Resources
PREPARED BY:	Ruth Williamson, PA
DATE PREPARED:	20 January, 2017
SUBJECT:	Charitable Funds Committee Report
PURPOSE:	To approve recommendations from the meeting held on 25 November, 2016
STRATEGIC OBJECTIVE:	To demonstrate first class corporate, financial and clinical governance, underpinned by effective business support systems

EXECUTIVE SUMMARY:

The Charitable Funds Committee met on 25 November, 2016. The key issues and actions discussed were:-

- The Committee agreed to obtain an external view of market conditions to enable an informed decision to be made as to whether to reinvest fund assets.
- Receipt of three generous legacies was gratefully acknowledged.
- The Fundraising Report advised that the Trust had been nominated for a Health Business Award for the NHS publicity Campaign, in respect of the Memory Walk.

Matters resulting from recommendations in this report	**Present**	**Considered**
Financial Implications	N/A	N/A
Workforce Implications	N/A	N/A
Impact on Equality and Diversity impact	N/A	N/A
Legislation, Regulations and other external directives	N/A	N/A
Internal policy or procedural issues	Yes	Yes

Risk Implications for West Suffolk Hospital (including any clinical and financial consequences):	**Mitigating Actions**
N/A	N/A

Level of Assurance that can be given to the Committee from the report based on the evidence [significant, sufficient, limited, none]: Significant

Recommendation to the Committee:

The Trust Board is asked to consider the report of the Charitable Funds Committee

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 27 January 2017

AGENDA ITEM	Item 21
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Georgina Homes, Foundation Trust Office Manager
DATE PREPARED:	19 January 2017
SUBJECT:	Declaration of interest summary report
PURPOSE:	For Information

EXECUTIVE SUMMARY:

The register of directors' interests is formally reviewed and updated on an annual basis. At each Board meeting declarations are also received for items to be considered.

Matters resulting from recommendations made in this report	**Present**	**Considered**
Financial Implications	No	
Workforce Implications	No	
Impact on Equality and Diversity impact	No	
Legislation, Regulations and other external directives	Yes	Yes
Internal policy or procedural issues	Yes	Yes
Risk Implications for West Suffolk Hospital (including any clinical and financial consequences):	**Mitigating Actions** (Controls):	

Level of Assurance that can be given to the Committee from the report based on the evidence [significant, sufficient, limited, none]: Significant

Recommendation to the Committee:

1. To note the updated declaration of interests report.

West Suffolk NHS
NHS Foundation Trust

REGISTER OF DIRECTORS' INTERESTS

The Codes of Conduct and Accountability for NHS Trusts requires all Trusts to draw up and maintain a register of director's interests. This register consequently lists all interests, defined by the Codes as relevant and material for all its Board and non-Board directors.

The definition of interests is as follows:

- Directorships held in private companies or plcs.
- Ownership or part ownership of private companies, businesses or consultancies, likely or possibly seeking to do business with the NHS.
- Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or a voluntary body in the field of health and social care.
- Any connection with a voluntary or other body contracting for NHS services.

	Declared Interest	Date Reviewed / Amended
Trust Chairman		
Roger Quince	Non-Executive Director, SQW Group Ltd (subsidiaries are SQW Ltd and IO Services) Chair, Theatre Royal Bury St Edmunds Management Committee Trustee, Emmaus Ipswich Ltd	27 January 2017
Non Executive Directors		
John Benson	General Practitioner, York St Medical Practice, York St, Cambridge (shortly moving to a Practice in Worcester) University Senior Lecturer in the Primary Care Unit, University of Cambridge (Involved in medical education research, Investigator on National Institute for Health Research grants, research collaboration with RAND Europe) Director of the GP Education Group within the Primary Care Unit, the team responsible for organisation, delivery and quality assurance of Cambridge medical student teaching in General Practice	27 January 2017
Neville Hounsome	Director NH Transitions	27 January 2017
Gary Norgate	I hold an executive position with BT Plc which is a regular provider of various services to the NHS. I am not a formal member of the Plc Board.	27 January 2017

	Declared Interest	Date Reviewed / Amended
Steven Turpie	Owner and Director of ASD1 Limited, Management Consultancy - Does not and has not ever provided services to the NHS. Some clients of ASD1 Limited have provided services to the NHS. Chair of Trustees for Brightstars, a registered charity that supports 5-19 year old children and young people with additional needs.	27 January 2017
Rosie Varley	Governor: St Benedict's School Bury St Edmunds Chair of Trustees : SENDAT (Special Educational Needs and Disability Academy Trust) Chair: General Dental Council Appointments Committee OCPA Public Appointments Assessor Member : Mental Health Review Tribunal Member : Personal Independence Payment Tribunal	27 January 2017
Chief Executive		
Stephen Dunn	Visiting Professor of Health Policy London School of Economics Visiting Professor of Economics Business School University of West England Trustee, Brightstars a registered charity that supports 5-19 year old children and young people with additional needs. Honorary Commander 48th Surgical Operations Squadron, RAF Lakenheath	27 January 2017
Executive Directors		
Craig Black	Wife – Marie McCleary, is Director of Finance for Havebury Housing Association	27 January 2017
Jan Bloomfield	Patron, Suffolk West NHS Retirement Fellowship Co-opted Governor, West Suffolk College Board Governor, Radio West Suffolk RWSfm-103 Governor – Sybil Andrews Academy	27 January 2017
Pam Chrispin *(left WSFT 16/11/16)*	Chair, Suffolk Accident Rescue Service. Senior HEMS Consultant, East Anglian Air Ambulance	29 January 2016
Jon Green	Parish Councillor for Nowton Parish Council	27 January 2017

	Declared Interest	Date Reviewed / Amended
Nick Jenkins *(joined WSFT 3/11/16)*	Executive Director, National Physician Associate Expansion Programme, Hillingdon Hospitals NHS FT	27 January 2017
Rowan Procter	Nil	27 January 2017
Trust Secretary		
Richard Jones	Director of Friars 699 Limited (which changed its name to "The Pathology Partnership Limited") Trustee of Brockley Village Hall Charitable Trust Councillor of Brockley Parish Council	27 January 2017

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 27 January 2017

AGENDA ITEM:	Item 22
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	20 January 2017
SUBJECT:	Items for next meeting
PURPOSE:	Approval

EXECUTIVE SUMMARY:

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

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

Linked Strategic objective (link to website)	6. To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by: (e.g. committees or forums)	The Board received a monthly report of planned agenda items.
Risk description: (including reference Risk Register and BAF if applicable)	Failure effectively manage the Board agenda or consider matters pertinent to the Board. .
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.
Legislation / Regulatory requirements:	
Other key issues:	

Recommendation:

To approve the scheduled agenda items for the next meeting

Scheduled draft agenda items for next meeting – 3 March 2017

DESCRIPTION	OPEN	CLOSED	TYPE	SOURCE	DIRECTOR
Declaration of interests	✓	✓	Verbal	Matrix	All
Patient story		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
DELIVERY FOR TODAY					
Quality presentation – report from Flow Action Group (FLAG)	✓		Written	Matrix	NJ
Quality & performance report, including consultant appraisal (quarterly)	✓		Written	Matrix	JG/RP
Finance & workforce performance report	✓		Written	Matrix	CB
Community services – report from Provider Management Group	✓		Written	Matrix	CB
Red risk report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP					
CQC action plan	✓		Written	Action	SD
Aggregated quality report	✓		Written	Matrix	RP
Nurse staffing report	✓		Written	Matrix	RP
Stroke option report	✓		Written	Matrix	JG
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
BUILD A JOINED-UP FUTURE					
Communications Strategy	✓		Written	Action point - schedule	JB
e-Care report	✓		Written	Action point - schedule	CB
Hospital concourse proposal	✓		Written	Action point - schedule	CB
Scrutiny Committee report		✓	Written	Matrix	GN
Operational plan 2017-19	✓		Written	Matrix	SD
Strategic update, including STP, ICO and TPP		✓	Written	Action point - schedule	SD
GOVERNANCE					
Trust Executive Group report	✓		Written	Matrix	SD
Audit Committee report	✓		Written	Matrix	RQ
Board Assurance Framework (BAF) report – carried forward		✓	Written	Matrix	RJ
Staff suspension report		✓	Written	Matrix – by exception	JB
Annual governance review report		✓	Written	Matrix	RJ
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	RQ