West Suffolk NHS
NHS Foundation Trust

Board of Directors

A meeting of the Board of Directors will take place on Friday, **3 March 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 27 January 2017	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.	**Flow Action Group (FLAG) (attached)** To receive a report on action to improve patient flow	Nick Jenkins
9.	**Quality & Performance reports (attached)** To receive the report	Jon Green / Rowan Procter
10.	**Finance & Workforce Performance report (attached)** To accept the monthly Finance & Workforce report	Craig Black
11.	**Community services report (attached)** To receive a report from the Provider Management Group	Jon Green
10:30 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.	**CQC action plan (attached)** To approve the updated action plan	Rowan Procter
15.	**Putting you first award (verbal)** To note a verbal report of this month's winner	Jan Bloomfield
16.	**Consultant appointment report (attached)** To note the report	Jan Bloomfield
11:00 BUILD A JOINED-UP FUTURE		
17.	**e-Care report (attached)** To receive a verbal update and a copy of the staff presentation	Craig Black
18.	**Communications Strategy (attached)** To receive the summary strategy	Jan Bloomfield
19.	**Operational plan 2017-19 (attached)** To receive the final document submitted to NHSI	Craig Black
11:10 GOVERNANCE		
20.	**Trust Executive Group report (attached)** To receive a report of meetings held during the month	Steve Dunn
21.	**Council of Governors report (attached)** To receive a report of meeting held on 8 February 2017	Roger Quince
22.	**Audit Committee report (attached)** (a) To receive a report of meeting held on 27 January 2017 (b) To approve the updated governance documents - Standing Financial Instructions and scheme of reservation/delegation	Steve Turpie Craig Black / Richard Jones
23.	**Agenda items for next meeting (attached)** To approve the scheduled items for the next meeting	Richard Jones
11:20 ITEMS FOR INFORMATION		
24.	**Health and safety framework (attached)** To receive the summary to provide clarity of roles and responsibilities	Richard Jones
25.	**Any other business** To consider any matters which, in the opinion of the Chairman, should be considered as a matter of urgency	Roger Quince
26.	**Date of next meeting** To note that the next meeting will be held on Friday, 31 March 2017 at 9:15 am in the Committee Room.	Roger Quince
RESOLUTION TO MOVE TO CLOSED SESSION		
27.	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
Item 5

West Suffolk NHS
NHS Foundation Trust

MINUTES OF BOARD OF DIRECTORS MEETING

HELD ON 27 JANUARY 2017

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			
Ali Bailey	Head of Communications		
Georgina Holmes	FT Office Manager *(minutes)*		
Richard Jones	Trust Secretary		

Action

GENERAL BUSINESS

17/01 APOLOGIES FOR ABSENCE

Apologies were noted as above.

17/02 QUESTIONS FROM THE PUBLIC

- Joe Pajak asked about TPP in terms of governance, operational quality and future models. Craig Black explained that this would be discussed in the closed session of this meeting, and a decision would be required about the model. The plan was to try to address both the financial and operational issues by having a more local arrangement with the STP, ie Ipswich, Colchester and West Suffolk Hospital, and the options in place were based on this.

  Neville Hounsome considered that the current operational communication had improved. The Chief Executive said that the issue was whether this was being reciprocated in terms of actions; there were still significant quality concerns. The financial implications would be discussed as part of agenda item 9, Finance report.

- June Carpenter referred to the increasing waits for ENT and vascular surgery, staff numbers for speech and language therapy and the significant number of medication errors. It was explained that these would be discussed as part of the relevant agenda items.

  She also referred to the increase in car parking charges which had received considerable adverse media coverage. She asked if staff Governors had been involved in discussions around staff charges in the same way that public Governors had been involved in discussions around charges for the public.

Jan Bloomfield confirmed that this had not been the case; however the Trade Unions had been involved. She agreed that in future staff Governors should be involved in these discussions.

- Justine Corney asked about the lack of data on the quality dashboard and noted that a lot of the boxes had not been completed. Craig Black explained that this reflected the continuing challenges around e-Care and this missing data would continue to be highlighted.

  Jon Green explained that the reporting system for Glastonbury Court was still being set up. However, he assured the Board that quality was being monitored in areas where the data had not been provided. Glastonbury Court community beds were not on e-Care but quality reports would be available. Rowan Procter confirmed that incidents were reported through Datex.

17/03 REVIEW OF AGENDA

The agenda was reviewed and the Chairman stressed the need to keep to time as this was a very full agenda.

17/04 DECLARATION OF INTERESTS

There were no declarations of interest.

17/05 MINUTES OF THE MEETING HELD ON 25 NOVEMBER 2016

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

17/06 MATTERS ARISING ACTION SHEET

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

Ref 1344 - research proposal for use of video in theatres – Richard Jones explained that this had been discussed at length both at the Board and outside the Board. The proposal was to focus on the human factors work that was being undertaken within the theatres area to prevent never events and ensure appropriate procedures were followed and embedded. Internal audit would look at this as part of their work for next year. Based on the findings of this work the Board would consider whether this was providing better assurance.

Rosie Varley noted the need for clarification around the link between the Safer Surgery group and Human Factors, so that everyone understood what each group was responsible for. Richard Jones confirmed that he would ensure that the approach of the Human Factors group was to address the issues of concern coming out of never event investigations, but it was not responsible for the investigation of never events. Rosie Varley considered the Human Factors group to be excellent, and very well led by Sue Deakin. It was explained that a Human Factors group event taking place and NEDs were welcome to attend. Richard Jones would circulate details of this to the NEDs. **R Jones** **R Jones**

Rosie Varley explained that there would be a programme of training around safer surgery which all relevant staff would be expected to attend.

The Board were asked to approve the proposal that the focus at this stage to mitigate the never event risk would be through the development of effective human factors interventions.

The Board recognised that while theatre recording could be a very useful learning tool, in the near term the human factors work was likely to pay greater dividends in terms of quality and safety improvement; and had wide support among theatre staff. Consequently, the Board were prepared to accept that for the time being the proposed research project on theatre cameras should be shelved.

The Human Factors group should consider how the results of its work could be monitored in order that the benefits of this work could be understood.

Ref 1357 – review the use of presentations to the Board, with focus on issues relevant to Board priorities and agenda - Richard Jones explained that a discussion had taken place at the last Board meeting around presentations and the need to allow appropriate time for these. It was proposed that the Quality & Risk Committee should be reinstated, with the second part being for a presentation focussed around quality or divisional issues for quality improvement. Provisional dates for these meetings were in the diary, and would be on an afternoon following a Board meeting.

The terms of reference would be amended to include being attendance of Board members. It was also proposed that the terms of reference for the Patient Experience Committee and CSEC should be looked at to ensure there was no duplication. **R Jones**

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

Ref 1341 – through the e-Care programme Board develop a system based performance report/dashboard, this would support the direction of ACO development – the Chief Executive referred to the dashboard to support the direction of ACO and explained that FLAG was slightly different. This would need to be clarified. It was confirmed that Cerner's population health functionality would also support this work.

17/07 CHIEF EXECUTIVE'S REPORT

The Chief Executive highlighted the following:-

- The Trust had been through a very difficult period over the last few months. The Christmas and New Year period had been particularly challenging with a 20% increase in admissions, compared to the average over the last three years. This had resulted in a major increase in pressure on resources; two and a half wards had also been closed to new admissions with norovirus. Staff had worked extremely hard to keep the hospital safe during this period and had continued to do so during the following weeks which continued to be very busy.

  Neville Hounsome referred to the joint NED and Council of Governors (CoG) meeting that had taken place last night, where it had been recognised what a good performance this was and that part of this was due to planning by the Executive team. Governors had also reported personal positive experiences with the hospital.

- Clarity had now been received on Community Services which meant that this could be progressed and services looked at in greater detail.

  Steve Turpie noted that this would be discussed further in the Audit Committee meeting this afternoon. However, he asked how much latitude/leeway would be given to move this forward. It was explained that this should be for a period of ten years which would allow greater progress.

Jon Green said that this was a great opportunity, working to a relatively blank canvas. There was an overarching vision around healthy communities and the CCG was allowing the creation of clinical pathways and pipelines; however there was only 6-9 months to set this up.

- Finance was an ongoing area of concern. Actions around FLAG and flow were designed to help with this, as well as patient safety.

- There continued to be a focus in the organisation around improving quality, which was excellent in these challenging times.

DELIVER FOR TODAY

17/08 (a)&(b) **QUALITY & PERFORMANCE REPORT**

Jon Green explained that A&E performance in December had started well but had worsened towards the end of the month and was not where he would have wished it to be. However, it was more sustainable over the Christmas and New Year period and this had been broadly maintained. He cautioned that winter was not over by a long way and the organisation was still in a very difficult position, with the forthcoming weekend being forecast as the busiest so far. There was also an increase in flu, and infection control issues around the region.

Trusts were receiving daily calls from NHSI asking about the current position and if there had been any 12 hour breaches each day. This had not been the case at WSFT but was not uncommon around the country. A&E performance was currently at 87.5% for the month to date, which was 1% above the second best performer in the region.

Performance for cancer 62 day waits was at 83.7% (this was a draft position which would not be finalised until the end of February and normally improved by around 1%). Performance for the quarter was currently at 87.5% and the final position would be reported at the next Board meeting.

Diagnostics had improved in the majority of areas, however there was now an issue around ECGs and how the Trust profiled new and follow-up patients. A recovery action plan had been put in place to address this and it was anticipated that 50% of the backlog should be cleared by the end of next week. The target should be achieved by the end of February but issues with staffing were a risk.

Jon Green said that this deterioration and position was a wholly unacceptable and apologised to the Board for this.

Rowan Procter reported that falls had increased but noted that these were in escalation areas. Patients with ward acquired pressure ulcers had reduced. However, there had been a grade 4 pressure ulcer; this had been anticipated and was an end of life patient who refused to be moved.

There had been increase in outstanding actions for completion of RCAs and internal audit had been asked to look at this.

Jon Green referred to ENT waits and explained that the reported waits were maximum waits. The Trust was currently taking both paper and electronic referrals, but from next week it would be running a different system which should improve this. There had been a significant increase in ENT referrals and this had been a challenge.

Oral surgery had been a long running problem due to internal capacity. From 1 April 2017 WSFT would no longer be taking any new referrals and the backlog should be cleared within the following six months.

There had been difficulties within Urology due to consultant availability. However numbers were relatively small and an action plan had been put in place.

Issues around Vascular surgery involved a small number of patients but might have to be escalated with Addenbrooke's.

Neville Hounsome noted the quarterly antibiotic audit (page 5) and actions that had been put in place to achieve best prescribing practice. He asked about education of junior doctors in this. Rowan Procter explained that rotation of junior doctors meant further education was required; therefore there was a need to work with junior doctors and consultants. Neville Hounsome suggested there needed to be a wider approach around this.

John Benson suggested that there was an issue around the role of junior doctors in governance processes as they moved on so quickly. He proposed consideration needed to be given as to how the importance of this should be stressed to junior doctors, and this should not just be around antibiotics.

Neville Hounsome also referred to New Zealand's approach to reducing falls and broken hips. Richard Jones confirmed that Tracy Oats was looking at this and taking this to the falls group.

John Benson noted the positive performance around pressure ulcers. He asked about the missing data on the dashboard, ie VTE and MEWS and if data would be available for these, as he considered these two indicators to be particularly important. Rowan Procter confirmed that these were reviewed regularly on the wards to ensure there were no gaps in patient care.

Gary Norgate noted the outstanding RCAs and Duty of Candour and asked if this was due to pressure of work on staff or due to lapses. Rowan Procter explained that this was being addressed and that she expected an improvement by the next Board meeting.

Rosie Varley expressed concern about the three month performance on nutrition and noted the actions that had been put in place. Rowan Procter confirmed that this was a priority a workshop was taking place with senior matrons on Monday which would focus on this.

Rosie Varley asked if the red SMR indicator (page 21) for anaesthetics was a particular concern, or if this was just a blip. It was explained that this was a very small number but an explanation would be given at the next meeting. It was proposed that in future narrative should be provided for red indicators. **N Jenkins**

Steve Turpie referred to paediatric performance and was very pleased that there were now enough clinics. He noted that most areas where the 100% target had not been met appeared to be where there was no paperwork and asked for narrative/actions for the next meeting, eg what the local authority proposed to do. Rowan Procter explained that it was not a contractual agreement for foster parents to take children to appointments. **J Green**

Steve Turpie noted the considerable improvement in speech and language performance and that the numbers had reduced by 50% in the past nine months. He referred to the service redesign which had been put on hold and was concerned that the situation would revert to where it started. Jon Green said that a report on this would come back to the Board next month. **J Green**

Steve Turpie referred to the Paediatric Strategy Group which had been proposed some time ago and asked if this was happening or not. Clarification on this would be provided at the next Board meeting. **J Green**

17/08(c) MANDATORY TRAINING REPORT

Jan Bloomfield explained that information on staff who had not completed Safeguarding training had been escalated to Rowan Procter. Rowan Procter explained that there had been cancellations in Safeguarding training recently but this was being addressed.

Information Governance was contacting individuals in person to find out why they had not attended training.

17/09 FINANCE AND WORKFORCE REPORT

Craig Black explained that this was the first opportunity to officially alter the forecast, ie a deficit of £12.1m. He had tried to split the performance into what was directly within the Trust's control and what was not.

The Trust would not achieve its stretch CIP of £3.9m for the year; therefore would not meet the control total. This meant that it would not receive £3m of the £6.1m Sustainability & Transformation funding.

Staffing costs had reduced in December, despite the considerable pressures. This was more a reflection of the ability to secure extra staff, rather than around controls put in place. Although WSFT was not achieving the target for agency spend set by NHSI, it was the lowest spending DGH for agency staff across the whole of Midlands and Eastern region.

The critical cash position for the organisation was shown on page 17. In order to continue with the planned capital programme and continue to pay salaries the Trust would need to borrow £38m by the end of the three year period, ie March 2019.

Steve Turpie asked if the Global Digital Excellence (GDE) money had been confirmed and when it would be received. Craig Black explained that the funding agreement should have been signed today but the date kept moving. Currently he had been assured that the money would be received in February. If this was not the case the Trust's creditors would be stretched at the end of the year. A meeting was taking place with NHSI next week to go through WSFT's financial performance and plan.

Craig Black explained that the level of funding coming into the hospital was not consistent with the quality it was expected to achieve and deliver. The decision could be that drastic action would need to be taken to recover the situation.

The Chairman asked if any discussions had taken place with the CCG about WSFT not delivering some of the services it was currently providing. Craig Black confirmed that these discussions were taking place, ie ceasing oral surgery. Discussions were also taking place with other organisations, ie CCG, Ipswich and Colchester hospitals around anything that could be done around back office. The scale of change to address the financial position would need to focus on where the most money was spent.

Ali Bailey asked how STP reported finances on a monthly basis and if these could be looked at across the system. Craig Black confirmed that discussions had already taken place about this and looking at the local health economy position as a whole. Currently all organisations reported their finances separately and were managed around these separately, which did not make sense.

The Chief Executive explained that discussions had been had with the regulators about a system control total and this would be looked at further. The aim of the stretch CIP had been to try and maintain the financial plan and develop a more sustainable system. The Trust would continue to engage with the whole organisation on this.

Gary Norgate referred to extra sessions and welcomed the additional information on the efficiency of these. He asked why so many additional sessions were required and if this was due to demand or inefficiency. Jon Green explained that that there were two reasons for these. One was capacity, either physical, ie as in endoscopy, or a shortage of consultants in a speciality. The second reason was due to timescales, ie two week waits and large variations in referrals which had to be managed through additional sessions.

He also explained that efficiency could always be improved in some areas. Currently efficiency in theatres was approximately 85% and the Trust was working hard to try to improve this, although it would never achieve 100% efficiency. Gary Norgate said that it would be helpful to understand the impact of everything being as efficient as possible and also see a plan to achieve the highest level of efficiency. **J Green**

17/10 TRANSFORMATION REPORT (Q3)

Neville Hounsome asked about the agency project and doctors' rates. Jan Bloomfield explained that the framework had only recently been introduced. HR Directors had talked about working together to try and maintain rates. However, this was very challenging due to low supply and high demand, which meant that agencies then escalated their rates.

It would be easier to hold the agency cap on nurses as there was a greater supply.

Neville Hounsome requested that the Board was kept updated on this as it could be a risk. **J Bloomfield**

The Chairman considered some of the figures in this report to be disappointing, as savings were not being delivered, eg theatres.

It was explained that CIPs would be discussed in greater detail by the Audit Committee.

17/11 COMMUNITY SERVICES REPORT

The Board considered this to be a good report.

Steve Turpie asked about the 18 breaches out of 83 in the 18 week pathway for consultant paediatricians. Jon Green explained that this was a capacity issues, particularly in the East. A recovery plan had been produced and would be available for the next report. **J Green**

The Chief Executive referred to the Buurtzorg presentation and explained that this was a different and innovative model of care which he considered to be very exciting. It had been supported by the Health and Wellbeing Board and would initially be trialled in the West (Bury locality). This highlighted working together locally.

Craig Black confirmed that this would also be evaluated from a financial point of view.

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

17/12 AGGREGATED QUALITY REPORT

Rowan Procter reported that the Trust was still on target with responses to complaints.

17/13 NURSE STAFFING REPORT

Rowan Procter explained that this report covered November and December.

There was an overall requirement for a minimum of an 80% fill rate of all vacant shifts. WSFT was achieving 83% for day shifts and was in the high 90% for the other areas. Therefore the Trust was doing well in filling vacant shifts, particularly compared to other organisations. However, Craig Black noted that organisations set their own targets; therefore it was difficult to compare organisations.

Rowan Procter reported that there had been an increase in incidents, which was partly due to the challenges being faced by the Trust. All incidents were being reported and actions were being taken. However, the more agency and bank staff were used, the more errors occurred. It was confirmed that if an individual from agency or bank made an error they did not work for the Trust again.

There were some areas of concern with G5, ie higher number of pressure ulcers and falls, but this was in line with the demographics of patients on this ward.

There was a high number of vacancies and sickness in the escalation area, but staff were working very well together.

John Benson asked about fill rates at night. Rowan Procter confirmed that this was at 95% and there was not a particular issue at night.

He also asked if a particular ward was not fully staffed for a week, if there was a level of data of available to look at the impact of this. Rowan Procter confirmed that this was the case and that staff were moved around the organisation on a daily basis and there was an audited process around this.

Gary Norgate asked if there were enough Nursing Assistants (HCAs) at night and if staff felt they had enough staff. Rowan Procter said that staff would probably not agree that there were enough staff as the Trust was in escalation. However this had improved considerably compared to a month ago. All vacancies in surgery for nursing assistants had been filled and would be starting within the next two months.

Jan Bloomfield considered there to be a fairly good retention rate for nursing assistants and she would bring a report back to the next meeting. **J Bloomfield**

17/14 STAFF CAR PARKING TARIFF

Jan Bloomfield explained that the additional income generated should be £18k per month (page 5).

Rosie Varley referred to the reporting from the press which had been very unfortunate and asked if anything more could have been done so that this was not so contentious.

Jan Bloomfield said that she had been disappointed with the press coverage as Communications had worked hard with them to explain the reasons for the increase. WSFT was not much more expensive than Addenbrooke's or Ipswich Hospital, therefore it was unlikely to lose staff.

The Chairman asked if there was any flexibility for staff working shifts as car parks were often not full when such staff wanted to park. Jan Bloomfield said that there could be flexibility with extending car parking at the rugby club and the free bus. There could also be an option for pay as go for shift staff but this would need to be looked at. Jan Bloomfield and Craig Black would discuss the financial implications of these options.

The Chief Executive said that it was regrettable that this had had to be done. Delaying the introduction of the increase had been considered, but the financial position of the Trust needed to be taken into account.

17/15 PUTTING YOU FIRST AWARD

Jan Bloomfield reported that three individuals had received a Putting You First Award this month:-

Barry Dixon, Porter. Barry was on the scene first when there was a cardiac arrest on G8 and began the CPR process before outreach and the doctors took over.

Vera Farinha, ED Sister. From the moment she started in her role as ED sister she had always remained calm, good humoured and focused in any situation, even when there had been a full ED, a full resus and eight patients on the ambulance inbound screen. She was a real asset to the ED team.

Dawn Hart, Team Cleaner. Dawn was always ready to help her colleagues and put others needs before her own. When a patient had a bad turn and was sitting in the middle of the first floor corridor, she did not hesitate to help, fetching a wheelchair, from the other side of the hospital, to make this person feel more comfortable. She was supportive to all her colleagues, did her best for her team and was always enthusiastic and willing.

The Board congratulated the above individuals and commended them for their dedication and commitment to patients and other staff.

BUILD A JOINED UP FUTURE

17/16 e-CARE REPORT

Jon Green explained that there had not been an e-Care Programme Board meeting in December. A meeting had taken place yesterday.

The Trust was now moving into phase 2 and Ordercomms. The go-live for Ordercomms was originally planned for the end of March but had now been put back two weeks to 8 April 2017.

The difficulties and issues around reporting had been discussed, particularly concerns around RTT performance which was still being estimated. A date for a fix to the data warehouse was to be discussed with Cerner. There were also difficulties with the system delivering a satisfactory word processing system for medical secretaries. Other alternatives continued to be looked at, but to date these continued to be unsatisfactory.

Although there were a number of concerns, considerable work was going on to progress to phase 2 and other elements of GDE.

Craig Black explained that phase 1 had gone live last May. Ordercomms and pathology had now become phase 2, and also the ability to document information on the system, ie paediatrics and improvements around prescribing and the patient portal.

An internal communication exercise now needed to be undertaken on e-Care and GDE. The Trust needed acknowledge that it was aware that some people were still struggling with e-Care. This exercise would highlight the problems that were known and what was being done to address these. It was proposed that the presentation given to staff on this should also be given to the Board. **C Black**

The GDE programme would represent an expansion of phase 2, eg ITU system, surgery, theatres, implementation of automatic entry of obs on each ward. Rowan Procter explained that the obs machines would have about 20 parameters, which would automatically be entered onto e-Care for each patient.

Gary Norgate referred to the appointment the new Head of IM&T, Mike Bone, who was very experienced and had provided considerable assurance around cyber security and had plans to address this and the critical need for disaster recovery.

He also referred to the difficulties experienced by medical secretaries and was very pleased that the Trust was not compromising on this, or from the ideal it set out with for the collection of data etc.

GOVERNANCE

17/17 REVIEW OF THE TRUST'S CONSTITUTION

Richard Jones highlighted the recommended amendments to the Constitution; he confirmed that Monitor were still a legal body.

Rosie Varley considered the arrangements for Board meetings by teleconference to be good. It was acknowledged that this would not be a regular occurrence but could be useful to enable absent Board members to partake in a meeting when necessary.

The Board approved the recommended changes to the Constitution and submission to the Council of Governors.

17/18 TRUST EXECUTIVE GROUP REPORT

The Board noted the content of this report.

17/19 COUNCIL OF GOVERNORS REPORT – 16 NOVEMBER 2016

The Board noted the content of this report.

17/20 CHARITABLE FUNDS COMMITTEE REPORT

It was noted that the Board were legal Trustees of charitable funds.

Craig Black highlighted the £520k of legacies from three individuals and explained that these were for the general fund which meant the money could be used across the organisation.

The Chairman confirmed that communication about these had been agreed at the meeting.

17/21 REGISTER OF INTERESTS REPORT

The Board noted the content of this report.

17/22 AGENDA ITEMS FOR NEXT MEETING

The scheduled agenda items for the next meeting were approved.

ITEMS FOR INFORMATION

17/23 ANY OTHER BUSINESS

There was no further business.

17/24 DATE OF NEXT MEETING

The next meeting would take place on Friday 3 March 2017 at 9.15am in the Committee Room.

RESOLUTION TO MOVE TO CLOSED SESSION

17/25 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 – 3 March 2017

AGENDA ITEM:	Item 6
PRESENTED BY:	Roger Quince, Chairman
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	23 March 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
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 Mar '17 (revised).	JG	31/03/2017	Green
1367	Open	27/1/17	Item 5	Terms of reference for Q&RC to be reviewed at its next meeting sand submitted to the Board	Scheduled for review	RJ	28/04/2017	Green
1368	Open	27/1/17	Item 8	Bring back explanation for the red rating for anaesthetics within the HSMR specialty tree (p21)	Dr Foster have been asked to undertake a preliminary analysis of this issue. These findings will inform the need for a patient level review and should be available for the next meeting	NJ	31/03/2017	Green

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1369	Open	27/1/17	Item 8	Seek clarification re what the local authority are doing to improve the quality of information provided for paediatric referrals. Also update on situation re paediatric redesign plan which are reported as 'on hold'.	The paperwork is reported to be improved but is obviously still a limitation due a to a known issue with foster families' delivering the requirements. The paediatric redesign is on hold until early 2018 while a full design can be worked through. In the meantime we are negotiating with the CCG with funding until the end of March for the planned deliver by Aug '17 and service continuity from this point.	JG	03/03/2017	Green
1370	Open	27/1/17	Item 8	Confirm with new clinical director whether a trust paediatric strategy group is still required	The new clinical director is delighted to have NED support and will be in touch shortly with dates.	JG	03/03/2017	Green
1371	Open	27/1/17	Item 9	In terms of additional sessions undertake assessment of what it would look like if we were running at optimum efficiency and based on the gap identified set out remedial action to improve current performance	Analysis of theatre productivity shows a downward trend in additional sessions. Further review is being undertaken at specify level and will be reported at the end of March.	JG	31/03/2017	Green

Completed actions

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery

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 live on Intranet.	RJ	03/03/2017	Complete
1354	Open	25/11/16	Item 9	As presentation in January receive a report from the newly formed Flow Action Group (FLAG)	**AGENDA ITEM**	NJ	03/03/2017	Complete
1356	Open	25/11/16	Item 14	Report on the planned site reconfiguration for car parking, including provision for disabled parking	New car park fully operational by 24 February 2017 (extra 400 spaces). Patient/visitor parking provided near the Macmillan Unit and in front of the Education Centre (approx.100 spaces) w.e.f. 01.02.17. This will ease pressure on car park A at front of hospital. Dedicated area for blue badge holders also provided in car park A from 6 February 2017 with zebra crossing access to disabled walkway to the hospital.	JB/CB	03/03/2017	Complete
1365	Open	27/1/17	Item 5	Confirm the accountability/reporting lines for never events for the Safer Surgery and Human Factors groups.	The Safer Surgery Group is being re-established chaired by Sue Deakin as Clinical Director. This group will be responsible for oversight of the safer surgery action plan, including learning from never events. This group will liaise with the Human Factors Group to ensure relevant learning is reflected in human factors interventions.	RJ	03/03/2017	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1366	Open	27/1/17	Item 5	Provide details of the human factors training being undertaken	On the 14 January 2017, 14 WSH staff attended a Human Factors training day at Colchester (mix of surgeons/anaesthetists, main theatres & day surgery staff). A further session is scheduled for 23 March for which we have places for 16 staff to attend the one day course. From these training days and the work of WSH's Human Factors Group there is a faculty being formed, this will be a multidisciplinary group of 10 who will attend further training of 5 days to become faculty members and they will form the WSH Human Factors Faculty, who will plan & deliver training that will be held at WSH for WSH staff, this will include some scenario training sessions as well.	RJ	03/03/2017	Complete
1372	Open	27/1/17	Item 10	Maintain visibility of agency cap performance within the transformation report	Included as a standing section of the quarterly transformation report	JG	03/03/2017	Complete
1373	Open	27/1/17	Item 11	Share the paediatric recovery plan for service access at next meeting	**Included in Quality Report**	JG	03/03/2017	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1374	Open	27/1/17	Item 13	Provide information on retention rate for nursing assistant staff	The current turnover rate for Nursing Assistants is 13.45%. This is higher than our average for the total trust which is 10.17%. These posts traditionally had a higher than average turnover. The Trust is currently investigating this and looking to develop retention strategies.Currently Nursing Assistants are interviewed and employed by individual wards/departments or offered positions with NHS Professionals. All newly recruited Nursing Assistants must undertake and complete the WSFT induction programme and the nationally recognised Care Certificate programme covering the fundamentals of care. Support is given throughout the 12 week process to complete the induction, programme, workbook and competencies. Action plans will be set in place for those who fail to achieve the requirements in a timely fashion and these are monitored by the ward/department manager with support from the Education Team.Opportunities are available for continued development via the apprenticeship route. Currently at the WSFT we are able to offer level 2 and 3 clinical apprenticeships in partnership with West Suffolk College. Delivery of these programmes is provided by the Education Team with assessment by the college.For those Nursing Assistants who are interested in further career development the Trust supports the Foundation Degree (FdA) in Healthcare that is run by the University of Suffolk. Completion of this 2 year programme allows HCAs to apply for Band 4 roles within healthcare.For those Nursing Assistants who have completed a level 5 qualification (FdA degree) a further opportunity exists which provides a 18 month route to become a Registered Nurse. Currently we have 4 nursing assistants who are undertaking this programme.	JB	03/03/2017	Complete

Ref.	Session	Date	Item	Action	Progress	Lead	Target date	RAG rating for delivery
1375	Open	27/1/17	Item 16	Board to receive the e-Care presentation being used as part of Trust communication (including phasing)	**AGENDA ITEM**	CB	03/03/2017	Complete

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 3 March 2017

AGENDA ITEM:	Item 7
PRESENTED BY:	Steve Dunn, Chief Executive Officer
PREPARED BY:	Steve Dunn, Chief Executive Officer
DATE PREPARED:	23 February 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.

Lesley Standring, Go Green implementation lead, has launched a campaign to remind us why the **red** to **green** approach is so important. She explained that "While we have had to get used to a new way of working as a result of red to green, I think it's really important that we remember why we're doing this. This makes a very real difference to our patients, to their physical and mental wellbeing. It means that each day something happens. All too often patients are waiting for something and we know that being in hospital is not always the best place to be. Yes we want to improve patient flow through the hospital but the priority is to ensure we get patients home."

If we put ourselves in our patients' shoes, many of whom are older people, would we want to spend chunks of our later life in hospital? If you had 1,000 days left to live, would you choose to spend it in hospital? What do we know about the impact of longs stays in hospital?

- Hospital based deconditioning due to habitual inactivity can lead to a reduction in muscle power of 2 – 5% in the first 24 hours of admission
- In the first seven days of hospital admission inactivity can lead to a reduction in circulating volume by up to 20%
- 10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80
- 48% of people over 85 die within one year of hospital admission

Deconditioning (#end PJ paralysis) is a real issue. We must do all we can to encourage our patients to sit up, get dressed and keep moving. We must support them to maintain as much of an active routine as possible and ensure we are delivering value added care on a daily basis that increases the number of green days across the Trust. Remember, we must help save their precious time.

In the next few weeks we will be building on this philosophy by encouraging our patients to ask four questions:

- What is the matter with me?
- What is going to happen today?
- How well do I need to be to go home?
- When am I going home?

I want to thank staff for their hard work. This is a long-term focus for the Trust and I'm sure will become second nature in the not too distant future.

The Go Green and information teams have worked together to create a **red to green data dashboard**, which is accessible for staff on the Trust's intranet. Staff are encouraged to review the data on a regular basis to see how we are delivering against the Go Green campaign. The dashboard collects data that identifies the number of: red or green patients, planned dates of discharge, patients discharged before or after midday. Information can be filtered by age, gender, ward or consultant.

This month's **performance pack** reflects the ongoing operational pressure that is being felt in the hospital and across region, including emergency flow. The draft 62 day cancer performance for January remains below the 85% target, however the final reported position for December did achieve the target. The 2-week cardiac rapid access performance deteriorated in January below the 100% target, this has now been recovered. We are still facing issues with e-Care and our ability to accurately report data. We continue to work with Cerner to resolve the technical reporting issues and this will be underpinned by robust procedures to ensure accurate data capture. However a revised estimation of out incomplete referral to treatment (RTT) performance is being reported for the first time in January as below the 92% target.

The **month 10 financial position** is behind plan by £6.8m year to date which is largely due to increased expenditure on escalation capacity and our failure to achieve our stretch CIP of £2.6m YTD. Consequently we will only receive £2.9m of the £6.1m Sustainability and Transformation funding we had anticipated in 2016-17, and therefore £2.1m 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.

We met with NHSI on the 2 February 2017 to discuss the Trust's operational and financial performance. We have subsequently received formal notification from NHSI that they will be opening an **investigation into our Licence compliance**, due primarily to our financial position and non-acceptance of the proposed control totals for 2017-19. NHSI have shared their 'Financial Recovery Learning Toolkit' from which we have identified initiatives which provide some additional opportunities for cost improvement. We will continue to work with NHSI as part of the investigation to ensure that all appropriate action is taken to deliver financial and operational improvement.

Please join me in congratulating our **chief operating officer Jon Green** on his appointment as the new chief executive of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. Jon will take up his new post in May. While this is a major loss for West Suffolk, I am so pleased Jon is able to take the next step in his career. I would like to thank him for his hard work and professionalism throughout his time at the Trust. He has been a valuable member of the exec team and has been an exceptional leader in his operational management role. We wish Jon every success in his new role and I'm sure there will be leaving celebrations closer to his departure.

The **Medicine Healthcare Regulatory Authority (MHRA)** undertook a planned inspection of the blood transfusion service operated within the hospital by TPP. The inspection highlighted several areas of concern and we are working closely with the inspection team to ensure action is taken by TPP to address issues identified which include staffing and quality management systems.

The e-Care programme board have confirmed that **e-Care Order Comms functionality** will go live date on Saturday 8 April 2017. From this date we will use e-Care to request, collect and/or receive

and endorse all pathology samples. In addition we will also be turning on the Sepsis and AKI alerting function within e-Care. e-Care will run algorithms in the background which will review vital observations and pathology results and will fire alerts if it believes that a person may be at risk of Sepsis or AKI. All of this will be covered in training for staff. The go-live is now only five weeks away and over the next few weeks we will be providing staff with more information on exact timings and support arrangements for the go-live period. This will include a clear position on how we will manage off site services during the go live. Order Comms training is mandatory for all affected staff that request, collect and/or receive and endorse results.

I am well aware of the depth of feeling that has been generated around **car parking** charging recently, especially for staff. While we did discuss the proposed changes with the staff travel group and the Unions, and did try to take on board suggestions, maybe more could have been done to discuss with staff. In an ideal world staff and patients would not have to pay for parking, however, parking has been a problem at our hospital for some time and staff have regularly raised this with me. We have taken action and spent £2m on creating 400 new extra spaces. We have done this when money is tight for the hospital. We are in financial deficit and we need to pay for this investment in car parking. That is why we are raising prices by around 30% for all staff groups based on the prices before we introduced number plate recognition. All the money raised pays for the extra spaces and staff on the wards. Nevertheless in response to staff feedback we are looking at extending the opening of the rugby club car park and exploring different methods of charging which are more sensitive to those working long day shifts.

Return Recycle Reuse - a new campaign launched this week, calling on people in Suffolk to help cut waste by returning as much unused NHS equipment as possible. While some patients need equipment for long periods of time, NHS services lose thousands of pounds each year because people do not return equipment they no longer need. We have been working with suppliers to ensure equipment, including crutches, walking frames and mattresses, can be returned easily as part of a month-long NHS amnesty from 1 to 31 March 2017.

Quarterly performance of the NHS provider sector has now been reported by NHS Improvement (NHSI). Analysis shows that 5.34 million patients attended providers' A&E units between October and December 2016, which is 200,000 more than at the same period last year. Providers also saw a 3.5% increase in the number of patients requiring major further in-hospital treatment.

This intense demand for emergency treatment coupled with a significant reduction in bed availability has led to providers collectively underperforming against several key national healthcare standards, and having to postpone some planned care. However, these pressures have been compounded by providers losing 390,392 'bed days' between October and December 2016 - a 28% increase on the same period last year - because of issues with discharging medically fit patients due to constraints on community or social care.

In Q3 2016/17 4-hour target performance dropped to 86.74% (NHS England performance was 87.87%). This quarter's performance was well below the level achieved in the same quarter last year (90.65%) and the 95% target. A&E performance in December also remained below the aggregate STF improvement trajectory of 91.99% for month six for the provider sector.

The sustained focus on providing emergency treatment and a reduction in planned care also led to a loss of income for providers. That income either remains in the NHS or has been paid to the independent sector to cover elective treatment. Despite this the sector's financial position is £1.3 billion better than at the same point last year; as it ended the quarter £886 million in deficit. In addition, 135 providers ended the quarter in deficit which is 44 fewer compared to the same period last year.

Measures to curb excessive agency staff spending are continuing to have a positive impact. Two-thirds of providers reported reduced agency costs with the sector delivering a £505 million improvement in its spending over the last nine months. Furthermore, providers' agency and locum spending in December 2016 was just £228 million – the lowest monthly spend since measures were introduced in October 2015 and 24% lower than December last year.

Chief Executive blog
http://staff.wsha.local/Blog/TisforTwo-waycommunication%e2%80%a6andTrust.aspx

DELIVER FOR TODAY

Winter pressures
Live interviews on BBC Radio Suffolk:

- Bed occupancy rates (Jon Green and Nick Hulme joint interview on the Mark Murphy Breakfast Show)
- A&E pressures and national headlines about an increase in abuse to staff (Tracey Oates on the Mark Murphy Breakfast Show)
- Impacts of norovirus outbreak at the hospital – lost bed days resulting in story from Royal College of Nursing (Rowan Procter on the drive time Stephen Foster show)

Go Green this winter
Lots of content around Go Green this winter campaign, across internal channels, supporting the drive to ensure staff do as much as possible each day to action patients from a red to green day. The daily planning of patient care and the focus on ensuring patients have value added care that we can assign as a green rather than red day is helping the Trust to identify trends in delays and how best we can overcome these.

Increased efficiency at West Suffolk Hospital
West Suffolk NHS Foundation Trust is undergoing a new development in order to improve its Sterile Services Department (SSD). The new structure will house the SSD and will be at the rear of the site's main building. The current SSD is housed at its Hospital Road site, which is 1.5 miles away from the main hospital. This department provides decontamination and sterilisation of clinical equipment and instrumentation to the Trust, West Suffolk Clinical Commissioning Group's GPs as well as Norfolk and Suffolk NHS Foundation Trust.

"The new building will help increase the efficiency of the hospital's theatres and contracted customers, and will have two additional floors to accommodate administrative functions which will free up space in the hospital's main building," commented Jacqui Grimwood, Estates and Facilities Development Manager. "The current SSD building, facilities and environment are ageing and placing constraints on service provision and future growth potential. Moving the service to the main site will improve work flow as it will be in closer proximity to the main theatres at West Suffolk Hospital."

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

Shining Lights staff awards

Promotion of our annual staff awards, Shining Lights, across internal channels, is now live. Open for entries staff are being urged to nominate their colleagues to be recognised for their achievements during 2016. The awards event will be held on 11 May 2017 and it is a real highlight of the WSFT calendar. The awards have been adapted this year with a range of new categories. The **deadline for entries is 31 March 2017**.

BUILD A JOINED-UP FUTURE

NHS special, BBC Inside Out
BBC Inside Out produced an NHS special which considered the impact of STPs across the region. The Inside Out team filmed in the hospital's emergency department, reviewing patient flow and the pressures on the service. Stephen Dunn was interviewed about the STP linked to West Suffolk, and a number of other staff including a care practitioner, a member of the nursing team and a member of the East of England Ambulance service were also interviewed. They followed the patient journey of Bill, an elderly patient who attended ED the previous day. He was in the clinical decision unit awaiting the go ahead to return home pending a review of his care needs. They also interview two further patients who attended ED.

Solutions to health and social care pressures, BBC Look East
As part of the NHS special on BBC Inside Out, BBC Look East included a link news item in the main evening news to introduce the programme. Sharon Basson, senior matron in charge of Glastonbury Court was interviewed at Glastonbury Court, discussing its aims to support patient flow out of the hospital and to rehabilitate patients in order to get home. Footage of the King Suite in action, and interviews with a patient were also included as part of the package.

NATIONAL NEWS

DELIVER FOR TODAY

Confidentiality: good practice in handling patient information
Revisions have been made to the guidance, last published in 2009, following a consultation exercise. While the principles of the current guidance remain unchanged, it now clarifies various issues including the public protection responsibilities of doctors and the importance of sharing information for direct care. It also includes a decision-making flowchart and explanatory notes. (GMC, January 2017, effective April 2017)

Sepsis Case Study Spot It. Treat It. (Stick It). Beat It!
Did you know that every year in the UK there are 150,000 cases of Sepsis, resulting in a staggering 44,000 deaths – more than bowel, breast and prostate cancer combined. A lot of these deaths can be avoided if we stop and treat Sepsis quickly. Did you know that when IV antibiotics are administered to a septic patient within one hour, the mortality is reduced by half? Case study from James Paget Hospital, Great Yarmouth.

Case Study: Deconditioning Syndrome Awareness campaign
Time to move: Get up, Get Dressed, Keep on moving. Older people, whether in hospitals, care homes or at their own homes, who do not get enough opportunity to mobilize, can have an increased risk of reduced bone mass and muscle strength, reduced mobility, increased dependence, confusion and demotivation. These problems can be attributed to the phenomenon of what can be termed as 'Deconditioning Syndrome'. This affects well-being as well as physical function and could result in falls, constipation, incontinence, depression, swallowing problems, pneumonia and leads to demotivation, and general decline.

But, are all health care staff and patients aware of the phenomenon of deconditioning? Are we doing enough to prevent deconditioning? What can be done? This case study describes a number of different methods and actions which may help prevent deconditioning. This trust produced a number of posters, banners, screensavers and leaflets, which can be viewed here

Falls in older people

This quality standard has been updated to set out the best practice for health and social professionals to support them in preventing falls. The guidance has been updated to highlight the importance of routine appointments with family doctors, at hospital, or during home visits by social care workers, as they can help to prevent falls, disability and loss of independence. It also calls for people aged 65 and over to be regularly asked questions about whether they have fallen over in the last year or feel unsteady on their feet. (NICE Pathway, January 2017)

INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

Allied Health Professions Into Action: Using AHPs To Transform Health, Care And Wellbeing
This document is a vision of how, with collective action, our nation would be different if all AHPs were used effectively. It is aimed at leaders and decision makers, to help them understand the transformative potential and role of AHPs within the health, social and wider care system. The document provides examples of innovative AHP practice and a framework to help develop local delivery plans. (NHSE, January 2017)

Nursing Associates – everything you need to know
The nursing associate is a new health care role the Department of Health has introduced in England. The role is designed to bridge the gap between health care assistants (HCAs) and registered nurses. The RCN has produced an online guide to this new role, how it fits in to the current framework and compares to the role of Assistant Practitioner.

BUILD A JOINED-UP FUTURE

Case Study: The Primary Care Home – A New care Model
The programme, which is supported by NHS England, strengthens and redesigns first contact, primary care, around the health and social care needs of local communities of between 30,000 to 50,000 people. 'A complete care community' provides care to this registered population. Patients are served by a single integrated and multidisciplinary team, including primary, secondary, community, social and voluntary sector carers. Whilst patients are provided with personalised, coordinated and responsive care nearer to their home, the needs of the registered population are also better analysed to inform early detection, prevention and improved health screening.
http://www.napc.co.uk/primary-care-home

Obesity and the public purse: weighing up the true cost to the taxpayer
This report analyses the cost of obesity to public services and estimates that the net cost is less than £2.5 billion a year or 0.3 per cent of government spending. The report argues that the economic burden of obesity has been exaggerated and that the health care costs of an ageing population should be the focus for public service efficiency savings. (Institute of Economic Affairs, January 2017)

West Suffolk NHS
NHS Foundation Trust

Trust Board

AGENDA ITEM:	Item 8
PRESENTED BY:	Nick Jenkins
PREPARED BY:	Lesley Standring & Marie Marfleet
DATE PREPARED:	27th February 2017
SUBJECT:	Flow Action Group (FLAG)
PURPOSE:	Information

EXECUTIVE SUMMARY:

In November 2016, following focused work on the processes within the emergency department the Trust made a decision to concentrate on patient flow throughout the rest of the organisation using Red to Green and SAFER as a model which is supported by the Emergency Care Intensive Support Team (ECIST).

An overarching group was set up to support and monitor the implementation and support the achievement of the 95% target – The Flow Action Group (FLAG). FLAG was launched on the 24th November and has since been meeting fortnightly.

FLAG consists of senior members of the clinical and management team of the Trust and is responsible for delivering improved patient flow for the hospital.

Introduction

NHSE set out recommendations for acute trusts to support throughout the winter. The recommendations included Implementation of Red to green and SAFER amongst other initiatives.

S - **Senior** Review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.

A – All patients will have a **Planned Discharge Date and Clinical Criteria for Discharge**. This is set assuming ideal recovery and assuming no unnecessary waiting.

F - **Flow of patients** will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am.

E – Early discharge. 33% of patients will be discharged from base inpatient wards before midday.

R – Review. A systematic MDT review of patients with extended lengths of stay (> 7 days – 'stranded patients') with a clear 'home first' mind set.

Implementation and progress to date

On the 28th November 2016 the red to Green methodology was piloted on two wards F9 and F10. In mid-December a decision was made to increase the speed of implementation and roll out. This led to a 'big bang' implementation on the 3rd January, of early morning 8.30am – 9am, Consultant led multi-disciplinary board rounds across all adult inpatient areas (excluding maternity).

An implementation team was developed consisting of WSFT and WSCCG staff.

The implementation required a whole hospital response find below examples:-

The Executive Team	Fully supportive and involved with the roll out plan, observing board rounds daily
Consultants	Leading and supporting the implementation attending each day at 8.30am on a rotational basis for their base ward
Ward Managers	Leading and supporting the process with their nursing team
Therapists	Attend and contribute to board rounds on every ward
Pharmacy	Change in working pattern to support each board round
Discharge planning	A member of the team to attend each day
Volunteers	Supporting the implementation by asking patients if they can answer 4

	critical questions: • *What is wrong with me?* • *What is happening to me today?* • *When can I go home?* • *What do I need to be able to do to go home?*
Service Managers & Matrons	Supported the ward managers and consultants with removing barriers and queries relating to what makes patients Red or Green
e-Care team	Changing the whiteboard to support the board round process adding red/green symbol and space to write the plan for the day amongst other changes.
Information Team	Developing a dashboard for each ward
Social Workers	Changed their way of working to attend board round each day
PA's	Collating manually collected data

ECIST have supported the implementation team and have visited onsite in November and February, with a plan to return in April.

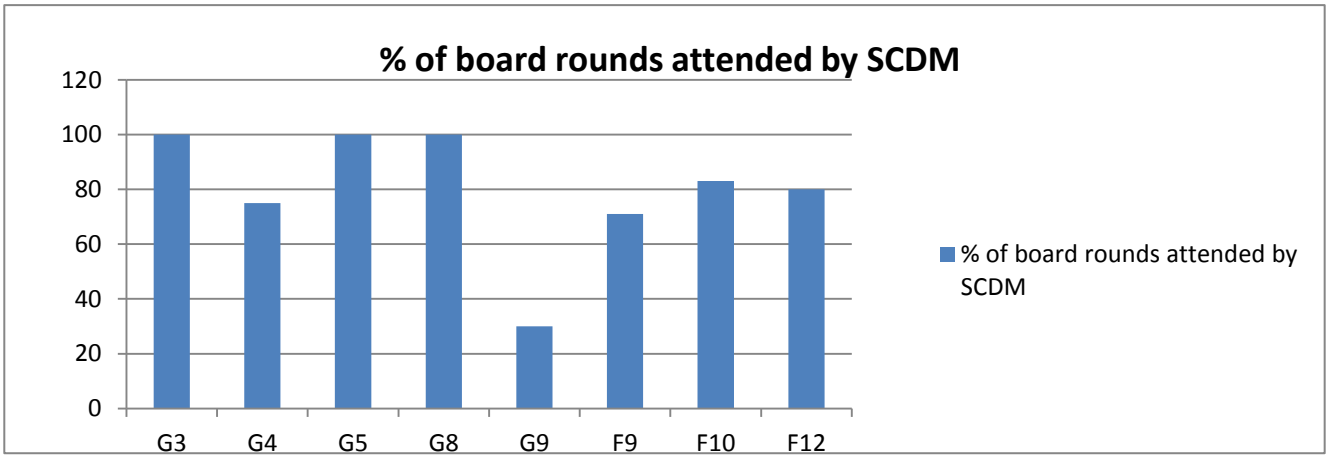
Progress to date

The Trust is now at the start of week 9 of Consultant led Red2Green board rounds across all adult inpatient wards (excluding maternity). Information was presented at TEG on the 30th January and the 17th February showing the observational data that had been collected from the board round support attendees in January.

The following observational data collected

1. Attendance at board round
2. Start time of board round
3. Completion of PDD & CCD
4. Top 3 constraints identified
5. Areas for improvement (medicine & surgery combined)

Medical Division:



Start times: All areas except, G8 & G9 start at 0830. G9 takes place at 0900 & G8 at 0930

Predicted Date of Discharge (PDD) & Clinical Criteria for Discharge (CCD):

PDD Completion Percentage

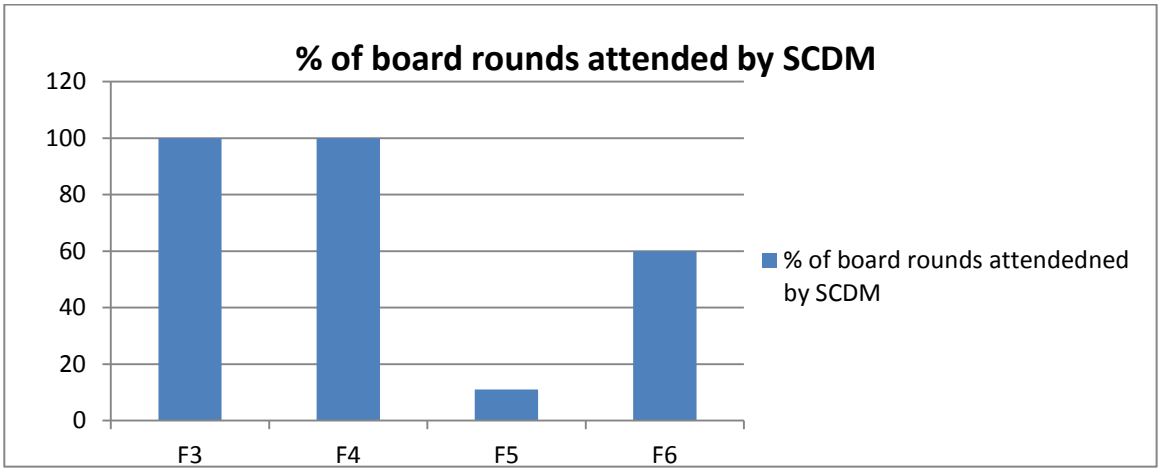
Ward	PDD Audit by Project Nurse (medicine only) Oct 2016	Ward Self Assessments Nov/Dec 2016	SAFER/Red2Green Implementation Jan 2017
F9	100%	100%	100%
F10	23%	97%	98%
F12	45%	13%	100%
G3	18% (on G9)	No data submitted	80%
G4	69%	94%	95%
G5	95%	97%	100%
G8	27%	51%	89%
G9	X	82%	100%
Range	23% - 100%	13% - 100%	80% - 100%

CCD completion variable & difficult to locate within documentation

Top constraints that lead to a patient Red day *(this is as perceived by team/observer):*

1. Awaiting care package
2. TTO completion in advance
3. Speciality review
4. Availability of administration of IVABs outside of an acute Trust
5. No SCDM present

Surgical Division:



Start times: All areas board rounds start at 0830

PDD & CDD:

PDD Completion Percentage

Ward	PDD Audit by Project Nurse (medicine only) Oct 2016	Ward Self Assessments Nov/Dec 2016	SAFER/Red2Green Implementation Jan 2017
F3	X	70%	100%
F4	X	X	X
F5	X	5%	100%
F6	x	15%	85%
Range	X	5% - 70%	85% - 100%

CCD completion variable & difficult to locate within documentation

Top constraints that lead to a patient Red day *(this is as perceived by team/observer):*

1. No SCDM present
2. TTO completion
3. Clinical review
4. OT/PT assessment
5. Fast track discharges

January/February

Identified opportunities for improvement	Update
Patient Transport	Paper submitted to FLAG with recommendations to review contract
Home IV Therapy service	Paper for expansion of the service submitted to FLAG
TTO process	Process to be reviewed
Need SCDM at round	Super user group of consultants (non-ward based) to support
Easy access & place for CCD needed	White board updated process in place
Still lots of variability around process and	Variability reducing – service managers, matrons

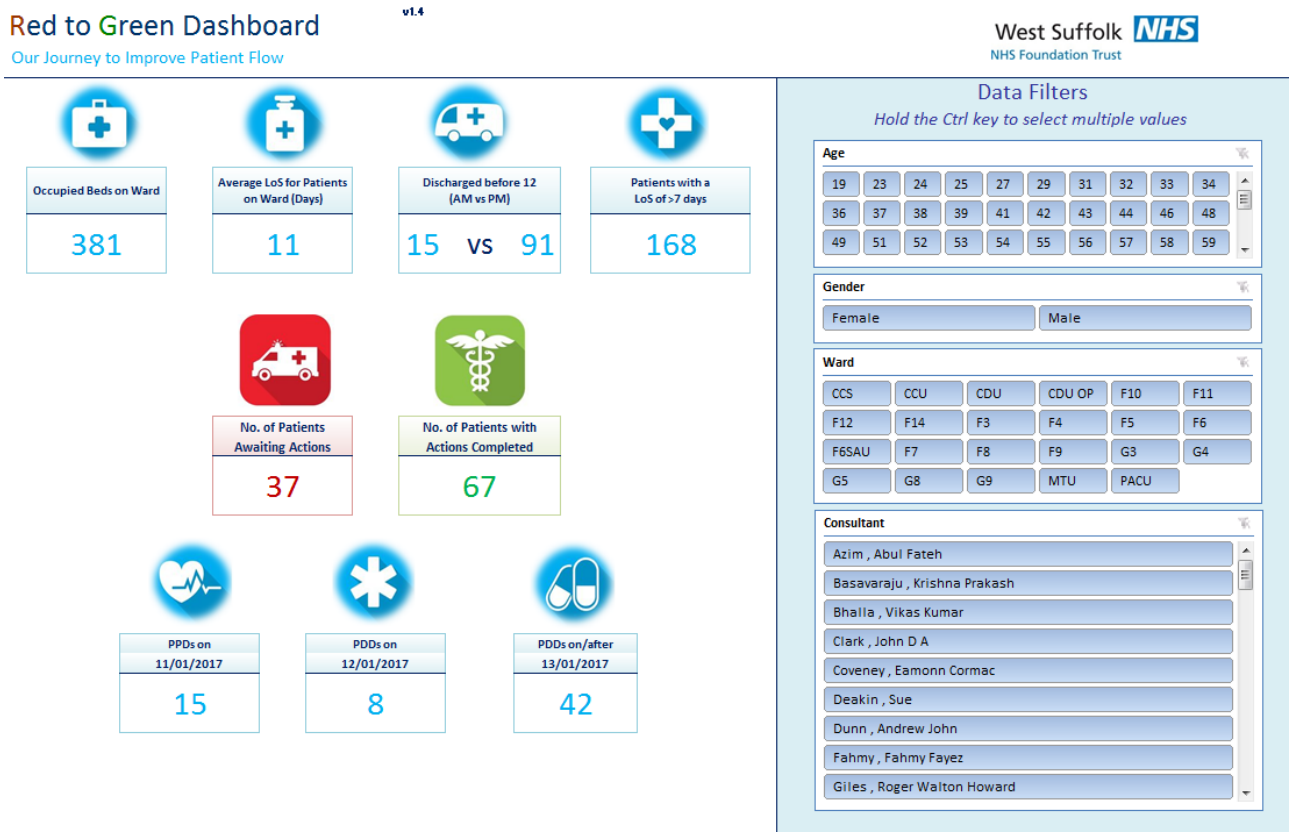
lack of consistency in Red2Green approach	and implementation team to continue with support Posters to enhance the campaign for patient involvement – increase movement and knowledge of the plan
Internal Professional Standards need updating	In process of being updated and developed
Posters to enhance the campaign focusing on patient involvement.	. Posters

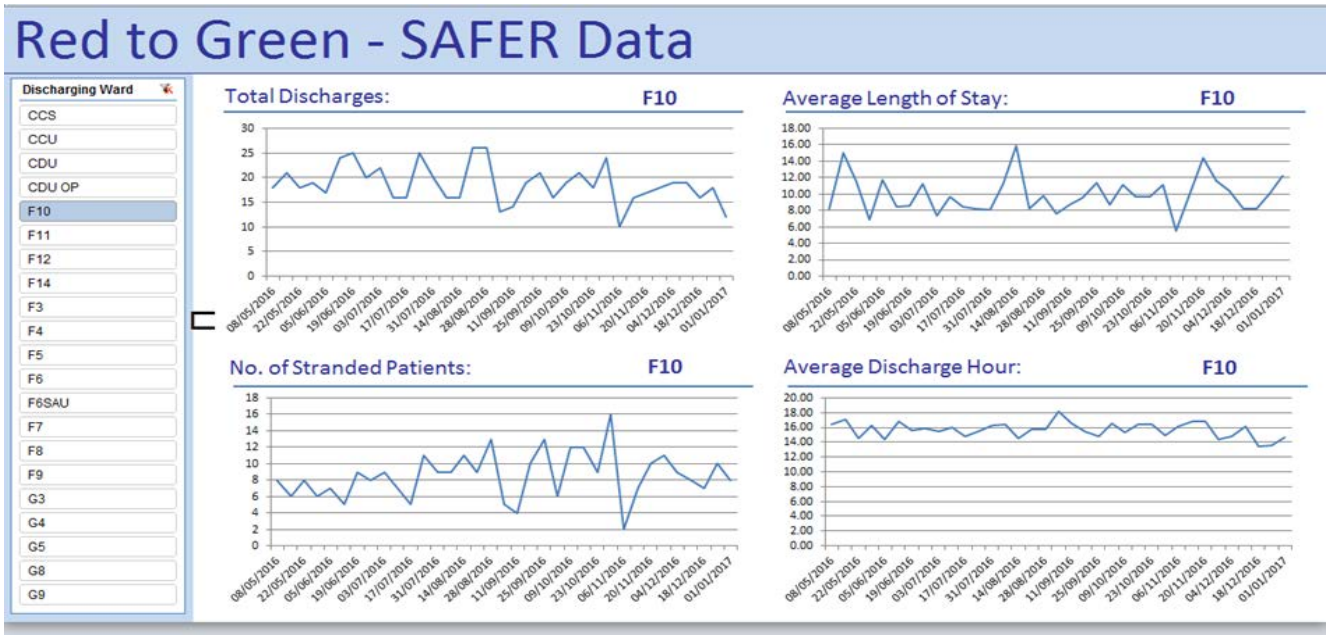
Positive comments

- I feel I really know my patients (Ward Manager)
- Feels like we are discharging more patients
- It's great having clear decisions and actions for each patient

Data

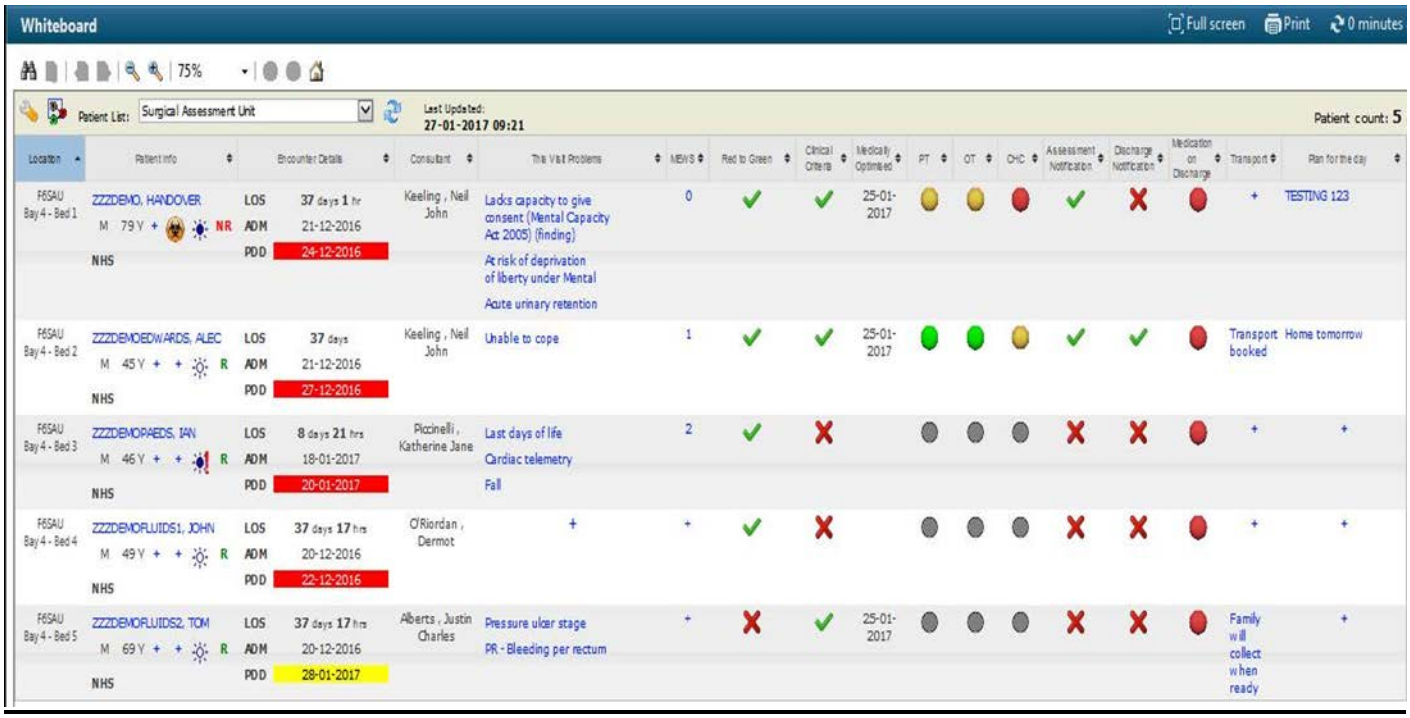
Below are two examples (numbers for display only) of the information available daily which shows previous days data. This can be filtered by ward, consultant, age and sex.





Whiteboard

The ecare team have made changes to the whiteboard as can be seen below to support Red 2 Green – changes include identifying red or green, CCD and actions for today.



Next Steps

- Follow up visit from Pete Gordon (ECIST) in April – All ward lead consultants to be asked to give a 5 minute presentation on how it is for them
- Focus on areas that continue not to have Consultant engagement
- Support to embed ’afternoon huddle’ on all areas consistently
- Continued work with the Information team to enable historical data to be reported
- Focus on timely TTO writing
- Focus on Fridays – ensuring clear plans for weekend through to Monday morning for all patients, inclusive of CCD
- Implementation of complete SAFER Patient Bundle

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 3rd March 2017

AGENDA ITEM:	Item 9
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:	21 FEBRUARY 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 no C Diff (2 in December) - however we have had 22 cases year to date against a threshold of 16. Falls for the month were 61 (65 in December) and 22 pressure ulcers (14 in December) – pages 4 to 5
- Looked after children performance; zero were completed within 28 days, however 10 out of 14 were completed within 28 days of paperwork received (13 offered) - page 37.
- RCA actions overdue are 9 – page 9.

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 87.28% for January; an improvement on December figures. The Flow Action Group continues to work across all wards in the support of the overall system A&E plan - page 23.
- Stroke performance achieved all targets with the exception of percentage of patient scanned within one hour of clock start which was only narrowly missed. All patients requiring support from the Early Support Discharge Team received this - page 27.
- The Cancer target for 62-day wait for first treatment has a draft performance of 82% against the 85% target - final December performance was confirmed as above 85% - page 23.
- The 6 week diagnostic target improved to 96.04% against the 99% target; this was largely due to the Cardiology Department - page 28.
- The Trust had seven breaches of the 52 week target. Full details are on pages 22/23.
- The Trust also failed the rapid access chest pain clinic target - page 28.

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	Nov	Dec	Jan
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	86	100	100
HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	100	100	98
HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	96	99	93
HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100	100	95	100
HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100	87	100	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	85	93	95
HII compliance 7: Clostridium Difficile- prevention of spread	= 100%	<85	85-99	= 100	100	100	NA
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	0	0	0
Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	NA	89	NA
MRSA decolonisation (treatment and post screening) (Trust Level only)	= 90%	<80	80-94	95-100	95	96	93
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	99	100	99
Total no of MSSA bacteraemias: Hospital	No Target	No Target	No Target	No Target	1	0	1
Quarterly Standard principle compliance	90%	<80	80-90%	90-100	NA	93	NA
Total no of C. diff infections: Hospital	= 16 per yr	No Target	No Target	No Target	3	2	0
Total no of C.diff infections: Community acquired (Trust Level only)	No Target	No Target	No Target	No Target	4	0	3
Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	NA	92	NA
Total no of E Coli (Trust level only)	No Target	No Target	No Target	No Target	16	ND	19
Isolation data (Trust level only)	= 95%	<85	85-94	95-100	95	93	90
Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	NA	93	NA
Quarterly VIP score documentation	= 90%	<80	80-89	90-100	NA	83	NA
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	62	65	61
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	18	19	11
No of avoidable serious injuries or deaths resulting from falls	= 0	>0	No Target	= 0	0	ND	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	22	14	22
No of patients with avoidable ward acquired pressure ulcers	= 0	>0	No Target	= 0	5	ND	ND
Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	83.87	83.44	83.85
No of SIRIs	No Target	No Target	No Target	No Target	11	11	14
No of medication errors	No Target	No Target	No Target	No Target	47	57	51
Cardiac arrests	No Target	No Target	No Target	No Target	6	7	3
Cardiac arrests identified as a SIRI	No Target	No Target	No Target	No Target	0	1	1
Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	NA	NA	68
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	87	NA
Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	98.03	98.73	96.69
RCA Actions beyond deadline for completion	0	>=10	5 - 9	0 - 4	11	15	9
% of 'Green' PSI incidents investigated	TBC	TBC	TBC	TBC	59	60	69
Median NRLS upload	26days	>48	27-47	0-26	92	40	50
SIRIs reported > 2 working days from identification as red	0	>1	1	0	0	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	Nov	Dec	Jan
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	0	0	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 January 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.

1.1 HII compliance 2b: Peripheral cannula ongoing

a) Current Position

A score of 98 in January was slightly lower than December (99) and was amber RAG rated for the seventh month in a row. This was based on 8 episodes of non-compliance; where there were two episodes of no documentation of VIP score on G3, four episodes of no ongoing indication for the cannula on G5 and G9 and two cannulas on G5 that had no clinical on-going need.

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 95 in January was higher than December (93) and was amber RAG rated for the seventh month in a row. This was based on 3 episodes of non-compliance; where there were two episodes of no documentation of care on G4, one on G9. G5 did better this month and scored 100%

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 Isolation data (Trust level only)

A score of 90 in January was lower than December (93) and was amber RAG rated for the second month in a row. This score predominantly reflects one patient within the Medical directorate with Mupirocin resistant MRSA for whom the risk of significant harm from falling were they to have been isolated in a single room was deemed to outweigh the risk of onward transmission. In light of this a series of actions were taken to mitigate the risk including a 10 decolonization regimen using Naseptin for the patient and strict hand hygiene observation by the staff. F12 Adult Isolation ward has been at full occupation throughout January 2016.

1.4 Nutrition: Assessment and monitoring

a) Current Position

A score of 83.4 in January was consistent with 83.44 in December failures on ward F7, G9, F10, G4, G5, G8, F3, G1 and F14 were mainly - not weighed on admission x 16, reweighed at 7 days x 3, no nutritional screen on admission x 2.

b) Recommended action

The lead Matron for nutrition has redesigned the audit form to reflect the documentation now on e-Care, it is hoped that this make auditing easier. We continue to raise awareness of importance of these parameters and will revisit at the next ward managers' meetings in February.

Quarterly Pain Audit

a) Current Position

68 in January and RAG rated Red due to insufficient recordings of pain score, the previous audit was 71 with July at 53.

b) Recommended action

Each matron has received ward specific feedback and will be addressing the issues at ward level

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1.5 Total no of C. difficile infections: Hospital

a) Current Position

Performance against trajectory is as follows:

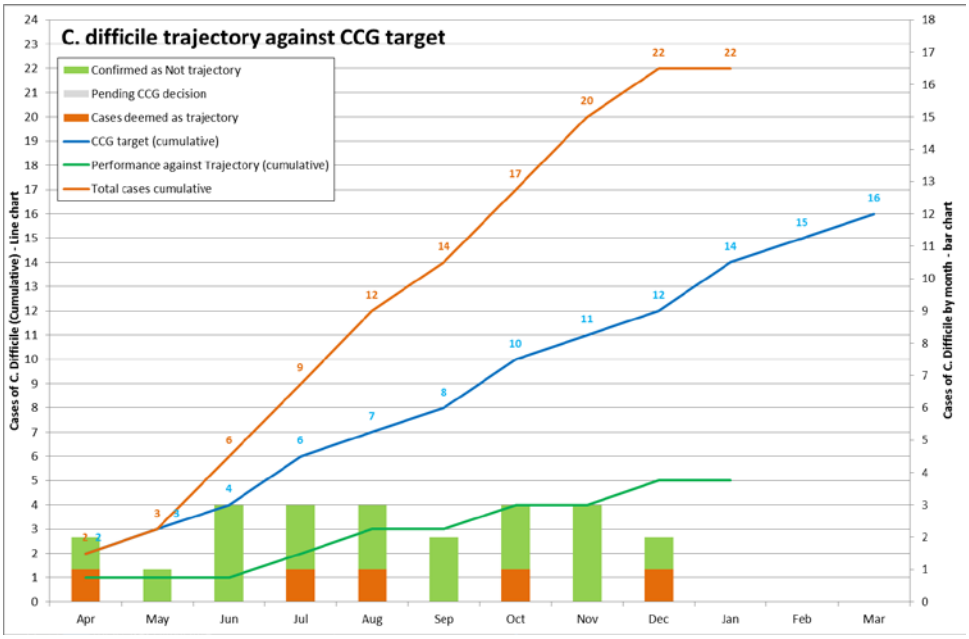
There were no cases of Hospital attributable CDT in January

At the end of January 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; 17 have been deemed non trajectory by our commissioners (no lapses of care) whereby they will not accrue a penalty, there are five trajectory cases and none are pending.

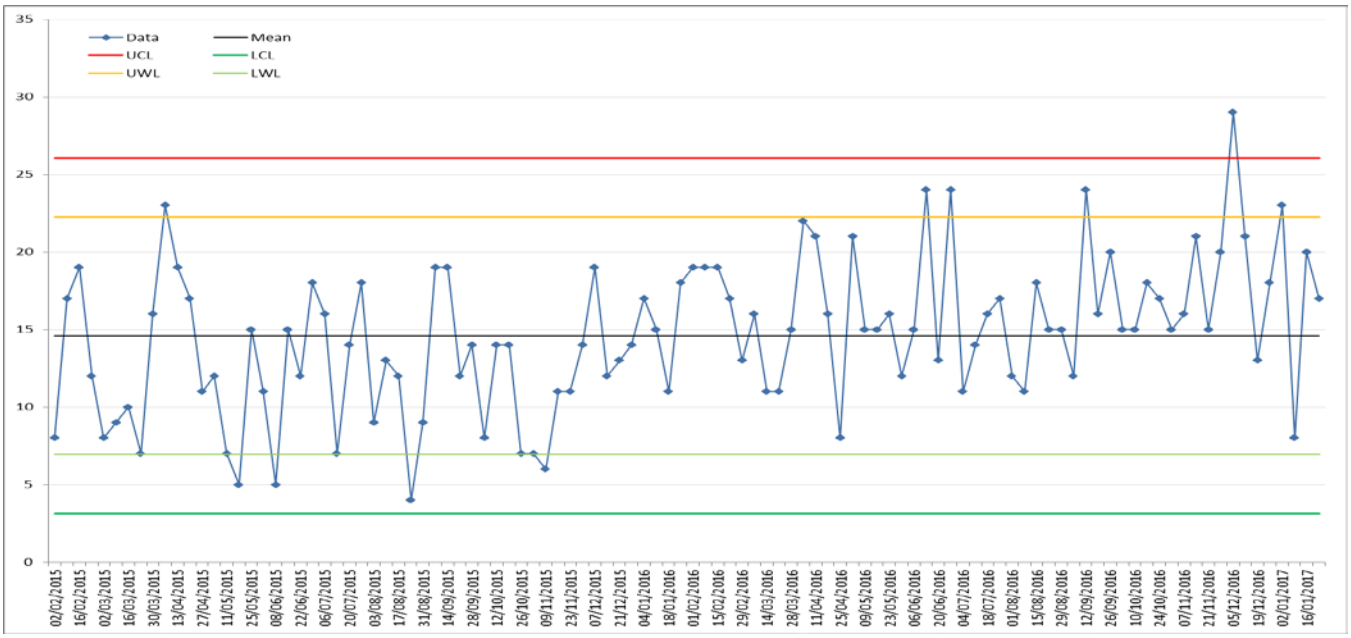
The graph below has been updated to demonstrate the Trust performance against the trajectory target set by the CCG.

b) Recommended Action

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



1.6 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 61 falls in January (65 in December), one with major harm where a patient sustained a fractured neck of femur, this occurred on G9, 2 patients were assisted to the floor one on F10 and one on F3 (3 in December) 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.

No of avoidable serious injuries or deaths resulting from falls. There is no data currently available for December and January as these cases are currently under investigation and these have a 60 working day deadline in line with the Serious incident framework.

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.

Two patients fell more than twice in their inpatient stay this month, three in December.

Six patients fell at Newmarket Hospital (7 in December), One sustained a fractured neck of femur. 5 patients fell at Glastonbury Court (12 in December), these falls are reported separately.

1.7 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	9		
HAPU-2	19	11	8	9	3	11	15	16	8	14		
*Avoidable (%) Cumulative YTD	46%	41%	43%	42%	41%	38%	36%	34%				
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 14 HAPU-2 in January. F3 had four ulcers, F10 had three ulcers, G8 had two ulcers. F7, G4, F9, G9 and Kings Suite had one ulcer each.

There were nine HAPU-3 in January. G9 had four ulcers, G5 had two ulcers. F3, F9 and G8 had one ulcer each.

There were eight DTI reported in January.

There has been a flag raised for G9 due to the number of HAPU reported in the recent period and an update on this will be provided to the next meeting.

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 January there had been 169 HAPU 2, 3 or 4 reported and currently 47 of these have been classified as avoidable, 102 as unavoidable with another 20 pending confirmation of grading as these cases are currently under investigation and these have a 60 working day deadline in line with the Serious incident framework.

This puts the Trust currently meeting the 34% threshold which has consistently has fallen since the beginning of the year

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 had agreed to provide data on numbers and avoidability to another trust who were coordinating an informal benchmarking exercise following a notable rise in the number of reported pressure ulcers at their trust however this has not resulted in any feedback and therefore we have approached Ipswich Hospital with a view to local benchmarking and sharing of lessons learned and good practice.

Pressure ulcer prevention

Lead nurse for Tissue Viability and Senior Matron have been working on developments within the Trust since June 2016, with the aim of making the reporting of pressure ulcers more user-friendly and robust for staff.

The emphasis of the campaign has been on the importance of early skin assessment, prevention and identification of patients at high risk. As part of this Action plan (detailed in the Pressure ulcer project plan) training sessions available to all staff have been set up, the focus has been on E-Care assessments such as the waterlow and skin assessment. Weekly ward walks are being undertaken by Matron Lead for PU and the Tissue Viability Lead to educate and support staff in area of high incidence.

Short competency packs have been rolled out a ward at a time, targeting high incidence areas first. These focus on the identification of patients who are at risk, clear assessments and preventative methods give staff the skills to grade and treat pressure ulcers appropriately. The tissue viability team will be leading on the completion of the competencies.

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

a) Current Position

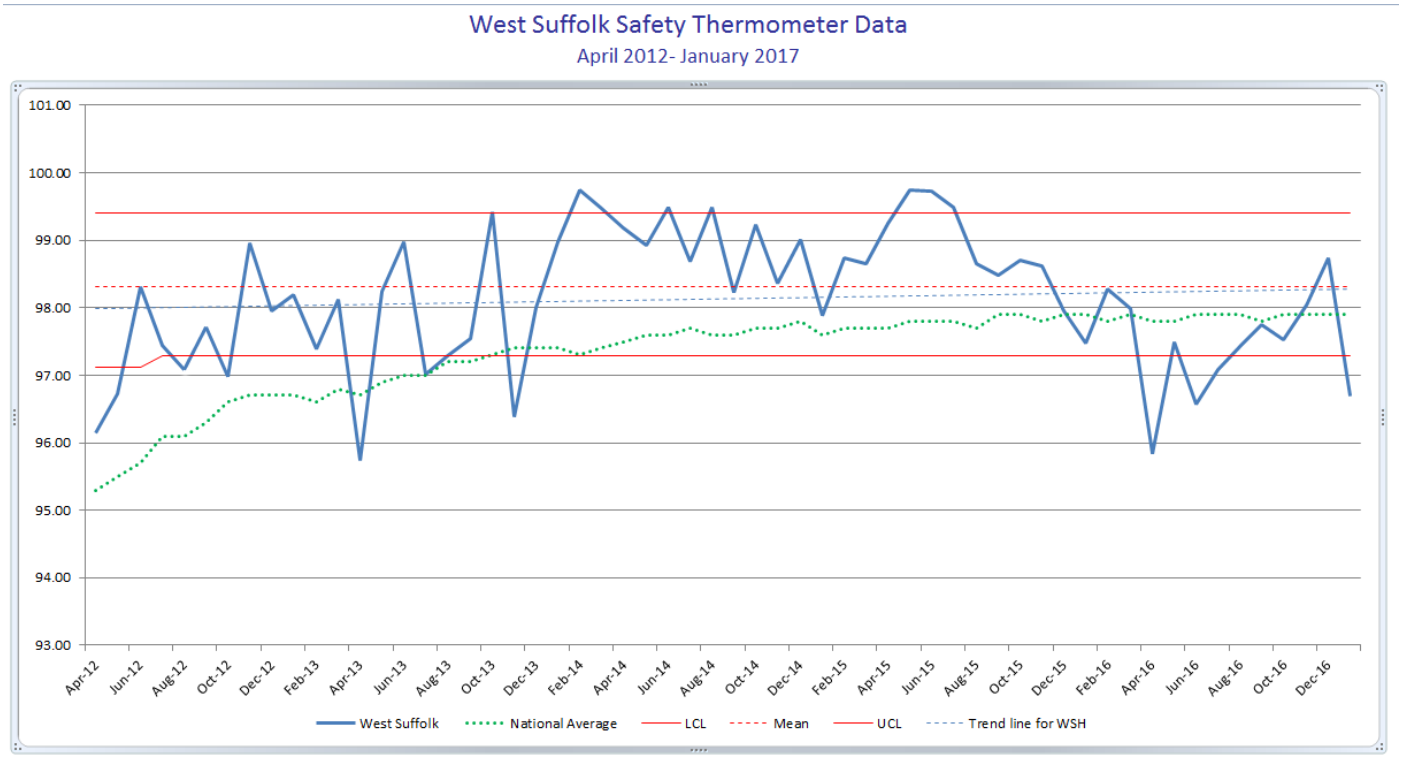
The National 'harm free' care composite measure is defined as the proportion of patients without a pressure ulcer (ANY origin, category II-IV), harm from a fall in the last 72 hours, a urinary tract infection (in patients with a urethral urinary catheter) or new VTE treatment.

	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec - 16	Jan-17
Harm Free	95.30	93.95	91.43	94.97	93.63	92.31	92.25	92.71	92.31	92.61	93.16	91.35
Pressure Ulcers – All	3.47	4.79	4.68	3.27	3.43	5.31	3.88	5.03	5.49	5.67	3.80	5.34
Pressure Ulcers - New	0.99	1.51	2.34	1.26	1.47	1.06	1.29	1.01	1.65	1.23	0.51	1.53
Falls with Harm	0.25	0.25	1.30	0.50	0.49	0.53	0.00	0.75	0.55	0.49	0.76	0.76
Catheters & UTIs	0.99	1.26	2.86	1.26	1.96	2.12	3.62	1.51	2.20	1.23	2.28	2.04
Catheters & New UTIs	0.50	0.00	0.78	0.50	0.98	0.53	0.78	0.50	0.00	0.25	0.00	0.25
New VTEs	0.00	0.25	0.00	0.25	0.49	0.80	0.52	0.00	0.27	0.00	0.00	0.76
All Harms	4.70	6.05	8.57	5.03	6.37	7.69	7.75	7.29	7.69	7.39	6.84	8.65
New Harms	1.73	2.02	4.16	2.51	3.43	2.92	2.58	2.26	2.47	1.97	1.27	3.31
Sample	404	397	3.85	398	408	377	387	398	364	406	395	393
Surveys	18	18	18	18	18	18	18	18	17	18	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 January 2017 is **3.31 %** therefore, our new harm free care is **96.69%** The National new harm for January 2017 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 January 2017. The Trust figures have dropped below the National Average for January.



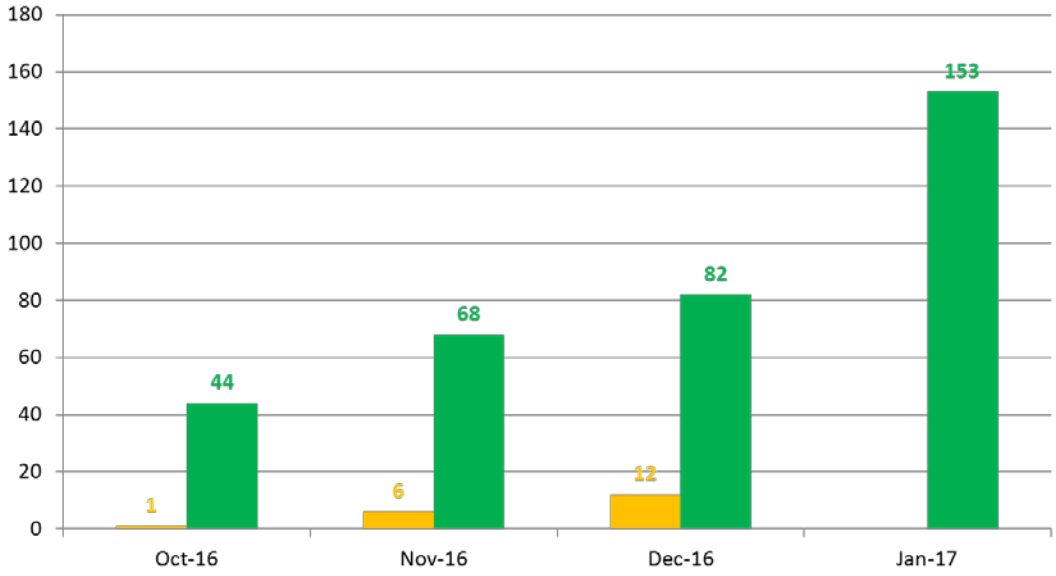
b) Recommended Actions

To continue to monitor actual harm against national benchmarks

1.9 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

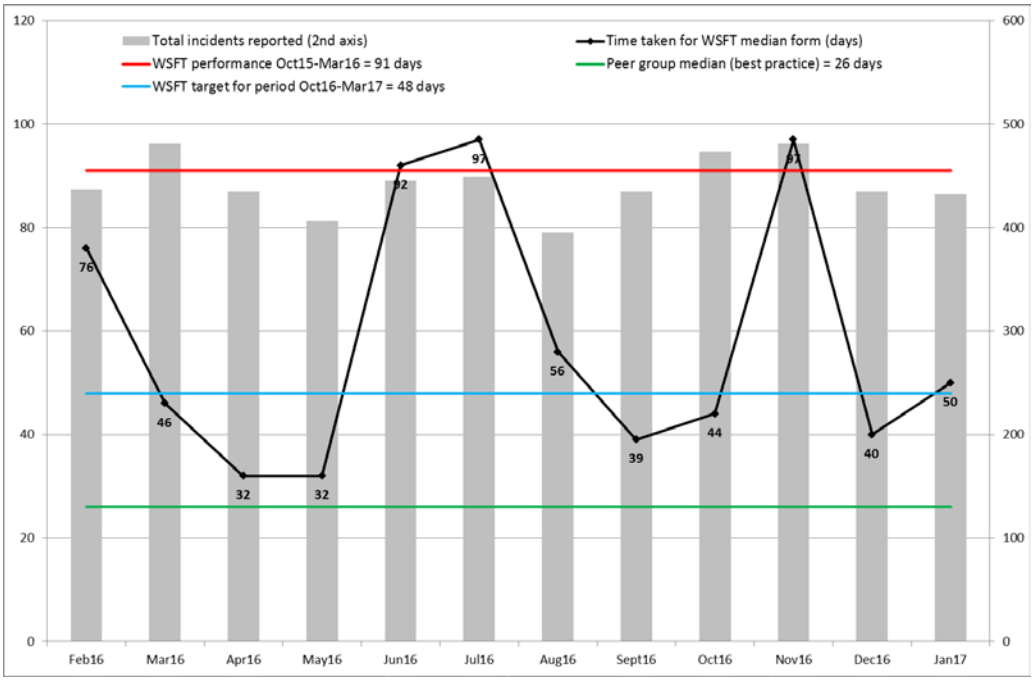
The graph above shows the number of green and amber incidents that are still awaiting investigation. NB: All green incidents up to September 2016 were closed off as part of the six monthly NRLS submission deadline.

291 (69%) of the January green incidents had been investigated at the time of this report compared to (60%) 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.

There are obvious variations in monthly performance and these reflect higher number of incidents reported in November and a recognition that additional administrative support is required to support this and this is now in place from March.



1.10 RCA Actions beyond deadline for completion

a) Current Position

There are currently nine RCA actions showing as overdue on Datix. Seven of these have a due date prior to January 2016.

b) Recommended Action

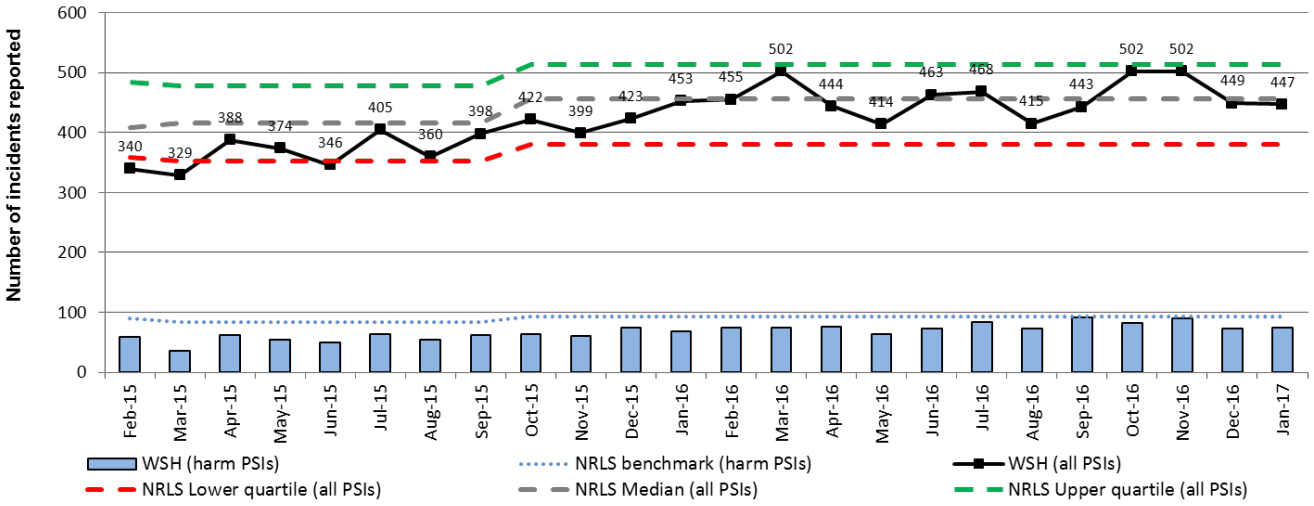
The individual staff members have been contacted to get a position update on each action and an estimated completion date.

1.11 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.

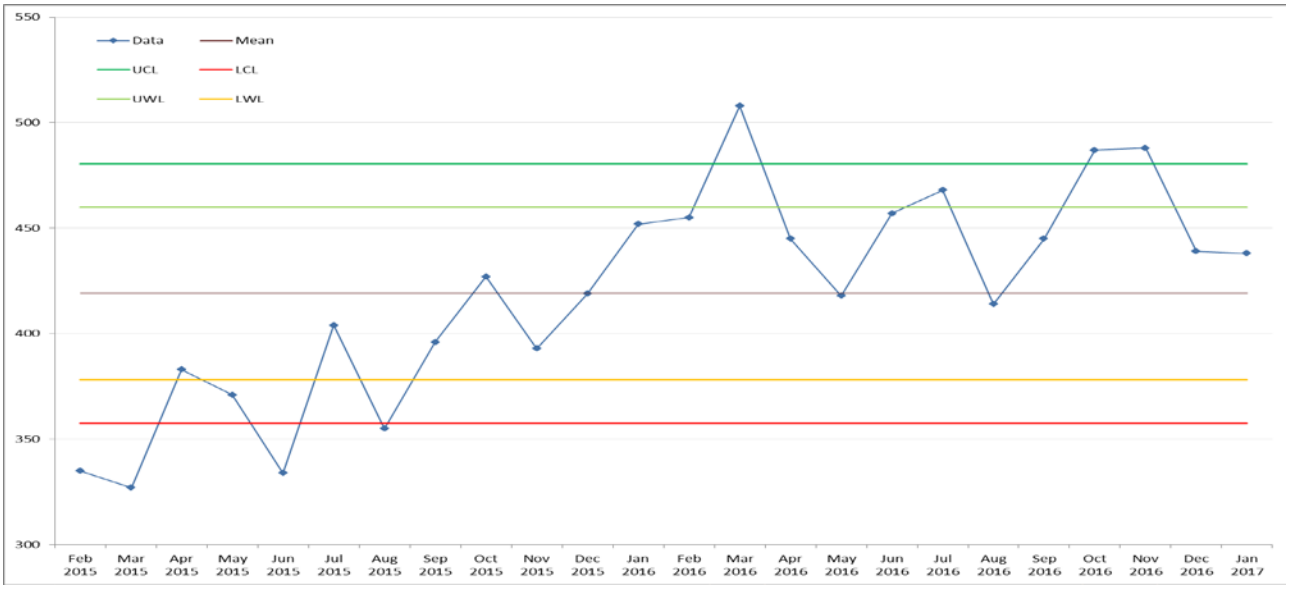
There were 550 incidents reported in January including 447 patient safety incidents (PSIs). This was lower than October / November and similar to December and is just below the median threshold for the peer group. Community incidents are now being captured through Datix e-reporting as of the 1st August 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



1.12 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.

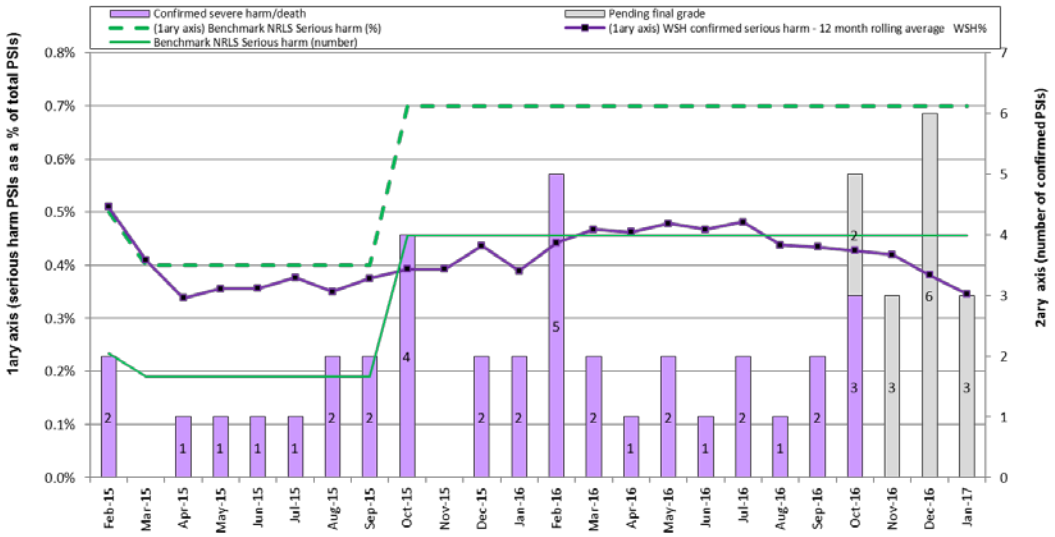
The Trust percentage sits below the NRLS average. The number of serious PSIs (confirmed and unconfirmed) is plotted as a column on the secondary axis.

In January there were three cases reported: two falls resulting in a fractured femur and one cardiac arrest all of which are awaiting RCA to confirm harm grading. The 11 incidents from previous months still awaiting confirmation of harm are still under investigation and therefore awaiting RCA to confirm harm grading. include:

- three intrauterine deaths,
- one complaint relating to a cancer diagnosis,
- one delay in diagnosis,
- one misdiagnosis in the emergency department,
- one cardiac arrest,
- one post-operative complication,

- one fall resulting in a fractured femur,
- one hospital acquired pulmonary embolism,
- one delay in diagnosis

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	Nov	Dec	Jan
Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	83	91	94
(In-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	97	95	99
Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	69	73	70
Timely call bell response	= 85%	<75	75-84	85-100	83	82	84
Patient Satisfaction: outpatient overall result	= 85%	<75	75-84	85-100	92	91	92
(Out-patient) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	97	97	97
Were you informed of any delays in being seen?	= 85%	<75	75-84	85-100	66	67	63
Were you offered the company of a chaperone whilst you were being examined?	= 85%	<75	75-84	85-100	79	76	65
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	98	100	100
Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	93	95	96
(A&E) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	85	95	95
Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	98	97	94
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	95	90	91
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	ND
How likely are you to recommend our antenatal department to friends and family?	= 90%	<80	70-89	90-100	99	100	99
How likely are you to recommend our post-natal care to friends and family?	= 90%	<80	70-89	90-100	93	98	100
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
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	83	93	86
Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	97	93	ND
(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	100	96	ND
Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	ND	98	ND

Indicator	Target	Red	Amber	Green	Nov	Dec	Jan
(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	ND	96	ND
Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	96	93	94
(Stroke) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	100	100	100

Additional Patient Experience indicators

Indicator	Target	Red	Amber	Green	Nov	Dec	Jan
Response within 25 working days or negotiated timescale with complainant	100%	<75%	75 – 89%	>=90%	88	100	86
Number of second letters received	0	>6	2 - 6	0 - 1	3	2	2
Health Service Referrals accepted by Ombudsman	0	>=2	1	0	0	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	2	0

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.

1.13 Inpatient: Noise at night

a) Current Position

Although three lower than last month (73, now 70), this area continues to flag as red.

a) Recommended Action

Staff are continuing to offer RoseVital trays to patients to aid their sleeping. A task and finish group met 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 which is hoped will encourage richer data.

1.14 Inpatient: Timely call bell response

a) Current Position

A score of 84 this month is only one score from a green grade which has shown a gradual improvement in this measure over time.

a) Recommended Action

Continue to monitor.

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

a) Current Position

There has been quite a drop in the score this month (67, now 63) however there was an increase in surveys submitted in the Main Outpatient Department which is likely to have impacted on the score.

b) Recommended Action

An outpatient area observation took place last month and issues were noted. It is planned to undertake further observations across the Trust, reviewing information about delays specifically.

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

a) Current Position

A decrease in this score of 11 is quite significant, flagging this area as red.

b) Recommended Action

Staff will continue to chaperone patients in appointments. As per 1.17, this question is being changed in the new financial year which will eradicate any confusion caused by the wording, giving us a clearer understanding of whether this is an issue.

1.17 Maternity: Information about the Birthing Unit

a) Current Position

This area has flagged as amber due to falling into the amber measures for two months in the last quarter.

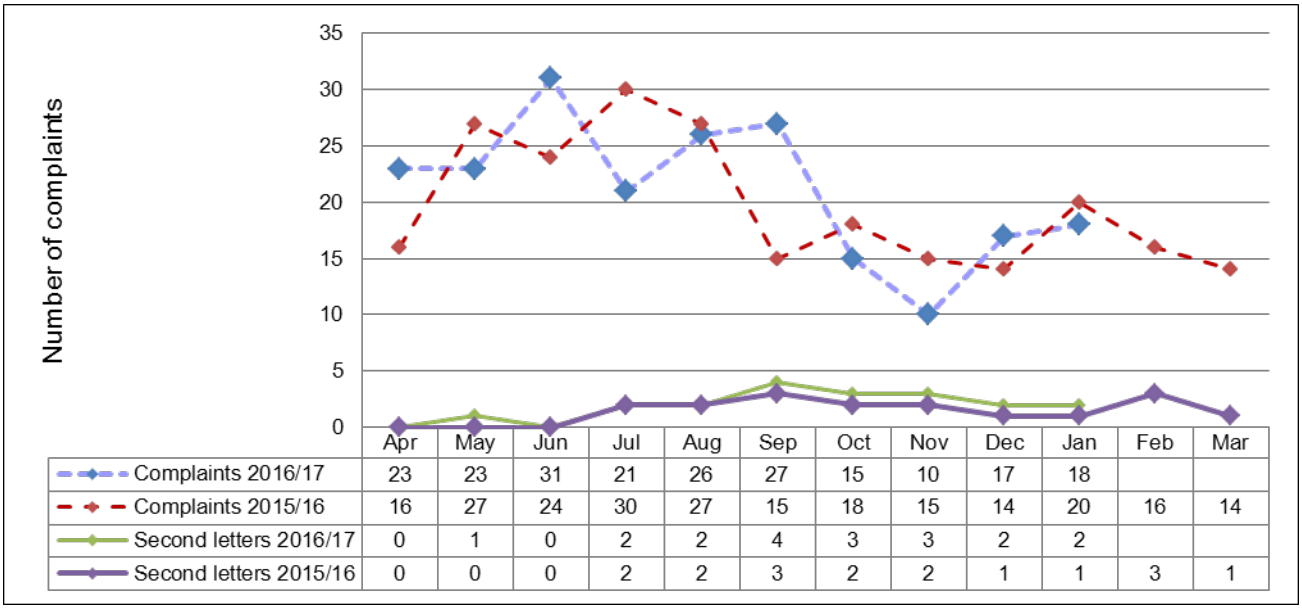
b) Recommended Action

Senior Midwives are looking at developing a booklet informing mothers of the birthing facilities in the hospital as this is not something we currently offer.

1.18 Complaints

18 complaints were received in January, a small increase compared to December (17). 86% of complaints were responded to in January within of the Trust's preferred timeframe. The breakdown of the complaints received in December is as follows by Primary Division: Medical (8), Surgical (8), Women & Children's Health (1) and Estates and Facilities (1). Trust-wide the top three most common problem areas are as below:

Patient Care – including Nutrition/Hydration	14
Clinical Treatment – Surgical group	3
Communications	3



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

1.19 PALS

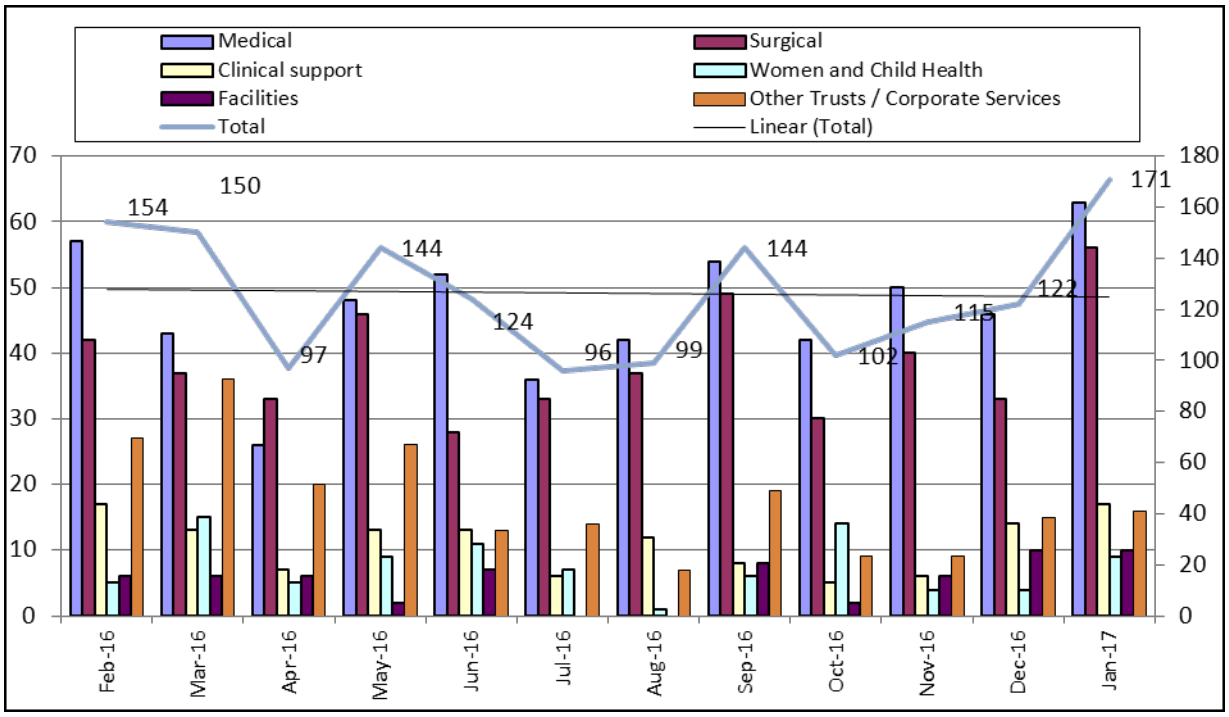
In January 2017 there were 171 recorded PALS contacts. This number denotes initial contacts and not the number of actual communications between the patient/visitor which can, in some particular cases, be multiple.

A breakdown of contacts by Directorate from Feb 16 – Jan 17 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.

Appointments; including delays and cancellations	46
Queries, advice & request information	38
Trust Administration	17

The category of 'Appointments, including delays and cancellations' appeared as the top issues in January, the main theme in this data was the waiting time for hernia operations. We are seeing an increase in rapid access referrals and these are having a direct effect on our ability to manage our non-urgent caseload. There were no identifiable themes for Queries, advice and request for information. Trust administration has seen a rise in patients requesting their medical records.

Eight contacts throughout January were felt to have been of complex nature and Fifteen 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	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	97	NA
Trust participation in relevant ongoing National audits (Quarterly)	100%	<75	75 – 89	>=90	NA	100	NA
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	82.57	84.13	85.85
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 below and elements already reported in the main quality report dashboard have been removed to prevent duplicate reporting. Where an element is co-reported in the Performance section of the report these indicators have been removed from the dashboard below to prevent duplicate reporting.

	Red	Amber	Green	Nov-16	Dec-16	Jan-17
ACTIVITY – Births						
Total Women Delivered	> 250 or < 2 00	>216 or <208	>208 or <216	192	231	195
Total Number of Babies born at WSH	> 250 or < 2 00	>216 or <208	>208 or <216	195	234	198
Twins	No target	No target	No target	3	3	3
Homebirths	< 1%	2% or less	2.5%	3.6%	ND	2.0%
Midwifery Led Birthing Unit (MLBU) Births	<=10%	13% or less	20%	17.2%	20.8%	24.1%
Labour Suite Births	<=64%	69% to 74%	75%	79.2%	76.2%	73.8%
BBAs	No target	No target	No target	2	5	1

	Red	Amber	Green	Nov-16	Dec-16	Jan-17
Normal Vaginal deliveries	No target	No target	No target	133	167	145
Vaginal Breech deliveries	No target	No target	No target	1	0	0
Non operative vaginal deliveries	No target	No target	No target	134	167	145
Water births	No target	No target	No target	11	21	20
Total Caesarean Sections	> 22.6%	No target	<22.6%	17.7%	19%	16.4%
Total Elective Caesarean Sections	>=13%	11 - 12%	10%	5.7%	6.9%	8.2%
Total Emergency Caesarean Sections	>=15%	13 - 14%	12%	12%	12.1%	8.2%
Second stage caesarean sections	No target	No target	No target	6	6	1
Forceps Deliveries	No target	No target	No target	7.8%	3.5%	5.6%
Ventouse Deliveries	No target	No target	No target	4.7%	5.2%	3.6%
Inductions of Labour	No target	No target	No target	34.4%	34.2%	33.8%
Failed Instrumental Delivery	No target	No target	No target	1	1	1
Unsuccessful Trial of Instrumental Delivery	No target	No target	No target	2	1	0
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%	93%	81	71
Total no. of women eligible for Vaginal Birth after Caesarean Section (VBAC)	No target	No target	No target	21	24	11
Number of women presenting in labour for VBAC against number achieved.	No target	No target	No target	10	8	8
ACTIVITY – Bookings						
Number of Bookings (1st visit)	No target	No target	No target	255	226	262
Women booked before 12+6 weeks	<=90%	91 - 94%	95%	97%	95%	93%
CLINICAL OUTCOMES - Maternal						
Postpartum Haemorrhage 1000 - 2000mls	No target	No target	No target	11	15	10
Postpartum Haemorrhage 2,000 - 2,499mls	No target	No target	No target	3	0	0
Postpartum Haemorrhage 2,500mls+	No target	No target	No target	0	4	5
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	0	0	0
Shoulders Dystocia	5 or more	3-4	2	5	7	3
3rd and 4th degree tears (All vaginal deliveries)	No target	No target	No target	7	4	5
3rd and 4th degree tears (Spontaneous Vaginal Deliveries)	10	7-9	6	5	3	5
3rd and 4th degree tears (Instrumental Deliveries)				2	1	0
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	16	20	8
Number of babies with Apgars of <7 at 5 mins at term (37 weeks or more)	No target	No target	No target	3	5	0
Number of Babies transferred for therapeutic cooling	1	No target	0	1	0	1
Cases of Meconium aspiration	No target	No target	No target	0	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	1
Stillbirths	No target	No target	No target	0	3	0
Postnatal activity						
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	75	63
Midwife/birth ratio	>=1:32	No target	1:30	1:28	1:30	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	54	48	54
Serious incidents	No target	No target	No target	0	3	0
Never events	No target	No target	No target	1	0	0
Complaints	No target	No target	No target	0	1	0
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

	Red	Amber	Green	Nov-16	Dec-16	Jan-17
Maternal Postnatal readmissions	No target	No target	No target	ND	ND	ND
Completion of WHO Checklist	80%	90%	100%	82%	96%	93%
Babies assessed as needing BCG vaccine	No target	No target	No target	12	ND	ND
Babies who receive BCG vaccine following assessment	No target	No target	No target	6	ND	ND
UNICEF Baby Friendly Audits	No target	No target	No target	**26**	10	10
Proportion of parents receiving a Safer Sleeping Suffolk Thermometer.	No target	No target	No target	108	ND	156

Exception reporting for red indicators in the Clinical Effectiveness Dashboard

1.20 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 less babies in January 2017 than would be expected, this follows a particularly busy December and appears to just be a nature variation in times of deliver. It is not planned to take any action on this.

1.21 Maternity - Grade 2 Caesarean Section (Decision to delivery time met)

The maternity service undertook 7 grade 2 caesarean sections in January 2017, unfortunately 2 of these were not achieved within the 75 minute target of decision to delivery. Both delays were caused by access to theatre and neither caused any harm.

1.22 Maternity - Number of Babies transferred for therapeutic cooling

In January 1 baby was transferred out to a tertiary centre for therapeutic cooling following an emergency caesarean section. An amber investigation is currently being undertaken at present.

1.23 Maternity - Reported clinical Incidents

The maternity service notes a slight reduction in the reporting of clinical incidents in January 2017, no cause noted but may be related to the lower delivery figure for the month, this will be monitored.

1.24 Maternity - Completion of WHO Checklist

In January 2017 the maternity service achieved a 93% completion rate of WHO checklists, identified in a documentation audit, the service has actions in place to address this, which are on-going. There are no reports of any clinical incidents stemming from this lack of documentation.

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

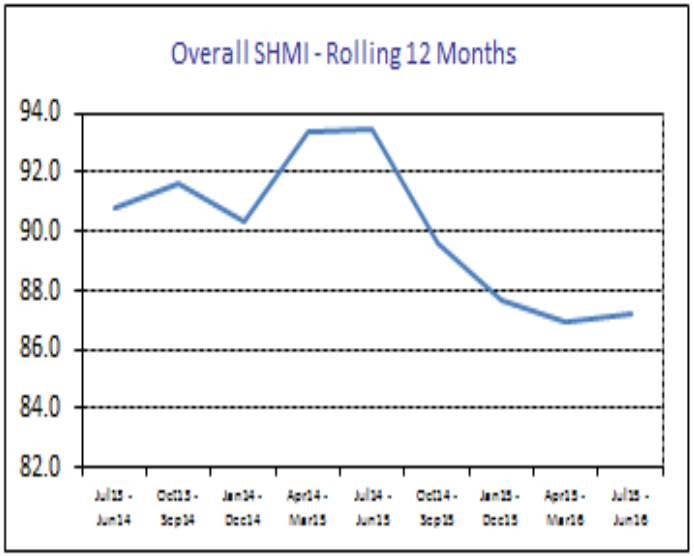
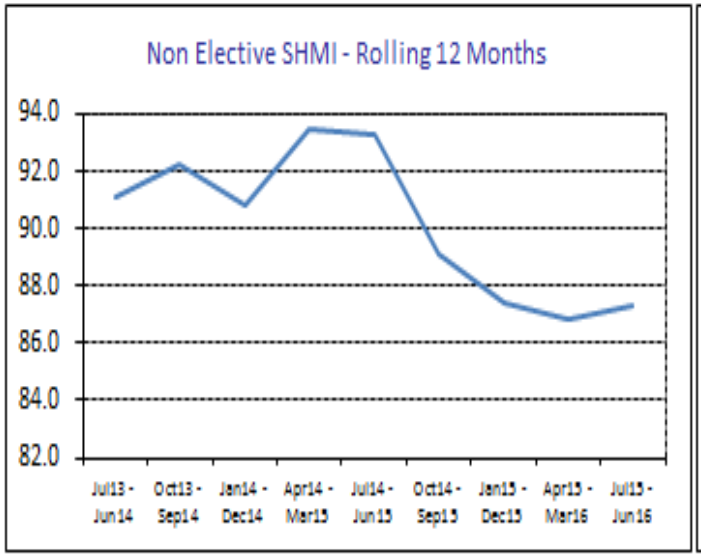
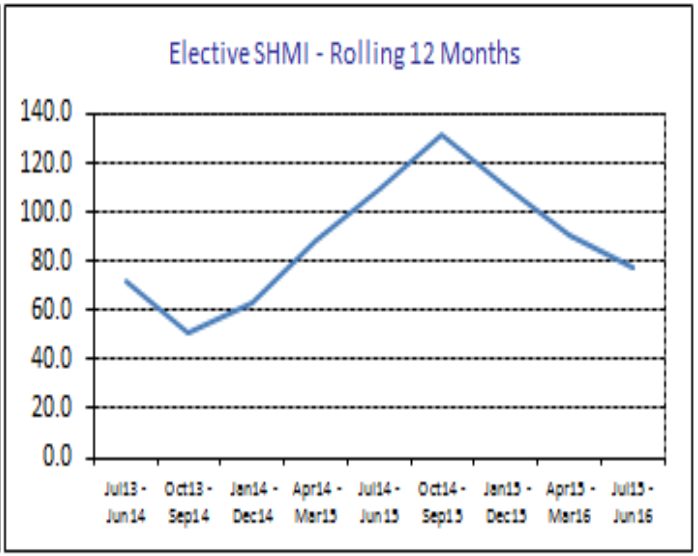
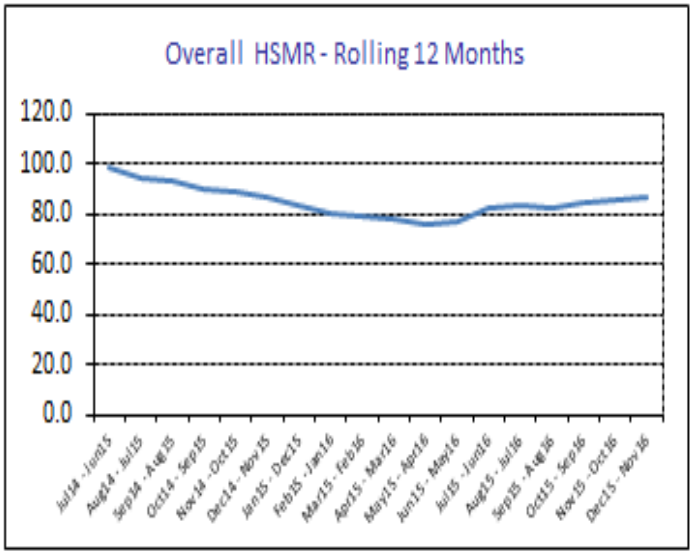
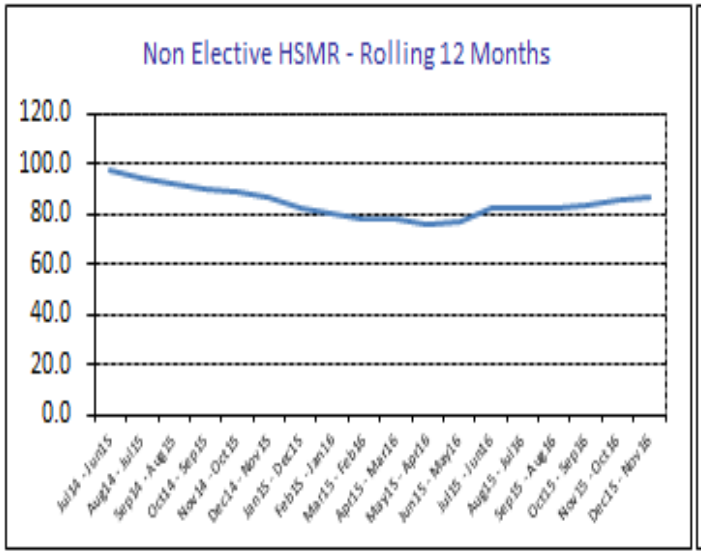
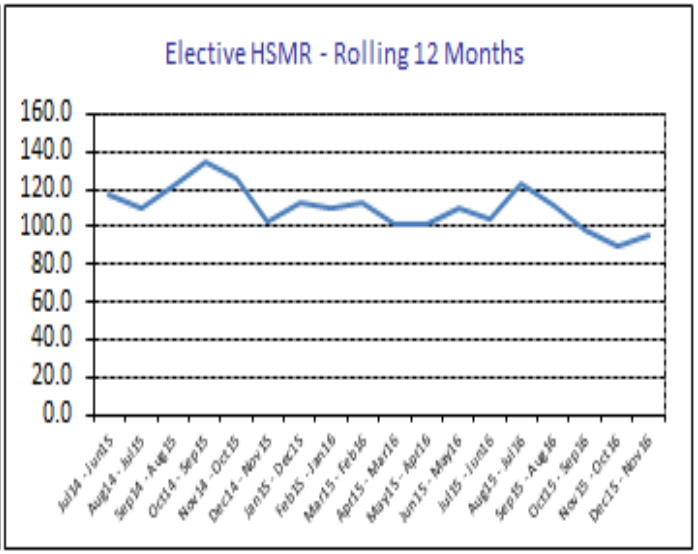
2. MORTALITY DATA

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	103		
No of Discharges	5,321	5427	5691	5410	5400	5674	5733	5950	5401	5577		
% Deaths	1.33%	1.60%	1.25%	1.07%	1.37%	1.45%	1.45%	1.65%	1.89%	1.85%		
HSMR*												

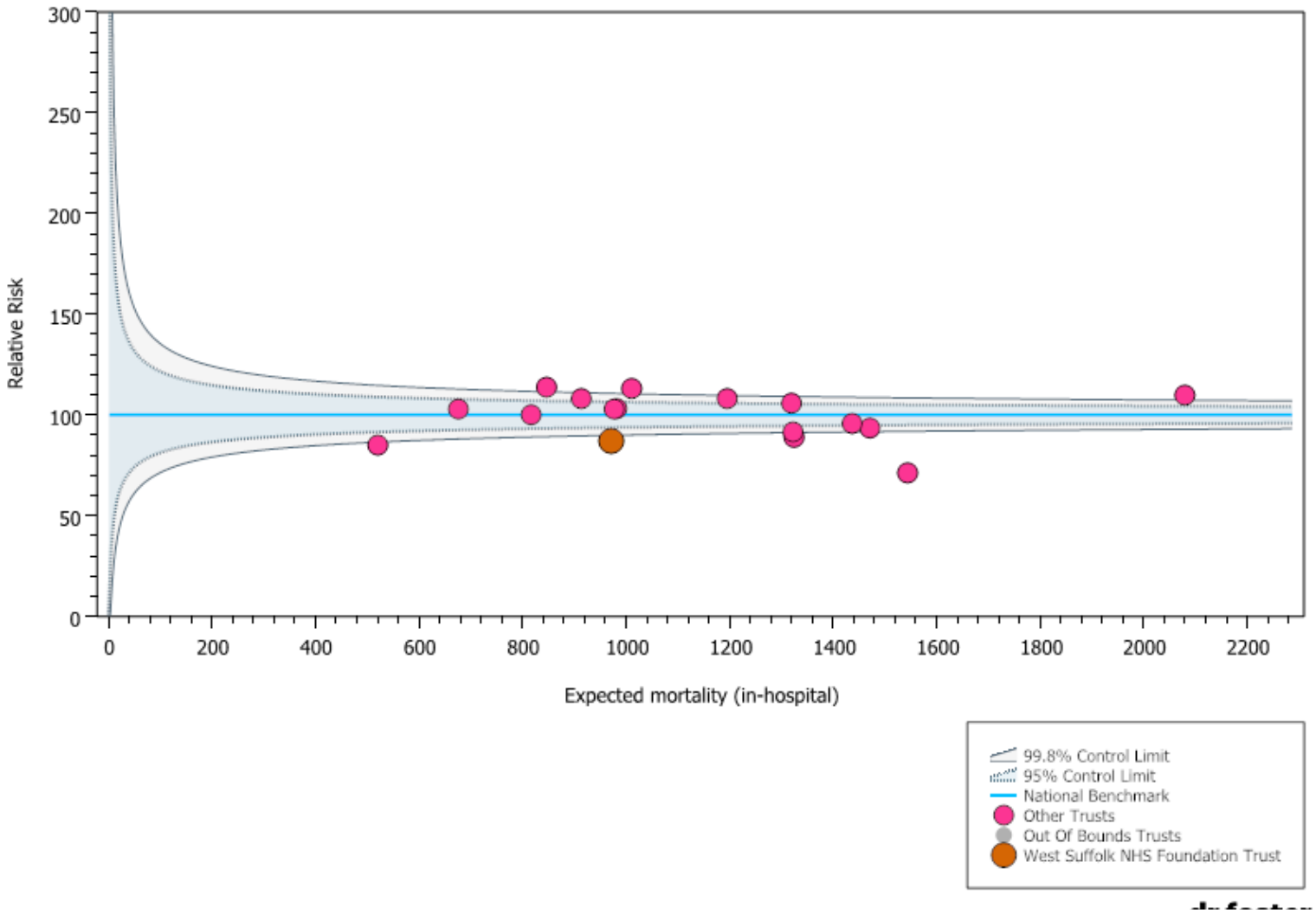
HSMR BENCHMARK IS USING FY 15 -16

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										

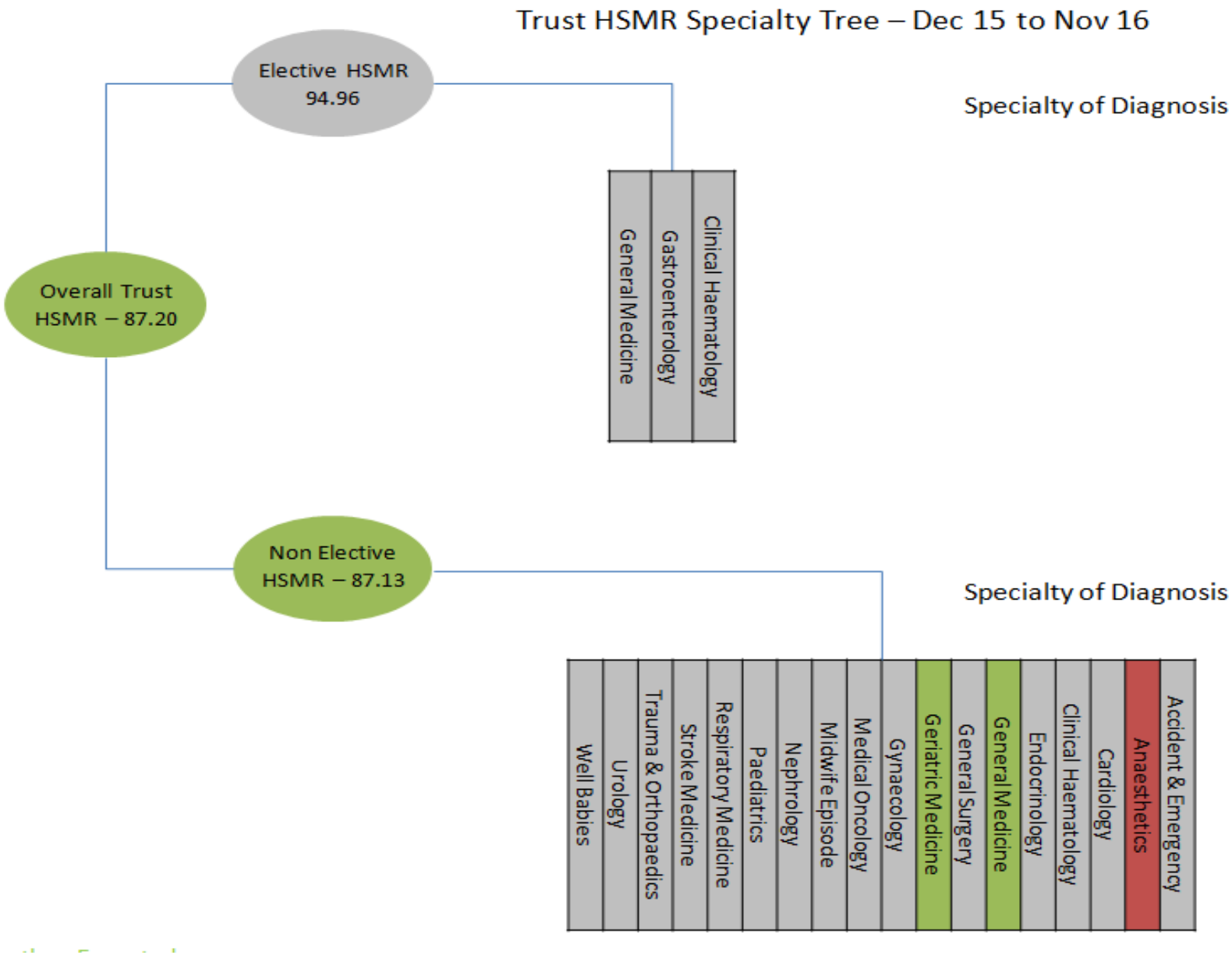
HSMR - Rolling 12 Months	Jun13 – May14	Jul13 – Jun14	Aug13 – Jul14	Sep13 – Aug14	Oct13 – Sep14	Nov13 – Oct14	Dec13 – Nov14	Jan14 – Dec14	Feb14 – Jan15	Mar14 – Feb15	Apr14 – Mar15	May14 – Apr15
Overall Observed Deaths	755	758	779	798	804	792	803	842	902	934	938	946
Overall Expected Deaths	883	894	902	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	850					
Overall Expected Deaths	1020	948	949	960	965	916	975					
Overall HSMR	77.1	82.4	83.3	82.6	84.1	85.9	87.2					
Non Elective HSMR	76.8	82.2	83.0	82.4	84.0	85.8	87.2					
Elective HSMR	109.8	104.4	122.4	111.3	99.2	89.8	95.3					

	Overall	Non-Elective	Elective
SHMI			
HSMR			

HSMR - December 2015 - November 2016



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


Trust HSMR Specialty Tree – Dec 15 to Nov 16
Elective HSMR 94.96
Specialty of Diagnosis
Clinical Haematology
Gastroenterology
General Medicine
Overall Trust HSMR – 87.20
Non Elective HSMR – 87.13
Specialty of Diagnosis
Accident & Emergency
Anaesthetics
Cardiology
Clinical Haematology
Endocrinology
General Medicine
General Surgery
Geriatric Medicine
Gynaecology
Medical Oncology
Midwife Episode
Nephrology
Paediatrics
Respiratory Medicine
Stroke Medicine
Trauma & Orthopaedics
Urology
Well Babies

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	January
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%	90.30%	92.13%	1.0	Jon Green	95.61%	95.69%	96.75%	93.25%	92.93%	92.16%	92.16%	92.09%	92.03%	90.30%
Number of RTT Waits over 52 weeks for incomplete pathways	0	7	7	-	Jon Green	1	1	1	0	0	0	1	0	0	7
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	87.28%	85.36%	1.0	Jon Green	90.62%	82.26%	83.56%	85.20%	88.59%	88.21%	86.14%	84.51%	86.50%	87.28%
All cancers: 62-day wait for first treatment (5) from:Urgent GP referral for suspected cancer - **See Further detail below**	85%	78.79%	85.70%	1.0	Jon Green	86.10%	86.80%	90.80%	100.00%	87.40%	83.80%	88.14%	84.31%	85.58%	78.79%
All cancers: 62-day wait for first treatment (5) from: NHS Cancer Screening Service referral	90%	100.00%	100.00%		Jon Green	100.00%	100.00%	100.00%	100.00%	92.60%	100.00%	100.00%	100.00%	96.43%	100.00%
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%	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%	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%	100.00%
Cancer: two week wait from referral to date first seen (8), comprising: all urgent referrals (cancer suspected)	93%	90.00%	97.19%	0.5	Jon Green	99.00%	95.90%	81.00%	97.30%	93.00%	94.30%	97.05%	97.48%	97.46%	90.00%
Cancer: two week wait from referral to date first seen (8), comprising: for symptomatic breast patients (cancer not initially suspected)	93%	88.50%	98.17%		Jon Green	99.20%	91.00%	64.30%	76.50%	57.90%	99.00%	98.31%	99.17%	93.23%	88.50%
Outcomes:															
Clostridium (C.) difficile - meeting the C.difficile objective - MONTH	2	0			Rowan Proctor	1	1	3	3	3	2	3	3	2	0
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	4.0

West Suffolk NHS Foundation Trust Cancer Waits Performance Report - December 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	11		11	100	95.9
Gynae	1+2x.5		2	100	78.4
Haem		1x.5	0.5	0	80.7
Head & Neck	1+1x.5	2x.5	2.5	60	64.5
Lower GI	5	2	7	71.4	74.4
Lung	2		2	100	72.9
Other					
Skin	6	1	7	85.7	94
Upper GI	3+2x.5	1x.5	4.5	87.5	75.6
Urology	12+2x.5	2+1x.5	15.5	83.9	79.7
Total	41+7x.5	5+5x.5	52	85.6	82.9

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 Maximum time of 18 weeks from point of referral to treatment in aggregate - patients on an incomplete pathway

a) Current Position

90.30% against a threshold of 92%

b) Recommended Action

The Trust reported a fail of the 18-week incomplete pathway target for the first time. Due to continued problems with e-Care reporting (see e-Care reports), this remains an estimated figure. However, a risk assessment of the of the overall position of the Trust has assessed the current position of individual specialties to estimate the position. The overall failure is driven by performance issues in five specialties; ENT, Urology, Vascular, Oral and Dermatology. Individual action plans to address each specialty demand and capacity issues along with backlogs are being worked on and progress will be monitored by the Executive Team as well as with the CCG.

3.2 Number of RTT waits over 52 weeks for incomplete pathways

a) Current Position
7 against a threshold of 0

b) Recommended Action
The Trust is reporting 7 breaches of the 52 week waiting standard. This involves three Vascular patients and four ENT patients. All seven patients involve a mixture of incorrect coding, lacking of a PTL to track patients, compounded by a human error for the ENT patients. The Vascular patients are also affected by a lack of capacity. With the introduction of a functioning PTL we have tested all +40 week breaches which has contributed to the identification of these patients. Currently all of the ENT patients have now been treated and two of the three Vascular patients have been treated.

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

a) Current Position
87.28% against a threshold of 95%

b) Recommended Action
The Trust has continued to experience significant surges in demand. 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.

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

a) Current Position
82% against a threshold of 85%

b) Recommended Action
A number of breaches are due to capacity around the Christmas and New Year time. All potential breaches were escalated to their relevant teams. There remain high numbers of incoming 2 WW referrals resulting in 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.

Breast
There was 2 x Complex Pathways. One required input from the specialist centre and there was 2 days delay due to issues around chemo prep and was treated on day 64.
The second patient was delayed for 2 days due to healing time for the diagnostic wound to treat metastatic conditions prior to commencing chemotherapy on day 64.

Colorectal
There were capacity issues around the Christmas and New Year time and the patient had surgery on day 63.

Skin
There was one patient delayed due to co-morbidity and two patients due to capacity issues.

Upper GI
This patient had a complex pathway requiring cross-MDT referrals and SMDT inputs before a decision to treat locally and was treated on day 112. RCA sent to the team for Clinical Harm Review.

Gynae
There were 3 x shared breaches with Addenbrookes. Two patients underwent changes in their treatment plan and were treated on day 65. One patient had a co-morbidity that caused a delay, although their original treatment was planned on time, and were treated on day 65.

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

a) Current Position
0 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	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Change mth on mth	On Plan To Achieve	Area of Concern	Forecast to Breach
A&E																					
A&E Time to treatment in department (median) for patients arriving by ambulance - CDM	Median time to treatment above 60 minutes	50	65		Jon Green	80	89	93	73	65	81	71	61	58	46	56	50	↗			
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	13:19	17:28		Jon Green	11:16	15:18	14:36	11:55	13:28	12:17	12:50	12:47	12:25	15:00	17:28	13:19	↗			
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	0	0	0	0	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%	34.91%	31.76%		Jon Green	28.31%	26.79%	26.01%	29.86%	31.43%	31.03%	32.74%	31.89%	32.30%	33.73%	34.02%	34.91%	↘			
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	ONE MET	ONE MET	ONE MET	ONE MET	ONE MET	ONE MET	ONE MET	ONE MET	↔			
A&E & AMU - Ambulance submit button complete	80%	90.16%	83.72%		Jon Green	86.11%	83.09%	81.44%	72.18%	77.73%	83.65%	83.22%	87.90%	91.57%	88.38%	90.46%	90.16%	↘			
A&E - Ambulance Handovers above 30 minutes	0 handovers over 30 minutes - £200 per breach	ND	242	**Unvalidated data until March; validated thereafter. Nov numbers updated from 33, 15.**	Jon Green	182	297	16	25	11	24	19	20	45	36	46	ND				
A&E - Ambulance Handovers above 60 minutes	0 handovers over 60 minutes - £1000 per breach	ND	53		Jon Green	24	63	3	9	2	5	1	3	7	10	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%	80.00%	78.71%		Jon Green	57.14%	66.20%	63.64%	72.73%	92.31%	78.26%	74.07%	79.17%	86.21%	83.33%	93.55%	80.00%	↘			
RTT																					
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway under 26 weeks	99.00%	96.07%	98.09%		Jon Green	99.04%	98.85%	98.82%	99.06%	99.06%	98.84%	98.76%	97.82%	98.01%	97.94%	97.15%	96.07%	↘			
Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted	90.00%	67.88%	74.90%		Jon Green	77.76%	77.83%	75.73%	81.27%	83.21%	78.15%	76.93%	68.55%	68.28%	70.34%	70.60%	67.88%	↘			
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95.00%	87.51%	92.61%		Jon Green	97.36%	97.12%	96.45%	97.14%	96.75%	95.83%	94.27%	92.17%	87.61%	86.35%	89.37%	87.51%	↘			
Stroke																					
% of patients scanned within 1 hour of clock start	77% (Contract) 57.5% (Upper Quartile)	76.32%	75.28%		Jon Green	NA	NA	57.00%	76.47%	81.08%	68.75%	77.27%	84.38%	77.50%	77.78%	80.56%	76.32%	↘			
% of patients scanned within 12 hours of clock start	96% (Contract) 96% (Upper Quartile)	100.00%	97.43%		Jon Green	NA	NA	96.00%	91.18%	97.37%	96.88%	97.73%	100.00%	100.00%	100.00%	97.22%	100.00%	↗			
% of patients admitted directly to Stroke Unit within 4 hours of clock start	75% (Contract) 70% (Upper Quartile)	83.78%	74.23%		Jon Green	80.00%	75.00%	62.50%	75.76%	78.79%	54.84%	77.27%	81.25%	76.32%	84.00%	77.14%	83.78%	↗			
>80% treated on a stroke unit >90% of their stay	90%	91.89%	88.03%		Jon Green	91.00%	89.00%	87.50%	96.97%	87.88%	74.19%	86.36%	93.75%	92.11%	83.33%	88.57%	91.89%	↗			
% of patients treated by a stroke skilled early supported discharge team	48% (Contract) 48% (Upper Quartile)	46.67%	43.96%		Jon Green	NA	NA	30.00%	55.56%	59.26%	44.00%	42.42%	31.03%	40.74%	47.37%	68.18%	46.67%	↘			
% of patients assessed by a stroke specialist consultant physician within 24 hours of clock start.	80% (Contract) 79% (Upper Quartile)	81.58%	85.61%		Jon Green	NA	NA	72.00%	82.35%	83.78%	84.38%	86.36%	87.50%	92.50%	92.59%	86.11%	81.58%	↘			
% 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)	77.14%	76.69%		Jon Green	NA	NA	82.61%	58.62%	78.57%	65.52%	76.19%	80.00%	87.50%	86.96%	88.89%	77.14%	↘			
% of eligible service users given thrombolysis	100% (RCA to be provided for breaches)	100.00%	30.26%		Jon Green	NA	NA	4.00%	14.71%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	↔			
All stroke survivors to have a 5 month follow up assessment.	50%	50.00%	57.59%		Jon Green						65.18%						50.00%	↘			
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)	B	B	Reports are generated by SSNAP every 4 months - this is as at November 2016, reported for February Board	Jon Green						D						B	↗			
Discharge Summaries																					
Discharge Summaries - Outpatients	85% sent to GP's within 3 days	ND			Pam Chrispin	93.64%	92.27%	91.94%	ND	ND	ND	ND	ND	ND	ND	ND	ND	-			
Discharge Summaries - A&E	95% of A&E Discharge Summaries to be sent to GPs within one working day	98.08%	97.69%		Pam Chrispin	97.99%	97.50%	96.77%	98.35%	98.81%	99.01%	97.29%	97.19%	97.41%	95.26%	98.85%	98.08%	↘			
Discharge Summaries - Inpatients	95% sent to GP's within 1 day	94.33%	91.94%		Pam Chrispin	90.02%	89.78%	92.13%	82.87%	93.75%	92.60%	93.80%	93.32%	93.39%	92.96%	92.28%	94.33%	↗			
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	ND	ND	ND	ND	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%	100.00%	100.00%	100.00%	100.00%	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	1.35%	0.83%		Jon Green	1.02%	1.60%	0.68%	1.32%	0.42%	0.58%	0.69%	0.89%	1.30%	0.83%	1.28%	1.35%	↘			
Patients offered date within 28 days of cancelled operation	100%	100.00%	94.68%		Jon Green	96.67%	95.56%	100.00%	90.63%	100.00%	85.71%	93.75%	90.91%	94.29%	100.00%	89.66%	100.00%	↗			
No urgent operation should be cancelled for a second time	0 2nd Urgent Cancellations	0			Jon Green	0	0	0	0	0	0	0	0	0	0	0	0	↔			
Maternity																					
Access to Maternity services (VS806)	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.	93.13%	95.92%		Rowan Proctor	92.79%	96.03%	94.23%	96.05%	97.40%	96.83%	94.44%	94.12%	97.24%	97.25%	95.13%	93.13%	↘			
Maintain maternity 1:30 ratio	1:30	01:28	01:29		Rowan Proctor	01:27	01:31	01:30	01:30	01:30	01:30	01:29	01:29	01:29	01:28	01:30	01:28	↗			
Pledge 1.4: 1:1 care in established labour	1:1	100.00%	99.95%		Rowan Proctor	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.50%	100.00%	100.00%	100.00%	100.00%	↔			
Breastfeeding initiation rates.	80%	73.98%	78.04%		Rowan Proctor	76.53%	77.88%	77.42%	76.85%	75.61%	75.78%	74.18%	80.36%	82.41%	80.00%	79.65%	73.98%	↘			
Reduction in the proportion of births that are undertaken as caesarean sections.	22.70%	16.33%	19.15%		Rowan Proctor	21.73%	22.42%	20.28%	16.67%	21.46%	15.70%	18.31%	23.08%	20.37%	17.44%	19.0%	16.33%	↗			
Other contract / National targets																					
Mixed Sex Accomodation breaches	0 Breaches	0	5		Jon Green	0	2	1	2	0	0	0	2	0	0	0	0	↔			
Consultant to Consultant referral	Commissioner 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	8.90%	8.90%	9.53%	ND	ND	ND	ND	ND	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	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	-			
MRSA - Elective screening	100% Screened prior to admission		TBC		Rowan Proctor	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	TBC	-			
Rapid access - chest pain clinic	100% of patients should have a maximum wait of two weeks	49.47%	79.56%	December revised as one less breach as patient cancelled	Jon Green	100.00%	100.00%	100.00%	100.00%	100.00%	95.45%	100.00%	97.44%	94.34%	73.44%	89.58%	49.47%	↘			
Acute oncology service: 1 hour to needle from diagnosis of neutropenic sepsis	100%	100.00%	98.48%	MacMillan	Jon Green	100.00%	100.00%	97.31%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	↔			
		54.55%	78.81%	ED	Jon Green	84.21%	89.47%	75.00%	87.50%	76.47%	73.33%	75.00%	78.95%	82.35%	83.33%	80.00%	54.55%	↘			
		72.22%	94.57%	Overall Trust (Inc AMU)	Jon Green	88.89%	93.75%	85.71%	92.31%	82.61%	82.61%	81.25%	84.00%	88.00%	88.24%	90.48%	72.22%	↘			
New to Follow up	Thresholds set at each speciality - overall Trust Threshold is 1.9	2.11	1.98		Jon Green	2.03	1.91	2.01	1.77	1.86	2.01	1.95	1.98	2.08	2.01	2.15	2.11	↘			
Patients receiving primary diagnostic test within 6 weeks of referral for diagnostic test	99%	96.04%	95.77%		Jon Green	99.81%	99.88%	99.02%	97.58%	94.17%	96.07%	92.16%	91.78%	96.40%	99.40%	94.83%	96.04%	↗			
All relevant inpatients undergoing a VTE Risk assessment	95%	TBC			Jon Green	100.00%	99.87%	97.60%	TBC	TBC	TBC	TBC	TBC	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
On this occasion the breach case which exceeded the 6hrs wait was that of a psychiatric patient who was waiting to be seen by the Access and Assessment team. There were also extended wait for this as the patient needed sectioning and transfer to a secure unit.

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

a) Current Position
34.91% against a threshold of 27%.

b) Recommended Action
The Trust has continued to experience significant demand. 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. In addition, the Trust is creating a daily 'pulling' approach for ambulatory emergency care patients. Both initiatives 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
96.07% against a threshold of 99%.

b) Recommended Action
This is due to known significant capacity issues within ENT and Oral Surgery particularly patients who are waiting over 30 weeks for their first appointment within ENT. There are also some capacity issues within Urology and Vascular where patients are waiting longer for surgery due to sickness and consultant availability, as well as standard capacity versus demand issues.

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

a) Current Position
67.88% against a threshold of 90%.

b) Recommended Action
This is mainly due to known major capacity constraints in ENT. Oral Surgery, Urology, Vascular and Dermatology are also unable to book patients within 18 weeks due to demand on the services. Trauma and Orthopaedics have also had some issues with long waiting complex patients, and an increase in cancellations due to trauma.

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

a) Current Position
87.51% against a threshold of 95%.

b) Recommended Action

Due to issues with first appointment waiting time, mainly in ENT and Dermatology.

4.6 Stroke - % of patients scanned within 1 hour of clock start

a) Current Position
76.32% against a threshold of:
77% (Contract)
57.5% (Upper quartile)

b) Recommended Action
9 patients breached the target. Of those 2 were delay in ED informing ESOT, 2 were medical registrar delay, 3 were inpatient wake-up strokes, 1 misdiagnosis,1 ED triage delay. Education in Emergency Department and wards continues.

4.7 Stroke - % of patients treated by a stroke skilled early supported discharge team

a) Current Position
46.67% against a threshold of:
48% (Contract)
48% (Upper quartile)

b) Recommended Action
Those patients requiring ESD were referred and treated by ESD.

4.8 Discharge Summaries – Inpatients

a) Current Position
94.33% 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.

4.9 Provider cancellation of elective care operation for non-clinical reasons either before or after patient admission

a) Current Position
1.35% against a threshold of 1% of all elective procedures

b) Recommended Action
Cancellations due to trauma pressures and closure of F5 due to Norovirus at the beginning of January.

4.10 Breastfeeding initiation rates

a) Current Position
73.98% against a threshold of 80%

b) Recommended Action

The Trust noted a further decrease in the breastfeeding initiation rate in January 2017. This is particularly disappointment as the maternity service continues to prepare for a BFI assessment in July 2017. Whilst not able to identify the cause of the reduction, some preliminary analysis has identified particular locations where rates appear to be particularly low and the specialist midwife is focusing additional support in this area as an initial response.

4.11 Rapid access - chest pain clinic

a) Current Position
49.47% against a threshold of 100%

b) Recommended Action
During the month of December we did not secure a sixth locum consultant. This factor combined with high levels of referrals and loss of clinics during Christmas/New Year bank holidays has resulted in high number of breaches. We do have a locum for January so targets should be met.

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

a) Current Position
Macmillan - 100%
ED - 54.55%
Overall Trust figure (including AMU) of 72.22% against a threshold of 100%

a) Recommended Action
There were 5 cases which did not meet the Neutropenic Sepsis pathway standards. All of these cases demonstrate a delay in triage and a delay in the administration of IV antibiotics. During each of these cases the Emergency Department was in escalation status of Red or Black with prolonged waiting times to be seen in all categories.

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

a) Current Position
96.04% against a threshold of 99%

b) Recommended Action
There continues to be improvements in diagnostic waiting times for the majority of diagnostic tests. However, due to the December position, the cardiology department was unable to recover in the short term to see an improvement in the January position. This was due to the obtainability of securing additional resources to meet the demands to deal with unprecedented increase in the number of patients where the Echocardiography diagnostic breached the 99% threshold.

In order to recover this unacceptable position, further work continues to be progressed - see table below:

Ref	Action	Objective	**Start date**	**End date**	**Update / Progress**
1	Secure locum cardiac physiologist	Reduce the number of patients waiting 6 weeks	23/01/17	21/02/17	An additional 0.8 WTE locum will start on 27th February 2017, for a three month period
2	Secure locum consultant	Reduce Outpatient RTT	23/01/17	13/02/17	In place

	cardiologist	waits			
3	Re-advertise for substantive Physiologist	Secure individual against vacant post	17/02/17	31/05/17	Advert to be placed
4	Procurement of an additional echo machine via friend's funds. Bid to be submitted	Enable Dept to increase echo sessions	23/01/17	31/01/17	Awaiting feedback from Jan Bloomfield
5	Review Diagnostic cardiac physiology core establishment	Meet the needs of the service demands	23/01/17	21/02/17	In Process
6	Use existing workforce to cover additional sessions	To provide additional capacity	August 2016	On-going	In place
7	Review potential changes relating to referral rates through activity & demand modelling	Understand the demand & manage staffing levels accordingly	23/01/17	21/02/17	In Process

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%	**3.95%**	
Turnover	<10%	**10.48%**	
Reviews	Grievance/Banding reviews	**4**	
Recruitment Timescales	Average number of weeks to recruit = 7	**7**	**This is longer than usual because of the Christmas period.**
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 apprasial within the previous 12 months. Appraisal is a rolling programme	**92.00%**	

5.1 Sickness Absence Rate

a) Current Position

3.95% against a threshold of <3.5%.

b) Recommended Action

Increased short term sickness absence as per last month.

5.2 Turnover

a) Current Position
10.48% against a threshold of <10%.

b) Recommended Action
A number of staff changing roles internally as well as retirements and resignations.

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

The following narrative provides an overview of the performance of the community services. The bullet points are the points of note from January's performance, the second section provides the detail of the contractual KPI position.

- Our patient experience survey continues to be very positive with an overall FFT for January of 97%, from 389 responses. There were no 'unlikely to recommend' responses this month.
- We received 3 complaints in the month, 2 for children's services and 1 for Aldeburgh Community Hospital.
- DToC's in January had a further increase to a total of 67 patients compared to 64 in December. See pages 9, 10 and 11 for detailed breakdown. Glastonbury Court has the highest number of DToC's at 20 patients for January.
- Waiting times for the paediatric SaLT clinic service has seen a further improvement in January.
- The Care Co-ordination Centre achieved its target for SOA in 60 seconds, achieving 96% for January.
- There have been 11 breaches of the 18 week RTT targets in consultant paediatric service out of 82. There were 8 breaches in the east service and 3 in the west service.
- The Community Equipment Service achieved all their KPI's in January. This is only the second month (June 2016) since contract commencement that all targets have been met. This achievement is against a backdrop of increased activity.
- The Children in Care performance has declined slightly in January down to 71.43% when compared to the December performance which was 85.71%.
- Overall there has been an increase in the number of pressure ulcers, falls and re-admissions back to the acute units(for January running at 20% re-admission rate) from the community sites.
- There has been an increase in the number of medication incidents reported. This rise is due to the trial of the Surefuser device which delivers a 24 hour IV dosage.

Adult KPI's									
Host	**Service**	**Technical Reference**	**Quality Requirement**	**Threshold**	**Jan-17**	**Method of measurement**	**January Comments / Queries 2017**	**Nov-16**	**Dec-16**
SCH		**D4-qoc1**	Number and % of service users who rated the service as 'good' or 'better'.	85%		Quarterly			97.00%
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'better'.	85%		Quarterly			94.18%
SCH		**D4-qoc2**	Number and % of service users who responded that they felt 'well informed'.	85%		Quarterly			92.87%
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 to be treated within 18 weeks	99.93%	Monthly		100.00%	99.92%
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	93.89%	Monthly	Foot and Ankle are compliant with the 18 week RTT. The breaches are in the Paediatric consultant service	87.28%	92.94%
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%	94.62%	Monthly		94.62%	94.10%
SCH	Canc by Prov	**c-gen7**	% of clinics cancelled by the Provider Q3 2012-13 establish baseline. Where benchmarking of community services shows a DNA rate worse then the best quartile. Q4 2012-13 agree an appropriate reduction on baseline. Pcanc-01 ONLY - Q1 2013/14 establish baseline. Where benchmarking of community services shows a DNA rate worse than the best quartile: Q2 reduction of 2.5% on baseline, Q4 reduction of 10% on baseline			Quarterly		.	0.12%
SCH	Safeguarding - children	**c-safe1**	% eligible staff who have completed level 1 training	98%	97.04%	Monthly		97.52%	97.12%
SCH	Safeguarding - adults	**c-safe2**	% eligible staff who have completed level 1 training	98%	97.04%	Monthly		97.25%	96.94%
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%	100.00%	Monthly		100.00%	98.00%
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	0.55	Monthly		0.00	0.58
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		Service no longer supports this KPI - as agreed with CCG Oct 2016	Service no longer supports this KPI - as agreed with CCG Oct 2016
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%	N/A	Monthly	No patients completed in January 2017. PR finished their courses in the week leading up to Christmas – meaning classes started in January. A course is 6 weeks long so there will be finishers in Feb onwards.	100.00%	97.92%

Host	Service	Technical Reference	Quality Requirement	Threshold	Jan-17	Method of measurement	January Comments / Queries 2017	Nov-16	Dec-16
IHT	CCC	**D4-int1**	Care coordination centre - % of telephone calls answered within 60 seconds	95% in 60secs	96.00%	Monthly	# of calls handled: 17,055 # of calls answered in 0-60 seconds: 16,372 **% 0-60 seconds: 96%** Number of abandoned calls: 386 Abandoned calls %: 2.21% Average Wait Time: 13 seconds	93.12%	93.75%
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%		Monthly			95.12%
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	65 offered	Monthly		58 offered	39 offered
IHT	COPD	**s-copd4**	Number of pulmonary rehab courses completed	At least 250 courses completed per year	0 completed	Monthly		10 completed	48 completed
IHT	COPD	**s-copd5**	Community pulmonary rehabilitation - review offered 6 months after completing the course	95%	N/A	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		no longer reporting as of November 16	no longer reporting as of November 16
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			98.72%
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			100.00%
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			97.56%
IHT	MIU	**s-miu5**	Total time spent in A+E department	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	98.82% (168/170)	Monthly		97.12% (135/139)	96.95% (191/197)
Mede	CES	**c-gen8**	Same Working day - Urgent equipment	98.00%		Monthly			
Mede	CES	**c-gen8**	Next Working day - Urgent equipment	98.00%	99.42% (861/866)	Monthly		98.31% (758/771)	99.74% (754/756)
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		99.48% (2090/2101)	Monthly		99.45% (2175/218	99.74% (1939/194
Mede	CES	**c-gen8**	Within 10 working days - to support hospital discharge or prevent admission	98.00%	99.82% (549/550)	Monthly		96.38% (559/580)	99.81% (526/527)
Mede	CES	**c-gen9**	Collection times: % of urgent next day collections for deceased Service Users	98% for all standards	98.47% (580/589)	Monthly		100% (137/137)	99.16% (354/357)
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%	98.38% (182/185)	Monthly		99.07% (425/429)	99.53% (213/214)
Mede	CES		% of urgent collections within 5 working days	98.00%		Monthly			
Mede	CES	**c-gen9**	% of collections within 10 working days	98.00%	99.05% (4884/4931)	Monthly		98.52% (4799/487	99.38% (4456/448
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%

Host	Service	Technical Reference	Quality Requirement	Threshold	Jan-17	Method of measurement	January Comments / Queries 2017	Nov-16	Dec-16
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 100%	N/A	Monthly		N/A	N/A
Mede	Wheelchair	**s-wchair1**	Low Priority	within 18 weeks 100%	90.00%	Monthly		88.89%	100.00%
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%	98.76%	Monthly		98.56%	97.36%
NCHC		**D5-ccc7**	Intermediate - 72 hrs	Intermediate - 95%	97.36%	Monthly		98.14%	98.81%
NCHC		**D5-ccc7**	18 weeks	18 weeks - 95%	99.28%	Monthly		99.28%	98.88%
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.	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	100.00%	Monthly		96.55%	96.00%
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		Service no longer supports this KPI - as agreed with CCG Oct 2016	Service no longer supports this KPI - as agreed with CCG Oct 2016
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%	50.00%	Monthly	There were 9 referrals to the service in the month. 1 was omitted as the patient was still an inpatient at the end of the month. Out of the remaining 8, 4 were excluded for care package delays, 2 were excluded for delays due to complex medical reasons. Out of the 2 referrals to be counted, one patient was discharged witin 24hours, the other was discharged between 48 and 62hours.	n/a	0.00%
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	90%		Monthly			
WSH	Adult SALT	**s-salt1**	All new referrals are triaged within 5 Operating Days of receipt of referral;	98%	100.00%	Monthly		97.74%	98.80%
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		90.91%	100.00%
WSH	Adult SALT	**s-salt2**	Priority 2 within 20 Operating Days	Priority 2 - 95%	98.81%	Monthly		98.51%	99.00%
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%

Host	Service	Technical Reference	Quality Requirement	Threshold	Jan 2017	Method of Measurement	Jan Comments/ Queries 2017	Nov 2016	Dec 2016
WSH	All Paediatric Services	**GP-1**	18 week RTT for Consultant led services	95%	86.59%	Monthly	This is 11 breaches (8 in East & 3 in West) out of 82 clock stops (48 in East & 34 in West)	73.49%	80.00%
WSH	All Paediatric Services	**GP-1**	18 week RTT for non-Consultant led services	95%	99.55%	Monthly		100.00%	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 80% completed a PHP	100.00%	Monthly		100.00%	100.00%
WSH	All Paediatric Services	**D4-qoc1 D4-qoc2 GP-4**	Quarterly Service User satisfaction surveys based on Suffolk Community Healthcare's processes prior to Effective Start Date. Number and % of service users who rated the service as "good" or better	85%		Quarterly	Now included in the Patient Experience		
WSH	All Paediatric Services	**D4-qoc1 D4-qoc2 GP-4**	Number and % of service users who responded that they felt "supported" and "well informed".	85%		Quarterly	Now included in the Patient Experience		
WSH	All Paediatric Services	**GP-6**	Safeguarding - % eligible staff who have completed level 1 training	98%	100.00%	Monthly		99.53%	99.04%
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		100.00%	100.00%
WSH	Paediatric SLT Paediatric OT Paediatric Physio CDC (East and West) School Aged Autism Service (5-14) Community Paediatric Medical Teams Therapy Focus Suffolk	**PaedSLT-5**	Personalised Care Planning - Percentage of Transition (to adults) Care Plans completed	Q3 2012/13 establish baseline From Q4 2012/13 no deterioration on baseline		Annual			
WSH	Newborn Hearing Screening Service (West)	**NBHS-2**	Timely screening – where consented screens to be completed by four weeks of age	95%	98.40%	Monthly		99.15%	99.62%
WSH	Newborn Hearing Screening Service (West)	**NBHS-3**	Screening outcomes set within 3 months	≥99%	98.56%	Monthly		99.54%	99.65%
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			
WSH	Therapy Focus Suffolk	**TFS-6**	All relevant staff that have been 'Bobath' update trained	100%		Annual			
WSH	Single Point of Access	**PSPOA-03**	% 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%		Monthly			
WSH	Single Point of Access	**PSPOA-04**	% of service users who were satisfied with the length of time waiting for assessment	85%		Quarterly			
WSH	Single Point of Access	**PSPOA-05**	% of referrers who were satisfied with the length of time waiting for assessment	85%		Quarterly			
WSH	Access	**cps-a02**	Children/young people in special schools receive speech and language interventions	100%	100.00% 241 contacts	Monthly		100.00% 273 contacts	100.00% 273 contacts
WSH	Access	**ots-a02**	Children/young people in special schools receive OT interventions	100%	100.00% 221 contacts	Monthly		100.00% 193 contacts	100.00% 193 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	0.00%	Monthly	14 IHAs completed in January. 0 were completed within 28 days of the child becoming CiC	10.00%	14.29%
WSH	Children in Care	**CiC-001b**	Initial Health Assessments that are completed within 28 days of receiving ALL relevant paperwork	100% in 28 days	71.43%	Monthly	14 IHAs in January, 10 of which were completed within 28 days,	80.00%	85.71%
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	92.86%	Monthly	13 out 14 patients had been offered appts within 28 days of the service being informed of the child but appts were declined or DNA'ed	90.00%	100.00%

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

a) Current Position
93.89% against a 95% target
8 breaches out of 48 patients treated are in the East Service and 3 breaches out of 34 patients treated in the West.
The 0.6 and 0.4wte vacancies in the East and West of the county respectively are now being covered by a permanent locum who commences on 1st March. This locum will support referrals across the county primarily in Stowmarket and mainly the school aged autism pathway.

- Vacancy has been out to advertisement for the 3rd time but there were no applicants .

b) Recommended Action

- The service lead and medical lead are going to review the possibility of a nurse practitioner role to support this service.
- Flexing resources between Children in Care and consultant medical Paediatricians thus increasing the capacity in consultant medical service.
- Implement agreed changes to multi-disciplinary assessment pathways.
- The service lead is producing a status report highlighting where there are differences in the Suffolk service to neighbouring services. This will be shared in the March Board report.

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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 94.62% against 95% target. A slight improvement on December's position (94.10%)

b) Recommended Action

- All service leaders and team leads receive a monthly report detailing which individual staff are out of date and will be out of date in the coming month.
- Additional sessions and individual team meeting is being provided.

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

a) Current Position
50% against 100% target.
9 patients referred to the service. 1 was omitted as the patient was still an inpatient at the end of the month.
Out of the remaining 8
4 were excluded for care package delays
2 were excluded for delays due to complex medical reasons.
Out of the 2 referrals to be counted, one patient was discharged within 24 hours, the other was discharged between 48 and 62hours.

b) Recommended Action

- The role of the team in this pathway is currently being reviewed as it is recognised that any failures cannot be attributed to this service.

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4 S-wchair1 – Wheelchair assessment - Service Users have a first appointment/contact seen after initial response time according to low priority - 18 weeks

a) Current Position
90.00% against a target of 100%

This relates to 1 patient out of 10. The patient had an appointment/first contact in week 19. The breach was due to the patient choosing a later date for the appointment when an earlier date had been offered.

b) Recommended Action

- Process for appointment bookings to be reviewed to ensure reasonable choice is offered.

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5 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 – 0.0% against a 100% target
CiC-001b – 71.43% against a 100% target
CiC -001c – 92.86% against a 100% target

14 Initial Health Assessments were completed in January. 0 was completed within 28 days of becoming CiC, 10 were completed within 28 days of the service receiving ALL the paperwork and 13 appointments were offered within 28 days. The 14th appointment was offered and accepted within 31 days.

b) Recommended Action

- Implement regular meetings with the Head of Safeguarding in Suffolk County Council to agree shared action plans to improve the quality and compliance with the pathway.
- Head of Service is monitoring the performance of the Suffolk County Council administration hub that is responsible with providing the paperwork. The hub has improved the previous delays in the service receiving the paperwork.
- The service is exploring the option of using a retired GP for 2 sessions a month (4 appointments/ month).
- Review with the CCG and designated Nurse the time allocated for each assessment and paperwork.
- Review the children who are placed in Suffolk from out of area who need access to mental health services which is currently un-commissioned and causes delays to our pathway.

	Units	Target	Red	Amber	Green	Aug	Sep	Oct	Nov	Dec	Jan
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				100	106	159	179	115	141
	%	85%	<80%	80%-85%	>=85%	95%	98%	94%	94%	94%	96%
Service users who felt 'well informed'	Nos.	No Target				165	133	187	190	144	182
	%	85%	<80%	80%-85%	>=85%	96%	94%	93%	90%	96%	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	47	26	59	60	51
Rolls out of Bed		No Target				4	1	1	1	5	2
Slip out of chair		No Target				3	2	0	3	3	8
Assisted Falls/ near misses		No Target				6	5	4	0	1	0
% of total falls resulting in harm	%	No Target				32%	19%	15%	29%	22%	31%
Numbers of falls resulting in moderate harm	Nos.	No Target				0	1	0	0	0	0
Numbers of falls resulting in severe harm	Nos.	No Target				1	0	0	0	2	2
Numbers of patients who have had repeat falls	Nos.	No Target				8	8	6	10	13	11
% 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	12.5	13.3	7.6	17.3	17.4	13.9
Pressure Ulcers											
Pressure Ulcers – In Our Care Community											
Grade 2		100 pa	>110	100-110	<=100	6	13	18	13	23	26
Grade 3		26 pa	>30	27-29	<=26	4	5	10	10	6	7
Grade 4		0 pa	>1	1	0	0	0	0	0	1	1
Pressure Ulcers – In our care In-patient											
Grade 2		13 pa	>17	13-17	<=13	0	2	2	4	5	2
Grade 3		2 pa	>4	02-Apr	<=2	1	0	1	2	0	1
Grade 4		0 pa	>1	1	0	0	0	0	0	1	0
Safeguarding People Who Use Our Services From Abuse											
Number of adult safeguarding referrals made		No Target				5	1	5	3	5	4
Satisfaction of the providers obligation eliminating mixed sex accomodation		No Target				100%	100%	100%	100%	100%	100%

	Units	Target	Red	Amber	Green	Aug	Sep	Oct	Nov	Dec	Jan
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	0	1	0	0	0	0
C.Diff associated diseases (CDAD) RCA reports		100%	<95%	95%-100%	=100 %	N/A	100%	N/A	N/A	N/A	N/A
Infection Control											
Infection control training		100%	<83%	83%-100%	=100 %	88.34%	88.82%	88.39%	90.17%	91.00%	98.00%
Essential Steps Care Bundles Including Hand Hygiene											
Hand hygiene audit results - 5 moments SCH overall compliance.	Yes	100%	<95%	95%-100%	=100 %	98.00%	99.00%	99.00%	98.00%	99.00%	98.00%
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				13	8	4	9	16	23
Level of **actual** patient harm resulting from medication incidents	No harm	No Target				10	5	4	8	15	23
(also includes those not attributed to SCH management)	Low harm	No Target				3	3	0	1	1	0
Number of medication incidents involving Controlled Drugs		No Target				3	1	1	1	0	0
Incidents											
NRLS (i.e. patient safety) reportable incidents in month		No Target				145	165	160	191	178	209
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				1	0	11	12	9	10
Number of SIs reported to CCG in month		No Target				1	0	11	10	9	10+4 Dec
Percentage of SI reports submitted to CCG on time in month		No Target				100%	N/A	0%	100%	100%	100%
Duty of Candour Applicable Incidents		No Target				7	7	11	9	10	10
Severity of NPSA Reportable Incidents											
None		No Target				97	115	117	125	119	136
Low		No Target				39	43	32	54	50	62
Moderate		No Target				8	7	11	12	6	8
Major		No Target				1	0	0	0	3	3
Catastrophic		No Target				0	0	0	0	0	0
Training Compliance											
Adult Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	92.31%	92.96%	96.45%	97.25%	96.94%	97.04%
Children Safeguarding – Mandatory Training Compliance		98%	<90%	90%-98%	>=98%	91.61%	94.28%	96.81%	97.52%	97.12%	97.04%
Dementia Care – Mandatory Training Compliance		95%	<90%	90%-95%	>95%	93.88%	95.60%	96.30%	94.62%	94.10%	94.62%
WRAP								35.50%	44.48%	44.47%	45.27%
MCA / DoLs- Training compliance								64.80%	71.46%	70.97%	69.76%

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec-16	Jan-17
Total Compliments	47	47	52	21	33	19	46	21	38	28	36	27	61
Total SCH Complaints	5	4	3	4	2	6	7	5	1	1	2	2	3
Acknowledged within 3 days	80%	100%	100%	60%	100%	50%	83%	100%	100%	50%	50%	100%	100%
% of Responses within 25 days	20%	50%	66%	25%	50%	33%	71%	TBC	0%	100%	50%	50%	
Responded to within 25 days	1	2	2	1	1	2	5	TBC	0	1	1	100%	
Responded to after 25 days	4	2	1	3	1	4	2	TBC	1	0	1	50%	
Average response time (days)	30	23	29	31	33	30	24	TBC	31	19	TBC	100%	

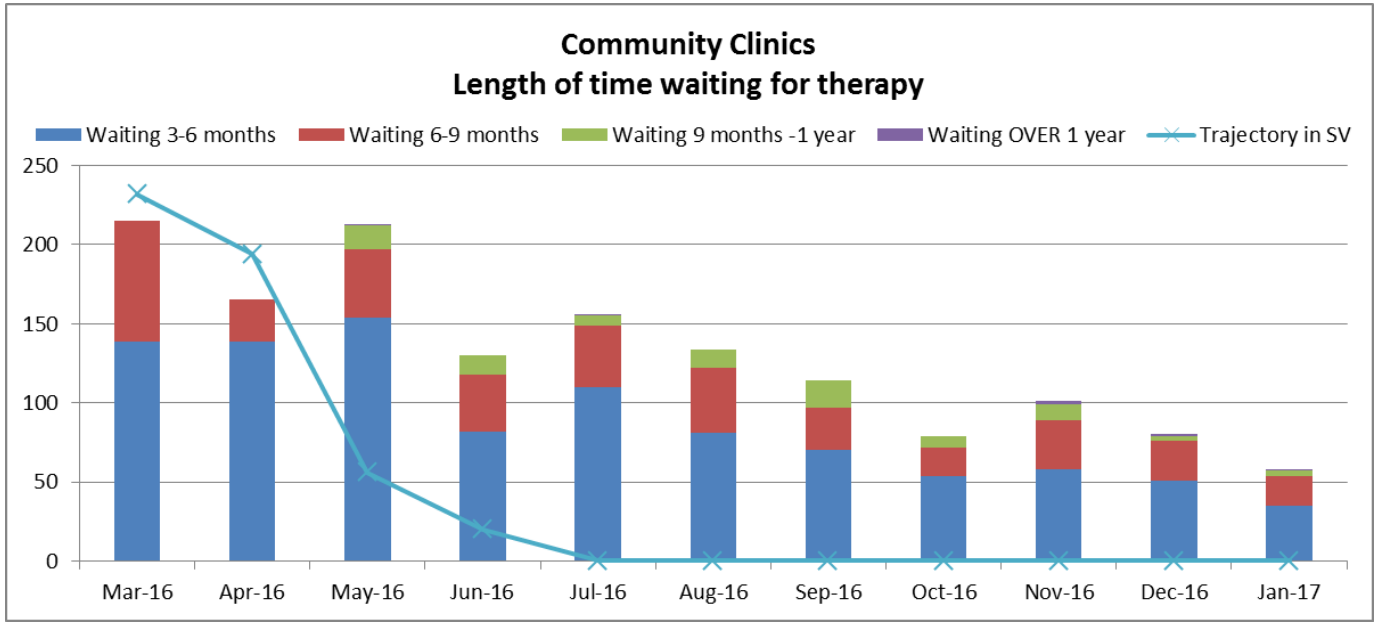
Paediatric Speech and Language Service Waiting times

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	No. of children waiting January 2017
Waiting up to 3 months	139	193	206	135	191	167	150	156	151	176	158	176
Waiting 3-6 months	139	139	139	154	82	110	81	70	54	58	51	35
Waiting 6-9 months	151	76	26	43	36	39	41	27	18	31	25	19
Waiting 9 months -1 year	106	0	0	15	12	6	12	17	7	10	3	3
Waiting OVER 1 year	0	0	0	1	0	1	0	0	0	2	1	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**	**234**
Already had PoC		62	78	70	66	119	97	72	75	67	75	55
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**	**289**

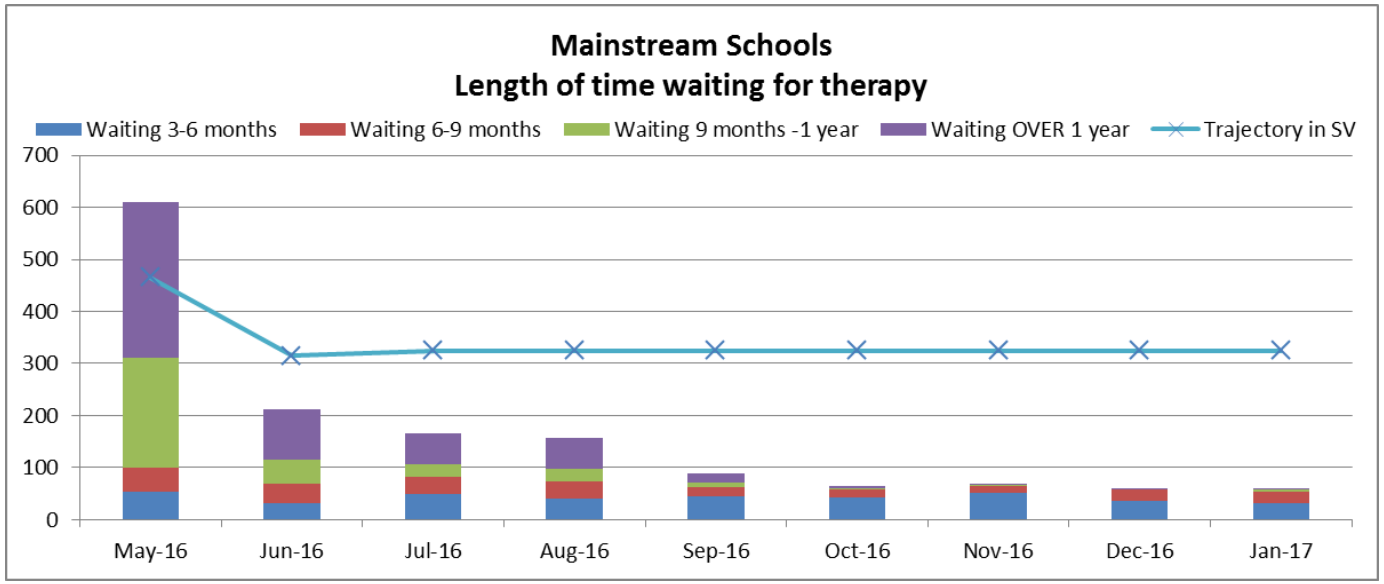


Mainstream Schools

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**	**No. of children waiting January 2017**
Waiting up to 3 months				142	126	117	119	88	72	68	60	56
Waiting 3-6 months				54	32	50	41	44	42	51	37	31
Waiting 6-9 months				46	36	33	33	18	16	13	22	22
Waiting 9 months -1 year				212	48	23	23	10	3	2	0	4
Waiting OVER 1 year				298	95	60	61	17	3	2	2	2
Caseload waiting for therapy *(Excluding patients who already had a package of care)*				**752**	**337**	**283**	**277**	**177**	**136**	**136**	**121**	**115**
Already had PoC				*unavailable*	264	356	396	395	377	392	332	277
Total waiting ***(Including patients who have already receive 1 POC and are waiting for another)***				**752**	**601**	**639**	**673**	**572**	**513**	**528**	**453**	**392**



							Surgery												
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED	CCU	GS	F9	F10
Patient Experience: in-patient	QR-PEI-10	Patient Satisfaction: In-patient overall result	= 85%	<75	75-84	85-100	80	99	93	97	NA	NA	NA	NA	NA	99	No Data	85	98
	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	88.89	100	97.47	96.3	NA	NA	NA	NA	NA	100	No Data	100	100
	QR-PEI-20	In your opinion, how clean was the hospital room or ward that you are in?	= 85%	<75	75-84	85-100	94	100	98	100	NA	NA	NA	NA	NA	100	No Data	97	99
	QR-PEI-340	Did you feel you were treated with respect and dignity by staff?	= 85%	<75	75-84	85-100	94	100	97	100	NA	NA	NA	NA	NA	100	No Data	98	100
	QR-PEI-330	Were Staff caring and compassionate in their approach?	= 85%	<75	75-84	85-100	92	100	97	100	NA	NA	NA	NA	NA	100	No Data	92	100
	QR-PEI-30	Were you ever bothered by noise at night from other patients?	= 85%	<75	75-84	85-100	36	92	65	89	NA	NA	NA	NA	NA	94	No Data	38	80
	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	80	100	96	96	NA	NA	NA	NA	NA	100	No Data	86	100
	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	82	100	98	96	NA	NA	NA	NA	NA	100	No Data	89	100
	QR-PEI-90	Were you given enough privacy when discussing your care?	= 85%	<75	75-84	85-100	86	100	97	98	NA	NA	NA	NA	NA	100	No Data	100	100
	QR-PEI-350	Did you get enough help from staff to eat your meals?	= 85%	<75	75-84	85-100	87	100	98	100	NA	NA	NA	NA	NA	100	No Data	100	100
	QR-PEI-100	(In-patient) Were you given enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	93	100	99	100	NA	NA	NA	NA	NA	100	No Data	100	100
	QR-PEI-150	Timely call bell response	= 85%	<75	75-84	85-100	58	98	85	94	NA	NA	NA	NA	NA	100	No Data	53	100
	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
	QR-PEI-300	Complaints	= 0	>2	1-2	= 0	0	0	1	4	0	0	0	0	3	0	0	1	0
	QR-PEI-310	Environment and Cleanliness	= 90%	<80	80-89	90-100	87	94	94	93	92	94	98	95	89	88	No Data	88	83

							Surgery		Medicine	
Group		Indicator	Target	Red	Amber	Green	F4	DSU	F7	F8
Patient Experience: short-stay	QR-PES-10	Patient Satisfaction: short-stay overall result	= 85%	<75	75-84	85-100	100	100	100	0
	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	100	100	100	0
	QR-PES-20	(Short-stay) Were you given enough privacy when being examined and treated?	= 85%	<75	75-84	85-100	100	100	100	0
	QR-PES-30	(Short-stay) Were staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	100	100	100	0
	QR-PES-40	Were you told who to contact if you were worried after leaving hospital?	= 85%	<75	75-84	85-100	100	100	100	0
	QR-PES-50	(Short-stay) Overall how would you rate the care you received in the department?	= 85%	<75	75-84	85-100	99	100	100	0
	QR-PES-70	Number of short stay surveys completed	No Target	No Target	No Target	No Target	129	38	10	0

							Medicine
Group		Indicator	Target	Red	Amber	Green	ED
Patient Experience: A&E	QR-PEA-10	Patient Satisfaction: A&E overall result	= 85%	<75	75-84	85-100	96
	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	94.57
	QR-PEA-30	Were A&E staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	99
	QR-PEA-110	Were you given enough privacy when discussing your condition at reception?	= 85%	<75	75-84	85-100	93
	QR-PEA-120	Did Doctors and Nurses listen to what you had to say?	= 85%	<75	75-84	85-100	98
	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	93
	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	95
	QR-PEA-140	Number of A&E surveys completed	No Target	No Target	No Target	No Target	504

							Surgery	Medicine	Women & Children
Group		Indicator	Target	Red	Amber	Green			
Patient Experience: A&E (Children questions)	QR-PEAC-70	Patient Satisfaction: A&E Children questions overall result	= 85%	<75	75-84	85-100	Currently no data for this		
	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			
	QR-PEAC-30	Did the Doctor or Nurse listen to what you had to say?	= 85%	<75	75-84	85-100			
	QR-PEAC-100	Were staff friendly and kind to you and your family?	= 85%	<75	75-84	85-100			
	QR-PEAC-50	Did we help with your pain?	= 85%	<75	75-84	85-100			
	QR-PEAC-60	Did staff explain the care you need at home?	= 85%	<75	75-84	85-100			
	QR-PEAC-130	Number of A&E children surveys completed	No Target	No Target	No Target	No Target			

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F11
Patient Experience: Maternity	QR-PEM-10	Patient Satisfaction: Maternity overall result	= 85%	<75	75-84	85-100	94
	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	91.11
	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
	QR-PEM-135	How likely are you to recommend our antenatal department to friends and family?	= 75%	<70	70-74	75-100	98.63
	QR-PEM-140	How likely are you to recommend our post-natal care to friends and family?	= 75%	<70	70-74	75-100	100
	QR-PEM-30	(Maternity) Were staff professional, approachable and friendly?	= 85%	<75	75-84	85-100	94
	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	89
	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	91
	QR-PEM-60	(Maternity) Were you given enough privacy when being examined or treated?	= 85%	<75	75-84	85-100	100
	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	100
	QR-PEM-80	Were you given adequate help and support to feed your baby whilst in hospital?	= 85%	<75	75-84	85-100	93
	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	89
	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	96
	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	93
	QR-PEM-20	In your opinion, how clean was the hospital room or ward that you were in?	= 85%	<75	75-84	85-100	95
	QR-PEM-125	Number of maternity surveys completed	No Target	No Target	No Target	No Target	202

							Women & Children
Group		Indicator	Target	Red	Amber	Green	MLBU
Patient Experience: Birthing Unit	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	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	86
	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	96
	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	100
	QR-PEBU-60	Did you have confidence and trust in the midwives caring for you during labour?	= 85%	<75	75-84	85-100	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	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	98
	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	100
	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	100
	QR-PEBU-110	Number of birthing unit surveys completed	No Target	No Target	No Target	No Target	28

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F1
Patient Satisfaction: Young Children	QR-PEYC-120	Patient Satisfaction: Children's Services Overall Result	= 85%	<75	75-84	85-100	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
	QR-PEYC-20	Did you understand the information given to you regarding your treatment and care?	= 85%	<75	75-84	85-100	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
	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
	QR-PEYC-40	Were you offered age/need appropriate activities?	= 85%	<75	75-84	85-100	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
	QR-PEYC-70	Was your experience during procedures/investigations (i.e.blood tests, X-rays) managed sensitively?	= 85%	<75	75-84	85-100	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
	QR-PEYC-160	Were staff kind and caring towards you?	= 85%	<75	75-84	85-100	na
	QR-PEYC-90	Is the environment child - friendly?	= 85%	<75	75-84	85-100	na
	QR-PEYC-100	Overall, how would you rate your experience in the Paediatric Unit?	= 85%	<75	75-84	85-100	na
	QR-PEYC-130	Number of young children surveys completed	No Target	No Target	No Target	No Target	na

							Women & Children
Group		Indicator	Target	Red	Amber	Green	F1
F1 Parent	QR-PEF1-120	Patient Satisfaction: F1 Parent overall result	= 85%	<75	75-84	85-100	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
	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
	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
	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
	QR-PEF1-40	Were there appropriate play activities for your child (such as toys, games and books)?	= 85%	<75	75-84	85-100	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
	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
	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
	QR-PEF1-140	Were staff kind and caring towards your child?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-90	Is the environment child-friendly?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-100	Overall, how would you rate your experience in the Children's Unit?	= 85%	<75	75-84	85-100	NA
	QR-PEF1-160	Number of F1 parent surveys completed	No Target	No Target	No Target	No Target	NA

							Medicine
Group		Indicator	Target	Red	Amber	Green	G8
Patient Experience: Stroke	QR-PEST-10	Patient Satisfaction: Stroke overall result	= 85%	<75	75-84	85-100	94
	QR-PEST-80	(Stroke) How likely is it that you would recommend the service to friends and family?	= 90%	<80	70-89	90-100	100
	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	97
	QR-PEST-30	Have you been involved in planning your recovery / rehabilitation?	= 85%	<75	75-84	85-100	87
	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	90
	QR-PEST-50	Have you received the help you require while eating?	= 85%	<75	75-84	85-100	100
	QR-PEST-60	Do you feel cared for?	= 85%	<75	75-84	85-100	98
	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	100
	QR-PEST-90	Number of stroke surveys completed	No Target	No Target	No Target	No Target	30

Medicine										Women & Children			
G1	G3	G4	G8	MTU	F12	G5 - Ward (OLD G9)	WEW – G9	F7	F8	F1	F11	F14	MLBU
98	na	91	NA	NA	96	99	91	91	91	NA	NA	95	NA
100	na	100	NA	NA	100	96.55	100	100	100	NA	NA	100	NA
93	na	98	NA	NA	100	100	93	98	98	NA	NA	99	NA
100	na	100	NA	NA	100	100	100	99	100	NA	NA	100	NA
100	na	98	NA	NA	100	100	100	98	98	NA	NA	98	NA
100	na	74	NA	NA	78	90	72	57	63	NA	NA	11	NA
89	na	92	NA	NA	90	100	94	87	88	NA	NA	92	NA
100	na	89	NA	NA	94	100	95	93	87	NA	NA	89	NA
100	na	100	NA	NA	100	100	100	100	100	NA	NA	98	NA
100	na	82	NA	NA	100	100	100	97	92	NA	NA	100	NA
100	na	98	NA	NA	100	98	97	97	100	NA	NA	100	NA
94	na	68	NA	NA	100	100	60	70	83	NA	NA	100	NA
0	0	0	0	0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	2	0	2	0	0	0	0	0
89	88	93	95	97	94	82	83	85	91	97	92	92	94

							Surgery								Medicine													Women & Children			
Group		Indicator	Target	Red	Amber	Green	F3	F4	F5	F6	CCS	Theatres	Recovery	DSU	ED	CCU	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	No Data	NA	NA	NA	100	NA	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	No Data	100	NA	NA	NA	NA	No Data	No Data	100	100	100	No Data	100	NA	No Data	100	No Data	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	90	No Data	NA	NA	No Data	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	100	100	100	100	NA	NA	NA	NA	No Data	100	100	100	60	100	100	NA	100	60	60	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
	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
	QR-PS-90	HII compliance 5: Ventilator associated pneumonia	= 100%	<85	85-99	= 100	NA	NA	NA	NA	100	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	100	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	100	100	100	100	80	100	NA	100	100	67	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	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
	QR-PS-400	Quarterly MRSA (including admission and length of stay screens)	= 90%	<80	80-89	90-100	No Data	No Data	No Data	No Data	No Data	No Data	No Data	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	No Data	No Data	No Data	NA
	QR-PS-250	Hand hygiene compliance	= 95%	<85	85-99	= 100	100	100	100	100	100	NA	100	100	100	100	100	100	95	100	100	100	100	100	100	100	100	82	100	100	100	100
	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	1	0	0	0	0	0	0	0
	QR-PS-117	Quarterly Standard principle compliance	90%	<80	80-90%	90-100	No Data	No Data	No Data	No Data	No Data	No Data	No Data	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	No Data	No Data	No Data	NA
	QR-PS-240	Total no of C. diff infections: Hospital	= 16 per year	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
	QR-PS-290	Quarterly Antibiotic Audit	= 98%	<85	85-97	98-100	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	NA	No Data	No Data	No Data	No Data	No Data	No Data	No Data	No Data	NA
	QR-PS-440	Quarterly Environment/Isolation	= 90%	<80	80-89	90-100	No Data	No Data	No Data	No Data	No Data	No Data	No Data	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	No Data	No Data	No Data	NA
	QR-PS-450	Quarterly VIP score documentation	= 90%	<80	80-89	90-100	No Data	No Data	No Data	No Data	No Data	No Data	No Data	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	No Data	No Data	No Data	na
	QR-PS-120	No of patient falls	= 48	>=48	No Target	<48	2	0	7	1	0	NA	NA	NA	2	1	4	3	3	2	1	12	0	1	10	3	9	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
	QR-PS-130	No of patient falls resulting in harm	No Target	No Target	No Target	No Target	1	0	0	0	0	NA	NA	NA	0	0	1	0	2	2	0	3	0	0	1	0	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
	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
	QR-PS-470	No of ward acquired pressure ulcers	No Target	No Target	No Target	No Target	5	0	0	0	0	NA	NA	NA	NA	0	2	3	0	0	1	3	0	0	2	5	1	0	NA	0	0	NA
	QR-PS-480	No of 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
	QR-PS-190	Nutrition: Assessment and monitoring	= 95%	<85	85-94	95-100	80	100	100	100	100	NA	NA	NA	NA	No Data	100	90	50	100	60	90	NA	83	70	80	No Data	No Data	NA	NA	0	NA
	QR-PS-260	No of SIRIs	No Target	No Target	No Target	No Target	1	0	0	0	0	0	0	0	0	0	2	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0
	QR-PS-500	No of medication errors	No Target	No Target	No Target	No Target	1	1	1	3	4	0	0	0	5	0	1	1	5	3	0	3	0	1	2	0	10	0	0	0	1	0
	QR-PS-300	Cardiac arrests	No Target	No Target	No Target	No Target	0	0	0	0	0	0	0	0	0	1	1	0	0	0	1	0	0	0	0	0	0	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	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	QR-PS-340	Pain Management: Quarterly internal report	= 80%	<70	70-79	80-100	50	98	93	56	NA	NA	NA	NA	NA	NA	55	74	72	55	59	64	NA	89	49	NA	21	53	86	90	89	NA
	QR-PS-370	VTE: Completed risk assessment (monthly Unify audit)	> 98%	< 98	No Target	> 98	0.0	0.0	0.0	0.0	0.0	na	na	0.0	na	0.0	0.0	0.0	na	0.0	0.0	0.0	na	0.0	0.0	na	0.0	0.0	na	0.0	0.0	0.0
	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
	QR-PS-390	Safety Thermometer: % of patients experiencing new harm-free care	= 95%	<95	95-99	= 100	97.06	90	100	100	100	No Data	No Data	No Data	No Data	100	96.67	96	No Data	87.1	96.77	96.67	No Data	No Data	96.88	92	100	No Data	No Data	100	No Data	No Data
Patient Experience: in-patient	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

West Suffolk NHS
NHS Foundation Trust

ITEM 10

FINANCE AND WORKFORCE REPORT

January 2017 (Month 10)

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

Financial Summary

I&E Position YTD	£10.6m	loss
Variance against plan YTD	£6.8m	adverse
Movement in month against plan	£1.3m	adverse
EBITDA position YTD	£4.8m	loss
EBITDA margin YTD	2.33%	loss
Cash at bank	£3,598k	
Use of Resources Rating (UoR)	4	

Executive Summary

- The Month 10 YTD position is behind plan by £6,809k.
- The Use of Resources Rating (UoR) (previously Financial Sustainability Risk Rating), is 4 YTD
- We forecast 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 - January 2017	Jan-17 Budget £m	Jan-17 Actual £m	Jan-17 Variance £m	Year to date Budget £m	Year to date Actual £m	Year to date Variance £m	Year end forecast Budget £m	Year end forecast Actual £m	Year end forecast Variance £m
NHS Contract Income	18.7	18.6	(0.1)	182.6	182.7	0.0	219.6	219.5	(0.2)
Other Income	2.3	2.4	0.2	24.9	22.7	(2.2)	28.9	26.6	(2.3)
Total Income	**21.0**	**21.0**	**0.1**	**207.6**	**205.3**	**(2.2)**	**248.5**	**246.1**	**(2.4)**
Pay Costs	11.8	11.9	(0.1)	117.5	118.6	(1.1)	141.3	142.6	(1.3)
Non-pay Costs	8.9	9.7	(0.7)	92.6	93.7	(1.1)	110.4	109.9	0.5
Operating Expenditure	**20.8**	**21.6**	**(0.8)**	**210.0**	**212.3**	**(2.2)**	**251.7**	**252.5**	**(0.8)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA	**0.2**	**(0.6)**	**(0.8)**	**(2.5)**	**(6.9)**	**(4.4)**	**(3.2)**	**(6.4)**	**(3.2)**
EBITDA margin	0.9%	(2.7%)	(3.6%)	(1.2%)	(3.4%)	(2.2%)	(1.3%)	(1.3%)	0.0%
Depreciation	0.6	0.7	(0.0)	5.0	5.1	(0.1)	6.2	6.8	(0.6)
Finance costs	0.1	0.1	(0.0)	1.5	1.5	0.0	1.7	1.7	0.0
SURPLUS/(DEFICIT) pre S&TF	**(0.6)**	**(1.4)**	**(0.8)**	**(8.9)**	**(13.5)**	**(4.6)**	**(11.1)**	**(15.0)**	**(3.9)**
Sustainability and Transformation funding	0.5	0.0	(0.5)	5.1	2.9	(2.2)	6.1	2.9	(3.2)
SURPLUS/(DEFICIT) incl S&TF	**(0.1)**	**(1.4)**	**(1.3)**	**(3.8)**	**(10.7)**	**(6.8)**	**(5.0)**	**(12.1)**	**(7.1)**

FINANCE AND WORKFORCE REPORT – January 2017

Contents:

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 January 2017

The reported I&E for January 2017 is a deficit of £1,375k, against a planned deficit of £55k. This results in an adverse variance of £1,320k (£6,809k 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 4 months relates to the underachievement of the stretch CIP, being £650k per month (£2.6m YTD).

As a result of our failure to meet our financial plan we are not eligible for any Sustainability and Transformation funding in Q3 or Q4 (£2.0m YTD). 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.

The remaining variance from budget relates largely to delayed transfers of care

CIP

The January position includes a YTD CIP target of £9.6m of which £6.9m has been achieved. The shortfall largely relates to stretch CIP (£2.6m). 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.

2017-18 Budget Setting

	£m
2016-17 control total	(5.0)
Reverse S&T funding	(6.1)
Non-recurrent CIPs in 16-17	(2.5)
Non achievement of stretch CIP	(3.9)
Recurring 17-18	**(17.5)**
17-18 efficiency requirement	(5.0)
STP activity changes	(1.9)
2017-18 'do nothing' position	**(24.4)**

CIP assumed in Operational Plan	4.0%	9.9
2017-18 plan (as per STP and Operational plan)		**(14.5)**
Stretch CIP to include NHSI Learning toolkit	4.7%	11.7
Revised planned deficit		(12.7)
CIP to achieve target suggested by NHSI	5.4%	13.5
Deficit		(10.9)
CIP to achieve control total	6.7%	16.7
Proposed Control total		**(7.7)**
Sustainability and Transformation funding		5.2
Deficit		(2.5)

We have not accepted the control totals proposed for 2017-18 and 2018-19 due to the requirement to achieve CIPs of 6.7% and 8.3% respectively. We believe a CIP of 4% is a challenge in 2017-18, and have planned for 4.4% in 2018-19.

Working across the STP we have produced an operational plan with a deficit of £14.5m. This is predicated on achieving a CIP of £9.9m and includes a contingency of £2.5m. However, having assessed the NHSI Learning toolkit we believe we can stretch our CIP target to £11.7m (4.7%) and adjust our planned deficit to £12.8m

The 2017-18 plan includes underlying cost pressures from 2016-17, as well as inflation funding towards 2017-18 cost pressures relating to the following :

- Pay awards including the revised junior doctors contracts
- Non-pay inflation (including CNST premium inflation)
- Depreciation relating to capital projects
- tPP uplift
- Apprenticeship levy

At the March Board meeting we will include Divisional budgets for 2017-18, signed off by each Clinical Director and General Manager

CIP Plan

We continue to have a block contract with WS CCG and I&E CCG for 2017-18 removing the risk of underperformance and penalties. Therefore the CIP must come from cost reductions, productivity gains or from patients currently being treated outside of Suffolk. We have a good record of delivering CIPs, averaging almost 4% per year over the last 5 years.

Year	CIP value £m	Turnover £m	%
2012-13	8.6	167	5.1%
2013-14	4.0	173	2.3%
2014-15	6.7	177	3.8%
2015-16	9.8	210	4.7%
2016-17	8.6	249	3.5%
Average	**7.5**	**195**	**3.9%**

The 2017-18 schemes which are in place are outlined below**.**

Planned Improvement	2017-18 £'000
Car Parking	400
Medicines Optimization	241
Outpatients	218
Nursing Review	200
Medical Products Usage	201
Agency	164
Other schemes <£100k	175
Total	**1,599**

The PMO Lead follows a gateway process for the development of each scheme.

Gateway One requires a Project Initiation Document (PID) to be developed and approved by the Transformation Group. The PMO assess each scheme as part of Gateway One and assigns a RAG rating based on the risk of non-delivery

Gateway Two requires the sign off of a fully developed project plan and QIA by the CCG or Trust Executive sponsor.

Progress is reported to the Transformation Profile Group (TPG), to the Trust Executive Group (TEG) and to the Scrutiny Committee.

Increased CIP target

NHSI have developed a learning toolkit with over 200 suggestions for cost improvements, which we have reviewed as follows.

	In place / business as usual (or n'a)		Currently reviewed / in 1617 position		Opportunity	
	Low impact	High Impact	Low impact	High Impact	Low impact	High Impact
Finance	62	12	13	7	3	1
HR	17	6	6	7	2	2
Clinical & Ops	6	10	7	6	2	2
Comms	2	0	7	1	0	0
Exec Team	15	7	3	3	1	2

This analysis suggests there are 7 high impact areas that provide CIP opportunity which could yield savings as below, meaning we could stretch to a CIP target of 4.7%, being £11.7m

Areas that will be reviewed with high impact	2017-18 £ '000
Further procurement savings identified	200
Savings on overtime	100
Review of business continuity for ward based staffing	800
Rationalising project expenditure	100
Further work on demand reduction	250
Supplier management	250
Review back office structures	100
Total	**1,800**

Divisions have identified CIP of 1.5%, being £3.6m,

Therefore £7.0m of the 2017-18 CIP target has been identified.

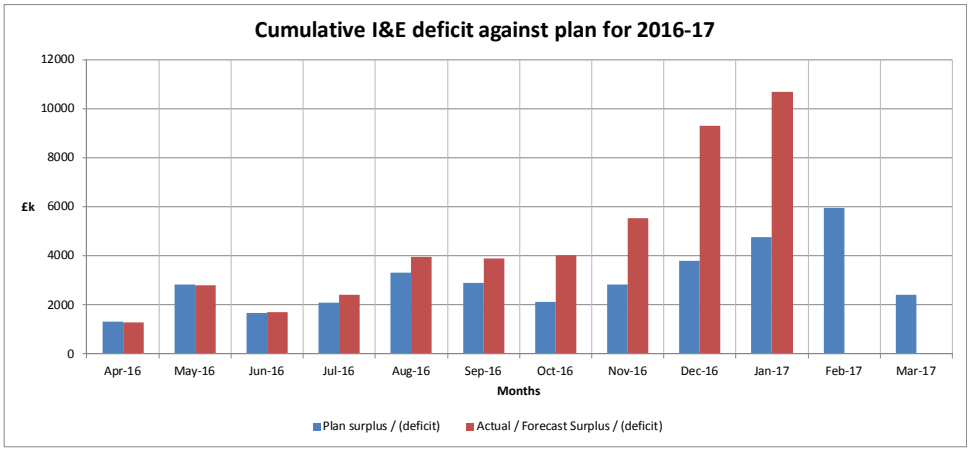
In order to achieve the higher CIP being suggested by NHSI (5.4%) or to meet the control total (6.7%) more unpalatable measures would have to be explored.

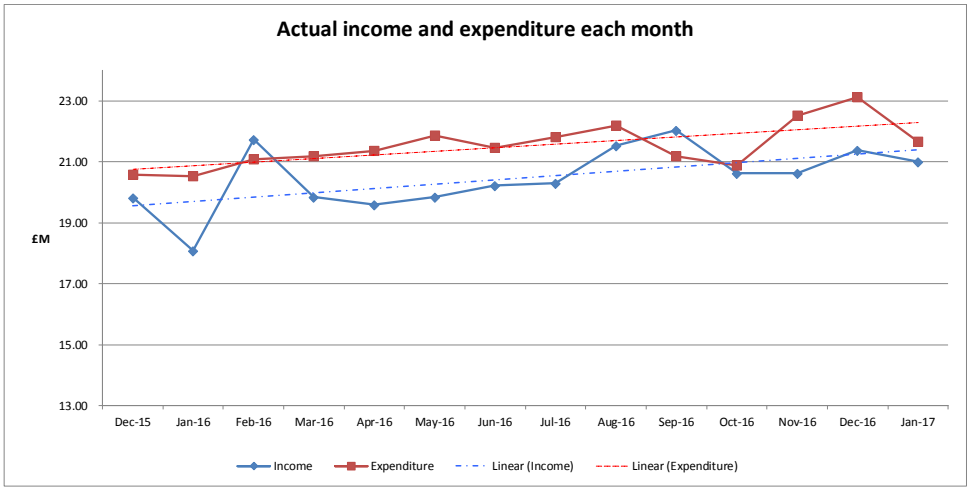
During 2017-18 progress against all CIP schemes totalling £11.7m will be monitored and included within this Board report

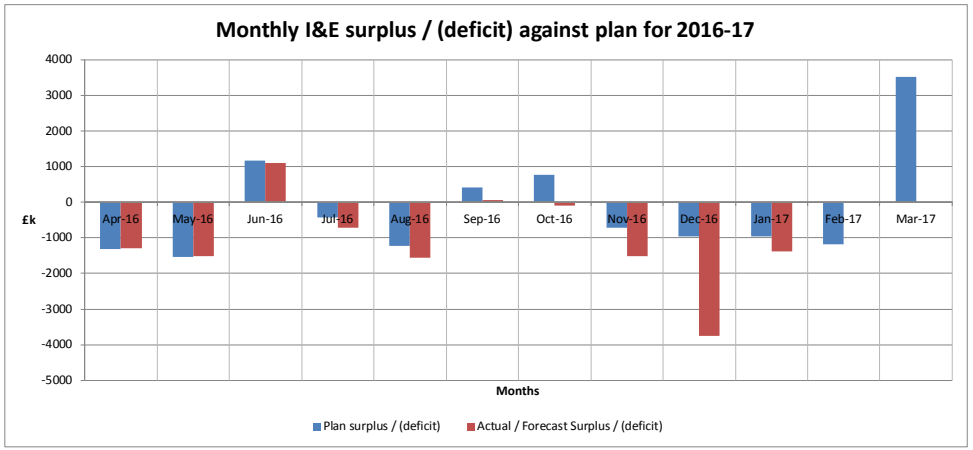
FINANCE AND WORKFORCE REPORT – January 2017

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)	(55)	(1,375)	(1,320)	↑	Red
YTD surplus / (deficit)	(3,842)	(10,651)	(6,809)	↑	Red
Forecast surplus / (deficit)	(5,000)	(12,100)	(7,100)	↑	Red
EBITDA YTD	2,597	(4,832)	(7,429)	↑	Red
EBITDA (%)	1.2%	(2.3%)	(3.6%)	↑	Red
Use of Resources (UoR) Rating fav / (adv)	3	4	1	↑	Amber
Clinical Income YTD	(182,646)	(181,903)	(743)	↑	Red
Non-Clinical Income YTD	(29,997)	(25,526)	(4,471)	↑	Red
Pay YTD	117,490	118,575	(1,084)	↑	Red
Non-Pay YTD	98,995	99,504	(509)	↑	Red
CIP target YTD	(9,554)	(6,286)	(3,268)	↑	Red

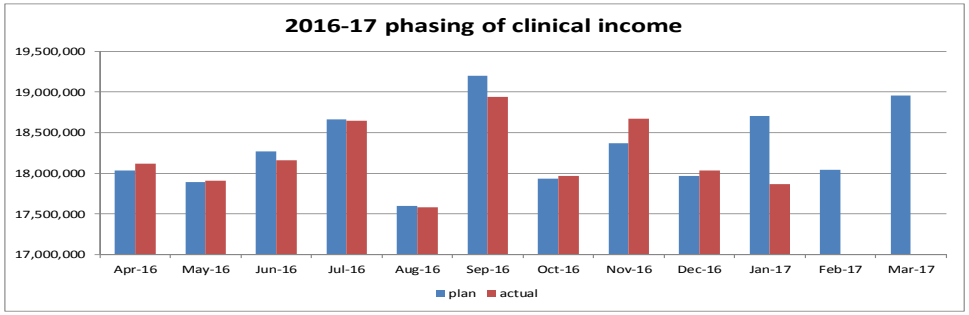






Income Analysis

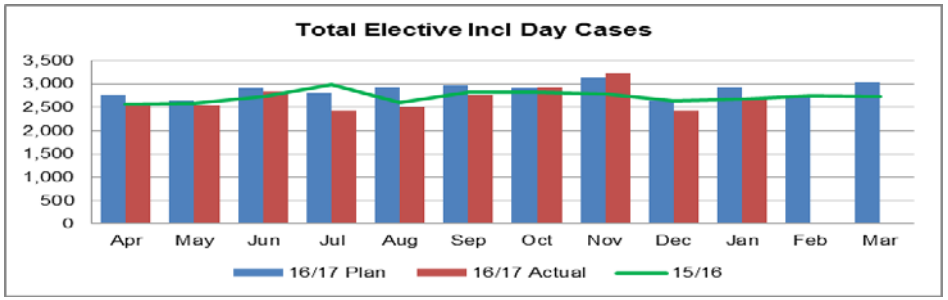
The chart below summarises the phasing of the clinical income plan for 2016-17, including Suffolk Community Health. This phasing is in line with activity phasing and does not take into account the block payment.

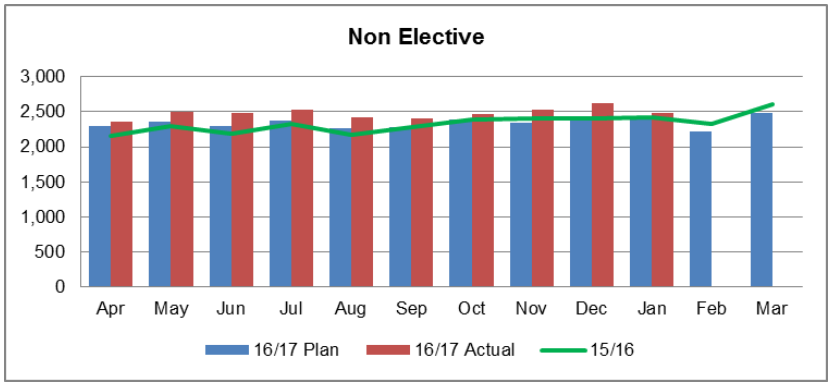


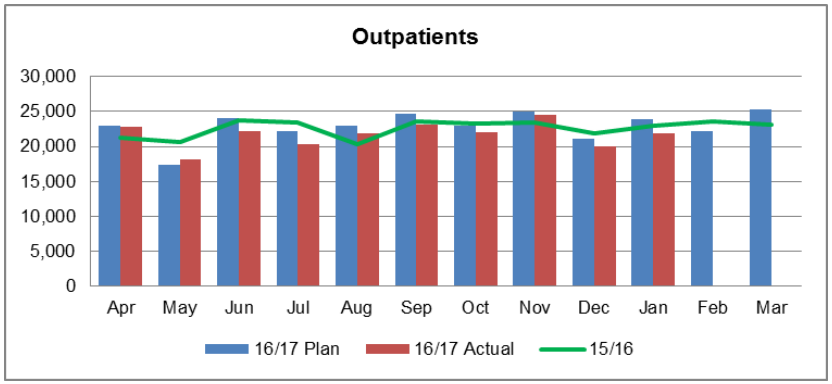
The income position was behind plan in January. Elective and Outpatients were the main areas behind plan within the month and have been consistently throughout the year.

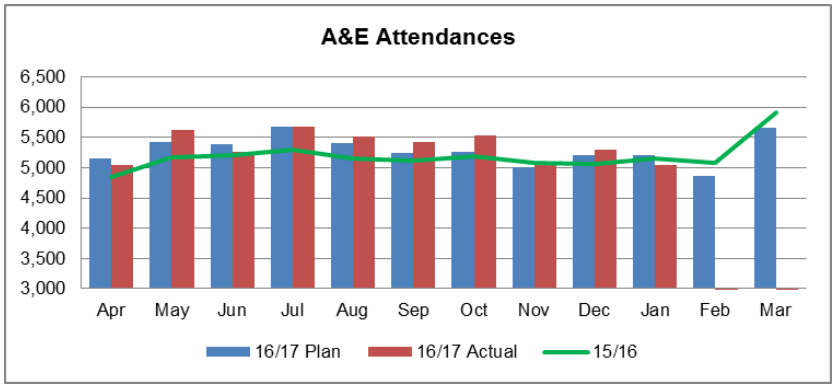
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	608	582	(27)	6,183	6,046	(137)
Other Services	2,260	2,218	(41)	21,529	25,363	3,834
CQUIN	314	306	(7)	3,057	2,944	(112)
Elective	2,932	2,728	(204)	29,186	26,491	(2,695)
Non Elective	4,811	4,897	86	46,109	47,158	1,049
Emergency Threshold Adjustment	(237)	(222)	15	(2,325)	(2,574)	(249)
Outpatients	3,075	2,822	(253)	29,490	27,462	(2,028)
Community	4,942	4,942	0	49,417	49,417	0
Total	**18,705**	**18,273**	**(432)**	**182,646**	**182,307**	**(338)**

Activity, by point of delivery

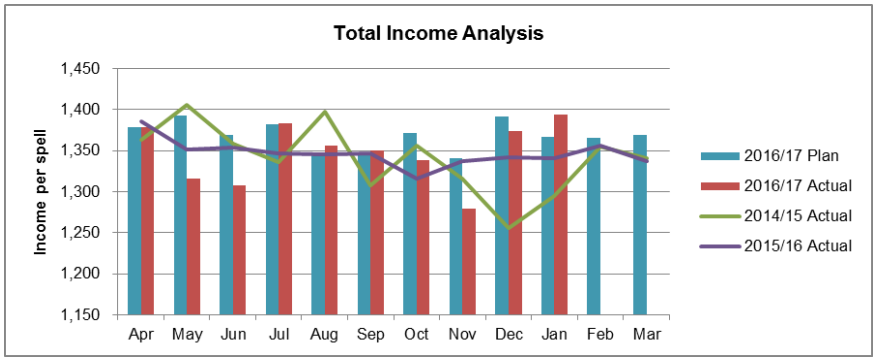


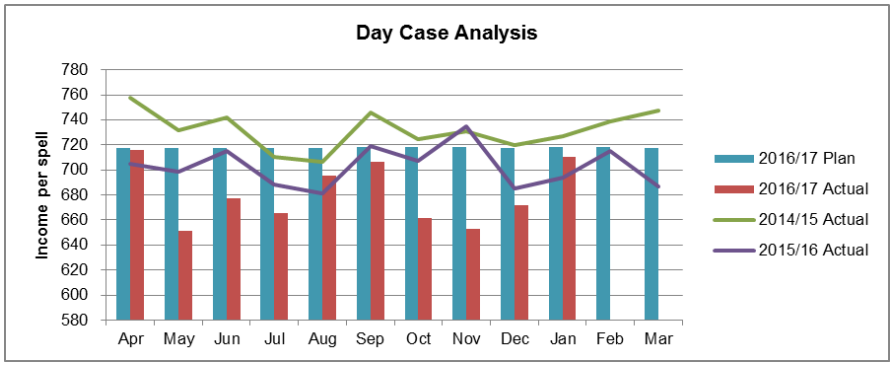


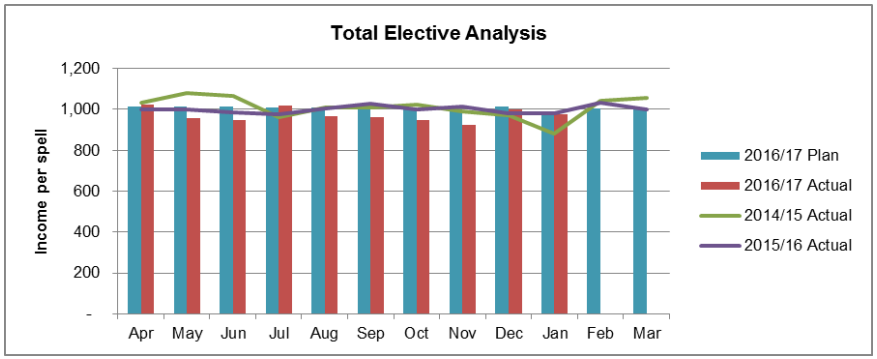


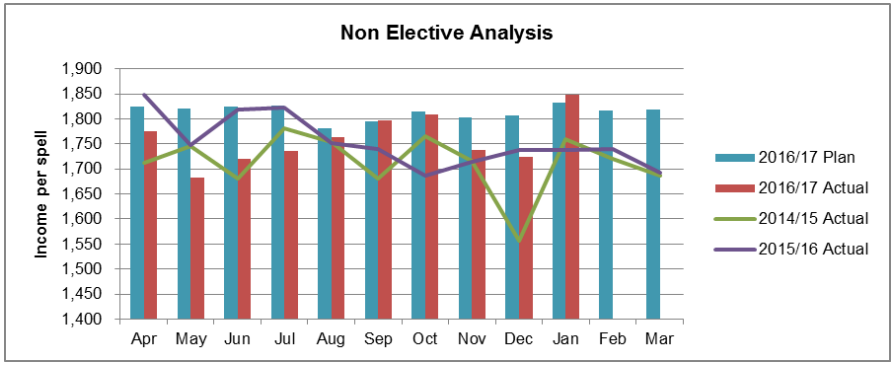


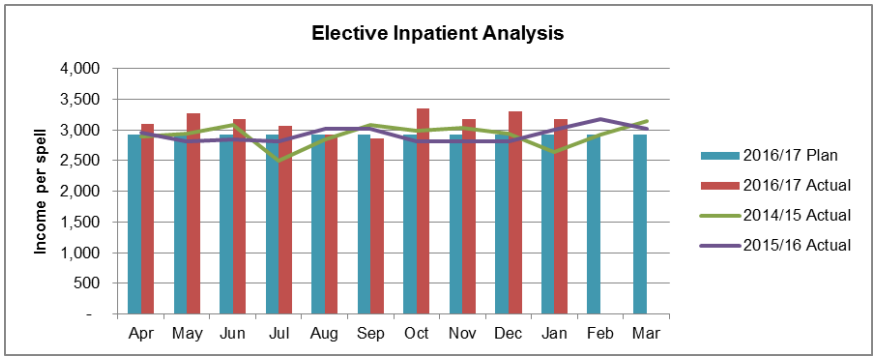
Trends and Analysis

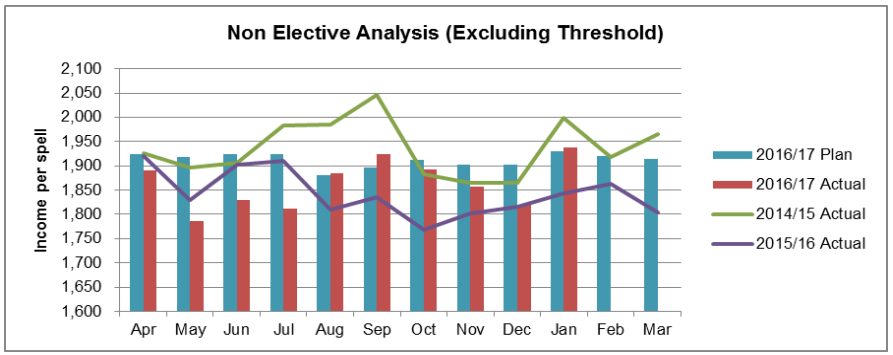












FINANCE AND WORKFORCE REPORT – January 2017

Workforce

Monthly Expenditure Acute services only				
As at January 2017	Jan-17	Dec-16	Jan-16	YTD 2016-17
	£'000	£'000	£'000	£'000
Budgeted costs in month	**10,550**	**10,710**	**10,233**	**105,661**
Substantive Staff	9,625	9,522	9,184	94,620
Medical Agency Staff (includes 'contracted in' staff)	181	160	202	2,044
Medical Locum Staff	116	163	123	1,474
Additional Medical sessions	214	238	254	2,361
Nursing Agency Staff	157	143	131	1,636
Nursing Bank Staff	190	175	230	2,285
Other Agency Staff	76	92	112	1,148
Other Bank Staff	129	127	129	1,343
Overtime	92	78	55	782
On Call	54	47	53	503
Total temporary expenditure	1,210	1,222	1,288	13,577
Total expenditure on pay	**10,835**	**10,743**	**10,472**	**108,197**
Variance (F/(A))	(10,824)	(33)	(239)	(2,536)
Temp Staff costs % of Total Pay	11.2%	11.4%	12.3%	12.5%
Memo : Total agency spend in month	415	394	445	4,828

Monthly Expenditure Community Service				
As at January 2017	Jan-17	Dec-16	Jan-16	YTD 2016-17
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,080**	**1,080**	**969**	**10,330**
Substantive Staff	1,027	1,011	931	9,711
Medical Agency Staff (includes 'contracted in' staff)	0	(15)	17	(15)
Medical Locum Staff	3	3	6	44
Additional Medical sessions	0	0	0	0
Nursing Agency Staff	3	5	0	33
Nursing Bank Staff	10	8	4	62
Other Agency Staff	42	38	3	361
Other Bank Staff	13	11	10	122
Overtime	8	4	2	46
On Call	1	3	1	13
Total temporary expenditure	80	57	44	667
Total expenditure on pay	**1,107**	**1,068**	**975**	**10,378**
Variance (F/(A))	(27)	11	(6)	(48)
Temp Staff costs % of Total Pay	7.3%	5.4%	4.5%	6.4%
Memo : Total agency spend in month	45	28	20	379

Monthly whole time equivalents (WTE) Acute Services only			
As at January 2017	Jan-17	Dec-16	Jan-16
	WTE	WTE	WTE
Budgeted WTE in month	**2,991.4**	**3,012.5**	**2,929.9**
Employed substantive WTE in month	**2701.04**	**2,730.6**	**2,677.0**
Medical Agency Staff (includes 'contracted in' staff)	11.34	12.1	14.8
Medical Locum	9.32	15.8	15.2
Additional Sessions	16.39	22.1	19.7
Nursing Agency	24.68	22.1	9.6
Nursing Bank	61.72	58.0	81.5
Other Agency	15.12	27.0	26.1
Other Bank	63.61	63.7	61.8
Overtime	41.58	36.1	27.0
On call Worked	8.51	8.5	8.7
Total equivalent temporary WTE	**252.3**	**265.4**	**264.3**
Total equivalent employed WTE	**2,953.3**	**2,996.0**	**2,941.2**
Variance (F/(A))	38.1	16.5	(11.4)
Temp Staff WTE % of Total Pay	8.5%	8.9%	9.0%
Memo : Total agency WTE in month	51.1	61.3	50.4
Sickness Rates (December / November)	3.95%	3.93%	3.8%
Mat Leave	1.8%	2.1%	2.0%

Monthly whole time equivalents (WTE) Community Services			
As at January 2017	Jan-17	Dec-16	Jan-16
	WTE	WTE	WTE
Budgeted WTE in month	**359.09**	**359.1**	**327.2**
Employed substantive WTE in month	**338.1**	**337.8**	**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	0.6	0.7	0.1
Nursing Bank	2.9	2.7	1.3
Other Agency	11.4	9.4	1.9
Other Bank	3.8	3.2	2.8
Overtime	4.2	2.2	1.2
On call Worked	0.0	0.9	0.4
Total equivalent temporary WTE	**23.2**	**19.5**	**9.1**
Total equivalent employed WTE	**361.3**	**357.3**	**328.2**
Variance (F/(A))	(2.2)	1.8	(0.9)
Temp Staff WTE % of Total Pay	6.4%	5.5%	2.8%
Memo : Total agency WTE in month	12.0	10.1	2.7
Sickness Rates (December / November)	4.02%	3.96%	
Mat Leave	1.5%	1.7%	

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

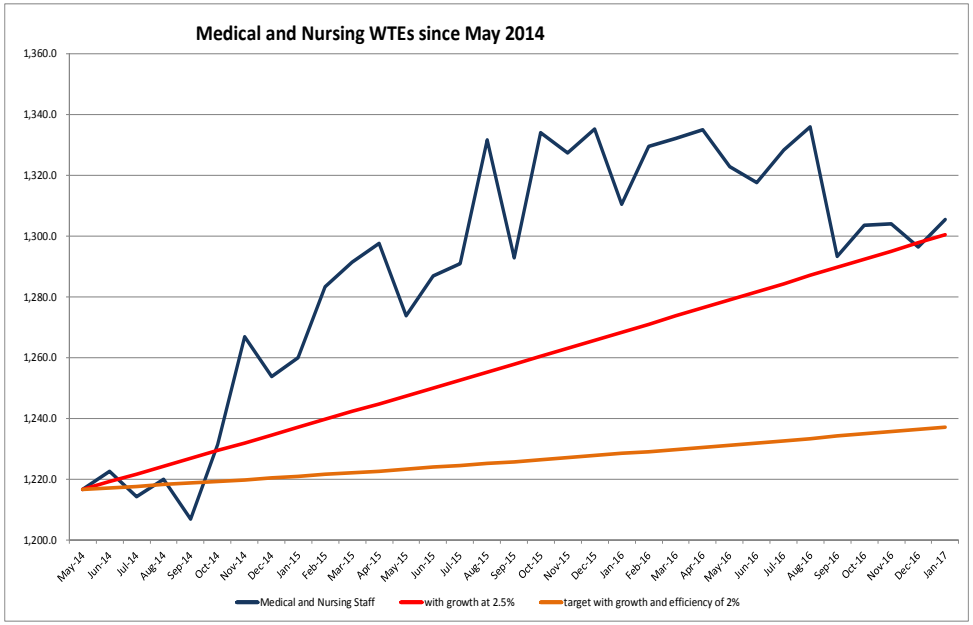
* Note that pay costs and WTE are gross, ie do not net off income or WTE relating to salary costs recharged to other organisations.

FINANCE AND WORKFORCE REPORT – January 2017

Staffing levels

The Trust overspent pay budgets by £112k in January, with £14k being in Nursing (£971k YTD).

The chart below shows the growth in Acute Medical and Nursing WTEs since May 2014 of around 90 WTEs (blue line). There has been an increase of 9 WTE during January.



Medical staffing have increased by 10 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 5 fewer staff (red line).

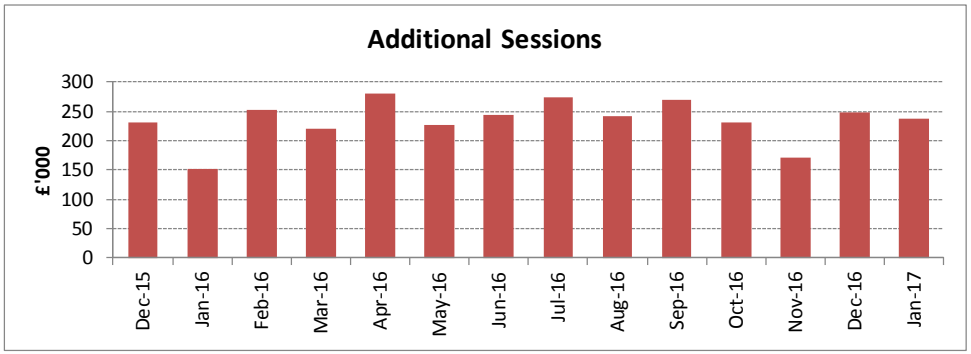
In order to achieve our 2% productivity target we should be staffing at the orange line, which is around 68 WTE fewer than we were at January 2017.

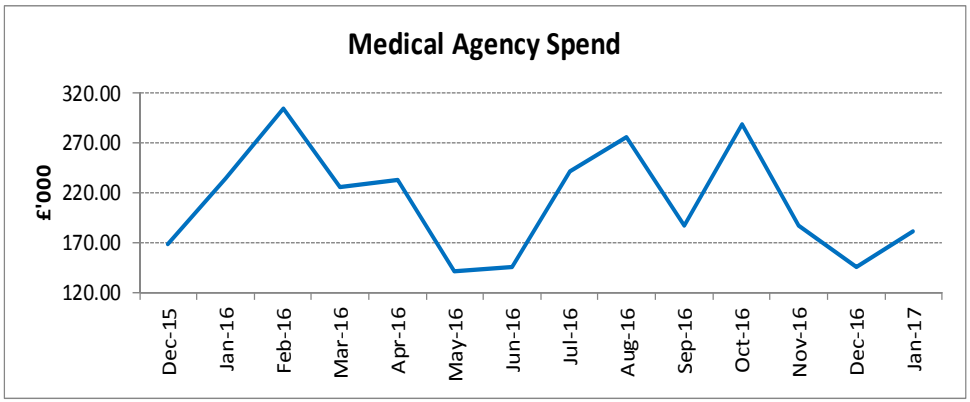
Over the last 12 months the Trust has spent an average of £1.15m per month (£13.8m since February 2016) on the following non-substantive payments. Average monthly expenditure:

- 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 £24k to £214k. These costs are for both Medical and Non-Medical staff. However, Medical Agency staffing costs increased by £36k, being £181k in January (£145k in December, which was the lowest since May 2016).





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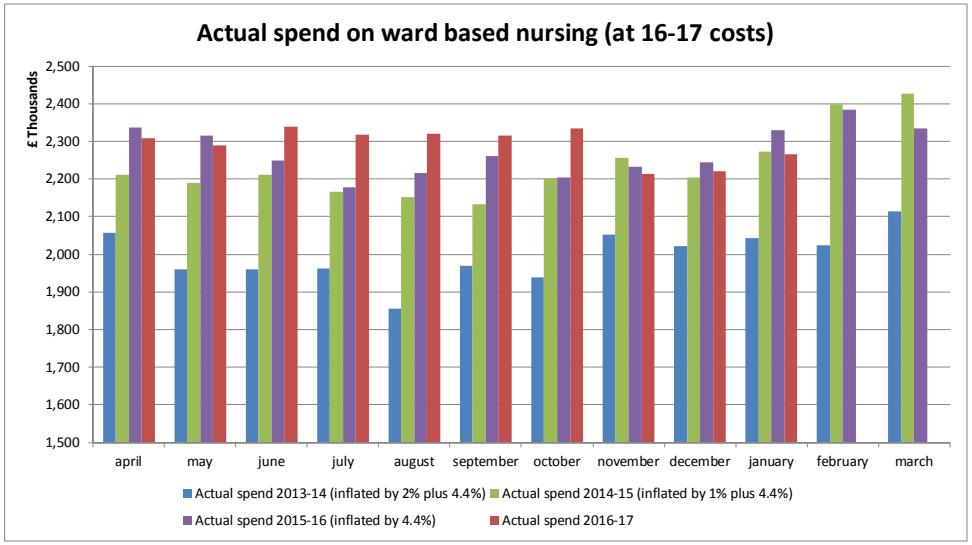
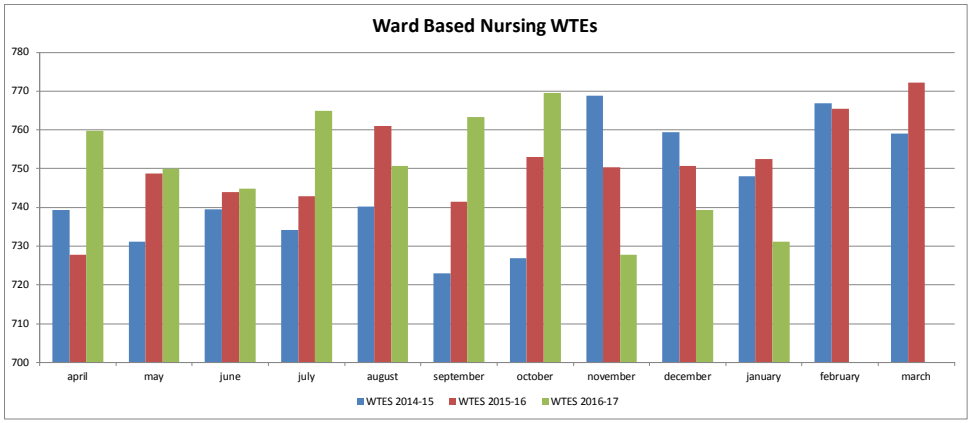
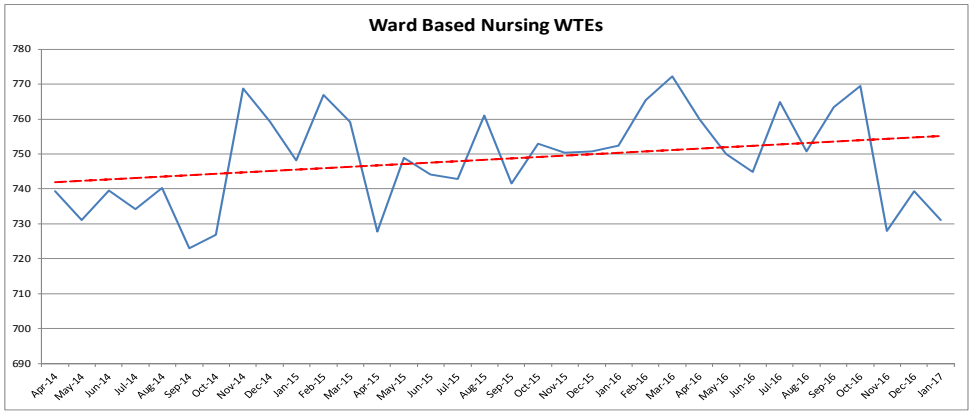
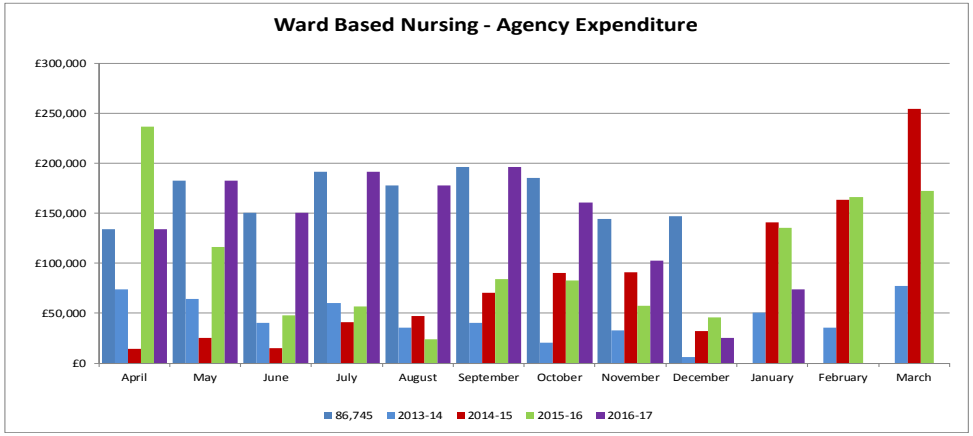
Ward Based Nursing



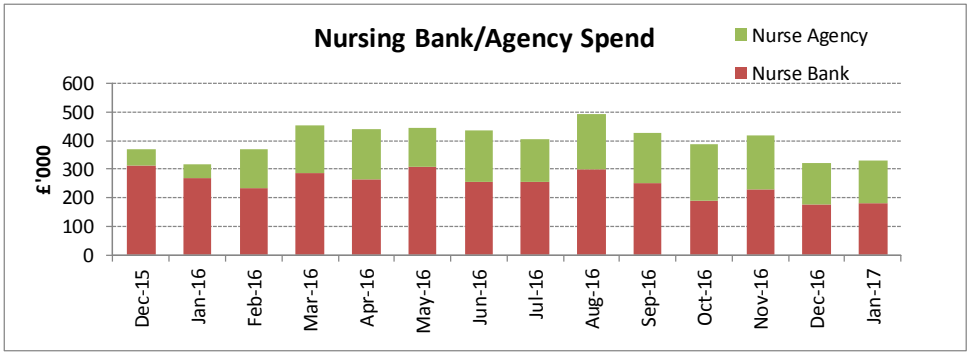
Ward based nursing costs increased by £60k to £2.27m in January as a result of re-opening escalation beds







All Nursing



FINANCE AND WORKFORCE REPORT – January 2017

Summary by Directorate

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Jan-17 Budget £k	Jan-17 Actual £k	Jan-17 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	(5,389)	(5,290)	(99)	(52,142)	(52,485)	343
Pay Costs	3,486	3,390	95	33,786	34,210	(424)
Non-pay Costs	1,260	1,294	(33)	13,104	13,335	(231)
Operating Expenditure	**4,746**	**4,684**	**62**	**46,890**	**47,545**	**(655)**
SURPLUS / (DEFICIT)	**643**	**606**	**(37)**	**5,252**	**4,940**	**(312)**
SURGERY						
Total Income	(5,280)	(4,993)	(287)	(51,526)	(49,672)	(1,854)
Pay Costs	2,977	2,916	61	29,858	29,573	285
Non-pay Costs	1,062	999	64	10,628	10,466	162
Operating Expenditure	**4,039**	**3,914**	**125**	**40,486**	**40,039**	**447**
SURPLUS / (DEFICIT)	**1,241**	**1,079**	**(162)**	**11,040**	**9,633**	**(1,407)**
WOMENS and CHILDRENS						
Total Income	(1,937)	(1,866)	(71)	(18,424)	(17,909)	(514)
Pay Costs	1,097	1,077	19	10,916	11,039	(122)
Non-pay Costs	141	147	(5)	1,399	1,482	(83)
Operating Expenditure	**1,238**	**1,224**	**14**	**12,315**	**12,520**	**(205)**
SURPLUS / (DEFICIT)	**699**	**642**	**(57)**	**6,109**	**5,389**	**(720)**
CLINICAL SUPPORT						
Total Income	(1,030)	(969)	(62)	(10,333)	(9,829)	(503)
Pay Costs	1,606	1,703	(96)	16,054	16,338	(284)
Non-pay Costs	1,007	994	13	10,384	10,074	310
Operating Expenditure	**2,614**	**2,696**	**(83)**	**26,438**	**26,412**	**26**
SURPLUS / (DEFICIT)	**(1,583)**	**(1,728)**	**(145)**	**(16,105)**	**(16,582)**	**(477)**
COMMUNITY SERVICES						
Total Income	(5,132)	(5,268)	136	(51,395)	(51,081)	(314)
Pay Costs	1,080	1,107	(27)	10,330	10,387	(57)
Non-pay Costs	3,968	4,091	(123)	41,298	41,031	267
Operating Expenditure	**5,048**	**5,198**	**(150)**	**51,628**	**51,417**	**210**
SURPLUS / (DEFICIT)	**84**	**70**	**(14)**	**(232)**	**(336)**	**(104)**
ESTATES and FACILITIES						
Total Income	(345)	(329)	(16)	(3,453)	(3,184)	(268)
Pay Costs	728	736	(8)	7,270	7,291	(20)
Non-pay Costs	621	632	(11)	6,095	6,098	(3)
Operating Expenditure	**1,349**	**1,368**	**(19)**	**13,365**	**13,389**	**(23)**
SURPLUS / (DEFICIT)	**(1,004)**	**(1,038)**	**(35)**	**(9,913)**	**(10,204)**	**(292)**
CORPORATE (excl penalties, contingency and reserves)						
Total Income (net of penalties)	(2,493)	(1,567)	(926)	(24,703)	(22,025)	(2,677)
Pay Costs	856	1,012	(156)	9,277	9,848	(571)
Non-pay Costs (net of contingency and reserves)	1,007	1,511	(504)	8,981	9,849	(868)
Finance & Capital	764	50	714	6,440	5,819	620
Operating Expenditure	**2,627**	**2,573**	**55**	**24,697**	**25,516**	**(819)**
SURPLUS / (DEFICIT)	**(135)**	**(1,006)**	**(871)**	**6**	**(3,491)**	**(3,496)**
TOTAL (including penalties, contingency and reserves)						
Total Income	(21,606)	(20,282)	(1,324)	(211,976)	(206,187)	(5,788)
Contract Penalties	0	0	0	0	0	0
Pay Costs	11,830	11,941	(112)	117,490	118,684	(1,194)
Non-pay Costs	9,068	9,666	(598)	91,888	92,334	(446)
Finance & Capital	764	50	714	6,440	5,819	620
Operating Expenditure (incl penalties)	**21,661**	**21,657**	**4**	**215,818**	**216,838**	**(1,020)**
SURPLUS / (DEFICIT)	**(55)**	**(1,375)**	**(1,320)**	**(3,842)**	**(10,651)**	**(6,809)**

Medicine (Annie Campbell)

The Division under performed by £37k in January, (£312k YTD).

Contract income was £12k ahead of plan in the month, and remains ahead of plan for the year.

Despite the bed pressures in the month ED attendance income was below plan, though there was a marked increase in income per attendance. This in turn translated into an increase in non-elective patients.

Outpatients continue to underperform across a range of specialties. The post the Division set up to review the use of e-care in clinics is already proving beneficial, and the Division has extended the post into next year. Issues in CDU and chemotherapy have been identified and should improve results.

Expenditure was underspent by £39k. Pay was below budget as the impact of the Divisional growth and escalation budgets took effect. Private patient income (13k), Drugs (£39k), security (£13k) and patient transport (£8k) were the main cause for concern. The Division anticipates it will break even over the next two months.

CIPs over performed in the month, and remain slightly behind plan.

Surgery (Simon Taylor)

The Division has underperformed by £162k in January (£1,407k YTD).

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

Elective income has improved compared to December; however there is still more room for improvement. The main area for concern is outpatients. The Division is reviewing the associated variances and reasons behind these. Where remedial action is possible this will be taken.

Three specialities are significantly struggling with their outpatient plan, Orthopaedics, General Surgery & Urology. But this is difficult to assess due to data quality and recording within eCare that may be impacting on this position.

Pay is underspent by £61k, the division still needs to cover shifts with agency, and this is likely to continue in some areas with vacancies and long term sickness impacting on safe staffing levels. The underspend relates to a reduction in additional sessions and vacancies in medical posts

Non-pay is underspent by £64k. This is due to a reduction in expenditure on prosthesis and MSE. This could be due in part to additional stock being purchased over the Christmas period.

In relation to CIP's Surgery has underachieved by £21k YTD due to overspend on orthotics and slippage on a service redesign.

Women and Children's (Rose Smith)

The Division reported an under performance of £57k in-month and £720k YTD.

Clinical income reported was £62k behind plan in-month and £444k behind plan YTD. This was due to under performance in elective admitted patient care within Gynaecology of £61k.

Pay reported £19k underspend in-month and £122k overspend YTD. The main underspend in-month is due to medical vacancies within Paediatric Services accounting for £17k. Recruitment for a Hybrid Consultant is underway.

Non pay reported £5k overspend in-month and £83k YTD. The overspend relates to an increase in drugs costs within Ward F1

Clinical Support (Rose Smith)

The Division reported under performance of £145k in-month and £477k YTD.

Clinical income for Clinical Support was £10k behind plan in-month and £161k behind plan YTD, mainly due to Interventional Radiology outpatient attendances.

Income was £52k behind plan in-month and £342k YTD. Main variances include Integrated Therapies Recharges £9k, Private Physiotherapy Service £15k and Pharmacy income from external contracts decrease in the month £17k (mostly offset against a decrease in drugs costs) and decrease in private patient income for Radiology £8k.

Clinical Support pay reported a £96k overspend in-month, £284k YTD. The main overspends are within Radiology due to agency, locum and emergency work accounting for a £44k variance in-month. There were also overspends within Pharmacy (£18k) due to additional hours worked and additional posts relating to pressures with E-care and the Red to Green initiative resulting in £18k in-month adverse variance and Endoscopy (£17k) relating to overtime, additional sessions and over establishment.

Non pay reported £13k underspend in-month and £310k underspend YTD. Main underspend of £43k is due to decrease in pharmacy drugs spend of £27k relates to West Suffolk Pharmacy and the remaining £16k relates to drugs spend on external contracts offset by a reduction in income. This favourable variance is offset by adverse variances in both Endoscopy and Pathology due to the engagement of external suppliers to help with backlog cases amounting to £23k and £14k respectively.

Community Services (Dawn Godbold)

Community Services reported a £14k overspend in-month and £104k YTD.

Contract Income reported £136k over recovery in-month, but is £314k behind plan YTD. This monthly variance is largely due to invoicing Suffolk County Council for their use of Community Equipment beyond the value of the block contract netted off somewhat by a one-off refund to Gt Yarmouth and Waveney, also relating to Community Equipment.

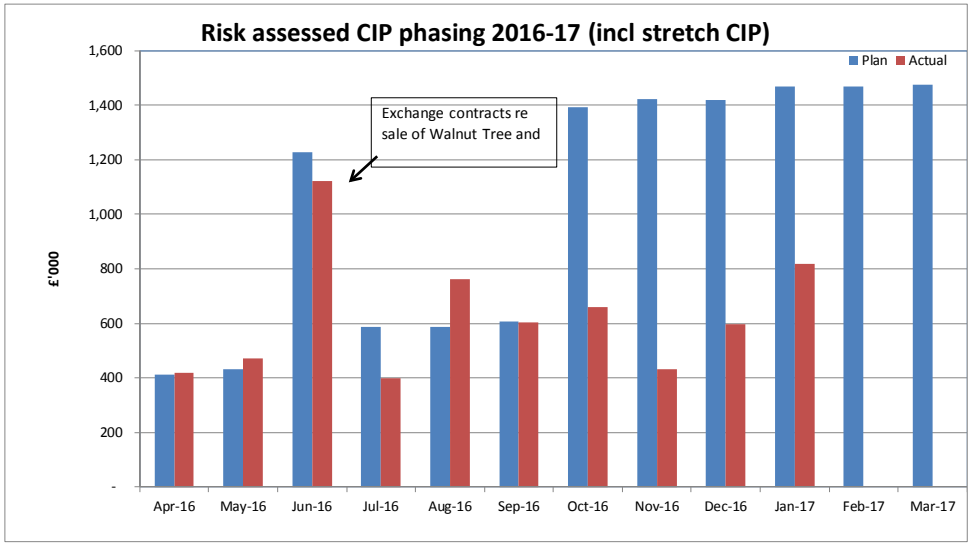
Pay reported £27k overspend in-month and £57k overspend YTD. In-month overspends were due to adult SALT (£13k) on agency spend due to staff vacancies and Glastonbury Court (£10k) on staffing above establishment due to delays in implementing the new rota.

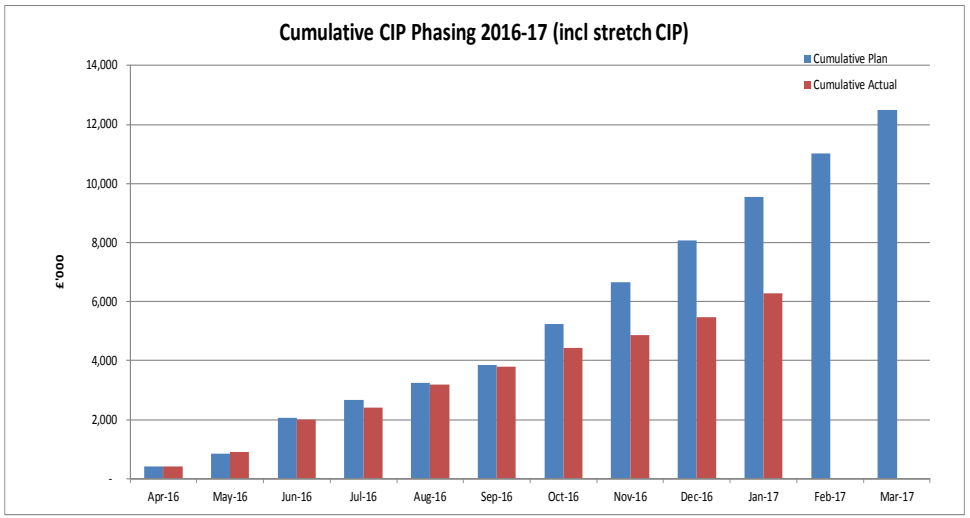
Non pay reported an overspend of £123k in-month (£267k underspend YTD). This included a one-off adjustment in January relating to the decommissioning of Alice Grange Beds resulting in a payment to the CCG of 50% of the savings. Other adverse variances include WSFT share of the First Dressings settlement with NCHC.

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

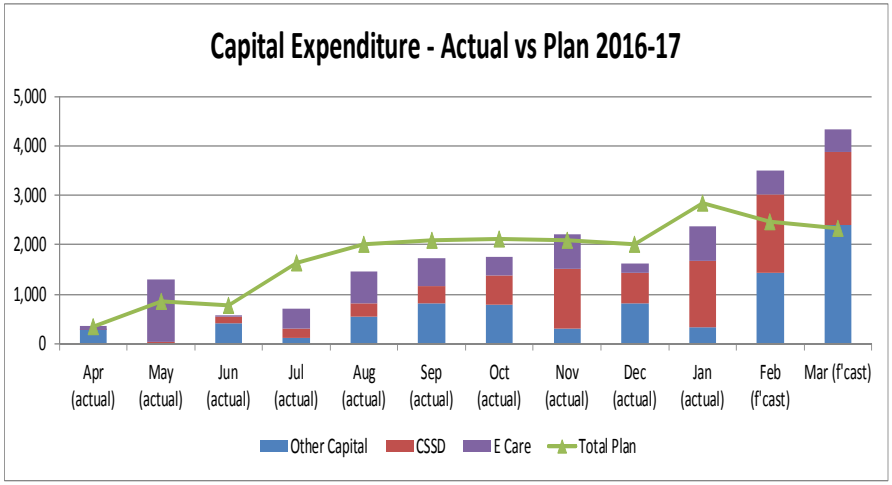
CIP schemes at Jan 17	Annual Plan	Plan YTD	Actual YTD	Forecast
	£'000	£'000	£'000	£'000
Activity growth	1,634	1,362	1,272	1,527
PCP	138	115	149	179
Price rise	31	25	25	30
Car parking	210	144	220	264
Staff review	552	447	405	486
Additional sessions	551	361	72	86
Agency reduction	405	207	150	180
Drugs	81	68	88	105
Pathology volume	68	54	-	-
Estates	375	269	106	141
DTOCs	540	395	200	267
Non-pay	407	372	462	617
Other	1,108	928	998	1,218
Non-recurring	2,500	2,208	2,758	3,500
Stretch CIP	3,900	2,600	-	-
Grand Total	**12,500**	**9,554**	**6,906**	**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 £3.2m (£2.6m as at December).

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

FINANCE AND WORKFORCE REPORT – January 2017

Capital Progress Report



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Forecast	Forecast	2016-17
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
E Care	94	1,262	19	412	625	561	378	705	198	691	473	473	5,890
CSSD	11	37	130	176	281	365	580	1,221	603	1,346	1,577	1,456	7,782
Other Schemes	270	15	426	124	548	806	793	299	819	343	1,440	2,413	8,295
Total Actual / Forecast	375	1,313	574	713	1,454	1,732	1,751	2,225	1,620	2,379	3,489	4,342	21,967
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 £2.7 million to the end of January. 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 £0.8m 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 above plan in January and £2.5 million behind plan YTD.

Slippage on the Cath Lab in 2016-17 is anticipated to be £2.4m by the end of the year and largely relates to a delay with the Mortuary move. Enabling works have now started. 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 £4.945 million at the end of January, (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 M10 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

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	-6.738	4
Liquidity rating	-19.695	4
I&E Margin rating	-5.13%	4
I&E Margin Variance rating	-2.64%	4
Agency	5.37%	2
Use of Resources Rating after Overrides		4

The Trust is scoring an overall UoR of **4**, the same as December 2016 which reflects the challenging financial position the Trust is in.

Statement of Financial Position at 31st January 2017

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2016 £000	Plan 31 March 2017 £000	Plan YTD 31 Jan 2017 £000	As at 31 Jan 2017 £000	Variance YTD 31 Jan 2017 £000
Intangible assets	10,876	13,487	13,210	15,852	2,642
Property, plant and equipment	61,923	74,893	71,830	66,455	(5,375)
Trade and other receivables	273	340	340	340	0
Other financial assets	1,688	2,409	2,309	1,909	(400)
Total non-current assets	**74,760**	**91,129**	**87,689**	**84,557**	**(3,133)**
Inventories	2,825	2,850	2,880	2,773	(107)
Trade and other receivables	11,191	9,230	9,530	11,313	1,783
Non-current assets for sale	1,400	0	0	0	0
Cash and cash equivalents	2,601	3,007	2,770	3,598	828
Total current assets	**18,017**	**15,087**	**15,180**	**17,684**	**2,504**
Trade and other payables	(21,692)	(20,686)	(18,363)	(28,383)	(10,020)
Borrowings	(130)	(130)	(130)	(130)	0
Provisions	(84)	(84)	(84)	(84)	0
Other liabilities	(1,892)	(295)	(541)	(244)	297
Total current liabilities	**(23,798)**	**(21,195)**	**(19,118)**	**(28,841)**	**(9,723)**
Total assets less current liabilities	**68,979**	**85,021**	**83,751**	**73,400**	**(10,352)**
Trade and other payables - Non current	(912)	(1,083)	(1,083)	(1,123)	(40)
Borrowings	(18,205)	(39,075)	(36,640)	(33,064)	3,576
Provisions- non current	(202)	(203)	(208)	(202)	6
Total non-current liabilities	**(19,319)**	**(40,361)**	**(37,931)**	**(34,389)**	**3,542**
Total assets employed	**49,660**	**44,660**	**45,820**	**39,011**	**(6,810)**
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)	(15,563)	(22,372)	(6,809)
Total taxpayers' and others' equity	**49,660**	**44,660**	**45,820**	**39,011**	**(6,809)**

Intangible Assets and Property Plant and Equipment:
The £2.6m variance on Intangible Assets is due to E-care which includes interest on the financing loan. 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. The Trust is now forecasting slippage at year end of £1.0m.

Other financial assets:
This investment relates to The Pathology Partnership (tPP) joint venture. The associated risk since Addenbrookes has announced its withdrawal from the partnership continues to be reviewed regularly and a full impairment review will be carried out at year end. A further investment of £625k has already been made since the cut off for this report and another £2.5m investment is planned for March 2017. The £2.5m investment relates to a PHE creditor held by tPP and the cash to finance this investment will come from an additional DH loan.

Trade and other receivables:
These have reduced by £1.8m since last month which is mainly due to payments made to TPP in response to a number of our invoices to TPP being paid. Work continues to reduce our receivables, particularly old balances that are overdue.

Cash:
The cash position at the end of January was higher than planned because of a backlog of invoices developing due to staff shortages. This backlog is being addressed and the cash position as we approach year end will be very tight.

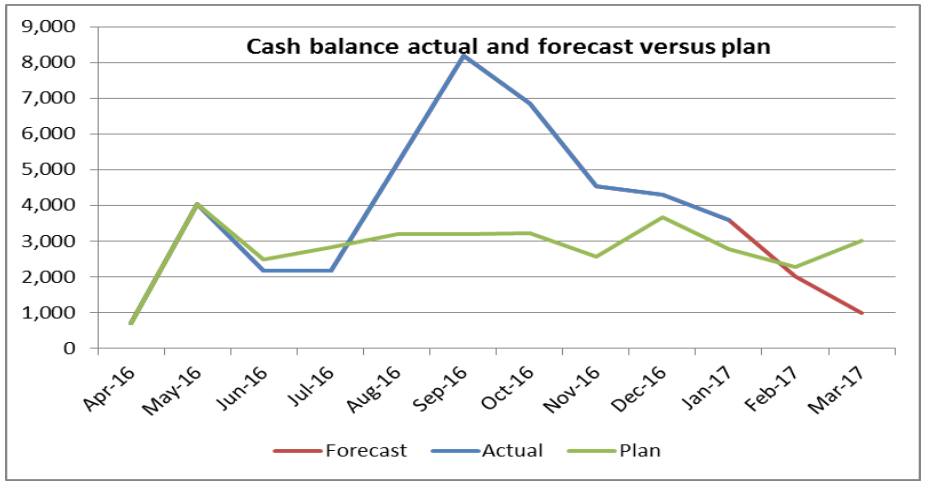
The Trust has still not received the anticipated £3.3m GDE cash which was expected by the end of January and there are ongoing conversations with DH to determine when this is likely to be received. If it is not received by mid-March this will cause the Trust significant operational difficulties. The Trust always planned to use the £5m working capital financing facility in 2016/17 which was agreed in 2015. £2.5m was drawn down in February 2017 and a further £2.5m will be drawn down in March 2017.

Trade and other payables:
Current payables have increased by £0.5m in January which reflects the backlog of invoices already referred to.

Borrowing:
Borrowing is less than planned at the end of January because the working capital financing facility had not been utilised but as highlighted already £5m will be drawn down by the end of March 2017.

The revenue and capital plan over the next two years exceeds the remaining loan finance available by £39m. This includes an assumption of £10.0m from the successful GDE bid. There is currently no agreed source of funds to cover this gap although distress financing has been requested from DH.

Cash Balance Forecast for the year



The graph illustrates the cash trajectory year to date, plan and revised forecast. It assumes receipt of £3.3 million cash prior to mid-March for the Global Digital Excellence Bid.

Cash forecast in line with Operational Plans

As reported in detail in the December finance report, the Trust will require distressed financing in 2017-18 as a result of the I&E forecast and capital programme. Since that report the Trust has agreed a front loaded cash payment profile with West Suffolk CCG for 2017/18 which means that the requirement for distressed financing is delayed to October 2017.

West Suffolk NHS
NHS Foundation Trust

Board of Directors - January 2017

AGENDA ITEM:	Item 10
PRESENTED BY:	Nick Macdonald, Deputy Director of Finance
PREPARED BY:	Nick Macdonald, Deputy Director of Finance
DATE PREPARED:	24 February 2017
SUBJECT:	January Board report
PURPOSE:	Review

EXECUTIVE SUMMARY:
The January position includes a forecast deficit of £12.1m for 2016-17, reflecting both the Trusts failure to achieve any of the stretch CIP (£3.9m) and the shortfall in Sustainability and Transformation funding (£3.2m).

The budget setting process is outlined in line with the operational plan submitted in December, including a deficit of £14.5m with a Cost Improvement Programme (CIP) of £9.9m (being 4%) and a contingency of £2.5m. However, this falls short of the control total proposed by NHSI which would require a CIP of £16.7m (6.7%) and would result in S&T funding of £5.2m.

Following discussions with NHS Improvement further CIP generating savings of £1.8m has been identified which improves the planned deficit to £12.7m in 2017-18. Budgets are therefore being set on this basis and will be signed off and included in the March Board report.

This report outlines the CIP process and progress towards identifying the £11.7m that is required to make a deficit of £12.8m. Whilst some schemes have been identified and will be managed through the PMO, there is a generic assumption that each Division can also reduce their costs by 3%, and around half of these savings have currently been identified.

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

Board of Directors – 3rd March 2017

AGENDA ITEM:	Item 11
PRESENTED BY:	Jon Green Executive Chief Operating Officer
PREPARED BY:	Dawn Godbold, Director of Community Services
DATE PREPARED:	17/02/2017
SUBJECT:	Provider Management Group report – January 2017 meeting
PURPOSE:	Information

EXECUTIVE SUMMARY:

The following provides a summary of the meeting:
Dawn Godbold presented the highlights from the December performance report as follows

1. Contract Performance KPI Summary:

- Friends and Family Test (FFT) remains good at 97%; two formal complaints have been received.
- The Delayed Transfer of Care position is worsening at 67 this month; Community beds do not currently feature on the A&E dashboards. Currently, Provider Management Group (PMG) requested that they are included so the system is aware of the high levels.
- Activity is slightly down, which is usual for December due to the Christmas holiday period.
- Paediatric Speech and Language Therapy – overall improvement seems to have plateaued.
- Care Co-ordination Centre – The CCG has agreed to close the remedial action plan (RAP). The trajectory has been delivered for January. Technical issues in December due to NEL resulted in the target trajectory being missed.
- 18-week referral to treatment (RTT) for Paediatric consultant lead services – 12 breaches out of 58 all in the East due to a Paediatric Consultant vacancy. The post has been recruited to; with a locum who will provide temp cover consistently, so improvements expected.
- Community Equipment Services – good improvement in terms of KPI's has been delivered. One failure against the 4 hour delivery target for 6 items of equipment, these were all for the same patient.
- Children in Care key performance indicators (KPIs) – further improvements made, 6 out of 7 children seen within 28 days of receiving all the paper work. The 7th child had been offered 2 appointments within 28 days, both of which were declined; the child was seen on day 30.

2. Provider updates

West Suffolk Foundation Trust

- Adult speak and language therapy (SaLT) – discussions have been held with CCG as to whether we provide services to patients with Learning Disabilities and Dementia. We have agreed to temporarily relax the criteria and see the dementia patients, a pilot is due to commence on 1/3/17.
- Stroke Early Supported Discharge (ESD) referrals - since it was agreed for the community service to absorb these referrals we now have a service model that has some clinical risk in it as the same

patients will be seen by 2 different therapists for different treatments. We will monitor this and potentially put a case forward to bring in-house all SaLT for the ESD service.

Ipswich Hospital Trust

- Aldeburgh Community Hospital – beds have been increased from 20 to 24 in December. Efforts are being made to reduce back to 20 but due to on-going escalation this has proved difficult.
- The process for requesting new I.T. equipment across the community contract has been drafted.

NCH&C

- Transformation plan has been completed, with the main change being changes to the skill mix. This will result in a 60/40 trained/untrained by the end of September 2017.
- Bank/agency – A new process has been instigated whereby all bank/agency requests require approval by the Director of Operations.
- Weekend therapy working – due to the infrequent number of referrals received at weekends it has been agreed that the Crisis Action Team will pick up any therapy needs at weekends.
- First Dressing Initiative – an ordering cap has been instigated whilst someone monitors stock levels for 3-months.
- Community Hospital Therapy provision – There is a need to review this as the patient cohort has changed. PMG agreed to explore the use of therapy resources and requested a verbal report on progress during the next provider update at the March PMG.

Medequip

- Performance has improved. There has been one failure for a late delivery, which was only late by 1 hour. Percentages for recycling rates/collection are increasing.
- Notice has been given on the Ipswich site and is due to vacate on 27/7/17. This is part of the 'one depot solution' previously agreed by PMG which will deliver some service efficiencies.

3. Risk Report

DG presented the risk report to PMG. There Was discussion on:

- Funding for the First Dressing initiative
- The increased number of falls across the community beds
- The increased number of pressure ulcers across community beds and teams

Discussion followed about the production and the format of the risk report and the difficulties with this being compiled by someone from WSFT, relying on information being provided by the other providers.

4. CIP/SIP update

PMG received this update from Michael Stonehouse.
Discussion followed on:

- The requirement to track benefits other than financial cash releases
- The need to produce an overarching assessment of the financial challenges
- The need to rework some of the financials to reflect current status of the projects
- The need to push ahead with phase 2 schemes
- The need to provide the Joint Venture Board (JVB) with a full report in March

5. Migration of paediatric services into the Care Co-ordination Centre

PMG received a paper which was presented by Scott Wootton CCC Manager.
The paper outlined the proposals to commence bringing paediatric services into the CCC from 1/3/17. There followed a discussion on the impact this may have on performance targets, staffing and IT resources needed to support this move. PMG approved the paper, but requested that the date was deferred to 1/4/17 to allow for the recent improvement in targets to embed, and for communications to go out to referrers.

6. Governance arrangements

Rowan Procter outlines to PMG the arrangements that would be put in place post Pam Chappell's departure on 28th February.

It is proposed to leave structures underneath Pam's current role "as is" due to forthcoming changes, the Head of Nursing and Head of Therapy posts (who both report into NCH&C) will report into Laura Clear NCHC. Fiona Whitfield (Nursing) will continue to pull together the central quality and risk report, but it is the intention to dissolve many of the community committees, such as infection control. The line management of the children's safeguarding lead will change to sit under safeguarding children at WSFT. Rowan Procter will be attending CCG contract meeting, quality sub-group, and sub- contract meetings in future.

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 – 3rd March, 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:	February 2017
SUBJECT:	Aggregated Quality Report
PURPOSE:	Information

EXECUTIVE SUMMARY

- This report will be reflective of the data from January 2017
- In January there were 447 Patients Safety Incidents (PSI) reported, similar to December (449).
- Level of harm in proportion to overall Patient Safety Incidents reported:
  - 84% (82% December) no harm (Green)
  - 12% (13% December) minor harm (Green)
  - 4% (2% December) moderate harm (Amber)
  - 0.4% (1.1% December) major harm (Red)
  - 0.2% (0.7% December) catastrophic harm (Red)
- In relation to type of incidents reported in January the highest areas of reporting related to Pressure ulcers, Slips Trips & Falls, and Discharge,Transfer and Follow up.
- 18 Complaints were received in January compared to 17 in December
- 171 PALS contacts were recorded in January compared to 122 in December.

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

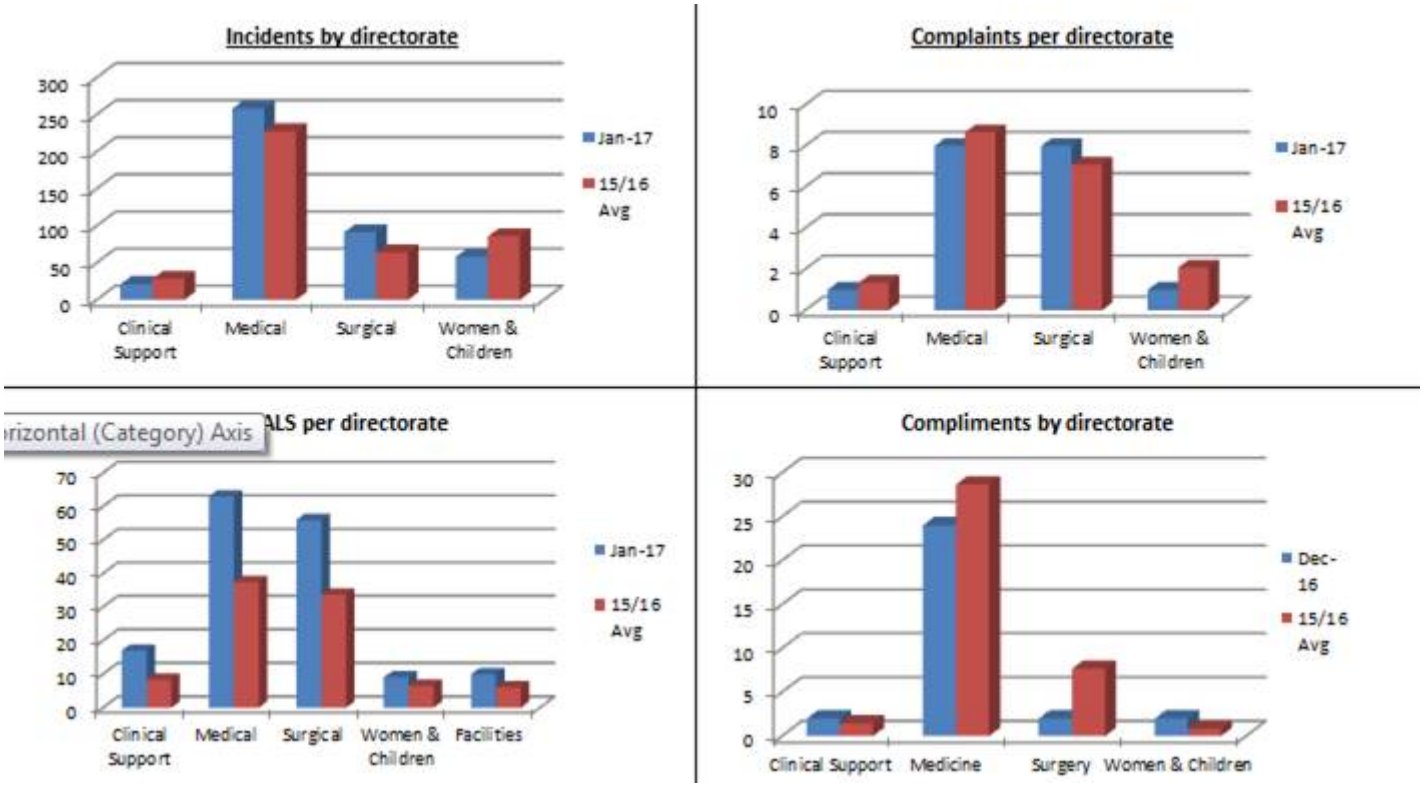


Table 2: PSIs reported by month (24 months)

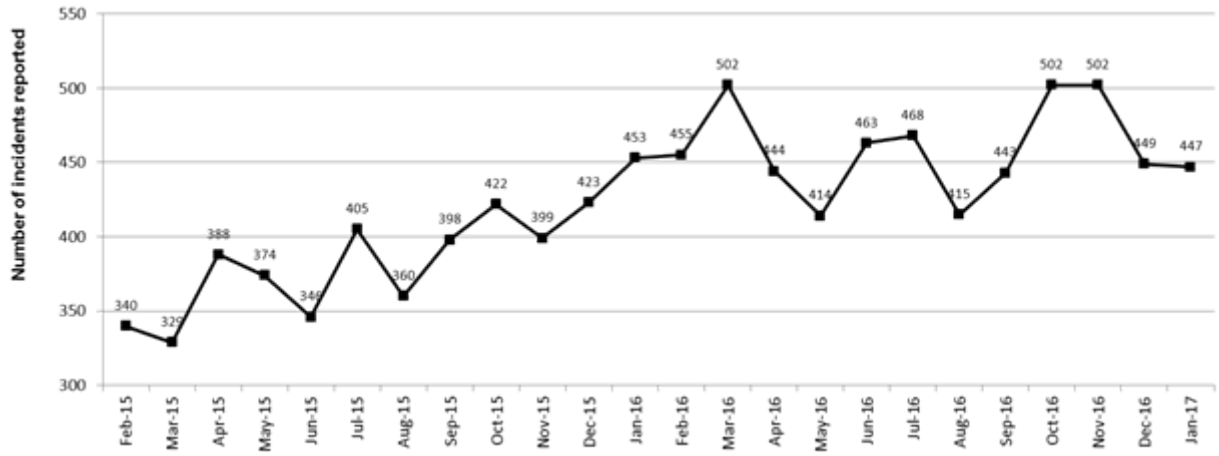
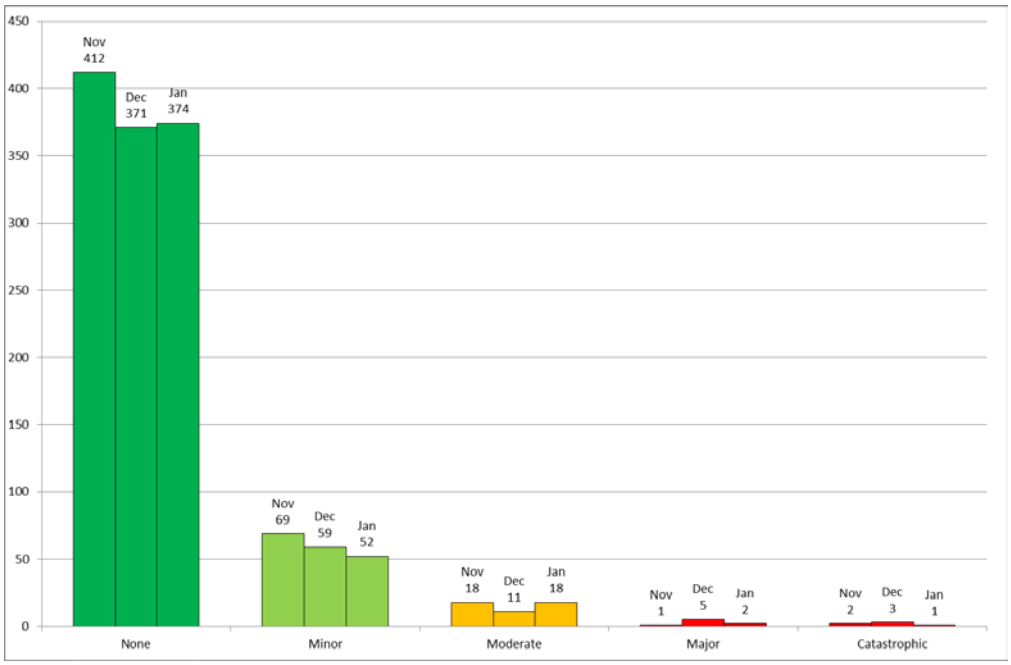


Table 3: Incidents reported by severity



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 January there has been a reduction in incidents reported as Major/Catastrophic (3) compared to December (8). There has been an increase in Moderate harm incidents of which a significant proportion relate to Hospital acquired Grade 3 Pressure Ulcers.

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

- One unexpected death
- Two falls resulting in neck of femur

The 18 moderate harm incidents relate to:

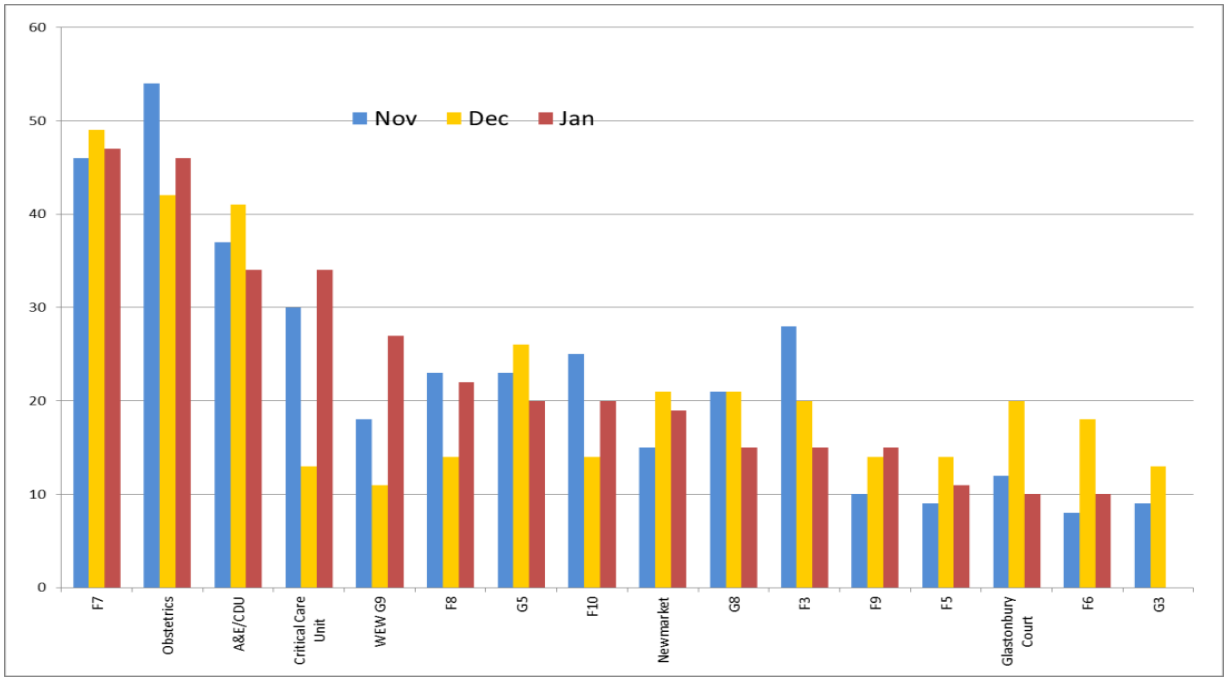
Medicine (11)

- Eight Hospital acquired Grade 3 pressure ulcers
- One delay in treatment
- One missed fracture
- One deterioration in condition during transfer

Surgical (7)

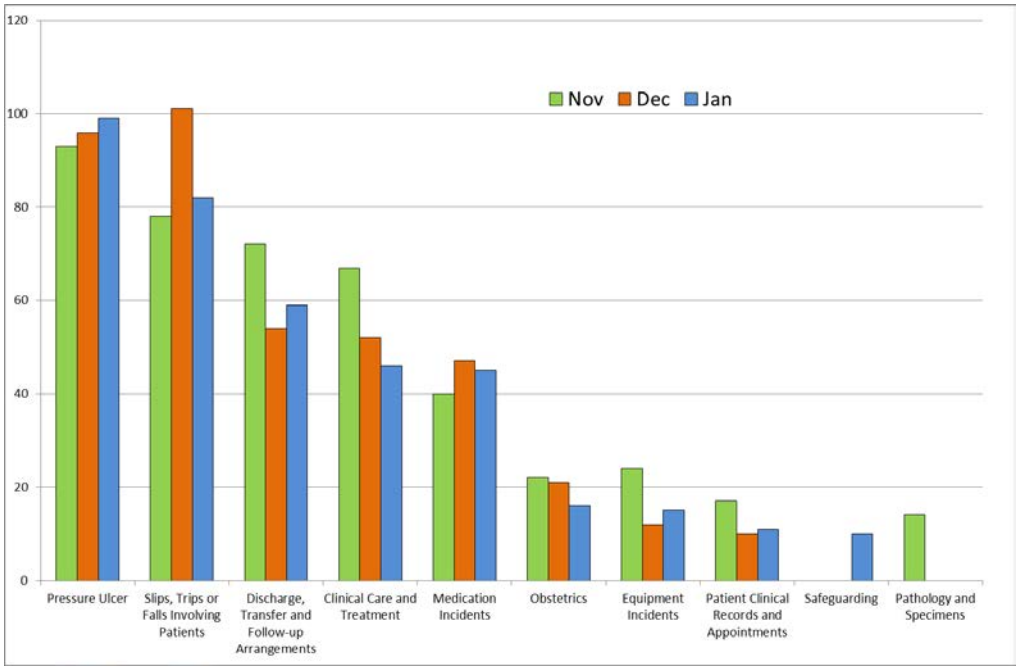
- One Hospital acquired Grade 3 pressure ulcer
- One complication of surgery
- One delay in treatment
- One failure to monitor
- One de-sterilisation of surgical area during surgical procedure
- One Inadequate post-surgical monitoring
- One treatment of Diabetes

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



During January there was a significant rise in reporting for Critical Care of which 50% related to delayed discharges of patients who no longer require the care provided within critical care and can be discharged to the ward to continue their recovery. The increase in reporting in G9, F10 and F9 related to inpatient falls and a combination of both Hospital and Community acquired pressure ulcers. Four of the pressure ulcers within G9 were Grade 3 hospital acquired. One of the falls resulted in Major harm. The high reporting within F8 relates predominantly to Community acquired Pressure Ulcers.

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



Pressure ulcers, Slips, Trips & Falls, 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.

Of the reported pressure ulcers, 31 relate to hospital acquired, 9 of these were Grade 3 and therefore reported

as moderate harm this is an overall increase in hospital acquired pressure ulcers, from December where 14 were reported. There is significant work ongoing in relation to the Tissue Viability Team and education across the trust to understand the increase in avoidable hospital acquired pressure ulcers.

We have been working with some of the clinical area to identify reporting triggers to support staff to know what should be reported in relation to both operational and quality of care issues. This work is being finalised within the Day Surgery Unit, Critical Care and Main Theatres and further detail will be provided in the march report.

Complaints

18 complaints received in January, an increase of one from the previous month. 86% of complaints were responded to in December within of the Trust's preferred timeframe. The breakdown of these complaints is as follows by Primary Division: Medical (8), Surgical (8), Women & Children's Health (1) and Estates and Facilities (1).

Table 6: Complaints by location

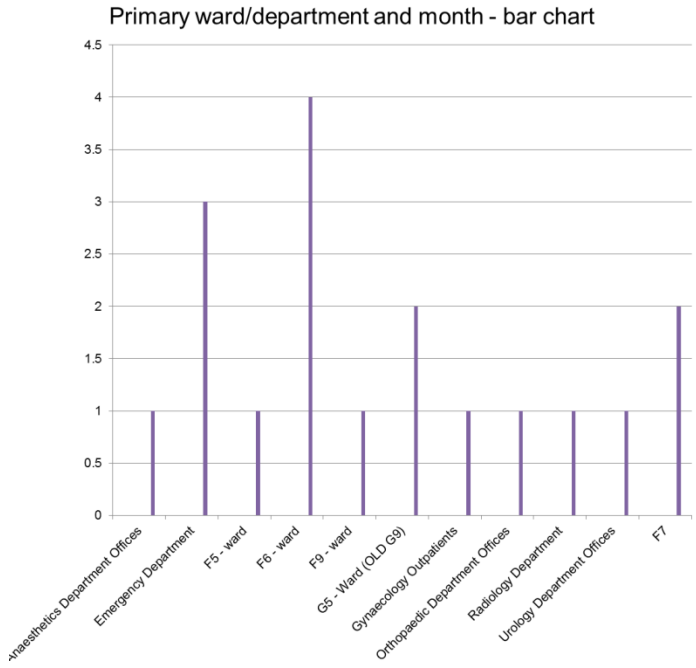
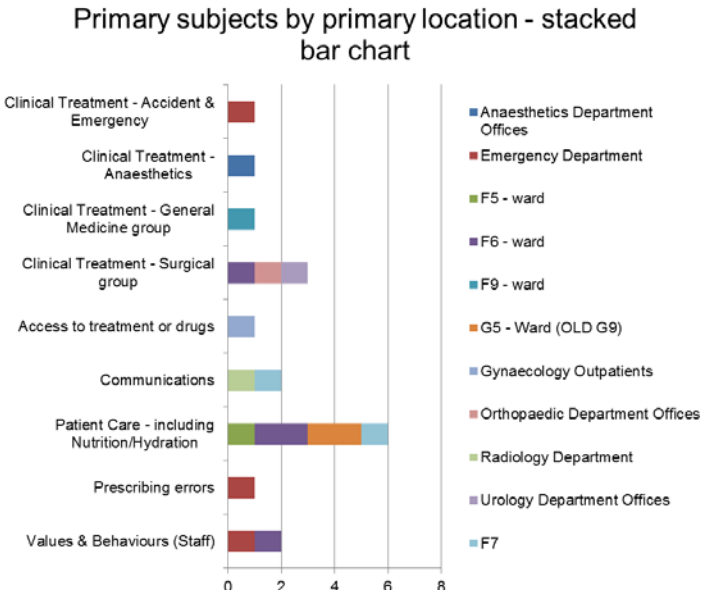


Table 7: Complaints by type



Patient Experience Themes

Area	*Analysis*	*RAG rating*
Car Parking	A number of concerns were raised about the impending charges for blue badge holders.	
ED	Three complaints against the Emergency Department (ED) were received however these were of differing nature. Of the 15 PALS enquiries about this area, themes were around patients not feeling they are being taken seriously and the attitude of staff. There were also several cases relating to patients not having received any food or drink whilst in the department. The Matron and Department Manager have been involved in these PALS cases where required and are aware.	
ENT	Several concerns were received via PALS in relation to the wait for an allocated outpatient appointment.	
Ward F6	Four formal complaints were lodged against Ward F6, three of which related to issues with nursing care and attitude. Senior Matron and Ward Manager are discussing these complaints in detail and are aware of these issues, thought to have been impacted by a significant decrease in staffing.	

Ward F7	Two formal complaints around patient care on Ward F7 were received. These related to discharge arrangements, assistance with cannula, nutrition issues and leaving a patient out on his chair. There were also eight enquiries through PALS relating to staff attitude, making unnecessary noise during the night time and a breakdown in communication between the ward staff and patients/relatives.	
Red rating = area for concern for >=3 months Amber rating = area for concern for 2 months Green rating = new area for concern		

West Suffolk NHS
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Trust Board – 3rd February 2017

AGENDA ITEM:	Item 13
PRESENTED BY:	Rowan Procter, Executive Chief Nurse
PREPARED BY:	Sinead Collins, Clinical Business Manager
DATE PREPARED:	22nd February 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. 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:

Observations in January and progress of nurse staffing review made below

Observations

January

ED – 5 medication errors due to higher flow of patients
F7 – Had 10 medication errors due to high vacancies, high % for roster effectiveness and high temporary staff use
F3 – Reduction in medication errors and but had 5 pressure ulcers due high use of agency staff
F4 – Had high use of bank staff and agency due to high level of sickness and ineffective rostering (high %)
G1 – High medication errors and 2 falls with harm (reason - high % for roster effectiveness?)
G9 – 5 pressure ulcers but high vacancies and high use of temporary staff

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

Update on progress of Nurse Staffing Review

Deeper review of their Nurse Specialist has been sent back from Medicine. Still waiting on Surgery, Paeds and Clinical Support reports.

Following an options appraisal being sent to the Chief Operating Officer, F14 move has not been seen as a viable option and this sub project has been removed from the Transformation Projects Group.

SCNT review of wards is currently being done and will be added into the paper next month following being shared with General Managers.

Theatres and Paediatrics are under review. Paediatrics was started at end of November and lead by General Manager; however no update has been given. Theatres is reviewing is Band 5 and band 3 roles, as well as looking into the effect on ODP recruiting when course turns into a degree. Critical Care initial review was postponed to the end of February.

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Jan-17			Establishment for the Financial Year 2016/17						Data for January 2017													
										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 (Jan 2017)	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	120.2%	105.6%	108.0%	132.9%	7.20%	9.30%	-5.59	-0.30	7.90%	N/A	16.60%	N/A	5	0
WSFT	F7	Short Stay Ward	34	78.04	53.99%	46.01%	N/A	6	9	90.9%	92.9%	91.6%	84.7%	7.80%	12.00%	26.54	20.18	10.70%	8.01	27.10%	1	10	1
WSFT	AMU	Acute Medical Unit	12 beds, 10 trollies and 4 chairs				N/A	6	N/A					1.30%	0.30%			4.80%	N/A	18.90%	0	0	0
WSFT	CCS	Critical Care Services	9	48.69	96.14%	3.86%	N/A	1 -2	1 -2	105.3%	97.3%	N/A	N/A	1.80%	0.00%	0.94	0.10	1.70%	17.03	14.20%	0	4	0
WSFT	Theatres	Theatres	8 theatres	87.84	74.00%	26.00%	N/A	1/3	(1/3)	115.5%	98.8%	N/A	N/A	1.00%	0.00%	12.50	-7.60	7.30%	N/A	23.20%	N/A	0	N/A
WSFT	Recovery	Theatres	11 spaces	22.56	96.00%	4.00%	N/A	1 -2	1 -2	139.3%	93.8%	55.0%	N/A	0.00%	0.00%	1.25	0.00	1.30%	N/A	17.20%	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	97.8%	N/A	145.9%	N/A	1.10%	0.00%	-0.20	0.32	6.20%	N/A	32.40%	N/A	1	N/A
WSFT	CCU	Coronary Care Unit	7	21.47	83.47%	16.53%	11.19	2 - 3	2 - 3	101.3%	95.7%	67.9%	N/A	1.10%	0.00%	-2.10	-0.40	3.90%	13.01	18.10%	0	0	0
WSFT	G1	Palliative Care	11	33.08	74.37%	25.63%	6.88	4	6	93.6%	100.2%	113.8%	N/A	1.30%	0.00%	1.04	-1.70	5.00%	8.43	21.40%	0	5	2
WSFT	G3	Cardiology	31	41.59	55.76%	44.24%	39.77	6	10	91.9%	94.8%	75.1%	93.8%	12.90%	0.00%	3.00	3.40	6.20%	5.31	21.60%	0	3	2
WSFT	G4	Elderly Medicine	32	48.04	50.06%	49.94%	31.67	6	10	100.4%	98.9%	87.9%	74.9%	10.20%	0.40%	4.54	4.71	5.90%	7.22	20.50%	1	0	0
WSFT	G5	Elderly Medicine	33	Waiting on Finance	Waiting on Finance	Waiting on Finance	41.35	6	11	90.5%	98.0%	94.3%	86.5%	5.50%	0.20%	4.24	1.24	8.00%	5.30	19.90%	2	2	1
WSFT	G8	Stroke	32	48.42	54.31%	45.69%	34.53	5	8	92.3%	95.5%	84.7%	83.7%	12.00%	1.10%	4.00	2.80	8.30%	7.34	25.00%	3	3	3
WSFT	G9	Winter Escalation	30	Waiting on Finance	Waiting on Finance	Waiting on Finance	Available Feb	6	10	99.1%	223.0%	95.3%	95.6%	21.50%	22.30%	-10.20	-9.80	3.50%	N/A	18.00%	5	0	0
WSFT	F1	Paediatrics	15 - 20	29.85	68.64%	31.36%	N/A	6	9	98.5%	119.4%	150.1%	N/A	9.70%	0.00%	3.86	-1.00	5.00%	N/A	18.30%	N/A	0	N/A
WSFT	F3	Trauma and Orthopaedics	33	37.89	59.07%	40.93%	33.35	7	11	94.5%	95.5%	124.9%	98.6%	1.80%	7.30%	2.50	-1.30	6.00%	5.12	18.20%	5	1	1
WSFT	F4	Trauma and Orthopaedics	32	24.37	56.54%	43.46%	19.73	8	16	96.2%	95.2%	50.2%	141.9%	12.80%	5.70%	3.50	3.30	14.20%	8.08	32.80%	0	1	0
WSFT	F5	General Surgery & ENT	33	35.49	63.71%	36.29%	37.58	7	11	92.7%	97.9%	91.5%	132.5%	2.70%	0.30%	1.36	0.50	4.50%	6.31	18.50%	0	1	0
WSFT	F6	General Surgery	33	35.70	58.77%	41.23%	46.28	7	11	81.2%	98.9%	107.1%	92.6%	4.40%	9.20%	4.57	2.70	7.20%	9.80	17.70%	0	3	0
WSFT	F9	Gastroenterology	33	43.77	52.34%	47.66%	49.42	7	11	102.3%	101.8%	83.6%	102.5%	10.70%	0.40%	3.40	3.32	6.40%	5.32	20.50%	2	1	1
WSFT	F10	Respiratory	25	40.76	56.58%	43.42%	39.10	6	6	114.2%	91.9%	106.2%	90.8%	4.90%	0.20%	3.24	4.40	4.20%	6.85	16.60%	3	1	0
WSFT	F11	Maternity	29	54.71	72.14%	27.86%	N/A	7.25	14.5	120.5%	96.5%	83.6%	65.5%	7.80%	0.00%	3.78	1.40	7.40%	N/A	21.20%	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	0	N/A
WSFT	F12	Infection Control	8	16.43	68.59%	31.41%	10.49	4	4	98.6%	90.5%	70.3%	86.5%	5.70%	1.80%	2.90	0.20	5.30%	9.08	24.10%	0	1	0
WSFT	F14	Gynaecology	8	11.58	96.55%	3.45%	6.49	4	4	100.8%	100.0%	N/A	N/A	0.00%	0.00%	0.70	0.40	1.50%	N/A	12.00%	0	1	0
WSFT	MTU	Medical Treatment Unit	9 trollies and 8 chairs	8.73	82.47%	17.53%	N/A	5 - 8	N/A	83.5%	N/A	36.7%	N/A	0.00%	0.00%	0.20	-0.30	9.20%	N/A	34.30%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.69	85.14%	14.86%	N/A	2 - 4	2 - 4	98.9%	88.9%	26.5%	35.5%	0.50%	0.00%	0.57	1.70	5.80%	N/A	22.00%	N/A	0	N/A
Newmarket	Rosemary Ward	Step - down	16	25.98	47.81%	52.19%	10.28	8	8	98.4%	100.3%	91.3%	99.2%	9.50%	0.0%	0.35	2.19	6.32%	6.50	N/A	0	1	1
Glastonbury Court	Kings Suite	Medically Fit	20	27.66	51.00%	49.00%	35.75	6.6	10	76.3%	102.8%	91.2%	94.6%	4.40%	2.0%	-10.51	-10.40	6.5%	5.20	19.90%	1	1	0
																60.38	20.06	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 (Feb 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

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Board Report – 3 March 2017

AGENDA ITEM:	Item 14
PRESENTED BY:	Rowan Procter, Executive Chief Nurse
PREPARED BY:	Rebecca Gibson, Compliance Manager Sinead Collins, Divisional Business Manager Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	24 February 2017
SUBJECT:	CQC Report and action plan to address requirement notices
PURPOSE:	Approval

EXECUTIVE SUMMARY:

On 21st October 2016, the **Care Quality Commission (CQC)** quality summit took place and the Trust action plan to address the three "MUST" was presented.

The aim of each action plan is to provide robust assurance of the work the Trust has undertaken since the visit as well as highlight work ongoing. To this end the document includes embedded evidence of completion (where available) as well as progress notes for those actions still ongoing.

As the action plan has progressed there have been additional actions added however all original actions highlighted at the time of the report issue have now been completed.

A list was drawn up of all issues highlighted as "SHOULD" in the main report. Not all of the issues were deemed to need a specific action to address the CQC's comment but, where they did have a defined action allocated (33 in total), Annex D lists the current status of these actions. 21/33 actions are complete, 12/33 are on track for completion and there are no actions overdue.

The CQC have issued a consultation document "*Our next phase of regulation. A more targeted, responsive and collaborative approach*" http://www.cqc.org.uk/content/our-next-phase-regulation which sets out changes to the inspection process from 2017/18. The April Trust Board meeting will contain more details about this change in methodology together with an outline of how the Trust proposal can ensure that internal assurance can be maintained.

Appendices

Annex A - Action plan Compliance with mixed sex accommodation regulations
Annex B - Action plan EPARS MCA and DOLS
Annex C - Action plan Medical photography
Annex D – Action plan for SHOULD issues highlighted in the CQC report

Recommendation

1. Approve the updated action plan with ongoing 'MUST' action monitored by the Deteriorating Patient Group, Safeguarding Adults Committee and IG Steering Group respectively which appropriate reporting via subcommittees to the Board
2. Receive proposed arrangements for future CQC compliance monitoring and assurance at the Board meeting in April

Annex 1 - Mixed sex breach

"The Trust must review and ensure robust processes are in place to provide compliance with mixed sex accommodation regulations especially within CDU, critical care (in relation to level one patients) and recovery when it is utilised for stepdown from critical care"

Clinical Decision Unit

Action	Progress summary	Subject Lead	Deadline	Status
Review current Standard Operating Procedure for CDU patients. Make the necessary adjustment to meet the standard.	 CDU - Policy.doc Policy updated	Kris Apps – Acting Service Manager ED	30/09/16	Complete

Critical Care / Recovery

Action	Progress summary	Subject Lead	Deadline	Status
Review staff knowledge of same sex accommodation (SSA) standard for Level 1 wardable patients.	Department staff surveyed to establish knowledge base. Highlighted need to provide structured definition of SSA. Sisters' meeting used as forum to communicate to staff.	Irene Serrant	31/07/16	Complete
Review arrangements in place to manage the transfer of patients from recovery and ensure all potential breaches of SSA are recognised and prevented.	Bed capacity report amended to capture wardable patients with an extended stay in recovery. This information is subject to review as part of the operational bed management meetings which take place three times a day.	Helen Beck	31/03/16	Complete
Review and refine departmental standard operating procedures (SOPs)	SOPs in place for Privacy & dignity and Avoidance of SSA breaches. SOPs reviewed to ensure clarity of information.	Irene Serrant / Sandy Lewis	31/10/16	Complete
Agree a timeframe for what is a 'reasonable' length of time for a Level 1 (wardable) patient to remain in Critical Care / Recovery awaiting a ward bed? Trust current in-house standard of 4 hours to be clarified. Network guidance states timeframe should be that 'agreed with local commissioners. WSFT to benchmark with IHT to ensure a consistent definition across West/East Suffolk CCG	NHS England National Standard states "within 4 hours of a clinical decision to discharge being taken within daytime hours"	Sandy Lewis	31/10/16	Complete

Action	Progress summary	Subject Lead	Deadline	Status
Monitor all extended stays and complete a Datix for any case that exceeds 24hours	Datix now includes a new incident category "*critical care capacity issues*" with sub-categories for: delayed admission, escalation plan activated, surgical delay/cancellation, reduced recovery capacity, non clinical transfer, out of hours discharge and delayed repatriation	Irene Serrant / Governance	31/10/16	Complete
Report and investigate all actual breaches.	New Datix sub-categories will categorise reasons for breach. New drop down tab for same sex accommodation breaches has been added under *Clinical Care & Treatment* category (this is where the similar '*Patient Dignity compromised* category is located) on Datix.	Irene Serrant / Governance	31/10/16	Complete
	Completion of a concise RCA for each identified case. Band 7 Senior Sisters check for potential and actual breaches. RCA done for each actual and reported to Governance monthly	Irene Serrant	Currently in place	Complete

Annex 2 – MCA / DOLS

"The Trust must review its 'Escalation Plan and Resuscitation Status' (EPARS) forms to ensure, specifically, that the Mental Capacity Act and Deprivation of Liberty Safeguards aspects are appropriate" and "review its Mental Capacity Assessment, Deprivation of Liberty Safeguards and EPARS policies to ensure they are compliant with law and reflect good practice"

Issue	Action	Progress summary	Subject Lead	Deadline	Status
Completion of Escalation Plan and Resuscitation Status (EPARS) forms was inconsistent and often did not match other documentation or had sections incomplete.	Review its 'Escalation Plan and Resuscitation Status' (EPARS) forms to ensure, specifically, that the Mental Capacity Act and Deprivation of Liberty Safeguards aspects are appropriate	Resuscitation Committee have instigated an EPARS sub-group to review policy and implementation. A comprehensive action plan has been developed (Nov16 copy attached)	Julie Head - Resuscitation & Outreach Services Mgr	31/12/16	Complete
The completion of and documentation on EPARS forms was often confusing, contradictory or incomplete. However records from the specialist palliative care					

Issue	Action	Progress summary	Subject Lead	Deadline	Status
team were well documented.	New action - Audit the above	The plan is to audit at the end of March 2017, then if all is well, the policy will be adapted to reflect e-Care process	Julie Head - Resuscitation & Outreach Services Mgr	31/03/17	In progress
During the unannounced inspection, an additional 17 patients were requiring a DoLS application to be completed. Staff informed us this was primarily due to a lack of staff, time and resources to complete them, and in part due to a change in policy.	Review MCA / DOLS policy to ensure they are compliant with law and reflect good practice	An external, independent review of the policy's compliance with current guidance has been commissioned from Dominic Nasmyth- Miller, Adult Safeguarding Manager, Suffolk County Council. The review indicated that the policy detail is, largely, taken from the MCA Code of Practice. Amendments have been made to the policy to clarify the assessment period required before the decision is made to apply for a Deprivation of Liberty Safeguard.	Tracey Oats – Deputy Chief Nurse / Anthony Green – Adult Safeguarding Lead	31/08/16	Complete
	Review EPARS policy PP(305) to ensure they are compliant with law and reflect good practice	See comment above re EPARS sub-group action plan. The plan is to audit at the end of March 2017, then if all is well, the policy will be adapted to reflect e-Care process	Julie Head - Resuscitation & Outreach Services Mgr	~~31/12/16~~ 31/03/17	In progress

Issue	Action	Progress summary	Subject Lead	Deadline	Status
Knowledge around the use and implementation of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was inconsistent.	Review training content and frequency	New Lead of Adult Safeguarding who started in early September has reviewed hospital safeguarding processes including pre-existing safeguarding training content. As a result of this and following feedback from staff, a number of changes have been made. The previous Trust Induction content, which focused heavily on learning disability, has been replaced with a training session focusing on adult safeguarding and deprivation of liberty safeguards; The Adult Safeguarding lead is currently developing a training session which will be separate from the Trust Induction and will focus on learning disability and autism. Up-to-date content reflecting the 'Adult Safeguarding Best Practice Guidance' (2016) has been developed for Mandatory training sessions and there has been positive feedback for this. The Adult Safeguarding lead is also in the process of introducing reflective practice training sessions with content focusing on the Mental Capacity Act, in line with the 'NHS Mental Capacity Act Workbook' (2016).	Anthony Green - Adult Safeguarding Lead	31/12/16	Complete
Staff did not always complete patient assessment documentation in relation to mental capacity appropriately.	Constant review of documentation on wards	Matrons on a fortnightly basis are reviewing at least 5 patient notes on each ward. If any document not filled in then will get them completed and report to ward manager and deem reasons	Tracey Oats – Deputy Chief Nurse	31/12/16	Complete
However, not all forms relating to patients' wishes regarding resuscitation in the event of heart failure were fully completed.	Education of staff and GP cover	Senior staff at Rosemary Ward, working with Matron Sharon Basson to educate staff where required but also review notes on regular basis	Sharon Basson – Matron (Medicine)	31/12/16	Complete

Annex 3 Clinical Photography

"The Trust must ensure a robust process for data management with regard to medical photography and comply with all information governance protocols including informed consent, data protection, tracking and tracing and appropriate audit systems implemented to ensure quality improvement".

Action	Progress notes and Evidence	Subject Lead	Deadline	Status
Review of options for process capture of Consent documentation including photo and/or scanning in of consent form image. Ascertain current status of capture of consent and agree way forward: • Scan in of completed paper forms • Photo-capture of completed forms	Agreed continue to use paper capture of consent documentation (Medical photography scans the consent forms; they are stored in WABA and are available with the images). Link to be added to Consent policy to make it easier for staff to print off paper consent form.	Sara Ames	31/10/16	Complete
Consider option for named person responsibilities for regular upload of images in high volume departments. Aim to pilot in ED.	Decision not to progress further with this action. Monthly auditing in place to monitor compliance with requirements.	Sara Ames Kris Apps Donna Romaine	31/12/16	Complete
Consider the option of use of a 'photo-upload app' for clinical photography.	Photo-upload app demonstration attended by Medical Photography and Governance Opportunity to be a test site (early 2017) – application to be considered Trial in ED (high use area) initially and, if successful consider roll out to clinicians across site with registration and training addressed in the 'bring your own device' policy	Nigel Beaton	2017/18	Planned
Audit of images on outlying cameras (i.e. not within the Medical photography department) undertaken and reported to Information Governance Steering Group (IGSG) with follow up of non-compliance	Audit tool  Camera audit summary.xlsx	Clinical Photography Dept	Currently in place	Complete

Action	Progress notes and Evidence	Subject Lead	Deadline	Status
where required.	Audit undertaken monthly  IG Steering Group report - camera audit	Sara Ames	Currently in place	Complete
	Audits presented at Quarterly IGSG  IG steering Group july 2016.docx	Sara Ames	Currently in place	Complete
	Feedback to areas of poor compliance	Sara Ames	Currently in place	Complete
	Remedial action plans in place where required	Sara Ames with service lead	Currently in place	Complete
	Additional guidance / support provided to locations with poor compliance [See enc. example of new step by step guidance on display with camera in ED]  Taking a clinical photograph process.(	Sara Ames with service lead	Currently in place	Complete
Trust Policy PP229 Photography & Video Recordings requires update to accurately reflect outcome of all described above including guidance for staff, documentation / forms and audit/monitoring process.	Policy updated, awaiting final sign of at IG Steering group	Sara Ames with Giles Arbon	31/12/16	Complete

Annex D – SHOULD

Issue	Action	Progress summary	Subject Lead	Deadline	Status
The trust should review the reporting of mortality and morbidity (M&M) discussions and learning in surgery services to ensure consistent and effective documentation across the service	Trust mortality group undertaking a review of all M&M meetings in the organisation with a view to standardise practice including documentation and reporting. Consideration of use of standard mortality reporting form for use in all specialities for discussion at audit meetings.	Mortality group has completed these actions, there is now a mortality review form	Sue Deakin / Patricia Mills (Sandy Lewis)		Complete
The trust should ensure staff compliance, across all staff groups, with mandatory and statutory training requirements	On a monthly basis all managers are sent two reports, one outlines the current percentage compliance status by mandatory training element at Divisional level and one gives a link to the current status of all staff with a filter in place to allow managers to review their own staff's current compliance status and take action to address any non-compliance. Consultant annual appraisal includes a review of mandatory training compliance which is co-ordinated by PGME through SARD system On a quarterly basis the Trust Board receives a Trust wide and subject matter breakdown of the current percentage compliance status by mandatory training element using the agreed RAG rating to highlight any subjects and/or Divisions not achieving the Trust target of 80% (95% for IG and 90% for safeguarding)	Reporting by staff group as well as by division and subject area currently under development to aid Divisions in ensuring improved compliance  Mandatory Training Division and Staff Grc	HR/Nursing Directorate (reporting)	01/01/2017	Complete
	The Divisional performance meetings receive reports on compliance	Continual and will adapt when and if receive feedback	Divisions (Compliance)	01/01/2017	Complete

Issue	Action	Progress summary	Subject Lead	Deadline	Status
The trust should review referral to treatment times and aim to improve to ensure that surgical patients receive care within 18 weeks.	Speciality action plans are being drawn up to track the trajectory of performance for each speciality. Where there capacity concerns i.e. oral surgery and ENT, these have been escalated to the executive team and discussions are underway with commissioners to work collaborate on a solution. Theatre capacity is being addressed alongside this work through the theatre and Anaesthetic PCP.	On-going capacity issues still affecting ENT & Oral Surgery. Work underway with commissioners to address the demand on these services. ENT – IHT providing assistance with major ear surgery. In additional to this CCG working on triage and referral refinement to address capacity and demand. Oral Surgery – Notice of intention to cease oral surgery and orthodontics sent to NHSE with a view to ceasing service 31st of March 2017. Work on going to reduce back log and support transfer of service with NHSE PCP and theatre capacity paper presented to ED's and a more detailed project plan around short term efficiency and capacity gains, and and projection of date by which an additional theatre will be required to be on stream. Feasibility study and client brief underway with estates team. Project plan and PID to be presented back to ED's mid-January.	Simon Taylor	Mar 17	In progress

Issue	Action	Progress summary	Subject Lead	Deadline	Status
The trust should ensure robust oversight of cancelled clinics and review theatre utilisation to support access to services and reduce patient treatment delays Reported noted *36% of gynaecology and 54% of colposcopy clinics had one slot or more cancelled in 2015*.	Ascertain current position (Sept16) with regard to status of these clinics.	Not received any information about cancelled clinics from the information team since April. Clinic cancellations were higher in Dec-16 than Dec 15 and on the whole are increasing, but the number of extra clinics is reducing. Through the OPD Transformation project, we are working through the following solutions to try and impact on cancelling clinics (for any specialty): • Pro-Active booking • Email Cancellations for patients • Changing the process for cancelling clinics around annual leave and 'hotspot' management (School holiday periods). • Proforma Clinics (which is when consultants choose pre-determined empty clinics to use, rather than the other way round, OPD trying to fit around Consultant spare time. • Pre/post e-care levels have been determined and are being adjusted accordingly. Through the Centre of Digital Excellence programme, other text/reminder companies are being looked at and demonstrations are being arranged.	Kirsty Rawlings	01/09/2017	In progress

Issue	Action	Progress summary	Subject Lead	Deadline	Status
The trust should ensure robust oversight of cancelled clinics and review theatre utilisation to support access to services and reduce patient treatment delays Reported noted *Theatre utilisation was below the England average. This was affected by late starts to operations were often due to the lateness or delay of surgeons and anaesthetists.*	Ongoing monitoring of theatre utilisation via the Surgical Division Board Meeting. Scrutiny of late starts by daily huddle by Theatre Clinical Service Manager. Ongoing monitoring and intervention to improve late starts	If the CQC ask for evidence this can be sourced from: Minutes of divisional board & divisional finance and performance paper. Data from Project Support Officer	Irene Fretwell	Already in place	Complete
The trust should ensure that the nutrition, hydration and toileting needs of patients are met when recovery is utilised as a step down area from CCU	Standard Operating Procedure to be written. (SOP CCS 4) "Maintaining privacy and dignity in PACU"	SOP written and available to all staff on network drive. All staff to be made aware via team meetings, social media critical care page and critical care newsletter.	Irene Serrant	Already in place	Complete
The trust should ensure the principles of infection control are appropriate and monitored within the critical care unit for caring for potentially infectious patients	Standard Operating Procedure to be written. (SOP CCS 5) "Infection prevention management in critical care"	Link nurses working with Trust IP team to promote a robust policy and updated the Infection Prevention Manual that will act alongside updated SOP	Anne How/ Irene Serrant	31/01/17	Complete
The trust should ensure appropriate senior staffing support to promote patient safety, including midwifery support in the management of complex cases on labour ward, appropriate supervision for high dependency patients and appropriate level of supervision within outpatients	To continue Band 7 development programme.	Recent preceptor assessments indicated that they felt supported to care for women in Labour suite and able to request/or decline to care for women.	Lynne Saunders	31/01/17	Complete
	Register for the RCM/RCOG labour ward lead course.	Discussed as part of the preceptor review in Sept 2016 and all report that they felt able to ask for support if needed, request or decline to look after patients.	Lynne Saunders	31/01/17	Complete
	Implement clinical manager for outpatients	Posts now filled for Inpatient and Outpatient/Community Service Managers	Lynne Saunders	31/12/16	Complete
The trust should consider quality measurements such as local targets for induction of labour, assisted deliveries and return of women with perineal problems	To amend dashboard in line with RCOG standards and national standards.	Included on 2016/17 dashboard as requested by CCG, details of required reported to be clarified by CCG	Lynne Saunders	31/03/17	In progress
	To commence collection of data for returns of women with perineal problems	To Commence	Lynne Saunders	31/03/17	In progress

Issue	Action	Progress summary	Subject Lead	Deadline	Status
The trust should have action plans where it is not reaching national standards in maternity	To have clear pathways for actions (i.e. audit/training) where national standards are not met.	To be included in the Terms of Reference for Womens Health Governance.	Lynne Saunders	31/03/17	In progress
The antenatal and postnatal ward F11 should review the practice of overnight stays for all partners on the ward.	Review the feasibility of implementation.	Review of the current visiting hours undertaken and extended for partners from 1/10/16 whilst the maternity service explores overnight stays for P/N partners.	Lynne Saunders	31/03/17	In progress
The trust should review the succession planning and development for staff in seconded or interim roles within the maternity service	Acting Head of Midwifery succession planning discussed and agreed with Acting HOM in Oct15. Backfill maternity risk manager post with 0.1 wte Acting maternity risk manager - fixed term contract for one year.	Acting HoM currently remaining until further notice. There is an HR process going on in the background	W&C General Mgr (Rose Smith)	31/03/17	In progress
The trust should consider developing strategic planning arrangements including - action plans to achieve service goals, - a performance dashboard for children's services - and a comprehensive transition policy to help all teenage patients adjust to adult health services	8th September : Paediatric Community & Acute Paediatricians' meeting from both Ipswich and West Suffolk to map out Strategic drivers and plans From 1st September Administrative support to CYP Strategy Group in place – First meeting planned for Autumn. West Suffolk Acute Paediatricians Strategy meeting November 4th. Continued engagement with Commissioners: Andrew Hassan GP lead for CYP services, Awaiting meeting with STP lead for CYP services. Continued attempts at engagement with GPs in 'Outreach' clinics and generation of combined guidance with GPs on agreed management plans for common Paediatric problems- 10 guides already available on CCG website. Pan Suffolk Strategic Meeting of Paediatric Consultants on Sept 8th and confirmed our overall plans for closer working arrangements between Acute and Community and both East and West patches of the County. We have revised the overarching Safeguarding arrangements and responsibilities and are planning a different pattern of Peer review and Supervision. We are looking at both Epilepsy and Psychology pathways across service delivery and we are looking at Outreach plans for Clinic delivery and upskilling primary care in more GP practices. Transition arrangements are well embedded for children with Diabetes, Epilepsy, Nephrology and Rheumatology who all have transition pathways with combined transition clinics. This also works for CF (looked after in Cambridge) and there are individual plans laid out for CYP with learning difficulties managed by the Community Paediatric team. We make individual arrangements for other sub-services like Cardiology & Gastroenterology with plans to formalise these arrangements too.		Peter Powell	Ongoing and in place	Closed

Issue	Action	Progress summary	Subject Lead	Deadline	Status
The trust should review the availability of staff with play specialist skills	Review current play specialist job plan to ensure best use of existing skills are being made.	The rainbow unit only has one health play specialist so is unable to be available to all areas at all times. This review was “paused” whilst the individual was on long term sickness and required their engagement. The review is now being taken on as part of the potential development of the Children’s & young people’s emotional wellbeing service.	Sharon Farthing	31/03/2017	In progress
The trust should review the options and nutritional value of food offered within the children’s service	There is already in an existence an alternative children's menu alongside the set daily menu, however discussions have already started regarding offering healthier option on this alternative menu, including finger foods for toddlers. Further meeting to be planned with Catering Dietetics & Paediatric unit.	Previous meetings have resulted in agreement with the catering department and the ward sisters that a. Breakfast items will be help on the ward b. A larger selection of snack items including finger foods for younger children will be held on the ward c. Two menus will be devised, including one for Older children (11-16 years), and one for Younger children (~1-11 years) within which there will be age-appropriate portion sizes. In the process in the dietetics office of re-writing the menu and allocating appropriate portion sizes for different age groups. When completed, will resubmit the new menus to the Catering department for discussion and approval.	Sara Ennew/ Holly Simpson	28/02/17	In progress
The trust should review medical staffing, particularly within end of life care services to ensure consultant cover meets recommended national guideline levels	Substantive appointment commenced started 2016.	No further action required	Karen McKinnon	2016	Complete

Issue	Action	Progress summary	Subject Lead	Deadline	Status
The trust should ensure that nurse staffing levels for children meet recommended national guideline levels	Staff Review being completed	Whilst the formal findings of the staffing review are still awaited, some work around developing band 4's within the paediatric area has begun to reinstate the skill mix that was present on the ward before the formation of a co-located CAU. Seasonal staffing plans are also under examination with the possibility of twilight shifts to cover peak CAU hours.	Sharon Farthing	March 2017	In progress
The trust should include sepsis monitoring on the maternity dashboard for inpatient areas	Included on 2016/17 dashboard as requested by CCG,	Details of reporting requirements to be clarified by CCG	Lynne Saunders	31/03/17	In progress
The trust should consider midwifery staffing and specialist midwives roles to support vulnerable groups	Midwifery Staffing Review (April 2016) included the implementation of some specialist roles.	Consultation for the changes resulting from this review in progress at present, implementation of these roles will follow this. Formal consultation process in progress.	Lynne Saunders	31/03/17	In progress
The trust should review the way patients in the last days or hours of life have their needs holistically assessed and how this is documented	1.Design of a holistic care plan template to be used in E-care (following pilot use and evaluation on 1 ward in December 2015) 2. Increase the workforce knowledge and use of the holistic template by: a) Adding into clinical guidelines b) Training and education of staff	1. Holistic care plan now available as an E-care template. 2. a) Incorporated into Trust clinical guideline - awaiting final sign off b) Incorporated in EOLC training in the Trust including: • Nurse induction (registered and non-registered) • Foundation training • End of Life Care Champion training • Palliative care team using and teaching alongside staff on the ward.	Sam Hobson / Dr McGregor		Complete

Issue	Action	Progress summary	Subject Lead	Deadline	Status
The trust should review its specialist palliative care service for medical staffing and provision of a seven day service	Bid has been accepted by Macmillan	Band 6 Post out to advert with interview in October and start date if appointed in the new year. Service Mgr developing action to implement 7 day working with a plan to be able to have a soft launch on a Saturday in Sept17, after initial training of Band 6 with full launch around Nov17.	The trust should review the way patients in the last days or hours of life have their needs holistically assessed and how this is documented		Complete
The trust should ensure that records management is secure and appropriate in all areas	Health Records Management Policy	In place and up to date Meetings ongoing and attended by IG manager	Kirsty Rawlings		Complete
	Health Records Committee – bi monthly meetings	2016 schedule available on Trust intranet	Kirsty Rawlings		Complete
	Records retention schedule issued and complied with. Corporate records audits completed	Corporate records audits undertaken annually for IG toolkit submission.	Kirsty Rawlings		Complete
The trust should ensure a robust process for oversight and management of all policies and procedures	All policies and procedures managed through database.	Ongoing	Sara Ames		Complete
	Renewal notifications sent to owners 3 months prior to expiry.	Ongoing	Sara Ames		Complete
	Overall status compliance reported to IG steering group quarterly.	Ongoing	Sara Ames		Complete

Issue	Action	Progress summary	Subject Lead	Deadline	Status
The service should ensure that risk scrutiny in governance meetings is robust and recorded so that there is assurance of management of risk	Internal audit of the Trust's Divisional Governance structures undertaken in July 2016. Six actions identified including: "*Standing agenda items should be introduced on ward/ departmental Governance Groups to ensure that Risk Registers, consideration of any new NICE Guidelines and Clinical Audit work are discussed and challenged as appropriate to ensure that the Group is fully discharging its duties on a regular and consistent basis*." Updated Divisional Steering Group structure reported via TEG includes new and outstanding risks report as standing agenda item.	Handbook in place to provide a framework to ensure organisational expectations of governance are evident at all levels. This includes the divisional meetings where governance items are to be discussed and the suggested subjects of those governance items. The representation at those meetings to ensure robust communication links between the staff groups and escalation framework with the division. The Handbook also demonstrates the Governance information and reporting flows for escalation and distribution across the division.	Richard Jones	Oct16	Complete
The trust should ensure dissemination of outcomes from audits and meetings is robust across all services	Processes to ensure this are being developed	Captured as part of the review and update of Divisional governance procedures following Internal Audit review	Sandy Lewis / Richard Jones		Complete

Item 16 Board of Directors – 3 March 2017

PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce and Communications
PREPARED BY:	Medical Staffing, HR and Communications Directorate
DATE PREPARED:	7th February 2017
SUBJECT:	Consultant Appointments
PURPOSE:	To receive report
STRATEGIC OBJECTIVE:	To continue to secure, motivate, educate and develop a committed workforce providing high quality patient focused services.

POST:	Consultant in A&E
DATE OF INTERVIEW:	8th December 2016
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]

QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED** **NO SHORTLISTED**	1 1 1

Item 16 Board of Directors – 3 March 2017

PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce and Communications
PREPARED BY:	Medical Staffing, HR and Communications Directorate
DATE PREPARED:	9th February 2017
SUBJECT:	Consultant Appointments
PURPOSE:	To receive report
STRATEGIC OBJECTIVE:	To continue to secure, motivate, educate and develop a committed workforce providing high quality patient focused services.

POST:	Consultant in Geriatrics
DATE OF INTERVIEW:	9th February 2017
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]

QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED** **NO SHORTLISTED**	2 1 1

Item 16 Board of Directors – 3 March 2017

PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce and Communications
PREPARED BY:	Medical Staffing, HR and Communications Directorate
DATE PREPARED:	7th February 2017
SUBJECT:	Consultant Appointments
PURPOSE:	To receive report
STRATEGIC OBJECTIVE:	To continue to secure, motivate, educate and develop a committed workforce providing high quality patient focused services.

POST:	Consultant in Urology
DATE OF INTERVIEW:	6th January 2017
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED** **NO SHORTLISTED**	1 1 1

[redacted]

Item 16 Board of Directors – 3 March 2017

PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce and Communications
PREPARED BY:	Medical Staffing, HR and Communications Directorate
DATE PREPARED:	7th February 2017
SUBJECT:	Consultant Appointments
PURPOSE:	To receive report
STRATEGIC OBJECTIVE:	To continue to secure, motivate, educate and develop a committed workforce providing high quality patient focused services.

POST:	Consultant in Rheumatology
DATE OF INTERVIEW:	7th February 2017
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]

	Medicine – University of Birmingham, Pass - 2004
NO OF APPLICANTS: **NO INTERVIEWED** **NO SHORTLISTED**	1 1 1

Item 16 Board of Directors – 3 March 2017

PRESENTED BY:	Jan Bloomfield, Executive Director of Workforce and Communications
PREPARED BY:	Medical Staffing, HR and Communications Directorate
DATE PREPARED:	10th January 2017
SUBJECT:	Consultant Appointments
PURPOSE:	To receive report
STRATEGIC OBJECTIVE:	To continue to secure, motivate, educate and develop a committed workforce providing high quality patient focused services.

POST:	Consultant in Geriatrics
DATE OF INTERVIEW:	10th January 2017
REASON FOR VACANCY:	Replacement
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC
PREVIOUS EMPLOYMENT:	[redacted]

	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED** **NO SHORTLISTED**	1 1 1

Item 17

West Suffolk NHS
NHS Foundation Trust

e-Care
Reflecting back and looking forwards

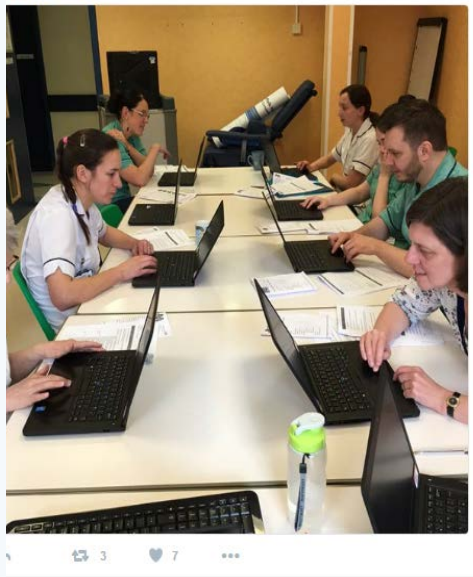
Jan/Feb 2017

Putting you first

THIS IS A LONG JOURNEY!

West Suffolk NHS
NHS Foundation Trust

STAFF WORKED INCREDIBLY HARD TO GET READY FOR GO LIVE



More than **2000** hours of classroom training attended

Peak of **250** users on play domain at same time

12,000 hits on website in April for people accessing training materials

But how does it feel?

West Suffolk NHS
NHS Foundation Trust

There are things that you like….

Accessible from anywhere

Single log on

Up to date information

Drugs administration faster – no more "chart in pharmacy"

Legible

Powerchart

Visit summary

Helps prioritise workload

Everything in one place

Able to personalise

Click through to Evolve

No more missing notes!

Easy to find my patients

But how does it feel?

West Suffolk NHS
NHS Foundation Trust

There are things that you don't like….

Secretarial workflow

Handover

Some interfaces clunky – IMPAX etc

Reporting

Logs me out too quickly

Pharmacy dispensing slow

Word functionality – spell check etc

I can't remember how to do the things I don't do very often

Things take longer

Need more help to personalise

Encounter driven – cumbersome!

West Suffolk NHS
NHS Foundation Trust

We have ways to help you now ….

Only 6.7% of staff are currently placing orders using "favourites"

We can increase productivity by helping people to work more smartly

Average time to place an order on e-Care is 60 seconds

However we know some people taking much longer. We can target support to these staff

Cerner evaluation planned in February

Will identify other areas for improvement

COMING SOON!!!

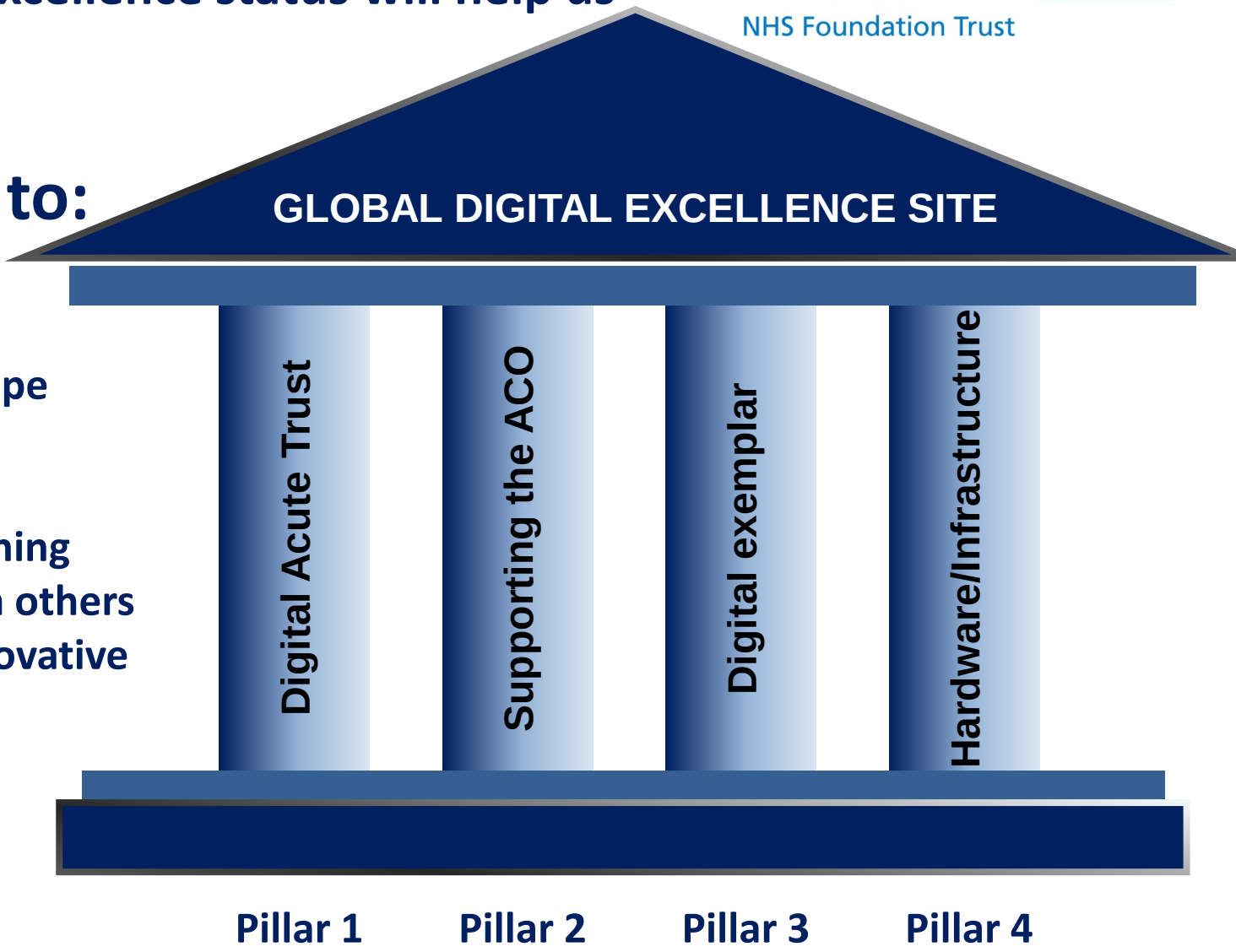
AT THE ELBOW "COACHING" SUPPORT TO HELP YOU WORK SMARTER

Global Digital Excellence status will help us

West Suffolk NHS
NHS Foundation Trust

Enables us to:

- Go faster
- Extend our scope
- Improve our hardware
- Share our learning and learn from others
- Work with innovative digital leaders



e-Care 2017 – current plan

Month	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov 2017 – Nov 2018
Phase	PHASE 2												PHASE 3

INTERNAL

GO LIVE! Ordercomms, (Sepsis/AKI) — Apr

GO LIVE!
- Paeds
- M pages
- Complex Care plans
- Capacity mgt
- Complex meds

— Aug

GO LIVE!
- Scope tbc

— Nov 2017 – Nov 2018

On-going general improvements — Dec–Jan

On-going general improvements — Jun–Jul

On-going general improvements — Nov 2017 – Nov 2018

On-going programme to develop integrated care pathways – combining advanced documentation and clinical decision support algorithms — Nov 2017 – Nov 2018

HEALTH SYSTEM

Developing patient portal and range of apps to support self care — Nov–Oct

Health Information Exchange (HIE)
GP's, community, neighbouring acute and mental health trusts, social services — Nov 2017 – Nov 2018

Population health
using information to underpin our clinical models of care — Nov 2017 – Nov 2018

Building the organisation into a centre of digital excellence and acting as mentor and guide for other developing organisations — Nov 2017 – Nov 2018

West Suffolk NHS
NHS Foundation Trust

Item 18 Trust Board – 3 March 2017

AGENDA ITEM:	Communications strategy 2017 - 2020
PRESENTED BY:	Jan Bloomfield, director of workforce and communications/Ali Bailey, head of communications.
PREPARED BY:	As above
DATE PREPARED:	22 February 2017
SUBJECT:	The communications strategy is a key corporate strategy to enable the Trust to achieve its overall vision and aims.
PURPOSE:	To note the executive summary of the communications strategy for the Trust.

EXECUTIVE SUMMARY:

The current communications strategy for WSFT was agreed in September 2011 and expired in 2015.

This new strategy is designed to identify priorities for communications at the Trust. These will enable it to achieve its objectives by managing its reputation and relationships with its key audiences. It maps closely to the WSFT Strategic Framework: "Our patients, our hospital, our future, together" and takes into account current strategic drivers for the Trust including the need to integrate services across west Suffolk.

Linked Strategic objective (link to website)	Links to all objectives as described in the paper
Issue previously considered by: (e.g. committees or forums)	Executive Directors (13 January 2017) TEG (16 January 2017)
Risk description: (including reference Risk Register and BAF if applicable)	N/A
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	N/A
Legislation / Regulatory requirements:	N/A
Other key issues: (e.g. finance, workforce, policy implications, sustainability & communication)	N/A

Recommendation:
Trust Board is recommended to note the executive summary of the communications strategy.

Item 18

NHS
West Suffolk
NHS Foundation Trust

Our patients, our hospital, our future, together

Communications strategy 2017 – 2020

Executive summary

The communications strategy sets out the vision, objectives, enabling strategies and work plan for communications at WSFT for the next three years.

An assessment of the current situation at WSFT has identified the following strategic drivers as important for the organisation for the period of this strategy:

- The ability to remain financially sustainable in an ever more challenging environment
- Recruiting and retaining the highest quality clinical and non-clinical staff in key roles
- Improving operational effectiveness to meet core performance standards
- Influencing across the system to transform services
- Driving a public health agenda that focuses on prevention and wellbeing
- Being an influential part of the local politics that affects the Trust
- Creating clear lines of accountability in the emerging partnership structures of the ACO
- Focusing on the offering that WSFT is uniquely positioned to make for its patients with the most complex conditions
- Staying on the leading edge of digital developments in the NHS

Reviewing the Trust's strategic framework, four over-arching priorities for communication have been identified:

Priority A: to deliver for today by **developing a highly engaged workforce of staff who have the information and understanding they need to perform highly in their area**

Priority B: to invest in quality, staff and clinical leadership by **developing a culture of excellence that fosters innovation, empowers leaders and attracts the best staff.**

Priority C: To build a joined-up future by **becoming a trusted partner in the health and social care economy in west Suffolk**

Priority D: To support the Trust in delivering its ambition by **supporting the delivery of personal care, and the health and wellbeing of our communities, including our staff.**

Our vision for communications at WSFT: we will talk effectively with our audiences to achieve our goals, developing positive relationships as a result of questioning, listening, engaging and then speaking.

Our enabling strategies and work plan are designed to ensure we follow our vision and achieve our objectives and a number of key metrics are proposed to measure the impact of what we do. The following areas of development have been identified as critical opportunities in the development of excellence in communications at the Trust:

- Clearly defining the organisation's key messages and adapting them for different audiences
- Developing a strong, clean and professional corporate identity so that the Trust can be trusted and easily recognised
- Providing excellent websites for the public, patients and staff so that information is easy to access and can be effectively shared
- A creative, proactive approach to media relations
- Generating attractive content based on patient stories
- Developing engagement approaches with staff, patients and members to generate two-way communication
- Utilise the Trust's FT membership to gain insights and support for key strategic projects
- Research, measure and evaluate communications to demonstrate effectiveness
- Begin to target and effectively manage external relations and stakeholder communications
- Develop a strong health and wellbeing message for staff and the public, becoming a 'health promoting' hospital

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 3 March 2017

AGENDA ITEM:	Item 19
PRESENTED BY:	Craig Black, Director of Resources
	Steve Dunn, Chief Executive
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	12 January 2017
SUBJECT:	Operational Plan 2017-19
PURPOSE:	For information and approval of next steps
STRATEGIC OBJECTIVE:	To deliver and demonstrate rigorous and transparent corporate and quality governance

EXECUTIVE SUMMARY:

The Board reviewed the draft operational plan at its meeting on 25 November and the plan was subject to further review by nominated Governors and at the Scrutiny Committee. The final version of the operational plan was submitted to NHSI on 23 December 2016.

The document and the position regarding the Trust's position of not accepting the proposed control totals for 2017-19 have been subject to further discussion with NHS Improvement.

Previously considered by:	As set out above
Risk description:	Failure to appropriately escalate risks considered at a committee or subcommittee level
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Formal consideration of issues for escalation is a standing for committees and subcommittees. The risk register and BAF are reported to the Board on a regular basis. These arrangements are reviewed by Internal Audit.
Legislation / Regulatory requirements:	Compliance with "good governance" and DH guidance for Board Assurance Framework. Monitor's quality governance framework, including escalation.
Other key issues:	None
Recommendation: To receive the report	

Item 19

West Suffolk NHS
NHS Foundation Trust

Operational Plan

2017-19

Putting you first

Operational Plan 2017-19

Contents

1. Strategic vision

West Suffolk NHS Foundation Trust (WSFT) serves a predominantly rural geographical area of roughly 600 square miles with a population of around 280,000. The main catchment area for the Trust extends to Thetford in the north, Sudbury in the south, Newmarket to the west and Stowmarket to the east.

Our hospital provides a range of acute core services with associated inpatient and outpatient facilities. With a turnover of £211m, we are one of the largest employers in Suffolk, employing around 2,997 whole time equivalent staff. There is a purpose built Macmillan Unit for the care of people with cancer, a dedicated Eye Treatment Centre and a Day Surgery Unit where children and adults are treated and go home on the same day.

During 2015, in partnership with Ipswich Hospital NHS Trust and Norfolk Community Health and Care NHS Trust, we were successful in our bid to deliver community services within Suffolk from 1 October 2015.

We have an excellent teaching and research base. Our undergraduate, delivered jointly with Cambridge University, and post-graduate medical education programmes are popular and achieve consistently excellent results. They underpin our ability to attract high quality clinicians which in turn underpins the high quality of care we provide. We must sustain and improve such programmes and further develop clinical leadership.

- Rated overall as 'Good' by the Care Quality Commission (CQC) and rated 'Outstanding' for care
- Good Friends and Family scores – consistently above national average scores for inpatients, outpatients, emergency department (ED) and maternity services
- 2015 national staff survey ranks West Suffolk Hospital as the region's best with the Trust's score in the highest (best) 20% when compared with trusts of a similar type
- One of only 41 acute trusts nominated for Health Service Journal (HSJ) 100 best places to work this year
- Top hospital for quality of care 2011 and 2012 and shortlisted in 2013, 2014 and 2015, awarded by independent healthcare intelligence company CHKS
- We are investing over £20 million in an integrated electronic patient record that will make us one of the safest and most paper-free hospitals and health systems in the NHS
- We have been successful in our bid for £10m of national funding through the Global Digital Excellence award.

These accolades are a testament to the professionalism and dedication of all our staff, clinical and non-clinical, who strive to provide the best possible services for our patients. Further details of our many achievements can be found in our Annual Report.

The population we serve is ageing; long term conditions are increasing and costs as well as public expectations continue to rise. The NHS has to change. Acute providers like WSFT must implement innovative and transformational strategic and operational plans for the delivery of safe, high quality, cost-effective and sustainable services that respond to these challenges.

We want to make sure that we build on the excellent work we have undertaken and, with the full involvement of all staff, develop ambitious plans to further improve what we do, whilst securing financial stability. This is expressed in our Strategic Framework document **Our patients, our hospital, our future, together**, which outlines our vision, our three priorities and seven ambitions to take us through the next five years.

If we are to respond to the challenges of an ageing population, then we need to ensure that our services are safe, integrated and focused on prevention and earlier intervention, rather than just on treating the patient who comes into our hospital.

Our vision is: to deliver the best quality and safest care for our community.

We can all be clear about how we contribute to this vision and each and every service is encouraged to ask two key questions:

1. Who are currently the best in the country and how can we build on what they do?
2. How can we integrate our services better with primary and community care and begin to break down the organisational barriers that exist, so that patients don't see the join?

The challenge for our hospital is clear: we must stay ahead on the quality agenda, we must maintain strong operational performance, we must secure financial sustainability and improve the facilities we work with. **Our priorities are:**

- **Deliver for today** - requires a sharp focus on improving patient experience, safeguarding patient safety and enhancing quality. It also means continuing to achieve core standards
- **Invest in quality, staff and clinical leadership** - we must continue to invest in quality and deliver even better standards of care which, over time, should deliver an 'outstanding' CQC rating
- **Build a joined up future** - we need to reduce non-elective demand to create capacity to increase elective activity. We will need to help develop and support new capabilities and new integrated pathways in the community.

Our seven ambitions take a holistic approach to the care of our patients.

These ambitions focus on the reason we all get out of bed in the morning and work in the NHS: to serve our patients and work with them and the public to deliver year-on-year improvements in the patient experience. We have joined the national 'sign up to safety' campaign and continue to ensure that at least 95% of patients receive harm-free care. This is measured by the incidence of quality indicators including pressure ulcers, falls and hospital acquired infections. These same high standards must also be consistently and reliably delivered to all our patients.

Evidenced through:

- **Low mortality rate** – below 90 based on SHMI, HSMR, SMR and was identified as Dr Foster Midlands and East Trust of the Year in 2014, reflecting its low comparative mortality

- **Strong performance in national audits** – demonstrates consistently strong performance when compared nationally across several national quality audits and international benchmarking databases (CIN, SNNAP, MINAP, NELA, TARN, NCAA, NJR, ICNARC, DAWN AC, NBOCAP, NHFD, NLCA, NCEPOD);
- **Early adopter within 'Sign up to safety campaign'** – focus on diabetes, acute kidney injury **(**AKI) and sepsis
- **Reduction in AKI deaths** - 40% since 2012
- **Targeted improvement in identification and management of patients with sepsis** – achieved 100% screening for emergency patients by end of 2015-16
- **Learning from 'never events'** – invited review by Royal College of Surgeons found a "culture that promoted the reporting of incidents and encouraged learning"
- **Quality and ward dashboard** - drives improvement action
- **Year-on-year reductions in healthcare associated infections (HCAIs)** and improved antimicrobial stewardship, including a 91% reduction in C. diff over seven years
- **Cleaning Industry Management Standard (CIMS) award** - first hospital in Europe to achieve this
- **Ensuring safe staffing** - we now have over a hundred more doctors and nurses than we had last year
- **Effective system for incident reporting and learning** – recognised through staff survey and through improvement against quality priorities
- **Learning from complaints** – includes care, training and patient information
- **Patient Friends and Family Test (FFT) scores** - deliver strong FFT scores during 2016 achieving some of the best FFT inpatient recommender scores in England
- **Outstanding outcomes for local health economy** - cancer and heart disease mortality; stroke patients directly admitted to a stroke unit within four hours; emergency admission rate for older people
- **Our DAWN AC performance is in the top 20% of sites worldwide -** DAWN AC is one of the most widely used computer-dosage programs for oral anticoagulant
- **National accreditation** - has led the way nationally and regionally in being amongst the first to achieve accreditation for several of our clinical services (anaesthetics ACSA, radiology ISAS, endoscopy JAG, Institute of Medical Illustrators (IMI) Quality Assurance Standards)
- **Outstanding critical care outcomes (ICNARC)** - audit of patient outcomes from adult, general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales and Northern Ireland
- **Diagnostic imaging underpins our outcomes** - first unit in the region to achieve ISAS accreditation.

We believe that by working more closely with other health, social care and voluntary organisations to deliver more joined up services we can provide better, more responsive and personalised care to patients and their families and carers.

Evidenced through:

- **Good pathway working:**
    - ED attendances – low attendance rates overall, and for children
    - end of life care – high percentage of deaths in usual place of residence
    - dementia – e.g. low rate of emergency admission
    - tooth decay – low rate of admission in children <5 years
    - working with the Clinical Commissioning Group (CCG) to improve diabetes care across west Suffolk.
- **Delivering quick access requires continual focus** – consistent delivery of access and treatment targets
- **More resilient emergency department (ED) performance this year** – during 2015/16, improvement in patient flow allowed a ward to be closed enabling a 'deep clean' programme to be developed to all wards
- **Great trauma and orthopaedics reputation** - joint 1st in peer group for first to follow up appointments; joint 3rd in peer group for elective length of stay; best in peer group for seven out of top 10 healthcare resource groups (HRGs) for length of stay; day case rates good
- **Consistently good performance for cancer targets** – best in the country for diagnosis rates for early stage cancers for three years running, best cancer survival rates in the region and has consistently delivered all national cancer targets treatment; 62 days from GP referral to first definitive treatment
- **Fast service access** – arthritis, audiology, ophthalmology, and ear, nose and throat (ENT)
- **Maintained access targets** - despite increasing referrals and demand for diagnostics
- **Our stroke unit is better than the big centres and one of the best in the region and country** – latest national audit data places WSFT in the top 10% nationally
- **Our rate of in-hospital cardiac arrests is low** – supported by timely identification of deteriorating patients.

Working with partners will be important in achieving these ambitions. We want to make sure every child is given the best start by promoting a healthy pregnancy, natural childbirth and breastfeeding. Staff are encouraged to use the contact they have with patients to offer appropriate advice on staying healthy, placing a greater focus on the prevention of poor health.

Increasing age brings an increasing chance of long-term conditions, frailty and dementia. We are working with primary and community care to support patients to retain their independence but when they do need to come into hospital we aim to

provide care in the most appropriate environment, with care plans developed with the patient and their family and carers.

Whilst we have always acknowledged that our staff are our most important asset and one of our three priorities, in response to significant feedback we introduced an ambition to 'Support all our staff'. This recognises the need for all staff to feel motivated, valued and supported with high quality training. It expands on our priority to invest in quality, staff and leadership and reiterates the Trust's commitment to development, education and training to support our staff. This in turn will support the delivery of safe and effective care.

Evidenced through:

- **Staff Friends and Family Test data** - for the final quarter of 2015/16, shows 93 per cent of staff recommended us for our care (sixth best district general hospital trust in the country), and 87 per cent as a place to work (best in the country)
- **2015 national NHS staff survey** - places us in the top 20 per cent of all acute trusts for overall staff engagement and the best acute trust in East Anglia for being recommended by its staff as a place to work or receive treatment. We are one of only 40 hospitals in the HSJ Top 100 Best NHS Places to Work (which is based on staff survey rankings drawn up by NHS Employers)
- **Strong outcomes in surgery** – fractured hip; emergency surgery care
- **Best regional hospital** - children's care, diabetes and Caesarean section rates
- **Hello my name is..** - supporting our culture of Putting You First we encourage staff to make it the norm for everyone who works in WSH to start every interaction with this small gesture that really makes a difference
- **Our staff go the extra mile** - to deliver excellent care to patients, drive through service improvements and support people to live healthy lives
- **Committed clinical leaders** – driving quality improvement for patients and staff
- **Pride in teaching and training** - consistently delivered outstanding teaching and training as evidenced through the General Medical Council (GMC) survey and the recent post-graduate dean visit by Dr Bill Irish whose closing summary was "This is a fantastic trust and people queue up to come here. What's been achieved here is simply stunning"
- **Junior doctors are supported and active** - developed a more efficient way to identify potential discharges over the weekend
- **Visible leadership** – from the Board and senior managers
- **Staff recommending WSH as a place to work: 82% (8th) and staff recommending WSH as place to receive care: 93% (5th)** - clear relationship between staff who feel engaged and happy and good patient outcomes
- **We are not complacent** – 'Freedom to speak up, freedom to improve' campaign
- **An experienced and stable board** with clear a strategy and priorities - Board of directors of WSFT won 'NHS board of the year' award at the East of England NHS Leadership Recognition Awards
- **Board focuses on big issues and risks** - e-Care and improved documentation; service and financial sustainability; impact of Transforming Pathology Partnership (TPP) investment on quality; never events; new risks with community services; upgrading the estate and infection control
- **Investing in our hospital** - for the future and planning a new hospital for the longer term
- **Clear strategy: Our patients, our hospital, our future, together** - over a third of our staff had a face-to-face briefing and local stakeholders signed up to our strategy as part of the biggest consultation in our history last spring

- **Successful tender for community services -** with The Ipswich NHS Trust and Norfolk Community Health and Care NHS Trust and working with the CCG on integration
- **Strong focus on quality** – demonstrated through accreditation and committed to continuous quality improvement. Unlike many trusts, our support services are independently accredited (IT department ISO9001; Housekeeping CIMS; Estates Premises Assurance Model (PAMs case study); 'Bronze' Soil Association Accreditation and 'Eat Out, Eat Well' Gold Award; Library and Information Service achieved 100% of the Library Quality Assurance Framework criteria for 2015; Sterile Services, ISO 9001:2008 Quality Management System, ISO 13485:2003 Medical Devices Quality Management System, MDD 93/42EEC European Directive for Medical Devices).

Priorities in a challenging environment

During 2016-17 we have been under sustained operational pressure. We have struggled to deliver the four hour wait performance target with flow through the hospital affecting our ability to deliver against the revised trajectory and escalation beds consistently open. This has negatively impacted on our financial position.

Working with staff we are putting in place a number of initiatives to support and improve patient flow (see section 5(b) Trajectory improvements and efficiency savings for more detail.

The 2016-17 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 income and expenditure position could have a detrimental effect on our cash position. The Trust has financing arrangements in place 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.

We are proud of the **quality of our services** and at the same time determined to keep improving wherever we can. We know from benchmarking data that many of our services offer among the best safety and outcomes recorded anywhere in the country. Our patient surveys demonstrate that most of the time we get it right for them and that they have a good experience of our care. However this is not the case in every instance and we receive concerns and complaints that we work hard to address and resolve.

Our staff remain our greatest asset and they have risen to the challenge of growing demand for our services while continuing to provide care that is outstanding for its quality. Our staff survey provides solid evidence that our staff are positive about working here and feel well engaged in the organisation. More staff recommend us as a place to work and as a place to receive treatment that at any other acute hospital in East Anglia. This is something we are proud of and want to build on. We recognise that our staff deliver change and improve our services, not management. Through Freedom to Speak Up, a campaign to encourage and support staff to speak up and act whenever they see anything that can be improved, issues that needs resolving or an area where praise can be given can be systematically addressed.

Looking forward, securing the contract for **community services** and using this as a driver to support development of truly integrated locality teams is critical to ensuring

services are ‘wrapped around’ patients’ needs and delivered outside the hospital setting.

Our successful bid for **global digital excellence (GDE)** funding will allow us to consolidate and build on our excellent reputation for the delivery of high quality clinical services and work across the health system to focus healthcare information to deliver enhanced quality of care and seamless services across our whole health and social care system.

2. Delivering for today - activity planning

We have a joint approach across the system to the calculation of the 2017/18 and 2018/19 demand and capacity. The growth assumptions have been based on the historic data seen in the previous years, with the jointly owned STP solutions tasked with removing the growth impact where possible. The aim will be for the STP solutions to deliver their reductions in activity once they are fully operational in 2018/19.

We are committed to finding a different way to deal with this activity growth and to handling the financial impact of any change in setting as we strive to implement the system-wide solution detailed with the STP.

The financial model has been constructed with the activity growth being included using traditional methodology but is subject to change pending the outcome of the accountable care organisation (ACO) discussions and STP implementation.

You can read more about the STP on page 27.

Table 1: Growth assumptions – system-wide

	17/18	
	Growth	STP solution
ED	2.43%	-2.45%
Outpatients	4.24%	-2.94%
Elective	2.55%	-1.10%
Non-elective	4.80%	-2.93%

	18/19	
	Growth	STP solution
ED	2.77%	-4.80%
Outpatients	4.51%	-3.95%
Elective	2.78%	-2.09%
Non-elective	4.80%	-5.82%

The block contract includes 2.5% for growth in activity which mitigates the growth risk inherent in a block contract, includes all CQUIN and no potential financial penalties.

3. Delivering personal and safe care - quality planning

(a) Approach to quality improvement

The Trust ensures effective quality improvement through a framework of measures and intervention:

- A monthly **quality and performance report** with a red-amber-green (RAG) rated dashboard and regular reports on patient and quality issues such as the complaints report, national patient survey reports, etc. The format of this report is regularly reviewed. This is supplemented by a monthly **transformation report** to the Board and an **aggregated quality report** which includes analysis of trends in incidents and complaints
- The **executive performance meeting** takes place prior to the Board and hold individual divisions to account for their performance. The outcome of the meeting informs discussion and debate at the Board regarding overall performance of the Trust
- Quality reporting is supported by a monthly **matrons performance meeting** to inform the quality narrative for the Board quality report
- The **board assurance framework** (BAF) which identifies the key risks and assurances to the delivery of the Trust's strategic objectives and is monitored by the Board on a quarterly basis. The BAF is subject to review by internal audit and this is used to refine the reporting arrangements
- The **risk register** is monitored by the corporate risk committee of the Board. This considers high risk issues and performance in managing risks. The risk register performance indicators form part of the monthly dashboard to the Board
- A coordinated approach to support delivery of the Trust's **ambitions** as set out in the Strategic Framework.

Compliance with **CQC requirements** is overseen by medical, nursing and management leads within each division, with each division undertaking self-assessment to identify aspects of good and outstanding practice as well as areas for improvement.

Weekly quality walkabouts involve executives, non-executives and governors. As well as observing and challenging practices within areas these visits ensure an overview of the issues by the Board and provider visibility of the senior leadership team. The quality walkabouts have been integrated with action plans that have been formulated by wards and supporting areas. The ownership of these action plans remains with the division, but areas of best practice are shared.

The **quality improvement governance systems** are headed by the quality and risk committee of the Board. This is chaired by the Trust chairman and membership includes executive and non-executive directors. This is supported by three other Board committees: clinical safety and effectiveness committee; patient experience committee; and corporate risk committee.

Within the divisions **governance steering groups** provide a forum at which clinical governance issues are reviewed and escalated from the ward areas and, equally, issues identified as requiring attention from the Board may be raised.

Quality is the gold thread for the organization for which the Board, all executives and staff have a clear responsibility. The **executive lead for quality improvement** is

Rowan Procter, executive chief nurse. The executive chief nurse will liaise with Dr Nick Jenkins, executive medical director, on medical issues relating to clinical risk management, patient safety and staff concerns regarding service delivery.

A range of quality indicators is reported to the Board on a monthly basis within the quality and performance report. There is particular focus on a small number of these which form the **quality priorities** for the Trust. The report provides the Board with the in-depth information necessary to ensure these priorities are achieved, whilst maintaining an overview of a wider range of issues.

There is an integrated governance framework for **community services** which operates across the community providers also reports into the Trust's governance systems. The community forum is chaired by the director of quality and governance for community services, who is line managed by the executive chief nurse, which ensures an overview of community quality.

(b) Quality improvement plans

In order to determine the priorities for improvement, progress against previous priorities and the information gained from the full range of indicators have been reviewed. In addition, consideration has been given to other quality issues arising nationally and locally, along with discussion with our service users and public foundation trust members. Through the commissioning process the CCG has identified performance targets for quality and innovation and these have directly influenced the way in which we measure performance against our priorities.

The Board has worked to ensure that a culture is developed to support and empower leaders and all staff within the organisation. This quality improvement quality is supported through access to improvement tools, resources and networks on health and social care. Our aim is to equip staff with quality improvement methodologies to enable further self-perpetuated improvements. The Trust communicates resource and knowledge through the monthly 'Health Management and Innovation Update' and the Chief Executive's report to the Board which is shared with senior clinical leaders. The Trust also subscribes to The Advisory Board, a global research, technology, and consulting firm helping hospital and health system leaders improve the quality and efficiency of patient care.

We have consulted with the public, staff and governors in delivering a new **strategic framework**, underpinned by clear vision and values; within these quality and safety are the top priorities.

The Trust's **governance framework** is reviewed regularly by the Board to ensure that responsibilities are clear and that quality, performance and risks are understood and managed.

The focus within Board, executive and operational discussions reflects our **vision and values**, putting patients and quality at the heart of what we do. This is also driven through a culture of openness and transparency. In December 2016 we also held our second Trust leadership day. Building on previous success, it brought managers from across the Trust and our community together to discuss the behaviours and qualities required to deliver our agreed vision, priorities and ambitions.

To strengthen divisional accountability for **patient experience improvement** we have established a new patient and carer experience group which includes patient

representatives. It has adopted a collaborative approach with patients and staff working together to identify learning and areas for improvement from patient feedback. Representatives from Healthwatch Suffolk and Suffolk Family Carers are also members of the group.

Representatives from the Trust's patient & carer experience group and governors are members of key committees and groups (e.g. patient experience committee, clinical safety and effectiveness committee, divisional governance steering groups, maternity services liaison committee, nutritional steering group, diabetes group and blood transfusion committee).

WSFT engages with the public, in particular 'seldom heard groups', through attendance at meetings such as the Healthwatch equality and diversity group and through the annual Suffolk Disability Day. This annual forum is an opportunity for the Trust to learn about the needs of various people with disabilities from all walks of life and is attended by a senior nurse and human resources representatives. WSFT has a number of user groups e.g. cancer services user group and cardiology services user group, which are supported by clinical staff and are involved in providing feedback on current services and service developments. the cancer services user group holds an open forum annually to gain patient views on services to identify areas for improvement.

Through these approaches we ensure that services are continuously improved. This integrated approach to quality and service improvement also ensures that sustainable services are maintained.

The Trust's **clinical audit programme for 2016/17** is made up of 118 audits to be achieved this financial year. These are broken down into:

- 44 mandatory national clinical audits
  The mandatory audits are from the Department of Health (DH) Quality Accounts and National Clinical Audit Patient Outcome Programme (NCAPOP).
- Six non-mandatory national clinical audits
- Six regional/multi-centre clinical audits
- 62 quality monitoring and trust priority clinical audits. These are ongoing audits that are regularly reported.

In addition, divisional clinical audit programmes are developed from the relevant Trust clinical audit programme projects and the local clinical audits registered for each division. There are 121 local clinical audits registered under the divisions, which are monitored through the divisional governance steering groups.

WSFT has strengthened its arrangements for undertaking **mortality reviews**. These enable consultants to review all inpatient deaths and identify elements of preventability and areas of learning. WSFT continues to achieve a HSMR and SHMI that are below the expected rate.

In addition to the consultants completing mortality reviews, we have established a mortality surveillance group to complete peer reviews for all patient deaths where an element of preventability has been identified.

Future quality improvement is focused on:

- Further development of the mortality peer review process
- Development of mechanisms to, as far as possible, identify more deaths attributable to problems in healthcare
- Further development of the internal mortality tool
- Robust capture of Dr Foster alerts reviews and learning.

Reducing **hospital-associated infections** continues to be one of the main priorities for our patients and the public. In addition, it remains a key priority for the NHS as a whole and for our commissioners. Within the Trust we continue to strive for further improvement, with a focus on the timely identification and management of patients with infections and at risk of infection. Further quality improvement is focused on:

- Installation of doors to bays in some clinical areas to improve the ability to isolate patients
- Improvement in antibiotic policy compliance, including identifying clinically appropriate 'non-compliance' with the policy, for example, extending an existing antibiotic regime for a further 24 hours
- Provision of a decant ward to facilitate rolling programme of 'deep cleaning'
- Consideration of use of bespoke isolation provision where space allows.

The Trust continues to monitor trends in **patient falls** on a monthly basis. When benchmarked, the number of falls in the Trust has consistently been below the national average of 6.63 falls per thousand bed days (Royal College of Physicians 2015). Key areas identified for quality improvement include:

- Use e-Care, our new electronic patient record, to improve on:
  - comprehensive medical review for patients at risk of falls
  - medication review to reduce polypharmacy
  - lying and standing blood pressure
- Focus on hydration to help reduce confusion in the elderly
- Focus on assessment of spinal injury post-fall, in line with NICE guidance.

Changes are being put in place through e-Care to monitor and escalate lying and standing blood pressure monitoring. This allows observations to be captured and monitored as clinical tasks.

We have focused on the improved identification and management of risks to patient safety, primarily those related to identification of factors indicating imminent **deterioration of patients, sepsis (infection that has entered the blood stream) and acute kidney injury** (previously known as kidney failure). The Board committed to the national Sign-up to safety campaign and approved an improvement plan for the initiative. The delivery of this plan forms the focus of our ambition to deliver reliable care through compliance with agreed pathways based on best practice for AKI, sepsis and diabetes.

Further quality improvement is focused on:

- Improving monitoring of patients with AKI as part of e-Care to enable prompt treatment
- Reviewing management of patients with a AKI stage 3.
- Reviewing and implementing the the new sepsis guidance from NICE
- The expansion of CQUIN data requirements relating to identification and treatment of inpatients with sepsis
- Further audits within critical care to monitor improvement from 2015 audit.

We continue to focus on improved prevention and management of **pressure ulcers,** including analysis of trends and incident characteristics, e.g. site on body. We are focusing on reducing the number of avoidable hospital acquired pressure ulcers (HAPU). The React to Red skin campaign is being implemented with the aim to educate as many people as possible about the simple steps that can be taken to avoid pressure ulcers. A trial is being undertaken on an acute medical ward to assess and proactively manage patients assessed as at risk of pressure ulcers – this includes the prophylactic use of padded dressings and pressure relieving mattresses. We are introducing the use of hybrid pressure relieving mattresses, which will be aimed at patients at moderate risk of developing a HAPU.

The programme of quality improvement for the Trust is consistent with the STP development plans and will provide evidence to support quality monitoring but enable closer working across agencies to share best practice and improvement quality across health and care settings.

One of the Trust's key quality priorities is to **Deliver measurable improvements in the patient experience**. Future quality improvement is focused on:

- Continuing to increase response rate in outpatient areas
- Determining methods of obtaining FFT responses from our hard-to-reach groups, such as patients with learning disabilities
- Using promotional material in public places across the Trust to encourage responses
- Developing different methods of returning questionnaires, such as drop-off boxes, to obtain more feedback
- Trialling nursing staff wearing scrubs at night to mimic pyjamas to help patients distinguish between night and day
- Introducing 'calm carts' on three further wards. These can be used by staff or volunteers on the wards to take soothing music, hand massage, aromatherapy, and reminiscent activities to the patient to help reduce distress and agitated behaviour
- Further developing our monitoring framework for moves at night and to focus on this to reduce noise at night
- Reviewing how we respond to feedback on public websites
- Continuing to implement new initiatives to improve the range of feedback methods
- Rebranding our patient advice and liaison service (PALS) to re-educate patients, carers and staff on the contribution and values of the service.

A **nursing and midwifery establishment review** was undertaken in June 2016. Staffing data was reviewed over a 20-day period along with patient acuity data. Recommendations from national guidance on staffing ratios and skill mix have been taken into consideration. A review of all relevant literature and guidelines was undertaken prior to commencement of this exercise and included:

- NICE guidance on safer staffing for nursing in adult inpatient wards in acute hospitals (2012)
- Compassion in practice, NHS England (2012)
- Safer nursing care tool
- Nurse sensitive indicators
- Safer staffing guidance, Trust Development Authority (2015)

- Nursing hours per patient day (NHPPD) – calculates registered and unregistered staff; the title is due to be amended nationally to care hours per patient day (CHPPD).

Research has demonstrated the link between staffing levels and quality of care will impact on patient safety issues such as falls and pressure ulcers but also on patient experience. Within the Trust falls at night and pressure ulcers are a concern and are directly impacted by staffing, with particular issues regarding staff available at night, all of which has been considered but could be explored further by the senior nurses.

This review indicates an increased requirement for staffing in a number of areas and that there are wards that are over-established. The review also identifies opportunities for changes in working practice and patient flow. The recommendations from the review will be implemented with the senior matrons.

WSFT has a well-represented **seven-day services group** leading the service development and improvement plan. The Trust already operates a full seven-day service for both the emergency department (ED) and in-patients across a wide range of clinical areas in order to manage weekend admissions. Future quality improvement is focused on:

- Standard 2: time to consultant review - WSFT has been meeting a CQUIN to achieve assessment within 14 hours of arrival, however some gaps in cover do exist. High risk patients are prioritised and a modified early warning score (MEWS) system is used
- Standard 5: access to diagnostics - The Trust met the commissioning for quality and improvement (CQUIN) requirement to assess timely X-ray, CT and MRI within one hour for critical patients (excluding MRI where this is not clinically safe) and within 12 hours for urgent patients. This is now a contractual agreement. A further CQUIN regarding these tests within 24 hours for non-urgent patients was met 2015-16. A focus on any possible increased adherence to the diagnostic standard is now planned within the context of recruitment and funding constraints
- Standard 6: access to consultant-directed interventions - WSFT currently provides some interventions on site and has formal arrangements with other sites to provide the remaining; however plans are in place to establish an angiography suite which will provide a pacing service and angiography
- Standard 8: on-going review - This standard will prove the most challenging to resource and recruit to. The main areas of recruitment required have been identified as cardiology and geriatric medicine.

WSFT have been scoping and working on the four priority standards for some time in liaison with Department of Health leads. Although progress has been made, the standards prove challenging in a provider the size of WSFT with constraints in medical rotas. The Trust has implemented a whole system electronic patient record this year which is still in optimisation stage. Recent data from the seven-day services self-assessment tool is reflective of this, making true interpretation of status more difficult. Work is taking place to address this in readiness for the next audit requirement.

We continue to monitor and improve compliance with the **national CQUIN goals**:

- Staff, health and wellbeing: wellbeing, musculoskeletal and stress; healthy food for staff, visitors and patients; and frontline staff – flu vaccinations

- Sepsis: emergency department – screening and treatment; and inpatients – screening and treatment
- Cancer waits: urgent GP referral for suspected cancer to first treatment in 62 days; and root cause analysis (RCA) on long waiters (>104 days) and clinical harm review
- Antimicrobial resistance and stewardship: reduction in antibiotic consumption; and empiric review of antibiotic prescriptions.

(c) Quality impact assessment process

The cost improvement plans (CIPs) and transformation plans have been setup on a system portfolio basis created and managed jointly with the CCG. This includes the shared allocation of project management office (PMO) resources from respective redesign and transformational teams. WSFT has invested in additional project management resource to ensure capacity is in place to deliver both the long term transformational plans as well as the shorter term plans focused on cost improvement and efficiency.

The development of this system approach has been supported by the block contract agreed with the CCG for 2016-17 allowing a focus on system transformation and joint savings, rather than traditional contractual monitoring.

All projects have an executive sponsor, either WSFT or CCG, with monitoring through the system portfolio management group. This group is jointly chaired by the WSFT and CCG accountable officers.

The underpinning plans for each project are developed by relevant subject matter experts with engagement from clinical leads. The quality assurance process prior to project go-live requires agreement by the WSFT medical director and chief nurse as well as the CCG's director of nursing and quality.

During implementation the quality impact of CIPs is monitored through the Board quality report, including the ward level quality dashboard. This set of measures allows early identification of concern in a single clinical area or where there is deterioration in a single metric across a number of clinical areas. During 2016/17 these arrangements have been strengthened with the development of ward performance dashboards which review quality, operational and financial indicators. Performance against CIP delivery is reported to the Board regularly through the finance and transformation reports.

In year changes and additions to the CIP programme will be subject to the same divisional and executive quality impact assessment and Board monitoring.

The quality impact assessment process will continue to be developed with clinical sign-off at divisional level by the responsible clinical director in addition to that of the medical and nursing directors.

(d) Triangulation of indicators

The monthly quality and performance reports to the Board provide an integrated view of performance across a range of indicators. Performance against indicators is reviewed at an organisational and ward level providing a level of 'deep dive' scrutiny at service level.

Key indicators are reviewed which cover:

- Quality metrics, including infection prevention, falls and serious incidents
- Staffing levels
- Financial performance.

These arrangements are underpinned by a regular review of nurse staffing levels based on the relevant national standards for the area.

4. Supporting our staff - workforce planning

The Trust takes part in the annual NHS workforce planning process which sets out detailed projected workforce numbers for the next financial year, and estimated levels of staffing for six years after that. These figures in turn inform commissioning of workforce and education programmes. Service delivery changes and financial constraints will necessitate new approaches to the delivery of patient care and how supporting services are designed. This has resulted in:

- Changes to current working practices
- Increased collaboration with other healthcare providers
- Re-profiling of skill mix, including reduction in temporary staffing (where this is expensive)
- The adoption of new technology to improve service delivery and productivity.

Health Education East of England (HEEoE) supports the workforce planning process and the Trust is involved in this process at all levels. In addition to the annual workforce plan, the Trust has developed a five-year workforce strategy (2016-2021), which outlines the way in which workforce will support the overall Trust strategy. The 2016 workforce plan was developed by service lines and specialist leads through an annual consultation process.

In addition to the annual process, workforce issues are routinely addressed though:

- Monthly staffing report
- Six-monthly nursing establishment report
- Monthly directorate key performance indicator reports – covering sickness absence levels, turnover, appraisal rates, bank and agency spend
- Vacancy approval process, requiring executive director approval
- Quarterly Friends and Family Test, in addition to annual staff survey.

The Board deliver their responsibility for assuring the workforce planning process by monitoring and ensuring that targets are achieved, and identifying and managing workforce risks. The main workforce risks have been identified as follows:

- Requirements for community integration
- Skill mix issues – the lack of certain specialist skills and a recent reduction in continuing professional development (CPD) funding to support this
- Ageing workforce
- Changes in working practices associated with seven-day working
- Reduction in national training numbers and the Francis report
- Shortages in consultant medical specialities
- Financial stability and CIPs
- Recruitment hotspots.

A nursing and midwifery workforce review has been initiated to support the Trust in meeting these challenges and ensure the symbiotic association with nursing and midwifery workforce, quality, finance, clinical outcomes and operational excellence.

Workforce risk management is monitored through our corporate risk committee, we also have a separate education strategy committee which co-ordinates all education and links to service, and provides liaison with external groups.

Alignment with local education training boards
The Trust workforce supply needs are identified through our workforce planning in both the short, medium and long term. In the short term we have identified hard to recruit areas/ hot spots, which we have identified action plans for. These are supported by HEEoE in terms of overseas recruitment, etc. In the medium to long term, the workforce plan contributes to the commissioning of education places for both registered and non-registered staff. The CPD funding identified and the bands 1-4 target set for apprenticeships, midwifery care assistants and assistant practitioner posts is reduced this year, and will change significantly next year significant changes will arise as a result of the STP and apprenticeship levy. The Trust is currently working through the implications. The Trust is currently meeting its targets, and in some cases is over the target numbers (apprenticeship target).

The workforce plan 2016-2021 will continue to focus on:

Workforce efficiency
As part of the Trust's drive to deliver workforce trust and efficiency the Trust has developed new ways of working, such as reducing unnecessary endoscopies which improve efficiency. The placement of specialist nurses has created an improved patient pathway. There has also been an increase in the departments providing seven-day services.

The Trust continues to monitor key performance indicators to ensure the best utilisation of staff. Further development of integrated working with community services is planned to ensure efficiencies in the way we approach our services.

Skill requirements and development
Where there are skills shortages in areas such as junior doctors, the Trust is planning to deploy physicians associates to lessen the impact in hard-to-recruit areas. The skill mix of staff is reviewed and new ways of working developed to utilise band 2-4 staff where appropriate. This is to be used in radiology for example.

There will be an ongoing need to access continuing professional development courses for our professional workforce, to maintain current levels of skill mix and efficiency. Due to an ageing workforce and difficulties recruiting, departments are restructuring to utilise the current workforce. This approach is being utilised in estates and facilities.

The Trust is developing apprenticeships in a range of clinical and non-clinical areas, delivered in partnership with West Suffolk College and UCS. The Trust is working with local schools and careers agencies to attract local people to work in the NHS and use value-based recruitment to ensure that those they attract are the right staff.

5. Delivering sustainable care

(a) Financial forecasts and modeling

Key assumptions underpinning the financial plan are detailed below:

- 2016-17 delivers recurring CIP of £6.1m
- 2016-17 delivers non-recurring CIP of £2.5m
- 2016-17 fails to deliver the stretch CIP of £3.9m
- 2017-18 CIP programme of £9.9m (4.0%) against an expected efficiency target of 2%
- 2018-19 CIP programme of £10.4m (4.2%) against an expected efficiency target of 2%
- 2017-18 and 2018-19 contingency of £2.0m
- 2017-18 and 2018-19 block contract with lead commissioner, and therefore no financial penalties.

The following assumptions are consistent across the STP:

- 2017-18 and 2018-19 activity growth of 2.5% as outlined above
- 2017-18 and 2018-19 tariff inflation as laid out by DH (2.1% and 2%)
- 2017-18 and 2018-19 expenditure inflation as assumed by DOH (broadly 2.1%).

You can read more about the STP on page 27.

The Trust has received a contract offer from West Suffolk Clinical Commissioning Group that is in line with these agreed assumptions. The offer is in the form of a block contract which reduces risk around activity and reporting issues relating to the implementation of e-Care, as well as removing financial penalties.

At this early stage, the Trust has been unable to prepare a plan that would secure £5.2m of sustainability and transformational (S&T) funding. This funding would require a commitment from the Trust to make a maximum loss of £2.5m (i.e. the required planned loss before such funding would be £7.7m).

Therefore, without S&T funding the Trust plans to make a loss of £14.5m in 2017-18, as summarised below. However, it is still early in the year to confidently assess all the risks relating to 2017-18, in particular risks relating to :

- The Pathology Partnership (tPP)
- Suffolk Community Health contract
- Depreciation relating to our capital programme including e-Care
- Cost pressures in relation to currency fluctuations.

Table 2: Summary income and expenditure account

SUMMARY INCOME AND EXPENDITURE ACCOUNT	1617 Forecast	1718 Plan	1819 Plan
	£m	£m	£m
Income			
NHS Contract Income	163.5	163.5	164.1
Full Year Community	60.8	60.8	60.8
Contract inflation 2.1% / 2%	0.0	3.4	3.3
Contract growth 2.5%	0.0	4.1	4.1
STP lost income	0.0	(1.9)	(4.0)
Productivity	0.0	(5.0)	(5.0)
Non-recurring	0.7	0.0	0.0
CIP	0.0	0.0	0.0
Other Income	27.3	27.6	27.8
Total Income	**252.3**	**252.5**	**251.2**
Pay Costs			
Recurring	145.7	146.7	147.4
Inflation 2% / 1.6%	0.0	2.9	2.4
Non-recurring	(1.8)	(2.0)	(2.0)
Cost reduction due to activity	0.0	0.0	(3.4)
Growth	0.0	2.8	2.8
CIP	0.0	(7.0)	(7.5)
Reduced DTOCs	0.0	0.0	0.0
Total Pay	**143.9**	**143.4**	**139.6**
Non-pay Costs			
Recurring	109.5	110.0	114.3
Cost reduction due to activity	0.0	0.0	(1.5)
Inflation 3.8%	0.0	4.1	4.3
Non-recurring	0.0	(0.5)	(0.5)
Additional NHSLA inflation 19.7%	0.0	1.0	1.0
CIP	0.0	(2.9)	(2.9)
Growth	0.0	2.1	2.1
Total Non-Pay	**109.5**	**113.8**	**116.8**
Contingency	0.0	2.0	2.0
Total Operating Expenditure	**253.4**	**259.2**	**258.4**
Total EBITDA	**(1.1)**	**(6.6)**	**(7.2)**
Depreciation & Impairments	6.1	6.1	6.1
Finance costs	1.7	1.8	1.8
INITIAL SURPLUS/(DEFICIT)	**(8.9)**	**(14.5)**	**(15.1)**

Table 3: Summary movements from 2016-17 to 2017-18 and 2018-19

	£m
2016-17 control total	(5.0)
Reverse S&T funding	(6.1)
Non-recurrent CIPs in 16-17	(2.5)
Non achievement of stretch CIP	(3.9)
Recurring 17-18	**(17.5)**
17-18 efficiency requirement	(5.0)
STP activity changes	(1.9)
2017-18 'do nothing' position	**(24.4)**
To achieve the STP target	
2017-18 plan (as per STP plan)	**(14.5)**
Control total	(7.7)
CIP to achieve STP 4.0%	9.9
CIP to achieve control total 6.7%	16.7

	£m
2017-18 plan	(14.5)
Non-recurrent CIPs in 17-18	(2.5)
Recurring 18-19	**(17.0)**
18-19 efficiency requirement	(5.0)
STP activity	(4.0)
2018-19 'do nothing' position	**(26.0)**
To achieve the STP target	
2018-19 plan (as per STP plan)	**(15.1)**
Control total	(5.2)
CIP to achieve STP 4.4%	10.9
CIP to achieve control total 8.3%	20.8

In order to agree to the control total for 2017-18 the Trust would need to agree to a CIP of £16.7m (6.7%) which is an increase of £6.8m on our current target of 4%. Our current target is already double the expected productivity target of 2% and any further CIP would have a significant impact on operational capacity. It would also represent a CIP significantly higher than the organisation has previously been able to achieve.

Assuming the STP is met in 2017-18, in order to agree to the control total for 2018-19 the Trust would need to agree to a further CIP of £20.8m (8.3%).

The Trust Board has discussed options which could be implemented in order to achieve an increased CIP target but these would mean a deterioration against our performance targets. Since the S&T funding is partially contingent on achieving referral-to-treatment, four-hour wait and cancer targets, missing these targets would be counterproductive in terms of our financial position.

The Board is mindful that once these targets slip they are extremely difficult and expensive to recover. Therefore we have prioritised achieving these targets over agreeing to a larger CIP.

(b) Trajectory improvements and efficiency savings

During 2016-17 we have been under sustained operational pressure. We have struggled to deliver the four hour wait performance target with flow through the hospital affecting our ability to deliver against the revised trajectory and escalation beds consistently open. This has negatively impacted on our financial position.

Working with staff we are putting in place a number of initiatives to support and improve patient flow:

- The **SAFER patient flow bundle** is a combined set of simple rules for adult inpatient wards. It is designed to improve patient flow and prevent unnecessary waits and is a major focus as the hospital prepares for winter
- The medical division has secured a ward area to open as the **winter escalation ward (WEW)** in preparation for the challenging months ahead. We commissioned 20 beds at Glastonbury Court, a local care home, to create a rehabilitation facility in the community for medically fit patients.

  From 7 November we will be using ward G9 as the WEW for a five month period. This means that F8, the acute medical unit (AMU), should not be used for escalation and can fulfil its intended purpose to provide an ambulatory emergency care (AEC) unit.

Action within the organisation 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 the local sustainability and transformation plan (STP). The Trust Executive Group agreed to establish a Patient Flow Group chaired by the medical director. This group will focus on defined workstreams to ensure timely assessment, review and discharge planning for patients in the hospital.

Key risk mitigations in delivering the **trajectory improvements** include:

- **Workforce** – The trust is dependent on the workforce to deliver safe quality care and will ensure that any shortfalls in the core establishments for nursing and medical staff are addressed in a timely fashion to maintain patient safety. The Emergency Department (ED) has recently recruited nursing and advanced Clinical Practitioners roles. Full enhanced establishment will be in place by January 2017.

- **Patient Flow** – The initiative created by NHSI, Red to Green days and 'Go Green this Winter' has been launched. Improved flow is the key to allowing us to provide top quality care safely whilst we face the challenges of winter. By introducing this initiative we anticipate a reduction in length of stay as well as developing a standard across the Trust to meet the SAFER requirements for each specialty

- **External factors** – Includes, patient attendance variations and unpredictable patient conveyance by ambulance crews. The Trust will build on recent activity data to ensure that any shortfalls in workforce and diagnostics will reflect the peaks and troughs of that activity.

- **GP streaming in ED** – The Trust has also worked collaboratively with commissioners to support additional primary care capacity. A recent pilot was conducted in WSFT to establish how primary care provision could assist in managing the demand of patients who presented at ED. The GP team provision included triage, assessment and treatment, not just streaming and redirection. The proposals timeframes are up to March 2017, where a full evaluation will be conducted with a view to embedding the model as business as usual.

Recover is forecast in February 2017 supported by detailed system and trust actions. The key risks to the plans, as described about have been mitigated to ensure delivery. We have in place a quality and performance framework to ensure effective and timely monitoring delivery of the agreed mitigation plans. This is driven through the ED operation forum and improvement in patient flow is being driven by the newly established Patient Flow Action Group (FLAG).

Table 4: Summary savings

2017-18 CIP	£'000	£'000
Productivity		1,500
Central schemes		
MSK SPOA	317	
Dialysis Service	263	
Delayed transfers of Care	1,500	
Procurement	224	
New Carer Service	222	
Medicines Optimization & Pharmacy	490	
E-Care	294	3,310
Agency premium		
Agency Costs - Medical	527	
Agency Costs - Nursing	263	
Agency Costs - Other	132	922
Other temporary pay reductions		
Efficient use of Clinics (cost reduction)	610	
Efficient use of Theatres (cost reduction)	158	
Improved discharges (cost reduction)	150	918
Local CIP (Acute only)		
Medical Services	600	
Surgical Services	900	
Woman & Children Services	300	
Clinical Support	450	
Community Services	500	
Facilites	300	
Corporate Directorates	200	3,250
Total (percentage of £210m)	**4.0%**	**9,900**

2018-19 CIP	£'000	£'000
Productivity		2,000
Central schemes		
Procurement	200	
GDE	200	
E-Care	500	900
Agency premium		
Agency Costs - Medical	300	
Agency Costs - Nursing	200	
Agency Costs - Other	100	600
Other temporary pay reductions		
Efficient use of Clinics (cost reduction)	150	
Efficient use of Day theatres (cost reduction)	150	
Efficient use of Main theatres (cost reduction)	150	
Improved discharges (cost reduction)	150	600
Local CIP (Acute only)		
Medical Services	600	
Surgical Services	900	
Woman & Children Services	300	
Clinical Support	500	
Community Services	500	
Facilites	300	
Corporate Directorates	200	3,300
Unidentified		3,000
Total	**4.2%**	**10,400**

Further details of the **STP** efficiencies are provided in section 6 of this plan. WSFT's plans are fully aligned with the STP financial bridge and delivery plans.

WSFT has been identified as a prestigious centre of **global digital excellence (GDE)** after successfully bidding for a share of £100 million in funding to further improve the way technology is used to benefit patients. The hospital was invited to bid for the money by NHS England after it was identified as one of the country's 26 most digitally advanced trusts following the introduction of its electronic patient record, e-Care, earlier this year. Over the next two years the funding will be invested in accelerating the hospital's existing plans to develop further its e-Care system. This will see the system fully integrated with those used by GPs, social services, other hospitals and care providers so that everyone can share the same records, avoiding duplication and making life easier for clinicians.

The Trust's vision for a digital future reflects the organisation's transformation goals, priorities and ambitions. The Trust does not see digitisation as an end in itself but as an enabler. Therefore, we will align all information management and technology initiatives with the outcomes and benefits we aspire to achieve through our transformation and benefits realisation programme. We have a clear organisational strategy, discussed with and countersigned by colleagues across the care economy and the wider public sector.

As a centre of GDE, WSFT will deliver enhanced quality of care and seamless services across our whole health and social care economy. The aims of the programme are three-fold and represent our five-year vision:

- A transformation-led digital acute trust – The programme will provide WSFT with a robust, fully digital platform which is paperless at point of care, resulting in operational efficiencies and improvements in quality of care. Real-time access to

accurate information about patients and their care plans, and enterprise-wide scheduling will ensure seamless and safe handover of care across care settings. Evidence-based decision support such as early warnings for AKI and sepsis will optimise care and prevent illness. Efficiency improvements such as device integration will allow more time for direct patient care. Effective use of medications through improved decision support, compliance and reconciliation across settings will deliver safer patient care

- Supporting the goals of the ACO - The programme aims to support fully the goals of the emerging west Suffolk ACO. A digitally mature acute trust is essential for achieving the goals of the wider care community. The complete deployment of e-Care combined with wider system integration will allow the Trust to provide an efficient and effective risk stratification approach to patient management. For example, Suffolk has an older than average population, resulting in increasing demand for services versus affordability. By applying a risk stratification approach and targeting segments of the population (e.g. over 85's), we can intervene in a way that abates demand. A centralised business intelligence and analytics function across the ACO will allow us to perform the sophisticated data analysis which is essential to delivering effective risk stratification
- Promoting our exemplar digital community – Working with our electronic patient record partner, Cerner, we will establish ourselves as a model digital community within two years. We will build on our strong foundations and extend our already recognised model approach to other organisations both nationally and globally. We will contribute to the increased digital maturity of our local partners, including neighbouring acute hospitals, community services, mental health, ambulance and social care, by providing mentorship in all aspects of deployment, including leadership, informatics and intellectual property (IP) development. We will contribute to delivering digital maturity in both Cerner and non-Cerner sites alike through the sharing of experiences, approaches and solutions. We will achieve this goal through strengthening existing partnerships such as those with Cerner, the Eastern Academic Health Science Network (ESHSN) and our teaching partner Cambridge University. We will also build new partnerships locally and internationally with other exemplar sites or IP development partnerships.

Lord Carter's provider productivity work programme

The PricewaterhouseCoopers (PwC) benchmarking report commissioned in 2014 assessed WSFT as, by and large, a productive organisation that regularly sits in the top quarter of quality, safety and productivity performance. This view is corroborated by Lord Carter's review which has calculated the Trust's adjusted treatment cost is 0.89. This means that we are approximately 11 pence less expensive per pound on national cost weighted output. Equally when you review the headline adjusted treatment cost data by trust type, we are the most efficient small acute provider and the fourth most efficient provider in the country.

Nonetheless we are not complacent and recognise the sentiments expressed in the Carter Report that all trusts have areas where improvements can be made to realise efficiency savings.

The 2017-18 plan assumes a CIP target of 4.0% which broadly reflects Lord Carter's initial findings.

We already have a number of efficiency workstreams which target the areas identified within the Carter Report. We welcome the focus on support from the national bodies to provide standardised approaches to measuring productivity and efficiency and to unlock barriers to achieving system-wide transformation. As an

urgent priority we will undertake a review against performance in the key areas of opportunity through service level reviews.

Agency rules

The two main clinical staff groups where agency staff are used are medical and nurses. When the initiative was first implemented it was difficult to fill these bookings as the agencies resisted and did not put forward staff to fill the shifts. However, we are now seeing the following benefits:

- We are getting a better response to adverts for substantive posts in terms of Trust doctors and junior doctor training posts
- We are beginning to see agency doctors asking to join our internal bank and we are advertising to join our medical bank.

The Trust recognises the risks to deliverability of the agency ceiling target and we are working towards mitigating that risk by working in collaboration with neighbouring trusts through the East of England Procurement Hub.

- The East of England Collaborative Procurement Hub has configured the region into the following clusters to ensure trusts adopt a standard and consistent approach to working with the market:
  - Cambridge & Peterborough
  - Essex
  - Norfolk & Suffolk
  - Hertfordshire & Bedfordshire
  - Mental Health and Community
- Each cluster has produced a joint procurement strategy and established a preferred supplier list (PSL) of 20 agencies willing to supply nursing and medical agency staff at national framework rates
- The suppliers on the PSLs will be managed against performance indicators, including: fill rate, cap compliance, recruitment at cap policy. This on-going monitoring will ensure PSLs flex to take into account performance. Suppliers failing to meet KPIs will be removed from the PSL and replaced with the next highest performing supplier. Tis regular review and update will be actively managed by the Procurement Hub on behalf of the clusters
- The PSLs for the Cambridge & Peterborough and Norfolk & Suffolk clusters went live in December 2016. WSFT participates in both of these clusters, but is more involved with Cambridge & Peterborough cluster.

Procurement

The Trust has a three-year procurement strategy that supports the Trust in achieving the following:

- A complete purchase-to-pay system that enables procurement to have clear visibility of spend across the Trust
- Ensure all EU procurement directives are followed
- Compliance with the Department of Health standards of procurement
- Contracts are tracked and monitored to ensure compliance and cost savings are being achieved.

Procurement actively engages in the utilisation of framework agreements through the NHS supply chain, Crown Commercial Services and the NHS procurement hub to

ensure best value is achieved. The Trust has a work plan that is communicated across the organisation and links with the NHS procurement hub. We undertake benching marking with acute trusts and NHS organisations across England to ensure pricing and commitments agreements offer the best opportunities for the Trust in line with its size and spend.

(c) Capital planning

The Trust has a five-year risk assesses capital strategy which focuses on addressing backlog issues and essential clinical developments. This is further enhanced by an annual prioritisation process for the assessment of investment of capital resources. This is assessed via a multi-professional group using a forced risk ranking process which assesses the benefits of investment against four criteria: compliance with the estate strategy; operational/clinical need; financial impact; and statutory compliance. The assessment ensures that:

- Risk priorities remain relevant and have not changed
- Any changes are incorporated from statute, alerts, NHS estates, etc.
- Any maintenance issues arising in year are considered and incorporated.

The Trust has a borough council approved master plan for the development of the main hospital site. The key strategic developments included in the plan are linked to clinical service delivery, with each development subject to a Board approved business case.

The Trust routinely considers leasing as the preferred option to investing capital for equipment through a partnership with Chrystal Leasing.

Table 5: Capital programme

Scheme	2017/18 Plan £'000	2018/19 Plan £'000
Pre-commitments		
Development Team/Feasibilites	499	504
Fire Compartmentation - above ceiling(including smoke & fire dampers)	650	-
Backlog schemes		
Plant Rooms	530	530
Roof Replacement	1,981	-
Replacement rooftop gas valves	218	
Northlight repairs	363	
Structural wall panels		1,167
Backlog wards/departments/theatres	1,000	1,000
Link corridor flooring	100	50
Road repairs	50	50
Replacement hot and cold water systems	20	
Replacement heating valves	10	10
Drainage internal	145	
Drainage external	268	
Resilience		
Emergency lighting	30	30
Generator upgrade (DSU T3)	100	
Repositioning of data cabinets	100	100
Electrical infrastructure resilience (2mw to 3mw capacity)	123	
Oxygen storage	120	
Development schemes		
SSD - including 2 additional floors	1,400	-
Decant ward	-	2,300
Environment improvement	50	-
E-care	2,000	-
A&E Redevelopment	-	2,000
Other operational priorities (priority order)		
Urology Relocation	170	
Labour Suite Refurb	-	800
F9/10 Procedure Room	150	
Audiology Refurbishment	320	200
Theatre Storage	1,000	
Total	**11,397**	**8,741**

6. Delivering joined-up care - sustainability and transformation plan (STP)

In Suffolk and north east Essex, the NHS, general practice and local government have come together to develop a five-year sustainability and transformation plan (STP). The STP is a unified plan to improve the health and care of our local people and bring the system back into a financially sustainable position. All partners are passionate about creating a plan which will deliver our vision for people across Suffolk and north east Essex to live healthier, happier lives by having greater choice, control and responsibility for their health and wellbeing. We are linking closely with other STPs within neighbouring areas, such as the Waveney area of Suffolk which has joined Great Yarmouth, and the mid and west Essex areas which are working on STPs across south Essex and Hertfordshire. We need to ensure we align with these neighbouring plans to ensure there are no significant patient safety and access issues.

A key issue driving our financial challenge is the increase in demand for service. We have in place a strong, visible, collective leadership and a well-structured programme of work to address this, and to focus on our key clinical priorities around reducing health inequalities and unwarranted variation.

The long-term goal and key focus within our STP is the design and mobilisation of two accountable care organisations, one to serve Ipswich and east Suffolk, and the other focussing on west Suffolk. These bring acute hospital, community, social care, mental health and primary care partners across Suffolk together to form an integrated financial and management delivery framework which will transform outcomes and experience for patients. Care will be based around localities and neighbourhoods, rather than around organisations.

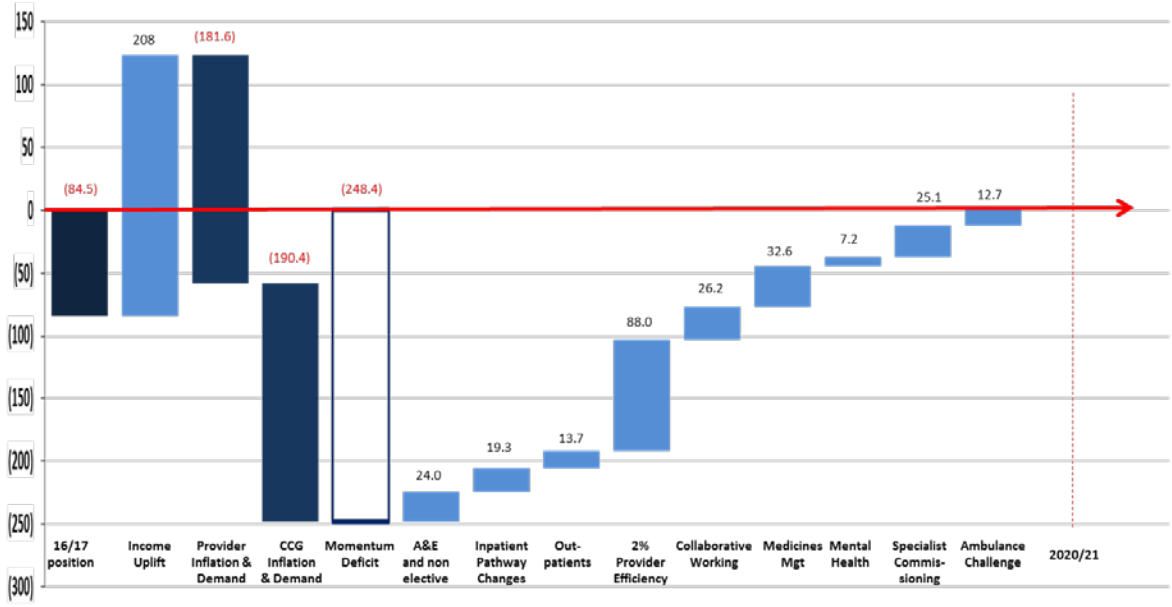
As part of our journey towards this new way of working we have established two alliances covering those footprints to bring health and care services together to provide one coordinated care response that is underpinned by prevention, self-care, early intervention, reablement and rehabilitation rather than long-term treatment and lifelong service dependency.

Our STP was submitted to NHS England in October this year and we are now working with commissioners and providers to embed the plans within our contractual and operational planning processes. It is clear that there are benefits for our population if we align our goals and actions and share knowledge and skills. The STP summarises the work to date and outlines how our system-wide plan can be delivered across organisations, how the known and emerging risks can be managed, and how by working together we believe we can improve the quality and safety of care provided.

Developing an ACO for the west of Suffolk is a key part of our STP planning. The development of a provider alliance formed of: community services, acute hospital, adult social care, mental health services and primary care will be the vehicle through which we will deliver our community services contract. The formation of this alliance will be the first phase towards a fully functioning ACO that will evolve over time to include commissioning functions. To mitigate engagement and operational risks the provider alliance will operate in shadow form from January 2017, testing integrated locality models building on the health and care integration already established. Over the next 9 months we will operate locality shadow boards with shared governance financial frameworks, gradually phasing in more services from the whole system.

The financial bridge (figure 1) describes the transformation journey to improve quality and safety and achieve a sustainable financial position. Our main focus is mitigating growth in demand.

Figure 1: STP financial bridge



Key programmes of work have been established to deliver the STP vision and improve the health and care services provided for our citizens. These programmes build on existing schemes that the Suffolk and north east Essex teams have been working on and we have now been able to share ideas and plans across the footprint to maximise the benefits offered to our patients and the system.

Figure 2: Delivering Our Vision

Self Care & Independence, and Community Based Care				Hospital Reconfiguration and Transformation			Collaborative Working across the System	
Safer Stronger Resilient Communities	Integrated out of hospital care	Mentally Healthy Communities	Primary Care Transformation	New Models of Care	Improving Care Pathways	Ipswich & Colchester Hospital Partnerships	Managed Care	Collaborative Working across Commissioners
• Shaping primary and community care to reduce demand for acute hospital and "bed based" care systems • Working with partner organisations to improve safety, resilience, and strengthen communities • Reduce need for follow up by the acute hospital through better management and "safe landing" within primary and community care • Reduce primary care variation, including for prescribing and referrals				• Re-shaping acute care to respond to resilient community work stream outputs • Aligning clinical systems and processes across all three sites where possible / appropriate • Reducing variation across the acute sites			• Shared clinical teams, systems and processes across the system • Shared back office functions • Shared and consistent commissioning and contracting approach	

By delivering our vision (figure 2) we aim to build stronger and more resilient communities which support our citizens to maintain independence as they take responsibility for managing their own health and wellbeing. This will enable people to

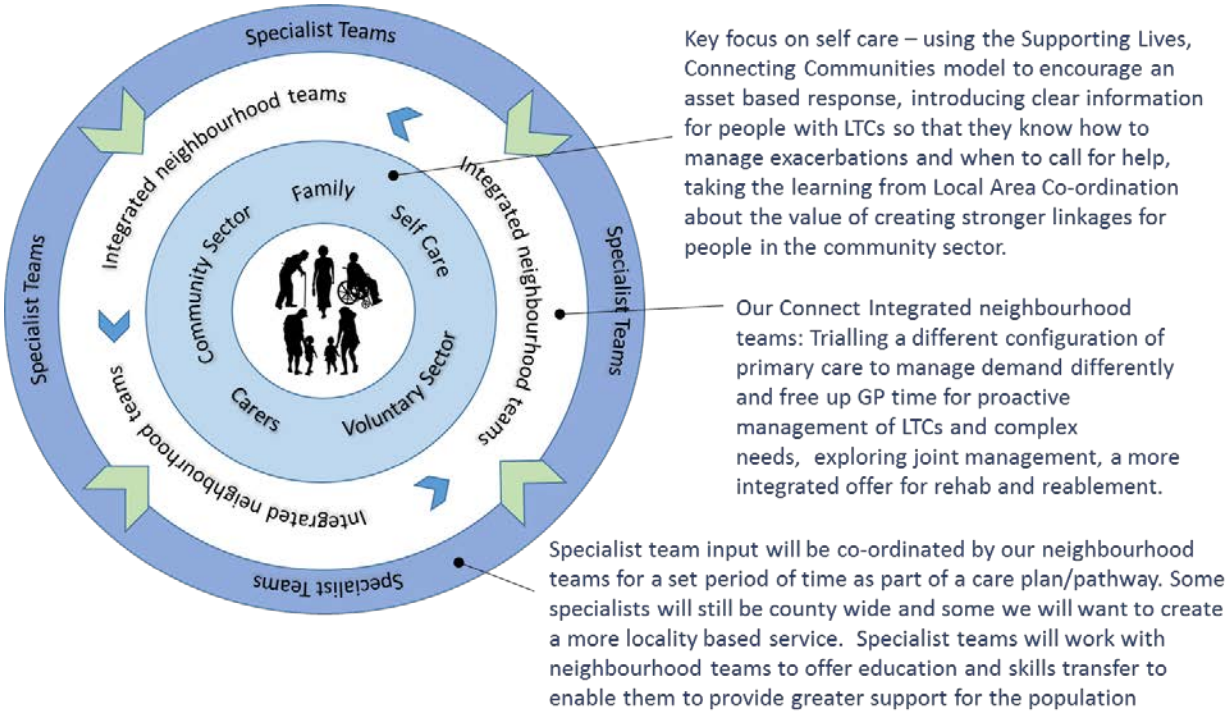
stay in their own home longer, reduce demand for social care packages, nursing and care home placements, and long hospital stays. This will create happier, less isolated, more empowered and independent citizens. In turn it will deliver system-wide benefits as we work together with community and social care partners to make the best use of our resources.

With the right knowledge and support, people can make a difference to their lives and those of their families.

Our future care system - adults

We will move to a place based care system with a much greater focus on proactive care and critical links to primary care and the urgent care system. True coordinated care wraps around the patient / service user and coordinates care for them rather than passing them from service to service.

Figure 3: Future care system - adults



Our future care system - children

We recognise that children's services draw on a complex support system across health, social care, community and education. A critical alignment is primary care and the optimisation of pathways between community and acute as required to put the children first.

Figure 4: Future care system - children

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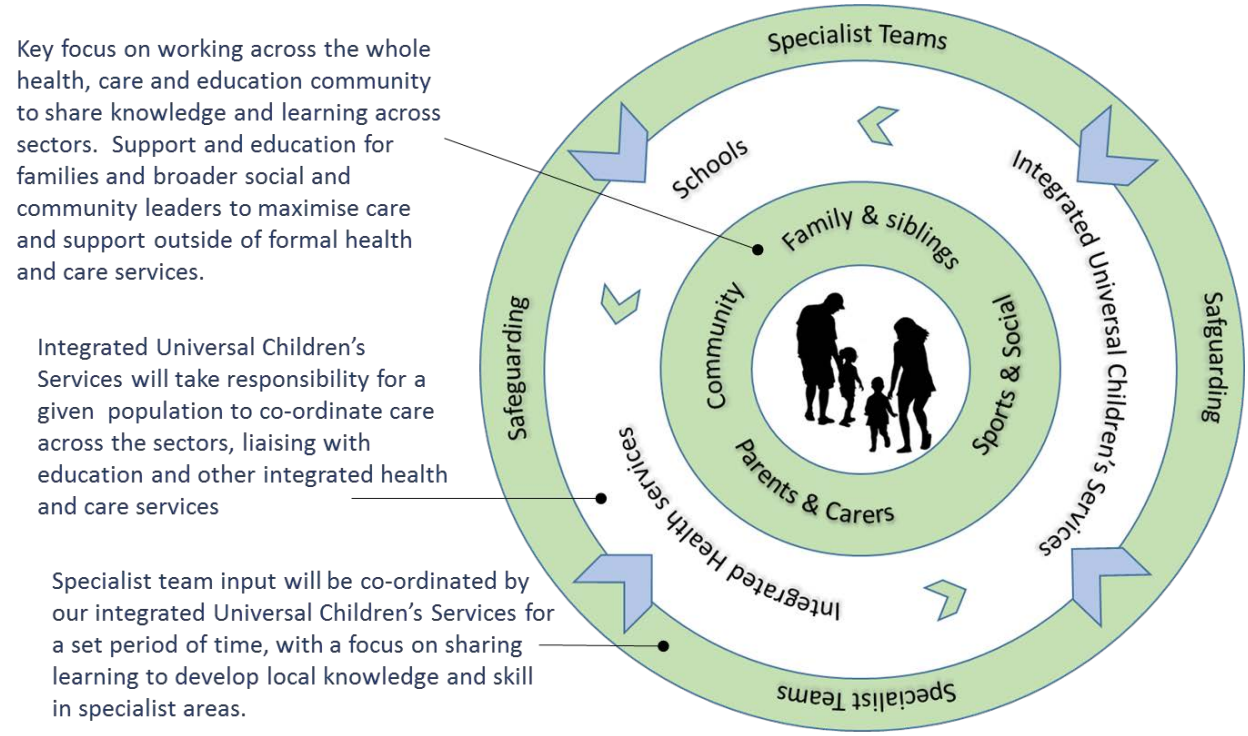

7. Membership and elections

(a) Governor elections

Governor elections took place on 30 November 2014. 40 candidates stood for 14 places in the public constituency and 16 candidates stood for five places in the staff constituency. Of the 14 public governors, eight governors were re-elected and there were six new governors.

Of the five staff governors, two were re-elected and there three new governors.

The next elections will take place on 30 November 2017. During the three-year term of office governors who resign are replaced by the next highest polling candidate in accordance with the Trust's constitution.

(b) Governor, members and the public

Governors attended a finance training session in February 2016 and a joint workshop with the Board of Directors in March 2016, which focussed on the strategic plans and the operational plan for 2016/17. A training and development day with an external facilitator took place in April 2016. This focussed on triangulation and assessment of assurance regarding the performance of the Board, and the role of governors in non-executive director recruitment and appraisal.

Governors take part in monthly public engagement sessions in the Trust's Courtyard Café, where they talk to patients and members of the public about their views and experiences of the Trust. They also use this as a way of recruiting new members and encouraging people to consider becoming a Governor in the future. Information

collected from these sessions is reported back to the Trust's patient experience committee (PEC) and any issues are also escalated to the Council of Governors.

Governors also attend the public Board meetings, annual members meeting and presentations/talks that are arranged for members and the public across the constituency. During 2016 six events took place (including the annual members' meeting) with a total of 630 members and the public attending these events.

Further events are planned focusing on cardiology and the Trust's strategy for the future.

(c) Engagement strategy

As set out in the engagement strategy, governors continue to focus more on engagement with current members and the public, rather than recruitment. The Trust has an active membership, with over 5,600 public members, which is considered to be an appropriate number which should be maintained. In early 2016, the engagement strategy was amended to put more emphasis on governors working with the Trust's partners to engage with the public in promoting prevention and a healthy lifestyle. This links with the ambitions in the Trust's strategic framework to support a healthy start, a healthy life and ageing well.

As a result of this there has been a greater focus on prevention and lifestyle within talks/presentation given to the public.

The engagement committee continues to work on developing a stronger link with West Suffolk College and other local schools and colleges. In November 2016 governors took part in an event - Step into the NHS - which was hosted by West Suffolk College. This was aimed at encouraging young people to work in the NHS and also to promote health and wellbeing. A number of new younger members were recruited from this event. It is proposed to develop this concept within other schools and colleges.

A members' newsletter is sent out to all members three times a year, with information on activities, achievements and plans for the Trust. At least once a year this includes a questionnaire, e.g. using feedback to shape our patient experience/safety priorities. The Trust has been able to secure an excellent response from members through these targeted mailings.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 3 March 2017

AGENDA ITEM:	Item 20
PRESENTED BY:	Dr Stephen Dunn, Chief Executive
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	23 February 2017
SUBJECT:	Trust Executive Group (TEG) report
PURPOSE:	Information

EXECUTIVE SUMMARY:

31 January 2017

Steve Dunn provided an update including a reflection on the **operational and financial performance** in the context of a meeting with NHSI on 2 February. A detailed review of the financial position was undertaken including agency spend and cash position with a projected £38m borrowing requirement. Review took place of divisional plans and stretch CIPs.

A report was received from the **Flow Action Group (FLAG).** Emphasis remained on Red to Green Board Rounds and ensuring these are consistently delivered each day on each ward. Improvements were noted in the documentation of patients' planned date of discharge (PDD).

The **red risk report** was reviewed with discussion and challenge for individual areas. The risk regarding duplicate registrations on e-Care was downgraded as a result of the mitigating action implemented.

Discussion took place regarding national guidance for **CPE (carbapenemase-producing enterobacteriacea)** testing within the hospital. The operational implications of this, and the potential to drive additional need for patient isolation, were considered. It was agreed that further clinical consideration was required to inform the Trust's response. This is scheduled for further consideration in March.

Discussion took place regarding the **MHRA inspection** findings for the blood transfusion laboratory and the Trust's response to this, working with TPP to ensure that the identified weaknesses are addressed in a timely manner. This issue will be reviewed on the Trust's risk register.

An update was received on **community and ACO** developments. This included next steps and arrangements for the 'most capable provider' assessment by the CCG for the community contract post September 2017.

6 February

A workshop was held which focused on the work of the STP with a presentation from Susannah Howard, STP Programme Director on plans and future developments, including a focus on governance and future clinical engagement. In addition, a presentation was received on population health with a focus on the link to the Trust strategic objectives and opportunities through business

and clinical improvement plans. This included risk stratification, lifestyle programmes and codification of population health.

20 February

Steve Dunn updated TEG on meetings with the MHRA regarding the inspection of **blood transfusion services** and NHSI regarding the Trust's **financial and operational performance**. These issues were both considered in more detail as part of the agenda of the meeting.

A report was received from the **Flow Action Group (FLAG)** with focus on continued improvement. It was noted that we are starting to see some early data which appears to demonstrate a link between improve flow/discharge and good performance against the 'red to green' standards.

The meeting reviewed the **e-Care lessons learnt report** which sets out learning from go-live at WSFT and other sites. As part of our global digital exemplar status this learning is being shared with other trusts. The focus of communication within the Trust includes consolidating the changes from go-live and preparation for delivery of phase 2 which will launch in April 2017.

A briefing paper was considered which set out the position regarding **referral to treatment (RTT)** reporting. WSFT had traditionally been a strong performer for RTT with the incomplete position around the 97% level during 2015 and just over 95% at the point of go-live in April 2016. At this point the number of patients within the Trust waiting list was approximately 14,000. Since go live there had been technical issues with the ability of the data warehouse to accurately capture and report information, which Jon Green commented, remained unresolved, despite high level escalation within both the Trust and Cerner. These issues have masked underlying data quality issues creating a complex picture in terms of addressing these issues. As a result the Trust has not had a functioning Patient Tracking List (PTL) and had therefore used a variety of assumptions supported by other data sources and some soft intelligence to manage the risk to patients and provide estimated reports. Speciality level reviews are currently being undertaken and will be report to TEG, following the next e-Care programme board.

TEG approved the **nursing recruitment proposals** which set out a range of initiatives to support the recruitment of registered nurses, nursing assistant and assistant practitioner.

An update was received on **consultant job planning** for 2017/18. It was noted that compared to previous years the position was good but the clinical directors stressed that they were disappointed more progress had not been made and would be pushing hard with their consultant colleagues.

A report and presentation was received from **OneLife** which provides a series of lifestyle programmes funded by Suffolk County Council. Based on the discussion it was agreed that there was a clear appetite to engage and build in a number of different areas with a need to do some prioritised work with women's and children, long term conditions and pre op assessment.

A report was received setting out the Trust's response to the requirements for **IR35 off payroll arrangements**. Action was agreed to communicate this to relevant staff.

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 – 3 March 2017

AGENDA ITEM:	Item 21a
PRESENTED BY:	Steve Turpie, Vice-Chairman
PREPARED BY:	Georgina Holmes, Foundation Trust Office Manager
SUBJECT:	Council of Governors Report – 8 February 2017
PURPOSE:	Information and Approval

EXECUTIVE SUMMARY:

This report provides a summary of the business considered at the Council of Governors meeting held on 8 February 2017. The report is presented to the Board of Directors for information to provide insight into these activities. Key points from the meeting were:

- Steve Turpie chaired the meeting in the absence of the Chairman.
- The Chief Executive provided an update on the challenges facing the Trust and recent achievements.
- Responses to the issues raised by Governors were noted.
- The quality and performance and finance reports were reviewed and questions asked on areas of challenge. Governors had received an update on the situation regarding TPP in the closed session of this meeting.
- An update was given on e-Care, including progress to date, the challenges and plans for the future.
- An update was given on Community Services and the ACO. Governors would be attending a joint Board/CoG development session on 23 February which would focus on this in more detail.
- Two Governors volunteered to act as readers and comment on the Annual Quality Report.
- A summary of the changes to the Constitution was given, including the widening of the membership area to include the whole of Suffolk. These changes had been approved by the Governors in the closed session of this meeting.
- The summary Register of Governors Interests was received.
- The appointment of June Carpenter as Lead Governor was approved.
- Justine Corney was elected to the vacant position on the Nominations Committee.
- The closed session of the meeting received a report and recommendation from the Nominations Committee. The Governors approved the appointment of Dr Richard Davies, to the University of Cambridge NED position and Alan Rose to the public NED position.

  They also supported the appointment of Angus Eaton as Board Advisor, and that he be appointed to the next Non-Executive Director vacancy without the need for further competition.
- The appointment of BDO as the provider of External Audit services was approved at the closed session of this meeting.
- Reports from the Engagement Committee and the Lead Governor were received.
- The Engagement Strategy for 1 April 2017 to 31 March 2019 was approved (attached).

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:

(a) receive the report for information
(b) approve the updated Engagement Strategy
(c) approve the appointment Angus Eaton as Board Advisor

West Suffolk NHS
NHS Foundation Trust

Item 21b Board of Directors – 3 March 2017

MEETING DATE:	3 March 2017
SUBJECT:	Review of Engagement Strategy – April 2017 to March 2019
AGENDA ITEM:	21(b)
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governanace
DATE PREPARED:	1 February 2017
FOR:	Approval

Introduction

The previous Engagement Strategy covered the period from April 2015 to March 2017. The strategy is reviewed annually and was last updated by the Council of Governors in February 2016 and approved by the Board in May 2016.

The Council of Governors reviewed the strategy at its meeting on 8 February 2017 and agreed a number of updates to the strategy in order to ensure that the document was fit for purpose and reflected the FT membership recruitment and engagement strategies being used by the Trust.

The key changes to the document were:

- Linking the engagement objectives (1.2) with the objectives in the Trust's strategic framework. These would also link with the work plan of the Engagement Committee.

- A greater focus on health prevention and wellbeing.

- Updated membership targets for 2019

- The public constituency of the Trust (Appendix 1) has been amended to reflect the expansion of its membership area.

Recommendation

The Board is asked to approve the revised strategy. Implementation of the strategy will be driven through the work of the Engagement Committee.

West Suffolk NHS
NHS Foundation Trust

Engagement Strategy

April 2017 to March 2019

Engagement Strategy

Contents Page **Page**

1. Introduction

West Suffolk Hospital NHS Foundation Trust is committed to being a successful membership organisation and strengthening its links with the local community.

We recognise that we need to commit significant resources both in time and effort to developing our membership and engaging with the public and this strategy sets out the actions that we will take in support of this.

1.1 Purpose of strategy

This strategy outlines our vision and the methods we intend to use to maintain and build a representative and engaged public and staff membership. It also outlines our future plans in terms of recruitment and engagement and how we will measure the success of our membership and future engagement.

Delivery of the future plans set out in this strategy will be achieved through an agreed development plan with defined responsibilities and timescales for delivery.

This is an evolving strategy and will be subject to change as lessons are learnt.

1.2 Engagement objectives

Our vision for engagement within the Trust must underpin the organisational vision, priorities and ambitions. We should support the organisation in achieving the Trust's strategy with our aspirations for engagement.

Deliver for today
• Increase understanding amongst the public and members of the Trust's strategy and the range of services offered by it, including current changes in health services and the challenges the Trust andlocal health and care services are facing • Maintain our existing membership base and ensure that it reflects the diversity of our local communities
Invest in quality, staff and clinical leadership
• Actively engage with the public and members to understand their views and aspirations for the Trust, including how it can develop and improve • Through our representative membership learn from, respond to and work more closely with our patients, public, staff and volunteers to develop and improve our services
Build a joined up future
• Deliver a range of engagement events and activities to focus on engaging on and communicating the strategic plans for the Trust • Through the range of events and contacts promote wellbeing

Through these objectives the Trust will develop a thriving and influential Council of Governors which is embedded in the local community, is responsive to the aspirations and concerns of the public and members, and works effectively with the Board of Directors.

2.0 The membership

Our Membership allows us to develop a closer relationship with the community we serve. It provides us with an opportunity to communicate with our members on issues of importance about our services.

We recognise that for the membership to be effective and successful, we must provide benefits and reasons for people to join us.

Our members will:

- be kept up to date with what is happening at the Trust by receiving the quarterly members' newsletter;
- be able to stand for election as a governor;
- have the opportunity to vote in the elections to the Council of Governors;
- be able to learn more about our services by attending member events, including Council of Governor meetings;
- have the opportunity to be included in consultation events on hospital and service developments – both internally for staff and externally for our patients and public;
- have the opportunity to pass on their views and suggestions to governors;
- be invited to attend the Annual Members' Meeting.

Membership is free and there is no obligation for members to get involved apart from receiving the quarterly newsletter.

2.1 Becoming a member

Our potential members can be drawn from the following:

- public, including patients who live within our membership area (**public members**)
- staff members and volunteers at the Trust (**staff members**)

An individual who satisfies the criteria for membership of the staff constituency may not become or continue as a member of the public constituency. Members can join more than one foundation Trust.

All members must be 16 years of age or over.

A person can become a member by:

- completing a membership application form, which is available on our website, by request from the membership office or from the hospital's main reception;
- joining 'online' via the Trust's website at www.wsh.nhs.uk;

- e-mailing membership. foundationtrust@wsh.nhs.uk;
- calling the membership office on 0370 707 1692.

2.2 Defining our membership

2.2.1 Public

Patients and members of the public who reside in the following areas are eligible to join our public constituency: Babergh (all wards); Braintree (selected wards); Breckland (selected wards); East Cambridgeshire (selected wards); Forest Heath (all wards); Ipswich (all wards); Kings Lynn and West Norfolk (selected wards); Mid Suffolk (all wards); South Norfolk (selected wards); St Edmundsbury (all wards); Suffolk Coastal (all wards) and Waveney (all wards).

Appendix 1 provides a detailed breakdown of eligible wards for our public constituency. Public members are recruited on an opt-in basis.

As we continue to develop and provide more services in out-of-hospital settings the Trust recognises that this may mean that services grow beyond the current boundaries of the organisation. Therefore the Trust expanded its membership area in 2016/17 and will continue to review this on an annual basis to ensure it is representative of the area served by the Trust.

2.2.2 Staff

To be eligible to be a staff member, people must either:

- be 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 have been continuously employed by the Trust under a contract of employment for at least 12 months; or

- exercise functions for the purposes of the Trust, without a contract of employment, 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.

All staff automatically become members unless they choose to opt-out of the scheme.

3.0 Recruitment of members

We wish to encourage and develop a strong sense of community involvement with the membership. Therefore, we will continue to actively recruit new members.

Our aim is to have a membership that is informed and engaged in our activities and members who feel part of our organisation.

3.1 Methods of recruitment

Our initial membership recruitment drive began as an integral part of our consultation process.

While we undertook some direct mail recruitment campaigns in the early days, more recently we have found that the most effective method of recruitment is face to face. This can be done internally within hospital or out in the community.

Methods of recruitment used in the past include:

- attending public meetings and events including festivals, stands in sports & healthy living events and recruitment fairs;
- targeted recruitment of staff members' friends and family;
- using local newspapers;
- on-line recruitment through the Trust's website;
- through a mail-shot to all households in the membership area;
- in-house , eg Courtyard Café, Friends shop and outpatients

3.2 Who is responsible for recruiting members?

The Board of Directors has overall responsibility for the membership strategy.

The Engagement Committee of the Council of Governors advises on where the Trust should focus its effort on recruitment to ensure we have a balanced membership, and it is the responsibility of all governors and the FT Office Manager to actively recruit members.

Staff and volunteers are also encouraged to recruit members; for example family members, friends or patients and members of the public visiting the Trust.

3.3 Recruitment plan

We aim to recruit new members year on year to maintain our public membership at the current numbers of engaged members. As part of the recruitment plan experience has shown that engaging with the public is a very effective way of recruiting new members and gaining their views on West Suffolk Hospital.

3.3.1 Public members

Direct recruitment plan

- active engagement and recruitment within the hospital and other healthcare environments e.g. courtyard café, out-patient clinics and healthy living centres
- membership form with out-patient appointment letters
- providing literature to staff working in out-of-hospital settings to share with service users and their families
- public education events e.g. "medicine for members"

- voluntary organisations – ensuring inclusion from ethnic and marginalised groups of people
- education facilities e.g. school talks and college events
- local non-NHS patient groups e.g. support groups
- sports organisations e.g. leisure centres, rugby and football clubs
- PALS office
- Work with partner organisations to establish best practice in membership recruitment e.g. NHS Providers and other NHS FTs.
- Encourage former staff members to become public members on leaving the Trust

Indirect recruitment plan

- website
- consider inclusion with other patient information e.g. bedside lockers for inpatient areas
- posters and leaflets in clinic and outpatient areas
- posters in GP surgeries, dentists, opticians and pharmacists

Media coverage

- membership newsletter
- local newspaper coverage e.g. the Bury Free Press and East Anglian Daily Times (EADT)
- local radio e.g. Radio Suffolk, Radio West Suffolk
- community newsletter coverage, including Parish Council and local Council information/resource guides

3.3.2 Staff

Staff are automatically members unless they choose to opt-out. New members to the Trust will receive information from HR in their induction pack explaining the benefits of membership. An individual who satisfies the criteria for membership of the staff constituency may not become or continue as a member of the public constituency.

We will seek to ensure that no more than 1% of staff opt-out of membership.

4.0 Engaging with public and members

Engagement with our members is as important as recruitment, to ensure that we have an effective and active membership.

4.1 Members' newsletter

The membership newsletter is distributed to all members.

Staff are able to access the newsletter via a link which is included in weekly staff bulletin (Green Sheet) when it is published on the website.

Hard copies are also available in key staff areas including Time Out and in patient waiting areas.

The newsletter provides an opportunity to communicate key issues and developments, including news and “dates for the diary”.

4.2 Public and Member events

It is proposed to hold regular events for the public and members. Suggestions for topics will be based on the most popular areas of interest of the members and by the views of governors. Subjects may also be chosen from topical issues, such as quality accounts.

These events will be advertised in the members’ newsletter and on the website. They will also be advertised in the weekly staff bulletin (“Green Sheet”) and by posters displayed within the Trust.

Members who have expressed an interest in a particular service or area of interest will be invited to relevant activities.

4.3 Staff involvement

Staff members will be encouraged to take part in public and member events, as it is an opportunity for departments to raise awareness of the services they provide, to highlight benefits of being treated at the Trust and to answer questions from members. It will also be a chance for us to receive valuable feedback from the public and our members.

4.4 Engagement plan

Positive engagement with our members is extremely important. The Engagement Committee of the Council of Governors have considered how we can most effectively engagement with our membership.

As described member recruitment and engagement are often most effective when undertaken together. Therefore the direct recruitment plans set out in section 3.3.1 will also in effect provide effective engagement activities. Future engagement plans with our members will also include:

- the members’ newsletter to be distributed to all members;
- regular member events with suggestions from governors of recommendations from their members for future member events e.g. “medicine for members”
- staff governors holding staff member engagement sessions
- staff governors to communicate to staff via the “Green Sheet”
- greater use of electronic communication with members
- the annual members’ meeting – this is an opportunity for members to hear more about the Trust’s achievements plus the opportunity to ask questions
- working with partner organisations to establish best practice in membership engagement e.g. NHS Providers and other NHS FTs

- using a short questionnaire to gain information on the public's expectations and/or experiences of West Suffolk Hospital; the results of which will be fed back to the Patient & Carers Experience Committee.

In addition we are developing an active campaign to engage with a range of local groups and forums. Presentations at these forums will allow governors to communicate the Trust's vision, priorities and ambitions as described in our "Together strategy" and engage with the public to gain an understanding of their views.

The Trust also has a role to play in promoting prevention and a healthy lifestyle. This will be done by working with our partners to engage with the public in promoting prevention and a healthy lifestyle.

5.0 The membership register

We maintain a register of staff and public members and this is available to the public. All members are made aware of the existence of the public register and have the right to refuse to have their details disclosed (Data Protection Act).

The public register is maintained on our behalf by Capita and contains details of the member's name and the constituency to which they belong. Eligible members of the public constituency who complete a membership application form will be added to the register of members.

The staff register is maintained by the Trust's HR department. Eligible staff will automatically be added to the register, unless they 'opt out'.

The public register is validated prior to any mailing to ensure that it remains accurate. Details of members who have moved away or died are removed from the register.

6.0 Monitoring success

The membership strategy will be monitored on behalf of the Board of Directors by the Engagement Committee of the Council of Governors.

The FT Office Manager and the Engagement Committee will also undertake a key role in leading and managing the implementation of this strategy and its future development.

An annual review of the strategy will take place by the Engagement Committee.

6.1 How will the success be measured?

The success of the strategy will be measured by the following criteria:

Criteria	Current Jan 2017	Target (Mar 2019)
1. Achievement of the recruitment target: a. Total number of Public members b. Staff opting out of membership	 **5946** **<1%**	 6000 <1%
2. Achieve a representative membership for our membership area, Priorities for action: a. Age – recruitment of under 50s b. Engagement and recruitment events in all market towns of Membership area (Thetford, Newmarket, Stowmarket, Haverhill and Sudbury)	 **1176** **20%**	 1250 100%
3. An engaged membership measured by: a. number of member events held April 2015 – March 2017 b. member attendance – total all events c. annual members' meeting attendance (each year)	 **5 (+1 cancelled)** **880** **261**	 6 600* 200

* Includes people attending Annual Members' Meeting, does not include 57 who would have attended cancelled event

A review of the membership recruitment targets will be take place each year as part of the annual plan submission to Monitor.

Appendix 1

PUBLIC CONSTITUENCY OF THE TRUST

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, Yeldham
Breckland:	Conifer, East Guiltcross, Harling and Heathlands, Mid Forest, Thetford-Abbey, Thetford-Castle, Thetford-Guildhall, Thetford-Saxon, Watton, Wayland, Weeting, West Guiltcross
East Cambridgeshire:	Bottisham, Burwell, Cheveley, Dullingham Villages, Fordham Villages, Isleham, Soham North, Soham South, 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, 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.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 3 March 2017

ITEM NO:	Item 22
PRESENTED BY:	Steve Turpie, Non-Executive Director
PREPARED BY:	Ruth Williamson, PA
DATE PREPARED:	February 2017
SUBJECT:	Audit Committee report
PURPOSE:	To approve recommendations from meeting held on 27 January 2017
STRATEGIC OBJECTIVE:	To demonstrate first class corporate, financial and clinical governance, underpinned by effective business support systems

EXECUTIVE SUMMARY:
The draft minutes of the meeting of the Audit Committee 27 January 2017 are attached. **Please note these have yet to be approved.** The key issues and actions discussed were:-

- **Deep dive review – Community Services Contract & ACO Developments**
  A presentation was received from Dawn Godbold detailing the "most capable provider process" that has been entered in to by the Trust and proposed way forward.

- **Review of Standing Orders, Standing Financial Instructions Reservations & Delegation of Powers**
  Amendments requested in respect of document, relating to reservations and delegation of powers. Following Board approval the document will be taken to TEG and cascaded via corporate briefings.

- **Internal audit progress report**
  Noted the CIP Assurance work had highlighted some issues in terms of controls and the overall opinion reflected these.

- **Charitable Funds Annual Report & Accounts**
  Noted approval of the accounts and annual report.

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): N/A	**Mitigating Actions** 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 Audit Committee

Item 22a **AUDIT COMMITTEE**

MINUTES OF THE MEETING HELD ON FRIDAY 27TH JANUARY, 2017, COMMENCING AT 14:00 IN THE COMMITTEE ROOM, WEST SUFFOLK HOSPITAL

COMMITTEE MEMBERS			**Attendance**	**Apologies**
Steve Turpie	**(ST)**	Non-Executive Director (Chair)	√	
John Benson	**(JB)**	Non-Executive Director	√	
Rosie Varley	**(RV)**	Non-Executive Director	√	
Gary Norgate	**(GN)**	Non-Executive Director	√	
Neville Hounsome	**(NH)**	Non-Executive Director	√	
IN ATTENDANCE:				
Stephen Dunn	**(SD)**	Chief Executive Officer	√	
Asam Hussain	**(AH)**	Senior Manager, RSM	√	
Dan Harris	**(DH)**	Partner, RSM	√	
Mark Kidd	**(MK)**	Counter Fraud, RSM	√	
Lisa Clampin	**(LC)**	Lead Partner, BDO		√
Liana Nicholson	**(LN)**	Manager, Public Sector, BDO	√	
Andrew Barnes	**(AB)**	Senior Manager, Public Sector, BDO	√	
Richard Jones	**(RJ)**	Head of Governance & Trust Secretary	√	
Craig Black	**(CB)**	Executive Director of Resources	√	
Roger Quince	**(RQ)**	Chairman	√	
Dr. Nick Jenkins	**(NJ)**	Medical Director		√
Jon Green	**(JG)**	Chief Operating Officer		√
Louise Wishart	**(LW)**	Assistant Director of Finance (Acting)	√	
Jan Bloomfield	**(JBI)**	Executive Director Workforce & Communications	√	
Dawn Godbold	**(DG)**	Head of Operations, Suffolk Community Health	√	
Rowan Procter	**(RP)**	Executive Chief Nurse		√
Ruth Williamson	**(RW)**	PA to Executive Directors, Medical & Resources (Minutes)	√	

Action

ST introduced Liana Nicholson, the new Audit Manager for BDO, who replaces Charlie Lovelee.

1. **Apologies**

Apologies received as detailed above.

2. **Minutes of Previous Meeting**

Minutes of the meeting held on 28th October, 2016 were approved as a true and accurate reflection of the meeting, subject to the following amendment; Page 6 second paragraph, *"Noted compensation payment regarding transfer of staff from SEPT to West Suffolk in September, 2015, in relation to the Community contract. It had been agreed that in light of issues in both organisations, ~~80% was to be paid by each side~~. WSFT would settle 80% of one issue and SEPT 20% and vice versa for the second.*

3. **Matters Arising**

Ref 180 (29.7.16) – Item 5.2 – LCFS Annual Report 2015/16

Noted Dan Harris anticipating a response in respect of the court case in April, 2017.

Ref 182 (29.7.16) – Item 7.3 – Financial Reporting – Supply Chain Risk

In respect of absolute critical services, request sent to newly appointed Head of Emergency Planning. LW to chase response. **LW**

Ref 191(28.10.16) – Item 14 – Audit Tender Process

Document circulated electronically. Matter Closed. Noted tender issued and interview of external auditors took place on 20 January, prior to approval by Council of Governors on 8 February.

The completed actions 185-190 were accepted as detailed.

4. **Board Assurance Framework – Deep Dive**

4.1 ***Deep Dive – Community Services Contract & ACO Developments***

DG advised that the initial community services contract, awarded to WSFT, together with Ipswich Hospital NHS Trust, in October 2015 is set to expire in September, 2017. As a result the Trust has now entered in to a "most capable provider" process, which was felt to be good news. The new community contract will split in to two, east and west with associated alliances, including the GP Federation, Suffolk Community Care Adult Care Service, West Suffolk NHS Foundation Trust (in the West) and Ipswich Hospital NHS Trust (in the East).

It was noted that Norfolk & Suffolk Community Health (NCHC) would not be part of the alliance, but had entered in to discussions regarding retention as a sub-contractor or finding an alternate role.

CB advised that the challenge thus far had been to ensure that both systems, i.e. east and west, were working at the same pace and level of quality. Thus far the east was struggling to keep the same momentum as the west.

There were many benefits to the new system, including removal of barriers, shared responsibility, pooled resources and joint focus. Noted pilot running across the alliance of new role - frailty co-ordinator. Reporting to a qualified nurse, occupational therapist or physio, they would be trained to conduct an holistic assessment and ascertain whether a formal assessment was required. This will be a Band 4 position. The aim of the role is to try and prevent a crisis occurring. Noted self-referrals would be accepted.

JB asked, in respect of self-referrals, how a UTI would be picked up. DG advised that part of the Frailty Co-ordinator's assessment would be to dip test urine. JB was concerned at the lack of clinical assessment and believed capacity for this needed to be built in. DG advised that where necessary, cases would be discussed via an MDT.

The Trust was now entering Stage 2, with working groups being established. Staff engagement had also commenced this week and a plan drafted for

engagement with other members of the alliance. There is a large piece of work required to determine the service delivery model, management and employment options, including separation and alignment of alliances in to east and west.

Noted the ultimate decision on the split will be made by the alliance Board and not via the CCG. RQ asked whether the commissioners had gone past the point of no return, or whether there was still scope for a legal challenge. CB advised that the only potential challenge would come from NCHC, who had not indicated at this stage that they intended to do so.

ST asked who owned the risk and what due diligence was being performed prior to commitment, both financial and operational. DG advised that this was part of the work stream and the process would involve going through each speciality/service, looking at the individual risks. CB advised that once the proposal had been crystallised the Trust would receive a clear statement of risk.

Noted matter to go before February's board. However, it was noted that this would not be the final version.

4.2 ***Reflections & Discussions***

As per item 4.1 above.

Governance & Assurance

5.1 ***Clinical Audit***

SL advised that the Trust was in the process of agreeing the National Audit Programme.

Noted the cancer audit showed a marked difference in data from that conducted in 2015. SL believed the reason related to data entry; clarification is awaited.

Issues around the stroke service audit, which is exceeding nationally every marker, except Thrombolysis. Dr. Nicolson is looking to obtain further data for checking.

ST asked if a timeline had now been agreed on the block management audit which was overdue. SL has asked for confirmation.

SL advised that the local audit database and registration form would be available from February.

JB referred to Item 5.1b (Clinical Audit Process diagram). He asked about the visibility of this to junior doctors. SL advised that Emma Instance, Clinical Audit Co-ordinator, was working with junior doctors and attending governance meetings.

ST asked for assurance on the following up of actions, with a centralised system for noting and passing on of learning. JB said in respect of career development and portfolios which clinicians were keeping, if they were able to record that their completed audits were seen at the Audit Committee or CSEC this would encourage them to feed in to governance. SL advised that this was being looked at in relation to consultant appraisals.

SD queried visibility through the organisation. Noted that national audits went

via CSEC. Whilst the local audits now had a central repository, there remained work to be done. ST stressed the need to stop doctors selecting audits that do not add any value to the organisation. SL left at 3.35.

5.2 ***Quality and Risk Sub-Committee Reports***

Minutes received for information. JB advised that at the CSEC meeting on 2nd December, 2016, the issue relating to blood transfusion had been escalated to the Board.

5.3 ***Review of Standing Orders, Standing Financial Instructions Reservations & Delegation of Powers***

Standing Orders

A constitutional review of standing orders took place at today's Board meeting and has been incorporated.

Reservations & Delegation of Powers

Final approval to be sought at Board Meeting on 3 March. Any feedback to be provided to RJ prior to this date.

ST asked if any comparisons had been made with other Trusts in this regard. RJ advised that most trusts were similar. WSFT was not an outlier, but some were more specific on budget responsibility than others.

ST asked the auditors for their observations. DH advised that he had seen elsewhere, in respect of delegated limits, the life of the contract, i.e. amounts coming in rather than just the single year's figures.

JBl advised, in respect of Page 46, Item 14, Receiving Hospitality, that she did not hold the hospitality register, it is held by Trust Office, via Georgina Holmes.

In respect of Page 45, Item 12, Reporting of Incidents to the Police, where stated in line with Trust policy, NH asked that this be more specific.

JBl asked that Page 50 – M, Staff Retirement Policy, be removed, due to a normal retirement age no longer being in existence.

Agreed RJ to make amendments as detailed above. **RJ**

Amended document to be taken to TEG, following which to be cascaded via corporate briefings. RJ to action. **RJ**

6 **Internal Audit & Counter Fraud**

6.1 ***Internal Audit Progress Report***

DH advised of the issuing of two final reports and two drafts. Implementation of agreed management actions have been followed up, with six on-going. One high priority action re. evidence on network security. This will be revisited in Quarter 4 and reported on at April's meeting. **DH**

AH advised that the CIP programme assurance had largely been focused on CIP being jointly delivered with the CCG i.e. £3.9million. At the time of the

review weaknesses in controls had been identified. The documentation around schemes that had been identified was either incomplete or did not reconcile. At the time of the review, work was needed to be done and was reflected in the overall opinion.

ST said in respect of the quality impact assessment the Trust needed to ensure it was not putting saving money ahead of patient safety. NH said the process of control was significantly lacking.

CB advised that this was a joint programme with the CCG that had not been done before or elsewhere. The programme was put in place at the end of the summer and audited in October, so whilst far from perfect, it was moving in the right direction with consistency of strategy. Working closely with the commissioners was a major part of the solution. He acknowledged that in the initial months the programme had not been resourced sufficiently.

AH advised of a positive cyber security report. CB reported that the Trust was one of a few organisations with ISO for cyber security and that had recently been re-credited.

6.2 ***LCFS Progress Report – 1 October – 31 December 2016***

MK advised that since issuing the report, the declaration on Page 2 was not final. Noted a stand to raise fraud awareness had been placed in "Time Out" in November. Further noted that the Fraud Awareness Group had been re-instigated, having met in December, with a further meeting scheduled for March.

In respect of guidance on new NHS Protect self-review kit, the assessment submission date has been amended to 31 March, 2017.

Noted Angie Manning, HR is looking at the issue of staff with periods of sickness and secondary employment and will draft a policy in this respect. It has been suggested that a yearly reminder be sent out to all staff. It was intended that this information be used by line managers in instances of regular periods of absence. ST expressed nervousness at controls that only reflect 1% of population. JBl advised that this was used mainly for health and safety reasons and was a working time directive issue.

Regarding declarations, a sample of consultants and doctors, authorised signatories and those over Band 8b had been looked at. The issue was what was being done with the information. Aim was to identify those roles most susceptible and put through the same process as for execs and non-execs. RJ to ratify process of assessment of materiality of a "gift" and action to be taken. **RJ**

RV asked if the matter of bogus emails was being addressed with staff. MK advised that this was highlighted at induction and, included in the Work Plan for next year, was a detailed session for the finance team, who were most likely to be in receipt of these.

6.3 ***Internal Audit Programme 2017/18***

ST reported that some audits had not made the plan and asked how a decision was reached on what to include. DH advised that following discussions with RJ and CB, a reduced plan had been submitted via the Exec team for review and comment. RJ stated that executives had looked at the projects, not the number of days utilised. They were not sighted on costs. CB advised that community

had been included, with a resultant extension in coverage. Noted Rowan Procter, Chief Nurse, had raised the matter of incident reviews to the Board Meeting that day, with a request to carry out an analysis of associated action plans and checking of delivery. Whilst not proposing to include at this stage, will need to discuss what can be replaced. DH suggested the possibility of including in the Never Events Review. **CB/DH**

ST stressed the need to learn from near misses and incidents. RV queried whether there was a means of triangulating information from appraisals, SIRIs etc. CB advised that this would be looked at when considering the scope of the never events review.

7 **External Audit**

7.1 Noted no reports scheduled for discussion.

8 **Financial Reporting**

8.1 ***Review of Waivers***

Noted 27 waivers authorised. LW advised of the instigation of the "no purchase order, no payment process", giving greater visibility to contracts being issued.

ST referred to the £96,000 in respect of e-Care consultancy fees and the statement that only one person/company could supply. CB advised that the individual concerned had previously been involved with the major IT implementation at Addenbrookes. They were formerly employed for a particular period, but as rolled in to GDE, the Trust was looking to repeat. RQ highlighted that this may be an HMRC issue.

8.2 ***Losses & Special Payments***

LW advised that in respect of the fridge failure in December, the Trust were awaiting January's figures to see if a continuing issue in respect of write-offs. Noted Trust excess is 20k.

ST queried whether incidents such as the missing gold necklace were reported to the police. CB advised that security would be informed and Darren Cooksey, Manager, would make a decision. Noted CB received a security management report on a monthly basis for his consideration.

9 **Reporting, Accountability, Monitoring and Review of Effectiveness**

9.1 ***Charitable Funds Annual Report & Accounts***

LW advised that the deadline for submission of the report and accounts to the Charities' Commission is Tuesday 31st January. Noted some issues remain from the audit, but these are nearing completion and the report will be updated.

LN advised that no material misstatements have been identified. However, some significant disclosure adjustments required to the financial statement to ensure that they were compliant. One large disclosure adjustment of £68,000 between accruals and trade creditors. Two audit risks noted; management override and revenue recognition. Testing on these has been completed and BDO satisfied that all is in order. In respect of management override, the journals were checked and auditors whilst satisfied they were reasonable, found

they were not appropriately authorised. A recommendation will be made in this regard.

LN advised of issues since report issued:

- Error in accruals.
- Noted through testing on expenditure, an item where VAT was paid by mistake - £2,497. This will be reclaimed. However the amount does not feature in the Accounts and therefore they are not incorrect.
- Testing of income, noted lack of some supporting documentation. However monies can be seen on the bank statement.

Unadjusted Audit Differences – one related to investment income for year that included 2 months outside the year under audit, (February and March, 2015), amounting to £2,782. Theoretically this means the accounts from last year were understated and overstated this. A factual error in accruals was identified in the sum of £1,778, a matter of expenditure being incorrectly recognised. A further error of £2,742 was identified, giving a total Charitable Funds balance overstatement by £4,520. These items are not material. Agreed Signed Letter of Representation to be sent by CB. **CB**

RQ highlighted that the report stated that all trustees gave their time freely and no trustee remuneration was paid during the year. However, the trustees were all paid (via the Trust, but not by the charity). LW to amend wording accordingly. **LW**

RJ to confirm whether any Board members, who were also a trustee of the Fund should be making a declaration of interest. **RJ**

The accounts and annual report were duly approved.

10 **Planned Agenda for Audit Committee**

The planned agenda was duly approved. JBl left at 4.35 p.m.

11 **Any Other Business**

11.1 ***Bobby Robson Auction*** - RQ queried monies spent on the Bobby Robson Auction. LW to investigate. **LW**

12 **Reflections on Meeting**

No reflections were noted.

13 **Date of Future Meetings**

2.00 p.m. – 4.30 p.m. – Committee Room

28 April 2017
26 May 2017 (8.30 am for 30 minutes)
28 July 2017
3 November 2017

14 ***Auditors Departed at 4.35 p.m.***

15 **Update on External Audit Tender Process**

ST advised that following the tender process, it had been agreed to retain the services of BDO. Whilst the more expensive, it was not by a large margin and the number of days supplied was greater. Noted decision yet to be communicated.

ST advised that BDO would be looking to include an element of "added value" in to their contract.

The Meeting closed at 4.45 p.m.

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 3 March 2017

AGENDA ITEM:	Item 22b
PRESENTED BY:	Craig Black, Director of Resources Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance Louise Wishart, Assistant Director of Finance (Acting)
DATE PREPARED:	24 February 2017
SUBJECT:	Review of Standing orders, standing financial instructions and scheme of reservation and delegation
PURPOSE:	Approval

EXECUTIVE SUMMARY:

At the Audit Committee meeting in October approval was given to extend the existing Standing orders, standing financial instructions and scheme of reservation and delegation to February 2017. The three elements were separated into three distinct documents to support maintenance and communication and subject to further review by the Audit Committee in January 2017.

The standing orders were subject to review and approval by the Board in January as part of the constitution review following comments from Audit Committee members.

The documents have been updated to reflect structures, responsibilities and procedures. The delegated authorities have also been updated to clarify the level of delegation based on both annual and life of contract valuation (previously on life of contract wa considered). When considering the delegated matters determined by the 'annual value' or 'life of contract' which drives the most senior decision must be used. The 'annual value' should be based on the average value for the contract life. An example is set out below for 'Expenditure including pay' *[extract page 39]*:

Annual value	Life of contract
• £0 - £10,000	£0 - £40,000
• £10,001 - £50,000	£40,001 - £200,000
• £50,001 - £100,000	£200,001 - £400,000
• £100,001 – £250,000	£400,001 - £1m
• £250,001 +	£1m +

As agreed at the January meeting the terms of reference for the Quality & Risk Committee will be subject to review in April. Any amendments will be incorporated into these documents as part of the Board review and approval.

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)	Audit Committee 28 October 2016 and 27 January 2017 Executive Directors

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:	
Recommendation: To approve the updated standing financial instructions and scheme of reservation and delegation documents.	

West Suffolk NHS
NHS Foundation Trust

Item 22bi

Trust Policy and Procedure **Document Ref. No: PP(14)222**

Reservation and delegation of powers and standing financial instructions

For use in:	All areas of the Trust
For use by:	All Trust staff
For use for:	Financial Governance matters
Document owner:	Assistant Director of Finance
Status:	Draft

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1. INTRODUCTION

1.1 Interpretation and definitions

1.1.1 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.

1.1.2 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.

1.1.3 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.

1.1.4 **the 2012 Act** is the Health and Social Care Act 2012.

1.1.5 **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.

1.1.6 **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.

1.1.7 **Annual Members Meeting** is defined in paragraph 9 of the constitution.

1.1.8 **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.

1.1.9 **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.

1.1.10 **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.

1.1.11 **Chief Executive** means the accounting officer of the trust.

1.1.12 **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.

1.1.13 **Council of Governors** means the elected and appointed Governors of the trust collectively as a body, as constituted in accordance with the Constitution.

1.1.14 **Constitution** means this constitution and all annexes to it.

1.1.15 **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.

1.1.16 **Director** means a Member of the Board.

1.1.17 **Executive Director** means a Member of the Board who holds an executive office of the trust.

1.1.18 **Finance Director** means the Chief Financial Officer of the trust.

1.1.19 **Governor** means a person who is a member of the Council of Governors.

1.1.20 **Licence** issued by Monitor the Licence sets out a range of conditions that the Trust must meet.

1.1.21 **Member** means any person registered as a member of the trust, and authorised to vote in elections to select Governors.

1.1.22 **Monitor** is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act. They are now part of NHS Improvement.

1.1.23 **Motion** means a formal proposition to be discussed and voted on during the course of a meeting.

1.1.24 **Non Executive Director** means a member of the Board of Directors who is not an Executive Director of the trust.

1.1.25 **Officer** means employee of the trust or any other person holding a paid appointment or office with the trust.

1.1.26 **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 NHS Improvement.

1.1.27 **SFIs** means Standing Financial Instructions.

1.1.28 **SOs** mean Standing Orders.

1.1.29 **Voluntary Organisation** is a body, other than a public or local authority, the activities of which are not carried on for profit.

1.2 General

1.2.1 These Standing Financial Instructions (SFIs) are issued in accordance with the Trust (Functions) Directions 2000 issued by the Secretary of State which require that each Trust shall agree Standing Financial Instructions for the regulation of the

conduct of its members and officers in relation to all financial matters with which they are concerned. They shall have effect as if incorporated in the Standing Orders (SOs).

1.2.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They also act to protect individuals against accusations of impropriety, fraud or failure to ensure value for money. They should be used in conjunction with the Schedule of Decisions Reserved to the Board and the Scheme of Delegation adopted by the Trust.

1.2.3 These Standing Financial Instructions identify the financial responsibilities which apply to everyone working for the Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Finance Director.

1.2.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Finance Director or their nominated representative must be sought before acting. The user of these Standing Financial Instructions should also be familiar with and comply with the provisions of the Trust's Standing Orders.

1.2.5 **The failure to comply with Standing Financial Instructions and Standing Orders can in certain circumstances be regarded as a disciplinary matter that could result in dismissal.**

1.2.6 **Overriding Standing Financial Instructions** – If for any reason these Standing Financial Instructions 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 Audit Committee for referring action or ratification. All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.3 Responsibilities and delegation

1.3.1 The Trust Board

The Board exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

(e) Approval of monitoring information received by the Board.

1.3.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the '"Scheme of Reservation and Delegation – decisions reserved to the Board" document. All other powers have been delegated to such other committees as the Trust has established.

1.3.4 **The Chief Executive and Finance Director**

The Chief Executive and Finance Director will, as far as possible, delegate their detailed responsibilities, but they remain accountable for financial control.

Within the Standing Financial Instructions, it is acknowledged that the Chief Executive is ultimately accountable to the Board, and as Accountable Officer, to the Secretary of State, for ensuring that the Board meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Trust's activities; is responsible to the Chairman and the Board for ensuring that its financial obligations and targets are met and has overall responsibility for the Trust's system of internal control.

1.3.5 It is a duty of the Chief Executive to ensure that Members of the Board, employees and all new appointees are notified of these instructions in way they can understand their responsibilities within these Instructions.

1.3.6 **The Finance Director**

The Finance Director is responsible for:

(a) implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;

and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Finance Director include:

(d) the provision of financial advice to other members of the Board and employees;

(e) the design, implementation and supervision of systems of internal financial control;

(f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

1.3.7 **Board Members and Employees**

All members of the Board and employees, severally and collectively, are responsible for:

(a) the security of the property of the Trust;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources;

(d) conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.8 **Contractors and their employees**

Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.9 For all members of the Board and any employees who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and employees discharge their duties must be to the satisfaction of the Finance Director.

2. AUDIT

2.1 Audit Committee

2.1.1 In accordance with Standing Orders, the Board shall formally establish an Audit Committee, with clearly defined terms of reference and following relevant guidance which will support the Board in advising on key risks and provide an independent and objective view of internal control. The Committee shall:

(a) Lead the assessment of the annual Governance Statement for the Board.
(b) Not have any executive responsibilities or be charged with making or endorsing any decision.

(c) Review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

(d) Ensure that there is an effective internal audit function established by management, which meets mandatory NHS Internal Audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Trust Board.

(e) Ensure that there is an effective counter fraud function established by management that meets the Standards set out by the NHS Counter Fraud and Security Management Service and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

(e) Review the work and findings of the External Auditor appointed by the Audit Commission and consider the implications and management's responses to their work

(f) Review the Annual Report and Financial Statements of the Trust and its Charitable funds before submission to the Board, to determine their completeness, objectivity integrity and accuracy.

(g) Review proposed changes to Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board for approval by the Board. To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

(h) Review the Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board on a two yearly basis for approval by the Board.

2.1.2 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chairman of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the Department of Health.

2.1.3 It is the responsibility of the Finance Director to ensure an adequate Internal Audit service is provided and the Audit Committee shall be involved in the selection process when an Internal Audit service provider is changed.

2.1.4 The Board shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

2.2 Finance Director

2.2.1 The Finance Director is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function;

(b) ensuring that the Internal Audit is adequate and meets the NHS mandatory audit standards;

(c) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption;

(d) ensuring that an annual internal audit report is prepared for the consideration of the Audit Committee. The report must cover:

(i) a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health including for example compliance with control criteria and standards;
(ii) major internal financial control weaknesses discovered;
(iii) progress on the implementation of internal audit recommendations;
(iv) progress against plan over the previous year;
(v) strategic audit plan covering the coming three years;
(vi) a detailed plan for the coming year.

2.2.2 The Finance Director or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or members of the Board or employee of the Trust;

(c) the production of any cash, stores or other property of the Trust under a member of the Board and an employee's control; and

(d) explanations concerning any matter under investigation.

2.3 Role of Internal Audit

2.3.1 Internal audit should fulfil its terms of reference by systematic review and evaluation of risk management, control and governance which comprises the policies, procedures and operations in place to:

(a) establish, and monitor the achievement of, the organisation's objectives;

(b) identify, assess and manage the risks to achieving the organisation's objectives;

(c) ensure the economical, effective and efficient use of resources;

(d) ensure compliance with established policies (including behavioural and ethical expectations), procedures, laws and regulations;

(e) safeguard the organisation's assets and interests from losses of all kinds, including those arising from fraud, irregularity or corruption;

(f) ensure the integrity and reliability of information, accounts and data, including internal and external reporting and accountability processes.

2.3.2 Internal audit should devote particular attention to any aspects of the risk management, control and governance affected by material changes to the organisation's risk environment.

2.3.3 Internal Audit shall also independently verify the Assurance Statements in accordance with guidance from the Department of Health

2.3.4 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Finance Director must be notified immediately.

2.3.5 The Head of Internal Audit will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the Chairman and Chief Executive of the Trust.

2.3.6 The Head of Internal Audit shall be accountable to the Finance Director. The reporting system for internal audit shall be agreed between the Finance Director, the Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards. The reporting system shall be reviewed at least every three years. Where, in exceptional circumstances, the use of normal reporting channels could be seen as a possible limitation on the objectivity of the audit, the Head of Internal Audit shall have access to report to the Chief Executive, Chairman or any non-executive Director of the Trust.

2.3.7 If the Head of Internal Audit or the Audit Committee consider that the level of audit resources or the terms of reference in any way limit the scope of internal audit, or prejudice the ability of internal audit to deliver a service consistent with the definition of internal auditing, they should advise the Board accordingly.

2.4 External Audit

2.4.1 The External Auditor is appointed by the Council of Governors and paid for by the Trust. The Audit Committee must ensure a cost-efficient service. If there are any problems relating to the service provided by the External Auditor, then this should be raised with the External Auditor and referred on to the Council of Governors if the issue cannot be resolved.

2.4.2 External audit responsibilities (in compliance with the requirements of the Independent Regulator) are:

(a) To be satisfied that the accounts comply with the directions provided, i.e. that the accounts comply with the Annual Reporting Manual issued by NHS Improvement
(b) To be satisfied that the accounts comply with the requirements of all other provisions, contained in, or having effect under, any enactment which is applicable to the accounts
(c) To be satisfied that proper practices have been observed in compiling the accounts
(d) To be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources

(e) To comply with any directions given by the Department of Health as to the standards, procedures and techniques to be adopted, i.e. to comply with the Audit Code
(f) to consider the issue of public interest report
(g) to certify the completion of the audit
(h) to express an opinion on the accounts
(i) to refer the matter to the Independent Regulator if the Trust, or any officer or director of the Trust, makes or are about to make decisions involving potentially unlawful action likely to cause a loss or deficiency.

2.4.3 External auditors will ensure that there is a minimum of duplication of effort between themselves and other agencies. The auditors will discharge this responsibility by:

(a) reviewing the statement made by the Chief Executive in the Annual Governance Statement and making a negative statement within the audit opinion if the Annual Governance Statement is not consistent with their knowledge of the Trust
(b) reviewing the results of the work of relevant assurers, for example the Healthcare Commission and Internal Audit, to determine if the results of the work have an impact on their responsibilities.
(c) Undertaking any other work that they feel necessary to discharge their responsibilities.

2.5 Fraud and Corruption

2.5.1 In line with their responsibilities, the Trust Chief Executive and Finance Director shall monitor and ensure compliance with Directions issued by the Secretary of State for Health on fraud and corruption.

2.5.2 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Department of Health Fraud and Corruption Manual and guidance.

2.5.3 The Local Counter Fraud Specialist shall report to the Trust Finance Director and shall work with staff in the Counter Fraud and Security Management Services (CFSMS) and the Regional Counter Fraud and Security Management Services (CFSMS) in accordance with the Department of Health Fraud and Corruption Manual.

2.5.4 The Local Counter Fraud Specialist will provide a written report, at least annually, on counter fraud work within the Trust.

2.5.5 The Bribery Act 2010, which repeals existing corruption legislation, has introduced the offences of offering and or receiving a bribe. It also places specific responsibility on organisations to have in place sufficient and adequate procedures to prevent bribery and corruption taking place. Under the Act, Bribery is defined as “Inducement for an action which is illegal unethical or a breach of trust. Inducements can take the form of gifts loans, fees rewards or other privileges". Corruption is broadly defined as the offering or the acceptance of inducements, gifts or favours payments or benefit in kind which may influence the improper action of any person; corruption does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using

their position to give some advantage to another. To demonstrate the organisation has sufficient and adequate procedures in place and to demonstrate openness and transparency all staff are required to comply with the requirements of Standing Financial Instructions and Standing Orders policy. For a more detailed explanation see the Anti Bribery Policy. Should members of staff wish to report any concerns or allegations they should contact their Local Counter Fraud Specialist.'

2.5.6 The NHS Fraud and Corruption Reporting Line (FCRL) is a freephone number 0800 028 40 60. The FCRL is a simple means of reporting genuine suspicions of NHS fraud. It allows NHS staff who are unsure of internal reporting procedures, or who wish to speak with complete confidentiality, to report their concerns. All calls are dealt with by experienced, trained staff. Callers may remain anonymous if they wish.

2.5.7. Any employee discovering or suspecting a loss of any kind must immediately inform their head of department, who must immediately inform the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies, which may indicate fraud, or corruption, the Director of Finance must inform the Local Counter Fraud Specialist (LCFS) in accordance with Secretary of State Directions.

2.6 Security Management

2.6.1 In line with their responsibilities, the Trust Chief Executive will monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

2.6.3 The Trust shall nominate a Non-Executive Director to be responsible to the Board for NHS security management through representation on Risk Management Executive Committee.

2.6.4 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Security Management Director (SMD) and the appointed Local Security Management Specialist (LSMS).

3. ALLOCATIONS, PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

3.1 Preparation and Approval of Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board a Plan which takes into account financial targets and forecast limits of available resources. The Business Plan will contain:

(a) a statement of the significant assumptions on which the plan is based;

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

3.1.2 Prior to the start of the financial year the Finance Director will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in any planning guidance issued from the Department of Health and relevant regulatory bodies;

(b) accord with workload and manpower plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds or be clear about the funding strategies for any planned deficit; and

(e) identify potential risks.

3.1.3 The Finance Director shall monitor financial performance against budget and plan, periodically review them, and report to the Board.

3.1.4 All budget holders must provide information as required by the Finance Director to enable budgets to be compiled.

3.1.5 Budget holders at an appropriate level will sign up to their allocated budgets at the commencement of each financial year.

3.1.6 The Finance Director has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget;
(b) the purpose(s) of each budget heading;
(c) individual and group responsibilities;
(d) authority to exercise virement;
(e) achievement of planned levels of service;
(f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board without prior authority.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Finance Director.

3.3 Budgetary Control and Reporting

3.3.1 The Finance Director will devise and maintain systems of budgetary control. These will include:

(a) monthly financial reports to the Board in a form approved by the Board containing:

(i) income and expenditure to date showing trends and forecast year-end position;

(ii) summary cash flow and forecast year-end position;

(iii) summary balance sheet;

(iv) movements in working capital;

(v) Movements in cash and capital;

(vi) capital project spend and projected outturn against plan;

(vii) explanations of any material variances from plan;

(viii) details of any corrective action where necessary and the Chief Executive's and/or Finance Director's view of whether such actions are sufficient to correct the situation;

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

(c) investigation and reporting of variances from financial, workload and manpower budgets;

(d) monitoring of management action to correct variances; and

(e) arrangements for the authorisation of budget transfers.

3.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(c) no permanent employees are appointed without the approval of the Chief Executive, or those he has delegated authority to, other than those provided for within the available resources and manpower establishment as approved by the Board.

3.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Trust Plan and a balanced budget over time.

3.4 Capital Expenditure

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in SFI 14).

3.5 Monitoring Returns

3.5.1 The Chief Executive is responsible for ensuring that the returns are submitted to DH and regulatory bodies as required.

4. ANNUAL ACCOUNTS AND REPORTS

4.1 The Finance Director, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by relevant regulatory bodies, the Trust's accounting policies, and other relevant accounting requirements;

(b) prepare and submit annual financial reports to relevant regulatory body certified in accordance with current guidelines;

(c) submit financial returns to the relevant regulatory body for each financial year in accordance with the timetable prescribed.

4.2 The Trust's annual accounts must be audited by an auditor appointed by the Trust's Council of Governors. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

4.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the relevant guidance and timetable.

5. BANK AND GBS ACCOUNTS

5.1 General

5.1.1 The Finance Director is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health. In line with 'Cash Management in the NHS' Trusts should minimize the use of commercial bank accounts and consider using Government Banking Service (GBS) accounts for all banking services.

5.1.2 The Board shall approve the banking arrangements.

5.2 Bank and GBS Accounts

5.2.1 The Finance Director is responsible for:

(a) bank accounts and Government Banking Service (GBS) accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) ensuring payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made;

(d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

(e) monitoring compliance with guidance from DH and the relevant regulatory body on the level of cleared funds.

5.3 Banking Procedures

5.3.1 The Finance Director will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated;

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts.

5.3.2 The Finance Director must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.4 Tendering and Review

5.4.1 The Finance Director will regularly consider the need to retain commercial bankding arrangements in addition to the GBS account. Where there is a need to maintain commercial banking arrangements, they will be reviewed at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's commercial banking business.

5.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board. This review is not necessary for GBS accounts.

6. INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income Systems

6.1.1 The Finance Director is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Finance Director is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall follow the Department of Health and other relevant regulatory guidance in setting prices for NHS and non NHS contracts

6.2.2 The Finance Director is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the guidance in the Department of Health's Commercial Sponsorship – Ethical standards in the NHS shall be followed.

6.2.3 All employees must inform the Finance Director promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt Recovery

6.3.1 The Finance Director is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Income not received should be dealt with in accordance with losses procedures.

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 Security of Cash, Cheques and other Negotiable Instruments

6.4.1 The Finance Director is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
(b) ordering and securely controlling any such stationery;
(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines;
(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques or IOUs.

6.4.3 All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Finance Director.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

7. TENDERING AND CONTRACTING PROCEDURE

7.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

7.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union (EU) promulgated by the Department of Health (DH) prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions. Following any changes to membership of the EU any replacement regulations will apply in the same way.

7.3 Reverse eAuctions

The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. For further guidance on Reverse eAuctions refer to www.ogc.gov.uk

7.4 Capital Investment Manual and other Department of Health Guidance

The Trust shall comply as far as is practicable with the requirements of the Department of Health "Capital Investment Manual" and “Health Building Note 00-08 Strategic Framework for the Efficient Management of Healthcare Estates and Facilities” in respect of capital investment and estate and property transactions. In the case of management consultancy contracts the Trust shall comply as far as is practicable with Department of Health guidance "The Procurement and Management of Consultants within the NHS".

7.5 Formal Competitive Tendering

7.5.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;

- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);

- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals.

7.5.2 **Health Care Services**

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 8 and No. 9.

7.5.3 **Exceptions and instances where formal tendering need not be applied**

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income for the contract period does not, or is not reasonably expected to, exceed **£75,000**;

(b) where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with;

(c) regarding disposals as set out in Standing Financial Instructions No. 16;

Formal tendering procedures **may be waived** in the following circumstances:

(d) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(e) where the requirement is covered by an existing contract;

(f) where PASA agreements are in place and have been approved by the Board;

(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(i) where specialist expertise is required and is available from only one source;

(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Finance Director will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

(m) where allowed and provided for in the Capital Investment Manual.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Audit Committee at each meeting.

7.5.4 Fair and Adequate Competition

Where the exceptions set out in SFI Nos. 17.1 and 17.5.3 apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than two firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

7.5.5 List of Approved Firms

The Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists. Where in the opinion of the Finance Director it is desirable to seek tenders from firms not on the approved lists, the reason shall be recorded in writing to the Chief Executive (see SFI 17.6.8 List of Approved Firms).

7.5.6 Building and Engineering Construction Works

Competitive Tendering cannot be waived for building and engineering construction works and maintenance (other than in accordance with Concode) without Departmental of Health approval.

7.5.7 **Items which subsequently breach thresholds after original approval**

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record. Such cases should be reported to the Audit Committee at the earliest opportunity.

7.6 Contracting/Tendering Procedure

7.6.1 Invitation to tender

(i) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(ii) All invitations to tender shall state that no tender will be accepted unless:

(a) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(b) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(iii) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(iv) Every tender for building or engineering works (except for maintenance work, when Estmancode guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health guidance and, in minor respects, to cover special features of individual projects.

7.6.2 Receipt and safe custody of tenders

The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

7.6.3 **Opening tenders and Register of tenders**

(i) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive and not from the originating department.

(ii) A member of the Trust Board will be required to be one of the two approved persons present for the opening of tenders estimated above £75,000. The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

(iii) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(iv) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Finance Director or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(v) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The Trust's Company Secretary will count as a Director for the purposes of opening tenders.

(vi) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(vii) A register shall be maintained by the Chief Executive, or a person authorised by him, to show for each set of competitive tender invitations despatched:

- the name of all firms individuals invited;
- the names of firms individuals from which tenders have been received;
- the date the tenders were opened;
- the persons present at the opening;
- the price shown on each tender;
- a note where price alterations have been made on the tender.

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(viii) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be

dealt with in the same way as late tenders. (Standing Order No. 17.6.5 below).

7.6.4 **Admissibility**

i) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(ii) Where only one tender is sought and/or received, the Chief Executive and Finance Director shall, as far practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.6.5 **Late tenders**

(i) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(ii) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

(iii) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

7.6.6 **Acceptance of formal tenders (See overlap with SFI No. 7.7)**

(i) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(ii) The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record.

It is accepted that for professional services such as management consultancy, the lowest price does not always represent the best value for money. Other factors affecting the success of a project include:

(a) experience and qualifications of team members;

(b) understanding of client's needs;

(c) feasibility and credibility of proposed approach;

(d) ability to complete the project on time.

Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(iii) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(iv) The use of these procedures must demonstrate that the award of the contract was:

(a) not in excess of the going market rate / price current at the time the contract was awarded;

(b) that best value for money was achieved.

(v) All tenders should be treated as confidential and should be retained for inspection.

7.6.7 **Tender reports to the Trust Board**

Reports to the Trust Board will be made on an exceptional circumstance basis only.

7.6.8 **List of approved firms (see SFI No. 7.5.5)**

(a) **Responsibility for maintaining list**

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

(b) **Building and Engineering Construction Works**

(i) Invitations to tender shall be made only to firms included on the approved list of tenderers compiled in accordance with this Instruction or on the separate maintenance lists compiled in accordance with Estmancode guidance (Health Notice HN(78)147).

ii) Firms included on the approved list of tenderers shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equal Pay Act 1970, the Sex Discrimination Act 1975, the Race Relations Act 1976, and the Disabled Persons (Employment) Act 1944 and any amending and/or related legislation.

iii) Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and/or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. Firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

(c) **Financial Standing and Technical Competence of Contractors**

The Finance Director may make or institute any enquiries he deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical / medical competence.

7.6.9 **Exceptions to using approved contractors**

If in the opinion of the Chief Executive and the Finance Director or the Director with lead responsibility for clinical governance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

7.7 Quotations: Competitive and non-competitive

7.7.1 **General Position on quotations**

Written quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income exceeds, or is reasonably expected to exceed £10,000 but not exceed £75,000.

7.7.2 **Competitive Quotations**

(i) Quotations should be obtained from at least three firms/individuals based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(ii) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(iii) All quotations should be treated as confidential and should be retained for inspection.

(iv) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

7.7.3 **Non-Competitive Quotations**

Non-competitive quotations in writing may be obtained in the following circumstances:

(i) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(ii) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(iii) miscellaneous services, supplies and disposals;

(iv) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (i) and (ii) of this SFI) apply.

7.7.4 **Quotations to be within Financial Limits**

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Finance Director.

7.8 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by the following staff to the value of the contract as follows:

Designated budget holders	up to	£75,000
Finance Director	up to	£100,000
Chief Executive and Finance Director	up to	£250,000
Trust Board	over	£250,000

These levels of authorisation may be varied or changed and need to be read in conjunction with the Trust Board's Scheme of Delegation.

In accordance with the Quotation procedures tenders are not required under £75,000.

At the time of approval may delegate the responsibility for signing of orders / requisitions to the Chief Executive and the Finance Director.

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

7.9 Instances where formal competitive tendering or competitive quotation is not required

Where competitive tendering or a competitive quotation is not required the Trust should adopt one of the following alternatives:

(a) the Trust shall use NHS Supply Chain for procurement of all goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use NHS Supply Chain - where tenders or quotations are not required, because expenditure is below £10,000, the Trust shall procure goods and services in accordance with procurement procedures approved by the Finance Director.

7.10 Private Finance for capital procurement (see overlap with SFI No. 24)

The Trust must assess the most competitive funding source for capital projects. This may include borrowing from DH (or delegated departments), borrowing commercially or PFI/ PPP schemes.The selection of the most competitive funding sources will be from a combination of business case shortlisting and competitive tendering.When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and for PFI/ PPP genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Department of Health for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.11 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Standing Orders and Standing Financial Instructions;

(b) EU Directives and other statutory provisions including any replacement regulations after leaving the EU;

(c) any relevant directions including the Capital Investment Manual, Health Building Note 00-08 Strategic Framework for the Efficient Management of Healthcare Estates and Facilities and guidance on the Procurement and Management of Consultants;

(d) such of the NHS Standard Contract Conditions as are applicable.

(e) contracts with Foundation Trusts must be in a form compliant with appropriate NHS guidance.

(f) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(g) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

7.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.13 Healthcare Services Agreements (see overlap with SFI No. 18)

Service agreements with NHS providers for the supply of healthcare services shall be drawn up in accordance with the NHS and Community Care Act 1990 and administered by the Trust. Service agreements are not contracts in law and therefore not enforceable by the courts. However, a contract with a Foundation Trust, being a PBC, is a legal document and is enforceable in law.

7.14 Disposals (See overlap with SFI No. 26)

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

(e) land or buildings concerning which DH guidance has been issued but subject to compliance with such guidance.

7.15 In-house Services

7.15.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering.

7.15.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Finance Director representative. For services having a likely annual expenditure exceeding £250,000, a non-Executive Director should be a member of the evaluation team.

7.15.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

7.15.4 The evaluation team shall make recommendations to the Board.

7.15.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

7.16 Applicability of SFIs on Tendering and Contracting to funds held in trust (see overlap with SFI No. 29)

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private resources.

8. NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES (see overlap with SFI No. 7.13)

8.1 Service Level Agreements (SLAs)

8.1.1 The Chief Executive, as the Accountable Officer, is responsible for ensuring the Trust enters into suitable Service Level Agreements (SLA) with service commissioners for the provision of NHS services.

All SLAs should aim to implement the agreed priorities contained within any planning guidance and priorities issued by the Department of Health and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

- the standards of service quality expected;
- the relevant national service framework (if any);
- the provision of reliable information on cost and volume of services;
- the NHS Outcomes Framework;
- that SLAs build where appropriate on existing Joint Investment Plans;
- that SLAs are based on integrated care pathways.

8.2 Involving Partners and jointly managing risk

A good SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and the commissioning of the service required. The SLA will apportion responsibility for handling a particular risk to the party or parties in the best position to influence the event and financial arrangements should reflect this. In this way the Trust can jointly manage risk with all interested parties.

8.3 Reports to Board on SLAs

The Chief Executive, as the Accountable Officer, will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA, including information on costing arrangements.

9. COMMISSIONING

Not applicable to NHS Foundation Trusts.

10. TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE TRUST BOARD AND EXECUTIVE COMMITTEE AND EMPLOYEES

10.1 Remuneration and Terms of Service (see overlap with SO No. 4)

10.1.1 In accordance with Standing Orders the Board shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See NHS guidance contained in the Higgs report.)

10.1.2 The Committee will:

(a) advise the Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors employed by the Trust and other senior employees including:

(i) all aspects of salary (including any performance-related elements/bonuses);

(ii) provisions for other benefits, including pensions and cars;

(iii) arrangements for termination of employment and other contractual terms;

(b) make such recommendations to the Board on the remuneration and terms of service of Executive Directors of the Board (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

(c) monitor and evaluate the performance of individual Executive Directors (and other senior employees);

(d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

10.1.3 The Committee shall report in writing to the Board the basis for its recommendations. The Board shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of Executive Directors. Minutes of the Board's meetings should record such decisions.

10.1.4 The Board will consider and need to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

10.1.5 The Trust will pay allowances to the Chairman and non-Executive Directors of the Board in accordance with instructions issued by the Secretary of State for Health.

10.2 Funded Establishment

10.2.1 The manpower plans incorporated within the annual budget will form the funded establishment.

10.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or those with the delegated authority.

10.3 Staff Appointments

10.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration:

(a) unless authorised to do so by the Chief Executive or those with the delegated authority;

(b) within the limit of their approved budget and funded establishment.

10.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service etc. for employees.

10.4 Processing Payroll

10.4.1 The Finance Director is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications;

(b) the final determination of pay and allowances;

(c) making payment on agreed dates;

(d) agreeing method of payment.

10.4.2 The Finance Director will issue instructions regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(I) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

10.4.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records, and other notifications in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Finance Director's instructions and in the form prescribed by the Finance Director;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Finance Director must be informed immediately.

10.4.4 Regardless of the arrangements for providing the payroll service, the Finance Director shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

10.5 Contracts of Employment

10.5.1 The Board shall delegate responsibility to an officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

10.6 Consultant staff appointments

10.6.1 All new and replacement Consultant Staff require the approval of the Trust Executive Group

11. NON-PAY EXPENDITURE

11.1 Delegation of Authority

11.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

11.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

11.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

11.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 17)

11.2.1 **Requisitioning**

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Finance Director (and/or the Chief Executive) shall be consulted.

11.2.2 System of Payment and Payment Verification

The Finance Director shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance. Methods of payment can include use of commercial bank accounts, Government banking Services accounts, Government Procurement cards and Trust authorised credit cards.

11.2.3 The Finance Director will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(i) A list of Board employees (including specimens of their signatures) authorised to certify invoices.

(ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

- the account is arithmetically correct;

- the account is in order for payment.

(iii) A timetable and system for submission to the Finance Director of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(iv) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

(e) be responsible for ensuring that payment for goods and services is only made once the goods and services are received. The only exceptions are set out in SFI No. 21.2.4 below.

11.2.4 **Prepayments**

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to NPV using the National Loans Fund (NLF) rate plus 2%).

(b) The appropriate officer must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

(c) The Finance Director will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

(c) (d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

(d) Where the industry norm requires payment in advance such that it is impossible to negotiate alternative terms e.g. software licences and maintenance contracts.

11.2.5 Official orders

Official Orders must be raised in advance on the Trust procurement system and:

(a) be consecutively numbered;

(b) be in a form approved by the Finance Director;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

11.2.6 **Duties of Managers and Officers**

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Finance Director and that:

(a) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Finance Director in advance of any commitment being made;

(b) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement or relevant legislation after leaving the EU;

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health;

(d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

(i) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

(ii) conventional hospitality, such as lunches in the course of working visits;

(This provision needs to be read in conjunction with Standing Order No. 6, the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff" and the principles set out in the Bribery Act 2010);

(e) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Finance Director on behalf of the Chief Executive;

(f) all goods, services, or works are ordered on an official order except works and services executed in accordance with a contract and purchases from petty cash;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) changes to the list of employees and officers authorised to certify invoices are notified to the Finance Director;

(k) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Finance Director;

(l) petty cash records are maintained in a form as determined by the Finance Director.

11.2.7 The Chief Executive and Finance Director shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and Health Building Note 00-08 Strategic Framework for the Efficient Management of Healthcare Estates and Facilities. The technical audit of these contracts shall be the responsibility of the relevant Director.

11.3 Joint Finance Arrangements with Local Authorities and Voluntary Bodies (see overlap with Standing Order No. 9.1)

11.3.1 Payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act **shall** comply with procedures laid down by the Finance Director which shall be in accordance with these Acts. (See overlap with Standing Order No. 9.1)

12. EXTERNAL BORROWING

12.1.1 The Finance Director will advise the Board concerning the Trust's ability to pay dividend on, and repay Public Dividend Capital and any proposed new borrowing, within the limits set by the Department of Health. The Finance Director is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

12.1.2 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must include the Chief Executive and the Finance Director.

12.1.3 The Finance Director must prepare detailed procedural instructions concerning applications for loans and overdrafts.

12.1.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position, represent good value for money, and comply with the latest guidance from the Department of Health.

12.1.5 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Finance Director. The Board must be made aware of all short term borrowings at the next Board meeting.

12.1.6 All long-term borrowing must be consistent with the plans outlined in the current Business Plan and be approved by the Trust Board.

12.2 INVESTMENTS

12.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and authorised by the Board.

12.2.2 The Finance Director is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

12.2.3 The Finance Director will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12.3 LEASES

12.3.1 Only the Finance Director or their nominated manager has the authority to authorise a lease in the Trust's name.

13. FINANCIAL FRAMEWORK

13.3.1 The Finance Director should ensure that members of the Board are aware of the Financial Framework. This document contains directions which the Trust must follow. It also contains directions to Strategic Health Authorities regarding resource and capital allocation and funding to Trust's. The Finance Director should also

ensure that the direction and guidance in the framework is followed by the Trust.

14. CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

14.1 Capital Investment

14.1.1 The Chief Executive:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost;

(c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including PDC.

14.1.2 For every capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case (in line with the guidance contained within the *Capital Investment Manual*) is produced setting out:

(i) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(ii) the involvement of appropriate Trust personnel and external agencies;

(ii) appropriate project management and control arrangements;

(b) that the Finance Director has certified professionally to the costs and revenue consequences detailed in the business case.

14.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of “Health Building Note 00-08 Strategic Framework for the Efficient Management of Healthcare Estates and Facilities”.

14.1.4 The Finance Director shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

14.1.5 The Finance Director shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

14.1.6 The approval of a capital programme shall not constitute approval for expenditure on any scheme.

The Chief Executive shall issue to the manager responsible for any scheme:

(a) specific authority to commit expenditure;

(b) authority to proceed to tender (see overlap with SFI No. 17.6);

(c) approval to accept a successful tender (see overlap with SFI No. 17.6).

The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Health Building Note 00-08 Strategic Framework for the Efficient Management of Healthcare Estates and Facilities" guidance and the Trust's Standing Orders.

14.1.7 The Finance Director shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the delegated limits for capital schemes included in Annex C of HSC (1999) 246.

14.3 Asset Registers

14.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Finance Director concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

14.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the *Capital Investment Manual* as issued by the Department of Health.

14.3.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

14.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

14.3.5 The Finance Director shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

14.3.6 The value of each asset shall be indexed to current values in accordance with methods specified in the *Capital Investment Manual* issued by the Department of Health.

14.3.7 The value of each asset shall be depreciated using methods and rates as specified in the *Capital Investment Manual* issued by the Department of Health.

14.3.8 The Finance Director of the Trust shall calculate and pay capital charges as specified in the *Capital Investment Manual* issued by the Department of Health.

14.4 Security of Assets

14.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

14.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Finance Director. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

14.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Finance Director.

14.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of Board members and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

14.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

14.4.6 Where practical, assets should be marked as Trust property.

15. STORES AND RECEIPT OF GOODS

15.1 General position

15.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum;

(b) subjected to annual stock take;

(c) valued at the lower of cost and net realisable value.

15.2 Control of Stores, Stocktaking, condemnations and disposal

15.2.1 Subject to the responsibility of the Finance Director for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Finance Director. The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of any fuel oil and coal of a designated estates manager.

15.2.2 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as health service property.

15.2.3 The Finance Director shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

15.2.4 Stocktaking arrangements shall be agreed with the Finance Director and there shall be a physical check covering all items in store at least once a year.

15.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Finance Director.

15.2.6 The designated Manager/Pharmaceutical Officer shall be responsible for a system approved by the Finance Director for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Finance Director any evidence of significant overstocking and of any negligence or malpractice (see also overlap with SFI No. 25 Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

15.3 Goods supplied by NHS Supply Chain

15.3.1 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Finance Director who shall satisfy himself that the goods have been received before accepting the recharge.

16. DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

16.1 Disposals and Condemnations

16.1.1 Procedures

The Finance Director must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

16.1.2 When it is decided to dispose of a Trust asset, the Head of Department or authorised deputy will determine and advise the Finance Director of the estimated market value of the item, taking account of professional advice where appropriate.

16.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Finance Director;

(b) recorded by the Condemning Officer in a form approved by the Finance Director which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Finance Director.

16.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Finance Director who will take the appropriate action.

16.2 Losses and Special Payments

16.2.1 Procedures

The Finance Director must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

16.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Finance Director or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Finance Director and/or Chief Executive. Where a criminal offence is suspected, the Finance Director must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Finance Director must inform the relevant LCFS and CFSMS regional team in accordance with Secretary of State for Health's Directions.

The Finance Director must notify the Counter Fraud and Security Management Services (CFSMS) and the External Auditor of all frauds.

16.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Finance Director must immediately notify:

(a) the Board,

(b) the External Auditor.

16.2.4 Within limits delegated to it by the Department of Health, the Board shall approve the writing-off of losses.

16.2.5 The Finance Director shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

16.2.6 For any loss, the Finance Director should consider whether any insurance claim can be made.

15.2.7 The Finance Director shall maintain a Losses and Special Payments Register in which write-off action is recorded.

16.2.8 No special payments exceeding delegated limits shall be made without the prior approval of the Department of Health.

16.2.9 All losses and special payments must be reported to the Audit Committee at every meeting.

17. INFORMATION TECHNOLOGY – FINANCIAL DATA

17.1 Responsibilities and duties of the Finance Director

17.1.1 The Finance Director, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which the Director is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as the Director may consider necessary are being carried out.

17.1.2 The Finance Director shall need to ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

17.1.3 The Finance Director shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Publication Scheme approved by the information Commissioner. A Publication Scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information about our Trust that we make publicly available.

17.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

17.2.1 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Trust's in the Region wish to sponsor jointly) all responsible directors and employees will send to the Finance Director:

(a) details of the outline design of the system;

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

17.3 Contracts for Computer Services with other health bodies or outside agencies

The Finance Director shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

Where another health organisation or any other agency provides a computer service for financial applications, the Finance Director shall periodically seek assurances that adequate controls are in operation.

17.4 Risk Assessment

The Finance Director shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

17.5 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Finance Director shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Finance Director staff have access to such data;

(d) such computer audit reviews as are considered necessary are being carried out.

18. PATIENTS' PROPERTY

18.1 The Trust has a responsibility to provide safe custody for money and other personalproperty (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

18.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets; ***(notices are subject to sensitivity guidance)***
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

18.3 The Finance Director must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

18.4 Where Department of Health instructions require the opening of separate accounts for patients' moneys, these shall be opened and operated under arrangements agreed by the Finance Director.

18.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

18.6 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

18.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

19. FUNDS HELD ON TRUST

19.1 Corporate Trustee

(1) Standing Order No. 2.8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust, along with SFI 4.9.3 that defines the need for compliance with Charities Commission latest guidance and best practice.

(2) The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

The Finance Director shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

19.2 Accountability to Charity Commission and Secretary of State for Health

(1) The trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

(2) The Scheme of Reservation and Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

19.3 Applicability of Standing Financial Instructions to funds held on Trust

(1) In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust. (See overlap with SFI No 17.16).

(2) The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

20. ACCEPTANCE OF GIFTS BY STAFF AND LINK TO STANDARDS OF BUSINESS CONDUCT (see overlap with SO No. 6 and SFI No. 21.2.6 (d))

The Finance Director shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the Department of Health circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' and is also deemed to be an integral part of these Standing Orders and Standing Financial Instructions (see overlap with SO No. 6).

21. PAYMENTS TO INDEPENDENT CONTRACTORS

Not applicable to NHS Foundation Trusts.

22. RETENTION OF RECORDS

22.1 The Chief Executive shall be responsible for maintaining archives for all records required to be retained in accordance with Department of Health guidelines.

22.2 The records held in archives shall be capable of retrieval by authorised persons.

22.3 Records held in accordance with latest Department of Health guidance shall only be destroyed at the express instigation of the Chief Executive. Detail shall be maintained of records so destroyed.

23. RISK MANAGEMENT AND INSURANCE

23.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Department of Health assurance framework requirements, which must be approved and monitored by the Board.

The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

f) a clear indication of which risks shall be insured;

g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to make the Annual Governance Statement- within the Annual Report and Accounts as required by current Department of Health guidance.

23.2 Insurance: Risk Pooling Schemes administered by NHSLA

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority or self insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

23.3 Insurance arrangements with commercial insurers

23.3.1 There is a general prohibition on entering into insurance arrangements with commercial insurers. There are, however, **three exceptions** when Trust's may enter into insurance arrangements with commercial insurers. The exceptions are:

(1) Trust's may enter commercial arrangements for **insuring motor vehicles** owned by the Trust including insuring third party liability arising from their use;

(2) where the Trust is involved with a consortium in a **Private Finance Initiative contract** and the other consortium members require that commercial insurance arrangements are entered into; and

(3) where **income generation activities** take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from the Litigation Authority. In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Finance Director should consult the Department of Health.

23.4 Arrangements to be followed by the Board in agreeing Insurance cover

(1) Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Finance Director shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Finance Director shall ensure that documented procedures cover these arrangements.

(2) Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for one or other of the risks covered by the schemes, the Finance Director shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Finance Director will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

(3) All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Finance Director should ensure documented procedures also cover the management of claims and payments below the deductible in each case.

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Additional Information:	

West Suffolk NHS
NHS Foundation Trust

Item 22bii

Trust Policy and Procedure **Document Ref. No: PP(14)222**

Scheme of reservation and delegation of powers

For use in:	All areas of the Trust
For use by:	All Trust staff
For use for:	Financial Governance matters
Document owner:	Assistant Director of Finance
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Contents **Page**

1. Interpretation and definitions

1.1 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.

1.2 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.

1.3 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa.

1.4 **the 2006 Act** is the National Health Service Act 2006.

1.5 **the 2012 Act** is the Health and Social Care Act 2012.

1.6 **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.

1.7 **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.

1.8 **Annual Members Meeting** is defined in paragraph 9 of the constitution.

1.9 **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.

1.10 **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.

1.11 **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.

1.12 **Chief Executive** means the accounting officer of the trust.

1.13 **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.

1.14 **Council of Governors** means the elected and appointed Governors of the trust collectively as a body, as constituted in accordance with the Constitution.

1.15 **Constitution** means this constitution and all annexes to it.

1.16 **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.

1.17 **Director** means a Member of the Board.

1.18 **Executive Director** means a Member of the Board who holds an executive office of the trust.

1.19 **Finance Director** means the Chief Financial Officer of the trust.

1.20 **Governor** means a person who is a member of the Council of Governors.

1.21 **Licence** issued by Monitor the Licence sets out a range of conditions that the Trust must meet.

1.22 **Member** means any person registered as a member of the trust, and authorised to vote in elections to select Governors.

1.23 **Monitor** is the body corporate known as Monitor, as provided by Section 61 of the 2012 Act.

1.24 **Motion** means a formal proposition to be discussed and voted on during the course of a meeting.

1.25 **Non Executive Director** means a member of the Board of Directors who is not an Executive Director of the trust.

1.26 **Officer** means employee of the trust or any other person holding a paid appointment or office with the trust.

1.27 **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.

1.28 **SFIs** means Standing Financial Instructions.

1.29 **SOs** mean Standing Orders.

1.30 **Voluntary Organisation** is a body, other than a public or local authority, the activities of which are not carried on for profit.

2. Introduction

2.1 Under the Standing Order relating to the Arrangements for the Exercise of Functions by Delegation (Standing Order 5) the Trust is given powers to:

> 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. [SO para 5.1]

2.2 Furthermore The Code of Accountability for NHS Board of Directors requires the Board of Directors to draw up a schedule of decisions reserved to itself and to ensure that management arrangements are in place to enable the clear delegation of its other responsibilities. This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation including financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those which have

been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

2.3 All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board of Directors Committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

(a) Role of the Chief Executive

The Chief Executive shall exercise all powers of the Trust, which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee, on behalf of the Board of Directors. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he shall perform personally and which functions have been delegated to other Directors and Officers.

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise. As Accounting Officer the Chief Executive is accountable to Monitor for the funds entrusted to the Trust.

(b) Caution over the use of delegated powers

Powers are delegated to Directors and Officers on the understanding that they would not exercise delegated powers in a matter, which in their judgment was likely to be a cause for public concern.

(c) Directors' ability to delegate their own delegated powers

The Scheme of Delegation shows only the "top level" of delegation within the Trust. The Scheme is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

(d) Absence of directors or officers to whom powers have been delegated

In the absence of a Director or Officer to whom powers have been delegated that Director or Officer's superior shall exercise those powers unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent powers delegated to him / her may be exercised by the nominated Deputy Chief Executive. If the Director of Finance is absent powers delegated to him / her may be exercised by the Deputy Director of Finance.

3. Scheme of reservation and delegation

A. Decisions reserved to the Board

Ref.	The Board	Decisions reserved to the Board
NA	BOARD OF DIRECTORS	**General Enabling Provision** The Board of Directors may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers. The Board's role is to provide active leadership of the Trust within a framework of prudent and effective controls which enables risk to be effectively managed. Board member share corporate responsibility for all decisions of the Board
NA	BOARD OF DIRECTORS	***Regulations and Control*** 1. Approve Standing Orders (SOs), a schedule of matters reserved to the Board of Directors and Standing Financial Instructions (SFIs) for the regulation of its proceedings and business. 2. Suspend Standing Orders. 3. Vary or amend the Standing Orders. 4. Ratify any urgent decisions taken by the Chairman and Chief Executive in accordance with SO 5.2 5. Approve a scheme of delegation of powers from the Board to committees**.** 6. Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration. 7. Require and receive the declaration of officers' interests that may conflict with those of the Trust. 8. Approve arrangements for dealing with complaints. 9. Adopt the organisation structures, processes and procedures to facilitate the discharge of business by the Trust and to agree modifications thereto. 10. Receive reports from committees including those that the Trust is required by the Secretary of State or other regulation to establish and to take appropriate action on. 11. Confirm the recommendations of the Trust's committees where the committees do not have executive powers. 12. Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

Ref.	The Board	Decisions reserved to the Board
		13. Establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board. 14. Approve arrangements relating to the discharge of the Trust's responsibilities as a bailer for patients' property. 15. Authorise and monitor use of the seal in line with SOs/SFIs. 16. Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention in accordance with SO 5.6. 17. Discipline members of the Board or employees who are in breach of statutory requirements or SOs in accordance with the Trust's disciplinary procedures.
NA	BOARD OF DIRECTORS	**Appointments/ Dismissal** 1. Nomination of the Deputy Chairman of the Board of Directors for ratification by the Council of Governors. 2. Appoint the Senior Independent Director following consultation with the Council of Governors. 3. Appoint and dismiss committees (and individual members) that are directly accountable to the Board. 4. Appoint, appraise, discipline and dismiss Executive Directors.. 5. Confirm appointment of members of any committee of the Trust as representatives on outside bodies. 6. Appoint, appraise, discipline and dismiss the Secretary (if the appointment of a Secretary is required under Standing Orders). 7. Approve proposals of the Remuneration Committee regarding directors and senior employees and those of the Chief Executive for staff not covered by the Remuneration Committee.
NA	BOARD OF DIRECTORS	***Strategy, Plans and Budgets*** 1. Define the strategic aims and objectives of the Trust. 2. Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Department of Health and directions from the Independent Regulator.. 3. Approve the Trust's policies and procedures for the management of risk. 4. Approve Outline and Final Business Cases for Capital Investment. 5. Approve the Trust's annual budget. Including submission of financial plans to Monitor 6. Approve the Trust's capital programme 7. Approve annually Trust's operational plan. 8. Ratify proposals for acquisition, disposal or change of use of land and/or buildings.

Ref.	The Board	Decisions reserved to the Board
		9. Approve PFI proposals. 10. Approve the opening of bank accounts. 11. Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £1,000,000 over the period of the contract. 12. Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation to the Chief Executive and Finance Director (for losses and special payments) previously approved by the Board. 13. Approve proposals for action on litigation against or on behalf of the Trust. 14. Review use of NHSLA risk pooling schemes (LPST/CNST/RPST). 15. Approve procedures for the declaration of hospitality and sponsorship
	BOARD OF DIRECTORS	**Policy Determination** 1. Approve management policies including personnel policies incorporating the arrangements for the appointment, removal and remuneration of staff. Policies so adopted shall be listed and published by the Director of Human Resources and Communications.
	BOARD OF DIRECTORS	**Audit** 1. Receive of the annual audit letter received from the external auditor and agreement of proposed action, taking account of the advice, where appropriate, of the Audit Committee. 2. Receive an annual report from the Audit Committee and agree action on recommendations where appropriate of the Audit Committee.
NA	BOARD OF DIRECTORS	**Annual Reports and Accounts** 1. Receipt and approval of the Trust's Annual Report and Annual Accounts. 2. Receipt and approval of the Annual Report and Accounts for funds held on trust. 3.
NA	BOARD OF DIRECTORS	**Monitoring** 1. Receive of such reports as the Board sees fit from committees in respect of their exercise of powers delegated. 2. Continuous appraisal of the affairs of the Trust by means of the provision to the Board as the Board may require from directors, committees, and officers of the Trust as set out in management policy statements. 3. Receive reports from the Director of Finance on financial performance against budget. 4. Receive reports from Director of Finance on actual and forecast income. 5. .

B. Decisions/duties delegated by the Board to committees

Ref.	Committee	Decisions/duties delegated by the Board to committees
SO 4 and SFI 2.1.1	AUDIT COMMITTEE	The Committee will: 1 <u>Governance and Assurance</u> 1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Audit Committee will look to the Quality & Risk Committee for assurance on items of clinical quality and corporate risk, including: health & safety, research and information governance. In particular, the Committee shall independently monitor and review: 1.1.1 the Annual Governance Statement (AGS) and the assurance system for all other external disclosure statements such as declarations of compliance with the Care Quality Commission registration, and any formal announcements relating to the Trust's financial performance, together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors. 1.1.2 the effectiveness of systems of internal financial and budgetary control and the integrity of reporting statements. 1.1.3 the effectiveness of systems for ensuring the optimum collection of income. 1.1.4 the effectiveness of risk management systems 1.1.5 the effectiveness of the Board Assurance Framework (BAF). 1.1.6 The Committee will use a programme of 'deep dive' reviews to test the BAF and its priority areas as part of an assurance programme 1.1.7 the Quality Report assurance and review alongside the annual report and accounts. 1.1.8 the systems for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements, including the NHS Constitution, as set out in relevant guidance. 1.1.9 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect previously the Counter Fraud and Security Management Service.

Ref.	Committee	Decisions/duties delegated by the Board to committees
		1.1.10 arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. 1.2 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. 1.2.1 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it. 1.2.2 The Committee will receive the minutes of the Quality & Risk Committee for the purpose of ensuring: that there is no duplication of effort between the two Committees; that no area of assurance is missed and; as part of its responsibility for reviewing the Annual Governance Statement prior to submission to the Board of Directors. 1.2.3 The Audit Committee shall ensure that there is a system for reviewing the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organisation. These will include, but will not be limited to, Monitor, any reviews by DH Arms length bodies or regulators/inspectors (CQC, NHSLA etc) and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies etc.) 1.2.4 In addition the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality & Risk Committee, its subcommittees and any other quality, risk, governance and assurance committees that are established. 1.2.5 In reviewing the work of the Quality & Risk Committee and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that the Quality & Risk Committee gains from the clinical audit function. *1.2.6* The Audit Committee will receive assurance on the arrangements for clinical audit within the Trust, including the process by which clinical audits are selected and agreed actions implemented.

Ref.	Committee	Decisions/duties delegated by the Board to committees
		2 <u>Internal Audit</u> The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standard and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Board of Directors. This will be achieved by: 2.1 considering the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal. 2.1.1 the review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework. consideration of the major findings of internal audit investigations, the effectiveness of the management's response and ensuring co-ordination between the Internal and External Auditors to optimise audit resources. The will include exception reports of management action beyond deadline and consideration of the findings of Internal Audit "testing" of completed actions. 2.1.2 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust. 2.1.3 assessing the quality of internal audit work on an annual basis. 3 <u>Counter Fraud</u> The Committee shall ensure that there is an effective counter fraud function established by management that meets the Standards set out by NHS Protect and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by: 3.1 consideration of the provision of the Counter Fraud service, the cost of the audit and any questions of resignation and dismissal. 3.1.1 consideration of the major findings of counter fraud work (and management's response). 3.1.2 ensuring that the Counter Fraud function is adequately resourced and has appropriate standing within the organisation. 3.1.3 receiving an annual review of the work undertaken by the counter fraud function.

Ref.	Committee	Decisions/duties delegated by the Board to committees
		4 External Audit The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work. 4.1 Consideration of the appointment, performance and cost effectiveness of the External Auditor, making a recommendation to the Council of Governors on appointment of External Audit. 4.2 To ensure that the External Auditor remains independent in its relationship and dealings with the Trust and to review the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements; 4.2.1 To review the annual audit plan and to discuss with the External Auditor, before the audit commences, the nature and scope of the audit. 4.2.2 As part of the audit plan, discuss with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee 4.2.3 To review External Audit reports, including value for money reports and management letters, together with the management response. 4.2.4 To consider where the external auditors might profitably undertake investigative and advisory work. 4.2.5 To develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and 4.2.6 To assess the quality of external audit work on an annual basis. 5 Financial Reporting 5.1 The Audit Committee shall review the Annual Report and Financial Statements of the Trust and its Charitable funds before submission to the Board, to determine their completeness, objectivity integrity and accuracy. This review will cover but is not limited to: • the wording in the Annual Governance Statement (AGS) and other disclosures relevant to the

Ref.	Committee	Decisions/duties delegated by the Board to committees
		Terms of Reference of the Committee; • changes in, and compliance with, accounting policies and practices; • explanation of estimates and provisions having material effect; • unadjusted mis-statements in the financial statements; • major judgemental areas; • the schedule of losses and special payments; and • significant adjustments resulting from the audit. 6 <u>Key Trust Documents</u> 6.1 Review proposed changes to Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board for approval by the Board of Directors. 6.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension. 6.3 To review the Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board on a two yearly basis for approval by the Board of Directors. 7 <u>Other</u> 7.1 Review compliance with Standing Orders and Standing Financial Instructions through a schedule of waivers 7.2 Review schedules of losses and compensations 7.3 Monitor the process to ensure that Supply Chain Risk is identified and appropriate actions have been taken.
SO 4 and SFI 10.1.2	REMUNERATION AND TERMS OF SERVICE COMMITTEE	The Committee will: 1. Advise the Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees including: a) All aspects of salary (including any performance-related elements/bonuses) b) Provisions for other benefits, including pensions and cars c) Arrangements for termination of employment and other contractual terms 2. Make recommendations to the Board on the remuneration and terms of service of executive directors and

Ref.	Committee	Decisions/duties delegated by the Board to committees
		senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff 3. Scrutinise the proper calculation of termination payments taking account of such national guidance as is appropriate advise on and oversee appropriate contractual arrangements for such staff 4. Monitor and evaluate the performance of individual executive directors (and as agreed by the Board other senior employees) including: a) Establish the objectives of the chief executive and review the performance of the chief executive against these objectives b) Scrutinise the objectives of the executive directors (to be established by the chief executive) and review performance reports on the executive directors prepared by the chief executive 5. Scrutinise the recommendations of the Clinical Excellence Awards Committee 6. Review the Terms of Reference of the Committee two-yearly 7. Report the frequency of meetings and the members of the Remuneration Committee in the Trust's Annual Report of the Trust. 8. The Committee shall report in writing to the Board the basis for its recommendations.
SO 4	QUALITY & RISK COMMITTEE	The Committee will: **1. General** The Quality & Risk Committee shall: 1.1 Monitor and review the Trust's quality performance indicators relating to clinical effectiveness, patient safety, including infection control and review feedback to the Trust on the experience, including patient and staff surveys and complaints. This will include organisational and directorate performance reports for quality and risk 1.2 Monitor and review the risk, control and governance processes delegated to the committee by the Board 1.3 Annually review and approve the Trust's quality and risk improvement plans to support their delivery 1.4 Review and approve annually the work plans of the reporting committees, monitor their activities and consider issues escalated by them and to receive an annual report from them on their performance and outcomes 1.5 Monitor and review directorate quality on a quarterly basis. This will include quality walkabouts and other feedback.

Ref.	Committee	Decisions/duties delegated by the Board to committees
		1.6 To consider risks escalated by the directorates and its subcommittees. The Committee will escalate risks, it determines as appropriate, directly to the Board. **2. Quality** 2.1 To advise the Board of Directors on the Trust's quality framework, including the appropriate quality and safety performance indicators for inclusion in the Trust's Quality Accounts 2.2 Review and monitor: • Compliance with CQC registration standards • the Trust's CQC Intelligence Monitoring and other quality intelligence • Any other relevant performance indicators relating to clinical effectiveness, patient safety and experience as the committee may from time to time agree. **3. Clinical Safety & Effectiveness** 3.1 Agree an annual work plan with and receive an annual report from the Clinical Safety & Effectiveness Committee 3.2 Review and monitor: • The activities of the Clinical Safety & Effectiveness Committee, including progress against the Trust's patient safety priorities and Serious Incidents Requiring Investigation (SIRIs) reported and actions being taken • The outcomes of clinical area reviews and the actions being taken (this includes patient safety walkabouts and the planned programme of structured reviews) • Key patient safety indicators 3.3 Promote learning and sharing, both from within and outside of the Trust. **4. Patient Experience** 4.1 Agree an annual work plan with and receive an annual report from the Patient Experience Committee 4.2 Review and monitor: • The activities of the Patient Experience Committee • The outcomes of Patient-Led Assessments of the Care Environment (PLACE) reports and the actions being taken

Ref.	Committee	Decisions/duties delegated by the Board to committees
		• Key patient experience indicators • Serious complaints received, any recurring themes from all complaints and actions being taken • Patient and staff survey results and actions being taken. **5. Corporate Risk** 5.1 Agree an annual work plan with and receive an annual report from the Corporate Risk Committee 5.2 Review and monitor: • The activities of the Corporate Risk Committee • Key corporate risk indicators • Any serious breaches of health and safety where an enforcement notice has or may have resulted and actions being taken. 6. **Other key activities** 6.1 Promote learning and sharing for all areas of activity, both from within and outside of the Trust 6.2 To review the adequacy of systems to ensure that the Trust meets, and where possible exceeds relevant statutory and regulatory obligations including the duty of quality set out in the NHS Act 2006 6.3 To monitor and make recommendations on the adequacy and effectiveness of any aspects of the Trust's performance as the Board may request 6.4 To oversee Trust's registration with the Care Quality Commission and its ongoing compliance 6.5 To oversee the process for the Trust acting on reports received from external accreditation bodies, where applicable consider any main findings arising from them and management actions being taken 6.6 To address any serious and sustained failure to meet minimum standards where this cannot be resolved through line management or professional self-regulation 6.7 To contribute to the Trust's Annual Governance Statement (AGS) and Internal Audit programme.
SO 4 and SFI 19	CHARITABLE FUNDS COMMITTEE	The Committee has the following duties: **1 Investment** 1.1 Consider any changes in investment strategy and policy, making recommendations to the Board of Directors.

Ref.	Committee	Decisions/duties delegated by the Board to committees
		1.2 Review performance of current investments in respect of both income and capital appreciation. **2 Fundraising** 2.1 The Committee will determine the strategy and policies for fundraising. 2.2 Review the fundraising methods used and ensure that they are acceptable in terms of a health / public body context. 2.3 To monitor the fundraising performance 2.4 To ensure that there are procedures in place to co-ordinate the fundraising activities of the Trust 2.5 To consider whether the Trust should undertake major fundraising appeals and establish the appropriate framework to ensure that any appeal is properly managed. **3 Expenditure** 3.1 To agree the expenditure strategy and policies of the Funds within the framework of the Governing Document which defines the purposes for which the charity has been established. 3.2 To monitor compliance with the strategy and policies and ensure that the wishes of the donors are met. 3.3 To consider and as appropriate approve Charitable Fund bids in accordance with the relevant procedures. **4 Reporting** 4.1 To determine the format of the performance information it requires in managing the Charitable Fund in the most effective manner. This will include information on fundraising, expenditure and investment. **5 Audit and Accounts** 5.1 To receive and consider the Charitable Funds Annual Report and Accounts prior to submission to the Audit Committee. 5.2 To receive and consider any Internal and External Audit Reports on Charitable Funds and monitor any action being taken to address matters of concern raised. 5.3 To consider any other return required by the Charity Commission or other statutory body. 5.4 To ensure that sound financial control is exercised, assets are safeguarded from fraud, that all income due to the Charity is received and that no breaches of relevant legal and other regulations occur.

Ref.	Committee	Decisions/duties delegated by the Board to committees
		6 Other 6.1 To develop formal links with outside voluntary organisations, such as the League of Friends, to ensure a co-ordinated approach. 6.2 To maintain a strong link to the Trust's Capital Investment Team through the presence of the Chief Operating Officer.
SO 4	SCRUTINY COMMITTEE	The Committee has the following duties: 1. To recommend to the Board of Directors projects and developments to be considered for inclusion in the Committee's work programme. The Committee's work programme will be determined through an annual review, taking into account the annual review of the operational and strategic plans, and supported by ongoing review of the meeting agendas of the Committee and the Board of Directors. 2. To report to the Board any new projects or developments proposed for inclusion in the work programme during the year. 3. To ensure project management structures and processes are in place to ensure effective scrutiny of the projects within the Committee's work programme. 4. To review committee's work programme as a standing agenda item at each meeting and report this to the Board. 5. To receive, review and recommend business cases when appropriate to the Board of Directors. All business cases of a level to require a Strategic Outline Cases (SOCs) will be considered by the Committee prior to presentation to the Board. 6. To secure the necessary Executive support to ensure the work programme is delivered and to: (a) Approve the scope of the projects and oversee their implementation (b) Approve the managers who will manage the project on its behalf and define their roles and responsibilities (c) Approve the project documentation

Ref.	Committee	Decisions/duties delegated by the Board to committees
		(d) Approve the reporting arrangements, structure and frequency (e) Approve the sequence and timescale of the work (f) Identify resource implications to the Board of Directors (g) Agree any changes to a project's scope (h) Initiate action to address any matters which are beyond the authority of other managers to resolve (i) Agree any arrangements for evaluation (j) Officially close the projects from the work programme 7. For all significant projects, and in line with its own Financial Instructions, Department of Health and NHS Improvement guidance as appropriate, the Committee will ensure that, if required, a third party is engaged to undertake a process of due diligence prior to any agreement on the transfer of services. This includes having an independent: (a) Assessment of the underlying financial position of services that WSFT may look to develop and/or take on; (b) Analysis and comment upon the assets and liabilities to be assumed; (c) Identification of internal control weaknesses including observations on systems and personnel; (d) Identification of transitional issues and potential assistance with post-transaction integration issues; (e) Identification of areas of risk (and opportunity) that may require specific protection (through warranties and indemnities) in any necessary agreements with other organisations.

C. Scheme of delegation derived from the NHS foundation trust accounting officer memorandum (April 2015)

REF	DELEGATED TO	DUTIES DELEGATED
7	CHIEF EXECUTIVE	The accounting officer has responsibility for the overall organisation, management and staffing of the NHS foundation trust and for its procedures in financial and other matters. The accounting officer must ensure that: • there is a high standard of financial management in the NHS foundation trust as a whole • the NHS foundation trust delivers efficient and economical conduct of its business and safeguards financial propriety and regularity throughout the organisation • financial considerations are fully taken into account in decisions by the NHS foundation trust.
8	CHIEF EXECUTIVE	The essence of the Accounting Officer's role is a personal responsibility for: • the propriety and regularity of the public finances for which he or she is answerable • the keeping of proper accounts • prudent and economical administration in line with the principles set out in Managing public money *[www.gov.uk/government/publications/managing-public-money]* • the avoidance of waste and extravagance • the efficient and effective use of all the resources in their charge.
9	CHIEF EXECUTIVE	Must • personally sign the accounts and, in doing, so accept personal responsibility for ensuring their proper form and content as prescribed by Monitor in accordance with the Act • comply with the financial requirements of the NHS provider licence • ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts (so that they disclose with reasonably accuracy, at any time, the financial position of the NHS foundation trust) • ensure that the resources for which you are responsible as accounting officer are properly and well managed and safeguarded, with independent and effective checks of cash balances in the hands of any official

REF	DELEGATED TO	DUTIES DELEGATED
		• ensure that assets for which you are responsible such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate • ensure that any protected property (or interest in) is not disposed of without the consent of Monitor • ensure that conflicts of interest are avoided, whether in the proceedings of the board of directors, or council of governors or in the actions or advice of the NHS foundation trust's staff, including yourself • ensure that, in the consideration of policy proposals relating to the expenditure for which you are responsible as accounting officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and brought to the attention of the board of directors.
10	CHIEF EXECUTIVE	Ensure that managers at all levels: • have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives • are assigned well-defined responsibilities for making the best use of resources (both those consumed by their own commands and any made available to organisations or individuals outside the NHS foundation trust), including a critical scrutiny of output and value for money • have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.
11	CHIEF EXECUTIVE	Accounting officers must make sure that their arrangements for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for internal audit should accord with the objectives, standards and practices set out in the Public Sector Internal Audit Standards.
12	CHIEF EXECUTIVE	An accounting officer has particular responsibility to see that appropriate advice is tendered to the board of directors and the council of governors on all matters of financial propriety and regularity and, more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. Accounting officers will need to determine how and in what terms

REF	DELEGATED TO	DUTIES DELEGATED
		such advice should be tendered, and whether in a particular case to make specific reference to their own duty as accounting officer to justify, to the Public Accounts Committee (PAC), transactions for which they are accountable.
13	CHIEF EXECUTIVE	The board of directors and the council of governors of an NHS foundation trust should act in accordance with the requirements of propriety or regularity. If the board of directors, council of governors or the chairman is contemplating a course of action involving a transaction which you as accounting officer consider would infringe these requirements, however, you should set out in writing your objection to the proposal and the reasons for this objection. If the board of directors, council of governors or chairman decides to proceed, you should seek a written instruction to take the action in question. You should also inform Monitor of the position, if possible before the decision is taken or in any event before the decision is implemented, so that Monitor, if it considers it appropriate, can intervene in accordance with its responsibilities under the Act. If the outcome is that you are overruled, the instruction must be complied with, but your objection and the instruction itself should be communicated without undue delay to the NHS foundation trust's external auditors and to Monitor. Provided that this procedure has been followed, the PAC can be expected to recognise that the accounting officer bears no personal responsibility for the transaction.
14	CHIEF EXECUTIVE	If a course of action is contemplated which raises an issue not of formal propriety or regularity but relating to your wider responsibilities for economy, efficiency and effectiveness, it is your duty to draw the relevant factors to the attention of the board of directors and the council of governors and to advise them in whatever way you deem appropriate. If your advice is overruled, and the proposal is one which as accounting officer you would not feel able to defend to the PAC as representing value for money, you should seek a written instruction before proceeding. Monitor should be informed of such an instruction, if possible, before the decision is implemented. It will then be for Monitor to consider the matter, and decide whether or not to intervene.
15	CHIEF EXECUTIVE	If, because of the extreme urgency of the situation, there is no time to submit advice in writing in either of the eventualities referred to in paragraphs 13 and 14 before the decision is taken, you must ensure that, if the advice is overruled, both the advice and the instructions are recorded in writing immediately afterwards.

REF	DELEGATED TO	DUTIES DELEGATED
17	CHIEF EXECUTIVE	The Comptroller and Auditor General (C&AG) may, under the National Audit Act 1983, carry out examinations into the economy, efficiency and effectiveness with which the NHS foundation trust has used its resources in discharging its functions. An accounting officer may expect to be called upon to appear before the PAC from time to time to give evidence on the reports arising from these examinations or reports following the annual certification audit, and to answer the PAC's questions concerning expenditure and receipts for which he or she is accounting officer. An accounting officer may be supported by one or two other senior officials, who may, if necessary, assist in giving evidence.
21	CHIEF EXECUTIVE	An accounting officer should ensure that he or she is generally available for consultation, and that in any temporary period of unavailability due to illness or other cause, or during the normal period of annual leave, there will be a senior officer in the NHS foundation trust who can act on his or her behalf if required.
22	BOARD OF DIRECTORS	If it becomes clear to the board of directors that an accounting officer is so incapacitated that he or she will be unable to discharge these responsibilities over a period of four weeks or more, the board of directors should appoint an acting accounting officer, usually the director of finance, pending the accounting officer's return. The same applies if, exceptionally, the accounting officer plans an absence of more than four weeks during which he or she cannot be contacted.

D. Scheme of delegation from standing orders (SOs)

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
1.1	CHAIRMAN	Final authority in interpretation of Standing Orders (SOs).
2.2	BOARD OF GOVERNORS	Appointment of Deputy Chairman
2.3	BOARD OF DIRECTORS	Appointment of Senior Independent Director
2.4	CHAIRMAN & CHIEF EXECUTIVE	Appointment of Deputy Chief Executive
3.1	CHAIRMAN	Call meetings.
3.9	CHAIRMAN	Chair all Board meetings and associated responsibilities.
3.10	CHAIRMAN	Give final ruling in questions of order, relevancy and regularity of meetings.
3.12	CHAIRMAN	Having a second or casting vote
3.13	BOARD OF DIRECTORS	Suspension of Standing Orders
3.13	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board)
3.14	BOARD OF DIRECTORS	Variation or amendment of Standing Orders (approval for incorporation into the Trust's constitution includes the Council of Governors)
4.1 – 4.7	BOARD OF DIRECTORS	Formal delegation of powers to sub committees or joint committees and approval of their constitution and terms of reference. (Constitution and terms of reference of sub committees may be approved by the Chief Executive.)
5.2	CHAIRMAN & CHIEF EXECUTIVE	The powers which the Board has retained to itself within these Standing Orders may in emergency be exercised by the Chair and Chief Executive after having consulted at least two Non-Executive

SO REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		members.
5.3	BOARD OF DIRECTORS	The Board shall agree from time to time to the delegation of executive powers to be exercised by other committees, or subcommittees
5.4	CHIEF EXECUTIVE	The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
5.6	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
7.1	BOARD OF DIRECTORS	Declare relevant and material interests.
7.2	CHIEF EXECUTIVE	Maintain Register(s) of Interests.
7.4	ALL STAFF	Comply with national guidance contained in HSG 1993/5 “Standards of Business Conduct for NHS Staff”. Including provisions of Bribery Act 2010.
7.4	ALL	Disclose relationship between self and candidate for staff appointment. CEO to report the disclosure to the Board.
8.1/8.3	CHIEF EXECUTIVE	Keep seal in safe place and maintain a register of sealing.
8.4	CHIEF EXECUTIVE/EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

E. Scheme of delegation from standing financial instructions (SFIs)

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.1.3	FINANCE DIRECTOR	Approval of all financial procedures.
10.1.4	FINANCE DIRECTOR	Advice on interpretation or application of SFIs and all written financial procedures..
10.1.6	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Have a duty to disclose any non-compliance with these Standing Financial Instructions to the Finance Director as soon as possible. Finance Director to report to the Audit Committee.
10.2.4	CHIEF EXECUTIVE	Responsible as the Accounting Officer to ensure financial targets and obligations are met and have overall responsibility for the System of Internal Control.
10.2.4	CHIEF EXECUTIVE & FINANCE DIRECTOR	Accountable for financial control but will, as far as possible, delegate their detailed responsibilities.
10.2.5	CHIEF EXECUTIVE	To ensure all Board members, officers and employees, present and future, are notified of and understand Standing Financial Instructions.
10.2.6	FINANCE DIRECTOR	Responsible for: a) Implementing the Trust's financial policies and coordinating corrective action b) Maintaining an effective system of financial control including ensuring detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions c) Ensuring that sufficient records are maintained to explain Trust's transactions and financial position and, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Finance Director include: d) the provision of financial advice to other members of the Board and employees e) the design, implementation and supervision of systems of internal financial control f) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
10.2.7	ALL MEMBERS OF THE BOARD AND EMPLOYEES	Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to Standing Orders, Financial Instructions and financial procedures.
10.2.8	CHIEF EXECUTIVE	Ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are made aware of these instructions and their requirement to comply.
11.1.1	AUDIT COMMITTEE	Provide independent and objective view on internal control and probity.
11.1.2	CHAIR OF AUDIT COMMITTEE	Raise the matter at the Board meeting where Audit Committee considers there is evidence of ultra vires transactions or improper acts.
11.1.3 & 11.2.1	FINANCE DIRECTOR	Ensure an adequate internal audit service, for which he/she is accountable, is provided (and involve the Audit Committee in the selection process when/if an internal audit service provider is changed.) Ensure there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective Internal Audit function; Ensure that the Internal Audit is adequate and meets the NHS mandatory audit standards;
11.2.1	FINANCE DIRECTOR	Decide at what stage to involve police in cases of misappropriation and other irregularities not involving fraud or corruption. (previously – Investigate any suspected cases of fraud or other irregularity)
11.3	HEAD OF INTERNAL AUDIT	Review, appraise and report in accordance with NHS Internal Audit Manual and best practice.
11.4	AUDIT COMMITTEE	Ensure cost-effective External Audit.
11.5	CHIEF EXECUTIVE & FINANCE DIRECTOR	Monitor and ensure compliance with Secretary of State for Health Directions on fraud and corruption including the appointment of the Local Counter Fraud Specialist.
11.6	CHIEF EXECUTIVE	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management including appointment of the Local Security Management

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		Specialist.
13.1.1	CHIEF EXECUTIVE	Compile and submit to the Board an business plan which takes into account financial targets and forecast limits of available resources. The Business Plan will contain: • a statement of the significant assumptions on which the plan is based; • details of major changes in workload, delivery of services or resources required to achieve the plan.
13.1.2 & 13.1.3	FINANCE DIRECTOR	Submit budgets to the Board for approval. Monitor performance against budget; submit to the Board financial estimates and forecasts.
13.1.6	FINANCE DIRECTOR	Ensure adequate training is delivered on an on going basis to budget holders.
13.3.1	CHIEF EXECUTIVE	Delegate budget to budget holders.
13.3.2	CHIEF EXECUTIVE & BUDGET HOLDERS	Must not exceed the budgetary total or virement limits set by the Board.
13.4.1	FINANCE DIRECTOR	Devise and maintain systems of budgetary control.
13.4.2	BUDGET HOLDERS	Ensure that a) no overspend or reduction of income that cannot be met from virement is incurred without prior consent of Board, this will be achieved through the responsibilities of budget holders to identify and escalate overspend. Monitoring will be implemented through monthly reports to the Board; b) approved budget is not used for any other than specified purpose subject to rules of virement; c) no permanent employees are appointed without the approval of the CE other than those provided for within available resources and manpower establishment; and d) provide information as requested by the Director of Finance.
13.4.3	CHIEF EXECUTIVE	Identify and implement cost improvements and income generation activities in line with the Business Plan.
13.6.1	CHIEF EXECUTIVE	Submit monitoring returns to regulators
14.1	FINANCE DIRECTOR	Preparation of annual accounts and reports.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
15.1	FINANCE DIRECTOR	Managing banking arrangements, including provision of banking services, operation of accounts, preparation of instructions and list of cheque signatories. (Board approves arrangements.)
15.3	DIRECTOR OF FINANCE	Prepare detailed instructions on the operation of bank and paymaster accounts.
15.3	DIRECTOR OF FINANCE	Advise the Trust bankers and the Paymaster General in writing of the conditions under which each account will be operated.
15.3	DIRECTOR OF FINANCE	Open a bank account in the name of West Suffolk NHS Foundation Trust.
15.4	DIRECTOR OF FINANCE	Review banking arrangements at regular intervals not exceeding three years, to ensure they reflect best practice and represent best value for money. Following such reviews, the Director of Finance shall determine whether or not to seek competitive tenders for the Trust's banking business.
16.	FINANCE DIRECTOR	Income systems, including system design, prompt banking, review and approval of fees and charges, debt recovery arrangements, design and control of receipts, provision of adequate facilities and systems for employees whose duties include collecting or holding cash.
16.2.3	ALL EMPLOYEES	Duty to inform DoF of money due from transactions which they initiate/deal with.
17.	CHIEF EXECUTIVE	Tendering and contract procedure.
17.5.3	CHIEF EXECUTIVE	Waive formal tendering procedures.
17.5.3	CHIEF EXECUTIVE	Report waivers of tendering procedures to the Board.
17.5.5	FINANCE DIRECTOR	Where a supplier is chosen that is not on the approved list the reason shall be recorded in writing to the CE.
17.6.2	CHIEF EXECUTIVE	Responsible for the receipt, endorsement and safe custody of tenders received.
17.6.3	CHIEF EXECUTIVE	Shall maintain a register to show each set of competitive tender invitations despatched.
17.6.4	CHIEF EXECUTIVE AND FINANCE DIRECTOR	Where one tender is received will assess for value for money and fair price.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
17.6.6	CHIEF EXECUTIVE	No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.6.8	CHIEF EXECUTIVE	Will appoint a manager to maintain a list of approved firms.
17.6.9	CHIEF EXECUTIVE	Shall ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.
17.7.2	CHIEF EXECUTIVE	The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money.
17.7.4	CHIEF EXECUTIVE or FINANCE DIRECTOR	No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.
17.10	CHIEF EXECUTIVE	The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.
17.10	BOARD	All PFI proposals must be agreed by the Board.
17.11	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.
17.12	CHIEF EXECUTIVE	The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.
17.15	CHIEF EXECUTIVE	The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis.
17.15.5	CHIEF EXECUTIVE	The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.
18.1.1	CHIEF EXECUTIVE	Must ensure the Trust enters into suitable Service Level Agreements (SLAs) with service commissioners for the provision of NHS services
18.3	CHIEF EXECUTIVE	As the Accountable Officer, ensure that regular reports are provided to the Board detailing actual and forecast income from the SLA

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.1.1	BOARD	Establish a Remuneration Committee
20.1.2	REMUNERATION COMMITTEE	*Advise the Board on and make recommendations on the remuneration and terms of service of the CE, other executive members and senior employees to ensure they are fairly rewarded having proper regard to the Trust's circumstances and any national agreements;* *Monitor and evaluate the performance of individual senior employees;* Advise on and oversee appropriate contractual arrangements for such staff, including proper calculation and scrutiny of termination payments.
20.1.3	REMUNERATION COMMITTEE	Report in writing to the Board its advice and its bases about remuneration and terms of service of directors and senior employees.
20.1.4	BOARD	Approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee.
20.2.2	CHIEF EXECUTIVE	Approval of variation to funded establishment of any department.
20.3	CHIEF EXECUTIVE	Staff, including agency staff, appointments and re-grading.
20.4.1 and 20.4.2	FINANCE DIRECTOR	Payroll: a) specifying timetables for submission of properly authorised time records and other notifications; b) final determination of pay and allowances; c) making payments on agreed dates; d) agreeing method of payment; e) issuing instructions (as listed in SFI 10.4.2).
20.4.3	NOMINATED MANAGERS*	a) Submit time records in line with timetable) Complete time records and other notifications in required form. c) Submitting termination forms in prescribed form and on time.
20.4.4	FINANCE DIRECTOR	*Ensure that the chosen method for payroll processing is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.*

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
20.5	NOMINATED MANAGER*	Ensure that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and Deal with variations to, or termination of, contracts of employment.
21.1	CHIEF EXECUTIVE	Determine, and set out, level of delegation of non-pay expenditure to budget managers, including a list of managers authorised to place requisitions, the maximum level of each requisition and the system for authorisation above that level. [It is good practice to append such lists to the Scheme of Delegation document.]
21.1.3	CHIEF EXECUTIVE	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
21.2.1	REQUISITIONER*	In choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought.
21.2.2	FINANCE DIRECTOR	Shall be responsible for the prompt payment of accounts and claims.
21.2.3	FINANCE DIRECTOR	a) Advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed; b) Prepare procedural instructions [where not already provided in the Scheme of Delegation or procedure notes for budget holders] on the obtaining of goods, works and services incorporating the thresholds; c) Be responsible for the prompt payment of all properly authorised accounts and claims; d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable; e) A timetable and system for submission to the Finance Director of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment; f) Instructions to employees regarding the handling and payment of accounts within the Finance Department; g) Be responsible for ensuring that payment for goods and services is only made once the goods and services are received
21.2.4	APPROPRIATE	Make a written case to support the need for a prepayment.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	EXECUTIVE DIRECTOR	
21.2.4	FINANCE DIRECTOR	Approve proposed prepayment arrangements.
21.2.4	BUDGET HOLDER	Ensure that all items due under a prepayment contract are received (and immediately inform DoF if problems are encountered).
21.2.5	CHIEF EXECUTIVE	Authorise who may use and be issued with official orders.
21.2.6	MANAGERS AND OFFICERS	Ensure that they comply fully with the guidance and limits specified by the Finance Director.
21.2.7	CHIEF EXECUTIVE FINANCE DIRECTOR	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE. The technical audit of these contracts shall be the responsibility of the relevant Director.
21.3	FINANCE DIRECTOR	Lay down procedures for payments to local authorities and voluntary organisations made under the powers of section 28A of the NHS Act.
22.1.1	FINANCE DIRECTOR	The DoF will advise the Board on the Trust's ability to pay dividend on PBC and report, periodically, concerning the PDC debt and all loans and overdrafts
22.1.2	BOARD	Approve a list of employees authorised to make short term borrowings on behalf of the Trust. (This must include the CE and DoF.)
22.1.3	FINANCE DIRECTOR	Prepare detailed procedural instructions concerning applications for loans and overdrafts.
22.1.4	CHIEF EXECUTIVE OR FINANCE DIRECTOR	Be on an authorising panel comprising one other member for short term borrowing approval.
22.2.2	FINANCE DIRECTOR	Will advise the Board on investments and report, periodically, on performance of same.
22.2.3	FINANCE DIRECTOR	Prepare detailed procedural instructions on the operation of investments held.
23	FINANCE DIRECTOR	Ensure that Board members are aware of the Financial Framework and ensure compliance
24.1.1 & 2	CHIEF EXECUTIVE	Capital investment programme: a) ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on plans

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		b) responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost; c) ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences; d) ensure that a business case is produced for each proposal.
24.1.2	FINANCE DIRECTOR	Certify professionally the costs and revenue consequences detailed in the business case for capital investment.
24.1.3	CHIEF EXECUTIVE	Issue procedures for management of contracts involving stage payments.
24.1.4	FINANCE DIRECTOR	Assess the requirement for the operation of the construction industry taxation deduction scheme.
24.1.5	FINANCE DIRECTOR	Issue procedures for the regular reporting of expenditure and commitment against authorised capital expenditure.
24.1.6	CHIEF EXECUTIVE	Issue manager responsible for any capital scheme with authority to commit expenditure, authority to proceed to tender and approval to accept a successful tender. Issue a scheme of delegation for capital investment management.
24.1.7	FINANCE DIRECTOR	Issue procedures governing financial management, including variation to contract, of capital investment projects and valuation for accounting purposes.
24.2.1	FINANCE DIRECTOR	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
24.2.1	BOARD	Proposal to use PFI must be specifically agreed by the Board.
24.3.1	CHIEF EXECUTIVE	Maintenance of asset registers (on advice from DoF).
24.3.5	FINANCE DIRECTOR	Approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.
24.3.8	FINANCE DIRECTOR	Calculate and pay capital charges in accordance with Department of Health requirements.
24.4.1	CHIEF EXECUTIVE	Overall responsibility for fixed assets.
24.4.2	FINANCE DIRECTOR	Approval of fixed asset control procedures.
24.4.4	BOARD, EXECUTIVE	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
	MEMBERS AND ALL SENIOR STAFF	losses in accordance with Trust procedure.
25.2	CHIEF EXECUTIVE	Delegate overall responsibility for control of stores (subject to FD responsibility for systems of control). Further delegation for day-to-day responsibility subject to such delegation being recorded. (Good practice to append to the scheme of delegation document.)
25.2	FINANCE DIRECTOR	Responsible for systems of control over stores and receipt of goods.
25.2	DESIGNATED PHARMACEUTICAL OFFICER	Responsible for controls of pharmaceutical stocks
25.2	DESIGNATED ESTATES OFFICER	Responsible for control of stocks of fuel oil and coal.
25.2	NOMINATED OFFICERS*	*Security arrangements and custody of keys*
25.2	FINANCE DIRECTOR	Set out procedures and systems to regulate the stores.
25.2	FINANCE DIRECTOR	Agree stocktaking arrangements.
25.2	FINANCE DIRECTOR	Approve alternative arrangements where a complete system of stores control is not justified.
25.2	FINANCE DIRECTOR	Approve system for review of slow moving and obsolete items and for condemnation, disposal and replacement of all unserviceable items.
25.2	NOMINATED OFFICERS*	Operate system for slow moving and obsolete stock, and report to DoF evidence of significant overstocking.
25.3.1	CHIEF EXECUTIVE	Identify persons authorised to requisition and accept goods from NHS Supplies stores.
26.1.1	FINANCE DIRECTOR	Prepare detailed procedures for disposal of assets including condemnations and ensure that these are notified to managers.
26.2.1	FINANCE DIRECTOR	Prepare procedures for recording and accounting for losses, special payments and informing police in cases of suspected arson or theft.
26.2.2	ALL STAFF	Discovery or suspicion of loss of any kind must be reported immediately to either head of

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		department or nominated officer. The head of department / nominated officer should then inform the CE and DoF.
26.2.2	FINANCE DIRECTOR	Where a criminal offence is suspected, DoF must inform the police if theft or arson is involved. In cases of fraud and corruption DoF must inform the relevant LCFS and CFSMS Regional Team in line with SoS directions.
26.2.2	FINANCE DIRECTOR	Notify CFSMS and External Audit of all frauds.
26.2.3	FINANCE DIRECTOR	Notify Board and External Auditor of losses caused theft, arson, neglect of duty or gross carelessness (unless trivial).
26.2.4	BOARD	Approve write off of losses (within limits delegated by DH).
26.2.6	FINANCE DIRECTOR	Consider whether any insurance claim can be made.
26.2.7	FINANCE DIRECTOR	Maintain losses and special payments register.
27.1	FINANCE DIRECTOR	Responsible for accuracy and security of computerised financial data.
27.1	FINANCE DIRECTOR	Satisfy themselves that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation assurances of adequacy must be obtained from them prior to implementation.
27.1.3	DIRECTOR OF INFORMATION	Shall publish and maintain a Freedom of Information Scheme.
27.2.1	RELEVANT OFFICERS	Send proposals for general computer systems to DoF
27.3	FINANCE DIRECTOR	*Ensure that contracts with other bodies for the provision of computer services for financial applications clearly define responsibility of all parties for security, privacy, accuracy, completeness and timeliness of data during processing, transmission and storage, and allow for audit review.* Seek periodic assurances from the provider that adequate controls are in operation.

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
27.4	FINANCE DIRECTOR	*Ensure that risks to the Trust from use of IT are identified and considered and that disaster recovery plans are in place.*
27.5	FINANCE DIRECTOR	Where computer systems have an impact on corporate financial systems satisfy himself that: a) systems acquisition, development and maintenance are in line with corporate policies; b) data assembled for processing by financial systems is adequate, accurate, complete and timely, and that a management rail exists; c) DoF and staff have access to such data; Such computer audit reviews are being carried out as are considered necessary.
28.2	CHIEF EXECUTIVE	Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.
28.3	FINANCE DIRECTOR	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of.
28.6	DEPARTMENTAL MANAGERS	Inform staff of their responsibilities and duties for the administration of the property of patients.
29.1	FINANCE DIRECTOR	Shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately.
30	FINANCE DIRECTOR	Ensure all staff are made aware of the Trust policy on the acceptance of gifts and other benefits in kind by staff
32	CHIEF EXECUTIVE	Retention of document procedures in accordance with HSC 1999/053.
33.1	CHIEF EXECUTIVE	Risk management programme.
33.1	BOARD	Approve and monitor risk management programme.
33.2	BOARD	Decide whether the Trust will use the risk pooling schemes administered by the NHS Litigation Authority or self-insure for some or all of the risks (where discretion is allowed). Decisions to self-insure should be reviewed annually.
33.4	FINANCE DIRECTOR	Where the Board decides to use the risk pooling schemes administered by the NHS Litigation Authority the Finance Director shall ensure that the arrangements entered into are appropriate

SFI REF	DELEGATED TO	AUTHORITIES/DUTIES DELEGATED
		and complementary to the risk management programme. The Finance Director shall ensure that documented procedures cover these arrangements. Where the Board decides not to use the risk pooling schemes administered by the NHS Litigation Authority for any one or other of the risks covered by the schemes, the Finance Director shall ensure that the Board is informed of the nature and extent of the risks that are self insured as a result of this decision. The Finance Director will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.
33.4	FINANCE DIRECTOR	Ensure documented procedures cover management of claims and payments below the deductible.

* Nominated officers and the areas for which they are responsible should be incorporated into the Trust's Scheme of Delegation document.

F. Detailed scheme of delegation for standing financial instructions (SFIs)

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. ***The delegation shown below is the lowest level to which authority is delegated.*** *Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.*

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
1. Management of Budgets		
Responsibility of keeping expenditure within budgets		
a) At individual budget /service level (Income, Pay and Non Pay)	Budget holder/General Manager	SFIs Section 13
b) All other	Chief Executive/Finance Director/Executive Director Or Other Delegated Officer	
2. Maintenance / Operation of Bank Accounts	Finance Director	SFIs Section 15
3. Expenditure- Pay, non pay including capital		

The following limits apply during routine financial controls. When the expenditure panel is implemented temporary delegated financial control limits may be bought into force. This will be notified and communicated to relevant staff.

Points of clarity:

- All financial limits within this document should be treated as VAT inclusive regardless of whether the VAT can be reclaimed or not except for contracts that may require Trust Board approval. For those contracts which may need Trust Board approval the amount net of reclaimable VAT should be the value used to determine the level of authorisation required. Finance must confirm the correct VAT treatment before this decision can be made
- NB items must not be split across multiple requisitions. All 'call off order' must have an indicative level of activity and therefore an indicative value for which the following limits should be applied
- When considering the delegated matters determined by the 'annual value' or 'life of contract' which drives the most senior decision must be used. The 'annual value' should be based on the average value for the contract life.

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
a) Expenditure including pay		
Annual value / Life of contract		
◊ £0 - £10,000 / £0 - £40,000	Budget Holder or authorised signatory	SFIs Section 11
◊ £10,001 - £50,000 / £40,001 - £200,000	General manager	
◊ £50,001 - £100,000 / £200,001 - £400,000	Executive Director	
◊ £100,001 – £250,000 / £400,001 - £1m	Chief Executive and Finance Director	
◊ £250,001 + / £1m +	Trust Board	
To determine the authorisation for pay it is the annual gross cost to the organisation that should be considered i.e. including employer national insurance and pension contributions.		
Pharmacy orders		
Annual value / Life of contract		
◊ £0 - £75,000 / £0 - £300,000	Head of Pharmacy	
◊ £75,001 - £100,000 / £300,001 - £400,000	Head of Pharmacy and Executive Director	
◊ £100,001 - £250,000 / £400,001 - £1m	Chief Executive and Finance Director	
◊ £250,001 + / £1m +	Trust Board	
Works orders		
Annual value / Life of contract		
◊ £0 - £75,000 / £0 - £300,000	Heads of Service (estates and facilities)	
◊ £75,001 - £100,000 / £300,001 - £400,000	Executive Director	
◊ £100,000 - £250,000 / £400,001 - £1m	Chief Executive and Finance Director	
◊ £250,001 + / £1m +	Trust Board	
b) Business Cases - Business cases are required for both revenue and capital requirements over and above existing resources – this is an		

approval process for the business case. The values must be based on gross annual costs, before any projected savings.

All business cases must have a completed business case template which must be developed with the divisional finance manager, and if approved the final signed copy submitted to the Deputy Director of Finance. The Deputy Director of Finance will coordinate tracking of benefits realisation.

The rules of authorisation for any subsequent requisitions / orders from a successful business case must follow the limits as specified above. The limits refer to gross annual expenditure and for the avoidance of doubt if the annual expenditure is variable over the life of the business case, it is the highest gross expenditure in any one year that the limit applies to. The same limits apply for I & E and capital.

◊ £0 - £50,000 <u>with no associated uplift in budget</u>	Divisional Board (or equivalent)	
◊ £0 - £50,000	Deputy Finance Director	
◊ £50,001 - £250,000	Executive Directors Meeting or Trust Executive Group	
◊ £250,001 +	Trust Board	
4. Leases		
All leases regardless of value	Finance Director or Assistant Director of Finance (Financial Services)	SFIs Section 12.3
5. Quotation, Tendering & Contract Procedures		
• Maintaining list of approved firms	Finance Director	SFIs Section 7
a) Obtaining **2 minimum verbal quotations** for contract value < £10,000	Budget holder/General Manager/Executive Director	SFIs Section 7, 11 & 15
b) Obtaining **3 written quotations** for contracts >£10,000 < £75,000	Finance Director/Nominated Deputy/Chief Operating Officer (or nominated Facilities Manager)	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
c) Obtaining **4 written competitive tenders** for contracts > £75,000	Executive Director (other than Chief Executive)	
d)	Chief Executive & Non Executive Director under seal	
d) Waiving of quotations & Tenders subject to SFIs (including the inability to obtain the minimum numbers of quotes/ tenders set out above)	Chief Executive/Finance Director (notified to Audit Committee)	
◊ £0 - £10,000	Assistant Director of Finance / Deputy Director of Finance	
◊ £10,001 - £75,000	Chief Executive or Finance Director	
◊ £75,001 +	Chief Executive	
f) Opening Tenders subject to SFIs.	A minimum of two Executive Directors or Trust Secretary with an Executive Director	
6. Setting of Fees and Charges		
a) Private Patient, Overseas Visitors, Income Generation and other patient related services	Finance Director/Nominated Deputy	SFIs Section 6
b) Price of NHS Service & Financial Framework Agreements	Finance Director	SFIs Section 7 and 8
7. Engagement of Staff Not On the Establishment		
a) Non-Medical Consultancy Staff	Executive Directors	SFIs Section 10 and

DELEGATED MATTER		AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
	Where aggregate commitment in any one year (or total commitment) < £75,000		Standing Order 4
b)	Where aggregate commitment in any one year >£75,000	Chief Executive/Finance Director	
c)	Engagement of Trust's Solicitors	Executive Director or Trust Secretary (or nominated deputy up to estimated value of £1,000)	
d)	Booking of bank, locums, agency staff, overtime and additional sessions	Budget Holder/Service Manager/General Manager/Site Manager/Senior Manager on Call	NHSP Operating Policy
	◊	Budget Holder/Clinical Director/General manager	Medical Locums Policy (PP006)
8.	**Expenditure on Charitable and Endowment Funds**		
	◊		SFIs Section 19
	◊ £0 – £1,000	Fundholder	
	◊ £1,001 – £5,000	Executive Director	
	◊ £5,001 – £25,000	Director of Finance **and** Chief Operating Officer	
	◊ £25,001 – £100,000	Charitable Funds Committee (including electronic approval if more practical)	
	◊ >£100,000	Trust Board	
10.	**Condemning & Disposal**		
a)	Items obsolete, obsolescent, redundant, irreparable or		SFIs Section 16

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
cannot be repaired cost effectively		
i. with current/estimated purchase price <£100	Budget Holder	
ii. with current purchase new price > £100	Condemning Officer	
iii.		
iv.		
v. disposal of mechanical and engineering plant (subject to estimated income < £1,000 per sale)	nominated Facilities Manager	
vi. Disposal of mechanical and engineering plant (subject to estimated income > £1,000 per sale)	Nominated Facilities Manager and Finance Director	
11. Losses, Write-off & Compensation		
a) Losses and Cash due to theft, fraud, overpayment & others < £50,000	Chief Executive & Finance Director	SFIs Section 16
b) Fruitless payments (including abandoned Capital Schemes) < £250,000	Chief Executive & Finance Director	
◊		
c) Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to: Culpable causes (e.g. fraud, theft, arson) or other < £50,000	Chief Executive/Finance Director	
d) Compensation payments made under legal obligation	Chief Executive/Finance Director	
e) ex-Gratia Payments		
Patients personal effects		
< £100	Budget Holder	
>£100 <£1000	Director of Operations/Finance Director	
>£1,000 < £25,000	Chief Executive & Finance Director	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
f) For clinical negligence up to CNST limits (negotiated settlements)	Chief Executive/Finance Director	
g) For personal injury claims involving negligence where legal advice has been obtained and guidance appliedup to CNST limit (including plaintiff's costs)	Chief Executive & Finance Director	
h) Other, except cases of maladministration where there was no financial loss by claimant < £25,000	Chief Executive & Finance Director	
	Reported to Audit Committee for Information:-	
i) Write off of NHS Debtors	Audit Committee	
j) Write off of Non NHS Debtors:		
< £250	Finance Director	
> £250	Audit Committee	
12. Reporting of Incidents to the Police		SFIs Section 2 & 16
a) Where a criminal offence is suspected		
i) Criminal offence of a violent nature	In line with Trust policy	Incident Reporting and Management PP105
Ii) other	In line with Trust policy	Incident Reporting and Management PP105
b) Where a fraud is involved	Finance Director	Fraud, Financial Irregularity and Corruption Policy
13. Petty Cash Disbursements (not applicable to central Cashiers Office)		SFIs Section 11
a) Expenditure < £50 per item	Budget holder	
b) Reimbursement of patients monies < £100	Patient Affairs Officer	
c) Reimbursement of patients monies > £100	Service Manager	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
14. Receiving Hospitality		
Applies to both individual and collective hospitality receipt items. > £25.00 per item received	Declaration required in Trust's Gifts and Hospitality Register held by Trust Secretary	Standards of business conduct (PP054)
15. Implementation of Internal and External Audit Recommendations	Finance Director	SFIs Section 2
16. Maintenance & Update on Trust Financial Procedures	Finance Director	
17. Investment of Funds (including Charitable & Endowment Funds)	Finance Director & Charitable Fund Sub-committee	SFIs Sections 12, 19
18. Personnel & Pay		SFIs Section 10
a) Authority to appoint new and replacement Consultant Staff	Trust Executive Group	
b) Pay and banding adjustments		
All requests for pay and banding adjustments shall be dealt with in accordance with Trust Procedure	Budget Holder & Director of Human Resources (unless Vacancy Approval Panel is in force)	Agenda for Change Implementation – Appeals Procedure

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
c) Pay		
Authority to agree starting salary	Budget Holder in consultation with Director of Human Resources	Starting Salary Policy (PP203)
Authority to complete standing data forms effecting pay, new starters, variations and leavers	Budget Holder	
Authority to complete and authorise positive reporting Forms	Budget Holder	
Authority to authorise overtime	Budget Holders	
Authority to authorise travel & subsistence expenses	Budget Holder	
Authority to waive contractual notice period	Director of Human Resources	
d) Leave- must be in compliance with HR policies		
i) Approval of annual leave	Line/Departmental Manger	Conditions of Service
ii) Annual leave - approval of carry forward (up to maximum of 5 days)	Line/Departmental Manager	Conditions of Service
iii) Annual leave - approval of carry over in excess of 5 days but less than 10 days	Human Resources Director/Chief Executive	Annual leave carry over policy (PP063)
iv) Compassionate leave up to 6 days	Director of Human Resoources	
v) Special leave arrangements	Budget Holder	

◊ Paternity leave	Director of Human Resources	Special Leave PP066
◊ Parental leave	Budget Holder	Special Leave PP066
◊ Carers leave	Budget Holder	Special Leave PP066
viii) Leave without pay	Budget Holder	
ix) Medical Staff Leave of Absence	Clinical Director/General Manager	
x) Time off in lieu	Line Manager	
xi) Maternity Leave - paid and unpaid	Automatic approval with guidance	Maternity Policies (PP058 medical) & (PP169 AFC)
g) <u>Sick Leave</u>		
i) Extension of sick leave on half pay up to three months	Director of Human Resources	Improving Employee Attendance PP036
ii) Return to work part-time on full pay to assist recovery	Budget Holder Director of Human Resources	Improving Employee Attendance PP036
iii) Extension of sick leave on full pay	Human Resources Director/Chief Executive	
h) <u>Study Leave</u>		
i) Study leave outside the UK	Chief Executive/Executive Director	
ii) Medical staff study leave (UK)	Medical Director	Prof & Study Leave for Snr Medical Staff PP032
iii) All other study leave (UK)	Budget Holder	Study Leave Policy PP067
i) <u>Removal Expenses, Excess Rent and House Purchases</u>		
Authority of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)		

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
i) < £8,000	Director of Human Resources	Removal, Accommodation and Associated PP079
j) <u>Grievance Procedure</u> All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of a Human Resources Officer must be sought when the grievance reaches the level of General Managers	Line Manager	Grievance Policy (PP035)
k) <u>Lease Car & Mobile Phone Users</u> Requests for new posts to be authorised as car users Requests for new posts to be authorised as mobile telephone users	Budget Holder Budget Holder	
l) <u>Renewal of Fixed Term Contracts</u>	Budget Holder (unless vacancy Approval Panel is in force)	
m) <u>Redundancy</u> • Executive Directors • All other staff	Remuneration committee Chief Executive	
n) <u>Ill Health Retirement</u>		

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
Decision to pursue retirement on the grounds of ill-health	Director of Human Resources	Improving Employee Attendance PP036
o) Dismissal	Dismissing Officer	Disciplinary Procedure
19. Authorisation of New Drugs		
◊ Estimated total yearly cost < £25,000	Drugs & Therapeutics Committee Sub-committee and referred to Finance Director for information	SFIs Section 11
◊ Estimated total yearly cost > £25,000	Drugs & Therapeutics Committee and referred to Finance Director approval	
20. Authorisation of Sponsorship deals	Chief Executive	
21. Authorisation of Research Projects	Chief Executive/Medical Director & Research Committee	
22. Authorisation of Clinical Trials	Research Committee	
23. Insurance and Risk Management Policies	Chief Executive	SFIs Section 23
24. Patients & Relatives Complaints		
a) Overall responsibility for ensuring that all complaints are dealt with effectively	Trust Secretary/Service Manager	
b) Responsibility for ensuring complaints relating to a Directorate are investigated thoroughly	Trust Secretary/Service Manager	
c) Medico-Legal Complaints Co-ordination of their management	Trust Secretary	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
25. Relationships with Press		
a) Non-Emergency General Enquiries		Media Policy (PP119)
◊ Within Hours	Communications Manager	
◊ Outside Hours	Senior Manager on Call	
b) Emergency		Media Policy (PP119)
◊ Within House	Communications Manager	
◊ Outside Hours	Senior Manager on Call or Executive Director on Call	
26. Infectious Diseases & Notifiable Outbreaks	Senior Manager on Call or Control of Infection Doctor	
27. Extended Role Activities		Nurse/Midwives/Health Visitors Act Midwives Rules/Code of Practice UKCC Code of Professional Conduct
Approval of Nurses to undertake duties/procedures which can properly be described as beyond the normal scope of Nursing Practice.	Director of Nursing	
28. Patient Services		
a) Variation of operating and clinic sessions within existing numbers		
◊ Outpatients	Director of Operations	
◊ Theatres	Director of Operations	

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
◊ Other	Director of Operations	
b) All proposed changes in bed allocation and use		
◊ Temporary Change	Director of Operations	
◊ Contract monitoring & reporting		
▪ Facilities	Director of Finance (or nominated Facilities Manager)	
▪ All other contracts	Finance Director (or nominated Contract Manager)	
29. Facilities for staff not employed by the Trust to gain practical experience		
Professional Recognition, Honorary Contracts, & Insurance of Medical Staff, Work experience student	Director of Human Resources	Honorary Contracts (Protocols for Issue) PP107
30. Review of Fire precautions	Director of Finance (or nominated Facilities Manager)	
31. Review of all statutory compliance legislation and Health and Safety requirements including control of Substances Hazardous to Health Regulations	Director of Nursing /Chief Operating Officer/ Director of Finance (or nominated Facilities Manager)/Governance Manager/Risk Manager/Occupational Health Manager	Health, Safety and Welfare Policy (PP018)
32. Review of Medicines Inspectorate Regulations	Chief Pharmacist	
33. Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Director of FInance (or nominated Facilities Manager)	
34. Review of Trust compliance with the Data Protection and Freedom of Information Acts	Information Governance Manager	Data protection policy (PP110)

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENT
35. Monitor proposals for contractual arrangements between the Trust and outside bodies		
• Facilities	Director of Finance (or nominated Facilities Manager)	
• All other contracts	Finance Director (or nominated Contracts Manager)	
36. Review of Trust's compliance with the Access to Records Act	Health Records Manager	Health Records Policy (PP136)
37. Review the Trust's compliance with the Confidentiality Code of Practice, NCRS Acceptable Use Policy and Caldicott Priciples for information sharing with other Authorities and Third Party Contractors.	Information Governance Manager	Safe haven policy (PP126)
38. The keeping of a Declaration of Interests Register	Trust Secretary (or nominated manager)	SOs Section 7
39. Attestation of sealings in accordance with Standing Orders	Chairman/Non-Executive Director & Chief Executive/ Executive Director	SOs Section 8
40. The Keeping of a register of sealing	PA to Chief Executive	SOs Section 8
41. The Keeping of the Gifts and Hospitality Register	Trust Secretary (or nominated manager)	Standards of business conduct (PP)54)
42. Retention of Records	Managers and Heads of Department in accordance with referenced policy	Retention, storage and disposal policy (PP192)
43. Clinical Audit	Medical Director & Clinical Standards Executive Committee	SFIs Section 23

Author(s):	Richard Jones, Trust Secretary and Head of Governance Louise Wishart, Acting Assistant Director of Finance
Other contributors:	
Approvals and endorsements:	Audit Committee and Board
Consultation:	
Issue no:	
File name:	
Supercedes:	Reservation and delegation of powers PP(14)222
Equality Assessed	Yes
Implementation	Policy is a standard reference document for Trusts
Monitoring: (give brief details how this will be done)	Policy monitored through financial systems and procedures
Other relevant policies/documents & references:	NHS trust model standing orders, reservation and delegation of powers and standing financial instructions - March 2006
Additional Information:	

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 3 March 2017

AGENDA ITEM:	Item 23
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	24 February 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 – 31 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 – none scheduled	✓		Written	Matrix	Execs
Quality & performance report, including quality priorities (quarterly)	✓		Written	Matrix	JG/RP
Finance & workforce performance report, including issues underpinning catheter lab decision (action point 1380)	✓		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					
Aggregated quality report, including external review of intrauterine deaths (IUDs)	✓		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
Education report - including undergraduate training	✓		Written	Matrix	JB
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
BUILD A JOINED-UP FUTURE					
Capital programme (final)	✓		Written	Matrix	CB
e-Care report	✓		Written	Action point - schedule	CB
Scrutiny Committee report		✓	Written	Matrix	GN
Strategic update, including STP, ICO and TPP		✓	Written	Action point - schedule	SD
Community services – decision approval point		✓	Written	Matrix	CB
GOVERNANCE					
Trust Executive Group report	✓		Written	Matrix	SD
Remuneration Committee report	✓		Written	Matrix	RV
Annual governance review report	✓		Written	Matrix	RJ
Board Assurance Framework (BAF) report – carried forward		✓	Written	Matrix	RJ
Staff suspension report		✓	Written	Matrix – by exception	JB
Use of Trust seal	✓		Written	Matrix – by exception	RJ
Agenda items for next meeting	✓		Written	Matrix	RJ
Reflections on the meetings (open and closed meetings)		✓	Verbal	Matrix	RQ

West Suffolk NHS
NHS Foundation Trust

Board of Directors – 3 March 2017

AGENDA ITEM:	Item 24
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance Mike Dixon. Health, Safety and Risk Manager
DATE PREPARED:	24 February 2017
SUBJECT:	Health & safety framework
PURPOSE:	Information

EXECUTIVE SUMMARY:

Following discussion at the Corporate Risk Committee it was agreed to prepare a summary framework for the arrangements for health & safety within the Trust. This considered operational management, escalation, accountability and assurance.

The attached framework was approved by the Corporate Risk Committee and felt to provide a helpful model for other complex disciplines to following in defining their governance arrangements. It was agreed to develop a similar approach for education and training.

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)	Corporate Risk Committee (18/11/16 and 10/2/17)
Risk description: (including reference Risk Register and BAF if applicable)	Clarity of governance arrangements
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Relevant policies and procedures with monitoring and reporting arrangements. CQC inspection (March 2016). Internal audit inspections.
Legislation / Regulatory requirements:	H&SW Act
Other key issues:	

Recommendation:

To receive the framework for information

Item 24

West Suffolk NHS
NHS Foundation Trust

Health and Safety Framework

The Health and Safety at Work etc. Act 1974 (HSWA) is the main piece of legislation that covers Health, Safety and Welfare within the WSFT. The HSWA lays down the general principles for the management of health, safety and welfare. Because these duties are expressed in general principles this allows for the creation of more specific Regulations enacted as Statutory Instruments supported with Approved Codes of Practice (ACoP's).

The significant sections of the HSWA which apply to the WSFT as a healthcare institution are:

- **Section 2-** this explains the general duty to the WSFT to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all employees
- **Section 3-** this puts a requirement on the WSFT to ensure so far as is reasonably practicable the health, safety and welfare of persons not in their employment e.g. patients, visitors and contractors
- **Section 7-** this defines the duty placed on employees while at work to take reasonable care for the health and safety of themselves and any other person who might be affected by their acts or omissions. And to co-operate with their employer to enable them to comply with the act.
- **Section 8-** this details the requirement that no person shall intentionally or recklessly interfere with or miss use anything which is provided for the purpose of health, safety and welfare
- **Section 9-** this put a requirement on the WSFT not to charge employees for any specific requirements for health and safety e.g. PPE
- **Section 37-** This details where an offence is committed by the WSFT as it is legally authorised to act as if it were one person (Body Corporate) with the consent or by the neglect, of a director, manager, secretary or a member acting in a managerial capacity, that individual too is guilty of an offence and can be prosecuted on an individual basis as well as the organisation

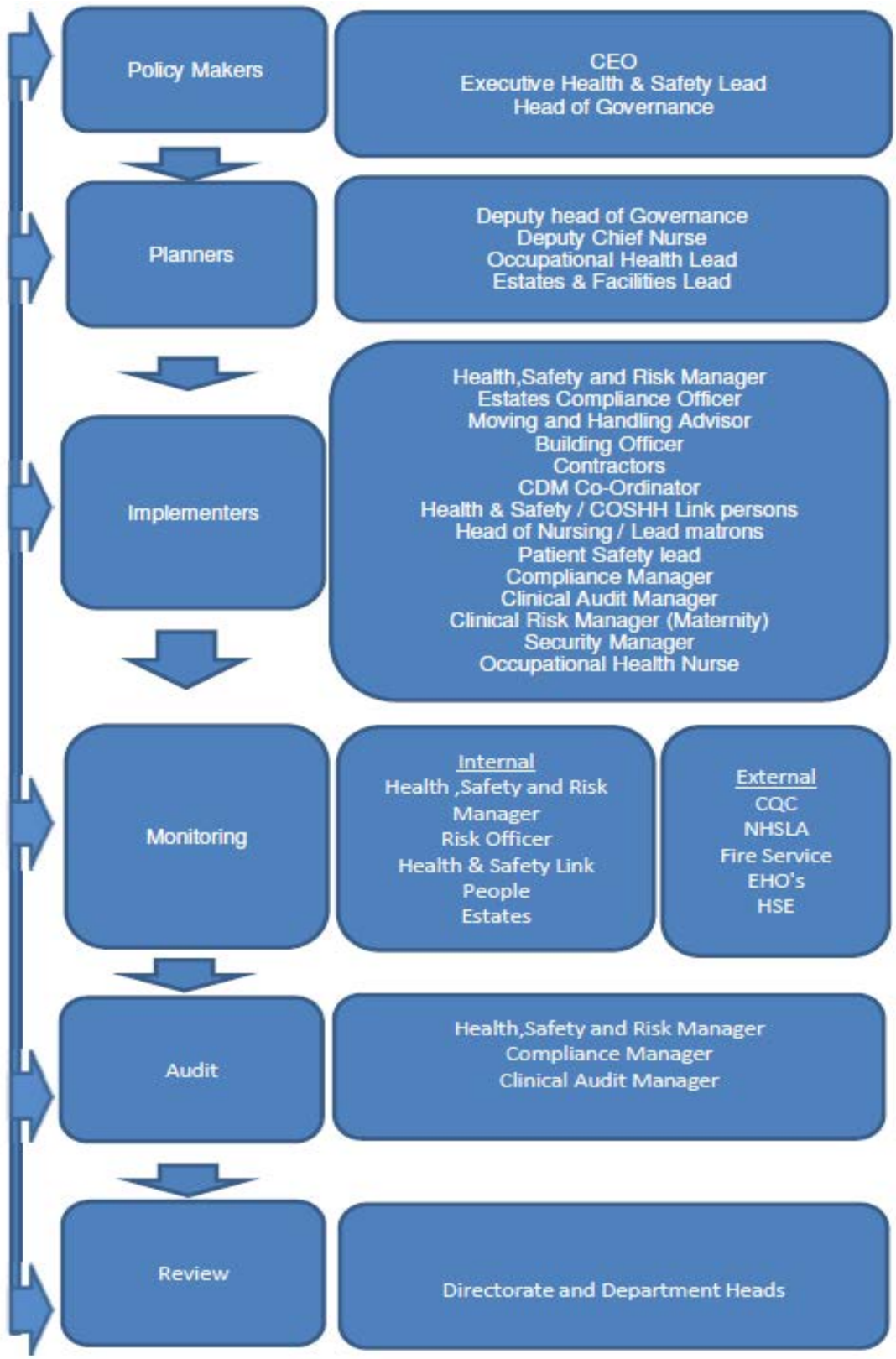
In order to comply with section 2(3) of the Health and Safety at Work etc. Act 1974, the Trust has in place an overarching Health, Safety and Welfare Policy PP018, which includes a statement of intent. The statement of intent details how the WSFT will ensure so far as is reasonably practicable the health, safety and welfare of all of the staff, patients and others who may be affected by the WSFT undertakings. The WSFT seeks to provide:

- A safe working environment with access to adequate welfare facilities;
- Work equipment, plant and systems of work which are without risk to health, are suitable, safe and maintained in good working order;
- Arrangements for ensuring safety and absence of health risks in connection with the use, handling, storage and transport of articles and substances;
- Such information, instruction, training and supervision as is necessary to ensure the health and safety a work of all employees and others on the premises;
- Maintenance for any place of work under the WSFT control to ensure it is in a safe condition without health risks, including means of access and egress

The Chief Executive has overall responsibility for health and Safety throughout the organisation and has signed the policy to demonstrate the Trusts commitment to health and safety. The policy contains the arrangements for health and safety which helps to ensure high standards are maintained.

Within the Trust health and safety is led from the top down, this ensures that a positive health and safety culture is imbedded within the organisation.

Figure 1: H&S management framework (based on HSG 65)



Responsibilities for Health and Safety

Within the Trust the Chief Executive has overall responsibility for the Health, Safety and Welfare of all staff and others. The Chief Executive monitors health and safety standards using information received from the Executive Lead of Health and Safety and information via the quality and risk committee and through attendance at the audit committee.

The responsibility for ensuring the day to day safe conditions of work rests with Managers and Supervisors at all levels. The Trust ensures that suitable training is given to this group of staff, as well as providing competent advice and support on health; safety and welfare issues by having a Nebosh Diploma qualified, full time Health, Safety and Risk Manager.

The Executive lead for Health and Safety within the Trust is the Executive Chief Nurse. The Executive Lead for health and safety assists in ensuring high standards of health and safety are achieved they are also responsible for monitoring the Trusts health and safety performance while promoting health and safety at an Executive level.

All employees while at work have a legal duty to take reasonable care for the health and safety of themselves and of other persons who may be affected by their acts or omissions.
Each department of the Trust should have a nominated health and safety link person and COSHH link person. The health and safety and COSHH link persons are a vital link between all departments of the Trust as communication of health and safety issues is key to ensuring a uniform and positive approach. The health and safety link role is supported with a fully accredited RSPH level 2 award in health and safety in the workplace. This is a full days training course with a multiple choice exam. In order to pass candidates are required to achieve 16 out of 25. The exam papers are marked externally by RSPH, if passed each candidate receives a qualification certificate.

Safety Representatives are appointed through recognised trade unions under the Safety Representatives and Safety Committee Regulations 1977 they are required to have either worked for the Trust for at least two years or have had at least two years' experience in similar employment. An appointed safety representative should keep themselves informed of the legal requirements relating to the health and safety of persons at work, the particular hazards of the workplace and the relevant health and safety policies of the Trust.

Arrangements for Health and Safety

The health and safety arrangements detail what the Trust is going to do in practice to achieve the aims set out in the statement of intent.

The Trusts arrangements for health and safety include:

- **Consultation**:
  The Trust communicates matters of health, safety and welfare through managers, safety representatives and health and safety link persons.
- **Health and Safety Training**:
  The Trust will ensure (so far as is reasonably practicable) that employees are provided with the information, instruction, training and supervision necessary to ensure the health, safety and welfare whilst at work.
- **Health and safety inspections:**
  Clinical and non-clinical environments will be subjected to regular departmental workplace inspections

- **Risk Assessments:**
  The Trust is required under the Management of Health and Safety at Work Regulations 1999 to conduct 'risk assessments' on its activities which involve significant and foreseeable hazards and risks.

- **Reporting incidents and Accidents:**
  It is the responsibility of all staff to report incidents, accidents and near misses using Datix within the Trust and other areas if connected to the Trusts undertakings.

- **Emergency Planning:**
  Every Acute Trust has to plan for its response to events which may jeopardise the delivery of its services. The incidence of an emergency or severe disruption to Trust services is relatively rare. However, if an emergency or disruption occurs it is vital that the Trust is prepared and can respond at short notice, providing a co-ordinated range of emergency, medium and longer term responses.

Monitoring Health and Safety

The **Trust Board** is responsible for monitoring the quality and performance of all services at WSH and it undertakes this role by considering a range of reports at its monthly meetings.
The information that the Board looks at covers:

- Serious incidents and never events
- Clinical audit results
- Complaints
- Staffing information
- Known risks to quality and performance identified in the corporate risk register
- Patient and staff feedback

To help it monitor quality and performance and assure itself that the hospital is safe and effective, the Board has also put in place **assurance committees** where executive and non-executive directors examine more closely key areas for quality delivery. The assurance committees include:

- **Clinical safety and effectiveness committee (CSEC)**
  To ensure that the Trust's clinical procedures and practices are effective in protecting staff, patients and others

- **Patient experience committee (PEC)**
  To ensure first rate customer and patient experience through a range of initiatives

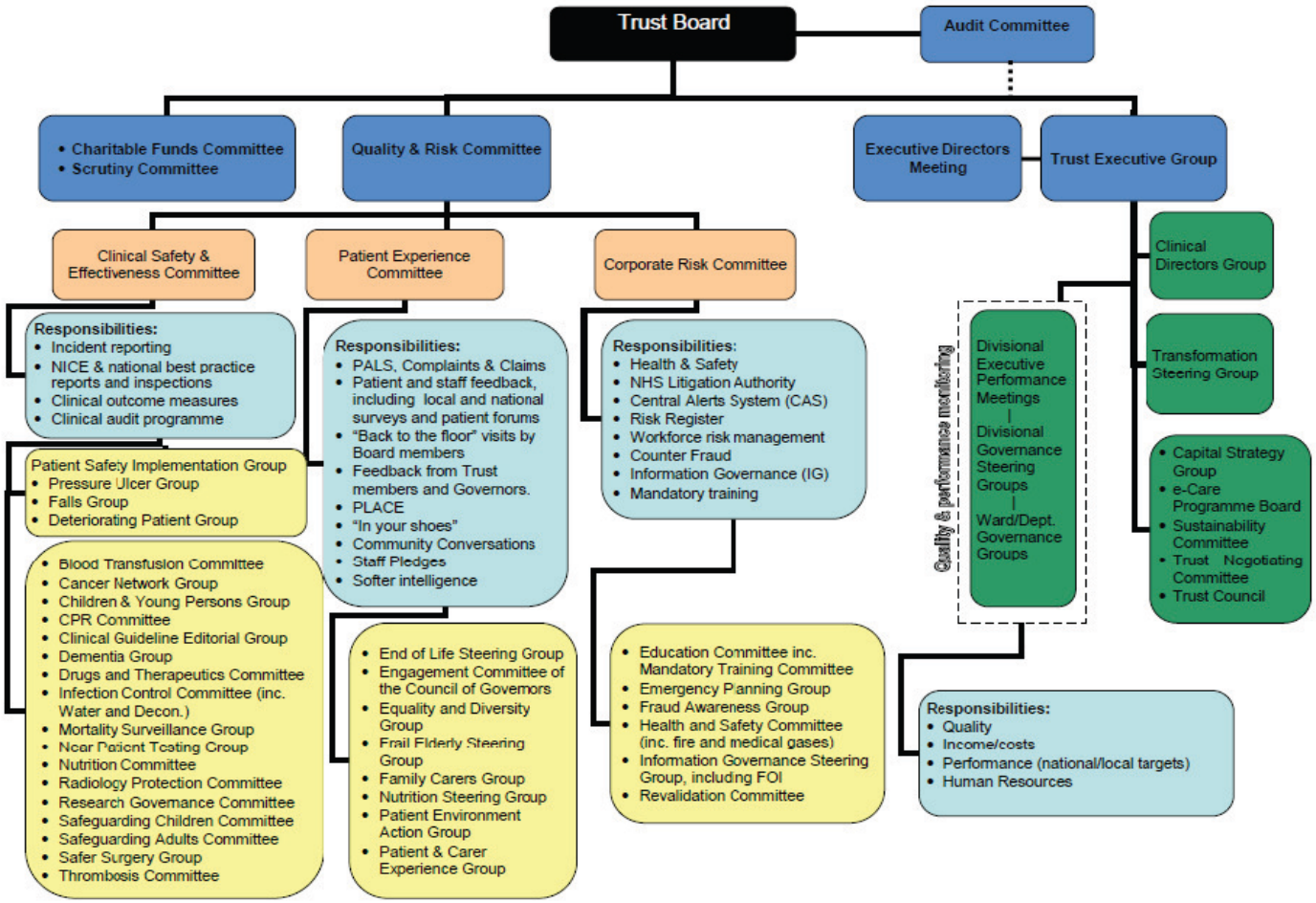
- **Corporate risk committee (CRC)**
  To ensure that the Trust's risk management, financial and workforce procedures are effective

The assurance committees of the Board are supported by a range of management committees and groups. These are described in more detail in Figure 2.

Audit Committee

The committee will provide an independent and objective view of the Trust's internal control environment and the systems and processes by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations.

Figure 2: Assurance and management committees

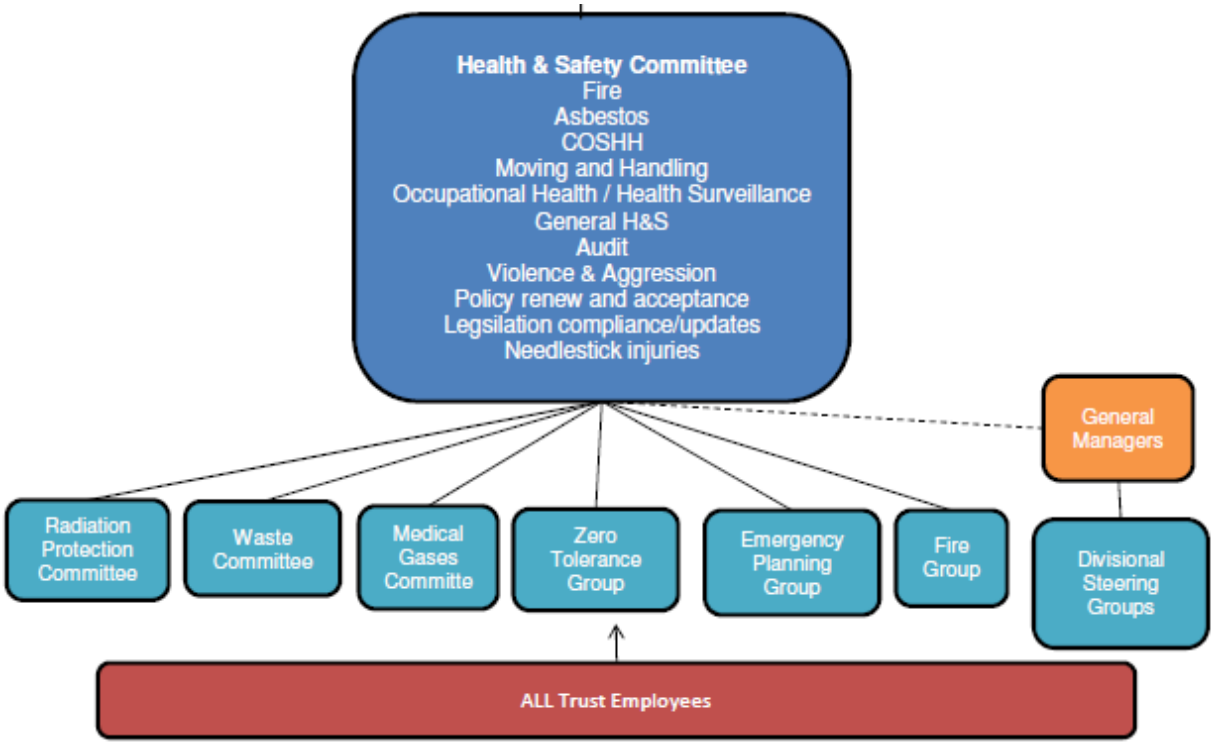


The Trust's health and safety performance is monitored by the Chief Executive, the Executive Lead for Health and Safety, the Corporate Risk Committee and the Health and Safety Committee.

The health and safety committee receives assurance of compliance to health and safety legislation and details of any non-compliance. In receiving such information through reports from named leads who have day to day responsibilities for key arrangements for health and safety, the health and safety committee will provide a report to the Corporate Risk Committee detailing issues which require action and escalation. Each Division represented at the committee enables operational health and safety issues to be discussed, representatives to then agree actions applicable to their area and actions/issues/outcomes to be communicated to the relevant Division forum. These committees meet quarterly. Issues that cannot be resolved or which need to be escalated are reported up to the Trust Executive Group and the Board of Directors accordingly.

Figure 3 below describes the accountability and reporting arrangements to the Trust's Health & Safety Committee.

Figure 3: H&S Committee accountability and reporting



Health and Safety Audits and Inspections

Regulation Compliance Audits:
Back in 2011 the Health and Safety Committee agreed that a program to audit the Trust against all of the relevant health and safety Regulations (n=38) to ensure compliance should be put in place. In order to do this piece of work each nominated H&S lead in the Trust was required to undertake a risk assessment and identify evidence of appropriate control measures relevant to their area of responsibility, assessing whether the Trust is compliant with the Regulation requirements. From the completed risk assessments one area of non-compliance was identified based on current processes and procedures. The non-compliant regulation is the Regulatory Reform (Fire Safety) Order 2005, due to the breaches in the above ceiling compartmentation.

The completed risk assessments then form the basis of the audits undertaken by the Health, Safety and Risk Manager and the Estates Compliance Officer. The audit focuses on the current controls (mitigation) documented in the risk assessment and tests to ensure they are in place by seeing written or physical evidence. Any actions required to address any shortfalls are added to the original risk assessment captured on Datix risk register. All completed audits are reported back to the Health and Safety Committee. The first round of audits was completed in 2013, and a follow up audit is now in place.

Workplace inspections:
Back in 2014 the Trust approved a proposal to allow the health and safety link persons to undertake a full workplace inspection in their area's/departments. In order to give them the additional knowledge required to do this the Trust became an accredited centre to the Royal Society to Public Health (RSPH) which enables the Health, Safety and Risk Manager to deliver the Level 2 award in Health and Safety. To date there are 119 qualified health and safety link persons throughout the Trust.

The health and safety link person completes a full walk round of their area/department and completes a health and safety inspection checklist. Once the checklist has been completed it is transferred on to Datix risk register in the form of a risk assessment, so actions can be monitored. The frequency of inspections is determined by the risk assessment grade. Red=quarterly, Amber=6 monthly and green= Yearly. Common themes from workplace inspections are reported to the Health and Safety Committee as part of the Health, Safety and Risk Managers report. The

Health, Safety and Risk Manager undertakes regular checks of workplace inspections carried out by the Health and Safety Link Persons and also helps complete workplace inspections

Deep Dive Audits:
The Corporate Risk Committee has commissioned a programme of deep dive audits to specifically look at the Wards and Departments risk management arrangements. The purpose of the audit is to test that the Datix Risk register is being fully implemented to capture the significant risks, current risk assessments are regularly reviewed and all departmental risk assessments have been transferred onto Datix. The audit is to being completed by the Health, Safety and Risk Manager and findings are reported back to the CRC as well as the relevant General Manager. Todate all of the wards have been audited, the focus is now on the departments and then the Community.

Central Alerting System (CAS Alerts):
The Health, Safety and Risk Manager is the nominated CAS Liaison Officer for the Trust. The CAS Liaison Officer ensures that all received alerts are disseminated to the appropriate lead either through Datix or direct email, the identified lead actions the alert or acknowledges that the alert is not relevant to the Trust. The CAS website is then updated to reflect the response given by the lead. If an alert cannot be actioned by the deadline then a risk assessment is written and captured on Datix risk register. This then allows the alert to be closed by the given deadline. A quarterly report on the status of alerts is provided to the CRC. The CAS Liaison officer also undertakes a quarterly audit on a random selection of not relevant, relevant and actioned alerts. The audit is to give an additional assurance to the CRC that action has been appropriately taken by the nominated lead.