Board of Directors – 25 January 2019

Agenda item:	Item 9			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Nick Macdonald, Deputy Director of Finance			
Date prepared:	18th January 2019			
Subject:	Finance and Workforce Board Report – December 2018			
Purpose:	x	For information		For approval

Executive summary:
The Trust has agreed a control total to make a deficit of £13.8m in 2018-19 which will enable Provider Sustainability Funding (PSF) of £3.7m should A&E and Financial targets be met. The Trust is planning on a net deficit (after PSF) of £10.1m for 2018-19.

The reported I&E for December 2018 is a surplus of £959k, against a planned surplus of £932k. This results in a favourable variance of £27k in month (£784k adverse variance YTD). We continue to forecast to meet our control total for 19-20.

NHSI have proposed a control total for 2019-20 for the WSFT to break even.

The PMO is leading workshops with each Division to formulate CIPs which are shared through the Transformation Steering Group (TSG). Currently £2.9m has been identified.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X		

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

Previously considered by:	*This report is produced for the monthly trust board meeting only*
Risk and assurance:	*These are highlighted within the report*
Legislation, regulatory, equality, diversity and dignity implications	*None*

Recommendation:
The Board is asked to review this report

FINANCE AND WORKFORCE REPORT
December 2018 (Month 9)

Executive Sponsor : Craig Black, Director of Resources
Authors : Nick Macdonald, Deputy Director of Finance and Louise Wishart, Assistant Director of Finance

Financial Summary

I&E Position YTD	£6.5m	loss
Variance against plan YTD	-£0.8m	adverse
Movement in month against plan	£0.0m	adverse
EBITDA position YTD	-£2.1m	
EBITDA margin YTD	-93.1%	adverse
Total PSF Received	£2.212m	accrued
Cash at bank	£4.306m	

Executive Summary

- The planned deficit for the year to date was £6.7m but the actual deficit was £7.5m, an adverse variance of £0.8m.
- Additional funding has been approved by WS CCG to recognise increased activity in relation to RTT and repatriated patients

Key Risks

- Delivering the £12.2m cost improvement programme.
- Since some CIP relates to non- cash (e.g. depreciation) there is additional pressure on the cash position.
- Containing the increase in demand to that included in the plan (3.2%)
- Recruitment of Registered Nurses to ensure the Trust is fully staffed for the additional capacity required for winter

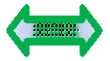
SUMMARY INCOME AND EXPENDITURE ACCOUNT - December 2018	Dec-18			Year to date			Year end forecast		
	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)	Budget	Actual	Variance F/(A)
	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS Contract Income	17.1	17.4	0.3	145.6	146.2	0.6	192.8	195.8	3.0
Other Income	3.9	3.8	(0.0)	29.8	29.7	(0.1)	38.7	37.3	(1.3)
Total Income	**21.0**	**21.3**	**0.3**	**175.4**	**175.9**	**0.5**	**231.5**	**233.1**	**1.7**
Pay Costs	13.4	13.8	(0.3)	119.3	120.8	(1.5)	159.5	162.4	(2.9)
Non-pay Costs	6.2	6.1	0.1	57.2	57.2	(0.0)	76.3	75.1	1.2
Operating Expenditure	**19.6**	**19.9**	**(0.2)**	**176.5**	**178.0**	**(1.5)**	**235.9**	**237.6**	**(1.7)**
Contingency and Reserves	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EBITDA excl STF	**1.3**	**1.3**	**0.1**	**(1.1)**	**(2.1)**	**(1.0)**	**(4.4)**	**(4.4)**	**(0.0)**
Depreciation	0.5	0.5	(0.0)	5.1	4.7	0.4	6.9	6.9	0.0
Finance costs	0.2	0.2	(0.0)	1.9	1.9	0.0	2.6	2.6	0.0
SURPLUS/(DEFICIT) pre PSF	**0.6**	**0.6**	**0.0**	**(8.1)**	**(8.7)**	**(0.6)**	**(13.9)**	**(13.9)**	**(0.0)**
Provider Sustainability Funding (PSF)									
PSF - Financial Performance	0.3	0.3	0.0	1.7	1.7	0.0	2.6	2.6	0.0
PSF - A&E Performance	0.1	0.1	0.0	0.7	0.5	(0.2)	1.1	0.9	(0.2)
SURPLUS/(DEFICIT) incl PSF	**0.9**	**1.0**	**0.0**	**(5.8)**	**(6.5)**	**(0.8)**	**(10.2)**	**(10.4)**	**(0.2)**

FINANCE AND WORKFORCE REPORT – December 2018

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	✗

FINANCE AND WORKFORCE REPORT – December 2018

Income and Expenditure Summary as at December 2018

The Trust has agreed a control total to make a deficit of £13.8m in 2018-19 which will enable Provider Sustainability Funding (PSF) of £3.7m should A&E and Financial targets be met. The Trust plans to make a net deficit (after PSF) of £10.1m for 2018-19.

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2019-20 Planning

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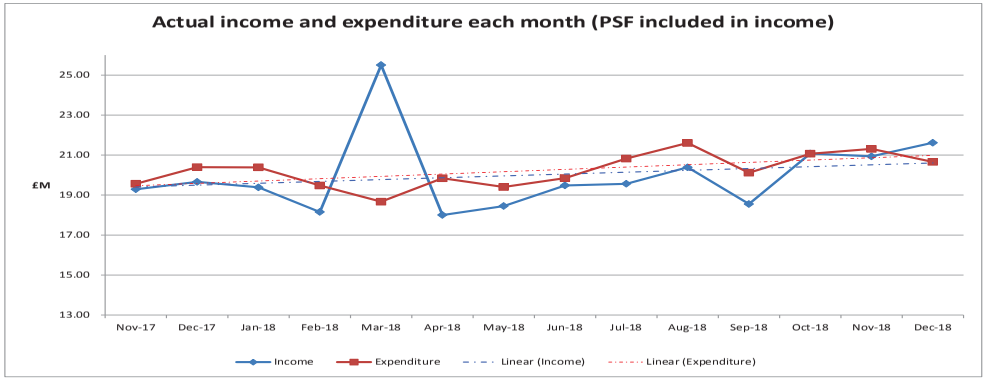
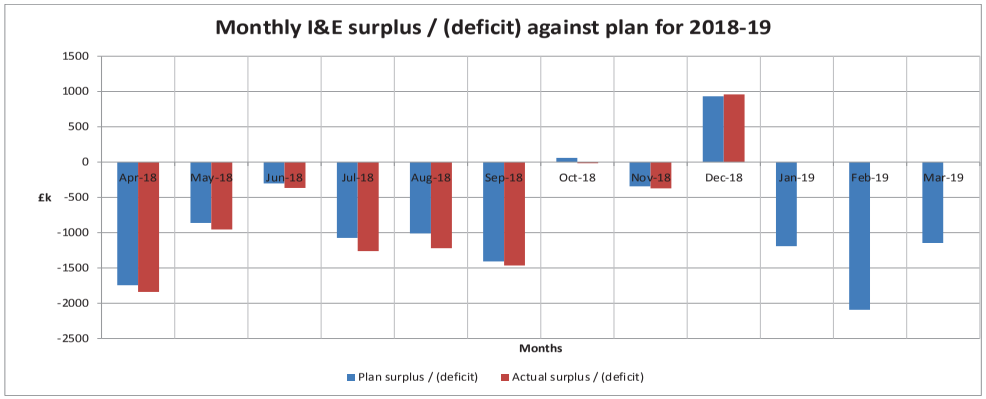
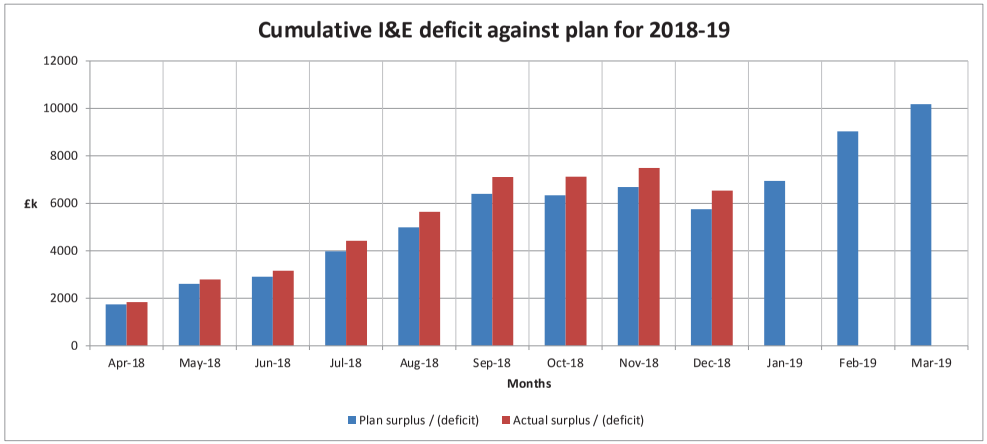
Summary of I&E indicators

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)	932	959	27	↑	Amber
YTD surplus / (deficit)	(5,751)	(6,535)	(784)	↓	Amber
Forecast surplus / (deficit)	(10,180)	(10,180)	0	↔	Green
EBITDA (excl STF) YTD	(1,072)	(2,119)	(1,048)	↓	Red
EBITDA (%)	(0.6%)	(1.2%)	(0.6%)	↓	Red
Clinical Income YTD	(145,614)	(146,237)	623	↑	Green
Non-Clinical Income YTD	(32,201)	(31,902)	(299)	↓	Red
Pay YTD	119,313	120,806	(1,493)	↓	Red
Non-Pay YTD	64,252	63,868	385	↑	Green
CIP target YTD	8,774	8,721	(53)	↓	Amber





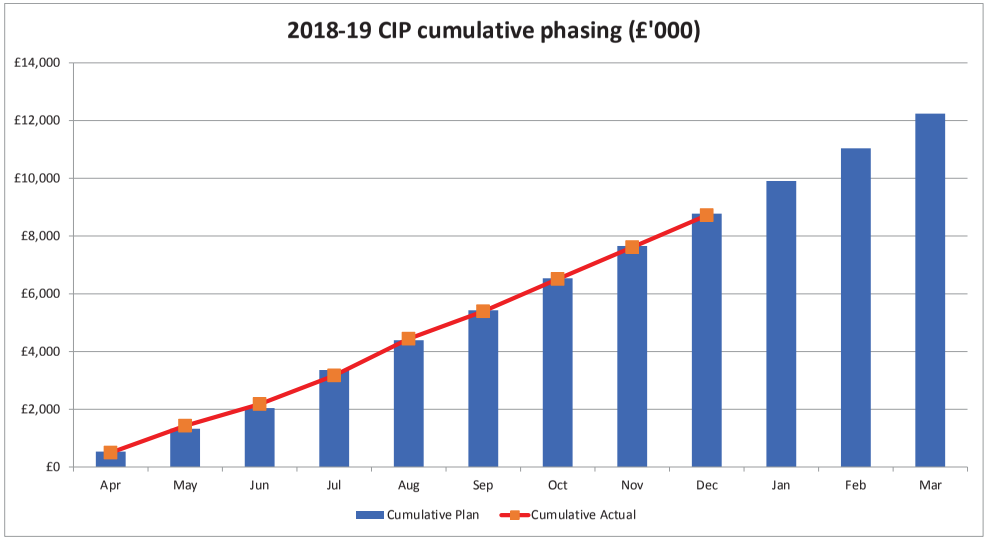


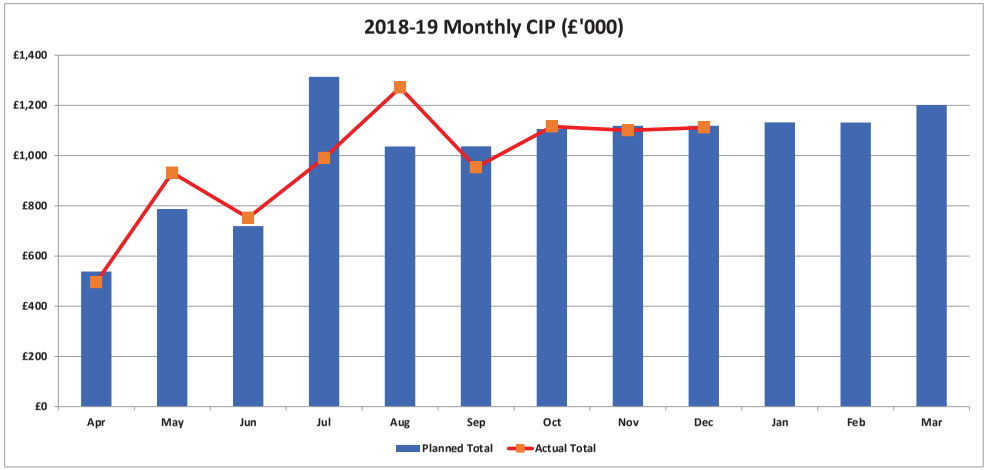
Cost Improvement Programme (CIP) 2018-19

In order to deliver the Trust's control target deficit of planned deficit of £13.8m deficit in 2018-19 we need to deliver a CIP of £12.2m (5%).

The December position includes a target of £8.77m YTD which represents 71.3% of the 2018-19 plan. There is a shortfall of £53k YTD against this plan.

Recurring/Non Recurring	Summary	2018-19 Annual Plan	Plan YTD	Actual YTD
		£'000	£'000	£'000
Recurring	Clinical Income	529	392	263
	Activity growth	186	137	-
	Private Patients	78	59	29
	Other Income	865	450	403
	Consultant Staffing	1,038	44	23
	Nursing productivity	61	41	59
	Staffing Review	80	761	992
	Additional sessions	10	9	9
	Temporary Pay	712	542	667
	Agency	98	77	105
	Pay Controls	-	-	-
	CNST discount	265	199	34
	Community Equipment Service	643	482	481
	Drugs	167	124	191
	Contract renegotiation	69	51	48
	Procurement	828	581	405
	Other	140	96	258
	Service Review	394	249	130
	Patient Flow	629	629	630
	Cancelled CIPs	324	222	-
	Divisional Cross Cutting allocation	1,880	1,295	371
Recurring Total		**8,994**	**6,440**	**5,098**
Non-Recurring	Capitalisation	1,550	144	68
	Other Income	-	1,125	1,125
	Additional sessions	268	70	155
	Contract review	100	996	1,406
	Non-Specific Divisional savings	-	-	662
	Other	1,327	-	208
Non-Recurring Total		**3,245**	**2,335**	**3,624**
Grand Total		**12,239**	**8,774**	**8,721**

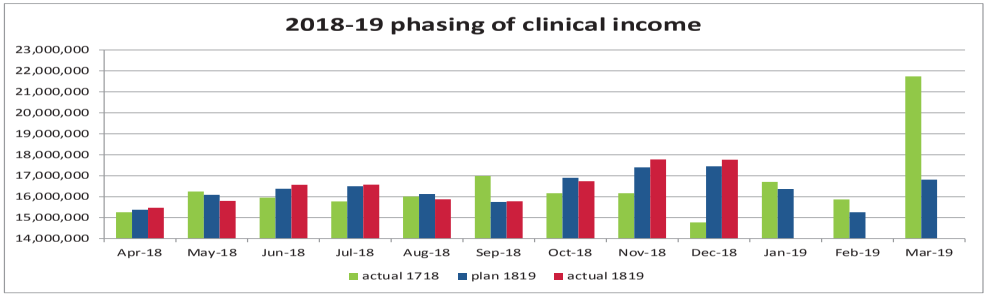




FINANCE AND WORKFORCE REPORT – December 2018

Income Analysis

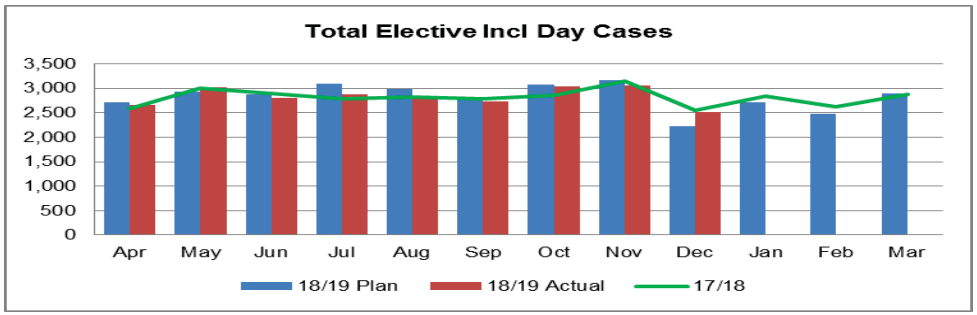
The chart below summarises the phasing of the clinical income plan for 2018-19, including Community Services. This phasing is in line with activity phasing which is how the income is recognised.

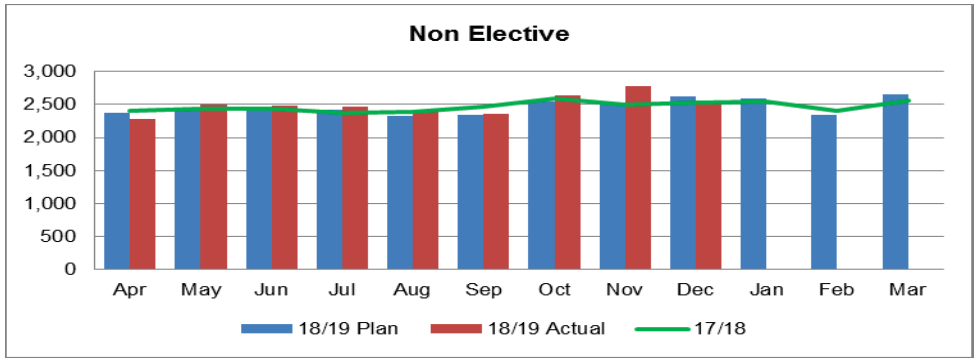


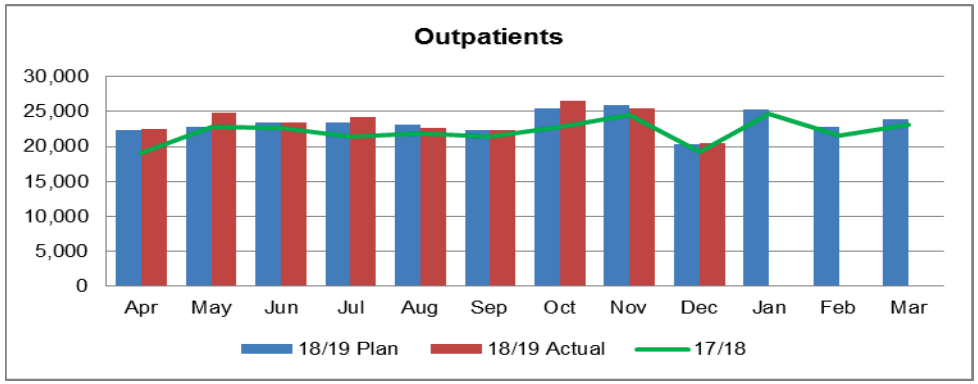
The income position was ahead of plan for December. The main area of over performance against the plan was seen within Electives.

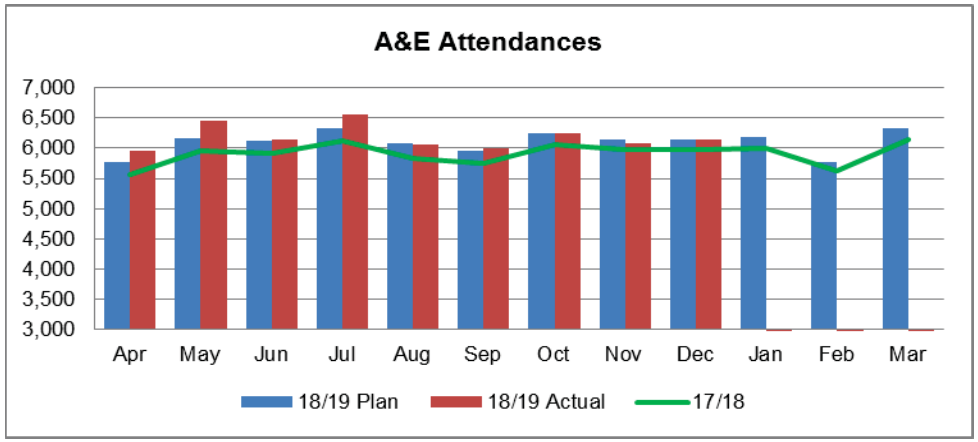
	Current Month			Year to Date		
Income (£000s)	Plan	Actual	Variance	Plan	Actual	Variance
Accident and Emergency	704	771	66	6,333	6,774	440
Other Services	3,810	3,871	61	19,438	19,728	290
CQUIN	297	303	6	2,850	2,860	11
Elective	2,169	2,546	377	26,042	24,528	(1,514)
Non Elective	5,847	5,410	(437)	49,187	49,387	200
Emergency Threshold Adjustment	(385)	(297)	88	(3,236)	(3,389)	(153)
Outpatients	2,454	2,562	108	25,334	26,569	1,235
Community	2,188	2,238	50	19,666	19,780	114
Total	**17,084**	**17,404**	**320**	**145,614**	**146,238**	**623**

Activity, by point of delivery

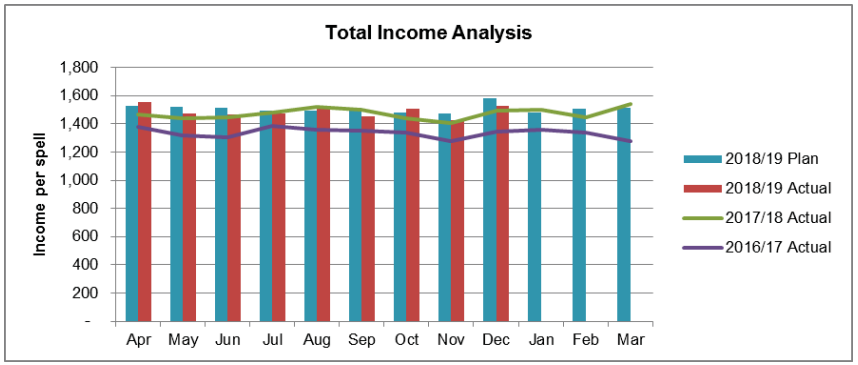


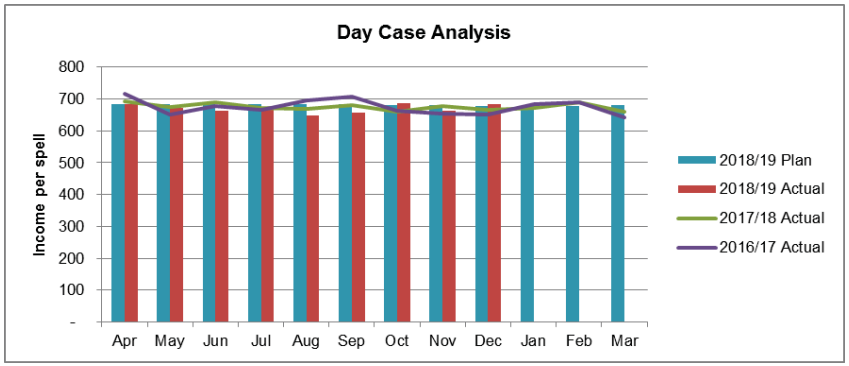


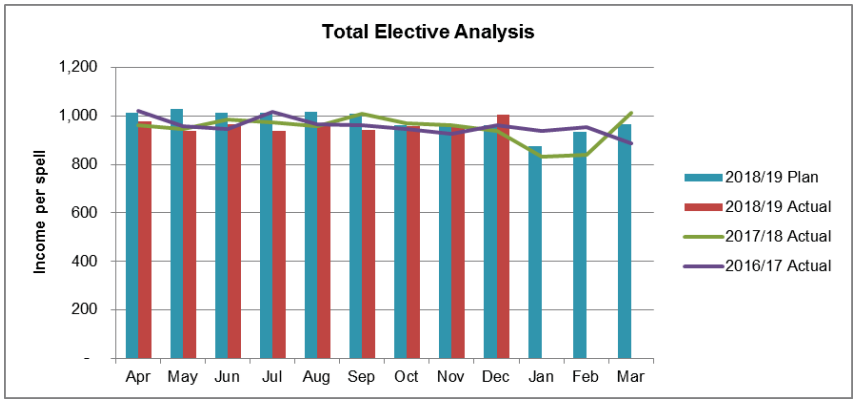


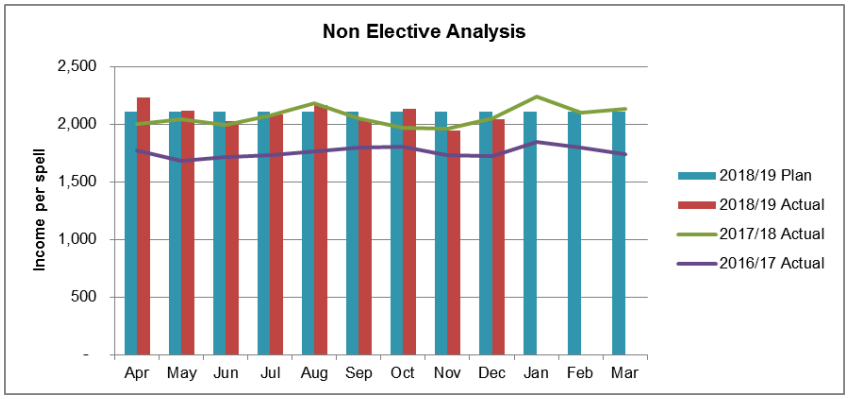


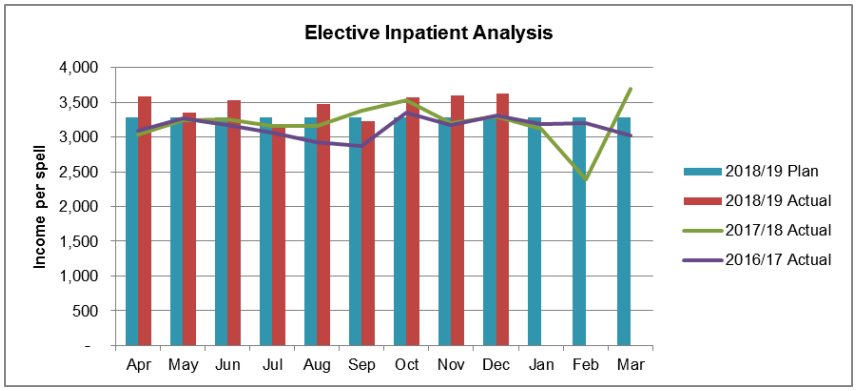
Trends and Analysis

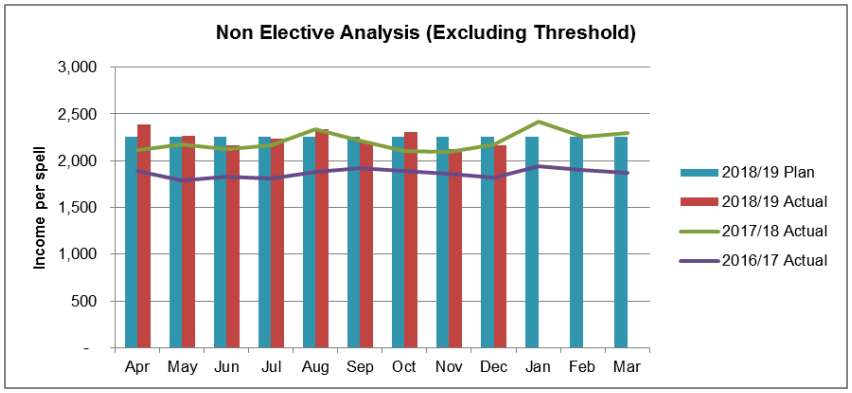












FINANCE AND WORKFORCE REPORT – December 2018

Workforce

Monthly Expenditure (£) Acute services only				
As at December 2018	Dec-18	Nov-18	Dec-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**11,827**	**12,171**	**10,920**	**105,278**
Substantive Staff	10,623	10,608	9,753	93,112
Medical Agency Staff (includes 'contracted in' staff)	246	319	102	2,001
Medical Locum Staff	294	237	391	2,215
Additional Medical sessions	266	288	286	2,413
Nursing Agency Staff	164	149	123	967
Nursing Bank Staff	233	245	245	2,773
Other Agency Staff	39	98	47	345
Other Bank Staff	122	134	135	1,249
Overtime	157	136	128	1,168
On Call	53	66	51	536
Total temporary expenditure	1,574	1,671	1,509	13,667
Total expenditure on pay	**12,197**	**12,279**	**11,262**	**106,779**
Variance (F/(A))	(370)	(107)	(343)	(1,501)
Temp Staff costs % of Total Pay	12.9%	13.6%	13.4%	12.8%
Memo : Total agency spend in month	449	566	273	3,313

Monthly Whole Time Equivalents (WTE) Acute Services only			
As at December 2018	Dec-18	Nov-18	Dec-17
	WTE	WTE	WTE
Budgeted WTE in month	**3,229.7**	**3,183.3**	**2,931.4**
Employed substantive WTE in month	2925.43	2899.27	2745.58
Medical Agency Staff (includes 'contracted in' staff)	13.82	23	8.44
Medical Locum	22.8	16.41	21.64
Additional Sessions	33.53	20.28	22.21
Nursing Agency	73.22	29.82	24.31
Nursing Bank	6.3	78.32	76.63
Other Agency	54.02	15.37	12.17
Other Bank	20.27	60.52	67.16
Overtime	44.58	39.03	35.42
On call Worked	6.96	8.04	6.64
Total equivalent temporary WTE	**275.5**	**290.8**	**274.6**
Total equivalent employed WTE	**3,200.9**	**3,190.1**	**3,020.2**
Variance (F/(A))	28.7	(6.8)	(88.8)
Temp Staff WTE % of Total Pay	8.6%	9.1%	9.1%
Memo : Total agency WTE in month	141.1	68.2	44.9
Sickness Rates (Nov / Oct)	3.13%	3.57%	3.51%
Mat Leave	2.90%	2.99%	1.3%

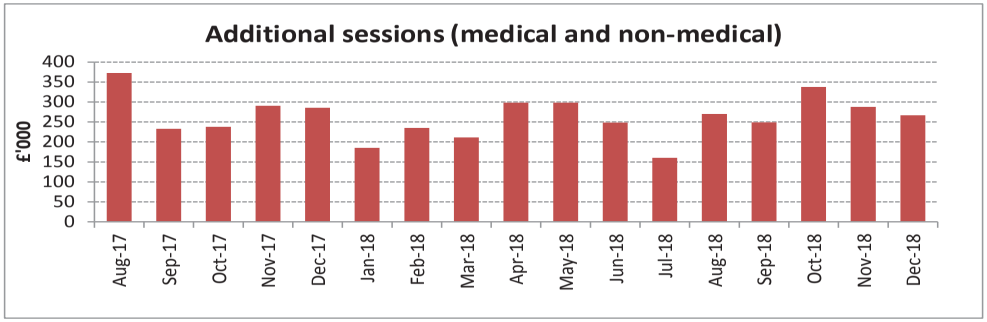
Monthly Expenditure (£) Community Service Only				
As at December 2018	Dec-18	Nov-18	Dec-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**1,565**	**1,557**	**1,528**	**14,035**
Substantive Staff	1,478	1,454	1,397	13,407
Medical Agency Staff (includes 'contracted in' staff)	12	12	12	107
Medical Locum Staff	3	3	3	27
Additional Medical sessions	0	0	0	4
Nursing Agency Staff	16	2	8	67
Nursing Bank Staff	21	13	16	167
Other Agency Staff	14	8	5	67
Other Bank Staff	16	9	2	84
Overtime	7	8	4	69
On Call	4	2	2	28
Total temporary expenditure	93	56	53	620
Total expenditure on pay	**1,571**	**1,510**	**1,449**	**14,027**
Variance (F/(A))	(6)	47	79	8
Temp Staff costs % of Total Pay	5.9%	3.7%	3.6%	4.4%
Memo : Total agency spend in month	41	22	25	241

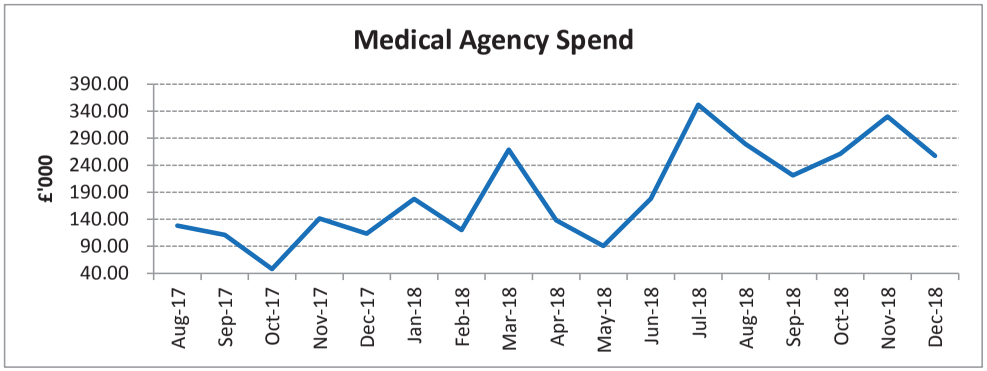
Monthly Whole Time Equivalents (WTE) Community Services Only			
As at December 2018	Dec-18	Nov-18	Dec-17
	WTE	WTE	WTE
Budgeted WTE in month	**486.25**	**484.98**	**497.6**
Employed substantive WTE in month	468.13	465.46	447.80
Medical Agency Staff (includes 'contracted in' staff)	0.74	0.74	0.70
Medical Locum	0.35	0.35	0.40
Additional Sessions	0.00	0.00	0.00
Nursing Agency	2.70	2.10	1.30
Nursing Bank	7.20	4.47	4.60
Other Agency	5.09	4.17	1.40
Other Bank	3.62	2.93	0.70
Overtime	2.27	2.59	1.40
On call Worked	0.00	0.00	0.00
Total equivalent temporary WTE	**22.0**	**17.35**	**10.5**
Total equivalent employed WTE	**490.1**	**482.81**	**458.3**
Variance (F/(A))	-3.85	2.17	39.30
Temp Staff WTE % of Total Pay	4.5%	3.6%	2.3%
Memo : Total agency WTE in month	8.5	7.0	3.4
Sickness Rates (Nov / Oct)	5.44%	3.77%	3.55%
Mat Leave	3.57%	3.99%	2.1%

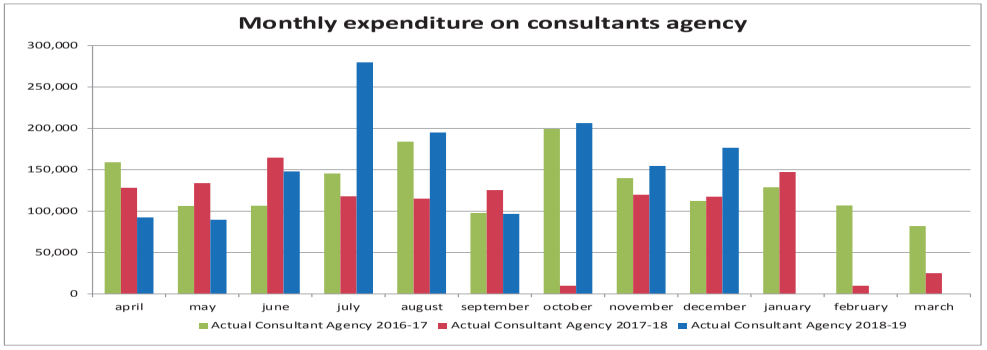
FINANCE AND WORKFORCE REPORT – December 2018

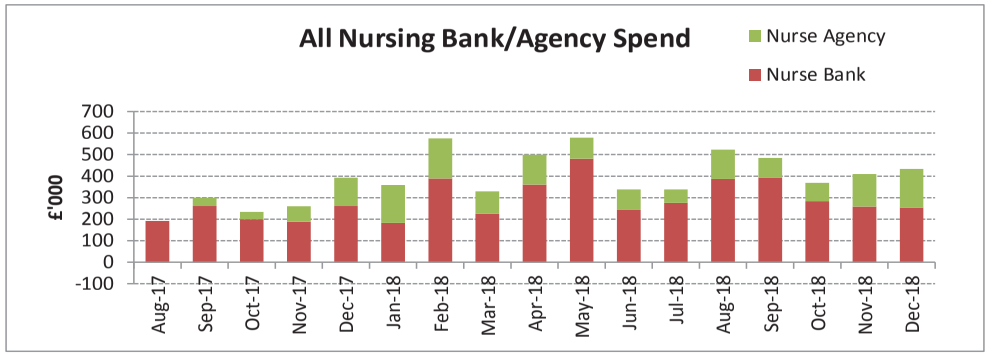
Pay Trends and Analysis

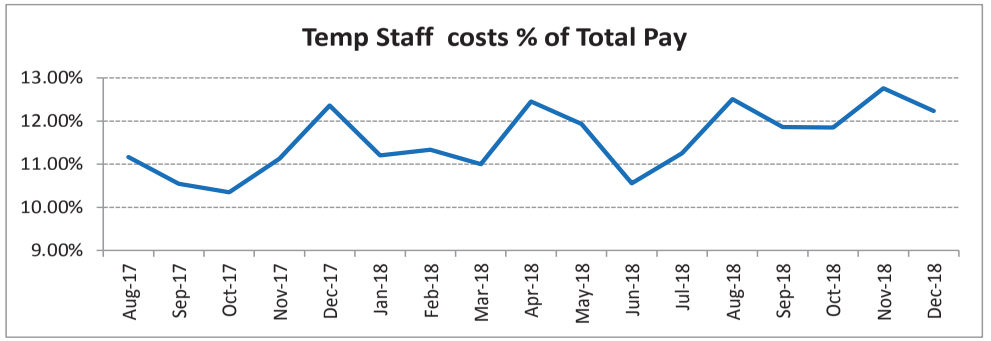
The Trust spent £376k more than budget on pay in December (£1,493k overspent YTD). This partly reflects the unfunded pay award which is estimated to be a cost pressure of £400k in 2018-19.











Registered Nurses					Nursing Assistants			
	Leavers 2018	Starters 2018	% Turnover		Leavers 2018	Starters 2018	% Turnover	
			Predicted (Based on 2017)	Actual 2018			Predicted (Based on 2017)	Actual 2018
January	1	4	0.84%	0.26%	2	8	1.51%	0.53%
February	2	2	2.15%	0.52%	4	5	1.00%	1.07%
March	4	6	0.88%	1.03%	5	6	1.04%	1.35%
April	1	6	0.44%	0.26%	2	8	1.54%	0.54%
May	2	0	0.67%	0.52%	1	0	0.78%	0.27%
June	2	2	1.59%	0.53%	3	12	0.26%	0.80%
July	6	0	1.15%	1.63%	9	8	0.76%	2.39%
August	3	1	1.16%	0.85%	1	11	1.02%	0.27%
September	3	15**	1.14%	1.21%	3	15	1.01%	1.19%
October	5	13**	0.23%	1.75%	1	19	1.76%	0.34%
November	0	5***	0.47%	0.00%	3	10	1.02%	1.27%
December	3	10***	1.43%	1.54%	3	10	2.09%	1.24%
Totals	32	49			37	112		

Summary by Division

DIRECTORATES INCOME AND EXPENDITURE ACCOUNTS	Dec-18 Budget £k	Dec-18 Actual £k	Dec-18 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE						
Total Income	(7,655)	(7,853)	198	(54,123)	(55,862)	1,739
Pay Costs	3,707	3,895	(187)	32,112	33,527	(1,415)
Non-pay Costs	1,228	1,262	(34)	12,236	12,392	(157)
Operating Expenditure	**4,936**	**5,157**	**(221)**	**44,347**	**45,919**	**(1,572)**
SURPLUS / (DEFICIT)	**2,720**	**2,696**	**(23)**	**9,775**	**9,942**	**167**
SURGERY						
Total Income	(4,022)	(3,922)	(100)	(45,559)	(44,743)	(816)
Pay Costs	3,031	3,071	(40)	27,145	27,381	(236)
Non-pay Costs	1,167	1,218	(51)	10,549	10,737	(188)
Operating Expenditure	**4,198**	**4,289**	**(91)**	**37,693**	**38,118**	**(424)**
SURPLUS / (DEFICIT)	**(176)**	**(368)**	**(192)**	**7,866**	**6,625**	**(1,240)**
WOMENS and CHILDRENS						
Total Income	(1,962)	(1,925)	(37)	(18,394)	(17,874)	(520)
Pay Costs	1,142	1,225	(83)	10,252	10,744	(492)
Non-pay Costs	154	175	(21)	1,397	1,469	(72)
Operating Expenditure	**1,296**	**1,401**	**(104)**	**11,649**	**12,213**	**(564)**
SURPLUS / (DEFICIT)	**666**	**524**	**(141)**	**6,745**	**5,661**	**(1,084)**
CLINICAL SUPPORT						
Total Income	(790)	(772)	(18)	(7,521)	(7,490)	(31)
Pay Costs	1,421	1,442	(21)	12,613	12,525	88
Non-pay Costs	1,040	997	43	9,344	9,450	(106)
Operating Expenditure	**2,461**	**2,439**	**23**	**21,958**	**21,976**	**(18)**
SURPLUS / (DEFICIT)	**(1,671)**	**(1,667)**	**5**	**(14,436)**	**(14,485)**	**(49)**
COMMUNITY SERVICES						
Total Income	(3,182)	(3,244)	62	(28,942)	(29,029)	87
Pay Costs	2,072	2,070	2	18,432	18,402	30
Non-pay Costs	1,028	991	37	8,762	8,949	(187)
Operating Expenditure	**3,100**	**3,062**	**38**	**27,194**	**27,351**	**(158)**
SURPLUS / (DEFICIT)	**83**	**183**	**100**	**1,748**	**1,678**	**(70)**
ESTATES and FACILITIES						
Total Income	(375)	(354)	(22)	(3,375)	(3,262)	(114)
Pay Costs	806	805	1	7,142	7,061	81
Non-pay Costs	629	632	(3)	5,297	5,480	(183)
Operating Expenditure	**1,435**	**1,437**	**(2)**	**12,439**	**12,542**	**(103)**
SURPLUS / (DEFICIT)	**(1,060)**	**(1,084)**	**(24)**	**(9,063)**	**(9,280)**	**(216)**
CORPORATE (excl reserves)						
Total Income	(3,406)	(3,548)	142	(20,184)	(19,879)	(304)
Pay Costs	1,212	1,259	(48)	11,618	11,166	452
Non-pay Costs (net of contingency and reserves)	1,072	860	212	9,895	8,761	1,133
Finance & Capital	752	755	(4)	7,056	6,628	428
Operating Expenditure	**3,035**	**2,875**	**160**	**28,569**	**26,555**	**2,014**
SURPLUS / (DEFICIT)	**371**	**673**	**302**	**(8,385)**	**(6,676)**	**1,709**
TOTAL (including reserves)						
Total Income	(21,393)	(21,618)	224	(178,098)	(178,139)	42
Pay Costs	13,392	13,768	(376)	119,313	120,806	(1,493)
Non-pay Costs	6,318	6,136	182	57,479	57,239	240
Finance & Capital	752	755	(4)	7,056	6,628	428
Operating Expenditure (incl penalties)	**20,461**	**20,659**	**(198)**	**183,849**	**184,674**	**(825)**
SURPLUS / (DEFICIT)	**932**	**959**	**27**	**(5,751)**	**(6,535)**	**(784)**

Note the clinical income figures are as earned within each Division as opposed to the contractual value (the adjustment to the block value is posted to Corporate, alongside other non-division specific income such as CQUIN and Excluded Drugs).

Medicine (Nicola Cottington)

The division was £23k behind plan for the month, (£167k ahead of plan YTD).

Contract Income was above plan in the month, and three quarters of the way through the year the Division remain in a surplus position, with the potential to meet the Divisional CIP target for the year as well.

ED performance in the month was £66k above budget, with attendances 2.76% higher than the same period last year. The Department's 4 hour wait performance (90.93%) was the best of all local Trusts in December – with no others exceeding 90%, and two failing to beat 80%. The performance meant the Trust met the target of 90% for the quarter, and earned the PSF payment. Income per attendance continues to increase, following the review of the ECDS. Emergency activity was subdued, and this is being investigated, as it does not appear to be consistent with ED attendances.

Elective activity was up significantly – bolstered by Chemotherapy income, Nephrology activity repatriated from Addenbrookes and a combination of angiographies, internal loop recorders and pacemakers making the new Cardiac centre extremely effective – all of this part of the Divisional CIP schemes. The Division is challenged with Diagnostic waits (6 week target) in echos and endoscopies. For the former there are still some recording issues due to interface problems, and with the latter, the sheer weight of demand.

Expenditure was overspent by £227k, primarily on pay. Key consultant vacancies in Diabetes, Haematology, Gastroenterology and Dermatology, together with demand pressures in Cardiology, ED and AMU were the key cost drivers. Qualified nurse vacancies continue to cause issues within the Division and Initiatives have been undertaken to improve the situation, as well as to alleviate the impact on the wards in the short term.

The Division over-performed on its CIP target (£187k) for the month by £66k, and the forecast is improved to being £143k off the annual Divisional target of £1,856k. The biosimilar project contributed £105k in December, with potentially much greater savings in subsequent months. The originator drug for Adalimumab (humira) reduced in price significantly as a reaction to the imminent introduction of the biosimilar (Imraldi), which delivers an even greater saving in subsequent months. The repatriation of income (Cardiology and Nephrology) also helped the Divisional position.

Surgery (Simon Taylor)
The division has overspent by £192k in month (£1,240k YTD).

This largely relates to income. Admitted Patient Care over achieved plan by £24k, however, this is due to elective patient care over achieving by £222k, whilst non elective is underachieving by £188k. Critical care over achieved by £82k.

Pay is overspending by £40k. There is a cost pressure relating to temporary medical staffing to support RTT and ward based junior doctors. This is partially offset by vacant nursing and admin posts.

Non-pay is overspending by £51k. This mainly relates to an over spend on T&O Prosthesis of £43k which may relate to the purchase of additional stock to cover the Christmas period.

The forecast positon for year-end remains unchanged from the Month 8 (November) position and stands at a forecast overspend of £945k.

Women and Children's (Rose Smith)
In December the division is behind plan by £141k (£1,084k YTD).

Income reported £37k behind plan in-month and is £520k behind plan YTD. In month, the activity in the Neonatal Unit was lower than planned. Year to date, elective gynaecology and non-elective paediatric activity has been behind plan which explains the majority of the year to date variance.

Pay reported an £83k overspend in-month and is £492k overspent YTD. In-month, a locum consultant was employed to cover long term sickness in Paediatrics and additional consultant cover was arranged to address some of the RTT pressures in Obstetrics & Gynaecology. Year to date, the medical staffing issues in Obstetrics & Gynaecology have been an issue and long term consultant sickness has put pressure on the Paediatric budget. The department is establishing whether the department should seek longer term cover, at a lower cost, to address the need to return to work on reduced duties.

Non pay reported a £21k overspend in-month and is £72k overspent YTD. The in-month overspend was driven by part-pathway charges and consumable spends for Hospital Midwifery and the Neonatal Unit. The YTD overspend has been driven by lease spends on new equipment in the Neonatal Unit and part-pathway charges for West Suffolk patients who have given birth at other trusts.

Clinical Support (Rose Smith)
In December, the division underspent by £5k (£49k overspent YTD).

Income for Clinical Support reported £18k behind plan in-month and is £31k behind plan YTD. In month, breast screening and direct access activity were behind plan. Year to date, the Radiology Department has seen a higher number of outpatient, direct access and breast screening patients.

Pay is £21k overspent in-month and is £88k underspent YTD. In month, the majority of the underspend has been driven by locum consultants in Radiology covering temporary gaps in the rota. Year to date, the Radiology and Pharmacy departments have not been able to fully backfill their vacancies with bank, agency and overtime.

Non pay reported a £43k underspend in-month and is £106k overspent YTD. In month, the majority of the variance relates to low levels of consumable orders in Radiology. Year to date, the underlying pressures from the HODS element of the Pathology contract continue to put pressure on the division's budget.

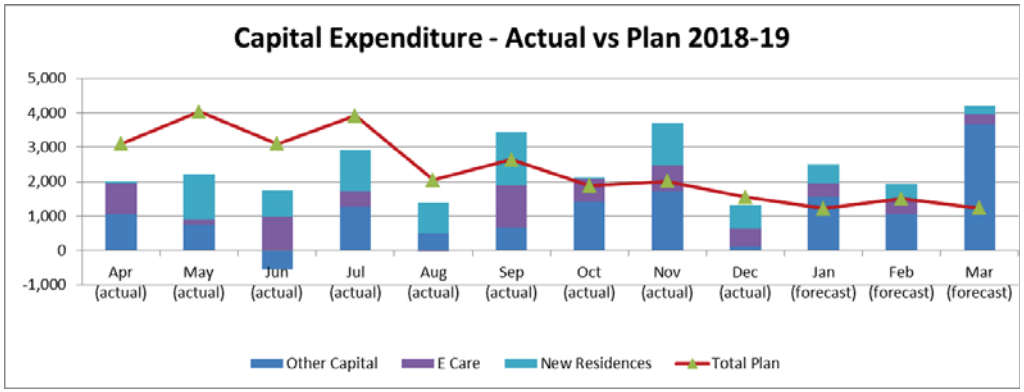
Community Services (Dawn Godbold)
The division reported a £100k underspend in month (£70k overspent YTD).

Overall income reported a £62k over recovery in month and £87k over recovery YTD. In month over recovery of income includes off FP10 staffing costs being invoiced (£45k) offset against a decrease in income relating to CES of £40k (linked to a decrease in costs). There was also additional contract income of £47k received in month.

Pay reported a £2k underspent in month and £30k underspend YTD. In-month underspend is due to a number of new starters across the division.

Non pay reported £37k underspend in month and £187k overspend YTD. This is mainly due to CES contract reporting a £92k underspend against budget, due to lower prices as part of the new contract. This has been offset against an overspend within commissioned beds of £28k, due to non-achievement of CIP, contract price increases and Paediatrics Off FP10 catch up charges relating to April to December 18 accounting for a £40k adverse variance.

Capital Progress Report



	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Actual £'000	Dec Actual £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	Total 2018-19 £'000
E Care	916	131	975	457	-11	1,217	670	766	501	386	386	324	6,719
New Residences	37	1,329	773	1,210	903	1,557	57	1,230	701	550	500	218	9,065
Other Schemes	1,047	760	-555	1,259	480	658	1,400	1,716	120	1,562	1,051	3,647	13,145
Total / Forecast	1,999	2,220	1,193	2,926	1,372	3,432	2,128	3,712	1,322	2,498	1,937	4,190	28,930
Total Plan	3,098	4,022	3,098	3,911	2,041	2,638	1,876	2,007	1,551	1,221	1,497	1,226	28,186

The capital programme for the year is shown in the graph above. The ED transformation scheme has now been approved subject to Full Business Case approval for £14.9m less £1.5m anticipated asset sale. The scheme will commence substantively in 2019/20.

Expenditure on e-Care and associated IT schemes for the year to date is £5.6m with a forecast for the year of £6.7m.

The actual for the year to date is behind the plan submitted to NHSI and shows a favourable variance of £3.98m. This is because the timing of the implicit finance lease equipment additions in radiology and endoscopy has changed plus there is slippage on Residences compared to plan. The next phase of the roof replacement programme commenced slightly later than the original plan forecast.

The project managers have reviewed their schemes and the forecasts have been amended to reflect the latest position.

The £8.1million PDC application has been turned down by DH but a repayable loan of £7.31 million has been agreed. The shortfall of £790k results in an equivalent reduction in the level of contingency available.

The forecast has increased this month because approval has been received for some NHS digital STP wide investment which will be received as PDC this financial year.

The full impact of further implicit finance leases in IT may increase the forecast in January subject to the assessment being completed but there will be no cash implications.

Statement of Financial Position at 31st December 2018

STATEMENT OF FINANCIAL POSITION

	As at 1 April 2018 * £000	Plan 31 March 2019 £000	Plan YTD 31 Dec 2018 £000	Actual at 31 Dec 2018 £000	Variance YTD 31 Dec 2018 £000
Intangible assets	23,852	27,909	26,919	27,907	988
Property, plant and equipment	94,170	111,399	108,780	105,736	(3,044)
Trade and other receivables	3,925	3,925	3,925	3,925	0
Other financial assets	0	0	0	0	0
Total non-current assets	**121,947**	**143,233**	**139,624**	**137,568**	**(2,056)**
Inventories	2,712	2,700	2,700	2,776	76
Trade and other receivables	21,413	19,500	19,700	21,258	1,558
Non-current assets for sale	0	0	0	0	0
Cash and cash equivalents	3,601	1,050	3,050	4,306	1,256
Total current assets	**27,726**	**23,250**	**25,450**	**28,340**	**2,890**
Trade and other payables	(26,135)	(27,499)	(27,129)	(25,457)	1,672
Borrowing repayable within 1 year	(3,114)	(3,357)	(3,367)	(3,083)	284
Current Provisions	(94)	(26)	(26)	(94)	(68)
Other liabilities	(963)	(1,000)	(5,500)	(5,143)	357
Total current liabilities	**(30,306)**	**(31,882)**	**(36,022)**	**(33,777)**	**2,245**
Total assets less current liabilities	**119,367**	**134,601**	**129,052**	**132,131**	**3,079**
Borrowings	(65,391)	(90,471)	(84,467)	(82,181)	2,286
Provisions	(124)	(158)	(158)	(130)	28
Total non-current liabilities	**(65,515)**	**(90,629)**	**(84,625)**	**(82,311)**	**2,314**
Total assets employed	**53,852**	**43,972**	**44,427**	**49,819**	**5,392**
Financed by					
Public dividend capital	65,803	66,103	65,803	68,308	2,505
Revaluation reserve	8,021	8,021	8,021	8,021	0
Income and expenditure reserve	(19,974)	(30,152)	(29,397)	(26,509)	2,888
Total taxpayers' and others' equity	**53,850**	**43,972**	**44,427**	**49,819**	**5,392**

Non-Current Assets

There is some slippage on the capital programme, mainly on Residences, implicit finance leases and the roof, although GDE is ahead of plan.

Trade and Other Receivables

These have decreased in December; by £2.8m. The balance is now £1.5m higher than planned. This is mainly £2m GDE income had been invoiced at the end of December but not received as NHS Digital sign off of the payment was still pending.

Cash

In December the Trust received:

- £4m loan for capital investment as part of a £7.3m loan agreed in December following the application for £8.1m PDC;
- £1.2m cash support for deficit funding;
- £1.8m PSF drawn down as a loan in advance of receipt for Q2 and Q3;
- £0.7m PSF Q2 received with no notice (as a result of this receipt the loan for Q2 PSF has been repaid in January); and
- £2.3m additional funding from the CCG for additional activity, cataract surgery, RTT wheelchair investment and refurbishment of St Helen's House.

As a result of these receipts the month end balance increased by £3.1m compared to November.

Although the pressure eased in December, cash is a challenge again in January and will remain so until the end of the financial year.

An additional pressure on cash is caused by some of the CIPs to meet the revenue deficit no longer coming from cash related schemes. In order to mitigate this the Trust has requested an increase of £4m to the working capital loan taken out previously which is currently £7.5m.

Trade and Other Payables

This is money owed to other organisations. Payables have decreased by £2.9m since November and are £1.7m less than estimated in the plan for December.

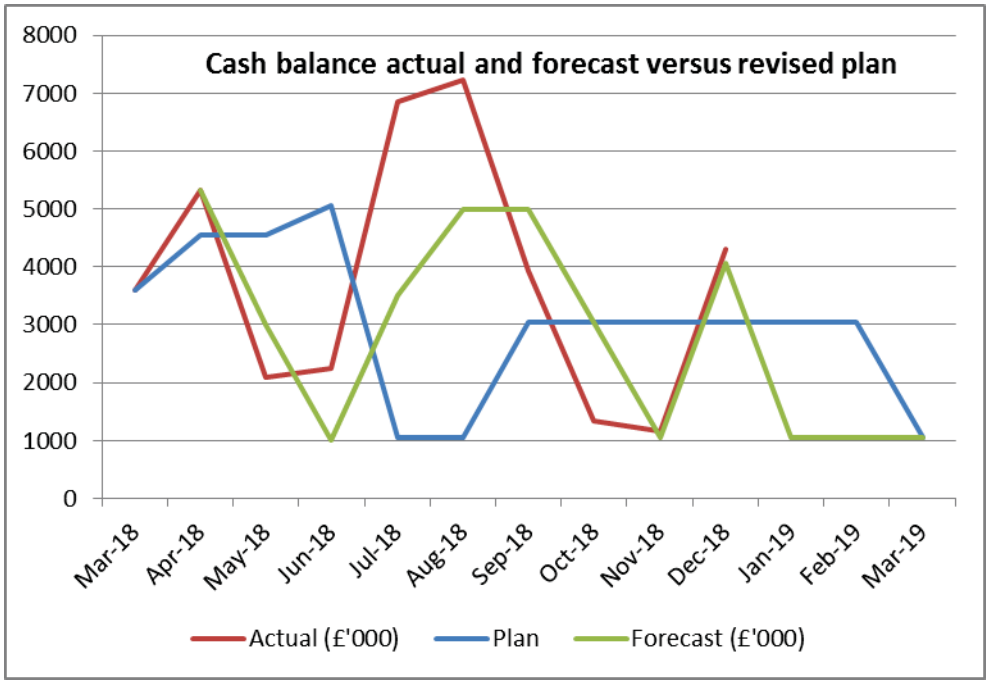
Borrowing

Borrowing has increased by £5.7m in December. This relates to the planned revenue deficit for the month and the Trust has drawn £4m of the £7.3m capital loan agreed in December.

The Trust has requested an additional £4m to reflect the element of the CIP programme now being found from non-cash schemes e.g. depreciation.

PDC is higher than planned because the Trust has been awarded £2.3 million capital PDC for the first phase of the Acute Assessment Unit which opened at the end of November 2018. PDC does not have to be repaid but does attract a cash charge of 3.5% per annum.

Cash Balance Forecast for the year



The graph illustrates the cash trajectory since March, plan and revised forecast. The Trust is required to keep a minimum balance of £1 million.

The 2017/18 STF (£5.3m) was paid earlier than expected in July with no notice.

The application for £8.1m PDC capital was still outstanding at the end of November and the cash position reached a critical position. In early December the application was declined but a repayable loan was agreed by DH for £7.31m and £4m was drawn down in December as a result.

Q2 PSF was received in December with 24 hours' notice but had already been drawn down in advance in the same month as a loan. This has been repaid in January but as a result the actual for the end of December was higher than plan.

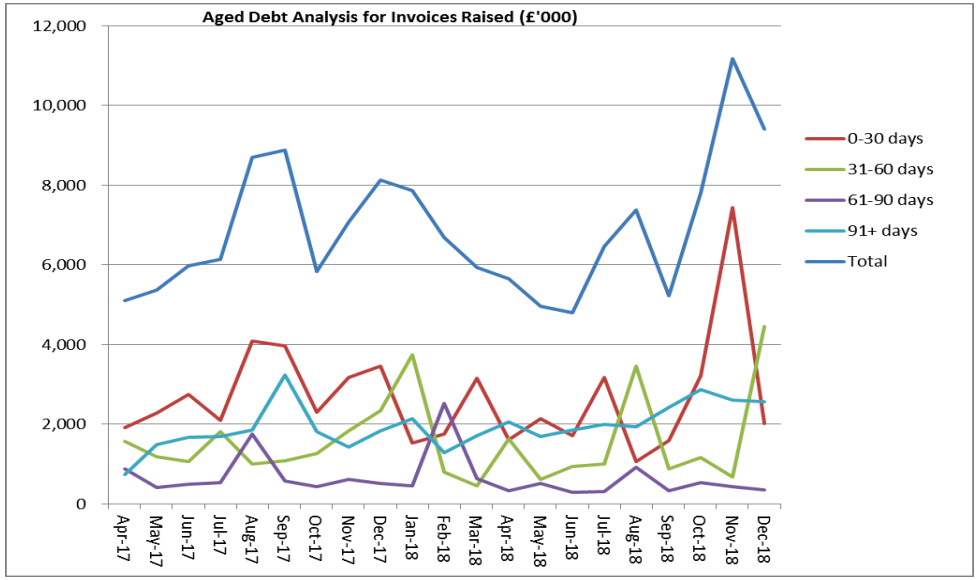
The profiling of the CCG contract payments has reduced significantly from October onwards following accelerated payments in the first half of the year.

The Trust is borrowing cash from DH equivalent to its control total deficit of £10.2m in 2018/19 in addition to capital borrowing. The Trust owes £85.2m at the end of December and this will increase significantly before the end of the financial year.

Debt Management

It is important that the Trust raises invoices promptly for money owed and that the cash is collected as quickly as possible to minimise the amount of money the Trust needs to borrow.

The graph below shows the level of invoiced debt based on age of debt.



The overall level of invoices raised but not paid has decreased by £1.8m in December. This is mainly due to West Suffolk CCG settling significant invoices raised at the end of November.

The significant increase in debts 31-60 days is caused by the GDE invoice for £2m moving into this category in December.

78% of the £2.6m 91+ days debt relates to other NHS organisations.

10. Transformation Q3 report

To ACCEPT the report

For Report

Presented by Helen Beck

Trust Board - 25 January 2019

Agenda item:	10			
Presented by:	Helen Beck - Chief Operating Officer			
Prepared by:	Lesley Standring – Head of Operational Improvement, WSFT Sandie Robinson - Associate Director of Transformation, CCG Jane Rooney - Head of Planned Care Transformation, CCG John Connelly - Head of PMO, WSFT Sheila Broadfoot - CQUIN Lead, WSFT			
Date prepared:	17 January 2019			
Subject:	Transformation Board Report			
Purpose:	√	For information		For approval

Executive summary:
This report provides an update from the last reporting period and relates to the programs of work being undertaken by the joint transformation teams, the Trust PMO and progress against CQUIN.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	√	√	√

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

Previously considered by:	Planned Care Board A&E Delivery Board
Risk and assurance:	*[Detail relevant issues within the report]*
Legislation, regulatory, equality, diversity and dignity implications	*[Detail relevant issues within the report]*

Recommendation:
The board is asked to note the content of the report and progress in a number in a number of key system wide transformation initiatives

1.0 Update on Hospital Transformation

1.1 Red to Green (R2G)/SAFER

Senior operational and matron support to board rounds continues each Monday and Wednesday within the medical division. The surgical division allocate a manager each day to R2G.
The patient flow team support the escalation of barriers to discharge supported by nominated divisional managers of the day.

Executive attendance at board rounds is now targeted at areas of concern as agreed at executive meetings.

Next steps include inclusion of the patient flow team in the R2G process; particularly the identification of the golden patient who will be discharged or moved the discharge area by 10 am the following day.

Internal professional standards – recently launched a TTO IPS to support the extended working hours in pharmacy and to ensure TTO writing does not drift to later in the day

1.2 Multi Agency Discharge Event - MADE

Following a successful MADE in October 2018, a second was planned for the 2 and 3 January 2019. It was anticipated that this would be timely in supporting the hospital to recover following the Christmas and New Year holiday period. We had excellent support from CCG and social care colleagues.
As with the previous event it was anticipated that we would showcase how we work together.

Evidence shows that running a MADE gives positive benefits:
- To patients, by ensuring care is delivered in the right place
- To acute staff who gain a greater understanding of services available outside of an acute organisation
- To wider system partners who get a flavour of the demands faced.

Expected outcomes:
- Increased discharges = more beds to allow us to cope with the predicted increase in demand
- Increased knowledge of the system and myth busting

Initial findings included:

- Further work needed to ensure all patients have a clear plan particularly to run over a weekend and into Monday
- Out of area delays require a formal escalation route
- IV antibiotic pathway for patients to go home needs to be reviewed

1.3 Diagnostic Virtual Ward (DVW)

Transformation funding has been agreed to test a DVW. We are running the service from the discharge waiting area.

Currently the patient cohort consists of:
- Cardiology for ECHO patients and
- Gastroenterology for scoping patients
- Surgical patients waiting for USS and CT

Inclusion Criteria:
- Inpatients identified by consultant in charge of their care
- Awaiting an inpatient investigation (Echocardiogram, Gastroscopy, Sigmoidoscopy, Colonoscopy).

- Planned for discharge after the inpatient investigation (i.e. medically fit for discharge provided the investigation is done in a timely fashion).

Adults:
- Support at home – not 'home alone'
- Easy access back to WSFT/Accident and Emergency
- Contactable by 'phone (preferably mobile)

Numbers to date have been minimal for various reasons i.e. relocation of cardiac services. It is planned to increase the numbers of patients from mid-January

1.4 Community Delayed Transfer of Care (DTOC)

Working with the discharge team to ensure all 3 community assessment bed sites follow national guidelines with regard to DTOC reporting. Glastonbury Court and Newmarket Community Hospital are all working within the guidelines. Next step is to engage and work with Hazel Court.

1.5 Trustmarque

An external consultant was engaged to work with us during October and November to conduct a data exploration exercise using our ED data. The project uses 3 years' worth of ED data which has generated various analytical charts which allows the ED team to drill into the data to identify trends. From this, changes can be implemented to make improvements. Whilst the external consultant has left, the model remains in use in the Trust and connected to our data. This allows it to continue to be used to drill further into any area of interest to better understand the demand at ED. It also means we can use it to measure the impact of test and learn changes which will allow small changes to be made quickly, measured quickly and either implemented fully or reverted back if no impact is achieved. Training on the product was delivered on 19th Dec and the Senior Analyst is currently finalising the model to make it easier to use and allow it to become embedded as a key analytical tool for the department.

1.6 Appointment of project manager

West Suffolk NHS Foundation Trust will host a CCG project manager post for 1 year to lead on high impact users across the health and care system.

2.0 Integrated Care Programme Project Highlights

2.1 Integrated Urgent Care

The Integrated Urgent Care (IUC) Service went live on 1 November 2018 followed by the Clinical Assessment Service (CAS) element from 6 December 2018. The CAS brings increased clinical triage to the heart of the service. With the support of winter monies, Care UK are undertaking clinical validation of Category 2 ambulance dispositions. Since the CAS and Category 2 scheme has gone live, the percentage of ambulance calls (November 15.6% - December 14.1%) and A&E calls (November 9.5% - December 8.3%) has decreased.

111 performance over the Christmas and New Year Period was much better than expected with 89% of days (16/18) over 90% between 18 December 2018 and 4 January 2019 and 9/18 days above 95% - although performance levels were aided by less calls than the provider predicted.

Care UK and Suffolk GP Federation are working together to mobilise the transfer of the Suffolk OOH element of the service to the GP Federation by the end of April 2019.

2.2 Buurtzorg

The alliance partners have committed their support to extend the pilot phase to cover Bury Town and have appointed a dedicated project nurse to oversee implementation. A workshop to consider the Kings Fund review of the implementation is being planned in March to ensure learning can be extended to the development of the Integrated Neighbourhood Teams. The Kings Fund Report is expected to be released in late February and will be presented to the March Health and Wellbeing Board.

2.3 Rapid Intervention Vehicle

This service has now been operational Monday to Friday across 3 localities for 3 months and extended to weekend working at the beginning of December. The vehicle is manned by a specialist Paramedic or Emergency Care Practitioner and an EIT Therapist and responds to EEAST and EIT Calls. Key activity ranges from falls, UTIs, SOB, COPD exacerbations, 'off legs'.

Up to 31 December 2018 183 patients have received a response split equally between an EEAST 999 and EIT call. 80.9% of these calls did not result in a conveyance to hospital with a clinical view that more than half of these would have resulted in a conveyance had the response not been available.

The service is funded to 31 March and an evaluation paper is due to go to the March A&E Delivery Board.

2.4 Connect Localities

The Transformation Team has now aligned to each West Suffolk Connect locality working with county council, St Edmundsbury and the community leads to form a core Locality Delivery Team. The Integrated Care Programme is now split across all 6 localities with Mildenhall and Haverhill being forerunners to shape a locality based plan.

2.5 Responsive Care

As part of Suffolk County Council's Home Care re-development work, system partners are co-designing the integrated responsive service element which is likely to bring together the existing reactive services of west Suffolk health and care services to meet to provide:

1. An urgent response irrespective of health or care need
2. An integrated reablement/rehabilitation response to support people at home. This might be after a fall, a stay in hospital or a period of illness and the person needs to recover functionality or be taught to adapt to a new condition

The services being considered as part of this integrated offer include the Early Intervention Team (EIT), Support to Go Home (STGH) and Homefirst. This may also include some elements of Adult Social Care (ACS) and Domiciliary Care.

The new service will be operational from September 2019 and will be integrated into the locality based delivery teams (Integrated Neighbourhood Teams) as much as possible whilst retaining the interface with acute pathways.

2.6 Discharge to Optimise and Assess

Pathway 1 is now available to 6 base wards and is working well. The teams support two to three referrals a day and this will be expected to increase as more wards join, confidence in the referral pathway matures and community and acute OTs integrate to share the responsibility of assessment. The delivery of the model is demonstrating strong integrated working and collaboration across health and care and is an excellent example of how practitioners cut through traditional ways of working to flex delivery to the needs of individuals.

An evaluation with case studies is currently being developed.

3.0 Planned Care Programme Project Highlights

3.1 100 Day challenge

The video conferencing pilot for follow up consultations went live in November 2018 with a small number of patients in the dietetics department. It was well received by both staff and patients. The gestational diabetes team are planning to join the pilot too. By February 2019, we anticipate having sufficient data and feedback to start rolling this programme out more widely.
The low priority procedures (LPP) programme is still in the final planning stages and will start it's 100 days next month. There will be an initial roll out of the revised process in five specialties with the remainder coming on board once the initial phase is embedded.

3.2 Right Care Programme – Cardio Vascular Disease (CVD), Respiratory and Neurology

'RightCare' is about the whole health system taking an evidence-based approach to focus on key areas that will improve health outcomes for the population, reduce unwarranted variation in care and save money. Going forward, RightCare will be working more closely with the GIRFT team to ensure that the two programmes are aligned and no opportunities are missed.

Revised and updated plans for CVD, respiratory, gastroenterology and Neurology in September 2018, have now received feedback and actions are being taken as appropriate. For CVD, neurology and gastroenterology the Rightcare work will be encompassed in the wider Elective Care Transformation Programme. Respiratory Rightcare will move to the Integrated Care Team.

3.3 Treatment and Care Funding – Diabetes Management

This month, the CCG has received an Outstanding Rating assessment from NHSE for the Diabetes service in West Suffolk. This is credit to the huge amount of work that has been done by the CCG and the Trust in the past 2 years.

Work continues to promote the structured education services and to encourage the uptake of mentor clinics at GP practices using the expertise from WSFT

3.4 Integrated Pain Management Service (IPMS)

Following the System Executive decision to approve the service after the MCP process, this will now be presented to the Governing Body on January 23rd for the final sign off of a new integrated service. The transition plans have been completed and the service is set to go live on April 1st 2019

3.5 Ophthalmology

Following agreement from the CCG to fund additional activity to clear the ophthalmology backlog, outsourcing of the work has now commenced. 64 patients have now been sent to the third party provider and to date, 20 have already had their surgery.
In addition, the Trust team is undertaking extra lists to help to clear the cataract waiting list backlog. An additional 61 patients have had their procedure in house to date.

Procurement needs to start to ensure that additional patients can be sent to the third party provider.

3.6 Stroke

The Stroke service continues to be discussed and reviewed both locally and across the STP.

In Suffolk, the three support service contracts are for re-procurement before their expiry in March 2020. Service specifications have been drafted for early supported discharge (ESD) and comments have been received which have been incorporated. This is now awaiting clinician sign off. Specifications for Communications and rehabilitation are in first draft and will be circulated for input from stakeholders.

Across the STP a review is pending to consider the HASU and ASU units across the STP. An independent person is to be engaged to run this process. WSFT and the CCG are working on the scope for the options appraisal as well as the considerations that West Suffolk would like included in the review.

Progress within AF detection, prevention, perfection and correction continue. There is sufficient funding from NHSE to move the GP review clinics from the GP surgery (for patients known to have AF) into the Trust to ensure that these are completed in a timely way. This is under discussion with the clinical and operational team.

3.7 Demand Management

Training for Teledermatology is almost complete with just one further GP practice to come on board. The Trust and Primary Care has now agreed a letter to be sent out to GPs following all referrals which are not routed via Teledermatology.

The gynaecology service review is underway and action plans for clinicians and operational teams will shortly be finalised. The findings demonstrate that significant work needs to be done on the processes that support the service to eliminate the potential clinical risk of patients waiting or being lost in the system. Meetings have been held with the operational team to discuss the findings and will take place with the clinicians next week. There are several 'quick fixes' that will be implemented to improve the service but the larger more cross cutting projects will be incorporated into the wider Elective Care Transformation Programme.

For 2019/20, to support demand management and the aspirations of the NHS Long Term Plan, a new programme of Elective Care Transformation is being developed across the West Suffolk Alliance. Currently the vision and scope are being determined prior to a workshop on March 6th to further define the elements of the programme

3.8 Cancer Care

From January 2019, Cancer will be an agenda item on the Planned Care Board agenda. This will entail representation from CCG and Trust presenting on performance, issues and future plans

4.0 PMO Update

4.1 CIP Programme

The 2018/19 CIP Programme continues to report as overachieving against target.

The 2019/20 CIP Programme build process continues with the completion of the divisional CIP workshops in January 2019. Cost improvement opportunities with a gross value of £4M have been identified, including cross cutting projects.

4.2 Medical e-Rostering

The eJobPlan module is now live for the 2019/20 Job Planning round. The e-Appraisal build is now also complete and clinical agreement has been reached regarding the migration of existing appraisal data. The implementation of the Medical Rostering modules for juniors will be complete by February 2019 with consultants following in March 2019. Activity Manager will be in place by April 2019. The business as usual model has also been agreed. A Band 6 Medical Rostering Business Manager in HR will be recruited to achieve the expected benefits from the system.

The Trust will benefit from additional implementation support for up to 3 days per week free of charge from the end of February 2019 as part of a shared learning partnership with Allocate

4.3 Procurement: Category Towers

The following are the category towers contracts:

1. Ward Based Consumables (DHL)
2. Sterile Interventions Equipment and Associated Consumables (CPP)
3. Infection Control and Ward Care (DHL)
4. Orthopaedics, Trauma and Spine, Ophthalmology (CPP)
5. Rehabilitation Disable Services, Women's Health and Associated Consumables (CPP)
6. Cardio-Vascular, Radiology, Audiology and Pain Management (HST)
7. Large diagnostic or capital devices
8. Diagnostic equipment and consumables
9. Office Solutions
10. Food
11. NHS Hotel Services

Category Towers (2-6) are in mobilisation. Category Towers (7-11) are in implementation

The Trust is currently awaiting work plans from the LLP to assist with mobilisation so the Trust can link in.

5.0 CQUIN Projects 2018-19

Staff CQUINs title:	Progress	RAG
1a) Staff Health & Wellbeing: Improve two specific results by 5% from 2016 on the national Staff Questionnaire re: H&W provision & MSK & Stress not 'due to work'.	H&W provision – target increase to 45% (2017-8 was 43%). Staff H&W initiatives in place. MSK survey via physio: Aug-Dec MSK – target reduce to 17% (2017-8 was 21%). Stress – target reduce to 28% (2017-8 was 33%). Rely on staff own perception to interpret and decide whether: 'Work was main cause of' Stress or MSK.	Q4 Q4
1b) Food & Drinks sold at WSFT: Continue changes made 2016-7 re: items high in fat, sugar or salt and new targets for 3 changes 2017-8.	All in place including liaison with W H Smith. 10% sales max of sugary drinks (no ban); by March 2019 20% of shelf allowed re: >250kcal sweets & 25% shelf re: >400kcal sandwich/wraps/salads. Submit data for NHS Digital.	
1c) Flu vaccination of staff: 75% uptake by end of February.	2017-8 was WSFT 74% (total incl Community 70.99%). No major outbreak like last year yet. Front line **72%.**	Q4
Patient CQUINs title:	**Progress**	**RAG**
2a) Sepsis screening of all ED and inpatients. Target 90%	eCare adds symptoms together & prompts 'Suspected Sepsis'. From Q4 (Jan) to use NEWS 2 criteria - eCare updated. Paediatrics yet to have alerts. Q2 audit Sept & Q3 in progress.	
2b) Severe/ High Risk Sepsis treatment ED & Inpatients: IV anti-biotic within 1 hour of diagnosis. Target 90%	Improvements required. Q1 ED 64%, Inpatient 74%. Sepsis/ eCare Group: decision to stay with current alert algorithm. Paediatrics yet to have alerts. Sepsis Nurse started in Jan re: education & audit. Q2 audit Sept & Q3 in progress.	Q1-4
2c) Severe/ High Risk Sepsis - ED & Inpatients: antibiotic prescription review & assessment. Q4 target 90%	2018-9 – predicted will be met. Note: additional criteria – review within 72 hours & additional documentation & IV to oral switch assessment. Q2 audit Sept & Q3 in progress. Data to be submitted to Public Health England.	
2d) Higher % reduction in 'total all' & Carbapenem Antibiotic use vs 2016. Increase usage within Access group AWaRe (Access, Watch & Reserve).	Note: Total antibiotics & Carbapenems increased 2017-8 re: Tazocin shortage. Challenge to reduce 1% & 2% in 2018-9. New: Increase (for in & outpatients), proportion >55% or by 3% vs 2016 antibiotics within the Access group of AWaRe category.	Q4 Q4
4) Mental Health need in ED – Selected 2 cohorts: reduced ED attendance. Outcomes information. Increased use of MH on ECDS, including audit & improvement plan	NSFT & ED: Maintain reduced attendance of year 1 cohort. Year 2 cohort of frequent attenders, final ID, plans, data: reduce 20%. Use of 'MH diagnosis' to increase. All recorded robustly via ECDS. Audit complete and data quality plan, with goals to be met Q2-4. Data on cohorts to be submitted to NHS Digital. **Q4: plan for BAU.** ED meeting to confirm all goals met.	
6) Advice & Guidance to GP pre referral via eRS. Specialties offering A&G covered at least 75% of referrals received 2016-7 (aim A&G reduce referrals).	Phased monitoring for a total of 20 specialties offering A&G to GPS via eRS. Daily checks on eRS queries in place & reminders sent.7 specialties 2017-8 & 10 in Q1-Q3 2018-9: varied compliance of 2 day turnaround. Clinician ideally responds direct on eRS: work arounds in place. 2019: Tariff income. **If GPs do not receive timely response: may refer / complain.** CCG – GPs ensure only use facility for A&G (not referral).	
9) Adult Inpatients – preventing ill health (excluding Maternity): **Targets By Q4** **9a)** Tobacco Screening 90% **9b)** Tobacco Brief Advice (if yes) 90% **9c)** Tobacco Referral and Medication Offer 30% **9d)** Alcohol Screening 50% **9e)** Alcohol Brief Advice Or Referral (if high score) 80%	**Q1: baseline data = 0%.** Design & education materials: 'met'. **Q2-3: % to improve on last quarter on:** Screening noting Alcohol drinking levels; plus recording 'Yes given' Brief Advice, Referrals, Prescribe. **Q4: high national % targets (shown opposite).** **eCare change requests agreed via eCare Board 13/12 and now live:** 1) Activity Daily Life to capture alcohol levels 2) Brief Advice, Refer & Prescribe (NRT) - doctor role: so task prompts improve data recording: (but no hard stop so can continue on with more urgent patient data). • Education & communication being updated. • Part of the Trust's Quality Priorities Plan.	Q2: 9a, 9d, 9e Q2: tbc 9b, 9c Q3-4
10) STP (Suffolk Transf) Support	Local CQUIN. Predict met re: evidence of meetings.	

10:30 INVEST IN QUALITY, STAFF AND CLINICAL LEADERSHIP

11. Nurse staffing report

To ACCEPT a report on monthly nurse staffing levels

For Report

Presented by Rowan Procter

Board of Directors – 25th January 2019

Agenda item:	11			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Rowan Procter, Executive Chief Nurse			
Date prepared:	23rd January 2019			
Subject:	Quality and Workforce Dashboard – Nursing			
Purpose:	X	For information		For approval

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 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

For in depth review of areas, please inquire for the Matrons' governance reports that are completed monthly for their divisions. Included are any updates in regards to the nursing review

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	**X**	

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

Previously considered by:	-
Risk and assurance:	-
Legislation, regulatory, equality, diversity and dignity implications	-

Recommendation:

Observations in October's and progress of nurse staffing review made below.

The December position

Whilst the normal format staffing report has been submitted it is to be noted that the figures require a quality cleanse.

Ward Based Unregistered Nursing Position

			Data		
Mancentretier4 Descrip	Mancentretier4 Descrip	Description2	Sum of ESTAB Ldr Amt 9	Sum of Dec actual	Sum of var M9
Group2	Community Provided Se	Newmarket Hosp-Rosemary ward	13.47	14.29	0.82
	Community Provided Services Total		13.47	14.29	0.82
	Community Contract	Community - Glastonbury Court	12.64	12.97	0.33
	Community Contract Total		12.64	12.97	0.33
Medical Services	Medical Services	Accident & Emergency	24.15	21.08	-3.07
		C.C.U.	0	0.21	0.21
		Ward F9	23.18	22.56	-0.62
		Ward F12	5.15	5.97	0.82
		Ward G1 Hardwick Unit	8.48	11.67	3.19
		Cardiac Ward	18.03	9.17	-8.86
		Ward G4	25.02	26.97	1.95
		Ward G5	23.19	26.84	3.65
		Ward G8	25.13	26.86	1.73
		Nephrology	0.4	0	-0.4
		Ward G9 Escalation Ward	0	19.55	19.55
		Respiratory Ward	20.6	23.74	3.14
		AAU	29.8	28.03	-1.77
		Ward F7 Short Stay	31.53	30.54	-0.99
	Medical Services Total		234.66	253.19	18.53
Surgical Services	Surgical Services	Critical Care Services	1.88	1.02	-0.86
		Ward F3	22.27	19.98	-2.29
		Ward F4	10.59	9.43	-1.16
		Ward F5	14.51	13.2	-1.31
		Ward F6	14.51	13.93	-0.58
	Surgical Services Total		63.76	57.56	-6.2
Woman & Children Serv	Woman & Children Ser	Ward F1 Paediatrics	7.16	7.27	0.11
		Gynae Ward (On F14)	1	0	-1
		Neonatal Unit	3.64	2.75	-0.89
	Woman & Children Services Total		11.8	10.02	-1.78
Grand Total			336.33	348.03	11.7

This Excludes Maternity leave and escalation, however, from an operational level;

	WTE	shifts
Maternity Leave	15.8	47.4
Escalation G3	27	81
Escalation G9	16	48
Total	58.8	176.4
per week		**44.1**

NB Sickness is not included, long or short term

Ward Based Registered Nurse Position

			Data		
Mancentretier4 Descr	Mancentretier4 Desc	Description2	Sum of ESTAB Ldr Amt 9	Sum of Dec actual	Sum of var M9
Group2	Community Provided	Newmarket Hosp-Rosemary ward	12.34	10.94	-1.4
	Community Provided Services Total		12.34	10.94	-1.4
	Community Contract	Community - Glastonbury Court	11.5	11.94	0.44
	Community Contract Total		11.5	11.94	0.44
Medical Services	Medical Services	Accident & Emergency	57.24	55.18	-2.06
		C.C.U.	0	1	1
		Ward F9	20.85	18.37	-2.48
		Ward F12	11.27	9.86	-1.41
		Ward G1 Hardwick Unit	24.6	18.56	-6.04
		Cardiac Ward	14.28	18.12	3.84
		Ward G4	19.78	20.03	0.25
		Ward G5	19.03	15.91	-3.12
		Ward G8	24.22	23.32	-0.9
		Nephrology	1	1	0
		Ward G9 Escalation Ward	1	8.01	7.01
		Respiratory Ward	20.47	18.63	-1.84
		AAU	27.3	22.98	-4.32
		Ward F7 Short Stay	23.67	21.23	-2.44
	Medical Services Total		264.71	252.2	-12.51
Surgical Services	Surgical Services	Critical Care Services	42.38	40.47	-1.91
		Ward F3	19.58	18.96	-0.62
		Ward F4	12.78	10.49	-2.29
		Ward F5	19.58	20.38	0.8
		Ward F6	19.57	19.57	0
	Surgical Services Total		113.89	109.87	-4.02
Woman & Children Se	Woman & Children S	Ward F1 Paediatrics	18.13	17.26	-0.87
		Gynae Ward (On F14)	11.18	11.61	0.43
		Neonatal Unit	20.85	19.34	-1.51
	Woman & Children Services Total		50.16	48.21	-1.95
Grand Total			452.6	433.16	-19.44

This Excludes Maternity leave and escalation, however, from an operational level;

	WTE	shifts
Maternity Leave	23.4	70.2
Escalation G3	20	60
Escalation G9	15	45
Total	58.4	175.2
per week		**43.8**

NB Sickness is not included, long or short term

Therefore for safety bank, agency and at times overtime is being sort to mitigate these risks.

QUALITY AND WORKFORCE DASHBOARD

Month Reporting	Dec-18			Establishment for the Financial Year 2018/19				Data for December 2018														
								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 (WTE) (Feb 2017)	Fill rate Registered %		Fill rate Unregistered %		Bank staff use %	Agency staff use %	Overtime (Hrs)	Vacancies (WTE)		Sickness (%)	Overall Care Hours Per Patient Day	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				Registered	Unregistered						
WSFT	ED	Emergency Department	21 trollies and 30 chairs	91.90	70.09%	29.91%	N/A	82.6%	98.8%	103.3%	100.1%	5.70%	12.00%	399	-4.55	-4.22	2.80%	N/A	19.30%	N/A	5	0
WSFT	AAU	Acute Admission Unit	23 assessment trolleys,13 AEC assessment trolleys with 21 chairs	60.90	47.99%	52.01%	I/D	55.8%	74.3%	96.0%	104.6%	7.72%	6.09%	395	-9.05	-3.10	6.90%	10.2	23.20%	0	2	0
WSFT	F7	Short Stay Ward	34	60.65	42.47%	57.53%	42.65	69.5%	77.4%	104.4%	99.7%	7.67%	11.37%	162	-6.73	-2.06	7.30%	6.9	25.30%	0	5	0
WSFT	CCS	Critical Care Services	9	47.01	95.62%	4.38%	N/A	92.4%	80.8%	N/A	N/A	3.20%	0.00%	70	-0.44	0.00	3.80%	27.9	21.40%	0	2	0
WSFT	Theatres	Theatres	8 theatres	85.60	73.47%	26.53%	N/A	98.7%	102.2%	N/A	N/A	0.54%	0.00%	309	1.15	-0.60	5.00%	N/A	21.10%	0	2	N/A
WSFT	Recovery	Theatres	11 spaces	22.59	95.67%	4.33%	N/A	139.5%	75.8%	83.1%	N/A	1.07%	0.00%	36	-0.54	-0.11	3.30%	N/A	19.60%	0	0	N/A
WSFT	Day Surgery Unit	Theatres	5 theatres, 1 treatment room, 25 trolley / bed spaces, 2 chairs, 5 consulting rooms and ETC ward	37.01	76.80%	23.20%	N/A	42.8%	N/A	64.7%	N/A	3.40%	0.00%	0	-1.71	0.00	4.90%	N/A	17.30%	0	1	0
	Day Surgery Wards			13.83	86.79%	13.21%						15.45%	0.00%	16	0.11	-0.15	17.40%		28.40%			
WSFT	Cardiac Centre	Cardiology	15 acute beds, 7 coronary beds & catheter lab	95.73	62.09%	37.91%	N/A	70.6%	104.8%	90.2%	91.9%	2.24%	0.53%	189	-10.68	-12.23	5.30%	4.4	19.80%	3	2	1
WSFT	G1	Palliative Care	11	36.28	74.25%	25.75%	18.32	80.1%	98.9%	133.8%	N/A	10.26%	0.88%	169	-7.86	2.03	9.50%	8.9	23.10%	1	1	0
WSFT	G3 WEW	Winter Escalation	32	*29.64*	*27.75%*	*72.25%*	N/A	109.1%	135.0%	129.3%	103.5%	14.03%	8.88%	152	Ward not budgeted		1.20%	5.4	14.20%	1	5	1
WSFT	G4	Elderly Medicine	32	47.36	44.05%	55.95%	44.78	88.3%	81.8%	107.1%	98.9%	16.76%	0.85%	681	-4.36	-3.61	7.00%	5.8	26.70%	2	1	0
WSFT	G5	Elderly Medicine	33	44.40	44.83%	55.17%	50.52	86.9%	88.4%	94.2%	116.8%	16.62%	7.05%	233	-6.42	-1.22	6.20%	5.3	18.30%	1	3	2
WSFT	G8	Stroke	32	51.75	49.23%	50.77%	42.26	84.7%	96.6%	86.6%	85.5%	16.37%	12.90%	284	-10.31	-2.01	8.60%	6.0	26.30%	1	0	2
WSFT	F1	Paediatrics	15 - 20	25.74	71.69%	28.31%	N/A	104.4%	161.8%	93.6%	N/A	21.99%	0.31%	40	-5.08	-0.44	1.70%	6.8	17.70%	N/A	0	N/A
WSFT	F3	Trauma and Orthopaedics	34	43.72	46.79%	53.21%	48.48	87.1%	93.2%	125.7%	106.6%	7.56%	5.52%	297	-2.56	-4.20	9.10%	5.4	25.40%	2	4	2
WSFT	F4	Trauma and Orthopaedics	32	27.95	54.69%	45.31%	21.71	72.2%	85.6%	93.9%	146.4%	2.66%	6.94%	150	-2.95	-1.91	5.80%	7.5	21.60%	1	2	0
WSFT	F5	General Surgery & ENT	33	38.30	57.44%	42.56%	40.19	91.0%	93.0%	98.8%	123.2%	0.90%	0.64%	184	2.66	-0.61	1.70%	5.9	18.00%	0	0	0
WSFT	F6	General Surgery	33	39.08	57.42%	42.58%	47.91	71.2%	82.0%	117.7%	117.3%	10.58%	3.42%	357	-4.17	-2.98	5.30%	5.1	22.60%	2	3	1
WSFT	F8	Respiratory	25	43.32	49.71%	50.29%	40.62	80.4%	75.1%	114.2%	103.3%	4.51%	9.64%	263	-4.30	1.45	6.40%	5.7	23.20%	3	3	2
WSFT	F9	Gastroenterology	33	46.57	47.38%	52.62%	48.16	80.4%	91.4%	72.1%	131.0%	16.46%	5.93%	407	-6.80	-5.21	8.60%	5.0	25.10%	0	2	1
WSFT	F11	Maternity	29																	0	3	0
WSFT	MLBU	Midwifery Led Birthing Unit	5 rooms	69.23	78.12%	21.88%	N/A	115.1%	95.6%	86.7%	59.8%	8.67%	0.00%	34	0.42	-1.33	6.20%	N/A	21.80%	0	0	0
WSFT	Labour Suite	Maternity	9 theatres, High dep. room, pool room, theatre																	0	0	0
WSFT	F12	Infection Control	8	17.42	68.79%	31.21%	9.61	86.9%	80.5%	33.2%	119.4%	1.69%	0.56%	196	-2.60	0.53	1.50%	9.0	18.60%	0	0	0
WSFT	F14	Gynaecology	8	13.18	91.79%	8.21%	I/D	100.3%	98.7%	N/A	N/A	8.55%	0.00%	147	-0.62	-1.00	2.90%	8.1	21.00%	0	1	0
WSFT	MTU	Medical Treatment Unit	9 trollies and 8 chairs	9.80	79.64%	20.36%	N/A	76.5%	N/A	40.5%	N/A	1.65%	0.00%	8	-1.11	-1.00	3.50%	N/A	17.40%	0	0	0
WSFT	NNU	Neonatal	12 cots	24.49	85.14%	14.86%	N/A	95.1%	89.3%	19.4%	38.7%	0.99%	0.00%	31	-1.65	-0.89	8.30%	19.4	26.10%	N/A	2	N/A
Newmarket	Rosemary Ward	Step - down	19	25.98	47.81%	52.19%	N/A	268.0%	75.9%	189.8%	109.0%	10.02%	15.11%	28	-5.60	0.20	9.90%	5.6	28.40%	0	1	1
Glastonbury Court	Kings Suite	Medically Fit	20	24.14	47.64%	52.36%	N/A	117.4%	102.3%	89.8%	103.4%	7.82%	0.37%	144	0.10	-0.90	8.40%	4.7	23.50%	0	1	2
								94.32% AVG	93.56% AVG	97.40% AVG	105.74% AVG	8.04% AVG	3.89% AVG	5381 TOTAL	-95.65 TOTAL	-45.57 TOTAL	6.02% AVG		21.94% AVG	*Trust standard is 20%*		

Trust	Team Name	Speciality	Current Funded Beds/Chairs Trolleys	Current Funded Establishment (WTE)	Current Funded Total Establishment Registered to Unregistered (%)		SCNT Establishment (WTE) (Feb 2017)	Patient facing contact (hrs)	Another method workload measurement to be determined	Bank staff use %	Agency staff use %	Overtime (Hrs)	Vacancies (WTE)		Sickness (%)	Overall Care Hours Per Patient Day (June 2017)	Unplanned requests	Pressure Ulcer Incidences (In our care)	Nursing/Midwifery Administrative Medication Errors	Missed visits
					Registered	Unregistered							Registered	Unregistered						
Community	Bury Town	Community Heath Team	No community equivalent	21.59	25.94%	74.06%	No equivalent tool for community nurses	1236.47		We are unable to collect this information this month		To be confirmed if can measure	-2.00	-1.00	5.66%	No equivalent tool for community nurses	47	2	0	0
Community	Bury Rural	Community Heath Team		11.20	10.71%	89.29%		627.33					-0.80	-1.00	1.29%		24	3	0	0
Community	Mildenhall & Brandon	Community Heath Team		14.50	20.07%	79.93%		797.03					-0.60	-0.11	5.85%		39	0	1	2
Community	Newmarket	Community Heath Team		11.25	28.00%	72.00%		598.12					0.00	0.00	6.90%		22	0	0	0
Community	Sudbury	Community Heath Team		25.92	32.25%	67.75%		1109.87					-6.80	0.00	2.73%		44	2	1	4
Community	Haverhill	Community Heath Team		13.20	32.05%	67.95%		822.33					0.00	0.00	0.58%		31	0	0	1
Community	Admission Prevention Service	Specialist Services		13.73	25.13%	74.87%		58.38					0.00	0.00	2.55%		0	0	0	0
Community	Children	Community Paediatrics		32.89	47.07%	52.93%		1050.80					-2.00	0.00	0.11%		1	N/A	0	0
									6300.33 TOTAL			#DIV/0! AVG	#DIV/0! AVG		-12.20 TOTAL	-2.11 TOTAL	3.21% AVG Target - 3.5%		208 TOTAL	

Explanations

WSFT have some significant environmental layout challenges and additional activity that are not reflected in the SNCT(F14/G1/G8/F12/CCU/NCH)
Fill Rate is an indication of patient safety - national target 80% (less than = red), Trust internal target 85% (equal and greater than = green)
Medication errors are not always down to nursing and can be pharmacist or medical staff as well
In vacancy column: - means vacancy and + means overestablished.
Roster effectiveness is a sum of Sickness (<3.5%), Annual leave (12% - 16%) and Study Leave (2.5% - 3.5%)
DSU has been split into ward and unit only by HR, that is why only a section has been split in this dashboard
CCU/G3 have closed to form Cardiac Centre on 10th Nov. G3 Winter Escalation Ward opened on the same day
Pressure Ulcer Incidences (In our care) - includes DTI's

Key	
N/A	Not applicable
ETC	Eye Treatment Centre
I/D	Inappropriate data
TBC	To be confirmed

12. Safe staffing guardian report – Q3

To ACCEPT a report

For Report

Presented by Nick Jenkins

Trust Open Board Report – 25 January 2019

Agenda item:	12			
Presented by:	Nick Jenkins, Executive Medical Director			
Prepared by:	HR			
Date prepared:	September 2018			
Subject:	Guardian of safe working report			
Purpose:	X	For information		For approval

Executive summary:

On this occasion the report has been compiled by the Medical Staffing Manager, whilst the Trust is recruiting a new Guardian of Safe Working. Francesca Crawley has been interviewed and has accepted the role pending an appointment to her current role as Foundation Training Program Director. Kaushik Bhowmick has accepted this appointment (21/1/19).

The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A system of Exception Reporting is in place, which replaces monitoring of working hours. This is done using Allocate software, a system already in place at West Suffolk, but extended for this purpose. This report covers the three month period (1st October 2018 – 31st December 2018 inclusive).

The report is also informed by the monthly Junior Doctors' Forum. This meeting is held in two parts: The first is an open (un-minuted) forum for all junior doctors; the second is chaired by the GOSW and includes Junior Doctor representatives, including the mess president, chief resident and BMA representatives, and also the Director of Education, The Director of the Foundation Programme, members of HR, rota co-ordinators, and BMA advisors. This meeting is minuted.

All trainees taking up appointments are on the New Contract. Trust grade positions are on contracts that mirror the new Contract.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
		X	

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

Previously considered by:	-

Risk and assurance:	-
Legislation, regulatory, equality, diversity and dignity implications	-
Recommendation: *To accept report*	

QUARTERLY REPORT ON SAFE WORKING HOURS
DOCTORS AND DENTISTS IN TRAINING
1st October 2018 – 31st December 2018
Executive Summary

Introduction

On this occasion the report has been compiled by the Medical Staffing Manager, whilst the Trust is recruiting a new Guardian of Safe Working. Francesca Crawley has been interviewed and has accepted the role pending an appointment to her current role as Foundation Training Program Director. Kaushik Bhowmick has accepted this appointment (21/1/19).

The purpose of the report is to provide evidence of safe rostering and compliance with the TCS, to highlight any difficulties which have arisen, and to explain how they are being addressed. A system of Exception Reporting is in place, which replaces monitoring of working hours. This is done using Allocate software, a system already in place at West Suffolk, but extended for this purpose. This report covers the three month period (1st October 2018 – 31st December 2018 inclusive).

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All trainees taking up appointments are on the New Contract. Trust grade positions are on contracts that mirror the new Contract.

Summary data

Number of doctors in **training on 2016** TCS (total):	136 (includes p/t trainees)
Amount of time available in job plan for guardian to do the role: per week	1 PAs / 4 hours
Admin support provided to the guardian (if any):	0.5WTE
Amount of job-planned time for educational supervisors: trainee[1]	0.125 PAs per
Amount of job-planned time for Clinical Supervisors:	0, included in 1.5 SPA time[1]

1. Exception reporting: 1st October – 31st December 2018

a) Exception reports (with regard to working hours)

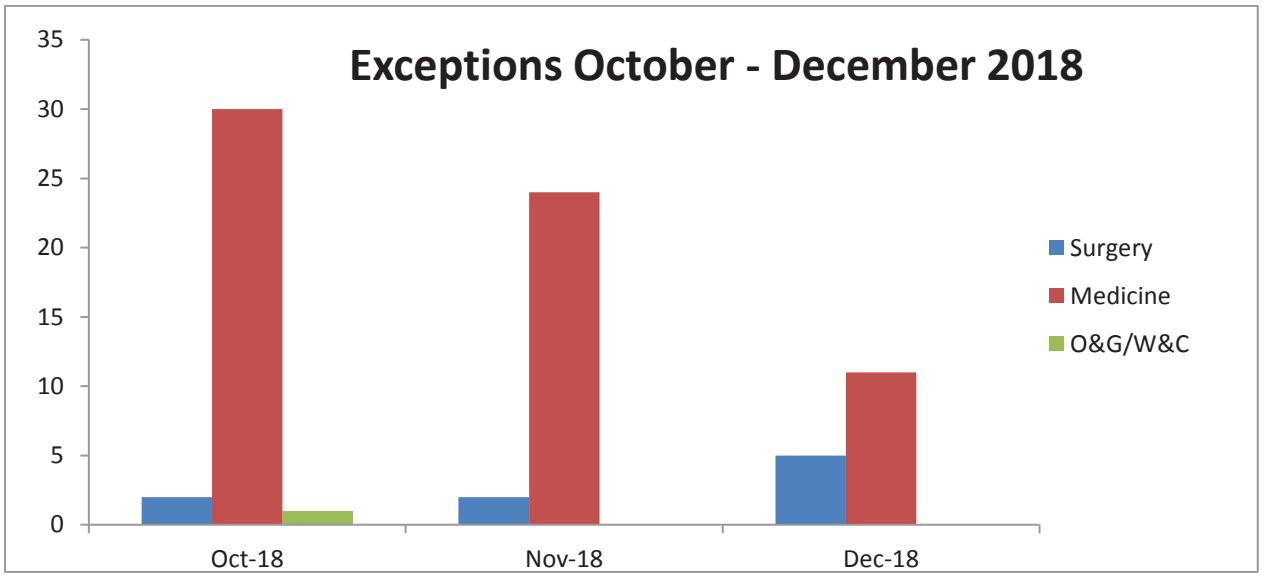
The purpose of exception reporting is to ensure prompt resolution and/or remedial action to ensure that safe working hours are maintained. If there are consistent problems a work schedule review should be carried out. A process is in place on Allocate for the Junior Doctors to fill in the report, which at present requires permission from a consultant and a narrative of the situation which led to exceeding the contractual obligation. Details are sent to the Guardian and Clinical /Educational Supervisor.

Exception Reports by EXCEPTION TYPE AND OVERTIME HOURS CLAIMED						
Department	Grade	Pattern of Hours worked	Educational Opportunities or available Support	Support available during Service Commitments	Hours of Work	Total overtime hours claimed
Surgery	F1	0	0	0	4	6.75
	F2	0	1	0	3	7.00
	GPST/ ST1	0	0	0	0	0
	ST3+	0	1	0	0	0
Medicine	F1	0	0	0	29	40.50
	F2	0	1	0	30	35.00
	TD FY2	0	1	0	4	5.00
Woman & Child	FY1, FY2	0	0	0	0	0
	GPST	0	0	0	1	1.25
Total		**0**	**4**	**0**	**71**	**95.50**

Exception Reports by DEPARTMENT				
Department	No. exceptions carried over from before 30th September 18	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Surgery	0	9	8	1
Medicine	0	65	61	4
Woman&Child/ Paeds	0	1	1	0
Clinical Support	0	0	0	0
Total	**0**	**75**	**70**	**5**

Exception reports by SPECIALTY & GRADE					
Department	Grade	Exceptions carried over from before 30th September 18	Exceptions raised	Exceptions closed	Exceptions outstanding
Surgery	F1	0	4	4	0
	F2	0	4	3	1
	GPST/ ST1	0	0	0	0
	ST3+	0	1	1	0
Medicine	F1	0	29	26	3
	F2	0	31	30	1
	TD FY2	0	5	5	0
Woman & Child	FY1, FY2	0	0	0	0
	GPST	0	1	1	0
Total		**0**	**75**	**70**	**5**

Exception reports – RESPONSE TIME			
Department	Addressed within 48 hrs	Addressed within 7 days	Addressed in longer than 7 days
Surgery	1	2	6
Medicine	11	36	18
Woman & Child	0	0	1
Total	**12**	**38**	**25**



b) Work schedule reviews for period 1st October 2018 – 31st December 2018

Work schedule reviews for individuals may be requested by either the doctor, or the education/clinical supervisor, service manager or guardian in writing. None have been carried out in this period.

2. Locum Bookings: 1st October – 31st December 2018

TABLE 1: Shifts requested between 1st October and 31st December 2018 by 'reason requested'

Locum bookings – by REASON REQUESTED						
Department	Extra/Rota Compliance/ Induction Cover	Leave (ie Annual/Study/ Interview)	Maternity Leave	Sickness/ Reduced Duties	Vacancy	Grand Total
A&E	62	146		34	353	**595**
Anaesthetics	2			2	1	**5**
Cardiology	60					**60**
Dermatology	20				31	**51**
ENT	1	6		2		**9**
General Surgery	79			53	39	**171**
Haematology				11		**11**
ITU					15	**15**
Medicine	244	23	10	79	389	**745**
O&G	2					**2**
Ophthalmology	3				11	**14**
Paediatrics				53	108	**161**
Radiology					104	**104**
T&O	1			4	37	**42**
Urology					50	**50**
Grand Total	**474**	**175**	**10**	**238**	**1138**	**2035**

TABLE 2: Shifts requested between 1st October and 31st December 2018 by 'Agency / In house fill'

	Locum bookings – by AGENCY															
Department	A&E	Anaesthetics	Cardiology	Dermatology	ENT	General Surgery	Haematology	ITU	Medicine	O&G	Ophthalmology	Paediatrics	Radiology	T&O	Urology	Grand Total
A&E Agency	3											40				**43**
Athona				10									5			**15**
ID Medical									15							**15**
IDM			60													**60**
Interact	26															**26**
Interact Med									16							**16**
Interact Medical	3															**3**
Locum People	108															**108**
Locum Vision	29															**29**
NC Healthcare	2						5									**7**
NHS	260	5		41	9	114		15	488	2	14	37	99	3		**1087**
No Doctor Booked	127					12	6		51			6		1		**203**
Pertemps	4								50						50	**104**
ProMedical	10								5					5		**20**
RM Medics	12					45			81					3		**141**
Total Assist	11											78		30		**119**
United Med									39							**39**
Grand Total	**595**	**5**	**60**	**51**	**9**	**171**	**11**	**15**	**745**	**2**	**14**	**161**	**104**	**42**	**50**	**2035**

TABLE 3: Shifts requested between 1st October and 31st December 2018 filled 'In house only by grade'

Locum bookings – by GRADE IN HOUSE						
Department	Cons	F1	F2/ST	SAS	SpR	**Grand Total**
A&E	6		105		276	**387**
Anaesthetics			2		3	**5**
Dermatology	20			21		**41**
ENT			1		8	**9**
General Surgery		7	89		30	**126**
Haematology	6					**6**
ITU			4		11	**15**
Medicine	265	5	262		7	**539**
O&G					2	**2**
Ophthalmology					14	**14**
Paediatrics			13		30	**43**
Radiology	99					**99**
T&O			3		1	**4**
Grand Total	**396**	**12**	**479**	**21**	**382**	**1290**

3. Vacancies - 1st October – 31st December 2018

HR have provided details of current junior doctor vacancies:

Department	Grade	Oct 18	Nov 18	Dec 18
A&E	ST3+	3	3	3
	GP/ ST1-2	1	1	0
	ACCS/CT	1	1	1
Anaesthetics	ST3+	3	3	3
Medicine	ST1-2	1	1	2
	ST3+	1	1	1
T&O	ST3+	1	0	0
	GP 1 – 2	0	0	1
Pediatrics	ST4+	1	1	1
Total		**12**	**12**	**12**

4. Fines - 1st October – 31st December 2018

There is a system of financial penalty now in place where exception reporting demonstrates the following:

- a breach of the 48-hour average working week across the reference period agreed for that placement in the work schedule
- a breach in the maximum 72-hour limit in any seven days
- the mimimum 11 hours rest requirement between shifts has been reduced to fewer than 8 hours.

This quarter there was no instance where a fine has been made.

Total breach fines paid by the Trust from August 2017 to date are £8,439.09 and the Guardian Fund currently stands at £4,585.59.

13. Learning from death report – Q2

To ACCEPT a report, including progress with quality priorities for 2018-19

For Report

Presented by Nick Jenkins

Trust Board – Friday 25th January

Agenda item:	13			
Presented by:	Dr Nick Jenkins, Medical Director			
Prepared by:	Vicky Thomspon, Head of Quality Improvement			
Date prepared:	15th January 2019			
Subject:	Learning for Deaths committee reporting update			
Purpose:		For information		For approval

Executive summary:
To provide the board with an update on LfD committee reporting and also to provide QI and Q2 LfD data

To support the integration of the Learning from Deaths reporting with other trust learning, the following has been agreed.

From February Open Trust Board the Quarterly Learning report will now include LfD data, both quartly reporting data and a free-text section LfD 'learning into action' (the national terminology for LFD learning).

LfD data will be reported in a table that allow categorisation of the stages of the LfD pathway that can be directly mapped to the Annual Quality accounts definitions.

From March CSEC the Quarterly LfD report is scheduled. This will include Q2 and Q3 data, plus a new section that undertakes a deep dive of LfD actions.

LfD Data

Please see below data for Q1 and Q2 below

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X		

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

Previously considered by:	*Learning from Deaths Committee on 21st January 2019*
Risk and assurance:	*Safety risk if the trust fails to identify problems in care which lead to patient harm and preventable death, and fails to act to reduce them.* *Reputational risk if the trust fails to report preventable deaths and fails to demonstrate action to reduce them*
Legislation, regulatory, equality, diversity and dignity implications	*The report describes the trust's approach to meeting the National Quality Board's guidance on Learning from Deaths, which must be reported in the annual report from 2017/18 onwards.*
Recommendation: To note the revision to LfD committee reporting	

Quarter	Total deaths as of 15/1/19	Deaths with completed SJR* as of 15/1/19	Cases reviewed as poor or very poor care	Cases reviewed as excellent	Cases reviewed as poor or very poor care therefore for further investigation						Final SI report found death was:	
					Awaiting classification	Straightforward case	Complex case	Following further investigation no further actions	Case requiring SI** decision making	Case confirmed as an SI	Unlikely to have been due to problems in the care provided to the patient'	More likely than not to have been due to problems in the care provided to the patient
Q1 18/19	227	225	9	81	1	3	1	1	3	1		
Q2 18/19	220	213	19	70	4	5	3	0	9(please note some cases go for an SI decision making but can then become Complex or straightforward cases)			

14. Consultant appointment report

To RECEIVE the report

For Report

Presented by Jan Bloomfield

BOARD OF DIRECTORS
25th January 2019

NHS West Suffolk NHS Foundation Trust

Agenda item:	14 Consultant Appointment Report			
Presented by:	Jan Bloomfield, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	15th January 2019			
Subject:	Consultant Appointments			
Purpose:	X	For information		For approval

Executive summary:

Please find attached confirmation of Consultant appointments

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

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

Previously considered by:	Consultant appointments made by Appointment Advisory Committees
Risk and assurance:	N/A
Legislation, regulatory, equality, diversity and dignity implications	N/A

Recommendation:

For information only

POST:	Consultant in Trauma & Orthopaedics
DATE OF INTERVIEW:	Thursday, 13th December 2019
REASON FOR VACANCY:	Replacement – Matthew Porteous
CANDIDATE APPOINTED:	Dr Konrad Wronka
START DATE:	1st August 2019
PREVIOUS EMPLOYMENT:	August 2018 – February 2019 - British Hip Society Travelling Fellow – St Georges Hospital, London August 2017- August 2018 – ST8 - Trauma & Orthopaedics – Prince Philip Hospital, Llanelli – Hip and Knee arthroplasty and revision August 2016 - August 2017 – ST7 - Trauma & Orthopaedics – Morriston Hospital, Swansea – Hip & Knee - Shoulder and Elbow surgery August 2015 – August 2016 - ST6 – Trauma & Orthopaedics – University Hospital of Wales, Cardiff August 2014 – August 2015 – ST5 – Trauma & Orthopaedics – University Hospital of Wales, Cardiff August 2013 – August 2014 - ST3 – Trauma & Orthopaedics – University Hospital of Wales March 2010 – August 2013 - LAT ST3 – Trauma & Orthopaedics - Various Hospitals August 2007 – March 2010 – Specialty Registrar Trauma & Orthopaedics Various hospitals August 2005 – August 2007 – FY1/FY2 – Wessex Rotation
QUALIFICATIONS:	• FRCS T & O - Part 2 -pass 7th May 2017; Part 1 -pass 7th February 2017 • PG Diploma in Medical Education Cardiff University awarded October 2013 • PG Certificate - Postgraduate Certificate in Medical Education, Cardiff University, awarded October 2011 • MRCS - Royal College of Surgeons of Edinburgh 22nd May 2009 • MBBS MD- Medical University of Lublin, Poland 1999 - 2005
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	30 4 5

POST:	Consultant in Trauma & Orthopaedics
DATE OF INTERVIEW:	Thursday, 13th December 2019
REASON FOR VACANCY:	Replacement – Kareem Abdullah
CANDIDATE APPOINTED:	Mr Majeed Shakokani
START DATE:	1st August 2019
PREVIOUS EMPLOYMENT:	August 2017 – Present - Senior revision Hip Fellow - Norfolk and Norwich University Hospitals August 2017- July 2018 – ST8 - Trauma & Orthopaedics – Lower Limb arthroplasty – Norfolk and Norwich University Hospitals August 2016 – July 2017 – ST7 - Trauma & Orthopaedics – Bone infection & lower limb reconstruction/Paediatrics, Cambridge University Hospital August 2015 – July 2016 – ST6 -Trauma & Orthopaedics – Upper limb (Shoulder) & lower limb arthroplasty , Ipswich Hospital August 2014 – July 2015 – ST5 – Trauma & Orthopaedics – Soft tissue knees & spine, Ipswich Hospital August 2013 – July 2014 - ST4 – Trauma & Orthopaedics – Foot & ankle & Lower limb arthroplasty, West Suffolk Hospital August 2012 – July 2013 – ST3 – Trauma & Orthopaedics – Upper Limb (Hands) + Lower Limb revision arthroplasty, Norfolk and Norwich University Hospital August 2011- July 2012 – Research Year – Orthopaedics Clinical & Research Fellow, Norfolk and Norwich University Hospital August 2009- August 2011 – Core Surgical Training - CT1 & CT2, Northern Lincolnshire and Goole NHS Foundation Trust , Airedale NHS Foundation Trust August 2008 - August 2009 – FY2 Training, Plymouth Hospitals, Derriford Hospital, Plymouth July 2006 – August 2008 – House Officer & Senior Officer posts
QUALIFICATIONS:	• CCT in Trauma & Orthopaedics Surgery – July 2018 • FRCS (T & O) Intercollegiate Specialty Fellowship– May 2017 • MRCS Intercollegiate Membership, Royal College of Surgeons February 2011 • M.B.B.S, Jordan University of Science and Technology, Jordon June 2006
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	30 4 5

POST:	Consultant in Healthcare Public Health
DATE OF INTERVIEW:	Friday 21st December 2018
REASON FOR VACANCY:	Fast Track Post
CANDIDATE APPOINTED:	Dr Helena Jopling
START DATE:	Fixed Term from 8th January 2018, Permanent from 21st January 2019
PREVIOUS EMPLOYMENT:	January 2018 – Present – Fixed Term Consultant in Healthcare Public Health, West Suffolk Foundation Trust October 2016 – January 2018 – Public Health Registrar – West Suffolk Foundation Trust November 2015 - Present – Senior Clinical Tutor – Department of Public Health and Primary Care , University of Cambridge April – Sept 2016 – Public Health Registrar – NHS England Sustainable Development Unit, Cambridge April 2015 - March 2016 - Public Health Registrar Bedford Clinical Commissioning Group, Bedfordshire, UK April 2013 - March 2015 - Public Health Registrar – Bedford Borough Council, Bedford May – October 2012 - Public Health Registrar Protection Team, Letchworth, UK 20/12/13 and 2016 – Two Terms as co-chair of Registrar Teaching Committee, Cambridge August 2006 - April 2011 – FY2/FY1 -West Suffolk Foundation Trust
QUALIFICATIONS:	• PG CERT Medical Education, University of Cambridge - 2015/2016 • Mphil Public Health, University of Cambridge – 2011/12 • Bachelor of medicine, bachelor of Surgery (MBBS) (Accelerated), University Of Oxford 2002-2006 • MA Archaeology and Anthropology, University of Cambridge; 1997-2000
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	1 1 1

15. Putting you first award

To NOTE a verbal report of this month’s winner

For Report

Presented by Jan Bloomfield

11:00 BUILD A JOINED-UP FUTURE

16. West Suffolk Alliance report

To ACCEPT the report

For Report

Presented by Kate Vaughton

Board of Directors – 25 January 2019

Agenda item:	16			
Presented by:	Kate Vaughton, Director of Integration Helen Beck, Chief Operating Officer			
Prepared by:	Kate Vaughton, Director of Integration			
Date prepared:	15 January 2019			
Subject:	Community Services and West Alliance update			
Purpose:	x	For information		For approval

Executive summary:

The Trust continues to drive forward the integration agenda both at a local and system level. There are a range of work programmes underway that demonstrate the pace and scale at which the system is evolving and maturing.

Main Points:
This paper outlines:

- The headline development in acute and community integration agenda
- Update on the implementation of the Rapid Intervention Vehicle (RIV)
- Alliance and System Development
- The development of locality teams
- Responsive Care Services Redesign
- STP funding for Primary Care and Voluntary and community Services

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	x	**x**	**x**

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

Previously considered by:	Monthly update to board

Risk and assurance:	Failure to effectively realise the benefits of integration with community and partners
Legislation, regulatory, equality, diversity and dignity implications	None
Recommendation: The Board is asked to note the progress being made.	

Community Services and Alliance Update

West Suffolk NHS Foundation Trust Board

25 January 2019

1.0 Introduction

This paper updates the Board on the development of the West Suffolk Alliance and the overall integration of the acute, community, local authority and GP Federation services in partnership with wider stakeholders, including District and Boroughs, the Ambulance Service, independent care providers and the voluntary and community sector.

2.0 Acute and Community Integration

2.1 Work on developing our integrated respiratory service is progressing well. The physio role has been integrated with the respiratory nurses who are now referring most patients for at least one physio consultation whilst on the caseload. This physio element is a new additional service offer made possible now that both acute and community teams are working as one team.

2.2 Two new nurses who (one funded from acute winter growth monies) will be starting in January. This will free resources so that the work with the ward nurses and physios so that trusted assisted discharge can increase at pace. This will assist with overall system flow.

2.3 We anticipate being able to restart the oxygen clinics at Sudbury & Newmarket in January. This will be a joint clinic so patients will have one appointment but will have a nurse & physio review rather than two separate appointments.

2.4 The newly created role in the Pulmonary Rehabilitation service has now been recruited to. The post will cover 2 days in the hospital and 2 days working in the community based service. They will also carry out some work with the physio in the Community Health Teams offering support and education on respiratory management of their longer term patients.

2.5 We have begun to explore how we can now work more closely with the acute based Asthma specialist nurse to identify further integration opportunities.

2.6 Work to develop an integrated falls pathway is continuing well, with acute and community therapists coming together for a session to: streamline referral processes, embed trusted assessment principles, review inpatient and community pathways relating to falls, share ideas of how we can learn, reflect, and share best practice with each other, and to improve some technical challenges we have with referral forms.

2.7 The session was well received and the following is a quote from a member of the joint transformation team who facilitated the session:

'The great thing about the meeting was how open and positive it was. The therapy staff from both acute and community were brilliant – open, receptive, and genuinely motivated to develop practices and learn from each other. Really nice to be involved with'

3.0 Rapid Intervention Vehicle

3.1 This pilot continues to progress well. Referrals are coming from various sources and current referral data is presented in the table below. There are 3 case studies shown in Appendix 1.

Activity from 01.10.18 to 31.12.18 (Monday to Sunday)					
	Total	Conveyed	Not Conveyed	Conveyed	Not Conveyed
Total	183	35	148	19.1%	80.9%
999 Triage	84	21	63	25.0%	75.0%
EIT Triage	99	14	85	14.1%	85.9%
Activity from 01.12.18 to 31.12.18 (Saturday – Sunday)					
	Total	Conveyed	Not Conveyed	Conveyed	Not Conveyed
Total	24	4	20	16.7%	83.8%
999 Triage	22	4	18	18.2%	81.18%
EIT Triage	2	0	2	0.0%	100.0%

4.0 Paediatric Physiotherapy joint working

4.1 The acute and community based services have been exploring opportunities for integration, and have initiated some changes to the way they work that are having a direct benefit for children, their families and staff.

4.2 Once a week a community paediatric physiotherapist attends WSFT from the community service and provides cover to the Neo Natal Unit in the morning and Dr Evans Premature Baby Clinic in the afternoons. This provides sharing of knowledge, continuity of care for parents when the baby is discharged, improves communication between services and breaks down traditional 'hand off' barriers

4.3 Once a week an acute rotational physiotherapist attends the community from WSFT and covers the Riverwalk Special School and holds a caseload of complex children. This provides a link and continuity for children with complex neuro-disability who may be admitted to Rainbow ward.

4.4 Pathways that offer shared care have been developed for:

- acute musculo-skeletal needs for children who also have chronic neurological conditions
- joint appointments with acute paediatric physio team for children with concerns of possible neurological origin
- respiratory: joined up working between acute and community for complex neurological children, this is on an individual basis (future plans are currently under development)
- shared acute and community paediatric physiotherapy training sessions.

4.5 Benefits to families:

- Improved transition of care from acute to community and back again
- Improved liaison between community physiotherapists and hospital consultants
- Early assessment and intervention for premature babies according to the needs of the child/family
- Early follow up in the community can be organised as required by child/family
- Support early transfer from acute paediatrician to community paediatricians which can support early diagnosis.
- Improved physical assessment within Premature baby clinic

- Seeing complex children in their community setting improves awareness for the acute physiotherapist of the whole family's needs and requirements if the child is admitted to Rainbow ward. This information can also be used in on-call training

4.6 Benefits to clinicians

- Supports development of acute band 6 physiotherapist in knowledge and skills of assessment and treatment of complex neurological children
- Broadens the experience and knowledge of rotational band 6 staff through seeing children in acute and community settings
- Development of knowledge and skills for established/static staff
- Development of standardised assessment on NNU, this can improve and facilitate early therapeutic intervention.
- Opportunities for learning across a wide range of conditions for all staff
- Ongoing development of Respiratory service and other opportunities for service development can occur with this joined up working
- Improves possible recruitment in the future both for acute and community teams

5.0 Alliance and System Development

5.1 The West Suffolk system continues to demonstrate its growing maturity and commitment to working differently. Suffolk County Council has been notified of a sum of winter monies that was to be used to reduce delayed discharge numbers and to support flow through the system.

5.2 In keeping with our integration agenda partners from health and care came together to agree how best this money could be spent to ensure benefits to the whole system. The table below shows the detail of the initiatives that have been agreed for the west of Suffolk.

West Locality – Social Care Winter Pressures 2018/19

Activity	Timescales	Purpose	System Connections	Impact on DTOC	Monitoring/ Evaluation	Funding
Extra support for Home Care provision	December – March	Additional carer capacity for the provision of home care – managed through the SCC in-house service Home First. This is to address the known drop in carer availability over winter and will be brought in from outside the Suffolk system to avoid creating additional capacity issues.	Stable and good quality homecare is vital to the health and care system as unstable care leads to increases crises and prevents opportunity for people to recover from episodes of ill health	Lack of home care provision is the main cause of delayed transfers of care; managing known seasonal shortages enables the system to reduce the impact on DTOCs	- Reduced levels of DTOCs in comparison to years of no extra capacity - Increased levels and reduced waits in pick up of care packages - Increased reablement capacity	£200,000
D2A Pathway 1	November – March	To provide additional capacity for people leaving hospital on pathway 1 of the D2A programme. This creates additional recovery time for people, opportunities to maximise reablement and reduced onward care packages (releases stretched capacity). Increased staff capacity with 2x OT sitting in STGH. 1x OT sitting in HF. 1 social worker sitting in the hospital to home team. Also ability to use live in care 2x customers per week up to 10 days for 7 weeks Possible transport need	The scheme will create a different use of health and social care teams with the focused on recovery and establishing stability for a more accurate assessment of need in the persons own home.	Creates more opportunities and capacity for discharge routes and will thereby reduce delays.	- Reduced discharge delays to people in need of long term care - Reduced care packages for those discharged in comparison to similar cohorts discharge in other ways	£103,800
Weekend Social work capacity at WSFT	November – March	To ensure that additional social work input is available throughout the winter period to help the system manage surges in demand	This will be aligned to ward based social work input to enable a fully integrated discharge planning process	Creates extra capacity for the system to reduce delays in planning and implementing discharges	- Reduction in delays to Social Care assessments	£3,500
Activity	**Timescales**	**Purpose**	**System**	**Impact on DTOC**	**Monitoring/**	**Funding**

			Connections		Evaluation	
Demand Management	November – March	To ensure the management of demand is met via effective processes in place so the system can react with accuracy and speed to sudden and planned demand with tailored responses.	Managing demand will help end to end system flow to work at its most effective creating accurate demand at more appropriate levels.	Creates ability to cope with demand effectively and at speed to reduce delays in planning discharge. Decreases customers going into crisis and therefore being admitted to hospital	-reduction in care placement prices -reduction in customers moving on to higher care packages	£150,000
Ad Hoc Provision	November – March	To enable the West system to flex as needed during the winter months to meet surges in demand	Use of funds will be agreed through the West Alliance	And Ad Hoc schemes will need to demonstrate how they relieve system wide pressures	Tba	£100-170k

Standard increased winter capacity

Activity	Timescales	Purpose	System Connections	Impact on DTOC	Monitoring/ Evaluation	Funding
2x Block Bed	7 weeks Dec - onwards	Ease hospital pressure for short term placements.		Reduction in DTOC because of short term placements	Reduction in DTOC	£10,000.00
4 x Spot bed	7 weeks Dec - onwards	Ease hospital pressure for short term placements.		Reduction in DTOC because of short term placements	Reduction in DTOC	£20,000.00
Extra care block flat	15 weeks Dec – end of March	Ease hospital pressure for short term placements of intense support		Reduction in DTOC because of short term placements	Reduction in DTOC	£15,000.00

It should be noted that any agreement would be subject to receipt of the full grant conditions

5.3 We have taken forward discussions on how to work more closely with the voluntary sector. A meeting was held between Community Action Suffolk (who represent and support over 600 VCS orgs across Suffolk) on 22nd November and members of the Alliance.

5.4 Community Action Suffolk are very keen and perfectly positioned to be able to work with the Alliance to ensure that we involve, engage and utilise the VCS resources and capabilities that we have in west Suffolk in a meaningful, efficient and effective way.

5.5 We will focus the next system executive workshop (to be held in February) on better integration and involvement with the VCS, and Community Actin Suffolk have agreed to support and facilitate this session for us.

6.0 Locality Development

6.1 The teams within the CCG, community, local authority, mental health and district and boroughs have now mapped dedicated capacity to each of the six localities within in West Suffolk. This is to begin to identify both the core and wider support teams for each area. Senior leadership at Associate Director level has also been agreed for each to oversee the development and delivery of key priorities.

6.2 Similar work is also underway with other system stakeholders such as Suffolk Sport, Abbeycroft Leisure and Public Health to identify core prevention teams in each locality who can also be skilled up to support the mental and physical health and care agenda.

6.3 Dedicated link worker posts for each of the six localities are in the process of being recruited to. These are band 4 positions and will support the running of the integrated neighbourhood teams and facilitate the join up of the stakeholders within the locality.

6.3 Work has begun in collaboration with Public Health to agree the proposed data set that will form each locality profiles. The process for production of each locality plan will be: locality data > locality profile>locality priorities>locality plan>service changes

6.4 These will provide the evidence base for the priorities for each locality and any associated bids for transformation funding. Appendix 2 shows an example of the proposed information and Appendices 3 and 4 are an example of the Connect profiles for both Sudbury and Haverhill to demonstrate the type of information that will be used to formulate each locality plan. **N.B the documents shown are work in progress**

6.5 The first locality planning meeting for Mildenhall was held on the 5th December, bringing together primary care, community health and social work teams, mental health, housing, families and community's teams, CCG, and the borough council representatives.

6.6 The meeting identified a number of common challenges, but also a number of areas where colleagues were able to assist with problems by sharing information and knowledge immediately. The meeting generated a real sense of locality working and commitment to becoming 'one team'.

6.5 From the discussion a list of agreed and shared priorities were generated. These will start to form the locality plan and will be cross-referenced with the data from the locality profile to ensure that we are tackling the things that are relevant to the locality. Dates are set for all other localities to replicate this initial meeting.

7.0 Responsive Care Services Re-design

7.1 This work is progressing well. We currently have separate services across both health and care that are aimed at providing an urgent response, either to avoid admissions to hospital or quickly expedite a discharge.

7.2 Currently these services are all commissioned separately from both health and social care and have separate contracts, service specifications and targets. The services involved are:Early intervention (WSFT), Support to Go Home (WSFT and SCC), Home First (SCC) and Admission Avoidance Nurses (WSFT). The aim of the work is to bring all of these services together as one service, and then organise the resource into each of our six localities.

7.3 This will enable each locality team to be able to provide a short term, longer term, planned and unplanned response across both health and care so that we have a fully integrated place based service that works across the health and care interface, and is integral to our integrated neighbourhood team (INT).

7.4 A task and finish group has been established to design the model detail. Suffolk County Council has supported a most capable provider process to be undertaken by the Alliance for the Home First element of the contract. The new service model will go live in October 2019.

8.0 Realising Ambitions' STP grants programme

8.1 In May 2018 Suffolk and North East Essex (SNEE) STP was one of four new systems to join the national system transformation programme at NHS England, working to become an Integrated Care System (ICS). Later in August 2018 an Memorandum of Understanding (MOU) was agreed between local leaders and NHS England which set out how NHS England would work with SNEE STP during 2018/19 as a 'shadow' ICS.

8.2 The MOU contained a number of specific local priorities and deliverables for SNEE, including the development a small number of agreed 'Higher Ambitions' for the ICS, together with an underpinning methodology for delivery through alliances and local neighbourhood teams. These ambitions are expected to relate to the following areas identified by local leaders at an away day in April 2018:

- reducing the burden of deprivation,
- improving mental health and reducing suicides,
- being more proactive in relation to obesity prevention and treatment,
- a reduction in unplanned cancer admissions,
- improved end of life care,
- neighbourhood action to combat loneliness

8.3 A transformation funding package of £3.34 million 'uncommitted funds' has now been made available to SNEE STP, to be used to support the system to deliver the priorities in the MOU. This includes a notional £1 per head population allocated to primary care network development as specified by the national primary care development programme, which for West Suffolk Alliance this equates to £251,760

8.4 At the STP Board in December 2018 it was agreed that the remaining funding over and above the £1 per head should be used to enable the voluntary and community sector to make progress in tackling the wider social determinants of health within the Alliance localities. For West Suffolk this equates to £480,840

8.5 A stipulation of the funding being passed through to the three Alliances in the STP footprint is that Suffolk Community Foundation (SCF) will be used as the vehicle to administer the grant allocation process. SCF will work with the Alliances to help to prioritise a small selection of STP higher ambitions to support and oversee a grants programme to manage the allocation of funds to the voluntary and community sector within each locality.

8.6 A paper will be taken to the January Alliance Steering Group and then for ratification at the System Executive Group to agree which Higher Ambitions will be prioritised by the West Suffolk Alliance and ensure that the wider system is mobilised to support this process.

8.0 Conclusion

The Board is asked to note the progress being made on individual initiatives and collaborative working across the system.

RIV Case Study 1

- RIV referral via 999 triage as CAT4 call. 80yr lady had fallen from kitchen bar stool and unable to get up from floor
- On arrival family had assisted patient up and to a chair
- No injury , obs taken and stable
- Patient explained fatigue, SOB and reduced appetite over 4 weeks. Now struggling with mobility, turning in bed and general ADLS
- EIT assessed environment. Advised removal of rugs for falls prevention. Also advised placement of chairs/furniture to aid energy conservation/rests when mobilising
- EIT ordered equipment to help with shower, bed transfers and a perch stool to replace bar stool (where fall occurred)
- EIT referral to Orbit for review of rails / equipment
- EIT referral to Hospice for ongoing support

RIV Case Study 2

- RIV referral from GP
- Patient prescribed ABX for UTI, after taking first tablet she had an episode where she was unable to speak and confused.
- RIV review with therapist – Obs stable Specialist paramedic changed ABX as episode likely reaction to ABX
- Patient very anxious being home alone. Independent mobility and with ADLS however did not wish to remain home alone as worried may have another episode.
- EIT arranged for an overnight carer to support overnight and reassure (felt if left at home alone patient would continue to call 111 or 999

RIV Case Study 3

- RIV referral via Community Nurse
- Patient stuck on toilet, Nurse had called 999 but advised ambulance would be a number of hours
- Nurse called EIT and Paramedic took call (CAT3) off 999
- Therapist and Paramedic assisted patient up from toilet
- Paramedic completed medical assessment. Recent UTI, non-compliant with anitibiotics for over a week. Paramedic liaised with GP and gave antibiotic and pain relief during assessment.
- Therapist assisted with personal care during visit, assessed mobility and assisted into bed.
- EIT arranged 3 times a day care package (including prompting medication) and equipment to support mobility. (both in place within the hour)
- EIT arranged therapy follow up after a day of antibiotics to progress mobility

West Suffolk Alliance Profile / Place-based Needs Assessment: Scope

Objectives:

- To assess and understand:
  - The health and care needs of the population in West Suffolk
  - How and why residents flow through different services within the West Suffolk Alliance
  - Capacity, demand, activity and associated costs across health and care services in West Suffolk
  - Interdependencies and the impact of service changes in one part of the system on other parts of the system
- Make recommendations to:
  - Inform West Suffolk Alliance priorities
  - Enhance the delivery of effective and cost-effective solutions that improve the health and wellbeing of the population, reduce health inequalities and achieve West Suffolk Alliance outcomes.

Data requirements

Reference	Data and rationale	Analysis required	Source	Lead / Contact person	Timescale
1	Geography -understand localities, available assets, access issues and potentially map travel times	• Description of place • Health and care services & facilities **Mapping: +/- schools, children's centres, GP surgeries, health centres, pharmacies, leisure facilities, access issues/rurality, travel time to facilities. • Community & other assets *Analysis by locality	PH District/Boroughs/VCS		
2	Demography • Understand current and future demographic challenges	• Population **Analysis by age, sex, ethnicity **Analysis by district and locality **Population projections to 2037	PH		

Jeptepkeny Ronoh
23/11/208

		**Deprivation **Benchmarking – England, statistical neighbours, EoE, ICS			
3	Lifestyle / Wider determinants /Prevention • Understand wider influences on health • Identify inequalities and unwarranted variation	• Physical activity • Smoking rates • Healthy eating • Obesity • Alcohol • Uptake o Vaccination o Screening o NHS Health checks ****analysis by age, sex, deprivation, locality, practice • Deprivation • Single parent families • Educational attainment • Employment • Housing **Analysis by district / locality **Benchmarking – England, EoE, ICS, statistical neighbours **Analysis by practice where data available (preventive services) **Trend over 5 years where possible to determine changing patterns	PH		
4	Morbidity and mortality • Understand leading causes of ill health and death / what is making our population “sick”	• Mortality ratios • Prevalence of LTCs (selected /QOF) – frailty, falls, fragility fractures, hypertension, diabetes, AF, COPD / asthma / respiratory,	PH/CCG		

Jeptepkeny Ronoh
23/11/208

		dementia • Mental health • Cancer **Trend (5years) **Future projections **Analysis by age group/bands **QOF Exception rates **Age-/sex- standardised **Analysis by deprivation **Analysis by GP practice /locality **Benchmarking – England, EoE, statistical neighbours, ICS **Costs			
5	Urgent and Emergency Care Activity • understand demand and cost	• 111 activity • Ambulance call outs • Emergency admissions (all conditions; to include analysis of ambulatory care sensitive conditions) • Emergency Mental Health Admissions • Readmissions • LOS / XS bed days • Admission prevention service activity i.e. EIT and other rapid response teams **analysis by age group/bands **analysis by time of day **age-/sex- standardised **analysis by GP practice / locality / deprivation	CCG / Community Services		

Jeptepkeny Ronoh
23/11/208

		**analysis by ICD-10/HRG **analysis of costs **Trends (5years) **Benchmarking – England, EoE, statistical neighbours, ICS			
6	Adult social care • Understand demand and cost	• Number of care packages • Type of care package • Cost of care packages **Analysis by age **Analysis by condition (e.g. dementia, mental health, LD, etc) **Trend in demand/provision (?5years) **Benchmarking – England, EoE, statistical neighbours, ICS.	ACS		
7	DTOCs • Understand local picture, causes, trend and impact	• NHS • Social care • Other **Analysis of duration **Trend (?3yrs) **Cost of delays **Benchmarking – England, EoE, statistical neighbours, ICS **Potential savings	CCG/ACS		
8	Community services	• Local Health Care Team / INT activity • Activity within various services e.g. falls, COPD, etc • Community hospitals admissions	CCG/Community Services		

Jeptepkeny Ronoh
23/11/208

		**Analysis by age/sex **Analysis by condition **Analysis by locality / GP Practice **Trend in activity (?5years) **Benchmarking where possible – England, EoE, statistical neighbours, ICS.			
9	PH Commissioned services	• OLS – smoking, weight management, other • Turning point • Sexual Health Services • NHS Health Checks **analysis of activity by age, sex, deprivation, condition, locality, practice **Trends	PH		
10	Primary Care	• GP practice profiles • GP Cancer profiles • ? Prescribing • ? Sustainability **Benchmarking – England, EoE, statistical neighbours, ICS.	PH/CCGs		
11	Workforce	• Analysis across all sectors • Acute trust – WSH • Mental Health Trust • Community services • General practice • Pharmacy • Adult Social Care	PH/CCG/WSH		

		• VCS **Staffing levels **Vacancies **Future need ** Analysis by locality where possible **Benchmarking – England, EoE, statistical neighbours, ICS.			

Explanatory text and caveats to data (“soft intelligence”)

CYP: Nowreen/Mash working on CYP profile for the Children’s Alliance.

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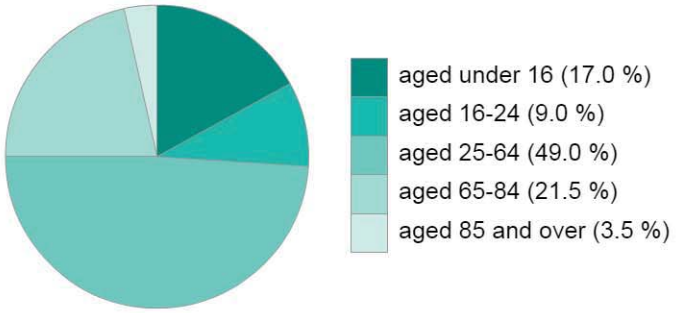
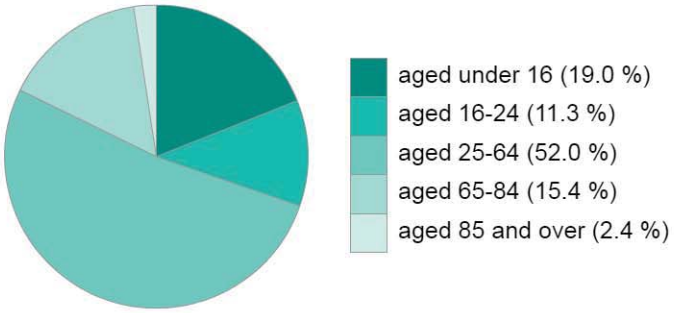
Population

Population by age group, 2015
Your selection



Source: ONS © Crown copyright 2016 - total: 42,113

Population by age group, 2015
England



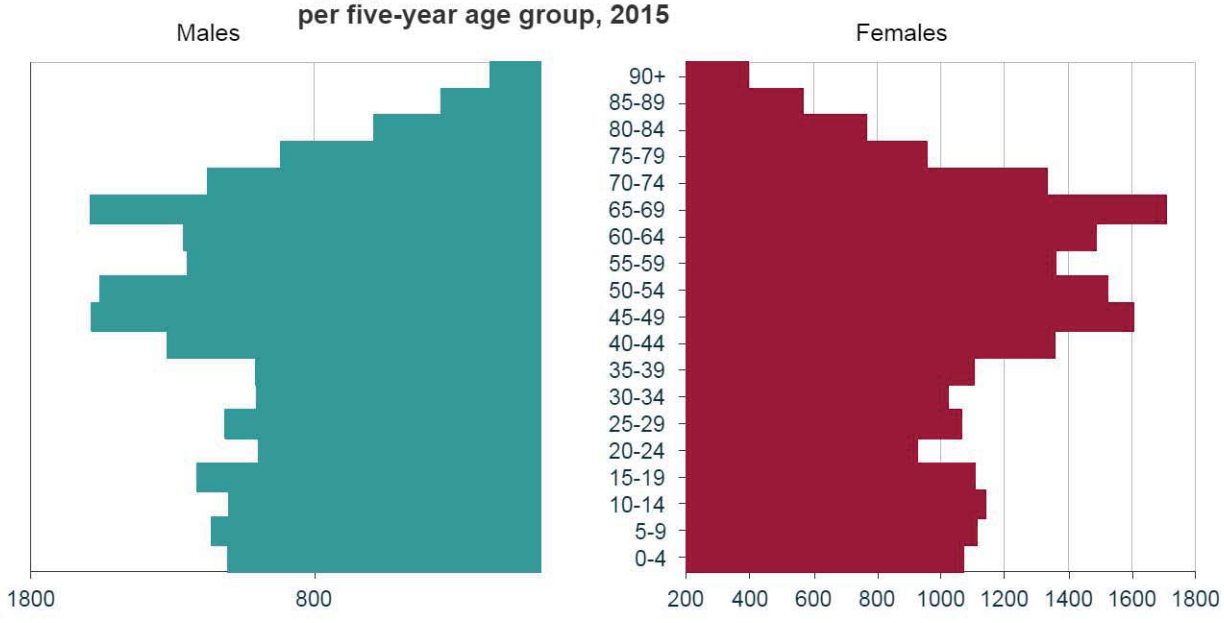
Source: ONS © Crown copyright 2016

Population by age group, 2015, numbers

Ages	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
aged under 16	7,169	15,539	134,030	10,405,114
aged 16-24	3,775	7,779	71,570	6,192,870
aged 25-64	20,631	43,534	369,937	28,476,771
aged 65-84	9,044	19,293	142,964	8,416,283
aged 85 and over	1,494	3,070	23,394	1,295,289
Total	42,113	89,215	741,895	54,786,327

Source: ONS © Crown copyright 2016

Age pyramid for selection: male and female numbers per five-year age group, 2015



Source: ONS © Crown Copyright 2016

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Ethnicity & Language

Ethnicity & Language indicators, 2011, numbers

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Black and Minority Ethnic (BME) Population	889	1,895	34,968	7,731,314
Population whose ethnicity is not 'White UK'	2,012	4,074	66,705	10,733,220
Population who cannot speak English well or at all	118	191	5,020	843,845

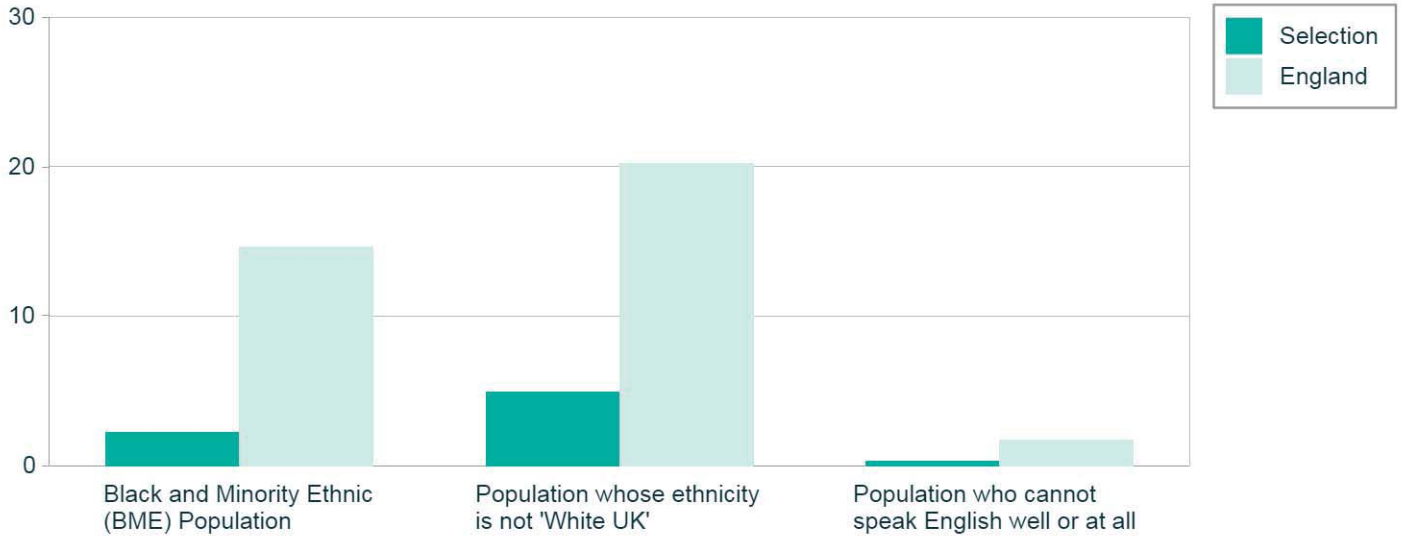
Source: ONS Census, 2011

Ethnicity & Language indicators, 2011, %

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Black and Minority Ethnic (BME) Population	2.2	2.2	4.8	14.6
Population whose ethnicity is not 'White UK'	4.9	4.6	9.2	20.2
Population who cannot speak English well or at all	0.3	0.2	0.7	1.7

Source: ONS Census, 2011

Ethnicity & Language indicators, 2011, %, Selection



Source: ONS Census, 2011

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Deprivation

Indices of Deprivation, 2015, Score

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
IMD 2015 Score	//	15.1	18.3	21.8

Source: DCLG © Copyright 2015. Please see metadata for further guidance on how to interpret IMD score

Indices of Deprivation, 2015, numbers

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
People living in means tested benefit households	4,989	8,325	83,372	7,790,220
Children living in income deprived households	1,237	1,952	19,980	2,016,120
People aged 60+ living in pension credit households	1,536	2,824	24,976	1,954,617

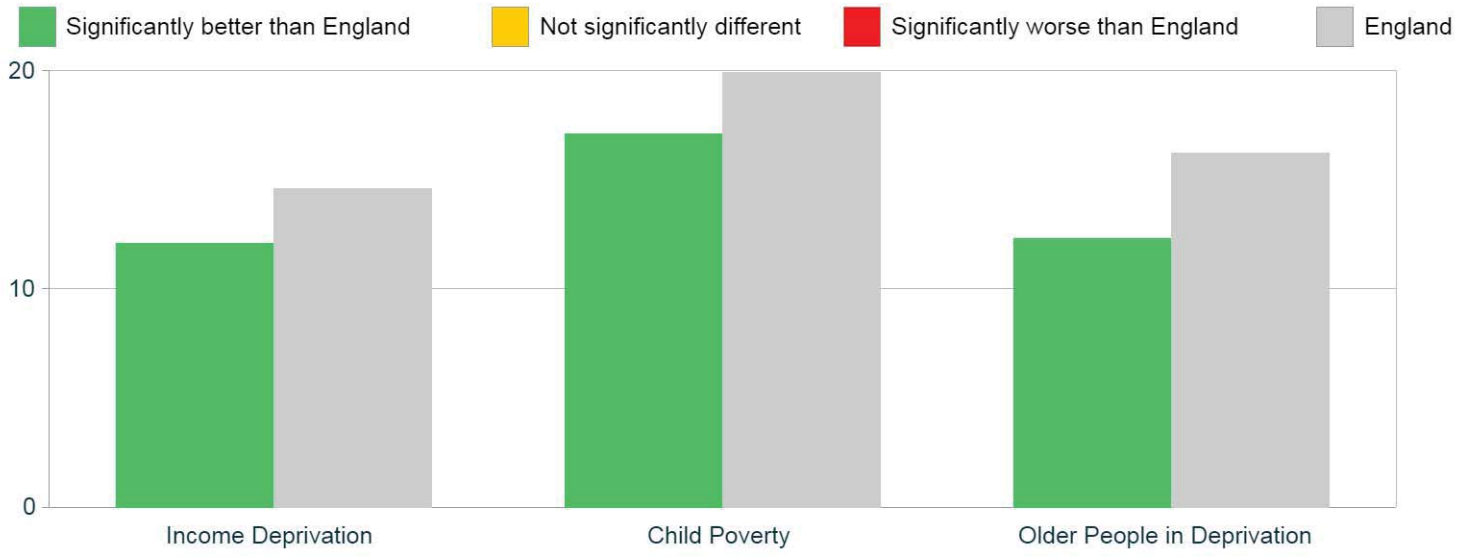
Source: DCLG © Copyright 2015

Indices of Deprivation, 2015, %

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Income Deprivation	12.1	9.5	11.4	14.6
Child Poverty	17.1	12.4	15	19.9
Older People in Deprivation	12.3	10.6	12.4	16.2

Source: DCLG © Copyright 2015

Indices of Deprivation, 2015, %, Selection (comparing to England average)



Source: DCLG © Copyright 2015

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Child Development, Education and Employment

Child development, education and employment indicators, numbers (estimated from MSOA level data)

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Low birth weight of term babies, 2011-2015	36	68	846	86,826
A good level of development at age 5, 2013/14	242	544	4,689	387,000
Achieving 5A*-C (inc Eng & Maths) GCSE, 13/14	213	485	3,835	315,795

Source: Public Health England, ONS, NOMIS, DfE

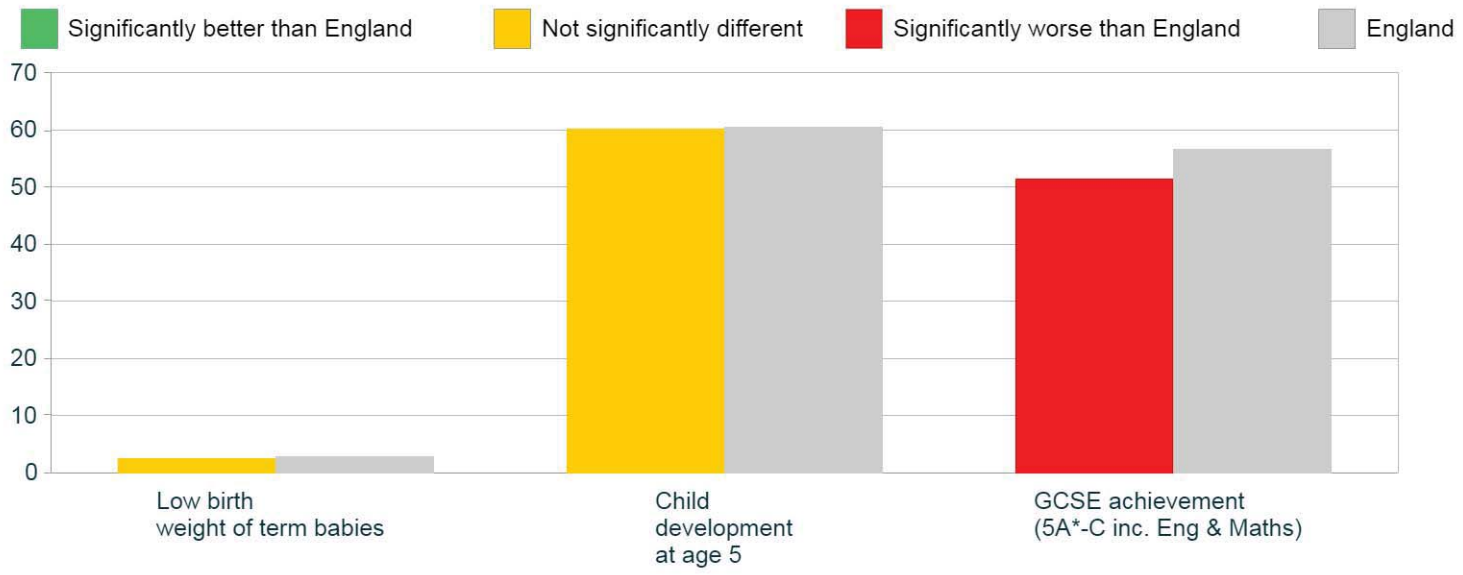
Please note employment data for Wards is not available at this time

Child development, education and employment indicators, values (estimated from MSOA level data)

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Low birth weight of term babies	2.5	1.9	2.3	2.8
Child development at age 5	60.1	62.5	58.9	60.4
GCSE achievement (5A*-C inc. Eng & Maths)	51.4	54.4	51.8	56.6

Source: Public Health England, ONS, NOMIS, DfE

Child development, education and employment indicators, Selection (comparing to England average)



Source: Public Health England, ONS, NOMIS, DfE

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Report - Ward 2016: Sudbury

Health and Care

Health and care indicators, 2011, numbers

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
General health: very bad	435	785	7,547	660,749
General health: bad or very bad	2,050	3,808	34,809	2,911,195
Limiting long term illness or disability	7,724	15,243	130,689	9,352,586
Provides unpaid care for 1 or more hours per week	4,443	9,716	77,745	5,430,016
Provides unpaid care for 50 or more hours per week	928	1,877	17,194	1,256,237

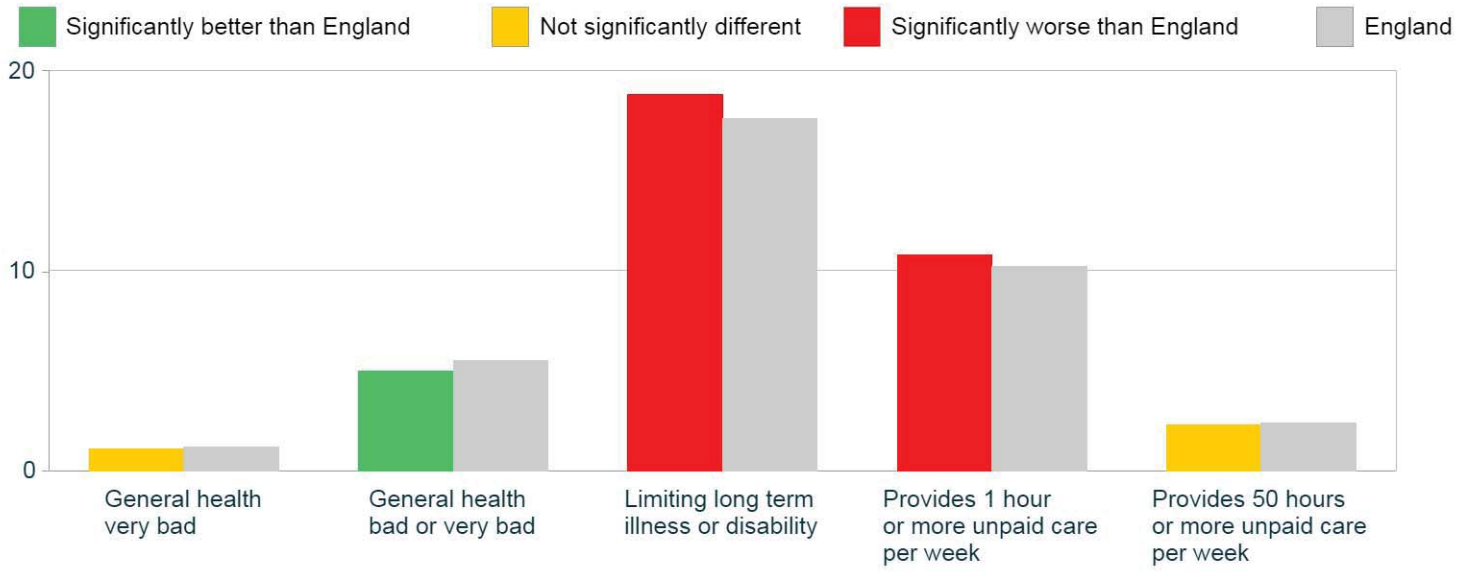
Source: ONS Census, 2011

Health and care indicators, 2011, %

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
General health very bad	1.1	0.9	1	1.2
General health bad or very bad	5	4.3	4.8	5.5
Limiting long term illness or disability	18.8	17.4	17.9	17.6
Provides 1 hour or more unpaid care per week	10.8	11.1	10.7	10.2
Provides 50 hours or more unpaid care per week	2.3	2.1	2.4	2.4

Source: ONS Census, 2011

Health and care indicators, 2011, %, Selection (comparing to England average)



Source: ONS Census, 2011

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Report - Ward 2016: Sudbury

Housing and Living Environment

Housing and living environment indicators, 2011 and 2014, numbers

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Fuel Poverty, 2014	1,743	3,985	31,371	2,379,357
Overcrowded households (at least 1 room too few)	709	1,142	14,933	1,928,596
Pensioners living alone	2,702	5,306	42,599	2,725,596

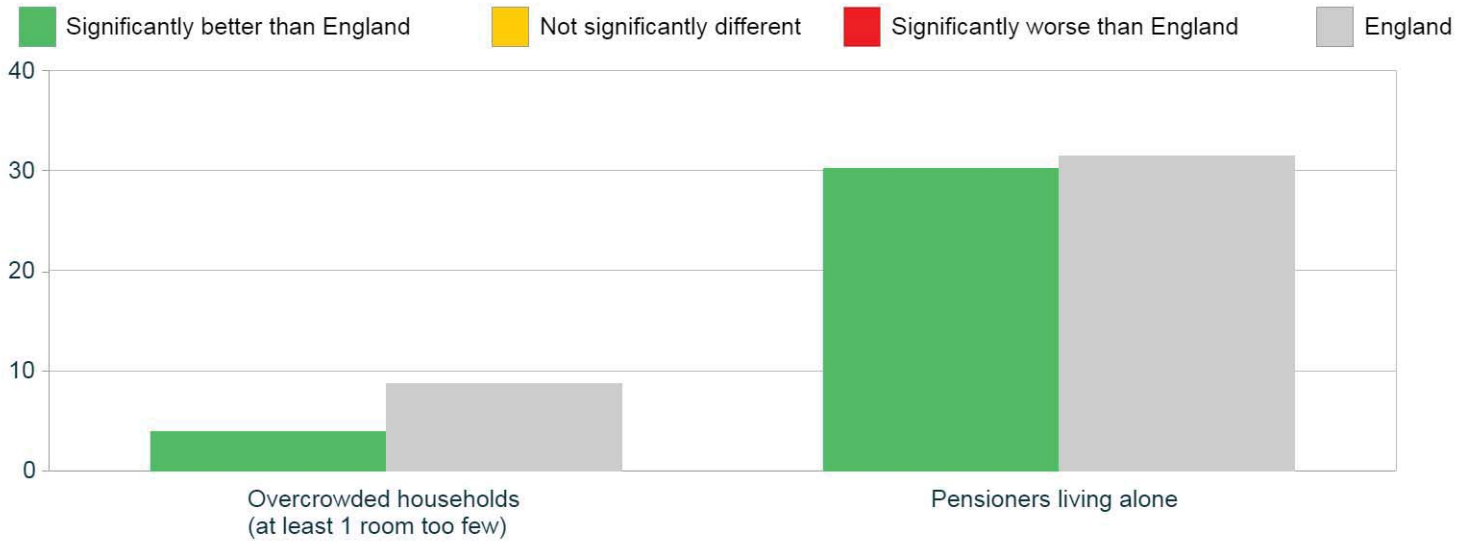
Source: ONS Census, 2011; Department of Energy and Climate Change, 2014

Housing and living environment indicators, 2011 and 2014, %

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Fuel Poverty, 2014	9.5	10.3	9.8	10.6
Overcrowded households (at least 1 room too few)	3.9	3	4.8	8.7
Pensioners living alone	30.2	28.3	29.4	31.5

Source: ONS Census, 2011; Department of Energy and Climate Change, 2014

Housing and living environment indicators, 2011, %, Selection (comparing to England average)



Source: ONS Census
Please note Fuel Poverty cannot be displayed on chart as it does not have confidence limits.

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Report - Ward 2016: Sudbury

Children's Weight

Children's weight indicators, 2013/14-2015/16, numbers (estimated from MSOA level data)

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Obese children (Reception Year)	107	201	2,005	169,362
Children with excess weight (Reception Year)	287	544	5,048	404,465
Obese children (Year 6)	214	411	3,623	307,544
Children with excess weight (Year 6)	403	817	6,652	535,056

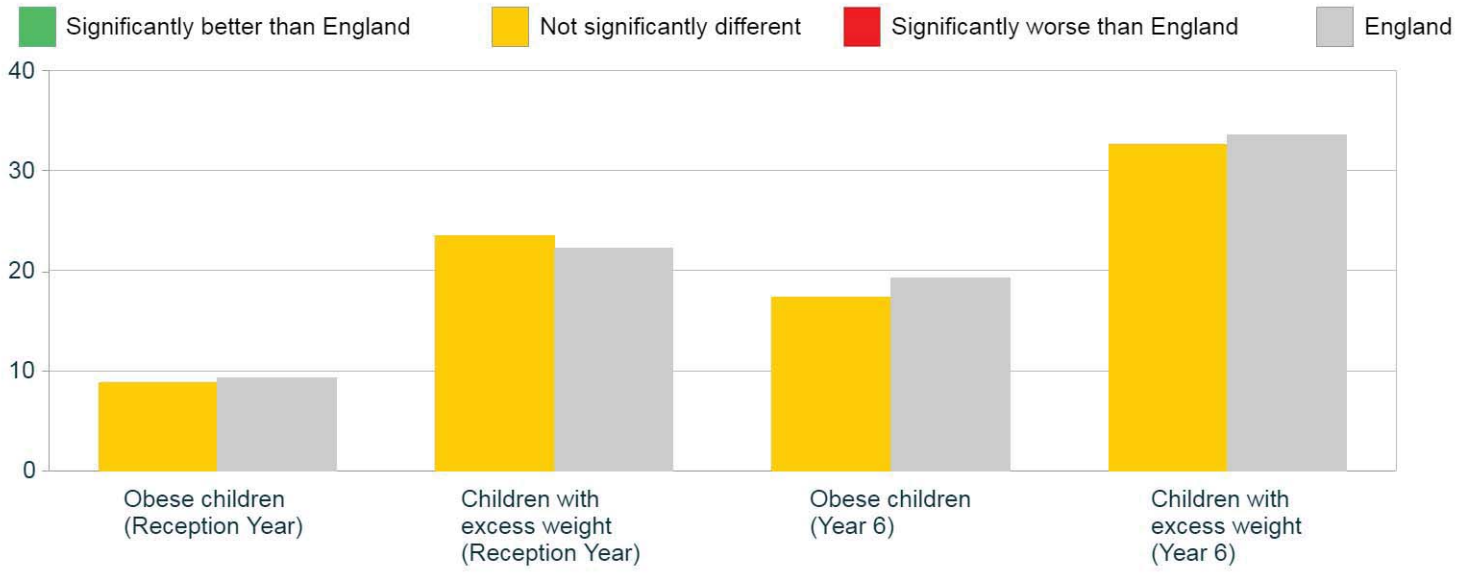
Source: National Child Measurement Programme, NHS Digital © 2013-2016

Children's weight indicators, 2013/14-2015/16, % (estimated from MSOA level data)

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Obese children (Reception Year)	8.8	8.1	8.7	9.3
Children with excess weight (Reception Year)	23.5	21.8	21.8	22.2
Obese children (Year 6)	17.3	15.5	17.3	19.3
Children with excess weight (Year 6)	32.6	30.9	31.7	33.6

Source: National Child Measurement Programme, NHS Digital © 2013-2016

Children's weight indicators, %, Selection (comparing to England average)



Source: National Child Measurement Programme, NHS Digital © 2013-2016

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Children's health care activity

Children's health care activity, numbers, 2013/14 - 2015/16 (estimated from MSOA level data)

indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Emergency Admissions 0-4 year olds	1,126	2,238	19,886	1,533,272
A&E attendances 0-4 year olds	1,888	3,867	41,680	5,670,099
Admission for injury 0-4 year olds	131	270	2,298	235,961
Admission for injury 0-15 year olds	310	682	5,593	527,519
Admission for injury 15-24 year olds	271	522	4,853	470,265

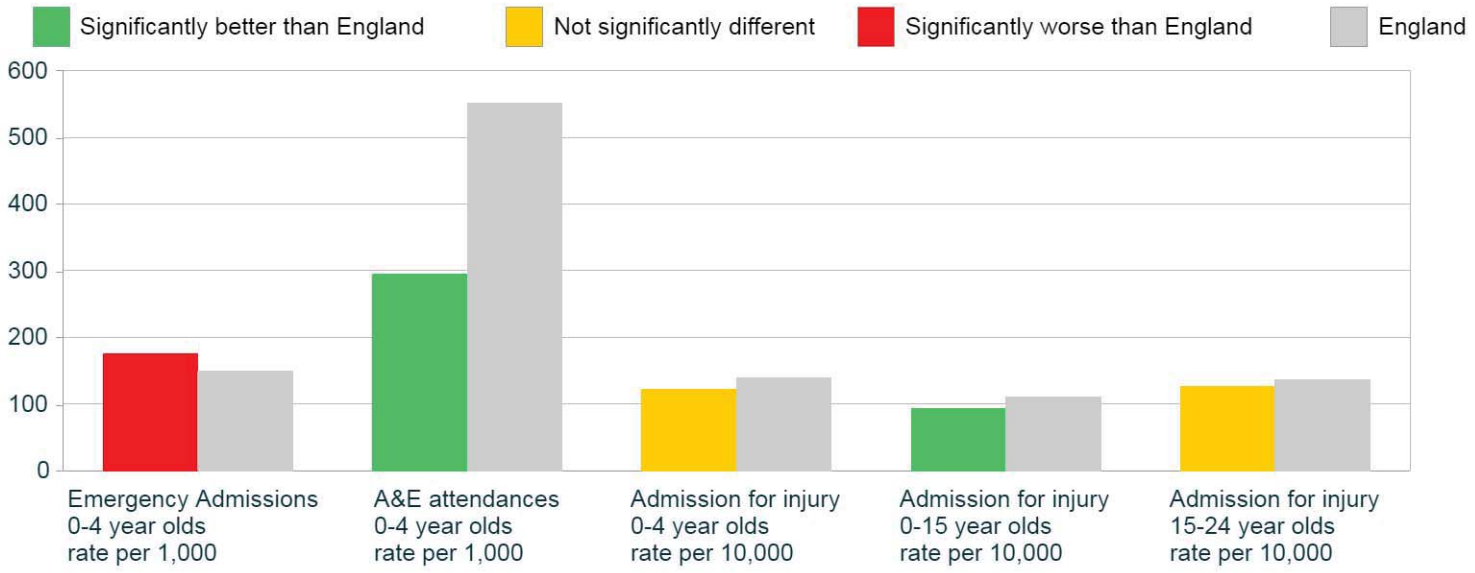
Source: Public Health England, NHS Digital 2017

Children's health care activity, values, 2013/14 - 2015/16 (estimated from MSOA level data)

indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Emergency Admissions 0-4 year olds rate per 1,000	175.5	173	156.8	149.2
A&E attendances 0-4 year olds rate per 1,000	294.3	298.9	328.7	551.6
Admission for injury 0-4 year olds rate per 10,000	121.5	123.9	108.5	138.8
Admission for injury 0-15 year olds rate per 10,000	92.4	93.6	89.7	110.1
Admission for injury 15-24 year olds rate per 10,000	126	116.1	118.2	137

Source: Public Health Enland, NHS Digital 2017

Children's health care activity, Selection (comparing to England average)



Source: Public Health England, NHS Digital 2017

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Report - Ward 2016: Sudbury

Adults' Behavioural Risk Factors

Adults' Behavioral Risk Factors, 2006-08, numbers (estimated from MSOA level data)

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Obese adults	8,502	16,804	140,328	9,983,436
Binge drinking adults	5,462	12,139	94,395	8,290,798
Healthy eating adults	9,651	22,404	174,930	11,907,157

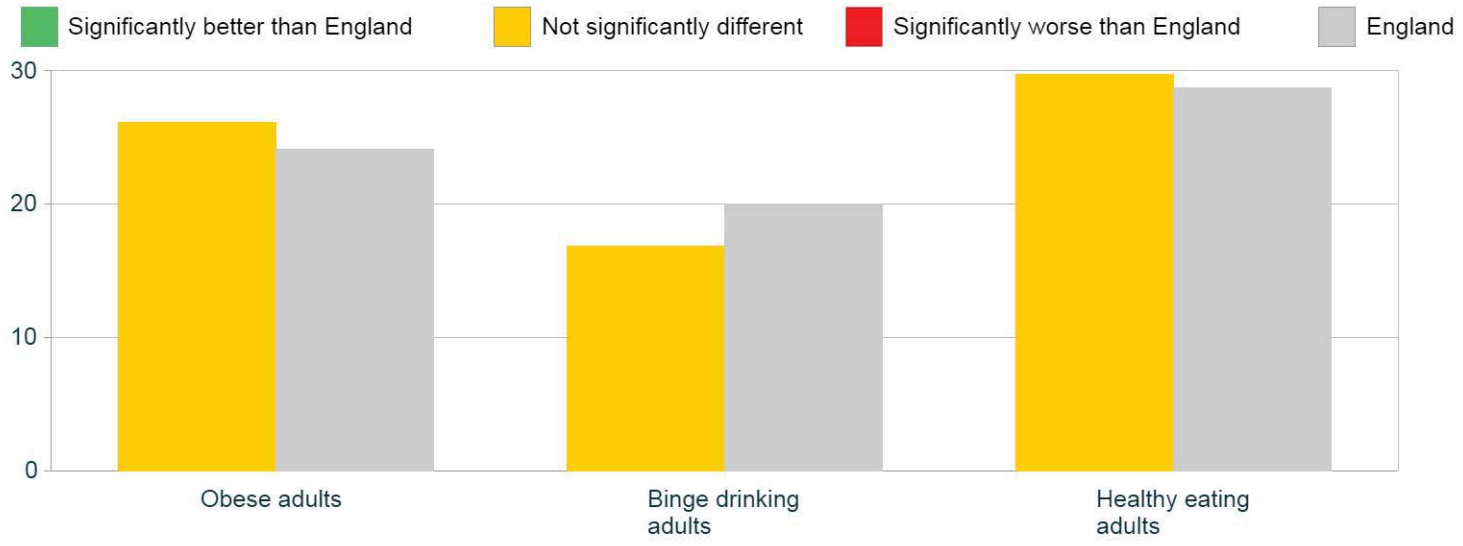
Source: Public Health England © Copyright 2010

Adults' Behavioral Risk Factors, 2006-08, % (estimated from MSOA level data)

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Obese adults	26.1	23.9	24.3	24.1
Binge drinking adults	16.8	17.3	16.4	20
Healthy eating adults	29.7	31.9	30.3	28.7

Source: Public Health England © Copyright 2010

Adults' Behavioral Risk Factors, %, Selection (comparing to England average)



Source: Public Health England © Copyright 2010

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Emergency hospital admissions

Emergency Hospital Admissions, numbers, 2011/12 to 2015/16 (estimated from MSOA level data)

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Emergency hospital admissions for all causes	20,542	40,239	339,060	26,930,251
Emergency hospital admissions for CHD*	602	1,198	10,345	688,090
Emergency hospital admissions for stroke	385	775	5,985	398,062
Emergency hospital admissions for MI*	335	661	5,696	335,723
Emergency hospital admissions for COPD*	423	752	7,360	583,448

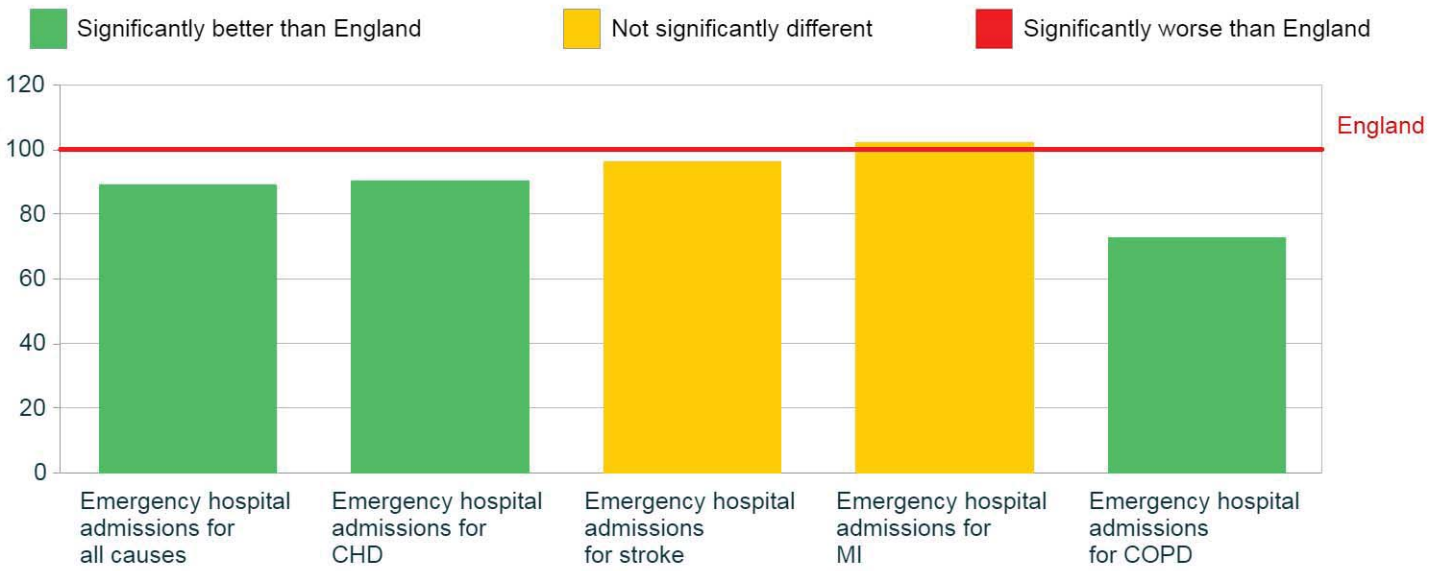
Source: Public Health England, NHS Digital © Copyright 2017
** CHD: Coronary Heart Disease; MI: Myocardial Infarction (heart attack); COPD: Chronic Obstructive Pulmonary Disease*

Emergency Hospital Admissions, Standardised Admission Ratios (SAR), 2011/12 to 2015/16 (estimated from MSOA data)

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Emergency hospital admissions for all causes	89	82.2	85.3	100
Emergency hospital admissions for CHD	90.2	83.1	93.4	100
Emergency hospital admissions for stroke	96.3	90.6	90.7	100
Emergency hospital admissions for MI	102.2	93.7	105	100
Emergency hospital admissions for COPD	72.6	59.8	76.7	100

Source: Public Health England, NHS Digital © Copyright 2017

Emergency Hospital admissions, SAR, 2011/12 to 2015/16, Selection (comparing to England average)



Source: Public Health England, NHS Digital © Copyright 2017

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Cancer incidence

Cancer incidence, numbers, 2011-2015 (estimated from MSOA level data)

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
All cancer	1,496	3,034	22,993	1,469,163
Breast cancer	231	465	3,343	221,700
Colorectal cancer	207	432	3,013	173,299
Lung cancer	134	253	2,424	186,030
Prostate cancer	240	531	3,714	196,749

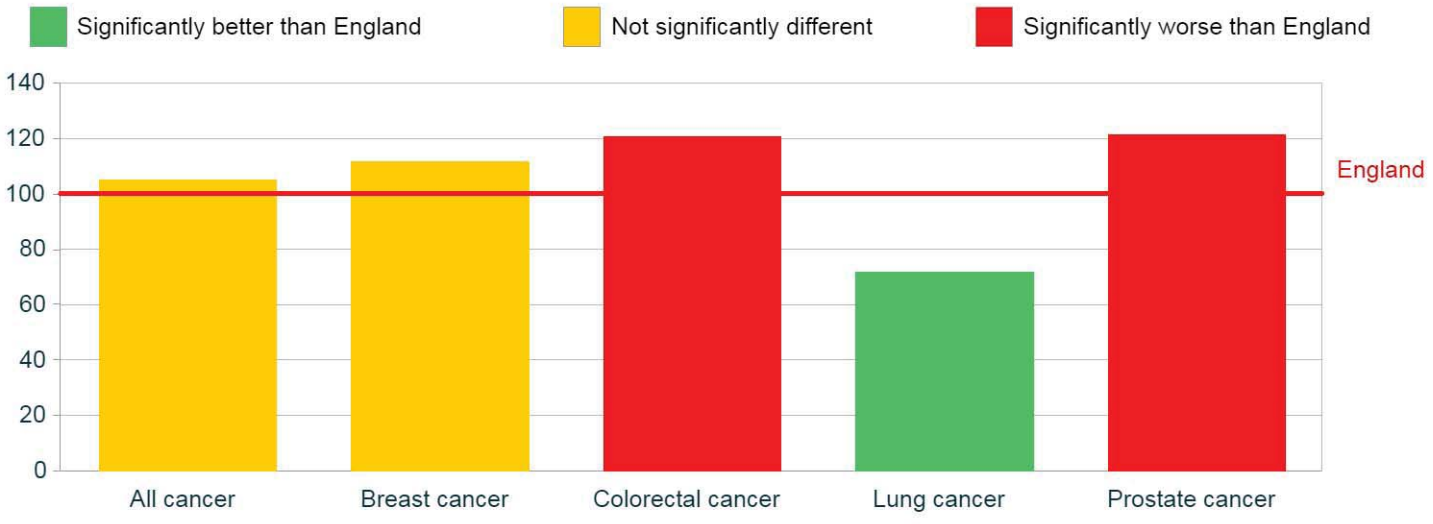
Source: English cancer registration data from the National Cancer Registration and Analysis Services' Cancer Analysis System (AV2015 CASREF01)

Cancer incidence, Standardised Incidence Ratios (SIR), 2011-2015 (estimated from MSOA level data)

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
All cancer	104.9	98.5	97.2	100
Breast cancer	111.4	104.3	97.8	100
Colorectal cancer	120.6	116.5	106	100
Lung cancer	71.8	62.5	78.5	100
Prostate cancer	121.3	122.2	112.6	100

Source: English cancer registration data from the National Cancer Registration and Analysis Services' Cancer Analysis System (AV2015 CASREF01)

Cancer incidence, SIR, 2011-2015, Selection (comparing to England average)



Source:
English cancer registration data from the National Cancer Registration and Analysis Services' Cancer Analysis System

Report - Ward 2016: Sudbury

Hospital admissions - harm and injury

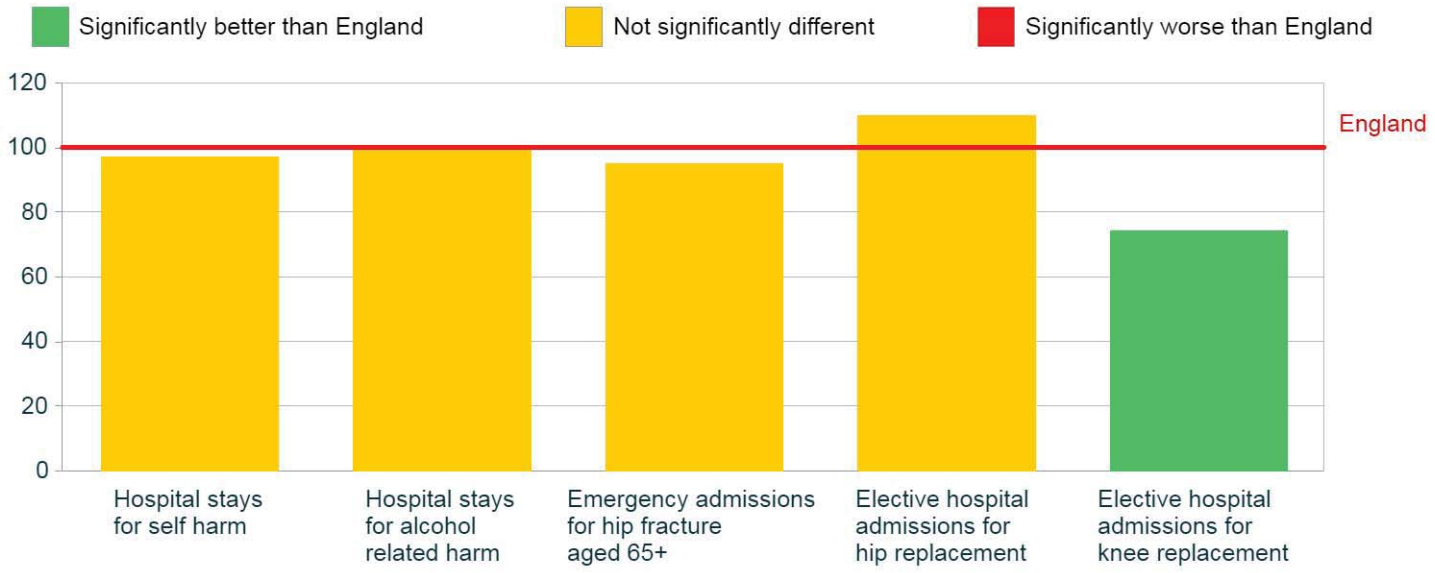
Hospital admissions - harm and injury, numbers, 2011/12 to 2015/16 (estimated from MSOA level data)

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Hospital stays for self harm	366	608	6,409	537,455
Hospital stays for alcohol related harm	1,359	2,486	21,000	1,633,232
Emergency admissions for hip fracture aged 65+	288	572	4,475	283,432
Elective hospital admissions for hip replacement	364	757	5,342	338,773
Elective hospital admissions for knee replacement	276	605	4,809	374,028

Hospital admissions - harm and injury, Standardised Admission Ratios (SAR), 2011/12 to 2015/16 (estimated from MSOA)

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Hospital stays for self harm	97	76.4	93.3	100
Hospital stays for alcohol related harm	99.8	85.3	89.7	100
Emergency admissions for hip fracture aged 65+	94.9	90.1	90.9	100
Elective hospital admissions for hip replacement	109.7	105.3	97.6	100
Elective hospital admissions for knee replacement	74.2	75	78.7	100

Hospital admissions - harm and injury, SAR, 2011/12 to 2015/16 , Selection (comparing to England average)



Report - Ward 2016: Sudbury

Mortality and causes of death - all ages

Causes of deaths - all ages, numbers, 2011-2015

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
All causes	2,243	4,474	36,248	2,357,381
All cancer	619	1,221	10,281	666,658
All circulatory disease	626	1,238	10,145	646,138
Coronary heart disease	264	553	4,468	289,738
Stroke	144	288	2,540	165,375
Respiratory diseases	305	616	4,620	325,764

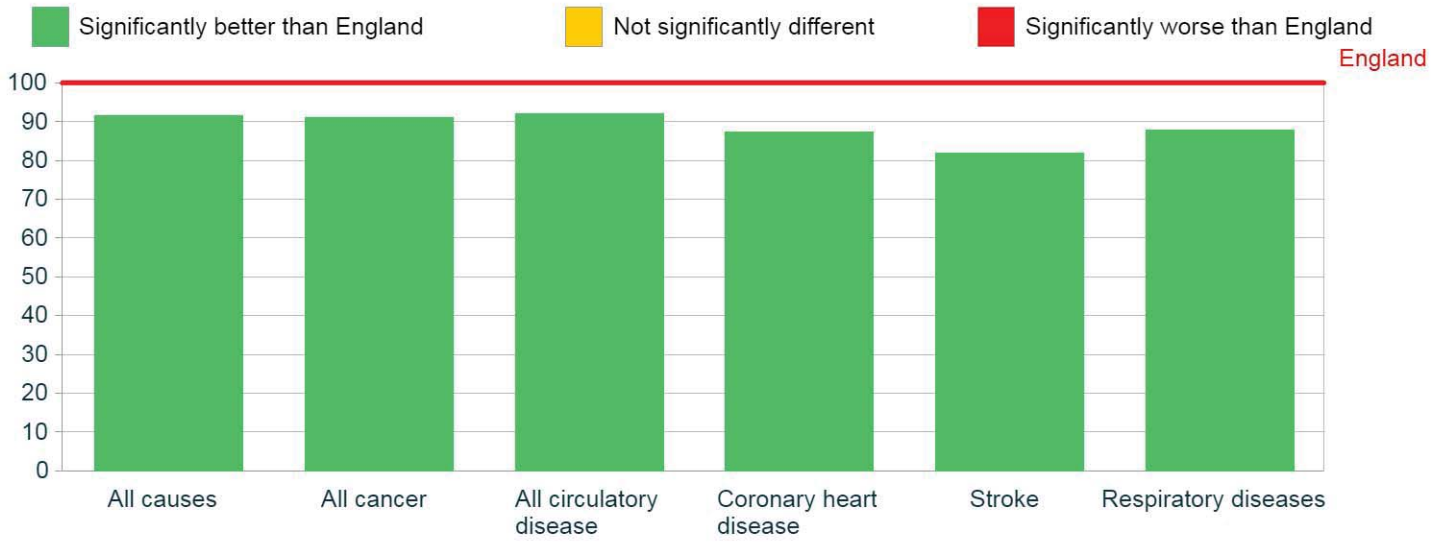
Source: Public Health England, produced from ONS data Copyright © 2017

Causes of deaths - all ages, Standardised Mortality Ratios (SMR), 2011-2015

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
All causes	91.6	87.2	91.2	100
All cancer	91.1	84.8	93	100
All circulatory disease	92	86.9	92	100
Coronary heart disease	87.4	87	91	100
Stroke	81.9	78.5	89.2	100
Respiratory diseases	87.9	85	82.4	100

Source: Public Health England, produced from ONS data Copyright © 2017

Causes of deaths - all ages, SMR, 2011-2015, Selection (comparing to England average)



Source: Public Health England, produced from ONS data Copyright © 2017

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Mortality and causes of death - premature mortality

Causes of deaths - premature mortality, numbers, 2011-2015

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
All causes, aged under 65	251	486	4,532	373,093
All causes, aged under 75	575	1,115	9,990	752,670
All cancer, aged under 75	247	510	4,605	310,786
All circulatory disease, aged under 75	139	246	2,166	166,529
Coronary heart disease, aged under 75	65	123	1,132	91,057

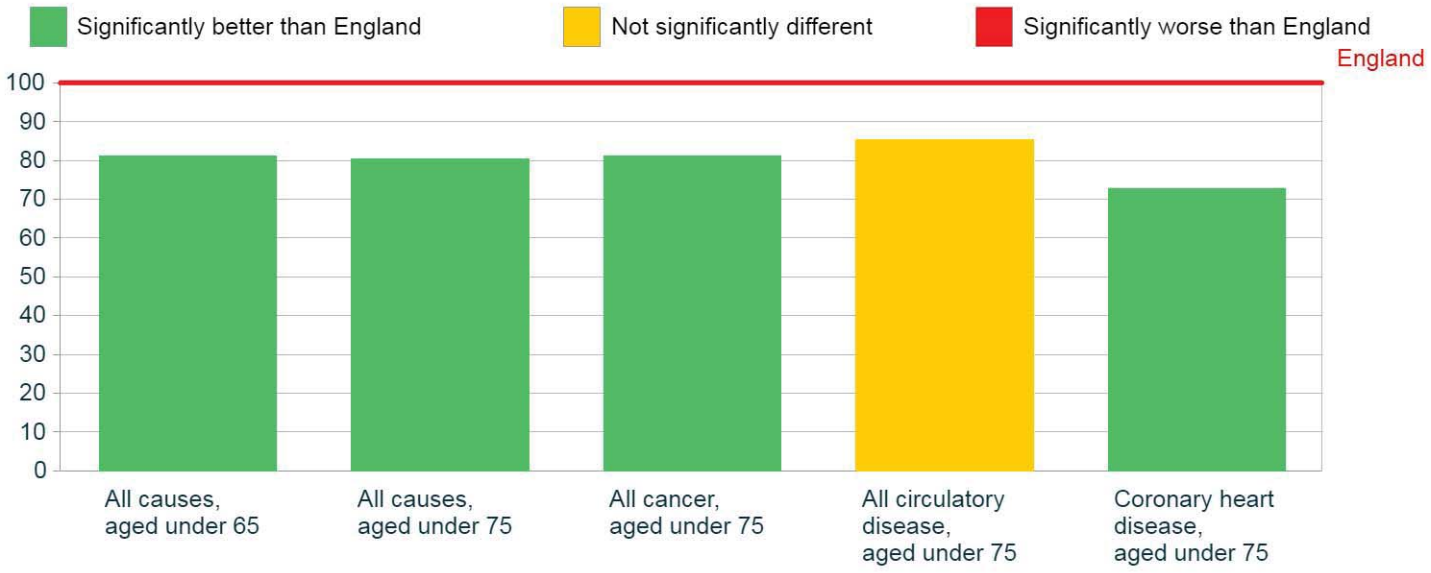
Source: Public Health England, produced from ONS data Copyright © 2017

Causes of deaths - premature mortality, Standardised Mortality Ratios (SMR), 2011-2015

Indicator	Selection	Babergh (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
All causes, aged under 65	81.2	72.4	85.3	100
All causes, aged under 75	80.3	72.6	85.4	100
All cancer, aged under 75	81.2	77.9	93.5	100
All circulatory disease, aged under 75	85.3	70.5	82.3	100
Coronary heart disease, aged under 75	72.7	63.9	78.3	100

Source: Public Health England, produced from ONS data Copyright © 2017

Causes of deaths - premature mortality, SMR, 2011-2015, Selection (comparing to England average)



Source: Public Health England, produced from ONS data Copyright © 2017

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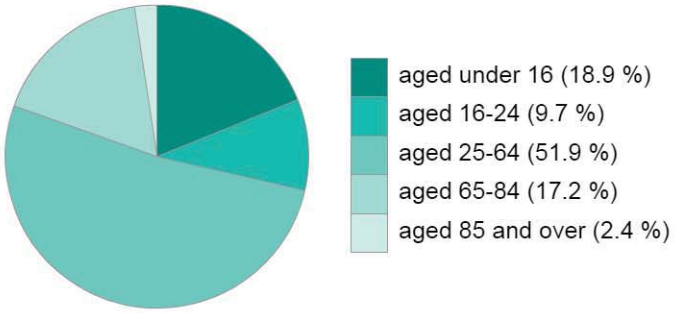
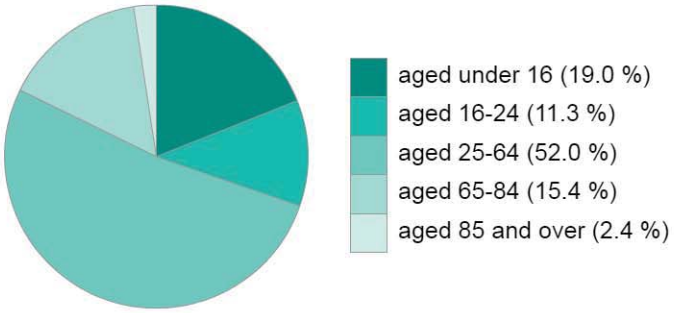
Population

Population by age group, 2015
Your selection



Source: ONS © Crown copyright 2016 - total: 43,177

Population by age group, 2015
England



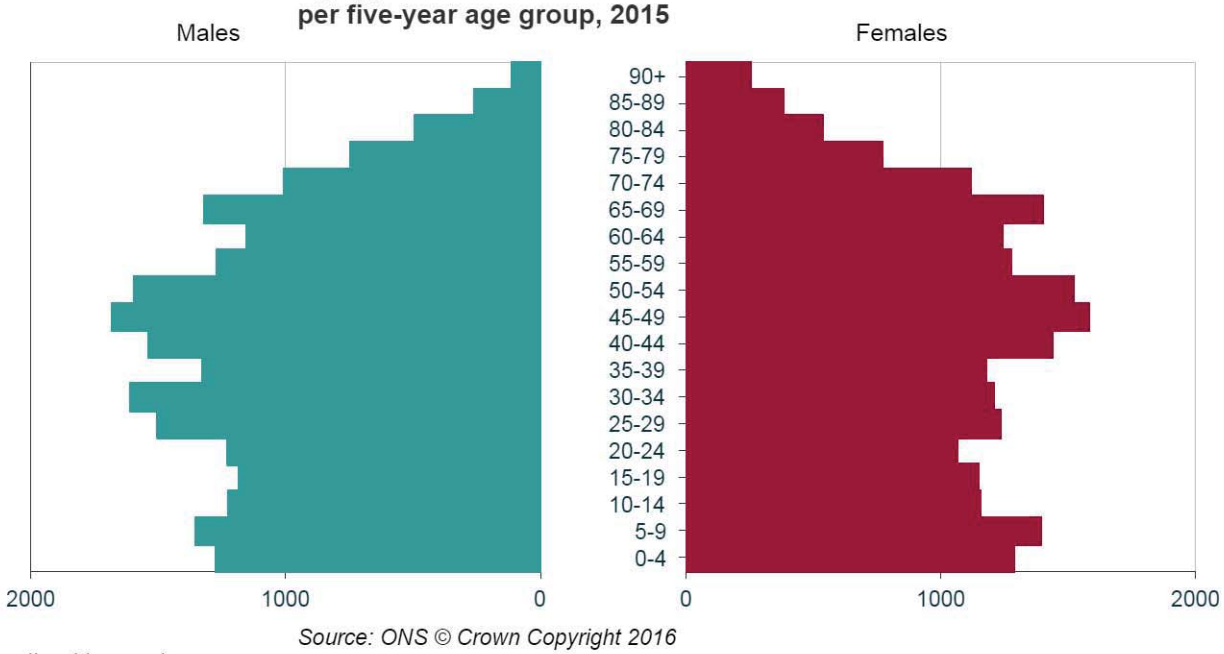
Source: ONS © Crown copyright 2016

Population by age group, 2015, numbers

Ages	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
aged under 16	8,170	20,172	134,030	10,405,114
aged 16-24	4,169	10,892	71,570	6,192,870
aged 25-64	22,403	57,191	369,937	28,476,771
aged 65-84	7,414	20,929	142,964	8,416,283
aged 85 and over	1,021	3,339	23,394	1,295,289
Total	43,177	112,523	741,895	54,786,327

Source: ONS © Crown copyright 2016

Age pyramid for selection: male and female numbers per five-year age group, 2015



Source: ONS © Crown Copyright 2016

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Ethnicity & Language

Ethnicity & Language indicators, 2011, numbers

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Black and Minority Ethnic (BME) Population	1,968	4,393	34,968	7,731,314
Population whose ethnicity is not 'White UK'	4,019	9,769	66,705	10,733,220
Population who cannot speak English well or at all	363	713	5,020	843,845

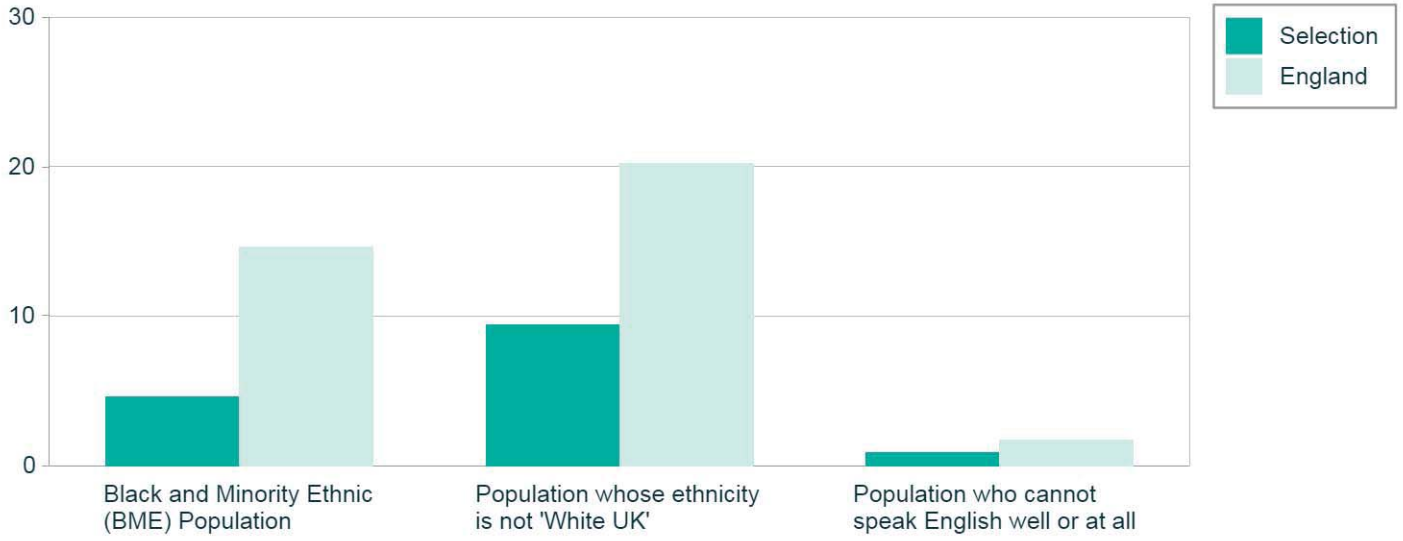
Source: ONS Census, 2011

Ethnicity & Language indicators, 2011, %

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Black and Minority Ethnic (BME) Population	4.6	4	4.8	14.6
Population whose ethnicity is not 'White UK'	9.4	8.8	9.2	20.2
Population who cannot speak English well or at all	0.9	0.7	0.7	1.7

Source: ONS Census, 2011

Ethnicity & Language indicators, 2011, %, Selection



Source: ONS Census, 2011

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Deprivation

Indices of Deprivation, 2015, Score

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
IMD 2015 Score	//	15.3	18.3	21.8

Source: DCLG © Copyright 2015. Please see metadata for further guidance on how to interpret IMD score

Indices of Deprivation, 2015, numbers

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
People living in means tested benefit households	4,112	9,910	83,372	7,790,220
Children living in income deprived households	1,041	2,318	19,980	2,016,120
People aged 60+ living in pension credit households	1,103	3,044	24,976	1,954,617

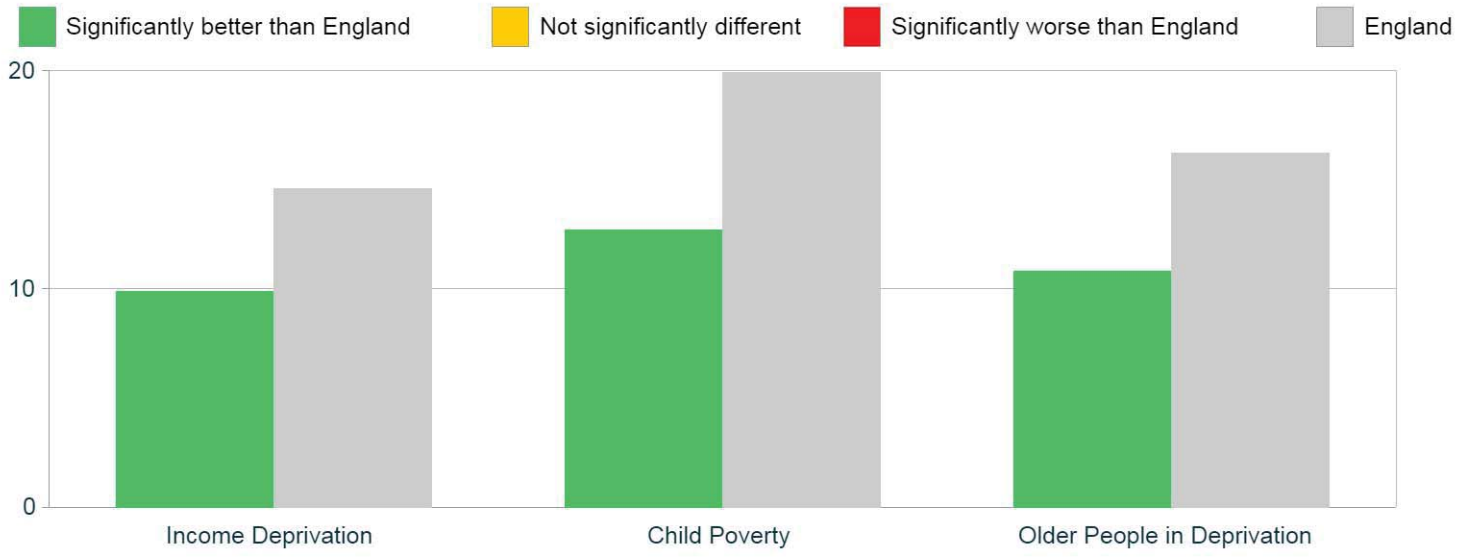
Source: DCLG © Copyright 2015

Indices of Deprivation, 2015, %

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Income Deprivation	9.9	9	11.4	14.6
Child Poverty	12.7	11.4	15	19.9
Older People in Deprivation	10.8	10.5	12.4	16.2

Source: DCLG © Copyright 2015

Indices of Deprivation, 2015, %, Selection (comparing to England average)



Source: DCLG © Copyright 2015

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Child Development, Education and Employment

Child development, education and employment indicators, numbers (estimated from MSOA level data)

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Low birth weight of term babies, 2011-2015	44	102	846	86,826
A good level of development at age 5, 2013/14	268	720	4,689	387,000
Achieving 5A*-C (inc Eng & Maths) GCSE, 13/14	233	642	3,835	315,795

Source: Public Health England, ONS, NOMIS, DfE

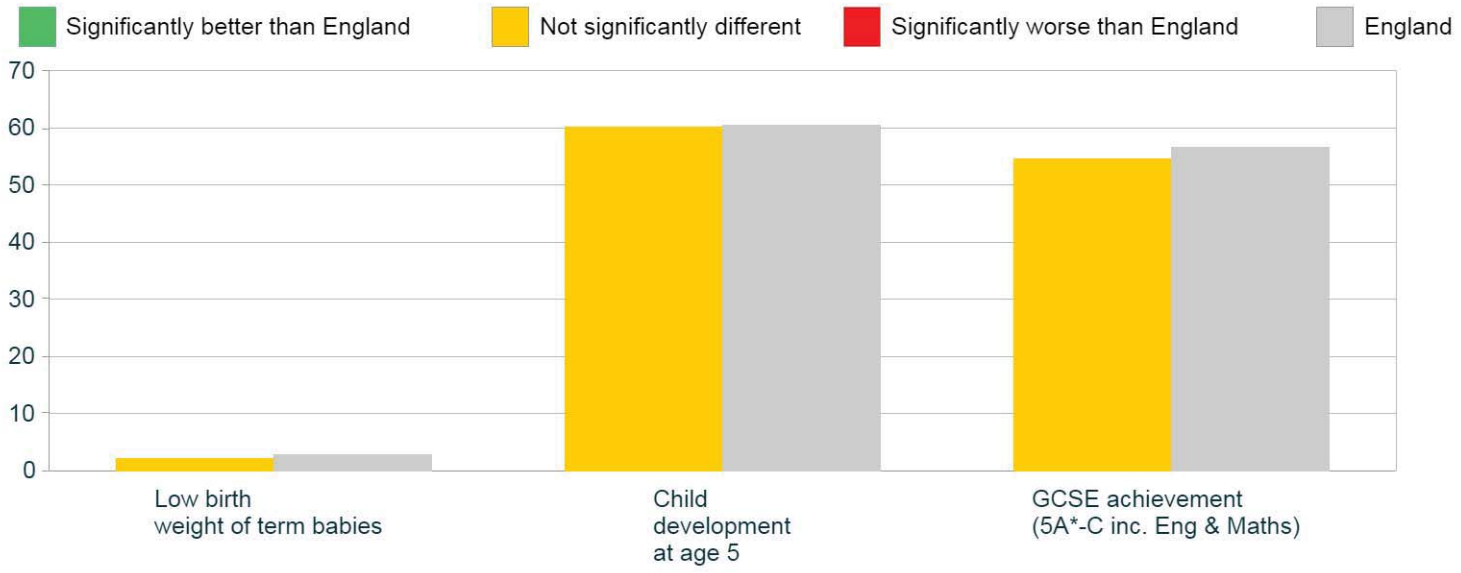
Please note employment data for Wards is not available at this time

Child development, education and employment indicators, values (estimated from MSOA level data)

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Low birth weight of term babies	2.1	1.9	2.3	2.8
Child development at age 5	60.1	61.6	58.9	60.4
GCSE achievement (5A*-C inc. Eng & Maths)	54.6	57.4	51.8	56.6

Source: Public Health England, ONS, NOMIS, DfE

Child development, education and employment indicators, Selection (comparing to England average)



Source: Public Health England, ONS, NOMIS, DfE

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Report - Ward 2016: Haverhill

Health and Care

Health and care indicators, 2011, numbers

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
General health: very bad	457	1,033	7,547	660,749
General health: bad or very bad	2,000	4,728	34,809	2,911,195
Limiting long term illness or disability	6,885	18,213	130,689	9,352,586
Provides unpaid care for 1 or more hours per week	4,177	11,059	77,745	5,430,016
Provides unpaid care for 50 or more hours per week	944	2,322	17,194	1,256,237

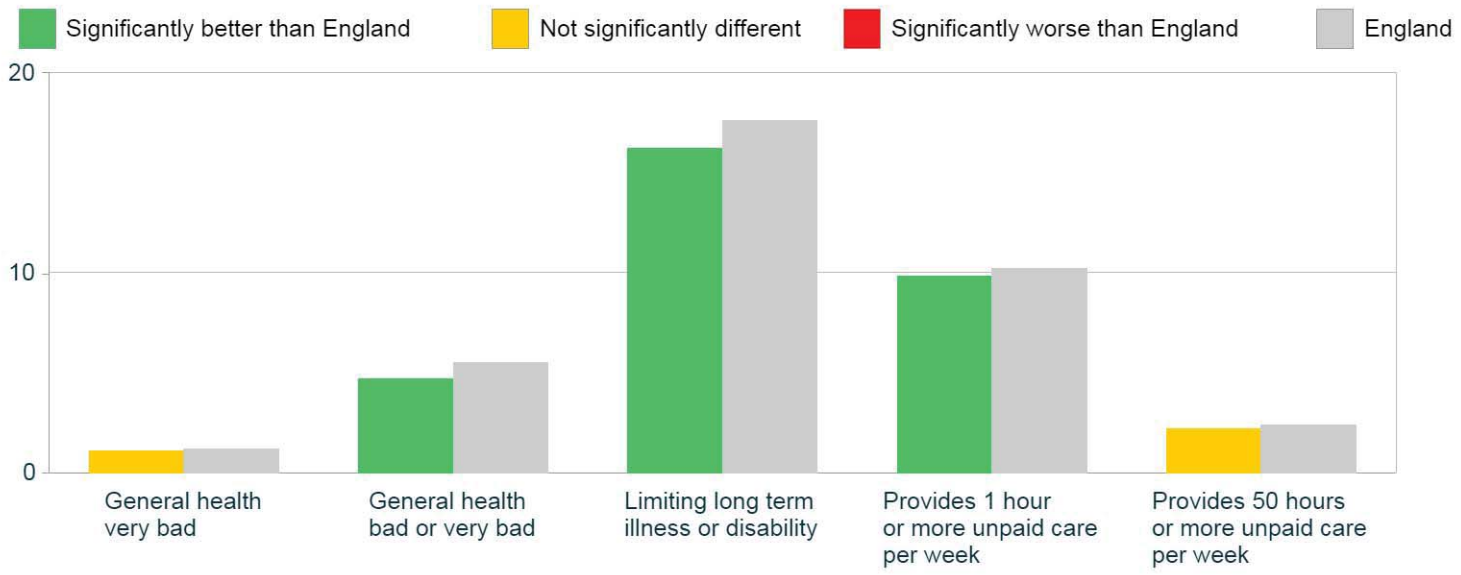
Source: ONS Census, 2011

Health and care indicators, 2011, %

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
General health very bad	1.1	0.9	1	1.2
General health bad or very bad	4.7	4.3	4.8	5.5
Limiting long term illness or disability	16.2	16.4	17.9	17.6
Provides 1 hour or more unpaid care per week	9.8	10	10.7	10.2
Provides 50 hours or more unpaid care per week	2.2	2.1	2.4	2.4

Source: ONS Census, 2011

Health and care indicators, 2011, %, Selection (comparing to England average)



Source: ONS Census, 2011

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Housing and Living Environment

Housing and living environment indicators, 2011 and 2014, numbers

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Fuel Poverty, 2014	1,636	4,374	31,371	2,379,357
Overcrowded households (at least 1 room too few)	835	2,355	14,933	1,928,596
Pensioners living alone	1,860	5,841	42,599	2,725,596

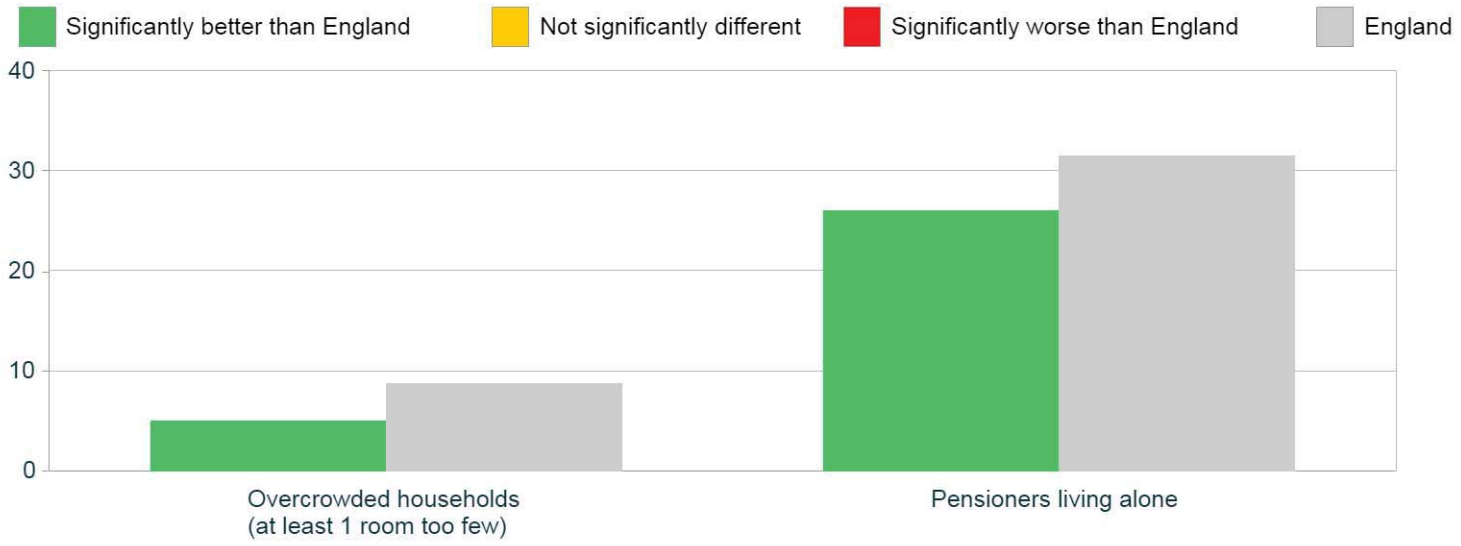
Source: ONS Census, 2011; Department of Energy and Climate Change, 2014

Housing and living environment indicators, 2011 and 2014, %

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Fuel Poverty, 2014	9.5	9.3	9.8	10.6
Overcrowded households (at least 1 room too few)	5	5.1	4.8	8.7
Pensioners living alone	26	27.8	29.4	31.5

Source: ONS Census, 2011; Department of Energy and Climate Change, 2014

Housing and living environment indicators, 2011, %, Selection (comparing to England average)



Source: ONS Census
Please note Fuel Poverty cannot be displayed on chart as it does not have confidence limits.

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Report - Ward 2016: Haverhill

Children's Weight

Children's weight indicators, 2013/14-2015/16, numbers (estimated from MSOA level data)

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Obese children (Reception Year)	130	296	2,005	169,362
Children with excess weight (Reception Year)	308	733	5,048	404,465
Obese children (Year 6)	239	509	3,623	307,544
Children with excess weight (Year 6)	432	967	6,652	535,056

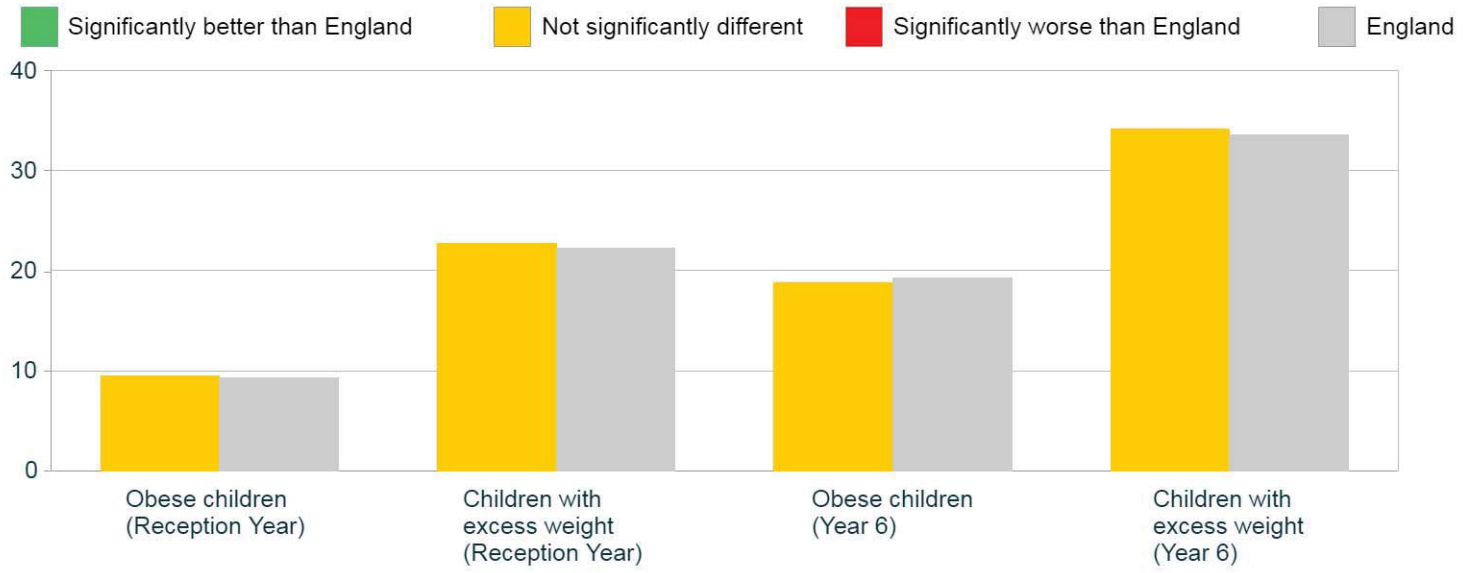
Source: National Child Measurement Programme, NHS Digital © 2013-2016

Children's weight indicators, 2013/14-2015/16, % (estimated from MSOA level data)

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Obese children (Reception Year)	9.5	8.6	8.7	9.3
Children with excess weight (Reception Year)	22.7	21.3	21.8	22.2
Obese children (Year 6)	18.8	16.2	17.3	19.3
Children with excess weight (Year 6)	34.1	30.8	31.7	33.6

Source: National Child Measurement Programme, NHS Digital © 2013-2016

Children's weight indicators, %, Selection (comparing to England average)



Source: National Child Measurement Programme, NHS Digital © 2013-2016

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Children's health care activity

Children's health care activity, numbers, 2013/14 - 2015/16 (estimated from MSOA level data)

indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Emergency Admissions 0-4 year olds	796	3,092	19,886	1,533,272
A&E attendances 0-4 year olds	2,747	6,535	41,680	5,670,099
Admission for injury 0-4 year olds	113	372	2,298	235,961
Admission for injury 0-15 year olds	261	850	5,593	527,519
Admission for injury 15-24 year olds	322	822	4,853	470,265

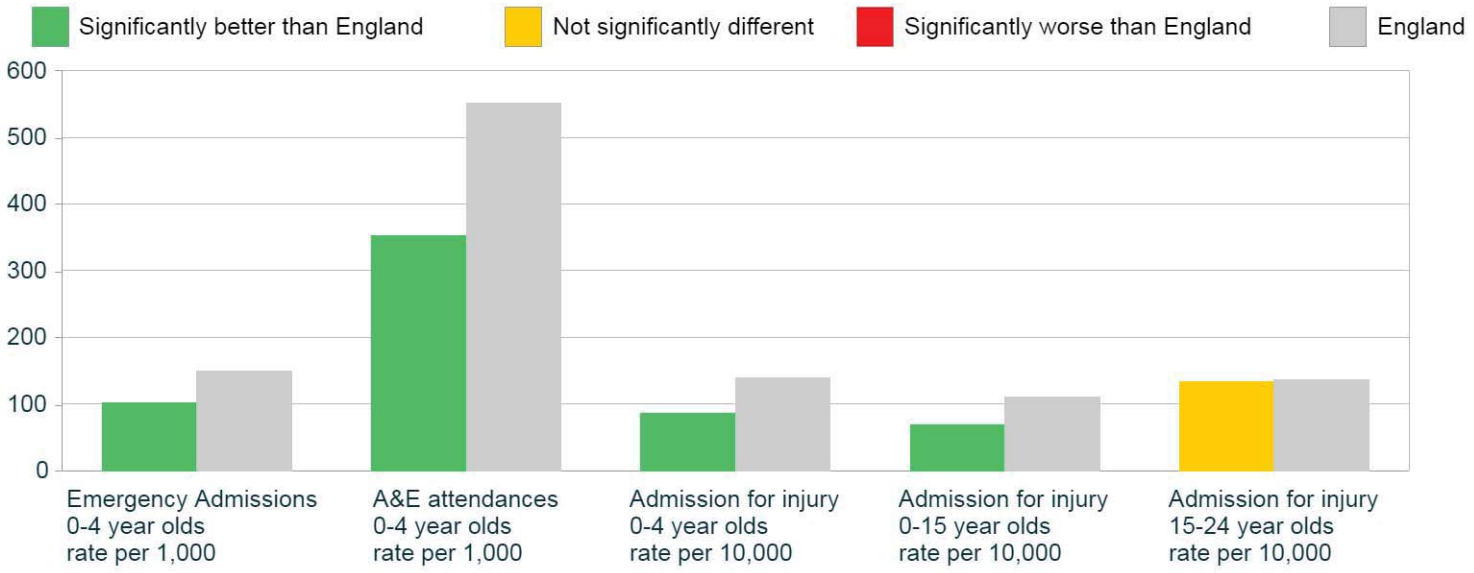
Source: Public Health England, NHS Digital 2017

Children's health care activity, values, 2013/14 - 2015/16 (estimated from MSOA level data)

indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Emergency Admissions 0-4 year olds rate per 1,000	102.2	162.6	156.8	149.2
A&E attendances 0-4 year olds rate per 1,000	352.8	343.7	328.7	551.6
Admission for injury 0-4 year olds rate per 10,000	85.2	114.9	108.5	138.8
Admission for injury 0-15 year olds rate per 10,000	67.9	89.6	89.7	110.1
Admission for injury 15-24 year olds rate per 10,000	133.1	130.7	118.2	137

Source: Public Health Enland, NHS Digital 2017

Children's health care activity, Selection (comparing to England average)



Source: Public Health England, NHS Digital 2017

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Report - Ward 2016: Haverhill

Adults' Behavioural Risk Factors

Adults' Behavioral Risk Factors, 2006-08, numbers (estimated from MSOA level data)

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Obese adults	8,286	20,456	140,328	9,983,436
Binge drinking adults	5,187	13,809	94,395	8,290,798
Healthy eating adults	8,861	26,320	174,930	11,907,157

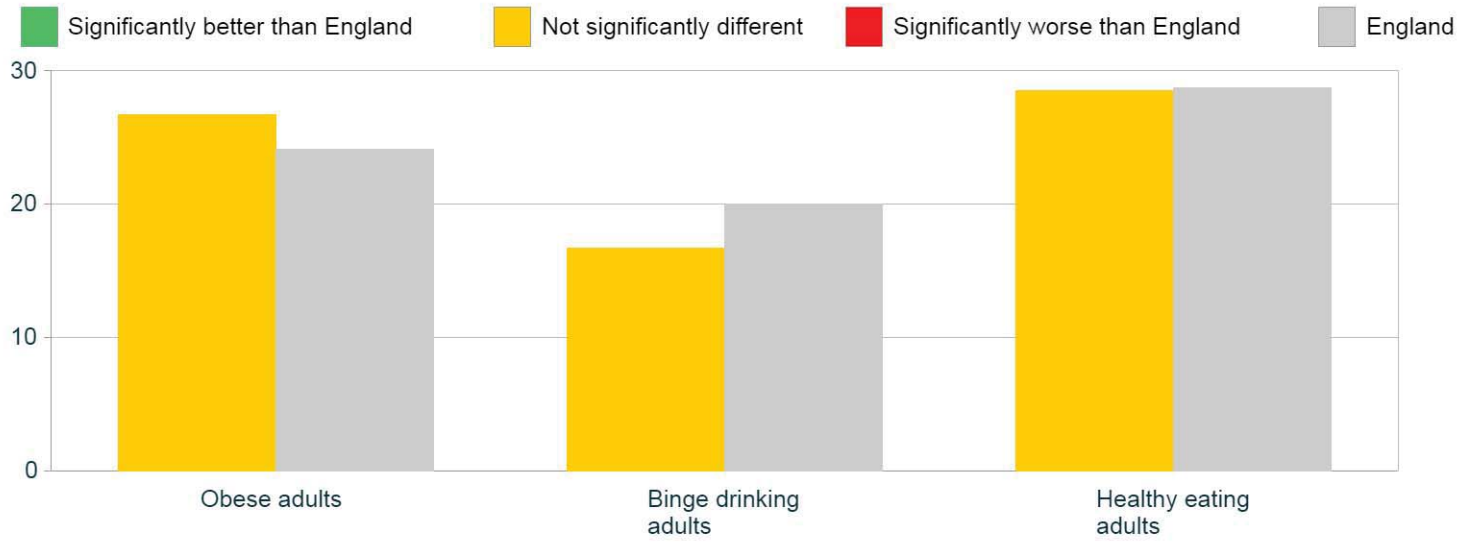
Source: Public Health England © Copyright 2010

Adults' Behavioral Risk Factors, 2006-08, % (estimated from MSOA level data)

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Obese adults	26.7	24.4	24.3	24.1
Binge drinking adults	16.7	16.5	16.4	20
Healthy eating adults	28.5	31.4	30.3	28.7

Source: Public Health England © Copyright 2010

Adults' Behavioral Risk Factors, %, Selection (comparing to England average)



Source: Public Health England © Copyright 2010

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Emergency hospital admissions

Emergency Hospital Admissions, numbers, 2011/12 to 2015/16 (estimated from MSOA level data)

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Emergency hospital admissions for all causes	18,756	52,978	339,060	26,930,251
Emergency hospital admissions for CHD*	535	1,494	10,345	688,090
Emergency hospital admissions for stroke	295	883	5,985	398,062
Emergency hospital admissions for MI*	274	809	5,696	335,723
Emergency hospital admissions for COPD*	485	1,134	7,360	583,448

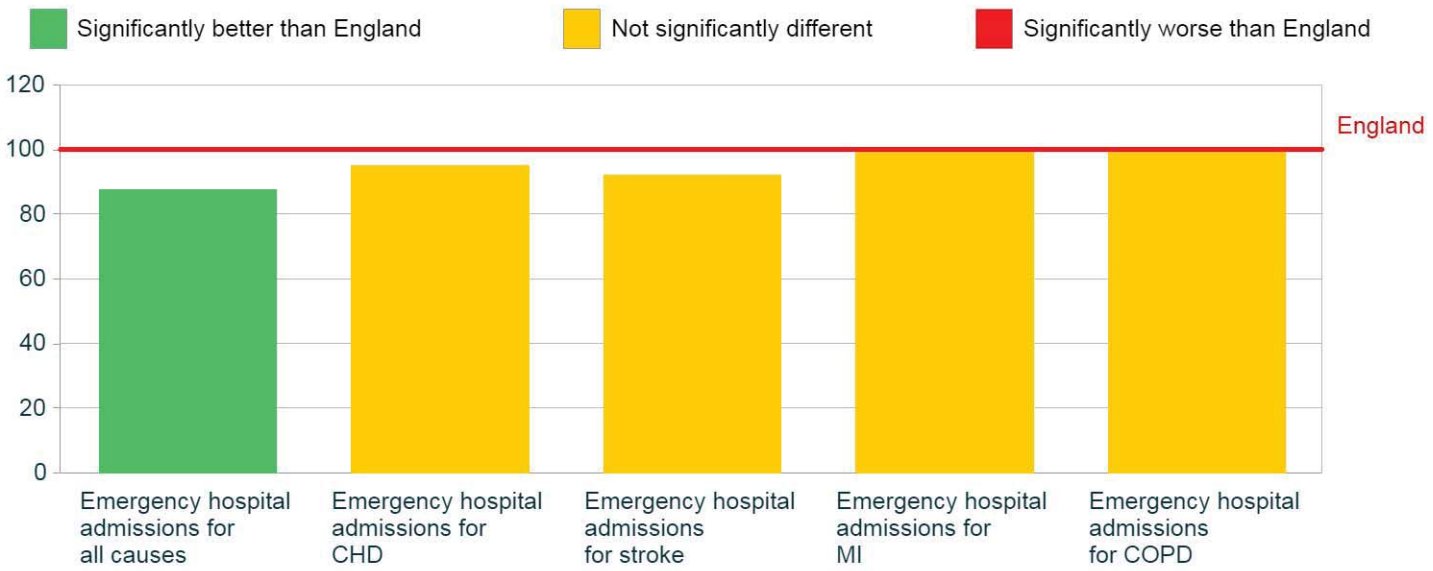
Source: Public Health England, NHS Digital © Copyright 2017
** CHD: Coronary Heart Disease; MI: Myocardial Infarction (heart attack); COPD: Chronic Obstructive Pulmonary Disease*

Emergency Hospital Admissions, Standardised Admission Ratios (SAR), 2011/12 to 2015/16 (estimated from MSOA data)

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Emergency hospital admissions for all causes	87.5	89.6	85.3	100
Emergency hospital admissions for CHD	94.9	92.7	93.4	100
Emergency hospital admissions for stroke	91.9	92.6	90.7	100
Emergency hospital admissions for MI	100.2	102.6	105	100
Emergency hospital admissions for COPD	100.7	81.5	76.7	100

Source: Public Health England, NHS Digital © Copyright 2017

Emergency Hospital admissions, SAR, 2011/12 to 2015/16, Selection (comparing to England average)



Source: Public Health England, NHS Digital © Copyright 2017

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Cancer incidence

Cancer incidence, numbers, 2011-2015 (estimated from MSOA level data)

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
All cancer	1,229	3,387	22,993	1,469,163
Breast cancer	188	517	3,343	221,700
Colorectal cancer	125	392	3,013	173,299
Lung cancer	148	380	2,424	186,030
Prostate cancer	188	541	3,714	196,749

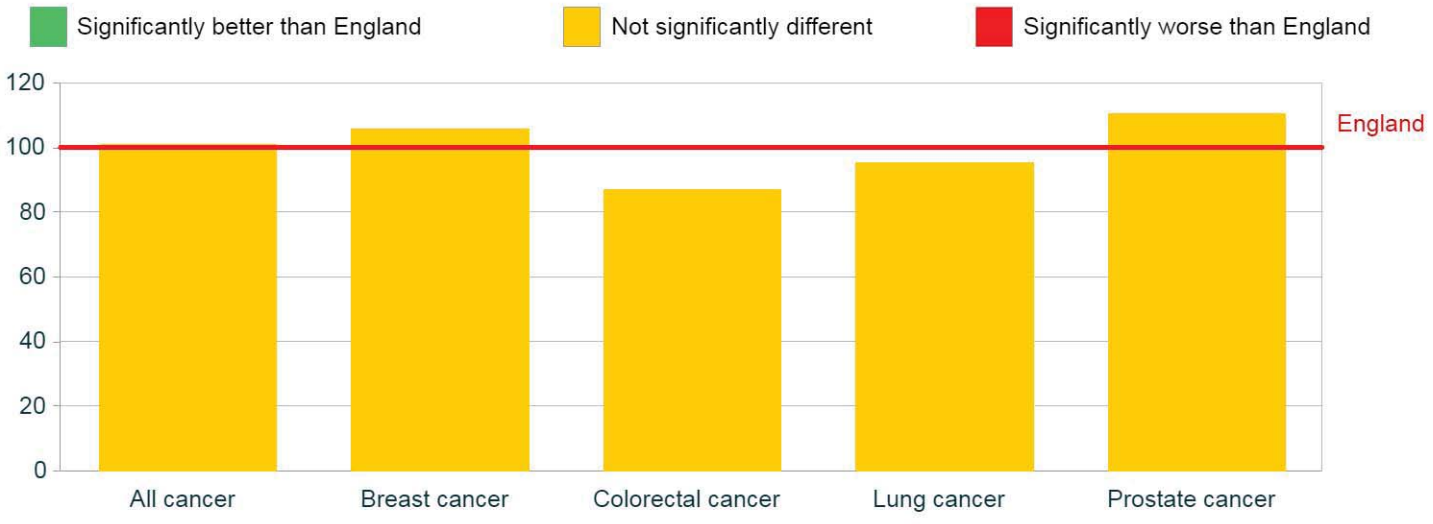
Source: English cancer registration data from the National Cancer Registration and Analysis Services' Cancer Analysis System (AV2015 CASREF01)

Cancer incidence, Standardised Incidence Ratios (SIR), 2011-2015 (estimated from MSOA level data)

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
All cancer	101	98.3	97.2	100
Breast cancer	105.6	102.6	97.8	100
Colorectal cancer	86.9	95.2	106	100
Lung cancer	95.3	85.1	78.5	100
Prostate cancer	110.3	113.9	112.6	100

Source: English cancer registration data from the National Cancer Registration and Analysis Services' Cancer Analysis System (AV2015 CASREF01)

Cancer incidence, SIR, 2011-2015, Selection (comparing to England average)



Source:
English cancer registration data from the National Cancer Registration and Analysis Services' Cancer Analysis System

Hospital admissions - harm and injury

Hospital admissions - harm and injury, numbers, 2011/12 to 2015/16 (estimated from MSOA level data)

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Hospital stays for self harm	430	1,060	6,409	537,455
Hospital stays for alcohol related harm	1,224	3,548	21,000	1,633,232
Emergency admissions for hip fracture aged 65+	207	602	4,475	283,432
Elective hospital admissions for hip replacement	294	789	5,342	338,773
Elective hospital admissions for knee replacement	293	686	4,809	374,028

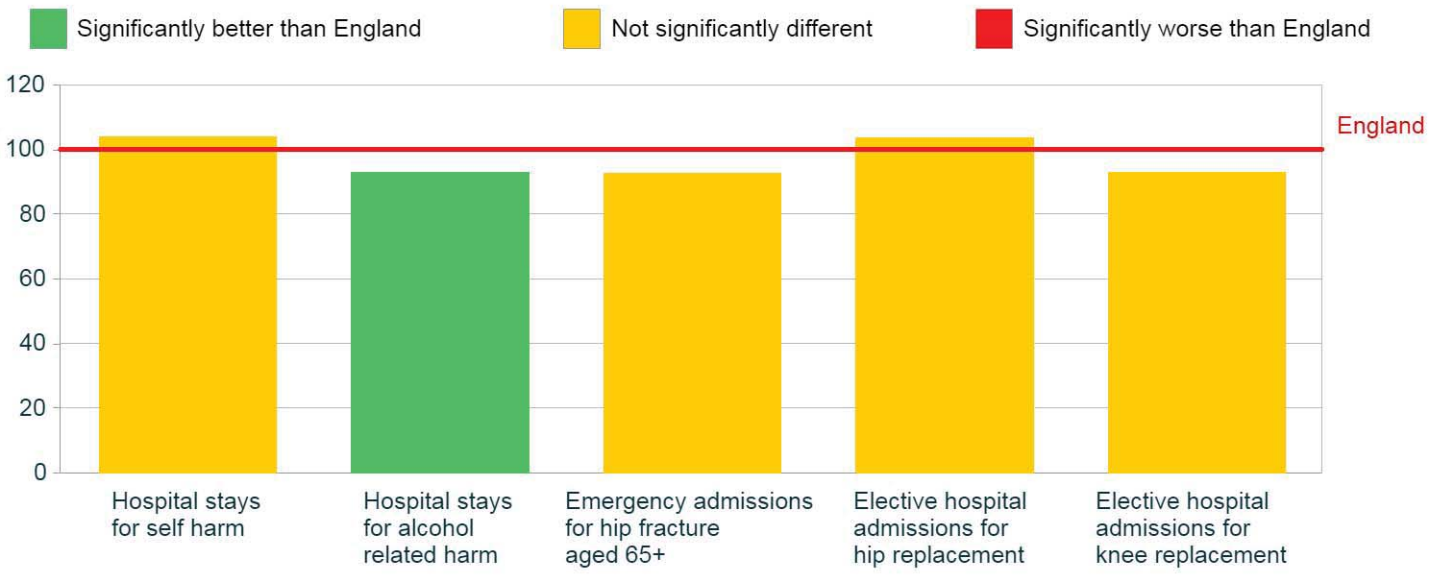
Source: Public Health England, NHS Digital © Copyright 2017

Hospital admissions - harm and injury, Standardised Admission Ratios (SAR), 2011/12 to 2015/16 (estimated from MSOA)

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
Hospital stays for self harm	103.9	99.5	93.3	100
Hospital stays for alcohol related harm	93	100.8	89.7	100
Emergency admissions for hip fracture aged 65+	92.6	85.3	90.9	100
Elective hospital admissions for hip replacement	103.6	98.9	97.6	100
Elective hospital admissions for knee replacement	92.8	77.2	78.7	100

Source: Public Health England, NHS Digital © Copyright 2017

Hospital admissions - harm and injury, SAR, 2011/12 to 2015/16 , Selection (comparing to England average)



Source: Public Health England, NHS Digital © Copyright 2017

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Report - Ward 2016: Haverhill

Mortality and causes of death - all ages

Causes of deaths - all ages, numbers, 2011-2015

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
All causes	1,704	4,939	36,248	2,357,381
All cancer	541	1,429	10,281	666,658
All circulatory disease	457	1,362	10,145	646,138
Coronary heart disease	196	573	4,468	289,738
Stroke	112	367	2,540	165,375
Respiratory diseases	215	612	4,620	325,764

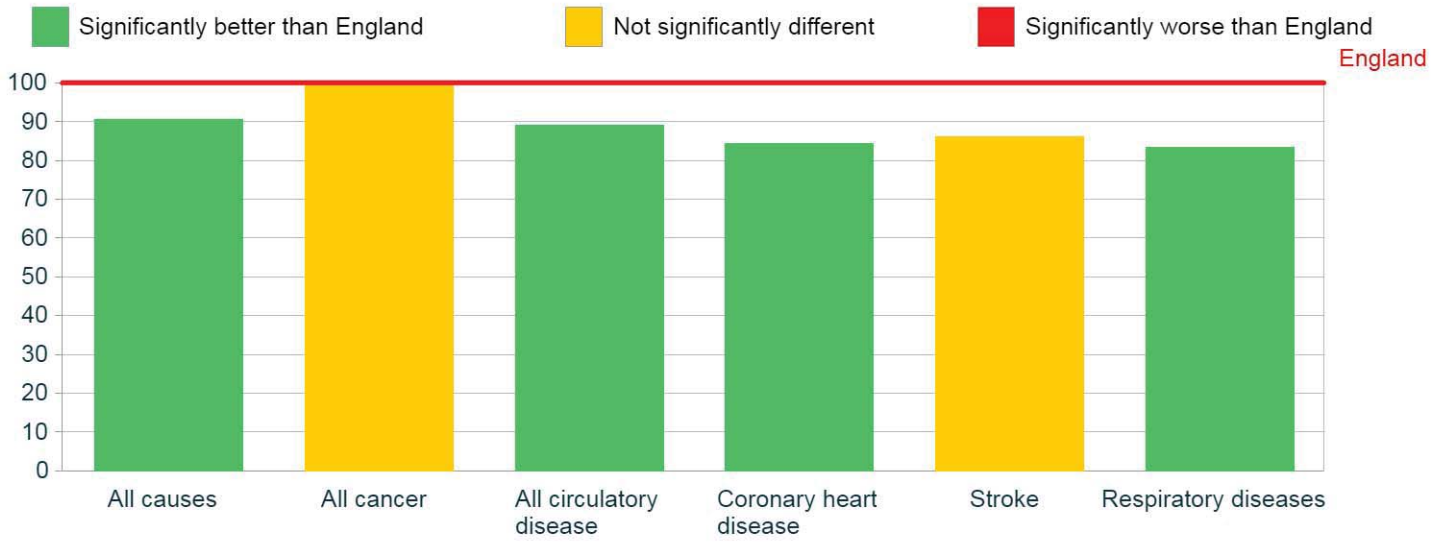
Source: Public Health England, produced from ONS data Copyright © 2017

Causes of deaths - all ages, Standardised Mortality Ratios (SMR), 2011-2015

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
All causes	90.6	86	91.2	100
All cancer	99.1	89.4	93	100
All circulatory disease	89.1	85.8	92	100
Coronary heart disease	84.4	81	91	100
Stroke	86.2	89.6	89.2	100
Respiratory diseases	83.3	75.9	82.4	100

Source: Public Health England, produced from ONS data Copyright © 2017

Causes of deaths - all ages, SMR, 2011-2015, Selection (comparing to England average)



Source: Public Health England, produced from ONS data Copyright © 2017

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Mortality and causes of death - premature mortality

Causes of deaths - premature mortality, numbers, 2011-2015

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
All causes, aged under 65	236	590	4,532	373,093
All causes, aged under 75	535	1,353	9,990	752,670
All cancer, aged under 75	269	653	4,605	310,786
All circulatory disease, aged under 75	114	269	2,166	166,529
Coronary heart disease, aged under 75	59	146	1,132	91,057

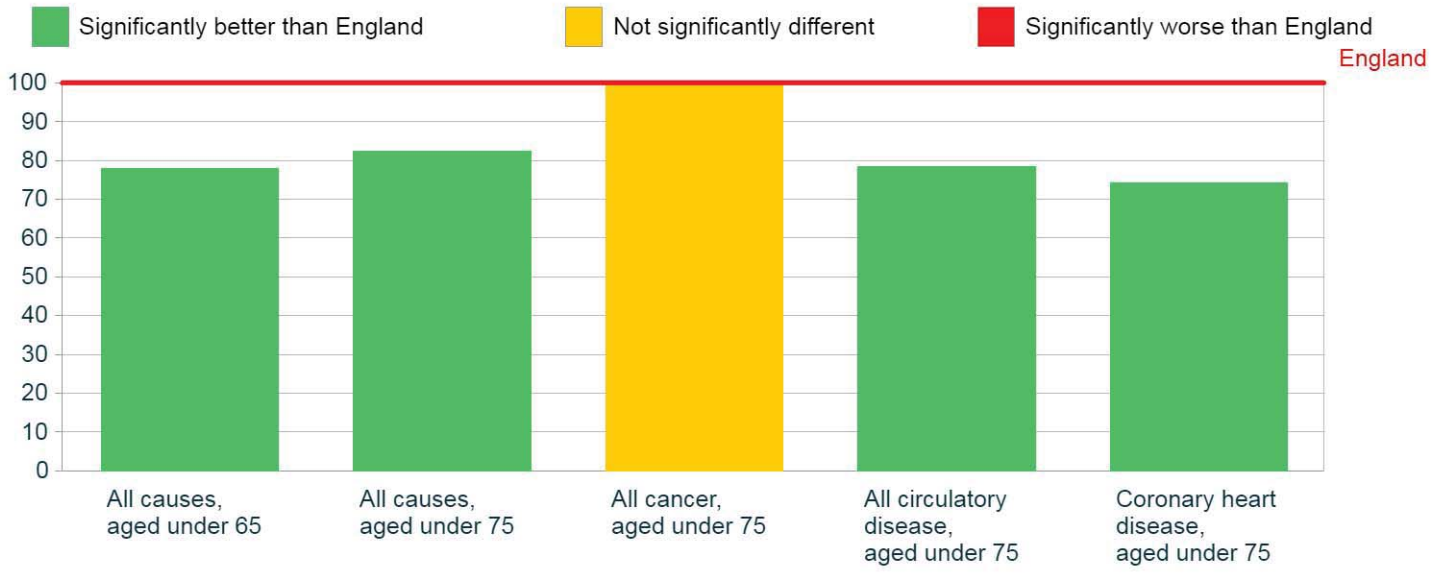
Source: Public Health England, produced from ONS data Copyright © 2017

Causes of deaths - premature mortality, Standardised Mortality Ratios (SMR), 2011-2015

Indicator	Selection	St Edmundsbury (Lower Tier Local Authority)	Suffolk (Upper Tier Local Authority)	England
All causes, aged under 65	77.8	75	85.3	100
All causes, aged under 75	82.4	77.9	85.4	100
All cancer, aged under 75	99.4	89.8	93.5	100
All circulatory disease, aged under 75	78.4	69.1	82.3	100
Coronary heart disease, aged under 75	74.3	68.4	78.3	100

Source: Public Health England, produced from ONS data Copyright © 2017

Causes of deaths - premature mortality, SMR, 2011-2015, Selection (comparing to England average)



Source: Public Health England, produced from ONS data Copyright © 2017

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11:15 GOVERNANCE

17. Trust Executive Group report

To ACCEPT a report

For Report

Presented by Stephen Dunn

Board of Directors – 25 January 2019

Agenda item:	17			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	17 January 2019			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

Executive summary

17 December 2018

Steve Dunn provided an **introduction** to the meeting recognising how busy it had been in the hospital and community in the first half of December. It was welcomed that a successful tender had been completed for 20 additional community beds to support our winter preparations was noted. An update was provided on the work to review the provision of pathology services. It was also noted that we reported a never event due to a wrong site anaesthetic block prior to surgery.

The meeting reflected on the experience of **Sky filming** - it was felt that the Trust and individuals came across well. It was also noted that Sky would likely wish to return after the New Year.

A review of performance focused on **cancer services** and the failure to deliver the target in October and November and anticipated performance for December. Changes to the allocation of 'shared' breaches was noted as impacting on the Trust's performance. Wider performance issues were reviewed including flu vaccination, mandatory training and appraisals.

The **red risk report** was reviewed with discussion and challenge for individual areas. Two new red risks were reviewed relating to: the level 3 containment facility within microbiology and delays in receiving human epidermal growth factor receptor 2 (HER2) test results. The key strategic risks identified were:

- **System financial and operational sustainability** will impact of the quality of patient services (linked to operational performance and CIP planning and transformation)
- **Winter planning** to ensure safe staffing and capacity for winter 2018-19.
- **Pathology services** – delivery of pathology services, including MHRA inspection, TPP reconfiguration and implementation of the new Clinisys System. These all have an impact on service delivery and patients services directly impacting of quality and sustainability of services.

A summary was provided of the learning from the **multi-agency discharge event (MADE)** held in October. Feedback from external agencies had been very positive and a further event is scheduled for 2 and 3 January when we expect to be in a challenging operational position. Further discussion and review took place of the plans to support winter pressures.

The proposal to appoint a further **stroke consultant** was supported. This will reduce the level of additional locum spend which is currently being incurred.

The meeting received feedback from the divisional testing of anonymous **whistleblowing concerns** raised earlier in the year with the CQC. The feedback was positive with areas for improved access and communication were highlighted. These will be triangulated and reported to the Board as part of the

scheduled report from Jan Bloomfield on staff engagement.

A report from the **Quality Group** was received. The CQC self-assessment undertaken within community services was recognised as valuable and will be reviewed within the other divisions. It was also recognised that this type of work must be part of business as usual activity not preparation for a CQC visit.

The CQC report for **Norfolk and Suffolk Foundation Trust** was received and discussion took place of the service and patient implications of the issues raised in the report.

A reported was received and supported which set out the proposed arrangements for the new **Integrated pain management service**. The service will be hosted by Trust as part of the West Suffolk Alliance and is expected to be operational from April 2019.

Relevant **policy documents**:

a) the **Overseas visitor policy** was approved
b) the **Mobile phone and device policy** was approved with some amendments
c) the **Access policy** was approved subject to further development to reflect community services requirements.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X		**X**		**X**		
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	X	X	X	X	X	X	X
Previously considered by:	The Board receives a monthly report from TEG						
Risk and assurance:	Failure to effectively communicate or escalate operational concerns.						
Legislation, regulatory, equality, diversity and dignity implications	None						

Recommendation:

The Board note the report

18. Quality & Risk Committee report

18.1. To ACCEPT the report of the meeting held on 14 December 2018

For Report

Presented by Sheila Childerhouse

Quality & Risk Committee Report – Friday 25 January, 2019

Agenda item:	18			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Ruth Williamson, PA			
Date prepared:	21 January, 2019			
Subject:	Quality and Risk Subcommittee Reports			
Purpose:		For information	X	For approval

Executive summary:

A presentation was received from Andrew Dunn, Consultant Orthopaedic Surgeon, outlining the work being undertaken as part of the Quality Improvement in Surgical Teams Collaborative (QIST).

Reports from the subcommittees of the Quality and Risk Committee were received. These reports are submitted for assurance and governance.

(a) **Corporate Risk Committee (16/11/2018)**
Containment Level 3 Laboratory (CLS3) requires updating. Lack of contingency plan by Public Health England for continuation of testing work is being progressed.

(b) **Patient Experience Committee (7/12/2018)**
Two items for escalation noted:

Car Parking Concessions – discussed at Scrutiny, taking in to account views of both patients and visitors.
Patient Experience Walkabout – to be undertaken with a view to obtaining more constructive feedback regarding the patient experience.

(c) **Clinical Safety & Effectiveness Committee (10/12/18)**
No issues were identified for escalation. Noted key issue relating to ***Point of Care Testing*** and pre-commitment of £200k to increase resource, in order to bring about improvements to the service.

Quality Group Report
Review of QI structure is to be undertaken, following resignation of head of QI.

Governance Review
Annex A approved by Committee for onward transmission to Board. Independent well-led external governance review is due. Options under investigation.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**		**Invest in quality, staff and clinical leadership**		**Build a joined-up future**		
	X						
Trust ambitions *[Please indicate ambitions relevant to the subject of the report]*	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
		X					
Previously considered by:	**-**						
Risk and assurance:	-						
Legislation, regulatory, equality, diversity and dignity implications	-						

Recommendation:

To receive the report for information and assurance.
To approve the annual governance review and action plan.

18.2. To APPROVE the annual governance review and action plan

For Approval

Presented by Richard Jones

NHS
West Suffolk
NHS Foundation Trust

Board of Directors – 25 January 2019

AGENDA ITEM:	18.2
PRESENTED BY:	Richard Jones, Trust Secretary & Head of Governance
PREPARED BY:	Richard Jones, Trust Secretary & Head of Governance
DATE PREPARED:	15 January 2019
SUBJECT:	Annual Governance Review
PURPOSE:	To demonstrate first class corporate, financial and clinical governance to maintain a financially sound business.

EXECUTIVE SUMMARY:

The Board undertakes an annual review of its governance structure in order to ensure that it is adequately discharging its responsibilities and managing risks to quality, performance and finance.

All Board members were asked to undertake a self-assessment based on the consultation document from the CQC and NHS Improvement for the new well-led assessment framework. This is structured around eight key lines of enquiry (KLOE) for leadership and governance:

1. Is there the leadership capacity and capability to deliver high quality, sustainable care?
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
3. Is there a culture of high quality, sustainable care?
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?
5. Are there clear and effective processes for managing risks, issues and performance?
6. Is appropriate and accurate information being effectively processed, challenged and acted on?
7. Are the people who services, the public, staff and external partners engaged and involved to support high quality sustainable services?
8. Are there robust systems and processes for learning, continuous improvement and innovation?

The well-led framework is used by the CQC as the basis for annual review of trusts' compliance. The results of the self-assessment are presented in the report with recommendations for areas of focus and improvement.

Developmental reviews

Guidance from NHSI indicates that in-depth, regular and externally facilitated developmental reviews of leadership and governance are good practice across all industries. Rather than assessing current performance, these reviews should identify the areas of leadership and governance of organisations that would benefit from further targeted development work to secure and sustain future performance.

While CQC's regulatory assessments of the well-led framework are primarily for assurance, developmental reviews are primarily for providers themselves to facilitate continuous improvement. Drawing on the latest research and evidence, we also describe updated good practice to help

providers identify their own areas for development and key barriers to overcome.

It is therefore proposed that a proportionate scope for an independent developmental governance review is prepared which considers:

- The key findings of this self-assessment report
- The view of the regulator (NHSI) on the scale and appropriate facilitation of such a review
- Options for commissioning an external party, including External Audit, peer reviews and other external facilitators

Based on engagement with the regulator and a testing with potential facilitators a proposal for a developmental review will be prepared for consideration at the March Board meeting. This will consider: scope, facilitation and timing.

Linked Strategic objective (link to website)	To deliver and demonstrate rigorous and transparent corporate and quality governance
Issue previously considered by: (e.g. committees or forums)	Annual governance review previously reported to the Board. The draft report was considered by the Q&R Committee on 14 December 2018
Risk description: (including reference Risk Register and BAF if applicable)	Failure to comply with NHSI's code of governance and quality governance framework and failure to comply with the CQC's well led framework.
Description of assurances: Summarise any evidence (positive/negative) regarding the reliability of the report	Previous governance reviews by the Board. Engagement of independent as part of the well led assessment process during 2019.
Legislation / Regulatory requirements:	NHSI's code of governance, risk assessment framework and quality governance framework
Other key issues: (e.g. finance, workforce, policy implications, sustainability& communication)	N/A

Recommendation:

The Board is asked to:

(a) Note the report including the KLOE summary assessments and recommendations for improvement

(b) Delegate authority to the Q&R Committee to review progress against an action plan to address the areas for improvement (Annex A)

(c) Approve the approach to developing a proposal for an independent development review with a proposal coming to the Board in March which considers scope, facilitation and timing.

Annual Governance Review

November 2018

1. Background

The Board undertakes an annual review of its governance structure in order to ensure that it is adequately discharging its responsibilities and managing risks to quality, performance and finance.

The CQC and NHS Improvement new well-led assessment framework is used as the basis for the review. This is structured around eight key lines of enquiry (KLOE) for leadership and governance:

1. Is there the leadership capacity and capability to deliver high quality, sustainable care?
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
3. Is there a culture of high quality, sustainable care?
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?
5. Are there clear and effective processes for managing risks, issues and performance?
6. Is appropriate and accurate information being effectively processed, challenged and acted on?
7. Are the people who services, the public, staff and external partners engaged and involved to support high quality sustainable services?
8. Are there robust systems and processes for learning, continuous improvement and innovation?

2. Methodology

The self-assessment questionnaire for the well led review was updated to reflect the CQC and NHSI consultation document in terms of the KLOEs and the underpinning prompts/questions to test compliance. A summary of the characteristics of each KLOE (Annex B) for Outstanding, Good, Require improvement and Inadequate was also provided to support the assessment process which for each prompt/question asked the responder to self-asses the Trust according to the CQC ratings:

Risk rating	Definition	Percentage *
Outstanding	The service is performing exceptionally well.	80 or higher
Good	The service is performing well and meeting our expectations.	65-79%
Requires improvement	The service isn't performing as well as it should and we have told the service how it must improve.	50-64%
Inadequate	The service is performing badly and we've taken action against the person or organisation that runs it.	<50%

* The application of a percentage to determine compliance rating is an estimate in order to apply a rating based on the compliance score for the individual KLOEs and the overall position in section 3.1.

The questionnaire acts as the self-assessment stage of the “Well-led framework for governance reviews” and allows preparation for an external review during 2019.

A questionnaire was sent to each member of the Board and returned to the Foundation Trust Office. The responses were collated and analysed both in terms of the quantitative figures and the narrative feedback. A summary of the responses to the questionnaire is provided in section 3 of this report structured around the eight KLOEs.

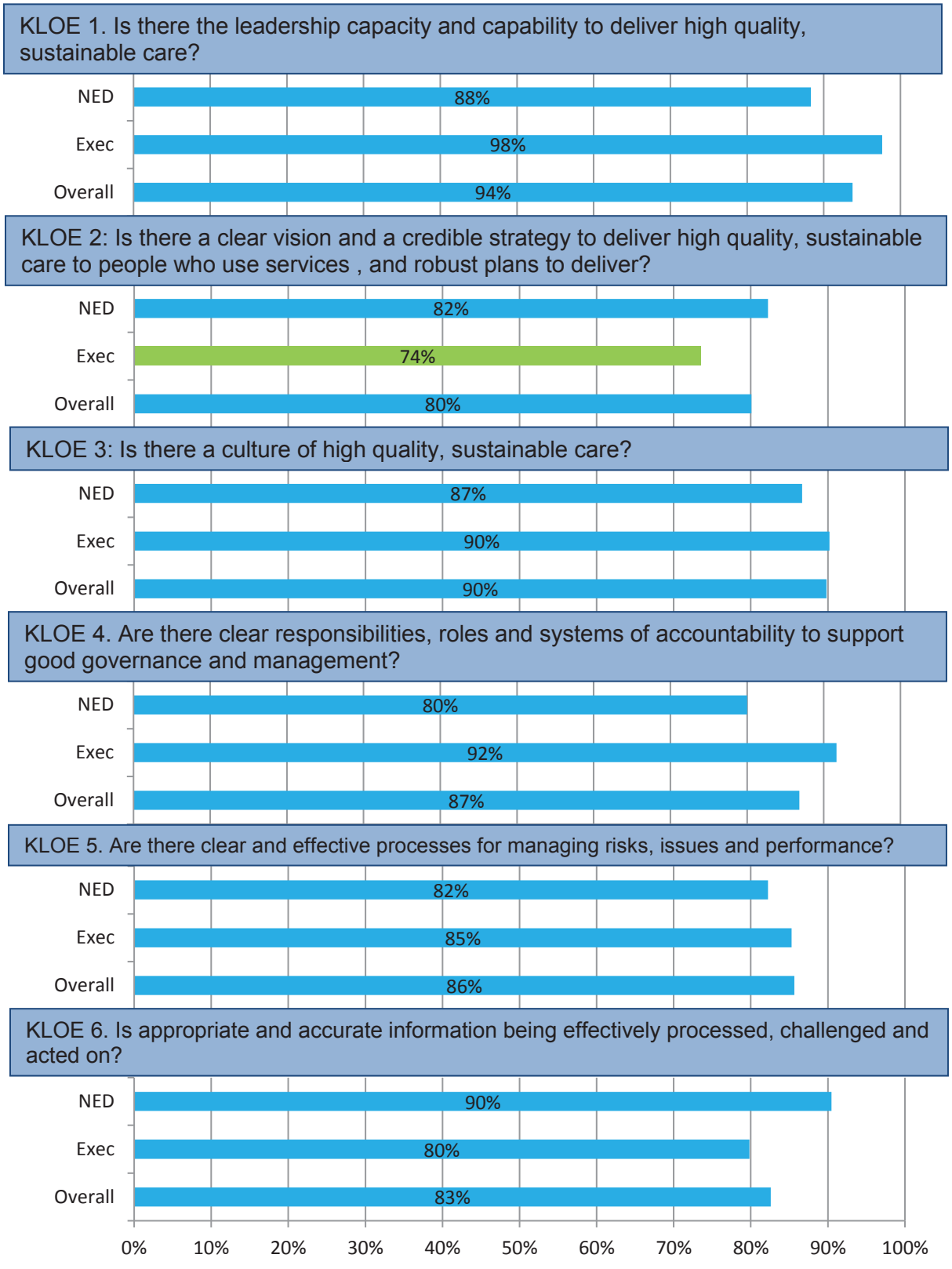
Summary assessments and recommendations based on the analysis are embedded within these results.

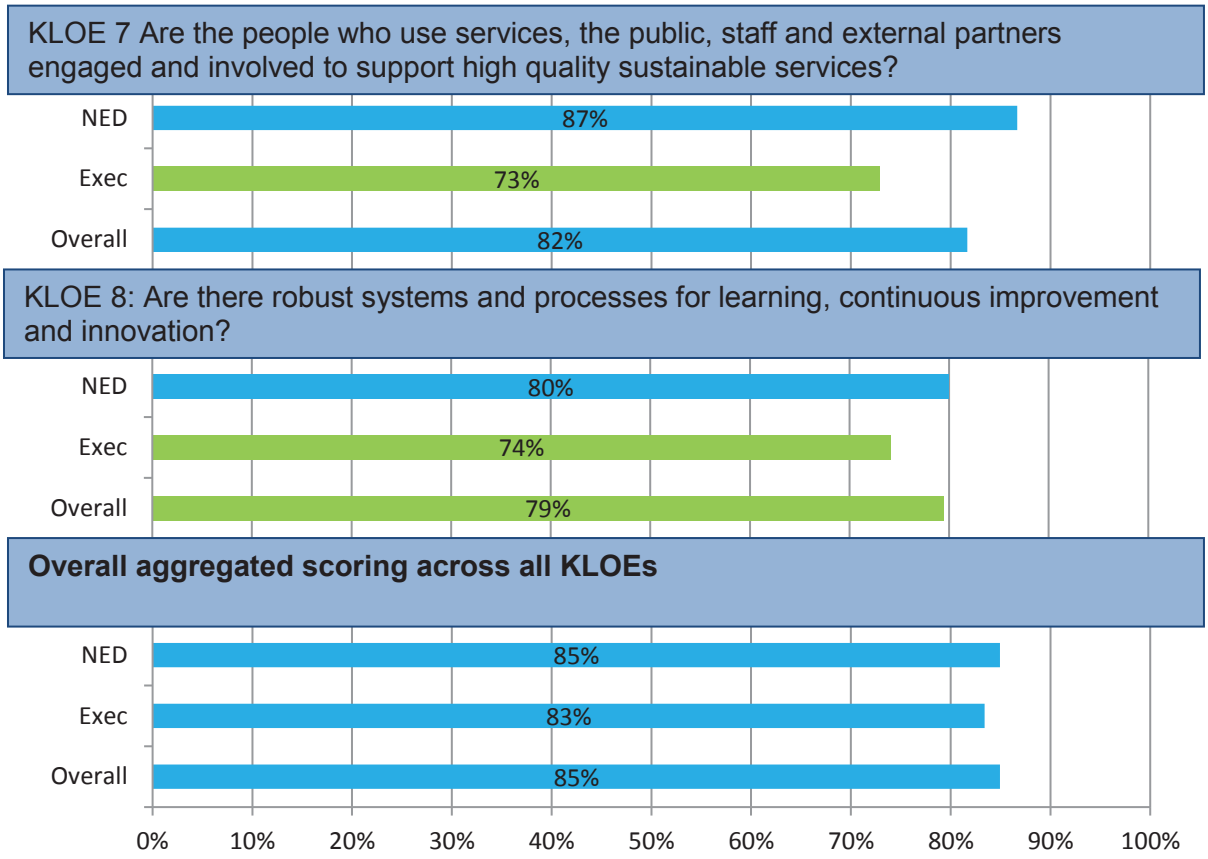
3. Data analysis

The analysis considered the aggregated compliance with the key lines of enquiry (KLOEs) and then the self-assessment with the individual prompts and questions for each KLOE.

3.1 KLOE compliance

A percentage compliance score was derived from the responses based on 100% being all prompts being score rated as outstanding and 0% all prompts rated as Inadequate.





Based on the aggregated scoring of the individual prompts and KLOEs the Board rated the organisation as having **'Outstanding' compliance** with the well-led framework. With seven of the eight KLOEs rated as outstanding, this well-led self-assessment rating is far higher than the previous review (seven good and one requires improvement (KLOE 8).

The two KLOEs with the **highest rated** compliance were:

- 94% - KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?
- 90% - KLOE 3: Is there a culture of high quality, sustainable care?

The two KLOEs with the **lowest rated** compliance were:

- 80% - KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people who use services , and robust plans to deliver?
- 79% - KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

In terms of whether executives or NEDs rated compliance with the KLOEs higher there is an **equal split** between the two groups (see Table 1).

Table 1: KLOE scoring

Executives scored highers	NEDs scored higher
• KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care? • KLOE 3: Is there a culture of high quality, sustainable care? • KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management? • KLOE 5. Are there clear and effective processes for managing risks, issues and performance?	• KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people who use services , and robust plans to deliver? • KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on? • KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services? • KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

There are three KLOEs with a difference or more than 10 percentage points **difference between executives and NEDs assessment**:

- 11% difference (NEDs higher) - KLOE 6. Is appropriate and accurate information being effectively processed, challenged and acted on?
- 12% difference (executives higher) - KLOE 4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?
- 14% difference (NEDs higher) - KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

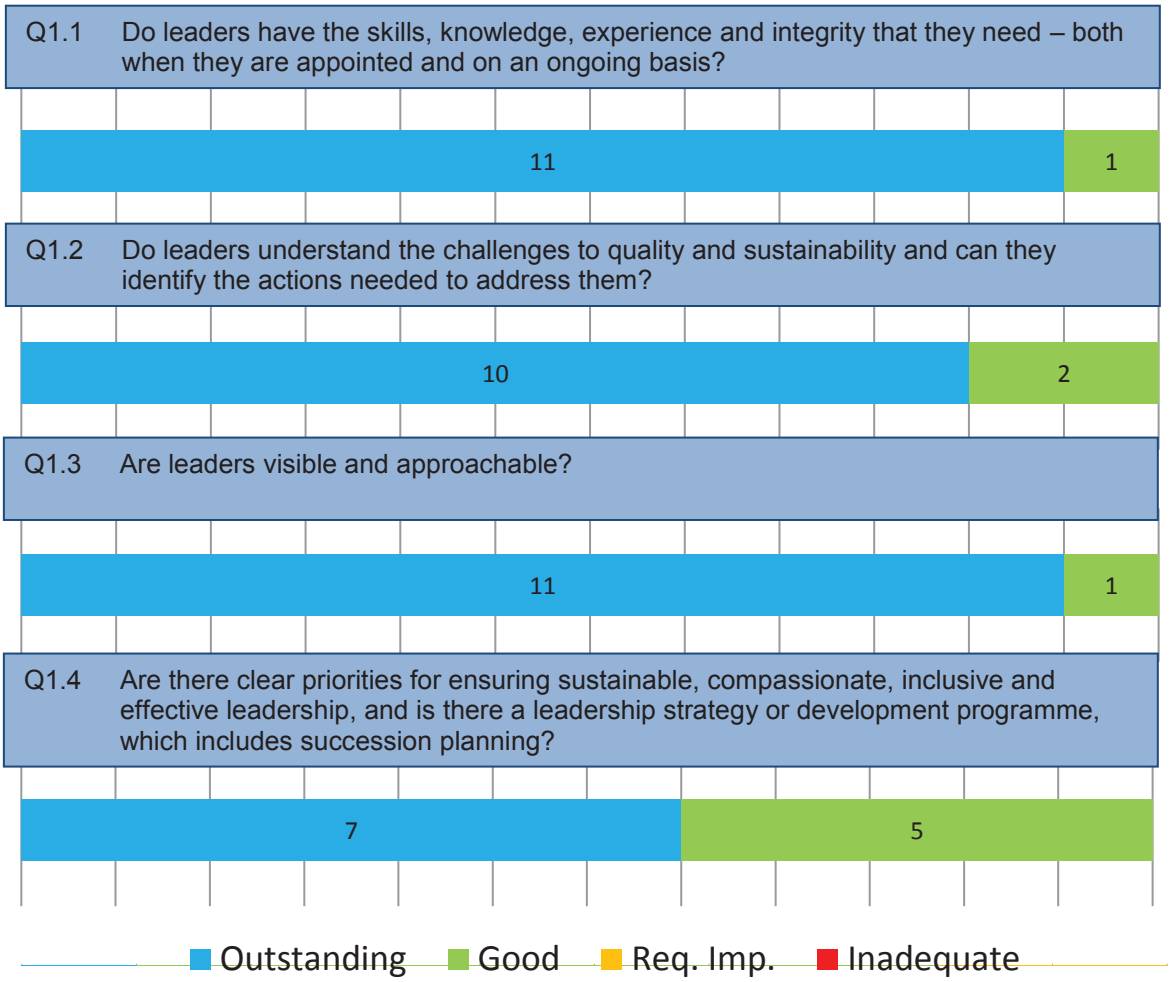
The detailed assessment of the **individual prompts** associated with these KLOEs in considered in Section 3 of the report.

3.2 Rating of compliance with KLOE prompts

Within this section of the report a summary of compliance is provided against each of the underpinning prompts. Any commentary provided as part of the self-assessment is also set out. Based on the information summary assessment is made with relevant recommendations.

3.2.1 KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?

This KLOE is underpinned by four prompts.



Q1 Commentary
CEO is extremely visible. Other executives colleagues could do more general walkabouts
Areas we can get stronger: • Driving further forward on the leadership strategy – ensure that it is permeates across and down through the organisation • Ensuring that leadership include community and the wider system in their mind-set is an important next step in the further strengthening of this area
Not sure we have a robust succession plan linked to the development plans of future leaders (replacement for Director of Workforce is a case in point)
There is work to do in relation to succession planning at the top level

KLOE 1: Summary assessment and recommendations

Overall this KLOE received the highest compliance rating. Particularly high levels of outstanding compliance are identified for leaders being visible and approachable and leaders have the skills, knowledge, experience and integrity that they need.

Based on the commentary the focus for improvement within the KLOE relates to:

- Leadership development strategy and succession planning
- Visibility of all members of the executive team

3.2.2 KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people who use services, and robust plans to deliver?

This KLOE is underpinned by six prompts.

Q2 Commentary
The framework for monitoring the local plan and how this fits with Trust strategy is clearly described but still evolving. This is understandable, as system wide monitoring frameworks are still being developed and introduced in a deliberate move away from organisational silo working
The Trust has a clear vision and strategy and this is complemented by the recently developed Alliance strategy. We are developing service and divisional level operational plans in line with the delivery of these strategies
Our strategy is over 3 years old and requires a review and updating
There is clear evidence of the strategy and values and you can feel and see them being lived in the organisation. With the evolution of the STP and changes more widely in some of the philosophies across the NHS system (e.g. financing, digital, wider system) as a leadership team we need to ensure that we are continuing to cover the bases. The strategy does anticipate this, keeping momentum up will be critical.
The Trust (perhaps understandably) does not have a strong plan to deliver its strategy within increasingly tight control totals (the Trust tends to plan for the current year and does not have a clear line of sight to a point where it can reliably achieve its control total).
The Trust has a very powerful example of how it is working across the system to provide community services (The Alliance), however, for a number of good reasons, I do not feel the Trust is yet embracing or truly leveraging the concept of a system wide approach to the creation and realisation of a strategy.
Clear strategy and vision that is constantly visible to all staff - clear focus on integration of services across community/secondary care boundary and alliance/STP working
The context of the STP has presented challenges in terms of long term planning

KLOE 2: Summary assessment and recommendations

Overall rated outstanding (at 80%) this KLOE received the second lowest compliance rating, with a high number of requires improvement ratings. A high level of outstanding compliance was identified for having a clear vision and a set of values, with quality and sustainability as the top priorities.

The focus for improvement within the KLOE relates to:

- Refresh of the Trust's strategy, aligned to Alliance working and integration opportunities
- Developing clinical service and divisional level operational plans

3.2.3 KLOE 3: Is there a culture of high quality, sustainable care?

This KLOE is underpinned by nine prompts.

Q3 Commentary
Staff surveys and staff FFT results demonstrate and evidence the above characteristics. According to a recent survey staff who are LGBT feel they do not have such a strong voice and therefore it has been recognised that this needs some dedicated action
Appraisal performance needs to improve and plans are in place to support this. Further work on equality and diversity is underway
The mechanisms are in place for appraisal and career conversations – we are still performing below our target of 90%
NHS staff survey underpins this assessment
Continue focus on appraisal processes
My reflection on the themes behind these questions is that the Trust is in the upper quartile. However there is more room for strengthening. That strengthening is not because there is inherent weakness and indeed my observation is that there is a high quality sustainable care culture. Focus must remain though as there will always be areas to improve. For instance the major focus on winter planning is shining light on more opportunities for cross Trust collaboration.
The scoring on the appraisal and development question is because the data available to me suggests it is not completely clear whether appraisals are being recorded properly and so it is difficult to get assurance that development is being addressed sufficiently.
We should be very proud of our culture and our staff. This position is supported by strong process and engagement. There will always be examples of poor behaviour but I am assured that we have the processes and culture that will identify and deal with these examples.
Organisation scores highly on staff satisfaction and staff recommendations as a place of care. There is a strong emphasis on reflective practice and continued organisational learning. Staff are strongly encouraged to raise concerns and the organisation has a nationally recognised 'learning from deaths' process. Ongoing work is required to improve the recording of staff appraisal. The appraisal/revalidation process for medical staff is effectively monitored through the revalidation support group with NED involvement
This is in general an area of high performance there are a few minority teams that have a less positive perception

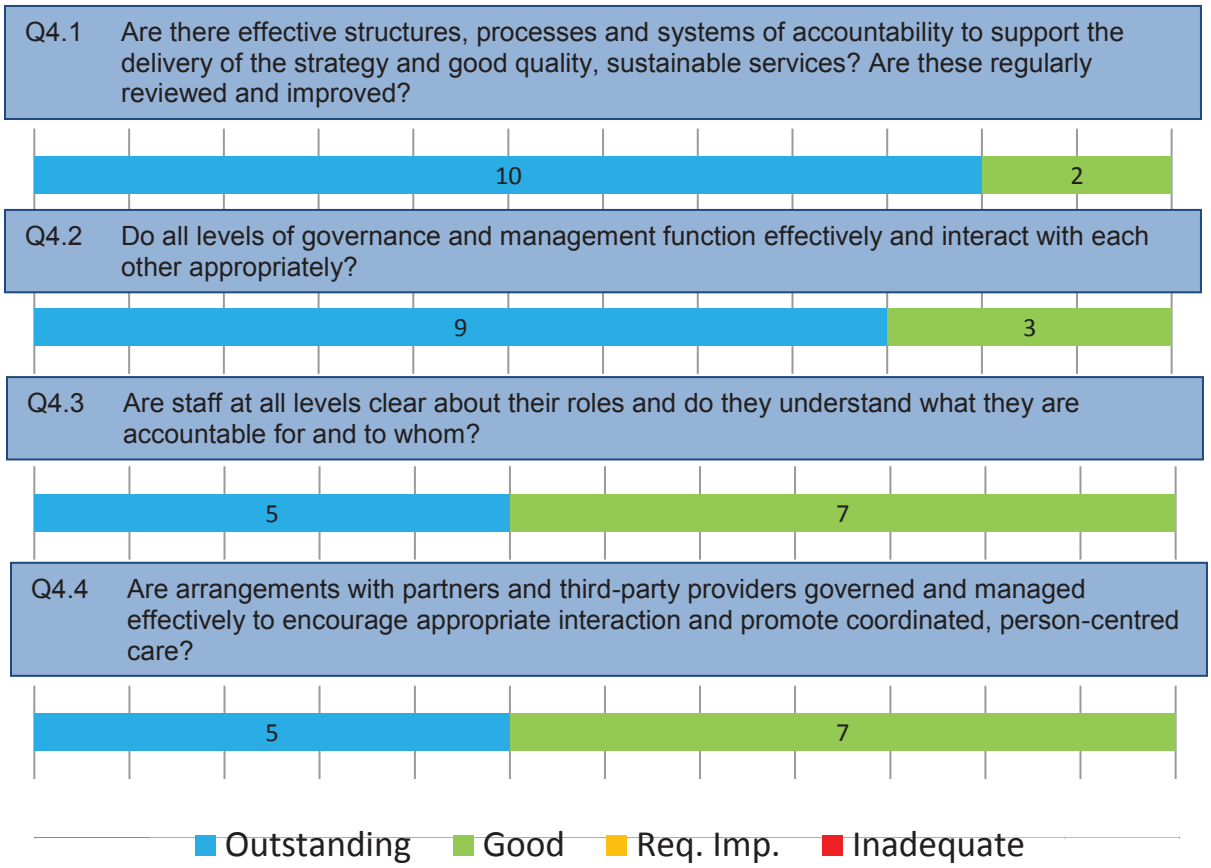
KLOE 3: Summary assessment and recommendations

Overall this KLOE received the second highest compliance rating. All Board members rated two of the prompts as Outstanding: 'Do staff feel positive and proud to work in the organisation?'; and 'Is there a strong emphasis on safety and well-being of staff?'.

The focus for improvement within the KLOE relates to:

- Systematically deliver high quality appraisal and career development conversations

3.2.4 KLOE 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?



Q4 Comments
The desire and ambition to operate as part of an integrated system can confuse accountability if changes are not fully understood. As part of developing a system wide governance framework, lines of accountability must remain clear, even when developing shared management arrangements and shared decision making forums. The above is marked as good, rather than outstanding to reflect the changing environment and integrated structures that are in the process of implementation. It would be impossible to be outstanding at this stage of change.
Improved governance since CQC inspection in spring 2016
Alliance needs continued focus
On third parties over the course of the year there have been instances where controls have flagged concerns, which is a positive. I would see third parties as an area of strengthening and capability to partner is becoming more and more important with the increased expectations arising from STPs
Governance structures are clear, coordinated and effective. Communication with 3rd parties is generally managed well. There is ongoing work to improve the quality and timeliness of discharge summary information to primary care - but effective IT links with primary and community services are a focus of innovative development as part of the GDE process
There is ongoing work to be done in relation to working with other partners and sectors

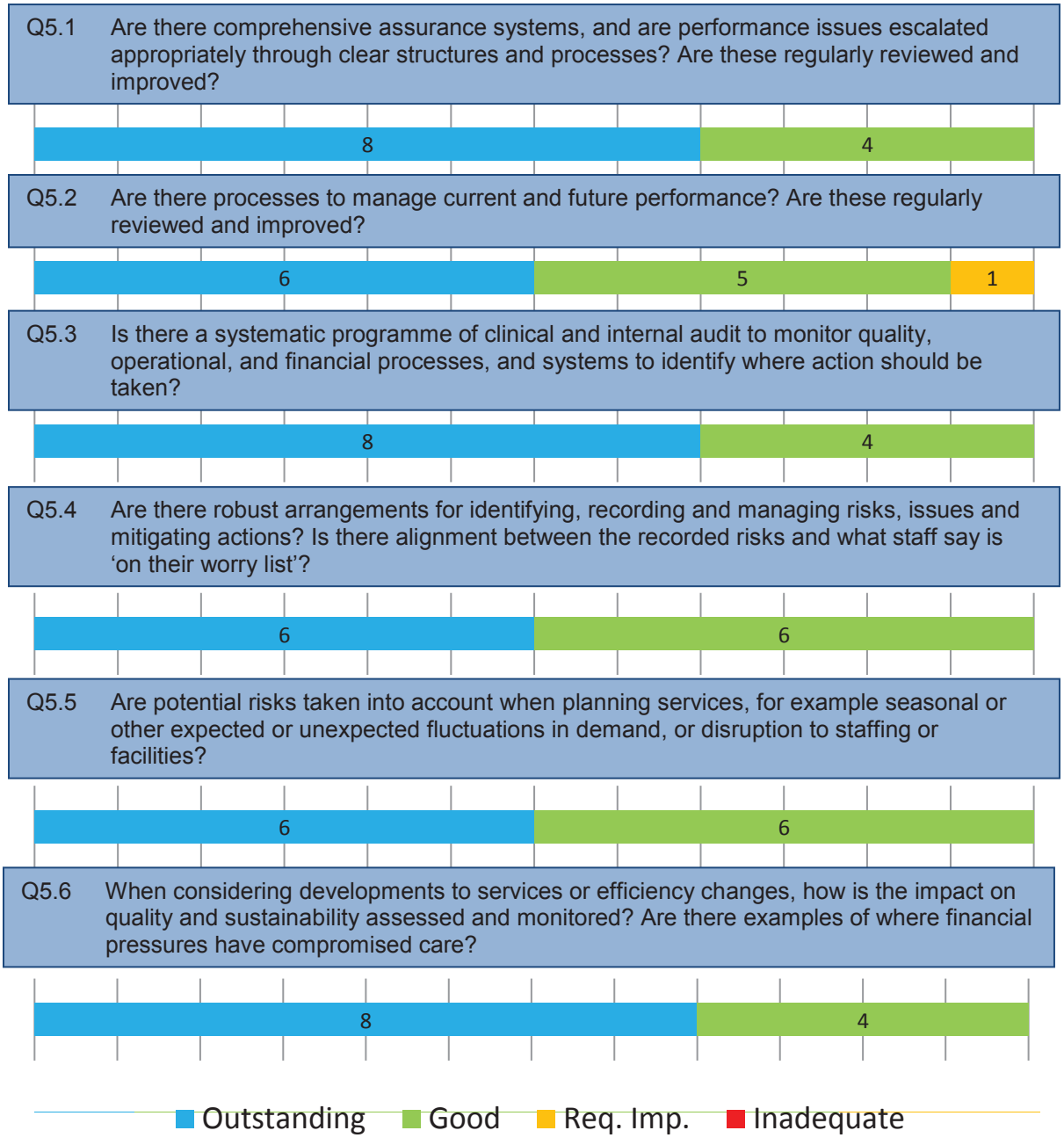
KLOE 4: Summary assessment and recommendations

Overall this KLOE was the third highest rated KLOE. Lower 'Outstanding' rating were provided for: staff being clear on their role and accountability; and arrangements with partners and third-party providers.

The focus for improvement within the KLOE relates to:

- Evolve the Alliance governance and accountability arrangements to reflect the changing environment and integrated structures

3.2.5 KLOE 5. Are there clear and effective processes for managing risks, issues and performance?



Q5 Comments
Proactive performance management metrics are developing to reduce reactive action to address deficiencies
Divisional review meetings minuted
There is a clear culture of not compromising quality and safety because of financial pressures as evidenced by the firm position Board took on the initial CIP request.
Our process of appraisal needs to be improved, compliance has been poor throughout the year and consequently we are focussed on completion rather than quality and outcomes.
We have learnt from previous years and have actively attempted to manage / plan ahead for the mitigation of annual leave and winter pressures (time will tell how effective these plans are).
We regularly and openly discuss the impact of financial constraints and challenges on patient care – ensuring balance without compromise.
Risk review, assessment and management is an ongoing core focus of the work of the Trust - through the Board and its various subcommittees. Internal and external audit is transparent and effective. The Chief Nurse and Medical Director - supported by the executive and the NEDs - maintain a central focus on quality of care and the philosophy of the organisation is quite clear in its insistence that financial management cannot be allowed to compromise the quality of care
There is an ongoing challenge to ensure that quality and safety are maintained in the current political and financial context. The board always puts patient safety as the top priority

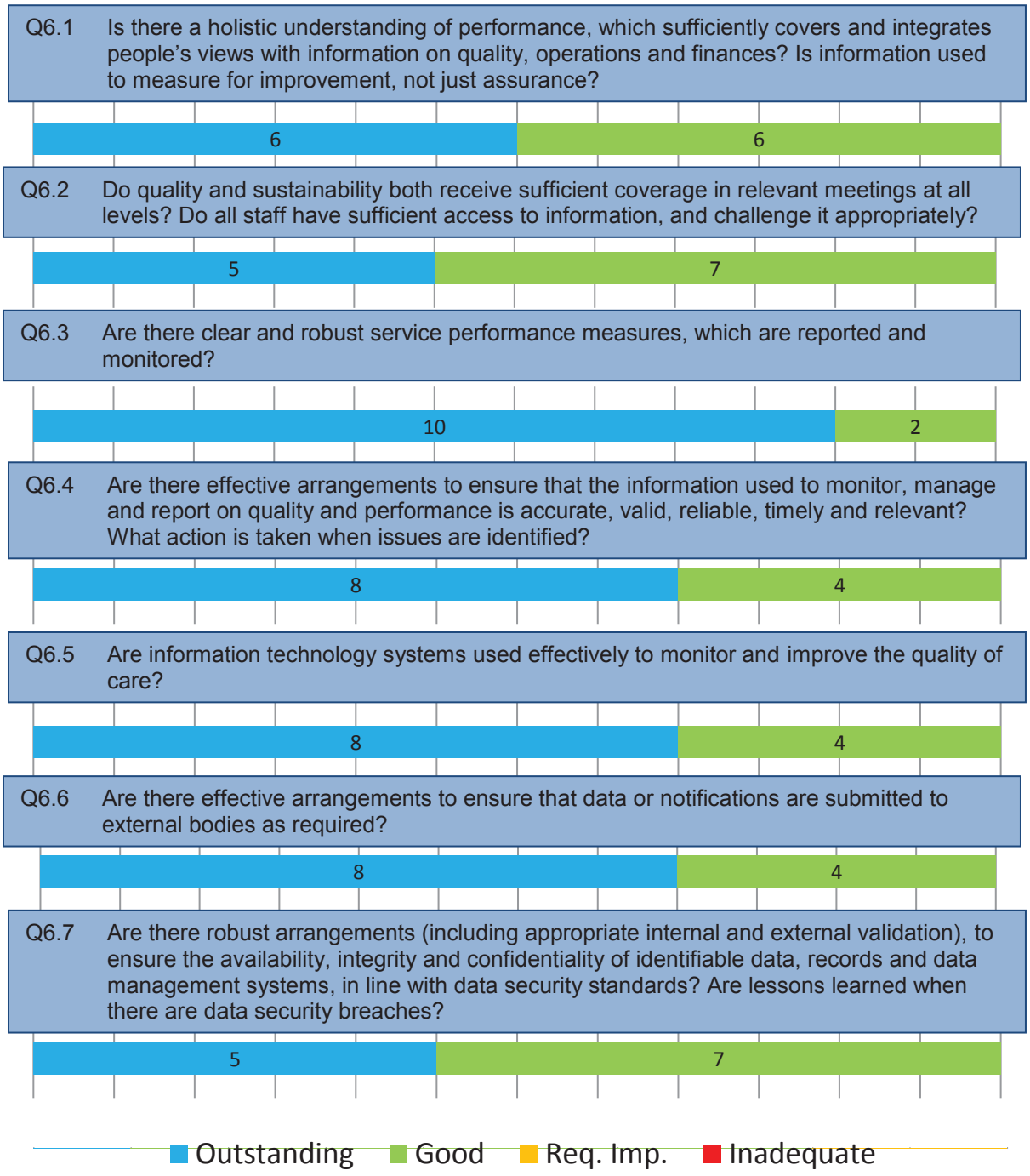
KLOE 5: Summary assessment and recommendations

Overall this KLOE received an equal balance of outstanding and good ratings across all prompts, within only one requires improvement provided. The focus for improvement within the KLOE relates to:

- Continue to develop the performance management framework through the IQPR

3.2.6 KLOE 6. Is robust and appropriate information being effectively processed and challenged?

This KLOE is underpinned by seven prompts.



Q6 Comments
Greater access to data and the creation of performance dashboards is still under development
Need to keep taking account of potential of e-Care
Board reporting is exceptional and continuously improving.
The Trust is an exemplar when it comes to embracing and leveraging the advantages of digitisation.
Data security is taken seriously and transparently.
Performance measures are detailed, timely and regularly reviewed at board level and through the various subcommittees down to ward level. Introduction of e-Care has enhanced the effectiveness of monitoring performance (after some initial technical glitches) and the GDE process is focused on driving the use of digital technology forward and leading development in this area. An increasing focus, in collaboration with a Public Health consultant, is the use of data to shape and enhance services not only within the trust, but through the alliance and STP footprints. Performance data is used to enhance care - for example the extensive work on pressure ulcer prevention driven by data from secondary care and community services.
The issue of sustainability of current services is complex and warrants further debate

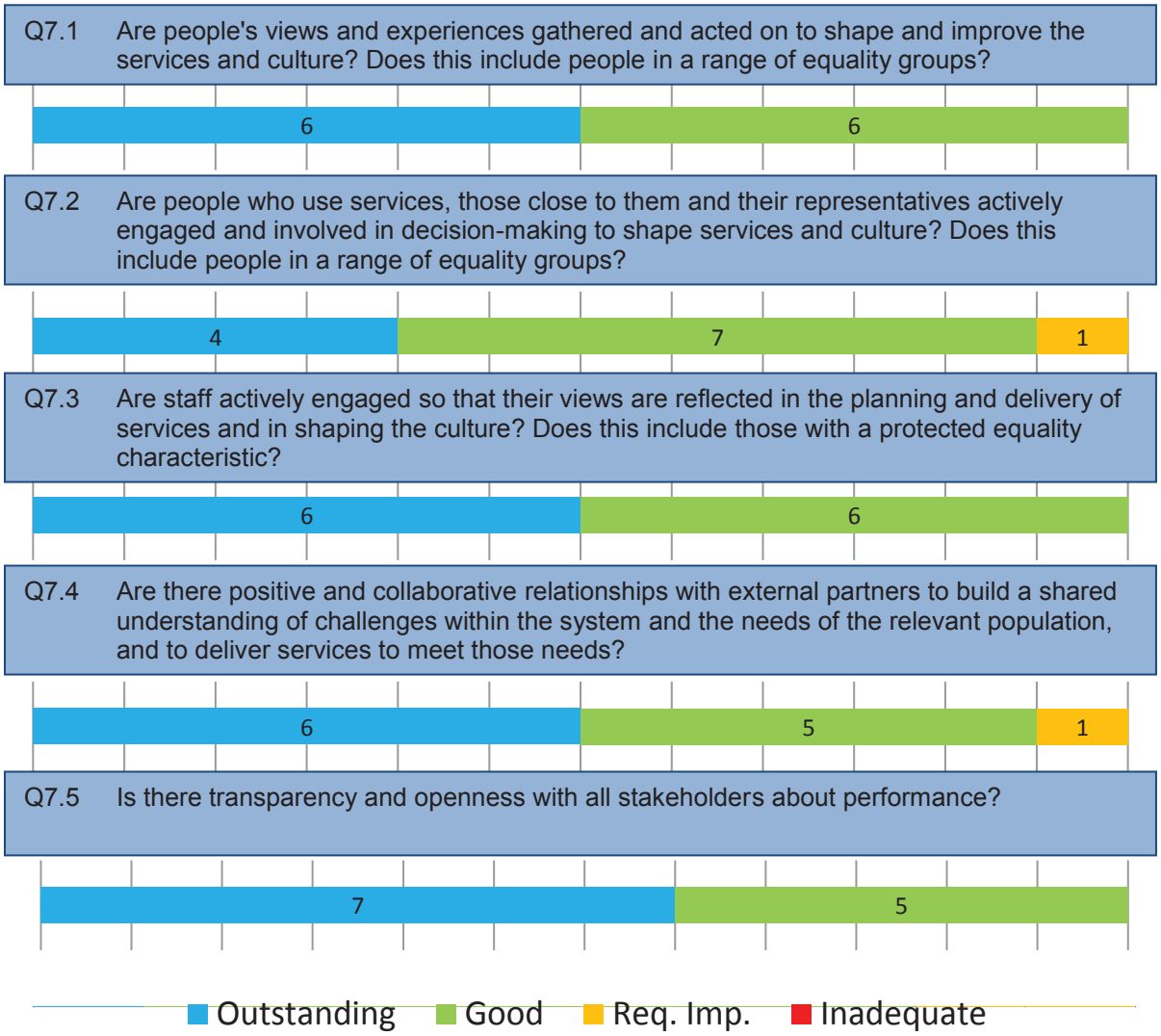
KLOE 6: Summary assessment and recommendations

Overall this KLOE was rated in the middle of the pack for compliance. Although the compliance assessment by the executives was significant lower than the NEDs. High levels of compliance were identified for: 'Are there clear and robust service performance measures, which are reported and monitored?'

The focus for improvement within the KLOE relates to:

- Continue to develop the performance management framework through the IQPR
- Drive use of information through e-Care for quality improvement and service sustainability

3.2.7 KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?



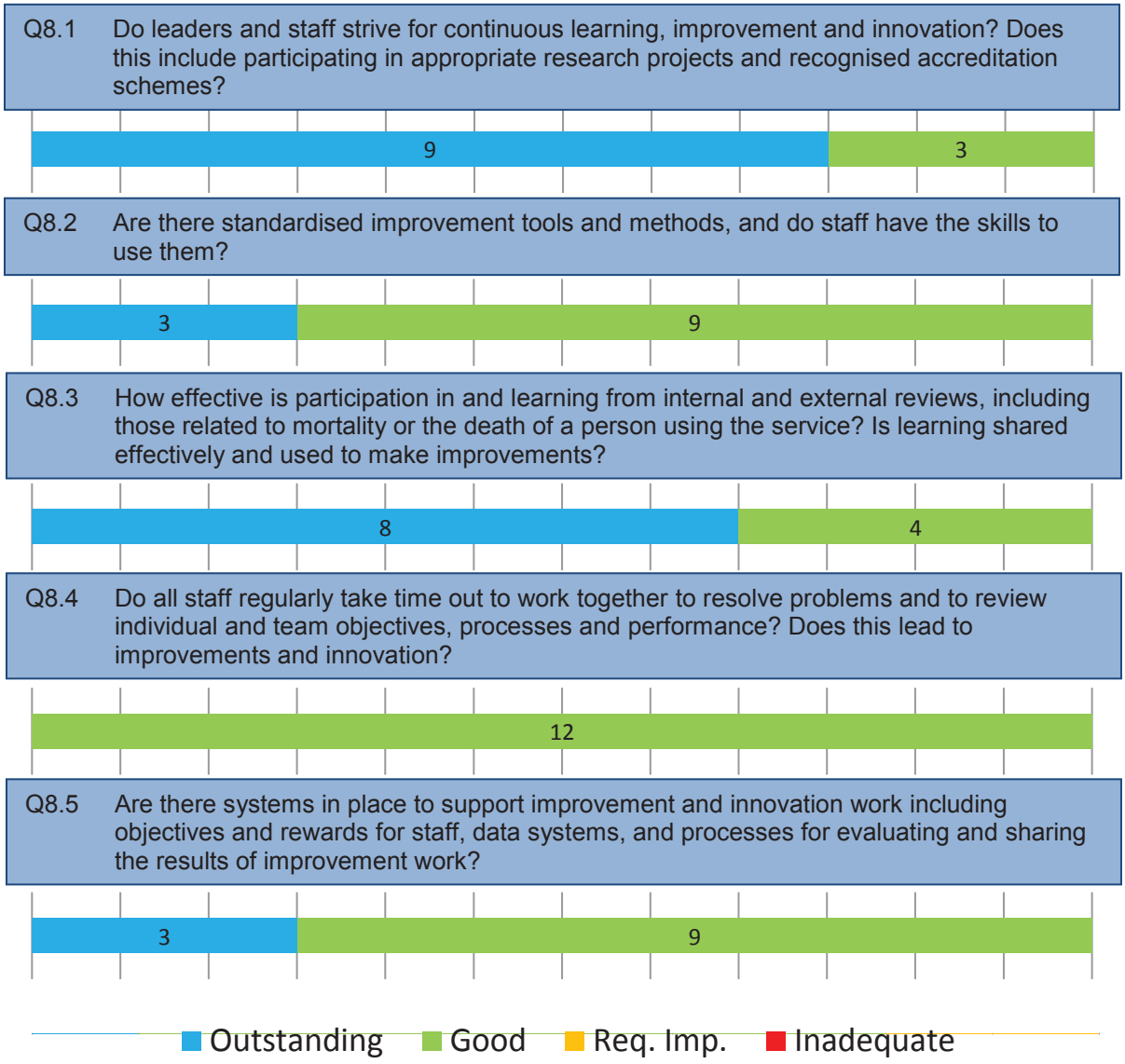
Q7 Comments
Collaboration with external partners is developing extremely well, the understanding of challenges for partners is becoming better understood, there is a strong commitment to finding system wide solutions and a clear move away from single organisational working and silo decision making that may impact negatively on partners
Equality and diversity engagement with the community requires improvement
Still more to be done on improving the patient experience
The Trust benefits from having a highly engaged, constructive and representative Board of Governors. AGM's regularly attract a full house of service users. Feedback from service users are regularly and openly discussed and actioned at Board (Patient Story, Complaints etc). We have robust PALs processes.
Our relationship with external partners is not without issue.
Performance data is transparent and accessible. Staff innovation and involvement in service development and improvement is encouraged (for example the introduction of coloured plastic cups to hold medication and prevent confusion was developed by a member of the nursing staff). The trust has been proactive and effective in developing effective working relationships with other stakeholders across the alliance and STP
An area of strength

KLOE 7: Summary assessment and recommendations

Overall this KLOE received the joint third lowest compliance rating, with executives rating significantly lower than NEDs. The focus for improvement within the KLOE relates to:

- Through the experience of care strategy ensure people who use services, those close to them and their representatives are actively engaged and involved in decision-making to shape services and culture
- Continued development of positive and collaborative relationships with external partners

3.2.8 KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?



Q8 Comments
Continuous quality improvement is still a work in progress. Needs to be fully owned by operational triumvirate
On one hand the innovation being driven by the digital exemplar program is outstanding, as is some of the research that is rewarded annually as part of EBACs – but I do wonder if we have enough basic innovation coming from more junior / non consultant members of staff? There are some great examples of 'home grown' innovation, just not sure it is part of or encouraged by formal process.
The Trust actively engages with local and national research and audit. Continuous improvement is at the heart of Trust culture - the achievement of an 'outstanding' rating by the CQC has not prevented the organisation from continually looking to identify areas in which it is not as effective as it would wish to be. The learning from deaths group has attracted national attention as an exemplar of this process. Dissemination of learning to all relevant staff from the various governance processes remains an area of focus - and steps are being taken with the communications team to develop this process further
Continuous improvement is a passion within the Trust

KLOE 8: Summary assessment and recommendations

Overall this KLOE received the lowest compliance rating, with executives rating slightly lower than NEDs. A high compliance rating was given for leaders and staff in relation to learning, improvement and innovation.

The focus for improvement within the KLOE relates to:

- Embed quality improvement at all levels of the Trust, using this to encourage and support innovation

4. Conclusion and recommendations

Overall the annual governance review provides a positive assessment by the Board of the well-led governance framework.

Based on the aggregated scoring of the individual prompts and KLOEs the Board rated the organisation as having **'Outstanding' compliance** with the well-led framework. With seven of the eight KLOEs rated as outstanding, this well-led self-assessment rating is higher than the previous review (seven KLOEs assessed as 'Good' and KLOE 8 as 'Requires improvement.

The two KLOEs with the **highest rated** compliance were:

- 94% - KLOE 1. Is there the leadership capacity and capability to deliver high quality, sustainable care?
- 90% - KLOE 3: Is there a culture of high quality, sustainable care?

The two KLOEs with the **lowest rated** compliance were:

- 80% - KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people who use services, and robust plans to deliver?

- 79% - KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

The Board is asked to:

(a) Review and approve the **KLOE summary assessments and recommendations for improvement** (Annex A)

(b) Approve the report and that an **action plan** to address the identified areas for improvement be submitted to the Board in January 2019

(c) With relevant suppliers use this report to **inform the scope** of a mandated independent well-led assessment to be undertaken in 2019-20 (timescale to be agreed with NHSI). The proposed emphasis of the this work to support a structural review of the divisional management structure, including operationalisation of the performance management framework

Richard Jones
Trust Secretary & Head of Governance
November 2018

Annex A: Summary assessment and recommendations for each KLOE

Key Line of Enquiry (KLOE)	Summary assessment	Focus for improvement
1. Is there the leadership capacity and capability to deliver high quality, sustainable care?	Overall this KLOE received the highest compliance rating. Particularly high levels of outstanding compliance are identified for leaders being visible and approachable and leaders have the skills, knowledge, experience and integrity that they need.	- Leadership development strategy and succession planning - Visibility of all members of the executive team
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	Overall rated outstanding (at 80%) this KLOE received the second lowest compliance rating, with a high number of requires improvement ratings. A high level of outstanding compliance was identified for having a clear vision and a set of values, with quality and sustainability as the top priorities.	- Refresh of the Trust's strategy, aligned to Alliance working and integration opportunities - Developing clinical service and divisional level operational plans
3. Is there a culture of high quality, sustainable care?	Overall this KLOE received the second highest compliance rating. All Board members rated two of the prompts as Outstanding: 'Do staff feel positive and proud to work in the organisation?'; and 'Is there a strong emphasis on safety and well-being of staff?'.	- Systematically deliver high quality appraisal and career development conversations
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?	Overall this KLOE was the third highest rated KLOE. Lower 'Outstanding' rating were provided for: staff being clear on their role and accountability; and arrangements with partners and third-party providers.	- Evolve the Alliance governance and accountability arrangements to reflect the changing environment and integrated structures
5. Are there clear and effective processes for managing risks, issues and performance?	Overall this KLOE received an equal balance of outstanding and good ratings across all prompts, within only one requires improvement provided.	- Continue to develop the performance management framework through the IQPR

Key Line of Enquiry (KLOE)	Summary assessment	Focus for improvement
6. Is appropriate and accurate information being effectively processed, challenged and acted on?	Overall this KLOE was rated in the middle of the pack for compliance. Although the compliance assessment by the executives was significant lower than the NEDs. High levels of compliance were identified for: 'Are there clear and robust service performance measures, which are reported and monitored?'	- Continue to develop the performance management framework through the IQPR - Drive use of information through e-Care for quality improvement and service sustainability
7. Are the people who services, the public, staff and external partners engaged and involved to support high quality sustainable services?	Overall this KLOE received the joint third lowest compliance rating, with executives rating significantly lower than NEDs.	- Through the experience of care strategy ensure people who use services, those close to them and their representatives are actively engaged and involved in decision-making to shape services and culture - Continued development of positive and collaborative relationships with external partners
8. Are there robust systems and processes for learning, continuous improvement and innovation?	Overall this KLOE received the lowest compliance rating, with executives rating slightly lower than NEDs. A high compliance rating was given for leaders and staff in relation to learning, improvement and innovation	- Embed quality improvement at all levels of the Trust, using this to encourage and support innovation

Annex B: Characteristics of well-led key line of enquiry (KLOEs)

	Outstanding	Good	Requires Improvement	Inadequate
WELL-LED	The leadership, governance and culture are used to drive and improve the delivery of high quality person-centred care.	The leadership, governance and culture promote the delivery of high quality person-centred care.	The leadership, governance and culture do not always support the delivery of high quality person-centred care.	The delivery of high quality care is not assured by the leadership, governance or culture in place.
KLOE 1 Is there the leadership capacity and capability to deliver high quality, sustainable care?				
Applicability	**Outstanding**	**Good**	**Requires Improvement**	**Inadequate**
Core	There is compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrate the high levels of experience, capacity and capability needed to deliver excellent and sustainable care, and there is a deeply embedded system of leadership development and succession planning which aims to ensure that the leadership is representative of the diversity of the workforce. Comprehensive and successful leadership strategies are in place to ensure and sustain delivery and to develop the desired culture. Leaders have a deep understanding of issues, challenges and priorities in their service, and beyond.	Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance are addressed. Leaders at all levels are visible and approachable. Compassionate, inclusive and effective leadership is sustained through a leadership strategy or development programme and effective selection, development and succession processes. The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and takes action to address them.	Not all leaders have the necessary experience, knowledge, capacity, capability or integrity to lead effectively. Staff do not consistently know who their leaders are or how to gain access to them. The need to develop leaders is not always identified or action is not always taken. Leaders are not always aware of the risks, issues and challenges in the service. Leaders are not always clear about their roles and their accountability for quality.	Leaders do not have the necessary experience, knowledge, capacity, capability or integrity to lead effectively. There is no stable leadership team, with high unplanned turnover and/or vacancies. Leaders are out of touch with what is happening on the front line, and they cannot identify or do not understand the risks and issues described by staff. There is little or no attention to succession planning and development of leaders. Staff do not know who their leaders are, what they do, or are unable to access them. There are few examples of leaders making a demonstrable impact on the quality or sustainability of services.

KLOE 2 Is there a clear vision and credible strategy to deliver high quality sustainable care to people who use services, and robust plans to deliver?				
Applicability	**Outstanding**	**Good**	**Requires Improvement**	**Inadequate**
Core	The strategy and supporting objectives and plans are stretching, challenging and innovative while remaining achievable. Strategies and plans are fully aligned with plans in the wider health economy, and there is a demonstrated commitment to system-wide collaboration and leadership. There is a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Plans are consistently implemented, and have a positive impact on quality and sustainability of services.	There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well-defined objectives that are achievable and relevant. The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and, external partners. The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population. Strategic objectives are supported by quantifiable and measurable outcomes, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place. Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them. Progress against delivery of the strategy and local plans is monitored and reviewed, and there is evidence to show this.	The strategy and plans have some significant gaps or weaknesses that undermine their credibility, and do not fully reflect the health economy in which the service works. They may not have been recently created or reviewed. Staff do not always understand how their role contributes to achieving the strategy. The statement of vision and guiding values is incomplete, out of date, or not fully credible. Results of stakeholder consultation are not always taken into account in strategies or plans. Staff are not always aware of or supportive of, or do not understand, the vision and values, or have not been fully involved in developing them. Progress against delivery of the strategy and plans is not consistently or effectively monitored, reviewed or evidenced. Leaders at all levels are not always held to account for the delivery of the strategy.	There is no current strategy, the strategy is not underpinned by detailed, realistic objectives and plans for high-quality and sustainable delivery, and it does not reflect the health economy in which the service works. Staff do not understand how their role contributes to achieving the strategy. There is no credible statement of vision and guiding values. Key stakeholders have not been engaged in the creation of the strategy. Staff are not aware of or supportive of, or do not understand, the vision and values, or they were developed without staff and wider engagement. There is no effective approach to monitoring, reviewing or providing evidence of progress against delivery of the strategy or plans. . The strategy has not been translated into meaningful and measurable plans at all levels of the service.

KLOE 3 Is there a culture of high quality, sustainable care?				
Applicability	**Outstanding**	**Good**	**Requires Improvement**	**Inadequate**
Core	have an inspiring shared purpose, and strive to deliver and motivate staff to succeed. There are high levels of satisfaction across all staff, including those with particular protected characteristics under the Equality Act. There is a strong organisational commitment and effective action towards ensuring that there is equality and inclusion across the workforce. Staff are proud of the organisation as a place to work and speak highly of the culture. Staff at all levels are actively encouraged to speak up and raise concerns. There is strong collaboration, team-working and support across all functions and a common focus on improving the quality and sustainability of care and people's experiences.	Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. Leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus the attention on the needs and experiences of people who use services. Behaviour and performance inconsistent with the vision and values is acted on regardless of seniority. Candour, openness, honesty and transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement and the benefit of raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated in a sensitive and confidential manner, and lessons are shared and acted upon. When something goes wrong, people receive a sincere and timely apology and are told about any actions taken to improve processes to prevent the same happening again.	Staff satisfaction is mixed. Improving the culture or staff satisfaction is not seen as a high priority. Staff do not always feel actively engaged or empowered. There are teams working in silos or management and clinicians do not always work cohesively. Staff do not always raise concerns or they are not always taken seriously or treated with respect when they do. People do not always receive a timely apology when something goes wrong and are not consistently told about any actions taken to improve processes to prevent the same happening again. Staff development is not always given sufficient priority. Appraisals take place inconsistently or are not of high quality. Equality and diversity are not consistently promoted and the causes of workforce inequality are not always identified or adequately addressed. Staff, including those with particular protected characteristics, do not always feel they are treated equitably.	There is no understanding of the importance of culture. There are low levels of staff satisfaction, high levels of stress and work overload. Staff do not feel respected, valued, supported or appreciated. There is poor collaboration or cooperation between teams and there are high levels of conflict. The culture is top-down and directive. It is not one of fairness, openness, transparency, honesty, challenge and candour. When something goes wrong, people are not always told and do not receive an apology. Staff are defensive and are not compassionate. There are high levels of bullying, harassment, discrimination or violence, and the organisation is not taking adequate action to reduce this. When staff raise concerns they are not treated with respect. The culture is defensive. There is little attention to staff development and there are low appraisal rates.

		There are processes to support staff and promote their positive wellbeing. Behaviour and performance inconsistent with the values is identified and dealt with swiftly and effectively, regardless of seniority. There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility is shared. There are processes for providing all staff at every level with the development they need, including high quality appraisal and career development conversations. Equality and diversity are actively promoted and work is undertaken to identify the causes of any workforce inequality and action taken to address these. Staff, including those with particular protected characteristics under the Equality Act, feel they are treated equitably.		
KLOE 4 Are there clear responsibilities, roles and systems of accountability to support good governance and management?				
Applicability	**Outstanding**	**Good**	**Requires Improvement**	**Inadequate**
Core	Governance arrangements are proactively reviewed and reflect best practice. A systematic approach is taken to working with other organisations to improve care outcomes.	The board and other levels of governance within the organisation function effectively and interact with each other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared	The arrangements for governance and performance management are not fully clear or do not always operate effectively. There has been no recent review of the governance arrangements, the strategy, or plans. Staff are not always clear about their roles, what they are accountable for, and to whom.	The governance arrangements and their purpose are unclear, and there is a lack of clarity about authority to make decisions and how individuals are held to account. There is no process to review key items such as the strategy, values, objectives, plans or the governance framework. Staff and

		services, are clearly set out, understood and effective. Staff are clear on their roles and accountabilities. ere		their managers are not clear on their roles or accountabilities. There is a lack of systematic performance management of individual staff, or appropriate use of incentives or sanctions.
KLOE 5 Are there clear and effective processes for managing risks, issues and performance?				
Applicability	**Outstanding**	**Good**	**Requires Improvement**	**Inadequate**
Core	There is a demonstrated commitment to best practice performance and risk management systems and processes, regularly reviewing their operation, and ensuring the staff at all levels have the skills and knowledge to use those systems and processes effectively. Problems are identified and addressed quickly and openly.	The organisation has the processes to manage current and future performance. There is an effective and comprehensive process to identify, understand, monitor and address current and future risks. Performance issues are escalated to the appropriate committees and the board through clear structures and processes. Clinical and internal audit processes function well and have a positive impact in relation to quality governance, with clear evidence of action to resolve concerns. Financial pressures are managed so that they do not compromise the quality of care. Service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care.	Risks, issues and poor performance are not always dealt with appropriately or quickly enough. The risk management approach is applied inconsistently or is not linked effectively into planning processes. The approach to service delivery and improvement is reactive and focused on short term issues. Clinical and internal audit processes are inconsistent in their implementation and impact. The sustainable delivery of quality care is put at risk by the financial challenge.	There is little understanding or management of risks and issues, and there are significant failures in performance management and audit systems and processes. Risk or issue registers and action plans, if they exist at all, are rarely reviewed or updated. Meeting financial targets is seen as a priority at the expensive of quality.

KLOE 6 Is robust and appropriate information being effectively processed and challenged?				
Applicability	**Outstanding**	**Good**	**Requires Improvement**	**Inadequate**
Core	The service invests in innovative and best practice information systems and processes. The information used in reporting, performance management and delivering quality care is consistently found to be accurate, valid, reliable, timely and relevant. There is a demonstrated commitment at all levels to proactively sharing data and information to drive and support internal decision making as well as system-wide working and improvement.	Integrated reporting supports effective decision making. There is an holistic understanding of performance, which sufficiently covers and integrates the views of people, with quality, operational and financial information. Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Performance information is used to hold management and staff to account. The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses. Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary. Integrated reporting supports effective decision-making. Data or notifications are consistently submitted to external organisations as required. There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Information technology systems are used effectively to monitor and improve the quality of care.	The information used in reporting, performance management and delivering quality care is not always accurate, valid, reliable, timely or relevant. Leaders and staff do not always receive information to enable them to challenge and improve performance. Information is used mainly for assurance and rarely for improvement. Required data or notifications are inconsistently submitted to external organisations. Arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems are not always robust	The information that is used to monitor performance or to make decisions is inaccurate, invalid, unreliable, out of date or not relevant. Finance and quality management are not integrated to support decision making. There is inadequate access to and challenge of performance by leaders and staff. There are significant failings in systems and processes for the management or sharing of data.

KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?				
Applicability	**Outstanding**	**Good**	**Requires Improvement**	**Inadequate**
Core	There are consistently high levels of constructive engagement with staff and people who use services, including all equality groups. Rigorous and constructive challenge from people who use services, the public and stakeholders is welcomed and seen as a vital way of holding services to account. Services are developed with the full participation of those who use them, staff and external partners as equal partners. Innovative approaches are used to gather feedback from people who use services and the public, including people in different equality groups, and there is a demonstrated commitment to acting on feedback. The service takes a leadership role in its health system to identify and proactively address challenges and meet the needs of the population.	A full and diverse range of people's views and concerns are encouraged, heard and acted on to shape services and culture. The service proactively engages and involves all staff (including those with particular protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture. The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.	There is a limited approach to sharing information with and obtaining the views of staff, people who use services, external partners and other stakeholders, or insufficient attention to appropriately engaging those with particular protected equality characteristics. Feedback is not always reported or acted upon in a timely way.	There is minimal engagement with people who use services, staff, the public or external partners. The service does not respond to what people who use services or the public say. Staff are unaware or are dismissive of what people who use the service think of their care and treatment. Staff or patient feedback is inappropriately filtered or sanitised before being passed on.

KLOE 8 Are there robust systems, processes for learning, continuous improvement and innovation?				
Applicability	**Outstanding**	**Good**	**Requires Improvement**	**Inadequate**
Core	There is a fully embedded and systematic approach to improvement, making consistent use of a recognised improvement methodology. Improvement is seen as the way to deal with performance and for the organisation to learn. Improvement methods and skills are available and used across the organisation, and staff are empowered to lead and deliver change. Safe innovation is celebrated. There is a clear, systematic and proactive approach to seeking out and embedding new and more sustainable models of care. There is a strong record of sharing work locally, nationally and internationally.	There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research. There is knowledge of improvement methods and skills to use them at all levels of the organisation. There are organisational systems to support improvement and innovation work, including, staff objectives, rewards, data systems, and ways of sharing improvement work. The service makes effective use of internal and external reviews, with learning shared effectively and used to make improvements. Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.	There is weak or inconsistent investment in improvement skills and systems among staff and leaders. Improvements are not always identified or action not always taken. The organisation does not react sufficiently to risks identified through internal processes, but often relies on external parties to identify key risks before they start to be addressed. Where changes are made, the impact on the quality and sustainability of care is not fully understood in advance or it is not monitored.	There is little innovation or service development, no knowledge or appreciation of improvement methodologies, and improvement is not a priority among staff and leaders. There is minimal evidence of learning and reflective practice. The impact of service changes on the quality and sustainability of care is not understood.

19. Remuneration Committee report

To APPROVE the report recommendation

For Approval

Presented by Angus Eaton

Board of Directors – 25 January 2019

Agenda item:	Item 19			
Presented by:	Angus Eaton, Non-executive director			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	15 January 2019			
Subject:	Remuneration Committee report			
Purpose:		For information	X	For approval

The Committee undertook:

1. A mid-year performance review for each of the executive directors. Discussion took place on the structure and focus of executive director objectives for 2019-20
2. Received the minutes of the Employers Based Awards Committee held on 5 October 2018
3. Consideration was given to remuneration of very senior staff that withdraw from the NHS pension scheme. The Committee will consider this matter further and, given the potential conflict of interest for executive directors, requests the Board's delegates authority for a decision on this matter to the Committee
4. Reviewed and approved the remuneration range for the director of human resources role ahead of interviews in December. *[Update: An appointment was not made following interview and appropriate arrangements are being considered]*

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
		X	

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

Previously considered by:	A summary of each meeting of the committee is provided to the Board
Risk and assurance:	Failure to comply with NHSI guidance on remuneration for very senior managers.
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:

To receive the report for information and approves delegated authority to the committee for any decision on remuneration for very senior staff that withdraw from the pension scheme.

20. Non-executive director responsibilities review

To APPROVE the report

For Approval

Presented by Sheila Childerhouse

Board of Directors – 25 January 2019

Agenda item:	Item 20			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	15 January 2019			
Subject:	Remuneration Committee report			
Purpose:	X	For information		For approval

This report sets out the agreed NED responsibilities and lead roles to ensure that key activities receive appropriate non-executive review and challenge.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
		X	

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

Previously considered by:	Review with NEDs
Risk and assurance:	Failure to provide relevant NED leadership and challenge to key responsibilities
Legislation, regulatory, equality, diversity and dignity implications	None

Recommendation:

To receive the report for information

Non-executive directors' responsibilities (January 2019)

NHS West Suffolk NHS Foundation Trust

	Primary responsibilities	Responsibilities as required	Lead roles
Sheila Childerhouse **Chair and Non-executive director** **Term:** 1 Jan 2018 - 31 Dec 2020	• Chair Board – Public, Closed (**Chair**) • Quality & Risk Committee (**Chair**) • Scrutiny Committee • Remuneration Committee • Council of Governors (**Chair**) • STP chairs meeting (Chair) *Option to attendance any other Board committee*	• Board Workshops • External relationships • Consultant appointments • Quality walkabouts • Governor meetings with NEDs • Investigations and appeals • CCG Board meetings	• Chair • STP • NHSI
Richard Davies **Non-executive director** **Term:** 1 Mar 2017 – 28 Feb 2020	• Board meeting – Public, Closed • Audit Committee • Quality & Risk Committee • Remuneration Committee Subcommittees of Q&RC: • Clinical Safety & Effectiveness Committee	• Board Workshops • Consultant appointments • Quality walkabouts • Revalidation Support Group • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• NED link to Medical Director • Learning from deaths • End of life • Children services, including, including safeguarding
Angus Eaton **Non-executive director** **Term:** 1 Jan 2018 – 31 Dec 2020	• Board meeting – Public, Closed • Audit Committee (**Chair)** • Remuneration Committee (**Chair**) • Charitable Funds Committee	• Board Workshops • Consultant appointments • Attend Q&RC • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• NED link to Director of Finance • Health and wellbeing programme

	Primary responsibilities	Responsibilities as required	Lead roles
Gary Norgate **Non-executive director** **Term:** 1 Sept 2013 - 31 August 2016 **Reappointed:** 1 Sept 2016 – 31 August 2019	• Board meeting – Public, Closed • Audit Committee • Scrutiny Committee (**Chair**) • Remuneration Committee • Charitable Funds Committee (**Chair**) • Digital Programme Board • Clinical Excellence & Discretionary Awards Committee Subcommittees of Q&RC: • 2nd Clinical Safety & Effectiveness Committee	• Board Workshops • Consultant appointments • Attend Q&RC • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Senior Independent Director • Digital • Whistleblowing • Procurement
Alan Rose **Deputy Chair and Non-executive director** **Term:** 1 April 2017 – 31 March 2020	• Board meeting – Public, Closed • Audit Committee • Quality & Risk Committee • Scrutiny Committee • Remuneration Committee Subcommittees of Q&RC: • Patient Experience Committee • 2nd Corporate Risk Committee	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Deputy Chair • Referral to treatment (RTT) • Patient experience and public engagement
Louisa Pepper **Non-executive director** **Term:** 1 September 2018 – 31 Aug 2021	• Board meeting – Public, Closed • Audit Committee • Quality & Risk Committee • Remuneration Committee Subcommittees of Q&RC: • Corporate Risk Committee • 2nd Patient Experience Committee	• Board Workshops • Consultant appointments • Quality walkabouts • Council of Governors and Governor meetings with NEDs • Investigations and appeals	• Safeguarding - adults • Security • Emergency preparedness, resilience and response (EPRR)

21. Register of interests

To ACCEPT the report

For Report

Presented by Richard Jones

Board of Directors – 25 January 2019

Agenda item:	21			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Georgina Holmes, Foundation Trust Office Manager			
Date prepared:	17 January 2019			
Subject:	Register of Interests			
Purpose:	X	For information		For approval

The register of directors' interests is formally reviewed and updated on an annual basis. At each Board meeting declarations are also received for items to be considered.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
		X	

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

Previously considered by:	The Board receive an annual review of the register of interests.
Risk and assurance:	Failure to adequately identify conflicts and manage accordingly
Legislation, regulatory, equality, diversity and dignity implications	WSFT constitution. NHSI (Monitor) Code of Governance

Recommendation:

To note the summary of the register of directors' interests.

NHS
West Suffolk
NHS Foundation Trust

REGISTER OF DIRECTORS' INTERESTS

The Codes of Conduct and Accountability for NHS Trusts requires all Trusts to draw up and maintain a register of director's interests. This register consequently lists all interests, defined by the Codes as relevant and material for all its Board and non-Board directors.

The definition of interests is as follows:

- Directorships held in private companies or plcs.
- Ownership or part ownership of private companies, businesses or consultancies, likely or possibly seeking to do business with the NHS.
- Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS.
- A position of authority in a charity or a voluntary body in the field of health and social care.
- Any connection with a voluntary or other body contracting for NHS services.

	Declared Interest	Date Reviewed / Amended
Trust Chairman		
Sheila Childerhouse	Trustee of the East Anglia's Children's Hospices Director of Charles Burrell & Sons (dormant company)	25 January 2019
Non Executive Directors		
Richard Davies	Sub Dean at University of Cambridge School of Clinical Medicine. The Clinical School has a contract with the WSFT to provide clinical student teaching.	25 January 2019
Angus Eaton	With effect from 14 January 2019 employed as Managing Director Consumer Legal Services and Chief Risk Officer for Slater and Gordon (law firm). As part of this employment will have an equity stake in Slater and Gordon. There is the possibility that Slater and Gordon act for clients contracting with or litigating against the NHS.	25 January 2019
Gary Norgate	I hold an executive position in BT Plc which is a service provider to the NHS. My role / division does not directly conduct business with the NHS.	25 January 2018
Louisa Pepper – appointed 1 September 18	Trustee for Suffolk Community Foundation Trustee for Daval Charitable Trust	25 January 2019

	Declared Interest	Date Reviewed / Amended
Alan Rose	Chairman, Howard House Patient Participation Group, Felixstowe Governor on Board of Anglia Ruskin University	25 January 2019
Chief Executive		
Stephen Dunn	Trustee of “Brightstars” charity Director of Helpforce Community Honorary Commander, USAF Lakenheath Visiting Professor of Economics, University of West of England	25 January 2019
Executive Directors		
Helen Beck	Nil	25 January 2019
Craig Black	Wife ,Marie McCleary, is Director of Finance for Havebury Housing Association	25 January 2019
Jan Bloomfield	Patron, Suffolk West NHS Retirement Fellowship Co-opted Governor, West Suffolk College Board Governor, Radio West Suffolk FM Governor – Sybil Andrews Academy	25 January 2019
Nick Jenkins	Nil	25 January 2019
Kate Vaughton	Nil	25 January 2019
Rowan Procter	Nil	25 January 2019
Trust Secretary		
Richard Jones	Director of Friars 699 Limited (which changed its name to "The Pathology Partnership Limited") Councillor of Brockley Parish Council	25 January 2019

22. Use of Trust seal

To ACCEPT the report

For Report

Presented by Richard Jones

Trust Board Meeting – 25 January 2019

Agenda item:	22			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Karen McHugh, PA			
Date prepared:	January 2019			
Subject:	Use of Trust's seal			
Purpose:	X	For information		For approval

Executive summary:

To note use of the Trust Seal, pursuant to Standing Order section 8. The Trust Seal was used on the following occasions:

Seal No. 132
Contract renewal for the chemo bus with Hope for Tomorrow Mobile Cancer Unit - Sealed by Craig Black, witnessed by Kathryn McMahon (29 Novmber 2018)

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
			X

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

Previously considered by:	None
Risk and assurance:	None
Legislation, regulatory, equality, diversity and dignity implications	WSFT's Standing orders

Recommendation:

To note the use of the Trust's seal

23. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Richard Jones

Board of Directors – 25 January 2019

Agenda item:	23			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	18 January 2019			
Subject:	Items for next meeting			
Purpose:		For information	X	For approval

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 Chair.

Trust priorities *[Please indicate Trust priorities relevant to the subject of the report]*	**Deliver for today**	**Invest in quality, staff and clinical leadership**	**Build a joined-up future**
	X	X	X

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

Previously considered by:	The Board receive a monthly report of planned agenda items.
Risk and assurance:	Failure effectively manage the Board agenda or consider matters pertinent to the Board.
Legislation, regulatory, equality, diversity and dignity implications	Consideration of the planned agenda for the next meeting on a monthly basis. Annual review of the Board's reporting schedule.

Recommendation:

To approve the scheduled agenda items for the next meeting

Scheduled draft agenda items for next meeting – 1 March 2019

Description	Open	Closed	Type	Source	Director
Declaration of interests	✓	✓	Verbal	Matrix	All
Deliver for today					
Patient story		✓	Verbal	Matrix	Exec.
Chief Executive's report	✓		Written	Matrix	SD
Integrated quality & performance report: appraisal & mandatory training	✓		Written	Matrix	HB/RP
Finance & workforce performance report	✓		Written	Matrix	CB
Risk and governance report, including risks escalated from subcommittees		✓	Written	Matrix	RJ
Invest in quality, staff and clinical leadership					
Nurse staffing report	✓		Written	Matrix	RP
Quality and learning report – Q3	✓		Written	Matrix	RP
Learning from death report – Q3	✓		Written	Matrix	NJ
Capturing and responding to issues and concerns from staff	✓		Written	Action - 1659	JB
"Putting you first award"	✓		Verbal	Matrix	JB
Consultant appointment report	✓		Written	Matrix – by exception	JB
Serious Incident, inquests, complaints and claims report		✓	Written	Matrix	RP
Build a joined-up future					
West Suffolk Alliance report	✓		Written	Matrix	KV
Strategic update, including Alliance, System Executive Group and System Transformation Partnership (STP)		✓	Written	Matrix	SD
Communication strategy	✓		Written	Matrix	JB
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Audit Committee report, including standing orders, standing financial instructions and accounting policies	✓		Written	Matrix	AE
Council of Governors report	✓		Written	Matrix	SC
Scrutiny Committee report		✓	Written	Matrix	GN
Draft operational plan 2019-20		✓	Written	Matrix	RJ
Risk management strategy and policy	✓		Written	Matrix	RJ
Confidential staffing matters		✓	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	SC

11:30 ITEMS FOR INFORMATION

24. Any other business

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

For Reference

Presented by Sheila Childerhouse

25. Date of next meeting

To NOTE that the next meeting will be held on Friday, 1 March 2019 at 9:15 am in Quince House, West Suffolk Hospital.

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

26. 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 1960

Presented by Sheila Childerhouse