15. Education report

To RECEIVE report

For Report

Presented by Jan Bloomfield

Board of Directors –28 September 2018

Agenda item:	15			
Presented by:	Jan Bloomfield, Executive Director Workforce & Communications			
Prepared by:	Mr Peter Harris, Director of Medical Education, Lorna Lambert, Medical Education Manager, Denise Needle, Deputy Director of Workforce (Development), Diane Last, Non-Medical Clinical Tutor, Dr John Clark, Associate Clinical Dean & Denise Pora, Deputy Director of Workforce (Organisation Development).			
Date prepared:	21st September 2018			
Subject:	Education Report			
Purpose:	☑	For information		For approval

This report provides an update on education and training issues of strategic and service delivery importance for Board Members' information

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:	March 2018 Trust Board paper
Risk and assurance:	Risk to patient safety due to lack of staff training and education, patient safety, correct staffing levels, staff morale, turnover etc. internal and external reputation. Staff perception of Education, Training & Development opportunities through the annual NHS Staff Survey. Medical Education - Royal College and HEEoE visits and assessments Results of annual GMC annual survey of training grade doctors
Legislation, regulatory, equality, diversity and dignity implications	Legislation & regulatory implications, linked to professional body requirements. Equality and health and safety legislation regarding skills, equipment and behaviours of all staff.

Recommendation: For information

Education and Training – Report for Trust Board Members 28th September 2018

Introduction

Future reporting of Education matter to the Trust Board.

This is the second report in the new format of the six monthly TEG/ Board paper; however this would not be a formal group and would meet with the express purpose of providing an update on current educational and training issues and developments.

It was agreed that this informal group would prepare a six monthly briefing paper for TEG, which could then go to the Trust Board meeting. The first paper will therefore be sent to TEG in October 2018.

This report demonstrates how Education and Training is contributing to the three priorities of the Trust's proposed Strategic Framework 'Our patients, our hospital, our future, together'.

Priority 1: Deliver for today

- A sharp focus on improving patient experience, safeguarding patient safety and enhancing quality.
- Continuing to achieve core standards

Leadership development

- The trust's leadership and quality improvement forum, the 5 O'clock Club continues to meet regularly and is well attended by leaders from across the organisation and outside. Speakers in 2017/18 have included Dr Kathy McLean, Executive Medical Director and Chief Operating Officer, NHS Improvement and Sir David Behan CBE, former Chief Executive of the Care Quality Commission. Invitations to join the Club have been extended to Alliance partners and colleagues at St Nicholas' Hospice.

Undergraduate Medical Education

- The Cambridge Graduate Course in Medicine continues to thrive at the West Suffolk Hospital with a large number of medical staff involved in teaching the students.

- Forty students will be starting the course at the end of September. This will double the size of the course and considerably increase teaching income for the Hospital. The Trust has agreed funding to replace Clinical and Communication Skills teaching equipment in the Education Centre; and there are on-going discussions to ensure departments are provided with appropriate funding to support the increased teaching requirement.

Postgraduate Medical Education

- **Junior Doctors Induction**
  This two day Doctors Induction programme (1st & 2nd Aug) is working well delivering the increased IT training. We continue to improve on this.

Exception Reporting

- The Trust reports to HEEoE on any fitness to practice concerns about doctors in training. This is for onward reporting to the GMC. Reports are required for:
  1. Serious incidents where the trainee has been named and investigated
  2. Complaints naming the doctor
  3. Concern about probity or conduct

  The Trust has reported on 2 incidents up to February 2018.

Nursing, Midwifery and Allied Health Professionals

- **Quality Improvement Performance Framework (QIPF)**
  Our January submission to Health Education England was accepted with no additional requirements. All risks were reviewed in June and an updated register was submitted in July (attached).

- **Adult Nursing Student Numbers**
  We have seen an increase in the number of students applying to study adult nursing via the traditional route with potentially 34 starting in the September 2018 cohort against a target of 30. We also have 16 students commencing the 4 year degree apprenticeship bringing a total potential number of 50 students:

Cohort	Target	Actual
September 2018	30	34 (potential) + 16
February 2018	20	8
September 2017	30	13
February 2017	20	11
September 2016	30	33
February 2016	20	3

The February cohort continues to be low but this is reflected in all organisations across the region. We therefore start the 2 year apprenticeship adult nursing programme in February to ensure that we continue to have newly qualified registered nurses at two points throughout the year. 2 assistant practitioners have completed this training and will be taking up posts as registered nurses within the organisation. 4 further APs are currently undertaking the 2 year apprenticeship programme and we will be interviewing for the 2019 cohort this month (likely to appoint 6 – 10)

- **Multi-professional Pre-registration Students**
  We have noticed a reduction in our ODP student numbers but this has been escalated to the university and we are waiting to see if this number increases through clearing. We are currently in a fallow year where the pre-registration programme has changed from a 2 year diploma to a 3 year degree so no newly registered ODPs will be qualifying.

  We have requested that the universities look at apprenticeships for ODPs, radiography, child nursing and physician associate programmes to ensure that we are able to other a variety of pathways to potential students within these fields.

- **International Registered Nurses**
  Some of our overseas nurses have arrived in the UK to begin their OSCE preparation ready for NMC registration. Expected numbers are as follows:

Cohort	Numbers	Potential OSCE exam date
August 2018	3	September 2018
September 2018	11	October 2018
October 2018	7	November 2018
November 2018	TBC	December 2018
December 2018	TBC	January 2019

We continue to offer financial and practical support to nursing assistants with an overseas registration to complete the NMC preparation. One nursing assistant in ED has completed this and is now employed as a registered nurse and two further NAs are partway through the programme.

Support Workforce/Other Staff Groups

- **Care certificate:**

  All health care support workers are required to complete a basic qualification to undertake their role. The following has been achieved for those undertaking the Care Certificate

Jan 2018 – Aug 2018:	New staff	= 86 (5 of these left within first 3 months of employment)
	Existing staff	= 10
Completions Jan 2018 – Aug 2018:	New staff	= 59
	Existing staff	= 5

  Care certificates are co-ordinated by the Nursing Directorate.

Apprenticeship levy:

- The Government Apprenticeship Levy, commenced in May 2017, and requires approximately £770,000 p.a. being charged from the Trust to the Levy in 2017/18.

  The Trust is now able to commission apprenticeship training, which allows the education provider the opportunity to draw down the cost of the training from the Levy. This new process is proving to be complicated and time consuming, as both the providers and the Trust are learning the new rules and procedures.

  For apprenticeships we now have 31 individuals on the Digital Apprenticeship Service (DAS) account and have spent £38,667.70 of our lev

  We have apprenticeships across the following subjects;
  - Business Administration Level 2
  - Business Administrator Level 3
  - Health Pharmacy Science Level 3
  - Operations/Departmental Manager Level 5
  - Engineering Manufacture Level 3
  - Senior Health Care Support Worker Level 3
  - Healthcare Assistant Practitioner Level 5
  - Registered Nurse Level 6
  - Team Leader Level 3

  We will also have our Lighthouse level 3 management cohorts starting in September and November which will be another 24 apprenticeships.

Priority 2: Invest in quality, staff and clinical leadership

- Invest in quality and deliver even better standards of care which, over time, should deliver an 'outstanding' CQC rating

Leadership development

- A spring leadership summit 'Leading self through challenging times' was held for around 80 band 7+ leaders on 16 May. The half day workshop provided participants with opportunities to learn practical techniques and tools for managing challenging events as well as developing a personal action plan. A 'marketplace of helpfulness' was held as part of the day. This was an exhibition of internal (e.g. human resources, health and wellbeing, estates) and external

resources (e.g. Neyber which works with staff to help them be more confident when it comes to personal finances) available to team leaders to help them deliver an excellent service. Feedback on the summit from participants was excellent. The next summit will be held in December 2019.

The first 2030 Leaders Programme ended in June 2018 and has been very positively evaluated by participants. The next programme will start in early 2019.

Postgraduate Medical Education

- **HEE East of England Quality Improvement Performance Framework (QIPF)**
  No additional requirements were required following our submission to Health Education England in January. In June all risks were reviewed and an updated register was submitted in July (attached).

- **GMC Survey results**
  The Trust scored top in the East of England for doctors' overall training satisfaction in acute trusts, in the GMC national training survey 2018. One ought to be mindful that nationally the East of England scores 11th in Overall Satisfaction out of 13 regions (previously called Deaneries)

- **Career Advice**
  A Medical Careers Fair is being held on the 31st October in the lecture theatre. Representatives from specialties across the hospital will occupy stalls allowing junior doctors to gather information about future career aspirations. Medical students have been invited.

- **Education/Clinical Supervisors Training**
  Requirements of the GMC state that all Educational and Named Clinical Supervisors must attend an approved training course for the role and then undertake refresher training every three years.
  Peter Harris & Francesca Crawley facilitated an accredited 3 hour "in-house" course. 28 consultants attended on 17th Jan 2018 and 20 on 4th July 2018.

- **Simulation Training for Junior Doctors**
  With effect from 1st Aug 2018 HEEoE increased mandatory SIM training for all FY1/2 trainees from ½ to 1 day, as part of their study leave allowance. Sessions are being run by the Simulation Team once a month involving 6 scenarios to work through based on situations commonly encountered during FY years. One candidate leads the scenario, the others observe. Upon conclusion there is a debrief and discussion of outcomes. The main focus of the debrief will be around human factors and team working but will include some clinical aspects. This learning experience allows the trainees to gain insight into working relationships and interaction with patients, highlight areas of good practise and to recognise areas where improvements can be made.

- **#2tired2drive Scheme**
  This is for Doctors too tired to drive home after a shift.To date the room has been used on 7 occasions. The PGME has agreed to refund this for Doctors in training as well as for locally employed Doctors.

Nursing, Midwifery and Allied Health Professionals

- **Continued Professional Development (CPD) Funding**
  Funding from Health Education England was received in June - £62,910.00. Following the submission of a business case it was agreed that charitable funds can also be used for education and development where there was a clinically based need with approval from the Executive Chief Nurse and Executive Director of Workforce and Communications.

Health Education England are funding 10 Advanced Clinical Practitioner training programmes for the Trust. These posts will be based in the Emergency Department, Surgery, Medicine and Paediatrics.

Support Workforce/Other Staff Groups

- **Work Experience Placements:**
  To date work experience students have taken part in programmes across the Trust.

  Work experience is co-ordinated by the Voluntary Services Department.

- **Library Annual Report and Appendices 2017/18:**

  Please find attached the annual library report, which outlines activity of the library and information services. (Appendix A)

Priority 3: Build a joined up future

- Reduce non elective demand to create capacity to increase elective activity. Help develop and support new capabilities and new integrated pathways in the community

Nursing, Midwifery and Allied Health Professionals

- **Promoting WSFT to Potential Healthcare Students**

  Between April and July we have attended 13 career events at local schools and colleges speaking and engaging with 1,063 students. We have offered 6 shadowing opportunities within nursing and paediatrics and have a number of events planned for September and October. Pharmacy and Endoscopy have facilitated open events to attract students and new staff.

Support Workforce/Other Staff Groups

- **Health Ambassadors: (careers advice to schools and colleges)**
  We have 34 staff registered as health ambassadors, who routinely visit schools and colleges to enthuse students to consider a career in the health service.

Highlight Summary Risk Report for HEE

Placement Provider (Name):						
Please include all risks identified where *managed risk rating* equals 12 or above or where you feel the sensitivity/profile of the issue warrants escalation to HEE. HEE expects that all risks rated 11 and below will be addressed by your organisation locally. Where there are no such risks identified, the top five risks must be reported.	**Initial Risk Rating**	**Description of Risk**	**Staff groups/learners/specialties affected**	**Urgent actions in place to manage this**	**Managed Risk Rating**	**Further Actions**
Risk 1	16	Reduced numbers of students	Adult nursing, Dietitics, Pharmacy Technicians	Development of partnership with additional HEI to increase student numbers. Continue to promote the role of the dietitian at health ambassador events and offer shadowing/work experience opportunities. **12.06.18** - Increased predicted numbers for adult student nurses in September 2018 and commencement of 4 year apprenticeship programme (16 students).	9	
Risk 2	12	Staff changes, vacancies, sickness and staff rotation have reduced the capacity for mentor support to meet the NMC requirements including sign off mentors within the midwifery department and district nursing	Midwifery and District Nursing	Increased numbers of staff supported to attend Preparation for Mentorship programmes. Increased hours for Clinical Practice Facilitator within department. Closer support from Education Team. **12.06.18** - Continue to support students on Prep for Mentorship programmes across the acute and community settings. Increased sign off mentors within midwifery.	6	
Risk 3	12	Lack of funds to backfill staff required to attend courses thereby reducing the numbers released across both the acute and community settings. Particular impact with apprenticeships	Adult nursing, child nursing, midwifery, physiotherapy, occupational therapy, paramedic, speech and language therapy, dietetics, ODPs, audiology, clinical psychology, pharmacy technicians, pre-registration pharmacy, physician associates, cardiac technicians, diagnostic radiography	Working with leaders to ensure appropriate allocation of available funds for maximum impact on patient care. Discussion with Trust board to highligh risk. **12.06.18 -** allocation of funds by organisation to support CPD. Money received from HEE. Clear process in place to ensure maximum benefit from funds in line with organisational, regional and national priorities	9	
Risk 3	10	There are gaps in the rota leading to reduced training opportunities. Reduced training opportunities will lead to reduced student satisfaction and delayed progress in knowledge, skills and experience	Foundation doctors, career trainees	This is a national problem and adverts have been placed for quality, non-career middle grade medical personnal. **12.06.18** - In the process of increasing support for LEDs to improve recruitment and retention	8	
Risk 4	9	Midwifery - students have witnessed negative attitudes towards the profession and reported episodes of bullying. This was investigated and addressed wtihin the department and positive progress continues to be monitored via the action plan at the Pre-registration Educators Forum	Midwifery	Increased hours for Clinical Practice Facilitator to provide support and guidance to staff and students. Action plan in place and assessed at Pre-registration Educators Forum bimonthly. **30.05.18** - Met with UOS (SCM) and HOM to discuss issues raised in survey. Workshop scheduled with lead midwives and UOS. Student survey comments disseminated via staff newsletter	4	

Click to add a risk

Please include all areas for commendation/good practice worthy of sharing more widely.	**Staff Group/Learners/Speciality**	**Describe the areas for commendation**	**What are the exceptional outcomes/good practice demonstrated by this?**
Area for commendation 1	Non-medical students	Multi-professional preceptorship programme	Led by a multi-professional working party with excellent feedback from newly registered staff. Attended by acute and community based practitioners.
Area for commendation 2	All professional groups	Health Ambassador programme	Interaction with 786 school and college students since April 2017. Shadowing, work experience, work placements and insight events available within the Trust
Area for commendation 3	Adult Nursing	Active recruitment process in place	Increased newly qualified interest from HEIs, overseas recruitment plan with dedicated suppport from an OSCE preparation nurse funded via the non-medical tariff. Increased applications from Access to Nursing programmes following provision of insight days to students
Area for commendation 4	Medical Trainers	All are recognised via approved training course	We hope this achieved the highest training standards
Area for commendation 5	Medical Foundation Trainees	Annual 'Trainee of the Year' awards	Encourages and rewards success. Awarded in PfPP by MD and CEO
Area for commendation 6	Medical Trainers and Trainees	In house senior trainee management sessions (STAMP)	Good feedback

Click to add an area for commendation

This self assessment should be inclusive of all professional groups and specialities who are responsible for supporting learner/ trainees.	
Author of the Self Assessment Return	Mr Pete Harris - Director of Medical Education Diane Last - Clinical Education Lead and Non-medical Clinical Tutor Julie Harper - District Nurse Development Lead
Approved by To be completed by organisation CEO.	
Date completed	11th July 2018

Please click this button to make a copy of the highlight summary sheet to be returned to HEE

Risk Assessment

The HEE corporate risk matrix, detailed below, will support the HEE Quality Cycle by determining the level of risk to education and training quality.

Likelihood						
	5	G	A	A/R	R	R
	4	G	A	A/R	R	R
	3	G	G/A	A/R	A/R	R
	2	G	G/A	A	A	A/R
	1	G	G	G/A	G/A	A
		1	2	3	4	5
		Impact				

Score	Likelihood	Impact
1	**Rare:** • Will probably never happen • Could only imagine it happening in rare circumstances	**Negligible:** • Very low effect on service, project or business area • No impact on patients , learners, public or staff • No reputational impact (i.e. no press interest) • No financial loss
2	**Unlikely:** • Do not expect it to happen • It is possible that it may occur	**Minor:** • Minimal disruption to service, project or business area • Limited impact on patients, learners, public or staff • Minimal reputational impact • Limited financial loss
3	**Possible:** • Might occur • Could happen occasionally	**Moderate:** • Moderate impact on service, project or business area • Moderate level of impact on patients, learners, public or staff • Medium level of reputational impact • Medium financial loss
4	**Likely:** • Will probably happen in most circumstances • Not a continuing occurrence	**Major:** • Major effect on service, project or business area • Major level of impact on patients, learners, public or staff • Major impact on reputation (i.e. major press interest) • Major financial loss
5	**Almost certain:** • Expected to happen • Likely to occur in most circumstances	**Significant:** • Loss of service, project or business area • Detrimental effect on patients, learners, public or staff • National press coverage • Significant financial loss

Further information on what evidence is expected to demonstrate quality is available in the HEE Quality Framework

Board Meeting – September 2018

Agenda item:	WSFT Library Annual Report April 2017 to August 2018			
Presented by:	Denise Needle			
Prepared by:	Laura Wilkes			
Date prepared:	8th August 2018			
Subject:	WSFT Library			
Purpose:	√	For information		For approval

Executive summary:
A summary of the main service developments, innovations and positive impact of the Library and Information Service April 2017 to August 2018. A description of how we achieved 100% full compliance with the Health Education England Library Quality Assurance Framework. How the Library is expanding services to Community staff to ensure equity of access to resources and expertise and meeting the challenge of increased student numbers across all staff areas.

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:	*N/A*
Risk and assurance:	*N/A*
Legislation, regulatory, equality, diversity and dignity implications	*N/A*

Recommendation:

- *A presence at meetings with senior leaders responsible for medical education, in line with current contact with Co-Medical, Nursing Directorate and Workforce leaders.*

WSFT Library Annual Report 2017/18

This report covers the period 1st April 2017 to 31st August 2018.

The Library and Information Centre is referred to as the Library, West Suffolk Foundation Trust as WSFT, Health Education East of England as HEEoE.

The primary drivers for the Library service are:

Our patients, our hospital our future, together – West Suffolk NHS Foundation Trust Strategic Framework for the Future (published July 2015)

The Library Strategy 2016-2020

*Knowledge for healthcare: a development framework for NHS library and knowledge services in England 2015 – 2020 (*published by Health Education England 2015)

The Library has achieved 100% full compliance with the required criteria in the annual HEEoE Library Quality Assurance Framework (LQAF) since 2015 and, as a result, had five core criteria to satisfy in the LQAF covering the period 2017/18.

In 2018, one of the criteria was altered and this Report will also address the current requirement to demonstrate: ***There is a designated board member accountable for the library/knowledge service with a clear 2-way communication process with the library/ knowledge service manager.***

This Annual report will concentrate on those five areas and demonstrate how we have met these requirements and aligned our service to Ambitions 1, 2, 3 and 7 of the Trust ambitions.

LQAF Criteria

1. Library/knowledge services are developed to support information provision for the patient and/or the public **(Ambition 1 deliver personal care).**

2. The positive impact of library/knowledge services can be demonstrated **(Ambition 2 deliver safe care).**

3. Library/knowledge service staff support clinical and management decision-making **(Ambition 2 deliver safe care).**

4. The library/knowledge service works in partnership with other organisations and agencies across the local health community to modernise and develop services to meet customer needs, expectations and choice **(Ambition 3 deliver joined up care).**

5. Members of the library/knowledge services (LKS) team are actively involved in the creation, capture, sharing, utilisation or reuse of knowledge in the organisation(s) served **(Ambition 7 support all our staff).**

6. [2018] There is a designated board member accountable for the library/knowledge service with a clear 2-way communication process with the library/ knowledge service manager.

1. Information provision for the patient and/or the public

At times this has proved problematic for the Library, as we are not funded or commissioned to provide a public health library service, and some of this work impinges on work already carried out by PALS. However we have sought to stage events and provide resources that supplement the work of PALS and other patient services, and it is possible to trace a clear link from the work we do, in particular evidence synthesis and summaries, to changes in clinical practice that directly affect patient care and safety.

- We have a comprehensive list of resources for patients and the public on our website.

- Working in partnership with Suffolk Libraries, in 2018 we negotiated the delivery of 19 boxes of children's and baby books to be delivered, free of charge, to various departments in the hospital and community, directly benefitting patients and their families..

- We regularly stage health information displays in the Library, usually linked to national health awareness days/months which we publish on the Staff Health, Wellbeing and Diversity Calendar. Patients are encouraged to visit the Library and view the displays.

2. The positive impact of library services

We have selected three areas to highlight the positive impact of library services and highlighted some of our achievements in 2017/18.

The Embedded Librarian Service – since its inception as a pilot scheme with Speech and Language Therapy in 2016, the ELS has expanded to cover all Integrated Therapies. The ELS embeds a librarian into therapy teams to undertake the following:

- attend in-service meetings
- support departmental journal clubs
- assist with research projects, including collation of audit evidence
- contribute to articles for publication and support publication by staff
- capture, share and utilise knowledge by facilitating Knowledge Cafes
- support research by delivering Critical Appraisal and Excel for Audit training customised for departments
- assist in the production of conference posters, including producing a conference poster about conference posters, with funding from the Co-Medical Education Committee

The ELS has further expanded to encompass support for:

- the Co-Medical Education Team, particularly in connection with support for nursing and AHP students
- the Transformation Team through co-ordination of Freedom to Improve.

The reach of the Library has also extended through our attendance at four key co-medical meetings

- The Co-Medical Education and Training Committee
- The Nursing and Midwifery Council
- The Pre-Registration Educator's Forum
- The Apprenticeship Levy

The next stage for the ELS is to expand into Community locations. This requires careful planning to utilise staff and resources as efficiently as possible. To aid this process, we took advantage of QI Training in January and April 2018 and we are using Life QI to develop a model for Community provision.

We surveyed all Community staff in March 2018 and analysis of those results shows a mixed picture of both awareness of library services and the type of service required. We have visited four Community sites so far:

- Haverhill Health Centre
- St Helen's House
- Child Development Centre
- Disability Resource Centre

These visits enable us to gather information about the type of service which is required and which we can realistically offer and sustain. The majority of resources we are able to offer will be online, but our visits have emphasised how much Community staff value and welcome a personal library service, and there is still an appetite for hard resources, such as books.

Appendix 1: Provision Maps for ELS and Core Library Services; Impact quotes.

The AHP Showcase

This event took place in February 2018 and showcased 37 conference posters designed by AHP teams at the hospital and from the community, and from the ELS. This was the largest showcase event ever staged at WSFT.

The purpose of the event was to showcase the excellent work and innovations undertaken by our Allied Health Professionals.

In total, 91 people attended the Showcase and teams were available to talk about their innovations. This could not have been achieved without the full support of the Therapy Team Leads.

The Library planned, organised and hosted this event and provided intensive support for conference poster design, which was extended to assist the first QI Conference at the Trust in April 2018.

Prior to and during the event we created the hashtag *#AwesomeAHPs* and tweeted regularly to promote the Showcase. We collated those tweets into a timeline of the event, here.

Post-event, we continue to share and disseminate these innovations internally by rotating displays of the posters in the Education Centre on a weekly basis and externally by sharing the posters and abstracts on our website

Demand for assistance with conference poster design continues to accrue and, to date, the Library has assisted in the design and creation of 40 conference posters in 2018.

A similar event for nursing staff is planned for the summer of 2019.

Appendix 2: Survey results and analysis for AHP Showcase.

Enhanced support for students in training

As part of our analysis of usage trends in recent years, we noticed an increase in the number of students, primarily from the University of Suffolk, accessing our search training and requesting assistance with academic skills, such as essay writing, research and critical appraisal.

Whilst we see student support as an integral part of our service, the type of support requested has veered more towards student tuition rather than support. Given that staff recruitment and retention in the NHS is a challenge, working with the Education Team, we have developed an enhanced student support/tuition service. This includes –

- a new course on academic writing, plagiarism and citing and referencing
- support for students wishing to get published or to present at Conference
- a comprehensive and updated range of resources to support study skills in a prominent location in the Library

As student numbers increase from the University of Suffolk and the University of East Anglia, and the Nursing Apprenticeship is rolled out across the region, we expect this service to expand.

We carry out an annual induction for medical students each September and in 2017 we introduced Library Bingo to make the sessions more interactive and enjoyable. As with nursing, we increased our stock of books suitable for medical students and displayed these prominently in the Library.

3. Library support for clinical and management decision-making

There are four main ways that we support clinicians, managers and administrative staff in their decision-making:

- The provision of articles and books to support the evidence base
- Carrying out comprehensive evidence searches, synthesising the results, which saves staff a lot of time, and producing a short summary of the main points ready for dissemination to other groups
- Encouraging staff to register for KnowledgeShare evidence updates, a tailored fortnightly evidence alert on an individuals' area of interest
- Tailoring our own current awareness bulletins to key Trust meetings – the Health Management and Innovation Update is aligned to the Core Brief and the Nursing Current

Awareness is aligned to the Nursing and Midwifery Council meetings. This enables us to deliver a broad range of evidence on related topics, but also to feature topics which are of particular relevance to the Trust, e.g. the Buurtzorg Nursing Model, the SAFER bundle, Red to Green.

Our KM expertise has enabled us to deliver two Knowledge Cafes linked directly to healthcare reports and a Peer Assist to aid NHS librarians to use data more effectively to demonstrate impact.

Appendix 3: Feedback from Knowledge Cafes and usage data for evidence searches.

4. Working with other organisations and agencies across the healthcare community

There are three main areas of partnership working:

- Our partnership with UNISON Suffolk Area Health Branch
- Our partnership with other NHS Library and Knowledge Services and Higher Education providers, as expressed in the Norfolk and Suffolk Partnership Working Group (which includes our individual work with Suffolk Libraries and the University of Suffolk)
- Our partnership with a commercial organisation with a remit to support global literacy schemes, Better World Books

Laura Wilkes (LKS Manager) and Helen Else (Deputy Librarian) are Union Learning Reps (ULRs). Laura is also the Branch Education Coordinator.

The ULRs ran a trust-wide Learning Survey in February 2017, open to all staff as well as UNISON members, to ascertain what type of learning staff wanted. The survey identified three main areas of learning – IT skills, numeracy and literacy skills.

As a result, we ran the Reading Ahead Challenge over the summer, with 87 participants. We were featured in a TUC Case Study https://www.unionlearn.org.uk/case-studies/reading-ahead-west-suffolk

In July 2018 we facilitated a one-day workshop, Essential Digital Skills, in partnership with the Workers Education Association (WEA) and open to all staff at WSFT. A proposal to offer a full Functional Skills course as well as a Community Translators course (to aid in the translation of information by qualified, home-grown translators) via the WEA is currently being drafted.

We have entered into a Memorandum of Understanding encompassing NHS LKS, public libraries and HE institutions across Norfolk and Suffolk. We have collaborated with Suffolk Libraries to promote their resources and their focus for 2017 on mental health. We updated our Library website with resources and links to Suffolk Libraries resources and events, and we regularly Tweet about their events, workshops and resources.

We also updated our links to student support via the University of Suffolk to aid in the increase in demand from students for academic support from both NHS and HE libraries.

Better World Books (BWB) is a commercial organisation which recycles and/or re-sells books. Our agreement with BWB ensures that any books in reasonable condition can be deposited at the Library in the knowledge that they will either be resold, with a proportion of the proceeds returned to the Library as a small income, or recycled into animal bedding.

We reinvest any income earned into Mood Boosting books or resources to support staff health and wellbeing.

We nominated the National Literacy Trust as the recipient of a proportion of our sale proceeds.

The benefit to Library users is that stock is disposed of at no cost to the Library creating space for new books, the Library has aided recycling in the Trust and staff can be assured that their donations are helping to support literacy in the UK.

5. **Capturing, sharing, organising and utilising knowledge across the Trust and community**

Our KM activities, as detailed under section 3 describe our impact in this area.

In addition, we coordinated the log for Freedom to Improve during 2016 and 2017 and we support our QI colleagues at WSFT to capture innovation and disseminate knowledge. Responsibility for the Freedom to Improve log has now passed to our QI colleagues, but we continue to assist with evidence searches when required.

The Library is responsible for populating the Trust Health and Wellbeing and Diversity Calendar.

The AHP Showcase presented an opportunity to share the innovative practice of our AHPs across the Trust and externally.

6. **There is a designated board member accountable for the library/knowledge service with a clear 2-way communication process with the library/ knowledge service manager**

Our communication with the Board takes place in both formal and informal settings. It is part of the culture at WSFT to have an open and inclusive approach, and the Library takes full advantage of the many informal opportunities to communicate with Board members, particularly via our Twitter feed.

The formal meetings that we attend, in particular Nursing and Midwifery Council, Co-Medical Committee, Pre-Registration Educator's Forum and Apprenticeship Levy, enable us to play a full part in trust-wide issues as well as supporting staff and Board members by carrying out evidence searches and providing information.

It is apparent from our usage data that our main users are Nurses and AHPs and this trend has increased since we became involved in the formal meetings outlined above.

The Library aspires to serve all staff at WSFT equitably, and it would be of direct benefit to medical and surgical staff if the Library gained access to medical education committees or established regular contact with senior leaders responsible for medical education.

Customer satisfaction and usage

Our latest general library survey reveals that our greatest asset is ourselves – the Library staff. Our expertise, knowledge and helpfulness are highly valued. The usage data in appendix 4 provides a clearer picture of usage trends and preferences.

Core Library Services

We continue to offer core library services such as book loans, articles, print and e-journals, as well as binding, laminating and photocopying/printing services. However, the nature of information retrieval is in a state of flux and rapid development, and we respond to those changes with

innovative service delivery, such as the ELS and enhanced student support. If staff cannot come to us, then the Library will go to them.

It is a mistake, however, to believe that ‘everything is on the internet now’ and freely available. A lot of content still remains behind pay walls and NHS librarians undertake a considerable amount of ‘hidden’ work seeking the best online resources at the best value for money in extremely challenging financial conditions.

Future service development

Our achievements and service development in 2017/18 lay the foundation for a further expansion of Library services into Community locations in 2018/19.

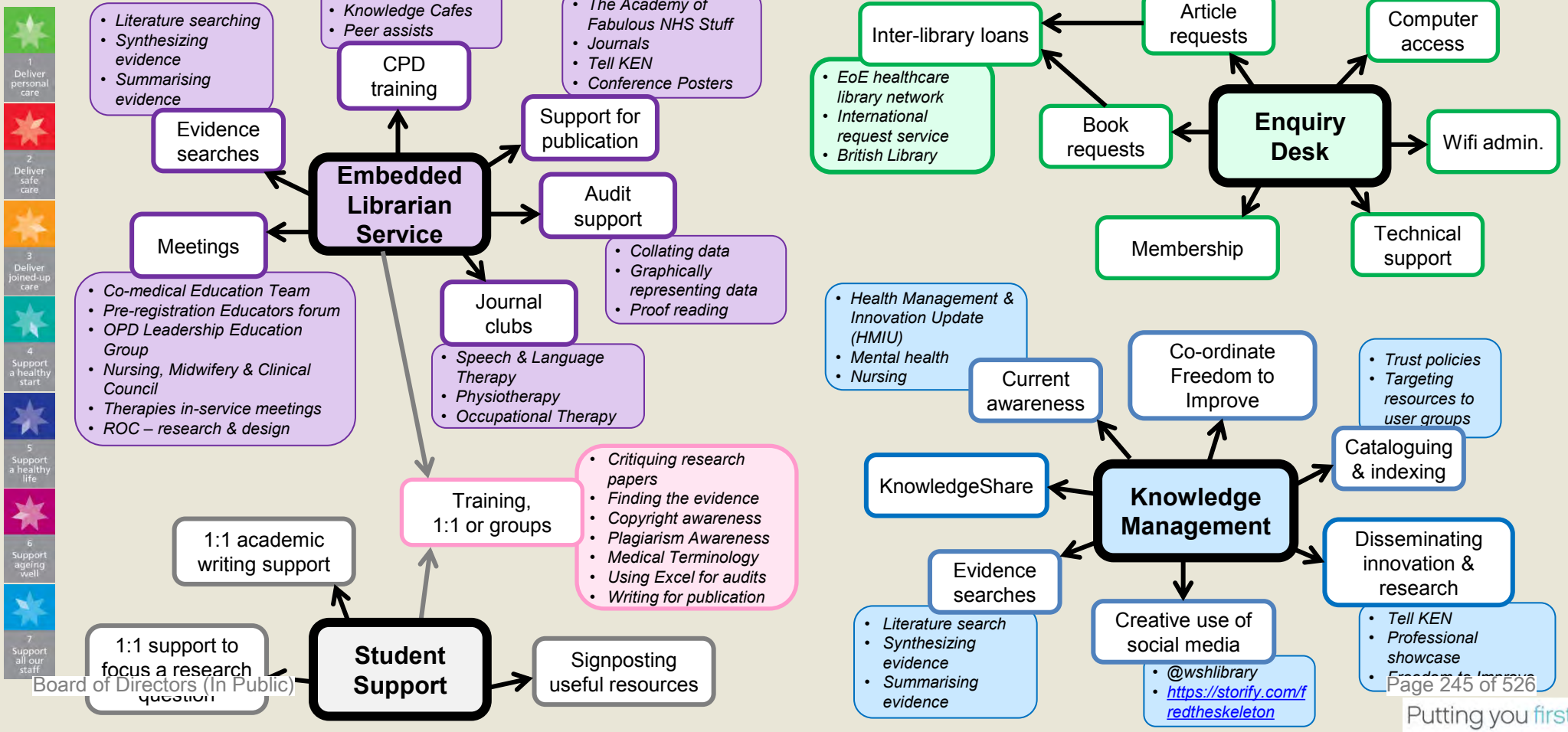
Our ambition is that by the end of 2019 every Library team member will have a professional library qualification and/or be working towards Chartered status. This reflects the professionalization of the service which is necessary to meet the more complex needs of clinicians and staff, to innovate and to grow our expertise with technological developments.

The Library
FIRST4Knowledge
West Suffolk NHS Foundation Trust

NHS
West Suffolk
NHS Foundation Trust

Library Provision Mapping: Services

"Professionally qualified experts supporting you in your role"



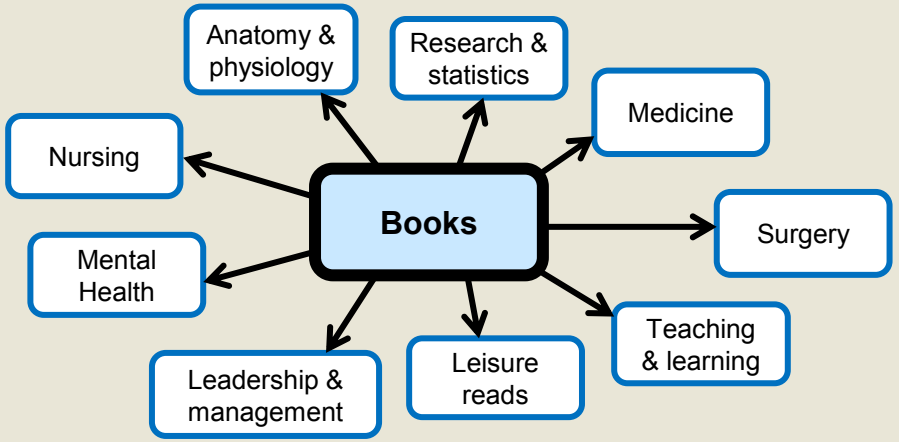
Putting you first

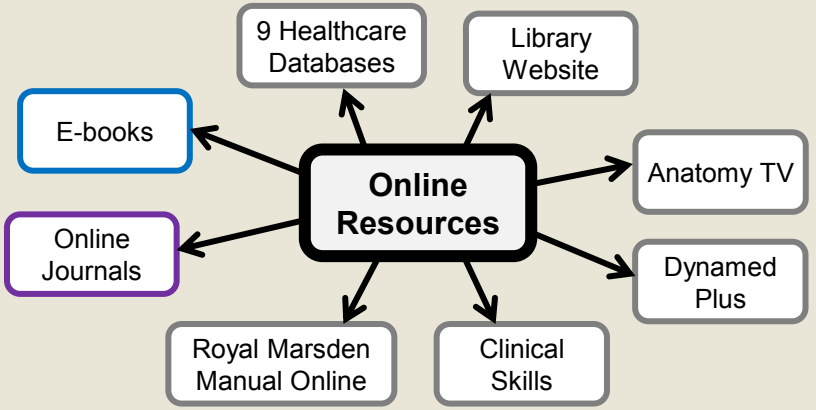
The Library
FIRST4Knowledge
West Suffolk NHS Foundation Trust

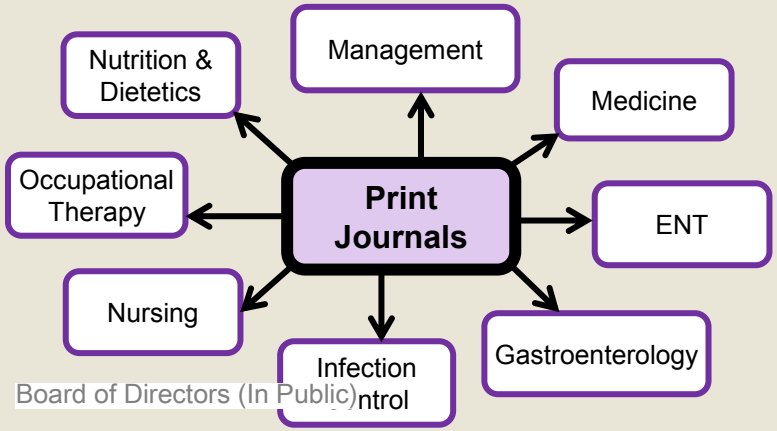
NHS
West Suffolk
NHS Foundation Trust

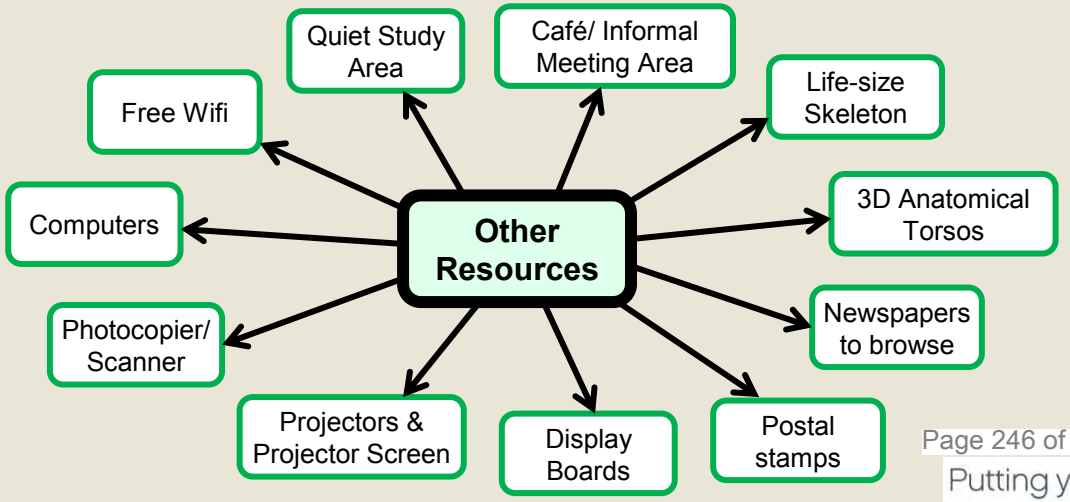
Library Provision Mapping: Resources

"Connecting you to the evidence base, 24/7"





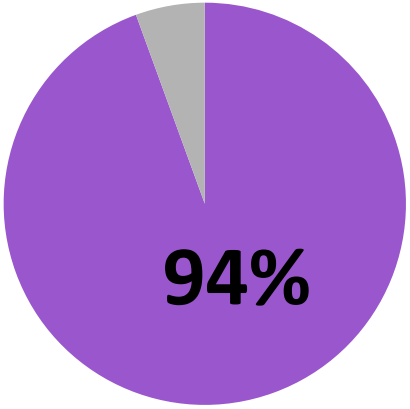




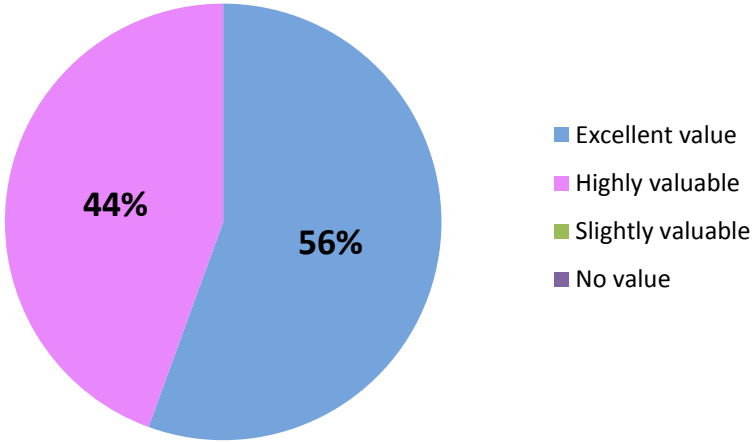
1 Deliver personal care
2 Deliver safe care
3 Deliver joined-up care
4 Support a healthy start
5 Support a healthy life
6 Support ageing well
7 Support all our staff

Pie charts

The AHP & Library Showcase raised awareness of library services by 94%

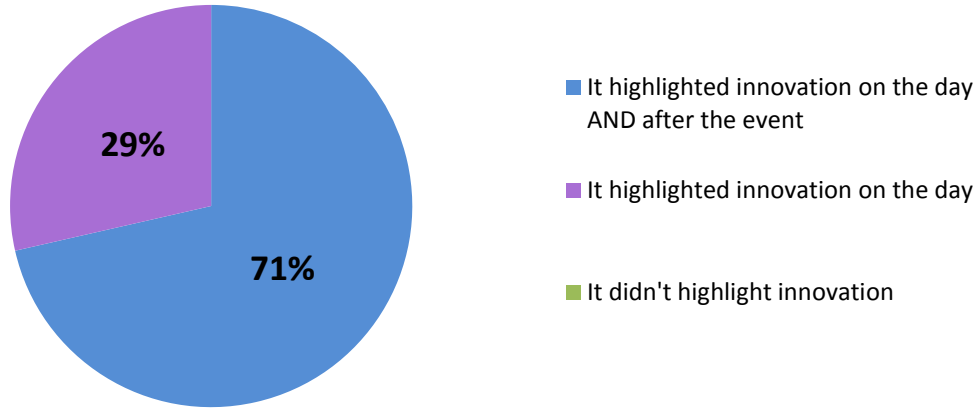


100% of respondents described the Embedded Librarian Service as either excellent or highly valuable

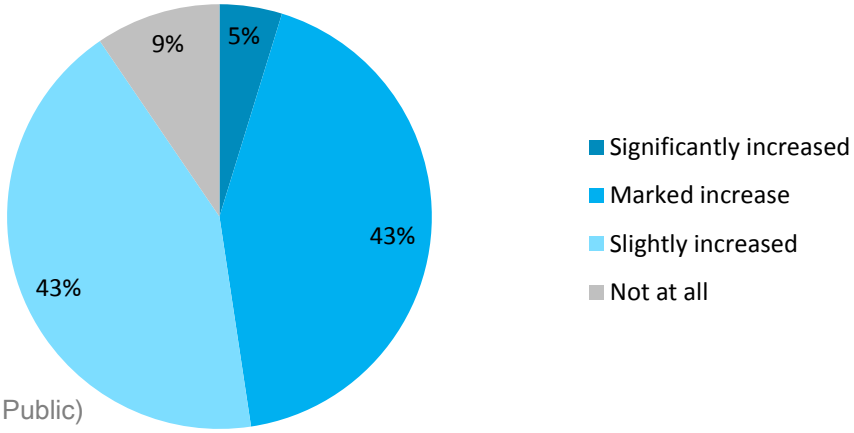


Pie charts

100% of survey respondents felt that the AHP & Library Showcase had highlighted innovation occurring within the Trust



90% of Showcase attendees felt that the Showcase raised awareness of the role played by AHPs in acute & community settings



Statements

- 100% of team leads stated that they are now more likely to encourage their team to use the Trust's library.

- 100% of survey respondents stated that when they requested information/ support, it was provided in a timely manner.

- 56% of conference poster designers said that they had reused their poster for other events following the Showcase.

AHP Showcase

The positive impact of the AHP and Embedded Librarian Service Showcase

27th February 2018

A post-Showcase survey was circulated to everyone who attended on the day, which was 90+ people. We recorded everybody's email addresses and sent the survey to them a few weeks after the event.

We have collated the responses as follows:

- Qualitative statements from the post-showcase survey

- Twitter posts via Wakelet storyline https://wakelet.com/wake/dd0886dd-81be-4612-a96e-a0dd62d29a09

- Quantative responses attached separately

Qualitative Statements

"I was impressed with the diversity and amount of entries. I think it reflects the progressive attitude of the AHPs and library at WSH and in the community."

"It was an amazing event which was very well attended, despite the snow. Lots of innovations explained through the use of conference posters and a fantastic networking opportunity for all."

"As part of the SALT team I have benefited from the embedded librarian service for some time now, from support with sourcing current research to providing a different perspective at our journal club and assisting with search methods. They [the Library] are a real asset to WSH."

"A watershed event for the AHP service"

Qualitative Statements

[in response to a question about the usefulness of the ELS] ***"they have obviously worked hard to raise their profile regarding how they can be of great help to clinical staff in a wide variety of areas - this is much appreciated."***

"a positive opportunity to see all the work that is going on amongst the AHPs which we may otherwise not have even heard about"

"It boosts morale to see in black and white the positive difference we are making. It is a boost to be able to share that positive information with our colleagues as we as see their achievements and give each other mutual support."

Qualitative Statements

"have always encouraged the team to use library services - hopefully this event has further demonstrated the value"

"The staff have a very deep understanding of academic and knowledge related processes and principles which adds a richness to clinicians roles."

"I regularly reference and recommend the ELS. I know we can make greater use of it in Physio - more work on my part to embed it even further."

Qualitative Statements

"Part of being 'outstanding' has been because we think about what we need to do well and how to do it - the library is a huge resource which can support ideas and initiate change as much as any clinician."

[in response to a question about what have they learned about the Library Service] ***"The range of services and support on offer. I am much more likely to promote the library services to my staff as a resource."***

[how did the AHP/Library Showcase benefit the team] ***"I think it encourages self/ team promotion to raise the profile of our profession. It enhances pride and motivation to improve, and to feel that our clinical input are recognised and valued."***

[what have you learned about the Library Service] ***"That they just don't provide books. The computer knowledge and support is very good."***

Qualitative Statements

"It really highlighted the different ways in which AHPs are essential in all aspects of patient care.
AHPs- as demonstrated by all the posters- see patients over time and are often instrumental in bringing about positive change."

"Amazing to see the breadth of work going on. I was not even aware of some of the work close colleagues were involved with. Fantastic."

"It taught us valuable lessons in how to stage such a large event and we have been able to share that knowledge and expertise with colleagues in the trust."

Qualitative Statements

"Brilliant it raised the profile of AHP and the OT profession with the benefit of having the viewing from a senior level audience with the 5 o'clock club."

"That they can assist with conference posters! Also opened the doors to other services such as the knowledge share café."

"Engaged and motivated the staff to be able to produce a poster and reflect on the work they have achieved. It has raised confidence with showcasing their work and has opened the conversations about how else they can raise the profile, evidence their clinical work and how enjoyable it is also to receive positive feedback and discussion."

Qualitative Statements

"Made juniors aware of how other services provided by AHP s can benefit their patients. Also made them more aware of the role of the community and our links within a patient's pathway during healthcare."

"Fantastic event enabling AHPs to showcase their innovative work. Opportunity for staff to network across the alliance breaking down the artificial barriers we create. Realisation of the what a library service is able to do. In this case facilitate and support therapists to put on and produce a great poster event."

Qualitative Statements

"Clinical time is a limited resource and the embedded librarian service can enable efficiencies by facilitating clinical group discussions, events, training to support clinical practice, research of relevant clinical material.....the list goes on. The skill set of the ELS is a message that must get out to support the change needed in clinical care."

Knowledge capture at West Suffolk Foundation Trust

Embedded Librarian Service in Integrated Therapies at West Suffolk NHS Foundation Trust

The Embedded Librarian Service (ELS) has worked as part of Integrated Therapies since 2016. The ELS aims to place a Librarian into a therapy team to locate, collate and share knowledge at the point of need. This usually takes the form of attending in-service meetings and supporting journal clubs, helping to collate audit data and producing evidence briefings from detailed and synthesised evidence searches.

But there is a secondary service we provide, to help teams share, organise and utilise tacit knowledge and experience, through the facilitation of Knowledge Cafes and Peer Assists. Using these simple, informal Knowledge Management tools, we diffuse knowledge among teams and departments. share innovation across wider networks in the Trust and promote the expertise and experience of our teams across the NHS.

Integrating Acute and Community Speech and Language Therapy Teams

We used a Knowledge Café to promote integrated working between acute and community Speech and Language Therapists.

The Café brings together a group of people to have an open and creative conversation on a topic of mutual interest to bring their collective knowledge to the surface, share ideas and gain a deeper understanding of the issues. The purpose of the conversation is to lead to action in the form of better decision-making and innovation.

It was the first time many of us had met members of the different teams and the knowledge café was a fantastic way for us to get to know each other whilst also considering ways we can better work together. Your facilitation and explanation of the process were excellent.

The knowledge café had a huge impact on the staff that attended – they report gaining a wealth of knowledge and experience from other colleagues. It also had positive reinforcement of the clinical reasoning they do on a day to day basis boosting confidence in their roles.

Using conversation to underpin 'Embracing Risk, Enabling Choice'

The Royal College of Occupational Therapists issued guidance to practitioners about managing risk and enabling choice for patients and their families.

The ELS facilitated a Knowledge Café to explore various themes around managing risk when discharging patients, including reflection on the ethos and attitudes around 'permission to fail', innovation and learning.

Impact

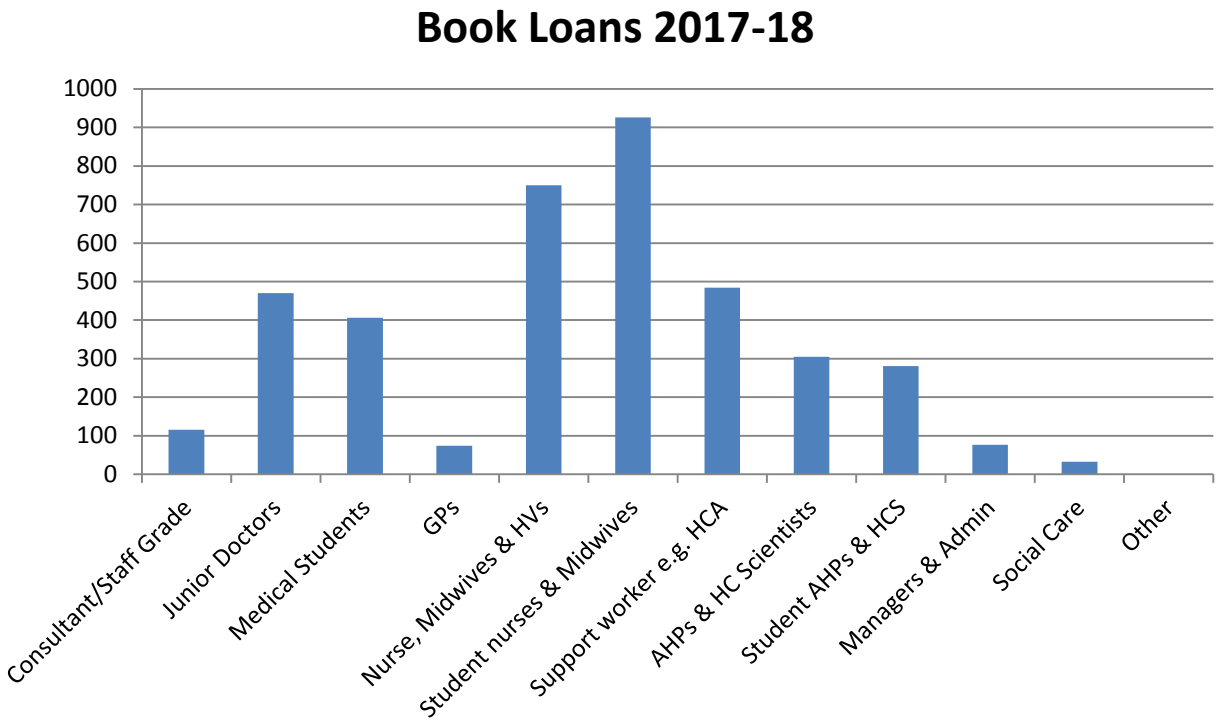
"The impact of the embedded librarian project for SALT has been huge – and is a model that my therapy colleagues are keen to replicate. Providing safe evidence based clinical care is central to our role and this project has enhanced our ability to do this significantly."

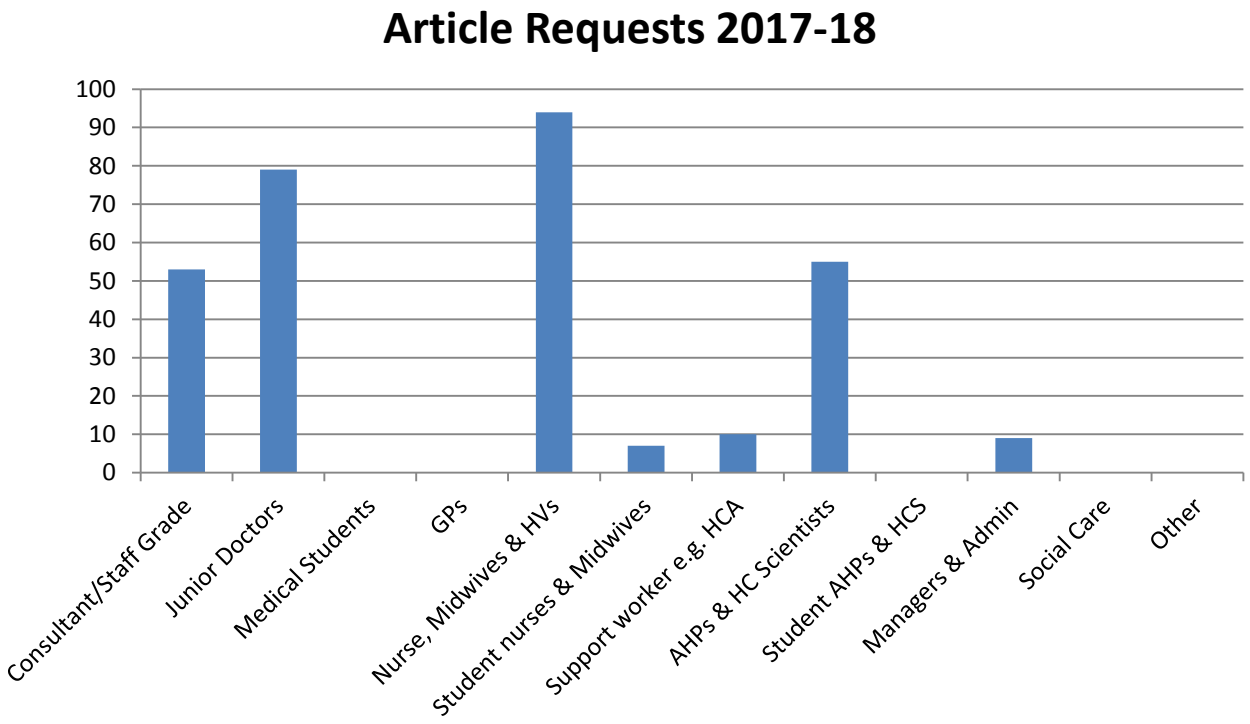
Liza Asti, Professional Lead Speech and Language Therapy

References

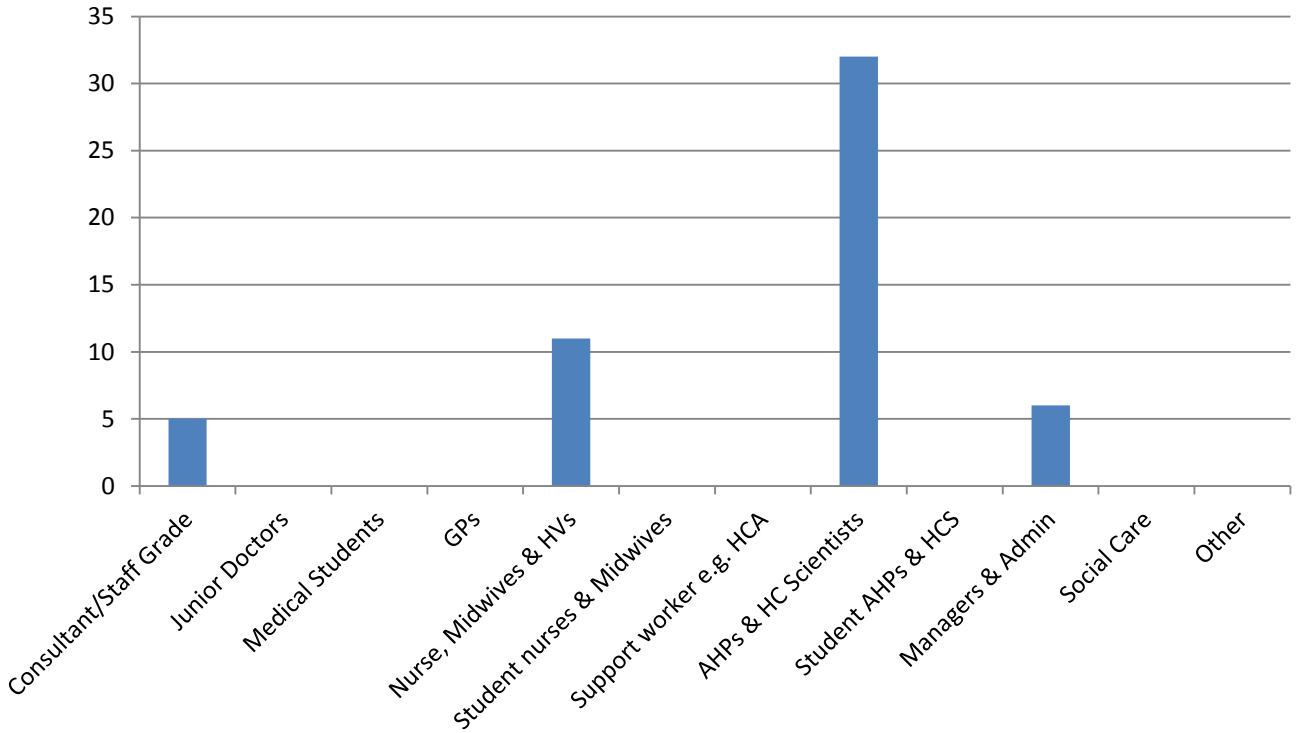
- HEE (2015) Knowledge for healthcare: a development framework https://hee.nhs.uk/sites/default/files/documents/Knowledge%20for%20healthcare%20-%20a%20development%20framework.pdf [Accessed 8.2.18]
- RCOT (2017) Embracing Risk, Enabling Choice: Guidelines for Occupational Therapists https://www.rcot.co.uk/practice-resources/rcot-publications/downloads/embracing-risk [Accessed 8.2.18]
- NHS England (2017) AHPs into Action: Using Allied Health Professionals to transform health, care and wellbeing. https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf [Accessed 8.2.18]

Library usage stats

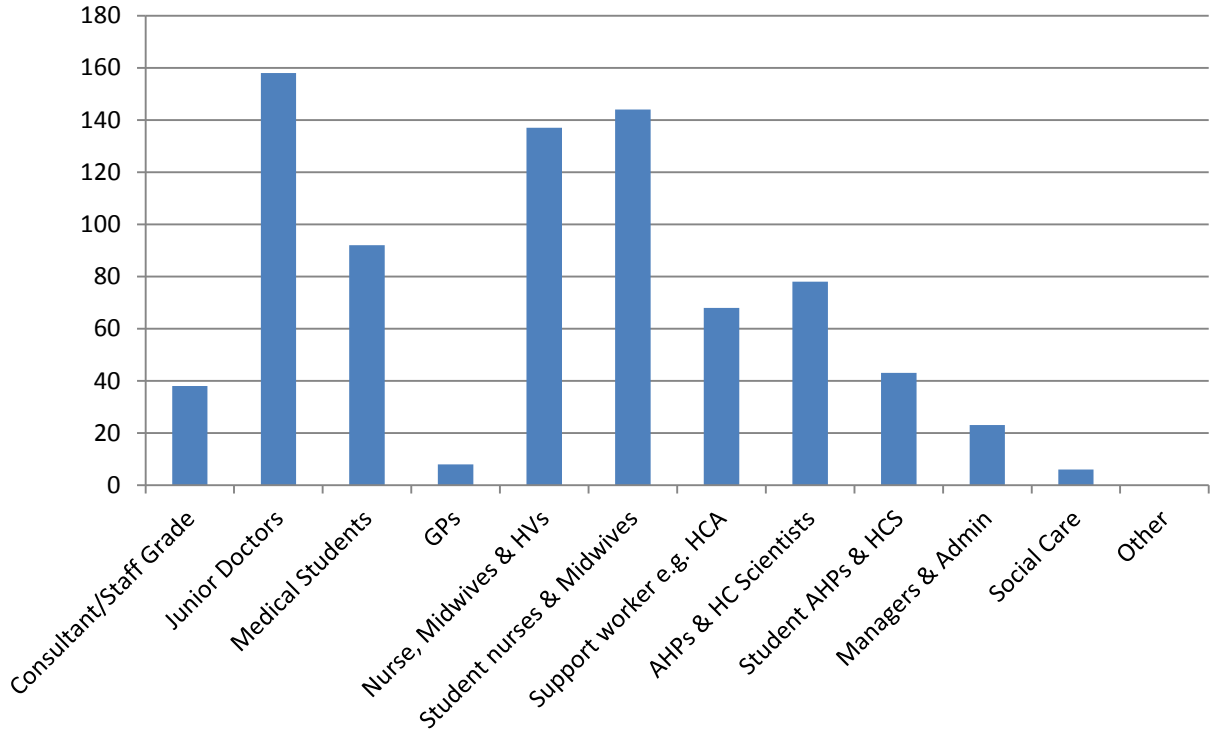




Evidence Searches 2017-18



New Users 2017-18



Positive Impact of Library Services - Quotes

- Evidence searches
- Knowledge Cafes
- Embedded Librarian Service
- Library Staff
- Patient Care
- Twitter
- Training
- Support for Publication
- Support for Overseas Nurses
- Royal Visit

Evidence search (patient care)

The Library provided us with an evidence summary and a synthesis about the benefits of swimming for disabled children. We were asked for the evidence by the special school that we work in, as a group of parents is fund raising for an accessible pool to be built at the new school site. We passed on the information to the group so that they could use it as evidence to support funding applications and more generally to spread the word about the benefits of swimming. Having the information enabled us to work collaboratively with the school and the parents and share information. The search highlighted some public health benefits, such as the propensity for disabled children to be overweight, which was not something which we had thought about, but which will give added weight to the group's case.

Hilary Whitwell
Children's Physiotherapist
West Suffolk Community Services

Evidence Search

"Areas impacted on:
Professional development, research and clinical decisions. I would also say integrated working

Impact: encouraged closer working between midwives and physio. This info provided midwives with information to change clinical practice on the birthing unit as it was felt old practices were still continuing, potentially having a negative impact on patients."

Zoe Noble
Senior Physiotherapist and Health Coaching Trainer

Knowledge Café

The knowledge café had a huge impact on the staff that attended – they report gaining a wealth of knowledge and experience from other colleagues. It also had positive reinforcement of the clinical reasoning they do on a day to day basis boosting confidence in their roles.

Lucy Whent, Clinical Specialist Occupational Therapist (2018)

Embedded Librarian Service

I would say Laura has been a really wonderful advocate for the multifaceted role of health librarian – she is proactive, professional and hugely knowledgeable. She has helped us to understand how knowledge never stops underpinning the work we do, in so many guises. The innovation in this is the embedded librarian role and the way she has brought the library service out into the front row.

Rosie Finch
Professional Lead
Physiotherapy

Embedded Librarian Service

From a small seed of a discussion about embedding librarians in a car park to the fantastic project that is Embedded Librarians!! Laura has tirelessly driven this project from the small pilot of SALT to where we are now – she has made the library accessible to my staff, she (ably assisted by Helen and Beverley) has led and taught by example – our journal club has been transformed and our in-service now more coordinated – the article searching service is great and also staff feel more empowered to be independent in their searches and critical appraisal.

Laura has been extremely supportive in a time of change and a listening ear – she and the team have helped us with various events working towards integration – knowledge café – away day, and always sharing new ideas and her passion for all things library shines through.

Liza Asti
Professional Lead
Speech and Language Therapy

Library Staff

The willingness of the staff to help you. I cannot fault this. Over the past 15 years of me using this service the team have consistently gone above and beyond what I have asked, always in the interests of optimising best quality care for our service users. Service wise, I most value the article request service, evidence searches.

Respondent of Library Survey 2018

Patient Care

The library supports me to provide optimal care for my patients. It helps me to stay on top of the current evidence base and it helps me access information I wouldn't otherwise know how to access or have time to access. A totally invaluable service which is the best it has ever been. Much appreciated.

Respondent to Library Survey 2018

Rosie Finch
@rosiefinch111

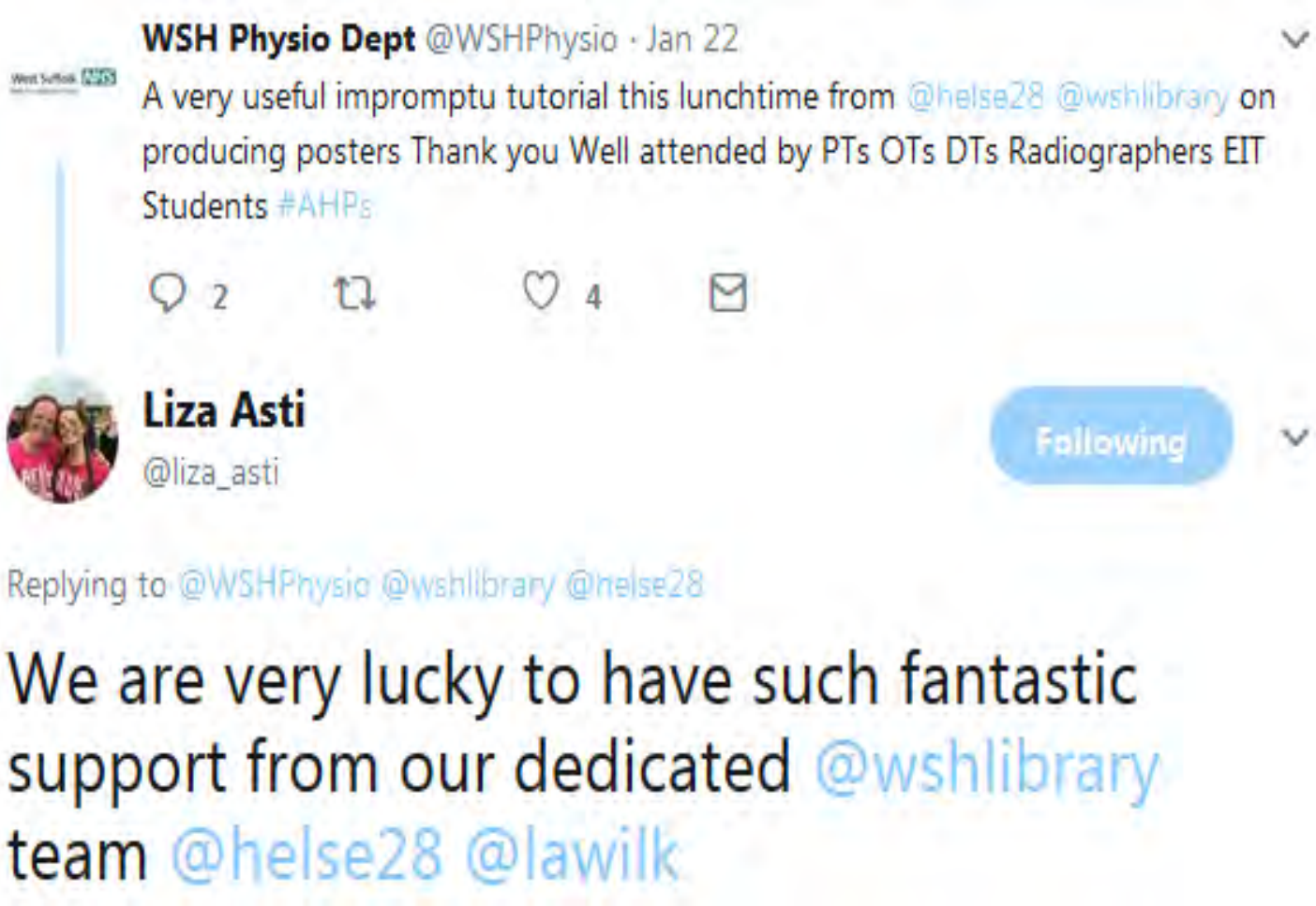
Following

And this @lawilk is all the proof you need that #librarians are integral to #NHS Writ large for all to see at the outstanding @WestSuffolkNHS Also add that Dr Siklos has championed #MDT working for years!!!

Prof Dr Steve Dunn @SteveDunnCEO

Fantastic lecture by the esteemed Dr Paul Siklos, father of our Cambridge Graduate Course, who in marking his retirement has placed an inspirational quote by William Osler, one of the fathers of modern medicine, at the heart of our education centre to inspir...

Training


WSH Physio Dept @WSHPhysio · Jan 22
A very useful impromptu tutorial this lunchtime from @helse28 @wshlibrary on producing posters Thank you Well attended by PTs OTs DTs Radiographers EIT Students #AHPs
2
4
Liza Asti
@liza_asti
Following
Replying to @WSHPhysio @wshlibrary @helse28
We are very lucky to have such fantastic support from our dedicated @wshlibrary team @helse28 @lawilk


Liza Asti
@liza_asti
Following
Always good to start a/l on a massive high - new project gets the go ahead and received the best ever evidence search from @lawilk @wshlibrary - love working @WestSuffolkNHS
6:16 PM - 2 Aug 2018 from Kesgrave, England
3 Retweets 11 Likes
1
3
11

Support for Publication

" The support of Laura and the library services team has given me renewed enthusiasm to continue with my project work. Knowing I can discuss problems, get advice and help with evidence based research has helped to reduce the pressure of writing up my findings. I never thought I would have the confidence to write an article for publication, however I am now planning to do this with Laura's help".

Michelle Buono
MacMillan End of Life Education Nurse
July 2018

Support for Overseas Nurses

"I just wanted to thank you and your colleagues at the library for your support with the first cohort of nurses from the Philippines.

They have fed back to me that they found it so useful. They have particularly said that the information provided will be so useful in future training and study.

Thank you so much for making such a big impact on these nurses already."

Ali Devlin
Clinical Practice Facilitator
Supporting Overseas Nurses
July 2018

Royal Visit

"We can all hopefully relax now after such a positive and successful visit from HRH and the Royal College of Occupational Therapy today.

Lisa and myself are so grateful for all the support that you and your teams gave to make it the success it was. We never envisaged the magnitude of preparation required and would have been left floundering without all of your input. To note just some of the departments that supported us , security, porters, communications, housekeeping, catering, facilities and library.

We now have the lasting memories of the visit with the cleanest and brightest department with the most pleasant smelling toilet in the Trust!"

Gylda Nunn
Integrated Therapies Manager

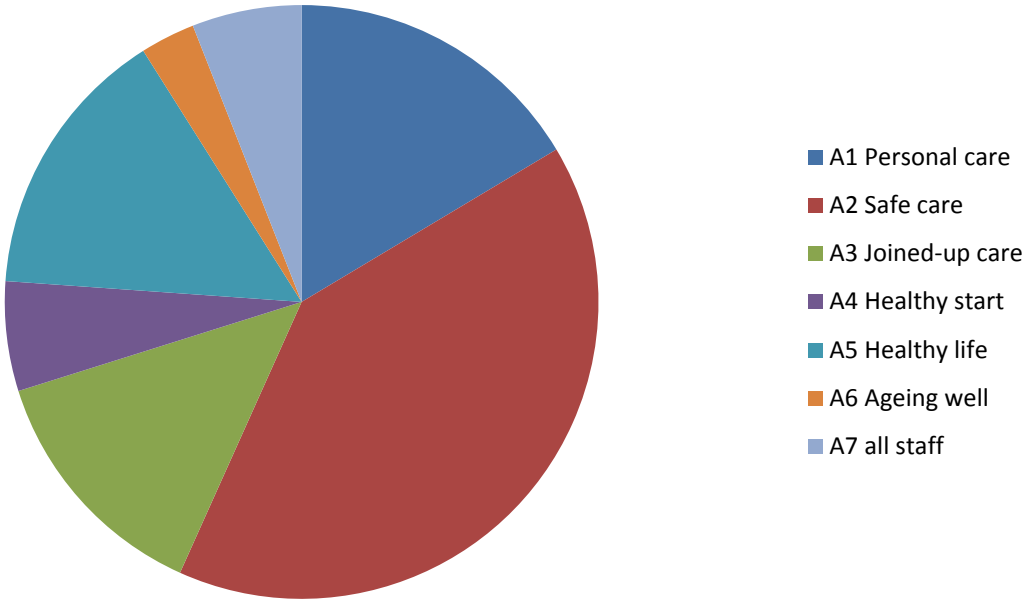
Response from CEO Professor Steve Dunn

"A great team effort by a great team in a great hospital. Everyone did us proud. That's the West Suffolk Way. Thanks all."

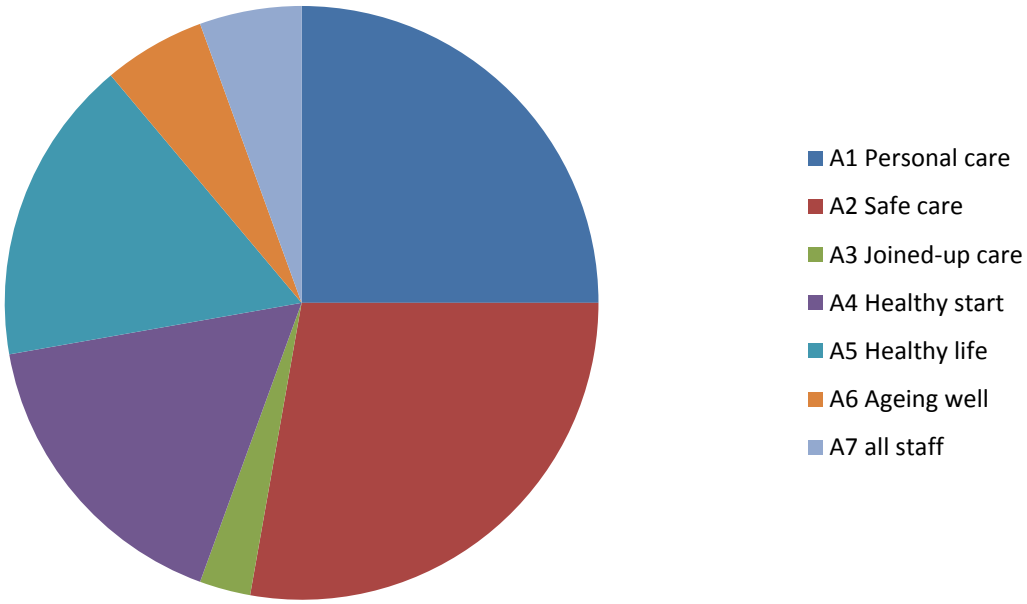
Steve Dunn
CEO
West Suffolk NHS Foundation Trust

Literature Searches
April 2017 – August 2018

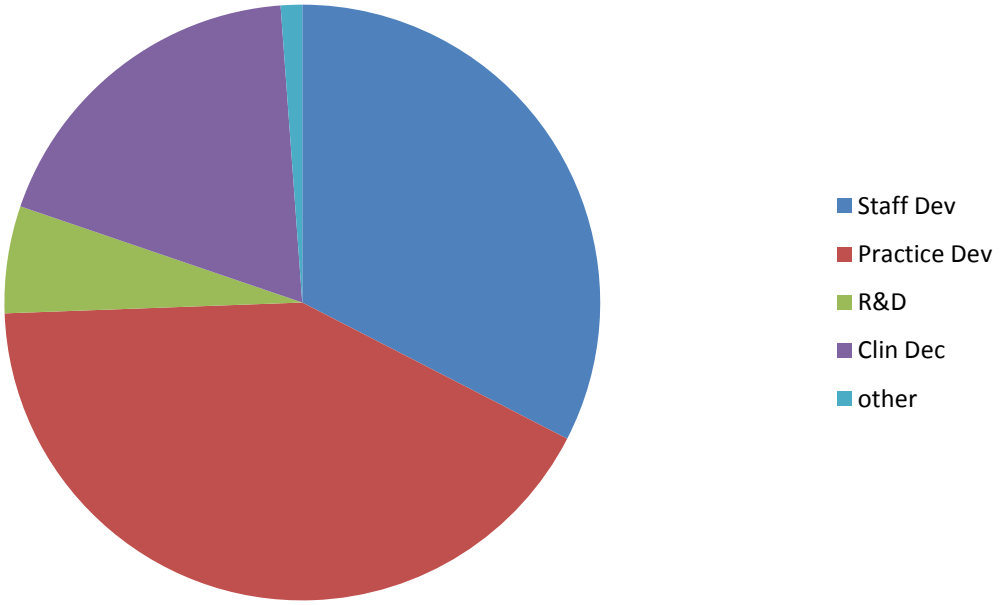
Ambitions Searches Apr 17-Mar 18



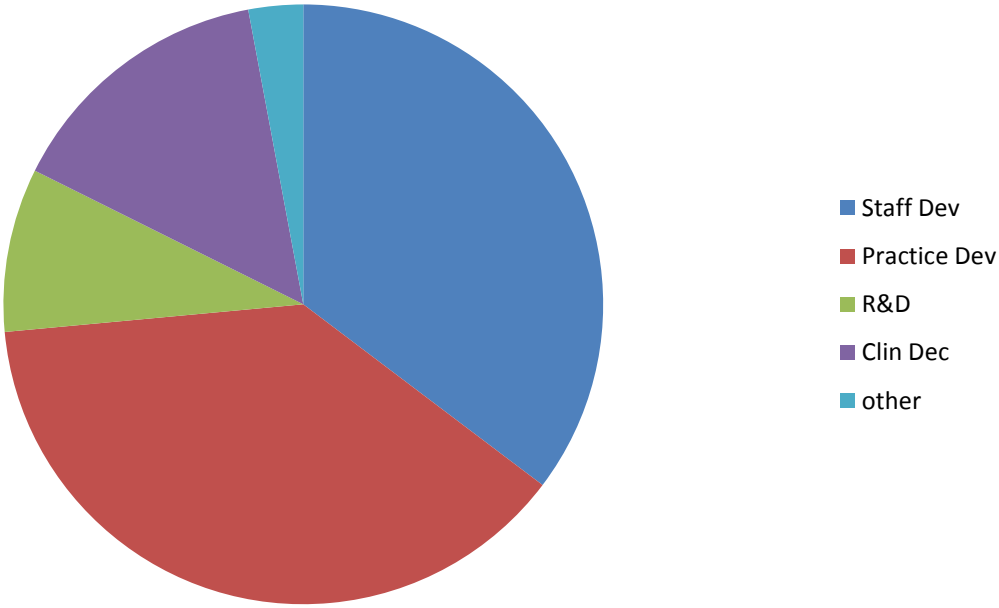
Ambitions Searches Apr-Aug 2018



Other Catagories Apr 17-Mar 18



Other Catagories Apr-Aug 2018



16. Annual reports:

16.1. Equality and diversity annual report

For Report

Presented by Jan Bloomfield

Trust Board Meeting – 28 September 2018

Agenda item:	16.1			
Presented by:	Jan Bloomfield, Executive Director of Workforce and Communications			
Prepared by:	Denise Pora, Deputy Director of Workforce (Organisation Development) and Ian Beck, Workforce Information Analyst			
Date prepared:	3 September 2018			
Subject:	Equality, Diversity and Inclusion Annual Report			
Purpose:		For information	X	For approval

Executive summary:
This report provides an update on progress with our Inclusion Strategy and Action Plan in support of the Trust strategic framework. It also provides assurance that the Trust is meeting the requirements of the NHS Standard Contract and equalities legislation, including our Public Sector Equality Duty.

The Trust Inclusion Strategy has nine objectives that address equality, diversity and inclusion for patients, service users, carers and staff. A two year rolling action plan is being implemented and this is overseen by the Trust Equality and Diversity Steering Group. The strategy and action plan provide an overarching framework for our local priorities and national requirements (e.g. Workforce Race Equality Standard (WRES), Gender Pay Gap reporting (GPG)).

Progress made since September 2017 includes:

- Membership of the Trust's Equality and Diversity Steering Group has been extended with eleven new volunteer members joining from across the Trust. This has resulted in a much richer mix of lived experience amongst the group's membership as well as better representation from across the whole organisation.
- A seminar was held in December 2017 to focus on LGBT+ inclusion – one action resulting directly from this was the extension of the role of Trusted Partner.
- The Trusted Partner role has been extended to include providing advice and information about any of the characteristics protected by the Equality Act based on Partners' own lived experience and expertise. Twelve new Trusted Partners have been recruited and trained. They are a key element in our efforts to tackle bullying and harassment.
- A 'staff supporters' page has been created on the intranet giving staff easy access to the full range of services available to provide support (this encompasses and extends beyond equality, diversity and inclusion issues). The Trusted Partner role is being actively promoted via 'staff supporters'.
- Unconscious bias and cultural competence e-learning are now available to all Trust staff. This has been made mandatory for those involved in the recruitment process and consultant employer based and discretionary awards.
- An audit has been carried out of the recruitment and selection process by our external auditors and an action plan agreed to minimise the risk of discrimination in the process. This plan is currently being implemented.

- An Equality Impact Assessment was carried out on the Trust policy on Employer Based Awards and Associate Specialist Discretionary Awards. The recommendations made as a result of this assessment have been adopted for implementation from 2019.
- Trust staff have been invited to express an interest in establishing networks based around the characteristics protected by the Equality Act 2010 (e.g. BME, disability, LGBT+). An initial workshop has been organised for 3.10.18 with the support of Stonewall to explore setting up a LGBT+ network. (The Trust joined the Stonewall Diversity Champions Programme in January 2018.)
- There has been regular communication about equality, diversity and inclusion issues in the Greensheet. This has included an article focussing on three members of staff from the LGBT+ community to mark Pride month in June by Tara Rose, Head of Communications.
- From 2019 there will be an Equality, Diversity and Inclusion Champion Award as part of Shining Lights. The Equality and Diversity Steering Group is drawing up criteria for the award.
- A new 'Supporting people who are trans' policy and supporting FAQ have been developed and published.
- The 'Disabled Go…' service providing detailed access information for patients, visitors and staff has been actively promoted on our website and through posters and leaflets. Details are also now given to shortlisted candidates for all posts at the Trust as part of the recruitment process.
- Orientation calendar clocks have been installed in all ward bays and clinic areas in support of older age patients, including those with dementia.
- A poster campaign 'Different Families, Same Care' is running in the Trust (WSH site, Newmarket and community) to reaffirm the inclusive service provided by WSH to patients/visitors and our staff.

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	X

Previously considered by:	n/a
Risk and assurance:	Equality monitoring processes within Workforce and Communications Directorate
Legislation, regulatory, equality, diversity and dignity implications	• Compliance with the 2010 Equality Act and Public Sector Equality Duty • Workforce Race Equality Standard included in NHS standard contract and CQC well-led domain

	• Annual Gender Pay Gap reporting is a legal requirement

Recommendation:

This report is presented for approval (including approval of our 2018 WRES report before it is published).

Annual equality, diversity and inclusion report 2018/19

Purpose of this report

The purpose of this report is:

- To update the Board on progress being made towards the development of a culture of inclusion, as a service provider and an employer, where all people are valued and respected for their individual differences as set out in our strategic framework Our patients, our hospital, our future, together' and

- To provide the Board with assurance about the steps taken to meet the Trust's commitment to comply with the 2010 Equality Act, our Public Sector Equality Duty (PSED), compliance with equality and diversity requirements of the NHS standard contract, NHS Constitution and CQC criteria.

Inclusion Strategy and Action Plan

The Trust's inclusion strategy and action plan address the requirements of and issues arising from: our strategic framework 'Our patients, our hospital, our future, together', the Workforce Race Equality Standard (WRES), the Equality Delivery Scheme 2 (EDS2), Gender Pay Gap reporting, National NHS Staff Survey inclusion issues and the Social Partnership Forum collective call to action on tackling bullying in the NHS. This approach has allowed us to develop specific local objectives as well as addressing legislative requirements and external standards.

Six equality and diversity objectives were identified in September 2017 and these have been added to as the agenda has developed over the past 12 months. Staff and the local community were consulted on the original objective. Further development and implementation has been overseen by the Equality and Diversity Steering Group. The Trust's inclusion objectives for 2017 to 2019 are:

For patients, service users and carers

- Improve the patient experience and care of older age patients (including those with dementia).

For staff

- Promote and support inclusive leadership at all levels of the trust
- Ensure the recruitment interview process is bias free
- Establish diversity network groups to provide a forum for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the trust
- Close the gender pay gap

For patients, service users, carers and staff

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

The strategy and action plan are attached at **Appendix 1**. This gives full details of the action taken since September 2017. Both the strategy and action plan are live documents evolving to address changing and developing circumstances. The Trust equality and diversity profile at 31.3.18 is attached at **Appendix 2.** Together Appendix 1 and 2 address the requirements of the PSED.

Standards and Assurance

Gender Pay Gap Report 2017/18

All employers with 250 or more employees are required by law to publish their gender pay gap each year on their own and the Government's website. The Trust published its first Gender Pay Gap report in March 2018. This showed that the mid-point salary for women was 8% lower than for men on 31.3.17. Overall men were paid almost a quarter more than women. The pay gap was caused by the Trust employing more men in more skilled, senior, higher paying jobs than women; in particular amongst senior management roles and senior medical staff. For bonus pay, using both mean and median averages men's bonus pay was just over 33% higher than that paid to women who received bonus payments. Bonus payments for gender pay gap reporting are made up of Clinical Excellence Awards and Discretionary Points paid to consultant medical staff. No other bonus payments are made to Trust staff. The reason for this gap on 31.3.17 was that more male than female consultants received the highest level (and paying) awards. This pay gap is expected to close as the proportion of female consultants with longer service increases. The Trust's 2017/18 Gender Pay Gap report was published on the Trust website in March 2018 and actions to address the issues raised are highlighted in the Inclusion Strategy and Action Plan (**Appendix 1**)

Workforce Race Equality Standard (WRES)

Implementing WRES is a requirement for NHS healthcare providers through the NHS standard contract and we are required to demonstrate through the nine WRES standards that we are addressing race equality issues in a range of staffing areas. The main issues arising from our 2018 WRES report remain those which gave concern in 2017.

- BME candidates remain less likely to be appointed from shortlisting than white candidates.
- BME staff report higher levels of bullying and harassment than white staff from both the patients, public and other staff.
- A lower percentage of BME staff than white staff believes that the trust provides equal opportunities for career progression or promotion.
- Voting members of the Trust Board remain 100% white and as such the Board is not representative of the wider workforce or community in terms of race.

On the positive side:

- BME staff are still less likely than white staff to enter the formal disciplinary process.
- BME staff are more likely to access non-mandatory training.

Actions that address WRES issues are highlighted in the Inclusion Strategy and Action Plan (**Appendix 1**). The Trust's 2018 WRES report is provided at **Appendix 3**

National Staff Survey 2017

A detailed analysis was undertaken of the 2017 staff survey by the characteristics protected by the Equality Act 2010 where possible. That is: age, gender, sexual orientation, religion, disability, and race (no data on marriage and civil partnership or pregnancy and maternity).

The overall results clearly showed that staff who are white British, heterosexual, without a disability of no religion or Christian are likely to be more satisfied with their experience of working at WSH than staff who are from an ethnic minority, LGBT+, disabled or of a religion other than Christianity.

Generally, such staff are more likely to experience:

- Physical violence from patients/service users, their relatives or other members of the public and generally they are less likely to report it than staff on average and/or
- Harassment, bullying or abuse from patients/service users, their relatives or members of the public and/or

- Harassment, bullying or abuse from managers and/or other colleagues and they are less likely to report it than staff on average
- Discrimination from patients/service users, their relatives or other members of the public and/or manager/team leader or other colleagues.

The inclusion strategy action plan has been updated as needed to take action on these issues. The full report presented to TEG in August 2018 is attached at **Appendix 4**

Performance Management

As part of the Trust's processes for equality monitoring the Workforce and Communications Directorate record all formal investigations for disciplinary, capability, grievance, bullying harassment and recruitment complaints.

The factors being monitored are age, ethnicity, gender and disability to identify any trends that may indicate discrimination. Sickness absence is monitored separately. In 2017/18 the Trust conducted a total of 40 formal investigations split into the categories listed in the table below.

	2017/18	2016/17	2015/16
Disciplinary	29	22	24
Capability	5	11	14
Grievance	4	3	7
Bullying and harassment	2	1	6
Recruitment discrimination	0	0	0
Total	**40**	**37**	**51**

Our analysis shows that 38 of the cases listed above involved White British or White European/White Other staff, and two cases were staff from ethnic minorities. One of the cases involved a member of staff with a disability and the age range was from 20 years to 59 years old. No significant trends have been identified during the analysis.

Disciplinary Cases 29
The proportion of cases between male and female staff is four male cases and 25 female cases. One case involved a member of staff from an ethnic minorities and the rest were White British or White European/White Other. Two cases went to dismissal and six cases for potential dismissal resigned before the hearing. One dismissal was an employee from an ethnic minority.

Capability Cases 5
We had five cases, one male and four female. None of the cases involved an employee with a disability and their ages ranged from 35 years old to 56 years old. One case involved an employee from an ethnic minority.

Grievance Cases 6
We had six grievances raised, one form a male employee and five from female employees. All six employees were White British.

Bullying and harassment 2
We had two cases involving female employees and both were White British.

On the basis of the data collected for 2017/18 we have not identified any trends or individual cases that indicate discrimination.

Summary of progress made since September 2017

The action taken in support of our inclusion strategy objectives since the last annual Trust Board report in September 2017 includes:

- Membership of the Trust's Equality and Diversity Steering Group has been extended with eleven new volunteer members joining from across the Trust. This has resulted in a much richer mix of lived experience amongst the group's membership as well as better representation from across the whole organisation.

- A seminar was held in December 2017 to focus on LGBT+ inclusion – one action resulting directly from this was the extension of the role of Trusted Partner.

- The Trusted Partner role has been extended to include providing advice and information about any of the characteristics protected by the Equality Act based on Partners' own lived experience and expertise. Twelve new Trusted Partners have been recruited and trained. They are a key element in our efforts to tackle bullying and harassment.

- A 'staff supporters' page has been created on the intranet giving staff easy access to the full range of services available to provide support (this encompasses and extends beyond equality, diversity and inclusion issues). The Trusted Partner role is being actively promoted via 'staff supporters'.

- Unconscious bias and cultural competence e-learning are now available to all Trust staff. This has been made mandatory for those involved in the recruitment process and consultant employer based and discretionary awards.

- An audit has been carried out of the recruitment and selection process by our external auditors and an action plan agreed to minimise the risk of discrimination in the process. This plan is currently being implemented.

- An Equality Impact Assessment was carried out on the Trust policy on Employer Based Awards and Associate Specialist Discretionary Awards. The recommendations made as a result of this assessment have been adopted for implementation from 2019.

- Trust staff have been invited to express an interest in establishing networks based around the characteristics protected by the Equality Act 2010 (e.g. BME, disability, LGBT+). An initial workshop has been organised for 3.10.18 with the support of Stonewall to explore setting up a LGBT+ network. (The Trust joined the Stonewall Diversity Champions Programme in January 2018.)

- There has been regular communication about equality, diversity and inclusion issues in the Greensheet. This has included an article focussing on three members of staff from the LGBT+ community to mark Pride month in June by Tara Rose, Head of Communications.

- From 2019 there will be an Equality, Diversity and Inclusion Champion Award as part of Shining Lights. The Equality and Diversity Steering Group is drawing up criteria for the award.

- A new 'Supporting people who are trans' policy and supporting FAQ have been developed and published.

- The 'Disabled Go…' service providing detailed access information for patients, visitors and staff has been actively promoted on our website and through posters and leaflets. Details are also now given to shortlisted candidates for all posts at the Trust as part of the recruitment process.

- Orientation calendar clocks have been installed in all ward bays and clinic areas in support of older age patients, including those with dementia.

- A poster campaign 'Different Families, Same Care' is running in the Trust (WSH site, Newmarket and community) to reaffirm the inclusive service provided by WSH to patients/visitors and our staff.

Future developments

The Workforce Disability Equality Standard (WDES) is due to be published in this autumn and Trusts will be required to report and prepare action plans against the standard in August 2019.

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Appendix 1

Inclusion strategy

We will develop of a culture of inclusion where all people are valued and respected for their individual differences. This supports our commitment to the provision of high quality, safe care for all members of the communities we serve and our ambition to support all our staff as set out in our strategic framework our patients, our hospital, our future, together'.

Our objectives 2017 - 2019

For patients, service users and carers

- Improve the patient experience and care of older age patients (including those with dementia).

For staff

- Promote and support inclusive leadership at all levels of the trust
- Ensure the recruitment interview process is bias free
- Establish diversity network groups to provide a forum for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the trust
- Close the gender pay gap

For patients, service users, carers and staff

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

Our objectives have been drawn from: an in-depth analysis of progress to date with our Equality Delivery System (EDS), a review of EDS2 goals and outcomes, a review of our performance against the nine Workforce Race Equality Standard indicators (2017 data), the 2016 and 2017 staff survey results, our 2017/18 Gender Pay Gap Report, the Trust's Strategic Framework 'our patients, our hospital, our future, together' and the requirements of the Equality Act (2010) including the Public Sector Equality Duty (PSED).

Performance Management and Review

Progress will be reported quarterly to the Trust Equality and Diversity Steering Group and to the Patient Experience Committee twice annually. A report will be made to TEG and the Trust Board annually.

West Suffolk NHS Foundation Trust

Appendix 1

Inclusion Action Plan 2017 to 2019

Objective	Action – by 31/8/19	Lead	Update – September 2018
For patients, service users and carers			
1. Improve the patient experience and care of older age patients (including those with dementia).	Cognitive screening – review dementia screening within eCare; process to include single question and request for review/referral for memory assessment services via GP Add delirium screening to eCare	Lead Nurse Dementia & Frail Elderly	Cognitive screening: single screening question, dementia AMT4 and delirium 4AT screening tools have been added to eCare clinical clerking and progress note workflow pages. Cognitive screening also forms part of the Comprehensive Geriatric Assessment (CGA) process. **COMPLETE**
	Dementia diagnosis: improve the referral pathway for memory assessment service	Lead Nurse Dementia & Frail Elderly, Consultant in Elderly Medicine	June 2018 met with CCG and NSFT to review referral pathway for memory assessment service (MATS). Current process is to request referral via GP. Working group to be set up to plan pilot of direct referral to MATS from Frailty Assessment Unit (FAU).
	Frailty screening for all patients over 65		Frailty screening is completed and recorded on eCare for patients over 65; frailty score is also documented on the GP discharge summary. **COMPLETE**
	Train volunteers to become 'Ward Companions' to offer comfort, compassion and company for patients at the ends of their lives and their families.	Voluntary Services Manager	Voluntary services have increased their team to include 5 ward companion roles and they are continuing with the recruitment process to develop the team.

	Install orientation calendar clocks in all ward bays and clinical areas Seek and act on feedback from carers, specific carer feedback forms within WSH carer packs. Provide quarterly reports of carer feedback Participate in Suffolk Family Carers Carer Friendly Hospital Award	Estates Manager Lead Nurse Dementia & Frail Elderly Lead Nurse Dementia & Frail Elderly	Installation of orientation calendar clocks in all ward bays and clinic areas **COMPLETE** Feedback from carers is collated monthly, fed back via quarterly reports to clinical teams and Matrons, and is monitored by the Involving Family Carer Group. This feeds into the Patient & Carer Experience Group and a biannual report is submitted to the Patient Experience Committee. **COMPLETE** **COMPLETE**
For staff			
2. Promote and support inclusive leadership at all levels of the Trust.	~~Include cultural competence in 2030 Leaders Programme and evaluate the impact.~~ Improve the understanding and recognition of managers and leaders cultural competence and of hidden and unconscious bias and its potential impact on patient care. (WRES and GPG)	Deputy Director of Workforce (Organisation Dev) Deputy Director of Workforce (Organisation Dev)	Action no longer needed since all staff to be encouraged to undertake e Learning for Health Cultural Competence training. Unconscious bias session to be provided as part of Expert Navy ward manager leadership development programme. **COMPLETE** Unconscious bias and cultural competence training available to all staff from July 2018. Mandatory for those involved in the recruitment and selection process and award of Employer Based and Discretionary Awards from 2019. **COMPLETE**

	Increase target for compliance with mandatory Equality and Diversity training from 80% to 90% by 1.4.18 and review with a view to increasing to 95% by 1.1.19	Deputy Director of Workforce (Organisation Dev)	Monitor uptake of training and seek feedback on impact by 31.7.19. Target has been increased but compliance has fallen steadily in past months. 79% in June 2018. Managers advised in areas where compliance is 20%+ below target.
3. Ensure that the recruitment interview process is bias free	Internal audit of recruitment interview process to seek to identify reason(s) for the reduced likelihood of shortlisted BME candidates being appointed by comparison to shortlisted white candidates. Identify action as appropriate. (WRES) Explore the potential of recruiting and training cultural ambassadors to support the selection process. (WRES/GPG)	Deputy Director of Workforce (Organisation Dev), Senior HR Manager and Medical Staffing Manager (Operational) Deputy Director of Workforce (Organisation Dev)	Audit report completed and action plan has been agreed and implementation underway. **COMPLETE** All actions to be completed by 31.12.19. Meeting held with RCN and Executive Chief Nurse on 3.5.18. Not currently a viable option. Review again with RCN late 2018.
4. Establish diversity network groups to provide a forum for individuals to come	Offer staff the opportunity and support to set up networks around Equality Act protected characteristics	Deputy Director of Workforce (Organisation Dev)	LGBT inclusion seminar held on 1.12.17 **COMPLETE** All staff invited to express an interest in participating in diversity networks June 2018. Stonewall to facilitate a workshop to set up LGBT+ network on 3.10.18.

together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the Trust			
5. Close the gender pay gap	Identify and publish Gender Pay Gap data and identify any action annually. (GPG)	Deputy Director of Workforce (Organisation Dev)	GPG 2016/17 report published March 2018. Action plan: review Employer Based Awards and Discretionary Awards and process to ensure any scope for bias on any basis is identified and removed. Updated policy agreed by TNC (M&D) – mandatory unconscious bias training for all committee members to be implemented in 2018, other agreed process changes in 2019 to be led by Medical Staffing Manager. GPG 2017/18 draft report to Trust Board by 31.3.19
For patients, service users, carers and staff			
6. Promote a culture of inclusion in the delivery of care to all patients and staff	Develop a policy to help staff support people who are trans and take action to ensure it is implemented. Encourage patients and staff to support a culture of inclusion. (WRES)	Deputy Director of Workforce (Organisation Development) Deputy Director of Workforce (Organisation	'Supporting people who are trans' policy and FAQ developed and published spring 2018. Understanding trans seminar planned for autumn 2018. 'Different Families, Same Care' poster campaign launched across Trust June 2018. **COMPLETE**

		Development)	Greensheet article by Head of Communications in June 2018, Pride Month, focusing on LGBT+ staff members **COMPLETE**
	Establish Shining Lights 'Equality, Diversity and Inclusion Champion' Award	Deputy Director of Workforce (Organisation Development) with Equality and Diversity Steering Group	Equality and Diversity Steering Group identifying criteria for award. Introduce for 2019 Shining Lights.
	Promote 'Disabled Go' to patients and staff	Estates and Facilities Business Manager, Assistant Communications Manager, Deputy Director of Workforce (Organisation Development)	Improve signposting of 'Disabled Go' on Trust website, and promote via leaflets in outpatient clinics. Include details in selection interview letters. **COMPLETE**
7. Improve information and data collected, in respect of protected characteristics, to ensure that the right services are delivered, and in order to improve patient experience	Review how we analyse and use complaints data relating to protected characteristics	Deputy Director of Workforce (Organisation Development) and Patient Experience Lead	Complaints with relevance to E&D to be reviewed by Equality and Diversity Steering Group as arise on an ad hoc basis. **COMPLETE**
	Work towards 100% workforce sample for the NHS staff survey with particular concerted focus on BME staff who are generally less likely to complete the exercise. (WRES)	Deputy Director of Workforce (Workforce Development)	Letter to accompany 2018 NHS Staff Survey will encourage completion of demographic data by staff.

and staff satisfaction.	Identify potential for additional patient data collection on protected characteristics via e-Care Work with e-Care team to ensure data is collected through implementation of the Sexual Orientation Monitoring Standard and Accessible Information Standard (AIS) Roll out ESR self-service giving all staff access to update their personal details (including some protected characteristics) and promote to staff.	Deputy Director of Workforce (Organisation Development) Deputy Director of Workforce (Organisation Development) Deputy Director of Workforce (Workforce Development)	Information team reviewing existing performance reports with protected characteristics currently collected to identify how the data might be used and possible extension. Sexual orientation: Solution made available by Cerner on 4.7.18 and implementation being monitored. AIS: due to be implemented in January 2019 ESR employee self-service rolled out. **COMPLETE**
8. Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours.	Promote 'Freedom to Speak Up, Freedom to Improve' campaign to all staff. Support and develop the roles of Freedom to Speak-Up Guardian and Guardian of Safe Working. Tackling Bullying and Harassment Campaign to be launched September 2018. (WRES)	Executive Director of Workforce and Communications Deputy Director of Workforce (Workforce Development) Deputy Directors of Workforce	National Guardian, Freedom to Speak up presentation at 5 O'clock club on 11.1.18. **COMPLETE** Explore options for feeding back FTSU without breaking staff confidence. 2017 NHS Staff Survey analysed by protected characteristics to identify areas for action. **COMPLETE**

			Trusted Partner role to be extended to include partners providing advice and information based on their own lived experience of characteristics protected by the Equality Act. 12 new Trusted Partners recruited and trained June/July 2018. Re-launch of role as part of Staff Supporters at the end of July followed by anti-bullying campaign starting in September 2018. Update definition/examples of non-physical assault in Trust Management of Violence and Aggression Policy to include discriminatory language and abuse. **COMPLETE**
9. Embed equality and diversity in mainstream business processes	Explore the potential of recruiting and training cultural ambassadors to support mediation processes. (WRES) Include equality impact assessment as part of the standard business planning template Ensure impact on equality is considered appropriately in all reports put before the Trust Board and Trust Executive Group	Deputy Director of Workforce (Organisation Development)	Meeting held with RCN and Executive Chief Nurse on 3.5.18. Not currently a viable option. Review again with RCN late 2018. **COMPLETE** EIA template on intranet and equality assessment included in WSH committee report template. **COMPLETE**

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Appendix 2

West Suffolk NHSFT equality and diversity profile 31 March 2018

The Trust workforce appears more diverse than immediate local areas, and less diverse than the whole of England with the exception of Asian groups. Ethnic groups account for approximately 10% of total workforce and 7.4% of total staff survey of respondents, a slight increase on last year.

The Staff Survey 2017 results have shown that the trust has maintained a score in line with the average for staff not experiencing discrimination at work. Further references to the 2017 Staff Survey are made within the text of the report.

Whilst the White British group make up around 83% of the workforce, this is not necessarily reflected across all staff groups:

- Nursing & Midwifery has a greater proportion of white groups overall, followed closely by Admin & Clerical.
- Medical & Dental has the smallest proportion of white groups and the highest proportion of minority groups, showing greater overall diversity within this group.

81.5% of the Trust's workforce is female, with the majority of these working in Nursing, Admin and Healthcare Support posts. Male staff members represent 18.5% of the workforce with a slight majority in the medical & dental roles.

Female staff members work almost equally part-time and full-time, whilst most male staff members work full-time. Overall, 56% of Trust staff work full-time, with 44% working part-time.

Pay by gender split roughly reflects the male/female ratio of the Trust with the exception of bands 8 and above, where there is a larger proportion of male staff at senior level. There are no disclosed minority groups in Bands 8b-d and 9.

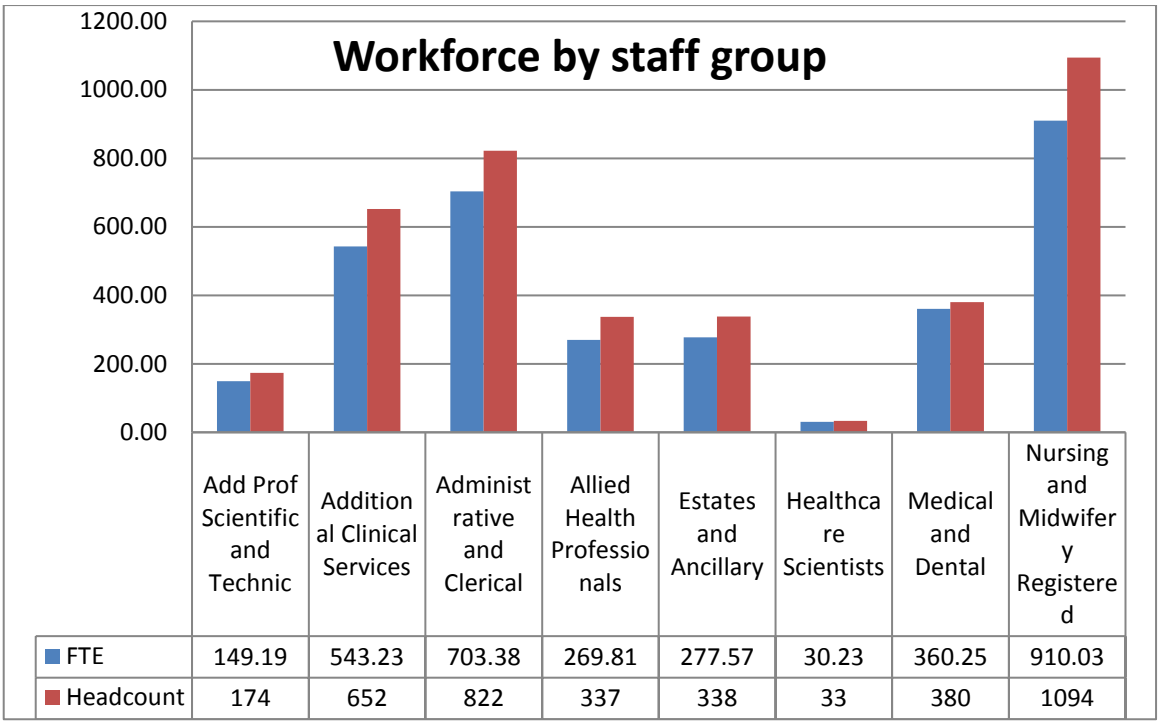
The majority of staff members are between the ages of 40-60, with a large number of staff having been with the trust between 5-10 years.

- Approximately 51% of the workforce falls within the 36 – 55 age bracket.
- There are 258 employees over 60, 12 of these are over the age of 71.
- The majority of staff have a length of service between 1-15 years.

Workforce by staff group

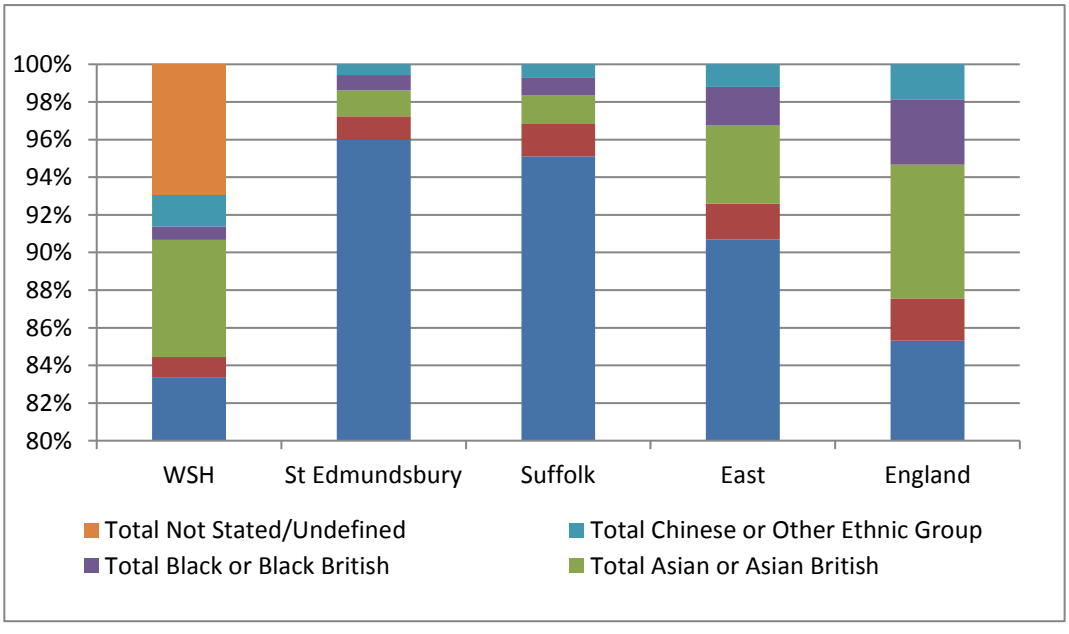
The Trust’s total headcount as of 31 March 2018 was approximately 3830 (permanent and fixed-term appointments). Nurses and midwives continue to be the largest single

staff group, accounting for almost 30% of total staff in the Trust, followed closely by administrative and clerical and additional clinical services.



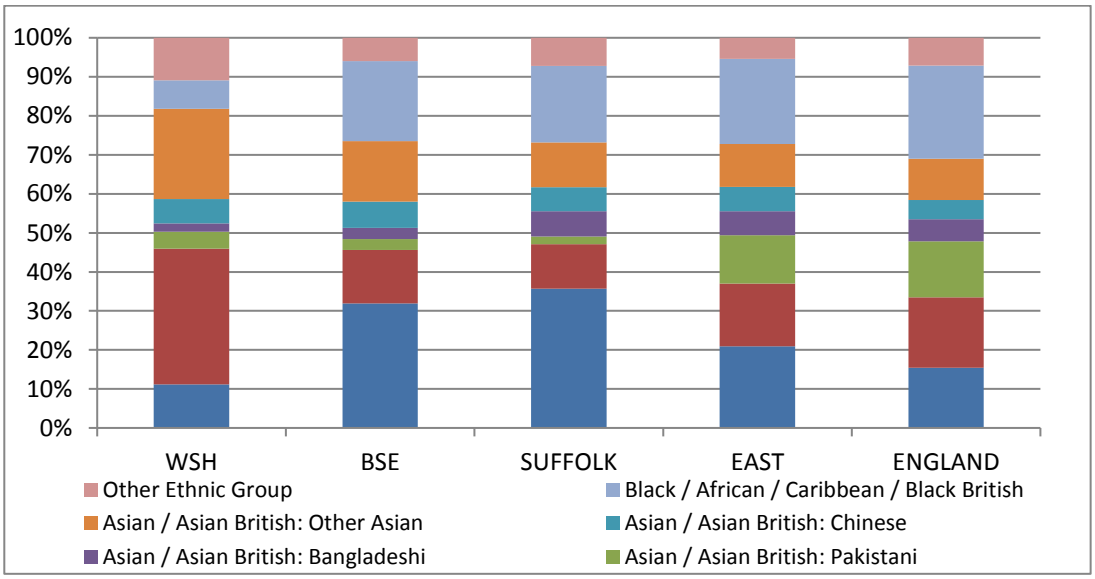
	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered
FTE	149.19	543.23	703.38	269.81	277.57	30.23	360.25	910.03
Headcount	174	652	822	337	338	33	380	1094

Population ethnicity



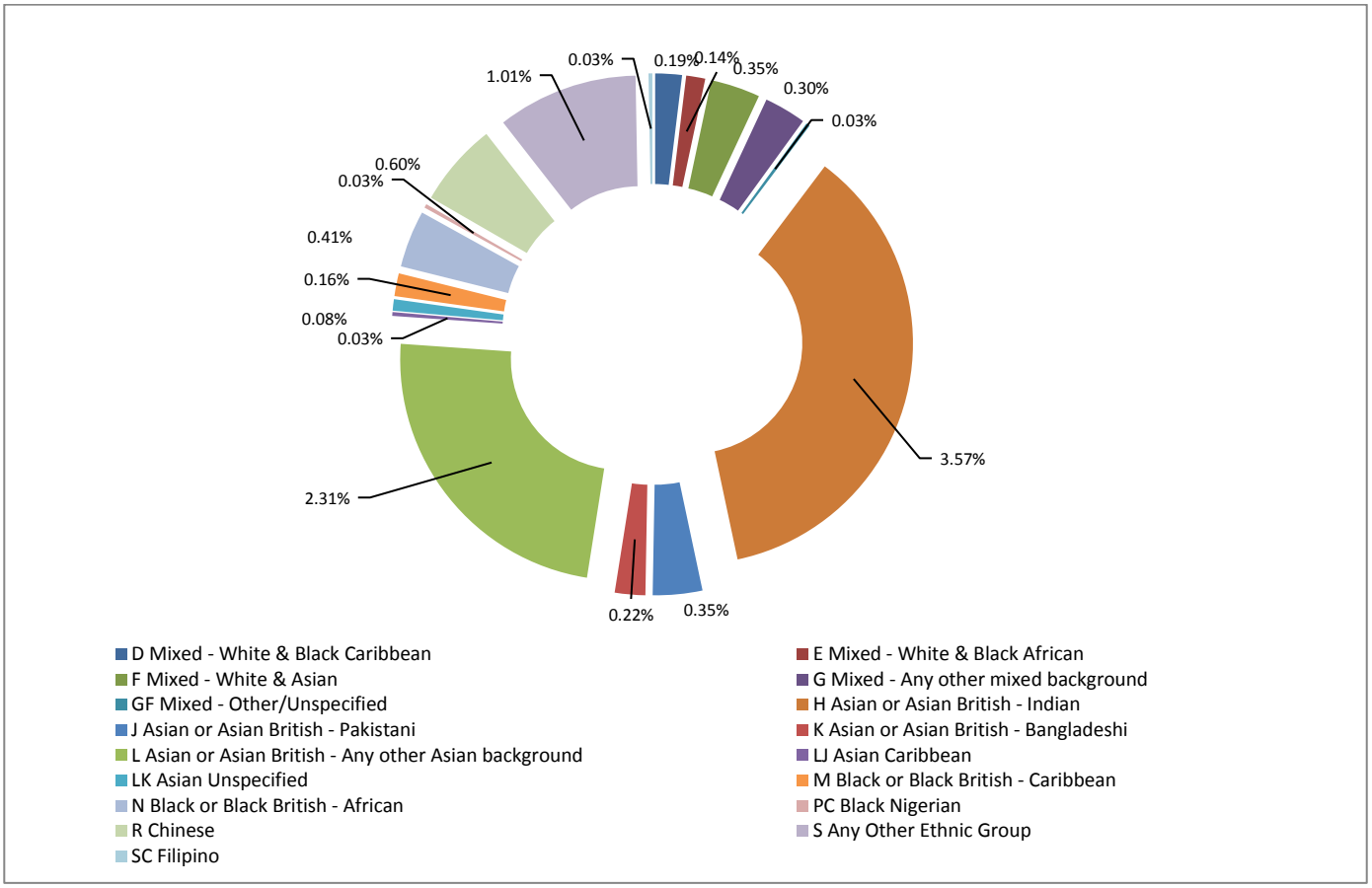
The chart above compares the overall ethnic profiles for the Trust, Bury St Edmunds, Suffolk, East of England and England as a whole. The Trust appears more diverse than the immediate local areas, however slightly less diverse when compared with England as a whole, with the exception of the Asian groups.

Minority group distribution



Workforce ethnicity breakdown

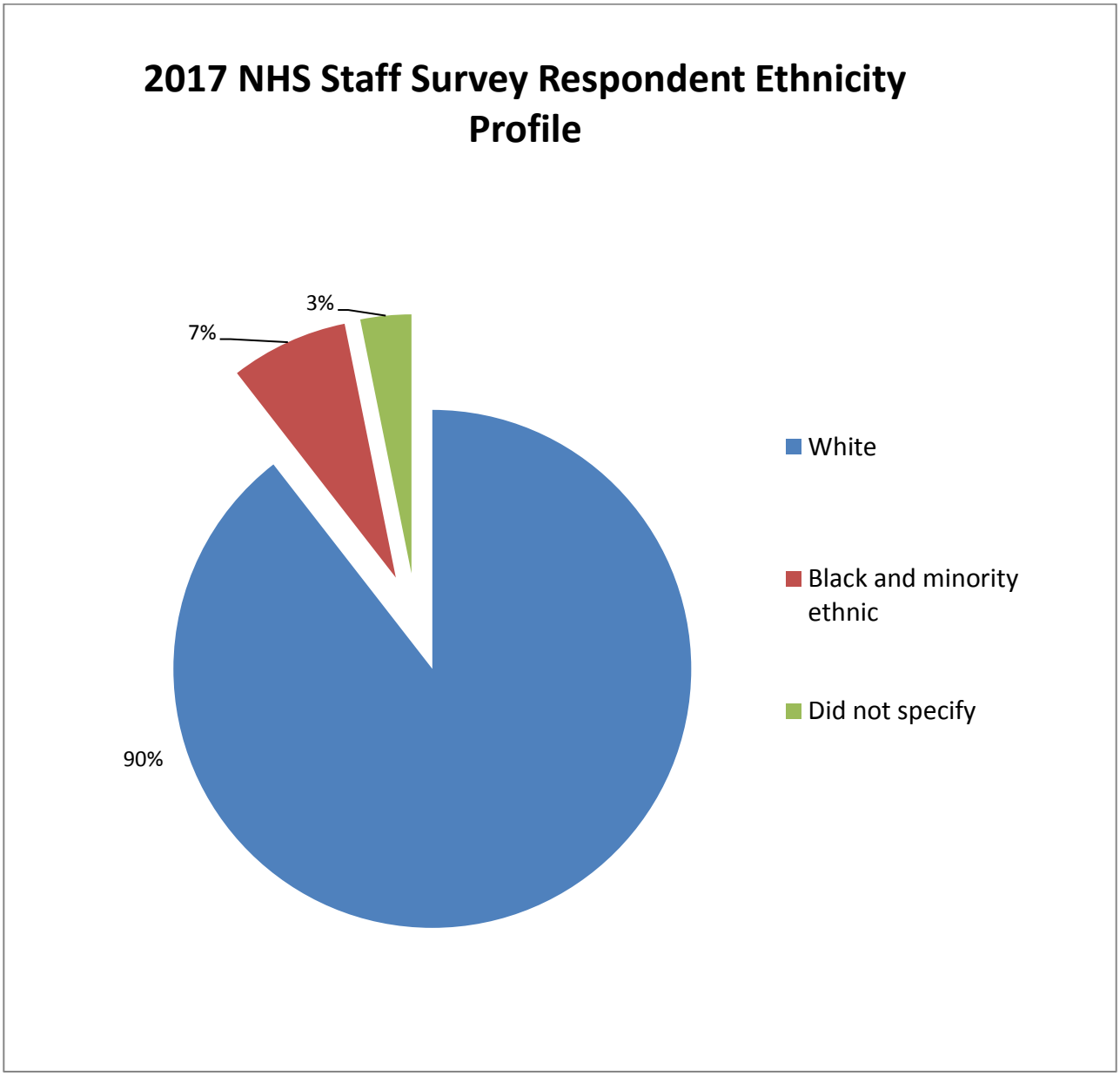
Overall, 7.3% of those staff choosing to disclose their ethnicity stated they were from a minority ethnic group. Currently 96.8% of the workforce has chosen to disclose their ethnicity.

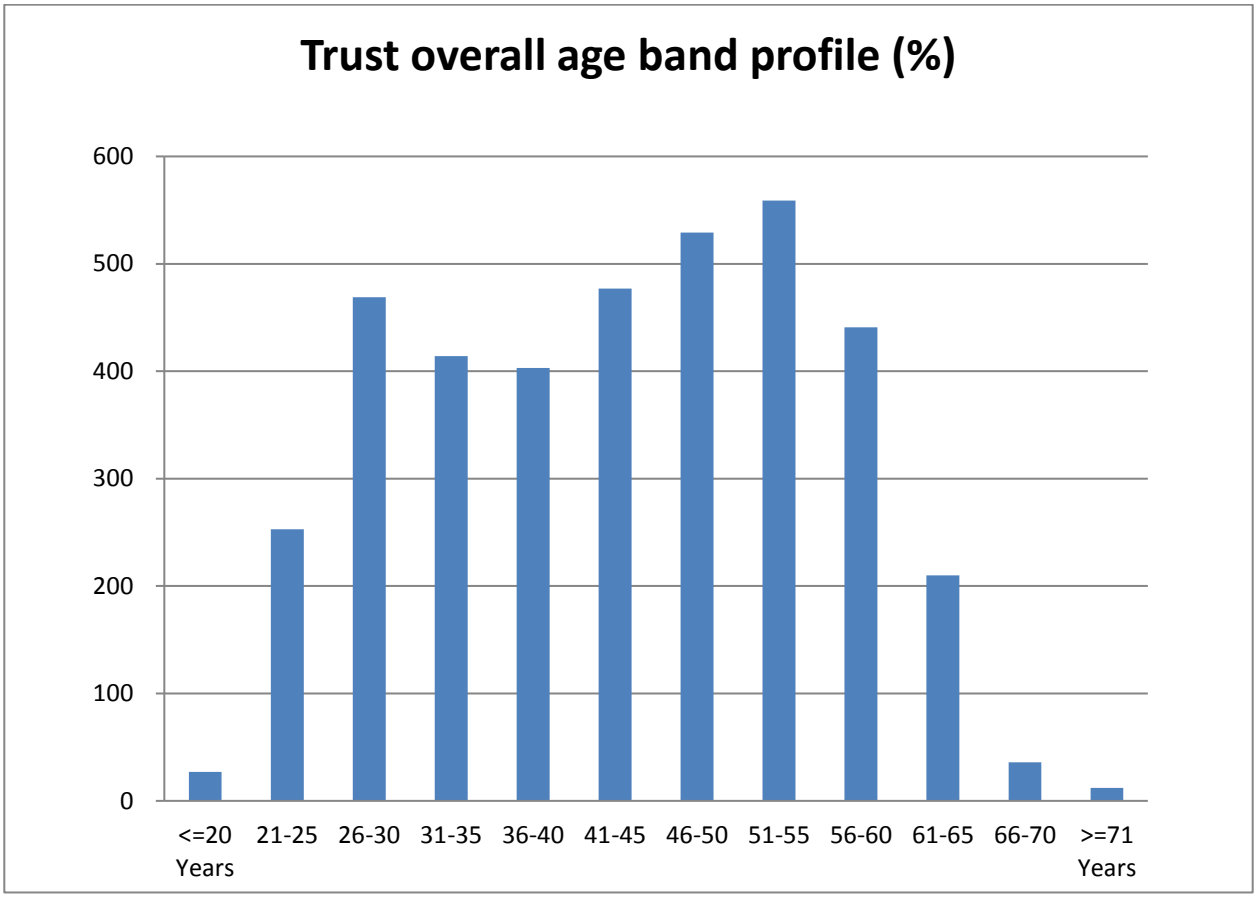


Staff Survey sample – ethnicity

Out of the 1250 eligible staff surveyed, 599 employees responded to the Staff Survey in 2017, giving a total response rate of 48% - above the Picker Institute average for Acute Trusts, which was 44%. The average response rate for England was 50%.

The chart below shows how our staff respondents described their ethnic background when completing the survey. In total 91% were recorded as white groups and 7% as minority.



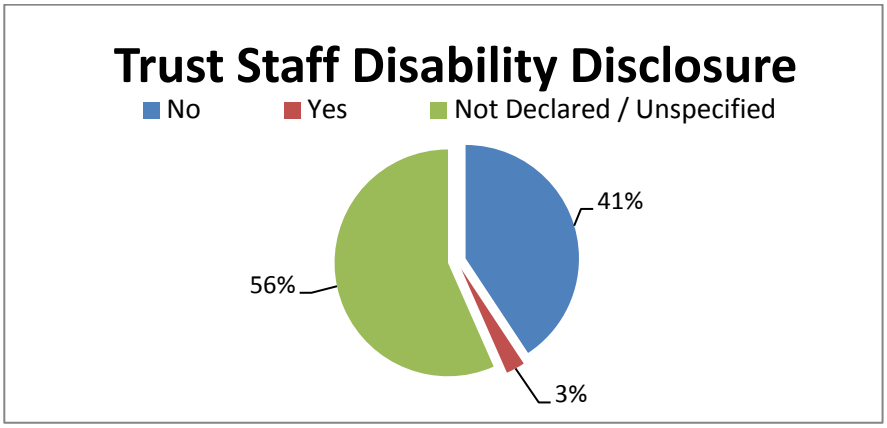


Age

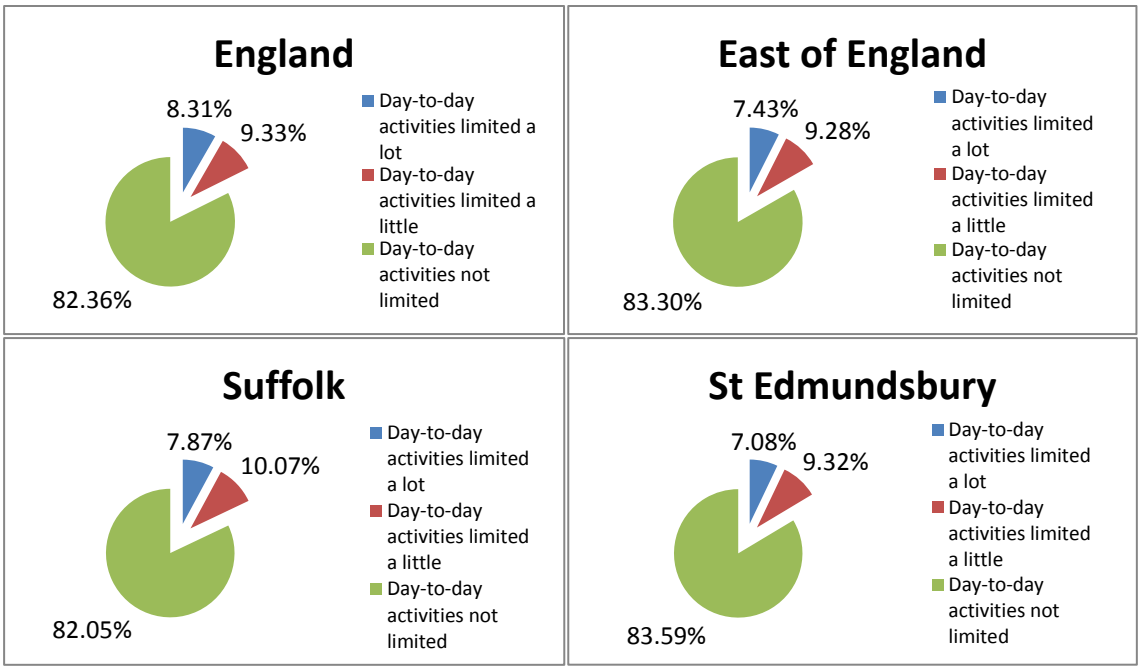
The average age for staff within the Trust is 44 years old. For female staff it is 44 and for male staff, 42.

Disability

Trust disability data shows that over a third of all staff have stated no disability. The number of staff whose disability status is not declared/undisclosed has fallen by another 4% indicating a further improvement in data quality.



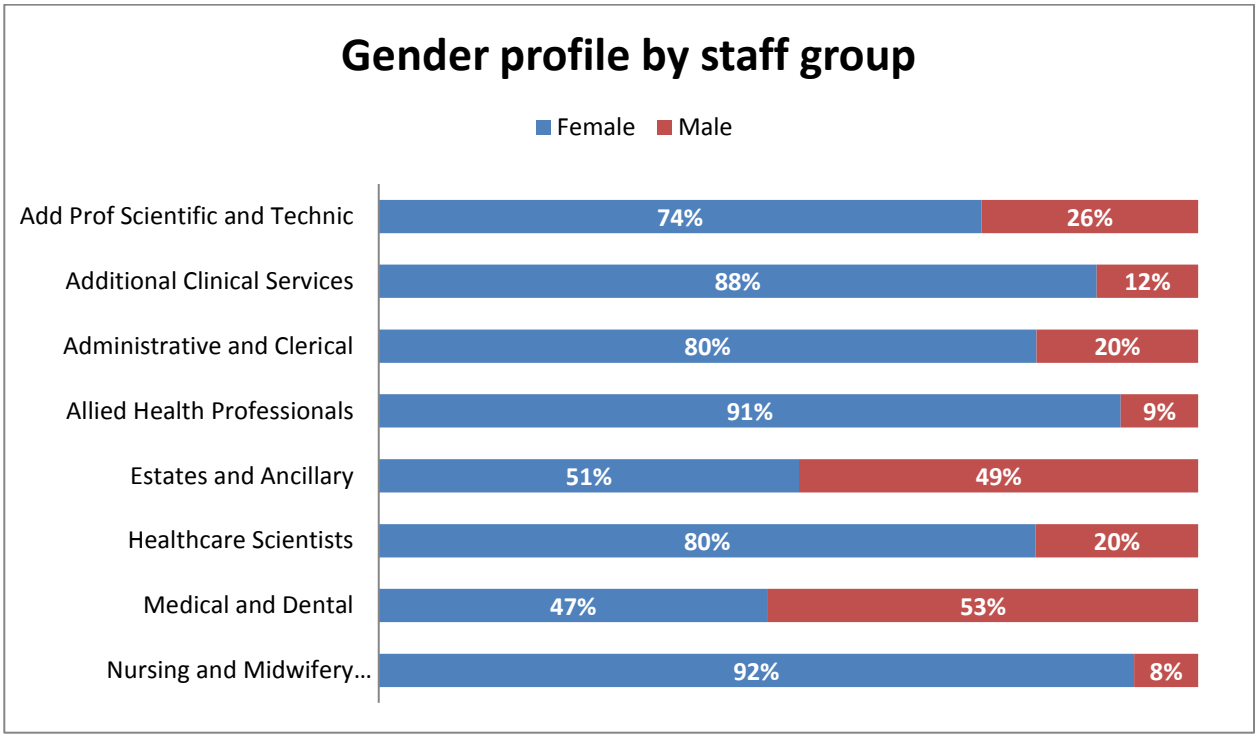
The data below shows the comparison between the locality, region and country as a whole in terms of the number of people who have either no disability/limitation with day-to-day activities, limited or more limited activity.



Gender

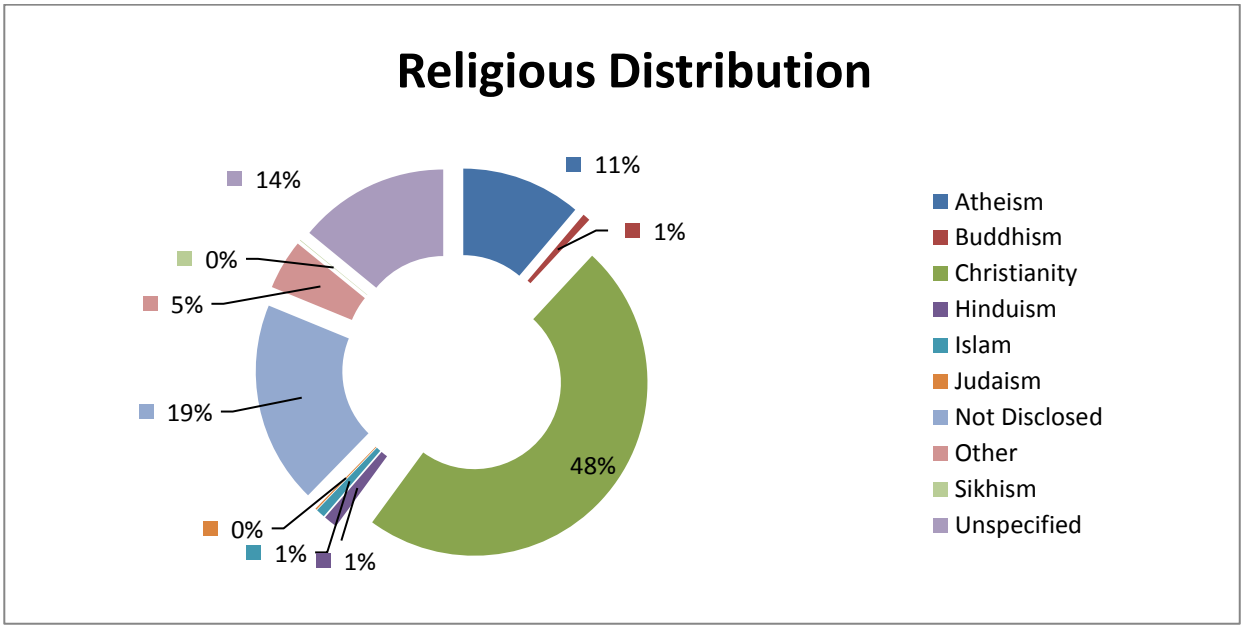
The gender split of the workforce remains reasonably constant; it comprises 81.5% female staff and 18.5% male staff. A similar distribution was seen in amongst the respondents to the Staff Survey.

The Trust has a consistently higher proportion of female staff compared to male staff with the exception of the medical and dental and estates and ancillary staff groups.

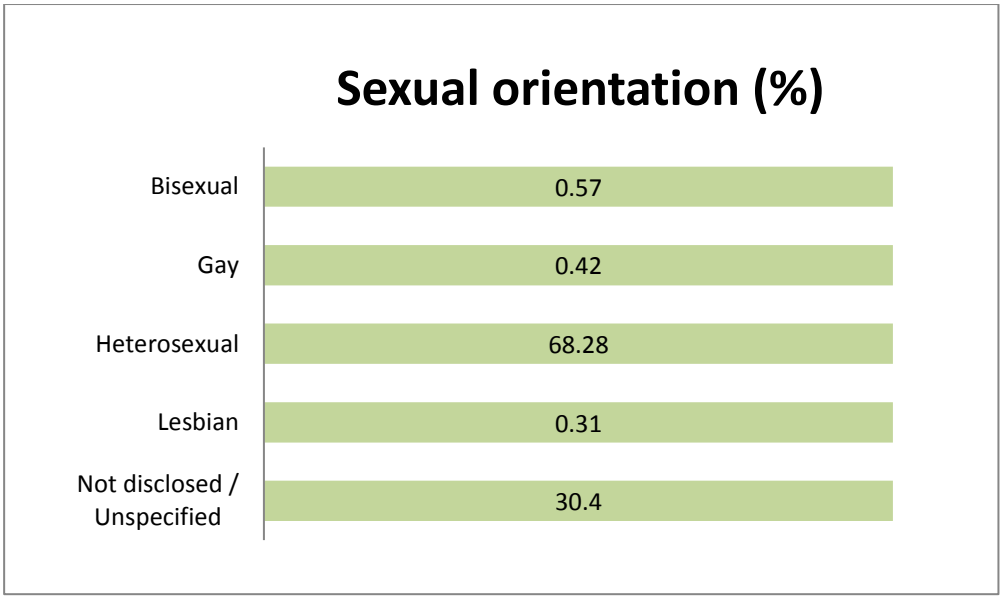


Religion and belief and sexual orientation

There is no current benchmark for religion and sexual orientation, however as part of the Public Sector Equality Duty (PSED) the Trust has an obligation to eliminate unlawful discrimination, harassment and victimisation. The Trust currently shows a diverse range of faiths, with over a quarter of staff choosing not to disclose their religion.

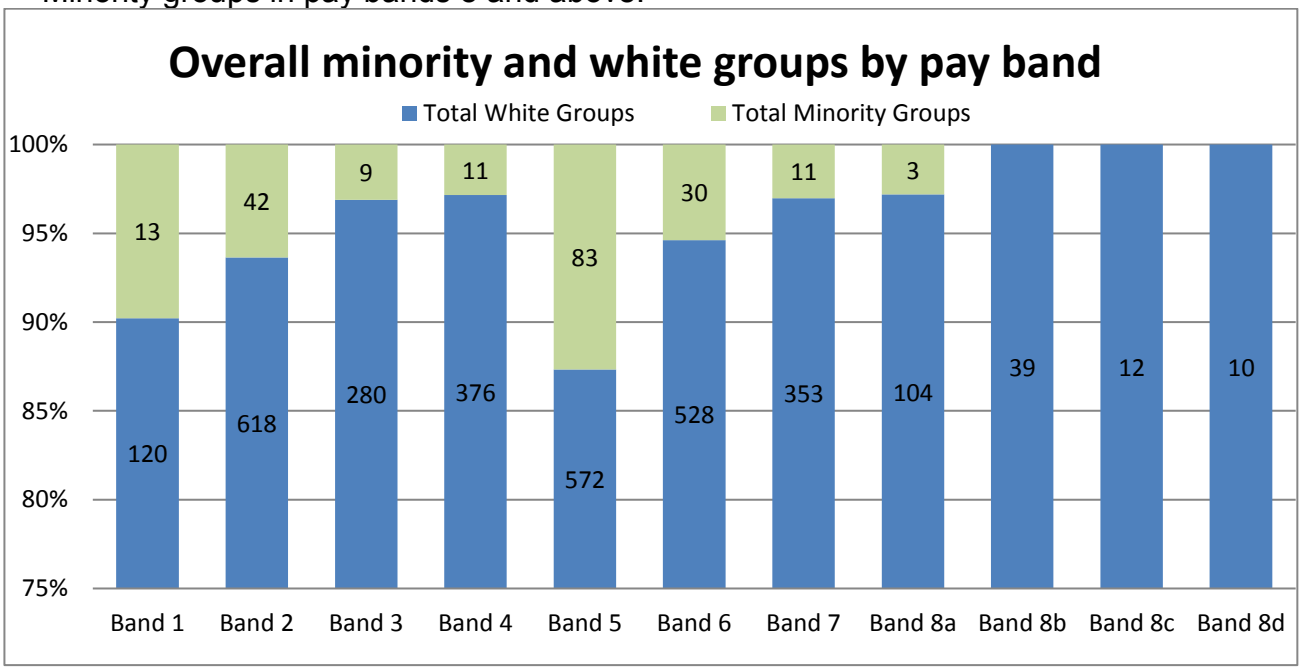


More staff have chosen to disclose their sexual orientation since last year. The number of staff choosing not to disclose their sexual orientation has fallen by 1%



Pay band by ethnicity

Bands 2 - 6 show the largest distribution of Minority groups. There are few disclosed Minority groups in pay bands 8 and above.



Appendix 3

Workforce Race Equality Standard 2018

Name and title of board lead for WRES		Jan Bloomfield, Executive Director of Workforce and Communications
Name, title and contact details of lead manager for compiling this report		Denise Pora, Deputy Director of Workforce (Organisation Development) denise.pora@wsh.nhs.uk
Name of commissioner this report has been sent to		Giles Turner, Human Resources Business Partner, West Suffolk CCG
This report has been signed off on behalf of the trust board by		Jan Bloomfield, Executive Director of Workforce and Communications
Background narrative. • **Issues of completeness of data** • **Matters relating to reliability of comparisons with previous years**		A problem has been identified with under reporting in 2016/17 data for indicator 2 (relative likelihood for staff being appointed from shortlisting across all posts). Whilst this has been corrected as far as possible for 2017/18 data between the two years cannot be directly compared. 2017/18 data still represents slight under reporting as overseas recruitment is not conducted via NHS jobs. A significant number of community staff joined the trust via a TUPE transfer in 2017 which, again impacts on comparability of 2016/17 and 2017/18 data.
Total Number of staff at 31.3.18		4557 (permanent, fixed term and bank staff as required by national report)
Proportion of BME staff employed within the trust at 31.3.18		10.2%
The proportion of staff who have self-reported their ethnicity		96.8%
Period this data refers to		1 April 2017 to 31 March 2018
Workforce Race Equality Indicators		
1	**Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive board members) compared to the percentage of staff in the overall workforce.**	See **Appendix A**

2	**Relative likelihood of staff being appointed from shortlisting across all posts**	2017 = shortlisted white candidates 1.94 times more likely to be appointed than BME 2018 = shortlisted white candidates 1.60 times more likely to be appointed than BME 2017 and 2018 data is not comparable on this indicator as described above. Actions put in place following our 2017 report still need time to have an impact. See Inclusion Strategy and Action Plan	
3	**Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator is based on data from a two year rolling average of the current year and the previous year**	2017 = BME staff were less likely than white staff to enter the formal disciplinary process (0.85) 2018 = BME staff remain less likely than white staff to enter the formal disciplinary process (0.29) **NB:** the numbers involved are very small in 2017 two BME staff entered the formal disciplinary process and in 2018 one member of staff entered the formal process.	
4	**Relative likelihood of staff accessing non-mandatory training and CPD**	2017 = White staff slightly less likely to access non-mandatory training and CPD compared to BME staff (0.96) 2018 = White staff remain slightly less likely to access non-mandatory training and CPD compared to BME staff (0.95) **NB:** The relatively high proportion of BME staff who are doctors may impact on this indicator i.e. medical staff generally have greater access to non-mandatory training and CPD than other staff groups.	
5	**National NHS Staff Survey Indicator Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months**	**2017**	**2018**
		White: 27.89	White: 26.52
		BME: 24.00	BME: 41.86
		Action to address this is being taken as part of the Trust's work to tackle bullying and harassment. See Inclusion Strategy and Action Plan.	

6	**Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months**	**2017**	**2018**
		White: 23.40	White: 18.53
		BME: 30.61	BME: 29.55
		Action to address this is being taken as part of the Trust's work to tackle bullying and harassment. See Inclusion Strategy and Action Plan.	
7	**Percentage believing that the trust provides equal opportunities for career progression or promotion**	**2017**	**2018**
		White: 92.06	White: 88.83
		BME: 80.00	BME: 81.82
		Continue to work to ensure all staff receive at least annual appraisal. Provide appraisal training for medical and non-medical appraisers.	
8	**Percentage staff personally experienced discrimination at work for manager/team leader or other colleague**	**2017**	**2018**
		White: 5.87	White: 5.51
		BME: 17.65	BME: 15.91
		Action to address this is being taken as part of the Trust's work to tackle bullying and harassment. See Inclusion Strategy and Action Plan.	
9	**Percentage difference between the organisations' board voting membership and its overall workforce**	**2017**	**2018**
		White +16%	White +16.7%
		BME -9.9%	BME -10.2%
		The Trust board voting membership remains 100% white. Recruitment consultants are instructed to actively seek candidates from all possible sources from within the constituency to provide a diverse range of candidates for all board appointments.	

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Appendix A

		31st MARCH 2017			31st MARCH 2018		
Non Clinical workforce	**MEASURE**	**Total staff**	**% of bands 1-9, VSM total**	**% of overall workforce**	**Total staff**	**% of bands 1-9, VSM total**	**% of overall workforce**
Under Band 1	Headcount	0	0.00%	0.00%	0	0.00%	0.00%
Band 1	Headcount	207	18.38%	5.71%	186	13.82%	4.08%
Band 2	Headcount	251	22.29%	6.93%	366	27.19%	8.02%
Band 3	Headcount	178	15.81%	4.91%	208	15.45%	4.56%
Band 4	Headcount	266	23.62%	7.34%	294	21.84%	6.44%
Band 5	Headcount	62	5.51%	1.71%	83	6.17%	1.82%
Band 6	Headcount	39	3.46%	1.08%	51	3.79%	1.12%
Band 7	Headcount	53	4.71%	1.46%	63	4.68%	1.38%
Band 8A	Headcount	24	2.13%	0.66%	38	2.82%	0.83%
Band 8B	Headcount	23	2.04%	0.63%	30	2.23%	0.66%
Band 8C	Headcount	8	0.71%	0.22%	6	0.45%	0.13%
Band 8D	Headcount	3	0.27%	0.08%	7	0.52%	0.15%
Band 9	Headcount	1	0.09%	0.03%	2	0.15%	0.04%
VSM	Headcount	5	0.44%	0.14%	6	0.45%	0.13%
of which: Exec Board members	Headcount	6	0.53%	0.17%	6	0.45%	0.13%

		31st MARCH 2017			31st MARCH 2018		
Clinical workforce	**MEASURE**	**Total staff**	**% of bands 1-9, VSM total**	**% of total workforce**	**Total staff**	**% of bands 1-9, VSM total**	**% of total workforce**
Band 1	Headcount	0	0.00%	0.00%	0	0.00%	0.00%
Band 2	Headcount	399	15.98%	11.01%	643	19.99%	14.09%
Band 3	Headcount	121	4.85%	3.34%	167	5.19%	3.66%
Band 4	Headcount	110	4.41%	3.04%	136	4.23%	2.98%
Band 5	Headcount	600	24.03%	16.56%	757	23.53%	16.59%
Band 6	Headcount	504	20.18%	13.91%	607	18.87%	13.30%
Band 7	Headcount	312	12.49%	8.61%	349	10.85%	7.65%
Band 8A	Headcount	67	2.68%	1.85%	74	2.30%	1.62%
Band 8B	Headcount	13	0.52%	0.36%	16	0.50%	0.35%
Band 8C	Headcount	6	0.24%	0.17%	7	0.22%	0.15%
Band 8D	Headcount	1	0.04%	0.03%	1	0.03%	0.02%
Band 9	Headcount	0	0.00%	0.00%	0	0.00%	0.00%
VSM	Headcount	0	0.00%	0.00%	0	0.00%	0.00%
Of which Medical & Dental		364	14.58%	10.05%	460	14.30%	10.08%

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Appendix 4

Tackling the bullying, harassment and abuse of WSH staff

1. Introduction – what the NHS staff survey is telling us

Bullying, harassment and abuse of staff is recognised as a chronic problem in the NHS and the national NHS staff survey consistently demonstrates that a significant number of our staff experience what they consider to be bullying, harassment or abuse both from other staff and patients, relatives and the public.

- 28% of staff reported experiencing bullying, harassment or abuse from patients, relatives or the public in the last 12 months. This is at the national average for acute trusts. (2017 NHS Staff Survey).

- 20% of staff reported experiencing bullying harassment or abuse from other staff in the last 12 months. This was 5% below the national average and a 5% improvement on the 2016 survey. (2017 NHS Staff Survey)

Whilst the comparison with similar acute trusts is given for context, the levels of bullying, harassment and abuse reported by staff are significant and clearly unacceptable regardless of how they compare with other organisations.

Additionally, more in depth analysis of the 2017 survey results reveal particular issues:

- In the 2017 survey there was a marked upward spike when 42% of BME staff who responded to this item on the survey reported experiencing harassment, bullying or abuse from patients, relatives or the public. This was 14% above the 28% national average for acute trusts.

- Further in depth analysis was also undertaken into the 2017 survey responses from staff on the basis of six of the nine characteristics protected by the Equality Act 2010: age, gender, sexual orientation, religion and belief, race and disability. This analysis showed that staff who are white British, heterosexual, without a disability of no religion or Christian are likely to be more satisfied with their experience of working at WSH than staff who from an ethnic minority, LBGT+, disabled or of a religion other than Christianity.

- Staff who have one or more of the six characteristics are more likely to experience physical violence from patients, the public and are less likely to report it and are also more likely to experience harassment, bulling or abuse from patients, the public, as well as other staff, and, again, they are less likely to report it. They are also more likely to experience discrimination from the public, patients etc. or from other staff.

- In view of the UK's planned departure from the EU in March 2019 it is worth particularly noting that non-British white staff (i.e. most likely colleagues who come from other parts of Europe) are significantly less satisfied with their experience of working at WSH than British staff and report higher levels of harassment, bullying or abuse from patients, relatives and the public, their managers and other colleagues. They are also less likely than British staff to report this.

It will be important to continue supporting this group of staff in the coming months and being clear to all staff and patients, visitors etc. about what is and is not acceptable.

2. Action to tackle bullying, harassment and abuse of staff

The analysis of the 2017 NHS Staff Survey by protected characteristic was discussed with the Equality and Diversity Steering Group in April 2018 and action has been agreed to tackle bullying, harassment and abuse which is now being implemented.

Our objectives are:

- Raise awareness of the problem of bullying, harassment and abuse across the Trust and acknowledge that for some staff it is a real issue and reinforce messages around the seriousness with which it is treated whether the perpetrators are other staff, patients or visiting members of the public.

- Encourage and increase the confidence of individuals who believe they are victims of bullying and harassment to come forward and formally report it or, as a minimum, access support.

- Increase our understanding of the behaviours staff are experiencing as bullying, harassment and abuse.

- Ensure a range of appropriate support is available to staff and access to it is easy and widely understood. This includes supporting those who are accused of bullying, harassing or abusing others until/unless convincing evidence is provided of inappropriate behaviour.

- Feedback and repeat clear messages to staff and the wider community about what constitutes unacceptable behaviour and the consequences for those who demonstrate such behaviour.

- Ensure our policy framework for dealing with bullying, harassment and abuse by staff, patients and the wider public remains robust and understood (i.e. Policies on Bullying and Harassment and Management of Violence and Aggression (NB: including non-physical assault since harassment includes unwanted conduct related to a protected characteristic and constitutes unlawful discrimination under the Equality Act 2010)).

Action planned has the support of staff side representatives and is as follows:

- Ensuring the policy framework is understood and can be operated effectively by managers. A series of workshops have been set up as part of the Senior Leaders Management Development Programme. These are: Handling Employee Investigations (run March 2018), 'Freedom to Speak Up, Tackling Bullying and Harassment' (run in May 2018), and Managing Capability (to be run in September 2018). The workshop led by our employment lawyers that was organised by the Medical Director on Managing High Professional Standards (June 2018) has also contributed to this strand.

- Providing leaders with the skills they need to work effectively with staff, even when dealing with difficult and contentious issues. Again workshops and masterclasses are being provided as part of the Senior Leaders Management Development Programme (e.g. managing positive conversations in difficult and conflicting circumstances) and the Skills Plus Programme for more junior leaders.

- A new intranet 'landing page' of staff support mechanisms has been developed and is being launched in early August. This includes promotion of the Trusted Partner and Freedom to Speak Up Guardian roles. Trusted Partners are volunteer staff members who are available to act as an independent listening ear and source of independent advice to staff who believe they are victims of bullying or harassment. Twelve additional Trusted Partners have been recruited and trained over the summer bringing the total to 17.

- From early September staff a range of communications will take place to raise awareness of bullying and harassment and the support available to staff. This will aim to increase staff confidence to formally report problems, access support and encourage them to tell their stories (anonymously if this is the only way they can do so). A range of mechanisms will be in place to facilitate this e.g. talking to a Trusted Partner, FTSU Guardian, a staff side representative, members of the Trust HR department. Depending on the initial level of response we may also set up an email address for anonymous reporting.

  In addition to any individual results from this (i.e. making a formal complaint of bullying, or accessing informal support) any themes arising in a particular area will be fed back via HR as appropriate.

- TEG will receive a summary of findings and details of the plan for feeding back to the organisation in late October/early November and feedback to staff, patients and visitors will commence in November.

Whilst it seeks to tackle bullying, harassment and/or discrimination for any reason, the action described above is a key part of the Trust's Inclusion Strategy and Action Plan which is working towards creating a culture of inclusion at WSH.

Other action being taken as part of the Inclusion Strategy will also indirectly support the work to address bullying, harassment and abuse. For example, unconscious bias and cultural competence training which is now available to all staff, the role of Trusted partner has been extended to include some partners who are available to provide advice and information about characteristics protected by the Equality Act based on their own lived experience, a number of LGBT+ trust staff are being supported to establish a network.

3. Conclusion and Recommendation

Tackling bullying, harassment and abuse is long-term and without quick fixes. The programme of action above is part of an on-going journey. However, it is reasonable to expect that consistent, unambiguous and continuous action, with visible support from all leaders within the Trust, will result in a reduction in bullying, harassment and abuse and a corresponding decrease in staff reporting this experience in the National Staff Survey.

16.2. Safeguarding children

For Report

Presented by Rowan Procter

Trust Board Meeting – 28 September 2018

Agenda item:	16.2			
Presented by:	Lisa Sarson Named Nurse Safeguarding Children			
Prepared by:	Lisa Sarson Named Nurse Safeguarding Children			
Date prepared:	10th September 2018			
Subject:	Safeguarding Children			
Purpose:	x	For information		For approval

Executive summary:

This is the annual report submitted to the Clinical Safety and Effectiveness Committee and Clinical Commissioning Groups

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:	*Safeguarding children and clinical safety committees*
Risk and assurance:	*Risk Medium. Current risks being addressed Training, Initial health assessments for Children in care, chaperone policy*
Legislation, regulatory, equality, diversity and dignity implications	*None*

Recommendation:
For information only

Safeguarding Children Annual report 2018

1. Risk Rating

Current Risk rating (LxC)	3x4=12 (medium)
Key risks being addressed	**Training, Initial health assessments for Children in care, chaperone policy**

2. Emerging issues/themes

Summarise issues or information which is impacting on the area.

Source	Commentary
Internal intelligence *e.g. incident trends, audit results and policy development/compliance.*	• Monthly audit continues to capture information on safeguarding activity with regards to referrals/medical examination/discharge planning and DNA follow ups. This data is reflected in quarterly reports to the CCG's via the County Safeguarding Designate team • Referral audit demonstrated compliance. • Policy review has incorporated national and local guidance.
External intelligence *e.g. review/inspection, external reports and guidance.*	• The Trust provides quarterly reports to the CCG's. • Two NICE guidance benchmark tools have been completed. • Data requested by LSCB for the annual performance report has been reviewed to more accurately reflect the Acute Trusts trends concerns and areas of good practice

3. Summary of performance

Summarise performance indicators that provide an overview in terms of quality and compliance.

Performance indicator	Target	R	A	G	Previous report	This report	Commentary
Up to date policy	Annual review	>1year old		<1 year old	complete	Reviewed December 2017	Next review to incorporate some of the indicators listed with the NICE guidance
Training level 1 for all staff	100% Trust staff	<60%	60-80%	>90%	90%	89%	Please see separate breakdown
Use of paediatric proformas for paediatric medical examination in CP cases		<100%		100%	75%	100%	See within body of the report; cases where not used were accidental and birthmarks.
Discharge planning meetings for all cases where CP concerns		<100%		100%	100%	100%	Discharge planning meetings for all cases where CP concerns

4. Overall level of assurance for activity

Please see development plan

Green	6	And 3 closed actions
Amber	2	Training and initial health care assessments for Children in care
Red	0	

Annual Report on Safeguarding Children

1. Introduction

The report will incorporate the information shared quarterly with the CCGs. Some evidence spans the financial year but audit results span the calendar year. Training figures will demonstrate where we currently are competent at the time this report will be received and the contrasting point for the previous year.

1.1 Background

The only statistics available remain with the mid-2015 survey stating there were 151,290 children and young people under the age of 0-17 living in Suffolk; 19,980 aged 0-15 years lived in income deprived households; approximately 5% of children and young people living in Suffolk have a disability and 4.4% of the 16-18 population were NEET (Not in education, employment or training). (Office for National Statistics) The Suffolk school census data from January 2017 indicated that 15.1% of school children are recorded as being of a non-white British ethnic group (where recorded)

In March 2018 there were **457** (442 in 2017) children subject to child protection plans in Suffolk: **272** for neglect (272 in 2017), **148** for emotional abuse (158 in 2017), **10** for physical abuse (12 in 2017) and **33** for sexual abuse (12 in 2017). There are also **2102** (2006 in 2017) children in Suffolk with a 'Child in need' plan and **858** (835 in 2017) 'Looked After Children,' i.e. those children under the care of a Court Order, in residential care or foster placement. The increase in the number of LAC can be attributed to the Unaccompanied Asylum Seeking Children emerging within Suffolk which stands at **70**. There have been **3792** (3503 in 2016/2017) children opened and closed to a Common Assessment Framework (CAF) plan or Early Help in the 2017/2018 period with **1,763** remaining open at the end of March 2018.

Further detailed information can be found in the annual report to the Local Safeguarding Children Board at www.suffolkscb.org.uk but from a health perspective concerns remain for health visitor and school nurse recruitment and retention, services being out to tender and IT problems. Another emerging concern is the increase in domestic abuse cases being referred to MARAC (Multiagency risk assessment conference) which is the highest it has ever been and equates to a 10.7% increase from last year. On average there is at least one child within every case discussed.

1.2 Activity

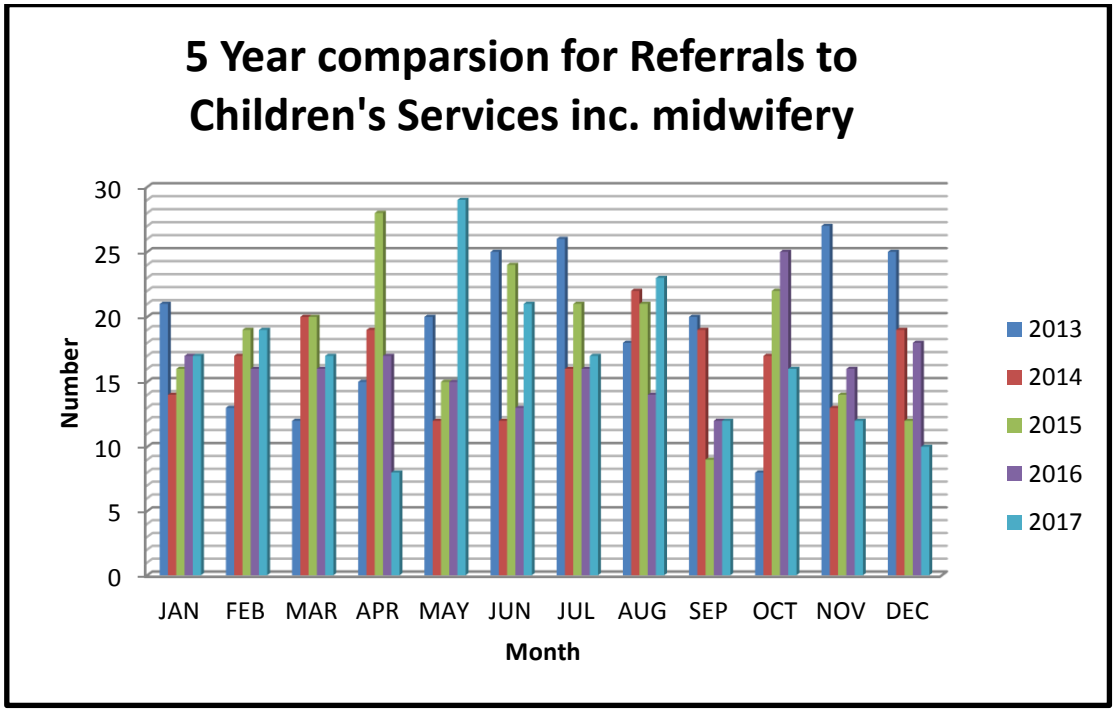
The average monthly attendance to the Emergency department is **1183**(1138**)** children under the age of 18 years and for the CAU **340**/month (358), a slight increase to previous years.

From the 1st April 2017-31st March 2018:

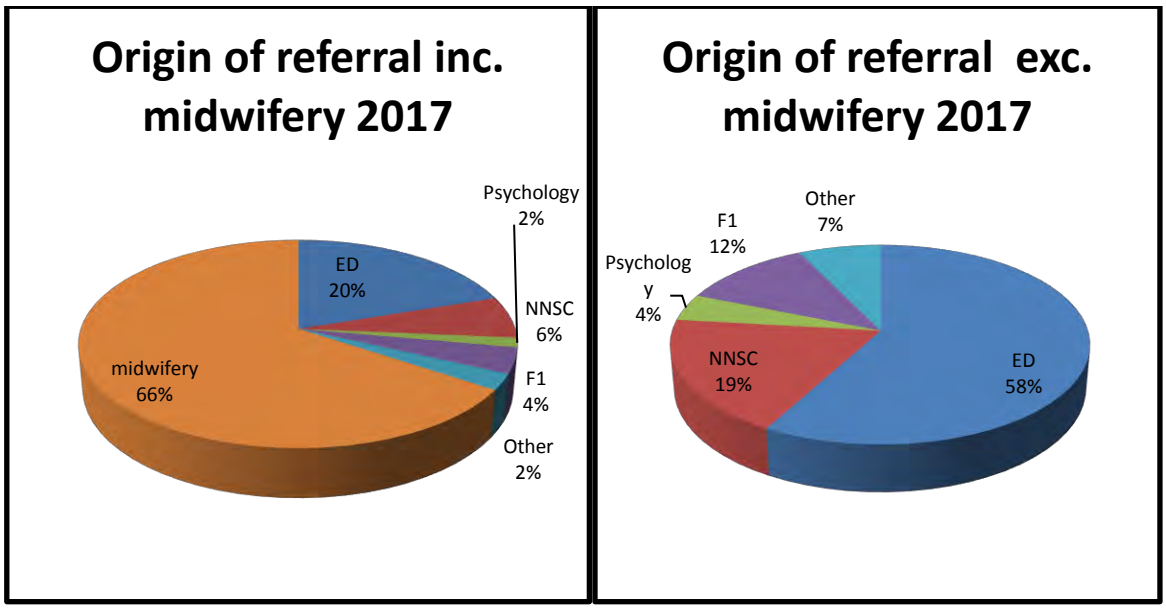
Total number of children seen in A&E (last year's figures) **14,204**(13,656)
Total number of children seen in Children's assessment Unit: **4088**
Total number of referrals to CYPS including midwifery for 2017 **201**(195**)**
Total number of referrals to CYPS excluding midwifery for 2017 **67**(75)
Total number of referrals from community services for 2017 **43** (no previous data)
Total number of records researched for MARAC **2,191** (182/month)

Data is collected monthly to demonstrate some of the safeguarding children activity within the Trust and to identify any trends. This data is reported to the Trust Safeguarding Committee at the quarterly meetings and has been expanded to collect data required for the County dashboard submitted to the CCGs. It has also been partially submitted to provide evidence for the LSCB annual performance report.

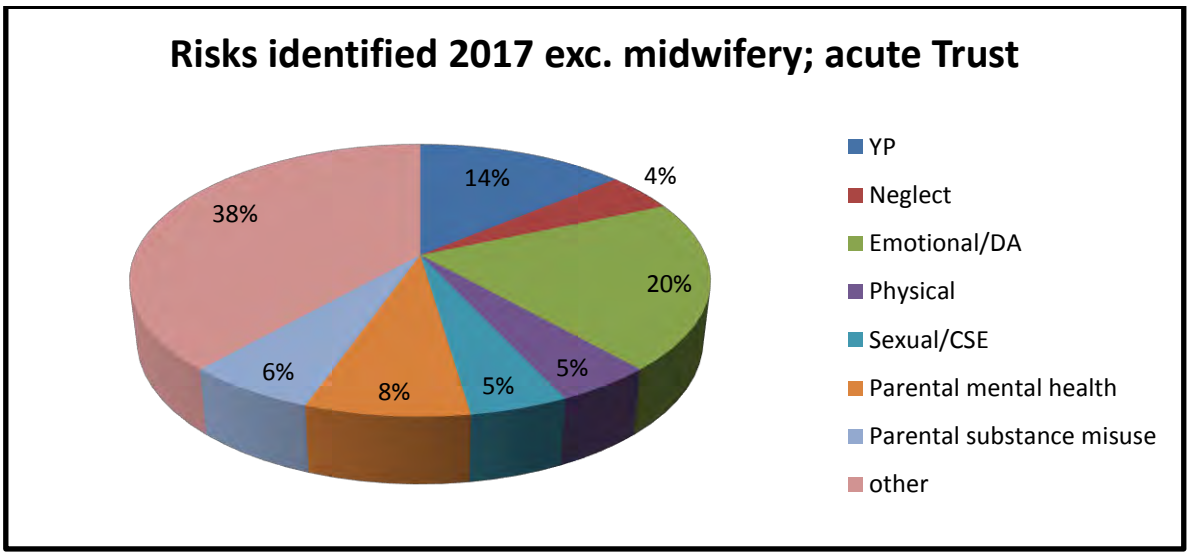
1.3 Referrals



For the year 2017 (2016 in brackets) the Trust submitted **201**(195) known referrals; **132**(120) for midwifery and **67**(75) for other areas within the acute Trust. A total of 43 referrals were made by professionals working within community services. This does not include those referrals made by telephone without submission of a form or those from the psychiatric liaison team. Due to the high volume of referrals received by the MASH priorities were set to encourage partners to complete DASH risk assessments in regards to domestic abuse. The Trust has facilitated this by employing a Clinical liaison nurse for domestic abuse and this service is now embedded within the safeguarding children and adults arena.



Year on year we continue to see the 'Toxic Trio' of domestic abuse, parental mental health and substance misuse as the strongest reasons for referring children to social care, with midwifery and the emergency department being the largest sources of referrals generated by the Trust. Community services hosted by the WSHFT referred children living with domestic abuse and parental mental health problems but they also identified parenting behaviours and disclosures of physical abuse and concerns for neglect.



2. Safeguarding Children Arrangements:

2.1

The Executive Lead for safeguarding children is still Rowan Procter, Executive Chief Nurse. Other members working within the safeguarding structure are the Named Nurse for Safeguarding Children (acute 0.72WTE) Named Nurse Safeguarding Children (community 1WTE) Named Midwife (0.6WTE), Named Doctor for the Trust (0.25PA's). A Specialist Midwife for perinatal health (0.8WTE) is in post working alongside a mental health nurse and a psychiatrist and the clinical liaison nurse for domestic abuse (0.6WTE) is spanning both safeguarding children and adults. The creation of both the mental health and domestic abuse services not only enables targeted specialist care for our patients but also appropriate assessment and safe signposting to partner agencies. Previously some of these cases were likely to have been referred inappropriately to safeguarding.

Vacancies for the community Named Doctor and County Designated Doctor remain. The absence of designated doctor has been added to the Trust risk register with mitigating actions and the CCGs continue to try and recruit to this position but the lack of access to specialist advice for complex cases of fabricated illness or sexual abuse causes concern amongst health professionals and those within partner agencies.

The Named Doctor PA's for the acute Trust have been requested to be increased as this is not adequate for the amount of work required especially as one of the mitigating actions for the community vacancies is to liaise with the Acute Named Doctor.

3. Safeguarding Children Policy:

3.1 Medical examinations for potential inflicted injuries

There have been 26 referrals to the hospital (27 last year) for examination of children for bruising/unexplained marks or faltering growth/issues of neglect from January – December 2017: 15 had no further action taken; 5 were already open to social care and 6 had section 47 investigations by police and social care. The vast majority of these cases are babies under the age of twelve months and referred in by health visitors and/or GP's as per the Suffolk protocol for non- mobile infants. Older children are examined by the Community Paediatricians within working hours and future reports will be able to demonstrate the numbers.

3.2 Sudden unexpected death in children.

From the last annual report in September 2017 to date there have tragically been 4 SUDIC; a teenage boy who hanged himself, a teenage girl with asthma, a small baby co-sleeping with her mother and a teenage girl who died of unknown circumstances and is still being investigated with a post-mortem pending. All deaths continue to be subject to review by the Child Death Overview Panel (CDOP) of the Safeguarding Children Board however several actions have been taken already:

- An information sharing agreement (GDPR compliant) has been written for approval by the Independent schools forum to enable us to share information about pupils in independent educational settings akin to that shared with health professionals in the state education sector.
- A standard operating procedure to follow up those children and young people who self-discharge from the emergency department and who may be at risk of harm. Both the above are as a result of the young man who hanged himself.
- An in-depth independent review of the asthma management of the young girl who died as exceptionally this was the second child of the same family to die of an acute exacerbation of asthma.

3.3 Incidents reported.

There has been one serious incident reported over the annual timeframe. The incident was based in the community and involved a district nurse raising concerns about the child of a family she visited. Instead of referring these concerns to social care or contacting the Named Nurse for advice she contacted the health visitor and the appropriate action wasn't taken and the child went on to suffer harm. This incident has been fully investigated and the Community Named Nurse has delivered training to the appropriate professionals reinforced by the distribution of the correct pathways and contact details for raising concerns.

Several other incidents have been reported:

- Incident that instigated the LADO reporting
- Report to NHS Digital re the CP-IS notifications inconsistency. This system is a nationally driven system to alert unscheduled care providers of a child's status re

child protection plan (CPP), children in care (LAC) or those at risk of Female Genital Mutilation (FGM). Tabs are visual if the child is subject to a CPP or LAC but all girls have an FGM tab which then needs to be 'activated' if the child is evidenced to be at risk. The report to NHS digital stated that we felt this was confusing to professionals and dangerous in that it might be wrongly highlighted to a child who was not at risk. Whilst conversations acknowledged our concerns no change has been evident and staff are advised to be vigilant.

- An incident of delayed access to specialist sexual abuse examination of a child was highlighted to the CCGs and NHS England who commission the service in Suffolk. This has been rectified by the leads for this service presenting at one of our Peer review presentations and speaking to community and acute staff about the correct processes and access to 24 hour advice.
- An incident of a young person with mental health problems whose behaviour escalated on the ward causing extreme distress to children, families and staff. These situations are not in isolation but access to out of hours specialist care for children remains extremely difficult.

3.4 Complaints.

There have been no complaints for this reporting period.

4. Supervision.

Supervision continues largely as group as opposed to individual within the acute Trust and community. The Named Nurse within the community has achieved 100% compliance for supervision, with practitioners understanding the benefit of such practice.

5. Training.

5.1

Level 1

Staff Group	% competent end of June 2017	% competent end of June 2018	August 2018	September 2018
A&E	96	95	84	94
Community midwifery	100	100	98	98
Hospital midwifery	96	96	97	98
Paediatrics	96	98	97	100
Neonatal unit	96	100	100	100
Trust medical staff perm & fixed	88	85	73	75
Trust nursing staff	92	92	95	95
Additional professionals	80	82	81	76
Additional clinical services	85	86	89	87
Admin & Clerical	86	89	90	91
AHP	90	96	92	97
Estates & facilities	94	96	97	96
Healthcare scientists.	78	90	90	90
Trustwide	**89**	**89**	**88**	**89**

Community Services	97	96	96	96

Level 2

	% competent end of June 2017	% competent end of June 2018	August 2018	September 2018
Nursing	92	92	95	95
Medical	86	85	76	78
A&E	98	95	86	96
Paediatrics	97	100	98	100
NNU	96	100	100	100
Hospital M/W	98	96	97	98
Community M/W	100	100	96	95
Trustwide	**91**	**91**	**89**	**90**
Community	97	96	96	

Level 3

Staff Group	% Competent June 2017	% competent end of June 2018	August 2018	September 2018
A&E	89	86	67	85
Paediatrics	97	100	94	94
NNU	96	100	100	100
Hospital M/W	93	96	97	97
Community M/W	98	100	95	95
Trustwide	n/k	94	89	91
Community Services	93	81	n/k	

5.2 As demonstrated above the training compliance has deteriorated for August*. Unfortunately two scheduled nurse training sessions for the ED nursing staff did not occur; one due to absence of the trainer and one cancelled due to clinical need. There are actions in place to rectify this. The new doctor induction attendance was not logged prior to the report being run which has also impacted on the ED compliance. During 2018 it was also evident that we had been reporting yearly compliance figures to the CCG and CSEC whilst other providers reported a 3 yearly compliance. We now have changed our reporting timelines to provide the same data.

For level 3 the staff without the competency for September are represented as follows:

A&E- 2 doctors, 2 trained nurses and 8 nursing assistants
Paediatrics- 2 newly appointed nursing assistants
Community midwifery- 2 midwives and
Hospital midwifery- 1 midwife and 1 maternity care assistant.

5.3 The peer review sessions continue to be well-attended by a variety of health staff across the Acute and community. A change to staff within our partner agencies has seen a decline in their participation but encouragement to get their perspective on cases will continue to be sought.

5.4 A domestic abuse training morning is scheduled for October inviting professionals and victims to discuss their roles and experiences.

6 Recruitment, vetting procedures and allegations against staff.

6.1 One case was referred to the LADO. Investigations have concluded and the staff member has left the Trust's employment.

6.2 93% of staff have completed DBS checks

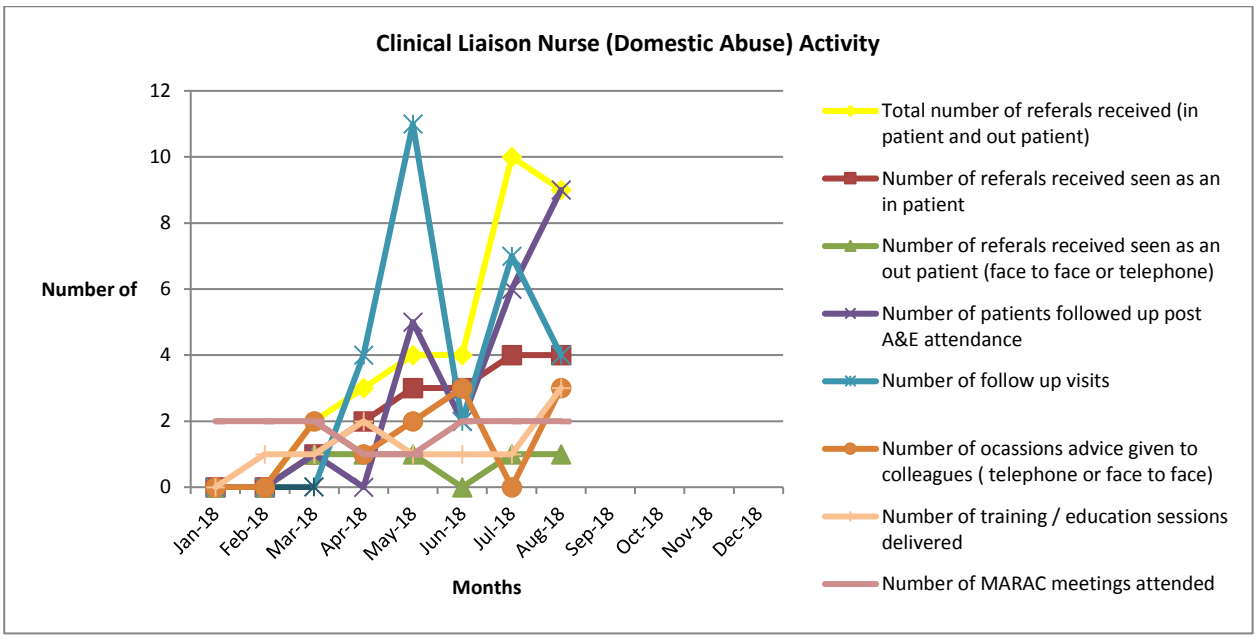
6.3 At June 2018 there is 0.6WTE band 5; 0.4WTE band 5; 0.4WTE band 3 and 0.5WTE band 6 vacancies in NNU
Current vacancies for paediatrics are 3.0 WTE band 5, one appointed to.
ED has 1.0WTE band 5 paediatric nurse vacancy
There are no vacancies in midwifery or paediatric Consultant posts.

7 Interagency working

7.1 See referral information within the report.

7.2 The domestic abuse nurse specialist role has been well received by patients, staff and partner agencies for providing a single point of contact. The role has provided valuable support to victims particularly the elderly who may have lived with domestic abuse for several years. Activity demonstrates the demand for this role:

Clinical Liaison Nurse (Domestic Abuse)								
	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18
Total number of referrals received (inpatient and outpatient)	0	0	2	3	4	4	10	9
Number of referrals received seen as an in patient	0	0	1	2	3	3	4	4
Number of referrals received seen as an outpatient (face to face or telephone)	0	0	1	1	1	0	1	1
Number of patients followed up post A&E attendance	0	0	1	0	5	2	6	9
Number of follow up visits	0	0	0	4	11	2	7	4
Number of occasions advice given to colleagues (telephone or face to face)	0	0	2	1	2	3	0	3
Number of training / education sessions delivered	0	1	1	2	1	1	1	3
Number of MARAC meetings attended	2	2	2	1	1	2	2	2



8 Information sharing

8.1 As previously mentioned in 3.2 an information sharing agreement with independent schools is awaiting approval.

8.2 CP-IS is functioning in unscheduled care environments and future plans are to integrate fully with Ecare thereby removing the current practice to manually check against the summary care record.

8.3 Following the Serious Case Review for young Person F the NNSC for the community has delivered county-wide training raising the importance for capturing the Voice of the Child and has provided several examples on how this can be done in the quarterly reports to CCG. A retrospective audit did highlight how this needs to be continued to be emphasised in supervision

9. Actions for next year

These can be found in the attached development plan.

Addendum:

*Training compliance as of September 2018 added to the report for Board as figures were not available when the original paper was presented to CSEC.

Safeguarding Children Development Plan 2018

Issue (and source)	Actions required	Lead	Timeframe	Progress
TRAINING All Trust staff will have attended training to the competency level assigned to their role in accordance to guidance in 'Working Together 2015' and the 'Intercollegiate document on roles & competencies 2015. Target aim as per Trust mandatory training targets of > 90% completion for levels 1, 2& 3.	• Monthly reports to budget holders • Annual review of training strategy by NNSC and approved by WSHSCC Reports need to be more explanatory for those not compliant ie percentages on maternity or long term sick leave and reflect the incidence when staff have been removed from mandatory training to cover clinical need. Discuss with HR. • Compliance level agreed to be 90% in alignment with dashboard reporting to CCG. • Agenda item for clinical directorate performance management committees • Identify areas of poor compliance. Provide details of weaknesses to unit managers / performance management committees. • Training packages to be reviewed in order to meet requirements and align with project for Regional Skills for Health passport for trainees • Strategy to be updated re requirements for level 3 for those clinicians working with a mixed caseload and approved by committee	MT team Lisa Sarson Lisa Sarson Named professionals Budget and Unit managers Lisa Sarson Supported by Jan Bloomfield All committee members Lisa Sarson	Ongoing Ongoing until compliance target reached 01/05/2018	
SUDIC	• Develop information sharing agreement with independent schools for young people attending with bullying, assaults, emotional ill health • Standard operating procedure for young people attending with emotional or safeguarding related problems and who do not wait to be assessed.	Lisa Sarson Lisa Sarson	April 2018 April 2018	**Awaiting agreement from IS lead**
	• Ensure adult medical clinicians aware of need to instigate protocol for 16-18year olds. • Maintain database for HTA • Report each SUDIC as 'Red' incident on datix with Executive review to downgrade as appropriate within two days	Rachel Furley Lisa Sarson Lisa Sarson	June 2017 March 2017 Each SUDIC	**Sent to MD for briefing 02.11.2017** **ED training session delivered** **COMPLETE**

DOMESTIC ABUSE: Increased incidence of activity within the Trust;	• Record workload for MARAC presentations currently undertaken by specialist nurse • Engage adult safeguarding champions to raise awareness of the generic DA policy. • Provide domestic abuse training within current packages and as stand alone • Develop information leaflet for staff • Develop Safety Planning card for patients • Raise awareness through Greensheet and Time Out display • Review domestic abuse policy and midwifery guideline • Audit dip sample of cases for policy adherence and evidence of patient outcomes • Complete SOP for alert management. • Open telephone advice service for Community colleagues	Julia Dunn Adult safeguarding nurse Named professionals Julia Dunn Julia Dunn Julia Dunn/Hayley Rowan Julia Dunn Julia Dunn Julia Dunn	Ongoing Ongoing June 2018 April 2018 April 2018 September 2018 June 2018	Complete Complete Complete Complete Outstanding Complete
ALERTS	• Present hazards to E-care leads. • Data cleanse resource required once E-care launched	Named professionals Ian Coe		Risk assessed and closed. Greater risk not having alert. COMPLETE
RECOMMENDATIONS FOLLOWING THE INDEPENDENT INSPECTION INTO DR MILES BRADBURY & GODDARD INQUIRY • Information for parents and patients • Training to include identifying someone who targets employment with easy access to vulnerable groups • Chaperone policy and identification of managerial lead • Transition policy • Appointment monitoring • Retention of documents and records • Datix recording of allegations	• Develop an information leaflet for patients and families their rights ,routes for challenge, expectations for behaviour and external sources of help • Review of chaperone policy to reflect national guidance. • Strengthen recording of chaperone presence or refusal. • Review transition policy to reflect national and professional guidance • Strengthen monitoring and recording of appointment scheduling. Implement pre and post clinic review.	Clinicians Named Professionals- Named Doctor to take lead. WSHSCC Clinicians/Named Doctor Alison Garters-Sister COPD Lead Adult OPD Lisa Sarson E-care lead	April 2018	Policy re-reviewed and published. Leaflet to be developed.

Young person 'F' SCR Recommendations • Opportunities given to see the child alone • Recognition and documentation of the importance of the Voice of the child • Staff should be clear about responsibilities to CiC • Staff should have access to supervision • Assumptions that CiC are safe in their placement should not be made • Health assessments should include physical and emotional health and incorporate the opinions of all health professionals working with the child • Staff should be clear how to challenge partner agency decisions and how to escalate their concerns • CiC status should be evident on all health records • CiC reviews should be attended by health or robust reports submitted to ensure information shared	• CiC policy to be developed and disseminated • Specific training to be delivered recognising the importance of the voice of the child, documentation and professional curiosity • Audit to be completed on documentation following training • LSCB escalation policy to be distributed and referred to in supervision • Staff to have access to Named professionals for advice and supervision • Electronic patient records to have systems to highlight a child's care status and update the groups and relationships within that child's family. • All reports need to be shared with appropriate professionals working with the child in order to present a full assessment for that child's needs.	Nic Smith-Howell Named Nurses Jo Hutchings Named Nurses Named professionals Named Nurses All professionals	April 2018 December 2018 Ongoing Ongoing Complete	Electronic systems able to highlight status
Children in Care Initial Health Assessments; • **Delays in initial health assessments for CiC in line with expected Statutory Framework**	• ICPS attendance at Partnership CIC assessment/performance meeting (held 6wkly) • Daily triage of referrals • Quarterly audit of IHA assessments to CCG and LAC • Data capture of referral outcomes shared with CCG • Options appraisal for increasing capacity to March Board • Children in Care policy (health)	Nic Smith-Howell	Ongoing	Approved funding from CCG
NICE guidance benchmark tools: • **CG89 When to suspect Child Maltreatment 88% met** • **NG76 Child abuse and neglect 94% met**	• Addition of 8 specific considerations of maltreatment to the safeguarding children policy e.g. hypernatraemia, intraabdominal injury, non-fatal submersion. Highlight in training and supervision • Raise awareness of impact of school non-attendance and daily activities	Lisa Sarson Named professionals	Next policy review	

	impeded by other responsibilities. • Consider faltering growth and ensure usage of growth charts within System1 and acute electronic records. Highlight in training and supervision • Follow recommendations for FII. Risk assessed and actions identified to mitigate against the vacant Designated Doctor post in Suffolk • Professionals to use their judgement in the detail of family history taking in relation to their role but to consider the impact this may have on the child and follow the safeguarding children policy. Highlight in training and supervision	Named professionals Named professionals Named professionals		
Emerging Gang culture and County Lines within Suffolk	• Liaise with other Named Nurses re developing a 'Toolkit' to aid recognition of YP presenting with potential gang or county line involvement. • Identify types of injuries YP have presented with • Engage with partners in developing and following countywide strategies to tackle gang culture and county line establishment	Lisa Sarson Lisa Sarson/Caroline Holt Named and Designate professionals	October 2018 October 2018 October 2018	
Installation of CP-IS system (Child Protection Information Sharing)	• Identify IT lead • Develop e-learning package • Identify staff to access and ensure smart cards functional • Roll out training • Inform partner agencies once 'live'	Liz Fox Georgina Horrobin Ward managers Lisa Sarson/Gemma Dale/ Liz Fox	'Live' by end of July 2017	COMPLETE

Completed actions from 2017

INFORMATION SHARING Information sharing system compatibility between Acute and primary health.	• Review access of IT systems used by community health. Meet and discuss. • Replicate systems used in East of County.	Lisa Sarson Designate team Identified IT lead in community	July 2016	COMPLETED JANUARY 2017
STAFF WITHIN THE EMERGENCY DEPARTMENT Levels of paediatric trained staff in the Emergency Department currently below recommendation in National guidelines	• Review of Trust Paediatric and Safeguarding skills deployed throughout the trust, particularly in areas of high Paediatric workload. • Seek reassurance that training is at a sufficiently high level to ensure safety. • Daily attendance for under 18 year olds to be reviewed by NNSC and information shared as appropriate. • Allocated hours for paediatricians to assess and treat patients and advise and educate ED clinicians • Identify staff who express interest in completing child health modules and escalate to Lead nurse if funding problems. • Rotation of staff from ED to F1	Rowan Procter Sharon Farthing Lisa Sarson Lisa Sarson Karine Cesar Rachel Shute	Ongoing	**COMPLETE**
AUDIT 1. Referrals to CYPS for 2016 (Policy compliance)	• Compile database • Finalise report and feedback to departments • Consider NSFT numbers of referrals for Trust patients in 2016 report	Lisa Sarson Lisa Sarson Lisa Sarson	March 2017	COMPLETE
2a. Audit of referrals for 2016 regarding potential inflicted injury (policy compliance)	• Utilise audit tool to ensure accurate documentation according to the joint protocol and compliance with Laming recommendations	Lisa Sarson Volunteer medical representative.	June 2017	COMPLETE
3. Sec.11 audit for the Local Safeguarding Board	• Provide relevant evidence for audit to Designate team when requested and implement any recommendations from appraisal • Quarterly reporting to Board and CCG will contain evidence for Sec. 11 requirements	Lisa Sarson		COMPLETE- QUARTERLY REPORTING TO CCG

PERINATAL MENTAL HEALTH/REDUCTION IN NAMED MIDWIFE	• Recruit to Named Midwife and perinatal mental health specialist midwife posts • Named midwife to continue to oversee those with a safeguarding concern identified • Datix incidents where perinatal mental health care suboptimal • Re-establish perinatal mental health service • Support new post holders	Lynne Saunders Named midwife Lisa Sarson	March 2017	PERINATAL MIDWIFE AND NAMED MIDWIFE APPOINTED. PERINATAL MENTAL HEALTH NURSE TO COMMENCE
SERVICE REVIEW: For families undergoing safeguarding referrals for medical examination	• Safeguarding questions to be identified and added to user survey • Cascade through paediatric staff to distribute • Collate responses and report back to committee • Question examples to DNSC	Lisa Sarson Lisa Sarson	Jan 2018	COMPLETE. Collation on receipt.
PELKA RECOMMENDATIONS	• Electronic recording of growth charts inclusion in new E-care system	IT dept.	Development of paediatric programme	COMPLETE
RECOMMENDATIONS FROM SUFFOLK SERIOUS CASE REVIEWS. **Baby E** • Recognition of role of Early Help and the impact of neglect not just in the child protection arena but in CIN and TAC • See the family as a whole • Ask 'what is life like for that child' • Understand the escalation process and be prepared to challenge partner agency decisions. • Recognise the impact chronic illness can have on family functioning • Recognise the impact parents with additional needs have on the ability to parent. • Ensure robust, respectful and focussed complaints processes are in place that do not undermine staff	• Dissemination of SCR, key findings and actions as part of training, newsletter, clinical governance to areas with high attendance of children and young people • Encourage staff to see the family as a whole and ask what life is like for the child • Ensure staff are aware of escalation processes through training • Ensure staff are aware of the neglect strategy and the impact of parents with additional needs • Develop a workforce that are confident and supported in the complaints process particularly with challenging parents.	Lisa Sarson Ian Evans Named Midwife Complaints and PALS department.	June 2017	COMPLETE THEME IN ALL TRAINING PACKAGES FOR 2017

16.3. Infection control

For Report

Presented by Rowan Procter

Trust Board – 28 September 2018

Agenda item:	16.3			
Presented by:	Rowan Procter, Executive Chief Nurse			
Prepared by:	Sue Partridge, Consultant Microbiologist and Anne How, Lead Infection Prevention Nurse			
Date prepared:	August 2018			
Subject:	Infection Prevention and Control Annual Report, 2017-18			
Purpose:	x	For information		For approval

Executive summary:

The Health and Social Care Act (2008) Code of Practice on the Prevention and Control of Infections and Related Guidance requires the Director of Infection Prevention and Control (DIPC) to produce an annual report on the Trust's performance in respect of healthcare associated infections (HCAIs). This report covers the period April 2017-March 2018 and provides information on the progress being made to reduce HCAIs.

The format of this annual report is aligned with the criteria in the Code of Practice.
In October 2017 the Trust took responsibility for community services in the West of Suffolk, which include infection prevention and control responsibilities as described 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	**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

Previously considered by:	Infection Prevention and Control Committee, chaired by Stephen Dunn.
Risk and assurance:	Identified risks, such as the lack of isolation facilities, are noted on the Trust's Risk Register and are regularly reviewed by the Infection Prevention and Control Committee. In May 2017 the Infection Prevention Team requested an external inspection by the IP&C Lead for NHS Improvement, East of England. Following this inspection, infection prevention practices were given a green rating.

Legislation, regulatory, equality, diversity and dignity implications	The annual programme of the work of the Infection Prevention team ensures compliance with the ten criteria of the Code of Practice. Compliance with the Code of Practice is assessed by the Care Quality Commission.
Recommendation: For information.	

Executive Summary

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Introduction

The strategic and operational aim of the Infection Prevention and Control service is to increase organisational focus and collaborative working to maintain standards and support compliance the ten criteria identified in the Health and Social Care Act 2008 (amended in 2015). The objective is to engage staff at all levels and to ensure effective leadership, in order to develop and embed a culture that supports effective Infection Prevention and Control within the Trust.

The Infection Prevention and Control Team (IPT) have worked in collaboration with operational leads and members of the Nursing and Quality teams to maintain an effective service in acute and community areas that has delivered a broad programme of work.

The programme of work has been supported and monitored by the Infection Prevention and Control Committee, which is chaired by the Chief Executive Officer. The Committee provides assurance to the Board through the Clinical Safety and Effectiveness Committee.

The following section of the report describes the annual programme of work in terms of compliance with the ten criteria of the Code of Practice. Compliance with the Code of Practice is assessed by the Care Quality Commission.

Compliance Criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection to other people. (That all staff and those employed to provide

	care in all settings are fully involved in the process of preventing and controlling infection).
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

Criterion 1
Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment or other users may pose to them.

The Trust Board is committed to fulfilling their responsibility to minimise the risk of preventable infection.

The Infection Prevention and Control Arrangements

The Chief Executive accepts on behalf of the Board responsibility for all aspects of Infection Prevention and Control within the Trust. This responsibility is delegated to the DIPC (who is also the Executive Chief Nurse). The DIPC works with the Infection Prevention Team.

The Infection Control Doctor provides expert microbiological and IPC advice and supports the DIPC and the IPT in the production of policies and procedures.

The Lead Infection Prevention Nurse has operational responsibility for management of the Infection Prevention Nurses and for ensuring that IP&C is embedded within the Trust. The Lead Nurse is a source of expert advice and is responsible for on-going development and evaluation of communication strategies at Trust and divisional levels aimed at promoting IPC policies, guidelines and procedures. The Lead IPN is line managed by the Executive Chief Nurse who is also the DIPC.

The IPN team comprises:
Lead IPN WTE 0.8, Band 8a
Two Infection Prevention nurses 1 WTE Band 6 & 1 0.8 WTE Band 6
Limited clerical support is provided by the Pathology Admin and Clerical staff
The Infection Prevention and Antibiotic audit nurses work closely with the IPNs. They are professionally accountable to the lead IPN, although they are managed within the Pharmacy Department, Clinical Support Services Division.
Band 7 WTE 0.8 (0.26 dedicated to Community IPN role)
Band 6 WTE 0.8

The Infection Prevention Doctor is a Consultant Microbiologist; a payment of 0.5 programmed activities is paid in respect of this role, although it is acknowledged that significantly more time is required that this to fulfil the role. Another Consultant Microbiologist acts ad Deputy IPD, without specific additional remuneration.

All members of the team undertake Continuous Professional Development as required by their respective registration bodies, and annual appraisal as required by the Trust. All are subject to revalidation by their respective professional bodies.

The Lead IPN is a member of the Suffolk Community Healthcare Infection Control Group and the Suffolk Community Water Safety Group.

Assurance Framework

The Trust Board receives reports from the IPC via CSEC, as described above. Additional reports are provided by other departments, which inform the Board in respect of compliance with the 10 criteria. These include:

ANNUAL PLAN

In addition to the regular activities described in subsequent sections, progress was made against the 2017-18 Annual Plan in the following areas:

- The use of hypochlorite-containing cleaning products as the Trust standard was again reviewed because of concerns about frequent exposure of staff, and of damage to some surfaces. So-Chlor was identified as being more acceptable to staff without compromising on effectiveness, so has replaced Chlorclean.
- Using ward G9 as a decant facility allowed deep cleaning of all wards except F14; this was undertaken in conjunction with the work to upgrade fire doors.
- The Trust Antibiotic Treatment and Prophylaxis guidelines were revised and re-issued on several occasions because of world-wide antibiotic shortages. They will be reviewed again as the availability of key antibiotics changes.
- The Anti-Microbial Management Team worked with other Trust staff with a view to meeting the requirements of National CQUIN target (see below).
- The IPT has been involved in planning for all major estates projects including the GP Screening area in the Emergency Department, and the development of the Urology assessment area.

Criterion 2
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection

Inspections and audits not undertaken by the IPT are presented to Trust Board by the Hotel Services Manager. They include:

- Dashboard
- Monitoring Officer audits (See attached flow chart)
- Patient Environment Action Group (PEAG) audits
- Annual Patient Lead Assessments of the Care Environment (PLACE)

The Trust Water Safety Group, at which the IPT are represented, considers matters relating to the supply and quality of water and water systems within the Trust. It reports to the IPCC.

The programme of testing for pseudomonas in augmented care areas continues. Significant remedial work has been undertaken (removal of redundant pipework, replacement and resupply of taps and showers) however some outlets continue to test positive. Further engineering solutions are undertaken where possible, however there are some outlets where the continued use of point of use filters is required.

Regular testing for Legionella is also undertaken. A trial of Acetic Acid for eradication of pseudomonas was undertaken on the Specialist Oncology unit. The IPT participated in an external Water Safety Audit undertaken by the Trust's specialist adviser in January 2018.

Criterion 3
Provide suitable accurate information to service users and their visitors

The IPT reports cases of Clostridium difficile, and Staphylococcus aureus bacteraemia (both meticillin-sensitive and meticillin-resistant) to the mandatory National Surveillance Scheme.

Mandatory surveillance of E coli bacteraemia commenced in June 2011 and going forward in 2017/18 will be assigned using PHE criteria to 'community onset' or 'Hospital onset' as part of the quality premium to reduce Gram negative bloodstream infections.

1. C. difficile infection (CDI)

A total of 19 cases of hospital-attributable (by timeframe) CDI were reported for the financial year. Of these 12 were deemed by the CCG to be non-trajectory as there had been no lapses in care. The nationally set objective for 2017-18 was 16. A Post Infection Review meeting is held for each case; these are a valuable forum where notable practice is acknowledged as well as any lapses of care discussed and appropriate actions identified. Prior to her retirement the CCG Infection Prevention nurse used to attend the majority of these meetings; her replacement has yet to take up post.

2. Meticillin-resistant Staph aureus bacteraemia

Three episodes of MRSA bacteraemia were identified (from two patients) which following review by the CCG and then by NHSE Eastern region were all deemed to be 'third party' i.e. not attributable to either the Trust or community.

As a result of the cases of persistent bacteraemia, WSFT and the CCG are still required to conduct a PIR for all cases (this is no longer a national requirement for all trusts).
The nationally-set objective for these cases remains zero.

3. Meticillin-sensitive Staph aureus bacteraemia

Six cases were identified; all were deemed to be unavoidable by Post Infection Review meeting process. There were no common themes.

The presence of a senior clinician at these meetings is very helpful in understanding the course of events, and the support of clinical colleagues is gratefully acknowledged.

4. Gram negative bacteraemia.

There were a total of 182 cases of E. coli bacteraemia across community and Trust, of which 15 were attributable to the Trust by time-frame. It was noted that many of the in-patients had significant comorbidities. A Root Cause Analysis tool is being developed for investigation of these cases and we are advised that this will be required in due course and will be reviewed by Public Health England. This will form part of their national initiative to reduce Gram negative Bloodstream infections.

From April 2017 Pseudomonas and Klebsiella bacteraemias were added to the mandatory surveillance scheme; no targets have yet been set for these cases. There were 5 Klebsiella and 4 Pseudomonas Bacteraemias attributable to the Trust; the only theme was urinary tract infection, this has been explored by the team and initiatives planned for 2018/19.

5. Surgical Site Infection Surveillance.

Surveillance of elective Large Bowel Surgery was undertaken between October 2016 and March 2017, the first time that this module has been undertaken. Comparative results for WSFT against the national results are shown below.

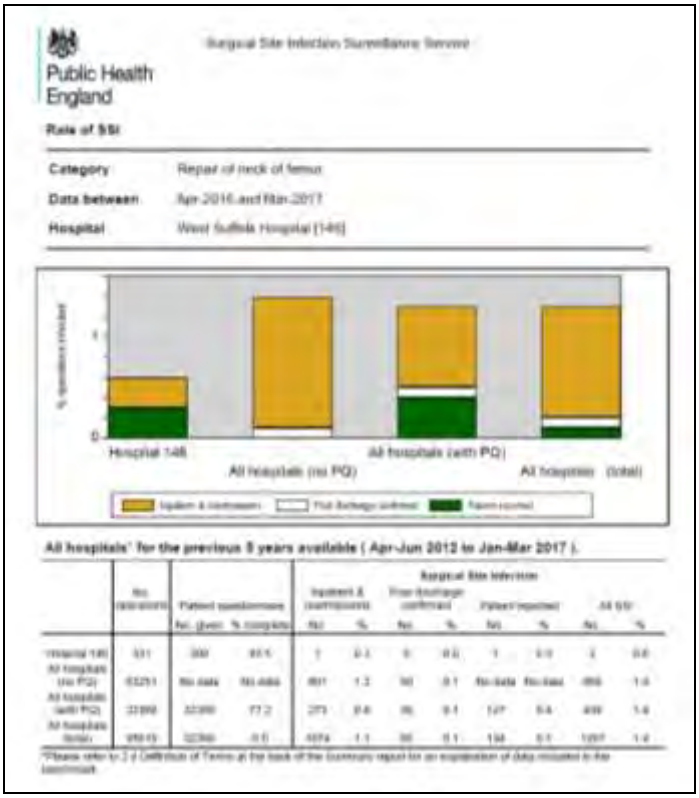
WSH V National

	WSH	National
SSI	9.2%	9.8%
Readmission rate	10.5%	10%
LoS (median)	7	7.8
Laparoscopic Surgery	69.7%	50% (41-68%)
Converstion rate	2.6%	8.5%

Surveillance of orthopaedic surgery was undertaken for three procedures: fractured neck of femur, total hip replacement and total knee replacement.

Surveillance data is collected for all patients having the procedure during the surveillance period. This is undertaken by review of the clinical records for their admission and at the six week post-operative consultation, looking for evidence of infection. Some Trusts also use a patient questionnaire (PQ in the tables below) to collect information about infections that were managed elsewhere; this is extremely time-consuming and is not feasible for WSFT at the present time.

NOF


Public Health England

Rate of SSI

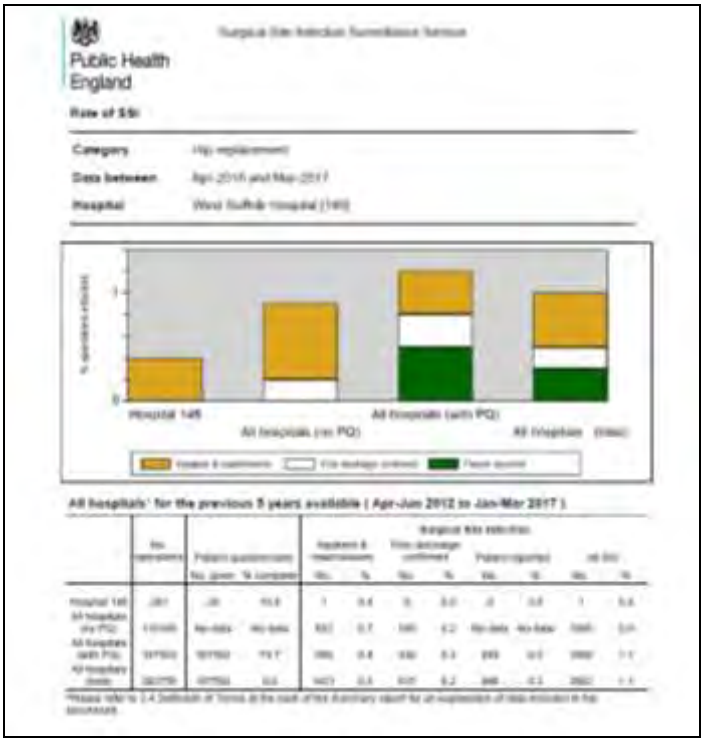
Category Repair of neck of femur

Data between Apr-2016 and Mar-2017

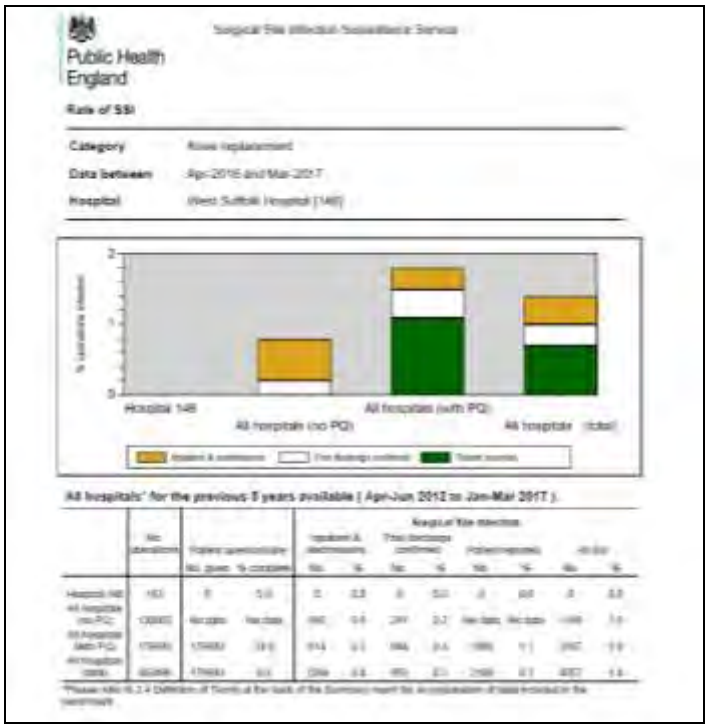
Hospital West Suffolk Hospital (146)

All hospitals' for the previous 8 years available (Apr-Jun 2012 to Jan-Mar 2017).

THR



TKR



Criterion 4
Provide suitable accurate information on infection to any person concerned with providing further support of nursing/medical care in a timely fashion

Infection Prevention advice is available 24 hours a day with from the IPNs or the duty consultant microbiologist.

To ensure that everyone is aware of their responsibilities the managers are responsible for ensuring that the suite of infection prevention & control posters is available for their staff and that there are leaflets or information available for their patients and visitors. The IPCT is responsible for ensuring that information is available for staff via the intranet site and for visitors/carers on the Trust website, this includes the latest Annual Report and Strategy.

A new patient information leaflet on Influenza virus was produced.

Criterion 5
Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people

The IPT strategy has been developed based on the key principles of successful prevention and control techniques, which include:

- Assessment and proactive response to the risk of infection
- Ensuring effective working practices that avoid the risk of transmission
- Universal application of applying fundamental infection prevention and control techniques and practices
- Managing specific infectious agents in line with best practice

The key objectives for 2017-2018 were :

- Following the integration of Acute and Community services to work effectively with the wider health and social care economies to reduce the incidence of health care associated infections and communicable diseases. With particular reference to the correct use of personal protective equipment. To work with colleagues across the whole health economy in respect of the quality premium to reduce gram negative bloodstream infections.
- Continue to build a culture where staff are prepared to challenge and be challenged on clinical practice including hand hygiene and the use of personal protective clothing.
- Ensure, through a system of audit and observation, that our services provide a clean safe environment conducive to good infection prevention and control practice. The audit tools are reviewed and adapted annually. The Perfect Ward app was introduced in the Trust in November 2017 and the IPT have adopted it for some of the IP audits which they undertake.
- Work effectively with operational services and the training teams to strengthen and promote IPC education and training. The Education and Training department have significantly updated the Mandatory Training and Induction programmes. The E&T department now actively promote effective hand hygiene practice in all their training activities.
- Ensure effective risk assessment and risk management strategies are employed whenever and wherever a risk is identified. For example, the ‘side-room list’ supplied to bed managers has been made more comprehensive, to support decision-making around prioritisation of side rooms out of hours.
- To review and improve elements of clinical practice. Preparatory work was undertaken with the Governance Lead around nurse-led removal of urinary catheters; this will be implemented during 2018-19.

These objectives will be supported by an annual development plan to strengthen the Trust’s compliance with the Health and Social Care Act (2008) Code of Practice. The work plan will be agreed and scrutinised by the Strategic Infection Control Committee, with a biannual report being presented to the Clinical Safety & Effectiveness Committee.

Updates on the progress of the work plan are presented to the Infection Prevention and Control Committee. The Executive Team and the Board also receive monthly reports on the

commissioner's infection control targets that include a year on year reduction in Clostridium difficile, zero tolerance of MRSA bacteraemia and the reduction in Gram Negative Bacteraemias. Information regarding audit results and training compliance is also presented.

Criterion 6
Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

All WSFT receive mandatory training at induction and regularly thereafter; the frequency is determined by their role:

- Non-clinical staff undertake e-learning every three years (95% are up to date against a Trust target of 80%).
- Frontline Clinical staff (predominantly but not exclusively Nursing staff) receive annual classroom training
- Consultants undertake annual e-learning. 95% are compliant (target 80%)

IP is a core element in Trust mandatory training.

All new staff job descriptions include the statement that 'it is the personal responsibility of the post holder to adhere to the West Suffolk NHS Foundation Trust policies and procedures outlined in the Infection Control Manual and any other Infection Control policies, procedures and practices which may be required from time to time'.

As part of IPC audit, if poor practice is noted than it is escalated to the area manager for resolution; part of this may be incorporated into appraisals.

Most clinical areas (Trust and Community) have an IP Link Practitioner who acts as a source of information and advice regarding appropriate practice. The Link Practitioners are supported by the IPT and there are four training days a year, each focussing on a different topic. The most recent meetings have covered:

- Aseptic Non-Touch Technique
- Meningitis
- Influenza
- Urinary Catheters

Criterion 7
Provide or secure adequate isolation facilities

The Trust has an acknowledged risk noted on the Trust Risk register describing the low number of single rooms (circa 10% of available beds are single rooms) which is recognised as being the lowest in the region. There has been no change to the number of single rooms during 2017-18.

The IPT attend as a minimum (and more frequently as required) the Midday patient flow meeting to ensure staff managing this key function can access accurate information on available isolation facilities.

The IPN's visit the acute wards daily in order to assess patients requiring isolation and those for whom monitoring is required to ensure all measures to reduce onward transmission are in place. Up to date information on the status of patients who are isolated, or who should be isolated when there is capacity to do so, is recorded by the every weekday by the IPT. This information is supplied to the patient flow bed team.

Our commissioners have set a target of 95% compliance with Isolation and this is reported on a monthly basis via the Infection Prevention Dashboard. Compliance was lower than in previous

years, ranging from 84-90% for most of the year. This reflects the shortfall in single rooms in the Trust.

Criterion 8
Secure adequate access to laboratory support as appropriate

Microbiology services are provided by Public Health England as a subcontractor of North East Essex and Suffolk Pathology Services (which replaced the Pathology Partnership in May 2017). The Microbiology laboratory is still on-site, as there have been further delays in the transformation process that is intended to move the laboratory service to Ipswich.

There are on-going difficulties with extracting data from the Laboratory information Management System (Clinisys WinPath Enterprise) in order to provide lists of in-patients with 'alert organisms' that are of particular concern from an IP point of view. In addition it has not yet been possible to replicate the searches for MRSA screens linked to in-patients to allow reporting of the percentage of patients who are screened. Work continues in these areas and the Information team finalised an MRSA screening report at the end of March 2018; this report has been circulated monthly in 2018/19.

Work continues with Cerner to determine whether the eCare infection prevention module can be implemented with WSFT as a pilot site. This has been delayed while issues of integration with WinPath Enterprise are investigated. The eCare module would offer significant advantages in surveillance of alert organisms and conditions, as well as procedures and devices.

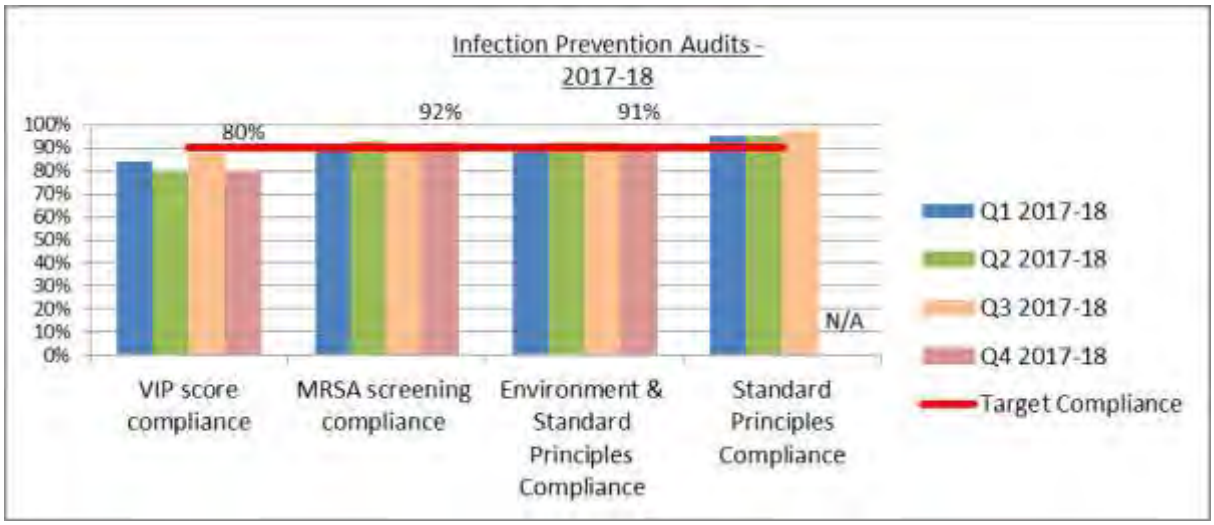
Criterion 9
Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Compliance with elements of the policies is assessed in the programme of Trust audits (High Impact Interventions and Hand Hygiene) and Infection Prevention audits. There is also a rolling programme of audits of compliance with Trust antibiotic treatment policies. These are reviewed quarterly and annually to direct patient safety initiatives.

HIIs and Hand Hygiene Audits

Indicator	Target	Red	Amber	Green	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
HII compliance 1a: Central venous catheter insertion	= 100%	<85	85-99	= 100	100	100	100	100	100	94	100	100	100	100	100	100
HII compliance 1b: Central venous catheter ongoing care	= 100%	<85	85-99	= 100	96	100	100	100	96	100	100	100	100	100	100	100
HII compliance 2a: Peripheral cannula insertion	= 100%	<85	85-99	= 100	100	100	100	100	97	100	98	97	100	100	100	100
HII compliance 2b: Peripheral cannula ongoing	= 100%	<85	85-99	= 100	100	97	98	93	97	99	99	97	96	99	100	100
HII compliance 4a: Preventing surgical site infection preoperative	= 100%	<85	85-99	= 100	100	100	100	100	100	100	100	100	100	100	100	100
HII compliance 4b: Preventing surgical site infection perioperative	= 100%	<85	85-99	= 100	100	85	100	95	100	100	100	100	100	100	95	100
HII compliance 6a: Urinary catheter insertion	= 100%	<85	85-99	= 100	100	100	100	100	100	100	78	100	100	100	100	100
HII compliance 6b: Urinary catheter on-going care	= 100%	<85	85-99	= 100	81	92	94	88	99	94	91	92	95	100	99	97
Hand hygiene compliance	= 95%	<85	85-99	= 100	98	99	99	100	99	98	99	99	99	99	100	100

Additional Infection Prevention Audits



Compliance with Visual Infusion Phlebitis scores has been below target since the launch of e-Care in May 2016. Both ad-hoc and formal training on how and why to complete this has been offered to wards and key groups of staff, and changes to e-Care have been made to request documentation of the care of the IV cannula in the nurse accountability that is completed each shift.

Screening of patients for MRSA on admission and throughout hospital stay has been at 90% or above each quarter this year.

In Quarter Four, following the introduction of the Perfect Ward app, the environment and standard principles audits were combined. The Perfect Ward reports enable easier identification of new, resolved or repeat issues to support action plan development.

Following the audit, areas of non-compliance/poor performance are reported to the Ward manager and Matron and the findings discussed. If there are on-going issues identified in previous audits a formal meeting is held with the Ward Manager and Matron. Audit results and issues identified during the audits are discussed at the IPT/DIPC meeting.

The results of the audits are formally reviewed by the Lead IPN and Audit Nurse. If there are concerns then additional review of practice on the ward is undertaken and support given as necessary to improve practice. This process has continued in 2017/18, allowing any themes to be identified and appropriate actions taken.

For 2018/19 the community in-patient beds at Newmarket Hospital and King Suite, Glastonbury Court, will be included in the Trust IP audit programme. Reviews of the IP audits undertaken by the community nursing teams are underway.

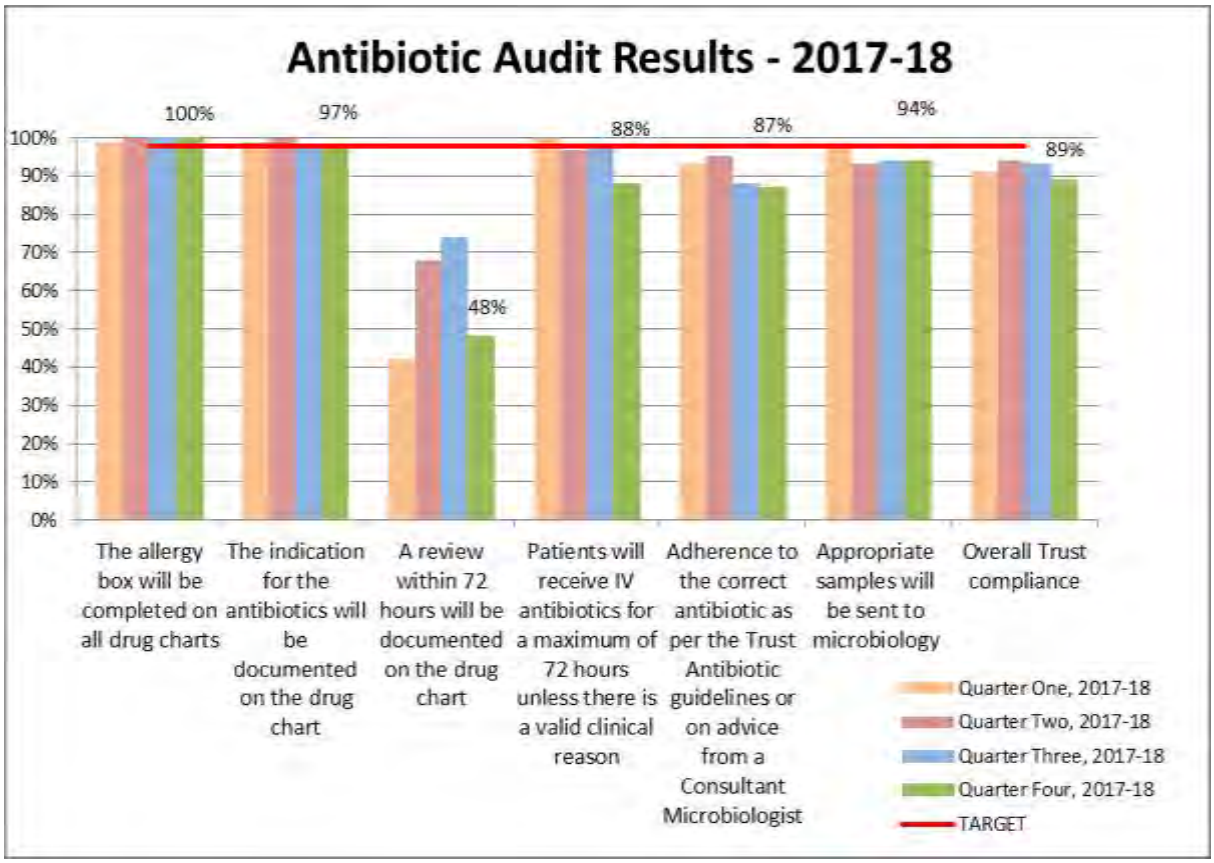
Aseptic Non Touch Technique (ANTT)

It is now 8 years since the ANTT training and assessment programme was introduced. At the end of 2017/18 the Trust compliance with ANTT assessments stands at 69.34%, with the standard being that all relevant staff are assessed every 3 years. Inconsistencies have been identified within the report and the team are reviewing all job roles to ensure that all staff that require an ANTT competency assessment have this allocated to their competency matrix.

There is a plan to roll out ANTT training and competency assessment over 2018-19 to our colleagues working in community services, however the Trust will see an initial drop in overall compliance until these staff have been trained and assessed.

ANTIMICROBIAL STEWARDSHIP

The rolling programme of audit has continued.



Overall results

The Trust was contractually required to achieve 98% compliance in 2017-18; however the Trust failed to achieve this in all quarters, with 91% compliance achieved in Quarter One, 94% compliance in Quarter Two, 92% in Quarter Three and 89% in Quarter Four.

Individual ward results are emailed to the Ward Manager, Senior Matron, Ward Consultants and Service Manager. Results are discussed at Antimicrobial Management Group, Infection Prevention & Control Committee, Matron Performance meetings and Divisional Governance meetings where required.

Dr Younis Dahar left the Trust in 2017, so the role of the Antibiotic lead was undertaken by Dr Tilley and Dr Partridge from that time (a third consultant was appointed in May 2018 and the allocation of lead roles will be reviewed).

Antimicrobial Stewardship Initiatives

- The nurse mandatory session has been updated to include more information relating to antimicrobial stewardship.
- The Antibiotic Audit Nurses have been supporting the student nurse curriculum, providing sessions at the University of Suffolk on antimicrobial resistance and stewardship.
- The second World Antibiotic Awareness Week was held in November 2018:

    1. The Antimicrobial Management Team visited all wards to promote best practice antimicrobial use.

2. The use of the 'Microguide' app was also promoted to all doctors, nurses and pharmacists.
3. 18th November was European Antibiotic Awareness Day & the team held an information display in Time Out.
4. Information was also displayed at the front entrance to the hospital and in the Pharmacy waiting room for patients and visitors.

- The weekly Microbiology ward round continued on F7 until Dr Dahar left the Trust.
- The Antimicrobial Management Team has provided support to Cerner in the build of a new antimicrobial stewardship module.
- The Antimicrobial Management Team has been working with the e-Care Medicines Management teams to develop a more functional review alert to further support medical staff to review prescriptions within 72 hours. Unfortunately the current e-Care system could not support the functionality of this alert; this will therefore not be available until the next systems upgrade in 2019.
- In November 2017 one of the antibiotic audit nurses presented at a national Patient First conference to promote the role of nurses within antimicrobial stewardship.

2017/18 AMR CQUIN

- **CQUIN No 2d): Reduction in antibiotic consumption per 1,000 admissions**

  - There were three parts to this indicator.
    i) Total antibiotic usage (for both IP and OP) per 1000 admissions

    ii) Total usage (Both IP and OP) of carbapenem per 1,000 admissions

    iii) Total usage (for both IP and OP) of piperacillin-tazobactam per 1000 admissions

  - (Baseline period January 2016-Dec 2016: 1% reduction for Trusts with 2016 consumption indicators below 2013/14 median value or 2% reduction for Trusts with 2016 consumption indicators above 2013/14 median value) The above targets 1-3 were not met, which was predicted as unachievable at the start of the CQUIN year. Part 4 was achieved.

The CCG agreed with the case put forward by the Trust that this CQUIN was met due to mitigating circumstances as reductions of total antibiotic usage and carbapenem usage were not possible due to the worldwide piperacillin-tazobactam shortage resulting in:

- Overall prescribing changes
- Multiple antibiotic combinations required to safely replace piperacillin-tazobactam, including for the treatment of Sepsis.
- When Gentamicin became short in supply, Meropenem then became the first line option (part of the Carbapenem group).

Surgical prophylaxis audit

The Trust guidelines for Surgical Prophylaxis were updated; the next audit will be conducted later in 2018.

Criterion 10
Ensure, so far as is reasonably practical, that care workers are free of infection and are protected from exposure to infection that can be caught at work and that staff are suitably

educated in the prevention and control of infection associated with the provision of health and social care.

Please see criterion 6 with respect to staff training.
Staff vaccination against influenza remained a national CQUIN target for 2017-18. The Trust achieved a vaccination rate of 70% against a target of 70-75%. The IPT were involved in the Trust's planning for the vaccination programme, which this year included community staff. Two of the IPT were peer vaccinators.

INCIDENTS – 1. Norovirus

See also Outbreak Table Below

The outbreaks were reported as Serious Incidents Requiring Investigation and RCAs undertaken (organised by the Governance Department).
Learning from these investigations.

The outbreaks on G4 & G5 in March & April 2017 were scrutinized as there appeared to be a link. The wards do not share Medical, Nursing staff or Allied Health Professionals and are separated by an electronically operated fire door which only opens in the event of a fire. Communal facilities were an issue in that there was one ward kitchen (on G4) to serve both wards and one housekeeping 'cupboard' for both wards also on G4. The housekeeping staff are paired between both wards.

At the comprehensive RCA into the outbreaks on G4 & G5 attended by both facilities leads , housekeeping leads , and Consultant staff and chaired by the DIPC it was agreed that a programme of works would be undertaken to provide both a kitchen and housekeeping facilities on G5 so that each ward could be managed separately.

The Assistant Housekeeping services manager had undertaken a review of the workload between both wards and additional resources identified to support both wards.

Since these interventions there has been no further spread of Norovirus between G4 & G5.

In the Winter of 2017/18 F9 & F10 have been affected twice at the same time. Whilst they have separate Kitchen and Cleaning facilities all other resources that may be shared are being scrutinized to ensure all possible measures to keep the wards separate are in place.

Community in patient facilities (Newmarket Hospital)

Included within the Outbreak Table there was 1 outbreak of suspected Norovirus at Rosemary Ward at Newmarket. The patients cardinal symptom was vomiting and therefore there were no stool specimens to test. The index patient was a patient whose family were affected but continued to visit. All actions were completed and the ward reopened in a timely manner.

2. Influenza

Ward G3 was affected by Influenza in March 2018. The ward was closed from 9/3/18 to 19/3/18 (10 days) there were 7 confirmed cases of three strains of Influenza of which there were, 3 Influenza B, 3 Influenza A H1N1 & 1 Influenza A H3. The comprehensive investigation identified learning for the Trust which has been implemented. The Trust does not yet have the facility to test for Influenza on site but this is currently being pursued with our Pathology partners for the coming Influenza season.

Ward affected	Patients with symptoms	Reported Staff with Symptoms	Ward/ Bay closed	Ward / Bay opened	Days affected	Confirmed Noro	Comments
G4	12	0	26/04/2017	03/05/2017	7	2	Possible spread from adjacent ward index patient in Bay 5 male second case was female in Bay 1 no crossover with staff (medical, nursing AHP) however shared housekeeping
G5	8	8	24/04/2017	30/04/2017	7	3	Index not identified
Rosemary Ward Newmarket Hospital	9	8	17/07/2017	24/07/2017	7	0	Predominantly vomiting with no onset of diarrhoea unable to establish cause. Index was patient who had grandchildren affected but family continued to visit Grandmother then symptomatic in the bay
F9	19		10/12/2017	22/12/2017	12	5	Source not identified Noted adjacent ward affected 2 days prior review of any communal facilities
F10	15		08/12/2017	18/12/2017	10	3	Source not identified patients affected well outside incubation period. See F9 above comment
G4	12		31/12/2017	05/01/2018	6	3	Index patient admitted from a Nursing Home following a fall the home was subsequently closed due to Norovirus patient was incubating un beknown to ward staff
G4	15		26/02/2017	07/03/2018	9	2	Extended by the cohorting of G9 into G4
G4	8		19/03/2018	27/03/2018	8	3	Index is a patient transferred to the ward who had had prior exposure unbeknown to either ward subsequently became symptomatic within incubation period of 72 hours
F10	10		7/3/`18	13/03/2018	10	4	Unable to establish index first symtpomatic patients long admission dates and no contacts affected. Adjacent ward F9 were affected two days earlier. Review to establish any communal staff and or areas shared
F9	10		04/03/2018	10/03/2018	6	3	Likely patient NOK with symptoms who continued to visit patient then affected in bay.
G9	5		23/03/2018	01/03/2018		2	Index case admitted with a surgical diagnosis to which her symptoms were attributed however patient also had Norovirus

SUMMARY

Infection Prevention remains a high priority for the Trust. Significant monitoring and audit of a variety of measures is undertaken and reported at Board level.

Following the retirement of the CCG Infection Prevention Nurse Adviser, the IPT have provided senior nursing support to the CCG.

The IPT have worked closely with the Trust Matrons (whose team had undergone significant changes during the year), on the implementation of new policies and procedures.

The main challenge remains the inadequacy of single room provision, both the number and the lack of rooms with en-suite toilets.

17. Consultant appointment report

To RECEIVE the report

For Report

Presented by Jan Bloomfield

Trust Board – 28 September 2018

Agenda item:	17			
Presented by:	Jan Bloomfield, Executive Director of Workforce and Communications			
Prepared by:	Medical Staffing, HR and Communications Directorate			
Date prepared:	Thursday 20th September 2018			
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 Urology
DATE OF INTERVIEW:	Thursday 26th July 2018
REASON FOR VACANCY:	[redacted]
CANDIDATE APPOINTED:	[redacted]
START DATE:	4th February 2019
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	3 1 1

POST:	Consultant Emergency Medicine
DATE OF INTERVIEW:	Thursday 13th September 2018
REASON FOR VACANCY:	New Post
CANDIDATE APPOINTED:	[redacted]
START DATE:	TBC – October 2018
PREVIOUS EMPLOYMENT:	[redacted]
QUALIFICATIONS:	[redacted]
NO OF APPLICANTS: **NO INTERVIEWED:** **NO SHORTLISTED:**	3 2 2

18. Putting you first award

To NOTE a verbal report of this month’s winner

For Report

Presented by Jan Bloomfield

11:15 BUILD A JOINED-UP FUTURE

19. Estates strategy

To APPROVE the document

For Approval

Presented by Craig Black

Board of Directors – Friday 28 September, 2018

Agenda item:	19			
Presented by:	Craig Black, Executive Director of Resources			
Prepared by:	Jacqui Grimwood, Estates and Facilities Development Manager			
Date prepared:	20th September 2018			
Subject:	Estates Strategy			
Purpose:		For information	X	For approval

Executive summary:

This document has been developed alongside the Trust's operating plan, clinical and digital strategies and represents the vision for the future of the Trust's estate. The strategy covers the provision of estates and facilities service for acute and community services between 2018 and 2023. It describes the existing estate and facilities services and the investment plan for the strategic period, it seeks to provide:

An assurance that the clinical and non-clinical services provided will be supported by a safe, secure and appropriate environment

- A method of ensuring capital investment reflects service plans and objectives
- A plan for change that enables progress towards goals to be measured
- A strategic context in which detailed business cases for all capital investment can be developed and evaluated
- A clear statement by the Trust to the public and staff that it has positive plans to maintain and improve services and facilities
- A means by which the Board of Directors and appropriate bodies can evaluate capital investment projects which will require formal approval
- A clear commitment to complying with sustainable development and environmental requirements and initiatives
- An assurance that asset management costs are appropriate and that future investment is effectively targeted
- Assurance that risks are controlled and that investment is properly targeted to reduce risk.

The strategy follows Department of Health guidance for developing an estate strategy and is presented in three parts:

- Where are we now
- Where we want to be
- How we plan to achieve it
- The same issues are discussed in each section, but with a different emphasis.

The strategy is set in a new strategic context and reflects the pivotal changes within the NHS generally, the current economic climate and refers to:

- Five Year Forward View
- Sustainability Transformation Partnerships
- Lord Carter Review - Operational productivity and performance in English NHS Acute Hospitals: Unwarranted Variations
- Naylor review - NHS Property and Estates: why the estate matters for patients
- Development of the West Suffolk Alliance.

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:	**- Scrutiny Committee and TEG.**						
Risk and assurance:	-						
Legislation, regulatory, equality, diversity and dignity implications	-						

Recommendation:

To receive and consider the strategy.

NHS
West Suffolk
NHS Foundation Trust

Estate & Facilities Strategy

2018 - 2023

Estate Development Manager

1. Foreword

We are pleased to be sharing the Estate and Facilities Strategy, which embraces the Trust's clinical, digital and financial strategies, it responds to the Trust's challenges and describes how the estate and facilities services will be developed over the next five years.

The strategy is set in the new strategic context and reflects the pivotal changes within the NHS generally, the current economic climate and refers to:

- Five Year Forward View
- Sustainability Transformation Partnerships
- Lord Carter Review - Operational productivity and performance in English NHS Acute Hospitals: Unwarranted Variations
- Naylor review - NHS Property and Estates: why the estate matters for patients
- Development of the West Suffolk Alliance.

The Naylor review builds on Carter and concludes that the NHS must manage and use its estate more efficiently and strategically. The government supports this view, with a vision of an efficient, sustainable and fit for purpose estate.

This strategy sets out high-level objectives together with the challenges that the estate and facilities service face over the coming years. It acknowledges that further work will be undertaken to develop the detailed delivery plans. The strategy has been developed through a consultation process and reflects the ambition for the estate and facilities services to effectively support the delivery of healthcare services.

This document incorporates the latest thinking in its field, and works across Community and Acute services referencing key Trust documents to demonstrate cohesion. Issues in the Premises Assurance Model assessment, Governance and Risk Management are formally documented - and their impact in terms of backlog constraints, both financial and physical space and structure. Good is celebrated and the challenges are quantified clearly.

Stephen Dunn
Chief Executive
West Suffolk NHS Foundation Trust

Ed Garratt
Chief Executive
Ipswich & East Suffolk and West Suffolk
Clinical Commissioning Group

2. Executive Summary

2.1 Introduction

This document has been developed alongside the Trust's operating plan, clinical and digital strategies and represents the vision for the future of the Trust's estate. The strategy covers the provision of estates and facilities service for acute and community services between 2018 and 2023. It describes the existing estate and facilities services and the investment plan for the strategic period, it seeks to provide:

- An assurance that the clinical and non-clinical services provided will be supported by a safe, secure and appropriate environment
- A method of ensuring capital investment reflects service plans and objectives
- A plan for change that enables progress towards goals to be measured
- A strategic context in which detailed business cases for all capital investment can be developed and evaluated
- A clear statement by the Trust to the public and staff that it has positive plans to maintain and improve services and facilities
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- An assurance that asset management costs are appropriate and that future investment is effectively targeted
- Assurance that risks are controlled and that investment is properly targeted to reduce risk.

The strategy follows Department of Health guidance for developing an estate strategy and is presented in three parts:
- Where are we now
- Where we want to be
- How we plan to achieve it

The same issues are discussed in each section, but with a different emphasis.

The strategy is set in a new strategic context and reflects the pivotal changes within the NHS generally, the current economic climate and refers to:
- Five Year Forward View
- Sustainability Transformation Partnerships
- Lord Carter Review - Operational productivity and performance in English NHS Acute Hospitals: Unwarranted Variations
- Naylor review - NHS Property and Estates: why the estate matters for patients
- Development of the West Suffolk Alliance.

2.2 Where Are We Now?

The Trust completed a comprehensive property appraisal to establish the condition and performance of its estate; this supplements the six facet survey which addressed the following categories at West Suffolk Hospital (WSH) site:
- Physical condition (2015)
- Functional suitability (2016)
- Space utilisation (2016)
- Quality (2009)
- Statutory and non-statutory requirements (2015)
- Environmental management (2009)

The evaluation of the condition and compliance facets of the estate highlight a backlog position of £25.6m and a critical infrastructure risk of £22.4m; this is detailed in Table 1, along with the critical infrastructure risk summary in Table 2. At 2017/18 69% of condition backlog is attributed to structural issues.

Backlog category	Risk	ERIC backlog definition 2015/16	With on cost 2015/16	ERIC backlog definition 2016/17	With on cost 2016/17	*ERIC backlog definition 2017/18**	*With on cost 2017/18**
Condition and statutory	High	4,768,505	7,343,498	3,602,360	5,547,634	*3,306,901*	*5,092,627*
	Significant	20,619,550	31,754,107	20,002,454	30,083,779	*19,150,958*	*29,492,475*
	Moderate	3,147,900	4,847,766	3,147,900	4,847,766	*3,034,200*	*4,672,668*
	Low	217,000	334,180	217,000	334,180	*170,000*	*261,800*
Total		28,752,955	44,279,551	26,969,714	40,813,360	25,662,059	39,519,570

Table 1: Estimated backlog profile

Risk	ERIC backlog definition 2015/16	With on cost 2015/16	ERIC backlog definition 2016/17	With on cost 2016/17	*ERIC backlog definition 2017/18**	*With on cost 2017/18**
High	4,768,505	7,343,498	3,602,360	5,547,634	*3,306,901*	*5,092,627*
Significant	20,619,550	31,754,107	20,002,454	30,083,779	*19,150,958*	*29,492,475*
Total CIR	25,388,055	39,097,605	23,604,814	35,631,414	*22,457,859*	*34,585,102*

Table 2: Critical infrastructure risk

* data not published until Oct 18

All aspects of the main building have a structural component (wall and roofing panels).The most significant condition risk to the organisation is the structural durability of the main building. A Board approved programme of re-roofing the main hospital building is in progress to extend the life of the building. Surveys are in progress to assess the performance of the new roofing system to establish its effect on structural deterioration. The survey work will also provide an understanding of the structural options for the walls, an initial report will be provided to the Board in December 2018.

From a resilience perspective the main area of concern for the Trust is electrical infrastructure. Power supply to the site is via a single point of entry and capacity for any further or development is significantly limited. In 2016 the incoming capacity was upgraded from 1.6MVa to 3MVa to provide additional capacity for developments taking place e.g. Cath Lab and Staff Residences. However, further significant investment is required provide future capacity and resilience. Work is in progress to explore the most viable options available to the Trust.

It should be noted that when solutions for the structural and electrical resilience issues are finalised this will have a significant negative impact on the Trust's backlog position.

There are also constraints for the delivery of any development and backlog works. The estate has limited decant facilities with a substantial presence of asbestos. This effects cost and programme, in addition to the consequential operational impact whilst the works are undertaken.

High Level Performance Indicators (PIs) and the facet surveys identify the Trust is generally using floor space efficiently at West Suffolk Hospital. However, the PI's suggest that the estate may be near the end of its designed life and, probably, in need of significant investment and rationalisation if it is to achieve a more modern and functionally suitable environment.

Section 4 identifies performance indicators derived from the Estates Reporting Information Collection and Model Hospital data collection tools identify areas to investigate further to improve performance.

From a space perspective the majority of concerns in the acute setting relate to the age of the estate, with a 50% shortfall in space when compared to current standards. In terms of utilisation the acute environment space use is generally good and there is no vacant space. However, use of space over time could be improved, particularly desk use in clinical and admin areas which is poor at 40 to 50%. In the community, linked to digital solutions, there are opportunities for rationalisation of the estate. This is being considered alongside the One Public Estate initiative where hubs integrating public sector services, with sharing of space and services are being planned in six key towns in west Suffolk.

The Space Utilisation Group will develop a formal space strategy that sets out the Trust's approach to the use of clinical and non-clinical space across acute and community services.

Energy management is generally good in terms of cost, consumption, CO^2 omissions, and water/sewerage. But the Trust is an outlier with a higher waste cost per tonne than peers. In the main this is attributed to incineration costs and offset by recycling and other recovery costs.

Analysis of customer feedback shows that the overall perception of EFM service provision is good, the environment is well maintained within the constraints of an old building, and supports patient care. Staff attitude is good, but communication and response times need to be improved. It was noted that there is a bias toward hard FM services (maintenance) and this could skew the perception of these services, meaning that some of the observations regarding response times may not apply to the soft FM services (cleaning, catering).

2.3 Where Do We Want To Be?

This section focuses on the long term aims of the estate.

The condition and compliance facet findings have been risk prioritised and incorporated into the backlog Investment plan (Section 5 and Appendices 5 and 7). Although included in the five year investment plan, progress is dependent on the availability of resources and access to undertake the works - both of these issues are included in the risk register for the Division. It is difficult, therefore, to predict when the backlog will be eliminated.

In terms of estate development, reviews are undertaken annually to identify the likely implications for the estate over the strategic period arising out of the proposed service strategy detailed in the operating plan. Reviews prioritise schemes and consider the most appropriate location for developments, based on functional suitability of the space and clinical adjacencies.

2.4 How Do We Get There?

The estate strategy concludes by developing a range of prioritised options to enable the Trust to achieve its objectives over the strategic period, including outline programmes for projects and capital costs. This includes:

Clinical services
- Acute Assessment Unit
- Emergency Department
- Labour Suite
- Ward/Theatres/Department Refurbishment Programme
- Critical Care Unit
- Pleural procedure room

Clinical Support Services
- Pharmacy Replacement Robot
- Diagnostics
- Radiology reporting space
- Audiology refurbishment

Community Services
- Developing localities and service portfolios
- Integrated Community Paediatric services - east Suffolk

Non-Clinical and Corporate Services
- Residences
- Car Parking
- Backlog
- Second lift for Eye Treatment Centre

In the longer term the estate on the Hardwick Lane site is facing key issues that need to be addressed:
- The nature of the main building structure which has a limited design life
- Other additional backlog maintenance issues
- The limitations of the existing buildings layout which is prohibiting proposed clinical service models and best practice in healthcare

These factors are resulting in an environment and experience for patients and staff that is extremely tired and not conducive to twenty first century medicine.

There are a range of options the Trust is considering regarding opportunities to deal with the aging estate, structural, backlog and functional suitability issues, these include:
1. A new hospital on the site (Westley)
2. Phased redevelopment of the existing site
3. Partial redevelopment of the existing site
4. Phased installation of structural supports.

The solutions considered above will all take time and considerable resources to deliver. Therefore, during the life of this strategy the Trust must make a decision on its preferred option to enable a case to be made and the solution delivered, before the constraints make the existing hospital unviable for the delivery of healthcare.

2.5 Internal Reference Documents

The following internal documents have been referenced in the development of the strategy incorporating the latest thinking in the Trust and Alliance across Community and Acute services:

1 WSFT Operating Plan
2 Sustainable Transformation Partnerships Estate Strategy
3 West Suffolk Alliance Strategy 2018 - 2023
4 Community services estate strategy
5 IM&T strategy
6 Imaging services strategy
7 2 facet survey
8 Equality Act survey
9 Environmental assessment
10 Energy saving opportunities assessment
11 Car park review
12 Car parking strategy
13 Green travel plan
14 Landscape and visual assessment
15 Structural condition survey
16 Roofing works condition survey and feasibility study
17 Electrical system condition and capacity assessment
18 Drainage survey
19 Sustainability plan and strategy 2017
20 Water hygiene risk assessment Ref 97, 1846
21 Board Assurance Framework 4.1 Implementation of estates strategy to provide a building environment suitable for patient care and adequately maintained with regard
22 to backlog maintenance incorporating the acute and community estate Backlog delivery risk assessment Ref 671
23 Structural failure risk assessment Ref 24, 1315
24 Compartmentation risk assessment Ref 72, 85, 1413, 2322, 3134, 3133
25 Electrical infrastructure risk assessment Ref 2224
26 Risk assessment policy and procedure PP 132
27 Experience of Care Strategy
28 St Edmundsbury Borough Council Local Plan
29 Estate disposal strategy
30 Food strategy
31 Fire strategy
32 Procurement strategy

3. Overview

3.1 Introduction

This document has been developed alongside the Trust's clinical strategy and represents the vision for the future of the Trust's estate and facilities services in order to deliver the service needs for the next five years. The strategy encompasses complete work streams with a focus on reducing the Trust's backlog maintenance position; development opportunities to improve the patient environment; and support for the development of the clinical environment as services evolve. The investment plan is reviewed annually and as redevelopment opportunities arise.

The estate and facilities services strategy is set within a strategic framework and follows the established guidance for the preparation of Estate Strategies i.e. the guidance given in 'Developing an Estate Strategy' published in December 1999 by NHS Estates, revised 2001 to comprise a six facet survey and updated in 2005. It is organised into three sections addressing the questions "Where are we now?", "Where do we want to be?" and "How do we get there?"

3.2 Where are we now?

This initial stage is aimed at developing a comprehensive analysis of the current position and performance of the Trust in relation to the services it provides and the estate used. This stage establishes a baseline against which the development of the strategy can be measured. Analysis includes estate and facilities services performance indicators and a description of the Trust's estate and facilities management services.

3.3 Where do we want to be?

In this section, the long-term service aims of the Trust are summarised and form the context within which the estate and facilities services strategy and performance targets have been developed.

3.4 How Do We Get There?

The document concludes with a range of prioritised options to enable the Trust to achieve its objectives and facilities services aspirations including outline programmes for investment plans during the period.

3.5 The Benefits of an Estate and Facilities Services Strategy

A robust estate and facilities services strategy is essential in the delivery of the Trust's clinical and non-clinical services. The benefits include:

- An assurance that the clinical and non-clinical services provided will be supported by a safe, secure and appropriate environment
- A method of ensuring capital investment reflects service plans and objectives
- A plan for change that enables progress towards goals to be measured
- A strategic context in which detailed business cases for all capital investment can be developed and evaluated
- A clear statement by the Trust to the public and staff that it has positive plans to maintain and improve services and facilities
- A means by which the Board of Directors and appropriate bodies can evaluate capital investment projects which will require formal approval

- A clear commitment to complying with sustainable development and environmental requirements and initiatives
- An assurance that asset management costs are appropriate and that future investment is effectively targeted
- Assurance that risks are controlled and that investment is properly targeted to reduce risk.

3.6 What is an Estate and Facilities Strategy

The Estate and Facilities Strategy provides an estate and facilities services vision, which will be flexible to the changing needs of the developing service requirements of both the Trust and the local health economy. This will allow the Trust to maintain and improve its high quality services and at the same time improve efficiency and effectiveness to ensure good value for money.

Figure 1 outlines current thinking regarding the Trust's asset management in a changing strategic operating environment, it sets out eight drivers that relate to the Trust's current operating environment. The asset impact is highlighted in orange text and relates to asset management issues which need further consideration. It identifies areas to strengthen alignment with the Trust's strategy, opportunities to diversify methods of procurement, e.g. lease or licenced space rather than freehold etc., along with the potential impact of estate requirements from clinical transformation work (emergency and planned care pathways).

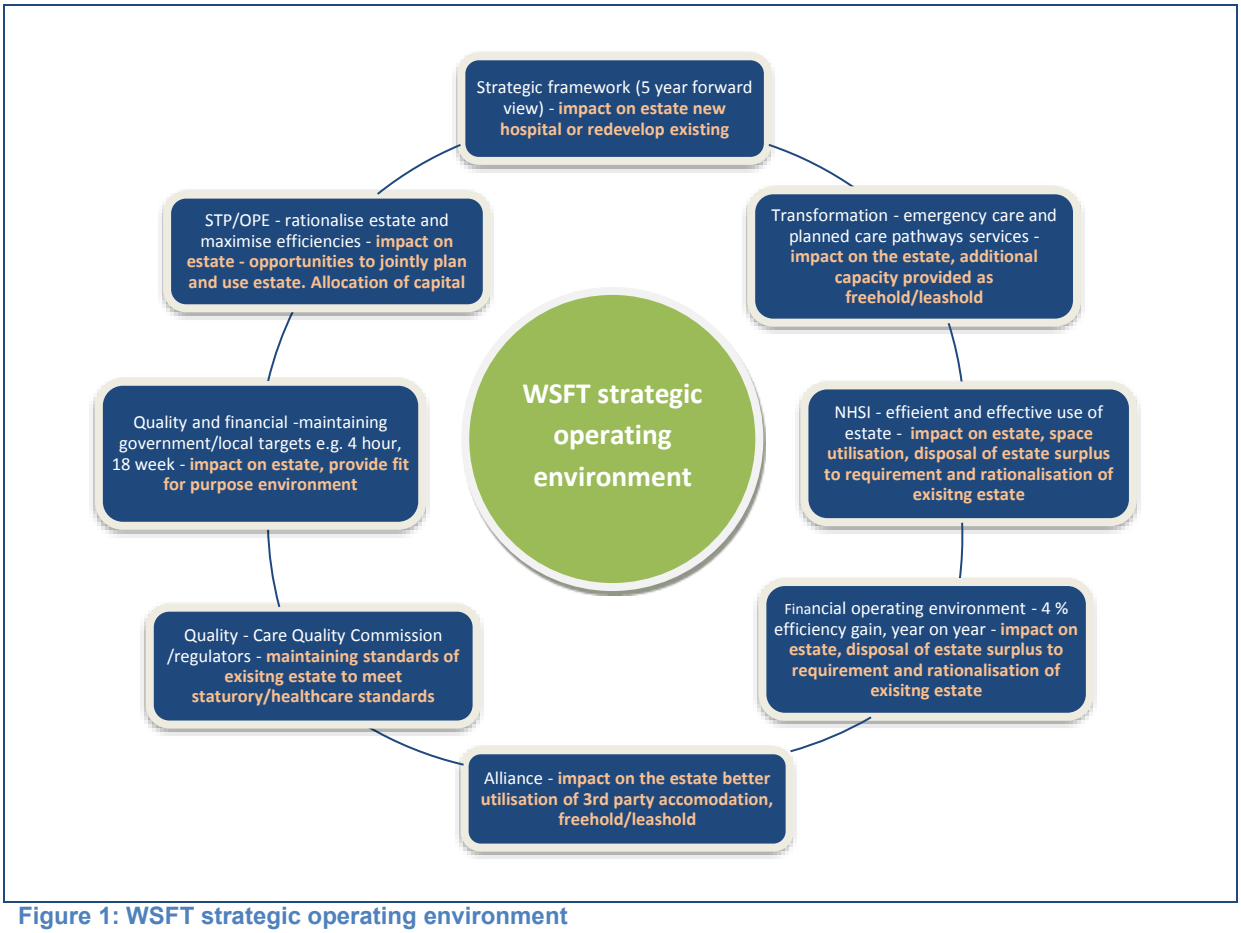


Figure 1: WSFT strategic operating environment

This document replaces the earlier versions and covers the strategic period 2018/19 - 2022/23.

4. Where are we now?

Patients and staff need to feel safe, secure and comfortable. Healthcare buildings should ensure good functionality, meet expectations in terms of privacy and dignity, provide good access for all, reduce infection and minimise accidents. Services should therefore be delivered in secure well-designed and serviced environments.

4.1 NHS policy context

There are three seminal documents that are driving change in the NHS estate and facilities arena. The Five Year Forward View, the Efficiency and Productivity Review led by Lord Carter and the 'Why the estate matters for patients' report, led by Sir Robert Naylor.

4.2 Five Year Forward View

The Five Year Forward View, published in October 2014, sets out how NHS services must change and move towards care models required for the future. It argues the NHS is too diverse for *'one size fits all'* solutions. Changes in policy and new approaches to NHS leadership are needed to deliver on the ambitions set out in the document (innovation, information, new care models, funding, wider themes and approaches). The original paper had limited reference to estate or facilities management services. In March 2017 Next Steps on the Five Year Forward View was released and this makes specific reference to the modernisation of primary care facilities; sharing of facilities between organisations; splitting 'hot' emergency and urgent care from 'cold' planned surgery clinical facilities; protecting and improving estates and facilities ensuring that premises are safe, warm and clean environments for staff and patients and by preparing high quality and nutritious hospital food.

4.3 Operational Productivity and Performance

Building on the themes set out in the Five Year forward View, Lord Carter was commissioned to provide an independent report for the Department of Health by reviewing operational productivity in acute trusts. An interim report was published in June 2015, to share the preliminary findings, with the full report published in January 2016. The reports focused on efficiency and productivity opportunities and looked at four significant areas of spend:

1. Workforce
2. Hospital Pharmacy and Medicines Optimisation
3. Estate Management
    - Effective use of the estate
    - Reduce holding costs
    - Sharing of property across sectors
    - Disposal of surplus estate
    - Effective estate investment
4. Procurement.

From an acute estate and facilities management perspective, the indications from the 32 cohort pilot sites are that a saving of 14.5% could be realised if the cohort moved to the average efficiency of their NHS peers. In terms of the estate and facilities running costs of the estate this equates to an annual saving of £1.2bn. A number of areas which impact on the estate and facilities were identified and targeted for improvement these are:

- hospitals to operate with no more than 35% non-clinical floor space by April 2017
- hospitals to operate with no more than 2.5% unoccupied or underutilised floor space by April 2017

- NHS estates and facilities departments should operate at or above the median benchmarks for the operational management of their estates and facilities functions by April 2017 (as set by NHS Improvement by April 2016)
- Investment in energy saving schemes to deliver opportunities for reduced energy consumption.

4.4 Why the estate matters for patients

In March 2017 an independent report was published, led by Sir Robert Naylor; it acknowledges that, if the NHS is to meet its pledge of better utilisation of the estate - and to release surplus land to deliver 26,000 new homes - then additional capital investment is required. It calls for Sustainable Transformation Plans to develop robust capital strategies, aligned with clinical strategies, to maximise value for money and address backlog maintenance issues.

The review also recommends a new NHS property organisation, a key function of which will be to provide a single, strengthened source of strategic estates planning expertise for the NHS.

The Naylor review identified that the need for additional capital stood at £10bn and suggested that this could be provided from a combination of public sector capital, proceeds from asset disposal and from private sector investment.

The DH responded to the report (January 2018) broadly accepting the recommendations. The response confirmed the actions outlined in the Naylor review will drive transformation of the NHS estate and help the NHS to deliver the Five Year Forward View. They combine targeted investment with clear leadership on estates matters from a new NHS Property Board and a strategic estates planning team to provide on the ground support for sustainability and transformation plans.

The Naylor review was a landmark report, highlighting the challenge of making sure the NHS has the buildings and equipment it needs, but also the scale of the opportunity that the NHS estate offers to generate money to reinvest in patient care. The government's response capitalises on those opportunities.

The Government is delivering on its share of the investment required by providing £3.5bn of additional capital by 2022/23, including:

- £2.6bn to support STP estates transformation plans, in addition to £425m already announced in the spring budget 2018
- £700m to tackle critical maintenance issues and support turnaround plans in struggling trusts£200m to support efficiency programmes to reduce running costs.

A Property Board, chaired by Lord O'Shaughnessy, has been established to ensure the NHS estate is developed and used to best effect in supporting modern-day patient care. This includes ensuring a credible pipeline of capital investment projects over a five year period to deliver real transformation on the ground; holding STP's to account for the successful delivery of approved capital development; reviewing the rules on the NHS trusts' use of capital funding, to make sure they are maintaining their facilities effectively.

4.5 NHS Improvement

From 1st April 2016, NHS Improvement (NHSI) became responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. NHSI provide strategic leadership and practical help to trusts, supporting and holding

providers to account to ensure patients receive consistently safe, high quality, compassionate care within local health systems that are financially sustainable. More recently, an Estates and Facilities Productivity and Efficiency Project Team has been established at NHSI to support trusts in achieving savings of up to £1bn, as well as additional potential savings for new sector organisations. This will be achieved through reducing the unwarranted variation in costs across the NHS in relation to the operational management of the estate.

4.6 Care Quality Commission

The Care Quality Commission ensures health and social care services provide people with safe, effective, compassionate, high-quality care and encourage care services to improve. They monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety.

Trusts are required to register with the Care Quality Commission under their category of provider to enable them to provide healthcare services. The Trust registered with the Care Quality Commission on 1st April 2009. The Trust's last inspection took place in November and December 2017 and it was graded as 'outstanding' overall, the Trust is one of just seven general hospitals in England, and the only one in the Midlands and East region to be graded at outstanding. A high level summary of the assessment outcome is shown in Figure 2. There were no key issues from an EFM perspective that were highlighted in the report.

Figure 2: CQC rating January 2018

4.7 Patient-led assessments of the care environment (PLACE)

Good environments matter. Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be able to draw it to the attention of managers and hold the service to account. PLACE assessments provide motivation for improvement by providing a clear message, directly from patients, about how the environment or services might be enhanced.

April 2013 saw the introduction of PLACE, which is the system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments apply to hospitals, hospices and day treatment centres

providing NHS funded care. The assessments see local people go into hospitals, as part of teams, to assess how the environment supports patient privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. The assessments take place every year, and results are published to help drive improvement in the care environment. The results show how hospitals are performing nationally and locally. The Trust's scores for the last five years are shown in Tables 14 and 15.

4.8 Premises Assurance Model (PAM)

Every NHS organisation has a unique combination of patient needs, priorities, requirements and resources, including its estate and facilities. There cannot be, therefore, a single overall approach to the provision of its estate and facilities that produces optimal results for all the NHS. However, all NHS patients, visitors and staff have the right to receive an appropriate level of service. The NHS is committed to provide services in line with the NHS Constitution right 'to be cared for in a clean, safe, secure and suitable environment'. NHS Boards have a responsibility to hold their own organisation to account and to account to the public about their performance, providing assurance on estate and facilities matters in the process.

PAM is a management tool, developed by the Department of Health (DH), to provide a consistent national approach for evaluating NHS estate and facilities management performance against a set of common indicators. The main benefits of PAM are to:

- Allow NHS organisations to demonstrate to their patients, commissioners and regulators that robust systems are in place to assure that their premises and associated services are safe
- Provide a consistent basis on which to measure compliance against legislation and guidance
- Allow NHS organisations to compare how efficiently they are using their premises
- Prioritise investment decisions to raise standards in the most effective way.

It is designed to be used locally by NHS organisations for Board reporting, and externally to provide assurance to regulators and commissioners. Currently the assessment is undertaken on an annual basis with the results forming part of an annual report to the Board. The Division has an aspiration to develop the system further to incorporate elements into existing processes e.g. the self-assessment question for fire safety could be integrated into the fire safety group; this would enable the assessment to be more dynamic.

On 29 January 2016, the DH issued a revised version of PAM (2016 version); the key change is that PAM has been updated to support the NHS constitution *'to have a right to be cared for in a clean, safe, secure and suitable environment'*. This Trust has been acknowledged, by the DH, in the updated PAM guidance document for its contribution in the development of PAM.

The 2016 version of PAM was prepared against a background of rapidly developing policy on patient safety and the DH has endeavoured to incorporate these emerging requirements and themes. In particular, a number of key reports and proposals have influenced the model:

- The Mid Staffordshire NHS Foundation Trust Public Inquiry
- Patient First and Foremost: The Initial Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry Report
- Hard Truths: The Journey to Putting Patients First, The Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry
- The Keogh Mortality Review outcome reports
- The Winterbourne View Review and The Berwick Review in to Patient Safety;
- Proposals to Change The Care Quality Commission Registration Regulations

- Changes proposed at the time in the draft Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A summary of the Trust's latest assessment is shown in Figure 11.

4.9 Model Hospital

The Model Hospital is a tool that has been developed by the Department of Health and can be used by anyone in the NHS - from board to ward. It facilitates comparison of productivity, quality and responsiveness to identify opportunities for improvement. The Model Hospital is broken down into five 'lenses' which offer different perspectives from which to review hospital activity:

- board-level oversight
- clinical service lines
- operational
- people
- patient services

Each aspect contains specific sections enabling more granular exploration of an area in the Trust to see where it is performing well and where there are opportunities to improve.

The Operational productivity and performance in English NHS acute hospitals: Unwarranted Variations Report concluded there was a need for a model to define *What an efficient NHS hospital looks like*. It stated that a *Model Hospital* can show how good clinical practice, workforce management, and careful spending, lead to measurable efficiency improvements whilst retaining or improving quality.

The Model Hospital forms the central element of the report and includes a number of measurements including space utilisation metrics for all acute hospitals which were mandated in 2017. These metrics consist of space standards which include the following:

- All NHS trusts to have no more than 35% non-clinical occupied space on an acute hospital site.
- All NHS trusts to have no more than 2.5% empty space on an acute hospital site.
- All NHS trusts to have no more than 2.5% underutilised space on an acute hospital site.

Highlighting variation requires the right metrics with detailed guidance on what good looks like. The weighted activity unit (WAU) can be used to compare performance and productivity across trusts. NHS Improvement continues to develop the model hospital and its underlying metrics, so that there is one source of data, benchmarks and good practice.

4.10 Local context

4.10.1 West Suffolk NHS Foundation Trust Overview - acute and community services

West Suffolk Hospital was founded in 1832, moving to its new site in Hardwick Lane in 1973.

The Trust serves a catchment population of circa 275,000 in an area of approximately 600 square miles, which extends to Thetford in the north, Sudbury in the south, Newmarket to the west and Stowmarket to the east, outlined in Figure 3. Community paediatric services are also provided pan Suffolk. Whilst mainly serving the population of Suffolk, the Trust also provides care for those in the neighbouring counties of Essex, Cambridgeshire and Norfolk.

Figure 3: Trust Catchment Area

The Trust provides acute hospital services from its 430-bed hospital set in parkland on the outskirts of Bury St Edmunds. The hospital has an emergency department, obstetrics, maternity and neonatal services, a day surgery unit, Eye Treatment Centre, Macmillan Unit and children's wards and provides the full range of secondary care services. In addition, the Trust trains the doctors and provides the clinical base for the Cambridge Graduate Medical course.

4.10.2 Outpatient services

The Trust provides outpatient services in the community which give convenient local access to our consultants and other clinical staff. Outpatient appointments are currently offered in the following locations:

- Newmarket Community Hospital
- Haverhill Health Centre
- Thetford Healthy Living Centre
- Stowmarket Health Centre
- Sudbury Health Centre
- Botesdale Health Clinic
- Mildenhall Clinic

4.10.3 West Suffolk Community Services

In 2017, the Trust secured a 10 year contract to provide community services for the residents of West Suffolk through an alliance between the Trust, Suffolk County Council, Suffolk GP Federation and Norfolk and Suffolk NHS Foundation Trust.

The Trust delivers community services in the west of Suffolk via locality teams who provide nursing and therapy care alongside specialist nurses and the community intervention service for urgent cases.

A community Paediatric service is run by the Trust, operating pan Suffolk to offer integrated services to children and young people with disabilities and longer term health conditions.

Community services also runs Newmarket Hospital which maintains 19 inpatient beds as well as outpatient clinics for acute and community services.

4.10.4 West Suffolk Hospital - freehold

West Suffolk Hospital was the first of a new design of hospitals to be known as 'Best Buy' hospitals. This was the first standard design to combine a compact and economical hospital to meet modern purposes; five hospitals of this design were constructed. Four are located in East Anglia (Hinchingbrooke in Huntingdon, James Paget in Great Yarmouth and Queen Elizabeth in King's Lynn). The fifth is Frimley Park based in Surrey.

This particular type of design and construction method places considerable constraints on the efficient operation and further development of the hospital. The building was designed with a 30 year functional life.

Since the original build, further development has taken place outside the original footprint, these are:

- A major extension providing facilities for older people - 1977
- Residences, Rowan House A and B - 1984
- The Day Surgery Unit - 1994
- The Education Centre - 2003
- The Eye Treatment Centre - 2004
- The Macmillan Unit - 2005
- Quince House - 2017

Buildings accommodating St. Nicholas Hospice (a registered charity), the Wedgwood Unit, where mental health services are provided by Norfolk and Suffolk NHS Foundation Trust and Busy Bees Nursery are located in the south east of the site on land subject to formal lease agreements which are due to expire on 14th August 2051 (60 year lease), 31st May 2118 (125 year lease) and 26th August 2040 (30 year lease) respectively.

The Trust's land and property portfolio includes a green field site (Churchfield Road) located in Sudbury.

4.10.5 Community services - leasehold

The Suffolk Community Services contract in the west of Suffolk is currently delivered from 23 sites for which the Trust is responsible. NHS Property Services (NHSPS) is the landlord for 11 sites, including Newmarket Community Hospital. The remainder of the estate comprises seven sites used on an ad-hoc basis and a further five subject to formal leases with other organisations. 22 further sites, in the east of Suffolk, are used to deliver services pan Suffolk which the Trust is responsible for delivering, although the responsibility of estate in the east is retained by East Suffolk and North Essex NHS Foundation Trust (ESNEFT). Further detail of the leasehold estate is at Appendix 1.

4.10.6 WSFT Strategic Framework

In response to the Five Year Forward Review, the Trust prepared a strategic framework '*Our patients, Our hospital, Our future, together*' 'which sets out its clear vision, focused priorities and ambitions, see Figure 4. These underpin our work with staff, patients and colleagues in primary and community care to improve the quality and safety of existing services and accelerate the introduction of new joined-up preventative and integrated services in the community. From an estate and facilities perspective these translate to:

- *Deliver for today*; maintain and improve the services and facilities we provide, explore public sector estate opportunities.
- *Invest in quality, staff and clinical leadership;* Extend ISO accreditation across the Division's services. Further develop the benchmarking systems and tools we use.

Continue the training and development programme for staff across the division. Celebrate our successes.

- *Build a joined-up future*; provide an estate that facilitates care at the right time in the right place. Explore the development of a health and social care campus. Build on service transformation initiatives.

Figure 4: WSFT Strategic Framework Our patients, Our hospital, Our future

4.10.7 Sustainability Transformation Partnership (STP)

All health and care organisations within the Suffolk and North East Essex health and care system have been working together since March 2016 to develop a shared vision, priorities for action and to explore benefits of partnership working. It is clear that there are benefits for our population if we align our goals and actions, and share knowledge and skills.

The STP plan, summarised below in Figure 5, details progress to date and outlines how the system-wide plan can be delivered across organisations; how the known and emerging risks can be managed; and how, by working together, we can improve the quality and safety of care provided.

Figure 5: Suffolk and North Essex STP Approach

The Suffolk and North Essex STP currently has two, board-approved, Strategic Estates Plans (SEP) across the system, one for North East Essex and one for Suffolk. Both strategies are aligned and aim to consolidate public sector estate and utilise the current assets to the maximum benefit. There are Local Estates Forums, in both Suffolk and North East Essex, which operate with estates professionals/stakeholders in work streams working on priorities identified within the SEP. It is essential that the local and regional estates strategies align with the STP programme. There may be opportunities to reduce or dispose of some high cost estate as services shift into different care settings. Figure 8 shows the health system estate governance structure adopted by the STP estate work stream used to progress investment planning.

4.10.7.1 Governance and accountability

The STP Governance framework and shows how the STP Estate Strategy Group links to other elements of STP governance, see Figure 6. The STP governance structure represents programme delivery, rather than an organisational delivery structure.

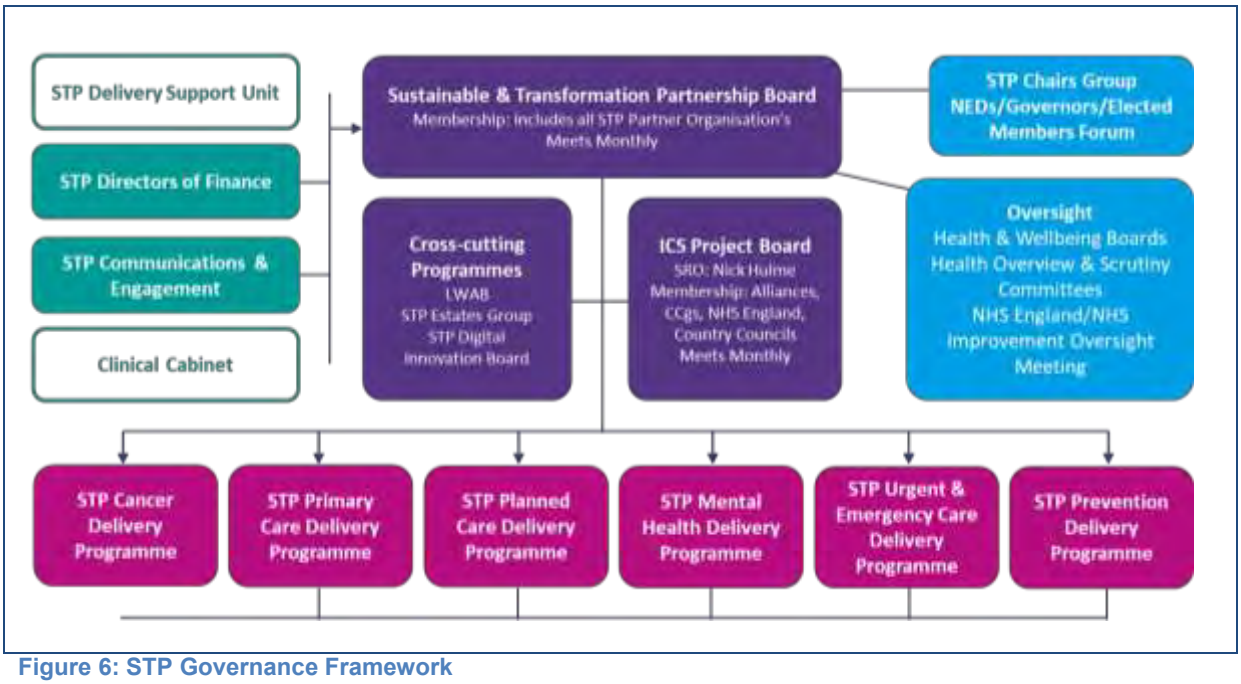


Figure 6: STP Governance Framework

The STP Estate Strategy Group Governance structure shown in Figure 7 demonstrates the system wide level at which the group operates, reporting to the STP Partnership Board in terms of progress, risks, issues and items for escalation. Additionally the group has a further role in reporting to the NHS England Capital Oversight Group with recommendations for review of business case documentation for STP capital schemes.

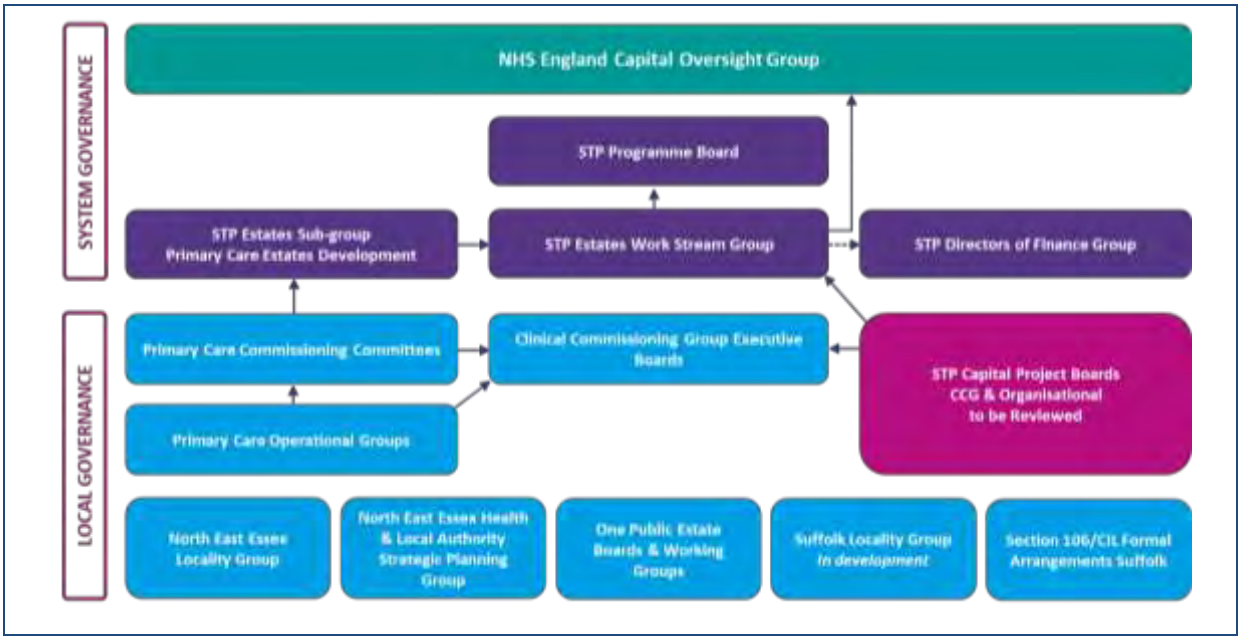


Figure 7: Estate Governance Structure

4.10.8 One Public Estate (OPE)

OPE is an established national programme delivered in partnership by the Cabinet Office Government Property Unit and the Local Government Association. It provides practical and technical support and funding to councils to help them deliver ambitious, property focussed, programmes in collaboration with other public sector partners. OPE has three core objectives:

1. Creating economic growth - new homes and jobs
2. Delivering more integrated customer-focussed services
3. Generating efficiencies through capital receipts and reduced running costs.

The Trust plays an active part in the OPE work in west Suffolk and is a member of the West Suffolk Property Board. Work is in progress to develop options for six key towns:

- Mildenhall
- Bury St Edmunds
- Haverhill
- Newmarket
- Clare
- Brandon

To ensure the process is joined up with the strategic estate planning work currently being undertaken by the STPs, representatives from the west Alliance and OPE team attend the STP estate work stream and the West Suffolk Property Board meetings.

Part of the West Suffolk estate portfolio (Sudbury) is not captured by the West Suffolk Property Board as it does not fall within the catchment area of West Suffolk Borough Councils, but falls within the remit of Babergh District Council. The OPE agenda is at an earlier stage in Sudbury, but there is representation from the OPE team at the STP Estate Work Stream Group. Discussions are taking place with Babergh District Council to progress the OPE initiative in Sudbury.

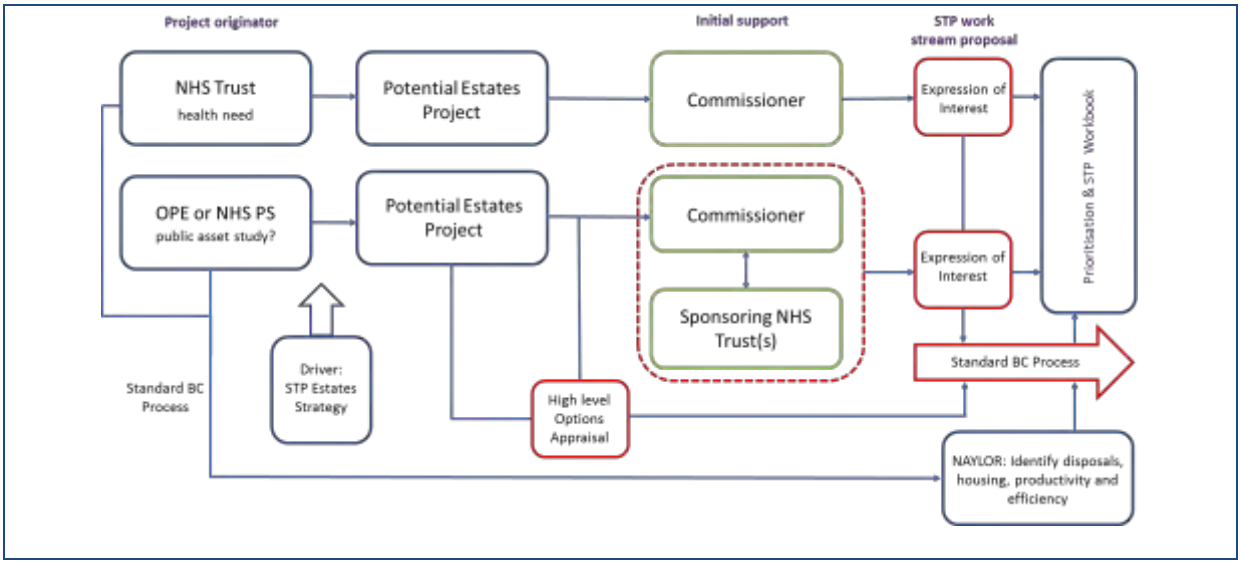


Figure 8: STP estate development/acquisition/disposal process

4.10.9 Management of the Trust's estate and facilities services

The Trust's acute estate and facilities budget is £11.7m (2018/19) with 346.99 (2018/19) whole time equivalent staff delivering EFM services. All EFM services are in-house with the exception of laundry, waste, pest control, car park management and professional services (architect, quantity surveying, and structural engineering), see Figure 9.

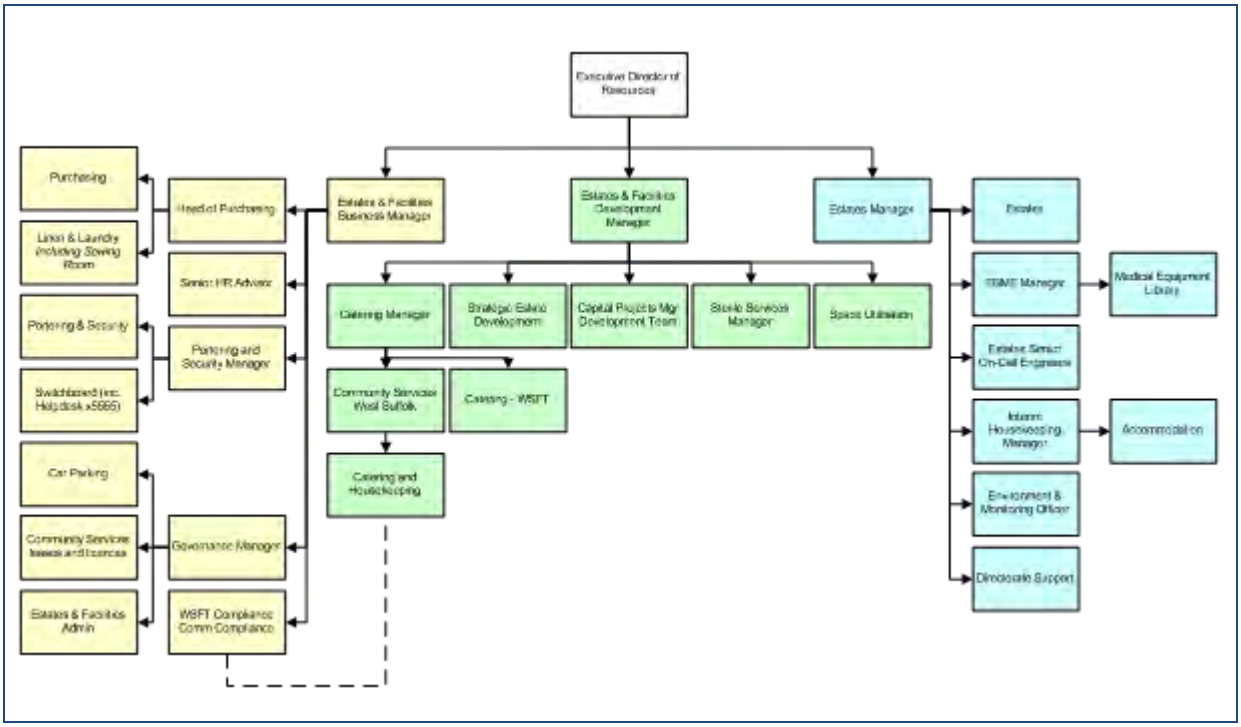


Figure 9: Estates and Facilities structure

In October 2017, the Trust secured a 10 year contract to provide community services in West Suffolk; its value is £24m. The estate and facilities management impact from the contract is a further £2m (2018/19) budget and an additional 21.09 WTE (2018/19) members of staff. The contract is delivered from a property portfolio of 23 leasehold sites in the west

and a further 22 in the east (estate managed by ESNEFT), to deliver pan Suffolk services, see Appendix 1, community services leasehold register for further detail.

The Division is managed by three senior managers reporting directly to the Executive Director of Resources/Deputy Chief Executive. The Division's portfolio of services is split across the senior managers with them each contributing to its overall management - see Figure 10 for further detail. This also indicates services that are provided in-house and those that are outsourced, along with departments that are ISO accredited.

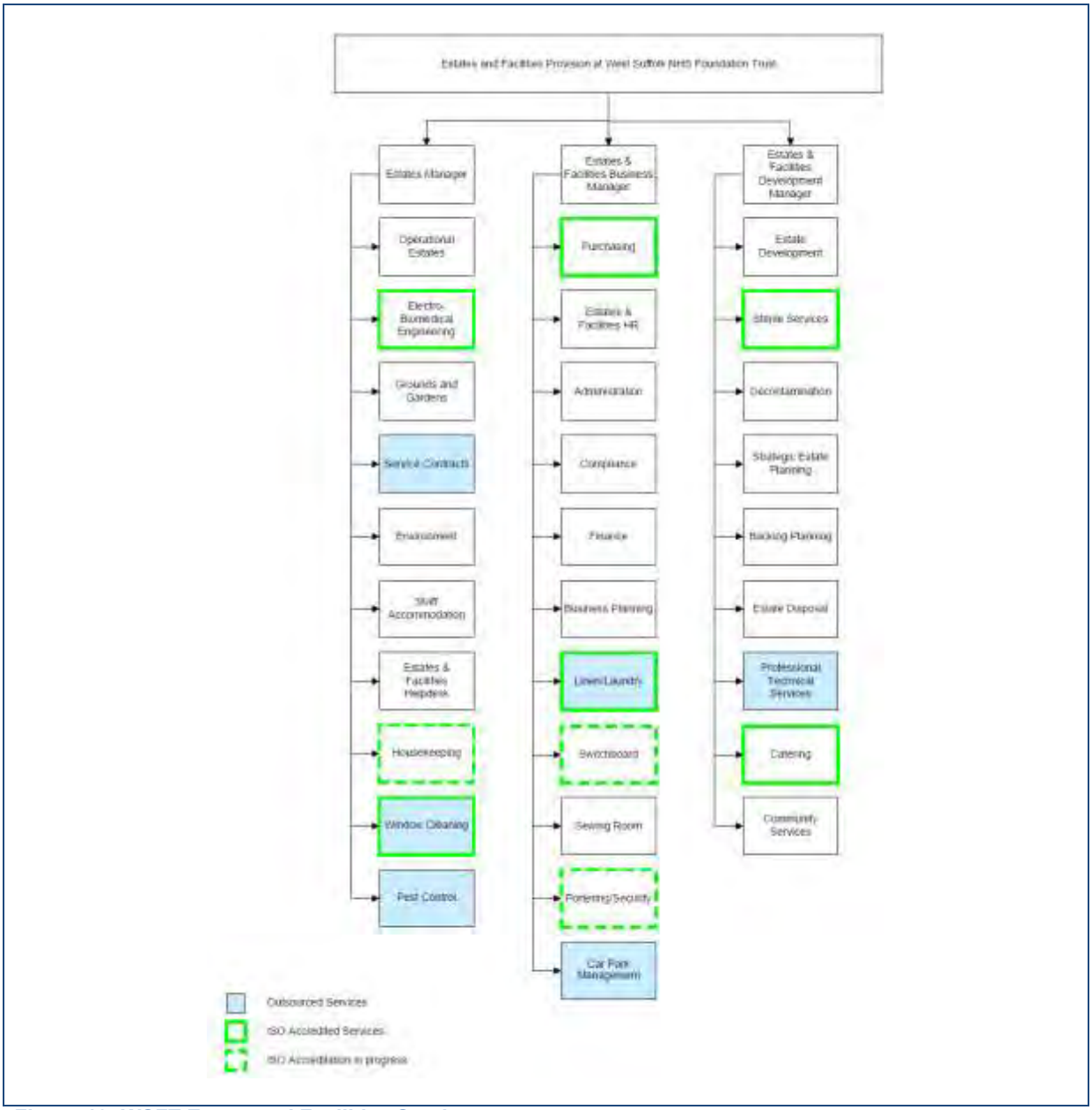


Figure 10: WSFT Estate and Facilities Services

4.10.10 Performance Management

An estates strategy is a starting point for the implementation of performance management measures to improve the performance and utilisation of the estate. Comparing results on a local, regional and national level will allow areas of difference to be identified. These areas

can then be prioritised for further investigation, to establish best practice and areas of transformation. Efficient estate planning offers an opportunity to release revenue tied up in poorly-utilised areas or inefficient systems e.g. energy, which can be reinvested into patient care and improving the building stock. In addition to benchmarking groups (NPAG and HefmA) the Trust uses 2 Department of Health primary sources for benchmarking (model hospital and ERIC)

Model Hospital - the portal provides nationally available performance information relating to productivity, efficiency and quality of care metrics. The estates and facilities section of the portal uses four sources of data PLACE, ERIC, reference costing and NHS England statistics KH03 Bed data. See Appendix 2 for a breakdown of the performance information.
ERIC - a mandatory return, collected annually a year in arrears and published nationally six months after the end of the reporting period. The Trust's profile is compared to those Trusts with a similar service and estate profile (basic small acute outside London (all)).

4.10.11 Developing the Strategy

In order to develop this strategy, the Trust has carried out a comprehensive review of its current estate, looking at the performance of buildings in connection with their current and proposed use as well as assessing the extent to which the Trust complies with current policy and best practice in connection with the operation and management of the estate.

The following analysis has been undertaken:

- A detailed assessment of the condition and performance of the West Suffolk Hospital estate
- A review of the Trust's performance in connection with sustainability and carbon management practice
- Patient, visitor and staff perception of the estate
- A review of accessibility and parking arrangements
- Environmental and ecological policy and constraints
- Future service requirements and their impact on the estate
- A review of risks associated with the continued operation of the estate and its infrastructure
- Structural survey/review of roof and walls for the main hospital building
- Suitability of management arrangements in connection with the operation and development of the estate
- Capacity and resilience review of site services infrastructure, e.g. electrical services
- Development of a Travel Plan and Car Parking Strategy.
- A masterplan review which establishes where and how the Trust could develop and replace its current Estate.

See reference documents 7 to 18 and for further detail of this work.

4.10.12 Governance

The Trust has a clear governance structure and Risk Management Policy that successfully manages key risks within the organisation through the use of its Board Assurance Framework. Any associated moderate/high level risks, within the estates strategy, are held on the Trust's corporate risk register and monitored appropriately with mitigation plans in place. Appendix 6 shows the governance structure for the Division, how key EFM groups link into the Trust wide governance structure and highlights escalation routes.

4.10.13 Risk Management/Assessment

The Trust has established an effective system for identifying, assessing and scoring the risks to the organisation. Each risk assessment is accompanied by a description of the controls that are already in place to manage the risk, as well action plans that have been developed to further manage or reduce the risk. All identified risks are recorded on the corporate risk register (Datix system) and are referenced to the board assurance framework (BAF) where relevant.

The Trust takes a pro-active approach to risk management in order to:

- Create a culture where the staff acknowledge that risk management is a responsibility for everybody
- Ensure the safety and security of the environment for the patients, visitors and staff
- Improve the quality of the healthcare services provided
- Enhance the core business and financial systems
- Meet statutory and legal requirements.

The corporate risk register is reviewed on a monthly basis by the Trust Executive Group, in addition, the Estates and Facilities Governance Steering Group (E&FGSG) receives a monthly report on the status of risks within the Division, this includes a summary of the Division's top 10 risks along with a summary of estates and facilities related active red and amber risks. The E&FGSG are responsible for reviewing new risks, ensuring risk assessments are up to date, tracking progress of risk actions and escalating risks where relevant. Table 3 identifies a summary of Estates and Facilities top 10 divisional risks.

Ref	Risk description	Risk lead	Risk register number (Datix)
1	Fire safety - non compliance to Regulatory Reform Order	Estate Manager	72, 85, 1413, 2322, 3134, 3133,
2	Water safety and front residences - Legionella	Estate Manager	97, 1846
3	Capital backlog - delivery of plan	Estate Development Manager	671
4	Lack of decant ward/space - isolation, privacy and dignity, deep cleaning	Executive Chief Nurse	15
5	Building structure condition	Estate Development Manager	24, 1315
6	Management of asbestos	Estate Manager	378
7	Community services compliance, lease status	Estate Development Manager	1779, 2122
8	Electrical infrastructure capacity	Estate and Facilities Capital Manager	2224
9	Medical gas infrastructure condition and capacity	Estate Manager	311, 1430, 1431, 2075
10	Workforce - recruitment and succession planning	Estates and Facilities Business Manager	3334

Table 3: Summary of Estates and Facilities key divisional risks

Improvement of patient areas and the working environment in itself reduces risk to patients and staff, risk mitigation in this respect will be via informed discussions with staff, the Trust's in house advisors (Health and Safety, Fire, Security, Infection Control etc) and using audits and inspections such as the Patient Lead Assessment of the Clinical Environment (PLACE).

4.10.14 Premises Assurance Model (PAM)

The Trust has completed an annual assessment of PAM since 2014 and reports findings to the open Board; the most recent assessment summary is detailed in Figure 11.

The Trust implemented a robust process in place using a six-stage approach:

- Set up
- Assessment preparation
- Assessment
- Organisational feedback
- Monitoring
- Annual review

Confirmation and challenge workshops chaired by the Executive Director of Resources, attended by a range of multi-disciplinary staff facilitated a robust and consistent approach to testing the self-assessment and supporting evidence for each criteria.

The Trust's PAM action plan is maintained and updated throughout the year and, following each assessment, any items ranked 'inadequate' or 'requiring moderate improvement', identified on the action plan, are added to the Divisional and corporate risk register. Monitoring of progress of the action plan is undertaken by the Corporate Risk Committee on a bi-annual basis and quarterly with the Facilities Management Team and Executive Director of Resources. Where actions require additional resources, these are escalated through the usual committees e.g. any fire compliance issues would be raised by the Fire Safety Group, escalated to the Health and Safety Committee who would escalate to the Corporate Risk Committee and/or committee with the delegated authority to make any necessary decision regarding resource allocation - this is in line with the Trust's Governance arrangements. Actions requiring capital investment are included within the Trust's annual business planning process.

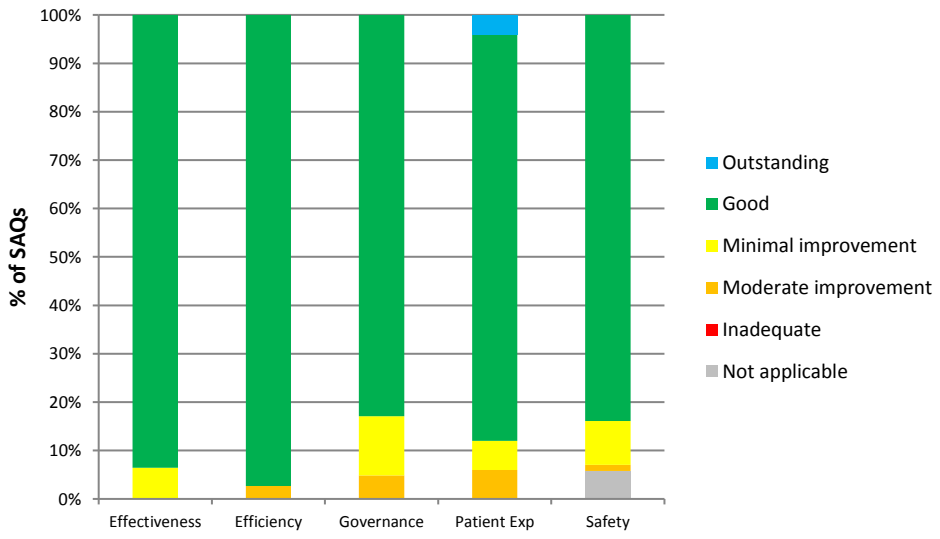


Figure 11: WSFT PAM 2016 Assessment

4.10.15 Land and Property Portfolio

The Trust has an estate with a Net Book Value (NBV) at 1st April 2017 of £59.6m. West Suffolk Hospital is an acute general hospital, with a total site area of 20.88 hectares (third party users occupy part of the site see Table 6) and 49,927m² gross internal site floor area. Its NBV is £59m; see site aerial view at Figure 12 and site plan at Figure 13.

A large part of the estate is more than 44 years old with an original design life of 30 years - this is reflected in the backlog maintenance costs.

Figure 12: West Suffolk Hospital site - Aerial Photograph

In the longer term, beyond 2023, the Trust faces the challenge of providing a level of care appropriate to the 21st century, within aging buildings, making it increasingly difficult to meet this challenge. Future changes are likely to be significant and involve working with St. Edmundsbury Borough Council to achieve the best outcome. The Council's planning framework sets out its policies and strategy for Bury St. Edmunds over the next 20 years and includes an option to build a new hospital on a 22ha site (Westley site) on the western edge of Bury St. Edmunds. Some preliminary work has been undertaken to establish the level of investment required to provide a new hospital (circa £500m), this excludes purchase of the land, on the assumption this will net off from the sale of the current site.

Property	Use	In use from	NBV at 01/04/17	Land Size Hectares	Tenure	Gross Internal Area (m^2)
West Suffolk Hospital	Acute general hospital	1974	£59,052,000	20.88	FH	49,927
Churchfield Road	Greenfield site	NA	£600,000	1.82	FH	NA

Table 4: Property Schedule

4.10.16 Estate disposal strategy

The Trust's Sudbury estate has been identified as surplus to requirement with all sites registered on the NHS Surplus Land Register. The Trust has completed 75% of its Board approved disposal strategy, with three out of four sites sold and work in progress for the

fourth site. Table 5 identifies these sites and provides an overview of the disposals that have taken place to date.

Site	Date constructed	Ha	GIA	Number of units	Year of sale	Capital receipt
Harps Close Meadow	NA	4.55	NA	100	2015	3,900,000
Walnuttree Hospital	1836	0.96	5,369m²	49	2016	1,900,000
St. Leonard's Hospital	1876	0.57	1,654m²	12	2016	200,000
Churchfield Road	NA	1.41	NA	NB transfer to PCT	2012	437,500
Churchfield Road	NA	1.82	NA	Est. 60 - 80	Est. 2021/22	Est. 1,500,000

Table 5: Disposal summary

4.8.17 Tenants

There are three separate buildings on site with leases ranging 30 to 125 years and two tenants occupying space in the main hospital building; these are detailed in Table 6.

Property	Size	Lease duration	Start date	End date	Rent
Wedgwood House	1.2ha	125 years	24/01/01	31/05/2118	Peppercorn
St. Nicholas Hospice	0.7 ha	60 Years	15/08/91	14/08/2051	Peppercorn
Busy Bees Nursery	0.15ha	30 years	27/08/10	26/08/2040	Peppercorn
Renal Unit	363m²	18 years	10/09/03	09/09/21	Commercial rent
WH Smiths	172 m²	Expired - rolling term	N/A	N/A	Commercial rent

Table 6: Third party site users

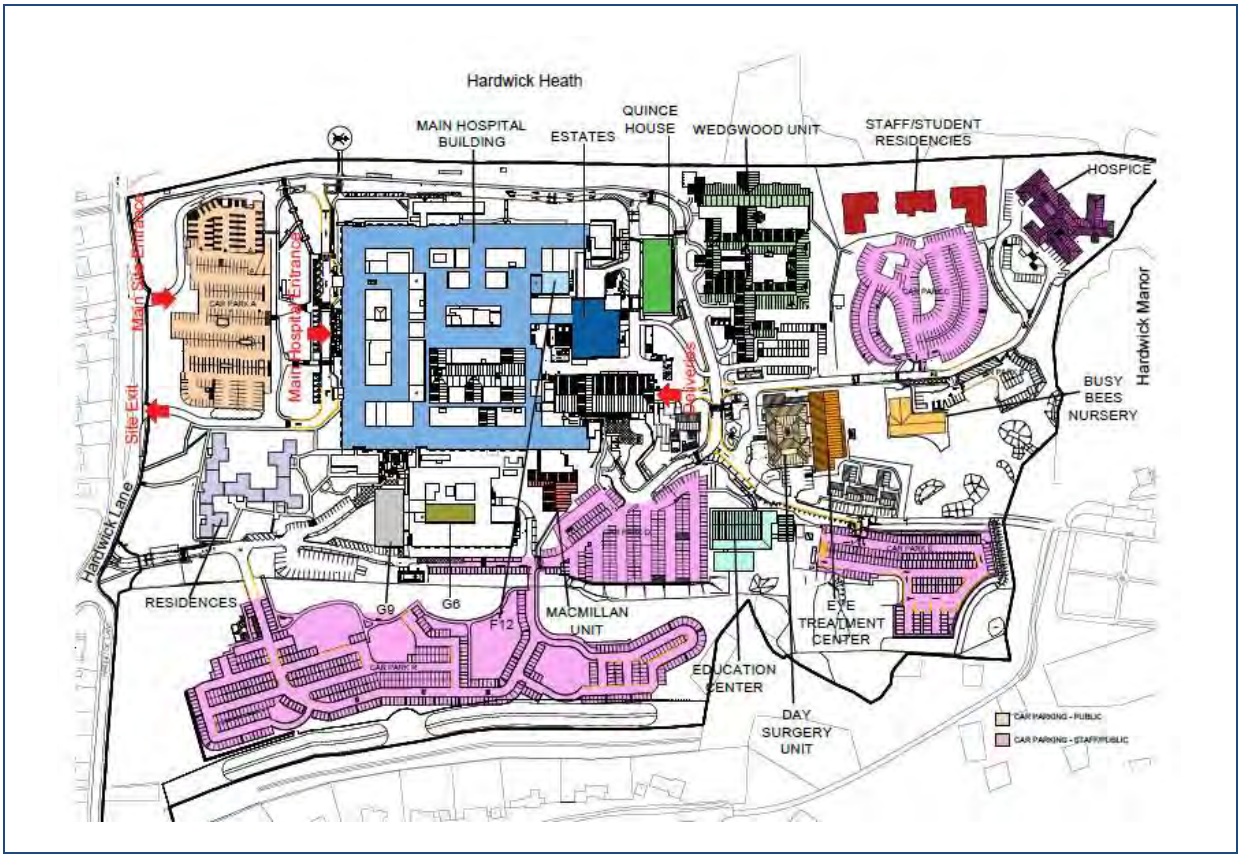


Figure 13: Site plan

4.10.18 Community estate

Two separate alliances have been formed to cover Suffolk; Ipswich and East Suffolk and West Suffolk. Across both footprints, the Trust and its partners deliver a range of services including: acute, community, mental health, primary care and social care services. The CCG has been through a process to ascertain whether the alliances are the 'most capable providers' for delivering the vision of the Health and Care Review, through integrating the delivery of community services. The West Alliance consists of WSFT, Suffolk GP Federation, Suffolk County Council and Norfolk and Suffolk NHS Foundation Trust.

The alliances will radically transform outcomes and the experience of patients. Care will be based in localities and neighbourhoods around the needs of individuals, rather than around organisations. It is expected that this will enhance our ability to:

- Improve health outcomes for patients
- Empower and support self-care
- Co-design services with patients and our staff across the alliances
- Build services, around our localities, that are seamless and which transcend organisational boundaries
- Maintain and integrate workforce across the system
- Deliver responsive but affordable services.

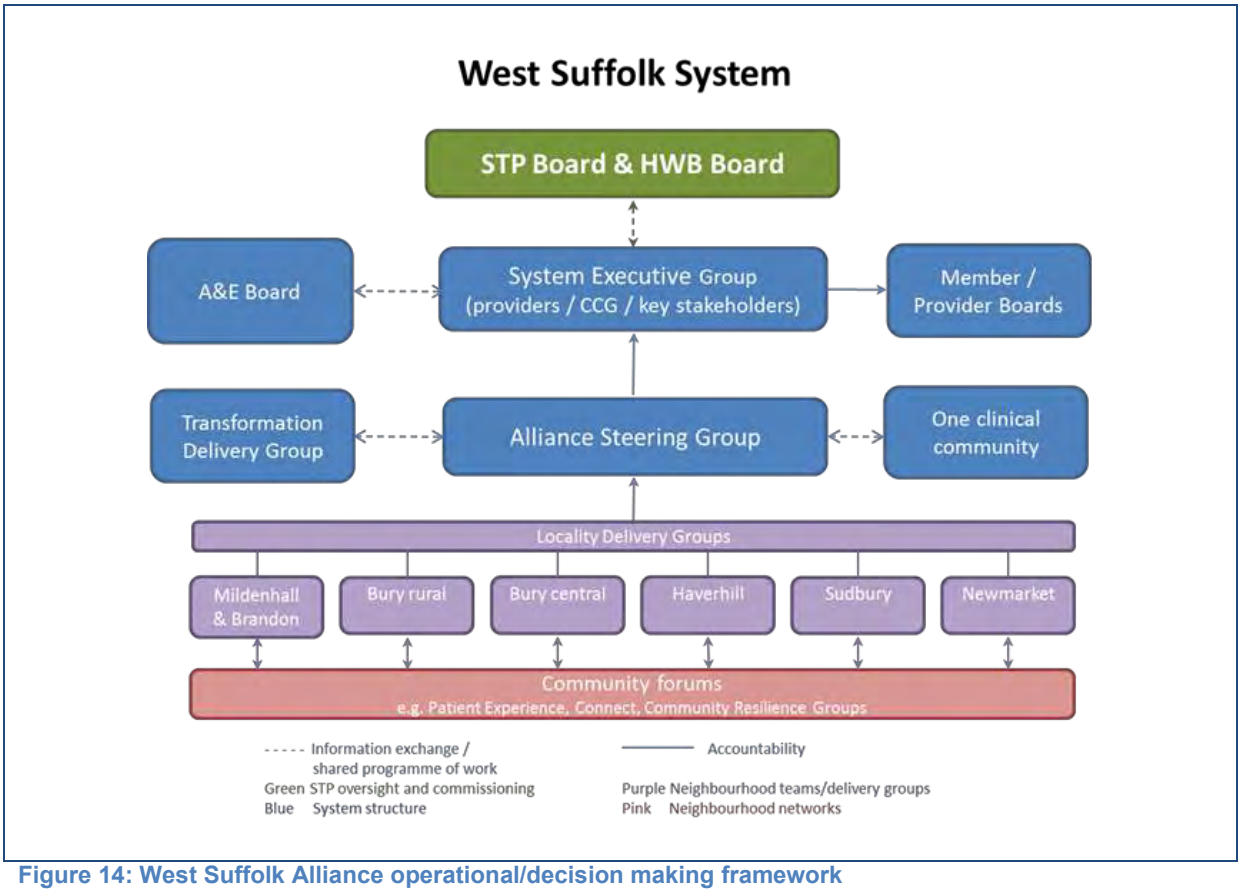


Figure 14: West Suffolk Alliance operational/decision making framework

The operational framework for the West Suffolk Alliance is under development and will consist of six locality delivery groups, one for each locality/neighbourhood team. Each locality delivery group will have statutory and non-statutory membership and will, in time, have devolved responsibility for resource allocation and decision making for the locality as well as overseeing service delivery and quality. The locality delivery groups will have responsibility for, collectively: managing demand; looking at service responses/offers; setting priorities; monitoring performance; and exploring local transformation and innovation to improve people's experience of services.

To ensure that the Alliance has system wide discussion and shared decision making wherever possible, it has formed a system executive group (SEG) whose members are partners in the alliance, CCG and other key system leaders across the west of Suffolk. The remit and primary function of the SEG is to:

- Oversee and ensure integration across the health and care system
- Oversee and ensure the successful evolution from alliance to fully functioning Integrated Care Service
- Support move to local commissioning.

The Alliance has also established an alliance steering group that brings together key operational and transformation leaders. The remit and primary functions of the steering group is to:

- Design, lead and support operational transformation across the alliance.
- Develop and mature the alliance and locality governance structures into a fully collaborative model
- Identify and support opportunities for integration and collaboration.

Figure 14, above, sets out the agreed working arrangements and governance structure for the West Suffolk system.

The Suffolk and North East Essex STP outlines a range of initiatives to deliver sustainable services, including improvements to community and urgent care. The East and West alliances form delivery mechanisms for those initiatives, and will need to maintain consistency with the vision and aims of the STP.

4.10.19 Planning Policy Context

The planning policy context for West Suffolk Hospital Site is provided by the Regional Spatial Strategy East of England Plan 2008, together with the Replacement St. Edmundsbury Borough Local Plan 2016 (see reference document 28) 2031 vision.

The Regional Spatial Strategy identifies Bury St. Edmunds as a 'key centre for development and change' and envisages significant growth within the Hospital's catchment area over the next 20 years. It is likely that this trend will continue beyond the 20 year period.

The Replacement Local Plan acknowledges that the hospital is a major employer and generates a high number of individual trips from within its catchment area. Transportation arrangements, sustainable travel and onsite parking are viewed as important issues associated with the development of the site.

Policy BV22 West Suffolk Hospital and St Nicolas Hospice, is the leading policy governing future development on the Hospital Site states:
'the local planning authority will support the provision of new buildings and extension of existing premises for health care and associated uses where:

- *Efficient use of land is maximised*
- *Additional and adequate parking is provided*
- *A travel plan to reduce dependency on access to the Hospital Site by the private motor car is prepared and implemented*
- *The proposal would not have an unacceptable impact on the amenity of the Hospital Site and the surrounding area'.*

The Trust has a Borough Council approved master plan (2015) for the development of the main hospital site. The key strategic developments included in the plan are linked to clinical service delivery, with each development subject to a Board approved business case. The approved master plan is detailed in Appendix 3.

4.10.20 Site Constraints

There are a number of environmental constraints that apply to the site which will need to be considered in the context of future development. The principal ones comprise:

4.10.20.1 Landscape and Trees

The existing buildings are set within a mature and attractive landscape setting that contains wooded areas, groups of trees and individual trees of significance. The trees within the Hospital Site are covered by two blanket Tree Preservation Orders (TPO): TPO No.28 (1960) which relate to the woodland groups within the site, and TPO No.257 (1998) which identifies the mature specimen trees.

Due to the outstanding natural beauty and parkland setting of the site, it is recognised that great care must be exercised when planning any future developments. In October 2003 landscape architects, Liz Lake Associates produced a 'Landscape and Visual Assessment

and Proposed Development Strategy Plan' (reference document 14) which included a full survey of all on-site trees and topography, and made necessary recommendations with respect to landscape management.

4.10.20.2 Construction works - trees

To ensure the appropriate management of trees during construction works, the Development Team work with a locally based arboricultural consultant to take advice and receive training on the protection of all the trees within the Trust site.

The site wide TPOs means that, if the Trust wishes to undertake any major works which will disturb any tree canopy or root system, a consultation with the local planning authority and more particularly the local tree planning officer, is required.

Only after this planning consultation can any work take place that will disturb the trees. In all cases, tree protection plans are enacted where they are to be retained. Where trees are to be removed, the work is completed under the supervision of qualified arboricultural consultants with ecology consultants monitoring the impact on the local wildlife population.

All the information from past, current and planned projects feeds into a central site tree conservation plan. In the future this conservation plan will help determine a tree management process for the whole site.

4.10.20.3 Maintenance works - trees

The grounds maintenance and survey tree tasks are broken down into seven zones across the main site. Each zone has seasonal tasks identified to assist the grounds team with planning of work (hedge/bush trimming etc.). Tree surveys/inspections are undertaken bi-monthly by a specialist contractor and the Estate Operational Manager rotating through the zones. A physical inspection of all trees is undertaken and any remedial/urgent works are recorded and maintenance work completed. Any urgent tree surgery requirements needed outside of the arrangements (due to inclement weather) set out above, are managed by the Estates Manager via the Senior On-call Engineer.

4.10.20.4 Ecology

The Hospital site does not lie within, or adjacent to, any areas of statutory ecological significance. However, the wooded area on the west side of the site, between the core buildings and dwellings in Sharp Road, is identified as a wildlife corridor linking urban areas with countryside and is an area of nature conservation interest.

4.10.20.5 Travel and Accessibility

The local authority will take into account transport implications of any development when considering and determining planning applications. Of particular relevance, for ongoing and future developments at the Hospital, is the need to recognise that the Hospital is a major generator of travel and should have good access arrangements for emergency vehicles and non-car modes, whilst providing for those who must rely on a car.

The site can be accessed by public transport (including bus and rail). There are bus stops on both sides of Hardwick Lane adjacent to the site frontage. The bus station is located a few minutes' walk from the town centre and provides a direct service to the Hospital every 30 minutes. The railway station is situated under a mile from the town centre and two miles from the existing hospital site.

Bury St. Edmunds town centre is within a 10-minute cycle time of the site, although cycle access is limited to the site. However, there is a cycle path and footpath link connecting the hospital to the town centre. Both the station and town centre can be reached within a 10-minute drive of the site.

Parking provision on the West Suffolk Hospital site is a key factor in the consideration of re-development schemes, due to its congested nature. The requirement for on-site parking needs to be controlled and reduced. The Trust's Travel Plan promotes sustainable transport choices, including car-share schemes, cycling and walking to work, as well as use of public transport.

4.10.20.6 Amenity to Neighbours

Care will need to be taken to protect the amenities of residents who live in Sharp Road and Hardwick Health if there is a proposal to develop any buildings in the adjacent wooded area.

4.10.21 Travel plan

The current Travel Plan, developed in September 2014, progresses a number of initiatives to encourage staff's interest in walking, cycling and car sharing as well as use of an off-site parking area and shuttle bus service.

In addition, there has been an emphasis on the Trust working with other organisations to address travel plan initiatives for the benefit of all users of the site including improved public transport.

An action plan was formulated to progress these initiatives which the Trust constantly monitors and reports status annually to the Trust Board as well as the Borough and County Councils.

Any new development on site is required to consider the corresponding need for cycle storage, changing and drying facilities as well as electric car charging points. All of these have been incorporated into current developments - i.e. car park with additional 400 spaces completed February 2017, Quince House completed May 2017 and the project for a new Accommodation Block due for completion February 2019.

The Trust remains in constant dialogue with the Borough and County Council in respect of new developments since the success of any planning application is closely linked to the Trust's commitment to its Travel Plan.

4.10.22 Asset Performance

In 2015, the Trust completed a comprehensive property appraisal to establish the condition and performance of the West Suffolk Hospital estate. From this, the Trust updated its backlog maintenance plan which has been developed on the assumption that the Trust will remain on the site for a further 20 years.

The backlog plans are reviewed annually, through a multidisciplinary group, using a forced risk ranking methodology. The review takes account of any changes in priority and new or updated guidance.

4.10.22.1 Physical Condition

The definitions in the Department of Health guidance indicate that the condition and compliance facets should be calculated using a direct replacement cost and do not take into account any associated enabling works, fees or VAT. The survey reports the condition of the West Suffolk Hospital estate based on the Department of Health 'Land and Property Appraisal' guidance categories shown in the key below in Figure 15.

The assessment for 'physical condition' by rank and risk at West Suffolk Hospital is shown in Figures 15 and 16.

At the time the survey was undertaken, Quince House, F12 bed wash/maintenance unit and G6 office block were under construction and therefore were not included in the assessment. Had they been included, they would have achieved a condition rating of A.

69% (2017/18) of backlog can be attributed to the original site structures which are constructed of pre-cast autoclaved aerated reinforced concrete (RAAC) panels. The structural issues are discussed further in Sections 5 and 6. Figures 15 and 16 show the status of condition by rank and what the impact would be if the structural issues were omitted.

Backlog category	Risk	ERIC backlog definition 2015/16	With on cost 2015/16	ERIC backlog definition 2016/17	With on cost 2016/17	*ERIC backlog definition 2017/18**	*With on cost 2017/18**
Condition and statutory	High	4,768,505	7,343,498	3,602,360	5,547,634	*3,306,901*	*5,092,627*
	Significant	20,619,550	31,754,107	20,002,454	30,083,779	*19,150,958*	*29,492,475*
	Moderate	3,147,900	4,847,766	3,147,900	4,847,766	*3,034,200*	*4,672,668*
	Low	217,000	334,180	217,000	334,180	*170,000*	*261,800*

Table 1: Estimated backlog profile

* data not published until Oct 18

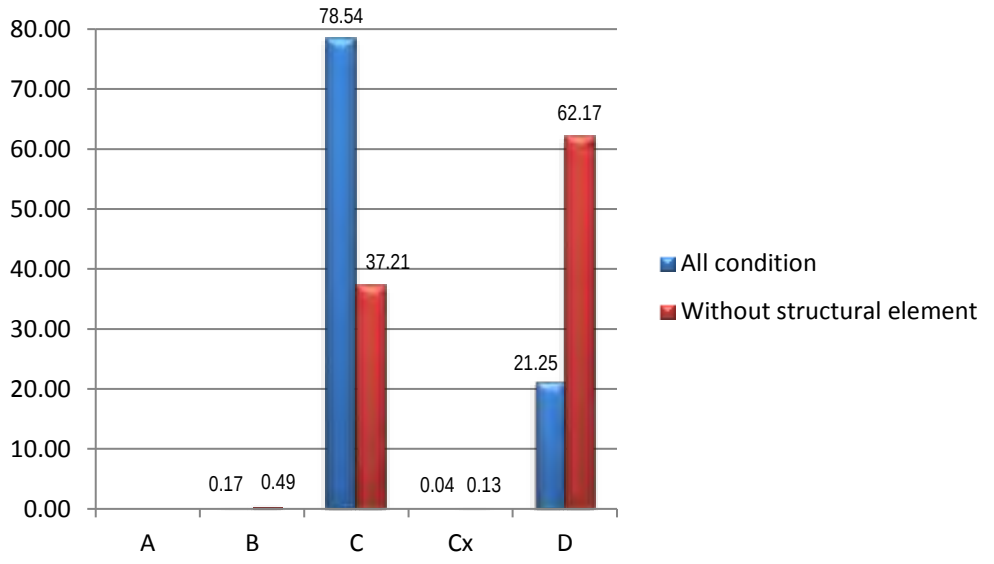


Figure 15: Percentage rank by condition

Key

A	The element is as new and can be expected to perform adequately to its full normal life
B	The element is sound, operationally safe and exhibits only minor deterioration.
B(C)	Currently as B but will fall below B within five years.
C	The element is operational but major repair or replacement will be needed soon, that is, within three years for building and one year for an engineering element.
D	The element runs a serious risk of imminent breakdown.
X	A rating that is added to C or D to indicate that it is impossible to improve without replacement.

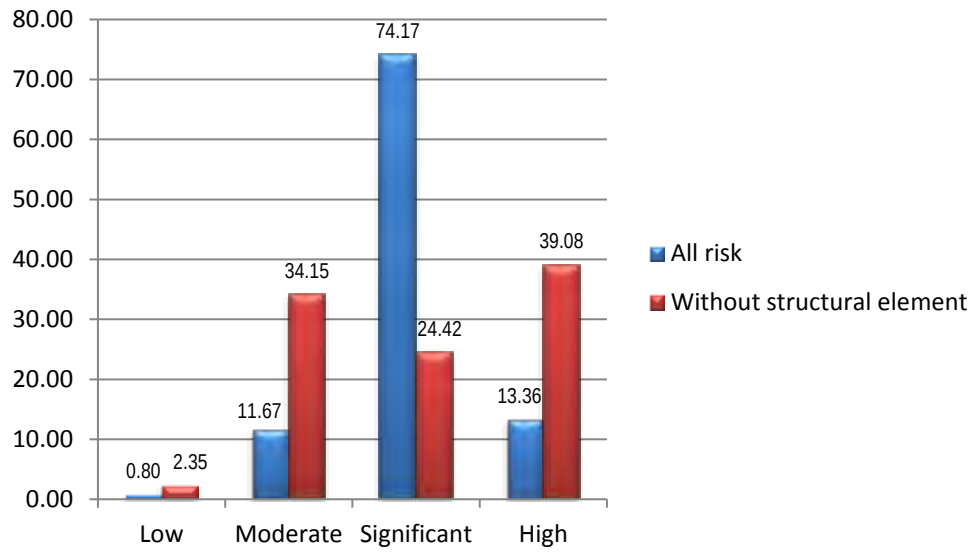


Figure 16: Percentage condition rank by risk

The backlog data identifies that, at 2016/17, through a condition lens, the majority of the estate is in in need of repair or replacement. From a risk perspective (excluding the structural element) 63.5% of the backlog is classified as critical risk (significant and high). This increases to 87.5% with the structural element included. 56% of the high risks are in relation to the roof structure and 21% relate to engineering plant/generators. Appendix 5 sets out the priority areas in need of repair/replacement.

The 2015 survey highlighted that there is significant backlog, though it tends to be generally well managed. Backlog is mainly due to items having reached or passed the design life. Proactive preventative maintenance (PPM) regimes are generally good.

The initial survey, competed in 2015, highlighted a total of £35m (or £54m with on costs) was required to address the backlog profile of the estate, with investment since 2015; this has reduced to £25.6m (or £39.5m with on costs).

It should be acknowledged that condition surveys are non-invasive and only provide an indication of potential problems and areas requiring further investigation. Currently, work is in progress to improve our intelligence regarding the structural integrity of the main building and front residences; the level of resilience in the electrical infrastructure; and drainage systems. This information will be available in December 2018 and it is anticipated that it will have a significant negative impact on the overall backlog position.

Figure 17 shows the national distribution of backlog for 2016/17, with the Trusts position highlighted in the black bar and peer group in the grey bars. The Trust is positioned in quartile 4 with a cost of £482 per m² against a benchmark of £156 per m². Backlog for the other Best Buy hospitals are stated as:

- Frimley Park, Frimley £235 per m².
- Queen Elizabeth, Kings Lynn, £369 per m².
- James Paget, Gorleston, £367 per m².
- Hinchingbrooke, Huntingdon, £48 per m².

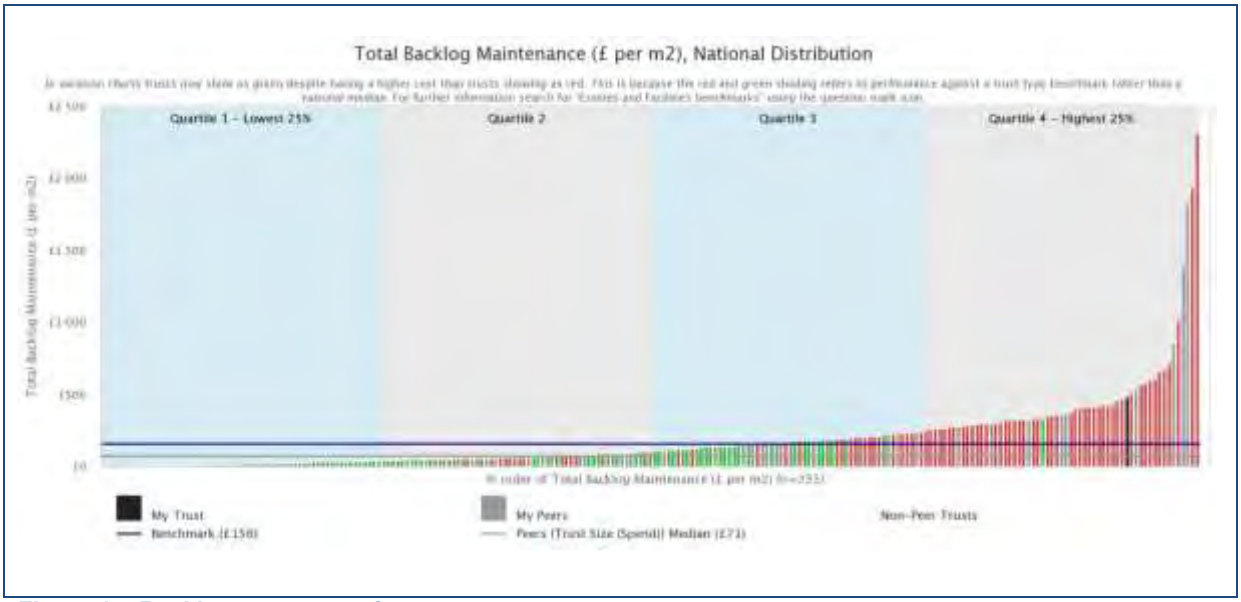


Figure 17: Backlog costs per m²

4.10.22.2 Statutory Compliance

The 6 facet survey identified that 94% of the compliance issues identified were categorised as condition 'D' based on the DH 'Land and Property Appraisal' guidance categories listed below in Figure 18.

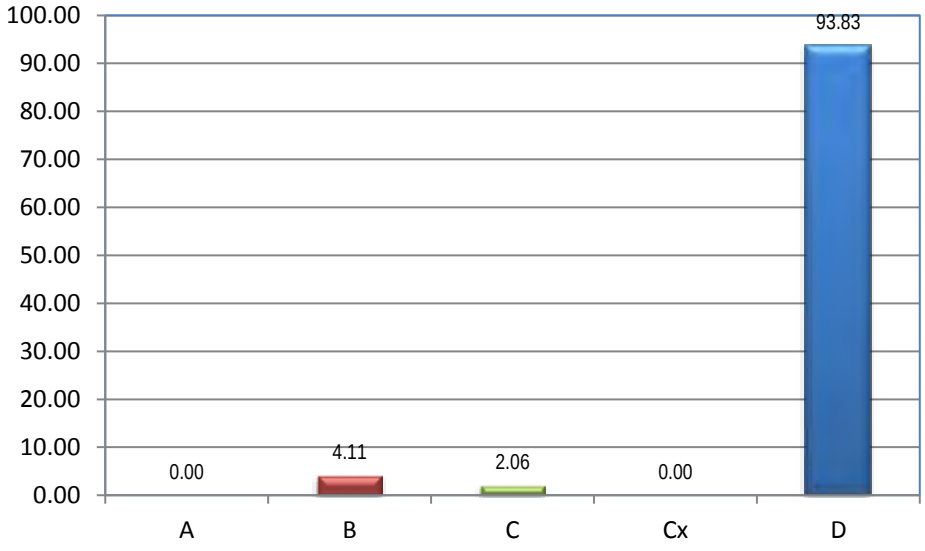


Figure 18: Percentage compliance by rank

Key

A	New building which complies with all statutory requirements and Firecode guidance.
B	Existing buildings which comply with Firecode guidance and statutory requirements.
B(C)	Currently as B but will fall below B within five years
C	A building which falls short of A or B.
D	Areas which are dangerously below either A or B.

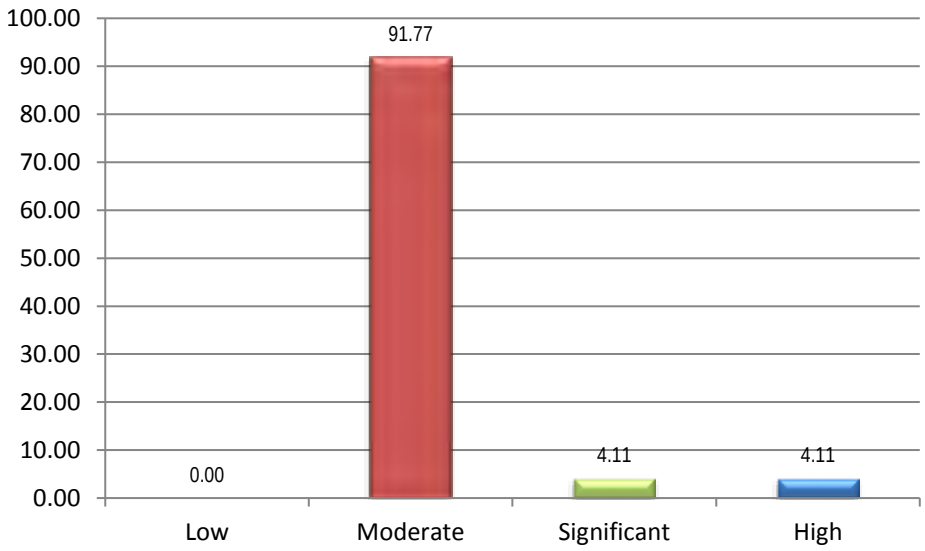


Figure 19: Percentage compliance by risk rating

Statutory compliance is generally well managed, but some areas require improvement. Figure 19 profiles the level of statutory compliance into risk categories.

The moderate category has the highest percentage of compliance issues identified; examples include asbestos, access and electrical safety. Examples of significant risks are associated with water safety. High risks include those relating to the management of asbestos, which are predominantly remedial actions for presumed asbestos-containing materials.

4.10.22.3 Critical infrastructure risk (CIR)

CIR is defined as the total of high and significant risk backlog maintenance categories. It represents investment needed to eliminate safety and resilience risks from the operational estate.

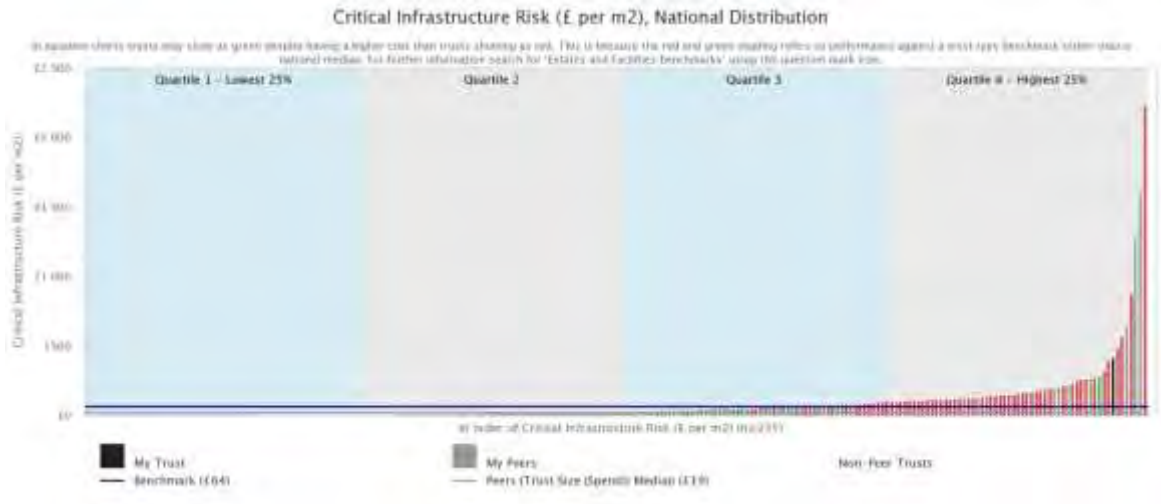


Figure 20: Critical infrastructure risk per m²

Figure 20 shows the national distribution of CIR for 2016/17, with the Trusts position highlighted in the black bar and peer group in the grey bars. The Trust is positioned in quartile 4 with a cost of £422 per m² against a benchmark of £64 per m². CIR for the other Best Buy hospitals are stated as:

- Frimley Park, Frimley £87 per m².
- Queen Elizabeth, Kings Lynn, £203 per m².
- James Paget, Gorleston, £223 per m².
- Hinchingbrooke, Huntingdon, £36 per m².

An important aspect of the Trust's estate strategy is to ensure that the Trust's infrastructure is fully able to support its activity. This section details the key issues surrounding the infrastructure and sets out the broad plans to ensure the estate can deliver the level of activity demanded both now and for the next 5 years.

An infrastructure resilience and capacity review was undertaken in 2009 by the Trust's professional framework advisors (reference documents 17 and 18). The purpose of the review was to establish capability of mains services to maintain business continuity. In addition to determining if there is sufficient capacity within the current service infrastructure to meet schemes included in the site master plan, work arising from this was incorporated into the estate investment plan. The review is in the process of being refreshed to take account of recent intelligence.

The key issues for the Trust in the strategy period are:

- Structural
- Electrical infrastructure
- Fire safety/compartmentation
- Water safety

Risk	ERIC backlog definition 2015/16	With on cost 2015/16	ERIC backlog definition 2016/17	With on cost 2016/17	*ERIC backlog definition 2017/18**	*With on cost 2017/18**
High	4,768,505	7,343,498	3,602,360	5,547,634	*3,306,901*	*5,092,627*
Significant	20,619,550	31,754,107	20,002,454	30,083,779	*19,150,958*	*29,492,475*
Total CIR	25,388,055	39,097,605	23,604,814	35,631,414	*22,457,859*	*34,585,102*

Table 2: Critical infrastructure risk

* data not published until Oct 18

4.10.22.4 Structural resilience

The hospital main building is constructed of a concrete ring beam with pre-cast reinforced autoclaved aerated concrete (RAAC) wall/roof panels. The structure of the building had an original design life of 30 years. Work has taken place with the Trust's structural advisors and representatives from Building Research Establishment (BRE) to establish the strength and stability of the wall RAAC panels. In addition, an inspection/survey and calculations were completed to establish the strength and stability of the roof RAAC panels. This work has identified degradation of the structure, including:

- 10 to 40% of the panels containing cracks
- 50% of the reinforcement bars assessed as rusty
- Cracks only aligned with bars in about 35% of cases
- There is limited damage on surface of panels associated with corrosion within the panels e.g. spalling by corrosion

It is estimated the corrosion could double in 20 years. The ongoing corrosion weakens the panels and could be critical to the structural strength and stability of parts of the buildings i.e. structural safety. Protecting the panels from moisture and the diffusion of air will slow down the rate of corrosion. Since these reports were commissioned there has been further deterioration of the structure with delamination of the concrete and exposure of the reinforced bars in three locations (non-patient areas). An option appraisal was completed to establish the way forward with regard to the roof and wall panels. The Trust Board approved investment for a phased replacement of the roofing system which is in progress, with the wall panel solution to follow on.

In 2017, further work was commissioned in partnership with BRE to understand how the panels are performing since the phased roof replacement programme commenced and to understand what options are possible for the wall panels. The aim of the work is to preserve the structure and ensure a safe environment for a further 20 years. It is worth noting that 69% of the current backlog programme is attributed to the structure, which is rated as a significant risk.

A Trust Board agreed strategy is in place to undertake remedial work to replace the roofing system to extend the life of the structure. Following completion of the survey/feasibility work, options for future solutions for the site are planned to be presented in December 2018.

4.10.22.5 Services resilience

As the estate is developed there is a requirement to ensure the site-wide infrastructure is maintained in an appropriate condition and with sufficient capacity to support further development with appropriate resilience/back up provision.

The essential services at the site comprise:
- Gas (including heating and hot water generation)
- Electricity
- Water (hot, cold, reverse osmosis)
- Medical gases (oxygen, vacuum and medical air)
- Drainage

More recently, the principle concern has been with the electrical infrastructure. Since 2016 the incoming capacity has been upgraded from 1.6MVa to 3MVa.

A standby generator has been provided adjacent to the Education Centre transformer to enable electricity from this location to be used for acute services. Work is in progress to replace the original switch gear (John Godden) adjacent to the Mortuary entrance which will facilitate further short term capacity.

Completion of the structural and services resilience survey/feasibility work is likely to result in a significant increase to the backlog plan.

4.10.22.6 Backlog Maintenance Liability

Figure 17 shows the 'heat map' that relates to the condition facet survey carried out during 2015. The majority of the significant work is located in the main building, which is predominantly occupied with clinical services and limited decanting options; this presents a challenge for the Trust in managing its backlog maintenance programme.

Based on the condition and compliance facet survey findings and using the ERIC definition - (excludes on costs VAT, fees and enabling works) the Trust has an investment requirement of £25.6m to eliminate backlog, with on costs this increases to £39.5m. The investment to eliminate critical infrastructure risk is £22.4m (£34.5m with on costs). This value represents

the WSFT investment required to return the estate to the DH preferred status of condition B. Further detail is provided in Appendix 5.

It should be **noted** that feasibility work is currently in progress to further understand key infrastructure issues that will **deteriorate** the Trust's critical infrastructure risk position. Examples are structure, electrical capacity/resilience, drainage.

Figure 17: Backlog heat map

A significant number of backlog maintenance capital schemes have been carried out over the period of the previous estate strategy (2009 - 2017) which have improved the condition of the estate and reduced risk. A summary is detailed below:

- Six phases re-roofing programme
- Replacement adiabatic cooler
- Phased replacement of main hospital roof
- Replacement pneumatic tube system
- Replacement ventilation plant - mortuary, plant rooms
- Plant room refurbishment x 5 including valves, pumps
- Replacement of water tanks x 5
- Main theatres medical gas infrastructure replaced
- Replacement of water ring main
- Installation of 3rd pipe heating ring main
- Surge protection to main incoming and sub main panels
- Installation of 2 new generators
- Refurbishment of lifts x 4
- Electrical fixed wire testing and remedial work
- Replacement of 4 submain panels
- Replacement of medical air plant
- Fire damper and compartmentation remedial works
- Phased upgrade of emergency lighting
- Asbestos removal

- Legionella compliance works
- Rolling programme of roadway and path repairs
- Window replacement

In addition the Trust has completed a number of capital developments over the period of the previous estate strategy. A summary is detailed below:

- Replacement of 2 MRI Scanners
- Upgrade of 3 x-ray rooms
- New Sterile Services Department and administrative accommodation (Quince House)
- Refurbishment of residential accommodation to provide administrative space
- 5 wards refurbished
- Birthing Unit
- Bereavement Suite
- Clinical Decision Unit
- Breast Screening Unit
- Clinical Skills Unit
- Education Centre lecture theatre
- Car park E (50 additional spaces)
- Car park R (400 additional spaces)
- Nursery
- Temporary Theatre
- Courtyard café extension
- F12 Bed wash and maintenance unit
- G6 office block

4.10.22.7 Investment planning

The Trust has a structure in place which manages the allocation of capital and planned works. Backlog is managed on a day to day basis by the Estate Development Steering Group, overseen by the Capital Strategy Group (CSG). The Estate Development Steering Group is responsible for preparing a list of risk-assessed capital schemes on an annual basis. It will also escalate any backlog issues that arise in year for consideration for funding to the CSG.

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

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

Following the prioritisation assessment, backlog work is further reviewed from a practical perspective to deliver the schemes; this is due to space constraints on site and because of the invasive nature of some work. To establish the viability of physically undertaking the work further consideration is given to:

- Projects that do not impact/have limited impact operationally e.g. external works, external fabric, and structural works
- Projects that require the ward or department to be decanted to an alternative location whilst the work takes place. This will ensure interruption to wards and departments is minimised by undertaking all of the backlog work required at the same time in a

specific location, this also benefits the Trust financially through the minimisation of duplication of work.
- Discrete internal projects that have limited impact operationally e.g. lift replacement, replacement of sub mains panel

The outcome of this consideration may impact on the ability to deliver elements of the investment plan and the priority ranking. If this is case, the investment plan will be adjusted to take this into account.

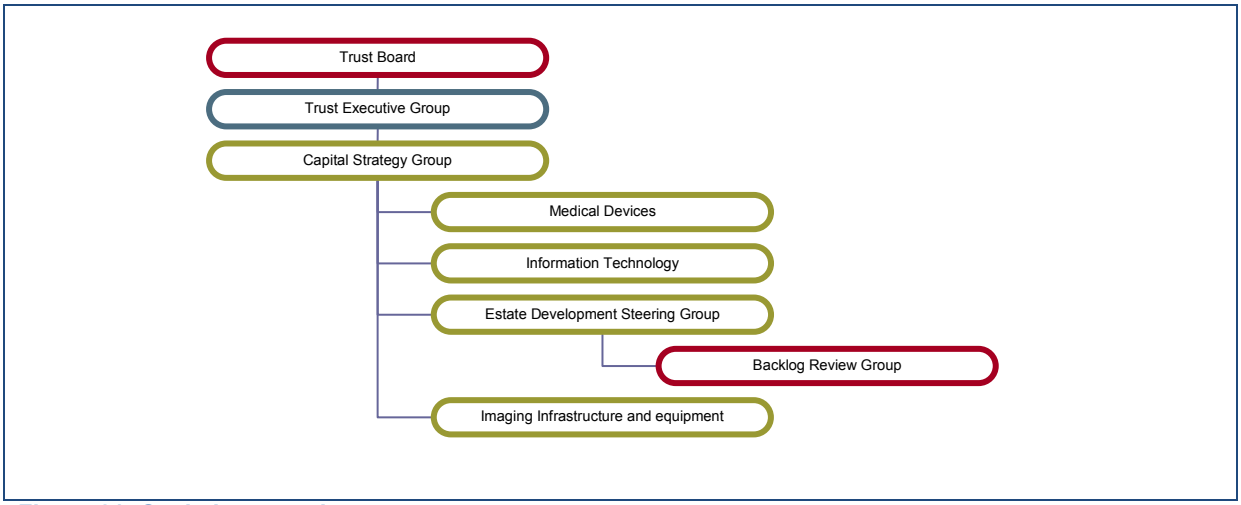


Figure 21: Capital approval process

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

Figure 21 shows the structure through which the capital programme is prioritised and agreed.

4.10.22.8 Space Utilisation

The Trust has a space utilisation group (SUG) which is responsible for managing requests for additional space and amendments to existing. The group is chaired by the Chief Operating Officer, with membership comprising of senior management from the Surgical, Medical and Clinical support services divisions, along with estates and facilities, community services and nursing representation.

The WSFT estate has expanded to the point that limited options remain to provide further accommodation. Consequently the SUG has to look at ways of amending/altering existing offices/areas to cope with growing staff groups and services.

The space utilisation facet - see Section 4.10 - explores how well available space is utilised, largely by making judgements about the intensity of use: that is, the number of people using it and the frequency with which they use it. To reach a balanced assessment, data was collected through visual inspections, discussion with users, consultation with technical guidance and surveying the area at different times of the working day.

Space utilisation was assessed under:
- Current use: space utilisation of a department when visited by the surveyor, i.e. a snap shot in time

- Use over time: space utilisation of the department over a longer period i.e. weeks, months and the potential to extend hours; this information is gained through the interviews with service/department managers.

The Naylor report highlights that non patient floor space should not exceed 35% of the available footprint and un-utilised space should not exceed 2.5%. Based on ERIC data, the Trust currently has 32.5% of space allocated to non-clinical use and report that 0% of its footprint is vacant, see Table 7.

Summary of utilisation	
Type of accommodation	**Use**
Clinical use	67.51%
Non-clinical use	32.49%

Table 7: Summary of space utilisation (ERIC)

The administrative use of space was reviewed during the survey and identified that 213 offices containing 667 desks were in use across the acute estate. Desk use over the week was an average of 40% with a high point of 50% during Tuesday and a low point of 32% on Friday pm.

Figure 22 shows desk usage over the course of the working week based on the visits undertaken.

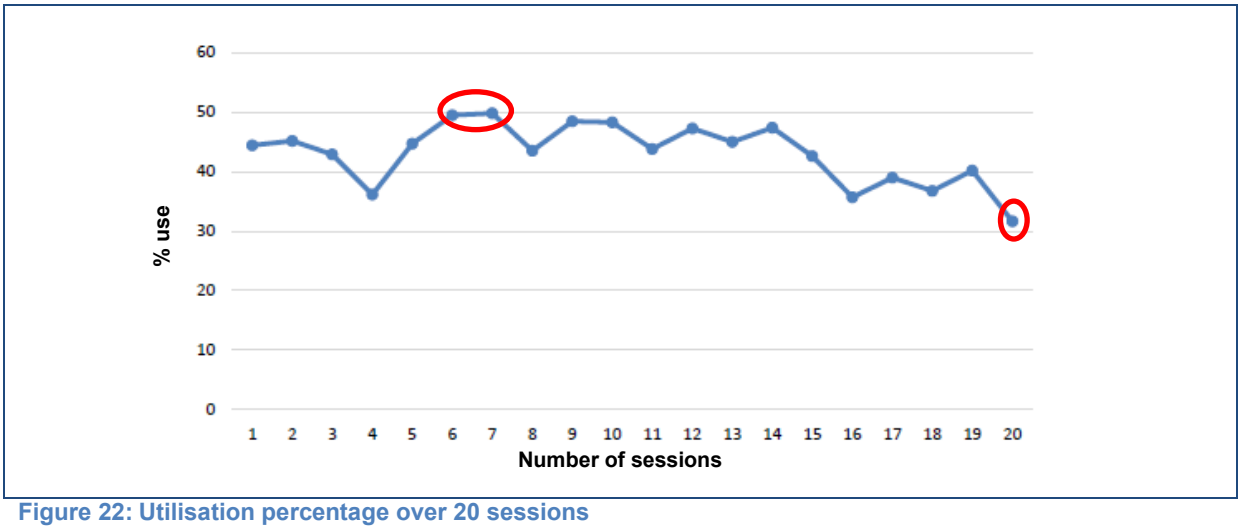


Figure 22: Utilisation percentage over 20 sessions

The data indicates that desk usage is likely to be consistently around the 35 - 50% range over the course of an average week. This level of usage (sub 50%) is a common theme across this type of accommodation where staff also deliver services to patients. However, flexibility in adjusting working practices should be considered to increase capacity.

The community estate has recently undergone a space utilisation survey, with the data showing that it is underutilised and has a high percentage of non-clinical space (60%) in comparison to clinical space (40%). Therefore there are opportunities for reconfiguration of clinical services to better utilise the estate for community services whilst at the same time seeking opportunities for the relocation of services from the main hospital site into community buildings and therefore closer to patients. The Department of Health has as yet

to confirm targets associated to community services in relation to clinical/non-clinical use and underutilised/vacant space.

4.10.22.9 Restrictive Physical Intervention/Security team (RPI)

The NHS has a statutory obligation to provide a safe and secure environment which protects service users, staff and visitors from criminal acts of violence, abusive or challenging behaviour as well as protecting its property against acts such as theft or criminal damage.
At WSFT there is a year on year increase of service users admitted to hospitals with either physical, cognitive, psychological/emotional or environmental/social issues which can manifest in challenging behaviour toward staff, other service users or visitors. There is also a year on year increase of persons attending NHS sites, causing a nuisance or disturbance

In May 2018, the establishment of an in-house full time permanent Restrictive Physical Intervention/Security Team (RPI) was approved. The RPI Team has responsibility for managing service users who are exhibiting challenging behaviour, including aggressive and violent behaviour towards staff, other service users or visitors. In addition, the team undertakes a security role across the site. Prior to this, an external provider was used to manage service users that were exhibiting challenging behaviour or where there was a need for prolonged supervision.

4.10.22.10 Procurement/linen/laundry

Purchasing incorporates all purchasing activity outside of Pharmacy. The aim is to achieve the benefits of economies of scale, allowing specialist procurement to be managed on a centralised basis. Multi-disciplinary stakeholder groups are established for key procurements which ensure the best mix of procurement expertise and specialist medical and technical knowledge. This mix and match approach allows flexibility and adaptability which will ensure that each element of the Trust's non-pay expenditure has a procurement process that is appropriate to the level of product complexity and the value of spend.

The Trust outsources linen and laundry to a specialist contractor, who manage the delivery and collection of all Trust and community linen requirements. They are monitored by Purchasing to ensure they meet all the contracted key performance indicators.

4.10.23 EFM Accolades and achievements

This section highlights the areas of best practice and demonstrates the quality and excellent services the EFM Division provides. The Division will continue to build upon this good practice to demonstrate how it achieves the Trust's ambitions for the benefit of patients, staff and visitors to the Trust.

4.10.23.1 Awards

Winner for CIBSE East Anglian Region Carbon Reduction Award (2012)
Finalist for HefmA project of year award, Clinical Decision Unit (2015)
Winner for HefmA project of the year award, Forget-me-not Walk (2016)
Finalist for HefmA project of year award, Quince House (2018)
Winner for HefmA individual development award - Hannah Sharland (2018)
Winner RIBA Suffolk Craftsmanship awards (2018)

4.10.23.2 ISO accreditation

Sterile Services Department - ISO 13485:2016 since 2006
Sterile Services Department - ISO 9001:2008 since 2006
Sterile Services Department - Directive 93/42/EEC Annex V since 2006
EBME - Management Accreditation ISO 9001:2008 since 2012
Purchasing ISO 9001:2015 since 2017

Catering ISO 9001:2008 since 1994 and ISO 9001:2015 since 2018
Switchboard ISO 9001:2008 application in progress
Portering ISO 9001:2008 application in progress
Housekeeping ISO 9001:2008 application in progress

4.10.23.3 Catering
Soil Association Bronze Award Food for Life
Eat Out Eat Well Gold Award
Timeout and Courtyard Café Food hygiene rating 5* since 2005
White Lodge Café Newmarket Hospital Food hygiene rating 5* since 2015

4.10.23.4 Housekeeping
CIMS (Cleaning Industry Management Standard) achieved with honours
Golden Service Awards (overseen by the BICS)
Shortlisted in the Reintec healthcare establishment with more than 250 beds category of Kimberley-Clark Professional

4.10.23.5 Purchasing
Standards of Procurement Level One

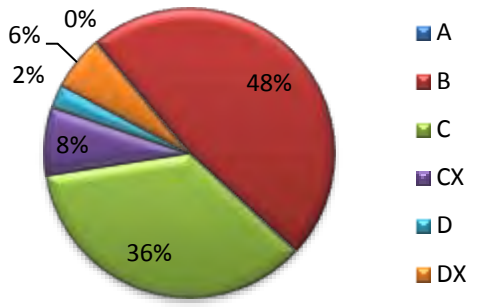
4.10.23.6 Estates
The Trust hosts the HefmA Eastern Branch Energy Group

4.10.23.7 Assurance
The Trust hosts the HefmA PAM Working Group

4.10.24 Functional Suitability
The Functional suitability facet is assessed on the basis of three main elements: internal space relationships; support facilities; and location. In addition to these three elements, each sub-element is assessed further in terms of 'fit for purpose' within the next five years or 'fit for purpose' in five years or more. All functional suitability assessments have been made with reference to departmental Health Building Notes (HBN) and Health Technical Memorandums (HTM) guidelines.

Throughout the main block at West Suffolk Hospital, many departments were found to have deficiencies in this facet, largely due to space constraints on the hospital, ageing facilities and not built for the current purpose. The lack of space fell into one of the three categories: lack of adequate storage space; overcrowded offices and inadequate bed space per patient; for many departments surveyed, all three of these problems were present.

Figure 23 shows, 36% of the hospital's accommodation was found to be in condition 'C', with 16% in condition CX or lower; indicating that 52% of the departments/areas surveyed are unsuitable for function.



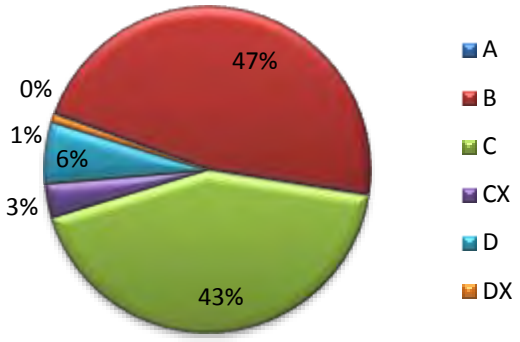
Key
A Very satisfactory, no change needed
B Satisfactory, minor change needed
C Not satisfactory, major change needed
D Unacceptable in its present condition
X A rating that is added to C or D to indicate that it is impossible to improve without replacement.

Figure 23: Function by rank

4.10.25 Quality of the Environment

Quality assessment takes into account the three main elements: amenity; comfort engineering; and design. All questions asked fall in line with the NHS Estates Land and Property Guidelines.

Figure 24 shows, 43% of the Trust's accommodation was found to be in condition 'C', with 10% in condition CX or lower; indicating that 53% of the departments/areas surveyed were a less than acceptable facility requiring investment. The areas falling into this category are mainly inpatient wards that have not yet been upgraded.



Key

A Facility of excellent quality
B A facility requiring general maintenance investment only
C A less than acceptable facility requiring capital investment
D A very poor facility requiring significant capital investment or replacement
X A rating that is added to C or D to indicate that it is impossible to improve without replacement.

Figure 24: Quality by rank

4.10.26 Equality Act (EA)

The EA came into force in October 2010, superseding the Disability Discrimination Act 1995. The act places a duty on service providers to make 'reasonable adjustments' to physical features to premises to overcome barriers to access.

An EA survey (reference document 8) was undertaken in December 2017 covering West Suffolk Hospital. From an environmental impact the survey reviewed all bathrooms, toilets, ramps, staircases, signage, walkways, and car parks. Actions identified through the process

have been collated into an action plan and will be incorporated into the annual backlog works prioritisation programme.

4.10.27 Sustainability

The Climate Change Act (2008) gives the government power to introduce measures to achieve carbon reduction and mitigate and adapt to climate change. It sets out legally binding targets to reduce CO^2 emissions by 34% by 2020 and 80% by 2050 against a 1990 baseline. All public sector organisations are required to develop and implement a plan to meet these targets.

In 2014, A Sustainable Development Strategy for the NHS, Public Health and Social Care System was launched. The strategy builds on the 2009 NHS Carbon Reduction Strategy, but has a clear focus on helping to create sustainable, resilient, healthy people and places. The strategy has three clear goals:

1. A healthier environment
2. Communities and services are ready and resilient for changing times and climates
3. Every opportunity contributes to healthy lives, healthy communities and healthy environments

The Trust has developed its Sustainable Development Management Plan (SDMP) which was approved by the Trust Board in 2018. The development of the SDMP demonstrates the Trust's commitment to carbon reduction through a range of practical but ambitious measures, including sharing of good practice from active engagement and the welcome support of its staff.

The key function of the SDMP is to act as a vehicle for the delivery of a comprehensive carbon footprint that acts as a measurement of progress made towards the agreed national objectives, while identifying milestones that have been created from within the documented action plans. These action plans are essentially a contractual commitment with each of the hospital's most environmentally influential departments, such as procurement and the estates maintenance team.

The fundamental incorporation of sustainability within the Trust's policies and procedures and its reinforcement at Board level, aligns the strategic estate delivery with:-

- Enhanced data management relating to energy, waste and water and the robust measurement of our carbon footprint
- The development of a communication strategy to ensure the effective implementation of the SDMP throughout the Trust
- The development and establishment of partnerships with key stakeholders, through local strategic partnerships, council meetings and joint community activities
- The development of a sustainable procurement strategy, incorporating supply chain activity, with the trust's procurement lead.
- Identification of opportunities to reduce the Trust's carbon emissions in particular through the active management of energy, transport, ICT and in using BREEAM within capital implementation.
- The Trust commits to produce clear targets against the footprint that has been generated from the Trust's carbon annual impact
- Action plans will be measured for success under the annual sustainability review
- The Trust is committed to the Sustainable Development Assessment Tool.

The SDMP, has set a target of 34% reduction in carbon emissions by 2020, and is currently set to achieve this via the many and varied energy efficiency initiatives, stakeholder group's

activity and the innovation presented by the estates team, (CHP, reduction in unnecessary use, etc.).

4.10.27.1 Current status

The 2015 NHS carbon footprint carried out by the Sustainable Development Unit shows an overall reduction in carbon emissions from 25.7 to 22.8 MtCO2e. This is equivalent to an 11% reduction, meaning the NHS has surpassed the 10% target set in the 2009 Carbon Reduction Strategy (target set against a 2007 baseline figure).

The Trust has seen a reduction in total 'liable carbon' from 7,573t CO^2e in 2007 to 5,979t CO^2e in 2016 - a reduction of 20.68%.

Table 8 details the Trust's sustainable development strategy, how it will be achieved and the methods of measuring the improvement.

Criteria	Target	Plan to achieve it	Measuring success
Carbon and energy	To reduce CO2e emissions by 34% by 2020 from 2007 baseline relative to activity	- Ensure the combined heat and power plant is running at optimum levels. - Continue to reduce unnecessary usage. - Planned major projects, such as sterile services and the residences, will make use of energy efficient technology and have a positive impact on our carbon footprint. - Provide training to ensure that every member of staff is able and encouraged to take responsibility for energy consumption and carbon reduction	- Annual reporting through carbon reduction Commitment scheme - Annual sustainability report to Trust Board - Consumption levels monitored monthly - Estates key performance Indicators
Built environment	Built environments should be designed to encourage sustainable development and low carbon usage in every aspect of their operation	- A BREEAM pre-assessment will be carried out for all major projects. - Sustainable Development criteria will form part of all tenders	- Energy efficiencies will be reflected in utility performance. - Staff and patient feedback - Sustainable Development Assessment Tool

Criteria	Target	Plan to achieve it	Measuring success
Water	To maintain water usage levels, within a 10% variation, despite increased activity and consolidation of Sterile Services to this site.	- Increase staff awareness on using water responsibly - Ensure leaks are reported and dealt with promptly - Water efficient appliances to be specified for new or replacement projects	- Monitor usage - Report against activity - ERIC data and Trust annual report - Estates KPI's - Sustainable Development Assessment Tool
Procurement	- Sustainable Development is assessed, considered, implemented and monitored in procurement decision making. - To minimise waste associated with our activities. - To ensure procurement is conducted in an ethically sound manner. To promote equality and diversity.	- Risk assess key suppliers' impacts against our sustainable development targets - Embed life time costing model - Continue to improve our stock management - Support SME (small and medium sized enterprises) - Train and develop our staff in the principles of sustainability and sustainable procurement	- NHS Standards of Procurement (reference 6.4 and 6.5) - Sustainable Development Assessment Tool - Procuring for carbon reduction (P4CR)
Workforce development	To make the Trust a great place to work. - Train, educate and motivate staff to be the best. - Nurture leadership at all levels. - Build on our excellent teaching and research base. - Encourage involvement and contribution of ideas.	We will encourage all staff to adopt a healthy lifestyle and support their physical and mental wellbeing via effective human resources and occupational health policies and practice. Continue to develop freedom to speak up campaign.	- Staff surveys - Staff development reviews Sustainable Development Assessment Tool

Criteria	Target	Plan to achieve it	Measuring success
	- Promote an open culture where staff can voice concerns without fear. - Encourage staff to achieve healthy work life balance. - Recognise and reward great performance.		
Models of care	Deliver year-on-year improvements in the patient experience. Maintain the Trusts position in the top 10% of hospitals with the lowest mortality.	- Focus on key indicators of harm; including pressure ulcers, falls, hospital acquired infections, medical errors and readmissions. - Promote standardisation of practice. - Train, educate and support staff to deliver safe and effective care. - Breakdown the barriers in how services are provided to deliver more joined-up care. - Ensure patients are given the right care, in the right place, at the right time. - Use e-Care to support the sharing of information across primary, community and secondary care.	- Sustainable Development Assessment Tool - Patient and family surveys - Benchmarking against other acute hospitals.
Community engagement	Ensure that the Trust plays a full part in the West Suffolk Forum, the Suffolk Health and Wellbeing Board and work with our councils, partner		- Sustainable Development Assessment Tool Patient and family surveys

Criteria	Target	Plan to achieve it	Measuring success
	trusts and other stakeholders.		
Travel and transport	- An overall reduction in business mileage - An increasing use of alternative sustainable travel options	- Make more use of video conferencing facilities - Where possible, Trust replacement vehicles will be of lower carbon emissions than their predecessors - Continue to work with community partners to improve opportunities for sustainable travel - Improve facilities on site for cyclists, additional storage and shower facilities - Review the grey fleet mileage and carbon footprint - Review driving for work policy and business travel expenses policy - Develop the use of Enterprise car share scheme - Promote existing car share and cycle2work schemes to staff	- Car park barrier data - Record and report business miles through Knowles - Monthly bicycle audit - Annual staff and visitor travel surveys - Travel plan reviews
Adaptation	Adaptation means responding to both the projected and current impacts of climate change and adverse weather events. Adaptation for the health and care system is two-fold: 1. Be prepared for	Heat wave plan	- Risk assessments on the risk register - Adaptation plan links to the business continuity plan - Report adaptation plan progress in the Trust Annual Report

Criteria	Target	Plan to achieve it	Measuring success
	different volumes and patterns of demand. 2. Be prepared for and resilient to weather events and other crises.		- Sustainable Development Assessment Tool

Table 8: Sustainable development strategy

4.10.28 Energy Performance and Environmental Management

Energy management at the hospital is generally good. However, there is no formal energy policy. The Trust's Estates Manager leads on energy management and represents the Trust on the Regional Health Estates and Facilities Management Association special interest group for energy management. Funding has been approved to appoint an Energy and Waste Officer in 2018.

The Trust procures its energy and utilities through national supply agreements negotiated by the Crown Commercial Services Governments Procurement Services Energy Division.

West Suffolk Hospital has a heated volume of 131,413m³, with a primary energy consumption of 79,514 GJ.

Utility	Energy Consumption kWh/year	%	Cost £/year	Site Energy Consumption kWh/100m³
Gas	22,915,910	12	1,073,831	13,405.33
Electricity	3,699,138	78		
Oil	2,823,162	10		
Total Energy	**29,438,210**	**100**		

Table 9: Energy performance - source ERIC 16/17

The model hospital data for 2016/17 shows that, for small acute trusts outside of London, (ERIC category for WSFT) the Trust has a lower energy cost per unit of £0.040 and falls within the benchmark and quartile 1. The Trust is represented by the black bar and peers by the grey bars, see Figure 25.

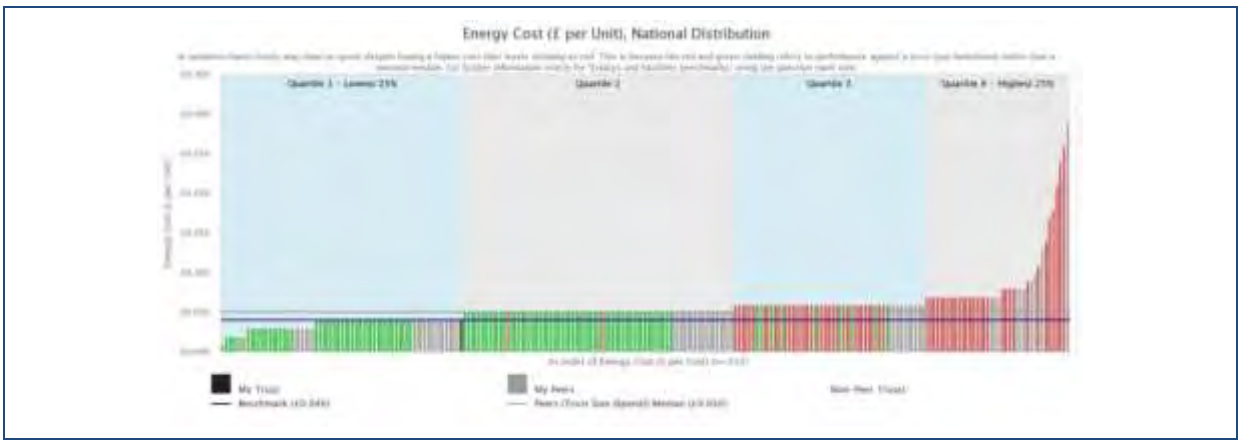


Figure 25: Energy Costs

As part of its energy strategy, the Trust installed a combined heat and power unit (CHP) in 2009. The aim of the installation was to improve energy efficiency, reduce carbon emissions and to ensure the Trust maximises the use of its resources in generating heat and power for the estate from one primary energy source - gas.

The Trust's activity increased during 2016/17 and the Trust's carbon emission impact did not increase from those recorded in 2015/16 (see Table 10 for 2016/7 position). Actions that helped maintain the same level of carbon emissions were:

- Continued operation of the CHP 24/7.
- Improved energy efficient engineering plant currently being installed under the Trust backlog programme.
- Continued use of PC Power Saver system which turns off computer base stations safely overnight if left on.

CHP	
Number operating on site	1
Size	800 watts
Efficiency	71%
Fossil energy input	16,998,484kWh
Thermal energy output	6,448kWh
Electrical energy output	5,656,174kWh

Table 10: CHP input and outputs - source: ERIC 16/17

The Trust's Display Energy Certificate/Performance Energy Certificate rates the buildings at West Suffolk Hospital site are shown in Table 11, for the period September 2017 to August 2018.

Location	Energy asset performance rating	Benchmark	
		New build	Existing stock
Main building	84 grade D	-	-
Education Centre	99 grade D	-	-
Day Surgery Unit/Eye Treatment Centre	103 grade E	-	-
Quince House	33 grade B	41	119

Table 11: Energy asset performance rating

A typical rating for hospitals similar to the Trust is 100 grade D.

4.10.28.1 Energy consumption

Source of data is the ERIC returns to the Information Centre. West Suffolk NHS FT is identified by the black bar with peers in grey bard, see Figure 26. This shows that the Trust has a higher (£520/m²) energy consumption than the benchmark of £457/m². The other best buy hospital consumption rates are:

- James Paget £446/m²
- Queen Elizabeth £656/m²
- Hinchingbrooke £363/m²
- Firmly Park £526/m².

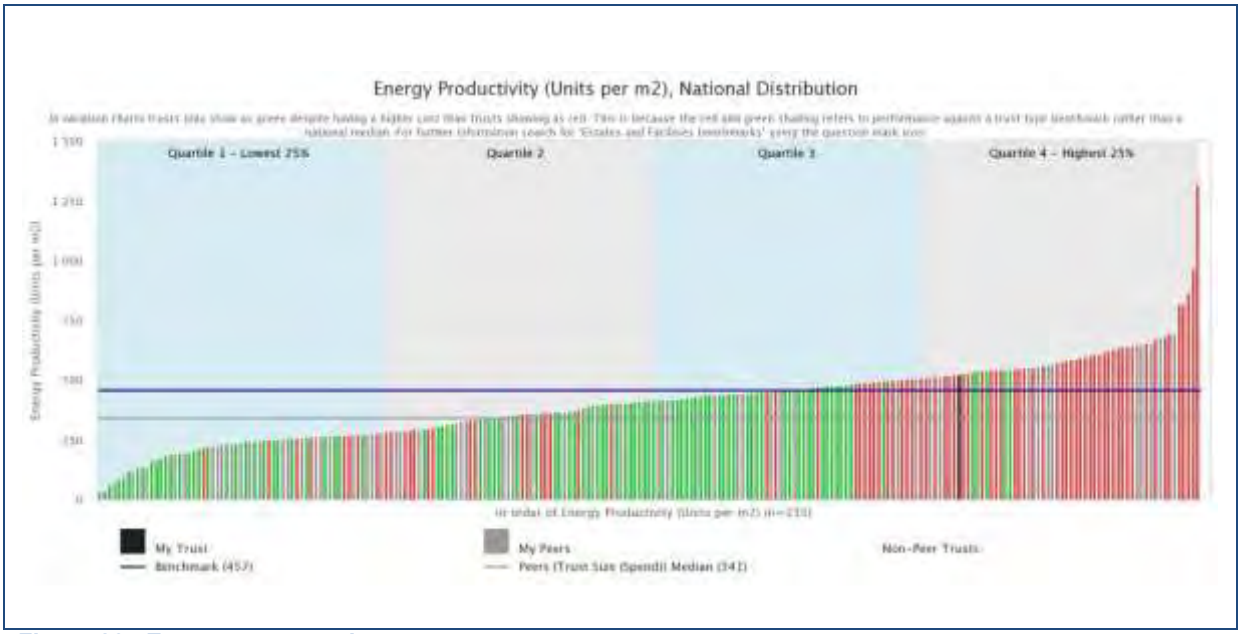


Figure 26: Energy consumption

4.10.28.2 Water

The model hospital data for 16/17 shows that for small acute trusts outside of London (ERIC category for WSFT) the Trust has a lower water and sewerage usage (£2.66 /m²) and falls with quartile 2 against a benchmark of £3.67, see Figure 27. The other best buy hospital rates are:

- James Paget £3.51/m²
- Queen Elizabeth £2.89/m²
- Hinchingbrooke £2.36/m²
- Firmly Park £4.28/m².

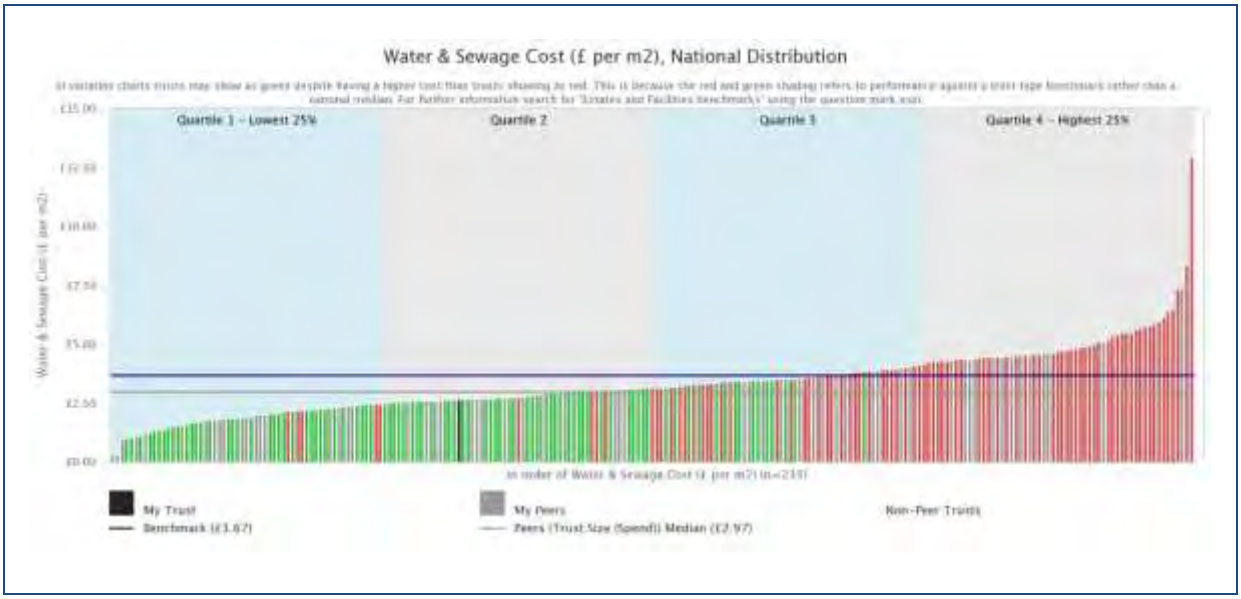


Figure 27 : Water and sewerage per m²

4.10.28.3 Waste

The model hospital data for 16/17 shows that for small acute trusts outside of London (ERIC category for WSFT) the Trust has a higher waste cost per tonne (£318) and falls with quartile 4 against a benchmark of £255/t, see Figure 28.
The other best buy hospital rates are:

- James Paget £99/t
- Queen Elizabeth £238/t
- Hinchingbrooke £193/t
- Firmly Park £201/t.

Figure 28: Waste per tonne

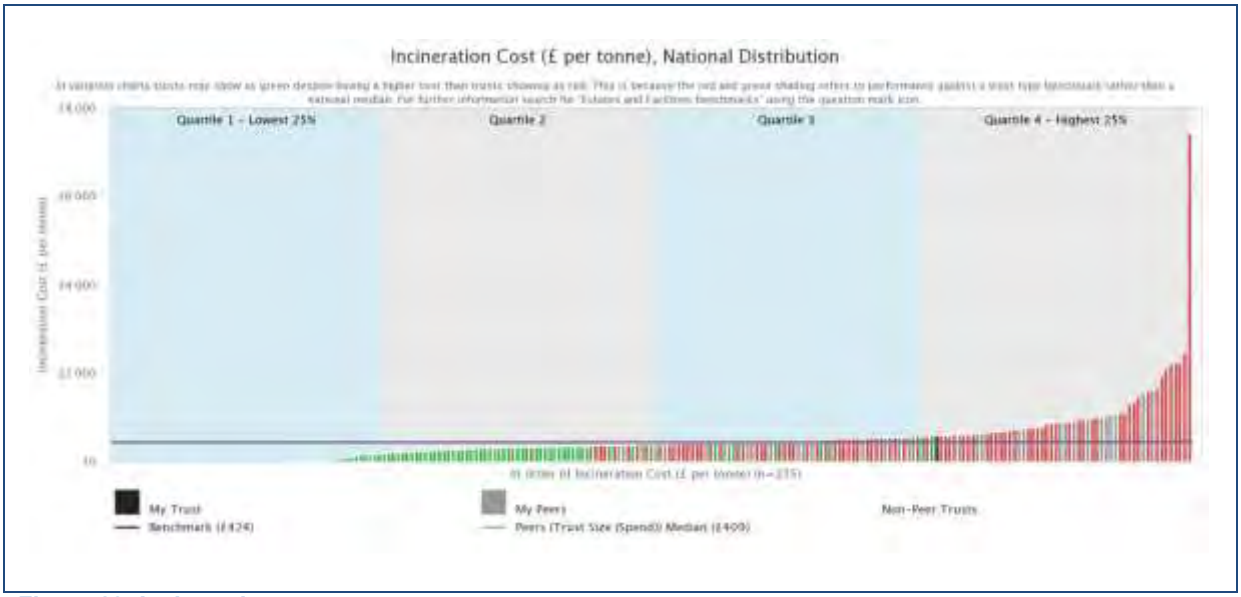


Figure 29: Incineration cost per tonne

This is attributed to incineration costs, which are high in quartile 4 at £571/t, above the median of £424/t. The impact of this is offset by recycling and other recovery costs at quartile 2. This area is currently under further investigation with other trusts in the peer group. The Trust is part of a waste consortium and the data looks irregular given the other trusts in the peer group use the same contractor and contracted rates. In addition to this VAT was included in error when omitted, this reduces the incineration cost to £474/t.

The waste productivity per weighted activity unit (WAU) is in quartile 1 at 17/Kg per WAU this cost is below the median and benchmark of 20/Kg per WAU, see Figure 29. Table 12

identifies the weight and cost of the different waste streams between 2013/14 and 2016/17, this information is also reported in the Trust's annual sustainability report.

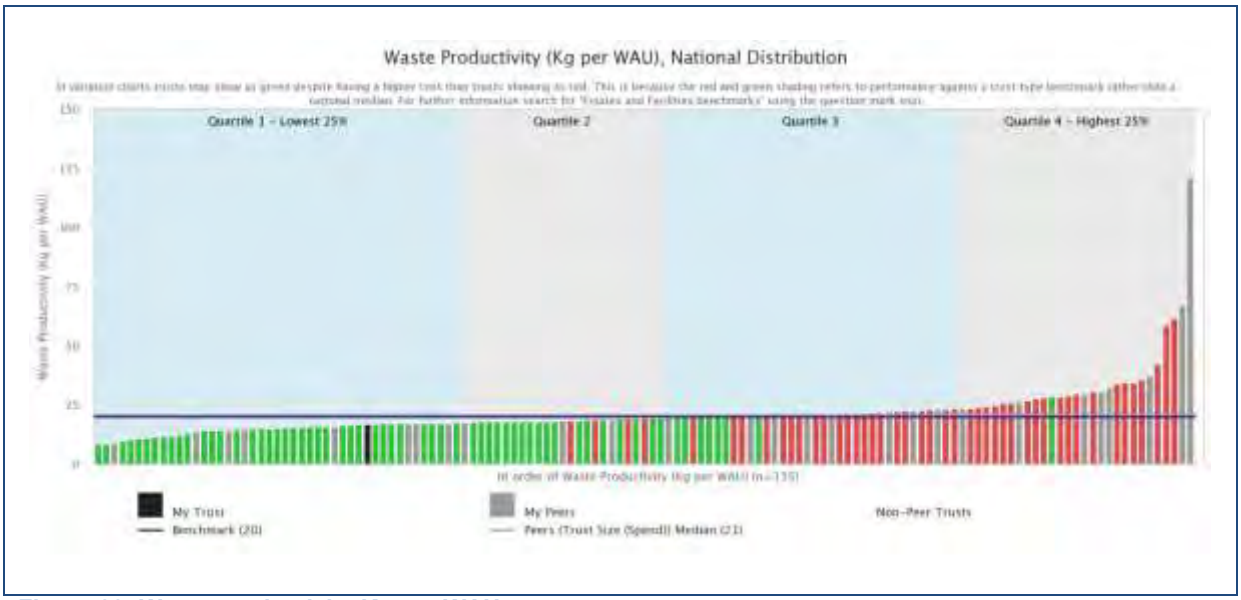


Figure 30: Waste productivity Kg per WAU

	2013/2014		2014/2015		2015/2016		2016/2017	
	Weight	Cost (£k)	weight	Cost (£k)	Weight	Cost (£k)	Weight	Cost (£k)
Total Waste	1093.28	£334.16	1078.81	£337.58	1052.48	£277.14	1085.78	£288.06
Hazardous /Clinical waste	425.47	£252.90	441.312	£257.23	457.35	£211.91	455.06	£216.41
Landfill	389.72	£68.67	376.16	£68.65	406.46	£56.07	0	0
Reused/recycled	278.09	£12.57	261.43	£10.67	198.67	£10.41	231.96	£16.79
Incinerated with energy recovery							398.76	£54.85

Table 12: Weight and cost of the different waste streams between 2013/14 and 2016/17

Any domestic waste from the hospital which is not recycled is sent to the energy-from-waste site at Great Blakenham. This facility takes domestic waste from Suffolk and Norfolk, reduces greenhouse gases by 75,000 tonnes a year and generates enough electricity to power 30,000 homes. Practically nothing goes to waste on this site. Metals are recycled and ash, left after the incineration process, is used as an aggregate for local building projects. The Trust target for recycling is 30% of total waste. The Trust achieved 21% in 2016/17 and 23% in 2017/18

The Trust is able to recycle the following:-
- WEE Waste (Waste Electronic and Electrical Equipment)
- IT waste, including toners
- Wood and furniture
- Confidential paper
- Non confidential paper
- Cardboard
- Crushed lamps
- Waste cooking oil
- Scrap metal
- Batteries

- Uniforms
- Asthma inhalers
- Mobile phones

The recycling of cardboard, metal and cooking oil generates a small income for the Trust.

4.10.28.4 Corporate Social Responsibility/Sustainability

Sustainable development is now part of a mainstream framework for NHS activity. Central to this is the Sustainable Development Unit's Sustainable Development Assessment Tool. This web based toolkit is designed to help NHS organisations to assess and improve their contribution to sustainable development. It is based around eight key areas:

- Corporate approach
- Asset management and utilities
- Travel and logistics
- Adaptation
- Capital projects
- Green space and biodiversity
- Sustainable care models
- Our people
- Sustainable use of resources
- Carbon/GHG

There are four cross cutting themes:

- Governance and policy
- Core responsibilities
- Procurement and supply chain
- Working with staff patients and communities

The Trust has used the toolkit to complete a self-assessment. The action plan for improvement based on the outcomes of the assessment are monitored by the Sustainable Development Steering Group, see Figure 31.

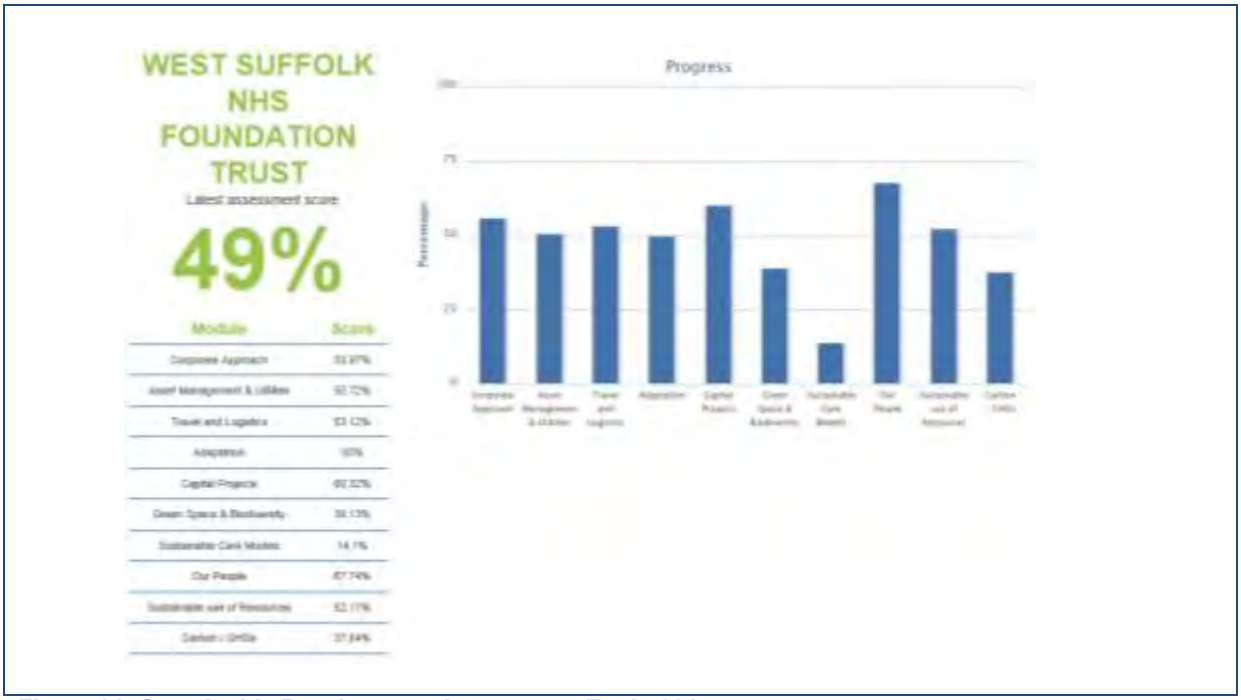


Figure 31: Sustainable Development Assessment Tool - 2017assessment

In 2018 the Trust aims to improve its score by 10%.

The Trust is contributing (6 no.) to the following Sustainable Development Goals (SDGs) of which there are a total of 17, see Figure 32.

Figure 32: WSFT sustainable development goals

The Trust has identified strategic themes to assist in reaching established carbon reduction targets these include:
Energy Saving Improvements - where possible, and cost effective, the Trust will continue to seek to make capital investment in efficient technology and replacement of out of date plant and controls which will result in reduced energy use and carbon emissions

- Reduce waste from both internal and external sources including working with suppliers and introducing new recycling facilities to divert waste from landfill
- Reduce emissions from staff travel through the Green Travel Plan, this includes the introduction of efficient vehicles, new facilities for cyclists and reducing both staff and patient travel
- Behavioural change - this is a major part of the programme and is vital if the Trust is to succeed and reach its reduction targets, we need to encourage staff to take a proactive role in reducing their own carbon emissions
- Policy alignment - examine existing policies and procedures to ensure that carbon reduction is embedded in the management within the entire Trust.

4.10.29 Car Parking

The site has 1823 spaces with a further 175 available off site; a breakdown of the types of parking available is detailed in Table 13 below.

Type	No
All Trust spaces	1677
Disabled spaces	73
Car share spaces	59
Drop off points	12
Electric charging points	6
Third party users	146
Spaces available across the site	**1823**
Off-site car park	175

Table 13: Parking spaces at West Suffolk Hospital

A car park review was undertaken in July 2008, (reference document 11). The purpose of the review was to consider the existing car park provision on the West Suffolk Hospital site and to develop car parking proposals to provide safe and accessible car parking on site.
The review concluded that none of the car parks are described as unsafe. All contain spaces which are non-compliant, usually as a result of insufficient size or manoeuvring. These can in most cases be addressed by minor alterations to the layout.
The report incorporates:

- Options for additional parking solutions
- Feasibility of car park barrier controls
- Suitable locations for contractor compounds

- Proposed circulatory access road
- Impact of residential development
- Lighting design/standardisation.

A number of actions have been taken since 2008 to improve the car parking arrangements on the West Suffolk Hospital site. Improvements have been made to address capacity issues and the overall parking experience for all users.

This has included:
- Provision of six dedicated electric charging bays at the rear of the site.
- Additional blue badge bays in the main patients/visitors car park to increase availability and accessibility close to the main entrance
- Additional general parking bays at the rear of the site offering staff and the general public more choice for parking near to place of work and external clinical units respectively.

As these improvements have been piecemeal, the size and condition of the individual car parks and parking bays is variable. Surface areas vary and lining in older car parks needs replenishing. Capital projects and the need for contractors to work closely to these projects/generate large compounds creates considerable disruption to other users of the site and impacts on capacity.

Consistent monitoring of the Trust's Travel Plan/programme of action assists the Trust in reducing volume of traffic with encouragement of walking to work, cycling to work (additional secure cycle storage units provided in 2017) and car sharing (additional car sharers bays provided February 2017).

Continued use of off-site parking and shuttle bus helps capacity but is a financial burden to the Trust.

Reconfiguration of the site with 80% one-way traffic control ensures smooth flow of traffic. However, barrier control to the rear of the site introduced in 2014 has generated its own problems with queuing at peak times. This is not helped by design of main access road to the site which cannot accommodate double lane traffic and/or emergency vehicles concurrently.

4.10.30 Estate and facilities management IT systems

The Trust replaced its patient administration system in 2016 and launched a new multi-million pound electronic patient record. Called e-Care, the state-of-the art, standardised IT system brings all available information about each patient into one place; making it easy to access from anywhere in the Trust while improving safety, preventing duplication and reducing costs. At a cost of around £19 million, e-Care was the biggest single investment the Trust had ever made in IT. E-Care was supplied by Cerner Millennium and replaced the Trust's patient administration system, which was around 20 years old.

4.10.30.1 EFM Information Technology Systems

The Estates team operates the Estates/FM helpdesk and provides all of the estate management services. This is a mix of planned work, including routine maintenance and reactive work, usually following a request being logged on the helpdesk. The helpdesk system is now a legacy solution that has limited supplier management, no integration capability and limited reporting tools.

Planned work is managed by the IFM solution which is now an obsolete system that needs to be replaced. It lacks the ability to record all of the required data for planned maintenance, cannot operate in real-time and does not support the use of mobile devices.

The Electro-Bio Mechanical Engineering (EBME) team manages electronic medical equipment and whilst the Trust has an inventory of all current equipment, there is little information regarding the location of the equipment -a notably acute position for equipment that is mobile. EBME also operate a helpdesk that manages requests for equipment or takes calls about equipment that is faulty or has failed.

The Facilities team manages support services including Housekeeping, Portering, Catering and Switchboard. The Facilities team also operates a helpdesk that picks up requests for housekeeping and portering services. Whilst the functionality is acceptable the solution is fairly basic. In addition, some of the work traditionally undertaken via the helpdesk now arises from the e-Care EPR solution for both housekeeping and porters. However, the e-Care solution currently only operates at WSH and there is clear benefit to deploy it to Newmarket Hospital. Housekeeping also operates a standalone stock control system that manages cleaning products and materials. The Trust is working with Cerner to develop the e-Care Materials Management module for use in the UK. This module has functionality that may offer an improved solution once it is operational for not only its target location (Theatres) but also for Facilities.

The Catering team operates a solution called Menumark that manages patient meal ordering, recipes, allergens the EPOS (electronic point of sale), catering stock and generates orders. Whilst Menumark has good catering functionality, reporting is limited and it is not integrated with the Powergate (procurement system). As a result, data has to be printed out of Menumark and manually re-entered into Powergate which is very time consuming. Work is in progress to establish a direct link into Integra, the Trusts finance system, which will allow caterings invoices to be processed for payment directly from Menumark.

Estates Development manages the on-going estate development of all Trust sites. Each year they deliver a substantial programme of capital works ranging from simple replacements through to full scale building projects. They work with many detailed scale drawings, complex tender documents and technical specifications as well as managing on site contactors who help to deliver the annual programme. As a result, the ability to securely share documentation with authorised suppliers and view drawings and specifications across the site is a key component of daily life.

The Sterile Services Department (SSD) sterilise a wide range of medical and surgical instruments, so they are safe for patient use. The Trust benefits from a new SSD unit on the ground floor of Quince House. The inclusion of Theatres and Anaesthetics as e-care modules in phase 3 presents an opportunity to improve the identification of instruments and the tracking of theatre instrument trays.

Refer to reference document 5 for further detail on the IM&T strategy.

4.10.31 Imaging services

The Trust, in common with similar services across the NHS, has noted a large surge in demand over the past five years. Of particular note is the move away from simpler techniques such as plain radiography or barium enema, towards more expensive, more complex techniques such as CT, MRI, and Endoscopy.

Ultrasound, too, has become a significantly well-used technique, and some scholars have wondered if ultrasound scanners are replacing the stethoscope as a primary clinical tool. There is an increasing demand for ultrasound to be provided in a primary care setting, and WSFT has a long and increasing history of responding to that demand, with ultrasound provided outside the hospital at the following locations:

- Newmarket
- Sudbury Community Health Centre
- Botesdale Health Centre
- Thetford Healthy Living Centre
- It is expected that an ultrasound service will open in Haverhill early in 2018.

There is concern about the ability of the main hospital building and its infrastructure to withstand additional development in terms of the power supply (both the mains supply to the hospital and the emergency generators), and the water supply and sewage capacity.

The Trust has been proactive in moving ultrasound capacity off site, computed tomography (CT) and magnetic resonance imaging (MRI) scanning is more problematic. The inevitability of the requirement for additional scanning capacity over the next five years leaves the following options:

- Identify space and the infrastructure to support additional fixed scanners on site.
- To provide parking space and electricity supply for mobile scanners on site
- To provide mobile scanners off site
- To provide fixed scanners off site.

In terms of space, there is developable space adjacent to radiology (housekeeping and the old pharmacy).

Refer to reference document 6 for further detail on the Imaging Services strategy.

4.10.31 Perception of EFM services

In addition to the PLACE assessment, which provides user feedback on services and the environment provided by the EFM team, this section also looks at specific feedback from customers and members of staff. Tables 14 and 15 highlight the Trusts PLACE scores between 2013 to 2017 at West Suffolk and Newmarket Hospitals.

Non clinical activities assessed	2013	2014	2015	2016	2017
Cleanliness	97.3%	99.76%	99.49%	99.92%	99.73%
Condition and appearance	84.92%	94.30%	84.77%	91.19%	96.14%
Privacy and dignity	80.93%	81.88%	79.89%	79.25%	83.96%
Food and hydration	83.87%	89.15%	84.72%		
Food				83.30%	93.99%
Organisation food				83.33%	88.61%
Ward food				83.28%	95.22%
Dementia			65.06%	75.69%	78.39%
Disability				74.70%	84.07%

Table 14: West Suffolk Hospital PLACE ratings from 2013 to 2017

Non clinical activities assessed	2013	2014	2015	2016	2017
Cleanliness	89.66%	97.09%	93.61%	93.54%	94.71%
Condition and appearance	72.04%	82.14%	83.78%	87.31%	83.47%
Privacy and dignity	70.29%	55.56%	74.72%	74.10%	73.50%
Food and hydration	72.33%	77.87%	89.99%		
Food				89.07%	86.56%

Non clinical activities assessed	2013	2014	2015	2016	2017
Organisation food				88.79%	84.12%
Ward food				89.36%	88.94%
Dementia			74.21%	81.21%	75.62%
Disability				88.14%	79.18%

Table 15: Newmarket Hospital PLACE ratings from 2013 to 2017

The PLACE assessment has changed over time with the introduction of dementia criteria in 2015 and in 2016 disability criteria was added and the food criteria was split into three sections to include sustainable procurement of produce, quality and temperature of food along with presentation, choice and availability.

Each year, following the assessment, an action plan is developed and is presented to the Patient Environment Action Group, who are responsible for monitoring progress against the action plan. The more significant actions are incorporated into the Trust's annual estate investment prioritisation assessment for inclusion in the annual estate investment planning process.

4.10.31.1 Customer perception of EFM services

At WSFT, specific EFM customer feedback is limited to Sterile Services Department (SSD), Catering, EBME and Procurement teams. These departments are ISO accredited and undertake regular questionnaires to gain customer feedback on the level of service provided.

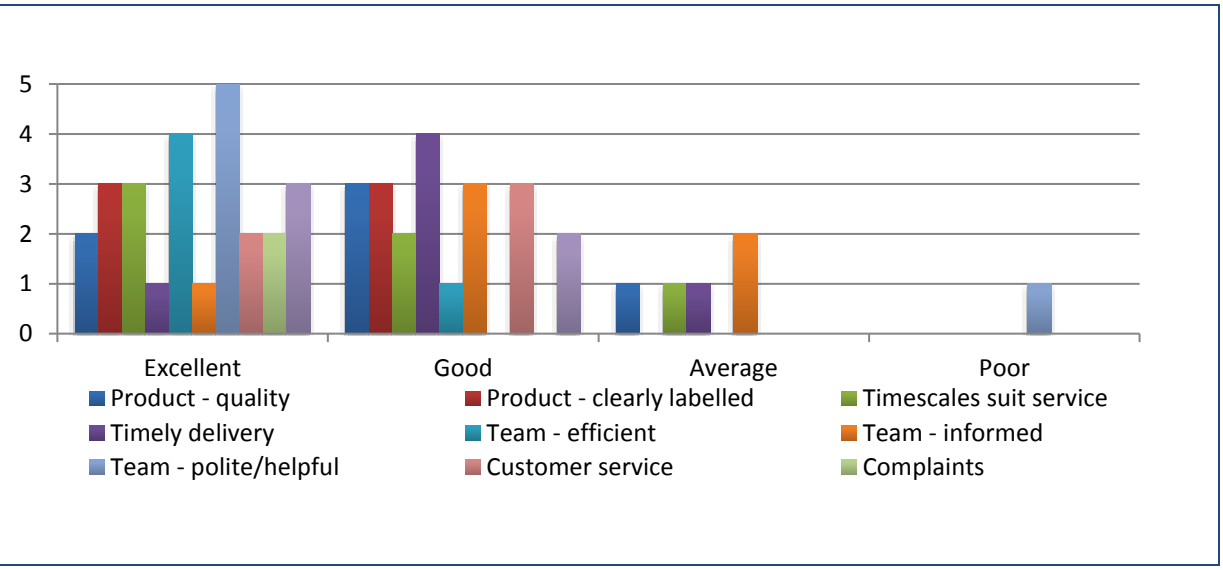


Figure 33: SSD customer service feedback

SSD use a paper-based system and undertake customer surveys on a bi-annual basis. The categories in SSD's questionnaire focus on the quality/level of service and timeliness of service received (see Figure 28). A 60% response rate was achieved with the majority of customers regarding the service received as excellent or good, see Figure 33.

EBME use an electronic system and survey 50 customers twice a year. The categories in EBME's questionnaire focus on staff knowledge, understanding of needs, reliability and efficiency of service received, see Figure 34. A 28% response rate was achieved with customers regarding the service received as excellent or very good.

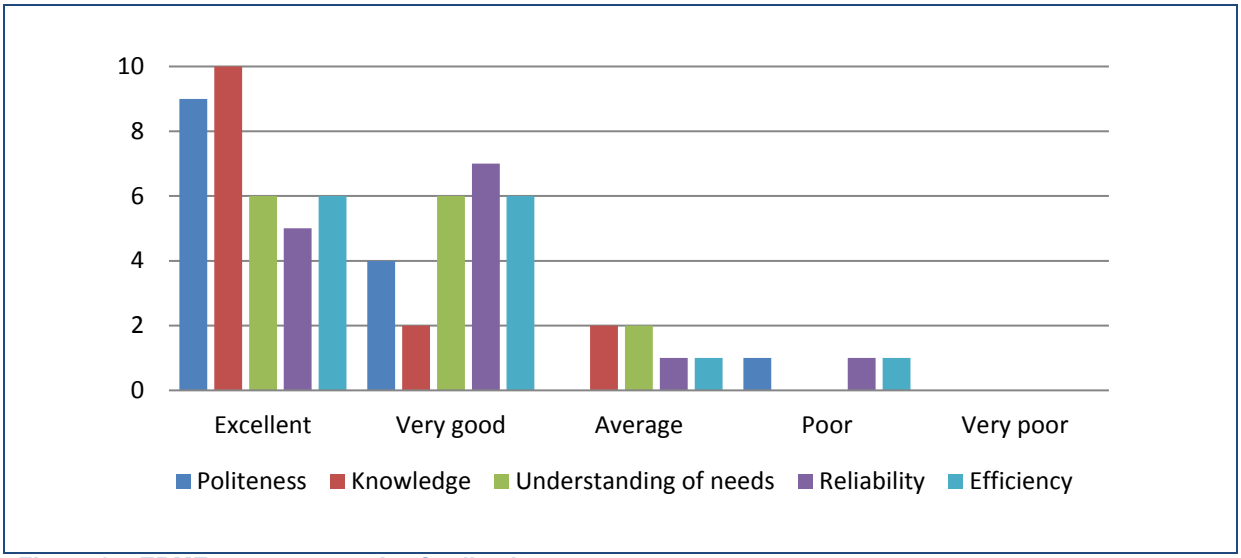


Figure 34: EBME customer service feedback

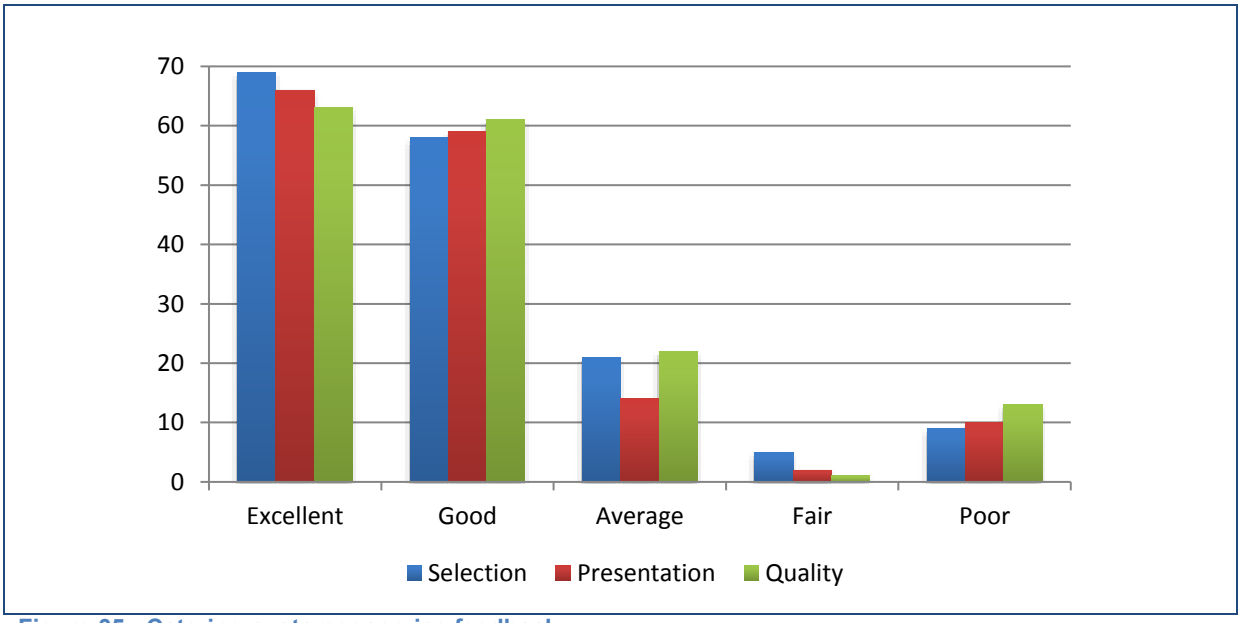


Figure 35: Catering customer service feedback

Catering use a paper based system and undertake a customer survey on an annual basis, the survey represents customer feedback from the staff/visitor restaurant, but does not capture feedback from patients. The categories in Catering's questionnaire focus on the quality, selection and presentation of food provided, see Figure 35 above. The Catering Team are unable to determine the response rate as the questionnaire is left in the restaurant for staff to complete on a voluntary basis. Out of 163 responses, customers regard the service received as excellent or good.

For the Purchasing survey, staff were invited to respond via an electronic link in the Green Sheet and on papercopies sent to Porters, Estates and House Keeping. 83 responses were received in total, 69 on line and 14 hard copy. In the main feedback is very posistive with 62 responses rating services as excellent/good and 10 responses indicating a poor experience, see Figure 36.

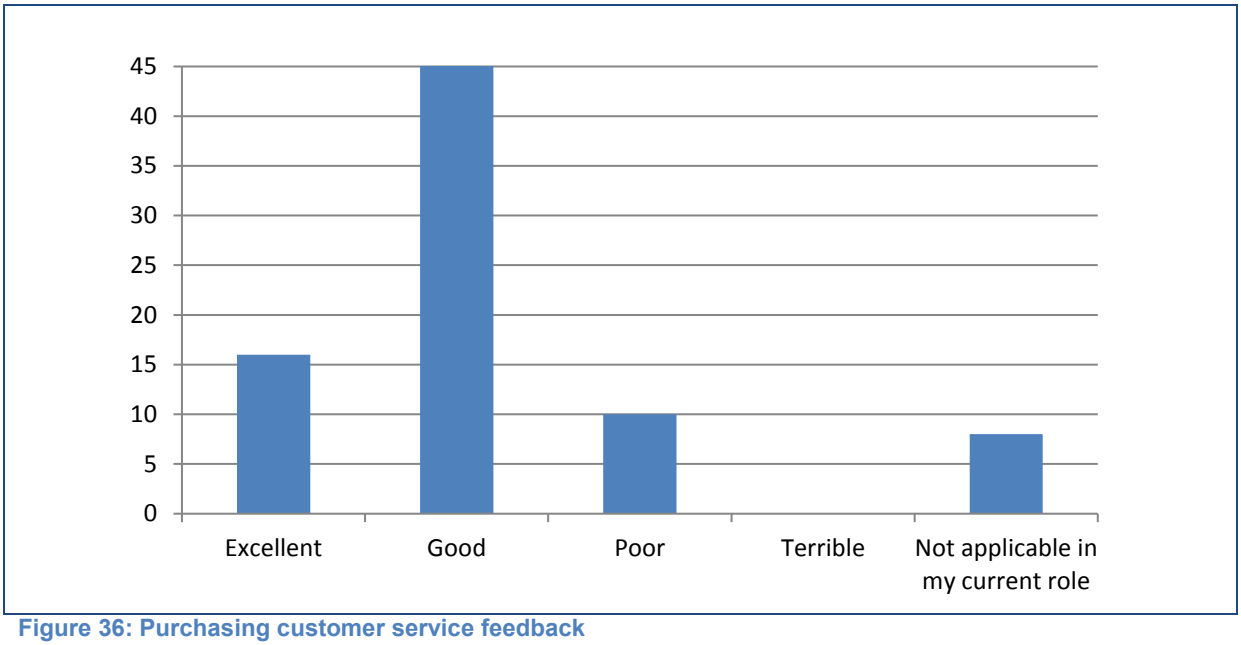


Figure 36: Purchasing customer service feedback

4.10.31.2 Staff perception of EFM services provided.

Research was conducted in 2016 to establish what members of staff think about the services provided by the EFM team. 1170 members of staff were invited to participate in the survey using a paper based or digital questionnaire, a response rate of 12% (140 no) was reached.

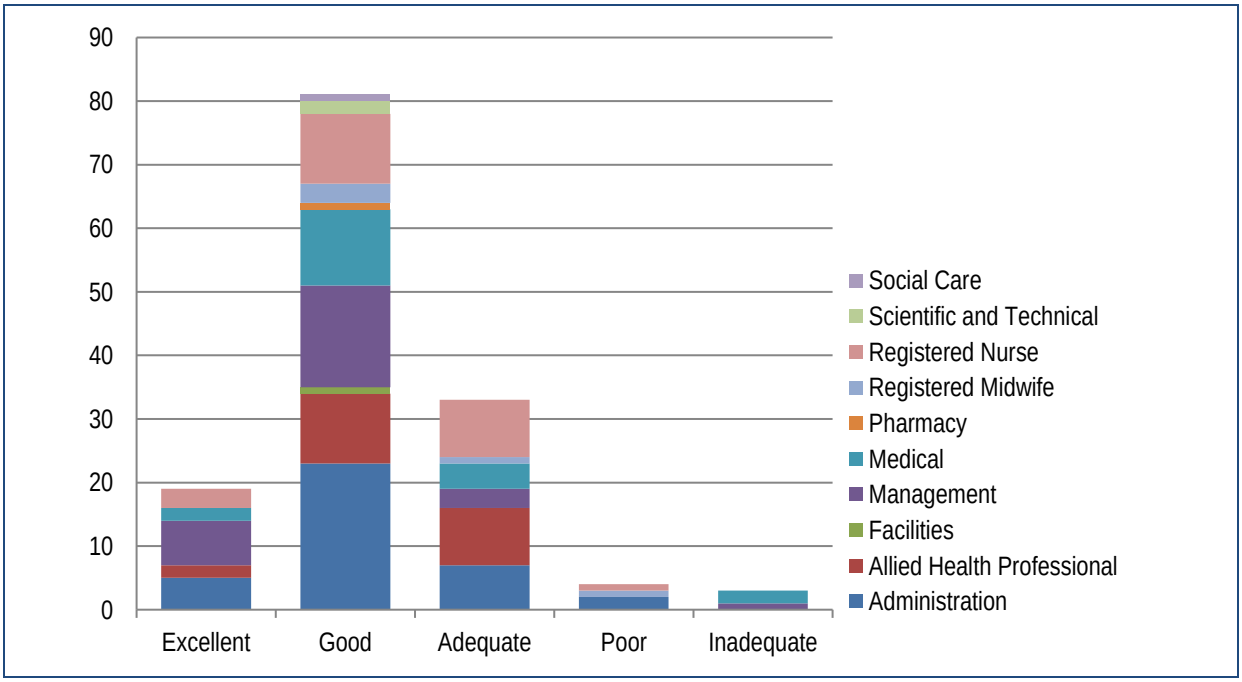


Figure 37: Survey questionnaire respondents' opinion of quality of services provided

In the main, feedback was very positive; research has indicated that 71% of respondents' rate their opinion of the service from excellent to good, with only 5% rating the service poor or inadequate, see Figure 37. Respondents were given the opportunity to provide reasons for their choice of rating. 26% of respondents noted negative comments; these were about time to complete requests. However, there were also 44 positive comments about the service delivery.

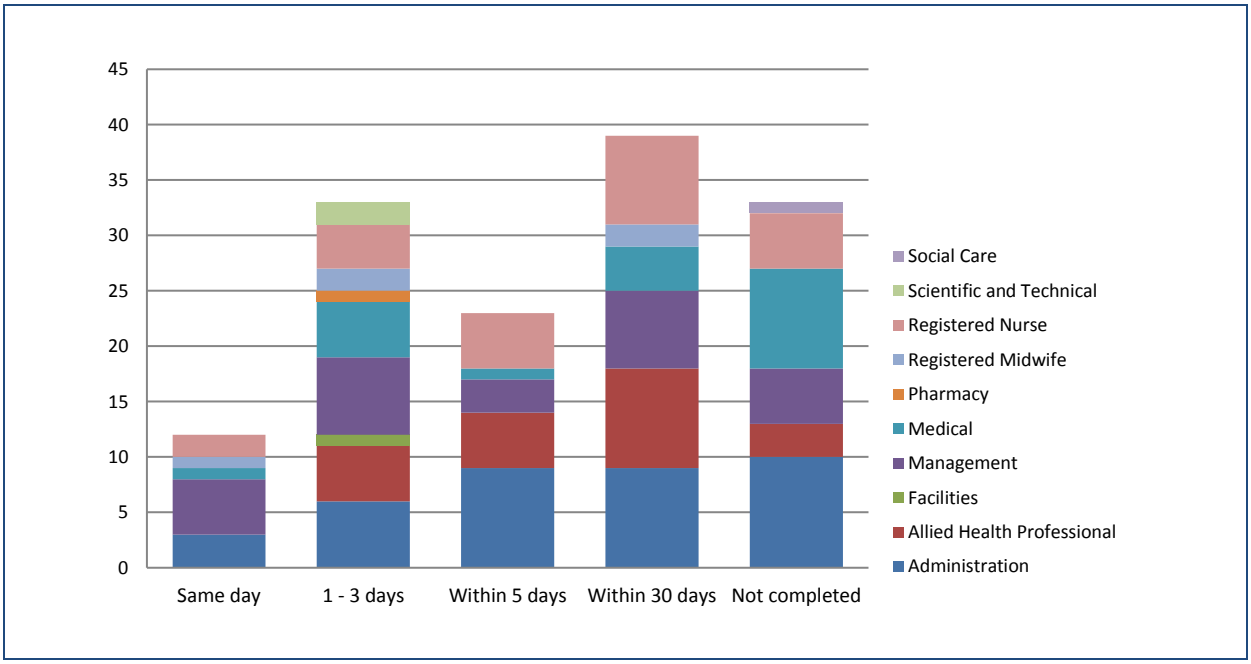


Figure 38: Survey questionnaire respondents' opinion response time

Staff were asked to feedback how quickly the EFM Team react to requests; Figure 38 shows that 9% of requests are processed the same day and 32% within three days. However 28% requests took up to 30 days and 24% were not completed at all. Members of staff were asked to describe what impact this has on the services they provide. 49% respondents commented that the speed of service was poor, 9% indicated that the delay had an impact on patient care and 24% of respondents made no comment.

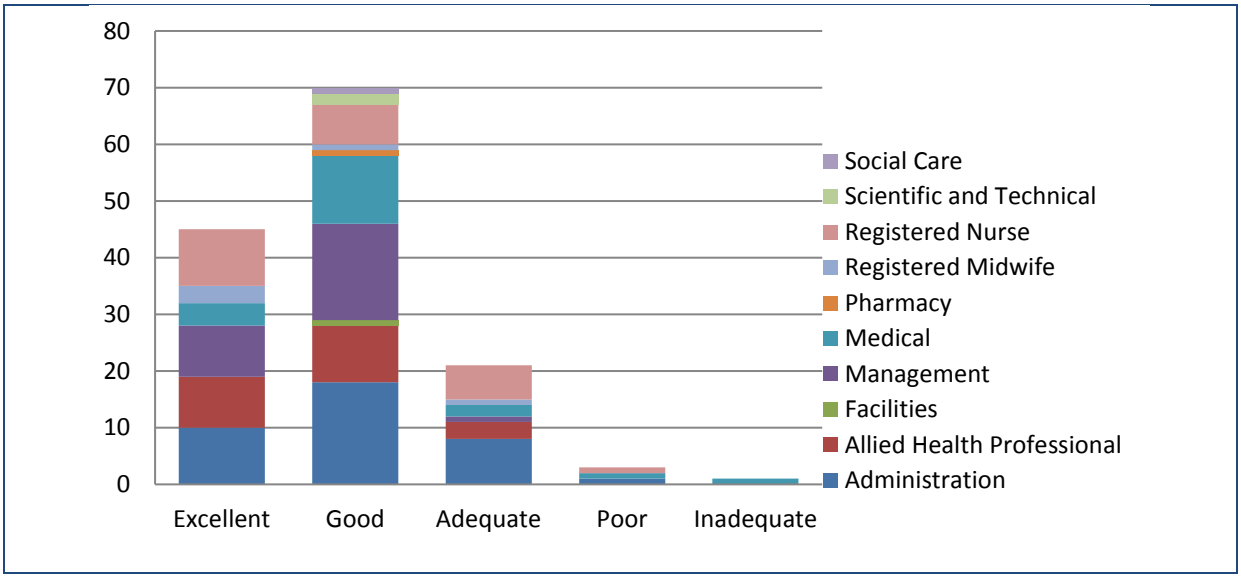


Figure 39: Survey questionnaire respondents' opinion regarding staff attitude

Staff were asked to describe what they thought about the EFM Team staff attitude. Figure 39 below shows the respondent feedback regarding staff attitude, with 97% rating staff attitude between 'excellent' to 'adequate' with 82% excellent and good. Respondents provided additional comments with 34% providing positive feedback about staff attitude being friendly, helpful and professional. 55% of respondents did not provide any additional feedback.

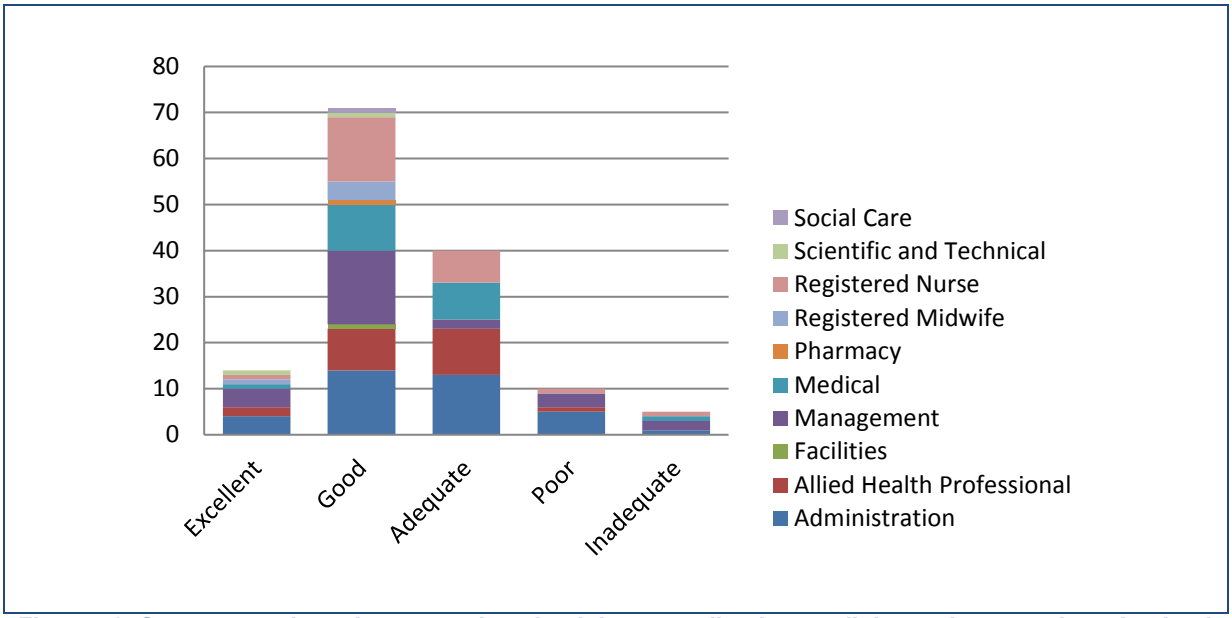


Figure 40: Survey questionnaire respondents' opinion regarding how well the environment is maintained

Staff were asked to rate their opinion of how well the environment is maintained. It is interesting to note that although it is widely known that the hospital is past its intended design life that the perception of how well the environment is maintained is high. Figure 40 indicates that there is a positive skew with 90% rating the environment between 'excellent' and 'adequate' with 51% rating it 'good'.

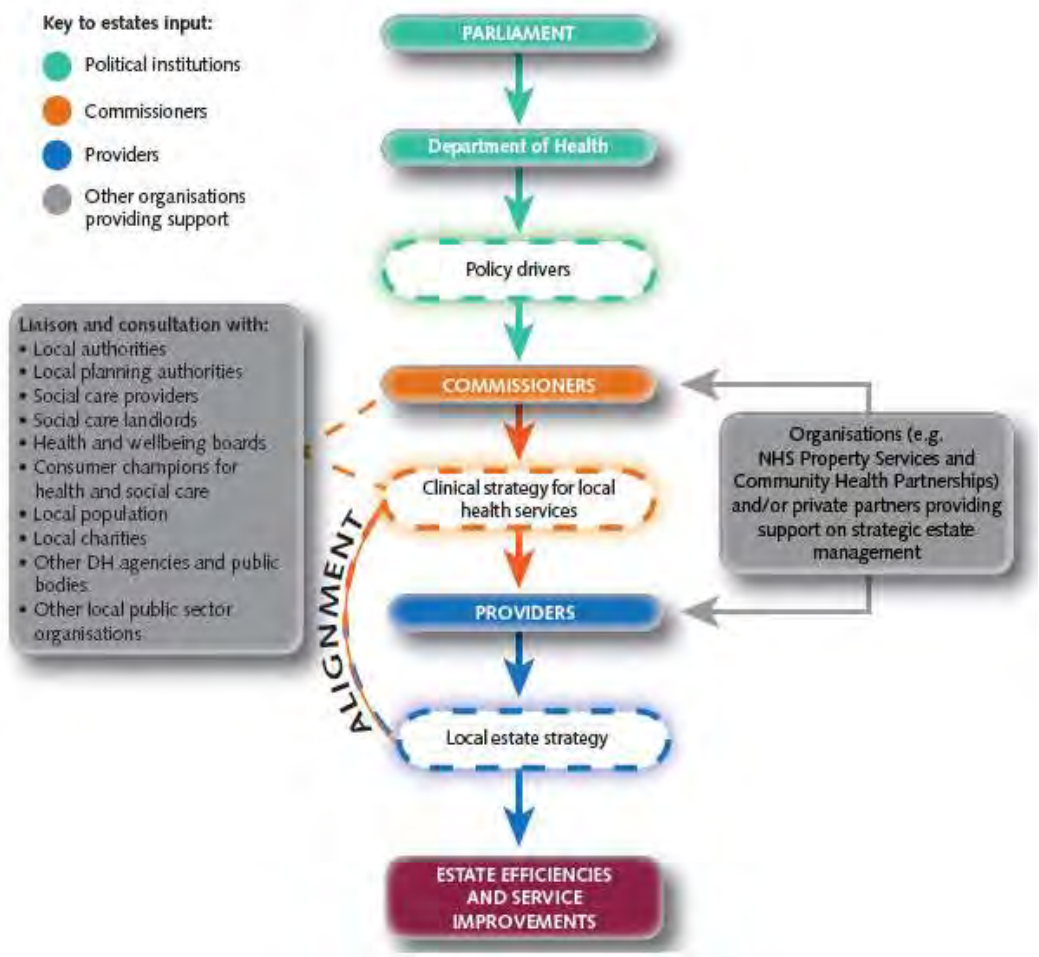
In summary the analysis identifies that the overall perception of EFM service provision is good, the environment is well maintained within the constraints of an old building, and supports patient care. Staff attitude is good, but communication and response times need to be improved. It was noted that there is a bias toward hard FM services (maintenance) and this could skew the perception of these services, meaning that some of the observations regarding response times may not apply to the soft FM services (cleaning, catering).

5. Where do we want to be?

This Section deals with the future requirements of the estate and builds on areas requiring improvement to meet current needs, or developments required to meet future demands, or expectations. It does this by developing solutions to gaps, weaknesses or risks associated with service delivery and by considering the options available to address these.

5.1 Impact of the clinical strategy on the estate

The Trust has aligned its estate strategy with clinical strategies and commissioners' clinical objectives and priorities. This has been carried out in partnership with other healthcare, social care and public sector organisations. This approach emphasises the need to engage at board level when developing estate strategies and to liaise with all those responsible for clinical decision-making and the planning of care see Figure 41. This approach aligns with the STP estate work stream and developing estate strategy covering the North East Essex and Suffolk foot print, in addition to incorporating the OPE initiative. The Trusts estate constraints, risks, issues and opportunities are also reflected in the STP estate strategy.



Department of Health (2014a)

Figure 41: Alignment of estate strategy/priorities with clinical strategy

The Trust's estate strategy has not been developed in isolation. Consultation has taken place with key clinical staff and the following table identifies some elements that have influenced this strategy, these are details in Table 16:

Future State	Possible Implications
Repatriation of services currently provided in tertiary centres e.g. cardiology, respiratory and bariatric surgery	- More patients in hospital with greater acuity and complex needs - Impact on length of stay
More services available for more of the day on more days of the week	- Changes in working patterns/arrangements/contracts for some clinical staff - More information to be shared across organisations and specialties
Solutions for care closer to home	- Hospital without walls/hospital at home model - more care delivered outside hospital both physically and virtually - Supporting and developing proactive primary and integrated neighbourhood-level community care services to help to minimise unnecessary acute hospital attendances / admissions - Development of clear discharge to assess and stepdown pathways, facilitating timely assessment and discharge for patients whose acute care episode has been completed - Outpatients provided in other settings e.g. in leisure centres - Labs and imaging in community - more information shared across organisations to support care and prevent admissions - Patients in hospital likely to have greater acuity and more complex needs - Hospital resources may support fewer acute beds but there may be more patients in different settings - Economies of scale efficiency avoiding duplication of services - Hospital estate available for other uses - Tele and video consultation suites - use of alternative methods of accessing information, results or treatment thereby reducing the number of hospital visits required
Technological advancements e.g. changes in treatments requiring different diagnostic modalities	- Greater pressure on mechanical and electrical systems - More or less space required in clinical rooms - Use of information technology to provide greater efficiency - Flexibility of design to allow for future adaptation as technology evolves

Future State	Possible Implications
Accommodating demographic change/ meeting the needs of the population better	- Dementia and frailty friendly environments - non-institutional, reduce potential risks, contrasting colours, appropriate lighting levels, careful use of patterns, elimination of shadows, clear way-finding, slip resistant floors, positive stimulation, multi-sensory environments access to outdoors - Provision for obese patients - structure, access, lifts, equipment - Language, ethnicity, religious needs - provision of information in different languages, expansion of translation services, facilities to meet religious needs, recognition of cultural differences - Transgender-friendly facilities - greater provision of single rooms, consideration in gender specific facilities such as toilets, changing rooms and changed waiting areas
Increasing family involvement in care e.g. visitors at all times, families providing some personal care	- Space for relatives/carers to stay overnight with patient - Space for relatives/carers to prepare food - Space for relatives/carers within sanitary facilities
More single rooms, not just for privacy and patient choice but also infection control with regard to new and emerging infections	- Ready availability of single rooms with en-suites - High quality patient support and sanitary facilities - Provision for isolation facilities, including lobbies and air pressure regimes
Adaptation to climate change - extreme weather (heat and cold)	- Providing appropriate environments to minimise adverse effects on either staff and patients due to extreme temperatures
Creating therapeutic environments	- High quality environments with enhanced amenities - Home-from-home environments where appropriate, e.g. paediatrics - Dispersed staff bases - evidence suggests patients anxiety is reduced if they are nearer staff - Ability to customise space - Elimination of unpleasant smells - Sightlines from windows into green space/connection with outdoors - Colours and materials which are calming, restorative, ergonomic measures e.g. to promote sleep at night - Physical designs which reduce noise - Easy access to outside for mobilising/fresh air/outdoor therapy

Future State	Possible Implications
Designing in health and wellbeing for staff	- Introduce natural light and ventilation to landlocked areas - Staircase/lift arrangements which promote default use of stairs - Rest areas, communal spaces, networking spaces, easy access to outside - Features which make it easier for staff who are older/disabled and those with long-term conditions to continue working including accommodating menopause symptoms
Adding social value	- Co-locating space with others e.g. clubs, charities, community events, art gallery - Promote the possibility of a one-stop service, thereby reducing the number of visits - Amalgamating a number of services under one roof to enhance efficiency - Flexibility of design to allow for future adaptation as the clinical policy evolves - Making facilities available out of hours - Making space for partner services to be co-located e.g. citizens advice bureau, job centre, housing office, lifestyle services - Making space available for peer support groups to meet e.g. breastfeeding group running alongside antenatal clinic - Facilities to host students & apprenticeships in all roles
Making effective use of resources	- Reducing duplication and waste - Working together with partners to use resources better - More co-located services - Shared roles/joint staffing posts
Emergency/urgent care	- Further development of the emergency village concept - Additional diagnostics
Elective care including daycase and short stay surgery	- Surgery will be undertaken in the most appropriate and least acute environment that's required

Table 16: Summary of high level clinical direction and possible implications

5.2 EFM Supporting the WSFT Strategic Framework

The Trust's strategic framework sets out three priorities for the Division in respect of the services it provides. Table 17 highlights how the Division will take forward the Trust's ambitions to meet the priorities.

Priority	Examples
1. Deliver for today	- Continuing to maintain safe services and staffing at all times. - Continue to deliver mandatory standards PLACE, PAM ERIC, Model Hospital.

Priority	Examples
	- Have business continuity and emergency plans and be prepared for a major incident/local emergency. - Keep its financial promises. - Continue to maintain the estate to provide a safe, fit for purpose environment for the delivery of healthcare. - Ensure effective backlog maintenance planning. - Hold landlords to account. - Extend ISO accreditation to all departments across the Division. - Explore public sector estate opportunities. - Consider a more flexible approach to the procurement of additional space.
2. Invest in quality, staff and leadership	- Invest in quality and continuous improvement. - Empower staff to be the best they can. - Invest in restrictive physical intervention/security team - Develop new roles e.g. technicians, apprenticeships. - Improve/develop benchmarking processes to measure performance. - Membership of professional groups e.g. HEFMA, IHEEM, NPAG - Invest in leadership, staff and training. - The estate and facilities workforce is aging, develop succession plans to ensure continuity of services and to retain organisational memory.
3. Build the future	- Continue to develop effective models of care in partnership with key stakeholders e.g. OPE - Review property holdings and reduce where possible - Develop a rolling programme of service transformation. - Contribute to STP estate strategy and service development. - Bid for estate development funding via STP/OPE. - Undertake a strategic assessment of the estate to determine whether a new hospital is built or the existing is re-developed. - Maximise the productivity and efficiency of the estate and EFM services.

Table 17: EFM Division priorities

5.2 Asset management

An assessment of the Trust's portfolio requirements has established that its needs can be identified using the Gibson (2000) model, see Figure 42. Mapping WSFT changing strategic requirements onto the model has identified the following real estate operating opportunities that the Trust could consider.

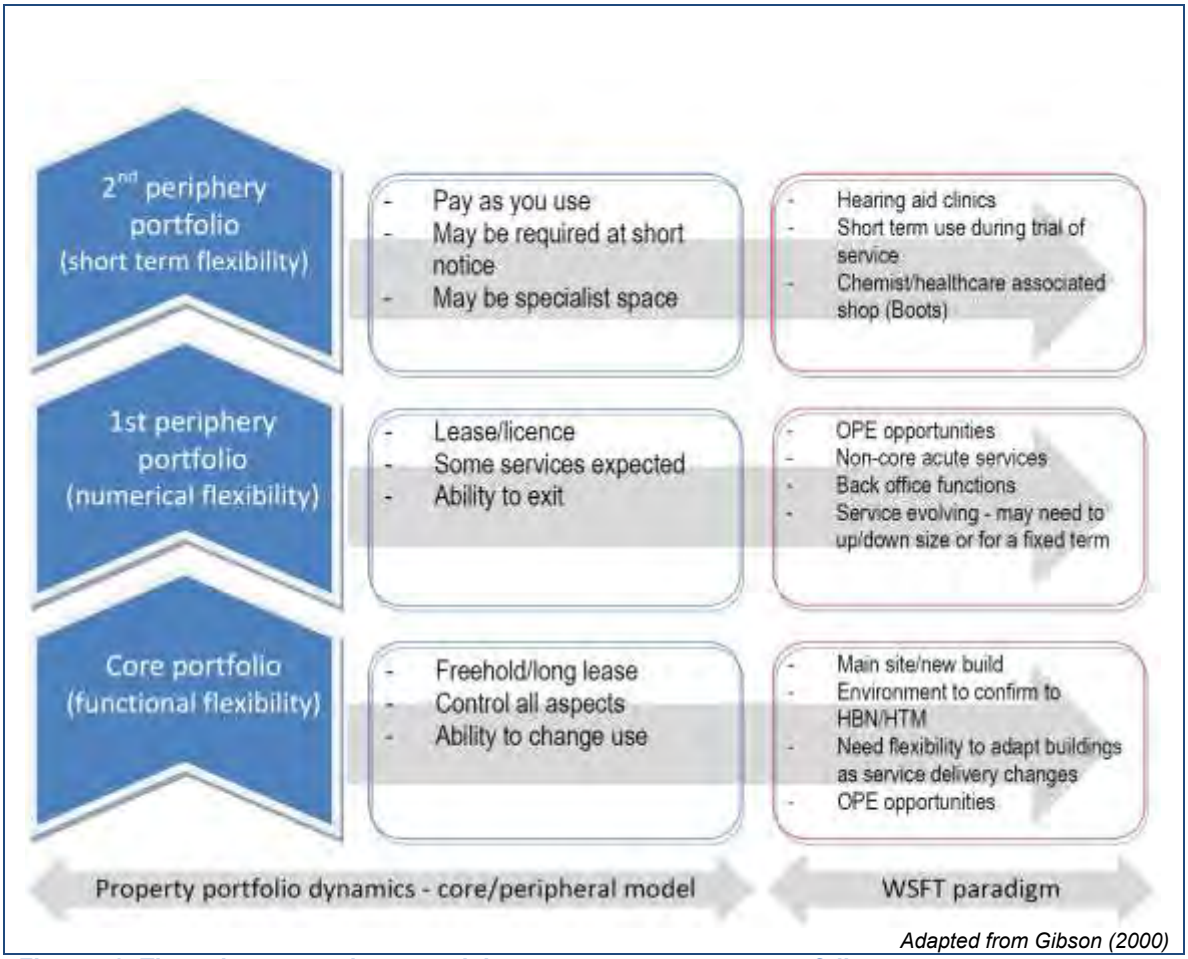


Figure 42: Three tier approach to examining a corporate property portfolio

Core portfolio (functional flexibility, ability to change the form/function of the asset) - this relates to the nucleus of the organisation's estate for WSFT, this is the Hardwick Lane freehold site, where the estate is specifically configured to provide acute care. The main hospital building is based on 1960's design, which does not reflect current layout/standards, is not functionally suitable and past its intended design life. DH guidance recommends that the Trust needs to consider the long term viability of the site and how the services can be provided in the future. Work has started to strategically assess the future options for the Trust these include a partial redevelopment of the current site (circa £200m) or provision of a new hospital (circa £500m), see Section 5.

1st periphery portfolio (numerical flexibility e.g. short term lease, not tied in financially for a long term) - This approach can be applied to community and acute space, where an increase/provision new clinics in the community is required. This could free up space in the main outpatients department which can be released for other services that require locating in an acute setting. It also aligns with the Trust's strategy to move to estate developed via the One Public Estate initiative.

2nd periphery portfolio (short term flexibility e.g. pay as you go, may be initially more expensive but is a short term fix) - an example is community based audiology clinics, which undertake basic repairs/maintenance on a drop in basis - these could be established within a healthcare related retail outlet, such as Specsavers/Boots, patients would be provided with a more accessible service and the freedom to have repairs undertaken at their convenience whilst they are in town.

The model's emphasis on core property, which is functionally flexible, should be supported by peripheral property which is flexible both financially and from the duration which is required to enable the estate to flex and change as determined by the core business strategy.

5.3 Space Utilisation

As discussed in Section 4.10 previous space utilisation studies have identified that under-utilised used administrative space represents an opportunity across the acute and community estate portfolio.

In terms of maximising space utilisation and demands in the future, the Trust has adopted an informal strategy of relocating administrative functions away from core clinical space. To support this strategy, the Trust intends to build a satellite office block on site (in one of the few remaining areas for development). The Trust is also aiming to move away from cellular offices with the exception of staff at executive level and embrace the benefits of open plan working. Moving towards, or exceeding Cabinet Office efficiency targets for new premises of 4 desks for every 5 WTE staff and allowing no more than 8m² per desk space the Trust can reduce space requirements.

5.4 EFM Information Management Systems

The EFM team in collaboration with IT will draw up specifications for the following systems which will be market tested and the results incorporated into a business case presented to the Capital Strategy Group and TEG:

- An integrated generic helpdesk solution that meets the needs of IT, Facilities, Housekeeping, Estates and the EBME teams, the specification will be market tested to determine whether or not a single helpdesk product could be shared across two or more client groups.
- A new planned maintenance solution to replace IFM. The specification will address the current shortfall issues.
- Building on the upgrade to the Trust wireless network, the Estates, Portering, Housekeeping and EBME teams will investigate the use of Radio Frequency Identification (RFID) to track both high value and high volume assets and establish the viability of such a system. The strategy is cognisant of the Materials Management modules proposed as part of phase 3 of the GDE e-Care Programme and RFID capabilities of the e-Care Care Aware solution. The functionality of both will be included in the review.
- Following completion of the GOVROAM wireless service at Newmarket General Hospital (NGH), the EFM team - in collaboration with the e-Care team - will review what is required to rollout the Care Aware package for Housekeepers and Porters to Newmarket Hospital over the nascent wireless network.
- Review the options for an interface between Menu Mark and the designated procurement solution (e.g. Integra). An options appraisal paper will be generated for evaluation and agreement as to the way forward.
- The Estate Development team, with support from the IT Department, will test the ability to access detailed scale drawings, complex tender documents and technical specifications over the new wireless network using one or more suitable tablets and/or computers. Initially this this will focus on the main hospital and Newmarket hospital sites, as Trust wireless networks.

5.6 Estate Development Proposals 2018/19 - 2022/23

An annual review is undertaken to identify the likely implications on the estate over the strategic period arising from the clinical service strategy. The review prioritises schemes and considers the most appropriate location for these developments based on functional suitability of the space and clinical adjacencies. Schemes are considered on a priority/risk basis and the outcomes are broken down into the following service categories:

- Clinical services
- Clinical support services
- Community services
- Non-clinical and corporate services.

5.6.1 Clinical services

5.6.1.2 Acute Assessment Unit (AAU)

This scheme seeks to improve the current facilities, which are currently configured as a general ward and improve patient flow associated with the AAU unit and surrounding areas. Co-located to ED the new AAU unit will achieve a reduction in emergency admissions for both medical and surgical patients, improve patient flow and will relieve pressure on the ED, ensuring that the highest acuity patients are seen more quickly and the 4 hour arrival to seen target can be met. It will also improve ambulance handover times and provide an additional area for ambulance escalation during times of high demand.

5.6.1.2 Emergency Department (ED)

The ED has a number of issues related to flow and effective decision making, in addition to estate that is no longer functionally suitable. Visits from both the Intensive Support Team and the CQC have resulted in recommendations that require a wholesale redevelopment of the department. The recommendations include the need for:

- separate entrances for ambulance transfers and walk in patients;
- separate paediatric waiting and cubicle areas; and
- increased clinical capacity (minors, majors, resus and primary care streaming).

The redevelopment scheme would provide:

- the solution to a number of patient flow issues and overcome many of the obstacles to reducing the attendance to admission conversion rate
- effective segregation of ambulance arrivals from other patients into major and minor areas;
- separated paediatric waiting and treatment facilities
- a paediatric service consistent with our community focussed paediatric strategy, centred around the development of a children's assessment unit that would facilitate a primary care driven paediatric service
- a more appropriate facility for the assessment and treatment of patients with mental health issues
- the ability for an ED nurse to stream patients directly to a GP, ambulatory emergency care or ED triage depending on their assessment of need
- an overall increase in capacity to meet the STP activity assumptions
- effective co-location of ED with the Clinical Decision Unit and the planned Acute Assessment Unit
- improved patient privacy and dignity

5.6.1.3 Labour Suite

All of the delivery rooms on the Labour Suite need to be upgraded as they are not functionally suitable and do not meet the requirements set out in the Health Building Note 09-02 Maternity Care Facilities. The scheme will address privacy and dignity issues by providing en-suite facilities to each delivery room, currently women have to leave the delivery room to access a toilet. The refurbishment will include piped medical air to each room, currently bottled gas is used which presents a safety risk. Infection control issues will also be addressed through the provision of a central clinical waste area and sluice.

5.6.1.4 Ward/Theatres/Department Refurbishment Programme

The Estate Investment Plan includes the continued modernisation and refurbishment of ward areas. Nine wards require major upgrade: G3, F3, F4, F5, F6, F7, F8, F12 and F14, three of wards, Fracture Clinic and Theatre 1 are being addressed during the strategic period (F8, G3 and F3). This programme will address nurse call systems, replacement of sanitary fittings and windows, upgrading electrical distribution, improving privacy/dignity, infection control and storage issues, which are highlighted in the facet survey.

5.6.1.5 Critical Care Unit

Subject to business case approval, the Trust plans to refurbish the Critical Care Unit. This will include the replacement of the existing clinical management system. The scope of the project incorporates the refurbishment of the combined Intensive Care and High Dependency Unit, as the current accommodation does not conform to HBN 57 (Facilities for Critical Care). This development is included in the Trust's Estate Investment Plan.

5.6.1.6 Pleural procedure room

The development of a dedicated pleural procedure room is required to enable catheters to be inserted into patients to drain pleural fluid from around the lungs. Ideally it will be located near to ward F10 or consultant offices so that either staff from ward F10 or the Specialist Nurses/Consultant can support the recovery of the patient post procedure. The pleural procedure room will be designed to treatment room standards with observation facilities.

5.6.2 Clinical Support Services

5.6.2.1 Pharmacy Replacement Robot

This project will cover the replacement of the existing robot which is at the end of the lease period and the associated building works to facilitate the installation of the new equipment.

5.6.2.2 Diagnostics

Equipment in rooms 1, 2 and 4 has been upgraded. Further upgrades/replacement of equipment and refurbishment of rooms have been included in the Estate Investment Plan to replace outdated equipment and associated services/building work. Other development planned during the planning period are:

- MRI - current growth rates for in and out patient MRI scans, capacity of the two scanners is likely to be exceeded during 2020.
- CT - plan for a third CT scanner sometime during 2021, which should be up and running before the two existing ones are due for replacement in 2022.
- Ultra Sound - providing at least one new room each for non-obstetric and obstetric U/S patients by 2023.

5.6.2.3 Radiology reporting space

The increases in CT and MR have brought about a significant increase in demand for reporting, which means that the development of additional reporting facilities is required. The possibility of constructing a reporting room in or near the x-ray store is being considered, in addition to developing rooms in the x-ray office area to accommodate the imaging services manager and x-ray superintendents, to re-provide radiologists offices and to facilitate the construction of further reporting facilities within the radiologist's area.

5.6.2.4 Audiology refurbishment

The refurbishment will update facilities in line with Health Building Note12, Supplement 3, ENT and Audiology Clinics Hearing Aid Centre. The work will also provide two additional testing booths, increased child friendly waiting space and improved sound proofing. This scheme is included in the Trust's Estate Investment Plan.

5.6.3 Community Services

5.6.3.1 Developing localities and service portfolios

As part of the Alliance work, the Trust is developing services in six localities across the west, with integrated neighbourhood teams working within them. This involves the development of health and care wellbeing hubs in each of the localities based at:

1. Mildenhall
2. Bury St Edmunds
3. Newmarket
4. Haverhill
5. Brandon
6. Sudbury

It is envisaged that the localities will contain a wide range of statutory and non-statutory services, but the philosophy is as much as about the *way* everyone works as it is the space they work from. The environment will be delivered through the One Public Estate initiatives being developed at the towns shown above.

5.6.3.2 Integrated Community Paediatric services - east Suffolk

The Integrated Community Paediatric Service (ICPS) consists of eight core services which operate as part of an integrated model of delivery:

- Medical services
- Audiology
- Nursing
- Physiotherapy
- Occupational therapy
- Speech and language therapy
- Child and family psychology

Aspects of the current service are delivered from Ipswich Child Development Centre. Notice was served by the landlord in September 2017 to vacate the site. Since this time Estates Development leads in the east and west have been working with ICPS to look at short and long term options for ICDC relocation and development of ICPS estate

A range of short term solutions (3 - 5 years) have been considered, with the most viable being the re-location of services to an existing site in Ipswich - St. Helens House. This is estimated to cost in the region of £315k, but will release annual rent of £52k.

Currently exploring the following long options:

- Co-location with a Suffolk County Council school/academy (linked to re - design projects)
- New build plan for the relocation of 3 merged GP practices (ex Tooks bakery site in Ipswich)

St Helens House is owned by NHSPS and the long term solution would release the side for disposal.

5.6.4 Non-Clinical and Corporate Services

5.6.4.1 Residences

The existing staff residential blocks at the front of the site are nearing the end of their structural design life. Feasibility studies have shown that the refurbishment of the existing accommodation is uneconomical due to the level of work required to adapt the units to modern standards, provide structural improvement and remove the asbestos.

The delivery of 160 new keyworker accommodation units is in progress and will replace the existing accommodation; completion is scheduled for February 2019.

The existing accommodation will be converted to provide administrative space for staff.

5.6.4.2 Car Parking

Following the introduction of a barrier controlled site in 2014, the benefits of access by automatic number plate recognition have been evaluated. Some modifications are required and, with effect from July 2018, a new barrier system is to be installed. This will initially address traffic flow issues and improve access and egress for all users of the site.

Other improvements to enhance the car parking experience to be considered are:

- improved access road
- review of car parking spaces for patients and visitors near to DSU/ETC/Education Centre.
- identify contractor compound sites exclusive of car parking spaces and, in particular, to avoid the use of blue badge bays adjacent to the hospital.
- if above not feasible, capital project needed for more parking spaces e.g. decking on existing car park E. This could also accommodate staff currently using the off-site parking and shuttle bus facilities.
- maintenance programme for surfacing and lining of car parks to be developed.

5.6.4.3 Backlog

The site has an aging infrastructure with an original intended design life of 30 years, currently in year 44. All works included in the plan are required to address unacceptable risk in terms of safety (legionella, fire, structure) and resilience (sufficient electrical, mechanical, medical gas capacity). The significant schemes are detailed below:

5.6.4.3.1 Re-roofing programme

The roof structure consists of reinforced autoclaved aerated concrete panels which form a flat surface supported by an arrangement of pre-cast reinforced concrete beams and columns. A structural survey has indicated that urgent work is needed to ensure the structural integrity of the building can be prolonged. The existing panels are beyond their design life and are sporadically failing. In order to do this a phased programme of works is in progress to replace the existing roof coverings to the main hospital with a new roof system that carries a 20 year guarantee. This project is

being delivered in phases, and 6 phases have been completed the remainder being subject to funding and strategy.

5.6.4.3.2 Site electrical infrastructure upgrade

The electrical capacity of the site is currently at its limit and, without an upgrade to the electrical infrastructure, the planned development of the site cannot continue. A strategy has been developed to provide additional capacity and resilience and is delivered in phases over 10 years. The phase planned for 18/19 and 19/20 upgrades transformers T1 and T2 (John Godden and Country Man panels).

5.6.4.3.3 Compartmentation

Works to ensure compartmentation is in line with Health Technical Memorandum 05-01 Managing Healthcare Fire Safety and Building Regulation guidelines. The scope of the project applies to the provision of fire safety works within the main building and includes the provision of new and remedial work to existing, vertical and horizontal compartmentation, in order to comply with 'WSH Fire Strategy', re-establishing fire compartment lines to aid in the evacuation process. The work comprises of four phases, two phases have been completed to date.

5.6.4.3.4 Plant rooms

There are 28 plantrooms ranging in size that serve the site, these have been prioritised for investment with the main plant rooms upgraded as the priority. There are eight main plant rooms and five have previously been refurbished. The investment plan makes provision to complete the remaining three plant rooms. Works include the replacement of ventilation plant, pumps, valves, hot and cold water vessels and plate heat exchangers.

5.6.4.4 Second lift for Eye Treatment Centre (ETC)

The ETC was constructed with a lift and a second shaft to enable a further lift to be installed at a later stage. A single lift presents accessibility problems for users when necessary maintenance needs to be carried out or when a breakdown occurs. A second lift will provide essential resilience to the building.

5.6.4.5 Feasibility studies

Feasibility studies are planned to investigate key backlog issues identified from the condition and compliance facets identified in the facet survey. This work will explore available options and solutions to resolve the issues identified, along with greater certainty for cost, programme and operational impact, to aid planning of future backlog works.

5.6.4.6 Carbon Reduction

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline), equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions, relative to activity, by 34% by 2020/21 using 2007/08 as the baseline year. A Sustainability Development Steering Group has been established and tasked with maintaining a sustainable development management/action plan to achieve the targets (see Reference Document 19 for further detail).

5.6.4.7 Asset Performance

The Trust's objective is to provide and maintain the estate in a manner that meets all statutory and relevant legislative requirements and is maintained in a way that does not place the Trust, its staff, patients, or visitors at risk, and does not present a risk to the ongoing operation of the business. In doing this, it looks at the cost to bring the existing

assets up to current legal standards and addresses any accrued maintenance liabilities. All elements of this work are risk assessed and prioritised.

A risk assessment has been completed to address risks associated with the overall delivery of the backlog plan (reference document 22), this risk assessment scored 10; in line with the Trust's risk assessment policy (reference document x) the assessment is reviewed on an annual basis. In addition, the Board Assurance Framework (BAF) tracks the implementation of the estate strategy to ensure a building environment that is suitable for patient care is provided and adequately maintained; this incorporates the acute and community estate (see BAF reference 4.1). This is risk rated as Amber with the existing controls in place and is regularly reviewed by the Trust Board.

5.6.4.8 Asset Maintenance

The Trust will aim to provide and maintain its estate in a condition that is sound, operationally safe and which only exhibits minor deterioration (i.e. at least to condition B as defined in Estate code, see Sections 4.10.22 and 6.8 and 6.9.

A risk assessment has been completed to address risks associated with the building structure (reference document 22). This risk assessment scored 15; in line with the Trust's risk assessment policy the assessment has been placed on the Trust's risk register (776) and is reviewed every six months.

5.6.4.9 Statutory Compliance

The Trust plans to eliminate statutory non-compliance issues at West Suffolk Hospital site by March 2023.

A risk assessment has been completed to address risks associated with the level/condition of compartmentation across the main building (reference documents 24 and 32). This risk assessment scored 15; in line with the Trust's risk assessment policy the assessment has been recorded on the Trust's risk register (713) and is reviewed every six months.

5.6.4.10 Space Utilisation

The majority of the concerns raised at West Suffolk Hospital relate to the age of the building which results from functional areas being too small for their intended purpose, with a 50% shortfall in terms of space identified when compared to current Health Building Notes. The financial and practical implications of addressing this make any meaningful improvement in the short term unachievable. The community estate study has indicated there are opportunities for rationalisation of the estate; these are in part reliant on the availability of digital solutions and the programme to deliver OPE initiatives.

There are opportunities through the OPE initiative to relocate some acute services out of the main building and create space for core clinical services to develop. Along with relocating community services from the NHSPS estate to the health hubs being developed in West Suffolk to facilitate integration of services across public sector agencies, see Sections 4 and 5.

In 2018/19 the SUG will develop a space strategy that sets out the Trust's approach for the use of the estate in clinical and non-clinical areas across acute and community services. Key stakeholders will be involved to develop a formal space strategy recognising the space opportunities that exist and develop an innovative plan for the future use of space. Changes to working practices such as hot desking, touch down points and home-working supported by appropriate technology will be considered, with the key principles of smart working including:

- Work taking place at the most effective locations and times - not necessarily in the office
- The traditional meetings culture is replaced by 'simplified collaboration and connectivity virtually everywhere'
- A flexibility first approach with flexibility as the norm rather than the exception
- Space is allocated to activities, not individuals and not on the basis of seniority
- Managing performance focuses on results and outcomes rather than presence

Once approved the strategy will need to be owned and embedded throughout the organisation.

Given that the estate is the third largest cost to the NHS, the SUG will also identify the extent of space used to deliver services at division and service level. This will be tracked at corporate and divisional meetings to review and monitor the type and extent of space used to ensure that it is used effectively and efficiently.

5.6.4.11 Functional Suitability

53% of the accommodation in the Hospital falls below acceptable levels of functional suitability. However, as discussed, a significant proportion of this results from the physical design of the hospital and the limitations that exist to reconfigure this accommodation. Again, the financial and practical implications of addressing this make any meaningful improvement in the short/medium term not feasible.

The Trust is pursuing a number of projects that, once implemented, will have the impact of reducing the extent of the accommodation falling below acceptable standards.

5.6.4.12 Quality

53% of the hospital's accommodation was found to be below the quality standards expected of a modern hospital. With the growing importance of patient expectations and the increased significance of the organisation's reputation the Trust should seek to reduce this figure over the strategic period.

A target of no more than 35% of the accommodation in the hospital falling below acceptable standards should be set. The proposed refurbishment of the remaining wards will contribute significantly towards this.

5.6.5 Assets Surplus to Requirements

The Trust has previously disposed of three assets in Sudbury, see Table 5 that were surplus to requirement and has a remaining site for disposal.

5.6.5.1 Churchfield Road Site

This site is located in Sudbury and situated adjacent to an industrial area and is currently zoned for employment use. Part of the site (3.5 acres) was transferred to NHS Suffolk for the development of healthcare premises in 2012.

The Trust has agreed to enter into a co-operation agreement with the adjoining land owner (Caverswall Holdings) to facilitate a joint planning application for a residential scheme and disposal of the remaining 4.5 acres.

The land is allocated in the current local plan for employment use. The Local Plan is currently being reviewed by Babergh District Council and a joint submission was made with Caverswall Holdings to '*the call for sites'*, consultation exercise promoting the land for

residential development. A pre application was submitted to Babergh District Council for their consideration on 3rd May 2018.

This site was registered on the NHS Surplus Land Collection 2011, reference plot ID 366.

5.6.6 Strategic estate development

The existing estate on the Hardwick Lane site is facing key issues that need to be addressed:

- The nature of the 'Best Buy' buildings structure which has a limited design life
- Other additional backlog maintenance issues
- The limitations of the existing buildings layout which is prohibiting proposed clinical service models and best practice in healthcare

These factors are resulting in an environment and experience for patients and staff that is extremely tired and not conducive to twenty first century medicine.

There are a range of options the Trust is considering regarding opportunities to deal with the aging estate, structural, backlog and functional suitability issues, these include:

1. A new hospital on the site (Westley) allocated in the Borough Council Local Plan.
2. Phased redevelopment of the existing site
3. Partial redevelopment of the existing site
4. Phased installation of structural supports

The solutions considered above will all take time and considerable resources to deliver. Therefore, during the life of this strategy the Trust must make a decision on its preferred option to enable a case to be made and the solution delivered, before the constraints make the existing hospital unviable for the delivery of healthcare.

5.6.6.1 Health and Social Care Campus

To determine the brief for the future provision of healthcare a series of clinical stakeholder engagement workshops were held to identify and develop a brief for clinical service model and brief for the new healthcare and social care campus. Following this, two options were identified for the delivery of the new facility.

- develop a greenfield site identified in Westley, on the outskirts of Bury St Edmunds, see Figure 40
- review a phased approach of new development on the existing Hardwick Lane site

Both options were developed at 1:500 scale layout to determine departmental adjacencies, using the briefed gross internal area of 73,195m².

For the Westley site it was established that a new build hospital utilising three and six storey elements can be achieved, with excellent departmental adjacencies both horizontally and vertically. Separate entrances have been designated to the main access, maternity and Emergency Department (both ambulance and ambulant).

Figure 43: Westley site, site plan

The site layout also achieves circa 2000 car parking spaces in a decked solution for public together with staff parking and a service delivery area. The access onto the site is currently indicated off the new 'developer proposed road' and there is a separated and designated blue light route. There is also an option to have staff only and delivery entrances off Fornham Lane, however road widening here would be likely, see Figures 43 and 44.

Figure 44: Westley proposed site plan

There is an excellent opportunity to include campus style health and social buildings within the site, including co-located primary care, community care, dementia care and a nursing home provision. This would be located around a community square or piazza, which produces a 'village green' style of layout and offers opportunity for children's play and other amenity areas to be realised. The dementia village is located to the east of the

site offering a more private location for the residential elements of the campus, see Figures 45 and 46.

The anticipated capital costs are £500m. It should be noted that this cost currently excludes any allowance for optimism bias, inflation; with land acquisition cost and receipt of Hardwick Lane site (early indicators are that these two items together would be cost neutral).

Figure 45: Aerial concept image

Figure 46: Front elevation concept image

5.6.6.2 Hardwick Lane Existing Site

For the Hardwick Lane existing hospital site, it was established that a three phase approach will achieve a new build hospital in three distinct buildings with reasonable departmental adjacencies in the completed scheme. Attention will need to be paid to connections to existing buildings that are required as the phases progress and departments are decanted.

It would probably be necessary to provide some temporary decked parking in the initial phases until the site is cleared through demolition and the existing departments decanted into the new build. This would then allow circa 1913 parking spaces on the site, utilising some of the existing areas but also creating a new main car park to the front of the main building.

A separate access will be provided to the Emergency Department, possibly via a ramp. However a closer study of the site levels in this area will be required. The infra-structure roads will need to be modified to achieve a circular route around the site and give access to an area to the south that may be used for some campus style health and social buildings within the site, see Figure 47.

The anticipated capital costs are £450m. It should be noted that this cost currently excludes any allowance for optimism bias and inflation.

Figure 47: Hardwick Lane proposed redevelopment site plan

An outcome work completed on the above options was the decision to consider a limited development of the existing Hospital at Hardwick Lane. This would not omit the long term structural issues.

5.6.6.3 Hardwick Lane site limited development option1

On the basis of a capital sum of £120m being available coupled with a separate sum from the Trust's annual capital programme for work to reduce backlog maintenance, three scenarios were considered:

	New build	Ward upgrade	Backlog
1	£120m new build 14,000-18,000m²	Not included	Not included
2	£90m new build 9,500-13,500m²	Not included	£30m of retained estate
3	£68m new build 7,000-10,000m²	£22m (£2m per ward)	£30m of retained estate

Detailed below are examples to assist in visualising the extent of spaces described above:

- 18,000m² is equivalent to the first floor and four additional wards
- A standard ward with link corridor is 800m²
- 7,140 m² is equivalent to a football pitch

5.6.6.4 Hardwick Lane site limited development option2

On the basis of a capital sum of £200m being available a partial redevelopment/new build has also been considered, comprising of 3 phases:

Phase 1 vacate wards G4, 5, 6, 7, 9 diabetes, occupational health, physiothrapy, gym to a decant area and build a new surgical centre comprising ED, radiology, cath lab, theatres/recovery, 5 surgical wards, assessment beds.
Realign the access road.

Phase 2 move the existing ED and main theatres to the new surgical block. Refurbish main theatres to create new day surgery unit and maternity theatres.
Move wards F3, 4, 5, 6, 7 and 8 to new surgical block and create 3 new acute medical wards from the space vacated, or 2 wards with a third with 50% single rooms.

Phase 3 move the eye treatment and day surgery unit to the refurbished theatre space, eye treatment OPD relocates to space vacated by ED, demolish existing treatment center. See Figure 48 for further detail.

Figure 48: Limited development option2

5.6.6.5 Phased installation of structural supports

The Trust's structural engineers are reviewing options to support the existing structure without the requirement to demolish the original building envelope. This is likely to unpalatable due to the level of operational disruption associated with the work. The option will be explored to establish the costs and viability of the solution.

5.6.6.6 One Public Estate

The Trust plays an active part in the OPE work in west Suffolk and is a member of the West Suffolk Property Board. Work is in progress to develop the options for six key towns. The community estate strategy will move away from a reliance on NHSPS estate and transfer services to OPE health hubs that are being planned across west Suffolk. This will facilitate improved integration of public sector organisations, enable the use of shared

functions, release sites no longer required for disposal and ensure facilities developed are flexible, adaptable and fit for purpose. A summary of the sites are detailed below:

Mildenhall - this site is the most advanced with construction due to commence in 2018. The development will facilitate co-location of health facilities with other public services notably leisure in a purpose built facility.
Bury St Edmunds - developing a business case for a public service village with the aim of relocating health services in the town to a purpose built facility.
Newmarket - public asset studies are in progress with the aim of building on existing plans to relocate GP services to the Newmarket Hospital site and to establish if this planned hub can be expanded further.
Haverhill - exploring opportunities for a large health hub.
Clare - focussing on GP practices and accommodating their future growth requirements.
Brandon - work has commenced to explore the potential for moving health facilities into the leisure centre.
Sudbury - The OPE agenda is at an earlier stage in Sudbury, the Trust is engaging with officers from Babergh District Council and the OPE team to explore opportunities in the town.

5.6.6.7 STP System Targets

The Suffolk and North Essex STP has two, board-approved, Strategic Estates Plans with system wide targets covered in the life of this strategy, these are to:

- Prioritise estate investment through an approved work programme
- Reduce GIA across the estate
- Reduce the level of non-clinical space
- Reduce the level of unoccupied space
- Reduce estate running costs, including high risk backlog maintenance
- Disposal of assets surplus to requirement.

Mechanisms to ensure the delivery of the ambitions have been incorporated into this document.

6. How do we get there?

This section outlines how the Trust will meet the demands placed on its estate, as outlined in Section 2 of this strategy, over the strategic period.

Appendix 7 identifies the resource requirements and timing where investment proposals or development initiatives have already been prioritised (e.g. capital expenditure).

6.1 Environmental and Waste Management

The Trust has conducted a number of reviews relating to compliance with statutory and NHS standards for environmental performance and compliance.

The main recommendations contained in this plan are:

- The appointment of a dedicated resource focussing on continued legislative compliance and on the reduction both in the use of energy and the production of waste.
- The development of environmental and waste management performance standards and a performance management system.
- Improvements in waste segregation, handling and education.
- Reducing the volume of waste produced.
- Increasing the percentage of waste recycled.
- Preparing and delivering a Carbon Management Strategy.

The Trust is in the process of appointing an individual to a new post with the knowledge and experience to pull together these various agendas and to draw up detailed proposals for achieving the numerous targets and obligations.

6.2 Travel

The Trust currently provides safe and secure parking arrangements at West Suffolk Hospital. The demand however exceeds capacity and the Trust has made concerted efforts to address this issue over the last two years.

In conjunction with the Trust's Travel Plan the following action has been taken:

- Improvements have been made to shower and changing facilities
- External facilities for cyclists have been increased and improved
- The Trust has developed its own car share web-site and promotions have been held to encourage staff to register on the car share scheme, as well as the cycle2work scheme
- A dedicated car park has been provided for car sharers
- Some roadways have been made "car parking free" or "restricted" to aid traffic flow
- Park and ride (shuttle bus) has been introduced between the Rugby Club and the Hospital for scheduled times in the morning and afternoon/early evening
- Discussions continue with Suffolk Borough and Suffolk County Councils in respect of increased cycle routes to the hospital; as well as improved and/or bespoke bus services.
- A bicycle user group has been established.

In addition, the Trust has introduced a car free day scheme for all staff working on the hospital site which has been operational since 2011. It is anticipated that this has reduced the number of vehicles on site by approximately 175 per day.

Work was completed in July 2018 to omit the current barrier arrangements and to move to an automatic number plate recognition system; this work was incorporated into the Estate Investment Plan.

6.3 Corporate Social Responsibility

This Trust strategy sets the ambition for it to play a leading and innovative role in ensuring the shift to a low carbon economy. This is in line with the Trust's stated objective of being viewed as a leader in Corporate Social Responsibility within the local economy. The Trust will continue to develop partnership arrangements to assist in meeting this target and supporting the local economy, and will build upon the current partnership arrangements developed with NHS Suffolk and Suffolk County Council.

6.4 Experience of Care Strategy

This Board approved strategy developed in 2018 links closely with the facilities provided by the EFM Team and highlights that effective engagement enhances services and care, improves health outcomes, strengthens public accountability and supports the Trust's reputation.

Consultation and engagement is being built into projects delivered by the Development Team. The Development Team and Patient Experience Team are developing a process where monthly meetings are held to consult on development projects at key stages. The most important consultation stage identified is the feasibility stage of a project. At the consultation projects are described with a focus on work description, programme and potential impact on the patient experience within the Trust close to the project activity. This information is taken away by the patient experience lead and discussed with members of the patient representative groups and patient focus groups that use the Trust's services.

The Patient Experience Team collates this vital information and feeds it back to the Development Team Project Lead. From this point on the comments are integrated into the project plans for the area in question. The focus is to ensure that projects are adapted to the needs of the patients that use the Trust facilities, based on the information and feedback received.

6.5 Performance Management System

A set of strategic and tactical performance indicators are set out in Appendix 2, these will be used to provide assurance to the Board that the estate meets the objectives set of it. It will also assist in the prioritisation and evaluation of proposed estate development and maintenance investment.

6.6 Master Plan

The Trust has a Borough Council approved master development plan, establishing how the West Suffolk Hospital site will respond to the demands being placed on it over the strategic period. It also addresses the constraints placed on the Trust arising either from the topography and environmental features that exist or through local planning policy.

A copy of the Master Plan is shown in Appendix 3.

6.7 Critical Infrastructure Risk/Resilience

The Trust commissioned a detailed assessment of the resilience and capacity of the business critical service infrastructure identifying the nature and extent of any risks to business interruption. Investment has been incorporated into the Estate Investment Plan to address the issues highlighted, see Appendix 7.

6.8 Prioritised Backlog Maintenance Plan

Appendices 5 and 7 show the required investment for reducing backlog and impending backlog maintenance costs at September 2018.

Further work has been completed by the internal estates team and an external group of multi-disciplinary professionals to verify and validate the issues identified in the six and two facet surveys. This has assisted with the prioritisation of works required. West Suffolk Hospital site backlog plan is presented at Appendix 5.

As previously discussed the costs identified in the six and two facet surveys are 'works costs' only and are exclusive of any additional costs that are dependent upon the project solution taken to address the backlog. To address this, and to provide a more realistic cost for planning purposes 54% has been added to the work required. See Appendix 5.

The sum of backlog planned (subject to the availability of resources) to be addressed between 2018 and 2023 is £23.1m, with a further £5.4m delivered through developments; these are indicated in green on Appendix 5.

The backlog plan will be reviewed annually to take account of the level of available resources, along with any changes to the priority of work, changes to the estate and any new legislation/guidance introduced.

6.9 Backlog plan delivery

The initial investment concentrates on addressing key risk areas and ensuring compliance with statutory legislation. The estate investment plan profiles completion of statutory compliance by 2023.

Work required at West Suffolk Hospital will be managed in three ways, this from a practical perspective, because of space constraints on site and the invasive nature of the work needed (could not be undertaken in an operational environment, from a noise and infection control perspective):

1. Projects that do not impact/have limited impact operationally e.g. external works, external fabric, and structural works
2. Projects that require the ward or department to be decanted to an alternative location whilst the work takes place. This will ensure interruption to wards and departments is minimised by undertaking all of the backlog work required at the same time in a specific location, this also benefits the Trust financially through the minimisation of duplication of work (decant ward becomes available in spring 2019)
3. Discrete internal projects that have limited operational impact e.g. lift replacement, replacement of sub mains panels.

Following this methodology backlog work has been prioritised and planned on a risk basis, organised by location and developed into 99 projects with 21 planned between 2018 and 2023.

6.10 Estate Capital Developments over the Strategic Period

Section 5 describes the estate development proposals for the strategic period, with Appendix 7 identifying the capital cost and timing associated with delivery of these required to implement the estate strategy. Appendix 5 identifies the level of backlog that will be addressed through the implementation of the development plan. Appendix 3 details the site master development plan and sequencing/interdependency of schemes.

7. Bibliography

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8. Glossary

Backlog Maintenance	Backlog maintenance costs are a measure of the condition and associated risks relating to fixed building components and engineering assets (sub-elements).
BRE	A UK government national laboratory (privatised in 1997) that provides out research, advice, training, testing, certification and standards for both public and private sector organisations in the UK and abroad.
BREEAM	Building Research Establishment Environmental Assessment Methodology - sets the standard for best practice in sustainable building design, construction and operation and has become one of the most comprehensive and widely recognised measures of a building's environmental performance. It encourages designers, clients and others to think about low carbon and low impact design, minimising the energy demands created by a building before considering energy efficiency and low carbon technologies.
CRC - EES	Carbon Reduction Commitment - Energy Efficiency Scheme.
DCP	Development Control Plan.
EFM	Estates and Facilities Management.
ERIC	Estates Return Information Collection: an annual return submitted by NHS organisations to NHS Estates providing data on Estates and Facilities Management.
Estatecode	NHS Estates guidance to NHS organisations for the effective management of their estate.
Estatecode Condition B	Estatecode property appraisal rating; property in physical condition B is sound, operationally safe and exhibits only minor deterioration.
EUETS	EU Emissions Trading Scheme.
GIA	Gross Internal Area, the overall internal area of a property measured within the perimeter walls with allowances made for projections, indentations, insets, voids and courtyards; usually measured in square metres.
Optimism bias	There is a proven tendency for appraisers to be over-optimistic about key project parameters, including capital costs, operating costs, project duration and benefits delivery. Because of this costs are adjusted to take this into consideration. The adjustments will have the effect of increasing the cost estimates, decreasing the projected benefits and extending the timescales over which the costs and benefits are assumed to accrue, compared to the initial unadjusted estimates for each option.

RAAC Panel	Reinforced autoclaved aerated concrete
SDMP	Having a board approved Sustainable Development Management Plan (SDMP) is one of the cornerstones of the Sustainable Development Strategy.
WAU	Weighted Activity Unit - The type of treatments provided by acute trusts differs substantially. This makes it difficult to make robust comparison between trusts. The model hospital uses a cost-weighting to adjust for differences in case mix known as a weighted activity unit (WAU). One WAU equates to around £3,500 'worth' of clinical output. For example, a trust that is paying £4,000 per WAU for an adult heart transplant might be able to find opportunities to improve because it is paying £500 more than the average.

9. Tables

10. Figures

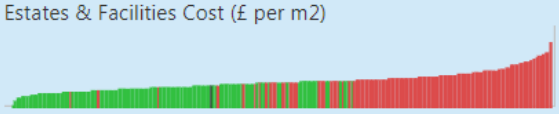
11. Appendices

Property	Town	Occupancy Arrangements / Landlord	Estate strategy
Botesdale Health Centre	Botesdale	Lease	
Brandon Health Centre	Brandon	NHSPS lease	Plan to relocate to OPE hub in Brandon dates TBC
Child Development Centre	Bury St Edmunds	NHSPS lease	Plan to relocate to Western Way Development 2021/22
Child Health Centre	Bury St Edmunds	NHSPS lease	Plan to relocate to Western Way Development 2021/22
Darbishire House	Bury St. Edmunds	NHSPS lease	Plan to relocate to Western Way Development 2021/22
Disability Resource Centre	Bury St Edmunds	NHSPS lease	Plan to relocate to Western Way Development 2021/22
Forest Heath District Council	Mildenhall	Lease	Plan to relocate to OPE hub in Mildenhall 2020
Hadleigh Health Centre	Hadleigh	NHSPS lease	
Hardwick Primary School	Bury St Edmunds	Informal arrangement adhoc use	
Haverhill Health Centre	Haverhill	NHSPS lease	
Hillside Special School	Sudbury	Informal arrangement adhoc use	
Mildenhall Health Centre	Mildenhall	NHSPS lease	Plan to relocate to OPE hub in Mildenhall 2020
Newmarket Community Hospital	Newmarket	NHSPS lease	
Phoenix Children's Centre	Sudbury	Informal arrangement adhoc use	
Priory school	Bury St Edmunds	Informal arrangement adhoc use	
Riverwalk School	Bury St Edmunds	Informal arrangement adhoc use	
Rookery Practice	Newmarket	Lease	
Stanton Health Centre	Stanton	NHSPS lease	
Thetford Healthy Living Centre	Thetford	Lease	
Thetford Sure Start Centre	Theford	Informal arrangement adhoc use	
Westgate Primary School	Bury St Edmunds	Informal arrangement adhoc use	
Woolpit Health Centre	Woolpit	NHSPS lease	
The Surgery	Wickhambrook	Lease	

Pan Suffolk Services Property	Town	Occupancy Arrangements / Landlord	Estate strategy
Allington Clinic	**Ipswich**	NHSPS lease	
St Helens House	**Ipswich**	NHSPS lease	
Woodbridge Clinic	**Woodbridge**	NHSPS lease	
Child Development, Centre, IHT	**Ipswich**	********	
Stowmarket Health Centre	**Stowmarket**	NHSPS lease	
Chantry Clinic	**Ipswich**	NHSPS lease	
Felixstowe Community Hospital	**Felixstowe**	NHSPS lease	
Beacon Hill Special School	**Ipswich**	Informal arrangement adhoc use	
Bridge Primary & Secondary Schools	**Ipswich**	Informal arrangement adhoc use	
Caterpillar Children's Centre	**Woodbridge**	Informal arrangement adhoc use	
Cornfields Childrens Centre	**Great Cornard**	Informal arrangement adhoc use	
Framfield Medical Centre	**Woodbridge**	*******	
Highfields Childrens Centre	**Ipswich**	Informal arrangement adhoc use	
Martlesham Pavilion	**Martlesham Heath**	Informal arrangement adhoc use	
Meadow Childrens Centre	**Saxmundham**	Informal arrangement adhoc use	
Ravenswood Medical Practice	**Ipswich**	Informal arrangement adhoc use	
Rushmere School	**Ipswich**	Informal arrangement adhoc use	
Saxmundham Clinic	**Saxmundham**	*******	
The Oaks Childrens Centre	**Felixstowe**	Informal arrangement adhoc use	
Thomas Wolsey School, Ipswich	**Ipswich**	Informal arrangement adhoc use	
Whitton Clinic, Ipswich	**Ipswich**	NHSPS lease	
Willows Children Centre	**Ipswich**	Informal arrangement adhoc use	

Compartment notifications (6)
"Cleaning Cost (£ per m2)" is above the recommended benchmark
"Estates & Property Maintenance (£ per m2)" is above the recommended benchmark
"Hard FM Cost (£ per m2)" is above the recommended benchmark
"Soft FM Cost (£ per m2)" is above the recommended benchmark
"Food Cost (£ per Meal)" is above the recommended benchmark
"Critical Infrastructure Risk (£ per m2)" is above the recommended benchmark

Estates & Facilities Cost (£ per m2)



£296
2016/17

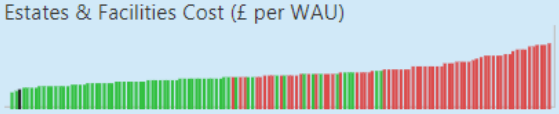
Hard FM Cost (£ per m2)

£84
2016/17

Soft FM Cost (£ per m2)

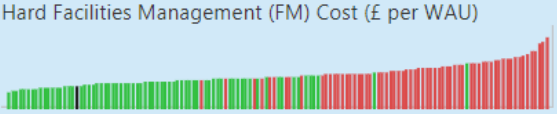
£132
2016/17

Estates & Facilities Cost (£ per WAU)



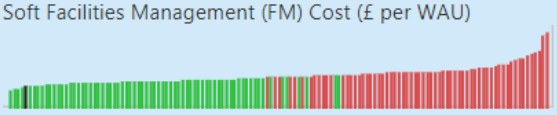
£255
2016/17

Hard Facilities Management (FM) Cost (£ per WAU)



£73
2016/17

Soft Facilities Management (FM) Cost (£ per WAU)



£114
2016/17

Cleaning Cost (£ per m2)

£50
2016/17

Food Cost (£ per Meal)

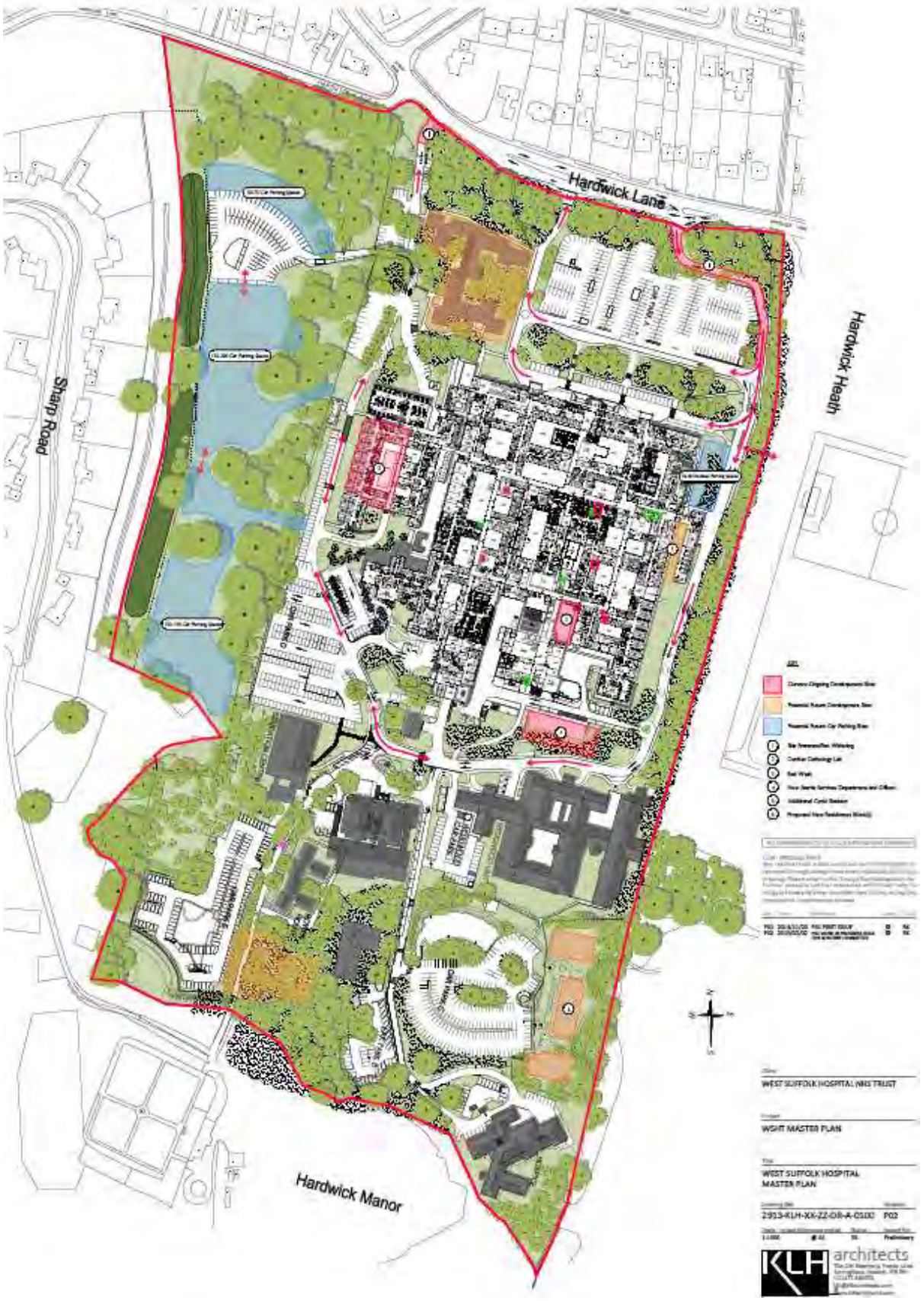
£3.59
2016/17

Critical Infrastructure Risk (£ per m2)

£422
2016/17

Estates & Property Maintenance (£ per m2)

£34
2016/17


Hardwick Lane
Hardwick Heath
Sharp Road
Hardwick Manor
WEST SUFFOLK HOSPITAL NHS TRUST
WSHT MASTER PLAN
WEST SUFFOLK HOSPITAL
MASTER PLAN
2913-KLH-XX-ZZ-DR-A-0100 P02
KLH architects

CONDITION

Condition	Value	+54% uplift	Percentage
A	£0	£0	0.00
B	£45,000	£69,300	0.17
C	£21,181,054	£32,618,823	78.54
Cx	£12,000	£18,480	0.04
D	£5,731,660	£8,826,756	21.25
Total	**£26,969,714**	**£41,533,360**	**100.00**

Structure cost element = £17,750,794
Condition = C Risk = Significant

WITHOUT STRUCTURAL COSTS

Condition	Value	+54% uplift	Percentage
A	£0	£0	0.00
B	£45,000	£69,300	0.49
C	£3,430,260	£5,282,600	37.21
Cx	£12,000	£18,480	0.13
D	£5,731,660	£8,826,756	62.17
Total	**£9,218,920**	**£14,197,137**	**100.00**

RISK STATUS

Risk	Value	+54% uplift	Percentage
Low	£217,000	£334,180	0.80
Moderate	£3,147,900	£4,847,766	11.67
Significant	£20,002,454	£30,803,779	74.17
High	£3,602,360	£5,547,634	13.36
Total	**£26,969,714**	**£41,533,360**	**100.00**

WITHOUT STRUCTURAL COSTS

Risk	Value	+54% uplift	Percentage
Low	£217,000	£334,180	2.35
Moderate	£3,147,900	£4,847,766	34.15
Significant	£2,251,660	£3,467,556	24.42
High	£3,602,360	£5,547,634	39.08
Total	**£9,218,920**	**£14,197,137**	**100.00**

STATUTORY COMPLIANCE by condition

Condition	Value	+54% uplift	Percentage
A	£0	£0	0.00
B	£40,000	£61,600	4.11
C	£20,000	£30,800	2.06
Cx	£0	£0	0.00
D	£912,200	£1,404,788	93.83
Total	**£972,200**	**£1,497,188**	**100.00**

STATUTORY COMPLIANCE by risk

Condition	Value	+54% uplift	Percentage
Low	£0	£0	0.00
Moderate	£892,200	£1,373,988	91.77
Significant	£40,000	£61,600	4.11
High	£40,000	£61,600	4.11
Total	**£972,200**	**£1,497,188**	**100.00**

High risks by condition	Value	+54% uplift	Percentage
A	£0	£0	0.00
B	£0	£0	0.00
C	£1,533,700	£2,361,898	42.57
Cx	£0	£0	0.00
D	£2,068,660	£3,185,736	57.43
Total	**£3,602,360**	**£5,547,634**	**100.00**

Significant risks by condition	Value	+54% uplift	Percentage
A	£0	£0	0.00
B	£45,000	£69,300	0.22
C	£18,466,654	£28,438,647	92.32
Cx	£0	£0	0.00
D	£1,490,800	£2,295,832	7.45
Total	**£20,002,454**	**£30,803,779**	**100.00**

Significant risks by condition (without structural costs)	Value	+54% uplift	Percentage
A	£0	£0	0.00
B	£45,000	£69,300	2.00
C	£715,860	£1,102,424	31.79
Cx	£0	£0	0.00
D	£1,490,800	£2,295,832	66.21
Total	**£2,251,660**	**£3,467,556**	**100.00**

Moderate risks by condition	Value	+54% uplift	Percentage
A	£0	£0	0.00
B	£0	£0	0.00
C	£963,700	£1,484,098	30.61
Cx	£12,000	£18,480	0.38
D	£2,172,200	£3,345,188	69.00
Total	**£3,147,900**	**£4,847,766**	**100.00**

Low risks by condition	Value	+54% uplift	Percentage
A	£0	£0	0.00
B	£0	£0	0.00
C	£217,000	£334,180	100.00
Cx	£0	£0	0.00
D	£0	£0	0.00
Total	**£217,000**	**£334,180**	**100.00**

Type of work	Value	+54% uplift	Percentage
Building	£22,868,864	£35,218,051	84.79
Statutory	£2,462,200	£3,791,788	9.13
M&E	£1,638,650	£2,523,521	6.08
Total	**£26,969,714**	**£41,533,360**	**100**

Without £17.75m structural costs

Type of work	Value	+54% uplift	Percentage
Building	£5,118,070	£7,881,828	55.52
Statutory	£2,462,200	£3,791,788	26.71
M&E	£1,638,650	£2,523,521	17.77
Total	**£9,218,920**	**£14,197,137**	**100**

Building works by condition

Condition	Value	+54% uplift	Percentage
B	£5,000	£7,700	0.02
C	£19,522,404	£30,064,502	85.37
Cx	£12,000	£18,480	0.05
D	£3,329,460	£5,127,369	14.56
Total	**£22,868,864**	**£35,218,051**	**100**

Building works by condition **minus £18m**

Condition	Value	+54% uplift	Percentage
B	£5,000	£7,700	0.10
C	£1,771,610	£2,728,279	34.61
Cx	£12,000	£18,480	0.23
D	£3,329,460	£5,127,368	65.05
Total	**£5,118,070**	**£7,881,828**	**100**

M&E by condition

Condition	Value	+54% uplift	Percentage
B	£0	£0	0.00
C	£1,638,650	£2,523,521	100.00
Cx	£0	£0	0.00
D	£0	£0	0.00
Total	**£1,638,650**	**£2,523,521**	**100**

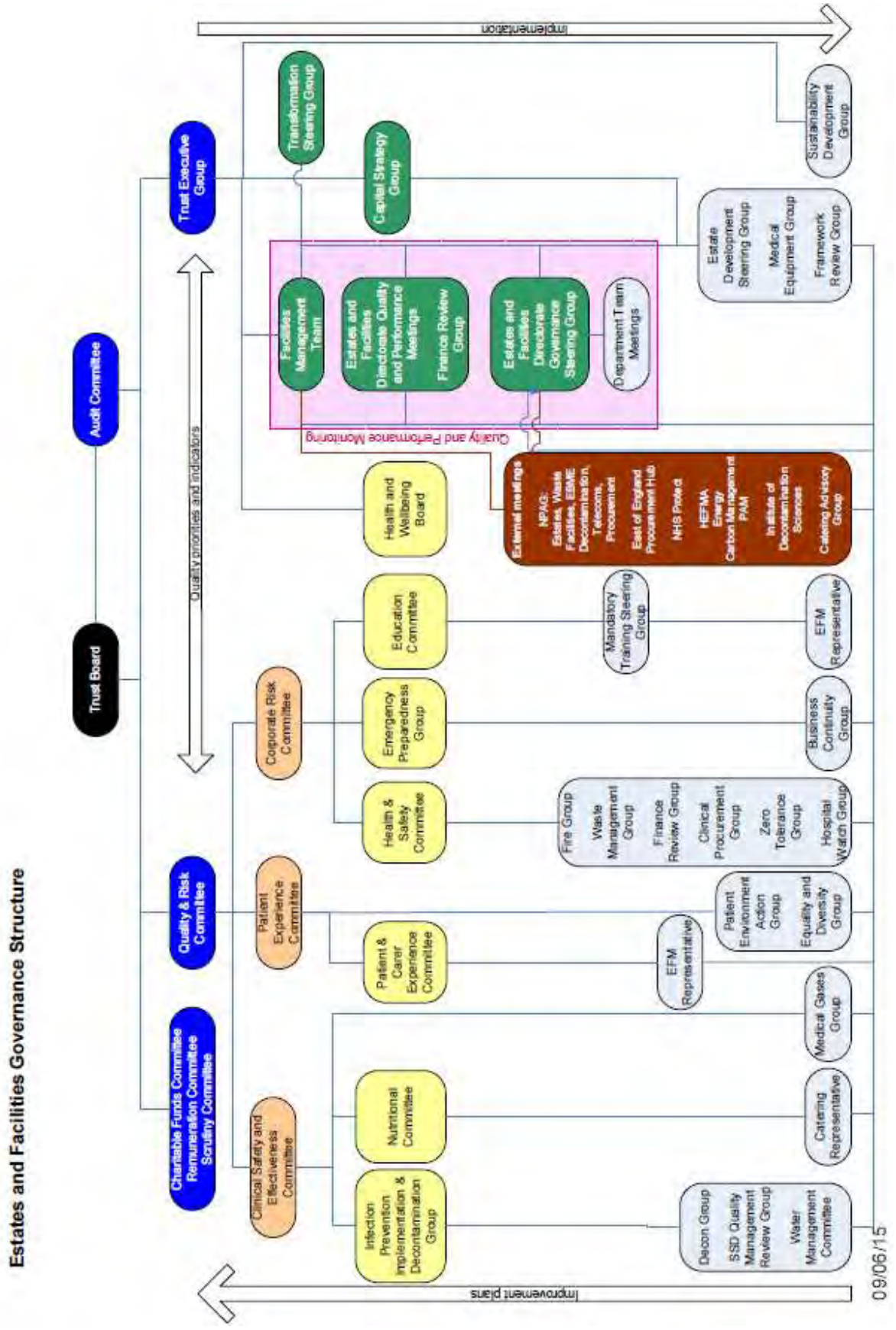
Statutory by condition

Condition	Value	+54% uplift	Percentage
B	£40,000	£61,600	1.62
C	£20,000	£30,800	0.81
Cx	£0	£0	0.00
D	£2,402,200	£3,699,388	97.56
Total	**£2,462,200**	**£3,791,788**	**100**

Ref	Ward/Department	Total impending backlog	Low	Moderate	Significant	High	Total backlog	Total impending & backlog	Total with on-costs
1	Emergency Department	£82,300	£16,000	£20,200	£20,000		£56,200	£138,500	£213,290
2	Ante-Natal	£65,000		£500			£500	£65,500	£100,870
3	Area at end of MRI/IT	£750			£150		£150	£900	£1,386
4	Cardiology	£300						£300	£462
5	Catering	£14,600						£14,600	£22,484
6	CDS Birthing Unit	£150						£150	£231
7	Chapel & Multi-Faith	£13,600						£13,600	£20,944
8	CHP Adjacent 5.37	£35,000						£35,000	£53,900
9	Circulation & WCs	£165,000						£165,000	£254,100
10	Clinical Coding/Liaison Nursing	£2,100						£2,100	£3,234
11	Clinical Decisions Unit	£3,000						£3,000	£4,620
12	Corridor to G7-G6		£4,000			£20,000	£24,000	£24,000	£36,960
13	Courtyard Café	£450						£450	£693
14	Day Surgery	£39,000		£800	£5,500	£600	£6,900	£45,900	£70,686
15	Delivery Suite				£10,000		£10,000	£10,000	£15,400
16	Diabetes	£2,200						£2,200	£3,388
17	EBME	£10,500		£2,000			£2,000	£12,500	£19,250
18	Education Centre	£31,500			£1,200		£1,200	£32,700	£50,358
19	Endoscopy	£12,000			£5,000		£5,000	£17,000	£26,180
20	External	£17,600		£2,000	£10,000		£12,000	£29,600	£45,584
21	External Boiler Room	£1,800						£1,800	£2,772
22	Front Residences	£175,000	£20,000				£20,000	£195,000	£300,300
23	Former Geriatric wing	£180,000						£180,000	£277,200
24	Fracture Clinic	£15,000		£6,000			£6,000	£21,000	£32,340
25	GP Out of Hours/Fracture	£1,200						£1,200	£1,848
26	GUM Clinic	£21,500		£3,000			£3,000	£24,500	£37,730
27	HDU	£32,000		£12,000	£6,000		£18,000	£50,000	£77,000
28	Health Records & Cash Office	£21,200	£16,000	£24,400		£800	£41,200	£62,400	£96,096
29	Hospital Street	£34,000		£30,000	£5,000		£35,000	£69,000	£106,260
30	Housekeeping	£600						£600	£924
31	IT Dept.	£31,750						£31,750	£48,895
32	ITU/HDU	£66,000			£6,000		£6,000	£72,000	£110,880
33	Kitchens & Dining	£69,500		£20,000			£20,000	£89,500	£137,830
34	Lower Ground Floor	£2,650	£22,000				£22,000	£24,650	£37,961
35	Macmillan Day Unit	£40,000						£40,000	£61,600
36	Main Building	£2,302,000		£50,800	£18,000,800		£18,051,600	£20,353,600	£31,344,544
37	Main Circulation Routes	£32,000						£32,000	£49,280
38	Main Entrance & Café	£20,000						£20,000	£30,800
39	Main Water Intake & Treatment to GUM Courtyard				£1,200		£1,200	£1,200	£1,848

Ref	Ward/Department	Total impending backlog	Low	Moderate	Significant	High	Total backlog	Total impending & backlog	Total with on-costs
40	Mortuary	£900						£900	£1,386
41	MRI	£3,000						£3,000	£4,620
42	Neo Natal	£5,000		£1,200			£1,200	£6,200	£9,548
43	Old Endoscopy	£8,000			£14,000		£14,000	£22,000	£33,880
44	Old G8	£6,250		£20,000			£20,000	£26,250	£40,425
45	OPD	£2,000						£2,000	£3,080
46	Operations	£150						£150	£231
47	Ophthalmology	£20,000	£36,000	£700	£600		£37,300	£57,300	£88,242
48	Outpatients Department A, B, C	£32,000		£45,000	£20,000		£65,000	£97,000	£149,380
49	Outpatients Department J	£12,000						£12,000	£18,480
50	Pain Clinic - OPDE	£15,350						£15,350	£23,639
51	Pathology	£72,000		£6,600			£6,600	£78,600	£121,044
52	Pharmacy	£12,000		£500	£1,500		£2,000	£14,000	£21,560
53	Physio	£41,300		£3,000	£1,500		£4,500	£45,800	£70,532
54	Plant			£85,000			£85,000	£85,000	£130,900
55	Plant Room	£39,000						£39,000	£60,060
56	Post Room	£750						£750	£1,155
57	Pre Admission Unit	£1,500						£1,500	£2,310
58	Pre-Assessment	£3,000						£3,000	£4,620
59	Renal/Dialysis	£44,500		£500	£300		£800	£45,300	£69,762
60	Residences			£2,100,000			£2,100,000	£2,100,000	£3,234,000
61	Rheumatology Offices (adjacent OPD J)	£8,850						£8,850	£13,629
62	Roof Covering - Flat	£6,000		£14,000	£9,000	£3,194,805	£3,217,805	£3,223,805	£4,964,660
63	Roof Covering - Pitched				£3,700		£3,700	£3,700	£5,698
64	Roof Plant	£103,200				£750,000	£750,000	£853,200	£1,313,928
65	Rowan House	£33,000						£33,000	£50,820
66	Shop	£7,300						£7,300	£11,242
67	Site	£1,078,170	£10,000	£20,500	£145,000	£750,500	£926,000	£2,004,170	£3,086,422
68	Social Services	£16,000						£16,000	£24,640
69	Statutory Compliance	£230,000		£92,200	£1,530,000	£40,000	£1,662,200	£1,892,200	£2,913,988
70	Switch	£400						£400	£616
71	Theatres	£194,600		£44,000	£186,000		£230,000	£424,600	£653,884
72	Therapy	£28,500						£28,500	£43,890
73	Treatment Centre	£6,000						£6,000	£9,240
74	Old Trust Offices inc East Wing	£177,000						£177,000	£272,580
75	VIE Plant					£10,000	£10,000	£10,000	£15,400
76	Ward F1	£32,000		£400	£5,000		£5,400	£37,400	£57,596
77	Ward F10	£4,000	£18,000				£18,000	£22,000	£33,880
78	Ward F11	£28,000						£28,000	£43,120
79	Ward F12	£68,500	£12,000	£34,000	£58,000		£104,000	£172,500	£265,650

Ref	Ward/Department	Total impending backlog	Low	Moderate	Significant	High	Total backlog	Total impending & backlog	Total with on-costs
80	Ward F14	£8,000						£8,000	£12,320
81	Ward F2 - CCU	£30,800		£3,000	£3,600		£6,600	£37,400	£57,596
82	Ward F3	£15,000		£88,400	£12,000		£100,400	£115,400	£177,716
83	Ward F4	£10,000		£88,400	£12,000		£100,400	£110,400	£170,016
84	Ward F5	£24,000		£88,400	£12,000		£100,400	£124,400	£191,576
85	Ward F6	£28,000		£95,400	£12,000		£107,400	£135,400	£208,516
86	Ward F7	£22,000		£56,000	£42,000		£98,000	£120,000	£184,800
87	Ward F7/F8				£5,000		£5,000	£5,000	£7,700
88	Ward F8	£30,000				£800	£800	£30,800	£47,432
89	Ward F9	£44,000						£44,000	£67,760
90	Ward G1	£5,000	£22,000	£11,000			£33,000	£38,000	£58,520
91	Ward G3	£28,200		£86,000	£141,400		£227,400	£255,600	£393,624
92	Ward G4	£17,200						£17,200	£26,488
93	Ward G5	£15,000						£15,000	£23,100
94	Ward G6	£3,400						£3,400	£5,236
95	Ward G7	£13,800						£13,800	£21,252
96	Ward G8	£10,000			£19,000	£500	£19,500	£29,500	£45,430
97	Ward G9 (Pre-Fab)	£60,000			£2,000		£2,000	£62,000	£95,480
98	Works Dept.	£32,000		£12,000	£600	£500	£13,100	£45,100	£69,454
99	X-Ray	£29,000	£36,000		£23,500		£59,500	£88,500	£136,290


Estates and Facilities Governance Structure
Implementation
Improvement plans
Quality priorities and indicators
Quality and Performance Monitoring
Trust Board
Audit Committee
Quality & Risk Committee
Charitable Funds Committee
Remuneration Committee
Scrutiny Committee
Trust Executive Group
Transformation Steering Group
Capital Strategy Group
Sustainability Development Group
Estate Development Steering Group
Medical Equipment Group
Framework Review Group
Facilities Management Team
Estates and Facilities Directorate Quality and Performance Meetings
Finance Review Group
Estates and Facilities Directorate Governance Steering Group
Department Team Meetings
External meetings
NPAG: Estates, Waste Facilities, EBME, Decontamination, Telecoms, Procurement
East of England Procurement Hub
NHS Pimco
HEFMA Energy/ Carbon Management PAM
Institute of Decontamination Sciences
Catering Advisory Group
Health and Wellbeing Board
Education Committee
Mandatory Training Steering Group
EFM Representative
Corporate Risk Committee
Emergency Preparedness Group
Business Continuity Group
Health & Safety Committee
Fire Group
Waste Management Group
Finance Review Group
Clinical Procurement Group
Zero Tolerance Group
Hospital Watch Group
Patient Experience Committee
Patient Environment Action Group
Equality and Diversity Group
Patient & Carer Experience Committee
EFM Representative
Medical Gases Group
Clinical Safety and Effectiveness Committee
Nutritional Committee
Catering Representative
Infection Prevention Implementation & Decontamination Group
Decon Group
SSD Quality Management Review Group
Water Management Committee
09/06/15

Planned Capital Expenditure	Contractual Commitment Stage	Risk and Consequence of Delay	2018/19 Plan £000s	2019/20 Plan £000s	2020/21 Plan £000s	2021/22 Plan £000s	2022/23 Plan £000s	2018/19-2022/23 5 Year Plan £000s
Residences	Committed opening February 2019	Opening February 2019	8,767					8,767
Development team	Permanent Staff in post	N/A	500	500	500	500	500	2,500
Cath lab	Committed opening Autumn 2018	Opening Autumn 2018	150					150
Roof replacement	Committed	Asset Life compromised, safety issues from leaks, less capacity winter 18/19	1,231	1,200				2,431
Site electrical infrastructure	Committed	loss of power and consequent risk to patient safety	500	1,500				2,000
Fire compartmentation	Committed	patient and staff safety	500	300	300	300	300	1,700
Fire alarms	Committed	patient and staff safety	225					225
Water	Committed	patient and staff safety	222	200	200			622
Supply and chiller	Committed	patient safety	250					250
Street lighting	Committed	patient and staff safety	325					325
Vacuum plant	Committed	patient safety	200	100				300
ETC Chiller	Committed	patient safety	120					120
Flooring link corridors	Committed	patient and staff safety	100	100	100	100	100	500
Other	Committed for 18/19	patient safety	1,441	5,400	3,000	3,000	4,100	16,941
Feasibility studies	Committed	inability to develop site efficiently	190	200				390
Community equipment replacement	Committed	patient safety	150	150	150	150	150	750
Ambulatory Assessment Unit	Committed	inability to deliver patient care this winter safely	2,970	1,500				4,470
Labour suite	Committed	patient safety risks and poor patient care environment	700	300				1,000
Pharmacy robot	Committed	patient safety due to inability to replace function with hard to recruit staff	160					160
Radiology reporting office	Committed	patient safety	170					170
Blue badge bays	Committed	patient service		300				
Mortuary	Committed	insufficient storage		1,400				

Planned Capital Expenditure	Contractual Commitment Stage	Risk and Consequence of Delay	2018/19 Plan £000s	2019/20 Plan £000s	2020/21 Plan £000s	2021/22 Plan £000s	2022/23 Plan £000s	2018/19-2022/23 5 Year Plan £000s
Medical equipment	Committed	patient safety	300	300	300	300	300	1,500
Radiology implicit lease	Committed	patient safety	1,092	1,506				2,598
Endoscopy implicit lease	Committed	patient safety	369	196				565
GDE central funding	Committed	lack of transformation and failure to meet CIP (£20m over life of project)	550					550
Trust funded GDE	Committed	lack of transformation and failure to meet CIP (£20m over life of project)	4,550					4,550
Acute IT investment	Committed for 1819	lack of transformation and failure to meet CIP	900	2,870	3,000	3,000	3,000	12,770
Monitors for theatres and anaesthetics	Committed	patient safety	450	330				780
Community IT investment	Committed	lack of transformation and failure to meet CIP	500	500				1,000
Other Acute IT Investment (locally managed)	Committed	lack of transformation and failure to meet CIP	250	500				750
Voice Recognition	Committed	lack of transformation and failure to meet CIP	354					354
Other schemes commencing after 2020/21	Uncommitted	tbc			5,000	2,300	2,900	10,200
Gross Capital Expenditure (nil IFRIC 12 impact)			28,186	19,352	12,550	9,650	11,350	81,088

20. Digital programme board report

To ACCEPT a report

For Report

Presented by Craig Black

Trust Open Board Meeting – 28 September 2018

Agenda item:	20			
Presented by:	Craig Black, Exec Director of Resources			
Prepared by:	Sarah Jane Relf, e-Care/Global Digital Exemplar Operational Lead			
Date prepared:	21 September 2018			
Subject:	To receive update from Digital Programme Board			
Purpose:	X	For information		For approval

Executive summary:
This paper confirms key points of interest raised and discussed at the Digital Board on 26 July 2018. Of particular note are delay to delivery of MMODAL project.

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:	*Digital Board*
Risk and assurance:	*All risks are monitored by the Digital Programme Board and Programme Groups*
Legislation, regulatory, equality, diversity and dignity implications	*Compliance with forthcoming General Data Protection Regulation (GDPR)*

Recommendation:
The Scrutiny Committee is asked to note the report

To receive update on e-Care and Global Digital Exemplar Programme

1. Background

1.1 In May 2016, the trust embarked on a major change programme to introduce a new electronic patient record (EPR). The programme was branded e-Care. In this initial phase, the programme introduced the following functionality:

- A new replacement Patient Administration System (PAS)
- FirstNet – a dedicated emergency department system
- EPMA – medicines management (prescribing and administration)
- OrderComms – requesting and reporting for cardiology and radiology
- Clinical documentation

1.2 Further enhancements have been made over the last 18 months including:

- AKI and sepsis alerts
- Full OrderComms functionality including pathology
- Paediatrics
- Capacity management – new functionality to improve patient flow
- New clinical documentation, care plans and care pathways
- Medication enhancements including duplicate paracetamol alerting
- New diabetic care plan

1.3 The West Suffolk Hospital NHS Foundation Trust (WSFT) is one of 16 hospitals chosen to become a flagship Global Digital Exemplar (GDE). As part of the GDE programme funding was awarded to those hospitals considered to be the most advanced digitally with the hospital receiving £10million.

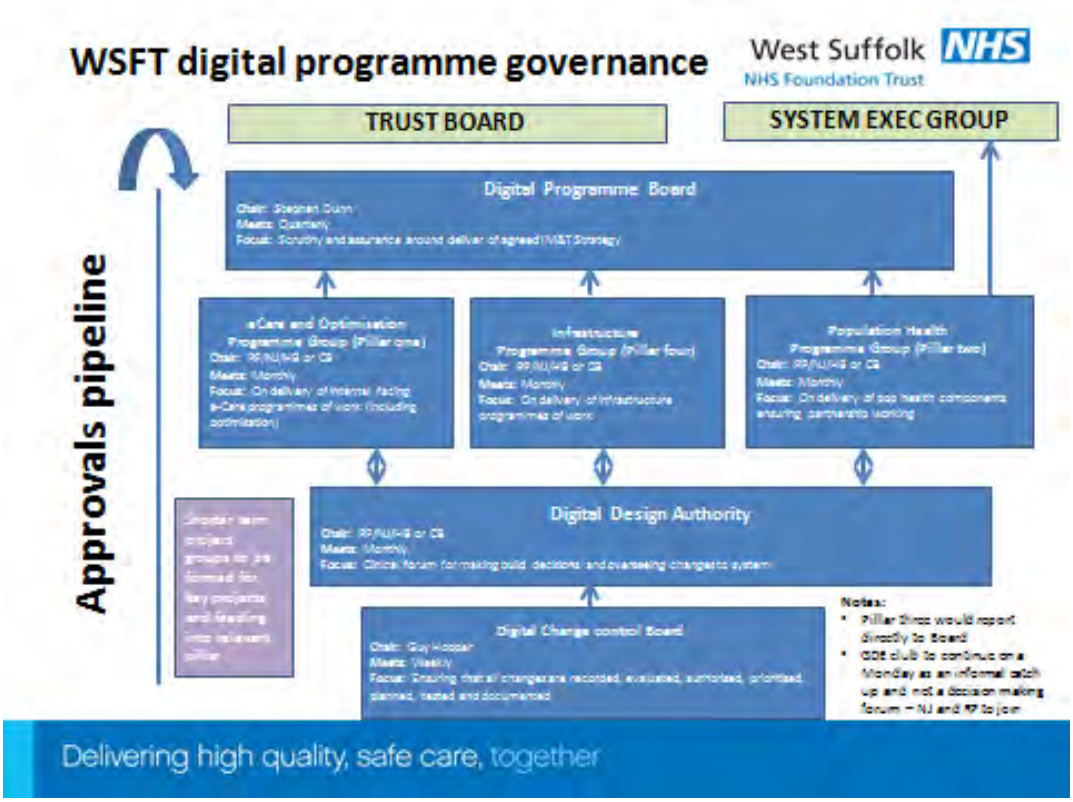
1.4 Our GDE programme comprises of four pillars:

Pillar 1	Digital acute trust	Completing the internal journey of digitisation
Pillar 2	Supporting the integrated care organisation	Creating the digital platform to support the regional ambitions of integrated care and population health.
Pillar 3	Exemplar digital community	Building the organisation into a centre of digital excellence and acting as mentor and guide for other developing organisations.
Pillar 4	Hardware and infrastructure	Ensuring that we have a robust and compliant infrastructure at the foundation of the programme

The remainder of this paper provides an update on implementation of the GDE programme.

2. Governance changes

2.1 At the May meeting it was agreed to adopt a new model of governance to reflect the business as usual requirements. The following diagram summarises the new structures:



The main changes are:

- Changing the remit, focus (and therefore title) of the e-Care Programme Board to become Digital Programme Board. The board would now focus on delivery of all elements of digital agenda rather than just e-Care.
- Moving to quarterly meetings for the WSFT Digital Programme Board to reflect the more strategic nature.
- Introduction of two further programme group meetings in addition to the current e-Care Programme Group. This would mean three programme groups as shown below:

e-Care and optimisation – pillar one	Population health – pillar two	Digital infrastructure – pillar four
Responsible for delivery of all internal programmes. It is proposed that all internal programmes come under the badge of e-Care including those that are not Cerner (e.g. .MedicBleep, M*Modal, Openeyes etc)	Responsible for delivery of all components of population health	Responsible
Proposed to meet monthly	Proposed to meet monthly	Proposed to meet every other month

- Pillar three and reporting would continue to be reported directly to the new Digital Board.
- Introduction of new formal approvals pipeline.
- Introduction of new performance scorecard reporting for the whole digital programme.

The July meeting was the first meeting in this new format.

3. Pilar one – digital acute trust

3.1 The board received an update on all programmes under pillar one. The following exceptions were called out.

- **Fetal links** – noted that the funding source for this is yet to be agreed. The board noted that maternity is likely to be delayed for go live now until 2019/20 and that this would therefore be looked at as part of investment round for that year.
- **Closed loop medication** – escalated to board concerns regarding our ability to deliver this GDE requirement. It was agreed to await the outcome of the HIMMS review and Mike Bone confirmed that he was actively working with NHS Digital to seek a UK wide solution.
- **M*Modal** – it was reported that we were unable to hit the original September go live dates and a new plan was approved with a go live date of mid November 2018. It was recognised that this would affect the original business case and the project manager was asked to review whether there is opportunity to expand the pilot areas and/or expedite the timings of rollout beyond the pilots, in order to recover the position.

4. Pillar two – supporting the integrated care organisation

4.1 All programmes for pillar two are on target currently.

5 Pillar three – exemplar digital community

5.1 It was reported that we had been selected to produce an initial blueprint on our HIE connection with Addenbrooke's. This has to be submitted by end of November 2018. Each GDE site has been asked to produce one blueprint each at this stage. After the meeting we have subsequently agreed that we will focus on our allied health professional workflow rather than HIE.

6. Pillar four – hardware and infrastructure

5.1 The board received an update on all programmes under pillar four. The following exceptions were called out:

- **Remote access** – the team reported a delay to implementing the published desktop to staff who are either not on a trusted device or who need to access clinical data from locations outside of the hospital. There are currently technical challenges with the authentication service that underpins this technology. This requires 3 suppliers to work closely together to achieve resolution and currently this deliverable is therefore behind.

11:30 GOVERNANCE

21. Trust Executive Group report

To ACCEPT a report

For Report

Presented by Stephen Dunn

Board of Directors – 28 September 2018

Agenda item:	21			
Presented by:	Dr Stephen Dunn, Chief Executive			
Prepared by:	Dr Stephen Dunn, Chief Executive			
Date prepared:	20 September 2018			
Subject:	Trust Executive Group (TEG) report			
Purpose:	X	For information		For approval

Executive summary

The **integrated quality and performance report** (IQPR) was reviewed. Through July and August, we experienced high levels of demand in the Trust and it was recognised that staff have been fantastic in responding to the challenges faced. It was noted that ED had continued to receive additional support, particularly during the challenging evenings and weekends. A review was undertaken of the stretch cost improvement programme to support delivery the revised control total for 2018/19.

It was recognising that with the busy summer and the demand on staffing across the whole Trust it is essential that the senior leaders maintain their focus on preparations to provide **resilience for winter and the need to avoid staff burnout**. The successful red2green initiative prior to the August bank holiday weekend was recognised and plans discussed to run an event in October, when demand is likely to once again be high.

An update was received on the **wireless network project** which, starting in September will provide a significant upgrade in our wireless network coverage. Deployment of an agreed protocol will allow any health and social care person working under the Suffolk and North East Essex STP umbrella to be able to use the wireless network to gain access to their own systems.

Business cases were approved for replacement/appointment for number of **consultant posts**: obstetrics and gynaecology; haematology; AMU/renal; ENT; and trauma & orthopaedic

A review was undertaken of the draft five year **estates strategy** prior to submission to the Board. This acknowledged the significant estates backlog maintenance programme of £25million and noted the structural and electrical distribution issues for the site.

The five year **radiology strategy** was received. This included the equipment replacement programme through to 2022 and discussed equipment and infrastructure and some of the strategic developments within the services during this period.

The meeting approved the objectives and action plan from the **equality and diversity group** with a focus on alleviating bullying, harassment and abuse. The equality, diversity and inclusion annual report was received prior to submission to the Board.

The **emergency planning resilience and response (EPRR)** report was received. As well as the finding of recent testing this included the annual EPRR core standards report (annex). This contains 65 core standards, which we are fully compliant with the exception of two areas - business continuity plans and the formal training for operational on-call staff (bronze, silver and gold). Work is ongoing to address these in the coming months.

The **red risk report** was reviewed with discussion and challenge for individual areas. One new red risks were received relating to returning results to referrers without the audit benefits offered by an order communications system. The key 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** (new) 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.

Risks relating to pathology services were reviewed in light of the recent MHRA inspection findings and an update received by TEG.

A proposal to replace the existing pharmacy **automated dispensing machine** (the robot) was approved. It was noted that the enabling works for the replacement and transition process have been costed and factored into Q4 of the 2018-19 capital programme.

A report was received on the **international dysphagia diet standardisation initiative (IDDSI)** which standardises terminology and definitions for texture modified foods and thickened liquids for people with dysphagia. The proposed approach was approved for use within the Trust.

Relevant **policy documents** were considered and approved:

a) A proposed procedure for managing **inspections, visits and accreditations** was approved. This will be monitored through the divisional performance review meetings.

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 and receipt of the EPRR core standards submission (annex)

Please select type of organisation: **Acute Providers**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	14	0	0
Command and control	2	2	0	0
Training and exercising	3	2	1	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	8	1	0
CBRN	14	14	0	0
Total	64	62	2	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Incident Coordination Centres	4	4	0	0
Command structures	4	4	0	0
Total	8	8	0	0

Overall assessment:	Substantially compliant

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below
1	**Governance**	**Appointed AEO**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for making sure the policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • business continuity, critical incidents and major incidents • the organisation's position in relation to the NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by lessons identified from: • incidents and exercises • identified risks • outcomes from assurance processes.	Y	• Process explicitly described within the EPRR policy statement • Annual work plan
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group
6	**Governance**	**Continuous improvement process**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register

8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document
Domain 3 - Duty to maintain plans					
9	**Duty to maintain plans**	**Collaborative planning**	Plans have been developed in collaboration with partners and service providers to ensure the whole patient pathway is considered.	Y	Partners consulted with as part of the planning process are demonstrable in planning arrangements
	Duty to maintain plans	**Planning arrangements**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the following risks / capabilities:		
11	**Duty to maintain plans**	**Critical incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
12	**Duty to maintain plans**	**Major incident**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as per the EPRR Framework).	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
13	**Duty to maintain plans**	**Heatwave**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heat wave on the population the organisation serves and its staff.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
14	**Duty to maintain plans**	**Cold weather**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
15	**Duty to maintain plans**	**Pandemic influenza**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to pandemic influenza as described in the National Risk Register.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

16	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including Viral Haemorrhagic Fever. These arrangements should be made in conjunction with Infection Control teams; including supply of adequate FFP3.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
17	**Duty to maintain plans**	**Mass Countermeasures**	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including the arrangement for administration, reception and distribution, e.g. mass prophylaxis or mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop Mass Countermeasure distribution arrangements. These will be dependant on the incident, and as such requested at the time. CCGs may be required to commission new services dependant on the incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
18	**Duty to maintain plans**	**Mass Casualty - surge**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to increase capacity by 10% in 6 hours and 20% in 12 hours.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
19	**Duty to maintain plans**	**Mass Casualty - patient identification**	The organisation has arrangements to ensure a safe identification system for unidentified patients in emergency/mass casualty incident. Ideally this system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
20	**Duty to maintain plans**	**Shelter and evacuation**	In line with current guidance and legislation, the organisation has effective arrangements in place to place to shelter and / or evacuate patients, staff and visitors. This should include arrangements to perform a whole site shelter and / or evacuation.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
21	**Duty to maintain plans**	**Lockdown**	In line with current guidance and legislation, the organisation has effective arrangements in place safely manage site access and egress of patients, staff and visitors to and from the organisation's facilities. This may be a progressive restriction of access / egress that focuses on the 'protection' of critical areas.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required

22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to manage 'protected individuals'; including VIPs, high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
23	**Duty to maintain plans**	**Excess death planning**	Organisation has contributed to and understands its role in the multiagency planning arrangements for excess deaths, including mortuary arrangements.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required
Domain 4 - Command and control					
24	**Command and control**	**On call mechanism**	A resilient and dedicated EPRR on call mechanism in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.
25	**Command and control**	**Trained on call staff**	On call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf on the Chief Executive Officer / Clinical Commissioning Group Accountable Officer. The identified individual: • Should be trained according to the NHS England EPRR competencies (National Occupational Standards) • Can determine whether a critical, major or business continuity incident has occurred • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout.	Y	• Process explicitly described within the EPRR policy statement
Domain 5 - Training and exercising					
26	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	Y	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff
27	**Training and exercising**	**EPRR exercising and testing programme**	The organisation has an exercising and testing programme to safely test major incident, critical incident and business continuity response arrangements. Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement.	Y	• Exercising Schedule • Evidence of post exercise reports and embedding learning
28	**Training and exercising**	**Strategic and tactical responder training**	Strategic and tactical responders must maintain a continuous personal development portfolio demonstrating training in accordance with the National Occupational Standards, and / or incident / exercise participation	Y	• Training records • Evidence of personal training and exercising portfolios for key staff

29	**Training and exercising**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems have been tested annually		• Exercising Schedule • Evidence of post exercise reports and embedding learning
Domain 6 - Response					
30	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has a pre-identified an Incident Co-ordination Centre (ICC) and alternative fall-back location. Both locations should be tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation.	Y	• Documented processes for establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards
31	**Response**	**Access to planning arrangements**	Version controlled, hard copies of all response arrangements are available to staff at all times. Staff should be aware of where they are stored; they should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and hard copies
32	**Response**	**Management of business continuity incidents**	The organisations incident response arrangements encompass the management of business continuity incidents.	Y	• Business Continuity Response plans
33	**Response**	**Loggist**	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for accessing and utilising loggists • Training records
34	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps • Evidence of testing and exercising
35	**Response**	**Access to 'Clinical Guidance for Major Incidents'**	Emergency Department staff have access to the NHSE 'Clinical Guidance for Major Incidents' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies
36	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	Guidance is available to appropriate staff either electronically or hard copies
Domain 7 - Warning and informing					
37	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work
38	**Warning and informing**	**Warning and informing**	The organisation has processes for warning and informing the public and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing
39	**Warning and informing**	**Media strategy**	The organisation has a media strategy to enable communication with the public. This includes identification of and access to a trained media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy which identifies and trains key staff in dealing with the media including nominating spokespeople and 'talking heads'
Domain 8 - Cooperation					
40	**Cooperation**	**LRHP attendance**	The Accountable Emergency Officer, or an appropriate director, attends (no less than 75%) of Local Health Resilience Partnership (LHRP) meetings per annum.	Y	• Minutes of meetings

41	**Cooperation**	**LRF / BRF attendance**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with other responders.	Y	• Minutes of meetings • Governance agreement if the organisation is represented
42	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, co-ordinating and maintaining resource e.g. staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA).	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate
43	**Cooperation**	**Arrangements for multi-region response**	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs
44	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency
45	**Cooperation**	**LHRP**	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas
46	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.
Domain 9 - Business Continuity					
47	**Business Continuity**	**BC policy statement**	The organisation has in place a policy statement of intent to undertake Business Continuity Management System (BCMS).	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders
49	**Business Continuity**	**Business Impact Assessment**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(s).	Y	Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support.
50	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's IT department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance
51	**Business Continuity**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation

52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against the Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers
53	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports
54	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans
55	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements

Ref	Domain	Standard	Detail	Acute Providers	Specialist Providers	NHS Ambulance Service Providers	Community Service Providers	Patient Transport Services	NHS111	Mental Health Providers	NHS England Director Commissioning Operations Team	NHS England Regional Team	NHS England National Team	NHS Improvement	Clinical Commissioning Group	Commissioning Support Unit	Primary Care Services - GP, community pharmacy	Other NHS funded organisations	Evidence - examples listed below	Self assessment RAG Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Command and control																							
Domain: Incident Coordination Centres																							
1	Incident Coordination Centres	Communication and IT equipment	The organisation has equipped their ICC with suitable and resilient communications and IT equipment in line with NHS England Resilient Telecommunications Guidance.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Fully compliant				
2	Incident Coordination Centres	Resilience	The organisation has the ability to establish an ICC (24/7) and maintains a state of organisational readiness at all times.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Up to date training records of staff able to resource an ICC	Fully compliant				
3	Incident Coordination Centres	Equipment testing	ICC equipment has been tested every three months as a minimum to ensure functionality, and corrective action taken where necessary.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Post test reports Lessons identified EPRR programme	Fully compliant				
4	Incident Coordination Centres	Functions	The organisation has arrangements in place outlining how it's ICC will coordinate it's functions as defined in the EPRR Framework.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Arrangements outline the following functions: Coordination Policy making Operations Information gathering Dispersing public information.	Fully compliant				
Domain: Command structures																							
5	Command structures	Resilience	The organisation has a documented command structure which establishes strategic, tactical and operational roles and responsibilities 24 / 7.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Training records of staff able to perform commander roles EPRR policy statement - command structure Exercise reports	Fully compliant				
6	Command structures	Stakeholder interaction	The organisation has documented how its command structure interacts with the wider NHS and multi-agency response structures.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	EPRR policy statement and response structure	Fully compliant				
7	Command structures	Decision making processes	The organisation has in place processes to ensure defensible decision making; this could be aligned to the JESIP joint decision making model.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	EPRR policy statement inclusive of a decision making model Training records of those competent in the process	Fully compliant				
8	Command structures	Recovery planning	The organisation has a documented process to formally hand over responsibility from response to recovery.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Recovery planning arrangements involving a coordinated approach from the affected organisation(s) and multi-agency partners	Fully compliant				

Overall assessment:			Substantially compliant						
Ref	**Domain**	**Standard**	**Detail**	Evidence - examples listed below	**Self assessment RAG** Red = Not compliant with core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months. Amber = Not compliant with core standard. The organisation's EPRR work programme demonstrates an action plan to achieve full compliance within the next 12 months. Green = Fully compliant with core standard.	**Action to be taken**	**Lead**	**Timescale**	**Comments**
26	**Training and exe**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are competent in their role; training records are kept to demonstrate this.	• Process explicitly described within the EPRR policy statement • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Partially compliant	Conduct formal training design	Head EPRR	Aug-19	Trust EPRR Strategy. Records are kept of all training delivered for key staff. The training is not subject to a formal TNA. A needs analysis is undertaken for emerging or just-in-time training according to the threat.
51	**Business Contin**	**Business Continuity Plans**	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure These plans will be updated regularly (at a minimum annually), or following organisational change.	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Partially compliant	Write or review BCPs	Head EPRR	Jul-19	BCPs exist for all Hospital areas but may require update ; lack of capacity preculdes to date. All Estates & Facilities BCPs up to date.

22. Audit Committee report

To RECEIVE the report

For Report

Presented by Angus Eaton

Trust Board Meeting – 28 September 2018

Agenda item:	22			
Presented by:	Angus Eaton, Non Executive Director			
Prepared by:	Louise Wishart, Assistant Director of Finance			
Date prepared:	July 2018			
Subject:	Audit Committee report - meeting held on 27th July 2018			
Purpose:		For information	X	For approval

Executive summary:

The draft minutes of the meetings of the Audit Committee on 27th July 2018 are attached. **Please note these have yet to be approved.** The key issues and actions discussed were:-

- **Clinical Audit-** The Committee received a Clinical Audit Process Assurance Report. The Committee discussed at length if the Clinical Audit Programme was set at the right level. The conclusion was that the key issue is if the clinical risks have adequate coverage. In order to better understand the position it was agreed that departments would be asked to identify all audit work they are doing that is not currently recorded on the clinical audit programme.

- Internal Audit and Counter Fraud- The Internal Audit Progress Report confirmed that 7 reports had been issued since the last report to the Committee; 3 relating to 2017/18 and 4 related to 2018/19. Of the 7 reports, 2 were rated as partial assurance, these were:

    1. 2017/18 Data Quality: 18 weeks referral to treatment and diagnostic waits; and

    2. 2018/19 NE Essex and Suffolk Pathology Service (NEEPS).

  The Committee has asked that East Suffolk and North Essex Foundation Trust (ESNEFT) Internal Audit is asked for assurance on risks relating NEEPS where we do not already have sufficient assurance.

- **External Audit Annual Audit Letter**- Mr. David Eagles, BDO Partner, presented the 2017/18 Annual Audit Letter:

    1. The auditors issued an unmodified true and fair opinion on the 2017/18 Financial Statements 25 May 2018;

    2. Although the Trust met its control total in 2017/18, due to the ongoing financial challenges faced by the Trust, the external auditors issued a qualified 'except for' Use of Resources opinion 25 May 2018; and

    3. The auditor issued an unmodified assurance report on the Quality Report 25 May 2018.

- **Audit Committee Annual Report** – The Committee approved the Annual Report to the Board summarising the work completed by the Committee over the past 12 months.

- **Revised Terms of Reference** – The Committee has recently completed a self-assessment of effectiveness and performance against recognised best practice. In response to the conclusions of that exercise, and as part of the annual review, a revised Terms of Reference is proposed for the Board's approval.

- **Report to the Council of Governors** – the Committee approved the report to the Council of Governors on the performance of external audit.

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

Previously considered by:	*This report has been produced for the monthly Trust Board meeting only*
Risk and assurance:	*None*
Legislation, regulatory, equality, diversity and dignity implications	*None*

Recommendation:
The Board is asked to:

- receive and note the Audit Committee report for meeting held on 27th July 2018
- receive the Annual Report from the Audit Committee
- approve the revised Audit Committee Terms of Reference

Audit Committee – 27 July 2018

Agenda item:	9.1			
Presented by:	Louise Wishart, Assistant Director of Finance			
Prepared by:	Louise Wishart, Assistant Director of Finance			
Date prepared:	18/7/18			
Subject:	Audit Committee Annual Report			
Purpose:		For information	X	For approval

Executive summary:

The Audit Committee is required to produce an Annual Report detailing the work undertaken during a financial year. Attached is the report for the year ended 31 March 2018.

The Committee is asked to review the report and agree a final submission to the Trust Board

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

Trust ambitions	*Deliver personal care*	*Deliver safe care*	*Deliver joined-up care*	*Support a healthy start*	*Support a healthy life*	*Support ageing well*	*Support all our staff*
	✓	✓	✓	✓	✓	✓	✓

Previously considered by:	N/A
Risk and assurance:	Sufficient
Legislation, regulatory, equality, diversity and dignity implications	None directly relevant to this report but the work of the Committee provides the Trust with assurance on compliance in a number of areas.

Recommendation:
The Audit Committee is asked to review and agree a final version for submission to the Trust Board.

1. Background

1.1 The Audit Committee of West Suffolk NHS Foundation Trust is established under Board delegation with approved Terms of Reference that are in line with those set out in the NHS Audit Committee Handbook.

1.2 This report covers the year from 1 April 2017 to 31 March 2018.

1.3 The Committee consists of a minimum of 3 Non-Executive Directors, one of whom has recent and relevant financial experience. The Committee has met on 6 occasions during the year to discharge its responsibility for scrutinising the risks and controls that affect all aspects of the organisation's business.

1.4 The meetings have also been attended, by invitation, by the Chief Executive, the Executive Director of Resources, the Executive Chief Nurse, the Deputy Chief Nurse, the Medical Director, the Trust Secretary and Head of Governance, the Assistant Director of Finance or Deputy Director of Finance, Internal Audit, External Audit and the Counter Fraud Service. The Chair of the Trust has also attended the Committee meetings.

1.5 The Committee focuses on all aspects of Corporate Governance including assurance on clinical governance and risk management.

1.6 This report deals with the Audit Committee meetings held between 1 April 2017 and 31 March 2018. Therefore, reports that are approved outside this period would be covered in the following year despite the subject matter of the report relating to the year. E.g. the annual report and accounts for 2017/18 will be reported in the year they were approved by the Committee i.e. 2018/19.

2. Meetings during 2017/18

2.1 There were 6 meetings of the Committee during 2017/18: 28 April 2017, 26 May 2017, 28 July 2017, 3 November 2017, 26 January 2018 and 2 March 2018 with the following member attendance.

Name	Title	Attendance / No. possible
Steve Turpie (Chair)	Non-Executive Director	6/6
Neville Hounsome	Non-Executive Director	4/6
Gary Norgate	Non-Executive Director	6/6
Alan Rose	Non-Executive Director	6/6
Richard Davies	Non-Executive Director	5/6
Angus Eaton	Board Adviser	3/3
	Non-Executive Director	2/3

2.2 Angus Eaton's role changed during the year from Board Adviser to Non-Executive Director from 1 January 2018.

2.3 There were no sub-committees of the Audit Committee during 2017/18. The minutes of the Quality and Risk Committee are considered at every meeting.

2.4 New Committee members received an induction from the Assistant Director of Finance and Trust Secretary and Head of Governance which also covered the Charitable Funds Committee delivered by The Technical Accountant.

3. Principal Review Areas

3.1 Annual Governance Statement

3.1.1 The Audit Committee reviewed the Annual Governance Statement for West Suffolk NHS Foundation Trust for the 12 months to 31 March 2017 and confirmed that it is consistent with the view of the Committee on the Trust's system of internal control.

3.1.2 The Audit Committee received the Head of Internal Audit opinion 2016/17 in May 2017 which concluded:

The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

Specific issues highlighted were:

- CIP (Cost Improvement Programme): Transformation and Delivery

  There was an absence of control in place to prevent double counting of savings between the CCG and Trust which could lead to a shortfall in cashable savings required to meet either organisation's control total. In addition there were issues in the quality, quantity and timeliness of project documentation and there was a lack of progress reporting from the Transformation Profile Group (a group set up with membership from both Trust and CCG to oversee the development of the joint transformational CIP schemes) to The Executive Group. The Trust was unable to provide completed Quality Impact Assessments to support ongoing schemes.

- Community Services: Equipment Services

  Whilst there were policies and procedures to govern ordering, fulfilment, delivery and payment of these items there remained a number of issues around the data quality of the inventory listing, lack of controls over peripheral stock stores and a backlog in servicing of large volumes of equipment which is being used within the Community. Issues were not being escalated and discussed regularly at the Provider Management Group or being recorded on the Community Services risk register.

- Income and Debt Management

  Weaknesses were identified in both the design of and compliance with the control framework. This included the Debt Management Policy not being up to date with current practice, issues surrounding the timeliness of issue of debt recovery letters for non NHS debt, timely referral of debts to the debt collection agency, evidencing of action taken on aged debt and routine reporting of the aged debt position to the Trust Board.

3.1.3 The Audit Committee also reviewed the draft Annual Governance Statement for the 12 Months to 31 March 2018 in March 2018. The draft 2017/18 Head of Internal Audit Opinion was received at the same meeting. Issues highlighted relating to 2017/18 at the draft stage were Data Quality, Business Continuity and Disaster Recovery and General Data Protection Regulations.

3.2 Annual Accounts Approval

3.2.1 The Committee reviewed the draft accounting policies proposed and considered the significant accounting estimates and judgements in advance of the production of the accounts.

3.2.2 The Committee reviewed the Annual Accounts, Annual Report and the Letter of Representation for the 12 months to 31 March 2017 and recommended these for approval by the Trust Board.

3.3 Terms of Reference

3.3.1 The Committee is required to review its Terms of Reference (ToR) during the year.

3.3.2 A revised version of the Terms of reference was agreed at the meeting in July 2017.

3.4 Governance Documents

3.4.1 The Committee has a duty to undertake a review of the Trust's Governance Documents every other year, unless there are matters that require review at an earlier date. These comprise the Standing Orders, Standing Financial Instructions and The Scheme of Delegation. These were last reviewed in January 2017 so no review was required this year.

3.5 Governance

3.5.1 In respect of Governance the committees responsibilities are set out in the terms of reference as:

- The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Audit Committee will look to the Quality & Risk Committee for assurance on items of clinical quality and corporate risk, including: health & safety, research and information governance

3.5.2 The Committee achieved this through a number of actions:-

- Monitor and review the Annual Governance Statement
- Receiving the annual Head of Internal Audit opinion
- Receiving the report of the External Auditors on the annual accounts
- Receiving the Annual Governance Report from the External Auditors
- Reviewing the effectiveness of the Board Assurance Framework (with support from internal audit)

3.5.3 Board Assurance Framework Deep Dive Reviews – during the 2017/18 financial year the Committee conducted deep dive reviews of key areas within the Trust:

- Financial Improvement Programme (FIP)- KPMG made a presentation on the plan of action for FIP and how it would be delivered (April 2017). This was followed by a question and answer session and time for reflection.
- STP Service Review Stroke- Dr Nicholson made a presentation to the Committee on developments required in stroke care which was followed by a question and answer session and time for reflection.
- General Data Protection Regulation (GDPR)- RSM made a presentation to the Committee on the new regulations which was followed by a question and answer session.

3.5.4 The Committee received a Supply Chain Risk Report in March 2018.

3.6 Charitable Funds Annual Accounts

3.6.1 The Board delegated authority to the Audit Committee to approve the Charitable Fund accounts for the full year to 31 March 2017. The committee approved the accounts at its January 2018 meeting.

3.7 Clinical Audit

3.7.1 A clinical audit progress report is presented to the Committee at every meeting by the Deputy Chief Nurse or their representative.

4. Other work undertaken

4.1.1 Internal Audit

4.1.1.1 The Audit Committee reviewed the progress against the risk based 2017/18 Internal Audit Plan in April 2017 and progress was reported against this plan at subsequent meetings.

4.1.1.2 The Committee received reports from the Head of Internal Audit on the progress made on audits undertaken during the year.

4.1.1.3 The Committee monitored progress made on recommendations made in Internal Audit reports.

4.1.1.4 The Committee approved the 2018/19 risk based audit plan in March 2018.

4.1.2 External Audit

4.1.2.1 The Committee received the following reports from the External Auditors:-

- 2016/17 Audit Plan- April 2017
- 2016/17 Audit Progress Report- April 2017
- 2016/17 Report to Those Charged with Governance (ISA 260)- May 2017
- 2016/17 Quality Report- May 2017
- 2016/17 Annual Audit Letter- July 2017
- 2017/18 plan for added value- November 2017
- 2016/17 Charitable Fund Accounts Report to Those Charged with Governance (ISA 260)- January 2018
- 2017/18 External Audit Plan- March 2018

4.1.3 Counter Fraud

4.1.3.1 The Committee received the following reports from the Local Counter Fraud Specialist provided by RSM:

- Progress Report- all meetings
- Regular Fraud Notices
- Benchmarking Report on referrals and cases
- Counter Fraud Annual Plan 2017/18- April 2017
- Counter Fraud Annual Plan 2018/19- March 2018
- Fraud Awareness Staff Survey- March 2018
- Wannacry No More Report- November 2017 following the cyber-attack across the NHS

5. Audit Committee Responsibilities – performance

5.1 As part of its responsibilities the Committee should assess its performance against its terms of reference not less than every 2 years. The Committee agreed to complete the HFMA self-assessment checklist with a deadline of April 2018 which would then be considered in July 2018. This review has fallen outside the 2 year timetable but additional measures will be put in place to avoid this delay again.

6. Audit Committee Impact

6.1 It is important that the Audit Committee makes an impact on the Trust, particularly around ensuring the robustness of the Governance Structure.

6.2 In assessing this, it is important to note that the main reports submitted to the Committee by External and Internal Audit supported the robustness of the Governance structure.

6.3 There were a number of specific areas where the Committee undertook action to address issues or where specific items were raised and discussed amongst these were

- The Committee received reports on losses and special payments at each meeting. Where levels of pharmacy losses exceeded the tolerance of 0.4% of issues a more detailed analysis was undertaken.
- The majority of other losses related to bad debts and patient property.
- The Committee received reports on waivers and critically reviewed the drivers behind the number of waivers.
- The Committee agreed additional controls for high risk suppliers following receipt of the Supply Chain Risk Report.
- The Trust critically reviewed management responses to Internal and External Audit Reports to ensure risks were being managed adequately and in a timely manner.

6.4 The above items reflect that the Committee has had a positive impact on the governance arrangements of the Trust

7. Conclusion

7.1 This report highlights the main areas of work undertaken by the Audit Committee during the period. It demonstrates that the Committee operated effectively and had a positive impact on the Trust.

7.2 The Committee is asked to review the report, make any changes and approve a final version for submission to the Trust Board.

Audit Committee – 27 July 2018

Agenda item:	9.2			
Presented by:	Louise Wishart, Assistant Director of Finance			
Prepared by:	Louise Wishart, Assistant Director of Finance			
Date prepared:	20 July 2018			
Subject:	Annual Review of Terms of Reference			
Purpose:		For information	✓	For approval

Executive summary:

The Committee is required to review its Terms of Reference annually. The previous Terms of Reference are included within this report with suggested highlights made using tracked changes. The Committee has recently completed a self-assessment exercise and issues highlighted by Members are included within the suggested changes to the Terms of Reference.

No changes are proposed to the Terms of Reference for Clinical Audit but the Committee is asked to consider this area in light of comments made in the self-assessment exercise. This area has been highlighted for 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**
	✓	✓	✓

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:	*The Terms of Reference were last reviewed in July 2017.*
Risk and assurance:	*The HFMA Audit Committee checklist has been used to inform the review of the Terms of Reference.*
Legislation, regulatory, equality, diversity and dignity implications	

Recommendation:
The Committee is asked to review and approve or change the suggested amendments to the Committee's Terms of Reference.

AUDIT COMMITTEE TERMS OF REFERENCE

1 Constitution

1.1 The Board of Directors hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference.

2 Aim

2.1 The Committee will provide an independent and objective view of the Trust's internal control environment and the systems and processes by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations".

3 Scope

3.1 The Committee has overarching responsibility for monitoring specific elements of the systems and processes relating to governance, including financial systems, records and controls; financial information; compliance with law, guidance and codes of conduct; independence of internal and external audit; and the control environment (including measures to prevent and detect fraud). The Committee is responsible for providing an opinion as the adequacy of the integrated governance arrangements and Board Assurance Framework.

3.2 The Committee has a statutory role in respect of assurance, controls, compliance, data and probity, and on behalf of the Board it will review the work of its Sub-Committees, requesting explanations where required. The aim is to ensure complete coverage while avoiding duplication by close liaison and cross-representation between these committees. The coverage required includes assurance for Trust owned and part owned organisations, as well as key partners.

4 Membership

4.1 The Committee shall be appointed by the Board of Directors from amongst the Non-executive Directors of the Trust and shall consist of no fewer than three members, one of whom has recent and relevant finance experience. One of the members will be appointed Chair of the Committee by the Board of Directors.

4.2 The Trust Chair will ensure that there is cross-representation by Non-executive directors on the Audit Committee and the Quality & Risk Committee and its Sub-Committees.

4.3 A quorum will be two members.

4.4 The Chair of the Trust shall not be a member of the Committee.

5 Attendance at Meetings

5.1 The Director of Resources and the Trust Secretary will normally attend all Committee meetings.

5.2 The Head of Internal Audit and a representative of the Trust's External Auditors will attend as necessary.

5.3 Other members of the Board of Directors have the right of attendance at their own discretion.

5.4 All other attendances will be at the specific invitation of the Committee.

5.5 The Committee will have the over-riding authority to restrict attendance under specific circumstances.

5.6 The Committee will meet with the External and Internal Auditors, without any other Board Director present at least once a year.

5.7 Attendance at meetings will be recorded as part of the normal process of the meeting. A record of attendance will be reported as part of the Committee's Annual Report.

6 Frequency of Meetings

6.1 Meetings will normally be held at least three times a year.

6.2 Special meetings may be convened by the Board of Directors or the Chair of the Committee.

6.3 The External Auditors or Internal Auditors may request a meeting if they consider that one is necessary.

7 Authority

7.1 The Board of Directors authorises the Committee to investigate any activity within its duties (as detailed below) and grants to the Committee complete freedom of access to the Trust's records, documentation and employees. This authority does not extend, other than in exceptional circumstances, to confidential patient information.

7.2 The Committee may seek any information (excluding confidential patient information, other than in exceptional circumstances) or explanation it requires from the Trust's employees who are directed to co-operate with any request made by the Committee.

7.3 The Trust Board authorises the Committee to obtain external professional advice or expertise if the Committee considers this necessary.

8 Duties and Responsibilities

The duties and responsibilities of the Committee are as follows:

8.1 Governance and Assurance

8.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives. The Audit Committee will look to the Quality & Risk Committee for assurance on items of clinical quality and corporate risk, including: health & safety, research and information governance.

In particular, the Committee shall independently monitor and review:

8.1.1.1 the Annual Governance Statement (AGS) and the assurance system for all other external disclosure statements such as declarations of

compliance with the Care Quality Commission registration, and any formal announcements relating to the Trust's financial performance, together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors.

8.1.1.2 the effectiveness of systems of internal financial and budgetary control and the integrity of reporting statements.

8.1.1.3 the effectiveness of systems for ensuring the optimum collection of income.

8.1.1.4 the effectiveness of risk management systems.

8.1.1.5 the effectiveness of the Board Assurance Framework (BAF).

8.1.1.6 The Committee will use a programme of 'deep dive' reviews to test the BAF and its priority areas as part of an assurance programme. The Committee's assessment of the effectiveness of the BAF should be included in the Committee's Annual Report to the Board of Directors. The Committee's assessment of the effectiveness of the BAF should be included in the Committee's Annual Report to the Board of Directors.

8.1.1.7 the Quality Report assurance and review alongside the annual report and accounts.

8.1.1.8 the systems for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements, including the NHS Constitution, as set out in relevant guidance.

8.1.1.9 the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud Authority.

8.1.1.10 arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.

8.1.2 In carrying out this work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

8.1.3 This will be evidenced through the Committee's use of an effective Assurance Framework to guide its work and that of the audit and assurance functions that report to it.

8.1.4 The Committee will receive the minutes of the Quality & Risk Committee for the purpose of ensuring: that there is no duplication of effort between the two Committees; that no area of assurance is missed and; as part of its responsibility for reviewing the Annual Governance Statement prior to submission to the Board of Directors.

8.1.5 The Audit Committee shall ensure that there is a system for reviewing the findings of other significant assurance functions, both internal and external to the

organisation and consider the implications to the governance of the organisation. These will include, but will not be limited to, NHS Improvement, any reviews by DH Arms length bodies or regulators/inspectors (CQC, NHS Resolution etc) and professional bodies with responsibility for the performance of staff or functions (eg Royal Colleges, accreditation bodies etc.)

8.1.6 In addition the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Quality & Risk Committee, its subcommittees and any other quality, risk, governance and assurance committees that are established. The conclusion of this review should be referred to specifically in the Committee's Annual Report to the Board of Directors. The conclusion of this review should be referred to specifically in the Committee's Annual Report to the Board of Directors.

8.1.7 The Committee will consider how its work integrates with wider performance management and standards compliance and include this within the Annual Report to the Board of Directors.

8.1.8 In reviewing the work of the Quality & Risk Committee and issues around clinical risk management, the Audit Committee will wish to satisfy themselves on the assurance that the Quality & Risk Committee gains from the clinical audit function.

8.1.9 The Audit Committee will receive assurance on the arrangements for clinical audit within the Trust, including the process by which clinical audits are selected and agreed actions implemented.

8.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management, which meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Board of Directors. An Internal Audit Charter will be agreed annually which will include objectives, responsibilities and reporting lines. An Internal Audit Charter will be agreed annually which will include objectives, responsibilities and reporting lines. This will be achieved by:

8.2.1 considering the appointment of the internal audit service, the audit fee and any questions of resignation and dismissal.

8.2.2 the review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Board Assurance Framework.

8.2.3 consideration of the major findings of internal audit investigations, the effectiveness of the management's response and ensuring co-ordination between the Internal and External Auditors to optimise audit resources.

The will include exception reports of management action beyond deadline and consideration of the findings of Internal Audit "testing" of completed actions.

8.2.4 ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust.

8.2.5 assessing the quality of internal audit work on an annual basis.

8.2.6 Ensuring any material objection to the completion of an assignment which has not been resolved through negotiation is brought to the Committee by the Chief

Executive Officer or Director of Resources with a proposed solution for a decision.

8.3 Counter Fraud

The Committee shall ensure that there is an effective counter fraud function established by management that meets the Standards set out by the NHS Counter Fraud Authority and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

8.3.1 consideration of the provision of the Counter Fraud service, the cost of the audit and any questions of resignation and dismissal.

8.3.2 consideration of the major findings of counter fraud work (and management's response).

8.3.3 ensuring that the Counter Fraud function is adequately resourced and has appropriate standing within the organisation.

8.3.4 receiving an annual review of the work undertaken by the counter fraud function.

8.4 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Council of Governors and consider the implications and management's responses to their work.

8.4.1 Consideration of the appointment, performance and cost effectiveness of the External Auditor, making a recommendation to the Council of Governors on appointment of External Audit.

8.4.2 To ensure that the External Auditor remains independent in its relationship and dealings with the Trust and to review the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements;

8.4.3 To review the annual audit plan and to discuss with the External Auditor, before the audit commences, the nature and scope of the audit.

8.4.4 As part of the audit plan, discuss with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

8.4.5 To review External Audit reports, including value for money reports and management letters, together with the management response.

8.4.6 To consider where the external auditors might profitably undertake investigative and advisory work, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm..

8.4.7 To develop and implement policy on the engagement of the external auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm; and

8.4.8 To assess the quality of external audit work on an annual basis.

8.5 Financial Reporting

8.5.1 The Audit Committee shall review the Annual Report and Financial Statements of the Trust and its Charitable funds before submission to the Board, to determine their completeness, objectivity integrity and accuracy. This review will cover but is not limited to:

- the wording in the Annual Governance Statement (AGS) and other disclosures relevant to the Terms of Reference of the Committee;
- changes in, and compliance with, accounting policies and practices;
- explanation of estimates and provisions having material effect;
- unadjusted mis-statements in the financial statements;
- major judgemental areas;
- the schedule of losses and special payments; and
- significant adjustments resulting from the audit.

8.6 Key Trust Documents

8.6.1 Review proposed changes to Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board for approval by the Board of Directors.

8.6.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

8.6.3 To review the Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved to the Board on a two yearly basis for approval by the Board of Directors.

8.7 Audit findings of key partners

8.7.1 To receive and consider relevant internal and external audit findings of operation for which we are full or part owners. For 2018-19 these were identified as:

8.7.1.1 North East Essex and Suffolk Pathology Services (NEESPS) audits undertaken by East Suffolk and North East Essex NHS FT
8.7.1.2 Category Towers audits undertaken by XXX
8.7.1.3 Suffolk GP Federation, as part of the West Suffolk Alliance

8.7.2 To receive and consider relevant assessments of key supplier risks.

8.8 Other

8.8.1 Review compliance with Standing Orders and Standing Financial Instructions through a schedule of waivers

8.8.2 Review schedules of losses and compensations

8.8.3 Monitor the process to ensure that Supply Chain Risk is identified and appropriate actions have been taken.

8.8.4 Entries recorded in the gifts and hospitality register would be considered on an exception basis as reported by the panel considering the entries made.

9 Reporting, Accountability, Monitoring and Review of Effectiveness

9.1 The Minutes of Audit Committee meetings shall be formally recorded and submitted to the Board of Directors along with a report of its activities no less often than three times a year; The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

9.2 The Audit Committee shall review its terms of reference annually;

9.3 The Audit Committee shall carry out a self-assessment in relation to its own performance no less than once every two years, reporting the results to the Board of Directors;

9.4 An annual report of the activities of the Audit Committee shall be presented to the Board of Directors and the Council of Governors, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

9.5 A separate section of the Trust's annual report will describe the work of the committee in discharging its responsibilities.

9.6 The Committee will report to the Board planned future workload and priorities for approval.

9.7 The Committee will agree on an annual basis a reporting framework for all areas of it terms of reference (Annex A). This determines standing items for the agenda and items for regular reporting.

9.8 Maintain and monitor performance against the agreed reporting framework.

9.9 Follow-up agreed actions to ensure these are implemented in a timely and effective manner.

Draft submitted to Audit Committee on 20 July 2018

NHS news briefing

Independent review of the Mental Health Act

The interim report on ‘The independent review of the Mental Health Act’ has been published. The review aims to examine ‘how the legislation in the Mental Health Act 1983 is used and how practice can improve.’ The interim report gives an update on the review’s findings and the areas that will be examined next. It is highlighted that ‘the Mental Health Act needs to change’ but improvements cannot be achieved by legislation alone and that the Act needs to be underpinned by improvements to mental health services. The review will examine the issues as set out in the report before making its final recommendations.

Read more

New mental health approach cuts hospital admissions

Since 2016, the NHS has been piloting new services that combine mental and physical treatments, as part of its ‘Improving Access to Talking Therapies programme.’ Early results from Cambridgeshire and Peterborough has shown that improved mental health care for patients has cut hospital admissions by 75 per cent, reduced demand for GP appointments by 73 per cent and cut A&E admissions by two thirds, resulting in a saving of approximately £200,000. Claire Murdoch, NHS England National Director of Mental Health, stated that ‘effective NHS mental health care for people with long-term illness is a game-changer … integrated talking therapy services are a big step forward for our patients and a crucial part of putting mental health at the centre of our plans for the future of the health service in England.’

Read more

Securing the future

The Institute for Fiscal Studies (IFS) and the Health Foundation have published a report commissioned by the NHS Confederation on 'securing the future: funding health and social care to the 2030s.' The report provides information on what the NHS spends its money on and presents options for funding health and social care. Key findings include:

- in 2016/17, public spending on health was £149.2bn compared to £12.9bn in 1949/50 and in 2016/17, a further £21.2bn was spent on adult social care by the government;
- NHS staff costs account for the majority of spending;
- reasons for increased spending includes 'rising incomes and expectation', 'demographic changes' and 'cost pressures';
- to maintain current services, UK health spending needs to rise by 3.3 per cent annually over the following 15 years;
- to meet the needs of an ageing population and increasing number of younger adults living with disabilities, social care funding will need to rise by 3.9 per cent annually;
- to recruit and retain the staff needed, pay will need to increase in accordance with public sector average earnings; and
- the NHS will need 64,000 additional hospital doctors and 171,000 additional nurses over the following 15 years and by 2033/34, will require around 500,000 more social care staff.

Read more

GDPR benchmarking analysis

The General Data Protection Regulation (GDPR) is designed to put the consumer first; and was introduced (and enforceable) from 25 May 2018. Its impact and reach is substantial and aims to formalise how organisations store, manage and process personal data. Significant penalties will be enforced should organisations not comply. As a result, organisations should enact policy and procedural change.

During 2017/18 we have undertaken a number of GDPR internal audits, where we have considered client preparation for the May 2018 changes. As part of our internal audit service we have undertaken a benchmarking exercise considering the findings from our GDPR audits between the period of August 2017 and January 2018.

Read our report

Making data count

NHS Improvement has published an interactive guide designed to support NHS staff to make the best use of their data to inform decisions. The guide explores the reasons why

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you should be presenting and using data more effectively and ways in which to do so. It provides a toolkit for those 'wanting to make better judgements and decisions in healthcare' and includes case studies, exercises and links to useful resources.

Read more

New system launched to help prevent errors

The Department of Health and Social Care (DHSC) has launched a system, that will help measure and prevent costly prescription medication errors, after research has shown around 237 million errors take place every year. The new system introduces several indicators used to establish whether a prescription may have resulted in a patient being admitted into hospital. The indicators will work by 'linking prescribing data in primary care to hospital admissions.' This will allow the NHS to monitor and have a better understanding of the errors related to medication, in the aim of preventing their occurrence. Other measures to reduce medication errors include 'new defences for pharmacists if they make accidental dispensing errors' and 'accelerating the introduction of electronic prescribing systems across more NHS hospitals this year.'

Read more

Strengthening cyber security

The DHSC has announced a new Microsoft package to ensure NHS 'organisations are using the latest Windows 10 software with up-to-date security settings to help prevent cyber attacks.' Over the following three years, £150m will be spent to improve the NHS's resilience against attacks. This includes setting up a digital security operations centre to 'prevent, detect and respond to incidents' and to allow NHS Digital to respond to cyber attacks quicker. Other measures to improve cyber security include the allocation of '£21m to upgrade firewalls and network infrastructure at major trauma centre hospitals and ambulance trusts' and 'a text messaging alert system to ensure trusts have access to accurate information – even when internet and email services are down.'

Read more

Next steps for social care funding reforms

The King's Fund and the Health Foundation have published a joint report on the 'next steps for social care funding reform.' The report pulls together 'new financial modelling, public perceptions work and policy analysis' to identify current problems with adult social care and the costs of alternative models. The report finds that social care is expected to rise by around £12bn by 2030/31, increasing at an average rate of 3.7 per cent a year. Yet, spending on social care is anticipated to increase by only 2.1 per cent annually, leading to a funding gap of £6bn by 2030/31.

The report reviews the five approaches set out in the interim report, reviewing each on 'the nature of the 'offer' itself and issues of expanding access more widely' and 'how funding could be raised for specific options.' The report notes that reforming the social care system will be expensive but is facing a choice between 'a better means-tested' approach and 'one that is more like the NHS; free at the point of use for those who need it.'

Read more

Urgent action on patient safety at independent hospitals

Jeremy Hunt, Health and Social Care Secretary, has written to the chief executives of independent healthcare ordering them to take action to improve patient safety. Mr Hunt has stated 'if the sector is to partner with the NHS and benefit from our world-leading medical training, we need urgent assurances that the independent sector will get its house in order on safety, as well as a commitment to take rapid action to match the NHS's world-recognised progress on transparency.'

Read more

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Head of Healthcare

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23. Council of Governors report

To ACCEPT the report

For Report

Presented by Sheila Childerhouse

Board of Directors – 28 September 2018

Agenda item:	23			
Presented by:	Sheila Childerhouse, Chair			
Prepared by:	Georgina Holmes, Foundation Trust Office Manager			
Date prepared:	14 September 2018			
Subject:	Report from Council of Governors, 9 August 2018			
Purpose:	X	For information		For approval

This report provides a summary of the business considered at the Council of Governors meeting held on 9 August 2018. The report is presented to the board of directors for information to provide insight into these activities. Key points from the meeting were:

- A report was received from the Chair who gave an update on the STP. She also explained that a closed session of this meeting had taken place, where the Council of Governors approved the appointment of Louisa Pepper as a Non-Executive Director of WSFT, and to appoint Alan Rose as deputy chair for a one year term. Governors had also received an update on NEESPS from Nick Jenkins at this meeting.
- The Chief Executive's report provided an update on the challenges facing the Trust and recent achievements.
- Responses to governors' issues raised were received and follow up actions agreed.
- The quality and performance and finance reports were reviewed and questions asked on areas of challenge.
- A presentation was received from Nick Jenkins on development to support emergency demand, including plans to increase capacity to manage winter pressures.
- The proposed governor training and development programme was agreed.
- The Council of Governors received and noted the Annual Report & Accounts for 2017/18 and the link to the Trust website.
- The Annual Audit Letter and Quality Report limited assurance review was received and the content explained by Angus Eaton.
- The Council of Governors agreed the continued appointment of BDO as the Trust's external auditors.
- The lead governor role specification and the process and timetable for nomination of the lead and deputy lead governor were approved.
- Reports were received from the Nominations committee and the Engagement committee.
- Reports were received from the lead governor and staff governors.
- Dates for Council of Governors meetings for 2019 were received and noted.

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:	Report received by the Board of Directors for information to provide insight into the activities and discussions taking place at the governor meetings.						
Risk and assurance:	Failure of directors and governors to work together effectively. Attendance by non executive directors at Council of Governor meetings and vice versa. Joint workshop and development sessions.						
Legislation, regulatory, equality, diversity and dignity implications	Health & Social Care Act 2012. Monitor's Code of Governance.						
Recommendation: To note the summary report from the Council of Governors.							

24. Use of Trust seal

To ACCEPT the report

For Report

Presented by Richard Jones

Trust Board Meeting – 28 September 2018

Agenda item:	24			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Karen McHugh, PA			
Date prepared:	September 2018			
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. 129
Agreement between WSFT and Chrystal Consulting Ltd relating to the Urology suite - Sealed by Craig Black and Stephen Dunn, witnessed by Karen McHugh (1 August 2018)

Seal No. 130
Lease for x-ray/radiology in Thetford Healthy Living Centre, between Community Health Partnerships Ltd and WSFT– Sealed by Craig Black, witnessed by Fiona Berry (28 August 2018)

Seal No. 131
Lease for library/meeting room in Thetford Healthy Living Centre, between Community Health Partnerships Ltd and WSFT– Sealed by Craig Black, witnessed by Fiona Berry (28 August 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,	WSFT's Standing orders

diversity and dignity implications	
Recommendation: To note the use of the Trust's seal	

25. Agenda items for next meeting

To APPROVE the scheduled items for the next meeting

For Approval

Presented by Richard Jones

Board of Directors – 28 September 2018

Agenda item:	25			
Presented by:	Richard Jones, Trust Secretary & Head of Governance			
Prepared by:	Richard Jones, Trust Secretary & Head of Governance			
Date prepared:	20 September 2018			
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 – 2 November 2018

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
Alliance and community service report	✓		Written	Matrix	DG
Integrated quality & performance report, including mandatory training	✓		Written	Matrix	HB/RP
Transformation report (Including Category Towers)	✓		Written	Matrix	HB
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
Staff Health and Wellbeing programme update					
Freedom to speak up guardian	✓		Written	Matrix	JB
Antenatal and newborn screening annual report 2017-18	✓		Written	Matrix	HB
"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					
Strategic update, including Alliance, System Executive Group and System Transformation Partnership (STP)		✓	Written	Matrix	SD
Governance					
Trust Executive Group report	✓		Written	Matrix	SD
Quality & Risk Committee report	✓		Written	Matrix	SC
Scrutiny Committee report		✓	Written	Matrix	GN
Board development plan	✓		Written	Matrix	RJ
Annual governance review report		✓	Written	Action point	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	RQ

11:40 ITEMS FOR INFORMATION

26. 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

27. Date of next meeting

To NOTE that the next meeting will be held on Friday, 2 November 2018 at 9:15 am at Sudbury Community Health Centre.

For Reference

Presented by Sheila Childerhouse

RESOLUTION TO MOVE TO CLOSED SESSION

28. 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