

Annual report 2022-23



West Suffolk NHS Foundation Trust

Annual Report and Accounts 2022-23

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Throughout this document the organisation West Suffolk NHS Foundation Trust is referred to as WSFT and West Suffolk Hospital as WSH.

1. Performance report

1.1 Overview

The purpose of this overview is to give a short summary that provides sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and performance during the year.

1.1.1 A message from the chair and chief executive

The ambitions of our Trust strategy – First for patients, first for staff and first for the future – underpin our commitment towards improving the care for our patients; supporting and listening to our staff; and investing in the future health of the Suffolk and North East Essex Integrated Care System.

We aim to provide the right care, in the right place, at the right time, to meet the individual needs of patients, and strive to ensure that our care is compassionate and safe. We are also working hard to ensure we are always learning and improving. We were the first of a small number of trusts taking part in the Patient Safety Incident Response Framework (PSIRF) pilot programme run by NHS Improvement and NHS England, designed to improve the quality and safety of the care we provide through learning from patient safety incidents. Our Quality Improvement team offers training and support to colleagues and works with them to develop ideas and projects that will improve the quality, safety and efficiency of our care and of our organisation. These ideas often lead to opportunities for shared learning and best practice, bringing tangible benefits for patients.

We know that patient care is improved when our staff feel they are listened to and valued, working for an organisation where they feel able to speak up and share any concerns. The drive to improve the culture of our Trust has made progress – we have expanded our Freedom to Speak Up (FTSU) network, introduced wellbeing champions to reflect our diverse workforce, and relaunched our peer-led staff networks to help us better understand the needs of everyone in our organisation – but we acknowledge there is much more which can and must be done.

To make real and lasting change it is vital to engage with colleagues, and we have this year run a trust-wide What Matters to You 2 exercise, encouraging frank discussion with staff about their priorities and concerns. With other national and Trust engagement opportunities open to all, we hope to continue conversations which support an open, honest and transparent culture and are taking action on the key issues colleagues have told us are important to them.

One of the biggest challenges for our staff and Trust is the focus on elective recovery - the need to reduce the number of people waiting for treatment, usually surgery. We have made progress in reducing the number of those experiencing the longest waiting times, but the list of people still waiting does not reflect the service we wish to provide. Through investment in advanced technology and smarter, better ways of working, we are aiming to improve our clinical care and at the same time meet the individual needs of patients and drive down waiting times.

Our adult and paediatric community services provide healthcare and support patients to achieve their best quality of life in their homes across Suffolk, and advances in digital healthcare mean we can provide enhanced care and interventions to support discharge and prevent admission to hospital. The successful launch last November of the virtual ward programme has allowed patients to be monitored and cared for in their own homes by a team of clinicians, and this will be developed and expanded in the coming months.

Integration with partners across the health, social care and voluntary sector has been a key driver in improving the quality and outcomes of care in both our adult and paediatric community service. Alliance working in our adult services is led by our integrated

neighbourhood teams, a multi-disciplinary, coordinated approach to meet the individual needs of people taking into account all aspects of their lives.

This commitment to progress can only be achieved because we have a highly-trained and motivated workforce. Investing in, celebrating and looking after the thousands of people who devote their working lives to the NHS and our Trust lays the foundation for attracting and retaining staff.

Throughout the NHS there are thousands of staff vacancies, and we know that many of our colleagues are nearing retirement age. Many who had retired returned to us during the pandemic but have now moved on. With increasing demand, and the rising age and acuity of our patients, we must explore better ways to secure a workforce for the future than simply advertising job vacancies. As well as promoting all that we and Suffolk have to offer, we are doing all we can to “grow our own”.

We offer opportunities for training and career development to ensure all our people have the chance to become the best they can be. We are a learning organisation and our training and education team ensure that whatever their role, colleagues meet the mandatory requirements for the NHS. The clinical educators and clinical skills trainers support our frontline staff with a broad range of courses and continuous training, and their work has been recognised by national awards (see the Highlights section for details).

Growing our own also demands support from senior colleagues on the frontline, who give their time and share their expertise and experience to ensure that in the future our community will have the best of care. We are developing our apprenticeships programme, combining practical experience with academic study – for example supporting a former member of our housekeeping team to this year achieve her registration as a nurse.

That colleague came to us from Brazil, and one in five of our workforce is originally from overseas, representing more than 80 countries. With the commitment and support of the clinical education team, we have recruited many staff from other countries, who have then achieved the necessary qualifications to practice here. As well as their training and education, the team is committed to the general wellbeing of people living far from home, and this year achieved recognition with a Pastoral Care award.

Our fruitful partnership with the West Suffolk College has developed across 15 years and is another way to secure a workforce for the future. Health and care BTEC students have this year had both practical and classroom-based experience; and in 2023 we shall welcome T-Level students on work experience.

The Trust is recruiting to a new organisational development and learning team, which will allow us to explore new ideas, and give us a foundation on which to develop all the initiatives we have in place for our workforce.

We know that our staff are our number one asset, so to support the mental and physical wellbeing of everyone who works at the Trust, we have continued to develop and invest in our staff support psychology team. Our FTSU champions, wellbeing champions and peer networks maintain a visible presence offering support and a listening ear. The offer of free gym membership at Abbeycroft Leisure has been extended for another year and includes a wealth of online activity that can be accessed anywhere at any time. The homegrown ‘Love Yourself’ Weeks encourage those who care for others to look after themselves, and recognise the need to rest, recuperate and focus on their body and mind.

Our Trust is a place where people stay, often throughout their working life. Recently we marked the 50 years of NHS service given by one of our district nursing sisters. Our long service awards are a chance to say thank you to people who have given decades to the NHS and help to demonstrate that our thousands of staff are all individuals who make up a special community. Our Putting You First awards regularly recognise people who have been nominated by colleagues for their commitment to quality, progress, care, and our patients.

In so many ways, the My WiSH charity is a key partner in all of these initiatives. This small team enhances the experience we can offer, and from improvements to the chaplaincy to toys for our most vulnerable young patients, the charity responds quickly and intuitively and makes a real difference every day.

The support we receive from our community in donations and fundraising events is truly humbling. The contribution of the people of Suffolk has enabled the charity to improve the care of patients and their families, as well as bringing benefits for our staff. Just two of the many examples of their work: the funding for a play specialist in our paediatric emergency department; and the funding for an extra member of our staff support psychology team.

The WSFT vaccination taskforce has been a significant part of the regional and national drive to vaccinate people against both coronavirus and seasonal influenza. As well as making sure our staff and those from partner organisations could access vaccines at a time and place convenient to them, the team has travelled all over Suffolk to vaccinate the community. They have focused on areas where uptake was low, and where vulnerable people lived to ensure they protected as many people as possible. They have undoubtedly saved many people from serious illness and the potentially fatal consequences of COVID-19 and have been instrumental in helping us to return to a more normal way of life.

This year we have come a step closer to the building of a new hospital, with outline planning permission granted for our preferred site at Hardwick Manor. The rebuilt West Suffolk Hospital is one part of a Future System programme that will transform the way healthcare is provided in the future. As well as working with system partners we continue to engage with our community, including hard to reach groups, to help us plan and deliver for the needs of future generations.

We continue to capitalise on our expertise as a Global Digital Exemplar, and to benefit from electronic patient records, the Health Information Exchange (HIE), a patient portal, access to the virtual ward, and other advances that are driving progress in healthcare to benefit patients. Digital communication is key to our joined-up working across public services and with partnership organisations, which has proved that integration is the way forward, and we will continue to harness the power of technology to improve our services.

While we welcome the progress being made across the Trust, significant challenges remain. Enormous efforts have been made to ensure the safety of staff, patients and visitors in our ageing West Suffolk Hospital, and thanks are due to the estates team who have worked day and night to maintain our estate to keep us as safe as possible.

Demand on our services increases every year, as our population is growing, ageing, and presenting us with ever more complex conditions. Largely due to the pandemic, there has been no reduction in pressure over the past few years, and our focus on reducing the number of people waiting for treatment means that pressure will remain.

The realities of working in the NHS mean that we have a significant number of vacancies, in common with services across the country. We have outlined the many ways in which we try to attract and retain staff, but the effects of trying to meet demand and patient need cannot be underestimated. In recent months, significant industrial action has added to the pressures on our services. We recognise that these disputes are between the unions and the Government, not the Trust, and support the legal right to strike, but there is an inevitable impact on our services and waiting times.

The WSFT continues to deal with the outcomes of the 2021 independent review and has fully acknowledged that the organisation's culture needed fundamental change. While progress has been made, we know there is much more to do, and this will take time. Thanks are due to all the staff who engaged in our Autumn of active listening and shared their views on how we can drive further improvement.

In February this year Dr Ewen Cameron joined the Trust as its chief executive officer, and has already visited many of our teams across Suffolk to learn more about their work and listen to their views. We want to express thanks to Craig Black, who served as interim CEO through very challenging times, and we are so pleased that he remains with us and is leading on the Future System programme. We have also seen changes to both our Council of Governors and team of non-executive directors and are grateful to all those who give the Board their time, knowledge and experience.

With so much learned in the recent challenging times, and an exciting future for which to prepare, most of all we are inspired by the commitment of colleagues in our hospitals and community services to delivering safe, quality and compassionate care.



Jude Chin
Chair
29 June 2023



Dr Ewen Cameron
Chief Executive
29 June 2023

1.1.2 About our Trust – a summary

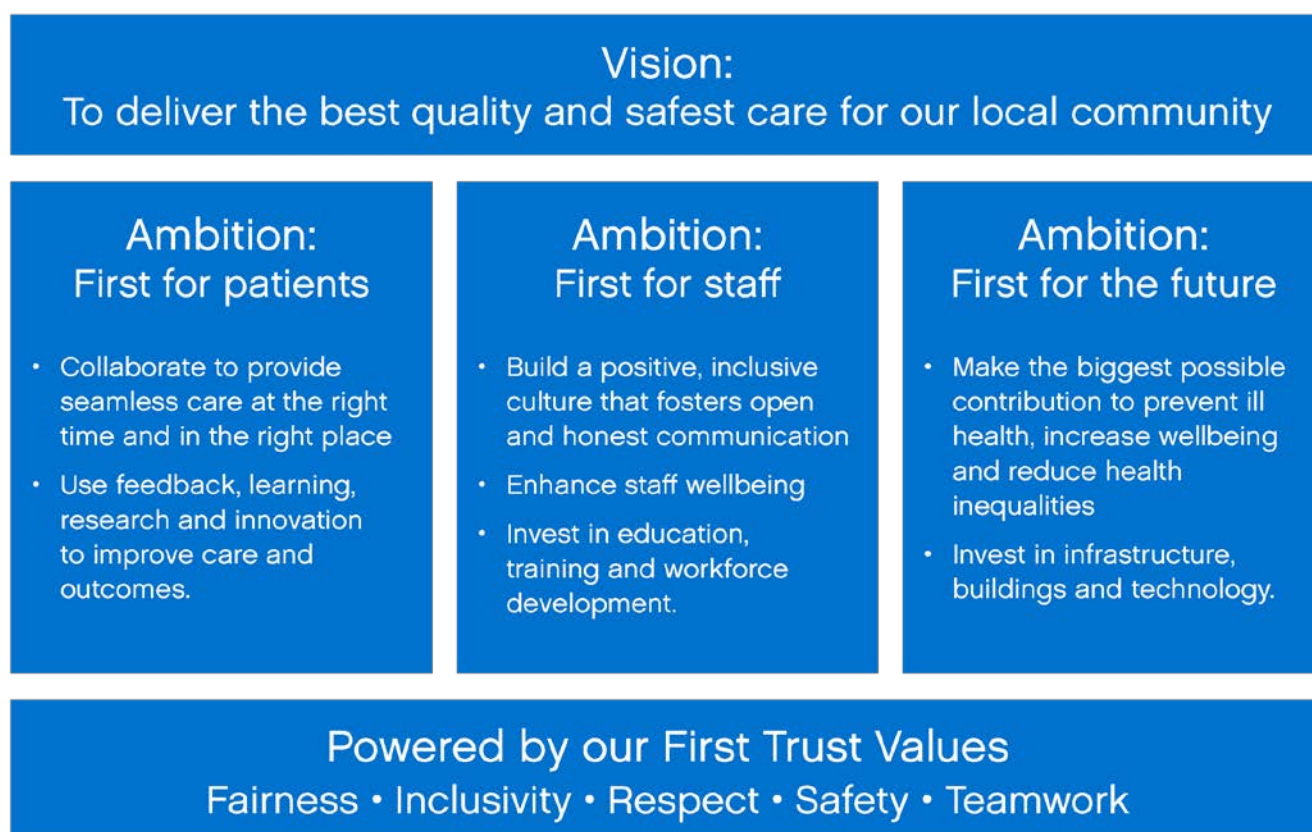
The WSFT provides hospital and community healthcare services to people mainly in the west of Suffolk, and is an associate teaching hospital of the University of Cambridge.

The Trust serves a predominantly rural geographical area of roughly 600 square miles with a population of around 280,000. The main catchment area for the Trust extends to Thetford in the north, Sudbury in the south, Newmarket to the west and Stowmarket to the east. Whilst mainly serving the population of Suffolk, WSFT also provides care for parts of the neighbouring counties of Essex, Cambridgeshire and Norfolk.

As part of this we provide community services in the west of Suffolk, but also some specialist community services across the county. This includes the delivery of care in a variety of settings including people's own homes, care homes, community hospital inpatient units and clinics, day centres, schools, GP surgeries and health centres.

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

Our vision and priorities align with our partners, including NHS Suffolk and North East Essex Integrated Care Board (SNEE ICB), whose vision is to deliver the best possible outcomes for every one of the million people in Suffolk and North East Essex. Through our new strategy, we put quality at the heart of everything we do.



The Board monitors quality through its **performance management arrangements** on a monthly basis. The Board also receives assurance regarding quality within the organisation through the three assurance committees of the Board, which ensure quality is delivered in a coordinated way to support safe, effective and patient-focused healthcare. During 2022-23 the Board continued to develop its working and the assurance structure to provide a greater focus on culture, patient safety and quality:

- **Insight Committee** with a focus on operations, finance and organisational risk
- **Involvement Committee** with a focus on people and organisational development
- **Improvement Committee** with a focus on quality, patient safety and change management.

The NHS Long Term Plan sets out the need to do more to prevent illness and reduce inequalities in health experienced by different groups of people.

A key **component** of our First for the future ambition is to make the biggest possible contribution to prevent ill health, increase wellbeing and reduce health inequalities. Our new strategy reflects the ways in which we are working towards two common aims: improving the health of our community and reducing inequalities.

This means looking after the community's physical, mental, emotional, social, and economic needs. We're here to help make people better when they are ill, and to support them to help keep themselves well in the first place. To do this:

- we will adapt our services to do more to increase everyone's wellbeing and prevent ill health
- we will recognise and value the role people play in managing their own health and wellbeing, involving them in conversations and decisions about their health and care, moving from 'what's the matter with you?' to 'what matters to you?'
- we will maximise our social impact as an anchor institution rooted in our local community – providing training and employment opportunities for local people, buying from local businesses, supporting local charities and community groups
- we will minimise our environmental impact with our Green Plan.

Our sites and services

The Trust's main facility is West Suffolk Hospital (WSH), a busy district general hospital which provides a range of acute core services with associated inpatient and outpatient facilities. There is a purpose-built Macmillan Unit for the care of people with cancer, a dedicated eye treatment centre and a day surgery unit where children and adults are treated and are mostly able to go home on the same day. WSH has around 500 beds and 14 operating theatres, including three in the day surgery unit and two in the eye treatment centre. Ongoing structural repairs to WSH continue to impact on this capacity. Access to specialist services is offered to local residents by WSFT networking with tertiary (specialist) centres, most notably Addenbrooke's and Royal Papworth hospitals. The Trust operates a streaming service embedded and co-located within the emergency department. Patients who attend the emergency department during the operating hours of the streaming service are assessed and directed to either the emergency department or the primary care unit, meaning they access the service that best addresses their healthcare need.

A range of nursing and therapy services are provided by our community health teams and specialist community teams; these services are provided in patients' own homes, health clinics/centres and community buildings, including a clinical assessment and prescribing service for a county-wide community wheelchair and equipment service, working with community therapists and community neurological nurse specialists among other specialist nursing services. We also own and operate Newmarket Community Hospital, a community hospital with approximately 33 beds. These inpatient beds provide rehabilitation care to patients referred by GPs, or who are transferred from an acute hospital as a step-down facility prior to discharge. The community hospital also has a radiology service and outpatient clinics which receive visiting clinicians from WSH. In addition, some of our community teams use Newmarket Community Hospital as a base. Oakfield GP surgery is also based at the site.

Glastonbury Court is a care home in Bury St Edmunds run by Care UK. The Trust has commissioned a 20-bedded unit to provide ongoing assessment and reablement to patients who are medically optimised, so no longer require the services of an acute hospital. The nursing and therapy staff are employed by WSFT, with ancillary staff and hotel services provided by Care UK.

We provide a number of outreach services to our population across various sites in Newmarket, Botesdale, Thetford, Stowmarket, Haverhill, Sudbury, Needham Market and Watton. This includes outpatient clinics and some diagnostic imaging – Newmarket Community Hospital (X-ray), Sudbury Community Health Centre (X-ray) and Thetford Healthy Living Centre (ultrasound and X-ray).

Linked to our early intervention team (EIT), we also have in place a service to provide personal care to patients in their home. Delivered by a reablement support worker, this forms part of a wider service, working to prevent unnecessary admission to hospital.

The community midwifery teams operate from administrative bases in Stanton Health Centre, Thetford Healthy Living Centre, Mildenhall Hub, Newmarket Community Hospital, Sudbury Community Health Centre, Haverhill Health Centre, Forbes Business Centre and Bury St Edmunds.

The Trust is also responsible for, through a contract with Suffolk and North East Essex Integrated Care Board (SNEE ICB), the provision of adult community healthcare teams, adult speech and language therapy (SALT), and community paediatric services, as well as specialist nurses and therapists in Parkinson's, neurology, epilepsy, cardiac rehabilitation, chronic obstructive pulmonary disease (COPD), heart failure and pulmonary rehabilitation. This includes services for lymphoedema and pain.

The Trust provides primary care services at Glemsford Surgery via a sub-contracting arrangement of the existing General Medical Services (GMS) contract. Existing GP partners continue to hold the GMS contract and, as employees of the Trust, provide primary care services on our behalf.

Our operational services are structured into divisions led by a triumvirate – assistant director of operations, clinical director and head of nursing. Accountability for the operational divisions sits with the executive chief operating officer. Further detail of the Board and accountability framework is provided in section 2.2 (directors' report) and section 2.6 (annual governance statement).

Our staff

We are one of the largest employers in Suffolk, employing 5,218 staff as of April 2023.

We firmly believe in the benefits of working in partnership with staff and trade unions. Further detail is included in section 2.8 (staff report), including work we are doing regarding the employment of disabled people.

Our partners

The Trust works closely with other public, private and voluntary stakeholders. These include NHS Suffolk and North East Essex Integrated Care Board (SNEE ICB), Suffolk County Council and the University of Cambridge as well as East Suffolk and North Essex NHS Foundation Trust (ESNEFT) and other local NHS providers, integrated care systems (ICSs), Suffolk GP Federation and Care UK.

In Suffolk and north east Essex, the NHS, general practice and local government came together to develop an integrated care system (ICS). The ICS is a unified approach and subsequently plans to improve the health and care of our local people and bring the system back into a financially sustainable position. Our partnership includes all NHS organisations within the footprint including the ambulance service, local government, other health sector bodies, local hospices and community and voluntary sector organisations. Leadership for the ICS is drawn from across these stakeholders.

Going concern

After making enquiries, the directors have a reasonable expectation that the Trust will continue in operational existence for the foreseeable future. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case and for this reason, the directors continue to adopt the going concern basis in preparing the accounts.

1.2 Performance analysis

The Trust uses its performance management framework to gather and analyse complex information across a range of quality, operational and financial measures and indicators. This allows the Board to ensure effective action is being taken to address risks or uncertainty to the delivery of plans and objectives. External assessment of the Trust is an important part of this risk and control environment.

The Trust's annual business planning cycle is informed by the performance management framework to ensure future objectives address areas of risk or uncertainty. Similarly, the strategic and operational plans for the Trust inform the performance management framework to ensure that the Board is sighted on indicators that are relevant to future plans.

This section of the report sets out key issues and risks for the Trust as well as opportunities and risks that could affect the delivery of Trust objectives and/or its future success and sustainability.

1.2.1 Performance management framework

The Trust has a board assurance framework (BAF) in place that sets out the principal risks to the delivery of the Trust's strategic objectives. The executive director with delegated responsibility for managing and monitoring each risk is clearly identified. The framework identifies the key controls in place to manage each of the principal risks and explains how the Board of directors is assured that those controls are in place and operating effectively. Controls and assurances include:

Performance monitoring:

- monthly quality and performance reports and performance dashboard. These include the Trust's priorities for improvement in the quality report, analysis of patient experience, incidents and complaints, review of serious incidents and ward-level quality performance
- monthly financial performance reports
- monthly quality and performance reports by divisions to executives
- quarterly reports to the Council of Governors on the work of the Board
- reports to the Board and its assurance committees setting out quality improvement and learning
- reports to the Board and its assurance committees from the Freedom to Speak Up guardian and guardian of safe working
- risk assessments and analysis of the risk register.

Governance framework:

- assurances provided through the work of the insight, involvement and improvement assurance committees of the Board
- reports from the Future System programme board, digital board and the audit committee received by the Board
- self-assessment against delivery of the Care Quality Commission (CQC) registration requirements
- assurances provided through the work of internal and external audit, the CQC, NHS England, NHS Resolution, patient-led assessments of the care environment (PLACE), and accountability to the Council of Governors (COVID-19 has impacted on some of these activities during 2022-23).

Engagement and measurement:

- The 15-step challenge focuses on seeing care through a patient or carer's eyes and exploring their first impressions. Reintroduced during 2022-23, they include executive directors, non-executive directors (NEDs) and governors. During the year due to the social distancing requirements of COVID-19 executives, NEDs and governors have engaged with staff through virtual meetings, including the regular all staff update
- external regulatory and assessment body inspections and reviews, including Royal colleges, post-graduate dean reports, accreditation inspections and Health and Safety Executive (HSE) reports
- benchmarking for clinical indicators

- the work of clinical audit, which within its scope includes national audits, audits arising from national guidance such as the National Institute for Health and Care Excellence (NICE), confidential enquiries and other risk and patient safety-related topics.

1.2.2 Principal activities and achievements

Care Quality Commission (CQC) registration

The Trust has unconditional registration with the CQC with no enforcement action. The Trust's overall rating is 'requires improvement'. The acute services are rated 'requires improvement' and the community services (adults, children and young people and inpatient services) are all rated as 'good'.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement ↓ Jan 2020	Good ↓ Jan 2020	Good ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓↓ Jan 2020
Community	Good Jan 2020	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020	Good Jan 2020
Overall Trust	Requires improvement Jan 2020	Good Jan 2020	Good Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020	Requires improvement Jan 2020

Core areas were inspected last in inspections in 2016, 2018, 2019 and 2021 (see chart below).

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and Emergency care	Requires improvement ↔ Jan 2020	Good ↔ Jan 2020	Good ↔ Jan 2020	Good ↔ Jan 2020	Good ↔ Jan 2020	Good ↔ Jan 2020
Medical care (including older people's care)	Requires improvement ↓ Jan 2020	Good ↓ Jan 2020	Good ↓ Jan 2020	Good ↔ Jan 2020	Requires improvement ↓ Jan 2020	Requires improvement ↓ Jan 2020
Surgery	Requires improvement ↓ Jan 2020	Good ↔ Jan 2020	Good ↔ Jan 2020	Good ↔ Jan 2020	Good ↔ Jan 2020	Good ↔ Jan 2020
Critical care	Good Aug 2016	Outstanding Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Outstanding Aug 2016	Good Aug 2016
Services for children and young people	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
End of life care	Good Jan 2018	Good Jan 2018	Outstanding Jan 2018	Good Jan 2018	Outstanding Jan 2018	Outstanding Jan 2018
Outpatients	Requires improvement ↓ Jan 2018	Not rated	Good ↔ Jan 2018	Requires improvement ↓ Jan 2018	Requires improvement ↓ Jan 2018	Requires improvement ↓ Jan 2018

Maternity services:

Latest inspection: 13 April 2021 Report published: 22 June 2021

Safe	Requires improvement ●
Effective	Requires improvement ●
Caring	Good ●
Responsive	Good ●
Well-led	Requires improvement ●

In the most recent comprehensive inspection (report published in January 2020) inspectors said staff "treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions they worked well together for the






benefit of patients, advised them on how to lead healthier lives and supported them to make decisions about their care”.

The Trust’s maternity services were inspected in April 2021 (report published June 2021), whilst the local service score did improve, it did not affect the overall rating of the organisation. Of note in the 2021 CQC report, it was stated that “Leaders ran services well and supported staff to develop their skills. Staff understood the service’s vision and values, and how to apply them in their work. Staff were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. Staff were committed to improving services continually”.

Additionally our maternity services hosted a formal NHSE and Local Maternity and Neonatal System (LMNS) visit in May 2022 to assess our progress in the maternity improvement programme. This assessment identified our improvements and lead to us formally exiting the programme in November 2022.

This year we also received a “Good” CQC rating for the Glemsford GP practice that is part of the WSFT, with the staff’s kindness and respect for patients highlighted. Please refer to the table below:

Latest inspection: 20 August 2022 Report published: 14 September 2022

Safe	Requires improvement 
Effective	Good 
Caring	Good 
Responsive	Good 
Well-led	Good 

The WSFT recognises that the CQC are developing a new inspection framework in 2023-24 and will anticipate a future inspection within this new regime and the opportunities it will bring to demonstrate how the organisation is working towards ‘Good’.

Our services

We provide a range of patient services:

Indicators	2022-23	2021-22	2020-21	2019-20	2018-19
Adult Community Services	279,026	260,237	239,900	247,700	291,032
Paediatric Community Services	85,637	84,885	69,491	77,269	94,891
Inpatient planned	3,476	2,407	1,722	3,475	3,548
Inpatient non-planned	33,977	32,708	29,623	32,374	32,832
Day cases	29,104	28,903	18,747	32,815	31,696
Outpatient attendances (inc. ward attenders)	267,015	281,162	234,464	271,316	266,157
Outpatient procedures	79,420	58,503	37,749	79,570	79,404
ED attendances	89,588	86,312	64,764	78,822	74,400

The 2021-22 activity started to return to pre-COVID-19 levels, and this continued in 2022-23. ED attendances and non-planned admissions are above pre-pandemic levels, when compared with 2018-19. The elective planned inpatient admissions, day case and outpatient activity have all increased to be comparable with the pre-COVID-19 levels. The elective recovery plan in place for 2022-23 increased this activity to improve patient waiting times.

Further detail of our performance regarding quality and local or national targets is provided in the annual governance statement (section 2.6) along with arrangements for quality governance within WSFT.

Our financial performance

Our reported position as at the end of 2022-23 was a surplus of £451k. This is in line with our plan to break even, but we achieved this as a result of £15m of non-recurring financial support via Suffolk and North East Essex Integrated Care Board (SNEE ICB).

	2022/23	2021/22	2020/21	2019/20	2018/19
	£000s	£000s	£000s	£000s	£000s
Operating income	383,628	352,179	321,282	283,173	244,952
Operating costs	(363,322)	(336,573)	(307,751)	(272,245)	(242,770)
EBITDA* surplus(deficit)	20,306	15,606	13,531	10,928	2,182
Depreciation, dividend and other costs	(20,610)	(15,386)	(12,767)	(10,642)	(8,226)
Fixed asset impairments net of reversals**	755	(4,647)	(1,496)	(7,903)	(5,506)
Retained earnings	451	(4,427)	(732)	(7,617)	(11,550)

* EBITDA – measurement of earnings before interest, taxes, depreciation and amortisation

** Fixed asset impairments – these occur when the value of individual fixed assets reduces as a result of damage or obsolescence.

Note:

The fixed asset impairment for 2022/23 includes reversals due to revaluations to give a net surplus.

Highlights of the year

First for Patients

This year saw the launch of the Suffolk and North-East Essex Integrated Care Board (SNEE ICB), and as a leading provider in the integrated care system (ICS), across the Trust we are committed to partnership working on the strategy and delivery of healthcare in the future. This replaced the previous arrangement with East and West Suffolk clinical commissioning groups.

Providing seamless care at the right time in the right place to meet people's individual needs and wishes means working in collaboration with partners across the NHS and other healthcare providers, the private sector, local councils, charity and voluntary services. We know that integrated working is the way forward, and this year progress has been made on ensuring the care we provide is joined-up, timely and effective.

We are using feedback, learning, research and innovation to improve care and outcomes. We have kept innovations which worked well during the pandemic, such as telephone and video consultations, wellbeing calls, patient-initiated follow up and ways for patients to stay in touch with loved ones in our care: Keeping in Touch and the clinical helpline.

The movement of patients through our services, especially the acute hospital, has been a major focus of our work this year as we strive to reduce the numbers of people waiting for care. We have extended the hours of our outpatient clinics and operating theatres to help us reduce the numbers of people on our waiting lists; and in November we launched virtual wards, part of a national programme which allows patients to receive care at home, instead of needing to reside in hospital. Using digital technology, patients can safely be monitored from the comfort of their own homes as part of their health and care needs. This year social prescriber Stefan Currington joined us at the acute hospital, offering support for people to improve their independence and quality of life after discharge, and preventing readmission.

We have made significant investment in our patient safety and quality improvement teams, using learning, best practice, new models and frameworks to support continuous improvement. We were a pilot trust for the PSIRF patient safety framework, aimed at improving the response to patient safety incidents, and are now helping to roll PSIRF out across the NHS and are just entering into our third year of our patient safety plan based on the new framework. An improvement event run by our medical division inspired and captured ways to make positive change, using and developing ideas

that came from staff.

This year a number of our teams, projects and services have been nominated for, and won, prestigious national awards and been recognised for their work.

Clinical nurse specialists (CNSs) are crucial in providing expert support for our patients, but a study by Macmillan Cancer Support found that 37 per cent of the current workforce is over 50 years old. Our Macmillan Unit team created an innovative way of tackling this potential future workforce shortage, with a bespoke 18-month programme to support band 5 nurses to progress into CNS positions. This won the Macmillan Professionals Innovation Excellence Award.

A pilot scheme pioneered on our acute renal ward was nominated for an HSJ (*Health Service Journal*) Patient Safety Pilot of the Year award and *Nursing Times* Best Use of Workplace Technology award. The team identified and introduced equipment that allowed staff to improve the accuracy of measuring and monitoring how much fluid each patient consumed.

The Trust's research team was recognised and praised for its participation in a wide range of regional, national and international research studies. One of our clinical research practitioners, Angharad Williams, was named the recipient of the 2022 Advancing Healthcare Awards for Clinical Research Practitioner (CRP) Leadership from the Academy of Healthcare Sciences. She won the award in recognition for her work in developing a regional network and national project to develop an approved accreditation scheme and register for CRPs.

The co-ordinators of the prestigious ORION-4 research study have congratulated WSFT colleagues on recruiting more than 100 participants. Consultant cardiologist Dr Pegah Salashouri, lead research nurse Jo Godden and research nurse Lily John were praised for their significant contribution to this collaborative research into a cholesterol lowering injection.

The SIREN (SARS-CoV2 immunity and reinfection evaluation) is a large-scale partnership launched two years ago with NHS workers, to evaluate the immune response to COVID-19, build understanding of the protection offered by vaccines and provide insight into COVID-19 reinfections. At the WSFT, 598 colleagues signed-up to participate, many of whom are continuing to support the study today.

Dr Justin Zaman and the cardiology research team have received national recognition for their work on the REACH HFpEF trial. The team have placed second in the country for the number of participants recruited, an amazing achievement.

Our stroke service has recently received its results from the Sentinel Stroke National Audit Programme (SSNAP), for acute admitting stroke units. Our service is ranked number one nationally during the October – December 2022 quarter (which is the latest data available at present) and was ranked joint second in the previous quarter. This achievement is due to the hard work, dedication and commitment of all the members of the stroke service.

Our Trust was shown to be performing better than most NHS acute trusts in the country in several areas of care, according to an adult inpatient survey from the Care Quality Commission. There is always room for improvement, but the findings underlined the efforts made to ensure our patients have a good experience. This year we also received a "Good" CQC rating for the Glemsford GP practice that is part of the WSFT, with the staff's kindness and respect for patients highlighted.

Patient experience is enhanced by our volunteers, a valued group of people now fully back with us after the pandemic. From helping people find their way around, to keeping our courtyard gardens planted and tidy, supporting ward staff, and offering companionship to people at the end of their lives, the volunteers make a real difference and we are grateful for their support.

We have recently achieved a Work Experience Quality Standard award for the student programme delivered through our voluntary services. This offers valuable opportunities for young people interested in a healthcare career. With the support of clinical and medical colleagues the programme

provides invaluable clinical shadowing opportunities, and a digital student academy programme.

Nutrition and hydration are a vital element in the care and recovery of our patients, and this year our award-winning catering team have maintained their excellent hygiene rating, scoring the highest score of 5, which means standards are “very good”. Meanwhile, two of our apprentice chefs won through to the national finals of the NHS chef of the year competition.

The My WiSH charity continues its sterling work to enhance the care the Trust provides, from funding posts such as a staff support psychologist and a play specialist for young patients in our emergency department, to supporting major appeals and projects. The charity receives amazing support from our community, with local people organising their own fundraising, or supporting My WiSH events such as the Soapbox Challenge, which returned this year to great success.

First for Staff

We know when staff feel confident that they have a voice, can speak up and raise concerns, there is a positive impact on patient safety and care.

In an Autumn of active listening, colleagues were able to respond to the annual NHS staff survey; a travel survey; and ‘What Matters to you 2’, which followed up on the 2020 staff engagement programme. The aim is to continue conversations with staff so that Trust leadership hear about what is important and can take action to improve. We know it is also important to show where and how we have listened – ‘You Said, We Did’.

We also focused on Freedom to Speak Up (FTSU) and have a growing number of FTSU champions throughout the Trust. We have relaunched our peer support networks for disabled people, LGBTQ+ colleagues, and those from the global majority. We have introduced wellbeing champions from diverse backgrounds, supported by the My WiSH charity, who are also helping us to build a positive and inclusive culture. After listening to concerns raised by staff, we have developed a more supportive and compassionate HR culture.

Another of our key objectives is showing that we value our staff by enhancing their well-being. We have expanded our dedicated staff psychology team, extended our free gym membership for all staff and modernised facilities in the Chaplaincy, including dedicated facilities for Muslim colleagues and visitors. Our vaccination team has ensured free and easy access to both the COVID-19 and seasonal flu vaccinations, as well as running a comprehensive programme in our wider community. This team has received national and regional recognition.

Nominations for our Putting You First awards have come from peers, and their citations are both moving and inspiring. The contribution that people have made to the NHS, often for their whole working lives, is marked through our long service awards – we have this year recognised people who have served for 50 years.

We are investing in education, training and workforce development, because we want staff, who come from all over the world to work with us, to build their careers here. One in five of our staff come from overseas, representing more than 80 countries. This year we were proud to receive the NHS Pastoral Care Quality Award in recognition of our commitment to providing high-quality pastoral care for internationally educated nurses and midwives.

We have a strong learning and training offer, recognised this year with six nominations in the *Nursing Times* Workforce Awards, including Best UK Employer of the Year for Nursing Staff. Two of our clinical education team were nominated for *Student Nursing Times* Awards, with one winning the Learner of the Year: post-registration category.

Throughout our organisation the year has been marked by celebrating the opportunities and funding staff can access for continuous personal development. Our professional nurse advocates are trained to listen and understand challenges and demands of fellow colleagues, and to lead, support and deliver quality improvement initiatives.

We have been joined by a corporate lead to facilitate advanced clinical practice, supporting colleagues in acute and community services to take up the challenge of advanced practice. Six new registered nursing associates are now working in acute and community settings, an investment in a recently-developed NHS role that brings significant benefits in patient care.

A supervisor role has been introduced in our health care support worker (HCSW) workforce, aimed at giving new HCSWs support and mentoring on our inpatient wards. This has improved retention of these important staff who do so much to care for our patients.

Keeping staff throughout the Trust informed is a priority for our communications team, which this summer developed and launched a new and improved intranet site, working with colleagues across the Trust. Using digital innovations, the team is exploring new ways to ensure our busy staff can easily access information to support patient safety and best practice, as well as the wellbeing support on offer. The team works closely with colleagues across the Trust and the wider system to drive awareness and engagement, in a rapidly changing environment for health and care.

First for the Future

This ambition in our strategy reflects how we are taking the organisation forward and our role as a large, anchor organisation in west Suffolk with the SNEE ICB.

A huge part of our priority to invest in infrastructure, buildings and technology is the work we are doing to plan for the new healthcare facility to replace the West Suffolk Hospital here in Bury St Edmunds. The new hospital, which is one of 40 to be built as part of the Government's New Hospital Programme, should be completed by 2030. Plans are well under way with outline planning permission agreed for our preferred site of Hardwick Manor.

While we work with our partners and our community to plan for a new hospital, our current hospital is reaching the end of its life. It was built in 1974, using reinforced autoclaved aerated concrete (RAAC) planks, and had a life expectancy of 30 years – through a substantial programme of essential maintenance the useful life of our hospital has been extended. Every day, our estates team continues to ensure our buildings remain as safe as possible for patients and staff.

Through our Future System project, we are looking at ways to develop services we provide in the heart of our community, so that many more people can be cared for without coming into the acute hospital. A diagnostic centre is planned for our Newmarket community hospital site, which will increase capacity and give people greater choice to be treated closer to home.

Planning for the future has meant looking at what the next decades will mean for west Suffolk and its population – which is likely to grow in number and in age. The most important asset in caring for people of all ages will be a highly-trained and skilled workforce, and we are exploring ways of supporting young people to become our staff in years to come.

As well as the commitment to “grow our own” through training, development and apprenticeships, we are celebrating 15 years of partnership with West Suffolk College. BTEC students joined us for work experience; and later this year we will welcome students on T-Level courses on placements. This partnership aims to give the workforce of tomorrow the skills they need to hit the ground running when they start their careers.

To support our goal of making the biggest contribution to prevent ill health, increase wellbeing and reduce health inequalities, our community health services are increasingly being co-located with partner organisations – for example at the Mildenhall Hub. The alliance working model of integrated neighbourhood teams allows us to care for people's individual needs where and how they live. Closer working with key allies such as the county council in social care and housing, but also providers such as Abbeycroft Leisure, has allowed us to improve patient care and experience.

This year saw changes to the membership of our Board, who will be leading on the work to take the

Trust forward. As well as a new chief executive officer, we have been joined by new non-executive directors (NEDs), who bring a wealth of experience with them to our foundation trust. We were delighted to be able to hold our Annual Members' Meeting in person once again, to reflect on the past, present and future, and hear the opinions and questions of local people. As well as engagement through the Future System programme, we have undertaken a travel survey, and organised and attended events across the county, including in Glemsford, where we run the GP surgery.

Many challenges remain, including in recent months extensive periods of industrial action. We recognise these disputes are between the unions and the Government and we support the legal right to strike. The willingness of our colleagues to help us plan and work flexibly around these actions has shown once again their commitment to each other and to our patients, and their dedication to serve the people of West Suffolk.

1.2.3 Quality and operational performance

Quality priorities for 2023-24

Our quality priorities are driven by our strategy and set out key improvements we aim to deliver and the measures that we will use to understand progress and success. These measures will be reviewed and developed as we progress.

Delivering our strategy

Use feedback, learning, research and innovation to improve our care and outcomes:

- we will give everyone the tools and support they need to put quality and safety first by ensuring staff have the confidence to raise concerns and to make changes when things go wrong
- we will ensure patients and families can share their experiences, positive and negative, to help us improve.

Priorities for 2023-24

- to deliver measurable improvements in safe care and confidence to raise concerns through implementation of our patient safety strategy by March 2024
- to deliver measurable improvements in experience through the implementation of our experience of care strategy by March 2024.

Measuring our progress and providing assurance

Safe and high-quality care

- increasing percentage of relevant staff completing the patient safety syllabus by March 2024
- increasing percentage of relevant staff completing the patient safety education programme by March 2024
- number of patient safety partners in post by March 2024
- coproduce the qualitative and quantitative measures we use to gauge and develop our safety culture by March 2024 e.g. temperature gauge and implement regular monitoring
- implement a programme of shared learning events, including an annual safety summit by March 2024
- deliver an increase in user access of the e-Care patient safety dashboard to support high standards of safe care by March 2024.

Experience of care

- evidence of learning by March 2024 - 90% complaints resolved within agreed timeframe, 90% of improvement actions from complaints/feedback implemented to timeframe and implement a programme of shared learning events
- Equality Delivery System assessments of accessibility and inclusivity of patient services by March 2024 - more than two Equality Delivery System assessments completed with associated quality improvement plans

- Parliamentary and Health Standards Ombudsman (PHSO) Complaints Standards updates - 100% compliance with recommendations and completion of action plan
- patient story programme by March 2024 - all open Board meetings include presenting patient or staff story and these are published on the staff intranet for training and reflection
- public engagement programme measures by March 2024 - patient experience/customer service training programme by March 2024 - 50% of reception/patient-facing/telephone administrative staff trained and >80% recommender rating in training evaluation.

Performance against 2022-23 priorities

The quality priorities agreed for the year 2022-23 were driven by our strategy and set out key improvements we aim to deliver and the measures that we will use to understand progress and success. Recognising that the strategy is a long-term plan, there is not an expectation that the priorities listed below would be completed in the 12-month period, but that progress on the initiatives could be demonstrated through the agreed measures.

Delivering our strategy

- use feedback, learning, research and innovation to improve our care and outcomes
- collaborate to provide seamless, accessible care at the right time and in the right place

Priorities for quality improvement

1. **Safe and high-quality care** - improve care and outcomes for patients through:
 - effective response to new and emerging guidance
 - evidence shared learning from incidents to reduce patient harm.
2. **Experience of care** - ensure patients' and families' experiences are captured and listened to, in order to help us improve through delivery of our experience of care strategy.

1. Safe and high-quality care measures - measuring our progress and providing assurance









- 1.1 Deliver improvements through our patient safety incident response framework (PSIRF)
- 1.2 Deliver improvements as measured by the CQUIN indicators for 2022-23
- 1.3 Through shared learning deliver improvements to reduce patient harm
- 1.4 Effectively respond to national reports to support quality improvements
- 1.5 Develop our quality assurance framework to support systematic quality improvement
- 1.6 Patient and staff recommender scores: percentage of patients recommending WSFT as a place receive care and percentage of staff recommending WSFT as a place to receive care.





1.1 Deliver improvements through our patient safety incident response framework (PSIRF)

We introduced our year 2 patient safety incident response plan (PSIRP). To define the WSFT patient safety risks and responses for 2022-23 the following stakeholders were involved:

- staff – through incidents reported on the Datix incident system
- senior leaders across the divisions – through a series of stakeholder events
- patient groups – through a review of thematic contents of complaints and PALS contacts
- commissioners/ICS partner organisations – through partnership working with ICS patient safety and quality leads.

WSFT patient safety incident response framework

Risk/incident type	Specific risk (or incident subtype)	Planned response	Example cases previously reported
1 - Transfer of care 	Potential for patient harm as a result of communication with multiple stakeholders for on-going patient care	3 PSII's will be undertaken to identify key common interlinked causal factors	<ul style="list-style-type: none"> ·Repatriation from tertiary unit ·Obstetric patient under medical care Discharge requirements not communicated to community team
2 - Discharge 	'Failed discharge' where a delay has led to an adverse outcome within the extended length of stay after the patient was MOFD	3 PSII's will be undertaken to identify key common interlinked causal factors	<ul style="list-style-type: none"> ·HAI related ·Fall on discharge unit EOL
3 - Medication 	Mis-selection of wrong medication or dose leading to harm or potential for harm	3 PSII's will be undertaken to identify key common interlinked causal factors	<ul style="list-style-type: none"> ·Weight based dosing ·Medication allergy ·Methotrexate
4 – Validation of results 	Potential for patient harm as a consequence of non-communication and action of diagnostic results	3 PSII's will be undertaken to identify key common interlinked causal factors	<ul style="list-style-type: none"> · Mis-fractures · Pathology results · Radiology results Communication of results from ED
5 – Digital systems 	Emerging risks identified as a result of the use of our digital systems	3 PSII's will be undertaken to identify key common interlinked causal factors	<ul style="list-style-type: none"> ·Discharge letters ·Lost to surveillance ·Deletion of stent register Multiple pathways with different end-points on e-Care
10 - Unexpected PSII 	Identified increase in incidence of subject of theme which has potential for harm	PSII	
11- Never Events 	https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf	PSII	
12 - Deaths more likely than not due to problems in care 	Medical Examiner has identified an issue in care which has made the death of a patient more than likely preventable (greater >50%)	PSII	

Risk/incident type	Specific risk (or incident subtype)	Planned response	Example cases previously reported
6 - Clinical care and treatment 	Wound care within community services	AAR	
7 – Falls 	Inpatient falls resulting in a bone fracture or haemorrhage	De-brief and AAR	
8 - Pressure ulcers 	Pressure ulcers developed in our care category 2-4.	PSA – Cat 2 & 3 AAR – Cat 4	
9 - Medication 	<ul style="list-style-type: none"> Opioids management Gentamycin/vancomycin, Medication patches, Extravasation Diabetes medicines management Thromboprophylaxis 	PSA program for incidents relating to medications listed	Continued rise in medication incidents with no accountable rationale

Key

PSIRF - Patient Safety Incident Response Framework

PSII - Patient Safety Incident Investigation

PSIRP - Patient Safety Incident Response plan

AAR – After action review

PSA – Patient safety audit

MOFD – Medically optimised for discharge
 EOL – End of life
 HAI – Hospital acquired infection

During 2022 we introduced a new safety implementation group. We also provided input to the national PSIRF programme through close working links with the national leads. This has included:

- our patient safety investigators trialling the system-based tools to enable the final national templates
- our Trust project leads recording videos and podcasts for the PSIRF national platform
- working with our SNEE / ICB colleagues, presenting to regional and national webinars
- with our East Suffolk and North Essex NHS Foundation Trust (ESNEFT) colleagues, attending national events as ‘early adopters’
- participation in the national maternity networks to assist in the development of PSIRF frameworks for that specialist focus.

Next steps: incorporate wider patient perspective into future planning through the introduction of patient safety partners. These roles will play an important part in supporting and contributing the Trust’s governance and management processes for patient safety.

Further information is provided in the ‘Incident reporting and learning’ section of the report.

1.2 Deliver improvements as measured by the CQUIN indicators for 2022-23

The national Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care. Further information about the national scheme can be found at <https://www.england.nhs.uk/nhs-standard-contract/cquin>.

In 2022-23 there were eight acute, three community and one shared CQUIN. In line with national guidance, five of the acute CQUINs and all three community CQUINs were prioritised (highlighted in the table below with an asterisk) with the remaining four managed through existing workstreams.

CCG1*	Influenza vaccinations for frontline healthcare workers (acute and community)
CCG2*	Appropriate antibiotic prescribing for urinary tract infections in people aged 16 and over
CCG3	Recording of National Early Warning Score (NEWS) 2 score, escalation time and response time for unplanned critical care admissions
CCG4	Compliance with timed diagnostic pathways for cancer services
CCG5*	Treatment of community-acquired pneumonia in line with British Thoracic Society care bundle
CCG6	Anaemia screening and treatment for all patients undergoing major elective surgery
CCG7*	Timely communication of changes to medicines to community pharmacists via the discharge medicines service
CCG8*	Supporting patients to drink, eat and mobilise after surgery
CCG9	Cirrhosis and fibrosis tests for alcohol dependent patients
CCG13	Malnutrition screening in the community
CCG14	Assessment, diagnosis and treatment of lower leg wounds
CCG15	Assessment and documentation of pressure ulcer risk

The CQUIN programme was successfully achieved in many areas during 2022-23 with funding received in line with prior arrangements. The programme will continue from 1 April 2023 during 2023-24, with unconditional payments agreed locally between both WSFT and SNEE ICB. Payments will continue to be made via the block contract arrangement.

1.3 Through shared learning deliver improvements to reduce patient harm

During the year we introduced the safety improvement group (SIG) to provide monitoring, oversight and support to the progression of safety recommendations. Examples of learning and safety recommendations are provided in the “Incident reporting and learning” section of this report. We have also:

- participated in peer review of cases (jointly with ESNEFT) as part of the integrated care system (ICS) safety oversight
- set up a patient safety section on the intranet to enable shared learning
- issued a maternity shared learning bulletin ‘Risky Business’.

Next steps:

- use the NHS England publication “Safety culture: learning from best practice” (issued Nov 2022) to benchmark our practice against the findings from trusts which had achieved an “Outstanding” CQC rating which also had at least a “Good” for “Safe”.
- explore opportunities for shared learning from cases as part of ICB safety oversight
- implement the patient safety summit planned as part of patient safety month.

1.4 Effectively respond to national reports to support quality improvements

During 2022-23 we have:

- participated in the national audit programme and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) studies
- strengthened links between the clinical audit and Quality Improvement (QI) teams to support the local response to the publications from the national audit programme
- participated in the NHS England user needs research survey which will be used to:
 - co-create a knowledge hub accessible to all those with an interest in national clinical audit
 - facilitate a community of practice and strengthen peer support
 - provide opportunities for shared learning
 - enable signposting of national clinical audit recommendations and best practice case studies.
- used the Healthcare Safety Investigation Branch (HSIB) national reports as a source of evidence for systems-based national learning to support the safety areas for improvement (AFIs).

Next steps:

- fully implement the learning from our approach and apply to national reports (outside the national audit programme) to enable timely review and identification of opportunities for learning. This includes Healthcare Safety Investigation Branch (HSIB), CQC, Royal colleges and other sources of national learning and best practice
- develop the use of quality improvement methodology to support implementation of actions and recommendations across other activities, including incidents, complaints and audits.

1.5 Develop our quality assurance framework to support systematic quality improvement

During the year we have participated in a range of external quality assurance activities, including working with the Integrated Care Board (ICB) to review frailty and assurance visits to WSH, Newmarket Community Hospital, King’s Suite at Glastonbury Court and the Mildenhall and Brandon integrated neighbourhood team (INT).

Next steps: co-produce and implement a structured quality assurance framework to support moving from assurance into improvement.

1.6 Patient and staff recommender scores

Information on the patient and staff recommender scores can be found the “Other quality indicators” section of this report under patient and staff surveys respectively.

2. Experience of care measures - measuring our progress and providing assurance

- 2.1 deliver improvements through the experience of care strategy
- 2.2 celebrate good practice and share learning for experience improvements
- 2.3 ensure equality of access and the use of the accessible information standard (AIS) to improve the experience for all service users
- 2.4 provide opportunities for patients, carers and families to give feedback in a variety of accessible ways, and ensure this is listened to and acted upon
- 2.5 improve opportunities for patients to become involved with decisions affecting care, services and developments across WSFT
- 2.6 measure the percentage of patients recommending WSFT as a place to receive care.

2.1 Deliver improvements through the experience of care strategy

The experience of care strategy has been developed with our patients and the public, drawing from feedback about what matters most to them. Through engagement activities, we have produced three quality priorities for the coming year. We aim to ensure equity of access and support to all patients, which we will carry throughout our work.

Building on our three-year objectives, the priorities set out in this section of the report describe our next steps in improving experience of care.

2.2 Celebrate good practice and share learning for experience improvements

During 2022-23 we have:

- improved processes for the sharing and publication of the CQC national patient survey programme results
- delivered quality improvement training for members of the patient experience and engagement department, as well as patient VOICE user group members
- held quarterly patient and carer experience group (PCEG) meetings to review, discuss and share improvements across the organisation, reporting to Board’s involvement committee
- utilised PCEG for sharing of best practice initiatives, including topic specific workshops identified through patient experience data.

2.3 Ensure equality of access and the use of the accessible information standard (AIS) to improve the experience for all service users

During 2022-23 we have:

- recruited to patient engagement officer positions to support engagement with our community, in partnership with the ICB, ensuring underrepresented groups have equity of access
- participated in the Equality Delivery System (EDS) 2022, assessing the equity, accessibility and inclusivity of services provided
- implemented a Trust-wide review of patient information in line with the accessible information standard, reviewing:
 - how we communicate with the public in the form of information leaflets, letters, web content etc.
 - how patient information is collated, reviewed and published
 - how it is delivered.

2.4 Provide opportunities for patients, carers and families to give feedback in a variety of accessible ways, and ensure this is listened to and acted upon

During 2022-23 we have:

- developed easy-read experience surveys, helping to support people with low literacy, English as a second language, learning disabilities and anyone requiring information in a plain format
- delivered a patient story programme for the Trust Board
- increased opportunities for patients to provide feedback via satisfaction surveys
- simplified the formal complaints process for those requiring additional support.

2.5 Improve opportunities for patients to become involved with decisions affecting care, services and developments across WSFT

Working with VOICE, community groups and the ICB engagement practitioners' network to connect with a diversity of patients in our community to better understand people's experiences and required improvements. We have established connections with many local groups, including but not limited to:

- multicultural Women's Group
- Steel Bones - charity supporting amputees
- BSE4BL (Bury St Edmunds 4 Black Lives)
- Disability Forum for Suffolk
- Suffolk Voluntary and Statutory Partnership - mental health and wellbeing support
- Suffolk Survivors - support for those subjected to domestic abuse
- Ace Anglia - advocacy and support for those with learning disabilities
- OneVoice4Travellers - connecting with Gypsy, Roma and Traveller communities.

Other quality indicators

WSFT has a comprehensive quality reporting framework that includes an array of quality indicators that are monitored and reported on a monthly basis. These include priorities identified by patients and staff, issues arising from national guidance and research, and other stakeholders such as SNEE ICB.

National standards

	2022-23 Target	2022-23 Actual	2021-22 Actual	2020-21 Actual	2018-19 Actual
C. difficile - health care associated infection ¹	55	52	37	27	12 (2)
18-week maximum wait from point of referral to treatment (patients on an incomplete pathway)	92%	63.8%	64.6%	57.2%	88.8%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge ²	95%	-	-	-	90.7%
62-day urgent GP referral-to-treatment wait for first treatment - all cancers	85%	65.3%	71.5%	75.0%	84.6%
62-day wait for first treatment from NHS cancer screening service referral	90%	85.2%	80.7%	94.2%	92.4%
31-day wait for second or subsequent treatment - surgery	94%	100%	100%	100%	99.5%
31-day wait for second or subsequent treatment - anti-cancer drug treatments	98%	100%	100%	100%	99.8%
31-day diagnosis-to-treatment wait for first treatment – all cancers	96%	100%	100%	100%	99.8%
Two-week wait from referral to date first seen comprising all urgent referrals (cancer suspected)	93%	70.6%	66.0%	71.5%	90.7%
Two-week wait from referral to date first seen comprising all urgent referrals for symptomatic breast patients (cancer not initially suspected)	93%	52.1%	35.2%	94.3%	82.2%
Maximum six-week wait for diagnostic procedures	99%	60.1%	67.1%	49.8%	97.3%

¹ From 2022-23 target and performance includes both hospital and community onset healthcare associated cases, prior data only includes hospital associated cases. Figures in brackets exclude cases that West Suffolk CCG at the time deemed to be non-trajectory (no identified lapses in care).

² WSFT is piloting a new emergency department reporting standards and therefore has not reported performance against this standard since 2018/19.

We recognise the underperformance in a number of areas and it has been the subject of scrutiny at Board, assurance committee and governance groups. Plans to achieve the agreed standards for 2023-24 are monitored and reviewed.

Elective access, including referral to treatment (RTT), diagnostics and cancer

There has been significant progress in reducing the waiting times for patients including those waiting over 104 weeks and 78 weeks, and the Trust achieved better than trajectory on the latter in 2022-23.

The Trust has committed to meet all requirements of the 2023-24 priorities and operational planning guidance with the exception of achieving zero patients waiting over 65 weeks for elective treatment by March 2024. This is due to capacity issues within the urogynecology pathway.

In summary, the Trust has submitted the following position:

- 154 patients waiting over 65 weeks for treatment at end of March 2024
- achievement of system activity target

- reduction in the number of patients waiting over 62 days on a cancer pathway in line with agreed trajectory, by March 2024
- achievement of the 28-day faster diagnosis standard for cancer by March 2024
- achievement of the 6-week diagnostic target by March 2025.

The mitigating actions for the non-compliant 65-week position include:

- review by NHSE regional medical director
- demand and capacity review using national intensive support team tools
- exploration of mutual aid with neighbouring trusts.

Due to the non-compliant 65-week position, the Trust will be placed in tier 2 for elective care (regional support).

Urgent and emergency care

The Trust has faced significant challenges in relation to urgent and emergency care performance, particularly in relation to the number of patients spending over 12 hours in the emergency department. The Trust has committed to meet all requirements of the 2023-24 priorities and operational planning guidance including:

- reintroduction of the 4-hour standard to the Trust following the participation in the NHS national clinical review of standards since May 2019. The Trust commenced external reporting of the 4-hour standard in May 2023
- achievement of 76% of patients seen within 4 hours by March 2024, in line with agreed trajectory
- reduce general and acute bed occupancy to 92% by March 2024.

There is a comprehensive urgent and emergency care recovery plan in place to achieve these commitments which includes:

- maximising use of the virtual ward
- extension of discharge waiting area service
- implementation of same day emergency care (SDEC)
- embedding of internal professional standards (clear description of the values and behaviours expected).

Stroke services

The focus nationally and within WSFT has been on performance against the national sentinel stroke national audit programme (SSNAP). SSNAP is the national source of stroke data for the NHS and audits stroke services throughout the whole pathway of care: from admission to hospital, across the whole inpatient stay, including rehabilitation at home or in the community, and outcomes at six months after stroke.

Our stroke team has retained its top grade A ranking for 20 quarters since April 2018. SSNAP is a major national health care quality improvement programme based in the school of life course and population sciences at King's College London reviewing data from hospitals across the country as part of the SSNAP, assessing stroke care against 43 key indicators.

We have in place a contract to deliver an early supported discharge service (ESD) for stroke patients across Suffolk. This will provide up to six weeks of intensive stroke rehabilitation in patients' own homes following their discharge from an acute hospital, helping them to regain their mobility and independence. The service is provided by the Suffolk Alliance, which is a partnership of WSFT, East Suffolk and North Essex NHS Foundation Trust, and Suffolk County Council, and is supported by a variety of third sector partners.

Incident reporting and learning

The Trust’s web-based electronic incident reporting system (Datix) supports multidisciplinary incident reporting which includes a high level of reporting near misses, no harm and minor harm incidents. Reporting of these “near-miss” incidents is seen as a key driver for identification and management of risks to prevent more serious harm incidents. By reviewing investigations and thematic learning, key learning can be identified, and actions put into place to prevent recurrence.

WSFT uses the new national patient safety incident response framework (PSIRF) to manage its incident reporting, investigation and learning programmes. PSIRF is a national initiative designed to further improve safety through learning from patient safety incidents and forms part of the wider national patient safety strategy .

More information about the PSIRF can be found on the NHS England website at <https://www.england.nhs.uk/patient-safety/incident-response-framework>.

Whilst many NHS organisations will still be implementing this model over 2023-24, WSFT and its colleagues in the SNEE ICS were early adopters and have had the new model in place over two full iterations of a local plan (the patient safety incident response plan – PSIRP).

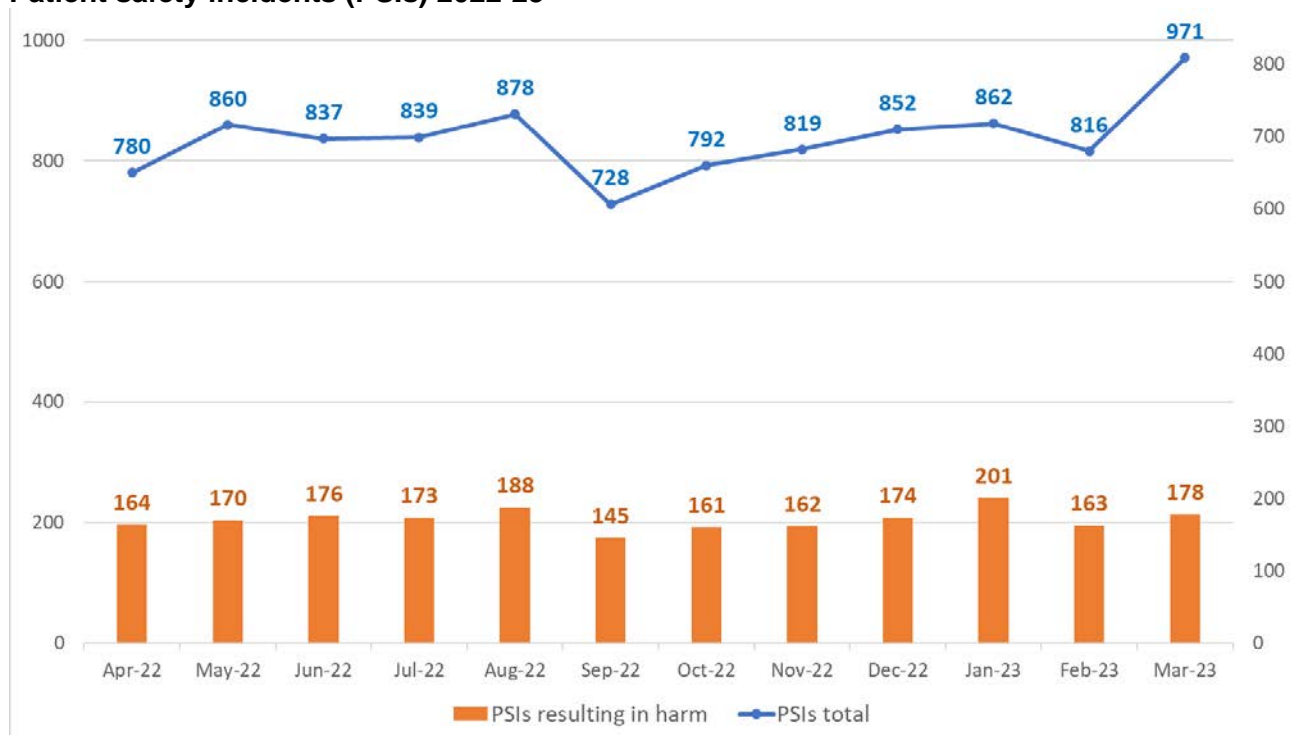
During 2022-23 the total number of patient safety incident investigations (PSIIs) commissioned was 16. Whilst this is significantly less than the number of serious incident (SI) reports produced in previous years it should be noted that many other incidents were subject to another method of review (such as “after action review”, patient safety audit or “structured judgement review”) and these are part of the overall principles of PSIRF, namely to enable focus on the improvement following system-based learning that will improve patient safety for the future. The 16 PSIIs were commissioned in 2022-23 according to the following (local and national) categories.

Local	Potential for patient harm as a result of communication with multiple stakeholders for ongoing patient care	3
	Mis-selection of wrong medication or dose leading to harm or potential for harm	2
	Potential for patient harm as a consequence of non-communication and action of diagnostic results	3
	Emerging risks identified as a result of the use of our digital systems	1
	Identified increase in incidence of subject of theme which has potential for harm	3
National	Never events (nationally defined incidents that are considered preventable because of guidance or safety recommendations)	2
	Death more likely than not due to problems in care	2

Patient safety incidents reported

The chart below shows how many patient safety incidents were reported in 2022-23. The organisation reviews this data monthly and recognises the high reporting rate as a positive reflection of an open culture within the organisation, which supports learning from incidents. The rise in March 2023 is as a result of the inclusion of a new reporting line for the use of restrictive physical intervention. Exclusion of this category makes March’s figures comparable with the previous 12 months.

Patient safety incidents (PSIs) 2022-23



Source: Datix

The Trust is required to upload all PSIs to the national reporting and learning system (NRLS). This is used to identify national themes and trends and emerging risks and supports the national patient safety alerts system. Data submitted also enables benchmarking of reporting rates against other NHS providers. In 2023-24 this national system will be replaced by the new learning from patient safety events system (LFPSE) however WSFT in common with many other organisations has not yet transitioned to the new reporting system.

Learning and identification of areas for improvement from patient safety incidents and investigations

Areas for improvement (AFIs) are broad, they do not define how improvement is to be achieved and are best created after aggregating learning across multiple investigations (and patient safety reviews) into a similar risk. The term “areas for improvement” is now used instead of “recommendations” to reduce the tendency to jump immediately to solutions at an early stage of the safety action development process.

AFIs identified from our PSIs in 2022-23 have included the following examples:

- in the event that patients need to be transferred away from their primary/specialty ward, ensure that any arrangements/specific patient needs are put in place before the patient is moved, that these are recorded as part of the risk assessment process, and that key information about ward changes and mitigations planned are communicated effectively with ward teams
- discharge letters should be sent to the GP according to the Trust discharge planning policy. Establish a consistent process across the Trust for identifying discharge letters not sent, escalation for action and monitoring that this has been completed.
- catheter management processes to include sufficient, appropriate documentation completed when a catheter is inserted, consistent completion of single point of access request for patients being discharged with catheter in place and consistent use of catheter passports and packs for patients being discharged with catheter in place.

In addition, wider learning can be gained from thematic review of common events such as:

- Pressure ulcers (PUs):
 - many new PUs are reported in community settings where patients are living with long-term conditions or experiencing changing needs
 - two acute wards experiencing increased number participated in a learning opportunity for their staff around the subject of PUs
 - positives around strong partnership working with staff in a care home highlighting benefit of involving community carers in after action reviews (AARs) where possible
 - prolonged stay in emergency department (ED) contributing to PU deterioration.
- Themes in reported falls resulting in harm:
 - communication with patient's next of kin
 - identification / management of patients with a high risk of falls in ED and awareness of issues around the prolonged stay in ED for patients with confusion
 - completion of the post-fall protocol, and manual handling following a fall
 - using the Abbey pain score for patients unable to clearly articulate their needs
 - identification of rib fractures
 - completing lying and standing blood pressure readings.

Duty of candour (DoC)

DoC is required for all safety incidents which have resulted in moderate, severe harm or death and prolonged psychological harm.

Since November 2014, this has been a legal requirement requiring NHS organisations to:

1. Have a face-to-face discussion and offer an apology to the patient or relevant person following a safety incident resulting in moderate harm or above.
2. Provide written communication following the face-to-face discussion with the patient, to include: an account of the known facts about the incident, details of any enquiries to be undertaken, the results of any enquiries into the incident and an apology.

The aim of this regulation is to ensure health service bodies are open and transparent when an incident happens. DoC can make an important contribution to creating a culture of openness and honesty which always places the safety and the needs of the patient and family above the reputation of the organisation.

WSFT's incident system (Datix) is used to record patient safety incidents and automatically notifies key members of staff when an incident of moderate harm or above is reported. These incidents are reviewed by the central quality and safety team in collaboration with senior nursing and medical colleagues to confirm that DoC is achieved in a timely fashion.

Timely DoC is monitored using a proxy indicator of 10 working days and the percentage compliance with this standard is reported monthly in the integrated quality and performance report (IQPR). Reported compliance is variable at least in part due to the overall low numbers of DoC required which makes statistical prevalence difficult.

During 2022-23 the Trust:

- further strengthened the local processes (introduced in 2021-22) to oversee timely DoC conversations and ongoing patient/family involvement in reviews of incidents through emerging incident review meetings.
- developed a new audit of DoC to introduce more qualitative measurements
- launched a quality improvement project with an aim to ensure timely and quality completion of all DoC conversations

- reviewed and updated the classification of severity when reporting healthcare associated infections. This review was based on national updates to the CQC's DoC guidance (June 2022) for providers on the definitions of unexpected or unintended safety incidents.

Learning from deaths

During 2022-23, 1,159 people who were in-patients at WSFT died (of which 1,150 were adult patients, 15 of those were people with learning disabilities and five had a severe mental illness, two were neonatal deaths, seven were stillbirths). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 271 in the first quarter (of which 0 were neonatal deaths, 1 was a stillbirth, 1 was a person with learning disabilities and 1 had a severe mental illness)
- 242 in the second quarter (of which 0 was a neonatal death, 1 was a stillbirth, 3 were people with learning disabilities and 0 had a severe mental illness)
- 325 in the third quarter (of which 0 were neonatal deaths, 4 were stillbirths, 7 were people with learning disabilities and 2 had a severe mental illness)
- 321 in the fourth quarter (of which 2 were neonatal deaths, 1 was a stillbirth, 4 were people with learning disabilities and 2 had a severe mental illness).

At 17 April 2023, 124 case record reviews and 16 investigations have been carried out in relation to these 1,159 deaths. In no cases was a death subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 33 case record reviews (2 investigations) in the first quarter
- 31 case record reviews (3 investigations) in the second quarter
- 44 case record reviews (8 investigations) in the third quarter
- 16 case record reviews (3 investigations) in the fourth quarter.

Four deaths, representing 0.35% of the patient deaths during the reporting period, were judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 1 (0.37%) for the first quarter
- 1 (0.41%) for the second quarter
- 2 (0.62%) for the third quarter
- 0 (0%) for the fourth quarter.

The number of case reviews and investigations completed in 2022-23 relating to deaths in reporting period 2021-22 which were not included in the annual quality account in 2021-22:

- 18 case record reviews (0 investigations) in the first quarter
- 34 case record reviews (0 investigations) in the second quarter
- 19 case record reviews (0 investigations) in the third quarter
- 6 case record reviews (0 investigations) in the fourth quarter.

Zero deaths, representing 0% of the patient deaths during the reporting period, were judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 0 (0%) for the first quarter
- 0 (0%) for the second quarter
- 0 (0%) for the third quarter
- 0 (0%) for the fourth quarter.

These numbers have been estimated using the following pathways: All inpatient deaths excluding

neonatal death and stillbirths are collated via the Trust's electronic patient record and recorded on a bespoke mortality database. Neonatal deaths and stillbirths are collated via the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) UK perinatal mortality surveillance system. Deaths of patients with a learning disability are recorded on the Trust mortality database but also reported to the national learning disabilities mortality review programme (LeDeR). Maternal deaths are also reported to the Healthcare Safety Investigation Branch (HSIB) for external review.

For adult deaths, the case record review is undertaken using the Royal College of Physicians' structured judgement review (SJR) method. The objective of the SJR method is to review the quality of the care provided, to provide information about what can be learned about the hospital systems where care goes well, and to identify points where there may be omissions or errors in the care process.

Stillbirths and neonatal deaths are reviewed locally using the PMRT (Perinatal mortality toolkit) or through external review by the HSIB (for cases meeting the notification and reporting requirement definitions of MBRRACE).

Bereaved families are invited to give feedback on the care their relative received, this can be via the medical examiner, the learning from deaths reviewer, the patient safety incident investigator or HSIB.

In a small number of cases, a further local investigation is warranted, and this is undertaken by the patient safety team (including maternity) via the Trust's incident reporting pathway. Where an incident relating to a patient death is considered (at the time of reporting) to be more likely than not to have been due to problems in the care provided, then a patient safety incident investigation (PSII) is undertaken, and a count of these reports has been used to collate the data for that indicator.

If a death is not considered to fit within this definition but opportunities for wider system learning are evident then a patient safety review (PSR) is completed. The sum of PSII's and PSRs as well as PMRTs and HSIB referrals in our maternity services have been used to provide the data for the number of investigations.

The Trust records and reviews deaths of patients with a learning disability and patients with a severe mental illness. Feedback from these reviews to enhance wider learning is included as scheduled agenda items in the new mortality oversight group meetings in 2022-23. This includes feedback from external reviews to incorporate wider national learning.

The Trust records and reviews deaths of patients in maternity services including stillbirth and neonatal death (there were no deaths of women during or immediately following delivery in 2022-23). Feedback from local HSIB reviews and wider learning from the national HSIB maternity reporting programme are included in the maternity programme of improvement.

Case record reviews and investigations conducted in relation to the deaths have highlighted the following themes:

Learning from reviews of adult deaths identified themes similar to previous years:

- multiple bed moves impacting on the quality of care received by patients particularly at the end of their life
- inability to fast-track discharge enabling those who wish to die at home to do so
- impact of reduced staffing and increased workload on the ability to perform timely nursing assessment
- delayed recognition that a patient is reaching the end of their life continues to be a theme, such that active treatment continues when, with the benefit of hindsight, it was likely to be futile with resultant delay in referral to palliative care
- end of life care – work with the palliative care team is ongoing. This includes the implementation of the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) tool across the organisation.

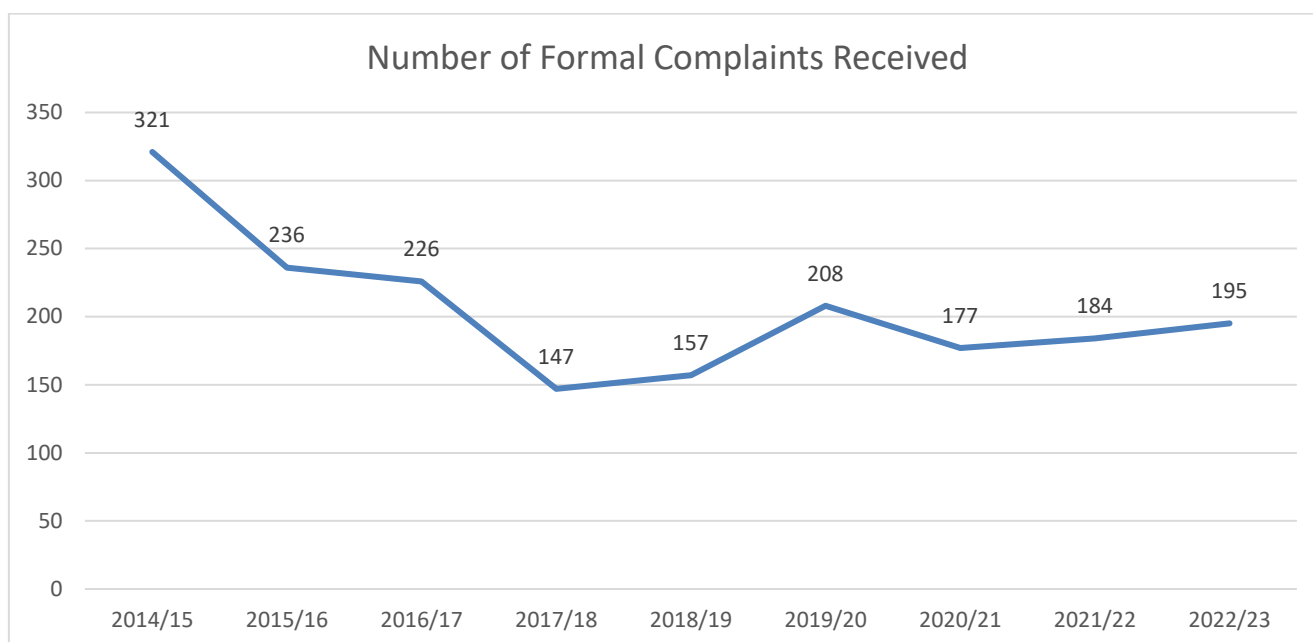
Complaints management

WSFT is committed to providing an accessible, fair and effective means of communication for anyone who wishes to express their concerns with regard to the care, treatment or service provided by the Trust. In responding to and reviewing complaints, WSFT adheres to the six principles for remedy as published in October 2007 by the Parliamentary and Health Service Ombudsman (PHSO).

Complaints are reviewed with service managers, associate directors, clinical directors and the senior nursing team to ensure that issues are addressed, learning takes place and trends identified.

Examples of learning are detailed below. Themes and lessons learned are also reviewed at divisional Board meetings and by the involvement committee.

WSFT received 195 formal complaints during 2022-23. The Board monitors complaints and learning each month as part of the quality reporting arrangements.

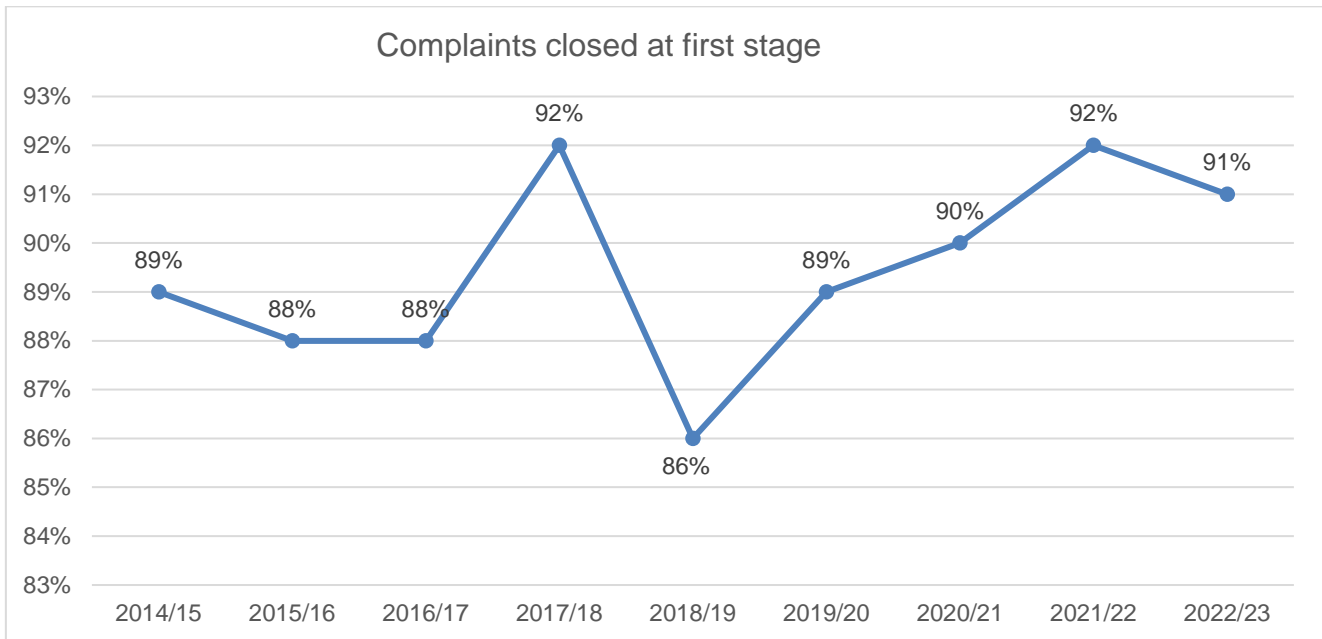


Source: Datix

As a Trust we aim to resolve complaints at first stage, resolving a person's concerns upon receipt of their first contact. On occasions people are dissatisfied with the outcome of our investigations and request a review; at this stage we would consider this to have gone beyond the first stage.

In 2022-23 the Trust successfully resolved 178 complaints at first stage, with 15 investigations escalating to second stage throughout the year.

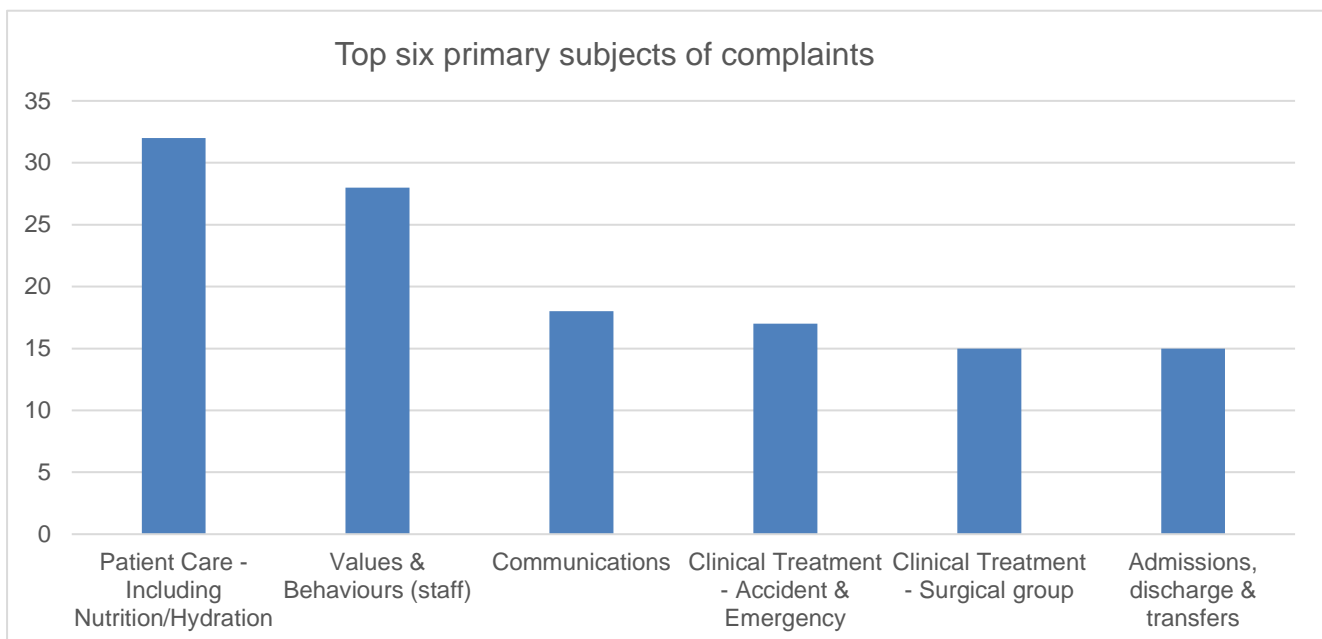
The consistent number of complaints resolved at first stage demonstrates quality investigations at local level. New complaints management processes were implemented to improve the complainants' experience with an aim to ensure complaints are resolved at the first stage.



Source: Datix

Complainants who are dissatisfied with the Trust’s response can refer their concerns directly to the PHSO or the Local Government and Social Care Ombudsman (LGSCO) for an independent review. During 2022-23, two complaints were referred to the LGSCO, and one complaint was referred to the PHSO compared to one (total) during 2021-22. Of the three complaints referred, two were found to be not upheld and one is still being investigated.

Whilst there is a slight increase of complaints being escalated to the Ombudsman, the first-time resolution rate remains high, with 91% of complainants satisfied with the Trust’s response. Further reassurance can be given that of the two investigations that have been completed by the Ombudsman were not upheld.



Source: Datix

The numbers identified in the chart above list only primary concerns; many complaints have multiple categories. Four out of six of the top categories have remained the same since the previous financial year; however, the clinical treatment for the surgical group has replaced clinical treatment for the general medicine group. An additional category of admissions, discharge and transfers has also been included as this subject received the same number of formal complaints as clinical treatment – surgical group.

Patient care remains the top category of concern, and the number of complaints under this subject has decreased from 33 in 2021-22 to 32 in 2022-23. Values and behaviours of staff has also decreased from 29 in 2021-22 to 28 in 2022-23. Complaints relating to communication have decreased from 23 in 2021-22 to 18 in 2022-23. Clinical treatment in the emergency department has decreased from 19 in 2021-22 to 17 in 2022-23.

Whilst clinical treatment within the surgical group did not feature within the top categories of concerns for the previous financial year, it has increased from 11 in 2021-22 to 15 in 2022-23. This is a 36% increase. Admissions, discharge, and transfer concerns have also increased from eight in 2021-22 to 15 in 2022-23, which is an 88% increase.

As well as responding to and learning from individual complaints, WSFT identifies themes and trends from local complaints and national publications such as the PHSO. We have provided a sample of the learning outcomes from complaints which has supported WSFT's quality priorities and other service improvements:

- a number of actions have been completed to improve communications between ward staff and relatives including the continuation of the clinical helpline and the keeping in touch service
- acute assessment unit (AAU) developing an information leaflet for relatives to ensure better communication is delivered about how AAU functions
- patients who attend multiple times for breast care services in a short period of time for the same problem that is not resolving will be discussed at a senior level or at the department multidisciplinary team (MDT) meeting
- extended imaging will be arranged for any breast care patients who have attended multiple times withing a short period
- mandatory study sessions have been arranged for all ward staff with the tissue viability team regarding pressure damage; and patient falls from the falls team
- abortion clinics will not be run on the same day as for women who are asked to attend for miscarriages due to the distress caused
- emergency department staff have received training in communication and customer service to reduce miscommunications
- a new policy has been implemented within radiology where a second opinion from another sonographer should be sought, to confirm the finding of any anomaly and measurements before referring a patient to the foetal medicine unit
- Ward F7 staff have implemented a thorough property check when patients are admitted to the ward, to ensure that all property is accounted for and securely stored if appropriate
- Parkinson's Disease management training for the F7 ward team has been completed with the Parkinson's specialist team
- information about patient consent has been added to the AAU competency pack and discussed in the unit's daily safety huddles to highlight this to all staff
- the gynaecology team has discussed and implemented a plan which includes clear questions to ask patients with a positive pregnancy test at three weeks, to determine if watching and waiting is appropriate or if an ultrasound scan should be arranged
- a clinical educator has been employed specifically for the AAU to support junior nurses in teaching and development which will include discharge planning
- the housekeeping team has introduced a monthly on-the-job knowledge programme for ward-based staff.

There were some complaints that were also investigated simultaneously with serious incident investigations and the actions identified through these investigations are being progressed and reported via this route.

Managing compliments

A total of 566 compliments have been formally received by WSFT. This figure only includes thank you correspondence shared with, or sent directly, to the patient experience team.

National CQC patient surveys

The CQC carries out a variety of patient surveys, the most frequent of which occurs annually. Feedback from national as well as local surveys is used to monitor service performance and focus on quality improvement. WSFT was involved in the following CQC surveys which have been reported on during 2022-23:

- 2021 Adult Inpatient Survey (published September 2022)
- 2021 Maternity Survey (published January 2023)

Interpreting our data

The “better” and “worse” categories are based on a statistic called the expected range, which determines the range within which the Trust’s score could fall without differing significantly from the average. If the Trust’s performance is outside this range, its performance is significantly above or below what would be expected. If it is within this range, we say that its performance is “about the same”. This means that where survey results have been identified as better or worse than the majority of trusts it is very unlikely that these results have occurred by chance.

2020 Adult Inpatient Survey (published September 2022)

Respondents and response rate

- 472 WSFT patients responded to the survey
- the response rate for was 39.76%.

Scoring

For each question in the survey that can be scored, individual responses are converted into scores on a scale of zero to 10. For each question, a score of 10 is assigned to the most positive response and a score of zero to the least positive. The higher the score, the better the trust’s results.

Banding

Better

WSFT results were **much better** than most trusts for 0 questions.

WSFT results were **better** than most trusts for 5 questions:

- Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?
- Q12. How would you rate the hospital food?
- Q29. Do you think the hospital staff did everything they could to help control your pain?
- Q33. Beforehand, how well did hospital staff explain how you might feel after you had the operations or procedures?
- Q40. To what extent did you understand the information you were given about what you should or should not do after leaving hospital?

WSFT results were **somewhat better** than most trusts for 1 question:

- Q25. How much information about your condition or treatment was given to you?

Worse

WSFT results were **much worse** than most trusts for 0 questions.

WSFT results were **worse** than most trusts for 1 question:

- Q5.1 Were you ever prevented from sleeping at night by noise from other patients?

WSFT results were **somewhat worse** than most trusts for 0 questions.

Same

WSFT results were **about the same** as other trusts for 40 questions.

2021 Maternity Survey (published January 2023)

Respondents and response rate

- 161 WSFT patients responded to the survey
- The response rate was 54.76%.

Banding

Better

WSFT results were **much better** than most trusts for 0 questions.

WSFT results were **better** than most trusts for 2 questions:

- C19. Thinking about your care during labour and birth, were you spoken to in a way you could understand?
- C20. Thinking about your care during labour and birth, were you involved in decisions about your care?

WSFT results were **somewhat better** than most trusts for 3 questions:

- C5. And before you were induced, were you given appropriate information and advice on the risks associated with an induced labour?
- C22. Did you have confidence and trust in the staff caring for you during your labour and birth?
- D6. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?

Worse

WSFT results were **much worse** than most trusts for 0 questions.

WSFT results were **worse** than most trusts for 0 questions.

WSFT results were **somewhat worse** than most trusts for 0 questions.

Same

- WSFT results were **about the same** as other trusts for 16 questions.

Action plans

Results are reviewed within relevant groups and reported on at the Patient and Carer Experience Group (PCEG). Action plans are established with the support of the patient engagement team alongside any existing work within the workstreams. Actions from the CQC survey results have included:

- the creation of focus groups in particular areas
- local surveys to determine whether situations have improved
- submission of business cases at department level for more staff resource
- creation of new roles
- improvements to physical appearance of areas.

Further details regarding quality and operational performance and risks are provided in the annual governance statement (section 2.6).

1.2.4 Principal risks and uncertainties

The Trust is able to demonstrate compliance with the corporate governance principle that the Board of directors maintains a sound system of internal control to safeguard public and private investment, WSFT's assets, patient safety and service quality through its board assurance framework (BAF).

Board assurance framework (BAF)

The BAF was regularly reviewed during 2022-23 to ensure that it provided an adequate evidence base to support the effective and focused management of the principal risks to meeting strategic objectives. The BAF illustrates the escalation processes to the Board and its sub-committees when risk, financial and performance issues arise which require corrective action.

The executive director with delegated responsibility for managing and monitoring each risk is clearly identified in the BAF. The BAF identifies the key controls in place to manage each of the principal risks and explains how the Board of directors is assured that those controls are in place and operating effectively.

The principal risks identified in the BAF are reviewed by the Board of directors. The Board reviews the potential impacts of these risks and considers the robustness of the existing controls and future plans to mitigate these. Assurance of the effectiveness of these controls and plans is also reviewed. A summary of the BAF is provided in the annual governance statement (section 2.6).

Effective risk and performance management

The Trust has a robust risk management strategy which ensures effective clinical governance and monitoring of compliance with best practice. The Board maintains a framework which ensures timely escalation of risk to the Board by committees and specialist groups.

Performance and quality improvement are connected from 'board to ward'. This is achieved through two-way communication between the Board, its assurance committees and management areas. Relevant aspects of the integrated quality and performance report (IQPR) are reviewed by the Board assurance committees to identify areas to share good practice and for more detailed review and improvement. This information is underpinned and informed by reviews from divisions and wards, with action-planning at these levels.

Delivery of improvement at an operational level is reported through the directorate executive performance review meetings, and is also tested through observational visits by Board members and governors as part of area observations. A programme of presentations and patient stories is also delivered to the Board and its subcommittees.

The Trust actively engages with its foundation trust membership and the public through regular talks, events and communications but these have been limited during the COVID-19 restrictions.

The Trust is a member of the NHS Resolution's Clinical Negligence Scheme for Trusts (NHSR CNST). Additional commercial insurance is in place to mitigate the risk for assets and services.

Mandatory service risk

The Trust's Board of directors was satisfied that:

- all assets needed for the provision of mandatory goods and services were protected from disposal
- plans were in place to maintain and improve existing performance
- WSFT had adopted organisational objectives and managed and measured performance in line with these objectives
- WSFT was investing in change and capital estate programmes that would improve clinical processes, efficiency and, where required, release additional capacity to ensure the needs of patients could be met.

A review of the risks associated with mandatory service provision was undertaken and no significant risks were identified.

Risk of any other non-compliance with licence

The Board of directors ensured that WSFT remained compliant with relevant legislation. Executive directors assessed the risk against each of the conditions in the licence. No significant risks were identified.

Contractors and suppliers

The Trust is committed to sourcing, ordering and delivering a complete range of healthcare products, services and infrastructure, whilst maintaining value for money, and is a committed member of the East of England NHS Collaborative Procurement Hub. This network, together with our local team, allows us to keep up with developing markets, benchmark products and services, and build close relationships with suppliers. We own one quarter of Collaborative Procurement Partnership LLP which, following a successful bidding process in 2018/19, is working with three procurement partners to deliver three of the Department of Health and Social Care's eleven procurement towers.

All purchasing falls in line with the European directive for procurement in addition to our standing financial instructions and standing orders.

We have assessed the risk of supplier failure. Where risks have been assessed as high due to credit risks or inability to find an alternative quickly, additional controls have been put in place.

Additional disclosures required by the financial reporting manual (FReM)

The accounts have been prepared under direction issued by NHS Improvement (NHSI) under the National Health Service Act 2006:

- chief executive's responsibilities statement (section 2.5)
- accounting policy note 1 (part of accounts).

The accounting policies for pensions and other retirement benefits are set out in note 9 to the accounts, and details of senior employees' remuneration can be found in section 2.7 (remuneration report).

Audit committee's review of the annual report and accounts

The audit committee did not identify or raise any significant issues when reviewing the annual report and accounts in relation to the financial statements.

Social, community, anti-bribery and human rights issues

The West Suffolk NHS Foundation Trust, as an NHS provider and employer, operates within the requirements of UK and European law, including its responsibilities for equity of access to services, employment and opportunities. The Trust operates within the NHS Constitution and has employment and service policies that address equality and human rights issues.

The Trust is an anchor institution, i.e. a large organisation which has a mission to advance the welfare of the populations it serves; supports local community development through employment and procurement of local services; and receives significant public resources. Through this we deliver our social responsibilities through widening workforce participation; engaging young people through apprenticeships and career development activities; and act as a good employer, supporting the health, wellbeing, professional and career development of our staff, and supporting fair pay and conditions of employment.

Over the past year the Trust has reviewed its policies in line with "Just Culture" principles and has embedded this within policy approval and decision-making frameworks.

The Trust remains committed to the effective implementation of policies and procedures in respect of fraud and corruption as well as the Bribery Act. It also has a nominated local counter fraud specialist (LCFS) whose role is to provide support and advice on all matters relating to fraud and to be a point of contact for fraud reporting. The LCFS reports to the audit committee.

Over the past year the LCFS has delivered the following:

- undertaken obligatory tasks specified by NHS Counter Fraud Authority (CFA) to inform the Counter Fraud Functional Standard Return
- delivered (bespoke) fraud awareness training to: finance, estates and facilities, procurement, pharmacy, community staff and digital services (the training audience has varied each year to ensure that everyone is covered on a cyclical basis)
- fraud and bribery awareness session was delivered to the Trust Board
- "Notice Frauds" sent to finance as and when LCFS receives a fraud alert, which is responded to and recorded by LCFS (to report back to NHS CFA)
- CFS has have completed work on the National Fraud Initiative (NFI) exercise, with nothing to report as a result.

Our modern slavery statement is published on our website and outlines the approach we have taken, and continue to take, to make sure that modern slavery or human trafficking is not taking place within our business or supply chain.

Emergency preparation, resilience and response (EPRR) core standards annual assurance report

Annual EPRR core standards reporting is the means by which NHS England obtains assurance that NHS funded organisations are sufficiently able to respond to emergencies. Organisations carry out a self-assessment against the core standards, which is subject to Integrated Care Board and Regional NHS England review, and then to Trust approval before formal submission.

In September 2022, the NHS returned to the full reporting on 64 core standards (from 46 in 2021/22 as a result of COVID impacts) for which there are grades of achievement; full, partial or non-compliance. Core standards require the "completion" of all activities to record "Full Compliance".

As a result of self-assessment, the Accountable Emergency Officer (AEO) considered that the Trust overall level of compliance was “Partially Compliant” in that there were nine core standards in three capability areas where there was not full compliance: exercising response plans (three standards); business continuity management (four standards); and full wet decontamination of self-presenters at the Emergency Department (two standards). There were mitigations in place, and there was confidence that the Trust could operate in the interim until each standard became fully compliant. The Trust has committed to achieving full compliance by the next assessment in September 2023.

Each year there is also a ‘deep dive’ into a specific topic for information purposes only and not used for the formal grading of compliance; this year the deep dive was assessing our evacuation capability, in which the Trust was seen as a regional leader.

1.2.5 Future business plans

1.2.5.1 Integrated care system (ICS)

West Suffolk Alliance is one of three place-based alliances that make up the Suffolk and North East Essex integrated Care System (ICS). The Alliance published its strategy in 2018 – All About People and Places - which established a shared set of ambitions which all alliance partners signed up to:

- strengthening the **support for children and adults** to stay well and manage their mental and physical health and wellbeing within their communities
- **focusing on individuals** and their needs and goals
- changing both the way we **work together** and how services are configured
- making effective **use of resources**.

Since the inception of the West Suffolk Alliance:

- membership has grown and now encompasses partners from the NHS, local government, the voluntary, community and social enterprise sectors and others, to form a broad collaboration of organisations signed up to work together to deliver our strategy
- the Alliance has shown throughout the pandemic that the relationships between partners allow for rapid implementation of changes to services, the ability to develop a joint approach to problems and issues, and that partners are willing to innovate and use their resources flexibly to meet need
- learning from the pandemic is being used to inform our future direction, priorities and opportunities
- the NHS White Paper - Integrating Care - has reinforced the importance of ‘place’ as a building block for alliance working within a wider integrated care system footprint.

Our alliance delivery plan for 2021-22 has been developed with these points in mind. We have agreed that we want to have a plan that:

- demonstrates that we are working differently - as partners rather than as individual organisations - showing the added value of the Alliance
- highlights where we are delivering our Alliance ambitions
- gives visibility to the range of transformation programmes going on within the West Suffolk Alliance area
- allows us to prioritise investment (financial and other resources)
- helps us develop as an alliance to meet future opportunities and challenges
- champions innovation
- shows how organisational priorities can be delivered through alliance working.

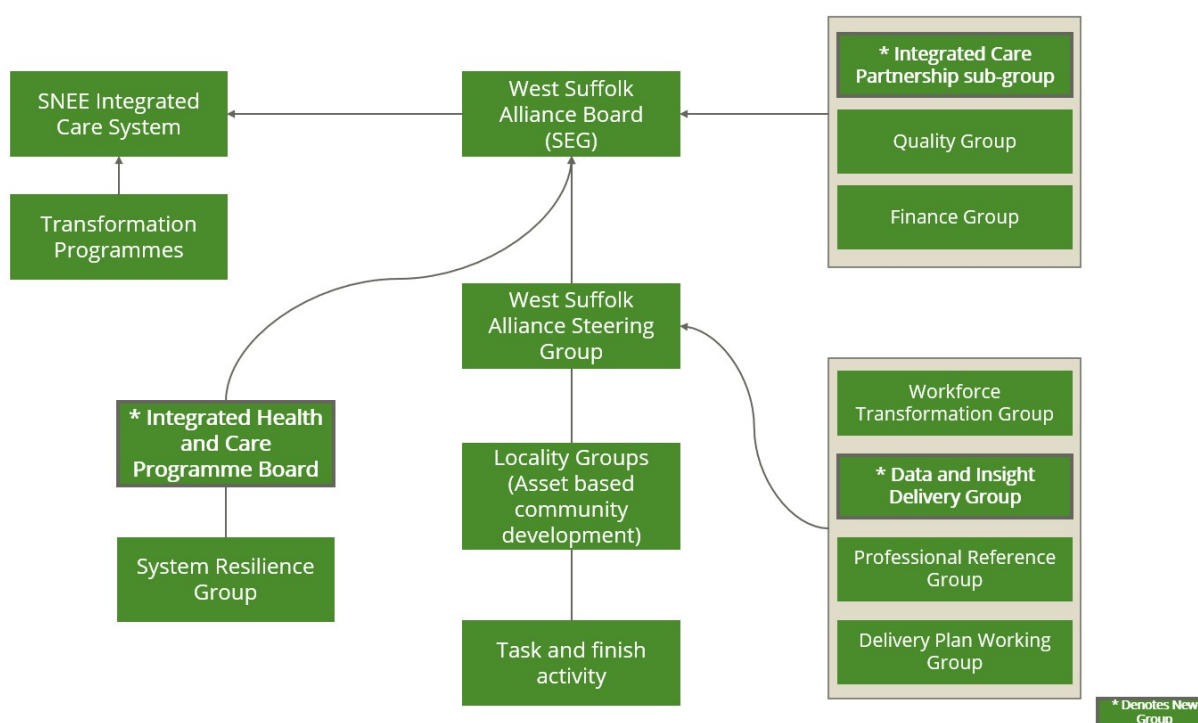
Actions include:

- building on our strategy to create a compelling mission and vision statement. The aim of this is to let people know what the Alliance is all about in a simple and straightforward way
- redesigning our governance to create a framework for action. This will mean a better understanding of where decisions are made and who holds accountability. Two new

- groups have been set up as part of the redesign to support health and care integration:
- Integrate Care Partnership Sub-group – a smaller group of public service leaders responsible for shaping plans to formalise integration across health and local authorities, and consider how this could shape future integrated care partnerships in each alliance
 - Integrated Health and Care Programme Board – supporting the change programme that will deliver integrated care, allowing cross-divisional sharing of solutions and learning. The board will oversee the west implementation of the wider ICS transformation programmes, translating NHS priorities into place-based delivery
- creating a west Suffolk data and insight approach to better understand the complex challenges facing people in west Suffolk and identify the emerging trends to inform strategic and operational decision making
 - developing a systems communications function that focuses on joint work, celebrating success and ensuring that our teams feel the benefits of alliance working
 - taking a system approach to inequalities, starting with the COVID-19 vaccination programme, and working to make sure that people most at risk, and from disadvantaged communities, get targeted support.

Alongside these actions there are many projects and initiatives across the partnership where alliance working is in action.

West Suffolk Alliance governance



Alliance partners

- Abbeycroft Leisure
- Allied Health Professionals Suffolk
- Babergh and Mid Suffolk District Councils
- Care UK
- Citizens Advice West Suffolk
- Community Action Suffolk
- Healthwatch
- Home-Start
- Local Pharmaceutical Committee
- Norfolk and Suffolk NHS Foundation Trust
- Primary care (24 GP surgeries)
- St. Nicholas Hospice

- Suffolk Constabulary
- Suffolk County Council
- Suffolk GP Federation
- Suffolk MIND
- West Suffolk Clinical Commissioning Group
- West Suffolk College
- West Suffolk District Council
- West Suffolk Foundation NHS Trust

1.2.5.2 Performance improvements and developments

Operational achievements during 2022-23

The NHS 2022-23 priorities and operational planning guidance continued a nationally-led focus on the recovery of services as the impact of the COVID-19 pandemic lessened, with systems and providers tasked with seeing more patients, increasing their activity and reducing waiting times. July 2022 also marked the date when all providers became part of Integrated Care Systems (ICSs), the statutory bodies that now form the primary unit of organisation of the NHS. We have developed close working relationships with all partners within our system to deliver the priorities both set out nationally and those which are defined at a local level.

Tackling the elective backlog and reducing long waits has been a key priority nationally and for the Trust. We have continued our focus on eliminating elective waits of more than 104 weeks, with only two patients exceeding this at the end of March 2023. Against the 2022-23 priority of eliminating waits of 78 weeks or more, we finished the year with 73 patients waiting longer than this, of which 40 were capacity related and the rest where patients had chosen to wait longer, or treatment within 78 weeks would not have been clinically appropriate.

This is a significant improvement on our forecast position of 100 capacity breaches at the start of the year and from 719 patients waiting in March 2022. This progress was made possible through the focus and dedication of clinical and administrative teams. Transformation programmes aimed at optimising our outpatients service are being delivered as part of the West Suffolk Alliance Stay Well domain projects and we have already seen the benefits of the work to improve utilisation of our operating theatres, using benchmarked data and external peer review as part of the getting it right first time (GIRFT) initiative.

Performance against the Cancer Waiting Times standards has been focused on reducing the backlog of patients waiting 62 days or more and on making progress towards meeting the faster diagnosis standard of at least 75% of patients receiving a definitive diagnosis or ruling out of cancer within 28 days. We have reduced the number of patients waiting 62 days or more from 149 to 121 during the year, and our faster diagnosis standard performance for the year is 67.4%, putting us on track to meet the standard by the deadline of March 2024. Our cancer board, in conjunction with the ICS and East of England Cancer Alliance (North), have embedded transformational improvements to our diagnostic pathways, including colon capsule endoscopy (a procedure used to record internal images of the gastrointestinal tract) as an alternative to more invasive tests such as colonoscopy for lower risk patients, and artificial intelligence to analyse and prioritise skin lesions that could be cancerous.

In 2022-23 we continued as a pilot site for the clinical review of standards for urgent and emergency care, whereby we focused on a wider suite of indicators and moved away from reporting against the target of patients spending less than four hours in our emergency department. As it has been confirmed that the proposals of the review will not be continued, we will once again start monitoring the four-hour standard from May 2023.

Our urgent and emergency care services have continued to experience high levels of demand throughout the year which at times of extreme pressure have increased the length of time patients spend in our Emergency Department. We monitor the number of patients waiting 12 hours or more, which peaked in December 2022 at 16% of all attendances, but which has since decreased to 13%

in March 2023. A number of workstreams are in place to reduce the length of stay for emergency attendances and to regain our focus on the four-hour standard.

We have worked to maximise the benefits of being a provider of both acute and community services by ensuring discharge pathways for people requiring additional care outside of hospital are optimised, using our discharge waiting area (DWA) to ensure patient flow through the hospital is timely and responsive. Our community services met and improved performance against the two-hour urgent community response target, being consistently above 80% against the 70% threshold.

Work has continued at pace on our programme of maintenance required to our estate because of the problems identified with reinforced autoclaved aerated concrete (RAAC). We have now fully completed failsafe works to the roof in 24 of 44 areas identified, with work ongoing to failsafe or work to strengthen the end bearings of roof planks complete in another 17 areas. Work to install anodes and apply new external coatings to wall planks has been completed in 19 areas, which will prevent degradation of those planks and ensure the existing hospital building can be used safely until the move to WSFT's new main facility takes place by 2030. Completing the works in a priority order has allowed the majority of our theatre complex to be returned to use.

Priorities and operational planning guidance for 2023-24

31 national NHS objectives form the basis of NHS planning in 2023-24, the majority of which apply to WSFT across our acute, community and primary care services. These are agreed in conjunction with the Suffolk and North East Essex Integrated Care Board (SNEE ICB).

All integrated care boards (ICBs) must demonstrate how they will deliver more activity across first outpatient appointments and elective procedures compared to pre-pandemic levels, the target for our ICB being 108.61%. This additional activity will also be required to continue our work on reducing the number of elective patients experiencing long waits. This year we have committed to reduce the number of patients waiting 65 weeks or more, building on the previous successes of minimising waits of 104 and 78 weeks. Changing the way in which we deliver outpatient follow-ups using "advice and guidance" pathways and a more tailored approach in patient initiated follow-up, as well as delivering on national expectations around maximising day surgery and theatre utilisation to at least 85% each will support increasing the number of patients seen.

Delivery of more diagnostic activity, whilst supporting the requirement to deliver more activity and reduced waiting times, is also critical to meeting the national ambition of 95% of patients receiving a diagnostic test within six weeks by March 2025. The opening of our community diagnostic centre (CDC) at Newmarket Hospital in 2024 will provide a step-change increase in capacity as well as enabling people living in the west of our population area to have tests performed closer to home. We are planning to meet the cancer faster diagnosis standard of 75% and will continue to reduce the number of patients waiting 62 days or more on a cancer pathway.

For urgent and emergency care pathways, our focus will be reintroducing the four-hour standard into our emergency department and delivering it for at least 76% of patients by March 2024. This involves teams from across the Trust ensuring that we have the right processes to be able get people into the department, assess them quickly, and can admit patients into hospital beds without delay when they require it.

To support this, we are building on the work completed by our community teams and social care partners to make use of intermediate care beds and enhance the wraparound support so that people who do not need the full facilities of a hospital bed can receive care in a more appropriate setting more quickly, including in their own homes. This will also be supported by the expansion of our virtual ward from 20 to 100 beds. By facilitating the right care, in the right time at the right place we can ensure that our system partners can deliver care when it is needed and reduce delays, including the two-hour urgent community response target of 70%.

Our primary care services delivered at Glemsford Surgery have contributed to an ICB-level trajectory for providing an increase in appointments which will mean more appointments can be given within a

two-week timeframe in line with national guidance. Changes to the GP contract in 2023-24 make clear that patients should be offered an assessment of need, or signposted to an appropriate service, at first contact with the practice. Practices will therefore no longer be able to request that patients contact the practice at a later time. We are currently exploring how to best implement this at Glemsford Surgery.

Business planning for 2023-24

Robust business plans are the foundations of well led services, providing structure and clarity to decision making, as well as supporting budget setting, business cases and workforce and succession planning. Each of our divisions across medicine, surgery, women's and children's and clinical support services, community and corporate services have produced a business plan covering:

- introduction to the division and service
- summary of the previous year
- national operational planning guidance requirements
- divisional strategy, linked to the Trust and West Suffolk Alliance strategic priorities
- transformation objectives
- performance trajectories
- quality and safety objectives
- financial forecast, including capital planning
- workforce ambitions
- sustainability objectives
- risks, issues and dependencies
- detailed deliverables, including measures of success and timeframes for delivery

Draft plans are first reviewed through the monthly performance review meetings between each division and the Trust executive team, before final approval is given by the senior leadership team. The process and template have undergone considerable development this year, allowing full alignment with our other business processes in future years.

Joint forward plan and capital resource plan

As mandated by the Health and Care Act 2022, ICBs and partner NHS Trusts / Foundation Trusts must prepare a five-year joint forward plan (JFP) in collaboration with local Health and Wellbeing Boards (HWBs). The JFP describes how SNEE ICB, and its partner trusts intend to arrange and provide NHS services to meet its population's physical and mental health needs, and how it will work with partners across the integrated care system to achieve this. This includes consideration for the delivery of universal NHS commitments and addressing the ICS's four core purposes.

The JFP proposed vision is for everyone at all stages of their life to be able to Live Well across SNEE. The JFP therefore adopted and defined the outcomes to be achieved using the six domains of the Live Well model:

- **Start Well** – giving children and young people the best start in life
- **Feel Well** – supporting the mental wellbeing of our local population
- **Be Well** – empowering adults to make healthy lifestyle choices
- **Age Well** – supporting people to live safely and independently as they grow older
- **Stay Well** – supporting adults with health or care concerns to access support and maintain healthy, productive and fulfilling lives
- **Die Well** – giving individuals nearing end of life choice around their care

The Trust has played an active role in the development of the JFP through the Board, executives and senior managers. The Trust Board received a briefing on the JFP at its meeting on 31 March 2023 and discussed the final document at its meeting on 26 May 2023.

The Trust worked with SNEE ICB to agree the distribution of capital and to bid for organisation specific developments to ensure system-support. There is high demand across the system for limited amounts of capital investment, but the JFP is consistent with the capital resource use plan.

New healthcare facility (Future System programme)

In September 2019, the Government announced its Health Infrastructure Plan, which aims to deliver a long-term programme of investment in health infrastructure. This included the New Hospital Programme which is providing funding for 48 hospitals. The Trust was named as one of the 48 hospitals and has embarked on a journey to bring a new hospital, replacing the existing West Suffolk Hospital, to fruition.

This is an exciting opportunity to transform the way that healthcare is delivered in west Suffolk. The aspiration is to create a state-of-the-art healthcare facility that provides a 21st century model of care; maximises use of digital technology for both clinical service delivery and building management. The aim is also that all new buildings will meet the net zero carbon standard. In essence, we want to provide the highest quality services in a new and improved setting, that are joined up appropriately with our local partners and most suited to the needs of our patients and community, in the greenest and most digitally advanced way possible. Better for our patients, community, staff and partners.

The Trust, its ICS partners, members of the central new hospitals programme (NHP) team and West Suffolk Alliance, are at the beginning of a comprehensive and inclusive programme of work that will encourage input from a broad range of stakeholders.

Progress to date

In March 2022, a hybrid planning application was submitted to West Suffolk Council with proposals to build a new hospital on the preferred Hardwick Manor site, replacing the existing hospital in Bury St. Edmunds. This application was approved by the West Suffolk Council planning committee on 30 November 2022.

The outline planning application was underpinned by our future clinical service plans which envisage how our clinical services look and run. To develop these plans, workshops were held with members of the public and staff both face-to-face and online. This work is ongoing, and the clinical team are continuing to engage with staff and the public in refining these departmental designs.

An ecology compensation strategy has been developed to set out how the irreplaceable habitat identified within the footprint of the new hospital, which will be lost because of the development, will be compensated in accordance with planning policy requirements. This includes translocation of one hectare of turfs to an offsite receptor site and the creation of circa 115 hectares of waxcap grassland / wood-pasture and parkland offsite.

A site ecology strategy has been devised which aims to avoid impacts to protected species and minimise impacts on priority habitats, whilst retaining all other habitats of ecological value at the Hardwick Manor site. Together with the landscape strategy, the ecology strategy will enhance the biodiversity of all other non-irreplaceable habitats on the site which will achieve a 10% net gain in biodiversity in these areas.

Next steps

The Trust is preparing an outline business case and, as part of the New Hospital Programme, is continuing to work closely with national colleagues to ensure designs and activities take full advantage of the centralised programmatic approach. The approval of the outline planning application means that, subject to business case approval, the completion of the new hospital is on target for before the end of the decade.

The approval of the outline planning application is a major milestone for the project. Upon the signing of the Section 106 Legal Agreement, the Local Planning Authority (LPA) will now be able to issue the

decision notice detailing the approval of the hybrid application. Following this, detailed design applications (known as Reserved Matters applications) will be prepared and submitted to the LPA for their approval. These applications (as well as other pre-commencement conditions and obligations) will need to be approved before any development can commence on site. The LPA will undertake consultation with the wider community and consultees in the usual way as the detailed design and conditions applications are processed.

The programme is governed by a board that has drawn its membership from across SNEE ICS as well as members from the central NHP team. This membership has collectively committed to making the new facility the most co-produced in the country – a tall ambition that confirms our commitment that the programme is designed by our people for our people.

For further information please visit <https://www.wsh.nhs.uk/New-healthcare-facility/New-healthcare-facility.aspx>

Trust digital programme

Clinical systems

A key focus for the digital programme is the continued replacement of paper-based systems with modern digital technology solutions, but only where these offer significant benefits to clinical and operational teams. A good example of this is the implementation of a solution for digital triage and processing of referrals from primary care. The system automatically downloads the referrals from the previous “Choose and Book” system, now called the electronic referral service (eRS), and presents them in our e-Care platform for consultant acceptance or rejection. As a digital solution this allows the process to be completed much more rapidly, at any location and with increased information security.

The digital teams have supported the implementation of virtual wards in line with national objectives to deliver on targets for the number of virtual ward beds that are available. This uses digital devices in the patient’s home to collect key health metrics that can be viewed through a dashboard in the Trust. This is managed by clinical staff who can contact the patient through the technology or via phone calls. This type of technology to support proactive care is one of the many ways that digital means can help address the challenge of future health care needs.

The pathology department has worked closely with digital team to implement a new digital pathology sample scanning and management solution for histopathology that allows slides of tissue to be digitised and thereby made available electronically for consultants to review. Again, this frees the clinician from the need to be in a specific location and can enable more effective discussion and sharing of findings with other clinicians.

We have worked closely with clinical teams to implement some good examples of the use of machine learning to support and enhance clinical practice. This has been with the stroke and dermatology teams who have implemented solutions that will compare captured images against large, trained datasets to be able to more quickly identify cases that need further referral and treatment. A key part of our approach to this new technology is the constant monitoring and validation of the outcomes to give maximum assurance of its effectiveness.

Supporting digital technology

The Trust has continued to invest in key digital infrastructure with a refresh of our core and edge networks together with upgraded computers, mobile phones and integrated medical devices. We were also able to upgrade the staff Wi-Fi portal, streamlining the process of registration and thereby giving a much more reliable connection which is key to the digital bleep replacement solution. Usage of Wi-Fi for patients and visitors continues to grow and is supported by access to a range of media including online newspapers and magazines, TV, radio and streaming services.

Whilst we can never feel fully protected given the ever-changing nature of threats and increasing attention on healthcare targets, we have been able to further strengthen our cyber defences with additional products, further configuration enhancements and external validation of our resilience.

Digital across West Suffolk and the wider community

A number of the Trust digital team are active members of the West Suffolk Alliance digital change group which aims to coordinate digital activities and align to the alliance strategic direction in support of the Live Well domain's objectives.

We continue to run the health information exchange (HIE) on behalf of the ICS and have seen further uptake in monthly usage to around 130,000 views per month, with connections to all the main providers in health and social care across the ICS. We estimate the patient population covered by the HIE to be around two million people, with almost 8,000 staff using it every month.

The digital team presented at the launch of the ICS in July with stands that demonstrated integration of our systems with medical devices, potential use of augmented and virtual reality technologies in health and the scope and usage of the shared care record. The selected candidates for the first cohort of the Mike Bone People Potential Programme were announced at the ICS launch and we were pleased to support three successful participants from the Trust, highlighting the importance we place on staff development.

The digital training team developed online material that can be delivered through the Trust learning management system specifically for use by schools. This consolidates this digital platform as an invaluable tool to support a wide range of uses across the Trust and wider community.

The Trust is an active participant in the eastern region digital imaging network, which is implementing an improved solution for sharing radiology images across all the acute hospitals in the region to help give greater responsiveness, resilience, and capability.

Future foundations

In 2021, NHS England released the "What good looks like framework" (WGLL) against which we can assess our digital readiness and capability. Initial assessment against the seven dimensions of well-led, smart foundations, safe practice, support for people, empower citizens, improve care, healthy populations was positive but further tools are planned to give a more standardised method of assessment.

Digital services continue to play a key part in the plans for the new hospital build under the direction of the Future System programme. Digital is key to NHS England and government ambitions for smart hospitals that take the best digital solutions and embeds them in the new hospital design from building infrastructure management to support for care that will be delivered on wards with single occupancy rooms. We are working through the list of required technologies to ensure that wherever possible they are implemented and we are already familiar with the technology whilst also developing plans to consider adoption of the full digital scope of a smart hospital.

There has been extensive coverage of the many new artificial intelligence and machine learning tools that we will watch with interest. There are challenges around the ethical, legal, and societal issues in their wider use, especially in a healthcare setting, which will need to be carefully considered and resolved.

Procurement

The impact of the pandemic, inflation increases, limited supply chain routes and availability of products has impacted procurement quite significantly. The procurement department works closely with the national teams and the integrated care system to review how procurement will evolve and support the requirements of the NHS over the coming 12 months. The areas of direction currently under review are:

- ensuring the new procurement regulations and requirements by all public sector bodies are implemented in 2023
- measure the social values requirements as part of contract management
- implement the new requirement for all procurements over the value of £5 million to have a carbon reduction plan in place
- undertake a review of procurement functions under the new Commercial Continuous Improvement Assessment framework introduced in 2022
- develop ICS procurement pipelines using the national workplan database. This will provide better visibility of contracts and ensure collaboration wherever possible.

Priorities for Trust procurement over the coming 12 months are to:

- support the directorates to achieve cost improvement targets
- achieve the Trust workplan which links with NHS England and NHS supply chain
- implement new e-procurement system so the Trust has one complete purchase to pay system
- align the procurement strategy with the ICS strategy.

Agency rules

The two main clinical staff groups where agency staff are used are doctors and nurses. During 2022-23 we continued to use the agencies on the collaborative procurement partnership (CPP) framework preferred supplier list for nursing staff and medical staff, which was developed with the East of England procurement hub. The CPP framework is audited by the procurement hub for framework compliance.

In 2022-23, as result of the increased demand on services and a challenging recruitment and retention position for the whole of the NHS, we significantly increased our reliance on agency staff, increasing the usage by 54% on the previous year.

Capital planning

The Trust has a five-year risk-assessed capital strategy that focuses on addressing backlog issues and essential clinical developments both in community and acute services. In addition, a high-level programme has been developed to support the Future System programme and NHP investment that has an impact on the retained estate and elements out of scope for that scheme. This programme is demonstrated through the 2023-2028 estates and facilities strategy approved by Trust Board in March 2023.

For 2023-24 we have reviewed the proposed programme to assure the appropriate investment of capital resources. This is assessed through a multi-professional group using a 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 previously unidentified issues arising in the year are considered and incorporated.

The estates and facilities strategy includes development control plans to demonstrate key strategic developments linked to clinical service delivery, with each development subject to a Board-approved business case. The approved outline planning application for the Future System programme is a key stage of this master plan.

A large part of the West Suffolk Hospital estate is approaching 50-years old with an original design life of 30 years - this is reflected in the high backlog maintenance costs, with the hospital identified

as an outlier in the Model Hospital data from NHS Improvement. In the short to medium term, the Trust faces the challenge of providing a level of care appropriate to the 21st century, within ageing buildings, making it increasingly difficult to meet this challenge. In May 2019 the Standing Committee on Structural Safety (SCOSS) published an alert advising that parts of the structure could be affected by shear failure with very limited warning. The alert related to a significant proportion of the hospital which is constructed of reinforced aerated autoclaved concrete (RAAC) planks. The Trust has a multi-year programme supported with Public Dividend Capital (PDC) to failsafe the RAAC panels, this supports the mitigation of risk to life but does not reduce the backlog liability.

The Trust has completed the investment in Newmarket Community Hospital's electrical infrastructure to support future phases of development. The first of these is the Community Diagnostic Centre (CDC) which will be complete late spring 2024 again funded by PDC.

Significant schemes planned for delivery include:

- **Newmarket CDC** – to support the national recovery programme in a community setting, the £14.7m scheme has two x-ray rooms, computed tomography (CT) and magnetic resonance imaging (MRI) scanners constructed using modern methods of construction. This scheme also supports the organisation in its journey to digitise the estate in preparation for the new hospital programme scheme on Hardwick Manor.
- **Imaging equipment** – the Trust ended its outsourced managed service contract in 2022-23 and has invested in a programme of replacing the equipment on this contract including three mammography machines, a CT scanner, two x-ray rooms and ultrasound machines. This work continues and along with an additional CT scanner, 2023-24 sees the replacement of one MRI and the second CT scanner.
- **Structural issue** – the Trust will be in year three of the significant capital investment available to support RAAC across the site and minimise the risk to patients, staff and visitors. This is an incredibly complex programme to deliver, notably for staff continuing to provide high quality patient care whilst the work takes place. It is disruptive and noisy, and the continual need to separate construction works and any dust created requires effective and active management.

Key schemes planned for 2023-24 include:

- installation of lamina flow ventilation hood in the day surgery unit
- refurbishment of the level three containment room in pathology.

Backlog projects – these are prioritised on an annual basis using risk-based methodology assessed by a range of disciplines including electrical, mechanical, architectural, etc.. Key schemes covered during 2022/23 include:

- hot and cold water systems associated with Legionella
- fire compartmentation upgrades (including a whole-site resurvey for 2023-24)
- electrical infrastructure in operational areas
- sluice room refurbishments
- replacement cooling plant for main theatres, recovery and critical care.
- ward kitchen refurbishments
- public toilet refurbishments.

Medical devices – the Trust has an allocation within the capital programme to invest in medical device replacement. These are prioritised on a risk-based methodology through the multidisciplinary medical devices group. Where possible, replacement devices are “connected” to maximise the opportunity to interact with and capture data in the patient record to provide an assurance loop of patient safety.

Digital – the Trust continues to invest in digital solutions wherever possible to support the digital first but not digital only programme. Improving the network performance and communications across the organisation are central to this along with ensuring investment in cyber security.

Sustainability

As an NHS organisation and a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

To fulfil our responsibilities for the role we play, WSFT has the following sustainability mission statement located in our Green Plan:

“West Suffolk NHS Foundation Trust will distinguish itself by making sustainability a part of all we do. In partnership with patients, staff and the local community, our plan captures the social, environmental and economic impact of our actions.”

The Green Plan was approved by the Trust Board in December 2022 and describes the action we will take. It will evolve over time as we achieve our goals and set ourselves even more ambitious targets. We are committed to playing a leading role in securing a healthy and sustainable Suffolk. The executive lead for sustainability and net zero is the chief operating officer and the programme is managed by the sustainability net zero steering group.

The NHS is committed to tackling climate change by reducing emissions to ‘net zero’.

Two clear and feasible targets emerge for the NHS net zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis:

- for the emissions we control directly (the NHS carbon footprint), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 from a 1990 baseline, equivalent to a 47% reduction from a 2019 baseline.
- for the emissions we can influence (our NHS carbon footprint plus), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 from a 1990 baseline, equivalent to a 73% reduction from a 2019 baseline.

(Delivering a ‘Net Zero’ National Health Service October 2020)

In order to embed sustainability within our business it is important to explain where sustainability features in our process and procedures. The Board-approved travel plan includes active travel approaches such as walking, cycling and car sharing and is reviewed annually. The procurement sustainability policy provides direction for the management of sustainable procurement which enables the Trust to contribute to the delivery of Government sustainable development aims, policy, strategy and targets.

As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

Adaptation

Climate change brings new challenges to the Trust.

Examples in recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods and droughts. Our Board-approved plans address the potential need to adapt the delivery of the organisation's activities and infrastructure to climate change and adverse weather events. Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change.

The Trust has responsibility to ensure all current and future planning includes measures to address climate-induced hazards. The Trust's business continuity and emergency response plans for climate-induced incidents include such awareness, and the overarching command and control capability has a programme of training and exercising to reinforce this. In addition, all purchasing, transformation and improvement planning are to include the same requirement.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Evidence of this commitment is provided in part through our work with strategic partners.

Strategic partnerships are already established with the following organisations:

- Suffolk and North East Essex Integrated Care System
- East of England Greener NHS
- Suffolk Growth Programme Board
- East of England Procurement Hub
- Alliance partners – Suffolk County Council, Suffolk GP Federation, Norfolk and Suffolk NHS Foundation Trust, working closely wider stakeholders such as the ambulance service, independent care providers, the voluntary community sector, employers, the education sector and business.

Energy

West Suffolk Hospital

Resource		2018/19	2019/2020	2020-2021	2021-2022	2022-2023
Gas	Use (kWh)	24,605,975	26,394,446	27,222,128	25,555,792	27,248,895
	tCO ₂ e	5,217	5,596	5,656	4,681	5511
Oil	Use (litres)	0	0	0	0	15,639
	tCO ₂ e	0	0	0	0	43
Electricity	Use (kWh)	4,594,967	5,578,407	5,217,833	5,694,398	4,111,584
	tCO ₂ e	2,048	1,946	1,503	1,209	795
Total energy CO ₂ e		7,265	7,542	7,159	5,890	5949
Total energy spend		£996,002	£1,040,357.60	£1,159,217	£1,515,326	£1,911,066

Source of data ERIC returns to the Information Centre.

Newmarket Community Hospital

Resource		2021-2022	2022-2023
Gas	Use (kWh)	1,495,016.79	1,622,246.92
	tCO ₂ e	274	328
Oil	Use (kWh)	0	0
	tCO ₂ e	0	0
Electricity	Use (kWh)	489,502.80	494,096
	tCO ₂ e	103	95
Total energy CO ₂ e		377	423
Total energy spend		£122,080.08	£166,583.48

Photovoltaic Panels – energy generation at the WSH site

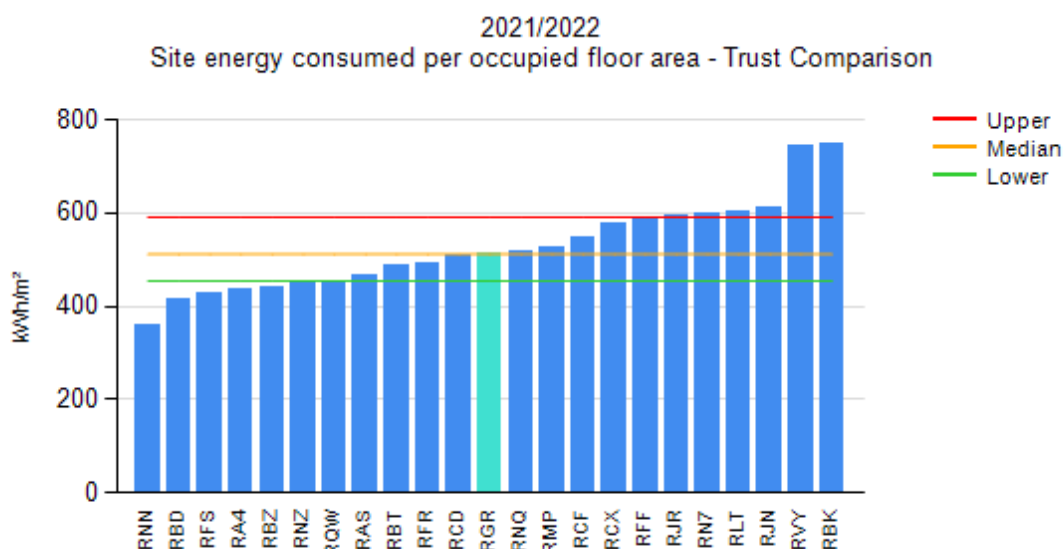
Energy output PV panels (kWh)	2018/19	2019/2020	2020/2021	2021-2022	2022-2023
Quince House	6,381	10,741	10,891	9,680	10,928
Accommodation (Beeton, Bloomfield and Clarke)	-	23,693	27,036	25,309	25,284
G10	N/A	N/A	N/A	10,824	19,758

2021-2022 data correct at 21/4/22

The Trust joined the Feed-in-Tariff (FIT) scheme and receives an income per kWh generated from the photovoltaic panels placed on Beeton, Bloomfield and Clarke House accommodation. During 2022-2023 this has generated an income of £1,054.22 from this scheme.

Combined heat and power (CHP) unit

	2018/2019	2019/2020	2020/2021	2021-2022	2022-2023
Fossil energy input to the CHP system (kWh)	14,514,629	17,176,672	15,971,654	14,023,976	17,308,104
Electrical energy output of CHP system (kWh)	5,144,790	5,501,661	5,128,958	4,557,809	5,665,645
Thermal energy output of CHP system (kWh)	4,160,030	7,272,380	7,479,210	5,761,290	7,427,276



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Paper

Paper (A4)		2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Volume used	Tonnes	44	42	38	39.8	37.8
Carbon emissions	tCO ₂ e	41	40	36	29.4	27.9

The Trust purchases recycled A4 paper, so the carbon factor applied in 2022-2023 is paper from a closed loop source.

Travel

We can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services

Every action counts, and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO₂e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

A travel expenses policy has been approved by the Trust executive group which reiterates the Trust travel hierarchy and the Trust expectations regarding business travel. In addition, the travel plan has been reviewed and active travel options are promoted through the staff newsletter.

The Trust reviews all requests for pool vehicles and ensures only low or ultra-low emission vehicles are leased. The option for electric and hybrid vehicles is also reviewed considering location, infrastructure and cost.

Business Travel – Agenda for Change and junior doctors

	Mileage	tCO ₂ e*
2019-20	574,593	160
2020-21	402,668	111
2021-22	1,115,310	307
2022-23	1,201,342	330

(*BEIS carbon factor 2022 average car, unknown fuel type 0.27465kgCO₂e/m)

WEEE Waste

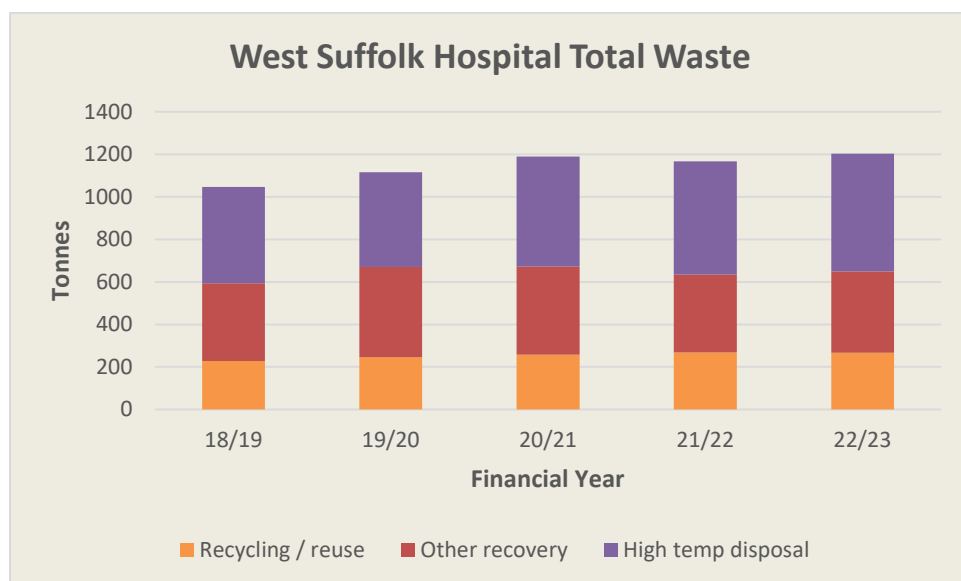
Through our contractor the Trust sent 6.77 tonnes of waste electronic and electrical equipment (WEEE) on for reuse out of a total of 16.67 tonnes collected. The Trust Waste Management Policy outlines our commitment to applying the principles set out in the waste hierarchy.

West Suffolk Hospital total waste (clinical and non clinical):

Waste		2017/18	2018/17	2019/20	2020/21	2021/22	2022/23
Recycling/ re-use	(tonnes)	254.14	228.28	246.1	257.94	268	267
	tCO ₂ e	5.53	4.88	5.36	5.5	5.7	5.68
Other recovery	(tonnes)	393.94	364.94	423.74	414	366	382
	tCO ₂ e	8.57	7.81	9.22	8.82	7.79	8.12
High temp disposal	(tonnes)	444.10	452.76	445.54	517.71	533	554
	tCO ₂ e	97.70	99.7	98.02	113.90	117.26	*489.98
Landfill	(tonnes)	0.00	0.00	0.00	0	0	0
	tCO ₂ e	0.00	0.00	0.00	0	0	0
Total waste (tonnes)		1092.18	1045.98	1,115.38	1,189.65	1168	1203
% Recycled or re-used		23%	21.8%	22%	22%	23%	22%
Total waste tCO ₂ e		111.80	112.39	112.60	128.22	130.75	503.78

Data source – quarterly waste returns, , BEIS carbon factors

*Emission factor taken from recently launched 'Waste carbon reduction tool' developed by NHS England



Data source – quarterly waste returns

Recycling Target

Current recycling rate – 22%

Target – 30% by end of 2025/2026 financial year.

Recycling Streams

The Trust sent 12.72 tonnes of plastic waste for recycling from West Suffolk Hospital. The plastic bottle recycling stream will be expanded to accept more types of recyclable plastic, similar to those we can recycle in the recycling waste stream in our homes. This stream, along with the aluminium recycling stream, will be made available in all non-clinical areas with the view to introduce these into clinical areas as part of a gradual rollout plan, accompanied by segregation checks.

The introduction of the pallet recycling waste stream has been a success, with 14.31 tonnes of pallets sent for recycling or reuse, generating a total of £642.50 in revenue for the Trust. This is up from 2.18 tonnes in the previous year.

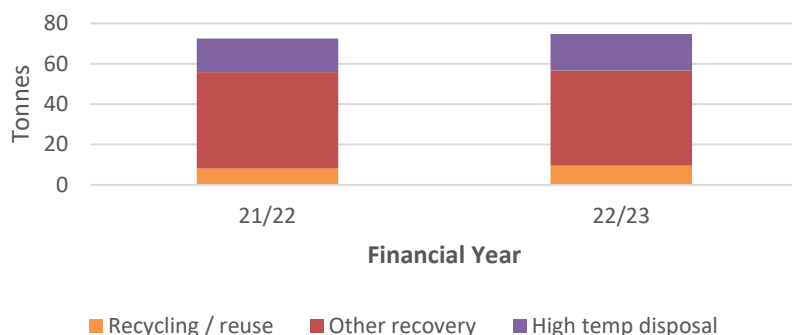
The Trust will seek to further implement the waste hierarchy in the months to come through sending waste formerly recycled or incinerated, for reuse. The Trust will prioritise reuse within the organisation, then opting to reuse items through external routes by utilising partnerships with local and nationwide reuse companies.

Newmarket Community Hospital Total Waste

Waste		2021/22	2022/23
Recycling/ re-use	(tonnes)	8.20	9.63
	tCO ₂ e	0.17	0.20
Other recovery	(tonnes)	47.66	47.08
	tCO ₂ e	1.01	1
High temp disposal	(tonnes)	16.73	18
	tCO ₂ e	3.68	*16.22
Landfill	(tonnes)	0.00	0
	tCO ₂ e	0.00	0
Total waste (tonnes)		72.58	74.71
% Recycled or re-used		11%	13%
Total waste tCO ₂ e		4.86	17.42

* Emission factor taken from recently launched 'Waste carbon reduction tool' developed by NHS England

Newmarket Community Hospital Total Waste



Finite resource use – water

West Suffolk Hospital

Water		2018/19	2019/20	2020/21	2021/22	2022/23
Mains water	m ³	121,030	111,001	133,409	145,244.22	158,015
	tCO ₂ e	110	101	140.34	21.6 (supply) 35.4 (treatment)	23.54 (supply) 36.53 (treatment)
Water and sewage spend	£	£263,086	£189,056	£320,387	£333,994.65	£295,888.99

Source of data - ERIC returns to the Information Centre.

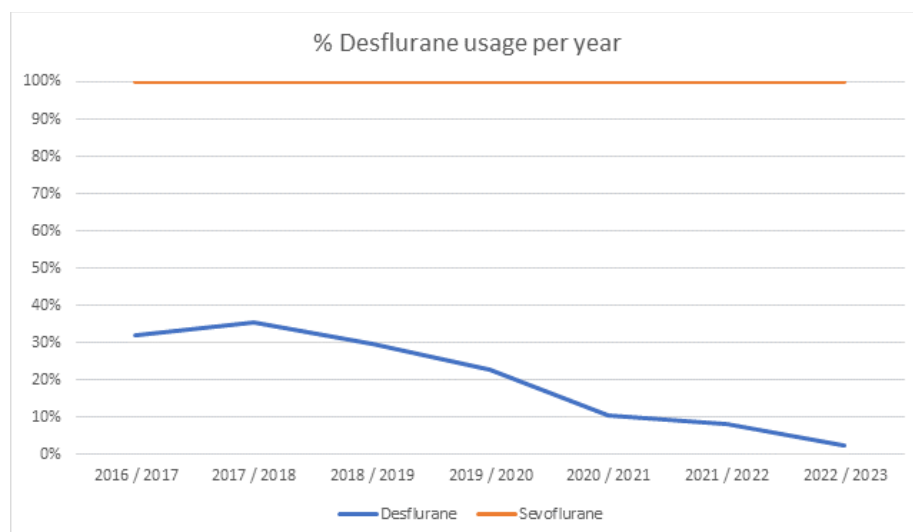
Newmarket Community Hospital

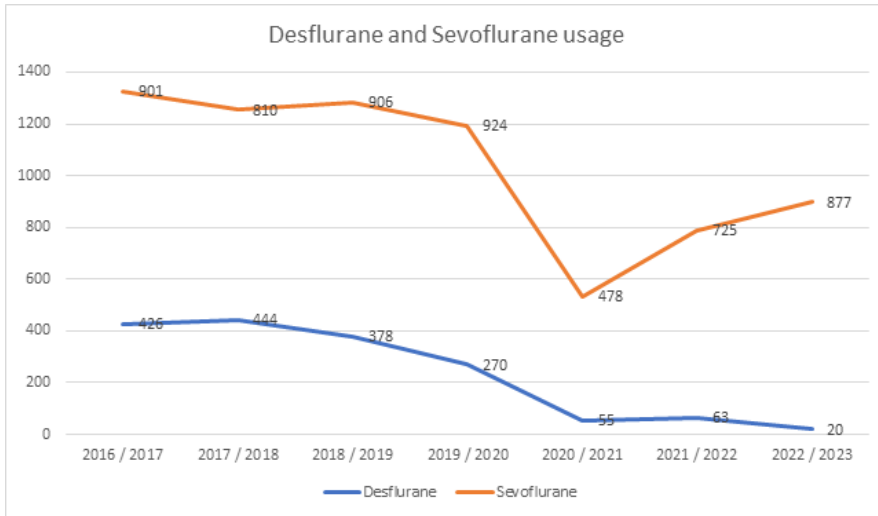
Water		2021/22	2022/23
Mains water	m ³	3,402	5,011
	tCO ₂ e	1.7 (supply) 0.79 (treatment)	0.75 (supply) 1.23 (treatment)
Water and sewage spend	£	£10,139.99	£16,015.27

Other initiatives

There are many examples of good sustainable development practice in the Trust, ranging from work in the community through the Alliance partnership, health and wellbeing of staff, sustainable procurement practices, estates management and capital project development, for example:

The Trust has been reducing the use of desflurane in surgery, with an aim for it to be less than 5% (2022/2023) by volume of total aesthetic gas use.





In 2023 – 2024 the aim is to further reduce the proportion of desflurane to all anaesthetic gases used in surgery to 2% or less by volume with a view to eliminating use of desflurane altogether, except as permitted by guidance, from 31 March 2024.

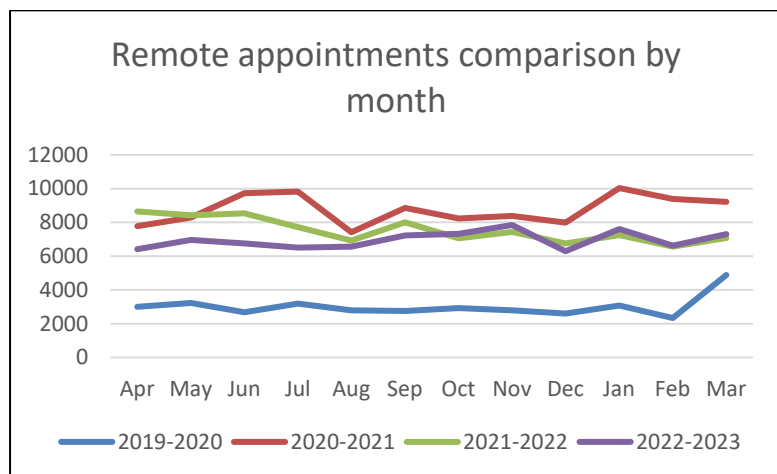
The number of remote appointments for patients in 2022-2023 was 83,445. The associated benefits, based on the avoidance of the appointments, are:

- 3,227,096 patient miles saved, equivalent of going around the world 130 times.
- 1,391 hours of patient time saved through avoided face to face appointments
- 38,596 car park spaces saved

A reduction of 594.9 tonnes of CO2 emissions (using the outpatient transformation benefits calculator v1 January 2021).

Remote appointments

Month	2019-2020	2020-2021	2021-2022	2022-2023
Apr	2997	7777	8,649	6419
May	3238	8295	8,427	6961
Jun	2683	9720	8,537	6754
Jul	3183	9825	7,712	6509
Aug	2785	7417	6,920	6571
Sep	2753	8856	8,014	7234
Oct	2922	8241	7,059	7331
Nov	2785	8383	7,444	7846
Dec	2600	7991	6,747	6294
Jan	3072	10033	7,238	7605
Feb	2339	9390	6,567	6622
Mar	4885	9227	7,075	7299



Walking aids for re-use or recycling

From 1 September 2022, the Trust has implemented a six-month pilot working with Medequip, to maximise the return of community equipment, including walking aids. Two 1,100 litre blue bins are located in the patient and visitor car park at the front of the hospital as a collection point for returns. The trial is reviewed regularly and has been extended. Medequip makes a weekly collection of returned items, which are cleaned, repaired and where appropriate returned to use.

Items returned are tracked back to the organisation that originally funded the equipment, where possible, and they receive a credit. Otherwise a credit is returned to the contract and each partner organisation receives a percentage of the unallocated credit value. Also, as items have been returned, they have not been requested to be collected and therefore a further saving can be attributed. The average collection is five days response speed (current cost £27.75) with an average of four items per collection, saving Medequip having to make an additional 35 collections. These 35 collections make a further estimated saving of £1,200.19 for the contract of which £721.50 (26 collections) would be an estimated direct saving for the Trust.

Month	Number of items returned in blue collection bins	Rebate to contract	Rebate to Trust
September 2022	9	£130.88	£25.20
October 2022	16	£335.40	£148.80
November 2022	30	£921.34	£442.10
December 2022	49	£1028.11	£351.57
January 2023	40	£572.92	£281.98
February 2023	34	£562.25	£291.14
Total	178	£3,550.90	£1,540.79

Across all collection points and methods, including services provisioned by WSFT services, 750 walking aids were returned between December 2022 – February 2023. This includes all walking aids (crutches, walking sticks, quad sticks, wheeled and non-wheeled walking frames for both adults and paediatric patients (core stock items)).

Equality of service delivery to different groups

As a Trust we are developing and promoting an inclusive culture. This means we embrace all people irrespective of, for example, race, religion or belief, sex, gender identity or expression, sexual orientation, age, marital status, pregnancy, maternity or disability. We strive to give equal access and opportunities to all and get rid of discrimination and intolerance. We will do this both as an employer and as a service provider. One of our FIRST Trust values is 'inclusivity' and we endeavour to live this value through all of our work.

Over the past year we have undertaken specific work in this area related to patients, service users and carers, which includes:

- full Trust-wide review of patient information and its accessibility, with recommendations put forward to improve
- roll-out of the patient profile, enabling additional means to collect patient demographic data
- improve local community engagement with underrepresented groups such as those affiliated with supporting protected characteristics, including Bury St Edmunds 4 Black Lives, Steel Bones, Suffolk LGBT Forum, Suffolk Sight, ACE Anglia, One Voice 4 Travellers
- showing support to patients and the public through rainbow lanyards, badges, and exploring flags of origin to represent the heritage of staff and create connection and belonging for patients
- connecting patient groups with staff networks
- improving easy-read provision for our patients
- rolling out health literacy and accessible information training.

We have also participated in the Equality Delivery System (EDS) 2022 assessing the accessibility of our chronic obstructive pulmonary disease (COPD) service and Patient Advice and Liaison Service (PALS). We plan to run the EDS on a rolling programme throughout the year, assessing services across the Trust with a focus on those from the Core20Plus5 (an NHS England approach to reduce health inequalities) in line with health inequalities data.

Our inclusion action plan sets out our priorities to achieve key objectives for our staff focused work. This continues to be developed and strengthened based on insights gained from a range of data sources through which staff have shared their lived experiences. Examples of work we have undertaken this year includes:

- relaunch of three of our staff networks:
 - Disability staff network
 - REACH (Race Equality and Cultural Heritage) – a network for Black, Asian and other ethnic minority staff
 - LGBT+ staff network
- Workforce Race Equality Standard (WRES) data has been analysed and triangulated with our staff survey and Workforce Disability Equality Standard (WDES) data, enabling further actions to be developed within the action plan
- online resources have been collated in readiness for launch of the new online learning hub for staff
- improvements have been made to our recruitment processes to reduced bias and to enable greater diversity, this is a continuing, long-term programme with many aspects to cover
- work to continue the development and embedding of Equality Impact Assessments.

Further information is provided within section 2.8.8 (equality and diversity).

2. Accountability report

2.1 Governors' report

2.1.1 Responsibilities

The Council of Governors is a key part of WSFT's governance arrangements. It works effectively with the Board of directors and represents the views of the population of the Trust's catchment area and its staff when considering WSFT's future strategy.

The Council of Governors holds the Board of directors collectively to account for the performance of WSFT, including ensuring that the Board of directors acts so the Trust does not breach the terms of its authorisation.

2.1.2 Composition

The Council of Governors comprises 14 elected public governors, five elected staff governors and seven partner-nominated governors. The term of office for all governors is three years.

Public governors – representing and elected by the public members of WSFT

Florence Bevan
Allen Drain ⁽¹⁾
Michael Durham ⁽²⁾
Keith Foss ⁽³⁾
Robin Howe
Ben Lord
Roy Mawford ⁽⁴⁾
Gordon McKay ⁽⁵⁾
Jayne Neal
Adrian Osborne
Joe Pajak
Margaret Rutter ⁽⁶⁾
Jane Skinner (lead governor) ⁽⁷⁾
Liz Steele ⁽⁸⁾
Clive Wilson

Staff governors – representing and elected by the staff members of WSFT

Rachel Darrah ⁽⁹⁾
Margo Elsworth ⁽¹⁰⁾
Louisa Honeybun ⁽¹¹⁾
Sarah Judge
Amanda Keighley
Martin Wood

Partner governors – nominated by partner organisations of WSFT

Councillor Carol Bull	West Suffolk Council also representing Mid-Suffolk District Council and Babergh District Council
Dr David Brandon ⁽¹²⁾	West Suffolk Alliance
Dr Andrew Hassan ⁽¹³⁾	SNEE ICB
Councillor Rebecca Hopfensperger	Suffolk County Council
Elsbeth Lees ⁽¹⁴⁾	West Suffolk College also representing University of Suffolk
Laraine Moody ⁽¹⁵⁾	West Suffolk College also representing University Campus Suffolk
Dr Thomas Pulimood	University of Cambridge
Vacant (second representative)	SNEE ICB in consultation with local general practitioners and West Suffolk Alliance
Vacant	Friends of West Suffolk Hospital

- 1) Allen Drain resigned from Council of Governors Apr 2023
- 2) Michael Durham appointed to Council of Governors Sept 2022 and resigned in Mar 2023
- 3) Keith Foss resigned from Council of Governors May 2022
- 4) Roy Mawford resigned from Council of Governors Apr 2022
- 5) Gordon McKay appointed to Council of Governors Sept 2022
- 6) Margaret Rutter passed away in Feb 2023
- 7) Jane Skinner Lead Governor from Jan 2023
- 8) Liz Steele Lead Governor until Dec 2022
- 9) Rachel Darrah resigned from Council of Governors Jan 2023
- 10) Margo Elsworth resigned from Council of Governors Jul 2022
- 11) Louisa Honeybun appointed to Council of Governors Sept 2022
- 12) Dr David Brandon appointed to Council of Governors Feb 2023
- 13) Dr Andrew Hassan resigned from Council of Governors Feb 2023
- 14) Elspeth Lees appointed to Council of Governors Mar 2023
- 15) Laraine Moody resigned from Council of Governors Mar 2023

Governor attendance at Council of Governors' meetings 2022/2023

There were nine formal meetings of the Council of Governors: 18 May 2022; 4 July 2022 (held in private); 20 September 2022 (held in private); 27 September 2022 (Annual Members Meeting); 10 November 2022; 18 November 2022 (held in private); 12 January 2023 (held in private); 10 February 2023 (held in private) and 1 March 2023.

The Trust was delighted to reintroduce face-to-face meetings with the public, following the easing of COVID-19 restrictions. The following governors were in attendance (note that attendance at AMM is not included in figures below):

Name	Title	Attendance (out of eight meetings)
Florence Bevan	Public governor	8
Dr David Brandon ⁽¹⁾	Partner governor	2 (of 2)
Carol Bull	Partner governor	7
Rachel Darrah ⁽²⁾	Staff governor	5 (of 5)
Allen Drain	Public governor	6
Michael Durham ⁽³⁾	Public governor	2 (of 3)
Margo Elsworth ⁽⁴⁾	Staff governor	1 (of 2)
Keith Foss ⁽⁵⁾	Public governor	1 (of 3)
Andrew Hassan ⁽⁶⁾	Partner governor	0 (of 0)
Louisa Honeybun ⁽⁷⁾	Staff governor	4 (of 6)
Rebecca Hopfensperger	Partner governor	8

Name	Title	Attendance (out of eight meetings)
Robin Howe	Public governor	6
Sarah Judge	Staff governor	7
Amanda Keighley	Staff governor	5
Elspeth Lees ⁽⁸⁾	Partner governor	0 (of 0)
Ben Lord	Public governor	5
Roy Mawford ⁽⁹⁾	Public governor	0 (of 0)
Gordon McKay ⁽¹⁰⁾	Public governor	2 (of 6)
Laraine Moody ⁽¹¹⁾	Partner governor	0
Jayne Neal	Public governor	7
Adrian Osborne	Public governor	6
Joe Pajak	Public governor	5
Thomas Pulimood	Partner governor	5
Margaret Rutter ⁽¹²⁾	Public governor	2 (of 7)
Jane Skinner (<i>lead</i>)	Public governor	7
Liz Steele	Public governor	8
Clive Wilson	Public governor	6
Martin Wood	Staff governor	4

- 1) Dr David Brandon appointed to Council of Governors Feb 2023
- 2) Rachel Darrah resigned from Council of Governors Jan 2023
- 3) Michael Durham appointed to Council of Governors Sept 2022 and stepped down on 1 Mar 2023
- 4) Margo Elsworth resigned from Council of Governors Jul 2022
- 5) Keith Foss resigned from Council of Governors May 2022
- 6) Andrew Hassan resigned from Council of Governors Feb 2022
- 7) Louisa Honeybun appointed to Council of Governors Sept 2022
- 8) Elspeth Lees appointed to Council of Governors Mar 2023
- 9) Roy Mawford resigned from Council of Governors Apr 2022
- 10) Gordon McKay appointed to Council of Governors Sept 2022
- 11) Laraine Moody resigned from Council of Governors Mar 2023
- 12) Margaret Rutter passed away in Feb 2023

In attendance at these meetings were: Craig Black, executive director of resources/interim chief executive (2); Ewen Cameron, chief executive (1); Jude Chin, non-executive director/chair (6 of 6); Nicola Cottington, chief operating officer (2 of 3); Dr Richard Davies, non-executive director (2 of 3); Tracy Dowling, non-executive director (2 of 2); Antoinette Jackson, non-executive director (1 of 2); Christopher Lawrence, non-executive director (1 of 1); Hilary McCallion, non-executive director (1 of 2); Louisa Pepper, non-executive director (3 of 3); Geraldine O'Sullivan, non-executive director (1 of 2); Jeremy Over, executive director of workforce and communications (1 of 1); Alan Rose, non-executive director (3 of 4); Krishna Yergol, non-executive director (2 of 2).

2.1.3 Register of interests

All governors are asked to declare any interests on the register at the time of their appointment or election. This register is reviewed and maintained by the Trust secretary. The register is available for inspection by members of the public. Anyone who wishes to see the register should contact the Trust secretary at the following address:

Trust secretary, Foundation Trust Office, West Suffolk NHS Foundation Trust, West Suffolk Hospital, Hardwick Lane, Bury St Edmunds, Suffolk IP33 2QZ.

2.1.4 Governors and directors working together

Governors and directors have developed a professional working relationship, on both a formal and informal basis. Governors attend and observe the monthly Board of directors' meetings. This gives them an insight into and an understanding of the performance of the Board, particularly from a quality and

finance perspective, and provides an insight into the role and performance of the non-executive directors (NEDs). At the start of 2023 Governors were invited to act as observers at the three assurance committees of the Board – the insight, involvement and improvement committees.

The NEDs present summary reports at the Council of Governors meetings. When required they also present reports on any other areas they lead on.

The senior independent director (SID) attends Council of Governors' meetings and workshops. Governors are aware that they should discuss any matters with the SID that they do not feel can be addressed through the chair.

A joint governor and NED training session took place on 17 March 2023 and to support governors in their role a range of joint Board/governor briefings took place during 2022-23:

- 6 Apr 2022 - briefing on finance and budget
- 12 Jul 2022 - Future System programme
- 27 Jun 2022 - digital strategy
- 12 Dec 2022 - ICB & provider collaboration briefing
- 17 Jan 2023 - Future System programme follow up session
- 23 Mar 2023 - Trust's infection prevention policy
- 25 Apr 2023 - operational planning guidance

At joint workshops, presentations and formal and informal meetings governors contribute to WSFT's forward plan.

To support governors in engaging with staff, patients and the public they have previously taken part in activities including quality and environmental walkabouts, area observations and engagement sessions in the WSH Courtyard Café. In line with social distancing requirements these activities were paused during the COVID-19 response, however governors have engaged with staff through virtual meetings, including the regular all-staff briefing.

The engagement committee, which is a sub-committee of the Council of Governors, meets quarterly. Governors provide feedback on key issues they have encountered when engaging with the public to the patient experience committee, which is attended by executive directors and NEDs. A report on how these issues are being addressed is provided to the Council of Governors meeting.

To support governors in their role training and development sessions have been held during the year:

- finance with executive director of resources
- quality and performance with chief operating officer and executive chief nurse
- governor training session with external trainer – governance, the Board and the role of the governor; effective questioning and challenge
- joint governor and non-executive director training session with external trainer – the Board and council working together.

After its review of the Trust Constitution, the Council of Governors established a standards committee as a standing committee of the Council of Governors. The purpose of the standards committee is to take responsibility to review issues relating to standards and governance of the council. Part of this remit is to review the constitution and specifically consider membership of the council in terms of number of seats and partner organisations.

Following the publication of the West Suffolk Review commissioned by NHS England in December 2021, WSFT was committed to taking appropriate action to meet the advisory recommendations and learnings in the report. To ensure that there is full accountability and engagement, it established a governor/director working group to take this forward. The work of this group recognised that governors and directors have distinct and separate roles in the governance of WSFT but have a shared responsibility to act in the best interests of the Trust. During the year it was agreed that the working group be dissolved as the activities are now being monitored through the involvement committee. The

importance of governors' observation of the Board assurance committee was recognised as critical in supporting this decision as these fora consider the issues within this group's remit in detail. As part of the proposal to cease the West Suffolk review governor director working group it is important to record the transition of responsibility to the involvement committee for review of relevant matters.

The Good Governance Institute (GGI) undertook a governance review of the WSFT Council of Governors between March and August 2022. A report of the review was received in September. The Council of Governors received the report from standards committee and noted the action plan which focused on the work being done following the recommendations from the good governance institute (GGI). Eight recommendations were made in the report and a training needs analysis for governors was carried out. The standards committee will maintain oversight to ensure delivery of the action plan in 2023-24.

2.1.5 Membership

The membership of WSFT is split into public and staff constituencies.

Public membership

Any person aged 16 or over who lives within the membership area is eligible to be a public member. Public members are recruited on an opt-in basis.

In May 2023 the Trust consolidated the existing membership area into a single public constituency for members living within the whole of Suffolk, Norfolk, Cambridgeshire or Essex.

Staff membership

All WSFT staff who are employed by the Trust under a contract of employment which has no fixed term; has a fixed term of at least 12 months; or have been continuously employed by the Trust under a contract of employment for at least 12 months are eligible to become staff members unless they choose to opt out.

In addition, staff who exercise functions for the purposes of the Trust, without a contract of employment, continuously for a period of at least 12 months are also eligible to become staff members unless they choose to opt out. For clarity this does not include individuals who exercise functions for the purposes of the Trust on a voluntary basis.

Membership numbers

At 31 March 2023 there were 6,953 public members and 5,218 staff members.

Membership strategy

The Trust's membership strategy is reviewed annually by the engagement committee for consideration by the Council of Governors and approval by the Board of directors. We aim to maintain and, where possible, increase our public membership and to ensure that staff membership is maintained at an appropriately high level. Experience has shown that engaging with the public is a very effective way of recruiting new members and gaining their views.

Governors use a short questionnaire to engage with members of the public during recruitment initiatives. As well as recruiting new members, this provides valuable feedback from patients and the public on their experiences and views of WSFT. In line with social distancing requirements these activities had paused during the COVID-19 response and are now reinstated following the easing of restrictions.

The Council of Governors' engagement committee meets regularly to review the membership numbers and the targets set in the membership strategy to ensure that it is representative. It also considers ways of increasing membership in areas where numbers are low. The chair of this committee gives a report to the quarterly Council of Governors meeting. Performance against the agreed targets remains good.

A number of engagement activities had paused as a result of the social distancing requirements, and a greater focus was being given to electronic communication and engagement methods. We are hoping to have more engagement activities in 2023-24 following the easing of restrictions.

Criteria	As at 31 March 2023	Target (Mar 2024)
1. Achievement of the recruitment target: a. total number of public members b. staff opting out of membership	6,953 <1%	6,000 <1%
2. Achieve a representative membership for our membership area, Priorities for action: a. age – recruitment of under 50s b. engagement and recruitment events in all market towns of membership area (Thetford, Newmarket, Stowmarket, Haverhill and Sudbury)	1,702 20%¹	1,250 40%
3. An engaged membership measured by: a. number of member events b. member attendance – total all events c. annual members' meeting attendance (each year)	1 150² 150 (2022)	3 400² 200

¹ Figure at March 2023 (impacted by COVID-19 restrictions)

² Includes people attending annual members' meeting – figure at March 2023

During the past year the Trust has paused its membership interest events on services it provides. The Annual Members Meeting was held at the Apex in Bury St Edmunds.

Contact procedures for members

Contact details for the foundation trust office are given on the website and queries/comments will be directed to the appropriate governors/directors.

A newsletter is sent to all members two or three times a year to update members on WSFT news, and give details of how to contact the Trust.

2.1.6 Nominations committee

The governors' nominations, appointments and remuneration committee is responsible for making recommendations to the Council of Governors on the appointment of the chair and other non-executive directors. The committee also makes recommendations for chair and non-executive director remuneration and terms and conditions.

The committee is chaired by the Trust chair, except when considering the appointment, remuneration and terms and conditions of the Trust chair, or feedback from their appraisal, when it is chaired by the senior independent director or lead governor.

In July 2022 the committee reviewed the feedback from the appraisals of the NEDs and key messages were fed back to each individual.

In July 2022 following a comprehensive interview process for substantive chair, the committee presented a report to the Council of Governors recommending the appointment of Jude Chin as Trust chair for a period of one year and to continue with the new NED appointments as planned. The recommendations were agreed at a closed Council of Governors meeting on 4 July 2022.

Following a shortlisting meeting in July 2022 and subsequent interview process five NEDs were appointed and approved at a closed Council of Governors meeting on 20 September 2022.

In November 2022, the committee met to agree next steps around the appointment process of University of Cambridge nominated NED and to consider appointment of the deputy chair early in the new year. The committee also considered the options for applying an inflationary pay award for NEDs and reached a decision.

In November 2022 the appointment panel made a recommendation for the appointment of the chief executive to the closed Council of Governors on 18 November 2022.

In January 2023 the committee also made a recommendation to appoint University of Cambridge nominated non-executive director (NED) at the closed Council of Governors meeting on 12 January 2023. In addition, the committee met to review the Chair's term of office and agree the preferred option for Chair appointment and made a recommendation to the closed Council of Governors meeting on 10 February 2023.

The committee also met in April 2023 to receive a progress report on the recruitment for the substantive chair position and a subsequent meeting was arranged in May to shortlist the chair candidates. Following a full and competitive recruitment process the council of governors appointed Jude Chin as chair of West Suffolk NHS Foundation Trust. A term he will serve for the next three years until June 2026.

Attendance at nominations committee meetings 2022-23

Name	Title	Attendance (out of 3)
Jude Chin (chair)	Chair	2 (of 2)
Richard Davies	Senior independent director	1 (of 1)
Carol Bull	Partner governor	2 (of 3)
Ben Lord ⁽¹⁾	Public governor	0 (of 0)
Roy Mawford ⁽²⁾	Public governor	0 (of 0)
Jayne Neale ⁽³⁾	Public governor	0 (of 0)
Joe Pajak ⁽⁴⁾	Public governor	0 (of 0)
Jane Skinner	Public governor	3 (of 3)
Liz Steele	Public governor	3 (of 3)
Clive Wilson ⁽⁵⁾	Public governor	2 (of 3)
Martin Wood	Staff governor	1 (of 3)

Shortlisting/longlisting discussions are not recorded or included in the figures above.

⁽¹⁾ Ben Lord committee member from February 2023

⁽²⁾ Roy Mawford committee member until resignation in April 2022

⁽³⁾ Jayne Neale committee member from February 2023

⁽⁴⁾ Joe Pajak committee member until stepping down from committee in April 2022

⁽⁵⁾ Clive Wilson committee member from May 2022

Meeting dates: 7 July 2022; 1 November 2022; 30 January 2023.

Shortlisting/longlisting discussions: 21 April 2022 (shortlisting); 13 July 2022 (NED shortlisting); 8 February 2023 (chair longlisting); 28 February 2023 (chair short listing).

2.2 Directors' report

2.2.1 Responsibilities

The Board of directors' functions as a unitary corporate decision-making body. Non-executive directors (NEDs) and executive directors are full and equal members. The role of the Board is to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions in accordance with the constitution.

The Board of directors comprises executive directors and part-time NEDs; the latter chosen because of their experience and skills relevant to the organisation's needs. The role of the Board is to set the strategic aims, vision, values and standards of conduct for the Trust and to be responsible for ensuring

that management delivers the Trust's strategy and operations against that framework.

Disagreements between the Board of directors and Council of Governors are resolved through a process which aims to achieve informal resolution in the first instance, following which a formal process will be taken that involves a resolution for discussion at a Board meeting.

The descriptions below demonstrate the balance, completeness and relevance of the skills, knowledge and expertise that each of the directors brings to WSFT.

2.2.2 Composition

(a) Non-executive directors

Jude Chin - Non-executive director and chair

(Appointed as interim NED from 1 September 2021 and interim chair from 1 February 2022. Jude was appointed for a one-year term as the substantive chair on 4 July 2022 and subsequently appointed on a three-year term from 2 June 2023).

Areas of special interest/responsibility: chair of remuneration committee and chair of the governors' nominations, appointments and remuneration committee. Jude is chair of the Board of Directors and Council of Governors of WSFT.

Previously, Jude was vice-chair of Colchester Hospital University NHS Foundation Trust and partner at KPMG.

Independent director – yes (satisfies criteria of code of governance B. 2.6)

Tracy Dowling: Non-executive director

(Appointed from 1 November 2022)

Areas of special interest/responsibility: chair of the involvement committee from April 2023, member of the audit committee, remuneration committee and improvement committee.

Tracy is the former chief executive of Cambridgeshire and Peterborough NHS Foundation Trust. Prior to this she was chief officer of the Cambridgeshire and Peterborough Clinical Commissioning Group and held director-level roles in commissioning and the acute sector. Tracy has qualifications in radiography, an MBA and a management qualification from the Institute for Health Service Management. Tracy is also chair of the Eastern Academic Health Science Network (AHSN).

Independent director – yes (satisfies criteria of code of governance B. 2.6)

Antoinette Jackson: Non-executive director and senior independent director

(Appointed from 1 November 2022)

Areas of special interest/responsibility: chair of the insight committee, member of the remuneration committee, audit committee, involvement committee and charitable funds committee, lead NED Board freedom to speak up guardian, including whistleblowing

Antoinette has a background in local government and was the chief executive of Cambridge City Council between 2009 and 2020. She began her career at Reading Borough Council before joining the London Borough of Camden in roles focusing on quality and customer services. Antoinette is also chair of trustees for Arthur Rank Hospice Charity and Cambridge and District Citizens Advice.

Independent director – yes (satisfies criteria of code of governance B. 2.6)

Dr Geraldine O'Sullivan: Non-executive director

(Appointed from 1 November 2022)

Areas of special interest/responsibility: deputy chair of the improvement committee, member of the remuneration committee and involvement committee.

Geraldine brings extensive experience gained within the NHS, including as a psychiatrist and then as executive medical director at Hertfordshire Partnership NHS Trust. She is an experienced NED with experience gained in healthcare and the not-for-profit sectors. Geraldine brings a wealth of knowledge around safety and quality improvement in healthcare as well as a detailed understanding around corporate governance.

Independent director – yes (satisfies criteria of code of governance B. 2.6)

Louisa Pepper - Non-executive director and deputy chair

(Appointed: 1 September 2018 until 31 August 2021; reappointed until 31 August 2024)

Areas of special interest/responsibility: chair of the improvement committee, member of the insight committee, audit committee, remuneration committee, RAAC risk committee, lead NED for safeguarding adults, security and emergency preparedness, resilience and response (EPRR), access and pathology.

Louisa joined Suffolk Constabulary in 1991, gaining promotion through all ranks from constable to assistant chief constable, until her retirement in September 2017. She undertook a number of roles, working with partners at all levels in the public, private and voluntary sector, including working for both Norfolk and Suffolk Constabulary as head of strategic change, head of professional standards and head of criminal justice.

Louisa is an elected parish councillor for Thorpe Morieux.

Independent director – yes (satisfies criteria of code of governance B. 2.6)

Dr Roger Petter (University of Cambridge nominated NED)

Appointed term 1 March 2023 – 28 February 2026

Areas of special interest / responsibility: remuneration committee, insight committee (deputy chair), improvement committee, board neonatal and maternity safety champion, doctors' revalidation support group.

Roger was appointed to the Board through the UofC. He recently retired from a General Practice Partnership in Cambridge. For many years he provided welfare support to medical students at the University of Cambridge School of Clinical Medicine, as well as to Cambridge University Hospitals doctors. He is actively involved in medical education: for two decades he was a GP trainer, and he continues with medical student teaching.

Independent director – yes (see Note 1)

Krishna Yergol: Non-executive director

(Appointed from 1 November 2022)

Areas of special interest/responsibility: deputy chair of the involvement committee, member of the remuneration committee, digital programme board and Future System programme board.

Krishna is chief technology officer at Suffolk County Council, leading the council's technology services across operations, change and innovation. Prior to this, he worked as an associate director for digital enablement within NHS North West and for the Scottish Government as head of digital transformation & national programmes. Krishna spent his early career working in the private sector. He joined the NHS in 2018.

Independent director – yes (satisfies criteria of code of governance B. 2.6)

Note 1

Dr Roger Petter is a nominated appointment by the University of Cambridge. The appointment as a NED is reviewed and approved by the Council of Governors. This review considered relevant skills and experience, including his ability to provide independent challenge to the Trust. As such the role is considered to be an independent director, despite his nominated status.

Non-Executive Directors who left the Trust during 2022-23

Dr Richard Davies – NED/ Senior Independent Director

(Appointed: 1 March 2017 until 28 February 2020; reappointed 1 March 2020 until 28 February 2023)

Areas of special interest/responsibility: senior independent NED; chair of the insight committee (from May 2021) and learning from deaths group; Trust wellbeing guardian, Board neonatal and maternity safety champion, member of the Future System programme board, remuneration committee, audit committee, and revalidation support group; NED link to medical director.

Richard was appointed to the Board through University of Cambridge; he is a general practitioner and worked from 2004 in a variety of roles within the Cambridge University School of Clinical Medicine; including director of GP studies, and from 2013 until 2020 as a sub-dean in the clinical school, with a particular responsibility for student welfare. He retired from clinical practice and from his formal university roles in August 2020. He continues to work as a clinical advisor to the university COVID-19 helpdesk and as a vaccinator.

Independent director – yes (see Note 1)

Christopher Lawrence

(Appointed on 1 June 2021 and stepped down on 31 October 2022)

Areas of special interest/responsibility: Chair of audit committee and charitable funds committee and member of future system board, red risk oversight committee and remuneration committee.

Prior to joining the Trust in June 2021, Chris was a chairman at Hertfordshire Partnership University NHS Foundation Trust and managing director at London Philharmonic Orchestra. He was also a director at Credit Commercial de France, assistant director at N M Rothschild and assistant vice president at Citicorp International.

Independent director – yes (satisfies criteria of code of governance B. 2.6)

Professor Hillary McCallion CBE: associate non-executive director

(Appointed: 1 November 2022 and stepped down on 31 March 2023)

Areas of special interest/responsibility: chair of the charitable funds committee, member of remuneration committee and improvement committee

Hilary was a nurse by background, Hillary spent her career working in the NHS and was executive director of education and nursing at South London and Maudsley NHS Foundation Trust for fourteen years. Hilary runs her own consultancy business, providing national leadership programmes, executive coaching and incident inquiries. Hilary was awarded a CBE for Mental Health Nursing in the Queen's Birthday Honours in 2012.

Independent director – yes (satisfies criteria of code of governance B. 2.6)

Alan Rose – NED and deputy chair

(Appointed: 1 April 2017 until 31 March 2020; reappointed 1 April 2020 until 31 March 2023)

Areas of special interest/responsibility: member of audit committee, chair of remuneration committee, chair of involvement committee, member of clinical excellence & discretionary awards committee and lead NED for patient experience and public engagement.

Alan was chair of Colchester Hospital University NHS Foundation Trust, having previously been a NED and chair of York Teaching Hospital NHS Foundation Trust for nine years. Prior to this he worked in the commercial sector in strategy and marketing roles. He is a member of the board of governors of Anglia Ruskin University.

Independent director – yes (satisfies criteria of code of governance B. 2.6)

Note 1

Dr Richard Davies is a nominated appointment by the University of Cambridge. The appointment as a NED is reviewed and approved by the Council of Governors. This review considered relevant skills and experience, including his ability to provide independent challenge to the Trust. As such the role is considered to be an independent director, despite his nominated status.

Non-Executive Directors who joined the Trust during 2023-24

Michael Parsons - Non-executive director

(Appointed from 1 May 2023)

Areas of responsibility: chair of the audit committee and charitable funds committee, member of the insight committee, Future System programme board, clinical excellence & discretionary awards committee.

A Chartered Institute of Public Finance and Accountancy qualified accountant, Michael developed his career at Cambridgeshire City, and Hertfordshire County Councils.

Michael moved into central government as director general for capabilities and resources (chief operating officer) for the Home Office. In 2017 he moved to the Cabinet Office as director general for government property and also as chief operating officer.

In 2021 he left government and took up his current role as bursar of Christ's College Cambridge. He has also been a non-executive director of Thera Trust, a learning disability service provider, and is a non-executive director on the University of Cambridge's Property Board. He has also recently been appointed a non-executive director at the Parliamentary and Health Services Ombudsman.

Independent director – yes

(b) Executive directors

Craig Black – interim chief executive (from August 2021 until 20 Feb 2023) and executive director of resources and deputy chief executive (from February 2023)

Areas of responsibility: finance, capital investment, commissioning, IT, information and performance, estates and environment.

Craig joined the Trust in April 2011 from Cambridge University Hospitals NHS Foundation Trust, where he was director of commissioning. Following his role as executive director for resources and deputy chief executive at this Trust, Craig stepped into the role of interim chief executive in August 2021.

He was previously deputy director of finance at both Cambridge University Hospitals NHS Foundation Trust and The Ipswich Hospital NHS Trust. Craig has 28 years' experience within the NHS. Having graduated from the national financial management training scheme he has worked in health authorities, a community and mental health trust and a primary care trust, as well as a number of acute hospitals in Surrey and East Anglia.

Following a substantive appointment of the chief executive, the interim CEO returned to the post of executive director of resources on 20 February, 2023.

Dr Ewen Cameron – chief executive officer (from February 2023)

Areas of responsibility: Ewen is responsible for meeting all the statutory requirements of WSFT, in addition to being the Trust's chief accounting officer to Parliament.

Ewen joined the Trust in February 2023 from Cambridge University Hospitals NHS Foundation Trust, where he was executive director of improvement and transformation.

He was previously interim Chief operating officer, divisional director, director of the Cambridge Bowel Cancer Screening Centre and clinical lead for endoscopy over his 16 years as a consultant gastroenterologist at Cambridge University Hospitals NHS Foundation Trust.

Ewen has 27 years of experience within the NHS. Having graduated from the University of Cambridge he has worked in hospitals across the East of England and the East Midlands.

Nicola Cottington - chief operating officer (from 1 November 2021)

Areas of responsibility: executive lead insight committee, executive lead for delivery of NHS operational standards, accountable officer for emergency planning, chair of investment panel, exec lead for change and transformation teams, exec sponsor for LGBT+ staff network, Trust representative at integrated care partnership, strategic sponsor for Stay Well domain in West Suffolk Alliance, co-lead (with director of resources) for delivery of the First for the future ambition of the Trust strategy, deputy senior responsible officer for East Coast Pathology Network.

Before returning to the Trust in November 2021, Nicola was deputy chief operating officer at James Paget University Hospitals NHS Foundation Trust, associate director of operations roles at West Suffolk NHS Foundation Trust and Mid Essex Hospital Trust and assistant director roles at Suffolk Community Healthcare and Bromley Healthcare.

Jeremy Over – executive director of workforce and communications

Areas of responsibility: oversees all aspects of the Trust's workforce strategy and practice, including: organisational development and culture; leadership and management development; education and training; staff wellbeing including occupational health; equality, diversity and inclusion; pay and reward; employee relations, recruitment and workforce planning. He is also executive lead for internal and external communications, fundraising and volunteers.

Jeremy has worked at director level in the NHS for the past nine years, building on over 20 years' experience in people management and development roles in the NHS, having started out as a training officer in his home town of Hereford. Now as a Suffolk resident Jeremy is proud to be part of the leadership team of his local healthcare Trust, supporting staff and serving our local population, and of the organisation's role as one of the largest employers in our geography.

Jeremy is a fellow of the Chartered Institute of Personnel and Development.

Dr Paul Molyneux - executive medical director (from 1 June 2021)

Areas of responsibility: professional leadership for doctors, responsibility for undergraduate and post graduate medical education, Trust Responsible Officer. Responsibility for Caldicott Guardian, Mortality Oversight Group, Medical Examiners, Executive responsibility for Quality Improvement, joint operational responsibility with Executive chief nurse and chief operating officer for operational management and delivery of all services, responsibility for Public Health team, liaison with Primary Care through LNC, delivery of the Clinical and Care Strategy.

Prior to being appointed Interim Medical Director in June 2021, Paul has been a Consultant Neurologist at WSFT and Cambridge University Hospitals since 2003. He has previously held roles of clinical lead for Neurology, Clinical Director for Specialist Medicine, Deputy Medical Director and Secondary Care Specialist at NEE CCG.

Susan Wilkinson – executive chief nurse

Areas of responsibility: professional leadership for nurses, midwives and allied health professionals, nursing strategy and nurse management, non-medical pre and post professional education, clinical governance and quality, safeguarding children, vulnerable adults, risk management, integrated governance, complaints and patient experience, litigation, chaplaincy and CQC lead for the Trust. Sue is also the director of infection prevention and control. She holds joint operational responsibility with the chief operating officer and medical director for the operational management and delivery of all clinical services.

Sue is a registered nurse and Florence Nightingale Scholar, she has a BSc in health care studies, including advanced practice and non-medical prescribing and an MSc in health care management and leadership.

Sue has been in post since June 2020.

Sue joined us from East and North Hertfordshire acute trust where she was deputy director of nursing. Prior to this she worked at Cambridge University Hospitals where she held a number of roles including clinical nurse specialist in colorectal surgery; divisional head of nursing for surgery, and assistant director of nursing.

During 2022-23 Clement Mawoyo, director of integrated adult health and social care who is a joint appointment funded by WSFT and Suffolk County Council and Peter Wightman West Suffolk Alliance Director who is a joint appointment funded by SNEE ICB attended WSFT Board meetings on a regular basis.

Executive directors who left the Board during 2022-23

Nick Macdonald - Interim executive director of resources (from 9 August 2021 to 20 Feb 2023)

Areas of responsibility: prior to being appointed as interim executive director of resources, Nick was deputy director of finance at WSFT.

Nick has also worked as head of financial management, Cambridge University Hospitals NHS Foundation Trust.

Following a substantive appointment of the chief executive, the interim CEO returned to the post of executive director of resources and Nick returned to his previous role of deputy director of finance on 20 February 2023

2.2.3 Register of interests

All directors are required to declare any interests on the register at the time of their appointment. This register is reviewed and maintained by the Trust secretary. The register is available for inspection by members of the public. Anyone who wishes to see the register should contact the Trust secretary, Foundation Trust Office, West Suffolk NHS Foundation Trust, West Suffolk Hospital, Hardwick Lane, Bury St Edmunds, Suffolk IP33 2QZ.

2.2.4 Appointment of chair and non-executive directors

The Council of Governors has the responsibility for appointing the chair and non-executive directors in accordance with WSFT's constitution and in accordance with paragraph 19(2) and 19(3) respectively of schedule 7 of the National Health Service Act 2006.

The nomination, appointments and remuneration committee of the Council of Governors makes a recommendation for appointment for a non-executive director to the Council of Governors. This committee comprises the chair of WSFT, five public governors (including the lead governor), one staff

governor and one partner governor. The committee is chaired by the Trust chair, except when considering the appointment, remuneration and terms and conditions of the Trust chair, when it is chaired by the lead governor.

Non-executive director appointments are normally for a term of three years. Following their first term, and subject to satisfactory appraisal, a non-executive director will normally be reappointed for a second term without competition. This assumes Board competency requirements have not changed. Following this second term, and subject to satisfactory appraisal, a non-executive director can be considered by the Council of Governors for a further term of office subject to annual renewal. Vacant non-executive directors' positions will be subject to an openly-contested process with appointment by the Council of Governors.

The removal of a non-executive director requires the approval of three-quarters of the members of the Council of Governors. Details of the criteria for disqualification from holding the office of a director can be found in paragraph 31 of WSFT's constitution.

Disclosures of the remuneration paid to the chair, non-executive directors and senior managers are given in the remuneration report (section 2.7).

2.2.5 Evaluation of the Board of directors' performance

Attendance at Board of Directors meetings 2022-23

Name	Title	Attendance (out of 6)
Jude Chin ^(a)	Chair	6
Ewen Cameron ^(b)	CEO	1 (of 1)
Craig Black ^(c)	Executive director of resources	5 (of 6)
Nicola Cottington	Chief operating officer	6
Jeremy Over	Executive director of workforce and communications	5 (of 6)
Paul Molyneux	Interim executive medical director	4 (of 6)
Susan Wilkinson	Executive chief nurse	6
Louisa Pepper	Non-executive director	6
Tracy Dowling ^(d)	Non-executive director	3 (of 3)
Krishna Yergol ^(e)	Non-executive director	3 (of 3)
Antoinette Jackson ^(f)	Non-executive director	3 (of 3)
Roger Petter ^(g)	Non-executive director	2 (of 3)
Michael Parsons ^(h)	Non-executive director	0 (of 0)
Individuals no longer on the Board		
Christopher Lawrence ⁽ⁱ⁾	Non-executive Director	3 (of 6)
Richard Davies ^(j)	Non-executive Director	4 (of 5)
Alan Rose ^(k)	Non-executive Director	6 (of 6)
Hilary McCallion ^(l)	Non-executive Director	1 (of 3)
Nick Macdonald ^(m)	Interim executive director of resources	5 (of 5)

a) Jude Chin appointed as chair on fixed term contract

b) Ewen Cameron appointed as CEO 20 Feb 2023

c) Craig Black returned to role of executive director of resources on 20 Feb 2023, from interim CEO

d) Tracy Dowling appointed as non-executive director on 1 Nov 2022

e) Krishna Yergol appointed as non-executive director 1 Nov 2022

f) Antoinette Jackson appointed as non-executive director on 1 Nov 2022

g) Roger Petter appointed as non-executive director on 1 Feb 2023

h) Michael Parsons appointed as non-executive director 1 May 2023

i) Christopher Lawrence stepped down (31 Oct 2022)

j) Richard Davies stepped down as non-executive director on 28 Feb 2023

k) Alan Rose stepped down as non-executive director on 31 Mar 2023

l) Hilary McCallion appointed as non-executive director on 1 Nov 2022 and stepped down on 31 Mar 2023

m) Nick Macdonald stepped down as interim executive director of resources on 20 Feb 2023.

Meeting dates

• 27 May, 2022	• 2 February, 2023
• 22 July, 2022	• 31 March, 2023
• 30 September, 2022	
• 25 November, 2022	

Drawing on best practice from the commercial sector the Board undertakes a regular review of its governance arrangements. The review takes into account regulator guidance on quality and governance.

The Trust's governance structure was strengthened during 2022-23 to provide a greater focus on culture, patient safety and quality through three assurance committees of the Board:

- **Insight Committee** with a focus on operations, finance and organisational risk
- **Involvement Committee** on people and organisational development
- **Improvement Committee** on quality, patient safety and change management.

A report from each meeting is received by the Board. The separation of this accountability and reporting line from the audit committee is fully consistent with good practice, allowing the audit committee to provide a truly independent and objective view of the Trust's internal control environment.

The escalation arrangements within the governance structure ensure timely and effective escalation from directorates and specialist committees to the Board via the senior leadership team. The chair key issues reports from the assurance committees, governance report and serious incident, inquests, complaints and claims report are standing agenda items for the Board meeting agendas and include escalation of risks from Board committees and other sources.

Committees of the Board of directors describe their activities through reports. These provide assurance to the Board on its committees' activities and effectiveness.

The chair and trust secretary have worked with the Council of Governors to develop an appropriate appraisal process for the chair and non-executive directors. The chair is formally appraised by the lead governor and senior independent director. Appraisal of non-executive directors is carried out by the chair. Governors and directors contribute to these appraisals through feedback questionnaires.

A 360° appraisal process is used for executive directors. The chief executive is subject to annual formal appraisal by the chair. Executive directors are subject to annual appraisal by the chief executive which informs development plans. Evidence of performance against objectives is monitored by the Board of directors through the remuneration committee, performance management arrangements and the board assurance framework.

The Board of directors has reviewed its skill set and uses this to inform a development programme for Board members. Appropriate external expertise is used to support delivery of this programme.

2.2.6 Audit committee

Membership of this committee is made up of non-executive directors and is chaired by a NED with appropriate financial expertise. 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 to the adequacy of the integrated governance arrangements and board assurance framework.

The directors are responsible for preparation of the accounts under direction by NHS Improvement (NHSI) in exercise of powers conferred on it by paragraphs 24 and 25 of schedule 7 of the National Health Service Act 2006.

External audit

KPMG was appointed as WSFT's external auditor in October 2021. KPMG reports to the Council of Governors through the audit committee. KPMG's accompanying report on the financial statements is based on its examination conducted in accordance with the audit code for NHS foundation trusts, as issued by NHSI, independent regulator of foundation trusts.

The responsibility of the Trust's external auditors is to independently audit the financial statements and the part of the remuneration report to be audited in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland).

As part of the approval of the annual external audit plan, the external audit process is subject to review by the Trust in terms of competency, efficiency and the relationship between the Trust and its auditors. The audit committee meets annually with the external auditor without officers present.

The Council of Governors in its closed session appointed KPMG as the Trust's external auditors for a three-year contract on 13 October 2021. The appointment covers three financial years 2021-22, 2022/23 and 2023/24. The estimated cost of statutory services/audit fee was £126k for the financial year 2022-23 (base fee without overruns).

Non-audit work may be performed by the external auditors where the work is clearly audit related and the external auditors are best placed to do that work. For all such assignments the audit committee will be advised, which will ensure that objectivity and independence is safeguarded. No such work was undertaken in 2022-23.

Internal audit

RSM, WSFT's internal auditor, is responsible for undertaking the internal audit functions on behalf of the Trust. Its role is to provide independent assurance that an organisation's risk management, governance and internal control processes are operating effectively. The head of internal audit reports to each meeting of the audit committee on the audit activity undertaken.

System of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

Attendance at audit committee meetings

Name	Title	Attendance (out of 5)
Richard Davies (end of term Feb 2023)	Non-executive director/senior independent director	3 (of 5)
Louisa Pepper	Non-executive director/deputy	3 (of 5)
Alan Rose (end of term Mar 2023)	Non-executive director (interim audit chair)	5 (of 5)
Christopher Lawrence (stepped down Oct 2022)	Non-executive director (audit chair)	3 (of 3)
Tracy Dowling (from Apr 2023)	Non-executive director	0 (of 0)
Antoinette Jackson (from Nov 2022)	Non-executive director/senior independent director	2 (of 2)

Meeting dates: 10 May 2022, 29 June 2022, 14 September 2022, 1 November 2022, 15 March 2023.

Newly appointed non-executive director Michael Parsons is the audit committee chair from 1 May 2023.

2.2.7 Well-led framework

Quality, which encompasses patient safety, clinically effective outcomes and patient experience, is at the heart of the Board and organisation's agenda. In times of financial constraints the challenge for WSFT is making sure that every pound spent brings maximum benefit and quality of care to patients. Improving quality can help to reduce costs by getting it right first time and avoiding harm to patients.

Details of improvements that we have made in patient safety are given elsewhere in this report, including section 2.6 (annual governance statement). The annual governance statement also describes the arrangements the Board of directors has put in place to deliver and monitor quality.

The Board of directors reviews the arrangements in place to deliver quality as part of the annual governance review it undertakes. This includes a review of relevant assurances within the board assurance framework. During 2022-23 the Board engaged with senior leaders to further develop its assurance committee structure, including arrangements for oversight of quality, safety, engagement and improvement. Discussion will take place with NHS England regarding timing of a well-led developmental review to evaluate the implementation and effectiveness of the new structure. Further details of the structure are provided in the annual governance statement (section 2.6).

2.2.8 Details of consultation

Local groups and the public and patient involvement activities

VOICE

The Trust's patient and public engagement group, VOICE, has recently undergone a re-structure in order to enable community interest and locality groups to channel feedback regarding healthcare services into the Trust. By engaging with groups who are already active in their respective domains, it ensures a wider and more diverse reach, simultaneously offering local groups an opportunity to contribute to improving patient experience at the Trust.

Groups who have been engaged with include:

- Steel Bones, a charity to support amputees and their families
- Bury St Edmunds 4 Black Lives
- Suffolk LGBTQ Forum
- Ace Anglia
- Steam House Café.

Engagement with local groups is ongoing.

Public engagement activities

It is recognised that effective engagement involves interacting with people in their own environment, and as such, the patient experience and engagement team have attended a number of local events as well as reaching out to individuals in their home settings. Activity has included attending local events such as a vaccination clinic at Brandon Leisure Centre, a graduate recruitment fair at West Suffolk College, and a visit to Kelly's Meadows Traveller site.

Glemsford Surgery joined WSFT as an integrated partner in healthcare in 2020. A community engagement event was organised in August 2022, with colleagues across the Alliance invited to attend. This event enabled the team to have a visible presence in the community and also to get helpful feedback regarding the surgery and local healthcare needs.

All engagement activities organised or attended by the patient experience and engagement team are carefully planned and assessed afterwards to ensure that events are well thought-out, productive, and followed up on with feedback recorded and analysed.

In terms of engagement across the ICB, the team attended the Joint Forward Plan public engagement event in February and will continue to be involved in ICB planning activities.

Healthwatch Suffolk

In the past 12 months, the patient experience and engagement team have organised three patient engagement sessions with Healthwatch Suffolk. Areas of focus have been:

- Emergency department
- Discharge waiting area
- Audiology department

Feedback obtained from these sessions has been shared with leads of these areas and compared against PALS and complaints data.

Public involvement activities

The team have established a successful bank of patient stories which are used at Trust Board and other forums to effectively communicate experiences of patients, both positive and negative.

The team is shortly going to be working with the estates and facilities team to review signage across the Trust. This project will analyse not only how clear it is for service users to find areas but also the wording used on signs, the colours and images used, and how signs are grouped together. A team of patients will be instrumental in this project, ensuring that recommendations made regarding wayfinding are made by and on behalf of those who access our sites on a regular basis.

Future events

Experience of Care Week took place from 24-28 April; this is an international initiative to celebrate work that is happening across health services to improve patient experience.

This year, the focus of the week included the patient journey from maternity and children's services to palliative care and end of life. This included engagement activities throughout the week as part of this annual event. A timetable of engagement events for the next 12 months is currently being planned.

Future System programme

A new healthcare facility is set to be built for the people of west Suffolk by the people of west Suffolk. Members of the local community, staff and stakeholders of WSFT have been and will continue to be involved in meaningful engagement to help develop the new hospital and its services. The result will be a building design and clinical model that is fit for the needs of our population now and, in the future for generations to come.

The Future System programme prides itself on being the most co-produced scheme as part of the wider Government New Hospital Programme (NHP). To meet this aim, we have carried out meetings and conversations with specific audiences which have included, but are not exclusive to;

- those with learning disabilities
- those with severe mental health requirements
- homeless and rough sleeper community
- young adults and students
- clinical patient support groups
- Romany, Gypsy and Traveller communities
- staff

- patients who have suffered a stroke or care for someone who has
- Women's Institute groups
- resident associations
- local councils and councillors

As a part of the Future System clinical co-production, the team has been working with staff and patients to understand how clinical services could (and arguably should) look like in the future. This has included the possibility of some clinical services being delivered in a different way and/or from a different location.

Duty to involve

NHS and foundation trusts have a duty to involve users of health services when planning or engaging on the provision of health services (section 242 NHS Act 2006) and this involvement can be in a variety of ways.

The Future System team is committed to involving our staff, patients and local community and a local Health Overview Scrutiny Committee task and finish group is linked to the Future System programme.

For any formal consultation, the Trust will follow advice and hold this over a period which is proportionate to the scale of change in line with best practice guidelines.

Engagement activity

Overview

Emphasis needs to be placed on the quality of output rather quantity of interactions however key stats for 2022-2023 include;

- more than 2,200 people spoken with
- 26 face to face engagement sessions
- 82 online engagement sessions

All members of staff are reached on a regular basis via news updates, online and face to face staff briefings as well as dedicated co-production workshops for each speciality. To co-produce the clinical visions, which provides a blueprint for how we could work in the future, we have spoken directly to nearly 1,700 members of staff.

Estate

In March 2022, a hybrid planning application was submitted to West Suffolk Council with proposals to build a new hospital on the preferred Hardwick Manor site, which would replace the existing hospital in Bury St. Edmunds. Following extensive pre-application public engagement and three rounds of public consultation carried out by the local planning authority, this application was approved on 30 November 2022 by the West Suffolk Council planning committee.

Clinical services

The clinical services operating in the West Suffolk Hospital buildings at Hardwick Lane have been split into 12 co-production workstreams, each with their own lead(s) recruited from the WSFT workforce.

Each workstream includes relevant clinical and operational staff and includes viewpoints from patients and the local community. Co-production leads are also tasked with working with peers and partners across the health and care system to develop plans fit for now, the future, and the healthcare system as a whole.

To support the clinical engagement co-production work, engagement with the public mirrored clinical development phases of work. Phases 1 to 3 were completed between 2020 and 2022. Details of phase 4 and subsequent engagement activity are detailed below.

Phase 4

Phase 4 was launched at the beginning of March 2021 and culminated in June 2022. 26 focus groups were arranged throughout March, comprising of two groups per department across 13 departments or services at various times of the day to capture as many people as possible. These groups were attended by 68 people. To support this, a survey ran which received more than 400 responses.

In June 2022, those who attended the workshops were invited back to see the latest designs that our co-production leads and our architect, Ryders, had been working on (note: patients had not seen any departmental designs at this stage). The feedback was generally positive with any key findings fed back to the co-production leads for consideration in their designs.

Additional engagement activity

To understand any challenges facing our community, and to inform our equalities impact assessment, a survey was launched in February 2022. To date, this survey has received more than 1,000 responses and has been supplemented with conversations, discussions and workshops with various areas of the community including;

- those on low income
- those with disabilities
- carer's
- socially isolated people
- homeless and rough sleepers
- Gypsy and Roma communities
- parents

The overall findings of the survey and impact assessment will be detailed in 2023-2024 annual report.

Communications

Website

Information about plans for the new hospital is available at <https://www.wsh.nhs.uk/New-healthcare-facility/New-healthcare-facility.aspx>.

The web pages include engagement opportunities, up to date information on the programme, news updates, frequently asked questions and contact details.

A dedicated section regarding the pre-application planning engagement and indicative designs was launched at <https://www.wsh.nhs.uk/Planning/Planning.aspx>

Newsletter

A newsletter has been launched and more than 300 people have subscribed to it.

Communication with residents

It is important for the programme team to maintain transparency and build good relations with our close neighbours. Regular communications have been sent to local residents, particularly relating to milestones and updates which may impact them. Feedback routes are also clear, allowing the relationship to be mutually beneficial.

Stakeholder briefings

Briefings are supplied to key stakeholders at each milestone, providing clear and transparent information which may be of interest.

2.2.9 Other disclosures

Companies Act disclosures

To improve the readability of the annual report a number of disclosures relevant to the directors' report have been included in the strategic report. These are:

- important events since the end of the financial year affecting WSFT
- an indication of likely future developments
- actions taken in the financial year to provide employees with information on matters of concern to them
- actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests
- actions taken in the financial year to encourage the involvement of employees in WSFT's performance
- actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of WSFT.

Cost allocation

The Trust has complied with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information guidance.

Income statement

The Trust has met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that the Trust's income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. Other income that the Trust has received has had no impact on its provision of goods and services for the purposes of the health service in England.

Political donations

The Trust did not make any political donations during 2022-23.

Better payments practice code

The Trust is a signatory to the better payments practice code. This requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust has paid £0k of interest under the Late Payment of Commercial Debts (Interest) Act 1998 in 2022-23 (2021-22 £3K).

	2022-23		2021-22	
	Number	£'000	Number	£'000
Total non-NHS trade invoices paid in the year	54,600	200,658	51,861	263,449
Total non-NHS trade invoices paid within target	42,929	175,544	32,417	208,951
Percentage of non-NHS bills paid within target	78.6%	87.5%	62.5%	79.3%
Total NHS trade invoices paid in the year	2,158	16,673	2,707	32,312
Total NHS trade invoices paid within target	1,338	1,565	1,661	24,104
NHS trade invoices paid within target (%)	62.0%	81.4%	61.4%	74.6%

Total percentage of bills paid within target	78%	87.0%	62.5%	78.8%

Statement regarding the annual report and accounts

It is the responsibility of the directors to present a fair, balanced and understandable assessment of the WSFT’s position and prospects. The directors consider the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess WSFT’s performance, business model and strategy.



Dr Ewen Cameron
 Chief Executive
 29 June 2023

2.3 Foundation trust code of governance compliance

The Trust has applied the principles of the NHS foundation trust code of governance on a comply or explain basis. The NHS foundation trust code of governance, most recently revised in October 2022, is based on the principles of the UK corporate governance code issued in 2014 and 2012. The code of governance 2022 will be applicable from April 2023.

The Board of directors supports the principles set out in the NHS foundation trust code of governance. The way in which the Board applies the principles and provisions is described within the various sections of the report and the directors consider that the Trust has been compliant with the code.

Disclosures relating to the Council of Governors and its committees are in the governors' report (section 2.1). Disclosures relating to the Board of directors and its committees are in the directors' report (section 2.2).

2.4 NHS oversight framework

NHS England's NHS oversight framework provides the framework for overseeing systems including providers and identifying potential support needs. NHS organisations are allocated to one of four 'segments'.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4). A segment does not determine specific support requirements. By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

- a) objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; local strategic priorities)
- b) additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity. An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach or suspected breach of its licence conditions.

Segmentation

The Trust has been placed in segment 3. This segmentation information is the Trust's position as at 8 June 2023. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website: <https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/>.

2.5 Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of West Suffolk NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require West Suffolk NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of West Suffolk NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the accounting officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.



Dr Ewen Cameron

Chief Executive

29 June 2023

2.6 Annual governance statement

West Suffolk NHS Foundation Trust annual governance statement – 1 April 2022 to 31 March 2023

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that *supports* the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of West Suffolk NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in West Suffolk NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The system of internal control is underpinned by compliance with the Trust's terms of authorisation and the requirements of regulatory bodies relevant to foundation trusts. The Trust has a risk management policy and strategy which make it clear that managing risk is a key responsibility for the Trust and all staff employed by it.

The Board of directors and Council of Governors receive regular reports that detail quality, financial and operational performance risk, and, where required, the action being taken to reduce identified high-level risks.

The audit committee provides an independent and objective view of WSFT'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. It reviews implementation of the board assurance framework to assure itself that risks are being appropriately identified and managed and appropriate assurance obtained. This is supported by "deep dive" assurance reviews by the assurance committees of the Board as well as the audit committee.

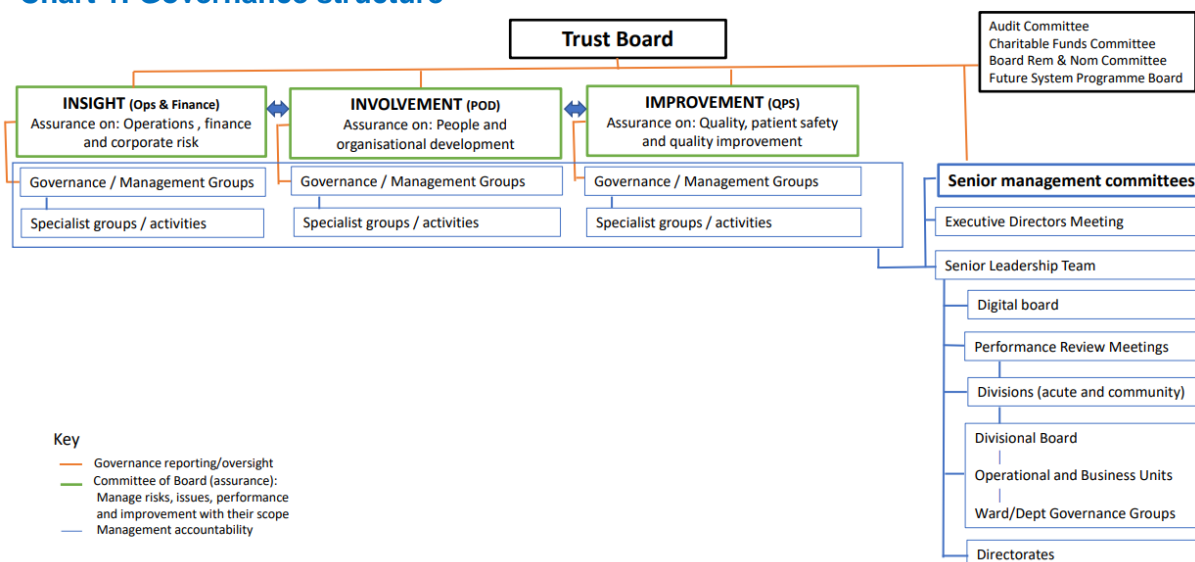
The audit committee independently reviews the effectiveness of risk management systems, ensuring that all significant risks are properly considered and communicated to the Board of directors.

The audit committee is supported by the three assurance committees of the board in order to improve understanding and provide assurance to the board in relation to:

- **insight committee** – operational delivery, finance control and corporate risk
- **involvement committee** – people and organisational development, including the Trust's strategies, plans and the management of risks, relating to staff engagement and involvement; patient engagement and involvement and system involvement & public engagement
- **improvement committee** - quality, patient safety and change management.

The assurance committees of the Board are supported by a range of governance and specialist groups. Management accountability remains with the executive and divisional leadership. This framework was introduced in September 2021 and has been subject to review and refinement.

Chart 1: Governance structure



The Council of Governors hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors.

The principles of risk management are included as part of the mandatory corporate induction programme and cover both clinical and non-clinical risk, an explanation of the Trust’s approach to managing risk, and how individual staff can assist in minimising risk.

Guidance and training is also provided to staff through refresher programmes, specific risk management training, wider management training, policies and procedures, information on the Trust’s intranet and feedback from audits, inspections and incidents. Included within all of this is sharing of good practice and learning from incidents. Further detail of the risk management arrangements are contained in the Trust’s risk management policy.

The risk and control framework

The risk management strategy and policy sets out the key responsibilities for managing risk within the organisation, including the ways in which risk is identified, evaluated and controlled. This is supported by the Board approved Organisational Framework for Governance which outlines the structure, accountabilities and processes by which governance and onward assurance to the board is achieved.

Risk is assessed at all levels in the organisation from the Board of directors to individual wards and departments. This ensures that both strategic and operational risks are identified and addressed. Risk assessment information is held in an organisation-wide risk register. The level of risk that the Trust is willing to take (risk appetite) is managed through this structured framework of risk assessment and appropriate escalation.

The Trust has in place a board assurance framework which sets out the principal risks to delivery of the Trust’s strategic corporate objectives. The executive director with delegated responsibility for managing and monitoring each risk is clearly identified. The board assurance framework identifies the key controls in place to manage each of the principal risks and explains how the Board of directors is assured that those controls are in place and operating effectively. These controls and assurances include:

- performance management framework
- monthly quality and performance reports, statistical process control (SPC) charts and performance dashboard. These include the Trust's priorities for improvement in the quality report, analysis of patient experience, incidents and complaints
- monthly financial performance reports
- self-assessment against delivery of the CQC registration requirements
- quarterly reports to the Council of Governors from the Board and its assurance committees covering quality, operational performance and financial
- assurances provided through the work of the three board assurance committees, using their chair key issues report to summaries issues for the board and governors
- reports from the future system board and the audit committee received by the Board
- assurances provided through the work of internal and external audit, the Care Quality Commission, NHS England, NHS Resolution, patient-led assessments of the care environment (PLACE), and accountability to the Council of Governors
- the work of clinical audit, whose scope includes national audits, audits arising from national guidance such as National Institute for Health and Care Excellence (NICE), confidential enquiries and other risk and patient safety-related topics
- 15 step challenge visits, including executive directors, non-executive directors and governors have restarted after social distancing restrictions due to COVID-19. During these restrictions executives, non-executives and governors colleagues have engaged with staff through virtual meetings, including the regular all staff briefing
- risk assessments and analysis of the risk register and board assurance framework
- benchmarking for clinical indicators
- external regulatory and assessment body inspections and reviews, including Royal Colleges, post graduate dean reports, accreditation inspections and Health and Safety Executive (HSE) reports.

The following, which are covered in more detail in this annual report, are examples of the product of our risk and control environment:

- **Care Quality Commission (CQC)** – an overall rating of “requires improvement”
- **performance against national standards**, meeting a number of national targets in 2022-23
- **focus on elective recovery** - the need to reduce the number of people waiting for treatment, usually surgery
- **adult and paediatric community services** - provide healthcare and support patients to achieve their best quality of life in their homes
- **integration with partners across the health, social care and voluntary sector** - as a key driver in improving the quality and outcomes of care
- **vaccination taskforce** - a sterling part of the regional and national drive to vaccinate people against both coronavirus and seasonal influenza
- **we continue to deal with the outcomes of the 2021 independent review** - we fully acknowledged that the organisation's culture needed fundamental change. While progress has been made, we know there is much more to do, and this will take time
- **run a trust-wide What Matters to You 2 exercise** - encouraging frank discussion with staff about their priorities and concerns
- **excellent reputation for teaching** – both undergraduate and graduate. We are a learning organisation and our training and education team support staff with a broad range of courses and training
- **patient Safety Incident Response Framework (PSIRF) pilot programme** - first of a small number of trusts taking part
- **expanded our Freedom to Speak Up (FTSU) network** - introduced wellbeing champions to reflect our diverse workforce, and relaunched our peer-led staff networks
- **our highly-trained and motivated workforce**- investing in, celebrating and looking after the thousands of people who devote their working lives to the NHS and our Trust
- **recruiting to a new organisational development and learning team** - this will allow us to explore new ideas, and give us a foundation on which to develop all the initiatives we have in place for our workforce

- **step closer to the building of a new hospital** - with outline planning permission granted for our preferred site at Hardwick Manor
- **capitalise on our expertise as a Global Digital Exemplar** - benefit from electronic patient records, the Health Information Exchange (HIE), a patient portal, access to the virtual ward, and other advances that are driving progress in healthcare to benefit patients.

The realities of working in the NHS mean that we have significant number of vacancies, in common with services across the country. We have outlined the many ways in which we try to attract and retain staff, but the effects of trying to meet demand and patient need cannot be underestimated. It has been an unprecedented and challenging time for the Trust, the NHS, the nation and the world, but there are many achievements to be proud of.

The ambitions of our Trust strategy – First for patients, first for staff and first for the future – underpin our commitment towards improving the care for our patients; supporting and listening to our staff; and investing in the future health of Suffolk.

First for patients

This year saw the launch of the Suffolk and North-East Essex Integrated Care Board (SNEE ICB), and as a leading provider in the integrated care system (ICS), across the Trust we are committed to partnership working on the strategy and delivery of healthcare in the future.

Providing seamless care at the right time in the right place to meet people's individual needs and wishes means working in collaboration with partners across the NHS and other healthcare providers, the private sector, local councils, charity and voluntary services. We know that integrated working is the way forward, and this year progress has been made on ensuring the care we provide is joined-up, timely and effective.

We are using feedback, learning, research and innovation to improve care and outcomes. We have kept innovations which worked well during the pandemic, such as telephone and video consultations, wellbeing calls, patient-initiated follow up and ways for patients to stay in touch with loved ones in our care: Keeping in Touch and the clinical helpline.

The movement of patients through our services, especially the acute hospital, has been a major focus of our work this year as we strive to reduce the numbers of people waiting for care. We have extended the hours of our clinics and theatres to help us reduce the numbers of people on our waiting lists; and in November we launched virtual wards, part of a national programme which allows patients to receive care at home, instead of needing to reside in hospital. Using digital technology, patients can safely be monitored from the comfort of their own homes as part of their health and care needs. This year social prescriber Stefan Currington joined us at the acute hospital, offering support for people to improve their independence and quality of life after discharge, and preventing readmission.

We have made significant investment in our patient safety and quality improvement teams, using learning, best practice, new models and frameworks to support continuous improvement. We were a pilot trust for the PSIRF patient safety framework, aimed at improving the response to patient safety incidents, and are now helping to roll PSIRF out across the NHS and are just entering into our third year of our patient safety plan based on the new framework. An improvement event run by our medical division inspired and captured ways to make positive change, using and developing ideas that came from staff.

This year a number of our teams, projects and services have been nominated for, and won, prestigious national awards and been recognised for their work.

Clinical nurse specialists (CNSs) are crucial in providing expert support for our patients, but a study by Macmillan Cancer Support found that 37 per cent of the current workforce is over 50 years old. Our Macmillan Unit team created an innovative way of tackling this potential future workforce

shortage, with a bespoke 18-month programme to support band 5 nurses to progress into CNS positions. This won the Macmillan Professionals Innovation Excellence Award, which is an incredible achievement.

A pilot scheme pioneered on our acute renal ward was nominated for an HSJ (Health Service Journal) Patient Safety Pilot of the Year award and Nursing Times Best Use of Workplace Technology award. The team identified and introduced equipment that allowed staff to improve the accuracy of measuring and monitoring how much fluid each patient consumed.

The Trust's research team was recognised and praised for its participation in a wide range of regional, national and international research studies. One of our clinical research practitioners, Angharad Williams, was named the recipient of the 2022 Advancing Healthcare Awards for Clinical Research Practitioner (CRP) Leadership from the Academy of Healthcare Sciences. She won the award in recognition for her work in developing a regional network and national work to develop an approved accreditation scheme and register for CRPs.

The co-ordinators of the prestigious ORION-4 research study have congratulated WSFT colleagues on recruiting more than 100 participants. Consultant cardiologist Dr Pegah Salashouri, lead research nurse Jo Godden and research nurse Lily John were praised for their significant contribution to this collaborative research into a cholesterol lowering injection.

The SIREN (SARS-CoV2 immunity and reinfection evaluation) is a large-scale partnership launched two years ago with NHS workers, to evaluate the immune response to COVID-19, build understanding of the protection offered by vaccines and provide insight into COVID-19 reinfections. At the WSFT, 598 colleagues signed-up to participate, many of whom are continuing to support the study today.

Dr Justin Zaman and the cardiology research team have received national recognition for their work on the REACH HFpEF trial. The team have placed second in the country for the number of participants recruited, an amazing achievement.

Our stroke service has recently received its results from the Sentinel Stroke National Audit Programme (SSNAP), for acute admitting stroke units. Our service is ranked number one nationally during the October – December 2022 quarter (which is the latest data available at present) and was ranked joint second in the previous quarter. This achievement is due to the hard work, dedication and commitment of all the members of the stroke service.

Our Trust was shown to be performing better than most NHS acute trusts in the country in several areas of care, according to an adult inpatient survey from the Care Quality Commission. There is always room for improvement, but the findings underlined the efforts made to ensure our patients have a good experience. This year we also received a "Good" CQC rating for the Glemsford GP practice that is part of the WSFT, with the staff's kindness and respect for patients highlighted.

Patient experience is enhanced by our volunteers, a valued group of people now fully back with us after the pandemic. From helping people find their way around, to keeping our courtyard gardens planted and tidy, supporting ward staff, and offering companionship to people at the end of their lives, the volunteers make a real difference and we are grateful for their support.

We have recently achieved a Work Experience Quality Standard award for the student programme delivered through our voluntary services. This offers valuable opportunities for young people interested in a healthcare career. With the support of clinical and medical colleagues the programme provides invaluable clinical shadowing opportunities, and a digital student academy programme.

Nutrition and hydration are a vital element in the care and recovery of our patients, and this year our award-winning catering team have maintained their excellent hygiene rating, scoring the highest score of 5, which means standards are "very good". Meanwhile, two of our apprentice chefs won through to the national finals of the NHS chef of the year competition.

The My WiSH charity continues its sterling work to enhance the care the Trust provides, from funding posts such as a staff support psychologist and a play specialist for young patients in our emergency department, to supporting major appeals and projects. The charity receives amazing support from our community, with local people organising their own fundraising, or supporting My WiSH events such as the Soapbox Challenge, which returned this year to great success.

First for Staff

We know when staff feel confident that they have a voice, can speak up and raise concerns, there is a positive impact on patient safety and care.

In an Autumn of active listening, colleagues were able to respond to the annual NHS staff survey; a travel survey; and 'What Matters to you 2', which followed up on the 2020 staff engagement programme. The aim is to continue conversations with staff so that Trust leadership hear about what is important and can take action to improve. We know it is also important to show where and how we have listened – 'You Said, We Did'.

We also focused on Freedom to Speak Up (FTSU), and have a growing number of FTSU champions throughout the Trust. We have relaunched our peer support networks for disabled people, LGBTQ+ colleagues, and those from the global majority. We have introduced wellbeing champions from diverse backgrounds, supported by the My WiSH charity, who are also helping us to build a positive and inclusive culture. After listening to concerns raised by staff, we have developed a more supportive and compassionate HR culture.

Another of our key objectives is showing that we value our staff by enhancing their well-being. We have expanded our dedicated staff psychology team; extended our free gym membership for all staff and modernised facilities in the Chaplaincy, including dedicated facilities for Muslim colleagues and visitors. Our vaccination team has ensured free and easy access to both the COVID-19 and seasonal flu vaccinations, as well as running a comprehensive programme in our wider community.

Nominations for our Putting You First awards have come from peers, and their citations are both moving and inspiring. The contribution that people have made to the NHS, often for their whole working lives, is marked through our long service awards – we have this year recognised people who have served for 50 years.

We are investing in education, training and workforce development, because we want staff, who come from all over the world to work with us, to build their careers here. One in five of our staff come from overseas, representing more than 80 countries. This year we were proud to receive the NHS Pastoral Care Quality Award in recognition of our commitment to providing high-quality pastoral care for internationally educated nurses and midwives.

We have a strong learning and training offer, recognised this year with six nominations in the Nursing Times Workforce Awards, including Best UK Employer of the Year for Nursing Staff. Two of our clinical education team were nominated for Student Nursing Times Awards, with Alex Levitt-Powell winning Learner of the Year: post-registration category.

Throughout our organisation the year has been marked by celebrating the opportunities and funding staff can access for continuous personal development. Our professional nurse advocates are trained to listen and understand challenges and demands of fellow colleagues, and to lead, support and deliver quality improvement initiatives.

We have been joined by a corporate lead to facilitate advanced clinical practice, supporting colleagues in acute and community services to take up the challenge of advanced practice. Six new registered nursing associates are now working in acute and community settings, an investment in a recently-developed NHS role that brings significant benefits in patient care.

A supervisor role has been introduced in our health care support worker (HCSW) workforce, aimed at giving new HCSWs support and mentoring on our inpatient wards. This has improved retention of these important staff who do so much to care for our patients.

Keeping staff throughout the Trust informed is a priority for our communications team, which this summer developed and launched a new and improved intranet site, working with colleagues across the Trust. Using digital innovations, the team is exploring new ways to ensure our busy staff can easily access information to support patient safety and best practice, as well as the wellbeing support on offer. The team works closely with colleagues across the Trust and the wider system to drive awareness and engagement, in a rapidly changing environment for health and care.

First for the Future

This ambition in our strategy reflects how we are taking the organisation forward and our role as a large, anchor organisation in west Suffolk with the SNEE ICB.

A huge part of our priority to invest in infrastructure, buildings and technology is the work we are doing to plan for the new healthcare facility to replace the West Suffolk Hospital here in Bury St Edmunds. The new hospital, which is one of 40 to be built as part of the Government's New Hospital Programme, should be completed by 2030. Plans are well under way with outline planning permission agreed for our preferred site of Hardwick Manor.

While we work with our partners and our community to plan for a new hospital, our current hospital is reaching the end of its life. It was built in 1974, using reinforced autoclaved aerated concrete (RAAC) planks, and has a life expectancy of 30 years. Every day, our estates team has continued its programme of essential maintenance to ensure our buildings remain as safe as possible for patients and staff.

Through our Future System project, we are looking at ways to develop services we provide in the heart of our community, so that many more people can be cared for without coming into the acute hospital. A diagnostic centre is planned for our Newmarket community hospital site, which will increase capacity and give people greater choice to be treated closer to home.

Planning for the future has meant looking at what the next decades will mean for west Suffolk and its population – which is likely to grow in number and in age. The most important asset in caring for people of all ages will be a highly-trained and skilled workforce, and we are exploring ways of supporting young people to become our staff in years to come.

As well as the commitment to “grow our own” through training, development and apprenticeships, we are celebrating 15 years of partnership with West Suffolk College. BTEC students joined us for work experience; and later this year we will welcome students on T-Level courses on placements. This partnership aims to give the workforce of tomorrow the skills they need to hit the ground running when they start their careers.

To support our goal of making the biggest contribution to prevent ill health, increase wellbeing and reduce health inequalities, our community health services are increasingly being co-located with partner organisations – for example at the Mildenhall Hub. The alliance working model of integrated neighbourhood teams allows us to care for people's individual needs where and how they live. Closer working with key allies such as the county council in social care and housing, but also providers such as Abbeycroft Leisure, has allowed us to improve patient care and experience.

This year saw changes to the membership of our Board, who will be leading on the work to take the Trust forward. As well as a new chief executive officer, we have been joined by new non-executive directors (NEDs), who bring a wealth of experience with them to our foundation trust. We were delighted to be able to hold our Annual Members' Meeting in person once again, to reflect on the past, present and future, and hear the opinions and questions of local people. As well as engagement through Future System, we have undertaken a travel survey, and organised and

attended events across the county, including in Glemsford, where we run the GP surgery.

Many challenges remain, including in recent months, extensive periods of industrial action. We recognise these disputes are between the unions and the Government and we support the legal right to strike. The willingness of our colleagues to help us plan and work flexibly around these actions has shown once again their commitment to each other and to our patients, and their dedication to serve the people of West Suffolk.

But, we also have some challenges and these are considered in more detail in the conclusion of this annual governance statement:

- **staff engagement and raising concerns**
- **building structure**
- **delivering patient access.**

Risks to our strategic objectives are regularly reviewed by the Board as part of the board assurance framework (BAF). A summary of the BAF is provided below.

Board assurance framework summary

Strategic ambition	Description of risk	Potential impacts being mitigated by controls and future plans
First for patients	Quality governance or service failure	Poor care and treatment of patients. Loss of public and GP confidence that leads to reduced referrals as a consequence of public choice. Restricted authorisation / licensing by regulators
	Ability to deliver sustainable services to meet operational standards in urgent and emergency care, community health services, primary care, elective care, cancer and diagnostics	Poor care and treatment of patients. Loss of public and GP confidence. Negative impact on staff wellbeing.
First for staff	Staffing workforce skills, competency and supply by: <ul style="list-style-type: none"> • Building a positive, inclusive culture that fosters open and honest communication • Enhancing staff wellbeing • Investing in education, training and workforce development 	Quality and safety and reputation impact. Adverse employee relations and staff motivation. CQC regulatory action. Withdrawal of Royal College recognition. Failure to achieve reduction in non-contracted pay as part of financial plans. Poor staff engagement hinders deliver of transformation and efficiency. Inability to recruit/retain key staff
First for the Future	Maintaining existing estate and implement the estates strategy to provide an adequately maintained building environment suitable for patient care caused by the deteriorating state of Trust buildings	Patient safety. Reputational impact and poor patient experience/satisfaction. Regulatory action. Negative impact on staff wellbeing Ageing building environment suitability for patient care which could lead to reputation damage and loss of income. Unknown financial impact if reputational consequences. Risk of improvement notices if fail to effectively maintain building(s). Ability to fund the capital programme

Strategic ambition	Description of risk	Potential impacts being mitigated by controls and future plans
	External financial constraints impact on Trust and system sustainability and model of service provision in the west Suffolk system	Quality and ability to deliver safe services. Non-compliance with national standards, targets and terms of authorisation leading to breach of licence (CQC or NHSE). Impact on cash flow and income and expenditure. Inability to generate sufficient surplus to support capital investment. Local position leads to tension between local health economy partners. Loss of provider sustainability funding to the local health system
	Digital, including cyber security	Delivery risk to patient safety and the operational effectiveness of the Trust. Ability to report patient care and activity both timely and accurately. Quality, service and financial impact of failure to deliver planned improvements and benefits

In considering the risks and challenges we face the Board recognises that in the last year has appointed five new non-executive directors. These appointments provide an opportunity for the Trust to drive its value-based recruitment but also represents a significant change in the senior leadership. Following a full and competitive recruitment process the Council of Governors appointed Jude Chin as chair of West Suffolk NHS Foundation Trust. A term he will serve for the next three years until June 2026.

Changes to the NHS landscape both locally and nationally will also play an important part in the future focus of the Board. Ensuring effective working with the new Suffolk & North East Essex Integrated Care Board (ICB) and maximising the benefits for patients and the population within our system through collaboration with partners.

Board assurance framework summary

The Trust ensures that short, medium and long-term workforce strategies and staffing systems are in place which provide assurance to the Board that staffing processes are safe, sustainable and effective; including compliance with the “Developing Workforce Safeguards” recommendations. These systems include:

- activities of the involvement committee of the board
- integrated quality and performance report (IQPR) and workforce report - both reports are received at each public Board meeting. These reports detail a range of metrics including patient outcomes, patient experience and staffing performance indicators
- nurse staffing monthly report to the Board which details the nurse staffing position and the Trust’s future plans for nurse staffing
- Board reporting is underpinned by monthly divisional workforce reports which details a range of performance indicators including sickness absence, turnover, maternity leave, training and average absence
- assessment of staff experience using the friends and family test (FFT), national staff survey and exit interviews. We have also established networks for staff including BAME, disabilities and LGBT+
- Freedom to Speak Up Guardian and Guardian of Safe Working reporting to the Board
- e-rostering and e-job planning system for medical staff
- the Trust’s clinical workforce strategy group oversees the development of new roles to support sustainability within the labour market.

These arrangements are underpinned by review and oversight by the chief nurse and medical director to ensure that effective systems are in place.

The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC).

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The board assurance framework provides evidence of the effectiveness of controls that manage the risks to the organisation achieving its principal objectives and that these have been reviewed. The annual governance statement is also informed by the latest CQC inspection report (WSFT (January 2020), maternity services (April 2021) and Glemsford Surgery (September 2022)).

The board assurance framework was reviewed and updated routinely during 2022-23 to ensure the principal strategic risks to the Trust's objectives were identified, recorded and correctly evaluated for impact and likelihood. Overall, analysis of key controls and assurances revealed that the Trust was managing its risks to a reasonable level, that the Board of directors was adequately informed of the effectiveness of control measures and that, where possible, appropriate corrective action was being taken to reduce identified high-level risks. This review has identified gaps in control or assurance as set out in the significant internal control section of the annual governance statement. The board assurance framework is subject to independent review by internal audit.

In considering the principal risks to compliance with the Trust's conditions of authorisation we have had particular regard to the:

- Effectiveness of governance structures – which are subject to annual review and recommendations for improvement monitored through an agreed action plan
- Responsibilities of directors – directors' objectives and performance are regularly monitored by the remuneration committee
- Responsibilities of subcommittees - are considered as part of the annual governance review and the quality and risk committee and audit committee provide an annual report to the Board on their activities and performance
- Reporting lines and accountabilities between the Board, its subcommittees and the executive team - are considered as part of the annual governance review and clear reporting and escalation channels exist between the Board and executive team
- Submission of timely and accurate information to assess risks to compliance with the Trust's licence
- Degree and rigour of oversight the Board has over the Trust's performance – the Board continually reviews and develops its reporting arrangements to the Board. The monthly quality

and performance report for the Board supports an open reporting culture and includes the results from the Friends and Family Test; the NHS safety thermometer, which covers falls, pressure ulcers and infection control; and patient and staff experience surveys building up a picture of care quality in our services. The range of indicators provides early warning of deterioration in performance and potential negative impact on quality. The finance and workforce report has been strengthened during the year including divisional reporting and performance against cost improvement programmes.

Information governance

The Trust's data security and protection assessment report overall score for 2021-22 was 'Standards not met'. Eight of the 108 mandatory evidence items were unable to be provided. The Trust submitted an improvement plan in October 2022 and the score was updated to 'Standards Met'.

The assessment for 2022-23 was submitted in June 2023 and achieved 'Standards not met' as not all 113 mandatory evidence items were reached. An internal audit of the assessment has been completed and the Trust is committed to addressing the standards not reached during 2023-24.

The Trust reported four data breaches to the Information Commissioner's Office (ICO) in 2022-23, the majority involved inappropriate access of records by members of staff. All actions agreed with the ICO are being implemented.

Data quality and governance

The Trust places a high priority on the quality of its clinical outcomes, patient safety and patient experience and strives to deliver the principles outlined in NHSE's well-led framework and its eight key lines of enquiry (KLOEs):

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

We will review our arrangements and framework for well-led based on the new CQC inspection framework during 2023-24.

Indicators relating to the quality report were identified following a process which included the Board of directors, clinical directors and senior managers of the Trust and have been incorporated into the key performance indicators reported regularly to the Board of directors as part of the performance

monitoring arrangements.

Scrutiny of the information contained within these indicators and its implication as regards to patient safety, clinical outcomes and patient experience takes place at the Board as well as the board assurance committees and the groups and activities that report into them.

The inter-relationship between the indicators in the quality report and other measures of the Trust's performance (quality, operational and financial) is reviewed through the assurance structure and reported to the Board of directors. Reviews of data quality and the accuracy, validity and completeness of all Trust performance information fall within the remit of the audit committee, which is informed by the reviews of internal and external audit and internal management assurances.

The Board has developed the use of statistical process control (SPC) charts to allow quality and performance indicators to be more systematically reviewed and to target action to the areas that require attention. The SPC method allows areas affected by change to be more easily identified and investigated, whether this change is positive or negative. The use of SPC intelligence will be developed to be used more widely across the Trust. During the Trust's Covid response reporting to the Board was amended to maintain the required oversight but recognising that many of the normal activity and access indicators were not meaningful.

Reviews of data quality, and the accuracy, validity and completeness of Trust performance information, fall within the remit of the audit committee, which is informed by the reviews of internal and external audit and internal management assurances.

Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and the quality and risk committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of directors' role is to determine the overall strategic direction and to provide active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed. The Trust's strategic objectives are derived from the priorities determined in the Trust's strategy.

The Board of directors has put in place a robust escalation framework which ensures timely and effective escalation from divisions and specialist committees to the Board. Executive directors and their managers are responsible for maintaining effective systems of control on a day-to-day basis.

In accordance with the public sector internal audit standards updated in 2017, internal audit provides the Trust with an independent and objective opinion to the accounting officer, the Board of directors and the audit committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives. Internal audit reported 13 reports from the 2022-23 plan; the "opinion levels" are summarised below:

Level of assurance	Number
Advisory report – no assessment made of the level of assurance	1
Substantial assurance - controls are suitably designed, consistently applied and operating effectively (one report in draft)	2
Reasonable assurance - identified issues that need to be addressed (two reports in draft)	5
Partial assurance - action is needed (two reports in draft)	4
No assurance - urgent action is needed	1

Consistent with the head of internal audit's opinion the following partial and unsatisfactory assurance opinions are highlighted and are subject to management action:

- **digital strategy implementation** - partial assurance
- **data security and protection toolkit (DSPT)** - unsatisfactory assurance opinion covering the 2021-22 submission
- **medicines Management** (draft report) - partial assurance
- **medical devices management** (draft report) - partial assurance.

The framework for monitoring and review of action in response to internal audit reports has resulted in reasonable progress against recommendations being reported by internal audit throughout the year.

For the 12 months ending 31 March 2023, the head of internal audit's opinion for WSFT is that: "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".

External audit reports that the annual report and accounts are true and fair.

In preparing this annual governance statement, as required under NHS foundation trust conditions, all relevant internal and external assurance have been taken into account regarding WSFT performance in respect of quality and finance.

Conclusion

In considering any significant internal control issues the following were recognised:

- **Staff engagement and raising concerns**

The development of a culture where all staff feel confident to speak up and raise concerns at work is crucially important to us. We continue to affirm its direct impact on a culture of safety with positive benefits for patient care, quality and staff experience and engagement.

The publication of the West Suffolk Review in December 2021 highlighted significant failures of governance and decision-making related to 'speaking up' and during the course of 2022-23 we have been delivering a Board-sponsored organisational development plan to enable the improvement in culture that we have defined and want to see. It contains five themes of work:

- 1) strategy & values
- 2) Board development
- 3) speak up culture
- 4) HR practice
- 5) staff engagement.

The delivery of this plan was reviewed by our internal audit function in Q4 2022-23 and a rating of substantial assurance was provided. However, the components of this plan are merely the building blocks and enablers, and we recognise that the change in culture as felt by staff and teams across the organisation will take much longer to embed.

The attitudes and behaviours of leaders and managers across the organisation is crucial to this cultural journey. As we identified last year, it involves being open to concerns, creating a culture in teams where concerns and feedback are genuinely welcomed, and ensuring that the handling of speak up issues does not become conflated with any other process, including performance management.

The development of a culture where all staff feel confident to speak up and raise concerns at work, and their concerns listened to, is crucially important to us all. It has a direct impact on a culture of safety with positive benefits for patient care, quality and staff experience. We know from the most recent set of staff survey results that further effort is required to develop this culture at WSFT.

In order to continue to inform the actions that will underpin this cultural improvement, we have identified six top-level priorities from the feedback of over 2,500 staff, as provided through the national staff survey, our 'what matters to you' staff engagement programme, and themes arising through speak up concerns that are raised.

The six priorities provide a structure for a 'people and culture' plan for 2023-24, which has been developed, and are as follows:

- continuing to build our speak up culture
- supporting leaders and managers to grow and develop
- building a strong workforce – recruiting and retaining our people
- an inclusive culture where everyone belongs – particularly addressing themes of race and disability
- rest, recovery and wellbeing – including from industrial action
- restoring pride after a challenging few years.

Progress with this plan will be overseen by the involvement committee of the Board and reported in public. Most importantly we will measure its impact and ensure clear communication with colleagues across the organisation from the perspective of "you said, we will".

• **Building structure**

The building structural challenges we face at West Suffolk Hospital are well known and we have long documented that, according to structural engineer experts, our building's 'shelf life' likely will not extend beyond 2030.

The Trust has faced estate challenges regarding its roof for a number of years, and has put approved mitigations in place, such as reducing weight on it. These mitigations are: recommended by structural engineers, well-managed, and reported to our regulators as part of our planned estates works.

The need for a new hospital has been nationally acknowledged and WSFT, and the rest of the west Suffolk health system, were delighted that the Trust was named as one of 40 to benefit

from the Government's New Hospital Programme. However, whilst this news is very much welcome, any new facility will not be open for several years and we have a duty to ensure that the existing hospital is appropriately maintained and we are able to continue to provide high quality health services for our community.

In 2019 an additional, specific structural risk was identified about a product called reinforced autoclaved aerated concrete (RAAC) planks, which were used in the original build of West Suffolk Hospital and the front residences in the 1970s.

The alert received was from the Standing Committee on Structural Safety (SCOSS), which reported one sheer RAAC plank failure in a non-NHS site built of similar material and construction. The alert recommended that inspection work be carried out on buildings of RAAC construction, giving guidance on how to further assess the condition and structural adequacy of the planks.

Our estates teams have been proactive and robust in tackling this issue.

Since receiving the alert, they have mapped every plank across the organisation, and implemented an assessment programme using sophisticated radar equipment and other approved tests to check all planks for signs of stress. The teams are carrying out remedial repairs across the estate as part of this; work has not stopped throughout the pandemic.

The Trust has engaged experienced structural engineers and experts to support the inspection work. All planks will be continually assessed in a rolling programme of routine estates work until we move to a new hospital site. In addition, proactive programmes of precautionary maintenance work are well underway around the hospital to further ensure the safety of our patients, visitors, and staff.

We are not complacent - this has and will continue to have our absolute attention and focus. Staff, patient and visitor safety matters to us above all else.

This issue has not been caused by a failing of the Trust, which has managed its estates repairs well within the means available, but by the ageing of a product in our roof that cannot be replaced. We want to be transparent about our challenges and to reassure our patients, staff and community.

The programme of works to inspect the building structure and implement required mitigating action continues and we have received additional funding to support the programme during 2023-24.

The Government have committed to prioritising the replacement of hospitals containing RAAC, including West Suffolk Hospital, taking us one step closer to making the replacement of our Hardwick Lane Hospital a reality. The next stage of the project is the completion of the second of three business cases, known as the outline business case. The project team will also continue to work closely with the New Hospital Programme team to ensure designs and activities take full advantage of the centralised programmatic approach.

- **Delivering patient access**

In 2023-24 the Trust is required to meet the standards set out in the NHS England priorities and operational planning guidance in order to:

- recover our core services and productivity
- as we recover, make progress in delivering the key ambitions in the NHS Long Term Plan (LTP)
- continue transforming the NHS for the future.

The RAAC remedial work in theatres is now largely complete and therefore not impacting on theatre capacity. There is an ongoing operational impact on non-elective capacity of remedial work in ward areas until 2025. In addition, subsequent waves of COVID-19 and flu will continue to impact on bed availability and patient flow.

This section considers delivery of the standards in terms of:

- elective access, including referral to treatment (RTT), diagnostics and cancer
- urgent and emergency care
- community and primary care
- industrial action.

Elective access, including referral to treatment (RTT), diagnostics and cancer

There has been significant progress in reducing the waiting times for patients including those waiting over 104 weeks and 78 weeks, and the Trust achieved better than trajectory on the latter in 2022-23.

The Trust has committed to meet all requirements of the 2023-24 priorities and operational planning guidance with the exception of achieving zero patients waiting over 65 weeks for elective treatment by March 2024. This is due to capacity issues within the urogynaecology pathway.

In summary, the Trust has submitted the following position:

- 154 patients waiting over 65 weeks for treatment at end of March 2024
- achievement of system activity target
- reduction in the number of patients waiting over 62 days on a cancer pathway in line with agreed trajectory, by March 2024
- achievement of the 28-day faster diagnosis standard for cancer by March 2024
- achievement of the 6-week diagnostic target by March 2025.

The mitigating actions for the non-compliant 65-week position include:

- review by NHSE regional medical director
- demand and capacity review using national intensive support team tools
- exploration of mutual aid with neighbouring trusts.

Due to the non-compliant 65-week position, the Trust will be placed in tier 2 for elective care (regional support).

Urgent and emergency care

The Trust has faced significant challenges in relation to urgent and emergency care performance, particularly in relation to the number of patients spending over 12 hours in the emergency department. The Trust has committed to meet all requirements of the 2023-24 priorities and operational planning guidance including:

- reintroduction of the 4-hour standard to the Trust following the participation in the NHS national clinical review of standards since May 2019. The Trust commenced external reporting of the 4-hour standard in May 2023
- achievement of 76% of patients seen within 4 hours by March 2024, in line with agreed trajectory
- reduce general and acute bed occupancy to 92% by March 2024.

There is a comprehensive urgent and emergency care recovery plan in place to achieve these commitments which includes:

- maximising use of the virtual ward
- extension of discharge waiting area service
- implementation of same day emergency care (SDEC)
- embedding of internal professional standards (clear description of the values and behaviours expected).

Community and primary care

The Trust consistently achieves the 2-hour urgent community response standard within community services. It has been challenging to monitor consistent primary care access performance data in relation to the Trust's GP surgery at Glemsford. The Trust has committed to meet all requirements of the 2023-24 priorities and operational planning guidance, including:

- consistently meet or exceed the 70% standard for urgent community response in 2023-24
- improve access to primary care.

In 2023-24, the Trust is committed to increasing the number of patients receiving urgent community response by 10%. This will be achieved through embedding the standard within integrated neighbourhood teams and progressing the work undertaken in the Suffolk and North East Essex community hub pilot, which diverts appropriate ambulance calls to community services.

Industrial action - operational response and impact

It is anticipated that there will be ongoing industrial action during 2023-24. As a Trust, we have a command, control and coordination plan, also known as a C3 plan. It covers the arrangements we use when responding to an incident that might affect our 'business as usual', or stop us from delivering services in the way we would normally. Responding to industrial action falls into that category, so we have followed the C3 plan with enhanced capability and resources to support our response. These include:

- strategic commander: the strategic commander is an executive director with overarching responsibility for the Trust's response to an incident. Supported by members of the executive team, the strategic commander leads a strategic group that considers and approves recommendations from the core resilience team (CRT), and tactical group.
- tactical: looks after the day-to-day issues, that is things that need action immediately. It also decides how to put strategic group decisions into practice and implements them. Its sub-groups include:
 - operational: how we put decisions into practice in a way that works
 - resources: managing things like personal protective equipment (PPE) stocks
 - divisional operational command centres (DOCCs): this is a technical name for the teams looking after specific operational areas – including surgery, community, medicine, women and children's services, and patient flow. Staff can contact the DOCCs directly regarding operational issues.
- core resilience team: looks after the 'mid-term' issues. It can include the following sub-groups:
 - clinical: made up of clinical colleagues from across the Trust. It covers things like making sure we are following and implementing the right clinical guidelines
 - community: community teams face very different challenges to acute colleagues, so this group looks at those specifically. It includes how we link with other providers, for example care homes

- workforce: all things staff related, including wellbeing and risk assessments, including linking with occupational health
- future planning: considers how we will turn services back on, in what order, and what support the Trust might need moving forward
- ethical: a group to temperature check some of the difficult decisions we're having to make. For example, the temporary suspension of, and then reinstating, services and activities.

Ongoing industrial action will impact on the Trust's ability to deliver the commitment set out in the 2023-24 priorities and operational planning guidance submission.

I am confident that the internal control systems are operating well and that the work we have done to maintain and develop our risk management systems will help us to consolidate this position in the future. The Trust is committed to the continuous improvement of processes of internal control and assurance. This includes the effective tracking of action to mitigate significant control issues through the board assurance framework.



Dr Ewen Cameron
Chief Executive
29 June 2023

2.7 Remuneration report

The Trust has identified the individuals in a senior position who have authority to control or direct major activities to be the executive and non-executive members of the Board.

The purpose of the remuneration report is to provide a statement to stakeholders on the decisions of the remuneration committee relating to the executive directors of the Board of directors. In preparing this report, the Trust has ensured it complies with the relevant sections of the Companies Act 2006 and related regulations and elements of the NHS Foundation Trust Code of Governance.

The following parts of the remuneration report are subject to audit:

- single total figure table of remuneration for each senior manager
- pension entitlement table and other pension disclosures for each senior manager
- fair pay disclosures
- staff report: exit packages, analysis of staff numbers and analysis of staff costs.

Annual statement on remuneration

Directors are employed on service contracts whose provisions are consistent with those relating to other employees within the Trust. There are no components within the remuneration relating to performance measures or bonuses.

Senior managers' remuneration policy

Senior managers' pay consists of the following elements:

- senior managers' salaries are reviewed on an annual basis by the remuneration committee. The objectives of the committee are set out below.
- benefits in kind – in line with the Trust policy for all employees, senior employees are eligible to access salary sacrifice schemes such as lease cars and computer equipment. These may be considered as benefits in kind and are declared to HM Revenue and Customs and employees pay any additional tax due as appropriate.

To determine senior manager salaries the remuneration committee may use one or more of the following:

- an assessment of the Trust's performance
- an assessment of an individual's performance against agreed objectives
- NHS cost of living pay rise, based on the national NHS pay award
- benchmarking data, including NHS Improvement guidance and established ranges
- NHS and other relevant advertised jobs
- the prevailing market position, including the ability to recruit and retain individuals.

Remuneration committee

The aim of the remuneration committee is to make appropriate recommendations to the Board on the Trust's remuneration policy and the specific remuneration and terms of service of the chief executive, executive directors, and other staff as determined by the Board. The committee will:

- advise the Board about appropriate remuneration and terms of service for the chief executive, other executive directors and other senior employees including:
 - all aspects of salary (including any performance-related elements/bonuses)
 - provisions for other benefits, including pensions and cars
 - arrangements for termination of employment and other contractual terms

- make recommendations to the Board on the remuneration and terms of service of executive directors and senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff
- scrutinise the proper calculation of termination payments taking account of such national guidance as is appropriate, advise on and oversee appropriate contractual arrangements for such staff
- monitor and evaluate the performance of individual executive directors (and as agreed by the Board other senior employees) including:
 - establishing the objectives of the chief executive and review the performance of the chief executive against these objectives which support the Trust's priorities
 - scrutinising the objectives of the executive directors (to be established by the chief executive and to support the Trust's priorities) and review performance reports on the executive directors prepared by the chief executive
- scrutinise the recommendations of the clinical excellence awards committee
- review the terms of reference of the committee every two years
- report the frequency of meetings and the members of the remuneration committee in the Trust's annual report
- the committee shall report in writing to the Board the basis for its recommendations
- consider the Trust's equality, diversity and inclusion policy in all decisions made, the objectives of which are linked to the Trust's overall strategy. Further detail regarding equality and diversity inclusion is provided within section 2.8.8 (staff report).

The committee comprises the Trust chair and non-executive directors of the Board. The committee is chaired by a non-executive director. The chief executive, executive director of workforce and communications and trust secretary may be present to advise but not for any discussions concerning their personal remuneration at the discretion of the remuneration committee's chair.

A quorum will consist of the committee chair (or nominated representative) and at least two non-executive directors. A nominated representative for the chair must be a non-executive director.

The committee acts with delegated authority from the Board and will usually meet at least annually. Minutes are taken and a report submitted to the Board showing the basis for the recommendations. Three meetings of the remuneration committee were held during 2022/23.

Attendance at remuneration committee meetings

Name	Title	Attendance (out of 3)
Jude Chin	Interim Trust Chair	3
Richard Davies	Non-executive director	3
Louisa Pepper	Non-executive director	2
Alan Rose	Non-executive director (remuneration committee chair)	3
Christopher Lawrence ⁽¹⁾	Non-executive director	2
Tracy Dowling ⁽²⁾	Non-executive director	1
Hilary McCallion ⁽²⁾	Non-executive director	0
Antoinette Jackson ⁽²⁾	Non-executive director	1
Geraldine O'Sullivan ⁽²⁾	Non-executive director	1
Krishna Yergol ⁽²⁾	Associate Non-executive director	1

Meeting dates: 17 August 2022, 28 September 2022, 16 December 2022

⁽¹⁾ Christopher Lawrence resigned as a non-executive director in October 2022

⁽²⁾ Tracy Dowling, Hilary McCallion, Antoinette Jackson, Geraldine O'Sullivan and Krishna Yergol all took up non-executive director posts in November 2022.

Senior managers' (executive directors') pay is annually reviewed by the remuneration committee. The committee is presented with benchmarking information to demonstrate where each executive director's salary sits alongside similar posts in the NHS market in the context of pay awards to other staff groups. Decisions to increase salaries are based on this information, internal equity, affordability, whether there has been a significant change in a director's portfolio and thus responsibility. Through these arrangements the committee must be satisfied that the remuneration for senior managers is reasonable, including any senior manager paid more than £150,000. In addition, each director can receive the NHS cost of living pay rise which is based on the national NHS pay award. In recent years the Department of Health and Social Care has advised the chair on the expected level. The arrangement for managing the remuneration policy for senior managers was strengthened from 2018/19 to include engagement with staff and public governors.

The Trust does not have a performance-related pay scheme. The committee, however, has the delegated authority to pay one-off discretionary payments in exceptional circumstances. The chief executive presents an annual report on executive directors' performance (in the case of the chief executive this is presented by the chair) based on the outcome of their annual appraisal.

The senior managers' salary does not include separate components and there are no performance measures that apply. Clinical elements are included in the salary of the Medical Director as part of the work undertaken in their medical role.

Service contracts obligations

The Trust's executive directors hold substantive service contracts. Notice periods apply based on the early termination of their contract. The notice periods are as follows:

- chief executive – six months
- executive directors – three months.

The non-executive directors hold a term for 3 years. Further details can be found in section 2.2 (directors' report).

Policy on payment for loss of office

Approval for any non-contractual severance payments should be obtained from the remuneration committee and NHS Improvement following submission of a business case. In respect of individuals earning over £100,000, any severance payment should include a provision requiring the repayment of the severance payment where the individual returns to work for the NHS in England within 12 months and/or before the expiry date of the period for which they have been compensated (as measured in equivalent months/part-months of salary). In such circumstances the employee would be required to repay any unexpired element of their compensation. This would be reduced to take account of any appointment to a lower grade post or reduced hours basis and reflect net salary.

Annual report on remuneration

In the financial year the directors' costs increased to £1,092k from £1,077k. There were no exit packages paid to Board members in the 2022/23 financial year or the comparative year.

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme; or arrangement to secure pension benefits in another pension scheme; or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include

any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Both directors and governors are able to reclaim expenses necessarily incurred during the course of their duties. Details of these are shown below. The numbers include individuals who have acted in their capacity as director or governor for any part of the financial year.

	2022/23		2021/22	
	Directors	Governors	Directors	Governors
Total number in office during the year	18	28	18	27
Total number receiving expenses	8	5	8	3
Aggregate total of expenses paid during the year (£)	11,186	611	10,895	105

Fair pay disclosure

NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest- paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the organisation in the financial year 2022/23 was £210k - £215k (2021/22 £195k - £200k), an increase of 7.59% (2021/22 0%) from the mid-point of the bands. This increase in remuneration reflects the greater proportion of the director's time that was spent carrying out Chief Executive duties as opposed to their substantive role as Director of Resources. There was also a reduced impact on their total remuneration from salary sacrifice arrangements during 2022/23.

Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2022/23 was from £13,859 to £297,364 (2020/21 £17,417 to £240,111). The increase in the high end of the range between periods is a result of enhanced medical sessions provided by consultants and the reduction in the low end of the range is the annualised remuneration for a non-executive director who commenced in post February 2023 and did not incur any taxable expenses before year-end. The percentage change in average employee remuneration (based on total for all employees on an annualised full time equivalent basis divided by full time equivalent number of employees) between years is 10.2% (2021/22 10.8%). The 2022/23 increase in average employee remuneration is a result of pay awards and incremental progression through pay bands. Ten employees received remuneration exceeding that of the highest-paid director in 2022/23 (2021/22 nine employees).

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2022-23	25th Percentile	Median	75th Percentile
Total pay and benefits exc. pension benefits	25,332	34,034	45,441
Salary component of pay	25,332	34,034	45,441
Pay and benefits excluding pension:pay ratio for highest paid director	8.4	6.2	4.7

2021-22	25th Percentile	Median	75th Percentile
Total pay and benefits exc. pension benefits	22,549	31,534	42,121
Salary component of pay	22,549	31,534	42,121
Pay and benefits excluding pension:pay ratio for highest paid director	8.8	6.3	4.7

The mid-point of the highest paid director's salary and allowances band was 6.2 times (2021/22 6.3 times) the median remuneration of the workforce, which was £34,034 (2021/22 £31,534). This is calculated based on all staff employed, including agency staff covering vacancies, as at 31 March 2023. The ratio reduced marginally because the mid-point of the highest paid director's remuneration band, per the single total figure table, increased at a lower rate than the median remuneration of the workforce. The primary factor in the median pay increase, and also to the increase in average employee remuneration, is increases awarded to the workforce generally, including additional non-consolidated awards on top of the 2022/23 pay award for those on an Agenda for Change contract.

Similarly consistent between 2021/22 and 2022/23 are the ratios between the mid-point of the highest paid director's salary and allowances band and the remuneration of the employee at the 25th and 75th percentiles – respectively 8.4 (2021/22 8.8) and 4.7 (2021/22 4.7). The reduction in the 25th percentile ratio is a reflection of the 2022/23 pay award being proportionally greater for those on lower Agenda for Change pay bands.

Table A – Single total figure

Name and title	Year to 31 March 2023				Year to 31 March 2022			
	Salary paid (bands of £5000)	Expense payments (taxable) to nearest £100	All pension- related benefits (bands of £2500)	Total (bands of £5000)	Salary paid (bands of £5000)	Expense payments (taxable) to nearest £100	All pension- related benefits (bands of £2500)	Total (bands of £5000)
	£000	£00	£000	£000	£000	£00	£000	£000
Mr C Black – Executive director of resources (Note 2)	210 - 215	14	-	210 - 215	190 - 195	29	-	195 - 200
Dr E Cameron - Chief executive (Note 1)	20 - 25	-	100 - 102.5	120 - 125	-	-	-	-
Mr J Chin - Chair	50 - 55	45	-	55 - 60	15 - 20	5	-	15 - 20
Ms N Cottingham - Executive chief operating officer	125 - 130	5	117.5 - 120	245 - 250	45 - 50	-	85 - 87.5	135 - 140
Dr R Davies – Non-executive director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Mrs T Dowling - Non-executive director (Note 3)	5 - 10	4	-	5 - 10	-	-	-	-
Ms A Jackson - Non-executive director (Note 4)	5 - 10	-	-	5 - 10	-	-	-	-
Mr C Lawrence - Non-executive director (Note 5)	5 - 10	-	-	5 - 10	10 - 15	-	-	10 - 15
Mr N Macdonald – Deputy director of finance (Note 6)	125 - 130	18	-	130 - 135	100 - 105	6	-	100 - 105
Ms H McCallion - Non-executive director (Note 7)	0 - 5	-	-	0 - 5	-	-	-	-
Dr P Molyneux - Executive medical director	205 - 210	-	97.5 - 100.0	305 - 310	160 - 165	3	167.5 - 170	330 - 335
Dr G O'Sullivan - Non-executive director (Note 8)	5 - 10	-	-	5 - 10	-	-	-	-
Mr J Over – Executive director workforce & communications	120 - 125	12	37.5 - 40	160 - 165	115 - 120	6	7.5 - 10	125 - 130
Mrs L Pepper - Non-executive director	10 - 15	-	-	10 - 15	10 - 15	-	-	10 - 15
Dr R Petter - Non-executive director (Note 11)	-	-	-	-	-	-	-	-
Mr A Rose - Non-executive director (Note 9)	10 - 15	9	-	10 - 15	10 - 15	7	-	10 - 15
Mrs S Wilkinson - Executive director chief nurse	125 - 130	-	52.5 - 55	180 - 185	120 - 125	-	150 - 152.5	275 - 280
Mr K Yergol - Non-executive director (Note 10)	5 - 10	6	-	5 - 10	-	-	-	-

No additional performance pay and bonuses were paid to directors in 2022/23 or 2021/2022.

Table B – Pension benefits to 31 March 2023

Name	Real increase / decrease in pension (Bands of £2,500)	Real increase / decrease in lump sum (Bands of £2,500)	Total accrued pension (Bands of £5,000)	Total lump sum (Bands of £5,000)	CETV 1/04/2023	Real increase in CETV	CETV 31/03/2023
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Dr E Cameron	0.0 - 2.5	0.0 - 2.5	50 - 55	95 - 100	825	8	949
Mr C Black (Note 12)	-	-	-	-	-	-	-
Ms N Cottingham	5.0 - 7.5	10.0 - 12.50	40 - 45	70 - 75	515	94	642
Mr N Macdonald (Note 13)	-	-	-	-	-	-	-
Dr P Molyneux	5.0 - 7.5	5.0 - 7.5	80 - 85	185 - 190	1,556	104	1,738
Mr J Over	2.5 - 5.0	0.0 - 2.5	35 - 40	60 - 65	498	25	556
Mrs S Wilkinson	2.5 - 5.0	2.5 - 5.0	50 - 55	155 - 160	1,153	71	1,278

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023/24 CETV figures.

Payroll benefits and related CETVs do not allow for potential future adjustments arising as a result of the retrospective remedy of the McCloud judgement.

Notes

1. Dr E Cameron was appointed Chief Executive Officer on 20 February 2023
2. Mr C Black was Interim Chief Executive to 20 February 2023 when he returned to his substantive post as Director of Resources
3. Mrs T Dowling was appointed as a NED from 1 November 2022
4. Ms A Jackson was appointed as a NED from 31 October 2022
5. Mr C Lawrence was a NED to 31 October 2022
6. Mr N Macdonald was Interim Director of Resources to 20 February 2023 when he returned to his substantive post as Deputy Director of Finance
7. Ms H McCallion was appointed as a NED from 1 November 2022 until 31 March 2023
8. Dr G O'Sullivan was appointed as a NED from 1 November 2022
9. Mr A Rose was a NED to 31 March 2023
10. Mr K Yergol was appointed as a NED from 1 November 2022
11. Dr R Petter was appointed as a NED from 1 February 2023
12. Mr C Black opted out of the pension scheme in January 2020. As the member is no longer active in the pension scheme there are no figures available to calculate by the NHS Pension Agency
13. Mr N Macdonald opted out of the pension scheme in December 2020. As the member is no longer active in the pension scheme there are no figures available to calculate by the NHS Pension Agency.



Dr Ewen Cameron
Chief Executive
29 June 2023

2.8 Staff report

2.8.1 Our staff

The Trust is one of the largest employers in west Suffolk, employing 5,218 staff in April 2023. It firmly believes in the benefits of working in partnership with staff and the trade unions, and this was highlighted during 2022-23 with the following activities:

- the Trust's results from the 2022 NHS Staff survey were, in the main, in line with national changes and tracked closely to the national average scores
- our Freedom to Speak Up Guardian, supported by Freedom to Speak Up champions across the organisation, continue to support an open and inclusive culture
- staff governors also continue to support staff to discuss challenges and achievements and report on these
- as part of the Trust's health and wellbeing programme we continue to focus on both emotional and physical health and wellbeing. We provide a clinical psychologist-led staff support psychology service and offer a wide range of benefits to support staff, including a staff physiotherapist
- all staff continue to have access to free membership of Abbeycroft Leisure which includes access to physical facilities and virtual classes
- all staff were offered both an influenza and COVID-19 vaccination in 2022-23
- we continue to invest in a full-time staff side lead role, replacing our part-time convenor role.
- we continue to develop our partnership working through the following groups:
 - Trust Council
 - Trust negotiating committee (medical and dental)
 - health and wellbeing steering group
 - equality, diversity and inclusion steering group.

2.8.2 Staff costs

Staff costs

	Permanent £000	Other £000	2022/23 Total £000	2021/22 Total £000
Salaries and wages	199,716	644	200,360	179,143
Social security costs	22,017	-	22,017	17,999
Apprenticeship levy	981	-	981	864
Employer's contributions to NHS pension scheme	32,356	-	32,356	29,653
Pension cost - other	86	-	86	66
Temporary staff	-	6,253	6,253	4,071
Total gross staff costs	255,156	6,897	262,053	231,796
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	255,156	6,897	262,053	231,796
Of which				
Costs capitalised as part of assets	2,382	-	2,382	1,651

2.8.3 Average number of employees (whole time equivalent (WTE) basis)

Average number of employees (WTE basis)

	Permanent Number	Other Number	2022-23 Total Number	2021-22 Total Number
Medical and dental	512	57	569	534
Administration and estates	950	52	1002	886
Healthcare assistants and other support staff	820	124	944	918
Nursing, midwifery and health visiting staff	1204	103	1307	1,260
Scientific, therapeutic and technical staff	789	20	809	782
Total average numbers	4,275	356	4,631	4,380

Of which:

Number of employees (WTE) engaged on capital projects	39	1	39	103
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2.8.4 Reporting of compensation schemes - exit packages 2022-23

There were no compensation schemes/exit packages recorded in 2022-23.

2.8.5 Breakdown at year end of the number of male and female staff

	Male	Female	Total
Executive directors (including CEO)	4	2	6
Non-executive directors (including chair)	4	4	8
Other senior managers (band 8d and above)	10	9	19
Employees	1,025	4,160	5,185

2.8.6 Sickness absence data

The Trust has systems and processes in place to manage both long- and short-term sickness absence, in accordance with best practice and legislative requirements. The performance for the year is available via <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates>.

2.8.7 Trade union facility time information

Number of employees who were trade union officials	Whole time equivalent
30	26.69
Percentage of time spent on facility time	Number of employees
0%	21
1%-50%	7
51% - 99%	1
100%	1
Total cost of facility time	Costs
Total pay bill	£256,071,000
Percentage of pay bill spent on facility time	0.02%
Time spent on trade union activities as percentage of total facilities time	Percentage
397.5	17.7%

2.8.8 Equality and diversity

The Trust is committed to the provision of high quality, safe care for all members of the communities it serves and to the development of a culture of inclusion where all people are valued and respected for their individual differences; as evidenced by our strategy: First for our patients, staff and the future.

This means we will embrace all people irrespective of, for example, race, religion or belief, gender identity or expression, sexual orientation, age, marital status, pregnancy, maternity or disability. We will give equal access and opportunities and remove discrimination and intolerance. We will do this both as an employer and as a service provider.

Our **inclusion strategy objectives** are:

For **patients, service users and carers**:

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

For **staff**:

- promote and support inclusive leadership at all levels of the Trust
- ensure recruitment and selection processes are bias-free and inclusive
- facilitate the voices of all staff, providing fora for individuals to come together, to share ideas, raise awareness of challenges, provide support to each other and feedback to the Trust on issues of equality, diversity and inclusion
- take action to support the mental health and wellbeing of all staff.

For **patients, service users, carers and staff**:

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

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 NHS Workforce Race Equality Standard indicators, national staff survey results, our gender pay gap report, the Trust's strategy and the requirements of the Equality Act (2010), including the Public Sector Equality Duty (PSED). We plan to review and refresh these objectives in 2023.

Progress is monitored quarterly by the equality and diversity steering group and an annual report is received by the Board. We also track our progress through our inclusion action plan, which is currently being reviewed and updated.

The data shows all current employees and public members broken down by protected characteristics (data is not available for all the characteristics protected by the Equality Act):

Employees and public members protected characteristics

	Staff in post				Public members			
	2022/23	2021/22	2020/21	2019/20	2022/23	2021/22	2020/21	2019/20
Age								
16	0	0	0	0	3	0	0	0
17-21	59	60	75	54	47	62	60	71
22+	5,159	4,785	4,673	4,299	6,795	6,874	6,077	6,105
Not specified	0	0	0	0	108	108	114	120
Total	5,218	4,845	4,748	4,353	6,953	7,044	6,251	6,296
Ethnicity								
White	4,017	3,801	3,765	3,500	6,048	6,180	5,540	5,600
Mixed	72	65	55	49	45	45	32	34
Asian or Asian British	622	517	485	461	166	167	106	95
Black or Black British	123	95	60	29	42	41	28	28
Other ethnic group	75	67	48	39	39	39	34	35
Not stated	134	162	186	198	613	572	511	504
Undefined	175	138	149	77	-	0	0	0
Total	5,218	4,845	4,748	4,353	6,953	7,044	6,251	6,296
Gender								
Female	4,175	3,887	3,833	3,544	4,629	4,663	3,953	3,932
Male	1,043	958	915	809	2,314	2,381	2,298	2,364
Not stated	0	0	0	0	10	0	0	0
Total	5,218	4,845	4,748	4,353	6,953	7,044	6,251	6,926
Disability								
No	3,164	2,754	2,436	2,104	-	-	-	-
Not declared	332	291	325	365	-	-	-	-
Undefined	1,088	1,225	1,370	1,227	6,389	6,265	5,670	5,661
Prefer not to answer	354	387	455	516	-	177	-	-
Yes	280	188	162	141	564	602	581	635
Total	5,218	4,845	4,748	4,353	6,953	7,044	6,251	6,296

Source: Electronic Staff Record and Civica membership database (as at 1/4/2023)

	Male	Female	Total
Executive directors (including CEO)	4	2	6
Non-executive directors (including chair)	4	4	8
Other senior managers (band 8d and above)	10	9	19
Employees	1,025	4,160	5,185

Source: Electronic Staff Record (as at 1/4/2023)

Disability and equal opportunities policies

The Trust is committed to a policy of equal opportunities in employment and service delivery. Everyone who comes to the Trust, either as a patient or visitor, or who works in the Trust, or applies to work in the Trust, should be treated fairly and valued equally. Our Trust policies and strategies (the equality delivery system, recruitment and retention of people with disabilities, supporting people who are trans policy and equal opportunities policy) all support this focus.

The Trust completes an annual action plan based on its performance against the NHS Workforce Race Equality Standard, Workforce Disability Equality Standard and gender pay gap reporting, the national NHS staff survey and other locally identified priorities.

Gender pay gap legislation requires all employers of 250 or more employees to publish their gender pay gap as at 31 March each year. You can download our gender pay gap report at <https://www.wsh.nhs.uk/CMS-Documents/EqualityandDiversity/GPG-Report.pdf>.

The Trust seeks to provide equitable employment opportunities for people with disabilities, ensuring that they benefit from all available training and opportunities for career development WSFT also has a policy to support the recruitment and retention of people with disabilities. Additionally, our policy on appraisal, personal development planning and the knowledge and skills framework supports and promotes the equal access of all staff to training and development.

The Trust has systems and processes in place to review staff turnover. Information for the year is available here: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics>

2.8.9 Health and safety report

The Trust's health and safety performance is reported to and monitored by the health and safety committee which then escalates any issues of concern to the corporate risk governance group. Issues that cannot be resolved or which need to be escalated are reported to the insight committee and the Board of directors accordingly.

Risk assessment

The strategy for the management of risk continues to be developed and promoted Trust-wide. The Datix risk register is a tool for capturing, prioritising and managing the Trust's significant risks and is integral to the Trust's risk management framework.

The risk register allows all divisions to manage, monitor and review their own risks. The responsibility lies with each departmental manager to ensure all their significant risks are captured on the risk register. Risk register training is provided by the head of health, safety and risk and the Trust's health and safety advisor.

Between April 2022 to March 2023, 39 members of staff were trained in the principles of health, safety and risk assessment. This has improved the quality and quantity of risk assessments and has helped to promote the use of the risk register.

Workplace inspections are undertaken by health and safety link persons who are qualified with the Royal Society for Public Health (RSPH) Level 2 award in health and safety. This qualification gives the link person the knowledge and understanding to undertake the inspection. 293 members of staff have now gained this qualification. Once completed, the inspection is captured on the risk register so actions can be monitored.

Reporting of Injuries, Diseases and Dangerous Occurrence Regulations 2013 (RIDDOR)

Between April 2022 to March 2023 13 incidents were reported to the Health and Safety Executive (HSE) as required under RIDDOR. This is a decrease of three from the previous year.

There were no RIDDOR reportable incidents relating to asbestos or violence and aggression. There was a decrease in the category of health and safety from five to two incidents and violence and aggression from five to zero. There was an increase in moving and handling from two to three, slips, trips and falls from four to seven and needlestick incidents from zero to one.

RIDDOR description	2021-22	2022-23
Moving and handling incidents	2	3
Slips, trips and falls	4	7
Health and safety	5	2
Violence and aggression	5	0
Needlestick	0	1

The Trust continues to improve standards which has helped to reduce the number of RIDDOR reportable incidents overall. this includes:

- level 2 award in Health and Safety training
- health and safety link persons in every department
- regular workplace inspections undertaken
- quarterly health and safety committee
- risk assessments captured on the Trusts risk register.

Of the 13 incidents reported to the HSE, 4 (31%) were due to being off work for more than seven days following an incident and 6 (46%) were due to suffering a specified injury. The health and safety committee reviews incident trends, including RIDDORs to ensure that appropriate learning takes place and action taken.

Incident reporting system

The Datix incident reporting system is used to capture all clinical and non-clinical incidents. Non-clinical incidents include reports of personal accidents, violence and aggression, abuse and harassment, fire, and security breaches. All incidents, no matter the grade, are investigated and reported according to the Trust's incident policy and procedure. Actions taken as a result of investigations are communicated through the divisional governance groups. The Board of directors receives a quarterly report summarising incident trends and action.

For the period April 2022 to March 2023 there were 288 violence, abuse, and harassment incidents, a decrease of 79 from the previous year. These incidents take into account physical assaults, verbal abuse, harassment and physically threatening behaviour towards staff by patients. Out of the 288 incidents reported there were 93 physical assaults, and 66 were recorded as having a clinical cause. Clinical-caused incidents are those whereby the patient is not aware or has no control of their actions. This can be postoperative due to having a general anaesthetic or, more commonly, the patient is suffering from dementia or is cognitively impaired.

There were 2,082 reported incidents of personal accident/ill-health during 2022-23. This is an increase of 269 incidents (13%) from the previous year. This figure includes staff, patients, visitors and others and is broken down into specific incident categories, which include slips/trips/falls, contact with an object, contact with a sharp, e.g. needle, lifting and handling, self-harm, exposure to a harmful substance, contact with electricity and a category of 'other'. Further detail of learning and action is provided in section 1.2.3 (quality and operational performance).

2.8.10 Occupational health report / occupational health and wellbeing service

Occupational health and wellbeing vision:

To deliver a professional, quality occupational health and wellbeing service to the West Suffolk NHS Foundation Trust and become an essential component in the quality service delivered to the local community by taking a public health approach to occupational health and wellbeing.

Promoting the health and wellbeing of all our staff is important to support them in delivering excellent care for our community as well as being a marker of a good employer.

Our health and wellbeing steering group oversees our programme of action to support our staff and our health and wellbeing plan sets out our annual priorities. During 2022/23 this has included:

- renewing our contract with Abbeycroft Leisure, providing free access for staff to gym, swimming and fitness facilities at different locations, including on-line fitness classes
- developing a comprehensive package of financial and cost of living resources, including a dedicated web page on our intranet
- launch of Wagestream – a new financial tool through which staff can have greater control of when they can access their earnings, helping staff to manage their finances more easily
- ongoing promotion of menopause support, including training menopause advocates
- delivery of a range of events to support health and wellbeing, including ‘Love Yourself Week’ in November 2022
- agreement to use the health and wellbeing framework adapted by SNEE to review our areas of strength and areas for further focus. This work is being progressed in 2023.

We have continued working in partnership with Workplace Health and Wellbeing, part of the Norfolk and Norwich University Hospitals NHS Foundation Trust, to provide comprehensive occupational health services for all our staff. Services have been delivered in a timely and professional way, with escalation of any issues dealt with promptly. An oversight group meets quarterly to review progress, matters arising and key performance indicators.

Our clinical psychologist-led staff support psychology service continues to provide on-going support for staff during what continue to be challenging operational conditions.

All our staff have had access to both an influenza and COVID-19 vaccination through our inhouse vaccination programme.

2.8.11 Staff survey

The NHS staff survey is conducted annually. From 2021/22 the survey questions align to the seven elements of the NHS “People Promise”, and retains the two previous themes of engagement and morale. These replaced the 10 indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those.

The response rate to the 2022 survey among trust staff was 41% (2021: 44 %).

Staff experience and engagement

The WSFT moved from a partial survey to a full census of all its staff for the 2019 survey. This was done so the Trust could better understand the thoughts of the staff on what was working well and how we can better improve our services for the benefit of patients and the public. The Trust encourages open and honest communication throughout the organisation. A number of methods have been developed to encourage all staff to feel that they can contribute:

- all-staff briefing – weekly live briefing and Q&A with executives
- ‘What Matters to You’ surveys – staff discussion and listening sessions
- Freedom to Speak Up Guardian and champions
- guardian of safe working for junior doctors
- senior independent director – non-executive director lead for whistleblowing
- electronic staff briefing issued at least once a week
- monthly medical director’s bulletin for medical staff
- Green Sheet weekly staff newsletter
- staff recognition programme
- staff health and wellbeing focus groups
- staff networks – LGBT+, BAME and disability networks
- staff engagement on corporate social media, e.g. Twitter and Facebook
- a telephone hotline and web-based reporting for raising concerns anonymously.

Response rate

For the 2022 survey the Trust utilised a mixed-mode (email/postal), full census survey of eligible staff members. The Trust has seen a decline in the response rate and is below average.

	2022	2021	2020	2019
Highest	68.7%	79.9%	79.8%	71.9%
Our organisation	40.8%	43.6%	45.7%	51.8%
Average	44.5%	46.4%	45.4%	47.5%
Lowest	26.2%	29.5%	28.1%	29.7%

2022/23 and 2021/22

Scores for each indicator together with that of the survey benchmarking group acute and acute community trusts are presented below.

Indicators (‘People Promise’ elements and themes)	2022/23		2021/22	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People Promise:				
We are compassionate and inclusive	7.2	7.2	7.3	7.2
We are recognised and rewarded	5.8	5.7	5.9	5.8
We each have a voice that counts	6.6	6.6	6.7	6.7
We are safe and healthy	5.9	5.9	6.0	5.9
We are always learning	5.3	5.4	5.4	5.2
We work flexibly	6.0	6.0	6.0	5.9
We are a team	6.6	6.6	6.7	6.6
Staff engagement	6.9	6.8	7.0	6.8
Morale	5.8	5.7	5.9	5.7

2020/21

Scores for each indicator together with that of the survey benchmarking group acute and acute community trusts are presented below.

	2020/21	
	Trust score	Benchmarking group score
Equality, diversity and inclusion	9.1	9.1
Health and wellbeing	6.2	6.1
Immediate managers	6.9	6.8
Morale	6.4	6.2
Quality of appraisals		
Quality of care	7.5	7.5
Safe environment – bullying and harassment	8.0	8.1
Safe environment – violence	9.4	9.5
Safety culture	6.6	6.8
Staff engagement	7.2	7.0

Highest five benchmarked scores (compared to average)

The following tables outline the five questions in which the Trust scored well:

Q23d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.

	2018	2019	2020	2021	2022
Your org	82.9%	86.3%	82.6%	73.4%	67.8%
Best	90.4%	90.6%	91.8%	89.5%	86.4%
Average	71.1%	70.6%	74.3%	67.0%	61.9%
Worst	39.7%	39.6%	49.6%	43.5%	39.2%
Responses	576	2006	1897	1930	1978

Q11a My organisation takes positive action on health and wellbeing

	2021	2022
Your org	61.5%	61.1%
Best	73.8%	71.4%
Average	56.4%	55.6%
Worst	42.4%	42.8%
Responses	1949	1970

Q24c As soon as I can find another job, I will leave this organisation.

	2018	2019	2020	2021	2022
Your org	11.9%	10.7%	11.1%	13.9%	14.9%
Best	8.5%	7.5%	7.5%	9.9%	10.2%
Average	15.1%	14.1%	13.2%	16.1%	16.8%
Worst	25.2%	23.6%	23.7%	26.0%	26.5%
Responses	555	2007	1894	1918	1973

Q5b I have a choice in deciding how to do my work.

	2018	2019	2020	2021	2022
Your org	61.1%	61.2%	58.4%	55.1%	55.0%
Best	63.7%	65.2%	62.7%	60.0%	61.1%
Average	54.9%	54.6%	54.3%	51.5%	51.7%
Worst	47.2%	48.6%	46.0%	44.1%	45.4%
Responses	583	2046	1931	1975	1975

Q3h I have adequate materials, supplies and equipment to do my work.

	2018	2019	2020	2021	2022
Your org	63.1%	63.5%	62.8%	59.8%	57.6%
Best	73.0%	74.6%	74.5%	72.9%	69.7%
Average	53.1%	54.2%	58.5%	55.3%	53.5%
Worst	35.3%	32.0%	45.0%	45.5%	43.6%
Responses	592	2063	1936	1989	1981

Lowest five benchmarked scores (compared to average)

The following tables outline the five questions in which the Trust did not score so well:

Q19a I would feel secure raising concerns about unsafe clinical practice

	2018	2019	2020	2021	2022
Your org	71.7%	75.2%	69.3%	68.8%	66.3%
Best	77.1%	79.5%	77.9%	83.2%	79.4%
Average	70.1%	71.0%	71.9%	74.1%	70.8%
Worst	60.9%	59.0%	62.8%	66.4%	61.8%
Responses	572	2018	1897	1948	1980

Q19b I am confident that my organisation would address my concern

	2018	2019	2020	2021	2022
Your org	63.4%	66.7%	54.9%	51.7%	49.8%
Best	69.5%	74.0%	74.2%	76.2%	69.1%
Average	57.6%	59.1%	59.2%	57.7%	55.7%
Worst	42.6%	37.7%	45.3%	44.1%	42.2%
Responses	573	2018	1899	1947	1979

Q18a My organisation treats staff who are involved in an error, near miss or incident fairly

	2022
Your org	53.6%
Best	67.8%
Average	58.2%
Worst	47.3%
Responses	1459

Q18c When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again

2022	
Your org	61.5%
Best	75.9%
Average	67.0%
Worst	52.7%
Responses	1687

Q18d We are given feedback about changes made in response to reported errors, near misses and incidents

2022	
Your org	54.6%
Best	69.1%
Average	58.8%
Worst	45.4%
Responses	1694

Areas of improvement / deterioration from prior year

The table below show where the Trust scores have improved, and scores have improved significantly in three of the questions:

Most improved scores	Org 2022	Org 2021
q14d. Last experience of harassment/bullying/abuse reported	50%	43%
q30b. Disability: organisation made reasonable adjustment(s) to enable me to carry out work	76%	72%
q11b. In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	73%	70%
q7b. Team members often meet to discuss the team's effectiveness	57%	55%
q12a. Never/rarely find work emotionally exhausting	22%	20%

The table below show where the Trust scores have declined, and scores have declined significantly in all five of these questions:

Most declined scores	Org 2022	Org 2021
q23d. If friend/relative needed treatment would be happy with standard of care provided by organisation	68%	74%
q23c. Would recommend organisation as place to work	60%	65%
q4c. Satisfied with level of pay	29%	33%
q6a. Feel my role makes a difference to patients/service users	84%	88%
q3g. Able to meet conflicting demands on my time at work	41%	44%

Future priorities and targets

The staff survey results have been shared with our colleagues across the Trust. Divisions are reviewing their own feedback in detail with HR business partners leading on the development of divisional action plans to address local findings from the survey.

At the same time as the NHS national survey was running, the Trust also undertook a large listening exercise 'What Matters to You 2'. This covered 19 community and 19 acute locations, and also included an online survey. Just under 3,500 comments were received and reviewed. A thematic analysis of this data has been undertaken. The results of this analysis have then been triangulated with the outcomes from the Trust wide staff survey results, and a review of Freedom to Speak Up themes collected since 2020.

The bringing together of these rich data sources has enabled the Trust to deeply listen to what is important to staff and therefore determine what our future priorities should be. Six key themes have emerged which have been used to support the development of our WSFT people and culture priorities for 2023-24 and are also informing the development and implementation of broader Trust objectives.

2.8.12 Pension liabilities for ill-health retirement

There was one ill-health retirement during the year to 31 March 2023 (2021-22: three); the additional pension liability borne by NHS Pensions was estimated as £40k (2021-22: £69k).

2.8.13 Policies and procedures for fraud and corruption

The Trust is committed to the elimination of fraud and corruption and is determined to protect itself and the public from such unlawful activities, whether they are attempted from within the Trust, or by an outside individual, group or organisation.

The Trust is committed to ensuring that opportunities for fraud and corruption are reduced to the lowest possible level by creating an anti-fraud culture that:

- deters fraud
- prevents fraud that cannot be deterred
- detects fraud that cannot be prevented.

To achieve this WSFT will:

- ensure that employees, contractors, suppliers and users of our services understand that fraud is unacceptable and that they are able to raise serious concerns easily
- share information with other trusts and organisations to deal with fraud and corruption locally and nationally, working within the law
- increase awareness of fraud and corruption through a programme of training and communication
- investigate all allegations of fraud and corruption in a professional manner
- apply appropriate sanctions such as disciplinary action, criminal proceedings and recovery of losses when necessary
- where appropriate, WSFT will publicise cases demonstrating the Trust's commitment to fighting fraud.

By creating an anti-fraud culture, the Trust will help ensure that money is not lost to the organisation that could have been invested in patient care. It will also provide an environment in which employees have the confidence to report any fraud concerns they may have.

To support this commitment the Trust has policies and procedures in respect of fraud and corruption as well as a Bribery Act policy. It also has a nominated local counter fraud specialist (LCFS) whose role is to provide support and advice on all matters relating to fraud and to be a point of contact for fraud reporting. The LCFS reports to the audit committee. The assistant director of finance is the nominated fraud champion at the Trust.

2.8.14 Off-payroll engagements

As required by HM Treasury per Public Expenditure System (PES) (2022)01, the Trust must disclose information regarding off- payroll engagements.

Highly paid off-payroll engagements as at 31 March 2023 earning £245 per day or greater:

No. of existing engagements as of March 2023	6
Of which:	
No. that have existed for less than one year at the time of reporting	0
No. that have existed for between one and two years at time of reporting	0
No. that have existed for between two and three years at time of reporting	1
No. that have existed for between three and four years at time of reporting	0
No. that have existed for four or more years at time of reporting	5

All highly paid off-payroll workers engaged at any point during the year ended 31 March 2023 earning £245 per day or greater:

No. of off-payroll workers engaged during the year ended 31 March 2023	0
Of which:	
Not subject to off-payroll legislation	0
Subject to off-payroll legislation and determined as in scope for IR35	0
Subject to off-payroll legislation and determined as out of scope for IR35	0
No. of engagements reassessed for compliance or assurance purposes during the year	6
No. of engagements that saw a change to IR35 status following the consistency review.	0

For any off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2022 and 31 March 2023:

No. of off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
No. of individuals that have been deemed Board members, and/or senior officials with significant financial responsibility, during the financial year. This figure should include both off-payroll and on-payroll engagements.	33

All existing off-payroll engagements, outlined above, have at some point been subject to a risk-based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought. All invoices relating to off-payroll engagements are subject to authorisation through the normal expenditure control processes.

The Trust has reviewed all off-payroll arrangements and from 6 April 2017, all arrangements have been terminated or moved on to payroll unless they are assessed as meeting HMRC's requirements to be paid gross. There were no off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2022 and 31 March 2023.

During 2022-23, the Trust spent £396k on consultancy costs (2021-22 £238k). Consultancy is commissioned when the Trust does not have its own internal resource or expertise to undertake the work in-house or when specific additional resource is required for a project.

2.8.15 Other disclosures

Other relevant disclosures for this section of the annual report are including within section 2.2 (directors report).

West Suffolk NHS Foundation Trust

Annual accounts for the year ended 31 March 2023

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Foreword to the accounts

West Suffolk NHS Foundation Trust

These accounts, for the year ended 31 March 2023, have been prepared by West Suffolk NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed



.....
Name Ewen Cameron
Job title Chief Executive Officer
Date 29 June 2023

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF WEST SUFFOLK NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of West Suffolk NHS Foundation Trust ("the Trust") for the year ended 31 March 2023 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2023 and of the Trust's income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in March 2023 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Trust's services or dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud (“fraud risks”) we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust’s high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust’s channel for “whistleblowing”, as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the Trust’s accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated targets, we performed procedures to address the risk of management override of controls in particular the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We also identified a fraud risk related to the cut off-of non-pay, non-depreciation expenditure in response to incentives to manipulate the results of the Trust and System to meet the expectations or performance targets set by the government or external regulators and the opportunity to manipulate the non-pay non-depreciation expenditure around the year end, particularly in relation to accruals.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included Journals posted post close down timetable, Journals with unexpected postings to cash or borrowings, Journals with unexpected postings to expenditure and Journals containing key words.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Inspection of a sample of invoices to expenditure in the period around 31 March 2023, to determine whether expenditure has been recognised in the correct accounting period.
- Selection of a sample of year end accruals and inspection of evidence in regard to the actual amount paid after year end in order to assess whether the accrual exists and has been accurately recorded.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer (as required by auditing standards), and discussed with the Accounting Officer the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

Firstly, the Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the Trust is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the regulated nature of the Trust's activities. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the Accounting Officer [and other management] and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2022/23. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2022/23.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 85, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 85, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have planned our work and undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006. We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of West Suffolk NHS Foundation Trust for the year ended 31 March 2023 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Emma Larcombe

Emma Larcombe

for and on behalf of KPMG LLP

Chartered Accountants

Dragonfly House

2 Gilders Way

Norwich

NR3 1UB

29 June 2023

Statement of Comprehensive Income for the year ended 31 March 2023

		2022/23	2021/22
	Note	£000	£000
Operating income from patient care activities	3	353,715	328,976
Other operating income	4	29,913	23,203
Operating expenses	6	(116,346)	(120,875)
Employee Benefits	8	(259,671)	(230,145)
Operating surplus from continuing operations		<u>7,611</u>	<u>1,159</u>
Finance income		330	13
Finance expenses		(1,592)	(1,701)
PDC dividends payable		(5,148)	(3,918)
Net finance costs		<u>(6,410)</u>	<u>(5,606)</u>
Other (losses) / gains		(820)	20
Share of profit of associates / joint arrangements		70	-
Surplus / (deficit) for the year		<u><u>451</u></u>	<u><u>(4,427)</u></u>

Statement of Financial Position as at 31 March 2023

	Note	31 March 2023 £000	31 March 2022 £000
Non-current assets			
Intangible assets	10	61,869	52,039
Property, plant and equipment	11	193,976	169,487
Right of use assets	13	9,817	
Investment property		-	1,400
Receivables	14	6,001	5,807
Total non-current assets		271,663	228,733
Current assets			
Inventories		4,365	3,574
Receivables	14	41,871	15,069
Non-current assets for sale and assets in disposal groups		520	-
Cash and cash equivalents	15	7,895	33,323
Total current assets		54,651	51,966
Current liabilities			
Trade and other payables	16	(73,503)	(60,164)
Borrowings	17	(4,801)	(5,858)
Provisions		(64)	(38)
Other liabilities		(1,336)	(2,888)
Total current liabilities		(79,704)	(68,948)
Total assets less current liabilities		246,610	211,751
Non-current liabilities			
Borrowings	17	(48,038)	(44,002)
Provisions		(507)	(415)
Total non-current liabilities		(48,545)	(44,417)
Total assets employed		198,065	167,334
Financed by			
Public dividend capital		230,215	200,285
Revaluation reserve		12,054	11,704
Income and expenditure reserve		(44,204)	(44,655)
Total taxpayers' equity		198,065	167,334

The notes on pages 138 to 171 form part of these accounts.



Name	Ewen Cameron
Position	Chief Executive Officer
Date	29 June 2023

Statement of Changes in Equity for the year ended 31 March 2023

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2022 - brought forward	200,285	11,704	(44,655)	167,334
Surplus for the year	-	-	451	451
Impairments	-	(2,949)	-	(2,949)
Revaluations	-	3,299	-	3,299
Public dividend capital received	29,930	-	-	29,930
Taxpayers' and others' equity at 31 March 2023	230,215	12,054	(44,204)	198,065

Statement of Changes in Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	158,650	8,743	(40,228)	127,165
Deficit for the year	-	-	(4,427)	(4,427)
Impairments	-	(77)	-	(77)
Revaluations	-	3,038	-	3,038
Public dividend capital received	41,635	-	-	41,635
Taxpayers' and others' equity at 31 March 2022	200,285	11,704	(44,655)	167,334

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care (DHSC). A charge, reflecting the cost of capital utilised by the Trust, is payable to DHSC as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows for year ended 31 March 2023

	Note	2022/23 £000	2021/22 £000
Cash flows from operating activities			
Operating surplus		7,611	1,159
Non-cash income and expense:			
Depreciation and amortisation	6	13,450	9,800
Net impairments	7	(755)	4,647
Income recognised in respect of capital donations		-	(149)
(Increase) / decrease in receivables and other assets		(26,996)	4,997
(Increase) / decrease in inventories		(791)	(93)
Increase / (decrease) in payables and other liabilities		(3,878)	11,945
Increase / (decrease) in provisions		120	(445)
Other movements in operating cash flows		(820)	-
Net cash flows from / (used in) operating activities		(12,059)	31,861
Cash flows from investing activities			
Interest received		330	13
Purchase of intangible assets		(3,448)	(8,174)
Purchase of PPE and investment property		(26,541)	(45,736)
Sales of PPE and investment property		12	20
Net cash flows from / (used in) investing activities		(29,647)	(53,877)
Cash flows from financing activities			
Public dividend capital received		29,930	41,635
Repayment of loans from DHSC		(2,307)	(2,307)
Repayment on other loans		(451)	(442)
Capital element of lease liability repayments		(4,041)	(1,567)
Interest on loans		(1,040)	(1,107)
Interest element of lease liability repayments		(728)	(573)
PDC dividend (paid) / refunded		(4,580)	(4,088)
Cash flows from (used in) other financing activities		(505)	-
Net cash flows from / (used in) financing activities		16,278	31,551
Increase / (decrease) in cash and cash equivalents		(25,428)	9,535
Cash and cash equivalents at 1 April - brought forward		33,323	23,788
Cash and cash equivalents at 31 March	15	7,895	33,323

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2022/23 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The Directors have a reasonable expectation that this will continue to be the case.

The Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. They have not identified any material uncertainties that may cast significant doubt on the Trust's ability to continue as a going concern. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Note 1.3 Interests in other entities

The Trust has a 25% share in Collaborative Procurement Partnership Limited Liability Partnership (LLP) with three other NHS Organisations. The LLP was established in 2017/18 and the investment in this is not yet material to the Trust. Therefore assets have not been reflected in the accounts. A profit of £70k has been accrued for in 2022/23 (Nil in 2020/21).

My Wish charity has not been consolidated into the Trust's accounts on the grounds of materiality.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's income is earned from NHS commissioners in the form of fixed payments to fund an agreed level of activity.

In 2022/23 fixed payments are set at a level assuming the achievement of elective activity targets. These are termed 'aligned payment and incentive' contracts.

Elective recovery funding provides additional funding for the delivery of elective services. In 2022/23 elective recovery funding was included within the aligned payment and incentive contracts. In 2021/22 income earned by the system based on achievement of elective recovery targets was distributed between individual entities by local agreement and income earned from the fund was accounted for as variable consideration.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This included assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end. The Trust received donated property, plant and equipment from the Department of Health and Social Care in 2020/21 but has not received any subsequently.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	30	86
Dwellings	49	87
Plant & machinery	5	25
Information technology	5	10
Furniture & fittings	10	10

Note 1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	7	20
Software licences	5	10

Note 1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash and bank balances are recorded at current values.

Note 1.10 Financial assets and financial liabilities**Recognition**

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by the Office of National Statistics.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.11 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 0.95% applied to new leases commencing in 2022 and 3.51% to new leases commencing in 2023.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Initial application of IFRS 16

IFRS 16 Leases as adapted and interpreted for the public sector by HM Treasury has been applied to these financial statements with an initial application date of 1 April 2022. IFRS 16 replaces *IAS 17 Leases*, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations.

The standard has been applied using a modified retrospective approach with the cumulative impact recognised in the income and expenditure reserve on 1 April 2022. Upon initial application, the provisions of IFRS 16 have only been applied to existing contracts where they were previously deemed to be a lease or contain a lease under IAS 17 and IFRIC 4. Where existing contracts were previously assessed not to be or contain a lease, these assessments have not been revisited.

The Trust as lessee

For continuing leases previously classified as operating leases, a lease liability was established on 1 April 2022 equal to the present value of future lease payments discounted at the Trust's incremental borrowing rate of 0.95%. A right of use asset was created equal to the lease liability. Hindsight has been used in determining the lease term where lease arrangements contain options for extension or earlier termination.

No adjustments have been made on initial application in respect of leases with a remaining term of 12 months or less from 1 April 2022 or for leases where the underlying assets has a value below £5,000. No adjustments have been made in respect of leases previously classified as finance leases.

2021/22 comparatives

Comparatives for leasing transactions in these accounts have not been restated on an IFRS 16 basis. Under IAS 17 the classification of leases as operating or finance leases still applicable to lessors under IFRS 16 also applied to lessees. In 2021/22 lease payments made by the Trust in respect of leases previously classified as operating leases were charged to expenditure on a straight line basis.

Note 1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 18 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.15 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.16 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.17 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.18 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2022/23.

IFRS 17 (Insurance Contracts) is being applied to the Government Financial Reporting Manual (FReM) from 1 April 2025. It is not anticipated that the Trust will adopt this accounting standard at an earlier date.

Note 1.19 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- **Equipment Deposits:** The Trust pays a deposit to an external company for equipment issued to patients in the community. If the equipment is returned and the company is able to re-use it, the deposit is returned. Based on experience in the last 7.5 years it is assumed that 71% of deposits outstanding at the balance sheet date will be recovered, which equates to £8.1m for 2022/23.
- **Valuation of Land & Buildings:** The Trust employs a professional Valuer to value all land and buildings and to estimate their useful economic lives which are used to calculate depreciation. Assets are revalued by the Valuer every five years and the last full valuation was undertaken in 2018/19. Every year the Trust requests that the Valuer considers the accuracy of this valuation and to apply a desktop valuation to ensure that the value of land and buildings remains materially accurate. The value of the Trust's land and buildings equates to £140.5m as at 31 March 2023. Further details can be found in note 12.

The Trust does not consider to have undertaken any critical judgements in applying accounting policies that do not involve the estimates noted above.

Note 2 Operating Segments

In the prior period the Trust reported five operating segments in line with divisions reported to the Board that constitute at least 10% of Trust income.

In the current year, in line with the wider sector, this has been changed to one segment, namely healthcare provision.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)	2022/23	2021/22
	£000	£000
Acute services		
Income from commissioners under API contracts*	248,490	231,571
High cost drugs income from commissioners (excluding pass-through costs)	10,824	15,929
Other NHS clinical income	22,192	16,683
Community services		
Income from commissioners under API contracts*	34,953	33,001
Income from other sources (e.g. local authorities)	9,761	9,784
All services		
Private patient income	1,277	1,500
Elective recovery fund	7,130	11,001
Agenda for change pay award central funding***	8,527	-
Additional pension contribution central funding**	9,824	9,004
Other clinical income	737	503
Total income from activities	353,715	328,976

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2022/23 National Tariff payments system documents.

<https://www.england.nhs.uk/publication/past-national-tariffs-documents-and-policies/>

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

*** In March 2023 the government announced an additional pay offer for 2022/23, in addition to the pay award earlier in the year. Additional funding was made available by NHS England for implementing this pay offer for 2022/23 and the income and expenditure has been included in these accounts as guided by the Department of Health and Social Care and NHS England. In May 2023 the government confirmed this offer will be implemented as a further pay award in respect of 2022/23 based on individuals in employment at 31 March 2023.

Note 3.2 Income from patient care activities (by source)

	2022/23	2021/22
Income from patient care activities received from:	£000	£000
NHS England	43,677	27,982
Clinical commissioning groups (CCGs)*	66,346	285,318
Integrated care boards (ICBs)*	227,224	-
Other NHS providers	13,073	12,477
Local authorities	1,381	1,196
Non-NHS: private patients	1,277	1,462
Non-NHS: overseas patients (chargeable to patient)	229	38
Injury cost recovery scheme	508	503
Total income from activities	353,715	328,976
Of which:		
Related to continuing operations	353,715	328,976

* CCGs demised on 1 July 2022 and formed ICBs.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2022/23	2021/22
	£000	£000
Income recognised this year	229	38
Cash payments received in-year	52	62
Amounts added to provision for impairment of receivables	158	16
Amounts written off in-year	-	1

Note 4 Other operating income

	2022/23			2021/22		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	776	-	776	709	-	709
Education and training	9,251	-	9,251	8,328	456	8,784
Non-patient care services to other bodies	14,658	-	14,658	8,420	-	8,420
Reimbursement and top up funding	210	-	210	510	-	510
Receipt of capital grants and donations and peppercorn leases	-	-	-	-	149	149
Charitable and other contributions to expenditure	-	542	542	-	871	871
Revenue from operating leases	-	-	-	-	96	96
Other income*	4,476	-	4,476	3,664	-	3,664
Total other operating income	29,371	542	29,913	21,631	1,572	23,203
Of which:						
Related to continuing operations			29,913			23,203

*Other income includes £1,085k of car parking (2021/22 £665k) and £766k of catering income (2021/22 £650k).

Note 5 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2022/23	2021/22
	£000	£000
Income from services designated as commissioner requested services	353,715	328,976
Income from services not designated as commissioner requested services	29,913	23,203
Total	383,628	352,179

Note 6 Operating expenses

	Note	2022/23 £000	2021/22 £000
Purchase of healthcare from NHS and DHSC bodies		72	-
Purchase of healthcare from non-NHS and non-DHSC bodies		6,497	3,802
Staff and executive directors costs	8	259,671	230,145
Remuneration of non-executive directors		146	126
Supplies and services - clinical (excluding drugs costs)		36,251	41,270
Supplies and services - general		4,400	3,362
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)		27,170	24,380
Inventories written down		-	265
Consultancy costs		396	238
Establishment		6,610	7,129
Premises		6,179	5,761
Transport (including patient travel)		1,738	1,323
Depreciation on property, plant and equipment and right of use assets	11	10,649	6,806
Amortisation on intangible assets	10	2,801	2,994
Net impairments		(755)	4,647
Movement in credit loss allowance: contract receivables / contract assets		231	(6)
Increase/(decrease) in other provisions		48	24
Change in provisions discount rate(s)		-	7
Fees payable to the external auditor			
audit services- statutory audit*		153	135
Internal audit costs**		160	163
Clinical negligence		7,987	9,304
Legal fees		70	203
Insurance		11	232
Education and training		1,091	1,623
Expenditure on short term leases (current year only)		111	-
Variable lease payments not included in the liability (current year only)		3,872	-
Operating lease expenditure (comparative only)			6,497
Car parking & security		7	19
Hospitality		22	61
Losses, ex gratia & special payments		39	-
Other		390	510
Total		376,017	351,020
Of which:			
Related to continuing operations		376,017	351,020

* The audit fee for 2022/23 is £126k plus VAT (2021/22 £135k plus VAT).

** All internal audit costs are non-staff related as the service is provided by an external firm.

Note 6.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1 million (2021/22: £2 million).

Note 7 Impairment of assets

	2022/23	2021/22
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Unforeseen obsolescence	(987)	4,647
Changes in market price	232	-
Total net impairments charged to operating surplus / deficit	<u>(755)</u>	<u>4,647</u>
Impairments charged to the revaluation reserve	2,949	77
Total net impairments	<u><u>2,194</u></u>	<u><u>4,724</u></u>

Impairments arose in 2022/23 as a result of a desktop revaluation exercise carried out at the end of the year. The Valuer has reviewed the value of the Trust's land and buildings and a reduction in asset value has occurred as follows:

	Net Impairment
	£000
Main Hospital Block	246
Land	(2,300)
Other Buildings	(140)
Total	<u><u>(2,194)</u></u>

The impairment on the main hospital block is due to unforeseen obsolescence with the structure and the works required to bring the asset into repair and back in to use. Land has fallen in value due to the current market.

Note 8 Employee benefits

	2022/23	2021/22
	Total	Total
	£000	£000
Salaries and wages	200,360	179,143
Social security costs	22,017	17,999
Apprenticeship levy	981	864
Employer's contributions to NHS pensions	32,356	29,653
Pension cost - other	86	66
Temporary staff (including agency)	6,253	4,071
Total staff costs	262,053	231,796
Of which		
Costs capitalised as part of assets	2,382	1,651

Remuneration of non-executive Directors is excluded from this note and is disclosed separately in note 6.

Note 8.1 Retirements due to ill-health

During 2022/23 there was 1 early retirement from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2022). The estimated additional pension liabilities of these ill-health retirements is £40k (£69k in 2021/22).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6%, and the Scheme Regulations were amended accordingly.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

Note 10 Intangible assets - 2022/23

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - brought forward	4,137	62,094	-	66,231
Additions	228	7,923	1,758	9,909
Reclassifications	-	3,655	-	3,655
Valuation / gross cost at 31 March 2023	4,365	73,672	1,758	79,795
Amortisation at 1 April 2022 - brought forward	628	13,564	-	14,192
Provided during the year	266	2,535	-	2,801
Reclassifications	-	933	-	933
Amortisation at 31 March 2023	894	17,032	-	17,926
Net book value at 31 March 2023	3,471	56,640	1,758	61,869
Net book value at 1 April 2022	3,509	48,530	-	52,039

Note 10.1 Intangible assets - 2021/22

	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - as previously stated	3,145	54,078	-	57,223
Additions	992	8,016	-	9,008
Valuation / gross cost at 31 March 2022	4,137	62,094	-	66,231
Amortisation at 1 April 2021 - as previously stated	218	10,980	-	11,198
Provided during the year	410	2,584	-	2,994
Amortisation at 31 March 2022	628	13,564	-	14,192
Net book value at 31 March 2022	3,509	48,530	-	52,039
Net book value at 1 April 2021	2,927	43,098	-	46,025

Note 11 Property, plant and equipment - 2022/23

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2022 - brought forward	11,730	105,369	11,596	25,962	16,741	13,477	135	185,010
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	-	-	-	(6,930)	(3,655)	-	(10,585)
Transfers by absorption	-	-	-	-	-	-	-	-
Additions	-	6,118	1,506	19,477	7,918	296	-	35,315
Impairments	(2,300)	(2,575)	(497)	-	-	-	-	(5,372)
Reversals of impairments	-	2,705	473	-	-	-	-	3,178
Revaluations	300	(874)	53	-	-	-	-	(521)
Reclassifications	-	5,297	1,613	(5,510)	-	-	-	1,400
Transfers to / from assets held for sale	(520)	-	-	-	-	-	-	(520)
Disposals / derecognition	-	-	-	-	(12)	-	-	(12)
Valuation/gross cost at 31 March 2023	9,210	116,040	14,744	39,929	17,717	10,118	135	207,893
Accumulated depreciation at 1 April 2022 - brought forward	-	4	-	-	9,741	5,644	134	15,523
IFRS 16 implementation - reclassification of existing finance leased assets to right of use assets	-	-	-	-	(4,380)	(770)	-	(5,150)
Provided during the year	-	3,566	250	-	590	2,970	-	7,376
Revaluations	-	(3,570)	(250)	-	-	-	-	(3,820)
Disposals / derecognition	-	-	-	-	(12)	-	-	(12)
Accumulated depreciation at 31 March 2023	-	-	-	-	5,939	7,844	134	13,917
Net book value at 31 March 2023	9,210	116,040	14,744	39,929	11,778	2,274	1	193,976
Net book value at 1 April 2022	11,730	105,365	11,596	25,962	7,000	7,833	1	169,487

Note 11.1 Property, plant and equipment - 2021/22

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - as previously stated	10,870	82,083	10,741	16,205	15,285	12,185	135	147,504
Transfers by absorption	-	-	-	-	-	-	-	-
Additions	-	21,766	-	17,742	1,476	1,292	-	42,276
Impairments	-	(6,814)	(38)	-	-	-	-	(6,852)
Reversals of impairments	108	1,076	868	-	-	-	-	2,052
Revaluations	752	(727)	25	-	-	-	-	50
Reclassifications	-	7,985	-	(7,985)	-	-	-	-
Disposals / derecognition	-	-	-	-	(20)	-	-	(20)
Valuation/gross cost at 31 March 2022	11,730	105,369	11,596	25,962	16,741	13,477	135	185,010
Accumulated depreciation at 1 April 2021 - as previously stated	-	4	-	-	8,380	3,290	127	11,801
Provided during the year	-	2,878	186	-	1,381	2,354	7	6,806
Impairments	-	(76)	-	-	-	-	-	(76)
Revaluations	-	(2,802)	(186)	-	-	-	-	(2,988)
Disposals / derecognition	-	-	-	-	(20)	-	-	(20)
Accumulated depreciation at 31 March 2022	-	4	-	-	9,741	5,644	134	15,523
Net book value at 31 March 2022	11,730	105,365	11,596	25,962	7,000	7,833	1	169,487
Net book value at 1 April 2021	10,870	82,079	10,741	16,205	6,905	8,895	8	135,703

Note 11.2 Property, plant and equipment financing - 31 March 2023

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	9,210	110,524	14,744	39,929	11,568	2,274	1	188,250
Owned - donated/granted	-	5,516	-	-	210	-	-	5,726
Total net book value at 31 March 2023	9,210	116,040	14,744	39,929	11,778	2,274	1	193,976

Note 11.3 Property, plant and equipment financing - 31 March 2022

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	11,730	100,746	11,596	25,962	2,517	7,709	1	160,261
Finance leased	-	-	-	-	3,675	94	-	3,769
Owned - donated/granted	-	4,619	-	-	808	30	-	5,457
Total net book value at 31 March 2022	11,730	105,365	11,596	25,962	7,000	7,833	1	169,487

Note 12 Revaluations of property, plant and equipment

A desktop valuation exercise on the land and properties comprising the West Suffolk NHS Foundation Trust estate was carried out with a valuation date of 31 March 2023. This desktop valuation was undertaken by an external Valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The desktop valuation was prepared in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book').

Property, Plant and Equipment on the Statement of Financial Position has a carrying amount of £194m. Within this, £130m is considered to be specialised property which is valued on a depreciated replacement cost basis. This includes the hospital site and residences. Here the Valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets.

The key assumptions that are most likely to affect the valuations are:

- **Cost data:** The Valuer uses actual cost data where it is available however this is adjusted to reflect price changes since the construction date and any differences between those costs and the costs that would be incurred in constructing the modern equivalent asset. Where actual cost data is not available the Valuer relies on published construction price data. Published price data is an estimate of the costs that would be incurred in constructing a modern equivalent asset and may differ to the costs that would actually be incurred in practice. If the cost data were 5% higher this would have an impact on the value of specialised properties recorded in the balance sheet of an increase of £6.5m.

- **Adjustments for obsolescence:** Once the cost of constructing a modern equivalent asset has been determined an adjustment is made to reflect the difference between the modern equivalent and the actual asset being valued. This adjustment is made by the Valuer based on his knowledge and experience, it takes into account physical deterioration, functional obsolescence and economic obsolescence. Had the adjustment for obsolescence been 2% higher than the Valuer assumed, this would have an impact on the value of specialised properties recorded in the balance sheet of a decrease of £5m.

The valuer also reviewed the useful economic lives of the Trust buildings. Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives by category of asset are detailed in note 1.7.

Note 13 Right of use assets - 2022/23

	Property (land and buildings)	Plant & machinery	Transport equipment	Information technology	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000	£000
IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets	-	6,930	-	3,655	10,585	-
IFRS 16 implementation - adjustments for existing operating leases / subleases	6,366	4,796	240	-	11,402	3,056
Additions	29	289	-	-	318	29
Remeasurements of the lease liability	13	724	(240)	-	497	(220)
Reclassifications	-	-	-	(3,655)	(3,655)	-
Disposals / derecognition	-	(3,747)	-	-	(3,747)	-
Valuation/gross cost at 31 March 2023	6,408	8,992	-	-	15,400	2,865
IFRS 16 implementation - reclassification of existing finance leased assets from PPE or intangible assets	-	4,380	-	770	5,150	-
Provided during the year	1,019	2,091	-	163	3,273	254
Reclassifications	-	-	-	(933)	(933)	-
Disposals / derecognition	-	(1,907)	-	-	(1,907)	-
Accumulated depreciation at 31 March 2023	1,019	4,564	-	-	5,583	254
Net book value at 31 March 2023	5,389	4,428	-	-	9,817	2,611
Net book value of right of use assets leased from other DHSC group bodies						2,611

Note 13.1 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 17.

	2022/23
	£000
Carrying value at 31 March 2022	4,143
IFRS 16 implementation - adjustments for existing operating leases	11,403
Lease additions	318
Lease liability remeasurements	497
Interest charge arising in year	563
Early terminations	(2,265)
Lease payments (cash outflows)	(4,769)
Carrying value at 31 March 2023	<u>9,889</u>

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 6. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 13.2 Maturity analysis of future lease payments at 31 March 2023

	Total	Of which leased from DHSC group bodies:
	31 March	31 March
	2023	2023
	£000	£000
Undiscounted future lease payments payable in:		
- not later than one year;	2,045	357
- later than one year and not later than five years;	5,566	1,288
- later than five years.	2,686	973
Total gross future lease payments	<u>10,298</u>	<u>2,619</u>
Finance charges allocated to future periods	(408)	(111)
Net lease liabilities at 31 March 2023	<u>9,890</u>	<u>2,507</u>
Of which:		
- Current	1,957	335
- Non-Current	7,933	2,172

Note 13.3 Maturity analysis of finance lease liabilities at 31 March 2022 (IAS 17 basis)

The following table details the maturity of obligations under leases the trust previously determined to be finance leases under IAS 17 at 31 March 2022.

	31 March 2022 £000
Undiscounted future lease payments payable in:	
- not later than one year;	3,021
- later than one year and not later than five years;	1,122
Total gross future lease payments	4,143
Finance charges allocated to future periods	-
Net finance lease liabilities at 31 March 2022	8,286
of which payable:	
- not later than one year;	3,021
- later than one year and not later than five years;	1,122

Note 13.4 Commitments in respect of operating leases at 31 March 2022 (IAS 17 basis)

This note discloses costs incurred in 2021/22 and commitments as at 31 March 2022 for leases the trust previously determined to be operating leases under IAS 17.

	2021/22 £000
Operating lease expense	
Minimum lease payments	6,488
Contingent rents	9
Total	6,497

	31 March 2022 £000
Future minimum lease payments due:	
- not later than one year;	1,134
- later than one year and not later than five years;	1,810
- later than five years.	42
Total	2,986

Note 13.6 Initial application of IFRS 16 on 1 April 2022

IFRS 16 as adapted and interpreted for the public sector by HM Treasury has been applied to leases in these financial statements with an initial application date of 1 April 2022.

The standard has been applied using a modified retrospective approach without the restatement of comparatives. Practical expedients applied by the Trust on initial application are detailed in the leases accounting policy in note 11.

Lease liabilities created for existing operating leases on 1 April 2022 were discounted using the weighted average incremental borrowing rate determined by HM Treasury as 0.95%.

Reconciliation of operating lease commitments as at 31 March 2022 to lease liabilities under IFRS 16 as at 1 April 2022

	1 April 2022 £000
Operating lease commitments under IAS 17 at 31 March 2022	2,986
Impact of discounting at the incremental borrowing rate 0.95%	
IAS 17 operating lease commitment discounted at incremental borrowing rate	2,802
Less:	
Commitments for short term leases	(93)
Irrecoverable VAT previously included in IAS 17 commitment	(262)
Other adjustments:	
Differences in the assessment of the lease term	3,058
Public sector leases without full documentation previously excluded from operating lease commitments	3,053
Finance lease liabilities under IAS 17 as at 31 March 2022	4,143
Other adjustments	2,844
Total lease liabilities under IFRS 16 as at 1 April 2022	15,545

Note 14 Receivables

	31 March 2023 £000	31 March 2022 £000
Current		
Contract receivables	34,370	10,417
Allowance for impaired contract receivables / assets	(298)	(221)
Deposits and advances	2,600	2,412
Prepayments (non-PFI)	2,793	1,265
PDC dividend receivable	500	500
VAT receivable	1,805	603
Corporation and other taxes receivable	93	90
Other receivables	8	3
Total current receivables	41,871	15,069
Non-current		
Deposits and advances	5,547	5,475
Other receivables	454	332
Total non-current receivables	6,001	5,807
Of which receivable from NHS and DHSC group bodies:		
Current	30,751	6,576
Non-current	454	332

Note 14.1 Exposure to credit risk

	31 March 2023 £000	31 March 2022 £000
Ageing of impaired financial assets		
0 - 30 days	0	0
31-60 Days	0	0
61-90 days	0	0
91 days- 1 year	139	8
1 year and over	159	213
Total	298	221
Ageing of non-impaired financial assets past their due date (not including accruals)		
0 - 30 days	18,109	3,384
31-60 Days	319	593
61-90 days	284	159
91 days- 1 year	761	1,137
1 year and over	638	935
Total	20,111	6,208

£18.7m of the non-impaired financial assets past their due date are owed by NHS organisations (£4.3m in 2021/22).

Note 15 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2022/23	2021/22
	£000	£000
At 1 April	33,323	23,788
Net change in year	(25,428)	9,535
At 31 March	7,895	33,323
Broken down into:		
Cash at commercial banks and in hand	7	6
Cash with the Government Banking Service	7,888	33,317
Total cash and cash equivalents as in SoCF	7,895	33,323

Note 16 Trade and other payables

	2023	2022
	£000	£000
Current		
Trade payables	7,570	11,638
Capital payables	18,972	3,875
Accruals	37,618	36,619
Social security costs	2,946	2,778
Other taxes payable	2,675	2,371
PDC dividend payable	568	-
Pension contributions payable	3,209	1,637
Other payables	(55)	1,246
Total current trade and other payables	73,503	60,164
Of which payables from NHS and DHSC group bodies:		
Current	4,758	2,721

Note 17 Borrowings

	31 March 2023 £000	31 March 2022 £000
Current		
Loans from DHSC	2,383	2,393
Other loans	461	444
Lease liabilities*	1,957	3,021
Total current borrowings	<u>4,801</u>	<u>5,858</u>
Non-current		
Loans from DHSC	38,153	40,460
Other loans	1,952	2,420
Lease liabilities*	7,933	1,122
Total non-current borrowings	<u>48,038</u>	<u>44,002</u>

* The Trust has applied IFRS 16 to lease arrangements within these accounts from 1 April 2022 without restatement of comparatives. More information about leases and the impact of this change in accounting policy can be found in note 13.

Note 17.1 Reconciliation of liabilities arising from financing activities - 2022/23

	Loans from DHSC	Other loans	Lease Liability	Total
	£000	£000	£000	£000
Carrying value at 1 April 2022	42,853	2,864	4,143	49,860
Cash movements:				
Financing cash flows - payments and receipts of principal	(2,307)	(451)	(4,041)	(6,799)
Financing cash flows - payments of interest	(978)	(62)	(728)	(1,768)
Non-cash movements:				
Impact of implementing IFRS 16 on 1 April 2022	-	-	11,403	11,403
Additions	-	-	318	318
Lease liability remeasurements	-	-	497	497
Application of effective interest rate	968	62	563	1,593
Early terminations	-	-	(2,265)	(2,265)
Carrying value at 31 March 2023	40,536	2,413	9,889	52,838

Note 17.2 Reconciliation of liabilities arising from financing activities - 2021/22

	Loans from DHSC	Other loans	Lease Liability	Total
	£000	£000	£000	£000
Carrying value at 1 April 2021	45,164	3,306	5,688	54,158
Cash movements:				
Financing cash flows - payments and receipts of principal	(2,307)	(442)	(1,567)	(4,316)
Financing cash flows - payments of interest	(1,025)	(82)	(573)	(1,680)
Non-cash movements:				
Application of effective interest rate	1,021	82	595	1,698
Carrying value at 31 March 2022	42,853	2,864	4,143	49,860

Note 18 Clinical negligence liabilities

At 31 March 2023, £85,843k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of West Suffolk NHS Foundation Trust (31 March 2022: £177,989k).

The Trust also held £36k (31 March 2022: £19k) of contingent liabilities for legal claims managed by NHS Resolution.

Note 19 Contractual capital commitments

	31 March 2023 £000	31 March 2022 £000
Property, plant and equipment	6,770	23,685
Intangible assets	-	6,446
Total	<u>6,770</u>	<u>30,131</u>

Note 20 Carrying values of financial assets

	31 March 2023	31 March 2022
Carrying values of financial assets as at 31 March 2023	Held at amortised cost £000	Held at amortised cost £000
Trade and other receivables excluding non financial assets	43,277	18,860
Cash and cash equivalents	7,895	33,323
Total at 31 March 2023	51,172	52,183

£30.7m of the Trust's financial assets relate to income owed from other NHS Organisations (2021/22: £6.4m). Of the remaining balance as at 31 March 2023, £8.1m relates to deposits recoverable when community equipment is returned based on the likely proportion that will be returned.

The remainder of the balance is money owed from non-NHS Organisations. The collection of this debt is monitored closely and the balance is impaired or written off when the collection looks unlikely.

There are no individually material debts owed by non-NHS Organisations and the risk profile of the asset is assessed as low, which is the same as in 2021/22.

	31 March 2023	31 March 2022
Note 20.1 Carrying values of financial liabilities		
Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost £000	Held at amortised cost £000
Loans from the Department of Health and Social Care	40,536	42,853
Obligations under leases	9,890	4,143
Other borrowings	2,413	2,864
Trade and other payables excluding non financial liabilities	67,149	55,015
Provisions under contract	109	29
Total at 31 March 2023	120,097	104,904

Borrowing excluding finance leases is at a fixed rate and, apart from £2.4m from a commercial loan provider, is from the Department of Health and Social Care.

There are no identified risks with the balance of payables which are almost exclusively UK based. This is the same as in 2021/22.

Note 20.2 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2023 £000	31 March 2022 £000
In one year or less	73,049	61,872
In more than one year but not more than five years	16,405	12,162
In more than five years	39,572	40,431
Total	129,027	114,465

Note 20.3 Fair values of financial assets and liabilities

The fair value of the financial instruments is based on book value (carrying value) because this is not considered to be significantly different to the initial transactions recognised.

Note 21 Losses and special payments

	2022/23		2021/22	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	1	1	12	5
Bad debts and claims abandoned	34	138	28	45
Stores losses and damage to property	3	267	3	265
Total losses	38	406	43	315
Special payments				
Extra-contractual payments	14	-	3	3
Ex-gratia payments	21	15	24	168
Total special payments	35	15	27	171
Total losses and special payments	73	421	70	486
Compensation payments received				

Note 22 Related parties

	Income		Expenditure	
	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000
Cambridge Univeristy Hospitals NHS Foundation Trust	832	1,152	2,830	2,939
East Suffolk and North Essex NHS Foundation Trust	13,469	13,259	2,299	3,526
NHS Cambridgeshire and Peterborough ICB	2,823	-	-	-
NHS Norfolk and Waveney ICB	15,365	-	-	-
NHS Suffolk and North East Essex ICB	212,402	-	11	-
NHS West Suffolk CCG*	60,084	235,921	-	92
NHS Ipswich And East Suffolk CCG*	15	29,345	-	50
NHS Norfolk & Waveney CCG*	5,018	19,147	-	0
NHS Cambridgeshire and Peterborough CCG*	923	3,533	2	0
Health Education England	9,129	8,209	6	30
NHS England	36,175	17,552	25	202
NHS Resolution (formerly NHS Litigation Authority)	-	-	8,123	9,447
Total	356,235	328,118	13,296	16,286

	Receivables		Payables	
	2022/23	2021/22	2022/23	2021/22
	£000	£000	£000	£000
Cambridge Univeristy Hospitals NHS Foundation Trust	105	285	700	-
East Suffolk and North Essex NHS Foundation Trust	1,702	1,231	458	129
NHS Cambridgeshire and Peterborough ICB	31	-	-	-
NHS Norfolk and Waveney ICB	8	-	-	-
NHS Suffolk and North East Essex ICB	18,111	-	1,629	-
NHS West Suffolk CCG*	-	1,296	-	715
NHS Ipswich and East Suffolk CCG*	-	177	-	50
NHS Norfolk and Waveney CCG*	-	8	-	-
NHS Cambridgeshire and Peterborough CCG*	-	-	-	-
Health Education England	53	1,500	34	86
NHS England	8,848	284	455	1,515
NHS Resolution (formerly NHS Litigation Authority)	-	-	-	-
Total	28,858	4,781	3,276	2,495

The Trust is the Corporate Trustee of My Wish Charity. During the year the Charity spent £0 on behalf of the Trust on capital items plus a further £609k on revenue items (2020/21: £149k on capital items plus a further £401k on revenue items). At the year end the Charity owed the Trust £54k (2021/22 £57k).

The Trust has disclosed transactions with NHS bodies where the income, expenditure, receivable or payable balance is over £2 million.

* The CCGs demised on 1 July 2022 and formed ICBs.

