West Suffolk NHS
NHS Foundation Trust

Annual Report & Accounts for 1 December 2011 – 31 March 2012

Putting you first

University of Cambridge Associate Teaching Hospital

West Suffolk NHS Foundation Trust

Annual Report and Accounts for 1 December 2011 – 31 March 2012

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006.

West Suffolk Hospital NHS Trust was authorised as an NHS Foundation Trust on 1 December 2011 and changed its name to West Suffolk NHS Foundation Trust abbreviated to WSFT. Throughout this document the organisation is referred to WSFT and West Suffolk Hospital as WSH. This Annual Report covers the periods from 1 April 2011 to 30 November 2011, as the West Suffolk Hospital NHS Trust, and 1 December 2011 to 31 March 2012 as the West Suffolk NHS Foundation Trust.

Contents

1. A Message from the Chairman and Chief Executive

One of the highlights of the year for the organisation was hearing that we had achieved NHS Foundation Trust (FT) status.

The good news came after we were able to demonstrate to Monitor, the body that authorises FTs, excellent performance in delivering quality services and ensuring patients' safety, good financial management and sound plans for the future. We were authorised as an FT from 1 December 2011.This has been a long and ultimately worthwhile journey and noteworthy in the fact that only four other acute trusts were authorised during 2011 and just four during 2010.

Other highlights of 2011/12 included being named 'top hospital' in the country for Quality of Care by independent healthcare intelligence company CHKS Ltd for the second year running.

We also played host to Professor Dame Carol Black, the UK National Director for Health and Work, who formally opened our Emergency Assessment Unit following a major £800,000 project to improve and modernise facilities.

Our new digital imaging unit, a £1.2m project, was opened by Lady Elsie Robson, widow of Sir Bobby Robson.The new system is providing a better service for patients by allowing us to produce high quality images quickly.

Operationally and financially the Trust performed well. We met our key quality and patient safety standards including around MRSA and Clostridium difficile infection rates, pressure ulcers, falls and achieving lower than expected mortality rates. We met the national A&E waiting time target and the 18 week referral to treatment time. Although lower than planned, we also achieved a surplus for the year, which will be invested in medical equipment, IT and refurbishment projects.

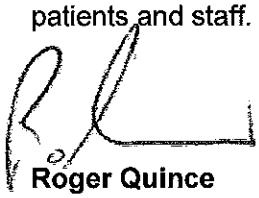
However, we performed less well in other areas, notably around the management of people following stroke, and this is receiving focused action to bring about the necessary improvements. Although we continued to record over 90% of patients choosing to use the hospital again, our internal surveys highlight a continuing problem with noise at night from other patients and call button response times.

Our success is down to the skills, quality, hard work and dedication of our staff, for which we are extremely grateful. But there are others too who deserve credit, including Governors, public members, volunteers, Friends of West Suffolk Hospital and key partners. Our thanks go to them all.

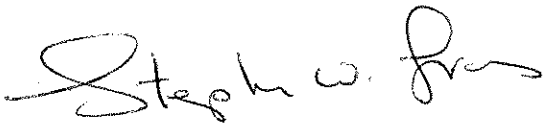
We are now facing the second year of the quality and productivity challenge which requires the NHS to make up to £20 billion of efficiency savings by 2014/15. For the Trust and the whole NHS it means that we are being asked to improve quality and do more with less. Our response will be to ensure that we focus on the needs of the patient and deliver high quality care as efficiently as possible, comparing ourselves with the best hospitals across the country and beyond. We need to be using our staff, beds, theatres and diagnostics to maximum efficiency, adopting flexible working arrangements and practices and aiming for better patient outcome and experience alongside a faster, smoother flow of patients through the hospital from admission to discharge.

Working in partnership with the newly emerging Clinical Commissioning Group, GPs, primary, community and social care colleagues to develop more integrated services will help patients have a smoother journey through the health and social care system. Also, with the help of our staff and patients, we will look innovatively at new ways of delivering our services that will meet the quality and financial challenges.

There are undoubtedly challenging times ahead, but as difficulties arise our main priority will continue to be on driving up standards. We will not always get it right but we will be open about our mistakes and ensure that we learn from them. We have very good staff engagement, clinical and non clinical, examples of strong leadership at all levels and a track record we can be proud of. We believe that we are in an excellent position to take our new NHS Foundation Trust forward for the full benefit of our patients and staff.



Roger Quince
Chairman



Stephen Graves
Chief Executive

2. Directors' Report

2.1 About our Trust – a summary

WSFT provides hospital and some community health care services to people mainly in the west of Suffolk and is an associate teaching hospital of the University of Cambridge.

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

Our Aims and Values

Our aim at WSFT is to offer the highest quality service for patients and this is encapsulated in our core value – to be 'first for patients and the community'.

Values are important to WSFT as they describe the way in which we work and are at the heart of all that we do. WSFT has worked hard to engage with its staff and those who use its services to develop the mission statement and **our values**.

First for patients and the community
Integrated team working
Respect and courtesy
Supporting and valuing staff
Two-way open communications

The Trust is working with staff to review these for 2012/13 and to maximise the opportunities created by becoming a FT.

Our sites

WSFT manages West Suffolk Hospital (WSH), a busy District General Hospital (DGH) 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 go home on the same day. WSH has around 440 beds and 13 operating theatres, including three in day surgery and two in the Eye Treatment Centre. Access to specialist services is offered to local residents by WSFT networking with neighbouring tertiary (specialist) centres, such as Addenbrookes Hospital.

Our staff

WSFT is one of the largest employers in Suffolk, employing 2,456 whole time equivalent staff in March 2012.

WSFT firmly believes in the benefits of working in partnership with staff and the Trade Unions and this is highlighted during 2011/12 with the following activities:

- working in partnership with the Trade Unions and Staff Governors to implement our new car parking arrangements which successfully came into effect on 1 August 2011
- the five Staff Governors hold quarterly Staff Conversations to discuss challenges and achievements. Action to address issues raised in 2011/12 includes the introduction of the Chief Executive staff walkabouts to meet and discuss issues with teams and individuals.
- as part of the Trust's Health & Wellbeing programme and in partnership with staff a Book Club, Gardening Club and Hospital Choir have been set up. The Trust held a successful Tag Rugby Competition in June 2011 and introduced a quarterly Staff Quiz

- we have continued to support the Trade Union Convenor role and a local steward to sit on the National Executive Committee
- we have commenced a review of the terms and conditions that determine the pay arrangements for on-call activities in partnership with our local Trade Union stewards
- by working in partnership with Trade Union colleagues, staff were able to participate in the 'Pension Day of Action' on 30 November 2011 without disrupting urgent and emergency services
- Trade Unions have contributed to the Trust's Equality Delivery Objectives
- the Executive Director of Workforce and Communications is the Management-side Chair of the Regional Social Partnership Forum
- we continue to develop our partnership working through the following committees:

  – Trust Council
  – Trust Negotiating Committee (General Staff)
  – Trust Negotiating Committee (Medical and Dental)
  – Policy Development Group
  – Travel Plan Steering Group
  – Health & Wellbeing Forum

Further detail is included in Section 9 on the work we are doing regarding the employment of the disabled.

Our partners

WSFT works closely with other public, private and voluntary stakeholders. These include NHS Suffolk, Suffolk Community Health Services, Suffolk County Council and Cambridge University as well as other local NHS providers and primary care trusts.

2.2 Principal activities and achievements

Care Quality Commission (CQC) registration

On 1 April 2010 the CQC confirmed the registration of WSFT without conditions. CQC made an unannounced inspection visit to the Trust in October 2011 and the final report was published on the CQC website in November 2011.

http://www.cqc.org.uk/sites/default/files/media/reports/RGR_West_Suffolk_Hospitals_NHS_Trust_RGR50_West_Suffolk_Hospital_RoC_201111.pdf

Overall this was a positive report. Seven of the 16 CQC standards were reviewed by the CQC visiting team and WSFT was judged compliant with them all. Three areas were identified for improvement and an action plan was developed and has now been fully implemented.

In March 2012 WSFT had an on-site assessment by the CQC as part of the CQC schedule of planned unannounced reviews of organisations providing termination of pregnancy services, as part of Outcome 21: Records. WSFT was assessed as compliant with the requirements of Outcome 21.

Regulatory rating

WSFT achieved a Green governance risk rating for every Quarter of 2011/12. This means that the Trust achieved all core standards set by Monitor. Further information is provided in Section 8.

Our services

WSFT provides a range of patient services:

Indicators	2011/12	2010/11	2009/10	2008/09
Inpatient Planned	**4,794**	4,770	5,038	5,195
Inpatient Non Planned	**25,142**	26,749	27,051	25,241
Day Cases	**19,848**	19,442	20,486	19,021
Outpatient Attendances (inc. Ward Attenders)	**162,990**	157,592	156,574	187,371
Outpatient Procedures	**60,404**	57,735	46,884	14,120
A&E Attendances	**55,774**	51,936	48,115	47,638

Procedures which were traditionally carried out as a day case or inpatient procedure are now being undertaken in an outpatient setting, which is more efficient for WSFT and more convenient for patients.

The time patients stay in hospital (length of stay) has reduced across directorates and specialties. The Trust continues to improve length of stay with the redesign of patient care pathways as part of its transformation programme. In achieving this reduction in length of stay, we continuously monitor the number of patients readmitted to hospital following discharge.

Activity continues to increase, particularly for emergencies, The Trust continues to work with NHS Suffolk and primary care to manage this activity through a locally agreed QIPP plan (Quality, Innovation, Productivity and Prevention).

Further detail of performance against local and national targets is provided in Section 6 (Quality Report).

Our financial performance

WSFT achieved a surplus of £619k for the full year 2011/12. Of this amount, £97k was achieved as a NHS Trust and the balance of £522k related to the period as a FT. Total income was £159.5m which was an increase of 2.3% over that for 2010/11.

The surplus was £381k less than planned. Pay costs, particularly for medical agency staff, contributed to this variance and agreed action to reduce this expenditure is being monitored by the Board of Directors on a monthly basis.

	2011/12 (Full Year) £000	8 Months to 30 Nov 2011 £000	4 Months to 31 Mar 2012 £000	2010/11 £000
Operating income	**159,501**	106,131	53,370	155,432
Operating costs	**(152,015)**	(101,258)	(50,757)	(148,669)
EBITDA* surplus	**7,486**	4,873	2,613	6,763
Depreciation, dividend and other costs	**(6,816)**	(4,776)	(2,040)	(6,728)
Fixed asset impairments**	**(51)**	0	(51)	(63)
Retained earnings	**619**	97	522	(28)

* 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

Awards and accolades

- **WSFT named the country's "top hospital" for quality of care for the second year running.** The award comes after WSFT recorded good performance against a number of key criteria, including the length of time patients stay in the hospital, waiting times and rate of emergency readmissions. Mortality rates and whether the patient's care pathway proceeded as originally planned were also included in the assessment. The Top Hospital Awards are run by independent healthcare intelligence company CHKS

- **WSFT was named as a "Creating the Greenest County" winner in the category of "Business: Transport** for which there were eight entries. The award celebrated WSFT's efforts to reduce emissions from transport by encouraging staff to find more environmentally friendly ways of reaching work

- **A project designed to save money on energy costs while cutting carbon emissions at WSFT won a regional environmental award**. The combined heat and power unit (CHP), which generates electricity and heat for the hospital site was given the East Anglia CIBSE (Chartered Institute of Building Services Engineers) Carbon Reduction Award 2012

- **WSFT was presented with a gold "Healthy Ambitions Suffolk" business award** in recognition of its commitment to encouraging healthy lifestyles among its staff

- **Patient Environment Action Team (PEAT) assessors rated the food at WSFT as "excellent" and its standards of cleanliness and patient privacy and dignity as "good".** The results are an improvement on last year's scores, when the hospital was ranked "good" in all three areas

- **WSFT's catering service was awarded five stars for meeting the highest standards of hygiene and food safety,** following a thorough inspection by St Edmundsbury Borough Council. The rating is an improvement on the hospital's score last year, when it was awarded four stars.

Recognition of best practice

- **WSFT was named in the national "Hospital Guide" published by Dr Foster** after recording low mortality rates and ensuring that patients who have suffered a hip fracture receive surgery quickly. The guide shows the hospital has recorded "better than expected" outcomes in these two areas compared with other acute hospitals

- **Occupational Health Nurse Advisor Elaine Ramsden, was presented with the "flu fighter" award** by NHS Employers in recognition of the innovative way she encouraged more frontline staff at WSFT to have the seasonal flu vaccination

- **An initiative designed to give patients undergoing major foot surgery** at WSFT more information about their operation and recovery was showcased as best practice at the British Orthopaedic Foot and Ankle Society national conference. The initiative was the first of its kind in the region and believed to be only the second in the country

- **WSFT picked up two winners' prizes and was highly commended in two further categories in the 2011 Safety Express Awards.** Lisa Nobes, Head of Nursing Development, was presented with the "inspirational individual" award. WSFT was also successful in a category which recognised the team which has implemented all aspects of the Safety Express programme. In addition, Chief Nurse, Nichole Day and Medical Director, Dermot O'Riordan were highly commended in the senior leader category for their work to embed a culture of patient safety across the Trust. WSFT was also highly commended in the quality improvement category.

National accreditation

- **The radiology department** became one of only five in the country and the first in the eastern region to achieve a prized national accreditation after meeting high standards for quality and safety. The Imaging Services Accreditation Scheme standard was awarded by the United Kingdom Accreditation Service

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- **The endoscopy service** was awarded national Joint Advisory Group (JAG) accreditation after meeting the highest standards of quality, safety and training.

Official openings

- **Lady Elsie Robson, widow of Sir Bobby Robson, officially opened WSFT's new digital breast imaging unit.** This followed a £1.2m project to replace analogue breast imaging equipment with state-of-the-art digital machinery that produces high quality images much more quickly

- **Professor Dame Carol Black, who is the UK national director for health and work, officially opened WSFT's new emergency assessment unit (EAU)**. The 17-bed EAU opened following a major £800,000 project to improve and modernise facilities

- **Local MP David Ruffley officially opened the new £273,000 interventional x-ray suite and the £1.2m improved endoscopy unit.** Ageing x-ray equipment has been replaced with new technology, which produces images of such a high quality that clinicians can carry out a much wider range of procedures. The endoscopy unit is larger and incorporates a new sterilisation unit.

Major investments

- **New state-of-the-art electric beds** which are designed to improve comfort for patients while reducing the risk of pressure ulcers are being introduced at WSFT. The Trust has taken delivery of 188 beds and the final consignment, taking the total number to 236, will arrive in 2012. Altogether, WSFT will invest £525,000 in the new technology

- **Stroke patients at WSFT can now access life-saving drugs 24 hours a day** following the introduction of new technology which allows specialist doctors to assess their condition remotely. The telemedicine equipment gives hospital staff a direct link to stroke experts from across the region so that patients who have a stroke outside of normal working hours can be assessed for their suitability for the clot-busting thrombolysis drug.

2.3 Future business plans

Monitor, the independent regulator of NHS FTs, authorised West Suffolk NHS Foundation Trust on 1 December 2011. On authorisation, and in line with the requirements set out by Monitor, the Trust reviewed its mission statement and strategic objectives as part of a comprehensive strategic review.

Following debate at a Board of Directors workshop in January 2012, a Trust Executive Group meeting, a Board of Governors workshop and the Trust's Strategic Development Committee, the Board of WSFT agreed the following revised mission statement:

> 'Excellence in Healthcare – We will provide high quality, safe and caring services; and promote well being'

The Board of Directors through the process set out above also agreed the following revised strategic objectives:

- To be the healthcare provider of first choice by providing excellent quality, safe, effective and caring services
- To work with partners to develop integrated healthcare services to ensure that patients receive the right care, at the right time, and in the right place
- To be the provider of urgent and emergency care services for the local population
- To continuously improve service quality and effectiveness through innovation, productivity and promoting wellbeing in patients and staff
- To continue to secure, motivate, train and develop an engaged workforce which will be able to provide high quality patient focused services
- To deliver and demonstrate rigorous and transparent corporate and quality governance
- To provide value for money for the taxpayer and to maintain a financially sound organisation.

The changes made to the Trust's strategic objectives reflect our increased focus on the strong governance arrangements put in place in readiness for operating as an FT and also on quality and productivity. Implementation of our substantial transformation programme is designed to take the Trust successfully through challenging economic times.

The Trust's strategic position

WSFT intends to provide broadly the same range of services as currently i.e. a range of secondary healthcare services that meet the needs of the population it serves. The integrated Suffolk QIPP plan forecasts that patient activity will not change over the next few years, taking into account population growth and an ageing demographic, balanced with investment in alternatives to hospital-based care.

The Trust will continue to work closely with other public, private and voluntary stakeholders and partners.

WSFT operates within a relatively stable environment with little variation in local market share for core acute services. With regard to community health services, a recent tendering exercise has awarded all Suffolk community health services to an independent sector provider (Serco). This means that from October 2012, WSFT will no longer provide specialised community Chronic Obstructive Pulmonary Disease (COPD) services in Suffolk. The Trust anticipates working closely with Serco, NHS Suffolk and West Suffolk Clinical Commissioning Group to ensure seamless services are provided for patients, and that opportunities to improve the quality of services, through integration of all aspects of clinical care, are not lost.

West Suffolk Hospital is a comparatively small DGH and is conscious of overhead cost pressures that may be less evident in larger organisations. We believe that our size makes us more cohesive than larger trusts, making transformational changes more acceptable and historically we have dealt with cost pressures and successfully delivered our cost improvement plans (CIPs).

The Board of Directors and Board of Governors have not, however, ruled out more significant change as part of the Trust's ongoing strategic review.

Our cohesiveness also allows us to provide a high quality of service, marked very recently by WSFT winning the CHKS Top Hospital award for Quality of Care for the second consecutive year.

During 2012/13 WSFT will also consider the market opportunities offered by the increase in the private patient cap which is included within the Health and Social Care Act 2012.

The Trust is not complacent in assuming that the relative stability of the acute sector in recent years will continue and has considered a number of options in relation to its strategic future.

The physical infrastructure of WSH is now in excess of 39 years old and, whilst it is well maintained, it is increasingly difficult to provide the environment that patients expect. It is for that reason that we will be exploring more innovative options on our current site and continuing our dialogue with the local

authority about an identified alternative site. The Trust recognises the need to provide a high quality environment which meets patients' expectations.

2.4 Principal risks and uncertainties

WSFT 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, the WSFT's assets, patient safety and service quality through its Board Assurance Framework (BAF).

The BAF was kept up-to-date in 2011/12 to ensure that it provided an adequate evidence base to support the effective and focused management of the principal risks to meeting our strategic objectives. The BAF illustrates the escalation processes to the Board of Directors 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.

Table: Board Assurance Framework
The principal risks identified in the 2011/12 BAF as reviewed by the Board of Directors on 30 March 2012 were:

Category of risk	Description of risk	Potential impact
Quality	Reputation damage due to quality/service failure leads to reduced activity	Risk of reputation damage due to quality or service failure, which could lead to reduced activity/income
Quality	Changing healthcare environment due to Health and Social Care Bill and its impact upon commissioning within the local economy, including the potential impact of QIPP (quality innovation, productivity and prevention)	Loss of activity/income due to changes in national commissioning decisions and the risk of diverted allocation of monies to other areas of the health economy in Suffolk. Risks include:- • 30% marginal rates for non-electives • Readmission rates • Inflationary pressures
Urgent care	Changes to the provision of services in light of national or regional recommendations: (i) paediatrics (ii) smaller service specialties (iii) hospital service sustainability (iv) Trauma unit status	• Potential loss of inpatient services regarding required standards for surgery and anaesthesia (published Dec 2010) • Breakdown of on call arrangements due to (small) size of rota, e.g. cardiology, ophthalmology, urology • Potential change to cardiology service provision • Potential loss of trauma unit status
Environment & effectiveness	Implementation of Estates Strategy with regard to backlog maintenance	Building environment not suitable for modern patient care which could lead to reputation damage and loss of income

Category of risk	Description of risk	Potential impact
Environment & effectiveness	Material re-organisation of Pathology services across the East of England. Proposal to move to Hub and Spoke Model	1) Potential impact of GP pathology testing being removed from Trust and Trust's ability to remove fixed cost 2) Efficiency of remaining activity once GP pathology testing commissioned elsewhere 3) Staff implications, possible redundancies, lack of clarity on transitional costs 4) The transition phase may impact upon the Trust's ability to continue to provide pathology services 5) The cost of transition may be a drain on trusts' cash position
Environment & effectiveness	Failure to identify and deliver the level of CIPs (cost improvement plans) assumed within the LTFM (long term financial model)	Capital plan would need to be reduced to reflect the reduced level of surplus. Financial Risk Rating would be adversely affected with associated impact upon service quality. Could lead to short term initiatives to reduce expenditure with associated impact upon service quality
Workforce	Staff responsiveness to current economic/environmental challenges	Impact of changes upon staff morale and responsiveness including resistance may lead to impact upon current discretionary efforts of staff
Workforce	Ability to meet Workforce Plan linked to the Trust's LTFM	Reduction of staff costs and whole time equivalents as part of existing CIP plans. Quality and safety. Reputation management. Adverse employee relations and staff motivation
Governance	Non-compliance with legislation, regulations and good practice guidelines, including failure to comply with internal policy and procedure	Poor care and treatment of patients (impact also links to choice for local patients and GPs). Qualified registration with regulators. Fines and civil awards. Loss of confidence. Delivery and monitoring of competing demands for mandatory training. Insufficient capacity to deal with regulatory reviews (including Monitor). Potential fines and legal costs
Governance	Local income level at risk through changes to the tariff and/or reduced activity levels. NHS Suffolk application of penalties through contract management and external influences/financial pressure upon NHS	Loss of activity/income due to changes in commissioning decisions, which include: referral practices; patients' choice; and new entrants to market. Local management of relationships through contract management

Incident reporting

The Board of Directors has monitored the Trust's incident reporting rate which is lower than expected within our peer group. Importantly, benchmarking within the staff survey shows that the incident reporting system is viewed positively by our staff, supporting the Trust's approach to develop a safety and risk management culture across the organisation.

WSFT has trialled electronic risk reporting in 2011/12 and plans to fully implement this in 2012/13. Staff are encouraged to report any incidents that occur so we can learn from them and improve practice.

All incidents categorised as “red” undergo detailed investigation to establish the root cause of the incident and are written into a formal report with an action plan, which is summarised for the Clinical Safety & Effectiveness Committee.

Effective risk and performance management

WSFT has robust risk management and clinical governance strategies in place, which ensure monitoring of compliance with best practice. WSFT set up a Project Management Office (PMO) in June 2011 The PMO draws together the talents of key members of staff from across the hospital to ensure delivery of key quality and performance standards.

WSFT is compliant with the NHS Litigation Authority’s Clinical Negligence Scheme for Trusts (NHSLA CNST) Level 1 for Maternity Services and the NHSLA Risk Management Standards Level 2.

Mandatory service risk

WSFT’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
- the Trust had adopted organisational objectives and managed and measured performance in line with these objectives
- the Trust was investing in change and capital estate programmes which would improve clinical processes, efficiency and, where required, release additional capacity to ensure we could meet the needs of patients.

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 terms of authorisation

The Board of Directors ensured that WSFT remained compliant with relevant legislation. Executive Directors undertook formal risk assessments against each of the conditions in the terms of authorisation. No significant risks were identified.

2.5 Quality governance framework

Quality, which encompasses patient safety, 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 which we have made in patient safety are given elsewhere in this report and in Section 6 (Quality Report) which provides information on external reviews and audits. The Annual Governance Statement also describes the arrangements the Board of Directors has put in place to monitor and delivery quality.

The Board of Directors reviews the arrangements in place to delivery Monitor’s quality governance framework on a quarterly basis; this includes a review of relevant assurances. Through this process the Board is able to make its quality declaration as part of its quarterly self-assessment submission to Monitor.

2.6 Additional statements and disclosures

Contractors and suppliers

WSFT is committed to sourcing, ordering and delivering a complete range of healthcare products, services and infrastructure, whilst maintaining value for money. A strategic purchasing group has been established to ensure the delivery of WSFT's procurement strategy and we are a committed member of the East of England Procurement Hub. This network, together with our local team, allows WSFT to keep up with developing markets, benchmark products and services, and build close relationships with suppliers.

All purchasing falls in line with European Directive for Procurement in addition to WSFT's Standing Financial Instructions and Orders.

Statement as to disclosure to auditors

So far as the Directors are aware, there is no relevant audit information of which the auditors are unaware. The Directors have taken all of the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

Additional disclosures required by the Financial Reporting Manual (FReM)

Accounts have been prepared under direction issued by Monitor:

- Chief Executives responsibilities certificate (attached)
- Accounting policy note 1 (part of accounts)

The accounting policies for pensions and other retirement benefits are set out in note 1 to the accounts and details of senior employees' remuneration can be found in Section 5 (Remuneration report).

Going concern

After making reasonable enquiries the Directors have a reasonable expectation that WSFT has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

3. Board of Governors

3.1 Responsibilities

Since its formation in February 2009 (in shadow form), the Board of Governors has continued to develop into a key part of the organisation. 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 the WSFT's future strategy.

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

3.2 Composition

The Board of Governors is composed of 14 elected Public Governors, 5 elected Staff Governors and 8 Partner Nominated Governors. The term of office for all Governors is for three years, effective from 1 December 2011when WSFT was authorised as a FT.

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

Mr Roy Banks
Mr David Beaven
Mr David Bevan
Mrs June Carpenter (Lead Governor)
Mrs Justine Corney
Mr Peter Clifford
Mrs Kathy Finney
Mrs Jayne Gilbert
Mr Rodney Knight
Dr Alan Lower
Mrs Helen Smith
Mrs Jane Upward
Mrs Adrienne Wakeling
Mr Stuart Woodhead

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

Mrs Jane Chilvers
Mrs Tanya Clark
Mr Nick Finch
Mr Carl Kwiatkowski
Mr Barry Moult

Partner Governors – nominated by partner organisations of WSFT

Mrs Judy Cory	Friends of West Suffolk Hospital
Mrs Sheila Childerhouse	NHS Norfolk
Dr Mark Gurnell	University of Cambridge
Mr David Howell	West Suffolk College also representing University Campus Suffolk
Mr Alastair McWhirter	NHS Suffolk
Councillor Jane Midwood	Suffolk County Council
Mr Mick Smith	West Suffolk Consortium for Voluntary Organisations
Vacant	Forest Heath District Council, St Edmundsbury Borough Council, Mid Suffolk District Council and Babergh District Council

Governor attendance at Board of Governors meetings 2011/12

There were five formal meetings of the Board of Governors: 18 May 2011, 17 August 2011, 16 November 2011, 13 December 2011 and 7 February 2012 with the following Governor attendance:

Name	Title	Attendance (out of 5 meetings)
Mr Roy Banks	Public Governor	4
Mr David Beaven	Public Governor	3
Mr David Bevan	Public Governor	3
Mrs June Carpenter	Public Governor	5
Mrs Sheila Childerhouse	Partner Governor	1 out of 3*
Mrs Jane Chilvers	Staff Governor	5
Mrs Tanya Clark	Staff Governor	4
Mr Peter Clifford	Public Governor	5
Mrs Justine Corney	Public Governor	3
Mrs Judy Cory	Partner Governor	4
Mr Nick Finch	Staff Governor	2
Mrs Kathy Finney	Public Governor	4
Mrs Jayne Gilbert	Public Governor	3
Dr Mark Gurnell	Partner Governor	1
Mr David Howells	Partner Governor	3
Mr Rodney Knight	Public Governor	4
Mr Carl Kwiatkowski	Staff Governor	4
Dr Alan Lower	Public Governor	5
Mr Alastair McWhirter	Partner Governor	1
Cllr Jane Midwood	Partner Governor	3
Mr Barry Moult	Staff Governor	5
Mr Roger Quince	Chair	5
Mrs Helen Smith	Public Governor	3
Mr Mick Smith	Partner Governor	5
Mrs Jane Upward	Public Governor	4
Mrs Adrienne Wakeling	Public Governor	3
Mr Stuart Woodhead	Public Governor	3

*Mrs Sheila Childerhouse was appointed a Governor in November 2011.

In attendance at these meetings were: Dr John Benson, Non-executive Director (1); Mr Stephen Graves, Chief Executive (4); Ms Gwen Nuttall, Chief Operating Office (3); Mr Graham Simons, Non-executive Director (3); Mr Brian Stewart, Non-executive Director (3); Mr Steve Turpie, Non-executive Director (1).

3.3 Register of Interests

All Governors are asked to declare any interests on the register of Governors' interests 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.

3.4 Governors and Directors working together

Governors and Directors are encouraged to work together, on both a formal and informal basis. Governors attend/observe the monthly Board of Directors meetings and a number attend on a regular basis. This gives Governors a greater insight into and understanding of the performance of the Trust, particularly from a quality and finance point of view and also a better knowledge of the role and performance of the Non-executive Directors (NEDs).

Each NED has attended a Board of Governors meeting to present on their background and role. In addition the Deputy Chair has, in the past year, presented the finance report at the Board of Governors meetings. This has been very well received by Governors and it is proposed to develop this in the future and to ask another NED to present the quality report.

The Senior Independent Director also attends Board of Governors meetings and Governors are aware that they should discuss any matters with him that they do not feel can be addressed through the Chairman.

A Board of Governors' workshop was held in February 2012 where proposals for the Trust's Annual Plan and future strategy were presented and discussed. This was also attended by members of the Board of Directors who acted as facilitators for the working groups. The feedback from Governors from a public perspective was considered to be extremely beneficial and a further workshop was held in April 2012 to present the draft Annual Plan and consider the next stage of the strategic review. This too was successful.

Governors are also asked to contribute to and act as readers for the Trust's Quality Report, Annual Report and Annual Plan.

The Chief Executive undertakes 'quality walkabouts' on a weekly basis and is accompanied by a Director or NED and a Governor on each occasion. This gives Governors a greater understanding of issues within all areas of the organisation, as well as providing an opportunity for them to interact with Directors, staff and patients.

The Membership Committee, which is a sub-committee of the Board of Governors, meets on a quarterly basis. It has been agreed that Governors will feedback key issues that they have encountered when engaging with the public to the Patient Experience Committee, which is attended by Directors and NEDs. This Committee will be asked to provide a report on how these issues are being addressed to the Board of Governors meeting.

The Trust's Patient Advisory Panel is chaired by one of the Governors who reports back to the Membership Committee on key issues.

3.5 Membership

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

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.

Patients and members of the public who reside in the following areas are eligible to join our public constituency:-

Babergh (selected wards):- Boxford, Brett Vale, Bures St Mary, Chadacre, Glemsford and Stanstead, Great Cornard North, Great Cornard South, Hadleigh North, Lavenham, Leavenheath, Long Melford, North Cosford, South Cosford, Sudbury East, Sudbury North, Sudbury South and Waldingfield.

Braintree (selected wards):- Bumpstead, Hedingham and Maplestead, Stour Valley North, Stour Valley South, Upper Colne and Yeldham.

Breckland (selected wards):- Conifer, East Guiltcross, Harling and Heathlands, Mid Forest, Thetford-Abbey, Thetford-Castle, Thetford-Guildhall, Thetford-Saxon, Watton, Wayland, Weeting and West Guiltcross.

East Cambridgeshire (selected wards):- Bottisham, Burwell, Cheveley, Dullingham Villages, Fordham Villages, Isleham, Soham North, Soham South and The Swaffhams.

Forest Heath (all wards):- Saints, Brandon East, Brandon West, Eriswell and The Rows, Exning, Great Heath, Iceni, Lakenheath, Manor, Market, Red Lodge, Severals, South and St Mary's.

King's Lynn and West Norfolk (selected ward):- Denton.

Mid Suffolk (selected wards):- Bacton and Old Newton, Badwell Ash, Elmswell and Norton, Eye, Gislingham, Haughley and Wetherden, Mendlesham, Needham Market, Onehouse, Palgrave, Rattlesden, Rickinghall and Walsham, Ringshall, Stowmarket Central, Stowmarket North, Stowmarket South, Stowupland, The Stonhams, Thurston and Hessett, Wetheringsett and Woolpit.

South Norfolk (selected wards):- Bressingham and Burston, Diss and Roydon.

St Edmundsbury (all wards):- Abbeygate, Bardwell, Barningham, Barrow, Cavendish, Chedburgh, Clare, Eastgate, Fornham, Great Barton, Haverhill East, Haverhill North, Haverhill South, Haverhill West, Horringer and Whelnetham, Hundon, Ixworth, Kedington, Minden, Moreton Hall, Northgate, Pakenham, Risby, Risbygate, Rougham, Southgate, St Olaves, Stanton, Westgate, Wickhambrook and Withersfield.

Map of Membership Area

Staff membership

All staff at WSFT who are employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months or have been continuously employed by the Trust under a contract of employment for at least 12 months 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 unless they are a registered Trust volunteer.

Membership numbers

As at 31 March 2012 there were 9,041 members; 5,137 public and 3,904 staff.

Membership strategy

WSFT's membership strategy was produced in support of its application for NHS FT status in November 2009. It was revised in April 2011 and is reviewed on an annual basis by the Membership Committee for consideration by the Board of Governors and approval by the Board of Directors.

We aim to achieve continual year on year growth for our public membership and to ensure that staff membership is maintained at an appropriately high level. As part of the recruitment plan experience has shown that engaging with the public is a very effective way of recruiting new members and gaining their views on WSFT. Governors are now using a short questionnaire to engage with members of the public during recruitment campaigns. As well as recruiting new members this has provided valuable feedback from patients and the public on their experiences/views of WSFT.

The Board of Governors' Membership Committee meets quarterly and reviews the membership numbers and the targets set in the membership strategy, to ensure that it is representative and consider ways of increasing members in areas where numbers are low. The Chair of this Committee gives a report to the quarterly Board of Governors meeting.

Criteria	Performance (Jan 2012)	*Target* (by Mar 2013)
1. Achievement of the recruitment target: a. Total number of Public members b. Staff opting out of membership	 5,104 0%	 5,200 <1%
2. A balanced representation in our membership for the population we serve. The following have been identified for action: a. Age – recruitment for under 50s b. Increase representation from King's Lynn & West Norfolk and South Norfolk	 1,004 94	 1,100 110
3. An engaged membership measured by: a. number of member events held b. member event attendance	 3 219*	 6 500
4. The minimum percentage of patients using the Trust's services that are within the public membership area	95%	90%

* Number deliberately limited in order to enable events to be more interactive

During the past year the Trust has held three 'special interest' events on individual services provided by WSFT. These have proved extremely popular and have been oversubscribed on every occasion, with more than 100 people attending each event. We have also used these events to gain feedback on the services provided by WSFT and what are considered to be the key quality priorities.

Our Staff Governors continue to engage with staff, attending department meetings and raising staff/patient issues with Executive Directors. Four 'staff conversation' events have been held over the last year. The Staff Governors are working closely with the Public Governors, NEDs and the Board of Directors to deliver excellent and efficient patient care, and to ensure the wellbeing of staff.

Contact procedures for members

WSFT's website gives information of Link Governors who represent the five main geographical areas of the public constituency and how they can be contacted. Contact details for the FT office are also given on the website and queries/comments will be directed to the appropriate Governors/Directors.

A newsletter is sent to all members three or four times a year, which also gives details of how to contact the Trust.

3.6 Nominations Committee

There is a Governors' Nominations, Appointments & Remuneration Committee which is responsible for making recommendations to the Board of Governors on the appointment of the Chairman and other NEDs. The Committee also makes recommendations for NED remuneration and terms and conditions.

The Committee is chaired by the Chairman, except when considering the appointment, remuneration and terms and conditions of the Chairman, when it is chaired by the Lead Governor.

The first meeting of this Committee was held on 14 March 2012.

Attendance at Nominations Committee Meeting 2011/2012

Name	Title	Attendance (out of 1)
Roger Quince (Chair)	Chairman	1
June Carpenter	Public Governor / Lead Governor	0
Justine Corney	Public Governor	1
Jayne Gilbert	Public Governor	1
David Howells	Partner Governor	1
Barry Moult	Staff Governor	1
Stuart Woodhead	Public Governor	1

Meeting dates: 14 March 2012

4. Board of Directors

4.1 Responsibilities

The Board of Directors functions as a corporate decision-making body. 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 both full-time Executive Directors and part-time NEDs, the latter chosen because of their experience. The role of the Board is to set the overall corporate goals for WSFT and to be responsible for the operational management of the hospital. The description below demonstrates the balance, completeness and relevance of the skills, knowledge and expertise that each of the Directors brings to the FT.

4.2 Composition

Non-executive Directors

Mr Roger Quince – NED and Chairman
(1 January 2008 - 31 December 2011; reappointed: 1 November 2011 - 31 December 2015*
**Reappointment made by Appointments Commission on 20 July 2011*)

Areas of special interest/responsibility: Chair of Quality & Risk Committee; member of Strategic Development Committee, Remuneration Committee and Chair of the Governors' Nominations, Appointments & Remuneration Committee.

Roger is Chairman of the Board of Directors and Board of Governors of WSFT and an advisor to the Board of Governors of Cambridge University Hospitals NHS Foundation Trust Board.

Roger was previously a director of MEPC Ltd (a large property company) and served on various government bodies, including Review of UK Atomic Energy Authority. His earlier career was in staff and line management roles in Dalgety Ltd and he was CEO of a public policy consultancy.

Independent director – Yes (satisfies criteria of Code of Governance A.3.1)

Dr John Benson – NED
(19 April 2007 – 18 April 2011; reappointed 19 April 2011 to 18 April 2015)

Areas of special interest/responsibility: lead NED for the Clinical Safety & Effectiveness Committee; member of the Remuneration Committee, Audit Committee and Quality & Risk Committee; NED link to medical director.

John was appointed to the Board through Cambridge University, bringing a range of experience from primary care, education and non-commercial organisations. He is a General Practitioner, a senior lecturer in the General Practice and Primary Care Research Unit (GPPCRU) at the University of Cambridge and Associate Dean in the University of Cambridge School of Clinical Medicine, contributing to curriculum design for University of Cambridge medical students and to medical research.

John is also director of the GP education group within the General Practice and Primary Care Research Unit and a former member of the Norfolk Suffolk Cambridgeshire Workforce Development Confederation stakeholder Board.

Independent director – No (appointed representative of Cambridge University)

Mr Graham Simons – NED and Deputy Chair
(1 November 2006 – 31 October 2010; reappointed 1 November 2010 – 31 October 2014)

Areas of special interest/responsibility: Chair of Charitable Funds Committee; lead NED for Corporate Risk Committee; member of Remuneration Committee, Audit Committee and Quality & Risk Committee. NED link for security. Special interest in HR issues.

Graham is Deputy Chair of the Board of Directors and Board of Governors. He is currently finance director of a leisure company and is an Associate of the Chartered Institute of Bankers with over 30 years banking experience gained within Midland Bank and HSBC. After leaving the banking industry he spent some time working for Center Parcs as their Head of Sports and Activities before setting up his own finance and leisure consultancy in 2006.

Independent director – Yes (satisfies criteria of Code of Governance A.3.1)

Mr Brian Stewart – NED and Senior Independent Director
(1 August 2009 – 31 July 2013)

Areas of special interest/responsibility: Chair of Strategic Development Committee and Remuneration Committee; second lead NED for Charitable Funds Committee and Corporate Risk Committee; member of Patient Experience Committee.

Brian has significant government and public sector experience in planning and development. He is a consultant adviser (part-time) to Bidwells on public engagement and consultation and Chair of the Board of Wherry Housing Association – with a seat on Circle Anglia Strategy Board. He is also Chairman of the Board of Trustees, Theatre Royal, Bury St Edmunds Theatre Management Ltd.

Brian was awarded an OBE in June 2010 for services to local government.

Independent director – Yes (satisfies criteria of Code of Governance A.3.1). Note: Brian Stewart was employed by the Trust from June 2008 until May 2009 in an advisory capacity, prior to being appointed as a NED. The nature of this advisory role was, in effect, that of a NED.

Mr Steven Turpie – NED
(1 March 2010 - 28 February 2014)

Areas of special interest/responsibility: Chair of the Audit Committee and member of Remuneration Committee. NED link to director of finance.

Steven is a qualified accountant with substantial experience in large commercial enterprises. He is currently Head of Sourcing and Operational Improvement for Zurich Insurance Group.

Steven previously held senior finance positions with Aviva, Cable and Wireless and Barclaycard.

Independent director – Yes (satisfies criteria of Code of Governance A.3.1)

Mrs Rosie Varley – NED
(1 April 2011 – 31 March 2015)

Areas of special interest/responsibility: NED lead for Patient Experience Committee; second lead for Clinical Safety and Effectiveness Committee; member of Strategic Development Committee, Quality & Risk Committee and Remuneration Committee.

Rosie brings wide ranging experience in health, social care, education and regulation. She is Chair of the General Social Care Council (the professional regulator for social workers), and of the Public Guardian Board (an advisory body in the Ministry of Justice which oversees the implementation of the Mental Capacity Act). She was Chair of the General Optical Council from 1997 to 2007 and acting Chair of the Council for Healthcare Regulatory Excellence from 2006 to 2008. She is a former NHS

Trust and Regional Chair, and NHS Appointments Commissioner.

Rosie has a particular interest in mental health and learning disabilities. She is a specialist member of the Mental Health Review Tribunal and of the Disability Living Allowance Tribunal, and is actively involved in a number of voluntary organisations in this field.

Rosie is a Governor of two local schools – The Priory Special School Academy and St Benedict's RC Upper School.

She has recently been appointed as an Independent Public Appointments Assessor.

Rosie was awarded an OBE for services to the NHS and healthcare in 2007 and an honorary doctorate from the University of East Anglia and University of Essex in 2009.

Independent director – Yes (satisfies criteria of Code of Governance A.3.1)

Executive Directors

Mr Stephen Graves – Chief Executive

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

Stephen joined the Trust as Chief Executive in May 2010 from Cambridge University Hospitals NHS Foundation Trust, where he was Director of Corporate Development and also a Partner Governor for Cambridge & Peterborough NHS Foundation Trust and a Director of the Greater Cambridge Partnership. His key responsibilities at CUH were strategy, 2020 vision, service planning and service change, University liaison including R&D and medical education and business development.

Stephen's previous experience was as a senior civil servant, Regional Office of the Department of Health and a manager for the District Audit Service of the Audit Commission. He continues to run his family farming business.

Mr Craig Black – Executive Director of Resources

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

Craig joined West Suffolk Hospital in April 2011 from Cambridge University Hospitals NHS Foundation Trust, where he was Director of Commissioning.

Previously Craig was Deputy Director of Finance at Ipswich Hospital NHS Trust

Mrs Nichole Day – Executive Chief Nurse

Areas of responsibility: professional leadership, nursing strategy and nurse management, professional education, clinical governance and quality improvement, risk management; integrated governance, complaints & litigation, chaplaincy and volunteers.

Nichole has over 25 years experience of working within the NHS spanning both clinical and managerial positions. She joined the Trust in September 1994 from Addenbrookes NHS Trust and has been a Director of Nursing for 18 years.

Ms Gwen Nuttall – Chief Operating Officer / Deputy Chief Executive

Areas of responsibility: joint operational responsibility with the Executive Medical Director for the operational management and delivery of all clinical services. Management responsibility for the management of the Trust estate and environment. Deputising for the Chief Executive.

Gwen joined the Trust in October 2004 from Barts and the London NHS Trust where she was General Manager for Surgery & Anaesthesia.

Prior to this Gwen was General Manager for Surgery at Chelsea & Westminster Hospital NHS Trust, where she had previously been information manager. Gwen was the project manager for the transfer of burns and plastics services from Queen Mary Roehampton to the Chelsea and Westminster.

Mr Dermot O'Riordan – Executive Medical Director

Areas of responsibility: joint operational responsibility with the Chief Operating Officer for the operational management and delivery of all clinical services. Also responsible for clinical governance; clinical networks; clinical research; GP liaison; post-graduate education.

Dermot was appointed as Executive Medical Director in June 2009, having previously been Deputy Medical Director and a Clinical Director at the Trust. Since 2001 he has been a consultant general laparoscopic surgeon at the Trust.

Dermot is an elected member of Council and Trustee, Royal College of Surgeons of England and was a Health Foundation Leadership Fellow from 2003-05.

Mrs Jan Bloomfield – Executive Director of Workforce and Communications**

Areas of responsibility: oversees all areas of the Trust's workforce, including leadership, management development and organisational development; education and training; welfare and wellbeing including occupational health; equality and diversity, pay and reward; employee relations and workforce planning. In addition she is Executive lead for communications (including public relations), Patient First standards, car parking, sustainability and fundraising.

Jan joined the Trust in February 1991 and was previously Deputy Personnel Manager at University College Hospital, London. She is Chair of Suffolk Leadership Academy Board,
Board Governor at West Suffolk College and Management-side Chairman of the Regional Social Partnership Board.

Jan has a wide experience of human resources within the NHS and has held a number posts in this area. She is a Fellow of the Chartered Institute of Personnel and Development.

Mr Andy Graham – Executive Director of Major Projects**

Areas of responsibility: strategic development; business planning; project direction including contract priorities, CIP and Commissioning for Quality & Innovation (CQUIN) schemes.

Andy joined the Trust in June 2011 having formerly been Head of Performance at NHS East of England.

He joined the NHS as a student nurse in 1986 and has since worked in a number of general management posts in Primary Care and Mental Health. He worked as a Commissioning Manager at Barnet Health Authority and was also Head of Health at HMP Pentonville.

** non-voting directors

4.3 Register of Interests

All directors are asked to declare any interests on the Register of Directors' Interests 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 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.

4.4 Appointment of Chairman and NEDs

The Board of Governors has the responsibility for appointing the Chairman and NEDs in accordance with the constitution and in line with paragraph 19(2) and 19(3) respectively of Schedule 7 of the National Health Service Act 2006.

Candidates are nominated by the Board of Governors' Nomination, Appointments and Remuneration Committee who select and recommend the appointment of NEDs, for approval by the Board of Governors.

This Committee comprises the Chair of WSFT, four Public Governors (including the Lead Governor) one Staff Governor and one Partner Governor. The Committee is chaired by the Chairman of the Trust for NED appointments only.

NED appointments are for a term of four years. Following this term, and subject to satisfactory appraisal, a NED is eligible for consideration by the Board of Governors for a further uncontested term of office of four years. Vacant NED positions will be subject to an openly contested process with an appointment by the Board of Governors.

The removal of a NED requires the approval of three-quarters of the members of the Board of Governors. Details of the criteria for disqualification from holding the office of a director can be found in paragraph 27 of the constitution.

Disclosures of the remuneration paid to the Chairman, NEDs and senior managers are given in the accounts.

4.5 Evaluation of the Board of Directors' performance

Attendance at Trust Board of Directors Meetings 2011/12

Name	Title	Attendance (out of 19)
Roger Quince	Chairman	18
John Benson	Non-executive Director	16
Craig Black	Executive Director of Resources	18
Jan Bloomfield	Executive Director Workforce & Communications	18
Nichole Day	Executive Chief Nurse	16
Andy Graham	Executive Director of Major Projects	17
Stephen Graves	Chief Executive	17
Gwen Nuttall	Chief Operating Officer	19
Dermot O'Riordan	Executive Medical Director	17
Graham Simons	Non-executive Director	19
Brian Stewart	Non-executive Director	17
Steven Turpie	Non-executive Director	16
Rosie Varley	Non-executive Director	13

Meeting dates

4 April 2011, 28 April 2011, 27 May 2011, 3 June 2011, 24 June 2011, 20 July 2011, 29 July 2011, 26 August 2011, 29 September 2011, 30 September 2011, 6 October 2011, 11 October 2011, 28 October 2011, 16 November 2011, 25 November 2011, 16 December 2011, 27 January 2012, 24 February 2012, 30 March 2012.

Drawing on best practice from the commercial sector, in 2010 the Board of Directors undertook a review of the governance structure. The revised model was largely based on the Trust's existing structures and accountabilities, modifying these to mitigate the potential for duplication between the then Patient First Programme Board and the Board's governance committee structure.

The revised structure is now implemented: reports are received by the Board through a dedicated Board committee with oversight for quality and risk (the Quality & Risk Committee). The minutes of each meeting of the Quality & Risk Committee are 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.

During 2011 the Board reviewed the escalation arrangements within the governance structure and put in place a robust escalation framework. This ensures timely and effective escalation from directorates and specialist committees to the Board via the Trust Executive Group.

The Board completed a planned review of the new governance arrangements in January 2012 and concluded that the arrangements were effective. Minor actions were agreed and will be monitored by the Board.

Committee's of the Board of Directors report on their activities through minutes and reports. These provide assurance to the Board on its committees' activities and effectiveness.

The Chair and Trust Secretary have worked with the Board of Governors to develop an appropriate appraisal process for the Chair and NEDs. The Chair is formally appraised by the Lead Governor and Senior Independent Director. Appraisal of NEDs is carried out by the Chair. Governors contribute to these appraisals through 360 degree feedback.

The Chief Executive is subject to annual formal appraisal by the Trust Chair. Executive Directors are subject to annual appraisal by the Chief Executive which informs development plans. Where appropriate 360 degree appraisal is used. 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 an approved development programme which focuses on: "core capabilities" for Board members (including mandatory training and themes from directors' Personal Development Plans (PDPs)); future developments (informed by NHS strategy and the Trust's Annual Plan); and how effectively the Board operates. Where appropriate external expertise is used.

4.6 Committees of the Board of Directors

Audit Committee

Membership of this Committee is made up of NEDs and is chaired by Steve Turpie. 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 Monitor in exercise of powers conferred on it by paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006.

PKF (UK) LLP, WSFT's external auditors, report to the Board of Governors through the Audit Committee. PKF (UK) LLP's accompanying report on the financial statement is based on its examination conducted in accordance with the Audit Code for NHS FTs, as issued by Monitor, independent regulator of FTs. Their work includes a review of our internal control structure for the purposes of designing their audit procedures.

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.

Attendance at Audit Committee Meetings 2011/12

Name	Title	Attendance (out of 4)
John Benson	Non-executive Director	4
Graham Simons	Non-executive Director	4
Brian Stewart	Non-executive Director	4
Steven Turpie	Non-executive Director (Chair)	4

Meeting dates
3 June 2011, 29 July 2011, 28 October 2011, 27 January 2012.

Remuneration Committee

Membership of the Committee includes all the NEDs and is chaired by Brian Stewart. At the discretion of the Chair, the Chief Executive and the Executive Director Workforce & Communications may be present to give advice. The role of the 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 and Executive Directors of the Trust, together with other staff members as determined by the Board. It is responsible for establishing the objectives of the Chief Executive and reviewing performance against these targets, together with approving the objectives of the Executive Directors and reviewing performance reports prepared by the Chief Executive.

It is also responsible for determining targets for any performance-related pay scheme contained within the Remuneration policy and reviewing the recommendations of the Clinical Excellence Awards Committee.

Attendance at Remuneration Committee Meetings 2011/12

Name	Title	Attendance (out of 3)
John Benson	Non-executive Director	2
Roger Quince	Chairman	3
Graham Simons	Non-executive Director	3
Brian Stewart	Non-executive Director (Chair)	3
Steven Turpie	Non-executive Director	2
Rosie Varley	Non-executive Director	2

Meeting dates
3 June 2011, 4 July 2011, 25 Nov 2011.

4.7 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 the Independent Regulator of NHS Foundation Trusts ("Monitor").

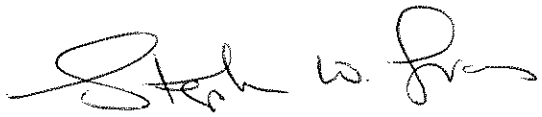
Under the NHS Act 2006, Monitor has directed West Suffolk NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of West Suffolk NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, 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* have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

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 him 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.

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



Stephen Graves
Chief Executive

30 May 2012

4.8 Annual Governance Statement

West Suffolk NHS Foundation Trust Annual Governance Statement – 1 December 2011 to 31 March 2012

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation 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 Foundation 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 Foundation Trust Accounting 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 WSFT, 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 WSFT for the four months ended 31 March 2012 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 FTs. The Trust has a risk management strategy and risk management policy 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 Board of Governors receive regular reports that detail risk, financial and performance issues and, where required, the action being taken to reduce identified high-level risks.

The Audit Committee has primary responsibility for financial governance, for overseeing the Trust's governance and assurance process and in particular for independently reviewing the effectiveness of risk management systems and ensuring that all significant risks are properly considered and communicated to the Board of Directors. It reviews implementation of the Board Assurance Framework at each meeting to assure itself that risks are being appropriately identified and managed and appropriate assurance obtained.

The Quality & Risk Committee has primary responsibility for assuring the Board of Directors on matters of clinical governance, quality and risk in the Trust, specifically clinical safety, patient experience and corporate risk. The Committee also oversees the management of information governance, research governance and health and safety.

The Board of Directors retains responsibility for reviewing financial and operational performance reports addressing, as required, emerging areas of financial and operational risk, gaps in control, gaps in assurance and actions being undertaken to address these issues.

The Strategic Development Committee supports the Board of Directors by scrutinising and advising on key developments to support the business objectives. This included overseeing the processes for the Trust's strategy review and site development plan.

The Nursing & Governance Directorate coordinates and supports risk activity across the Trust. Full details of this work are contained in the Trust's risk management policy.

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 are also provided to staff through the 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.

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.

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 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 that those controls are in place and operating effectively. These include:

- Performance management framework
- Monthly quality & 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
- Quarterly self-certification against the compliance framework
- Quarterly quality & performance reports by directorates to the Quality & Risk Committee
- Quarterly quality and performance reports to the Board of Governors. This provides information which is similar to that reviewed by the Board of Directors on a monthly basis (1,2 and 3 above)
- Assurances provided through the work of the Clinical Safety & Effectiveness Committee, Corporate Risk Committee and Patient Experience Committee
- Minutes of the Quality & Risk Committee, Strategic Development Committee and the Audit Committee
- Assurances provided through the work of internal and external audit, the Care Quality Commission, Monitor, the NHS Litigation Authority, Patient Environment and Action Team inspections, and accountability to the Board of Governors
- The work of clinical audit, whose scope includes national audits, audits arising from national guidance such as NICE, confidential enquiries and other risk and patient safety related topics
- Weekly quality walkabouts, including Executive Directors, NEDs and Governors
- Risk assessments and analysis of the risk register and Board Assurance Framework
- Benchmarking for clinical indicators using Dr Foster
- External regulatory and assessment body inspections and reviews, including Royal Colleges, Post Graduate Dean reports; accreditation inspections and Health and Safety Executive (HSE) reports.

WSFT is registered as fully compliant with the requirements of the CQC. Work continues to address minor concerns identified at registration regarding the management of medicines.

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.

WSFT has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's 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 me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives has been reviewed. My review is also informed by:

- The accreditation visit of our maternity services from the NHS Litigation Authority in January 2012. The outcome of this was achieving Level 1 accreditation, demonstrating compliance with 48 of the 50 criteria at level 1
- The Trust's assessment against the Department of Health's information governance assessment for 2011/12, the outcome of which was a compliance score of 79% (Green), an increase from the 71% recorded in 2010/11
- The Trust's evaluation of compliance to the CQC standards for 2009/10. Following an evaluation of compliance against all of the standards and at each location, the Trust made a declaration of compliance as part of the registration process with the CQC. The Trust was registered in March 2010 with no compliance conditions
- Two unannounced visits from the CQC. The first visit took place in October 2011 and reviewed compliance with seven outcomes. All seven outcomes were judged to be compliant with a small number of minor concerns identified. Action to address these concerns has been completed. The second visit took place in March 2012, when the CQC reviewed the termination of pregnancy services. The Trust was judged to be compliant with the outcome reviewed and no concerns were raised.

The Board Assurance Framework was reviewed and updated routinely during 2011/12 to ensure the principal strategic risks to the Trust's objectives were identified, recorded and correctly evaluated for impact and likelihood. 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 identified that there were no major gaps in control or assurance, and Board reporting for areas with a high residual risk was sufficiently frequent.

Quality governance framework

WSFT places a high priority on quality of its clinical outcomes, patient safety and patient experience and abides by the principles outlined in Monitor's quality governance framework, as follows:

1. **Quality strategy**: Quality underpins WSFT's strategy. Quality key performance indicators are identified, monitored and reported to the Board of Directors on a regular basis. Both current and future risks to quality are listed in the BAF and in the operational risk register and used to inform decision priorities. Potential initiatives (e.g. cost improvement measures) and investments are assessed for the potential risks to quality. These risk assessments are reviewed by Executive

Directors before proceeding, and the outcomes reported to the Board of Directors through the Trust Executive Group.

2. **Capabilities and culture**: the Board of Directors has identified its quality priorities through the quality reporting process. In defining these priorities the directors engaged with Governors and FT members. Both the Board of Governors and Board of Directors receive quarterly reports on patient safety and patient experience. The Trust has a mature reporting culture which is seen as effective by staff when benchmarked against other trusts.

3. **Structures and processes**: Quality is a standing item in all meetings of the Board of Directors and Board of Governors, and both boards receive reports routinely on complaints, patient and staff feedback surveys, incident reporting trends and any ongoing actions to address concerns identified. The Quality & Risk Committee has the delegated authority to review actions in hand to address quality performance issues. The Trust has engaged with its key stakeholders on quality through the quality reporting process, which has ensured input from its lead commissioner, the Suffolk Overview and Scrutiny Committee and Suffolk Local Involvement Network (LINk).

4. **Measurement**: the Board of Directors reviews its priority metrics on a monthly basis through the quality and performance reports. All metrics are reviewed on a quarterly basis. These metrics are linked to the Trust's strategic objectives, national priority indicators, Monitor governance ratings, CQUINs and local priorities.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare a Quality Report for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

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 patient safety, clinical outcomes and patient experience takes place at the Quality & Risk Committee. There are a number of committees and executive groups with direct responsibility for key aspects of the quality agenda reporting to the Quality & Risk Committee. The Patient Experience Committee reviews the data from the patient experience surveys and provides feedback to the Quality & Risk Committee. The Clinical Safety & Effectiveness and Patient Experience Committees inform the Quality & Risk Committee on relevant performance relating to the Trust's quality strategy and quality improvement plan. This is underpinned by quality walkabouts and continuous monitoring of defined quality indicators.

The inter-relationship between the indicators in the quality report and other measures of the Trust's performance (financial and operational) is reviewed monthly by 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. This included an internal audit of our assessment against the information governance toolkit during 2012. The Board of Directors takes further assurance from the External Auditor's review of the Quality Report.

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 WSFT who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other 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 Quality & 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. Strategic objectives, set out in Section 2.3 of the Annual Report, are derived from the priorities determined in the Trust's strategy.

During 2011 the Board of Directors reviewed the escalation arrangements within the governance structure and put in place a robust escalation framework. This ensures timely and effective escalation from directorates and specialist committees to the Board via the Trust Executive Group.

The Board of Directors completed a review of the governance committee arrangements in January 2012, taking into account the internal audit findings, and concluded that the arrangements were effective. Minor actions were acted upon and will be monitored by the Board.

Executive Directors and their managers are responsible for maintaining effective systems of control on a day-to-day basis.

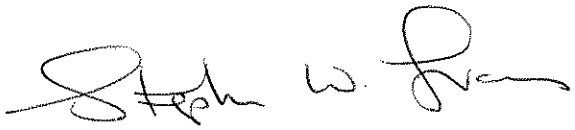
In accordance with the Internal Audit Standards for the National Health Service (April 2002), internal audit provides the Trust with an independent and objective opinion to the Accounting Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

External Audit provide an opinion on the true and fair status of the Annual Report and Accounts and the adequacy of the Trust's management arrangements to ensure economy, efficiency and effectiveness in its use of resources.

Conclusion

No significant internal control issues have been identified and my review confirms that West Suffolk NHS Foundation Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives.

Signed



Stephen Graves
Chief Executive

30 May 2012

West Suffolk Hospital NHS Trust Annual Governance Statement – 1 April 2011 to 30 November 2011

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the West Suffolk Hospital 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.

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 Hospital NHS 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 Hospital NHS Trust for the eight months ended 30 November 2011 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 requirements of relevant regulatory bodies. The Trust has a risk management strategy and risk management policy 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 Board of Governors receive regular reports that detail risk, financial and performance issues and, where required, the action being taken to reduce identified high-level risks.

The Audit Committee has primary responsibility for financial governance, for overseeing the Trust's governance and assurance process and in particular for independently reviewing the effectiveness of risk management systems and ensuring that all significant risks are properly considered and communicated to the Board. It reviews implementation of the Board Assurance Framework at each meeting to assure itself that risks are being appropriately identified and managed and appropriate assurance obtained.

The Quality & Risk Committee has primary responsibility for assuring the Board of Directors on matters of clinical governance, quality and risk in the Trust, specifically clinical safety, patient experience and corporate risk. The Committee also oversees the management of information governance, research governance and health and safety.

The Board retains responsibility for reviewing financial and operational performance reports addressing, as required, emerging areas of financial and operational risk, gaps in control, gaps in assurance and actions being undertaken to address these issues.

The Strategic Development Committee supports the board by scrutinising and advising on key developments to support the business objectives. During 2011 this has included the FT application and transformation of pathology and community services.

The Nursing & Governance Directorate coordinates and supports risk activity across the Trust. Full details of this work are contained in the Trust's risk management policy.

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 are also provided to staff through the 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.

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.

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 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 that those controls are in place and operating effectively. These include:

- Performance management framework
- Monthly quality & 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
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- Quarterly quality & performance reports by directorates to the Quality & Risk Committee
- Quarterly quality and performance reports to the Board of Governors. This provides information which is similar to that reviewed by the Board of Directors on a monthly basis (1,2 and 3 above)
- Assurances provided through the work of the Clinical Safety & Effectiveness Committee, Corporate Risk Committee and Patient Experience Committee
- Minutes of the Quality & Risk Committee, Strategic Development Committee and the Audit Committee
- Assurances provided through the work of internal and external audit, the Care Quality Commission, Monitor, the NHS Litigation Authority, Patient Environment and Action Team inspections, and accountability to the Board of Governors
- The work of clinical audit, whose scope includes national audits, audits arising from national guidance such as NICE, confidential enquiries and other risk and patient safety related topics
- Weekly quality walkabouts, including Executive Directors, NEDs and Governors
- Risk assessments and analysis of the risk register and Board Assurance Framework
- Benchmarking for clinical indicators using Dr Foster
- 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 Trust is registered as fully compliant with the requirements of the CQC. Work continues to address minor concerns identified at registration regarding the management of medicines.

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 Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's 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 me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives has been reviewed. My review is also informed by:

- The Trust's assessment against the Department of Health's information governance assessment for 2011/12, the outcome of which was a compliance score of 79% (Green), an increase from the 71% recorded in 2010/11
- The Trust's evaluation of compliance to the CQC standards for 2009/10. Following an evaluation of compliance against all of the standards and at each location, the Trust made a declaration of compliance as part of the registration process with the CQC. The Trust was registered in March 2010 with no compliance conditions
- One unannounced visits from the CQC. The visit took place in October 2011 and reviewed compliance with seven outcomes. All seven outcomes were judged to be compliant with a small number of minor concerns identified. Action to address these concerns has been completed.

The Board Assurance Framework was reviewed and updated routinely during 2011/12 to ensure the principal strategic risks to the Trust's objectives were identified, recorded and correctly evaluated for impact and likelihood. 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 identified that there were no major gaps in control or assurance, and board reporting for areas with a high residual risk was sufficiently frequent.

Quality governance

The Trust places a high priority on quality of its clinical outcomes, patient safety and patient experience and abides by the principles outlined in Monitor's quality governance framework, as follows:

1. **Quality strategy**: Quality underpins the Trust's strategy. Quality key performance indicators are identified, monitored and reported to the board on a regular basis. Both current and future risks to quality are listed in the BAF and in the operational risk register and used to inform decision priorities. Potential initiatives (e.g. cost improvement measures) and investments are assessed for the potential risks to quality. These risk assessments are reviewed by Executive Directors before proceeding, and the outcomes reported to the Board of Directors through the Trust Executive Group.

2. **Capabilities and culture**: the board has identified its quality priorities through the quality reporting process. In defining these priorities the directors engaged with shadow Governors and shadow FT members. Both the Board of Governors and Board of Directors receive quarterly reports on patient safety and patient experience. The Trust has a mature reporting culture which is seen as effective by staff when benchmarked against other trusts.

3. **Structures and processes**: Quality is a standing item in all meetings of the Board of Directors and shadow Board of Governors, and both boards receive reports routinely on complaints, patient and staff feedback surveys, incident reporting trends and any ongoing actions to address concerns identified. The Quality & Risk Committee has the delegated authority to review actions in hand to address quality performance issues. The Trust has engaged with its key stakeholders on quality through the quality reporting process, which has ensured input from its lead commissioner, the Overview and Scrutiny Committee and Suffolk Local Involvement Network (LINk).

4. **Measurement**: the board reviews its priority metrics on a monthly basis through the quality and performance reports. All metrics are reviewed on a quarterly basis. These metrics are linked to the Trust's strategic objectives, national priority indicators, Monitor governance ratings, CQUINs and local priorities.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare a Quality Report for each financial year.

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 patient safety, clinical outcomes and patient experience takes place at the Quality & Risk Committee. There are a number of committees and executive groups with direct responsibility for key aspects of the quality agenda reporting to the Quality & Risk Committee. The Patient Experience Committee reviews the data from the patient experience surveys and provides feedback to the Quality & Risk Committee. The Clinical Safety & Effectiveness and Patient Experience Committees inform the Quality & Risk Committee on relevant performance relating to the Trust's quality strategy and quality improvement plan. This is underpinned by quality walkabouts and continuous monitoring of defined quality indicators.

The inter-relationship between the indicators in the quality report and other measures of the Trust's performance (financial and operational) is reviewed monthly by 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. This included an internal audit of our assessment against the information governance toolkit during 2012. The Board of Directors takes further assurance from the External Auditor's review of the Quality Report.

Review of effectiveness

As Accountable 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 NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual report and other 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 Quality & 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. Strategic objectives, set out in Section 2.3 of the Annual Report, are derived from the priorities determined in the Trust's strategy.

During 2011 the Board reviewed the escalation arrangements within the governance structure and put in place a robust escalation framework. This ensures timely and effective escalation from directorates and specialist committees to the Board via the Trust Executive Group.

Executive Directors and their managers are responsible for maintaining effective systems of control on a day-to-day basis.

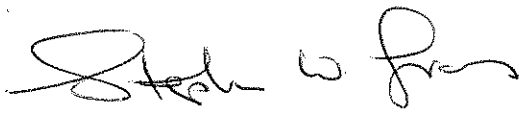
In accordance with the Internal Audit Standards for the National Health Service (April 2002), internal audit provides the Trust with an independent and objective opinion to the Accountable Officer, the Board of Directors and the Audit Committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

External Audit provide an opinion on the true and fair status of the Annual Report and Accounts and the adequacy of the Trust's management arrangements to ensure economy, efficiency and effectiveness in its use of resources.

Conclusion

No significant internal control issues have been identified and my review confirms that the West Suffolk Hospital NHS Trust has a generally sound system of internal controls that supports the achievement of its policies, aims and objectives.

Signed



Stephen Graves
Chief Executive

30 May 2012

5. Remuneration Report

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 objectives of the Committee are to:

- Make recommendations to the Board of Directors on the remuneration and terms of service of the Chief Executive, the Executive Directors and other staff as determined by the Board
- Determine targets for any performance related pay scheme contained within the Policy
- Review performance and objectives, and agree a policy for the remuneration of the Chief Executive, Executive Directors and other staff as determined by the Board
- Ensure that contractual terms of termination are fair and adhered to
- Make recommendations to the Board of Directors on staff pay awards
- Make recommendations to the Board of Directors on the level of any additional payments contained within the Policy (review annually in the light of future National Directors Scheme)
- Ensure that remuneration packages enable high quality staff to be recruited, trained and motivated and are within levels of affordability and are publicly defensible and amenable to audit
- Ensure Terms of Reference of the Remuneration Committee are available which should set out the Committee's delegated responsibilities and be reviewed and updated annually
- Report the frequency and members of Remuneration Committee in the Annual Report.

The Committee comprises the Chairman and NEDs of the Board of Directors. The Committee is chaired by the Senior Independent Director, The Chief Executive and Executive Director Workforce & Communications 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's Chair (or nominated representative) and at least two NEDs. A nominated representative for the Chair must be a NED.

The Committee acts with delegated authority from the Board of Directors.

The Committee meets as a minimum half yearly. Minutes are taken and a report submitted to the Board of Directors showing the basis for the recommendations.

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. Decisions to uplift salaries are based on this information, internal equity, affordability, whether there has been a significant change in a Director;s portfolio and thus responsibility. 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 has advised the Chairman on the expected level.

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 Chairman) based on the outcome of their annual appraisal.

WSFT'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

Prior to becoming an FT Non-executive Directors were paid in line with guidance issued by the Department of Health. Their terms and conditions of employment were also in accordance with this guidance. Arrangements as a FT are described in Section 2.6.

In the financial year the Directors costs increased to £1,059k from £968k. This increase was due to the effects of changes in directors during the 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 - This 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.

Pension Liabilities

WSFT made contributions totalling £10,121,000 to the NHS Pensions Agency in the year. Note 1 to the Trust's accounts provides further details as to the nature of the pension scheme and accounting practice in relation to its associated liabilities.

The median remuneration of all Trust staff is £27,185. The ratio of the midpoint of the banded remuneration of highest paid director to this figure is 7:1. This is calculated based on all staff employed as at 31 March 2012.

The following tables reflect the remuneration for the senior staff (Table A) and Pension entitlements for the senior staff (Table B). The figures in these tables have been subject to External Audit. As NEDs do not receive pensionable remuneration, there will be no entries in respect of pensions for NEDs.

Table A – Remuneration

Name and Title	4 Months to 31 March 2012			8 Months to 30 November 2011			2010/11		
	Salary Paid (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind rounded to nearest £100	Salary Paid (bands of £5000)	Other Remuneration (bands of £5000)	Benefits in Kind rounded to nearest £100	Salary Paid (bands of £5000)	Other Remuner-ation (bands of £5000)	Benefits in Kind rounded to nearest £100
	£000	£000	£	£000	£000	£	£000	£000	£
Mr R Quince – Chairman	5 – 10			10 – 15			20 – 25		
Dr J Benson – Non-executive Director	0 – 5			0 – 5			5 – 10		
Mr J Cullum – Non-executive Director							5 – 10		
Mr G Simons – Non-executive Director	0 – 5			0 – 5			5 – 10		
Mr B Stewart – Non-executive Director	0 – 5			0 – 5			5 – 10		
Mr S Turpie – Non-executive Director	0 – 5			0 – 5			5 – 10		
Mrs R Varley – Non-executive Director (Note 1)	0 – 5			0 – 5					
Mr S Graves – Chief Executive (Note 2)	45 – 50			90 -95			120 – 125		
Ms G Nuttall – Chief Operating Officer / Deputy Chief Executive	30 – 35		200	60 – 65		400	95 – 100		200
Mr C Black – Executive Director of Resources (Note 3)	35 – 40		300	70 – 75		300			
Dr D O'Riordan – Executive Medical Director	5 – 10	55 - 60		10 – 15	110 - 115		20 – 25	160 – 165	
Mrs J Bloomfield – Executive Director Workforce & Communications	25 – 30		800	55 – 60		1,600	75 – 80		1,400
Mrs N Day – Executive Director Chief Nurse	35 – 40		500	50 – 55		900	75 – 80		900
Mrs L Potter – Executive Director Finance & Information (Note 4)							90 – 95		
Mr A Graham – Executive Director of Major Projects (Note 5)	30 – 35			35 – 40					
Mr G Corser – Director of Strategy & Planning (Note 6)				25 – 30			75 – 80		

Table B1 – Pension Benefits to 30 November 2011

Name	**Real increase / (decrease) in pension at age 60 (bands of £2,500)**	**Real increase / (decrease) in pension lump sum at aged 60 (bands of £2,500)**	**Total accrued pension at age 60 at 30 November 2011 (bands of £5,000)**	**Lump sum at age 60 related to accrued pension at 30 November 2011 (bands of £5,000)**	**Cash Equivalent Transfer Value at 30 November 2011**	**Cash Equivalent Transfer Value at 31 March 2011**	**Real increase / (decrease) in Cash Equivalent Transfer Value**
	£000	£000	£000	£000	£000	£000	£000
S Graves	0 – 2.5	2.5 – 5.0	30 – 35	100 – 105	702	637	40
G Nuttall	(5.0 – 7.5)	(15.0 – 17.5)	20 – 25	65 – 70	334	361	(41)
C Black (Note 3)							
D O'Riordan	0 – 2.5	2.5 – 5.0	40 – 45	125 – 130	663	557	84
J Bloomfield	(0 – 2.5)	(0 – 2.5)	25 – 30	85 – 90	496	450	28
N Day	(0 – 2.5)	(0 – 2.5)	20 – 25	70 – 75	378	329	36
A Graham (Note 5)							

Table B2 – Pension Benefits to 31 March 2012

Name	**Real increase / (decrease) in pension at age 60 (bands of £2,500)**	**Real increase / (decrease) in pension lump sum at aged 60 (bands of £2,500)**	**Total accrued pension at age 60 at 31 March 2012 (bands of £5,000)**	**Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)**	**Cash Equivalent Transfer Value at 31 March 2012**	**Cash Equivalent Transfer Value at 30 November 2011**	**Real increase / (decrease) in Cash Equivalent Transfer Value**
	£000	£000	£000	£000	£000	£000	£000
S Graves	0 – 2.5	0 – 2.5	35 – 40	105 – 110	734	702	20
G Nuttall	(2.5 – 5.0)	(7.5 – 10)	20 – 25	60 – 65	321	334	(21)
C Black (Note 3)			20 – 25	65 – 70	317		
D O'Riordan	0 – 2.5	0 – 2.5	40 – 45	125 – 130	716	663	42
J Bloomfield	(0 – 2.5)	(0 – 2.5)	25 – 30	85 – 90	518	496	14
N Day	(0 – 2.5)	(0 – 2.5)	25 – 30	75 – 80	402	378	18
A Graham (Note 5)			30 – 35	90 – 95	449		

Note

1 R Varley was appointed as NED on 1 April 2011
2 S Graves was appointed as Chief Executive with effect from 10 May 2010
3 C Black was appointed as Executive Director of Resources with effect from 1 April 2011. Figures for prior periods relate to employment outside of the Trust and are therefore not available.
4 L Potter resigned as Executive Director of Finance and Information with effect from 31 March 2011.
5 A Graham was appointed as Director of Major Projects with effect from 4 July 2011. Figures for prior periods relate to employment outside of the Trust and are therefore not available.
6 G Corser resigned as Director of Strategy & Planning with effect from 31 July 2011
7 Real increases reflect the increase after allowing for inflation of 6% as prescribed by the NHS Pensions Agency

Stephen Graves
Chief Executive

6. Quality Report

6.1 Chief Executive's Statement

At West Suffolk Foundation Trust, WSFT, we promise to put patients first and to do everything we can to provide the best quality of care. Emphasis is placed on listening to patients and fully involving them in their treatment.

Patients tell us that they want to feel safe and cared for in a clean and comfortable environment, with professional staff who are courteous and respectful. Our Patients First Service Standards have been developed by patients and staff to help us create the experience our communities deserve.

What matters to patients and our Foundation Trust members determines our quality priorities. We take every opportunity to ask patients about how they were treated and their overall experience. Patient complaints and patient safety incidents are fully investigated so that lessons can be learnt and services continually improved.

The Board provides leadership in developing a culture of learning, and continuous quality improvement. During my regular walkabouts around the Trust I see the skill and dedication of staff who are living our Trust values of making sure everyone feels safe, cared for and confident in their treatment.

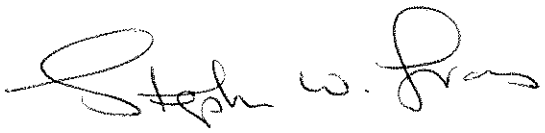
WSFT was awarded a prestigious national title at the Top Hospital Awards 2011 after being named the country's top hospital for the quality of care it delivers to its patients. The hospital picked up two winners' prizes and was highly commended in two further categories in the national 2011 Safety Express Awards. The Head of Nursing Development was presented with the "inspirational individual" award, which recognises staff who have inspired others to deliver quality services.

The Trust was also rewarded for successfully reducing patient falls, pressure ulcers, urinary tract infections and venous thromboembolisms (blood clots), important indicators of quality care. In addition, our Chief Nurse and Medical Director were highly commended in the senior leader category for their work to embed a culture of patient safety across the Trust.

This year our performance has continued to improve, including significant improvement for both falls and pressure ulcers. But there is no room for complacency and we know how and where we need to do better, notably to continue to improve the care of older people and people following a stroke.

All this was delivered against a backdrop of increasing financial pressures and the need to ensure that each pound spent is used to bring maximum benefit and quality of care to patients. The financial challenges are set to continue but quality will remain the main focus of our patient care.

In my view, the Quality Report 2011/2012 provides an honest and balanced account of the quality of the services we deliver.



Stephen Graves
Chief Executive

6.2 Quality structure and accountabilities

The Quality Report highlights the action WSFT is taking to improve the quality of services we provide. We have structured our priorities and measures according to the three domains of quality defined in High Quality Care for All, published in June 2008:

1. **Patient safety** - doing no harm to patients
2. **Clinical effectiveness** - measured using survival rates, complication rates, measures of clinical improvement and patient-reported outcome measures
3. **Patient experience** - care should be characterised by compassion, dignity and respect.

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 Quality & Risk Committee and its three subcommittees which ensure quality is delivered in a coordinated way by WSFT to support safe, effective and patient-focused healthcare. The subcommittees are:

(a) Clinical Safety & Effectiveness Committee – ensuring clinical procedures and practices are effective in protecting patients, visitors and staff, by ensuring compliance with national requirements, promote best practice and are effective in the identification and elimination or reduction of clinical risk
(b) Corporate Risk Committee – ensuring risk management, financial and workforce procedures are effective in promoting good business standards, protect the organisation, patients, visitors and staff, and comply with national standards and guidance
(c) Patient Experience Committee – ensuring exemplary customer and patient experience through the implementation of the Quality Improvement Strategy and Patients First initiative.

6.3 Priorities for improvement for 2012/13

The quality priorities for 2011/12 were reviewed along with a large number of other quality indicators reported to the Board on a monthly basis and other quality issues arising nationally and locally. From these and discussion with our service users and public FT members, the quality priorities for 2012/13 have been agreed.

During 2010 we canvassed FT members on a range of quality priorities and over 700 members ranked each issue according to what was important to them. During 2011, further opportunities have been taken to identify current issues of importance to patients through feedback at various events for FT members and the public.

Through the commissioning process NHS Suffolk has identified performance targets for quality and innovation that have directly influenced the way in which we measure performance against our priorities.

High Quality Care for all domains of quality	Patient safety		Patient experience	Clinical effectiveness
Our Patients First priorities	"I feel safe"		"I feel cared for"	"I feel confident"
Our quality goals 2011 - 2014	**To further reduce hospital associated infections**	**To achieve the highest levels of patient safety**	**To continuously improve the experience of patients**	**To achieve optimal outcomes and effectiveness**
Focus during 2012/13	Timely identification and management of patients at risk from infection	Achieving at least 95% harm free care	Improvements in communication, information and involvement –"No decision about me without me"	Ensuring patients receive specialist management and referral according to their individual needs
Our 2012/13 priorities	To maintain hospital MRSA bacteraemia at no more than 1 case between April 2012 and April 2013	To implement the "Safety Thermometer" to measure our performance in relation to pressure ulcers, VTE, falls and catheter care with the aim of achieving at least 95% harm free care by April 2014	Patients would recommend the service to their family and friends (Recommender score of at least 50)	To consistently achieve a HSMR that is below the expected rate
	To reduce hospital associated **C. difficile** infection to no more than 27 cases between April 2012 and April 2013	To consistently identify those patients at risk of dehydration and take action to address this	To ensure that all patients with learning disabilities and their carers have their needs assessed and reasonable adjustments made to enable a positive patient experience	To improve the care and management of people following a **stroke** in line with national targets and indicators
			To assess the experience of elderly patients and those with dementia against the dignity in care recommendations	To improve the effectiveness of midwifery input in encouraging breast feeding amongst new mothers through staff training and provision of information to mothers
				To carry out dementia screening and assessment for patients over 75 yrs and ensure specialist referral

Goal 1: To further reduce hospital associated infection
Our patients and public identified that reducing hospital acquired infection continues to be a main priority for them and an indicator of quality of care. The focus of our effort in 2012/13 will be on the timely identification and management of patients at risk from infection as this is felt to be the key for further improvement. The Trust has limited facilities for the isolation of patients who present an infection risk to other patients and therefore this issue is of particular importance.

A decision has been made to continue to measure our performance in relation to the reduction of hospital associated infection in terms of numbers of MRSA bacteraemia and Clostridium *difficile* as these are understood by the public and are often seen as an overall indicator of general standards of infection prevention and control.

Goal 2: To achieve the highest levels of patient safety
Over the last three years the Trust has focused on reducing the number of patients developing pressure ulcers and who fall in hospital and on the assessment and management of patients at risk of developing blood clots (Venous Thrombo-Embolism (VTE)). These issues are now being monitored through the NHS Information Authority under an initiative called the “Safety Thermometer”. The Safety Thermometer aims to achieve “95% harm free care”, and monitors pressure ulcers, falls , VTE prevention, and catheter associated urinary tract infections. The Trust has therefore identified the implementation of the Safety Thermometer as one of its patient safety priorities. The other priority identified for 2012/13 relates to the identification and prevention of dehydration in patients. This will be measured by the use of the dehydration risk assessment tool and the implementation of a quality improvement action plan. Along with nutrition, adequate hydration maintains well being, aids recovery, and helps to prevent complications. This complements the work previously carried out in the Trust to improve the nutritional care of patients.

Goal 3: To continuously improve the experience of patients.
Most of the issues that patients identify as priorities for them are related to customer care issues such as communication, information and involvement alongside staff behaviour and attitude in terms of caring, compassion, and the maintenance of privacy and dignity. The focus for 2012/13 under patient experience will therefore be on improving, communication, information and involvement - “no decision about me, without me”. Key measures of this will be the feedback from the patient experience surveys carried out continuously within the Trust and a focus on groups of patients in which these issues have been highlighted nationally such as people with learning disabilities or dementia and the elderly.

Goal 4: To achieve optimal outcomes and effectiveness
The overarching measure of effectiveness and clinical outcome is a reduction in deaths in our population (mortality) by helping people live longer. In addition, it has been identified that patients are treated more effectively and their outcomes are better if they are referred to, and managed by, specialist staff according to their individual needs. Our priorities for 2012/13 therefore focus on maintaining low mortality rates and monitoring care provided to groups of patients such as those with stroke, those suffering from dementia, and maternity patients.

6.4 Statements about the quality of services

This section of the Quality Report is prescribed by regulation. It provides a series of mandated statements from the Board which directly relate to the drive for quality improvement.

The statements provide assurance in three key areas:

- Our performance against essential standards and the delivery of high quality care, for example our registration status with the Care Quality Commission (CQC)
- Measuring our clinical processes and performance, such as participation in national clinical audit
- Providing a wider perspective of how we improve quality, for instance through recruitment in clinical trials.

Review of services

During 2011/12 the WSFT provided and/or sub-contracted 54 NHS services.

The WSFT has reviewed all the data available on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2011/12 represents all of the total income generated from the provision of NHS services by the WSFT for 2011/12.

Information about the quality of these services is obtained from a range of sources which address the three quality domains described early (safety, clinical effectiveness and experience). Key sources of intelligence are summarised in Table A. Many of these sources of information provide an indication of quality across more than one domain.

Table A: Key Sources of quality intelligence

Patient safety	Clinical effectiveness	Patient experience
• CQC registration and intelligence regarding compliance (e.g. Quality & Risk Profile (QRP) and self-assessment) • Trust-wide compliance monitoring, including: - Hand hygiene - Infection control - Pressure ulcers - Falls - VTE • Incident and claims analysis and national benchmarking (e.g. NRLS) • External regulatory and assessment body inspections and reviews, such as peer reviews and NHS Litigation Authority • National safety alerts • Infection control, including high impact interventions • Quality walkabouts	• CQC registration and intelligence regarding compliance (e.g. QRP) • Trust-wide compliance monitoring, including: - Stroke care - Mortality - Re-admission • Clinical benchmarking data from Dr Foster Intelligence • National and local clinical audits • Self-assessment against national standards and reports, for example NICE guidance • PROMs • NHS Outcomes Framework	• CQC registration and intelligence regarding compliance (e.g. QRP) • Trust-wide compliance monitoring, including: - Patient environment - Patient experience - Same sex accommodation - Pain management - Nutrition • Complaints analysis • PALS themes • Patient and staff feedback, including local and national surveys and patient/staff forums and communication • “Back to the floor” visits by Board members and Governors • Feedback from FT members and Governors • “In your shoes” event • Community conversations

Quality improvement is connected from “Board to Ward” - this is achieved through two-way communication between the Board and operational areas (e.g. wards) across WSFT. The monthly

Quality Report to the Board provides an organisational overview, but is underpinned and informed by review and by ward by ward analysis with action planning at service level. Delivery of improvement at an operational level is managed through directorate Quality & Performance Meetings but is also tested through observational visits by Board members and Governors as part of the weekly Quality Walkabouts.

Participation in clinical audits

During 2011/12, 38 national clincial audits and four national confidential enquires covered NHS services that WSFT provides.

During 2011/12 WSFT participated in 95% of national clinical audits and 100% of national confidential enquires of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquires that WSFT was eligible to participate in during 2011/12 are listed in Annex A. Alongside the number of cases submitted for audits or enquires for which data entry was completed during 2011/12, are listed each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports of 14 national clinical audits and 228 local clinical audits were reviewed by the provider in 2011/12 and the action WSFT intends to take to improve the quality of healthcare provided is listed in Annex A.

Research & Development

The number of patients receiving NHS services provided or sub-contracted by WSFT that were recruited during that period to participate in research approved by a research ethics committee was 1,230. This continues the high level of recruitment achieved in 2010/11 (1,112 patients recruited).

WSFT was involved in conducting 118 active (open to recruitment) clinical research studies in 2011/12 of which 73% were National Institute for Health Research (NIHR) portfolio studies, approving 38 new studies.

There were an additional 11 clinical staff participating in research approved by a research ethics committee at WSFT during 2011/12. These staff participated in research covering 11 medical specialties. The most research-active areas at WSFT are (in descending order) cancer, women and children's health and anaesthetics. In addition, research activity in the areas of rheumatology and stroke is increasing in the forthcoming year.

Also, during 2011/12, 14 publications resulted from our involvement in NIHR research, which shows our commitment to learn and to improve patient outcomes and experience across the NHS.

Goals agreed with commissioners

A proportion of WSFT's income in 2011/12 was conditional on achieving the quality improvement and innovation goals agreed between WSFT and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

In 2011/12 WSFT had 12 goals containing 19 quality measures/targets covering the following topics:
:

1. Reducing avoidable death, disability and chronic ill health from venous thrombo-embolism (VTE)
2. Reducing the number of patients acquiring pressure ulcers
3. Reducing the number of inpatient falls and referral of patients to an appropriate falls prevention service on discharge
4. Improving responsiveness to the personal needs of patients
5. Capturing monthly experience data and demonstrating service improvements
6. Improving the assessment and monitoring of nutrition in hospital and the review of nutritional supplements on discharge
7. Increasing the understanding of hydration needs of patients and risk assessment
8. Prompt identification and management of the deteriorating patient
9. Delivering effective stop smoking advice and referral to the stop smoking service
10. Establish an Emergency Assessment Unit (EAU) consultants advice and guidance service to support clinical management in the community
11. Active therapy to enable stroke patients to meet their rehabilitation goals
12. Root Cause Analysis (RCA) to be undertaken on patients readmitted up to 28 days after discharge from hospital

WSFT achieved improvements against all of the goals and met all the targets set, apart from the level of increase required to the national patient survey “responsiveness to patient needs” questions.

In 2012/13 a greater percentage of the Trust’s income will be conditional on achieving the CQUIN targets. This amounts to a total of £2,875,000.

CQUIN goals have been finalised for 2012/13 with the Commissioners to reflect local and national priorities. These will cover:

- Reduction of Venous Thrombo-Embolism (VTE)
- Improvement of patient experience
- Improvement in awareness and diagnosis of dementia
- Implementation of the “Safety Thermometer” to reduce harm from pressure ulcers, falls, urinary tract infection and VTE
- Using opportunities to give health messages relating to prevention of illness through “Every Contact Counts”
- Improvement in recognition and management of the deteriorating patient
- Improvement in the quality of discharge summaries
- Integrated Care

What others say about us

WSFT is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional. The CQC has not taken enforcement action against WSFT during 2011/12.

WSFT has not participated in special reviews or investigations during the reporting period.

WSFT has been subject to two visits during 2011/12:

- In October 2011 WSFT had an on-site assessment by the CQC as part of the CQC routine schedule of planned but unannounced reviews. This focused on seven outcomes for which WSFT is registered: Outcome 1: Respecting and involving people who use services, Outcome 4: Care and welfare of people who use services, Outcome 5: Meeting nutritional needs, Outcome 7: Safeguarding people who use services from abuse, Outcome 8: Cleanliness and infection control, Outcome 12: Requirements relating to workers and Outcome 16: Assessing and monitoring the quality of service provision.

All seven outcomes were judged to be compliant, with a small number of minor concerns identified during the visit relating to explanations of delays in patients' discharge whilst waiting for take-home drugs, timeliness of staff response to patients' requests, explanation of treatment programmes, patient information boards, food temperature maintenance and cleaning schedules for toilets in public areas.

An action plan was developed to respond to each minor concern listed in the CQC final report following the October 2011 visit. This action plan was formally accepted by the Quality & Risk Committee and each action given a timescale for delivery. At the Quality & Risk Committee on 30 March 2012 it was confirmed that all actions had been fully implemented within the agreed deadlines and an evidence portfolio was offered to demonstrate this. The completed action plan has been submitted to the CQC.

- In March 2012 WSFT had an on-site assessment by the CQC as part of the CQC schedule of planned unannounced reviews of organisations providing termination of pregnancy services, as part of Outcome 21: Records. The WSFT was assessed as compliant with the requirements of the outcome.

During 2011/12 WSFT consolidated its approach to the review of the CQC Quality & Risk Profiles (QRPs). The QRP collates performance and intelligence information about an organisation which can be used to inform and drive quality improvement. The Quality & Risk Committee monitors the completion of actions taken to address concerns identified in WSFT's QRP.

In 2011/12 WSFT updated the self assessment for each CQC Outcome to reflect current practice and captured evidence to demonstrate compliance using the CQC's structured Provider Compliance Assessment (PCA) templates. During 2011/12 WSFT also undertook a series of spot check audits across clinical areas to assess the implementation of the processes described in the PCA. These audits were undertaken in a style similar to that used by the CQC for their on site assessment visits. The audits served a two-fold purpose, both to provide assurance of compliance and to raise awareness of the requirements of the CQC *Essential standards of quality and safety* amongst staff working in the areas assessed.

WSFT has strengthened its arrangements for monitoring CQC compliance using structured ward based self-assessment, this is supported by external peer review. This will continue to support improvement at an operational level and provide further assurance on compliance to the Board through its reporting and accountability structure.

The Health and Safety Executive (HSE) visited WSFT in October 2011 to review the management of falls. As a result of this visit and subsequent correspondence a meeting was held in March 2012 with the local HSE inspector to review arrangements for managing health and safety and progress with the management of falls. The meeting was supportive of the arrangements in place and future plans.

Data quality

WSFT submitted records during 2011/12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and valid General Medical Practice Code are shown below:

	Valid NHS number	Valid General Medical Practice Code
Admitted patient care	99.6%	100%
Outpatient care	99.7%	100%
Accident and emergency care	98.5%	100%

WSFT's Patient Administration System (PAS) is unable to automatically source NHS Numbers from the national spine (database).

When compared with available benchmark data for NHS Numbers WSFT performs better than both NHS Midlands & Eastand national compliances for Admitted patient care and Accident & Emergency (A&E) care. Outpatient care compliance is better than national compliance and the same as the NHS Midlands & Eastcompliance.

WSFT's Information Governance Assessment Report overall score for 2011/12 was 79% (Green). The Trust achieved a score of at least two for all requirements, within a range of zero to three.

WSFT will be taking the following actions to improve data quality:

- Continue to conduct data quality audits on WSFT data to ensure its completeness and accuracy, and feedback audit results to the clinicians involved in the recording of that data
- Continue to increase awareness of the importance of accurate data recording throughout WSFT
- Continue to work towards improving self assessment scores for Connecting for Health's Information Governance Toolkit (IGT).

WSFT was subject to the Payment by Results (PbR) clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Data field	PbR audit error rate	Internal audit error rate
Primary Diagnosis	10.9%	9.0%
Secondary Diagnosis	5.2%	7.6%
Primary Procedure	7.2%	4.2%
Secondary Procedure	3.0%	7.6%

These rates are not directly comparable to previous years' figures because of the different methodology used in this year's PbR audit. The audit sample was taken directly from the Secondary Uses Service (SUS) and covers 94 Finished Consultant Episodes (FCEs) selected randomly from the Trauma and Orthopaedics specialty which was agreed by the host commissioner, and 100 FCEs selected randomly from all activity across the Trust covered by a mandatory PbR tariff. The results of this audit should not be extrapolated further than the actual sample audited.

The internal audit work demonstrated an improvement on last year. Performance exceeded the level 2 Information Governance Toolkit requirements for Primary Diagnosis (at least 90% accuracy) and exceeded level 3 requirements for Primary Procedure (at least 95% accuracy) and Secondary Diagnosis and Procedure (at least 90% accuracy).

6.5 Performance against 2011/12 priorities

This section of the Quality Report provides a summary of performance against last year's priorities.

Patient Safety	**Priority 1**: To reduce hospital acquired infections in line with national and local targets
	Priority 2: To improve patient safety
Patient Experience	**Priority 3**: To continuously improve the experience of patients using our services
Clinical Effectiveness	**Priority 4**: To improve clinical outcomes and effectiveness

For each priority a summary is provided of the rationale for selection, current status, steps taken to improve performance and initiatives to be implemented in 2012/13. Unless otherwise stated the data provided is sourced from internal reporting arrangements.

Priority 1: To reduce hospital acquired infections in line with national and local targets

Objectives:

(a) To reduce hospital associated Methicillin-resistant *Staphylococcus* aureus (**MRSA**) bacteraemia in line with national and local targets
(b) To reduce hospital associated *Clostridium difficile* (**C. difficile**) infection in line with national and local targets
(c) To improve the **management of antibiotics** as demonstrated by achieving at least 100% compliance with the WSFT's antibiotic policy.

(a) To reduce hospital associated Methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections in line with national and local targets

Description of the issue and rationale for selection
Continued focus on MRSA has remained a priority for WSFT in order to consolidate last year's achievements, thus minimising hospital associated MRSA bloodstream infections. MRSA bloodstream infections are potentially life threatening and therefore prevention is vital. During 2010/11 WSFT exceeded the reduction targets set by external bodies and was recognised for its achievement of zero MRSA bloodstream infections. Nationally, MRSA bloodstream infections are seen as one of the indicators of overall infection prevention and control performance and are also identified by the public as a priority issue. A target of no more than 2 hospital associated MRSA bloodstream infections was set for WSFT.

Additional action taken during 2011/12
- Audits to examine compliance with MRSA screening protocols and decolonisation procedures
- Education and re-emphasis of correct procedures for obtaining blood culture samples and MRSA screening procedures
- Training and assessment of aseptic non-touch technique when carrying out clinical procedures
- Audits of recording of Visual Infusion Phlebitis (VIP) scores
- Continuation of universal screening of patients for MRSA on admission to hospital.

Current status
The introduction of universal screening of patients on admission to hospital ensures that if patients are already colonised with MRSA when coming into hospital, this is identified quickly and action can be taken to reduce the risk of this affecting their recovery and also reduce the risk of spread to other patients. Ongoing monitoring of clinical practice to ensure that staff adhere to best practice guidance when carrying out procedures that have a high impact on the development of infection has also continued throughout the year.

Given the tremendous achievement during 2010/11 of no MRSA bloodstream infections the target for WSFT this year was no more than two hospital acquired MRSA bloodstream infections. There was one case of MRSA bloodstream infection in July 2011 although this was not felt to be clinically significant for the patient and there have been no further incidences for the year.

Initiatives to be implemented in 2012/13
- Improving consistency of assessment and documentation of inflammation at intravenous line sites using the standardised scoring tool (VIP scores)
- Encouraging improvements in compliance with decolonisation protocols and re-screening for MRSA.

(b) To reduce hospital associated *Clostridium difficile* (C. *difficile)* infection in line with national and local targets

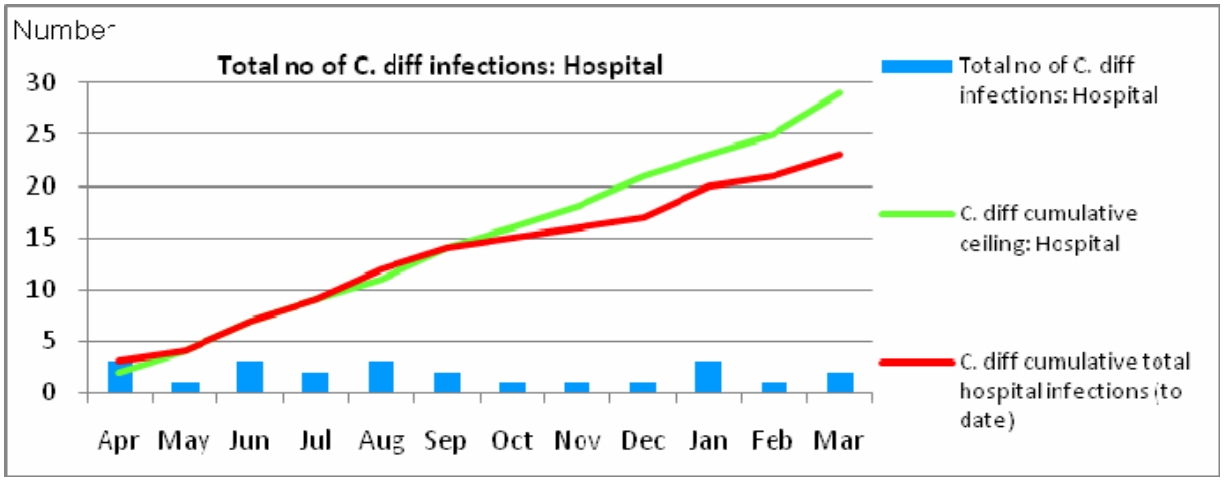
Description of the issue and rationale for selection

As with MRSA, the incidence of hospital associated *C. difficile* diarrhoea is monitored nationally and further reductions in incidence continue to be a priority. Dramatic reductions have been achieved over the last five years and a challenging ceiling of 27 cases has been set for 2012/13. A target was set for WSFT for 2011/12 of no more than 29 hospital associated cases.

Steps taken to improve during 2011/12

- Implementation of initiatives identified under the antibiotic prescribing element of these accounts
- Continuation of RCAs completed on all cases of C. *difficile* diarrhoea
- Changes to cleaning policies, including utilisation of a hydrogen peroxide vapour machine to further enhance deep cleaning programmes
- Review of the ward kitchen arrangements
- Multidisciplinary review of ward environments
- External review commissioned to provide secondary assurance of policies and procedures.

Current status



We recorded 23 cases of hospital acquired C. *difficile* infection in 2011/12, thus achieving the target set. This included an outbreak of five cases on one ward in the autumn. The investigation carried out as a result, identified issues related to leadership and the prompt escalation of problems as areas for learning. RCAs completed on all cases this year concluded that the majority were unavoidable, but inappropriate antibiotic prescribing was felt to be a contributory factor in a number of cases.

The area used to isolate patients with C. *difficile* was closed in January 2012 due to reduced numbers of cases and winter bed pressures. During this period C. *difficile* infected patients were placed in side rooms. WSFT is currently looking at alternatives for the provision of isolation facilities which would enable patients with a range of infectious conditions to be isolated from other patients to reduce cross infection. This includes the provision of doors at the entrance to bays and the development of an isolation unit.

Initiatives to be implemented in 2012/13

- Gain approval for the provision of appropriate isolation facilities
- Implementation of new Department of Health guidance on laboratory testing of samples for C. *difficile* and impact assessment.
- Review and updating of the antibiotic guidelines.

(c) To improve the management of antibiotics as demonstrated by achieving 100% compliance with WSFT's antibiotic policy.

Inappropriate antibiotic use and the emergence of strains of bacteria that are resistant to antibiotics are now major global issues and a constant concern for healthcare. Patients in hospital, especially the critically ill, are at significant risk of infection with an expanding range of organisms that are resistant to most antibiotics as well as C. *difficile* associated diseases.

A key factor in the reduction in C. *difficile* has been the introduction of tight controls on the use of antibiotics and this is also important to limit the emergence of other resistant strains of bacteria. Adherence to local policy on the use of antibiotics is therefore important to ensure that they are used as effectively as possible. WSFT therefore identified this as a priority and has a robust audit programme to monitor the use of antibiotics.

Steps taken to improve during 2011/12

- Ensuring that locum doctors have access to, and follow, WSFT antibiotic policy
- Continuation of the antibiotic audit programme
- Revision of the drug charts to ensure that antibiotics are reviewed 48 hours after initiation.

Current status

An ambitious target of 100% compliance with WSFT antibiotic policy was set for 2011/12 following improvements during 2010/11 culminating in 90% compliance by year end. There have been fluctuations in compliance through the year, with an average compliance of 93%.

One recent issue that has affected compliance has been the tendency for junior medical staff, who rotate between hospitals during their training, to prescribe an antibiotic that is not included in WSFT antibiotic policy but which is used routinely at neighbouring hospitals. The lead microbiologist is discussing the issue with Consultant colleagues to decide whether this antibiotic should be included when the policy is reviewed or whether further steps need to be taken to limit its use.

Initiatives to be implemented in 2012/13

- Revision of antibiotic policy
- Strengthen the antibiotic audit programme by increasing the number of criteria within the audit

Priority 2: To improve patient safety

Objectives:

(a) To assess at least 90% of admissions for risk of **Venous Thrombo Embolism (VTE)** and provide prophylaxis to all patients at risk
(b) To reduce the number of patients who **fall** in hospital
(c) To reduce the number of avoidable grade 3 and 4 **pressure ulcers**.

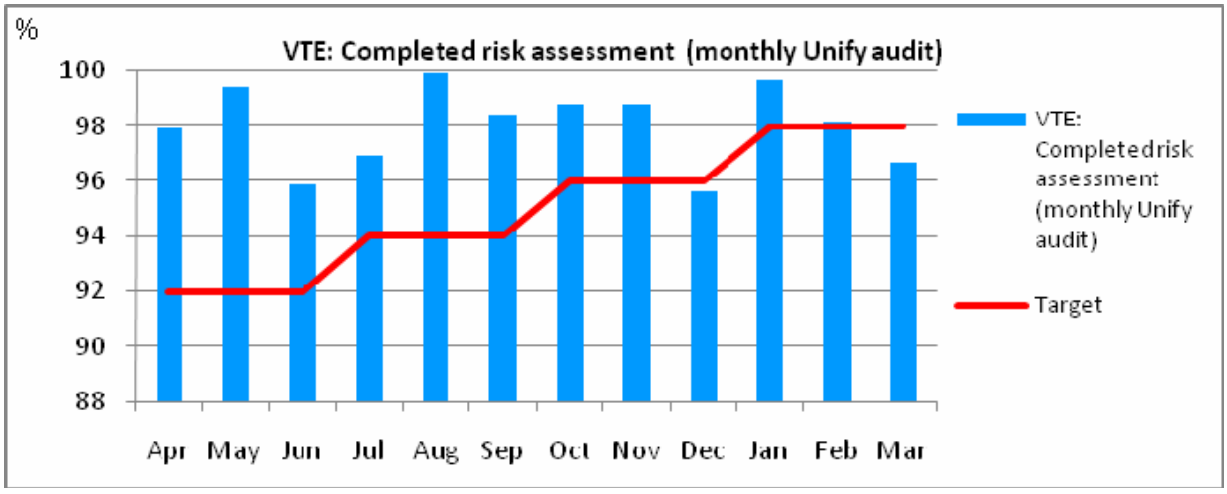
(a) To assess at least 90% of admissions for risk of Venous Thrombo Embolism (VTE) and provide prophylaxis to all patients at risk

VTE or blood clots can occur following surgery or other periods of immobility and potentially result in acute or chronic disability and even death. The Department of Health (2007) identified that there were 16,670 recorded deaths in England and Wales where pulmonary embolism and deep vein thrombosis, collectively known as VTE, were mentioned on the death certificate. The momentum to reduce harm and deaths associated with VTE increased in 2010 and the Department of Health Commissioning for Quality and Innovation (CQUIN) payment framework linked the uptake of risk assessment with payments to trusts and compliance with risk assessment is reported monthly.

Steps taken to improve during 2011/12

- Re-design WSFT drug chart to include risk assessment documentation and pre-printed orders for preventative treatment
- Feedback to individual Consultants on compliance data
- Development of WSFT policy for VTE
- Review and monitoring through ward Quality Walkabouts

Current status



In 2010/11 carrying out risk assessments improved from 44% in April 2010 to 95% in March 2011. This was maintained and exceeded during 2011/12 with small fluctuations from month to month demonstrating the need to maintain a focus on this issue and the importance of regular feedback to staff. Quarterly audits also examined whether all patients identified as being at risk from VTE were given appropriate preventative treatment. The results from these audits showed at least 98% compliance throughout the year.

Initiatives to be implemented in 2012/13

- Renewed focus on the prescribing and dispensing of VTE prophylaxis
- Continuation of the steps taken in 2011/12 to maintain good practice in relation to risk assessment
- Ongoing review and monitoring through ward Quality Walkabouts.

(b) To reduce the number of patients who fall in hospital

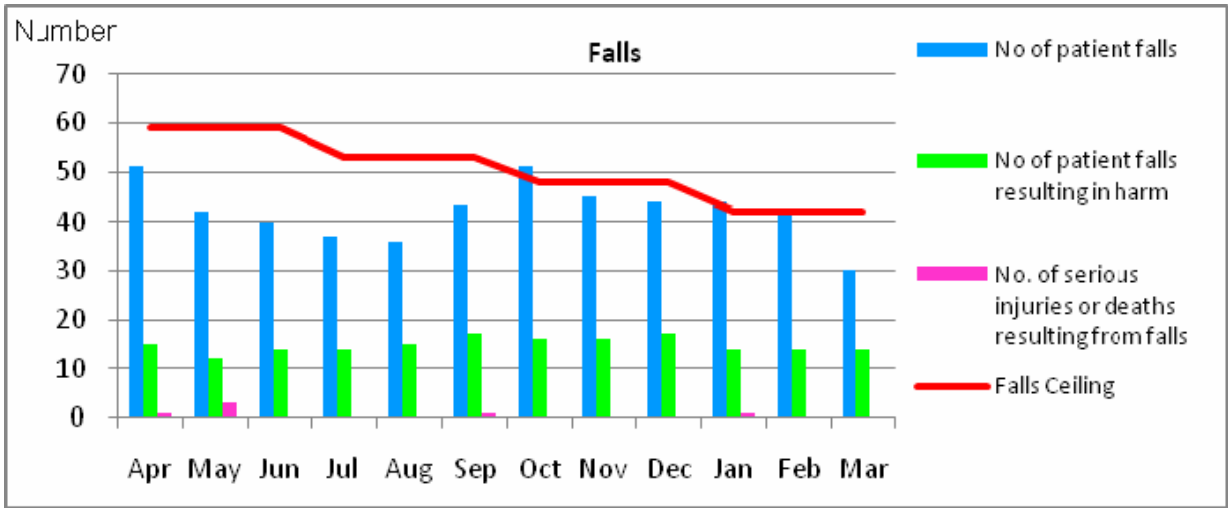
Description of the issue and rationale for selection
Slips, trips and falls are one of the most common patient safety incidents reported to the National Patient Safety Agency (NPSA) and one of the initiatives within the Department of Health QIPP Safe Care work stream "Safety Express" programme. Falls result in pain and distress for the patient, and may delay discharge or result in a loss of long term independence, or even death. Patients of all ages fall and the conditions which require them to be admitted to hospital can make them more vulnerable to falls. However, the elderly are at the greatest risk of falling in hospital and they are also more likely to suffer serious injury.

The need to maintain patient safety and prevent falls has to be balanced with the need to promote independence, maintain privacy and dignity and provide rehabilitation. As identified by the Patient Safety First Campaign – "a patient who is not allowed to walk alone will very quickly become a patient who is unable to walk alone. Addressing inpatient falls and fall-related injuries is therefore a challenge for all health care organisations".

Steps taken to improve in 2011/12
- Implementation of the QIPP Safety Express initiative
- Introduction of intentional rounding to ensure that call bells are in easy reach, patients are offered drinks as well as the opportunity to go to the toilet and that other comfort needs are addressed
- Introduction of the falling leaf symbol above patients beds to identify patients at risk of falling
- Onward referral of patients at risk from falls on discharge from hospital to an appropriate falls prevention service
- Piloting of the national "Safety Thermometer" initiative which aims to achieve at least "95% harm free care"
- Review and monitoring through ward Quality Walkabouts.

Current situation
Challenging targets for the reduction of falls during 2011/12 were set for WSFT. The number of falls per month was approximately 65 at the end of 2010/11 and considerable further reductions have been achieved in 2011/12 with an average of 42 per month throughout the year, although there have been some month on month fluctuation in numbers. Considerable emphasis has been placed on identifying any further action that can be taken to preventing falls in patients with dementia as these are a particularly vulnerable patient group.

When comparing our falls rate with those of other acute hospitals, we compare favourably. For example, an average 800 bed acute hospital trust will have about 24 falls per week (NICE). Our incidence at average performance would therefore be 13 falls/week (447 beds). In March we averaged 7 falls per week (30 falls over 31 days).



Initiatives to be implemented in 2012/13

- Full roll out and implementation of the national “Safety Thermometer” initiative
- Provision of non-skid slippers/socks. Most patients are provided with stockings to prevent deep vein thrombosis and non-slip versions of these have recently become available
- Consider the potential of integrated programmes with physiotherapy to improve muscle strength and balance
- Ongoing review and monitoring through ward Quality Walkabouts.

(c) To reduce the number of avoidable grade 3 and 4 pressure ulcers

Description of the issue and rationale for selection

Pressure ulcers are areas of damage to the skin and underlying tissues due to pressure, shear or friction on vulnerable areas of the body. Patients in hospital are prone to pressure ulcers due to reduced mobility and their medical condition/treatment. However, the majority of pressure ulcers are preventable through the provision of high standards of preventative care. WSFT has reduced the incidence of pressure ulcers over the last five years and is committed to achieving “zero” avoidable pressure ulcers.

Steps taken to improve in 2011/12

- Development of a pressure ulcer prevention group and improvement plan
- Purchase of additional pressure relieving mattresses, cushions and heel protectors
- Improvement in the availability of pressure relieving mattresses at weekends
- Provision of improved pressure relieving mattresses for A&E
- Increased education and training of staff
- Review and monitoring through ward Quality Walkabouts.

Current situation

WSFT identified that none of the grade 3 and 4 pressure ulcers reported during 2011/12 were avoidable This is a significant achievement and a result of a coordinated approach to resolving issues and taking practice forward. There has been a focus on taking early action to prevent the development of grade 2 pressure ulcers and ensuring that accurate assessment takes place.

Initiatives to be implemented in 2012/13

- Full roll out and implementation of the national “Safety Thermometer” initiative
- Maintenance of education and training on risk assessment and documentation
- Ongoing review and monitoring through ward Quality Walkabouts.

Priority 3: To continuously improve the experience of patients using our services

Objectives:

(a) To achieve at least 90% of patients **choosing to use the hospital** again in similar circumstances
(b) To achieve at least 85% satisfaction rating in response to our internal **patient experience surveys**
(c) To achieve at least 90% compliance with **environment and cleanliness** standards.

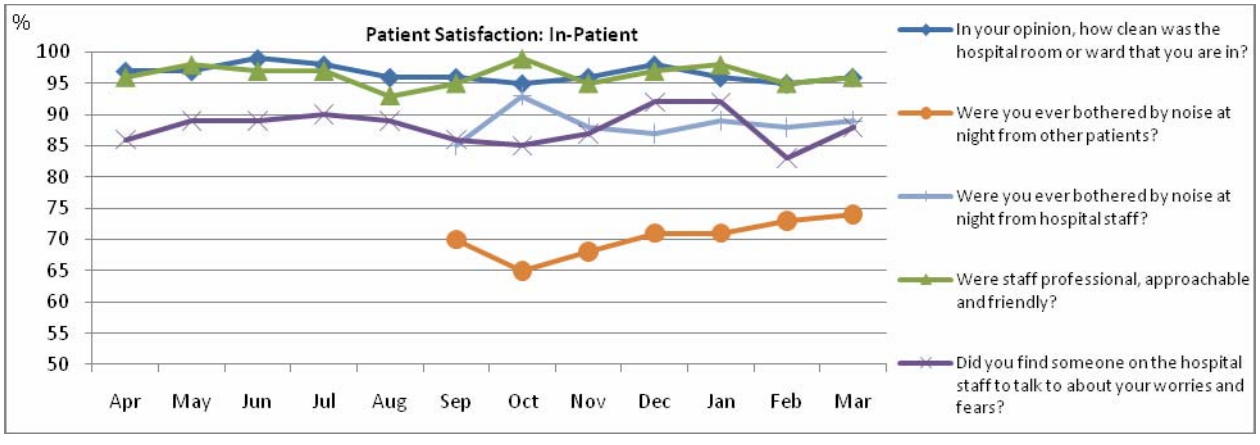
(a) To achieve at least 90% of patients choosing to use the hospital again in similar circumstances <u>and</u>
(b) To achieve at least 85% satisfaction rating in response to our internal patient experience surveys

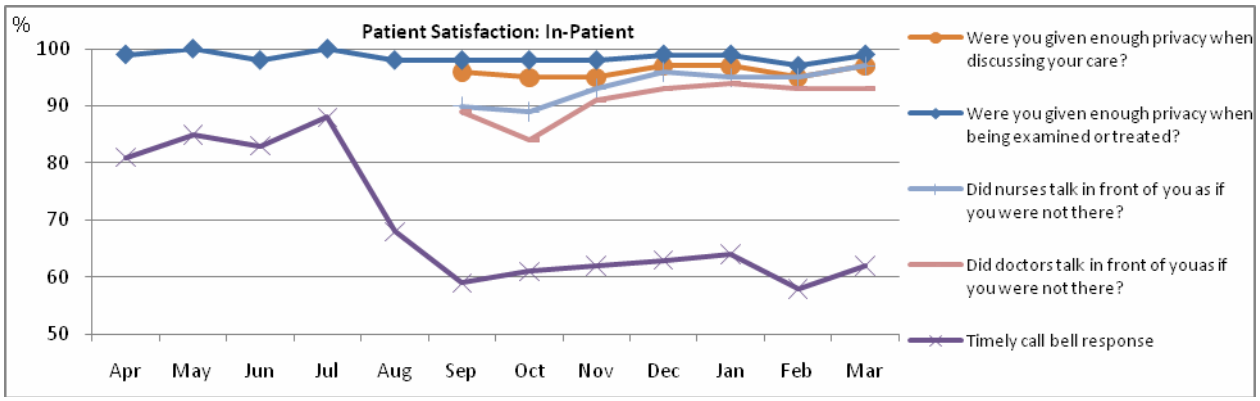
Description of the issue and rationale for selection

Patients are at the centre of everything we do and delivering the best possible experience for every one of our patients is a major priority for WSFT. Our Patients First programme focuses on this and sets out the standards we are committed to delivering consistently. In order to evaluate our success and ensure that we address areas of concern for patients, it is important that we obtain regular feedback from patients themselves.

Current situation

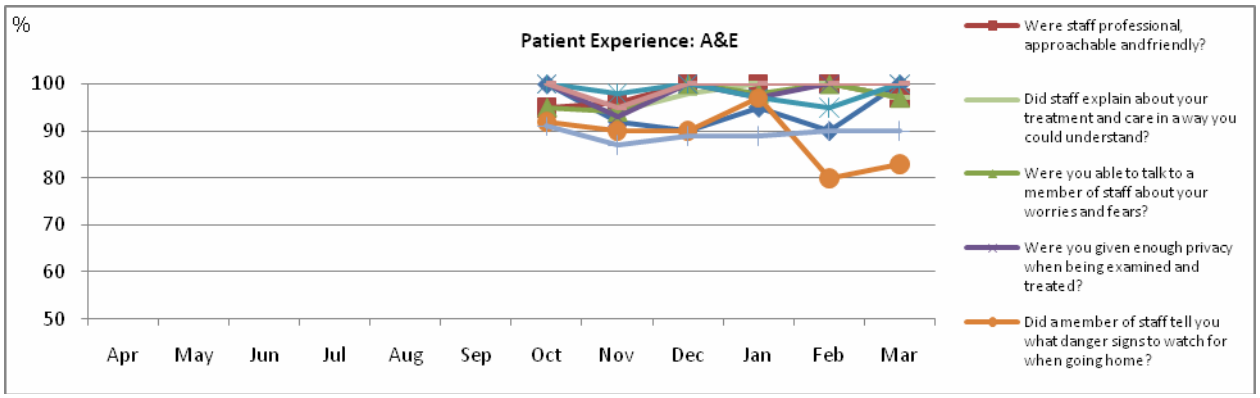
Over recent years we have developed a comprehensive system of ongoing patient experience surveys for patients on all our inpatient wards and in short stay areas such as the Day Surgery Unit, Eye Treatment Centre, A&E department, Outpatients department and Pre-assessment Clinic. During August/September 2011 we standardised our approach to obtaining feedback across WSFT and invested in an electronic system that utilises touch screen technology. At this point we also reviewed the questions we ask patients, although the focus has remained on aspects of care in which we scored less well in the national patients' surveys. In addition to the specific questions we ask about patient experience, all our surveys ask patients whether they would choose to use the hospital again in similar circumstances for themselves, their family and friends as the final question. Over 95% of patients responded positively to this question each month. The monthly response rate is approximately 8% of inpatients and approx 500 responses from other departments.





The graph above provides a breakdown of experience in relation to the more specific questions asked within the surveys. Patients' perception of time waited for a response to their call bells scored poorly. The scoring for this question was changed in September when the new survey system was introduced to reflect the more stringent scoring used in the national patient survey rather than the 3 minute Trust target that had previously been used. Therefore the drop in score relates to this rather than a longer wait for the bell to be answered. However, timely response to call bells remains a focus across WSFT and on wards where new call bell systems have been introduced it is possible to monitor actual response times. Early results suggest that the average response time is approximately 2 minutes.

Improvements have been seen in several of the experience issues in the A&E department.



Initiatives to be implemented in 2012/13

- Implementation of the Strategic Health Authority "Patient Revolution" with associated net promoter question. The net promoter question identifies the proportion of patients who would recommend the service to family and friends
- Focus on improving the experience of people with dementia and those with a learning disability.

National Patient Surveys

Each year WSFT participates in a number of national patient surveys. A national outpatient survey was carried out during 2011 to obtain feedback on the experience of people attending Outpatient Departments in June 2011. WSFT receives a benchmark report that compares the results with those of other trusts. WSFT scored very well for most questions, sitting on or above the threshold for the top 20% of trusts for 22 of the 39 questions and had no scores in the bottom 20% of trusts indicating a performance in line with the best in the country.

A national survey of inpatients was also carried out during 2011. The results indicate that the Trust's performance is "about the same" as other Trusts in all of the categories examined, but improved its national position amongst trusts to 46th in 2011, from 120th in 2010. The Trust demonstrated significant improvements as compared to the previous year in questions related to:

- Waiting time from arrival at the hospital to getting a bed on a ward
- Sharing a sleeping area with patients of the opposite sex
- Using the same bathroom or shower as patients of the opposite sex
- Noise at night from other patients
- Written information on discharge about what you should or should not do
- Danger signals to watch for after leaving hospital
- Information given to family on how to care for you
- How well the doctors and nurses worked together
- Being asked for views about the quality of care
- Length of time waiting for a response when using the call bells

Considerable effort has been made to improve in all aspects of care identified above, this has included the introduction of written information attached to patients take home medication, and revision of written information on discharge. However, some of these aspects remain a focus for further improvement as the overall score is lower than we would wish.

(c) To achieve at least 90% compliance with environment and cleanliness standards.

Description of the issue and rationale for selection

Achievement of high standards of cleanliness is essential in the prevention of infection and is also vital in the maintenance of public confidence. The standard of upkeep of the environment is important to the perception of cleanliness and also affects the ease in which cleanliness can be maintained. Independent monthly audits of both environmental issues and cleanliness are carried out in all areas and reported to the Trust Board. It is felt that this is an issue that is fundamental to achievement of both high levels of patient experience and quality of care.

Steps taken to improve during 2011/12
- Dishwashers introduced to enable wards to sanitise all patient drinking utensils to minimise the risk of cross-contamination.
- Implementation of a floor maintenance team to improve standards of cleanliness
- The ward deep cleaning programme has continued
- Monthly training days for all housekeeping staff
- Patient chairs have been replaced on several wards
- Purchase of 79 new electric beds which facilitate moving and positioning of patents.

Current situation
Overall standards have remained high during 2011/12 with an overall score of 90% or above throughout the year. The main issues identified have related to re-decoration requirements or soft furnishings such as patient chairs that have budgetary implications. The Patient Environment Action Group has prioritised these issues to ensure that they are addressed systematically.

Initiatives to be implemented in 2012/13
- Introduction of the new Publicly Available Specification (PAS) 5748 for the planning and measurement of cleanliness in hospitals.

Priority 4: To improve clinical outcomes and effectiveness

Objectives:

(a) To consistently achieve a Hospital Standardised Mortality Ratio (**HSMR**) that is below the expected rate
(b) To improve early identification and management of the **deteriorating patient**
(c) To reduce re-admissions of patients within 28 days of a hospital admission
(d) To improve the care and management of people following a **stroke** in line with national targets and indicators.

(a) To consistently achieve a Hospital Standardised Mortality Ratio (HSMR) that is below the expected rate

Description of the issue and rationale for selection

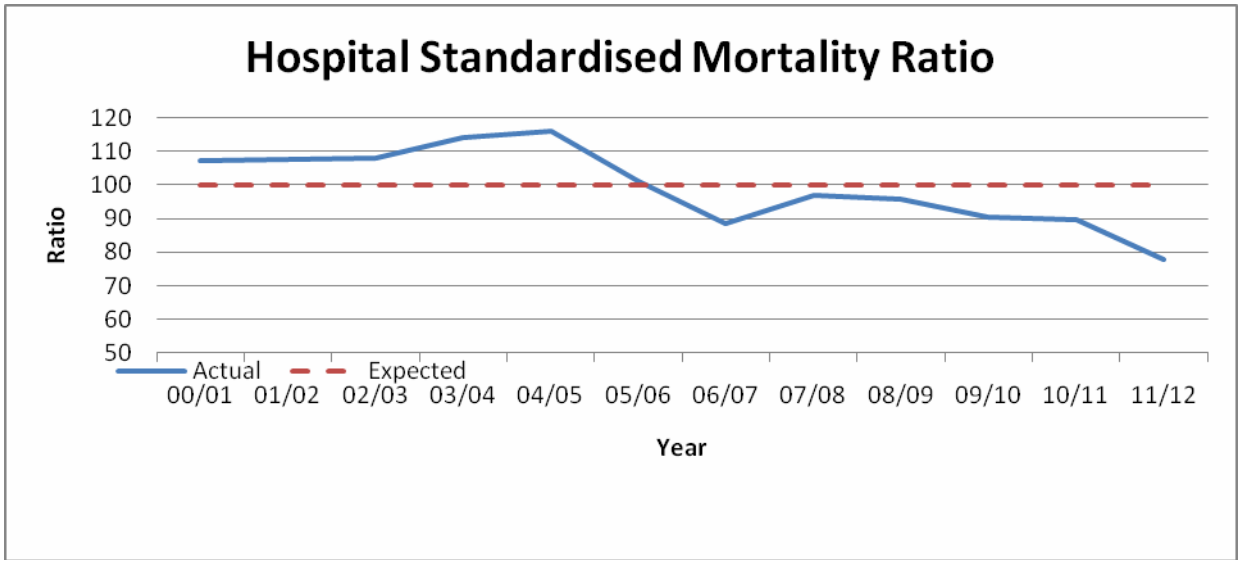
HSMR is one of the key measures that are considered to be indicators of system wide safety and quality. The HSMR compares the number of patient deaths with the expected number taking into account patient factors such as age, diagnosis, and other medical conditions. An HSMR of 100 indicates that the expected number of patients died. If the HSMR is above 100, more patients died than expected, whilst an HSMR of below 100 means that fewer patients died than expected.

The NHS Institute for Innovation and Improvement (2007) reported that a reduction of just 10% in the HSMR would mean 100,000 lives saved per year in England alone.

Steps taken to improve in 2011/12

- The critical care outreach team increased to provide a 24 hour, 7 day a week service
- Review of deaths occurring in hospital.

Current status



Source: Dr Foster Intelligence

The HSMR has been significantly better than the national benchmark during 2011/12 as can be seen in the graph. The rate is reported to the Trust Board monthly along with a breakdown of mortality rate for the five Dr Foster - How Safe is Your Hospital indicators. These indicate that WSFT is performing well in regard to reducing mortality. Dr Foster is introducing a new indicator in relation to mortality called the Summary Hospital-level Mortality Ratio (SHMI). This includes deaths occurring outside the hospital within 30 days of discharge and includes all diagnostic groups. In addition it makes allowances for palliative care. WSFT will utilise the information gained from this to further examine mortality rates.

Initiatives to be implemented during 2012/13
- 7 day a week working to provide enhanced senior medical staff cover at weekends
- Continued focus on the diagnoses and procedures that are the most common cause of death.

(b) To improve early identification and management of the deteriorating patient

Description of the issue and rationale for selection
Early identification of patients at risk of deterioration is vital if optimal outcomes are to be achieved for the patient. WSFT has an established critical care outreach team to provide prompt input when patients on the general wards deteriorate and an early warning score is completed at every set of observations to ensure that early signs of deterioration are recognised.

Current status
During 2011/12 RCAs were carried out on all patients who had a cardiac arrest on the general wards in order to inform future care and embed learning. The results were reviewed and a number of general themes were identified. Recommendations were made and implementation is being monitored by the Patient Safety Implementation Group.

Initiatives to be implemented during 2012/13
- Continuation of RCAs for cardiac arrests
- Review and audit of medical and nursing documentation.

(c) To reduce re-admissions of patients within 28 days of a hospital admission

Description of the issue and rationale for selection
There has been a national focus on the number of patients who are re-admitted to hospital within 28 days of their initial admission as it is felt that many of these should be avoidable. Re-admission with a similar problem within a few weeks of the initial admission may indicate that the patient was discharged inappropriately or that the issues arising after discharge could have been foreseen and addressed during the admission. WSFT felt that it was important to examine a selection of re-admissions to obtain a fuller understanding of the issues and identify whether any themes or actions could be identified to reduce the number of re-admissions.

Current situation
During the year a substantial number of re-admissions were examined. In 83% of cases, no actions were identified retrospectively that might have been taken before discharge to prevent re-admission. Issues identified for the remaining 17% relate to close working with other agencies such as social services (to identify alternatives to admission), mental health services, and specialist community teams (e.g. falls prevention service, stoma care, community palliative care teams).

Initiatives for 2012/13
- Develop and establish pathway criteria and obtain support from Social Services and the Palliative Care Teams in the community
- Develop standardised approach to involving the family/carer on discharge through case conferences outlining the risks of re-admission (where Social Services' input is considered necessary).

(d) To improve the care and management of people following a stroke in line with national targets and indicators

Description of the issue and rationale for inclusion
Stroke is the main cause of adult disability in England and is responsible for a large proportion of deaths. Improving the care and management of patients following strokes can have a significant impact on outcome for the patient. This is a national priority and every trust reports on a number of performance indicators on a monthly basis.

Steps taken to improve during 2011/12

- Introduction of 24 hour, seven day a week, thrombolysis (clot busting) service to enable initial treatment to be provided at WSFT
- Further reduction in the number of non-stroke patients admitted onto the stroke unit
- Recruitment of additional senior nursing staff to provide high level stroke expertise out of hours
- Development of early supported discharge, allowing patients to return home as soon as possible to continue their rehabilitation
- Further increase in the number of stroke patients that have a CT brain scan within one hour of arrival at WSFT.

Current status
During the year a number of initiatives have been implemented to improve the care and management of stroke patients. The number of beds on the Stroke Unit has been increased and where possible one empty bed is ring fenced for use for the emergency admission of patients following a stroke. However, the number of patients admitted with stroke has increased this year and this has caused some challenges for WSFT. Whilst we have not achieved all of the targets set consistently through the year our performance when compared to other trusts in the region is good.

Initiatives to be implemented in 2012/13

- Further development of stroke rehabilitation programmes to allow early supported discharge
- Continue to provide ongoing knowledge & skills training for registered and non registered staff across WSFT to support service delivery out of hours
- Continue to promote the stroke strategy
- Introduction of SNNAP (quality & data monitoring tool)
- Reduce length of stay for stroke patients.

6.6 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 NHS Suffolk. Performance against these can be found within the Trust Board reports.

National targets and benchmark indicators

Effectiveness Measures	2011/12 (Apr-Jan)	2010/11	2009/10	2008/09	2007/08	National Avg.	Peer group Avg. (as at 2/12)
Hospital Standardised Mortality Rate (HSMR)	**78.0**	89.6	90.5	95.7	97.0	100	90.3
Length of Stay - Relative Risk	**85.0**	78.7	81.6	84.6	87.1	100	93.1
Readmissions - Relative Risk	**95.4**	102.9	104.8	97.3	95	100	93.2
Death in Low-Risk Diagnosis Groups	**0.60**	0.49	0.57	N/A	N/A	0.76	N/A

Source: Dr Foster Intelligence

The Trust has performed well against the Effectiveness Measures. The review processes put in place to share the lessons learned from re-admissions has helped to improve performance in this indicator. Although the Length of Stay indicator has risen when compared to 2010/11 the performance is still below the national benchmark of 100 (which denotes average performance) and also below the peer group average. Death in Low-Risk Diagnosis Groups has increased, but this change is not statistically significant and raises no clinical concerns.

National Targets	2011/12 Target	2011/12 Actual	2010/11 Actual	2009/10 Actual	2008/09 Actual	2007/08 Actual
C *difficile* - Hospital acquired	29	**23**	37	44	72	252
MRSA bloodstream infections	2	**1**	0	9	11	14
31 Day Diagnosis to Treatment Wait for First Treatment: All Cancers	96%	**100%**	100%	100% (Q4 only)	100% (Q4 only)	N/A
18-week maximum wait from point of referral to treatment (admitted patients)	90%	**99.94%**	99.90%	99%	95%	87%
18-week maximum wait from point of referral to treatment (non-admitted patients)	95%	**100%**	100%	99%	98%	96%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	95%	**98.13%**	96.86%	96.88%	97.10%	96.90%
A&E Unplanned re-attendance rate	<5%	**1.39%**	N/A	N/A	N/A	N/A
Total time spent in A & E (95th percentile)	< 4 hours	**03:59**	N/A	N/A	N/A	N/A
A&E Left department without being seen	<5%	**1.49%**	N/A	N/A	N/A	N/A
A&E Time to initial assessment (95th percentile)	<15 minutes	**00:50**	N/A	N/A	N/A	N/A

Time to treatment in department (median) - CDM	<60 minutes	**00:42**	N/A	N/A	N/A	N/A
62 Day - Urgent GP Referral to Treatment Wait for First Treatment: All Cancers	85%	**88.00%**	89.14%	89%	97% (Q1-3) , 87% (Q4)	98%
31 Day Wait for Second/Subsequent Treatment: Anti Cancer Drug Treatments	98%	**100%**	100%	100%	N/A	N/A
31 Day Wait for Second/Subsequent Treatment: Surgery	94%	**100%**	100%	100%	N/A	N/A
All Cancer Two Week Wait	93%	**94.43%**	93.72%	95%	99% (Q1-3), 93% (Q4)	100%

The Trust has maintained and, in most cases, shown improved performance against 2010/11 levels. All the measures, with the exception of stroke patients eligible for an urgent brain scan have met or exceeded the target levels of performance. The in-year performance against this metric has improved significantly when compared to 2010/11.

National Targets	Target (2011/12)	2011/12 Actual	2010/11 Actual
Stroke - 75% of patients with low risk transient ischaemic attacks (TIAs) have access to MRI or carotid scan within 7 days of the onset of symptoms (seen, investigated and treated)	65%	**71%**	57%
Patients with suspected stroke, who are eligible for an urgent brain scan (as defined by NICE criteria) to have access to a scan in the next slot within usual working hours or less than 60 minutes out of hours as defined from time to time by the Anglia Stroke & Heart Network	100%	**82%**	45%
80% of stroke patients spending at least 90% of their stay on a stroke unit	80%	**86%**	67%
Stroke - >60% people who have a TIA and are high risk (ABCD 2 score 4 or more) are scanned and treated within 24 hours of referral but not admitted	60%	**73%**	55%

Incident reporting and learning

Reporting and learning from incidents within WSFT is recognised as critical to maintaining and improving quality. The investigation of incidents is undertaken to ensure effective learning takes place within the area in which the incident occurred and more widely across the organisation. As part of this learning themes have been identified and prioritised during 2011/12. These have informed service improvements for:

- Falls (avoidable)
- Pressure ulcers (avoidable)
- Management of the patient with dementia
- Medication errors
- Infection Prevention
- Discharge Planning Documentation
- Recording and handover of patient transfer through the hospital
- Information Governance
- Assurance of Blood Transfusion policy and practice
- Unexpected deaths
- Re-admissions > 24 hours from discharge
- Maternity reporting processes.

Action to address these themes is monitored and reported to the Board and reflected in WSFT's priorities for quality improvement during 2011/12.

WSFT has conducted weekly Quality Walkabouts to different clinical and non clinical areas specifically focused on the themes identified or linked to serious incidents. These have included a focus on falls, pressure ulcers, nutrition & hydration and the care of patients with dementia.

WSFT has continued to build and strengthen the arrangements for managing Serious Incidents Requiring Investigation (SIRI). The Board takes the lead on this process and reviews the management, investigation and learning from SIRIs on a monthly basis. The total number of SIRIs reported relating to 2011/12 was 45. These can be broken down into incidents which touch on a number of themes including falls, pressure ulcers, infectious outbreaks, incidents involving patient data loss and obstetrics.

The Trust proactively encourages staff at all levels to engage with the investigation of SIRIs and significant learning continues to take place. The Falls Prevention Group meets on a regular basis and has developed a long term action plan to reduce the numbers of unavoidable falls. Ongoing improvements have been seen with the implementation of an intentional 'rounding' programme called the Red Flag Checklist which ensures that patients are regularly reviewed to ensure their needs are met throughout the day and night and reduces the frequency of patients attempting to go the bathroom unsupervised. The Trust has invested in appropriate footwear for all patients at high risk of falls to ensure that where possible the risk of slipping can be reduced. Ongoing work is taking place to review medications which might be indirectly linked to falls. Trends in analysing the root causes of patient falls has highlighted these often occur in bathrooms and the Trust is currently engaged in reviewing the layout of bathrooms to ensure call bells are within reach, rails are appropriately fitted and pedal bins are placed near a rail to ensure patient stability.

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The Pressure Ulcer Prevention Group also meets on a regular basis to review incidents and ensure that lessons can be learned regarding hospital acquired pressure ulcers. Training for pressure ulcer identification has been implemented across the Trust and specific manuals are available on wards to prompt early escalation. The process for ensuring timely access to specialist equipment has been reviewed to support the management of patients at risk of pressure ulcers.

The Trust has conducted a single comprehensive investigation into the infectious outbreaks that have occurred in the year and collaborative working with the Community Healthcare providers has been highlighted to address the issue of transmission of infectious diseases from the community into the acute setting. The promotion of the Admission Avoidance Scheme will be a priority for all healthcare providers in the coming months.

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The Trust identified three serious incidents relating to information governance. None of these were reportable to the Information Commissioner. Lessons were learned in regards to different modes of communication (faxes) in the Trust, and patient confidentiality.

Incident Reporting

	2008/09	2009/10	2010/11	2011/12
Personal accidents/ill health	1,868	1,652	1,458	**1,072**
Total incidents reported	4,701	4,105	3,859	**3,655**

The total number of personal accidents / ill health incidents reported in 2011/12 is 1,072. This is a decrease of 386 from the last financial year. The main type of incident being reported is slips, trips and falls of which there were 699 (reducing from 1,078 in 2010/11), this accounts for the overall reduction in reported incidents. WSFT encourages systematic reporting of all falls and a Falls Group meets on a regular basis to discuss the issues and future targeted action. The action against this quality priority area is described earlier in the report.

Complaints Management

WSFT is committed to providing an accessible, fair and effective means of communication for those persons who wish 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.

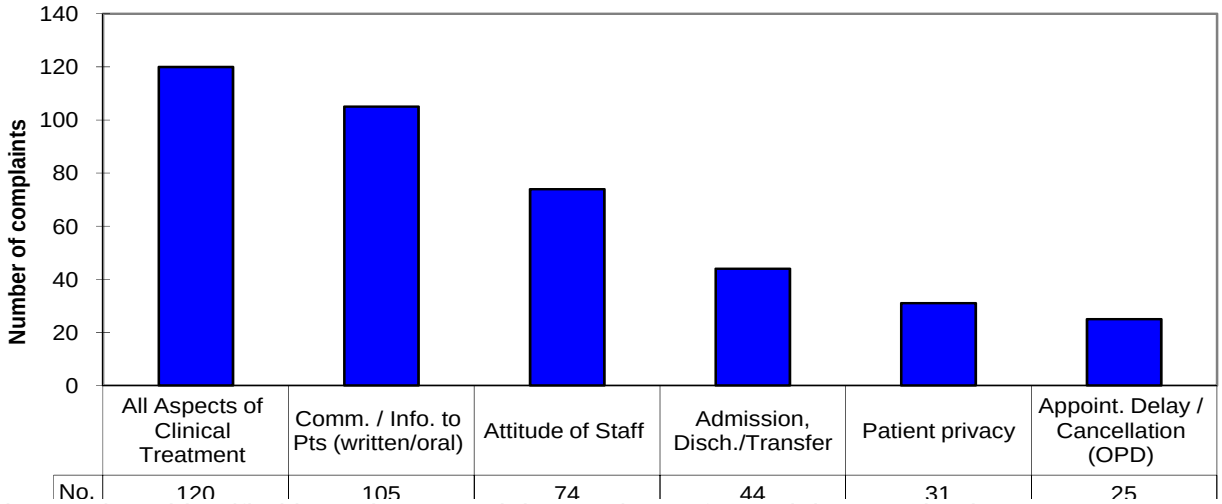
Complaints are reviewed with Service Managers and Matrons to ensure that learning takes place, issues are addressed and trends identified. Examples of learning are detailed below. Themes and trends are also reviewed by the Patient Experience Committee.

WSFT received 280 formal complaints during 2011/12, an increase of 60 from 2010/11. The Board of Directors monitors complaint analysis and learning on a monthly basis as part of the quality reporting arrangements. Through this process the increase in complaints has been kept under review with a particular focus on communications and privacy & dignity. WSFT is currently undertaking further work to benchmark its complaint levels with other trusts. As of 30 April 2012 88% of complaints received during 2011/12 were resolved with the first response. Of the 280 complaints a meeting between staff and the complainant was, or is being arranged in 10 cases to assist with resolving concerns, either prior to any written response or following an initial written response.

Complainants who are dissatisfied with the Trust's response can refer their concerns directly to the Parliamentary and Health Service Ombudsman for an independent review. The Parliamentary and Health Service Ombudsman did not accept any cases from WSFT received by them for independent review. This indicates satisfaction with the manner in which the complaints were handled by WSFT.

The main themes and trends remain static and are described below.

Category of complaint



Note: the numbers identified here do not total the numbers of complaints received as many complaints have more than one category.

As well as responding and learning from individual complaints WSFT identifies themes and trends from local complaints and national publications, such as the Parliamentary and Health Service Ombudsman. Learning from complaints has supported WSFT's quality priorities and other service improvements including:

- Educational programmes set up for staff regarding different stoma equipment and how to deal with leakage problems

- Junior doctor induction in Accident & Emergency to include information about examination of small children, including guidance on specific questions to ask
- E-Learning package to be developed for annual assessment of medication calculations
- Some wards to develop information booklets for patients and relatives to include contact numbers, details of visiting, Ward Manager and Matron's names and how to contact. Also information about how to raise a concern.

Managing compliments
A total of 450 compliments have been formally logged during 2011/12. These figures do not include letters/cards complimenting staff that are received on the ward and not shared with the Complaints Office.

There were many general letters of thanks for the care received, support given, and consideration shown. Themes also included excellent team working, staff attitude and skills, professionalism, having a proactive approach, offering a calm environment and having excellent communication skills.

A quote from one such letter is provided below:

"I am writing to you regarding my father, during his time at the hospital he was cared for by a wide range of staff. On behalf of my family I would like to thank all of your staff for the care and attention he received. In particular, I would like to commend all your nursing and auxiliary staff for their continued kindness…."

NHS Litigation Authority assessment

The NHS Litigation Authority (NHSLA) provides insurance for NHS organisations. As part of this scheme a series of standards are defined and trusts assessed against them to demonstrate compliance and good practice in relation to governance, safety and clinical care. There are two sets of standards relevant to WSFT covering acute and maternity services.

Each of the NHSLA risk management standards are made up of 50 criteria (both clinical and non-clinical) with three levels of compliance:

- Level 1 (policy) – the process for managing risks has been described and documented
- Level 2 (practice) – the process for managing risks, as described in the approved documentation at Level 1 is in use
- Level 3 (performance) – the process for managing risk, as described in the approved documentation at Level 1, is working across the entire organisation. Where deficiencies have been identified through monitoring, action plans must have been drawn up and changes made to reduce the risks.

In 2011/12 WSFT was successful in maintaining Level 2 compliance with the acute standards and was assessed as Level 1 compliant against the Maternity standards. Maternity services took the decision to consolidate its position against the standards and have a three year programme to achieve Level 3 compliance.

National Patient Safety Alerts (NPSA)

A national system exists to issue and manage safety alerts targeted to address issues of significant risk. WSFT monitors progress with the implementation of these safety alerts through monthly reports to the Board. If an alert passes the deadline without completion, an entry is made onto the Trust Risk Register. This includes the actions required to become fully compliant with the alert.

There are currently two alerts outstanding relating to:

1. SPN/2008/014 –'Right Patient, Right Blood'

2. NICE/NPSA/PSG/2007/001 – Technical Patient Safety Solutions for Medicines Reconciliation on admission of adults to hospital.

Progress to achieve compliance is managed through WSFT's Operational Steering Group and monitored by the Board.

Learning disabilities

During 2010/11 the WSFT self-assessed against the recommendations of the national Ombudsman's report "Six Lives" about the care of people with Learning Disabilities. As a result, additional training on learning disabilities has been provided to at least one member of staff in every ward and department. It was also added to the mandatory training programme for staff from August 2011 to ensure that awareness regarding the needs of people with learning disabilities is strengthened.

Information leaflets such as the complaints leaflet and an explanation of the consent process have been made available in easy read format. A flag has also been added to the Patient Administration System (PAS) to alert staff to the fact that the patient has a learning disability. A further self assessment was carried out in January and February 2012 against the East of England Learning Disabilities Framework which provided a gold standard framework for Trusts. This was externally validated and an improvement plan developed to further improve services for people with Learning Disabilities.

Dementia

Following publication of the first National Audit of Dementia (2010), a two year work plan was developed to improve the care and management of people admitted to the hospital with dementia. The Trust's Dementia Strategy Steering Group identified priorities for actions, to be driven through four work streams:

Work Stream 1: National Audit and National Guidance
Work Stream 2: Dementia Pathway
Work Stream 3: Patient and Carer Experience
Work Stream 4: Training and Development

The Trust, in collaboration with other healthcare providers, has been successful in obtaining funding for a Workforce Dementia Training and Development Project. This is a Suffolk-wide project, including WSFT, Ipswich Hospital and Suffolk Community Healthcare. Each Trust has its own respective trainer and WSFT hosts the project lead and administration support. The team has developed training packages for staff groups, documentation and is developing key messages to be delivered at each contact with staff. Training commenced at the end of September 2011. In addition, we have been reviewing the patient pathways and have started to implement new practices to support people with dementia such memory boxes, a specialised pain assessment tool, "this is me" documentation to give staff more information about the patients' likes, dislikes and things that are important to them.

National staff survey

In the 2010 Staff Survey the WSFT was placed within the Top 20% in 14/38 of the Key Findings. The recent 2011 Staff Survey has shown an improvement, with WSFT achieving results within the Top 20% in 23/38 of the Key Findings – a 9 point increase on the previous year's score. The number of Key Findings placed in the Bottom 20% rose by 2 points, from 2/38 in 2010 up to 4/38 in 2011.

This brings the total number of positive findings for 2011 to 34/38 and the total number of negative findings to 4/38.

6.7 Development of the Quality Report

WSFT has continued its commitment to listening to the views of our service users and FT members in developing the priorities set out in the Quality Report and its format and content.

At the end of 2010 the Trust asked all its members to identify the most important quality measures for reporting in the accounts. Over 700 members ranked their priorities and these were collated. Following this exercise members who had expressed an interest in discussing this further were invited to a Quality Matters workshop where these priorities were further explored and patients described how they felt the softer elements should be interpreted and could be measured.

During 2011/12 we have built on this work through FT membership engagement events. These provide an opportunity to seek views on our current and future quality priorities. The results of these consultation exercises are reflected in the format and content of these accounts.

In preparing the Quality Accounts we also sought the views of:

- NHS Suffolk
- Suffolk Health Scrutiny Committee
- Suffolk Local Improvement Network (LINk)
- Our Governors.

Commentary from these organisations is detailed in Annex B. As a result of the feedback received, changes were made to improve readability and structure the content to fit with the quality domains. The Board of Governors which includes representation from the public we serve, our staff and identified partner organisations also reviewed the content and layout of the Quality Report, including the priorities for improvement.

Annex A: Participation in clinical audit

This Annex provides detailed information to support the Clinical Audit section of the Quality Report.

Table 1: National audits relevant to the Trust during 2011/12

Audit title	Participated (Yes/No)	Cases submitted	Percentage compliance
Peri-and Neo-natal			
Perinatal mortality (MBRRACE-UK)	Yes	20	100
Neonatal intensive and special care (NNAP)	Yes	389	100
Children			
Paediatric pneumonia (British Thoracic Society)	Yes	18	100
Paediatric asthma (British Thoracic Society)	Yes	10	100
Pain management (College of Emergency Medicine)	Yes	30	60
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	12	100
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	105	100
Acute care			
Emergency use of oxygen (British Thoracic Society)	Yes	16 wards	100
Adult community acquired pneumonia (British Thoracic Society)	Yes	54	100
Non invasive ventilation - adults (British Thoracic Society)	Yes	Active to end May	
Pleural procedures (British Thoracic Society)	Yes	20	100
Cardiac arrest (National Cardiac Arrest Audit)	Yes	110	100
Severe sepsis & septic shock (College of Emergency Medicine)	Yes	30	100
Adult critical care (ICNARC CMPD)	Yes	365	74
Potential donor audit (NHS Blood & Transplant)	Yes	24	100
Seizure management (National Audit of Seizure Management)	Yes	20	100
Long term conditions			
Diabetes (National Adult Diabetes Audit)	Yes	79	100
Chronic pain (National Pain Audit)	Yes	Not applicable - pilot audit	
Ulcerative colitis & Crohn's disease (UK IBD Audit)	Yes	10	100
Parkinson's disease (National Parkinson's Audit)	Yes	30	100
Adult asthma (British Thoracic Society)	Yes	9	100
Bronchiectasis (British Thoracic Society)	Yes	11	100
Heavy menstrual bleeding (RCOG National Audit of HMB)	No	-	-
Elective procedures			
Hip, knee and ankle replacements (National Joint Registry)	Yes	807	100
Elective surgery (National PROMs Programme)	Yes	893	100
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	0	No cases*
Cardiovascular disease			
Acute Myocardial Infarction & other ACS (MINAP)	Yes	268	100
Acute stroke (SINAP)	No	-	-
Heart failure (Heart Failure Audit)	Yes	240	100
Cancer			
Lung cancer (National Lung Cancer Audit)	Yes	117	84%
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	175	100
Oesophago-gastric cancer (National O-G Cancer Audit)	Yes	495	100
Trauma			
Hip fracture (National Hip Fracture Database)	Yes	314	100
Severe trauma (Trauma Audit & Research Network)	Yes	81	100
Blood transfusion			
Bedside transfusion (National Comparative Audit of Blood Transfusion)	Yes	40	100
Medical use of blood (National Comparative Audit of Blood Transfusion)	Yes	32	100

Health promotion			
Risk factors (National Health Promotion in Hospitals Audit)	Yes	100	100
End of life			
Care of dying in hospital (NCDAH)	Yes	44	100
NCEPOD			
Bariatric Surgery	Yes	0	No cases*
Cardiac Arrest Procedures	Yes	2	100
Peri-Operative Care	Yes	116	100
Surgery in Children	Yes	0	No cases*

* No cases – means that WSFT participated in the audit but no cases were identified for submission during the audit period.

Table 1: Action from national audit reports

Report	Actions taken
National audit of provision and outcomes of mastectomy and breast reconstruction surgery. Fourth annual report.	WSFT was already compliant with the recommendations within the report. Identified areas of further improvement were: a three month post discharge follow-up with patients, to ascertain levels of satisfaction (now in place); and a sensitive aspect of care identified that would benefit from a patient information leaflet was the benefits/effects of combined mastectomy and breast reconstruction surgery (currently in progress).
National Diabetes audit-paediatric summary 2009/2010	No recommendations contained within the report as it contained summary data only. Work continues to embed and monitor the actions and subsequent changes to practice identified from the last main audit.
Parkinson audit 2010 report	WSFT did not have any local results from this audit report as we were unable to take part last year. The department has made a commitment to take part in the next audit.
UK Inflammatory bowel disease audit 3rd round	Patients are currently able to request a copy of their consultation notes; complex patients receive a written statement of their management plan. There has been an action identified to develop this for a great number of patients.
Multiple sclerosis audit	Self assessment against the audit recommendations identified access to a psychologist for patients with MS should be followed up. This is currently underway through a programme of improvement.
National care of the dying audit	WSFT performed well against the audit, especially in the areas of access to information in the last days or hours of life, managing the symptoms of the end of life and ensuring the Liverpool care pathway is completed. Identified a review of the written information leaflets provided to support conversations both for the patients and relatives to cover all areas of care including after death.
Report of the National Audit of Dementia Care in General Hospitals 2011	This is a large area of development for WSFT: the recommendations from the audit report have been linked into the Trust's Dementia work plan to be achieved in the next 12-24 months. The development work is led by the Dementia Strategy Group.
BTS emergency oxygen audit 2011 analysis	WSFT continued to perform well in the audit, the guidance for the use of oxygen has been reviewed and continues to support good practice in the Trust.
BTS pleural procedures 1 June 2011 to 31 July 2011 (national audit period)	A summary of results was published with no recommendations. The Trust did not take part in this round of audit but has taken part in more recent rounds where action can be more easily identified.
BTS paediatric pneumonia analysis 1 November 2010 - 31 January 2011 (national audit)	The audit reflected on the antibiotic management of patients with Paediatric Pneumonia. A new guideline suggests amoxicillin as the most appropriate antibiotic. WSFT is already working in line with this practice.
National Sentinel Stroke clinical audit 2010 round 7	The recommendations have been self assessed and a gap analysis undertaken to identify possible actions which would need to be taken to achieve full compliance. A programme of actions for consideration is in progress led by the Stroke Group.

National lung cancer audit 2011	The area of development identified by the report was the involvement of the specialist nurse in patient care and the subsequent level of data collection for that area of activity, which is now under review.
NCEPOD death after paediatric surgery 2009	The recommendations have been self assessed and a gap analysis undertaken to identify possible actions which would need to be taken to achieve full compliance. A programme of actions for consideration are in progress led by the Paediatric Surgery Multidisciplinary Group
NCEPOD preoperative care 2010	The recommendations have been self assessed and a gap analysis undertaken to identify possible actions which would need to be taken to achieve full compliance. A programme of actions for consideration is in progress led by the Surgical Directorate Governance Steering Group.

Annex B: Comments from third parties

Board of Governors

The WSFT has only recently gained Foundation Trust status and the Board of Governors, with support from the hospital management, is adapting to its new role. A major part of the Governors' role is to represent the concerns and aspirations of the public in the catchment area of the Trust and to influence its strategic plans.

The governors fully support the Board of Directors' commitment to improving the already high standard of care for our patients.

To aid and support this we, the governors, have planned the following:

- Regular contact with patients and their supporters
- Capturing patients' feedback and sharing this with hospital management
- Taking part in "Quality Walkabouts"
- Membership of a range of quality and governance related committees and groups
- The Membership Committee – encouraging the public to join as members of the Foundation Trust and engaging with these members to take an interest in the hospital
- Support regular clinical talks for FT members and the public (Medicine for Members), including chronic obstructive airway disease (COPD) and ophthalmology
- Review information received from the Board of Directors, holding the Directors to account and challenging appropriately.

We look forward to reporting on the progress and continuing improvements in next year's report and would like to take this opportunity to thank all the staff and volunteers for their considerable dedication and hard work which has made the West Suffolk NHS Foundation Trust the respected and valued institution that it is.

NHS Suffolk

NHS Suffolk, as the commissioning organisation for West Suffolk NHS Foundation Trust, confirms that the Trust has consulted and invited comments from NHSS including West Suffolk Clinical Commissioning Group regarding the Quality Account. This has occurred within the agreed timeframe and NHSS is satisfied that the Quality Account incorporates all the mandated elements required.

NHSS has reviewed the Quality Account data to assess reliability and validity, and to the best of our knowledge consider that the data is accurate. The information contained within the Quality Account is reflective of both the challenges and achievements within the Trust over the previous 12 month period. The priorities identified within the account for the year ahead reflect and support local priorities.

NHS Suffolk including West Suffolk Clinical Commissioning Group are currently working with clinicians and managers from the Trust and with local service users to continue to improve services to ensure quality, safety, clinical effectiveness and good patient/carer experience is delivered across the organisation. This Quality Account demonstrates the commitment of the Trust to improve services. NHS Suffolk is pleased to endorse the publication of this account.

Suffolk Local Involvement Network (LINk)

Suffolk LINk thanks West Suffolk NHS Foundation Trust for the opportunity to comment on the Quality Accounts for 2011/2012.

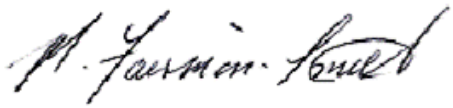
The report is readable and the language used should prove to be accessible to the wider public. The report makes it clear that WSFT is an organisation which takes seriously the business of improving quality across the trust.

The trust has shown an improvement in quality in their main focus areas over the last few years since these quality accounts have been reviewed. It is good to note that they have again this year exceeded all but one of their targets; they are somewhat short of achieving one of their stroke targets.

Suffolk LINk is pleased to note the initiative in workforce training and development project.

The trust has set new objectives and targets for the coming year, many of the targets are quite ambitious though achievable and given the continuous improvement they have so far demonstrated the Suffolk LINk has every reason to expect that they will achieve their targets.
Suffolk LINk congratulates West Suffolk Hospital in having achieved Foundation Trust status as well as the improvements it has achieved thus far and looks forward with pleasure to closer working with the trust in the coming year.

Yours sincerely



Marion Fairman-Smith
Chairman

Suffolk Health Scrutiny Committee

The Suffolk Health Scrutiny Committee has been happy with the engagement of the NHS trusts in the work of the Committee over the past year, particularly in developing trust and dialogue at an early stage, in an ever changing environment where the critical friend role is becoming increasingly important. The Committee is keen that these relationships should be developed to ensure the new health and social care architecture provides delivery of the best possible health services for the people of Suffolk. The Suffolk Scrutiny Committee has decided not to comment individually on any of the Suffolk provider NHS trust's Quality Accounts again this year, and would like to stress that this should in no way be taken as a negative comment. The Committee has taken the view that it is appropriate for Suffolk's Local Involvement Network (LINk) to consider the Quality Account and comment accordingly.

Yours sincerely

Councillor Anne Whybrow
Chairman of the Health Scrutiny Committee on behalf of the Committee

Annex C: Statement of directors' responsibilities in respect of the quality report

The directors are required under the *Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010* to prepare quality accounts for each financial year.

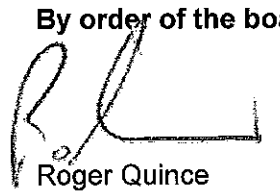
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

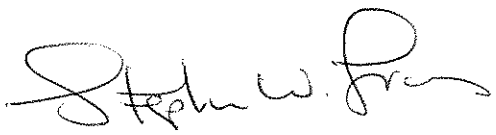
- the content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual* 2011-12;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2011 to June 2012
    - papers relating to quality reported to the Board over the period April 2011 to June 2012
    - feedback from the commissioners dated 30/05/2012
    - feedback from governors dated 16/05/2012
    - feedback from Suffolk LINks dated 14/05/2012
    - Feedback from the Suffolk Health Scrutiny Committee dated 9/5/2012
    - the Trust's complaints report published under regulation 18 of the *Local Authority Social Services and NHS Complaints Regulations 2009*, dated 25/05/2012
    - the [latest] national patient survey 24/04/2012
    - the [latest] national staff survey 26/3/2012
    - the head of internal audit's annual opinion over the Trust's control environment dated 10/05/2012
    - CQC quality and risk profiles monthly from 01/04/2011 to 31/05/2012
- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the quality accounts regulations) (published at www.monitornhsft.lreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board



Roger Quince
Chairman



Stephan Graves
Chief Executive

30 May 2012

Annex D: Independent Auditor's Report to the Board of Governors of West Suffolk NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Board of Governors of West Suffolk NHS Foundation Trust to perform an independent assurance engagement in respect of West Suffolk NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Percentage of cases seen within the maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers
- Number of cases of hospital acquired C. difficile

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the list below; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for our report if we became aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the period April 2011 to May 2012;
- Papers relating to Quality reported to the Board over the period April 2011 to May 2012;
- Feedback from the Commissioners dated 30/05/2012;
- Feedback from LINks dated 16/05/2012;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 25/05/2012;
- The national patient survey dated 24/04/2012;
- The national staff survey dated 26/03/2012;
- Care Quality Commission quality and risk profiles from 01/04/2011 to dated 31/05/2012; and
- The Head of Internal Audit's annual opinion over the trust's control environment dated 10/05/2012.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the “documents”). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Board of Governors of West Suffolk NHS Foundation Trust as a body, to assist the Board of Governors in reporting West Suffolk NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Board of Governors to demonstrate that is has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and West Suffolk NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – Assurance Engagements other than Audits or Reviews of Historical Financial Information issued by the International Auditing and Assurance Standards Board (ISAE 3000). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by West Suffolk NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the list above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

David Eagles (Senior statutory auditor)
for and on behalf of PKF (UK) LLP, Statutory auditor
Ipswich, UK
30 May 2012

Annex E: Glossary

C. *difficile*	*C. difficile* is a spore-forming bacterium which is present as one of the normal bacteria in the gut of up to 3% of healthy adults. People over the age of 65 are more susceptible to developing illness due to these bacteria. *C. difficile* diarrhoea occurs when the normal gut flora is altered, allowing *C. difficile* bacteria to flourish and produce a toxin that causes a watery diarrhoea. Procedures such as enemas and gut surgery, and drugs such as antibiotics and laxatives cause disruption of the normal gut bacteria in this way and therefore increase the risk of developing *C. difficile* diarrhoea.
CQUIN	The Commissioning for Quality and Innovation (CQUIN) payment framework enables our commissioner, NHS Suffolk, to reward excellence by linking a proportion of the Trust's income to the achievement of local quality improvement goals.
Dr Foster Intelligence	Dr Foster Intelligence provides comparative information on health and social care services.
EAU	The Emergency Admissions Unit (EAU) is a short-stay ward which enables staff to assess the condition of patients admitted as an emergency before deciding on the most appropriate care and treatment that they should receive.
Global Trigger Tool	The Institute for Healthcare Improvement's (IHI) Global Trigger Tool for measuring adverse events provides a useful method for identifying adverse events and measuring the rate over time. The trigger tool methodology uses a retrospective review of randomly-selected patient records using triggers (or clues) to detect adverse events.
MRSA	MRSA (*Methicillin Resistant Staphylococcus Aureus*) is an antibiotic-resistant form of a common bacterium called Staphylococcus aureus. *Staphylococcus aureus* is found growing harmlessly on the skin in the nose in around one in three people in the UK.
NCEPOD	National Confidential Enquiry into Patient Outcome and Death (NCEPOD). This year NCEPOD celebrates 23 years of promoting improvements in health care. They have published 30 reports derived from a vast array of information about the practical management of patients.
NRLS	The National Reporting & Learning System is a database administered by the National Patient Safety Agency (NPSA) who receive confidential reports of patient safety incidents from healthcare staff across England and Wales. Clinicians and safety experts analyse these reports to identify common risks to patients and opportunities to improve patient safety.
Patient Revolution	NHS Midlands and East's definition of the 'Patient Revolution' covers three core elements:

- Engagement between the health professional / worker and the individual patient and carer
- Involvement of patients, carers and the public
- Patient and Customer Experience.

Productive Ward Programme	The Productive Ward (releasing time to care) focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care, thereby improving safety and efficiency.
PROMs	Patient Reported Outcome Measures (PROMs) measure quality from the patient perspective. Initially covering four clinical procedures, PROMs calculate the health gain after surgical treatment using pre and post operative surveys.
Quality Walkabouts	A programme of weekly visits to wards and departments by Board members and Governors. These provide an opportunity to talk to staff about quality and test arrangements to deliver the WSFT's quality priorities.
QIPP	Quality, Innovation, Productivity & Prevention (QIPP) is a collection of evidence to support quality and productivity at a local level.
QRP	The Quality & Risk Profile (QRP) is a tool used by the CQC for gathering together key information about trusts to support how they monitor compliance with the essential standards of quality and safety. The QRP enables CQC compliance inspectors to assess where risks lie and may prompt further enquiries.
RCA	A Root Cause Analysis (RCA) is a structure investigation of an incident to ensure effective learning to prevent a similar event happening.
Safety Express	National safety initiative targeted towards high impact areas as part of the QIPP programme. The focus includes pressure ulcers, catheter care, VTE and falls.
Safety Thermometer	The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and harm free care. As well as recording pressure ulcers, falls, catheters with urinary tract infections (UTIs) and VTEs, you can record and analyse additional local information.
VTE	Venous thrombo-emobolism or blood clots are a complication of immobility and surgery.

7. Staff Survey

Introduction

The following report includes commentary on the Staff Survey (2011). It contains detail on staff engagement and survey response rates, top and bottom ranking Key Finding scores, key areas of improvement and future priorities and targets.

Statement of approach to staff engagement

"The NHS commits to engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families." **– Fourth Staff Pledge, NHS Constitution.**

The table below shows the questions used in the Staff Survey to calculate WSFT's overall indicator of staff engagement. It compares the recent survey scores (2011) to those of the previous year.

Key Finding (KF)	2010		2011		Target trend	Trust improvement / deterioration
	Trust	National Average	Trust	National Average	Up (+) Down(-)	% / pts since 2010
Overall Staff Engagement						
KF31. % able to contribute towards improvements at work	65%	62%	**66%**	**61%**	+	1% (improvement)
KF34. Staff recommendation of the Trust as a place of work or to receive treatment	3.7	3.52	**3.82**	**3.5**	+	0.12pt (improvement)
KF35. Staff motivation at work	3.89	3.83	**3.94**	**3.82**	+	0.05pt (improvement)

WSFT recognises that motivated and involved staff are better placed to know what is working well and how to improve services for the benefit of patients and the public. WSFT actively encourages open and honest communication, which is two-way and responsive to feedback.

The Core Brief is presented for discussion by the Chief Executive at the monthly corporate managers' meeting and aims to achieve a common awareness amongst all staff of the financial and economic factors that affect the performance of WSFT. Monthly Team Briefings ensure that everyone receives the same corporate messages in the same format and within the same time frame.

Regular briefing sessions – Staff Conversations - are hosted by the Staff Governors, and are open to all staff, creating a forum for them to ask questions and give their views.

The staff newsletter, Green Sheet, is published on the WSFT website each week and a link is circulated to staff via email. In addition, a number of printed copies are made available for distribution.

The Buzz is a staff community area located on the Trust's intranet, which promotes the free flow of communications via an electronic Notice Board, a Staff Forum, InfoX – a confidential channel for staff to raise issues and concerns with the Executive Directors and senior management team, and the Bright Ideas scheme where ideas and suggestions can be made with regard to creating benefits for patients and staff.

The Trust runs several regular staff award schemes and events, including the annual Shining Lights Awards recognising commitment, achievement and innovation, a monthly Putting You First Award presented to a member of staff seen to be putting our service standards into action, and the Michael

Williams Shield recognising the WSFT Porter of the Year, awarded annually in memory of Michael Williams who spent ten years working as a porter at WSFT.

Summary of Staff Survey response

The following summaries provide details on the response rates to the recent Staff Survey and how this compares to the previous year's results.

Overall staff survey response	No. eligible staff	Sample size	Returned	Trust response rate % and performance against previous survey	
2009	whole Trust	1798	712	40%	1% (deterioration)
2010 sample	2677	783	430	55%	15% (improvement)
2011 sample	**2600**	**792**	**498**	**63%**	**8% (improvement)**

Summary of Key Findings (KF) performance

The KF summary is split between the previous year (2010) and the most recent survey (2011), with details of target trends and improvement/deterioration in performance for the Trust's **Top 20%** and **Bottom 20%** scores.

Scores in the **Top 20%** show how WSFT compares favourably against other acute trusts in England.

Scores in the **Bottom 20%** show how WSFT compares unfavourably against other acute trusts in England, and how these Key Findings can be used as areas for improvement.

Key Finding (KF)	2010		2011		Target trend	Improvement / Deterioration	Trust KF Result
	Trust	National Average	Trust	National Average	Up (+) Down (-)	% / pts since 2010	
Top four ranking scores							
KF16. % receiving health and safety training in last 12 months	76%	80%	**94%**	**81%**	+	18% (improvement)	Top 20%
KF18. % suffering work-related stress in last 12 months	24%	28%	**22%**	**29%**	-	-2% (improvement)	Top 20%
KF28. Impact of health and wellbeing on ability to perform work or daily activities	1.53	1.57	**1.44**	**1.56**	-	-0.09pt (improvement)	Top 20%
KF38. % experiencing discrimination at work in last 12 months	10%	13%	**8%**	**13%**	-	-2% (improvement)	Top 20%
Bottom four ranking scores							
KF12. % appraised in last 12 months	74%	78%	**69%**	**81%**	+	-5% (deterioration)	Bottom 20%
KF14. % appraised with personal development plans in last 12 months	63%	66%	**58%**	**68%**	+	-5% (deterioration)	Bottom 20%
KF17. % suffering work-related injury in last 12 months	19%	16%	**16%**	**16%**	-	-3% (improvement)	Bottom 20%
KF23. % experiencing physical violence from patients / relatives in last 12 months	12%	8%	**11%**	**8%**	-	-1% (improvement)	Bottom 20%

'+' indicates a target increase in this figure, a higher score is better.
'-' indicates a target decrease in this figure, a lower score is better.

The following table shows local changes in four Key Findings where the staff experience has improved the most since the 2010 survey,

Key Finding (KF) - where staff experience has improved	2010		2011		Target trend	Trust improvement / deterioration
	Trust	National Average	Trust	National Average	Up (+) Down (-)	% / pts since 2010
KF5. Work pressure felt by staff	3.09	3.11	**2.98**	**3.12**	-	-0.11pt (improvement)
KF16. % receiving health and safety training in last 12 months	76%	80%	**94%**	**81%**	+	18% (inprovement)
KF28. Impact of health and wellbeing on ability to perform work or daily activities	1.53	1.57	**1.44**	**1.56**	-	-0.09pt (improvement)
KF36. % having equality and diversity training in last 12 months	38%	41%	**48%**	**48%**	+	10% (imporovement)

Overall scores

Overall Key Finding (KF) Performance Scores	2010	2011	Trust improvement / deterioration
	/38	/38	% / pts since 2010
Score category			
Top 20%	14	**23**	9pt (improvement)
Positive findings (Top 20%, Average or Above Average)	29	**34**	-5pt (improvement)
Below Average	7	**0**	-7pt (improvement)
Bottom 20%	2	**4**	2pt (deterioration)

From the table above we can see that, in the 2010 Staff Survey WSFT was placed within the Top 20% in **14/38** of the Key Findings. The recent 2011 Staff Survey has shown an improvement, with WSFT achieving results within the Top 20% in **23/38** of the Key Findings – a 9 point increase on the previous year's score.

This brings the **total number of positive findings for 2011** to **34/38** and the **total number of negative findings** to **4/38**.

Action plans for areas of concern and future priorities

STAFF PLEDGE 2: To provide all staff with personal development, access to appropriate training for their jobs, and line management support to succeed.			
Action	**Risk Rating**	**Progress rating**	**Description of progress**
KF12. % appraised in the last 12 months	Amber	Amber	This Key Finding has decreased from last year, from 74% to 69%. WSFT is still below average (81%). The following will continue: • Specific action plan from 2011/12 to improve appraisal take up
KF14. % appraised with personal development plans in the last 12 months	Amber	Amber	WSFT's score has decreased from last year, from 63% to 58%, below the average of 68%. All Trust appraisal processes have a PDP element.

STAFF PLEDGE 3: To provide support and opportunities for staff to maintain their health, wellbeing and safety.			
Action	**Risk Rating**	**Progress rating**	**Description of progress**
KF17. % suffering work-related injury in the last 12 months	Amber	Amber	This Key Finding has decreased compared to last year, from 19% to 16%. This meets the national average (16%), however WSFT's score still falls within the threshold for the Bottom 20% as calculated by Picker Institute Europe. • Increased training has been put in place and compliance is now being reported for moving and handling, as part of mandatory training • The Staff Governors will investigate this Key Finding as part of their "staff conversation " programme to gather more evidence as to why this factor is in the worst 20% • WSFT will also investigate "work related stress" figures as a possible cause of staff feeling this is an issue.
KF23. % experiencing physical violence from patients/relatives in the last 12 months	Amber	Amber	This Key Finding did decrease compared to last year, from 12% to 11%. However WSFT's score still falls within the threshold for the Bottom 20% as it is higher than the average (8%). • Nursing Assistant (NA) induction now includes "Breakaway" training as a mandatory requirement • Existing NAs have Breakaway as part of their mandatory training (level 2) programme. All NAs to be covered by September 2012 • Improved reporting of mandatory training through OLM will ensure that compliance will be regularly monitored by the Board of Directors, Directorates and individual mangers/ budget holders • Restrictive Physical Intervention Team will continue to respond to incidents • Proximity readers have been fitted to the entrances of wards which have patients with cognitive impairment. The Suffolk Dementia Workforce Strategy will address further training needs and skills development for those staff working with cognitive impaired patients.

8. Regulatory ratings

WSFT achieved high levels of performance during 2011/12 including the best performing Trust in England for elective waiting times and the highest performing Trust on A&E waiting times in the first two quarters of the year. Significant improvements are noted in A&E and cancer waiting times performance compared to the previous year.

WSFT also performed well compared to regional peers in areas outside of the regulatory ratings indicators including on stroke services, VTE assessment and in reducing the number of falls and pressure ulcers.

There were no regulatory interventions.

	Annual Plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial Risk Rating	4	3	3	3	3
Governance Risk Rating	Green	Amber/Green	Amber/Red	Amber/Green	Green

	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial Risk Rating	3	3	3	3	3
Governance Risk Rating	Green	Green	Green	Green	Green

9. Other disclosures

9.1 Health and Safety report

WSFT's health and safety performance is reported to and monitored by the Health & Safety Committee who then escalate issues for information or of concern to the Corporate Risk Committee. These committees meet quarterly. Issues that cannot be resolved or which need to be escalated are reported up to the Trust Executive Group and the Board of Directors accordingly.

Risk Assessment
The strategy for the management of risk within WSFT has continued to be developed and promoted Trust-wide. The Risk Register is a tool for capturing, prioritising and managing risk assessments and is integral to the Trust's Risk Management arrangements.

During the period April 2011 to March 2012, 46 members of staff (including 22 who attended the H&S link person training) were trained in the fundamental principles of risk assessment and how to use the updated risk assessment template in accordance with the revised Risk Assessment Policy and Procedure. This has improved the quality and quantity of risk assessments undertaken across the Trust and has promoted use of the Trust Risk Register. The Risk Register is to be updated and revised as part of the electronic Datix Risk Management System roll out.

Reporting of Incidents, Diseases and Dangerous Occurrence Regulations 1995 (RIDDOR)
A total of 25 incidents were reported to the Health and Safety Executive as required under RIDDOR.

RIDDOR description	2011/12
Result of slip, trip or fall	1
Caused during the moving and handling of patients	10
Occurred during the moving and handling of objects	6
Occurred due to contact with moving, falling or flying object	4
Occurred due to contact with static object	1
Contact with sharp - material or object	1
Incidents falling into the category of dangerous occurrence and major injury	2

For an explanation of these categories please refer to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (copyright HMSO).

Incident Reporting System
The WSFT incident reporting system is used to capture clinical and non-clinical incidents. Non-clinical incidents include reports of personal accident, violence, abuse and harassment, fire, and security breaches. All incidents are investigated and reported according to the Trust's policies and procedures. Actions taken as a result of investigations are communicated through the Directorate Clinical Governance Steering Groups. The Board of Directors are given regular reports summarising incident trends and action. There were 169 violence, abuse and harassment incidents – a decrease of 7 from the previous year. These incidents take into account physical assaults, verbal abuse, harassment and physically threatening behaviour towards staff by patients. Of the 73 physical assaults reported, 72 had a clinical cause while 1 assault was caused by a visitor. Clinical caused incidents are incidents whereby the patient is not aware or has no control of their actions towards staff. 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 1,072 reported incidents of 'personal accident/ill health' for 2011/2012. This figure includes staff, patients, visitors and contractors and is broken down into specific incident categories, which include: slips/trips/falls, contact with an object, contact with a sharp, lifting and handling, self-harm, exposure to a harmful substance, contact with electricity and a category of 'other'. The most significant decrease was in the category of slips, trips and falls with a decrease of 380 on the previous year. The Trust's incident statistics are uploaded monthly to the National Patient Safety Agency who produce biannual reports which benchmark the performance of similar small acute trusts. The last report indicates that the Trust reports its incidents in a timely fashion in comparison to its cluster group.

Health and Safety Executive (HSE)
The Health and Safety Executive (HSE) visited WSFT in October 2011 to review the management of falls. As a result of this visit and subsequent correspondence a meeting was held in March 2012 with the local HSE inspector to review arrangements for managing health and safety and progress with the management of falls. The meeting was supportive of the arrangements in place and future plans.

9.2 Occupational Health Report / Occupational Health & Wellbeing Service

The name of the Occupational Health Service has changed to reflect the increased awareness that the health and wellbeing of staff is vital to the delivery of a quality service to the Trust's patients and should be embedded into the culture of WSFT.

The Boorman Report (2009) identifies clear links between staff health and wellbeing and the three dimensions of service quality:

- Patient Safety
- Patient Experience
- The effectiveness of patient care.

The Occupational Health & Wellbeing vision is to:
"Deliver a professional, quality Occupational Health & 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".

The WSFT Occupational Health & Wellbeing Service has registered for Occupational Health Service Standards for Accreditation (SEQOHS) and will undergo accreditation assessment in June 2012 to meet the requirements of the NHS document *'Healthy Staff, Better Care for Patients*' (July 2011) and the Operating Framework for the NHS in England 2012/13.

The Occupational Health & Wellbeing Service has made changes to various occupational health assessment protocols following involvement in the National Audit of back pain and depression. These changes have improved the assessment process and follow the NICE guidelines for managing depression and long-term sickness.

Participation in the National Audit on implementing the NICE Public Health Guidance for the Workplace demonstrated much of the good work that the Trust is carrying out in relation to Health & Wellbeing and highlighted where further action should be focused.

Subsequent to the Public Health Audit and as part of the Operating Framework for the NHS in England 2012/13, the Trust has signed up for seven Public Health Responsibility Deal pledges:

- Chronic Conditions Guide
- Occupational Health Standards
- Health & Wellbeing
- Healthier Staff Restaurants

- Smoking Cessation/Respiratory Health
- Staff Health Checks
- Physical Activity in the Workplace.

The Public Health Responsibility Deal has been established by the Government to maximise the benefits to Health & Wellbeing working in partnership between public health, commercial and voluntary organisations.

The appointment of an enthusiastic and motivated Health & Wellbeing Fundraiser/ Coordinator within the Occupational Health & Wellbeing Service has contributed greatly to the implementation of the Trust's Health & Wellbeing Strategy and Action Plan.

The changes which are being implemented to the practices and protocols of the Occupational Health & Wellbeing Service will ultimately benefit the Trust and its entire staff. The future will see more changes within the service with the opportunity for it to develop further and meet the vision of Healthy Staff, Better Care for Patients: Realignment of Occupational Health Services to the NHS in England.

9.3 Details of consultation

The stakeholder management processes associated with the disposal of the Sudbury estate included a stakeholder forum event on 3 May 2012 at the Town Council in Sudbury. The Sudbury Town Council invited relevant local people/groups to attend the event, in addition to other key stakeholders identified by WSFT which included local councillors from Babergh District Council.

The event was an interactive process. Following an introduction attendees were invited to look at the strategy boards for each site with members of the Trust's consultant team located by each board to address any queries that were raised. Feedback was collected on the evening by way of questionnaires. This information will be used to inform the public consultation process for each site.

In addition to this, formal public consultation events will be held for each site prior to the submission of planning applications. Members of the public also have an opportunity to make representation as part of the planning application process. A communication strategy to support this consultation is in place.

Consultation with local groups and other public & patient involvement activities

Suffolk LINks have made a positive contribution to the structure and content of the Trust's Quality Report. Representatives from LINks meet with the Trust's Chief Executive, and other members of the senior team. There is a commitment to continuing the collaborative working during the progression towards Healthwatch. The Health Overview and Scrutiny Committee liaise directly with the Chief Executive and there is a positive working relationship.

WSFT has an active Patient Panel that meets regularly to discuss issues relating to the Trust and its services and provide feedback from a patient perspective. There is patient representation on Trust project groups including the Productive Ward Steering Group, service development groups, and process mapping groups for the Productive Ward initiative. Representatives from the Trust's Patient Advisory Panel and Governors are members of key committees and groups (e.g. Patient Experience Committee, Clinical Safety & Effectiveness Committee, Directorate Governance Steering Groups, Maternity Services Liaison Committee, Nutritional Steering Group, Diabetes Group and Blood Transfusion Committee).

WSFT engages with the public, in particular 'seldom heard groups', through attendance at meetings such as the Suffolk Disability Partnership Board and through the "Community Conversations". This annual process is undertaken in conjunction with other Suffolk Healthcare organisations and attended by the Chief Executive, an Executive Director and other senior managers. WSFT is a member of Ipswich and Suffolk Council for Racial Equality (ISCRE).

WSFT has a small number of user groups e.g. Chronic Pain Support Group and Cardiology Services User Group, which are supported by clinical staff and are involved in providing feedback on current services and service developments. Suffolk's Breath Easy Group helped staff to develop a special Suffolk COPD Services website to help patients with COPD. Individual departments also use a variety of mechanisms to obtain feedback from patients e.g. orthopaedic patient 'tea parties' and breast care patient feedback survey.

9.4 Equality and diversity

WSFT is committed to the provision of high quality and safe care for all members of the communities that we serve and the development of a culture where people are valued and respected for their individual differences.

Having developed and published a Single Equality Scheme in line with its public duty, incorporating the race, disability, and gender equality schemes, the Trust has since chosen to use the recommended NHS national framework - The NHS Equality Delivery System (EDS) - to review the Trust's equality performance and to identify future priorities and actions. Use of this system will also show our compliance with the 2010 Equality Act and the public sector equality duty (PSED). It will address the alignment of EDS Outcomes with CQC Essential Standards and with the NHS Constitution.

The data in the table below analyses all current employees and public members. Employee data is sourced from the Electronic Staff Record and membership data is sourced from the Trust's membership database.

Age	Staff in post 2011/12	Staff in post 2010/11	Public Members 2011/12	Public Members 2010/11
<16	**1**	0	**1**	1
17-21	**70**	76	**80**	78
22+	**2,879**	2,831	**4,934**	4,786
Not Specified	**0**	0	**118**	116
Total	**2,950**	2,907	**5,133**	4,981
Ethnicity				
White	**2,600**	2,581	**4,972**	4,640
Mixed	**28**	21	**18**	18
Asian or Asian British	**204**	195	**49**	40
Black or Black British	**24**	19	**20**	16
Other Ethnic Group	**46**	44	**13**	11
Not Stated	**48**	47	**61**	256
Total	**2,950**	2,907	**5,133**	4,981
Gender				
Female	**2,373**	2,335	**2,386**	2,590
Male	**577**	572	**2732**	2379
Undefined	**0**	0	**15**	12
Total	**2,950**	2,907	**5,133**	4,981
Disability				
No	**597**	433	**0**	0
Not Declared	**104**	40	**0**	0
Undefined	**2,199**	2,390	**4,250**	4,078
Yes	**50**	44	**883**	903
Total	**2,950**	2,907	**5,133**	4,981

Summary of performance – NHS workforce statistics

NHS FTs are already required to analyse equality and diversity in their membership bases. This has been extended to the Trust's workforce.

Protected characteristics

The 2010 Equality Act protects people from unfavourable treatment because of the following characteristics, some of which apply to everyone, while others apply to groups of people:

- Age
- Disability
- Gender re-assignment (trans)
- Marriage and civil partnership
- Race (including national identity and ethnicity)
- Religion or belief
- Gender (sex - male or female)
- Sexual orientation
- For parts of the Equality Act pregnancy and maternity are also protected characteristics.

At the heart of the EDS is a set of 18 outcomes grouped into 4 goals (see details below). These outcomes focus on the issues of most concern to patients, carers, communities, NHS employees, and Boards of Directors. It is against these outcomes that our performance has been assessed, graded and our actions determined.

Equality Delivery System goals

The four goals are:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and included staff
- Inclusive leadership at all levels.

WSFT’s 2012 Equality Objectives are available on the website.

All of the objectives will be achieved by April 2016, but will be reviewed on an annual basis by the Board of Directors as part of the annual Equality Report. As a result the objectives may change over time.

Our Single Equality Scheme and action plan has been integrated with the work on the Equality Delivery System to avoid duplication.

- The Equality objectives and EDS performance grading have been published on WSFT’s website in line with our Public Sector Equality Duty (PSED)
- Continuing engagement with staff, patients, and the community with regard to meeting the agreed objectives and our improvement in achieving the EDS outcomes.

Monitoring arrangements

The Equality & Diversity Technical Group, chaired by the Executive Director Workforce & Communications, will review the Trust’s performance against the objectives within the EDS when it meets on a quarterly basis. It will also receive and review the equality impact assessment reports. The Board of Directors will receive an annual Equality Report as linked to the EDS. The Trust is working towards enabling real time equality reporting.

9.5 Sustainability

SUSTAINABLE DEVELOPMENT MISSION STATEMENT

"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 strategy captures the social, environmental and economic impact of our actions"

The mission statement is illustrative of everything WSFT is committed to and encompasses the culture of creating a 'Sustainable Environment' for today and the future.

As part of this commitment the Trust has implemented a number of programmes:

- Car Share – provides select parking for those who take part in car sharing
- Cycle to Work Scheme – Tax relief for bicycles purchased through this programme
- Car Free Day – Every member of staff who drives to work has been appointed a day where they must find alternative parking
- Introduced non-confidential papers recycling bins, battery, cardboard, metal, wood and equipment recycling
- WSFT is piloting a 'Just-in-Time' Programme on Ward G4, which examines the way in which we procure consumables
- Held an NHS Sustainability Day of Action, Wednesday, 28 March 2012
- Provides support to the local charity Aid to Hospitals Worldwide. In one instance the Trust donated eight consignments of old beds saving the NHS landfill demands and disposal costs. It was the very best news to the people of Zambia, Malawi, Ghana and Togo. Each country received units of six to 16 beds, often where there had previously been no beds at all
- In partnership with the East of England Procurement Hub, WSFT is piloting a new tool for measuring and analysing the procurement carbon footprint
- Procurement hold quarterly amnesty days where staff can bring anything no longer used in their area and replace it with something they do use thus reducing waste in the hospital
- A feasibility study is in progress for the introduction of LED lighting technology for street lighting and car parks on the site
- A Combined Heat & Power (CHP) generating plant produces over 50% of the site's electricity demand and 65% of the hospital's heat demand.

Some of our achievements over the past year are:

- In the first full year of service the CHP achieved £144k reduction on the utility spend for the site and reduced the carbon emissions by 1,790 tonnes of displaced CO2
- Due to the continued success of the CHP unit the project was nominated for and won the East Anglia CIBSE (Chartered Institute of Building Services Engineers) Carbon Reduction Award 2012
- The Trust has been named as a "Creating the Greenest County" winner in the category of "Business: Transport" for which there were eight entries in Suffolk. The award is designed to celebrate businesses which have made an exceptional effort to reduce emissions from transport, such as by reducing business mileage or encouraging staff to find more environmentally friendly ways of reaching work
- West Suffolk Hospital partners, Aid to Hospitals Worldwide, received the East of England Sustainability Award, sponsored by the British Standards Institution (BSI).

We continuously examine the approach we take in doing business and that includes considering 'Sustainability' in all our actions. We are committed to developing and implementing systems which create a sustainable and healthier environment for all.

WSFT is currently working with CCL Consulting Limited (Low Carbon Energy Assessors & Consultants) in developing an annual Sustainability report which meets the requirements listed in:

HM Treasury
PUBLIC SECTOR ANNUAL REPORTS:
SUSTAINABILITY REPORTING
Guidance for 2011-12 Reporting

9.6 Policies and procedures for fraud and corruption

WSFT is committed to the elimination of fraud and corruption. The Trust 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.

9.7 Pension liabilities for ill health retirement

WSFT has no additional pension liabilities in respect of ill health retirements during the 4 months to 31 March 2012 or in either of the comparative periods.

9.8 Sickness absence data

The Trust manages both short-term and long-term sickness absence in accordance with best practice and legislative requirements. The performance for the year is shown below.

Staff sickness absence

	Number

Days lost (long term)	6,686
Days lost (short term)	8,056
Total days lost	**14,742**
Total staff years	2,971
Average working days lost	5
Total staff employed in period (headcount)	2,971
Total staff employed in period with no absence (headcount)	1,648
Percentage staff with no sick leave	**55.5%**

9.9 Interest in land

The Board of Directors has determined that there is not a material difference between the market value of land and the carrying value in the accounts.

9.10 Cost allocation

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

9.11 Serious incidents involving data loss

No serious incidents involving data loss were reported to the Information Commissioner during 2011/12.

9.12 Better payment practice code

The Trust is a signatory to the Better Payment 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 not paid any interest under the Late Payment of Commercial Debts (Interest) Act 1998 in either the 4 months since becoming a FT nor in either of the comparative periods shown.

	4 Months to 31 March 2012		**8 Months to 30 November 2011**		**2010-11**	
	Number	**£000**	**Number**	**£000**	Number	£000
Total non-NHS trade invoices paid in the year	**11,177**	**11,420**	**29,026**	**29,417**	43,273	41,356
Total non-NHS trade invoices paid within target	**10,210**	**9,940**	**27,276**	**26,871**	40,766	37,971
Percentage of non-NHS trade invoices paid within target	**91%**	**87%**	**94%**	**91%**	94%	92%
Total NHS trade invoices paid in the year	**428**	**2,857**	**1,072**	**7,618**	1,520	10,397
Total NHS trade invoices paid within target	**372**	**2,299**	**991**	**7,073**	1,417	9,764
Percentage of NHS trade invoices paid within target	**87%**	**80%**	**92%**	**93%**	93%	94%

Section 10 –Accounts for 2011/12

10.1 West Suffolk NHS Foundation Trust – Accounts for the period 1 December 2011 to 31 March 2012

10.2 West Suffolk Hospitals NHS Trust – Accounts for the period 1 April 2011 to 30 November 2011

West Suffolk NHS Foundation Trust

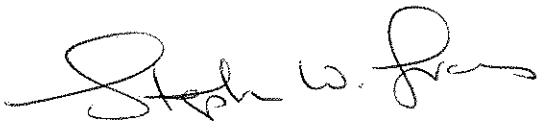
Accounts for the Period from 1 December 2011 to 31March 2012

Foreword to the Accounts

West Suffolk NHS Foundation Trust

West Suffolk NHS Foundation Trust ("the Trust") is required to "keep accounts in such form as Monitor may with the approval of Treasury direct" (paragraph 24(1), Schedule 7 of the National Health Services Act 2006 ("the 2006 Act"). The Trust is required to "prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of Treasury direct" paragraph 25(1), Schedule 7 to the 2006 Act). In preparing their annual accounts, the Trust must comply with any directions given by Monitor, with the approval of Treasury, as to the methods and principles according to which the accounts are to be prepared and the information to be given in the accounts (paragraph 25(2), Schedule 7 to the 2006 Act).

In determining the form and content of the annual accounts Monitor must aim to ensure that the accounts present a true and fair view (paragraph 25(3), Schedule 7 to the 2006 Act).



Stephen Graves
Chief Executive

Date: 30 May 2012

Independent auditor's report to the Board of Governors of West Suffolk NHS Foundation Trust

We have audited the financial statements of West Suffolk NHS Foundation Trust (the Trust) for the four months ended 31 March 2012 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the NHS Foundation Trust Annual Reporting Manual 2011/12 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

This report is made solely to the Board of Governors of West Suffolk NHS Foundation Trust, as a body, in accordance with paragraph 5.2 of the Audit Code for NHS Foundation Trusts. Our audit work has been undertaken so that we might state to the Board of Governors of the Trust those matters we are required to state to it 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 Board of Governors, as a body, and the Trust for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements which give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accounting Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of West Suffolk NHS Foundation Trust's affairs as at 31 March 2012 and of its income and expenditure for the four months then ended;
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12; and
- have been prepared in accordance with the National Health Service Act 2006.

Opinion on other matter prescribed by the Audit Code for NHS Foundation Trusts

In our opinion:

- the part of the Remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12; and
- the information given in the Directors' Report within the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We have nothing to report in respect of the following other matters which the Audit Code for NHS Foundation Trusts requires us to report to you if we are not satisfied that:

- the financial statements are prepared in accordance with directions under paragraph 25 of Schedule 7; or
- the financial statements comply with the requirements of all other provisions contained in, or having effect under, any enactment which are applicable to them; or
- proper practices have been observed in their compilation; or
- the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- the annual governance statement meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with other information that is forthcoming from the audit; or
- the quality report has been prepared in accordance with the detailed guidance issued by Monitor.

Certificate

We certify that we have completed the audit of the financial statements of West Suffolk NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

David Eagles (Senior statutory auditor)
for and on behalf of PKF (UK) LLP, Statutory auditor
Ipswich, UK
30 May 2012

West Suffolk NHS Foundation Trust - Accounts from 1 December 2011 to 31 March 2012

STATEMENT OF COMPREHENSIVE INCOME	Note	4 Months to 31 March 2012 £000
Operating Income from continuing operations	2	53,370
Operating Expenses of continuing operations	3	(52,380)
OPERATING SURPLUS / (DEFICIT)		**990**
FINANCE COSTS		
Finance income	6	18
Finance expense - financial liabilities	7	(34)
PDC Dividends payable		(452)
NET FINANCE COSTS		**(468)**
SURPLUS/(DEFICIT) FOR THE YEAR		**522**
Other comprehensive income		
Other reserve movements		0
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD		**522**
Prior period adjustments		0
TCS and merger adjustments		0
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**522**

Note: Allocation of Profits/(Losses) for the period:	2011/12 £000
(a) Surplus/(Deficit) for the period attributable to:	
(i) minority interest, and	0
(ii) owners of the parent.	522
TOTAL	**522**
(b) total comprehensive income/ (expense) for the period attributable to:	
(i) minority interest, and	0
(ii) owners of the parent.	522
TOTAL	**522**

The above Statement of Comprehensive Income and Expenditure is for a part year period, from 1 December 2011 to 31 March 2012. This set of aacounts does not have comparative figures as West Suffolk NHS Foundation Trust only became a legal entity on 1st December 2011

The accounts for the period ended 31 March 2012 have been prepared in accordance with paragraph 24 and 25 of schedule 7 to the National Health Services Act 2006.

The notes on pages 110 to 134 form part of these accounts.

All income and expenditure is derived from continuing operations.

STATEMENT OF FINANCIAL POSITION	note	31 March 2012 £000	1 December 2011 £000
Non-current assets			
Property, plant and equipment	9	71,553	69,451
Total non-current assets		71,553	69,451
Current assets			
Inventories	11	2,474	2,386
Trade and other receivables	12	5,123	8,640
Non-current assets for sale and assets in disposal groups	10	1,000	1,000
Cash and cash equivalents	14	10,539	6,302
Total current assets		19,136	18,328
Current liabilities			
Trade and other payables	15	(14,244)	(10,661)
Borrowings	16	(1,000)	(1,505)
Provisions	19	(70)	(112)
Other liabilities	18	(2,248)	(2,100)
Total current liabilities		(17,562)	(14,378)
Total assets less current liabilities		**73,127**	**73,401**
Non-current liabilities			
Borrowings	16	(500)	(1,000)
Provisions	19	(284)	(284)
Other liabilities		0	(296)
Total non-current liabilities		**(784)**	**(1,580)**
Total assets employed		**72,343**	**71,821**
Financed by (taxpayers' equity)			
Public Dividend Capital		58,250	58,250
Revaluation reserve	21	11,549	11,694
Income and expenditure reserve		2,544	1,877
Total taxpayers' equity		**72,343**	**71,821**

The financial statements on pages 106 to 134 were approved by the Board on 25 May 2012 and signed on its behalf by:

Signed ..... (Chief Executive) 30 May 2012

West Suffolk NHS Foundation Trust
Accounts from 1 December 2011 to 31 March 2012

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' Equity at 1 December 2011	**71,821**	58,250	11,694	1,877
Surplus for the year	**522**	0	0	522
Transfers between reserves	**0**	0	(145)	145
Taxpayers' Equity at 31 March 2012	**72,343**	**58,250**	**11,549**	**2,544**

West Suffolk NHS Foundation Trust
Accounts from 1 December 2011 to 31 March 2012

STATEMENT OF CASH FLOWS	note	4 Months to 31 March 2012 £000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations		**990**
Operating surplus/(deficit) of discontinued operations		0
Operating surplus/(deficit)		**990**
Non-cash income and expense:		
Depreciation and amortisation		1,572
Impairments		51
(Increase)/Decrease in Trade and Other Receivables		3,815
(Increase)/Decrease in Inventories		(88)
Increase/(Decrease) in Trade and Other Payables		1,959
Increase/(Decrease) in Provisions		(42)
NET CASH GENERATED FROM/(USED IN) OPERATIONS		8,257
Cash flows from investing activities		
Interest received		18
Purchase of Property, Plant and Equipment		(1,906)
Net cash generated from/(used in) investing activities		(1,888)
Cash flows from financing activities		
Loans repaid to the Department of Health		(500)
Interest paid		(47)
PDC Dividend paid		(1,080)
Net cash generated from/(used in) financing activities		(1,627)
Increase/(decrease) in cash and cash equivalents		4,742
Cash and Cash equivalents at 1 December 2011		5,797
Cash and Cash equivalents at 31 March 2012		**10,539**

NOTES TO THE ACCOUNTS

1. Accounting Policies

Monitor has directed that the financial statements of NHS foundation Trusts shall meet the accounting requirements of the Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequentially, the following financial statements have been prepared in accordance with the FT ARM 2011/12 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's FREM to the extent that they are meaningful and appropriate to NHS foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 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.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.4 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the Trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.5 Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave 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.

1.6 Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.7 Other expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised if:
● 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 will be supplied to, the Trust;
● it is expected to be used for more than one financial year;
● the cost of the item can be measured reliably; and
● 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 a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
● Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost 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. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Depreciation, amortisation and impairments
Freehold land, properties under construction, and assets held for sale are not depreciated

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.10 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.11 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.12 Leases
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.

The Trust as lessee
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor
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 so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line 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 on a straight-line basis over the lease term.

1.13 Inventories
Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.14 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 equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.15 Provisions
Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (2.8% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.16 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 19.3.

1.17 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 the NHS Litigation Authority 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 as and when they become due.

1.18 EU Emissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.19 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.20 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Available for sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.21 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of

The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

The amount of the obligation under the contract, as determined in accordance with IAS 37*Provisions, Contingent Liabilities and Contingent Assets.*

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.22 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.

1.23 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's surplus/deficit in the period in which they arise.

1.24 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 27 to the accounts.

1.25 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.26 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, including losses which would have been made good through insurance cover had trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.27 Subsidiaries

For the 4 month period to 31 March 2012 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the corporate Trustee.

1.28 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.29 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2011-12. The application of the Standards as revised would not have a material impact on the accounts for 2011-12, were they applied in that year:

IAS 1 Presentation of financial statements (Other Comprehensive Income) - subject to consultation
IAS 12 - Income Taxes (amendment) - subject to consultation
IAS 19 Post-employment benefits (pensions) - subject to consultation
IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 7 - Financial Instruments: Disclosures (annual improvements) - effective 2012-13
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation

2. Operating Income

Note 2.1 OPERATING INCOME (by classification)	**4 Months to 31 March 2012**
Income from Activities	**Total**
	£000
Acute Trusts	
Elective income	10,155
Non elective income	15,803
Outpatient income	10,202
A & E income	1,847
Other NHS clinical income	8,829
Mandatory income	46,836
PTS income	16
Private patient income	178
Other non-protected clinical income	167
Total income from activities	**47,197**

Other operating income	**Total**
	£000
Education and training	**2,137**
Charitable and other contributions to expenditure	**155**
Non-patient care services to other bodies	**2,139**
Other	**1,742**
Total other operating income	**6,173**
TOTAL OPERATING INCOME	**53,370**

All income from activities and the income in respect of education and training arise from the provision of mandatory services as set out in the Monitor terms of authorisation.

The other operating income with the exception of education and training relate to the provision of non protected services.

Note 2.2 Private patient income	**4 Months to 31 March 2012**	**Base Year**
	£000	**£000**
Private patient income	178	408
Total patient related income	47,197	78,261
Proportion (as percentage)	**0.38%**	**0.52%**

Section 44 of the National Health services Act 2006 requires that the proportion of private patient income received by the NHS Foundation Trust must not exceed it's proportion whilst the body was an NHS Trust in 2002/03 (the base year). The Trust was compliant with this in 2011/12.

Note 2.3 OPERATING INCOME (by type)	**4 Months to 31 March 2012**
Income from activities	**Total**
	£000
Primary Care Trusts	**46,807**
Non NHS: Private patients	**178**
Non-NHS: Overseas patients (non-reciprocal)	**5**
NHS injury scheme (was RTA)	**139**
Non NHS: Other *	**68**
Total income from activities	**47,197**
Education and training	**2,137**
Charitable and other contributions to expenditure	**155**
Non-patient care services to other bodies	**2,139**
Other **	**1,742**
Total other operating income	**6,173**
TOTAL OPERATING INCOME	**53,370**

*** Analysis of Income from activities: Non-NHS Other**	**4 Months to 31 March 2012**
	Total
	£000
Other government departments and agencies	68
Total	**68**

**** Analysis of Other Operating Income: Other**	**4 Months to 31 March 2012**
	Total
	£000
Car parking	240
Estates recharges	197
Staff accommodation rentals	120
Catering	386
Property rentals	32
Grossing up consortium arrangements	691
Other	76
Total	**1,742**

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Note 3 OPERATING EXPENSES (by type)

	4 Months to 31 March 2012 Total £000
Purchase of healthcare from non NHS bodies	**125**
Employee Expenses - Executive directors	**345**
Employee Expenses - Non-executive directors	**18**
Employee Expenses - Staff	**35,782**
Drug costs	**4,388**
Supplies and services - clinical (excluding drug costs)	**4,684**
Supplies and services - general	**896**
Establishment	**464**
Transport	**366**
Premises	**1,435**
Increase / (decrease) in provision for impairment of receivables	**(2)**
Inventories write down	**5**
Depreciation on property, plant and equipment	**1,572**
Impairments of property, plant and equipment	**51**
Audit fees - statutory audit	**40**
Clinical negligence	**915**
Legal fees	**17**
Consultancy costs	**295**
Training, courses and conferences	**126**
Patient travel	**14**
Insurance	**25**
Other services, eg external payroll	**67**
Grossing up consortium arrangements	**691**
Other	**61**
TOTAL	**52,380**

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Note 4.1 Employee Expenses

	4 Months to 31 March 2012 Total	4 Months to 31 March 2012 Permanently Employed	4 Months to 31 March 2012 Other
	£000	£000	£000
Salaries and wages	**29,811**	29,811	0
Social security costs	**2,245**	2,245	0
Pension cost - defined contribution plans Employers contributions to NHS Pensions	**3,422**	3,422	0
Agency/contract staff	**1,471**	0	1,471
TOTAL GROSS STAFF COSTS	**36,949**	**35,478**	**1,471**
less income in respect of Salaries and wages where netted off expenditure	**(494)**	(494)	0
less income in respect of Social security costs where netted off expenditure	**(37)**	(37)	0
less income in respect of Pension costs where netted off expenditure	**(57)**	(57)	0
TOTAL STAFF COSTS	**36,361**	**34,890**	**1,471**
of which			
Costs capitalised as part of assets	**(234)**	(234)	0
Total Employee benefits excl. capitalised costs	**36,127**	**34,656**	**1,471**

Note 4.2 Average number of employees (WTE basis)

	4 Months to 31 March 2012 Total	4 Months to 31 March 2012 Permanent	4 Months to 31 March 2012 Other
	Number	Number	Number
Medical and dental	**319**	307	12
Administration and estates	**542**	531	11
Healthcare assistants and other support staff	**591**	591	0
Nursing, midwifery and health visiting staff	**749**	749	0
Scientific, therapeutic and technical staff	**284**	283	1
Income in respect of staff costs where accounted on gross basis	**2,485**	**2,461**	**24**

Note 4.3 Employee benefits

	4 Months to 31 March 2012
	£000
TOTAL	**0**

During the period there were no early retirements from the Trust agreed on the grounds of ill health.

4.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2012 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

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Note 5.1 Operating leases	**4 Months to 31 March 2012**
	£000
Minimum lease payments	517
Contingent rents	0
Less sublease payments received	0
TOTAL	**517**

Note 5.2 Arrangements containing an operating lease	**31 March 2012**	**31 March 2012**	**31 March 2012**	**31 March 2012**
	£000	**£000**	**£000**	**£000**
	Land	**Buildings**	**Other**	**Total**
Future minimum lease payments due:				
- not later than one year;	0	0	811	**811**
- later than one year and not later than five years;	0	0	2,087	**2,087**
- later than five years.	0	0	218	**218**
TOTAL	**0**	**0**	**3,116**	**3,116**

Note 5.3 Limitation on auditor's liability*	**31 March 2012**
	£000
Limitation on auditor's liability	500

Note 5.4 The late payment of commercial debts (interest) Act 1998	**4 Months to 31 March 2012**
	£000
Amounts included within other interest payable arising from claims made under this legislation	0
Compensation paid to cover debt recovery costs under this legislation	0

Note 5.5 Auditors Remuneration
No remuneration was paid to the auditors for services other than fees paid for work undertaken in relation to statutory work.

Note 6 Finance income

	4 Months to 31 March 2012
	£000
Interest on bank accounts	18
TOTAL	**18**

Note 7 Finance costs - finance costs

	4 Months to 31 March 2012
	Total
	£000
Interest expense:	
Loans from the Department of Health	**34**
TOTAL	**34**

Note 8 Impairment of assets

	4 Months to 31 March 2012
	£000
Loss or damage from normal operations	**51**
Total Impairments	**51**
of which	
Total Departmental Expenditure Limit	**51**
Total Annually Managed Expenditure	**0**

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Note 9.1 Property, Plant and Equipment - 1 December 2011 - 31 March 2012

	Total	Land	Buildings excluding dwellings	Dwellings	Assets Under Construction and Payments on Account	Plant & machinery	Transport equipment	Information Technology	Furniture & fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 December 2011	**92,850**	13,798	46,410	4,060	3,488	16,695	15	8,354	30
Additions - purchased	**3,710**	0	1,834	0	320	529	0	1,027	0
Additions - donated	**15**	0	0	0	0	15	0	0	0
Reclassifications	**0**	0	51	0	(1,113)	6	0	1,056	0
Disposals	**(694)**	0	0	0	0	(694)	0	0	0
Valuation/Gross cost at 31 March 2012	**95,881**	**13,798**	**48,295**	**4,060**	**2,695**	**16,551**	**15**	**10,437**	**30**
Depreciation at 1 December 2011	**23,399**	0	5,705	203	0	11,100	13	6,371	7
Provided during the year	**1,572**	0	862	29	0	366	1	313	1
Impairments	**51**	0	0	0	0	51	0	0	0
Disposals	**(694)**	0	0	0	0	(694)	0	0	0
Accumulated depreciation at 31 March 2012	**24,328**	**0**	**6,567**	**232**	**0**	**10,823**	**14**	**6,684**	**8**
Net book value at 31 March 2012	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned	**69,002**	13,798	39,492	3,828	2,695	5,416	1	3,750	22
Donated	**2,551**	0	2,236	0	0	312	0	3	0
NBV total at 31 March 2012	**71,553**	**13,798**	**41,728**	**3,828**	**2,695**	**5,728**	**1**	**3,753**	**22**

Note 9.2 Economic life of property, plant and equipment

	Min Life Years	Max Life Years
Buildings excluding dwellings	10	35
Dwellings	10	35
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture & Fittings	7	10

Note 9.3 Analysis of property, plant and equipment at 31 March 2012

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
Protected assets	**59,354**	13,798	41,728	3,828	0	0	0	0	0
Unprotected assets	**12,199**	0	0	0	2,695	5,728	1	3,753	22
Total	**71,553**	**13,798**	**41,728**	**3,828**	**2,695**	**5,728**	**1**	**3,753**	**22**

Note 9.4 NBV of property, plant and equipment in the Revaluation Reserve as at 31 March 2012

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & POA	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
as at 1 December 2011	**11,694**	6,459	4,537	404	0	294	0	0	0
movement in period	**(145)**	**0**	**(107)**	**(3)**	**0**	**(35)**	**0**	**0**	**0**
as at 31 March 2012	**11,549**	**6,459**	**4,430**	**401**	**0**	**259**	**0**	**0**	**0**

Note 10 Non-current assets for sale and assets in disposal groups

	Total	Property, Plant and Equipment
	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 December 2011	**1,000**	1,000
Movement in period	**0**	0
NBV of non-current assets for sale and assets in disposal groups at 31 March 2012	**1,000**	**1,000**

Note 11.1 Inventories

	31 March 2012	1 December 2011
	£000	£000
Drugs	867	856
Consumables	1,539	1,462
Energy	68	68
TOTAL Inventories	**2,474**	**2,386**

Note 11.2 Inventories recognised in expenses

	4 Months to 31 March 2012
	£000
Inventories recognised in expenses	8,104
Write-down of inventories recognised as an expense	5
TOTAL Inventories recognised in expenses	**8,109**

Note 12 Trade receivables and other receivables[4]

	Total 31 March 2012	Total 1 December 2011
	£000	£000
Current		
NHS Receivables - Revenue	1,802	5,111
Provision for impaired receivables	(13)	(16)
Prepayments (Non-PFI)	930	1,036
Accrued income	555	986
PDC dividend receivable	193	0
VAT receivable	244	172
Other receivables	1,412	1,351
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**5,123**	**8,640**

Note 13.1 Provision for impairment of receivables

	4 Months to 31 March 2012
	£000
At 1 December 2011	16
Unused amounts reversed	(3)
At 31 March 2012	**13**

Note 13.2 Analysis of impaired receivables	**31 March 2012**	**31 March 2012**	**1 December 2011**	**1 December 2011**
	£000	**£000**	**£000**	**£000**
Ageing of impaired receivables	Trade Receivables	Other Receivables	Trade Receivables	Other Receivables
0 - 30 days	0	0	0	0
30-60 Days	0	0	0	0
60-90 days	0	0	0	0
90- 180 days	0	0	0	0
over 180 days	13	0	16	0
Total	**13**	**0**	**0**	0
Ageing of non-impaired receivables past their due date				
0 - 30 days	67	0	96	0
30-60 Days	23	0	23	0
60-90 days	1	0	0	0
90- 180 days	13	0	10	0
over 180 days	5	0	48	0
Total	**109**	**0**	**177**	**0**

Note 14 Cash and cash equivalents

	£000
At 1 December 2011	5,797
Net change in year	4,742
At 31 March	**10,539**
Broken down into:	
Cash at commercial banks and in hand	27
Cash with the Government Banking Service	10,512
Cash and cash equivalents as in SoFP	**10,539**

Note 15.1 Trade and other payables	**Total**	**Total**
	31 March 2012	**1 December 2011**
	£000	**£000**
Current		
NHS payables - revenue	1,281	2,501
Other trade payables - capital	1,855	36
Other trade payables - revenue	4,701	2,084
Social Security costs	988	1,006
Other taxes payable	1,162	1,163
Other payables	2,292	3,169
Accruals	1,965	267
PDC dividend payable	0	435
TOTAL CURRENT TRADE AND OTHER PAYABLES	**14,244**	**10,661**

An amount of £1,223,000 relating to outstanding pension contributions is included within Other Payables. This liability will be paid in April 2012

Note 16 Borrowings	**31 March 2012**	**1 December 2011**
	£000	**£000**
Current		
Loans from Department of Health	**1,000**	1,000
TOTAL CURRENT BORROWINGS	**1,000**	**1,000**
Non-current		
Loans from Department of Health	500	1,000
TOTAL OTHER NON CURRENT LIABILITIES	**500**	**1,000**

Note 17 Prudential borrowing limit	**31 March 2012**
	£000
Total long term borrowing limit set by Monitor	23,500
Actual (contracted) working capital facility	12,300
Total Prudential Bollowing Limit	**35,800**
Borrowing as at 1 December 2011	2,000
Net actual repayment in period	(500)
Borrowing at 31 March 2012	**1,500**
Working capital borrowing at 1 December	0
Net actual borrowing/(repayment) in year - working capital	0
Working capital borrowing at 31 March 2012	**0**

Note 18 Other liabilities	**31 March 2012**	**1 December 2011**
	£000	**£000**
Current		
Other Deferred income	2,248	2,100
TOTAL OTHER CURRENT LIABILITIES	**2,248**	**2,100**
Non-current		
Other Deferred income	0	296
TOTAL OTHER NON CURRENT LIABILITIES	**0**	**296**

Note 19.1 Provisions for liabilities and charges

	Current		Non-current	
	31 March 2012	1 December 2011	31 March 2012	1 December 2011
Pensions relating to other staff	3	4	33	33
Other legal claims	54	95	0	0
Other	13	13	251	251
Total	**70**	**112**	**284**	**284**

Note 19.2 Provisions for liabilities and charges analysis

	Total	Pensions - other staff	Other legal claims	Other
	£000	£000	£000	£000
At 1 December 2011	**396**	37	95	264
Utilised during the year	**(17)**	(1)	(16)	0
Reversed unused	**(25)**	0	(25)	0
At 31 March 2012	**354**	**36**	**54**	**264**
Expected timing of cashflows:				
- not later than one year;	**70**	3	54	13
- later than one year and not later than five years;	**65**	14	0	51
- later than five years.	**219**	19	0	200
TOTAL	**354**	**36**	**54**	**264**

Pensions relating to other staff £36,000 - this comprises provisions for early retirements of staff calculated in line with Government guidelines.

Legal claims - comprising staff/visitor personal injury claims. This is calculated in line with Department of Health Guidance and information supplied by NHS Litigation Authority. The amount provided for at the year-end represents the excess payments for which the Trust may become liable, as adjusted for the likelihood of the liability being incurred.

Other claims £264,000 comprising expected future pension costs relating to injury benefit. This is calculated on the basis of guidance originally provided by the NHS Pensions Agency.

Note 19.3 Clinical Negligence liabilities

	Total
	£000
Amount included in provisions of the NHSLA at 31 March 2012 in respect of clinical negligence liabilities of West Suffolk Hospital NHS Foundation Trust	20,228

Note 20 Contingent Liabilities

	31 March 2012	1 December 2011
	£000	£000
Value of contingent liabilities		
Equal pay	25	25
Other	29	42
Gross value of contingent liabilities	54	67
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**54**	**67**

Other contingencies comprise the Trust's potential liability in respect of personal injury claims, over and above that considered probable to be incurred. The contingency is calculated in line with information supplied by the NHS Litigation Authority. These liabilities are likely to crystallise and result in payment within the 2012/13 financial year. A further contingency in respect of pay claims has been included as a contingency as it is improbable that this will occur and the timing of any payment is unknown.

The Trust had previously received a number of equal pay claims during the year. The outcome and potential liability in respect of these is unknown. The Trust has therefore made no provision for these in the accounts.

Note 21 Revaluation Reserve

	Total Revaluation Reserve	Revaluation Reserve -property, plant and equipment
	£000	£000
Revaluation reserve at 1 December 2011	**11,694**	11,694
Transfers to other reserves	**(145)**	(145)
Revaluation reserve at 31 March 2012	**11,549**	11,549

Note 22.1 Related Party Transactions

	Income	Expenditure
	£000	£000
Value of transactions with board members in the period	0	0
Value of transactions with key staff members in the period	0	0
Value of transactions with other related parties in the period		
Other NHS Bodies	51,317	3,525
Charitable Funds	155	0
Total value of transactions with related parties in the period	**51,472**	**3,525**

The Department of Health is regarded as a related party. During the period West Suffolk NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

		£000
East of England Strategic Health Authority	Income	2,008
Suffolk PCT	Income	40,469
Norfolk PCT	Income	5,386
Cambridgeshire PCT	Income	1,567
Cambridge University Hospitals NHS Foundation Trust	Income	274
South East Essex PCT	Income	291
Suffolk PCT	Expenditure	421
Cambridge University Hospitals NHS Foundation Trust	Expenditure	324
NHS Litigation Authority	Expenditure	933
National Blood Authority	Expenditure	317

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the NHS Trust board. A total of £155,000 was received from the charitable fund during the period.

Note 22.2 Related Party Balances

	Receivables £000	Payables £000
Other NHS Bodies	3,068	2,875
Total balances with related parties at 31 March 2012	**3,068**	**2,875**

Note 23 Contractual Capital Commitments

	31 March 2012 £000
Property, Plant and Equipment	280
Intangible assets	0
Total	280

Note 24.1 Financial assets by category

	Total £000	Loans and receivables £000	Assets at fair value through the I&E £000
Assets as per SoFP			
NHS Trade and other receivables excluding non financial assets (at 31 March 2012)	**1,802**	**1,802**	**0**
Non-NHS Trade and other receivables excluding non financial assets (at 31 March 2012)	**1,849**	**1,849**	**0**
Cash and cash equivalents at bank and in hand (at 31 March 2012)	**10,539**	**10,539**	**0**
Total at 31 March 2012	**14,190**	**14,190**	**0**
NHS Trade and other receivables excluding non financial assets (at 1 December 2011)	5,111	5,111	0
Non-NHS Trade and other receivables excluding non financial assets (at 1 December 2011)	1,507	1,507	0
Cash and cash equivalents (at bank and in hand (at 1 December 2011)	6,302	6,302	0
Total at 1 December 2011	12,920	12,920	0

Note 24.2 Financial liabilities by category

	Total £000	Other financial liabilities £000	Liabilities at fair value through the I&E £000
Liabilities as per SoFP			
Borrowings excluding Finance lease and PFI liabilities (at 31 March 2012)	**1,500**	1,500	0
NHS Trade and other payables excluding non financial assets (at 31 March 2012)	**1,281**	1,281	0
Non-NHS Trade and other payables excluding non financial assets (at 31 March 2012)	**10,998**	10,998	0
Total at 31 March 2012	**13,779**	**13,779**	**0**
Borrowings excluding Finance lease and PFI liabilities (at 1 December 2011)	2,505	2,505	0
NHS Trade and other payables excluding non financial assets (at 1 December 2011)	2,501	2,501	0
Non-NHS Trade and other payables excluding non financial assets (at 1 December 2011)	7,618	7,618	0
Total at 1 December 2011	12,624	12,624	0

Note 24.3 Fair values of financial liabilities at 31 March 2012

	Book Value £000	Fair value £000
Provisions under contract	354	354
Loans	1,500	1,500
Total	**1,854**	**1,854**

25. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with primary care Trusts and the way those primary care Trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2012 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care Trusts, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 26 Losses and Special Payments (approved cases only)	**4 Months to 31 March 2012 Total number of cases**	**4 Months to 31 March 2012 Total value of cases**
	Number	**£000's**
LOSSES:		
Losses of cash due to:	Numbers	Value
- overpayment of salaries etc.	1	0
Bad debts and claims abandoned in relation to:		
- private patients	4	0
Damage to buildings, property etc. due to:		
- other	4	6
TOTAL LOSSES	**9**	**6**
SPECIAL PAYMENTS:		
a. loss of personal effects	9	1
TOTAL SPECIAL PAYMENTS	**9**	**1**
TOTAL LOSSES AND SPECIAL PAYMENTS	**18**	**7**

27 Third party assets

The Trust held £NIL cash and cash equivalents at 31 March 2012 (£25 - at 1 December 2011) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

West Suffolk Hospitals NHS Trust

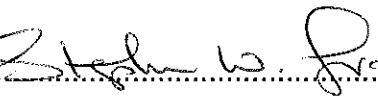
Accounts for the Period from 1 April 2011 to 30 November 2011

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTABLE OFFICER OF THE TRUST

The Chief Executive of the NHS has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Department of Health. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed.....  .....Chief Executive

30 May 2012

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

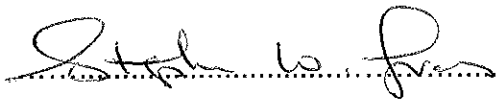
The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

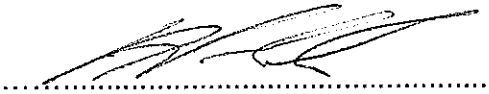
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

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

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

By order of the Board

30 May 2012  .....Chief Executive

30 May 2012  .....Director of Resources

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF WEST SUFFOLK HOSPITAL NHS TRUST

We have audited the financial statements of West Suffolk Hospital NHS Trust for the eight months ended 30 November 2011 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is described as having been audited.

This report is made solely to the Board of Directors of West Suffolk Hospital NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit the accounting statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of West Suffolk Hospital NHS Trust's affairs as at 30 November 2011 and of its income and expenditure for the eight month period then ended; and
- have been prepared properly in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

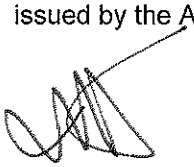
We report to you if:

- in our opinion the governance statement does not reflect compliance with the Department of Health's Guidance;
- we refer the matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have a reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998

We have nothing to report in these respects.

Certificate

We certify that we have completed the audit of the accounts of West Suffolk Hospital NHS Trust in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.



David Eagles, Partner
for and on behalf of **PKF (UK) LLP**
Statutory auditor
Ipswich, UK

30 May 2012

Statement of Comprehensive Income for the 8 months ended 30 November 2011

	NOTE	8 Months to November 2011 £000	2010-11 £000 (restated)
Employee benefits	7.1	**(70,460)**	(106,253)
Other costs	5	**(33,981)**	(46,992)
Revenue from patient care activities	2	**94,712**	139,071
Other Operating revenue	3	**11,419**	16,361
Operating surplus/(deficit)		**1,690**	2,187
Investment revenue	9	**17**	31
Other gains and (losses)	10	**0**	(63)
Finance costs	11	**(74)**	(157)
Surplus/(deficit) for the financial year		**1,633**	1,998
Public dividend capital dividends payable		**(1,536)**	(2,026)
Retained surplus/(deficit) for the year		**97**	(28)
Other Comprehensive Income			
Impairments and reversals		**0**	0
Net gain/(loss) on revaluation of property, plant & equipment		**0**	0
Net gain/(loss) on revaluation of intangibles		**0**	0
Net gain/(loss) on revaluation of financial assets		**0**	0
Net gain/(loss) on other reserves		**0**	0
Net gain/(loss) on available for sale financial assets		**0**	0
Net actuarial gain/(loss) on pension schemes		**0**	0
Reclassification adjustment on disposal of available for sale financial assets		**0**	0
Total comprehensive income for the year		**97**	(28)

Financial performance for the year		
Retained surplus/(deficit) for the year	**97**	-28
Prior period adjustment to correct errors	**0**	0
IFRIC 12 adjustment	**0**	0
Impairments	**0**	0
Adjustments iro donated asset reserve elimination	**154**	222
Adjusted retained surplus (deficit)	**251**	**194**

In accordance with Department of Health guidelines donated asset reserves have been transferred to retained earnings and the revaluation reserve.

Statement of Financial Position as at 30 November 2011

	NOTE	30 November 2011 £000	31 March 2011 (restated) £000	31 March 2010 (restated) £000
Non-current assets:				
Property, plant and equipment	12	**69,451**	70,443	71,788
Total non-current assets		**69,451**	70,443	71,788
Current assets:				
Inventories	16	**2,386**	2,312	2,205
Trade and other receivables	17.1	**8,640**	3,348	6,583
Cash and cash equivalents	18	**6,302**	11,119	10,846
Total current assets		**17,328**	16,779	19,634
Non-current assets held for sale	19	**1,000**	1,000	0
Total current assets		**18,328**	17,779	19,634
Total assets		**87,779**	88,222	91,422
Current liabilities				
Trade and other payables	20	**(12,761)**	(13,149)	(14,748)
Provisions	23	**(112)**	(116)	(82)
Borrowings	21	**(505)**	0	(1,054)
Working capital loan from Department	21	**(1,000)**	(1,000)	0
Total current liabilities		**(14,378)**	(14,265)	(15,884)
Non-current assets plus/less net current assets/liabilities		**73,401**	73,957	75,538
Non-current liabilities				
Trade and other payables	20	(296)	(445)	(988)
Provisions	23	(284)	(288)	(298)
Working capital loan from Department of Health	21	(1,000)	(1,500)	(2,500)
Total non-current liabilities		**(1,580)**	(2,233)	(3,786)
Total Assets Employed:		**71,821**	71,724	71,752
FINANCED BY:				
TAXPAYERS' EQUITY				
Public Dividend Capital		58,250	58,250	58,250
Retained earnings		1,877	1,088	767
Revaluation reserve		11,694	12,386	12,735
Total Taxpayers' Equity:		**71,821**	71,724	71,752

The notes on pages 144 to 176 form part of these accounts.

The financial statements on pages 140 to 176 were approved by the Board on 25 May 2012 and signed on its behalf by

Signed ..... (Chief Executive) 30 May 2012

Statement of Changes in Taxpayers' Equity
For the period ended 30 November 2011

	Public Dividend capital	Retained earnings	Revaluation reserve	Total reserves
	£000	£000	£000	£000
Balance at 1 April 2011	58,250	1,088	12,386	**71,724**
Opening balance adjustments	0	0	0	**0**
Restated balance at 1 April 2011	58,250	1,088	12,386	**71,724**
Changes in taxpayers' equity				
Retained surplus/(deficit) for the period	0	97	0	**97**
Transfers between reserves	0	692	(692)	**0**
Net recognised revenue/(expense) for the period	0	789	(692)	97
Balance at 30 November 2011	**58,250**	**1,877**	**11,694**	**71,821**
Included above:				
Transfer from revaluation reserve to retained earnings in respect of impairments	0	0	0	0
Changes in taxpayers' equity for 2010-11				
Balance at 1 April 2010	58,250	767	12,735	71,752
Retained surplus/(deficit) for the year		(28)		(28)
Transfers between reserves		349	(349)	0
Net recognised revenue/(expense) for the year	0	321	(349)	(28)
Balance at 31 March 2011	**58,250**	**1,088**	**12,386**	**71,724**

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
30 November 2011

	8 Months to November 2011 £000	2010-11 £000
Cash Flows from Operating Activities		
Operating Surplus/Deficit	**1,690**	**2,187**
Depreciation and Amortisation	**3,183**	**4,576**
Impairments and Reversals	**6**	**0**
Donated Assets received credited to revenue but non-cash	**0**	**(13)**
Interest Paid	**(54)**	**(153)**
Dividend paid	**(1,031)**	**(2,003)**
(Increase)/Decrease in Inventories	**(74)**	**(107)**
(Increase)/Decrease in Trade and Other Receivables	**(5,292)**	**3,235**
Increase/(Decrease) in Trade and Other Payables	**(662)**	**(1,657)**
Provisions Utilised	**(102)**	**(39)**
Increase/(Decrease) in Provisions	**90**	**57**
Net Cash Inflow/(Outflow) from Operating Activities	**(2,246)**	**6,083**
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest Received	**17**	**31**
(Payments) for Property, Plant and Equipment	**(2,593)**	**(4,800)**
Net Cash Inflow/(Outflow) from Investing Activities	**(2,576)**	**(4,769)**
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING	**(4,822)**	**1,314**
CASH FLOWS FROM FINANCING ACTIVITIES		
Loans repaid to DH - Working Capital Loans Repayment of Principal	(500)	(1,000)
Capital grants and other capital receipts	0	13
Net Cash Inflow/(Outflow) from Financing Activities	**(500)**	**(987)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS	**(5,322)**	**327**
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	11,119	10,792
Opening balance adjustment	0	
Restated Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period	11,119	10,792
Cash and Cash Equivalents (and Bank Overdraft) at year end	5,797	11,119

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011-12 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual 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 NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 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.

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.4 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.5 Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of leave 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.

1.6 Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.7 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- 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 will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- 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 a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost 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. All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Notes to the Accounts - 1. Accounting Policies (Continued)

Land and buildings used for the trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives

At each reporting period end, the trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

Notes to the Accounts - 1. Accounting Policies (Continued)

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.10 Donated assets

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated.

1.11 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.12 Leases
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.

The Trust as lessee
Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The Trust as lessor
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 so as to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line 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 on a straight-line basis over the lease term.

1.13 Inventories
Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.14 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 equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management.

1.15 Provisions
Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (2.8% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.16 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 23.

1.17 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 the NHS Litigation Authority 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 as and when they become due.

1.18 EU Emissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.19 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.20 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Notes to the Accounts - 1. Accounting Policies (Continued)

Available for sale financial assets
Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.21 Financial liabilities
Financial liabilities are recognised on the statement of financial position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of:

The premium received (or imputed) for entering into the guarantee less cumulative amortisation.

The amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets* ; and

Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Notes to the Accounts - 1. Accounting Policies (Continued)

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.22 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.

1.23 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 30 November. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.24 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 27 to the accounts.

1.25 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

1.26 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, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

Notes to the Accounts - 1. Accounting Policies (Continued)

1.27 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust's or where the subsidiary's accounting date is before 1 January or after 30 June.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

For 2010-11 and 2011-12 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the corporate trustee.

1.28 Associates

Material entities over which the Trust has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the Trust's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the Trust's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the Trust from the entity.

Associates that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

1.29 Joint ventures

Material entities over which the Trust has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

1.30 Joint operations

Joint operations are activities undertaken by the Trust in conjunction with one or more other parties but which are not performed through a separate entity. The Trust records its share of the income and expenditure; gains and losses; assets and liabilities; and cashflows.

1.31 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.32 Accounting Standards that have been issued but have not yet been adopte

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2011-12. The application of the Standards as revised would not have a material impact on the accounts for 2011-12, were they applied in that year:

IAS 1 Presentation of financial statements (Other Comprehensive Income) - subject to consultation
IAS 12 - Income Taxes (amendment) - subject to consultation
IAS 19 Post-employment benefits (pensions) - subject to consultation
IAS 27 Separate Financial Statements - subject to consultation
IAS 28 Investments in Associates and Joint Ventures - subject to consultation
IFRS 7 - Financial Instruments: Disclosures (annual improvements) - effective 2012-13
IFRS 9 Financial Instruments - subject to consultation - subject to consultation
IFRS 10 Consolidated Financial Statements - subject to consultation
IFRS 11 Joint Arrangements - subject to consultation
IFRS 12 Disclosure of Interests in Other Entities - subject to consultation
IFRS 13 Fair Value Measurement - subject to consultation
IPSAS 32 - Service Concession Arrangement - subject to consultation

2. Revenue from patient care activities	**8 Months to November 2011** **£000**	2010-11 £000
Strategic Health Authorities	**0**	0
NHS Trusts	**191**	0
Primary Care Trusts - tariff	**71,681**	107,066
Primary Care Trusts - non-tariff	**17,689**	25,752
Primary Care Trusts - market forces factor	**3,102**	4,325
Foundation trusts	**141**	240
Local Authorities	**7**	11
Department of Health	**0**	14
NHS other	**0**	0
Non-NHS:		
Private patients	**1,580**	1,161
Overseas patients (non-reciprocal)	**28**	25
Injury costs recovery	**249**	469
Other	**44**	8
	94,712	139,071

3. Other operating revenue	**8 Months to November 2011** **£000**	2010-11 £000
Recoveries in respect of employee benefits	**542**	1,336
Patient transport services	**34**	55
Education, training and research	**4,229**	6,299
Charitable and other contributions to expenditure	**222**	297
Receipt of donations for capital acquisitions	**0**	13
Non-patient care services to other bodies	**3,071**	5,012
Income generation	**1,866**	2,120
Other revenue	**1,455**	1,229
	11,419	16,361
Total operating revenue	**106,131**	155,432

4. Revenue	**8 Months to November 2011** **£000**	2010-11 £000
From rendering of services	**106,131**	155,432
From sale of goods	**0**	0

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

5. Operating expenses (excluding employee benefits)	8 Months to November 2011 £000	2010-11 £000
Purchase of healthcare from non NHS bodies	**621**	888
Trust chair and non executive directors	**36**	54
Supplies and services - clinical	**18,796**	26,875
Supplies and services - general	**1,678**	2,498
Consultancy services	**178**	507
Establishment	**871**	1,044
Transport	**976**	1,810
Premises	**3,055**	4,613
Impairments and Reversals of Receivables	**6**	(3)
Inventories write down	**26**	43
Depreciation	**3,183**	4,576
Impairments and reversals of property, plant and equipment	**6**	0
Audit fees	**77**	128
Other auditor's remuneration	**0**	0
Clinical negligence	**2,001**	2,683
Education and Training	**227**	361
Other	**2,244**	915
	33,981	46,992
Employee benefits		
Employee benefits excluding Board members	**70,424**	106,199
Board members	**36**	54
Total employee benefits	**70,460**	106,253
Total operating expenses	**104,441**	153,245

6 Operating Leases

The Trust as part of its normal operations enters into operating lease arrangements for vehicles and certain medical equipment, primarily radiology and pathology equipment. The maximum term of these agreements is 7 years.

6.1 Trust as lessee	Land £000	Buildings £000	Other £000	8 Months to November 2011 Total £000	2010-11 £000
Payments recognised as an expense					
Minimum lease payments				**943**	1,143
Contingent rents				**0**	0
Sub-lease payments				**0**	0
Total				**943**	1,143
Payable:					
No later than one year	**0**	**0**	**675**	**675**	486
Between one and five years	**0**	**0**	**1,776**	**1,776**	1,218
After five years	**0**	**0**	**174**	**174**	190
Total	**0**	**0**	**2,625**	**2,625**	1,894
Total future sublease payments expected to be received:				0	0

7 Employee benefits and staff numbers

7.1 Employee benefits

	Total £000	Permanently employed £000	Other £000
Employee Benefits - gross expenditure			
Salaries and wages	59,642	53,191	6,451
Social security costs	4,438	4,438	0
Employer contributions to NHS Pensions scheme	6,756	6,756	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Total employee benefits	70,836	64,385	6,451
Less recoveries in respect of employee benefits	-542	-542	0
Total - Net Employee Benefits including capitalised costs	70,294	63,843	6,451
Employee costs capitalised	376	376	0
Total employee benefits excluding capitalised costs	70,460	64,009	6,451

	Total £000	Permanently employed £000	Other £000
Employee Benefits 2010-11 - net expenditure			
Salaries and wages	90,032	79,993	10,039
Social security costs	6,841	6,841	0
Employer contributions to NHS Pensions scheme	9,799	9,799	0
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	70	70	0
Total employee benefits	106,742	96,703	10,039
Employee costs capitalised	489		
Total employee benefits excluding capitalised costs	106,253		

7.2 Staff Numbers

	8 Months to November 2011			2010-11
	Total Number	Permanently employed Number	Other Number	Total Number
Average Staff Numbers				
Medical and dental	326	300	26	342
Ambulance staff	0	0	0	0
Administration and estates	529	526	3	535
Healthcare assistants and other support staff	602	593	9	586
Nursing, midwifery and health visiting staff	726	723	3	734
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	311	309	2	307
Social Care Staff	0	0	0	0
Other	0	0	0	0
TOTAL	2,494	2,451	43	2,504
Of the above - staff engaged on capital projects	17	17	0	12

7.3 Staff Sickness absence and ill health retirements

	8 Months to November 2011 Number	2010-11 Number
Total Days Lost	**21,776**	**31,729**
Total Staff Years	**1,663**	**2,504**
Average working Days Lost	13	13

7.4 Exit Packages agreed in 2011-12

	8 Months to November 2011			2010-11		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
	Number	**Number**	**Number**	**Number**	**Number**	**Number**
Less than £10,000	**0**	0	**0**	0	0	**0**
£10,001-£25,000	**0**	0	**0**	0	0	**0**
£25,001-£50,000	**0**	0	**0**	0	0	**0**
£50,001-£100,000	**0**	0	**0**	0	0	**0**
£100,001 - £150,000	**0**	0	**0**	0	0	**0**
£150,001 - £200,000	**0**	0	**0**	0	0	**0**
>£200,000	**0**	0	**0**	0	0	**0**
Total number of exit packages by type (total cost	**0**	**0**	**0**	**0**	**0**	**0**
Total resource cost (£000s)	0	0	**0**	0	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme.**Exit costs in this note are accounted for in full in the year of departure**. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

7.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

8 Better Payment Practice Code

8.1 Measure of compliance

	8 Months to November 2011 Number	8 Months to November 2011 £000	2010-11 Number	2010-11 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**29,026**	**29,417**	43,273	41,356
Total Non-NHS Trade Invoices Paid Within Target	**27,376**	**26,871**	40,766	37,971
Percentage of NHS Trade Invoices Paid Within Target	94.32%	91.35%	94.21%	91.81%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,072**	**7,618**	1,520	10,397
Total NHS Trade Invoices Paid Within Target	**991**	**7,073**	1,417	9,764
Percentage of NHS Trade Invoices Paid Within Target	92.44%	92.85%	93.22%	93.91%

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

8.2 The Late Payment of Commercial Debts (Interest) Act 1998

	8 Months to November 2011 £000	2010-11 £000
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0

9 Investment Income

	8 Months to November 2011 £000	2010-11 £000
Rental Income		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Subtotal	**0**	0
Interest Income		
Bank interest	**17**	31
Subtotal	**17**	31
Total investment income	**17**	31

10 Other Gains and Losses

	8 Months to November 2011 £000	2010-11 £000
Gain/(loss) on disposal of property, plant and equipment	**0**	(63)
Total	**0**	(63)

11 Finance Costs

	8 Months to November 2011 £000	2010-11 £000
Interest		
Interest on loans and overdrafts	**70**	151
Provisions - unwinding of discount	**4**	6
Total interest expense	**74**	157
Other finance costs	**0**	0
Total	**74**	157

12.1 Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:									
At 31 March 2011	13,798	46,410	4,060	1,590	16,692	30	8,278	30	**90,888**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
Merger adjustments	0	0	0	0	0	0	0	0	**0**
At 1 April 2011 restated	13,798	46,410	4,060	1,590	16,692	30	8,278	30	**90,888**
Additions Purchased	0	0	0	1,898	223	0	76	0	**2,197**
Disposals other than for sale	0	0	0	0	(220)	(15)	0	0	**(235)**
At 30 November 2011	**13,798**	**46,410**	**4,060**	**3,488**	**16,695**	**15**	**8,354**	**30**	**92,850**
Depreciation									
At 31 March 2011	0	3,981	145		10,583	28	5,704	4	**20,445**
Prior period adjustments	0	0	0		0	0	0	0	**0**
Merger adjustments	0	0	0		0	0	0	0	**0**
At 1 April 2011 restated	0	3,981	145		10,583	28	5,704	4	**20,445**
Disposals other than for sale	0	0	0		(220)	(15)	0	0	**(235)**
Impairments	0	0	0	0	6	0	0	0	**6**
Charged During the Year	0	1,724	58		731	0	667	3	**3,183**
At 30 November 2011	**0**	**5,705**	**203**	**0**	**11,100**	**13**	**6,371**	**7**	**23,399**
Net book value at 30 November 2011	13,798	40,705	3,857	3,488	5,595	2	1,983	23	**69,451**
Purchased	13,798	38,418	3,857	3,488	5,274	2	1,979	23	**66,839**
Donated	0	2,287	0	0	321	0	4	0	**2,612**
Total at 30 November 2011	**13,798**	**40,705**	**3,857**	**3,488**	**5,595**	**2**	**1,983**	**23**	**69,451**
Asset financing:									
Owned	13,798	40,705	3,857	3,488	5,595	2	1,983	23	**69,451**
Total	**13,798**	**40,705**	**3,857**	**3,488**	**5,595**	**2**	**1,983**	**23**	**69,451**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	**£000's**
At 31 March 2011	6,459	5,077	410	435	0	5	0	**12,386**
Prior period adjustments	0	0	0	0	0	0	0	**0**
Merger adjustments	0	0	0	0	0	0	0	**0**
At 1 April 2011 restated	6,459	5,077	410	435	0	5	0	**12,386**
Movements - transfer to retained earnings	0	(545)	(6)	(141)	0	0	0	**(692)**
At 30 November 2011	6,459	4,532	404	294	0	5	0	**11,694**

12.2 Property, plant and equipment

2010-11	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation:									
At 1 April 2010	14,798	44,922	4,060	661	17,339	30	7,342	30	**89,182**
Additions - purchased	0	1,240	0	1,305	898	0	838	0	**4,281**
Additions - donated	0	0	0	0	13	0	0	0	**13**
Reclassifications	0	248	0	(376)	0	0	128	0	**0**
Reclassified as held for sale	(1,000)	0	0	0	0	0	0	0	**(1,000)**
Disposals other than by sale	0	0	0	0	(1,558)	0	(30)	0	**(1,588)**
At 31 March 2011	**13,798**	**46,410**	**4,060**	**1,590**	**16,692**	**30**	**8,278**	**30**	**90,888**
Depreciation									
At 1 April 2010	0	1,489	58		10,996	26	4,825	0	**17,394**
Disposals other than for sale	0	0	0		(1,495)	0	(30)	0	**(1,525)**
Charged During the Year	0	2,492	87		1,082	2	909	4	**4,576**
At 31 March 2011	0	3,981	145	0	10,583	28	5,704	4	20,445
Net book value	**13,798**	**42,429**	**3,915**	**1,590**	**6,109**	**2**	**2,574**	**26**	**70,443**
Purchased	13,798	40,038	3,915	1,590	5,738	2	2,570	26	**67,677**
Donated	0	2,391	0	0	371	0	4	0	**2,766**
Total at 31 March 2011	13,798	42,429	3,915	1,590	6,109	2	2,574	26	**70,443**
Asset financing:									
Owned	13,798	42,429	3,915	1,590	6,109	2	2,574	26	**70,443**
	13,798	42,429	3,915	1,590	6,109	2	2,574	26	**70,443**

12.3 (cont). Property, plant and equipment

The Trusts land, buildings and dwellings were independently revalued by the Valuation Office as at 31 July 2009. The methodology applied during the valuation agrees with the Accounting Policy as set out in note 1.

Economic Lives of Non-Current Assets	Min Life Years	Max Life Years
Buildings exc Dwellings (new build)	10	35
Dwellings (new build)	10	35
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture and Fittings	7	10

13 Analysis of impairments and reversals recognised in the 8 months to 30 November 2011

	8 Months to November 2011 Total £000
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	6
Total charged to Departmental Expenditure Limit	6
Total Impairments of Property, Plant and Equipment	6
Total Impairments charged to Revaluation Reserve	0
Total Impairments charged to SoCI - DEL	6
Total Impairments charged to SoCI - AME	0
Overall Total Impairments	6

14 Commitments

19.1 Capital commitments

Contracted capital commitments at 30 November not otherwise included in these financial statements:

	30 November 2011	31 March 2011
	£000	£000
Property, plant and equipment	**2,188**	769
Total	**2,188**	769

15 Intra-Government and other balances

	Current receivables £000s	**Non-current receivables £000s**	**Current payables £000s**	**Non-current payables £000s**
Balances with other Central Government Bodies	4,536	0	1,704	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	575	0	797	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	3,529	0	10,556	0
At 30 November 2011	**8,640**	**0**	**13,057**	**0**
prior period:				
Balances with other Central Government Bodies	813	0	4,481	0
Balances with Local Authorities	0	0	0	0
Balances with NHS Trusts and Foundation Trusts	365	0	1,242	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	2,170	0	7,426	445
At 31 March 2011	**3,348**	**0**	**13,149**	**445**

16 Inventories

	Drugs £000	Consumables £000	Energy £000	Total £000
Balance at 1 April 2011	774	1,466	72	**2,312**
Prior period adjustment	0	0	0	**0**
Merger adjustment	0	0	0	**0**
Restated at 1 April 2011	774	1,466	72	**2,312**
Additions	7,703	8,393	123	**16,219**
Inventories recognised as an expense in the period	(7,595)	(8,397)	(127)	**(16,119)**
Write-down of inventories (including losses)	(60)	0	0	**(60)**
Reversal of write-down previously taken to SoCI	34	0	0	**34**
Transfers (to)/from other bodies	0	0	0	**0**
Transfers (to) Foundation Trusts	0	0	0	**0**
Balance at 30 November 2011	856	1,462	68	**2,386**

17.1 Trade and other receivables

	Current		Non-current	
	30 November 2011 £000	31 March 2011 £000	30 November 2011 £000	31 March 2011 £000
NHS receivables - revenue	**5,111**	1,007	**0**	0
Non-NHS receivables - revenue	**476**	549	**0**	0
Non-NHS prepayments and accrued income	**2,022**	705	**0**	0
Provision for the impairment of receivables	**(16)**	(14)	**0**	0
VAT	**172**	171	**0**	0
Other receivables	**875**	930	**0**	0
Total	**8,640**	3,348	**0**	0
Total current and non current	**8,640**	3,348		
Included in NHS receivables are prepaid pension contributions:	**0**	0		

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

17.2 Receivables past their due date but not impaired

	30 November 2011 £000
By up to three months	**119**
By three to six months	**18**
By more than six months	**41**
Total	**178**

22.3 Provision for impairment of receivables

	30 November 2011 £000
Balance at 1 April 2011	**(14)**
Adjustments	**0**
Restated balance at 1 April 2011	**(14)**
Amount written off during the year	**4**
Amount recovered during the year	**9**
(Increase)/decrease in receivables impaired	**(15)**
Transfer to NHS Foundation Trust	**0**
Balance at 30 November 2011	**(16)**

18 Cash and Cash Equivalents

	30 November 2011 £000	31 March 2011 £000
Opening balance	**11,119**	**10,846**
Restated	**11,119**	10,846
Net change in period / year	**(4,817)**	273
Closing balance	**6,302**	11,119
Made up of		
Cash with Government Banking Service	**6,292**	11,085
Commercial banks	**0**	28
Cash in hand	**10**	6
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**6,302**	11,119
Bank overdraft - Government Banking Service	**0**	0
Bank overdraft - Commercial banks	**(505)**	0
Cash and cash equivalents as in statement of cash flows	**5,797**	11,119
Patients' money held by the Trust, not included above	0	0

19 Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2011	1,000	0	0	0	0	0	0	0	0	**1,000**
Merger adjustments	0	0	0	0	0	0	0	0	0	**0**
Restated at 1 April 2011	1,000	0	0	0	0	0	0	0	0	**1,000**
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	**0**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from other bodies	0	0	0	0	0	0	0	0	0	**0**
Balance at 30 November 2011	**1,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,000**
Liabilities associated with assets held for sale at 30 November 2011	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2010	0	0	0	0	0	0	0	0	0	**0**
Plus assets classified as held for sale in the year	1,000	0	0	0	0	0	0	0	0	**1,000**
Less assets sold in the year	0	0	0	0	0	0	0	0	0	**0**
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	**0**
Balance at 31 March 2011	**1,000**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,000**
Liabilities associated with assets held for sale at 31 March 2011	0	0	0	0	0	0	0	0	0	0

20 Trade and other payables

	Current		Non-current	
	30 November 2011	31 March 2011	**30 November 2011**	31 March 2011
	£000	£000	**£000**	£000
Interest payable	**21**	5		
NHS payables - revenue	**2,501**	2,395	**0**	0
NHS accruals and deferred income	**0**	0	**0**	0
Non-NHS payables - revenue	**2,084**	2,170	**0**	0
Non-NHS payables - capital	**36**	432	**0**	0
Non-NHS accruals and deferred income	**2,642**	4,651	**296**	445
Social security costs	**1,006**	961	**0**	0
Tax	**1,163**	1,169	**0**	0
Payments received on account	**0**	0	**0**	0
Other	**3,308**	1,366	0	0
Total	**12,761**	13,149	**296**	445
Total payables (current and non-current)	**13,057**	**13,594**		

Included above:	**£000**	£000
outstanding Pension Contributions at the year end	**1,273**	1,194

21 Borrowings

	Current		Non-current	
	30 November 2011	31 March 2011	**30 November 2011**	31 March 2011
	£000	£000	**£000**	£000
Bank overdraft - commercial banks	**505**	0	**0**	0
Loans from Department of Health	**1,000**	1,000	**1,000**	1,500
Total	**1,505**	**1,000**	**1,000**	**1,500**
Total other liabilities (current and non-current)	**2,505**	**2,500**		

Loans - repayment of principal falling due in:

	30 November 2011		
	DH	**Other**	**Total**
	£000	**£000**	**£000**
0-1 years	1,000	505	1,505
1 - 2 Years	1,000	0	1,000
2 - 5 Years	0	0	0
Over 5 Years	0	0	0
TOTAL	2,000	505	2,505

22 Deferred income

	Current		Non-current	
	30 November 2011 £000	31 March 2011 £000	**30 November 2011 £000**	31 March 2011 £000
Opening balance at 1 April 2011	**2452**	3125	**445**	988
Deferred income addition	**340**	111	**0**	0
Transfer of deferred income	**(479)**	(784)	**(362)**	(543)
Current deferred Income at 30 November 2011	**2,313**	2,452	**83**	445
Total other liabilities (current and non-current)	**2,396**	**2,897**		

23 Provisions

Comprising:

	Total	Pensions to Former Directors	Pensions Relating to Other Staff	Legal Claims	Restructuring	Continuing Care	Equal Pay	Agenda for Change	Other	Redundancy
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2011	404	0	38	101	0	0	0	0	265	0
Prior period adjustment	0	0	0	0	0	0	0	0	0	0
Merger adjustments	0	0	0	0	0	0	0	0	0	0
Restated Balance 1 April 2011	404	0	38	101	0	0	0	0	265	0
Arising During the Year	92	0	1	87	0	0	0	0	4	0
Utilised During the Year	(102)	0	(2)	(91)	0	0	0	0	(9)	0
Reversed Unused	(2)	0	0	(2)	0	0	0	0	0	0
Unwinding of Discount	4	0	0	0	0	0	0	0	4	0
Change in Discount Rate	0	0	0						0	
Balance as at 30 November 2011	**396**	**0**	**37**	**95**	**0**	**0**	**0**	**0**	**264**	**0**
Expected Timing of Cash Flows:										
No Later than One Year	**112**	**0**	**4**	**95**	**0**	**0**	**0**	**0**	**13**	**0**
Later than One Year and not later than Five Years	**66**	**0**	**15**	**0**	**0**	**0**	**0**	**0**	**51**	**0**
Later than Five Years	**218**	**0**	**18**	**0**	**0**	**0**	**0**	**0**	**200**	**0**

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:	**£000s**
As at 30 November 2011	19,090
As at 31 March 2011	22,844

Pensions relating to other staff £37,000 - this comprises provisions for early retirements of staff calculated in line with Government guidelines.

Legal claims - comprising staff/visitor personal injury claims. This is calculated in line with Department of Health Guidance and information supplied by NHS Litigation Authority. The amount provided for at the year-end represents the excess payments for which the Trust may become liable, as adjusted for the likelihood of the liability being incurred.

Other claims £264,000 comprising expected future pension costs relating to injury benefit. This is calculated on the basis of guidance originally provided by the NHS Pensions Agency.

24 Contingencies

	30 November 2011	31 March 2011
	£000	£000
Contingent liabilities		
Equal Pay	**(25)**	**(25)**
Other	**(42)**	**(106)**
Net Value of Contingent Liabilities	**(67)**	**(131)**

25 Financial Instruments

25.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Primary Care Trusts and the way those primary care trusts are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's Internal Auditors.

Currency risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the Strategic Health Authority. The borrowings are for 1 – 2 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 30 November 2011 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Primary Care Trusts, which are financed from resources voted annually by Parliament The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

25.2 Financial Assets	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0	0	0	0
Receivables - NHS	0	5,111	0	5,111
Receivables - non-NHS	0	1,507	0	1,507
Cash at bank and in hand	0	6,302	0	6,302
Other financial assets	0	0	0	0
Total at 30 November 2011	0	12,920	0	12,920
Embedded derivatives	0	0	0	0
Receivables - NHS	0	1,007	0	1,007
Receivables - non-NHS	0	1,636	0	1,636
Cash at bank and in hand	**0**	11,119	0	11,119
Other financial assets	**0**	**0**	**0**	0
Total at 31 March 2011	**0**	**13,762**	**0**	**13,762**

25.3 Financial Liabilities	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	0
NHS payables	0	2,501	2,501
Non-NHS payables	0	7,618	7,618
Other borrowings	0	2,505	2,505
PFI & finance lease obligations	0	0	0
Other financial liabilities	0	0	0
Total at 30 November 2011	0	12,624	12,624
Embedded derivatives	0	0	**0**
NHS payables	0	2,395	2,395
Non-NHS payables	0	6,579	6,579
Other borrowings	0	2,500	2,500
PFI & finance lease obligations	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2011	**0**	11,474	11,474

26 Related party transactions

During the period none of the Department of Health Ministers, trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with West Suffolk Hospitals NHS Trust.

The Department of Health is regarded as a related party. During the period West Suffolk Hospitals NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department.

	8 Months to 30 November 2011	2010-11	
	£000	£000	
East of England Strategic Health Authority	4,083	6,030	income
Suffolk PCT	83,202	119,814	income
Norfolk PCT	8,824	13,612	income
Cambridgeshire PCT	1,947	3,176	income
Norfolk and Suffolk NHS Foundation Trust / Suffolk Mental Health NHS Trust	200	465	income
Cambridge University Hospitals NHS Foundation Trust	216	723	income
South East Essex PCT	1,146	1,673	income
Cambridge University Hospitals NHS Foundation Trust	703	883	expenditure
Suffolk PCT	244	949	expenditure
NHS Litigation Authority	2,064	2,773	expenditure
National Blood Authority	743	1,044	expenditure
East of England Ambulance Trust	454	903	expenditure

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the NHS Trust board. A total of £222,000 was received from the charitable fund during the period (2010-11 £297,000).

27 Losses and special payments

The total number of losses cases in the 8 month period to 30 November 2011 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	30,445	14
Special payments	4,601	17
Total losses and special payments	35,046	31

The total number of losses cases in 2010-11 and their total value was as follows:

	Total Value of Cases £s	**Total Number of Cases**
Losses	59,609	31
Special payments	3,618	30
Total losses and special payments	63,227	61

28. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

28.1 Breakeven performance	2005-06 £000	2006-07 £000	2007-08 £000	2008-09 £000	2009-10 £000	2010-11 £000	8 Month period to 30 November 2011 £000
Turnover	98,022	116,264	122,007	139,099	152,471	154,318	106,131
Retained surplus/(deficit) for the year	(12,995)	974	2,588	4,600	6,105	194	97
Adjustment for:							
Timing/non-cash impacting distortions:							
Use of pre - 1.4.97 surpluses [FDL(97)24 Agreements]	0	0	0	0	0	0	0
2006/07 PPA (relating to 1997/98 to 2005/06)	0						
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0					
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0				
Adjustments for Impairments				0	168	0	0
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*					0	0	0
Adjustments for impact of policy change re donated/government grants assets							154
Other agreed adjustments	9,043	0	0	0	0	0	0
Break-even in-year position	(3,952)	974	2,588	4,600	6,273	194	251
Break-even cumulative position	(13,178)	(12,204)	(9,616)	(5,016)	1,257	1,451	1,702

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	8 Month period to 30 November 2011 %
Materiality test (I.e. is it equal to or less than 0.5%):							
Break-even in-year position as a percentage of turnover	-4.03	0.84	2.12	3.31	4.11	0.13	0.24
Break-even cumulative position as a percentage of turnover	-13.44	-10.50	-7.88	-3.61	0.82	0.94	1.60

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

28.2 Capital cost absorption rate

Until 2008/09 the trust was required to absorb the cost of capital at a rate of 3.5% of forecast average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital bears to the actual average relevant net assets.

From 2009/10 the dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

28.3 External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	8 Months to November 2011		2010-11
	£000	**£000**	£000
External financing limit		**4,822**	**(1,319)**
Cash flow financing	**4,822**		(1,314)
Finance leases taken out in the year	**0**		0
Other capital receipts	**0**		(13)
External financing requirement		**4,822**	**(1,327)**
Undershoot/(overshoot)		**0**	**8**

28.4 Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	8 Months to November 2011	2010-11
	£000	£000
Gross capital expenditure	**2,197**	4,294
Less: book value of assets disposed of	**0**	(63)
Less: capital grants	**0**	0
Less: donations towards the acquisition of non-current assets	**0**	(13)
Charge against the capital resource limit	**2,197**	4,218
Capital resource limit	**6,615**	6,863
(Over)/underspend against the capital resource limit	**4,418**	2,645

29 Third party assets

The Trust held £25 cash and cash equivalents at 30 November 2011 (£25 - at 31 March 2011) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

30 Subsequent Events