West Suffolk NHS
NHS Foundation Trust

Annual Report & Accounts

2015/16

Putting you first

West Suffolk NHS Foundation Trust

Annual Report and Accounts 2015/16

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

Contents

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

1. Performance report

1.1 Overview

1.1.1 A message from the chairman and chief executive

We are delighted to introduce our annual report for the year 2015/16.

The year brought significant challenges and changes to the organisation and you can read more about them and how we have responded throughout this report. We remain a high-performing hospital and our achievements this year have once again been publicly recognised with further awards to add to our growing trophy cabinet. Our latest accolades are described on page 17 and they are a tribute to the excellent staff who work in our services.

A changing health economy
The environment we operate in continues to change with our clinical commissioning groups (CCGs) and NHS England seeking to develop new models of care that will strengthen and support the closer integration of hospital services with community-based teams, primary care, mental health and social care. Here in Suffolk our two CCGs (east and west) are now working closely together with a single accountable officer and are moving towards further integration of services for our populations.

In October 2015 we took a significant step towards integration when we were awarded a one-year contract to run Suffolk community healthcare services as part of a joint venture with The Ipswich Hospital NHS Trust. Other partners are involved in providing these services with us and our success so far in delivering quality care for patients has been recognised with a one-year extension to the contract. The challenges of achieving this transition and making the new arrangements work make this a significant achievement for the Trust. We know there is much more to do to genuinely transform services and we are in a better position to start this work now that we have the agreement that the current arrangement will stay in place until October 2017.

Maintaining financial balance
The move towards new models of care is urgently needed because acute hospitals as well as other parts of the health economy are struggling to manage the growing cost of their services. This is driven by higher numbers of patients needing care and the increased expense of the drugs and technologies used to treat them. Like many hospitals across the country we came under significant financial pressure during the year which ended with us being £9.8m in deficit. This was slightly worse than we had expected and we are working hard inside and outside the organisation to identify where whole system changes and productivity improvements can be made to bring us back into balance.

Quality
We are proud of the quality of our services and at the same time determined to keep improving wherever we can. We know from benchmarking data that many of our services offer among the best safety and outcomes recorded anywhere in the country. Our patient surveys demonstrate that most of the time we get it right for them and that they have a good experience of our care. However this is not the case in every instance and we receive concerns and complaints that we work hard to address and resolve. You can read more about the quality of our services in our quality report on page 74.

Growing demand for services and our performance
We are seeing significant growth in demand for our services particularly in the area of urgent and unplanned care. During March 2016 we had two days of record-breaking attendances at our emergency department when the number of patients turning up needing assistance was nearly 40 per cent above the average levels. This has affected our ability to deliver the four hour standard for either admitting or discharging patients after arrival at our emergency department (ED) and our performance this year is described on page 111 of this report.

In our elective services we are measured against a target of treating patients within 18 weeks of their referral to us by either a GP or another hospital. We have performed consistently well in this area and continue to meet all targets. Similarly we have met all the targets set for our performance in treating patients with cancer who need to be diagnosed and treated within safe timeframes.

Our excellent staff
Our staff remain our greatest asset and this year they have risen to the challenge of growing demand for our services while continuing to provide care that is outstanding for its quality. Our staff survey provides solid evidence that our staff are positive about working here and feel well engaged in the organisation. More staff recommend us as a place to work and as a place to receive treatment that at any other acute hospital in East Anglia. This is something we are proud of and want to build on and you can read more about our staff survey including the areas where we need to improve on page 68 of this report.

We recognise that our staff deliver change and improve our services, not management. This year we launched *Freedom to Speak Up*, a campaign to encourage and support staff to speak up and act whenever they see anything that can be improved, an issue that needs resolving or an area where praise can be given for exceptional achievement. Hundreds of staff have now signed our pledge '*never to walk by'* and we are now continuing to develop the campaign with staff and also patients who we have also asked to speak up. In a recent patient feedback day patients were able to talk to us around the hospital about their thoughts about our services and how they can be improved.

Updating our IT system
If we are to transform and improve services we need to modernise the infrastructure that we are working with. During the year we have undertaken extensive work to prepare for the implementation of e-Care, a single integrated electronic patient record, to improve the quality and safety of services and support the delivery of our vision. The new system will enable us to manage demand more effectively and provide safer, more effective care for patients. Implementation of these systems is notoriously challenging, however we feel that we have prepared as well as we can for all eventualities and are confident of the benefits the system will bring once it is fully rolled out and established with our staff.

The future and our vision
This has been the first year of delivery for our strategic framework, '*Our patients, our hospital, our future, together'*, and its seven ambitions. The document has enabled staff to understand our aims and priorities and the role they can play in taking us forward on the road to ever greater success. It has enabled other strategies to be developed under the framework and this year we will be launching our new nursing strategy, '*Caring with compassion, together'* which will set out what we want to achieve in patient care for the next five years.

Education
Education and training for staff is a key priority for us and an area where we excel as a trust. Our close links to Cambridge University in under-graduate and post-graduate medical education ensure we attract the best clinicians to work in our hospital. We are developing a modern workforce with new roles such as clinical skills practitioners, anaesthetic assistants, advanced nursing practitioners and emergency nurse practitioners. There was widespread public interest in Lauren Rottman the region's first physician associate who works alongside doctors to enhance patient care with a unique set of skills and experience. Lauren works in the medical model alongside consultants and is supporting the hospital to meet growing demand in urgent care services.

Our wider role in the community
The Trust plays an important role in the local economy and community employing more than 3,000 staff across a wide range of careers and bringing families and wealth to the area. We are fortunate to have an excellent council of governors drawn from our community as well as our staff and more than 5,600 members who have a say in how we operate. In addition to this we have hundreds of volunteers at the hospital who help directly with patient care. We are grateful as well to the tremendous support we receive from the Friends of West Suffolk and West Suffolk Hospital Charity. We are indebted to all of our supporters and could not manage our Trust without them.

We hope you will enjoy reading this report and look forward to another year in which West Suffolk NHS Foundation Trust continues to serve its patients and its community to the very best of its ability.

Roger Quince
Chairman

Dr Stephen Dunn
Chief executive

1.1.2 About our Trust – a summary

WSFT provides hospital and some community healthcare 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.

In October 2015 we were awarded the contract to provide community services for Suffolk in partnership with The Ipswich Hospital NHS Trust and other partners. We have since had our contract extended beyond the original 12 months so that we will provide these services until October 2017. The challenge now is to achieve the service transformation possibilities that this arrangement presents and to work with our clinical commissioning group and other partners towards ever closer relationships in an integrated care system for west Suffolk.

Suffolk Community Healthcare services have not altered, meaning that existing staff remain in place. The contract covers a range of adult community services, specialist children's services and community hospitals. Community services in summary:

- Delivers community-based services to people of all ages across Suffolk
- Provides services to local clinical commissioning groups (CCGs), hospitals, community healthcare organisations in Norfolk, Suffolk and Cambridgeshire and Suffolk County Council
- Serves the population of Suffolk, with the exception of the Waveney area
- Delivers services in a variety of settings including people's own homes, care homes, community hospital inpatient units and clinics, day centres, schools, GP surgeries and health centres
- Employs around 1,400 staff, including nurses, healthcare assistants, occupational therapists, physiotherapists, specialist clinicians, generic workers, technicians, administrators and support staff

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

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

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

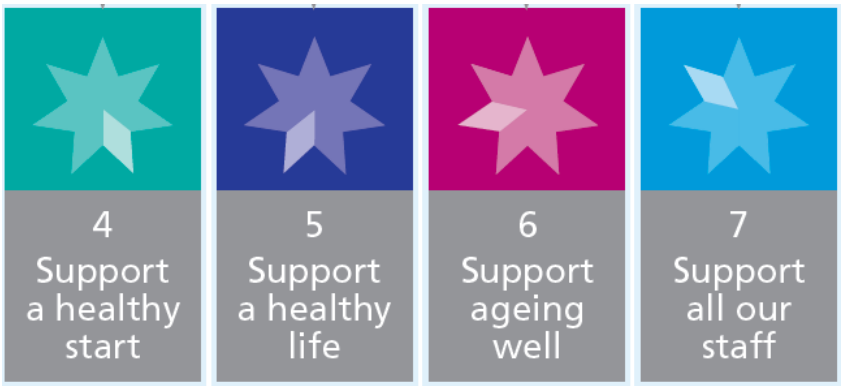
The challenge for our hospital is clear: we must stay ahead on the quality agenda, we must maintain strong operational performance, we must secure financial sustainability and improve the facilities we work with. **Our priorities are:**

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

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

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

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



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

Increasing age brings an increasing chance of long-term conditions, frailty and dementia. We are working with primary and community care to support patients to retain their independence but when they do need to come into hospital we aim to provide care in the most appropriate environment, with care plans developed with the patient and their families and carers.

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

Our sites

WSFT's main facility is West Suffolk Hospital (WSH), a busy district general hospital which provides a range of acute core services with associated inpatient and outpatient facilities. There is a purpose-built Macmillan unit for the care of people with cancer, a dedicated eye treatment centre and a day surgery unit where children and adults are treated and go home on the same day. WSH has around 500 beds and 14 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 tertiary (specialist) centres, most notably Addenbrooke's and Papworth hospitals.

As part of the community services we have taken on responsibility for Newmarket Hospital, a community hospital in Suffolk with 16 beds. These in-patient beds provide rehabilitation care to patients referred by GPs or transferred from an acute hospital as a step-down facility prior to discharge. The community hospital also has a radiology service and outpatient clinics which receive visiting clinicians from WSH. In addition, community teams use Newmarket Hospital as a base.

Davers Court is a care home in Bury St Edmunds run by Care UK. WSFT purchased 10 beds in the unit to provide rehabilitation and optimisation to patients who are medically fit and no longer require the services of an acute hospital and as a step-down facility prior to discharge.

We provide a number of outreach services to our population across a number of sites in Newmarket, Botesdale, Thetford, Stowmarket, Haverhill, Sudbury, Needham Market and Watton. These include outpatient clinics and, for the following areas diagnostic imaging – Newmarket Hospital (x-ray), Sudbury Community Health Centre (x-ray) and Thetford Healthy Living Centre (ultrasound).

WSFT is also responsible for the provision of adult speech & language therapy (SALT), community paediatric services and specialist nurses in Parkinson's, neurology and epilepsy services. These operate from a number of locations across Suffolk.

Our staff

WSFT is one of the largest employers in Suffolk, employing 3,298 whole-time equivalent staff in March 2016.

WSFT firmly believes in the benefits of working in partnership with staff and the trade unions. Further detail is included in section 6 (Staff report), including work we are doing regarding the employment of the disabled.

Our partners

WSFT works closely with other public, private and voluntary stakeholders. These include West Suffolk CCG, Suffolk County Council and Cambridge University as well as other local NHS providers, CCGs and Care UK.

The 44 national sustainability and transformation plan (STP) footprints were announced during 2015/16. These are geographic areas that will bring local health and care leaders, organisations and communities together to develop local blueprints for improved health, care and finances over the next five years, delivering the NHS Five Year Forward View. We are part of the Suffolk and north-east Essex footprint which is being led by Nick Hulme, chief executive, at The Ipswich Hospital NHS Trust. The approach will allow us to progress our ambitions and work more closely with Ipswich and Colchester hospitals to better align services.

We are working with partners to develop the west Suffolk integrated care organisation (ICO) board which includes leaders from all the major organisations including the WSFT, West Suffolk CCG, Suffolk County Council, Norfolk and Suffolk Foundation Trust and primary care.

1.1.3 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, WSFT's assets, patient safety and service quality through its board assurance framework (BAF).

Board Assurance Framework (BAF)

The BAF was regularly reviewed during 2015/16 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.

The principal risks identified in the BAF as reviewed by the board of directors are summarised below. The board reviews the potential impacts of these risks and considers the robustness of the existing controls and future plans to mitigate these. Assurance of the effectiveness of these controls and plans is also reviewed. A summary of the BAF is provided within the annual governance statement (section 4.10).

Incident reporting

During 2015/16 the number of patient safety incidents reported rose month-on-month to above the average for our peer group. The board reviews this data on a monthly basis and recognises the increased reporting rate as a positive reflection of an open culture within the organisation which supports learning from incidents. Benchmarking within the national staff survey shows that the Trust's incident reporting system is viewed positively by our staff.

WSFT has continued to build and strengthen the arrangements for managing serious incidents requiring investigation (SIRIs). The Board takes the lead on this process and reviews the management, investigation and learning from SIRIs on a monthly basis.

Effective risk and performance management

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

Performance and quality improvement 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 and performance report to the board provides both an organisational and ward-level dashboard. This information is underpinned and informed by review by directorates and wards with action planning at these levels. Delivery of improvement at an operational level is managed through directorate executive performance meetings but is also tested through observational visits by board members and Governors as part of the weekly quality walkabouts. A programme of internal peer assessment supports continuous quality improvement with CQC standards. A programme of presentations and patient stories relating to the quality priorities and strategic/service developments is also delivered to the board. WSFT also actively engages with its members and the public through regular talks and events.

WSFT is a member of the NHS Litigation Authority's Clinical Negligence Scheme for Trusts (NHSLA CNST).

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
- WSFT had adopted organisational objectives and managed and measured performance in line with these objectives

- WSFT 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 licence

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

Contractors and suppliers

WSFT is committed to sourcing, ordering and delivering a complete range of healthcare products, services and infrastructure, whilst maintaining value for money. The Trust is 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 the European directive for procurement in addition to WSFT's standing financial instructions and orders.

Additional disclosures required by the financial reporting manual (FReM)

Accounts have been prepared under direction issued by Monitor under the National Health Service Act 2006:

- Chief executive's 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 enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. In addition, the Trust has a borrowing arrangement in place with the Department of Health to support its liquidity position. For this reason, the directors continue to adopt the going concern basis in preparing the accounts.

Audit committee's review of the annual report and accounts

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

1.2 Performance analysis

1.2.1 Performance management framework

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 controls and assurances include:

- Monthly quality and performance reports and performance dashboard. These include the Trust's priorities for improvement in the quality report, analysis of patient experience, incidents and complaints, review of serious incidents, and ward-level quality performance
- Monthly financial performance reports
- Quarterly self-certification against the compliance framework
- Quarterly peer review against delivery of the CQC registration requirements
- Quarterly quality and performance reports by directorates to the quality & risk committee
- Quarterly quality and performance reports to the council of governors. This provides information which is similar to that reviewed by the board of directors on a monthly basis
- Assurances provided through the work of the clinical safety & effectiveness committee, corporate risk committee and patient experience committee
- Reports from the quality & risk committee, scrutiny committee and the audit committee received by the board
- Assurances provided through the work of internal and external audit, the Care Quality Commission, Monitor, the NHS Litigation Authority, patient-led assessments of the care environment (PLACE), and accountability to the council of governors
- The work of clinical audit, whose scope includes national audits, audits arising from national guidance such as NICE, confidential enquiries and other risk and patient safety-related topics
- Weekly quality walkabouts, including executive directors, non-executive directors 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.

1.2.2 Principal activities and achievements

Care Quality Commission (CQC) registration

WSFT has unconditional registration with the CQC with no identified concerns or enforcement action.

WSFT was the subject of a formal CQC inspection in March 2016 as part of the national programme of inspection of all acute NHS trusts. The final outcome of this inspection has not been issued and is expected in June 2016. The CQC team fed back during the assessment on some examples of great practice and the quality of care that we provide to our patients every day. We are taking the action in response to the preliminary feedback from the CQC's visit.

Regulatory ratings

As at March 2016 WSFT had a financial sustainability risk rating (FSRR) of 2 and a governance rating of 'green' (no evident concerns). WSFT met all national targets in 2015/16 with the exception of Accident & Emergency. Further information is provided in section 2.3 (Regulatory ratings).

Our services

WSFT provides a range of patient services:

Indicators	2015/16	2014/15	2013/14	2012/13	2011/12
Inpatient planned	**4,291**	4,290	4,275	4,026	4,828
Inpatient non-planned	**31,383**	30,173	28,517	28,494	27,945
Day cases	**29,392**	28,210	25,889	22,895	20,743
Outpatient attendances (inc. ward attenders)	**239,675**	228,384	216,597	176,650	165,658
Outpatient procedures	**106,032**	161,317	102,989	93,445	93,738
ED attendances	**64,979**	62,106	59,485	59,305	55,779

The change in recorded outpatient procedures is due to the exclusion of diagnostic imaging appointments that were included in 2014/15. The 2014/15 activity excluding diagnostic imaging appointments was 112,116.

As patients choose to receive their treatment at WSH our planned activity continues to grow, particularly in day cases.

We have been working with the West Suffolk CCG and primary care practitioners to modernise emergency care services and thereby reduce demand. Despite these efforts non-planned activity has increased by 4.0%, compared with 2014/15. The emergency threshold adjustment means that we did not receive £2.5m of tariff income for this activity in 2015/16; this has impacted on our financial position. This is in line with our plan, but goes some way to explaining why our plan is a deficit.

Further detail of WSFT's performance regarding quality and local / national targets is provided in the Quality Report (Section 6). The annual governance statement (section 4.10) describes arrangements for quality governance within WSFT.

Our financial performance

WSFT recorded a deficit of £9,802k for the year 2015/16.

Note that since 1st October 2015 WSFT has hosted Suffolk Community Health services which has increased both the income and expenditure by £32m year-on-year.

	2015/16 £000	2014/15 £000	2013/14 £000	2012/13 £000	2011/12 £000
Operating income	**210,252**	172,589	172,714	166,988	159,501
Operating costs	**(213,783)**	(171,998)	(169,793)	(158,627)	(152,015)
EBITDA* surplus	**(3,531)**	591	2,921	8,361	7,486
Depreciation, dividend and other costs	**(5,860)**	(7,075)	(6,531)	(6,827)	(6,816)
Fixed asset impairments**	**(411)**	1,062	(30)	(22)	(51)
Retained earnings	**(9,802)**	(5,422)	(3,640)	1,512	619

* 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. The 2014/15 figure includes the Trust's share of the surplus on the sale of Harps Close Meadow (£1.3m)

An award-winning hospital

The following section outlines our many achievements during 2015/16.

Awards and accolades

WSFT board named as 'NHS board of the year' in regional awards
The Board of Directors of WSFT has picked up the 'NHS board of the year' award at the East of England NHS Leadership Recognition Awards held at Duxford Air Museum. The title was awarded in recognition of the effective leadership it provides and its commitment to the highest quality of patient care. The hospital provides high quality, award-winning care and consistently high standards of operational performance. This includes meeting every cancer target and recording low mortality rates as well as ranking as one of the best in the country for stroke care and treatment for hip fracture patients.

Rose's 'vital' innovation wins national patient experience award
An innovative tray design by a West Suffolk Hospital nursing assistant to make it easier for patients to clean their hands and get a good night's sleep has won a national award. The RoseVital tray won the 'environment of care' category in the Patient Experience Network awards 2015. The tray is the brainchild of Rosario Preston and was trademarked by the Trust before being rolled out across the hospital. It carries the words "please use me before every meal" with an arrow pointing to hand wipes and "please use me at night" indicating earplugs and an eye mask.

West Suffolk Hospital the first in Europe to receive cleaning award
WSFT was the first hospital in Europe to achieve a prized international accreditation in recognition of the excellent cleaning service provided by its housekeeping team. The department was presented with the Cleaning Industry Management Standard (CIMS) award with honours, after demonstrating it meets the highest standards during a two-day inspection.

Recognition for quality and safety

Hip fracture care among the best in the country
The results of the national hip fracture database audit for 2015 have placed the hospital as the best-performing in the region and one of the best in England for the treatment provided to patients with a break to the hip joint, known as a fractured neck of femur. The audit looks at a range of success measures including the time it takes to get to theatre for surgery and a set of critical care and outcome criteria.

National accreditations

Hospital catering awarded quality standard in recognition of high standards
The catering department at West Suffolk Hospital has been re-awarded an international accreditation in recognition of the high standards of hygiene, production, safety and service it provides to patients and visitors. The hospital has been given the ISO 9001 – 2008 standard by the LRQA following a rigorous inspection that looked in detail at the way the department is run. The hospital will be reassessed every six months to make sure it continues to meet the criteria.

Macmillan Unit at West Suffolk Hospital re-awarded national accreditation
The Macmillan Unit at West Suffolk Hospital has been re-awarded a national accreditation in recognition of the high quality service it provides for cancer patients. The hospital has been presented with the Macmillan Quality Environment Mark (MQEM) following a visit from assessors at the end of last year. The award shows that the unit is welcoming and accessible, provides choice and respects privacy and dignity as well as supporting comfort and wellbeing.

Investment in equipment and facilities

Work begins on £9.5m sterile services unit
Work has begun to build a state-of-the-art sterile services unit and new office accommodation on the West Suffolk Hospital site. The unit will provide a full decontamination and sterilisation service to clean equipment used in the hospital's operating theatres. The current unit is based off-site requiring items to be transported on the roads and its equipment was becoming out of date. Office staff will occupy the upper floors of the building which houses the unit meaning that space will be available in the hospital to provide a new 35-bed ward space.

State-of-the-art MRI suite opens
A state-of-the-art MRI suite has improved the service patients are receiving at West Suffolk Hospital after it was opened by Bury St Edmunds MP Jo Churchill. The £2.1m project to refurbish the existing scanner and install a new additional machine has helped meet growing demand for the diagnostic technology enabling patients to be diagnosed and treated in a more timely fashion. The project has enabled the hospital to offer MRI scanning seven days a week as well as providing higher quality images that help detect conditions such as cancer at an earlier stage.

Patients and visitors to benefit from new hospital car park
Patients and visitors at West Suffolk Hospital are set to benefit from 400 additional parking spaces this year as work begins on a new £2m car park project. The extra spaces which will also be available to staff will be available from December 2016. It is hoped that the project will relieve growing pressure on hospital parking, which has resulted in patients queuing for spaces during busy times.

Investing in services

Additional support for children with eczema
Children with eczema and other skin conditions are now receiving targeted care to help them successfully manage their condition and enjoy a better quality of life thanks to the introduction of a new specialist service at West Suffolk Hospital. Liz Quarton has been appointed as the hospital's first paediatric dermatology clinical nurse specialist and is providing a nurse-led service for children and young people aged up to 16, initially concentrating on those with eczema.

Dedicated unit to help support frail elderly patients
A dedicated unit has been set up at West Suffolk Hospital to provide vulnerable older patients with specialist care. A total of 21 beds on ward G5 have been transformed into the hospital's FAME unit which stands for frailty acute medicine for the elderly. The unit cares for patients over the age of 75 who need to stay in hospital for more than 72 hours. Their care is co-ordinated by the older people's assessment team.

Excellent staff survey feedback

2015 national staff survey ranks West Suffolk Hospital as the region's best
The latest staff survey shows that West Suffolk Hospital is the best in East Anglia for being recommended by its staff. A key finding of the survey showed that more staff at the Trust would recommend it as an employer or as a place to receive treatment than at any of the region's other hospitals. The Trust also received positive feedback from staff on a range of other key areas scoring in the top 20% of trusts nationally against seven criteria.

1.2.3 Future business plans

In response to the 'Five Year Forward View' a strategy based on the primary and acute care system (PACS) model for delivery in west Suffolk has been developed with four main objectives, which are central to the wider public sector reform agenda in Suffolk:

1. People manage their own health and social care with the right support when needed
2. Our communities are easy and supportive places to live with a health or care need
3. Our health and care providers are co-ordinated by one clinically-led organisation
4. Higher cost interventions are replaced with lower cost interventions.

Although the system was not successful in its bid for national funding, we are working with partners within the local health and social care system to ensure we can take forward the strategy which formed the basis of the vanguard application. This is being progressed as an integrated care Organisation (ICO) model with the CCG and other partners.

The transformation plans for 2016/17 are focussed on three areas of development, each of which includes internal as well as system-wide opportunities:

- Demand management
- Business development
- Efficiency

Cross-cutting enablers for this transformation programme include implementation of e-Care (our new electronic patient record which went live in May 2016) and transformation of community services. These are both considered in more detail at the end of this section.

(i) Demand management

Working with West Suffolk CCG and ICO partners a transformation programme is being developed to deliver the change required to meet our agreed health and care vision, principles and outcomes. The transformation programme's priorities for the system are fully integrated within the Trust's transformation programme to deliver quality improvement, ensure clinical effectiveness and reduce emergency demand within the system. The clinical priorities for 2016/17 include:

- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Atrial fibrillation (AF)
- Hypertension
- End of life care.

WSH has an established emergency care pathway (ECP) programme which seeks to improve the flow of patients within WSH and back into primary care; support a reduction in the number of emergency admissions, reduce length of stay and improve the patient experience, through integrating health and social care as well as internal process improvements. In line with our Trust ambitions and our recently acquired management of local community services we have seen the scope and scale of this work develop significantly. The Trust and WSCCG are working collaboratively to achieve system-wide transformation with a focus on the following key areas:

- Improved access to GP services to reduce unnecessary ED attendances
- An increased range of ambulatory care pathways to avoid unnecessary admissions
- Merging of the admission prevention service and the early intervention service to support early discharge and signpost patients to appropriate community care
- Delivery of the four priority standards for seven day services
- Increased focus on the management of patients with complex care and social needs
- The development of interface geriatrician clinics to provide specialist input in the community and reduce admissions and readmissions.

(ii) Business development

The Trust continues to implement the five year strategies developed as part of our planned care programme of service line reviews. These plans are developed in collaboration with WSCCG to ensure that WSH business development plans remain in line with the CCG objectives and financial envelope. It was recognised that repatriation of activity to WSH from some of our neighbouring trusts would deliver an overall reduction in cost to the CCG through a lower market forces factor. The current round of contract negotiations is aiming to deliver an open book contract with financial risk shared between both organisations. Individual service line reviews will be reviewed in line with any revised contracting arrangements to ensure maximum business opportunity benefits across the health system.

(iii) Efficiency

The PwC benchmarking report commissioned in 2014 assessed the WSFT as by and large a productive organisation that regularly sits in the top quarter of quality, safety and productivity performance. This view is corroborated by Lord Carter's review which has calculated that our organisation's adjusted treatment cost is 0.89, this means that we are approximately 11 pence less expensive per pound on national cost weighted output. Equally when you review the headline adjusted treatment cost data by trust type, we are the most efficient small acute provider and the 4th most efficient provider in the country.

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

We have a number of programmes which are aimed at delivering improved performance which align closely with the themes in the report and underpin the realisation of additional capacity to support our service line reviews.

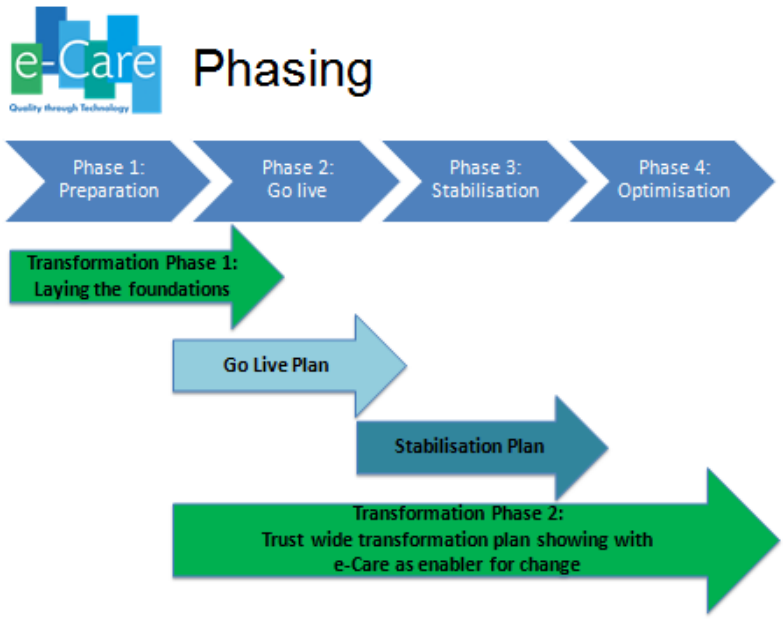
- **Project theatres**: Over the past year we have focused on improvements to our underpinning processing for the scheduling and booking of operating lists, the pre-operative preparation of patients and the development of performance metrics to drive efficiency. These practices are now embedded within the organisation and we are moving our focus to maximise in-session utilisation through a reduction in late notice cancellations.

- **Project outpatients**: Within the outpatient setting we have also focused on improved systems and processes over the last year which are showing benefits, although our ability to drive performance in some areas is hampered by the limitations of our current PAS. The deployment of our new EPR in May 2016 will be a major step forward in this area and support the delivery of improved operational efficiencies. Working with 4 Eyes Insight we have rolled out demand and capacity models for outpatients along with a 42-week tracking proforma which will be used to monitor delivery of clinics in line with consultant job plans.

- **SARD job planning tool**: We have worked with the supplier of our consultants' appraisal software to develop a job planning tool which is currently being rolled out across the Trust. This will give us improved consistency around job planning and will in turn underpin work being undertaken as part of our theatres and outpatients transformation programmes.

e-Care

Our new electronic patient record went live at the beginning of May 2016. The Trust has made a significant investment in this programme which we believe underpins the delivery of our strategic vision and ambitions. We have developed a strong team, integrating clinical and operational leadership with IT technical skills to deliver this very ambitious programme.



Our transformation strategy outlined four phases as shown above. Over the past year we have delivered on the preparatory phase and achieved international recognition for the success of our approach to engagement of the organisation.

As we move beyond 'go live' and stabilisation we will switch focus to delivering a range of transformation programmes that will form the basis of the wider Trust transformation programme.

Work is already underway to review the benefits profile in the original business case and to develop specific transformational programmes to deliver the benefits during the optimisation phase. It is well recognised that there will be a significant period of system and user stabilisation following the deployment of an EPR . As a result significant benefits are not expected to be realised during 2016/17, however work is underway to establish transformational programmes aligned with the e-Care benefits profile.

Community services

Our partnership of community service providers, led by the Trust have continued to operationalise community services. Regular provider management groups meet to look at delivery of the Suffolk Community Healthcare contract, governance, service improvement and cost-saving plans for the contract longer term. We aim to continue the delivery of services ensuring it is business as usual for patients, whilst playing our part to improve the integration of services in the region and in partnership with our colleagues at The Ipswich Hospital NHS Trust, Norfolk Community Health and Care NHS Trust and the CCG. This is aligned with our long-term strategy to provide more integrated, joined-up services that remove the barriers which can get in the way of great patient care.

Lord Carter's provider productivity work programme

The 2016/17 plan assumes a CIP target of 4.1% which broadly reflects Lord Carter's initial findings. It should be noted that WSFT was reported as the most efficient acute provider of its size and the fourth most efficient in the country.

We already have a number of efficiency workstreams which target the areas identified within the Carter report. We welcome the focus on support from the national bodies to provide standardised approaches to measuring productivity and efficiency and to unlocking barriers to achieving system-wide transformation. As an urgent priority we will undertake a review against performance in the key areas of opportunity through service level reviews.

Procurement

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

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

Procurement actively engages in the utilisation of framework agreements through NHS Supply Chain, Crown Commercial Services and NHS Procurement Hubs to ensure best value is always achieved. The Trust has a work plan that is communicated across the organisation and links with the NHS Procurement Hub. We undertake benchmarking with acute trusts and NHS organisations across England to ensure pricing, commitments and agreements offer the best opportunities for the Trust in line with our size and spend.

Capital planning

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

- Risk priorities remain relevant and have not changed
- Incorporates any change from statute/alerts/NHS estates etc.
- Considers and incorporates any maintenance issues arising in year.

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

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

The Trust has a board approved strategy for the disposal of land and buildings in Sudbury that are surplus to requirement. Asset values are maximised by securing planning permission for each site to minimise developer risk and eliminate conditional bids.

The Trust has previously been successful in applications for national capital funds to ensure the delivery of these schemes, e.g. the improving maternity care settings fund.

Sustainability and Transformation Plans (STPs)

In Suffolk, the east and west Suffolk health and care system has proposed that they come together to form one transformation footprint covering the population of east and west Suffolk (with the assumption that the Waveney area of Suffolk will be joined with Great Yarmouth into a Norfolk footprint). The system is collaborating to create a five-year STP which will set out the shared vision for health and care in Suffolk and its plans for delivering better health, transformed quality of care delivery and sustainable finances by 2020/21.

Underpinning the overarching STP will be a suite of transformation programmes which are being developed to deliver the change required to meet our agreed health and care vision, principles and

outcomes. The transformation programmes will describe the priorities for the system in line with the health and care review and building on the integrated health and care model (approved by the system in January 2015) and include:

- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Atrial fibrillation (AF)
- Hypertension
- End of life care.

The transformation programmes will deliver national planning requirements, local health and wellbeing priorities and other specific system-wide strategies.

The system has agreed to work together towards two integrated care organisations (ICOs) in Suffolk, one for west Suffolk and one for Ipswich and the east. The ICOs will be the vehicles for delivery of the health and care model and will be enablers for the changes required to achieve financial and workforce sustainability whilst maintaining or improving the service provided for the local population.

The west Suffolk ICO board includes leaders from all the major organisations including WSFT, West Suffolk CCG, Suffolk County Council, Norfolk and Suffolk Foundation Trust and primary care. The system is seeking to adopt a more collaborative approach with joint teams focusing on productivity, pathways and clinical innovation. As a first step the Trust is working with the CCG to agree a three to five-year contract that aligns incentives and clinical outcomes to create a sustainable care delivery system for Suffolk.

The successful bid for the Trust to provide community services in Suffolk enables creative service models to be designed and implemented across traditional organisational boundaries. This learning will help shape, influence and lay down the foundations for sustainable collaboration as we move towards the ICO model.

Sustainability

'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 Trust has continued to make strides in reducing our carbon footprint and provides the example to the community. Our commitment to the environment and sustainability is highlighted in our actions.

- **Phone recycling scheme –** we continue to provide this service for staff and patients and at present the Trust is renegotiating this contract
- **Non-confidential waste paper shredding –** this programme is being provided at zero cost to the Trust with all paper shredded and turned into hand towels and toilet rolls
- **Confidential waste paper –** recycled at a cost
- **Recycling of cardboard –** the Trust now has a contract with Bolton Brothers, suppliers of a cardboard compactor. With the purchase of this service the Trust is now collecting cardboard and is receiving a small income from this. Collected cardboard is now sent to a local paper mill for recycling
- **Old batteries –** with the concerns around heavy metals within batteries, the Trust continues to support the NHS supply chain framework agreement with Battery Back and is recycling all used batteries. This too is cost neutral to the Trust
- **Wood, pallets and scrap metals –** with our sustained efforts to reduce the Trust contribution to landfill, we continue to recycle all of these items through a local company. This is now generating a small income of around £350 per year
- **Cooking oil – t**his has been one of our true success stories. Through our continued efforts with Bio Power and the collection of used cooking oil we are now generating an additional income of

£300 per year. All oil is removed from site, processed and used to run a small power station which feeds into the National Grid

- **Combined heat and power Unit (CHP) –** the Trust's current CHP unit is ongoing and continues to save the Trust in energy costs and carbon reduction. From July 2014 the unit was set to run 24 hours per day. For the year 2015/16 the CHP unit generated cost savings against utilities of £200,100 and also contributed greatly to a carbon reduction of 3,179 tons of CO_2 for the site in 2015/16
- **Revised travel technology –** the Trust has introduced an online business travel system which now allows to measure its business travel carbon footprint and to be able to calculate sustainable improvements. The Trust encourages staff to use low-emission hire cars and provides an incentivised lease car deal for those who choose a low-emission car
- **Green travel plan –** the Trust updated its 2010 travel plan in 2014. An action plan has been formulated to achieve a number of targets (in conjunction with the local council). These include increasing secure storage for bicycles (60 unit lockable storage area to be provided by December 2016) and the appointment of a sustainability officer – whose duties will include re-launching car sharing scheme and promoting walking and cycling wherever possible. Six electric charging bays will be in operation by June 2016 (two temporary posts in use at present). Provision also to be made for (20) charging bays if needed in new c400 car park currently being built (ready for December 2016)
- **Patient transport –** all newer non-emergency ambulance vehicles have been or are being fitted with speed limiters which will restrict speed to 62mph. The impact will be reduced fuel consumption and fuel costs
- **PC power savings –** the Trust purchased the IE power management system for PCs. This is a programme to monitor PC usage and to shut down those computers which remain inactive for designated periods of time
- **Inhalers -** the Trust is running an inhaler recycling scheme working with Glaxo-Smith Klein. This enables patients and staff to return empty inhalers to the Trust's pharmacy department. This is cost neutral to the Trust
- **Ink and toner cartridges -** The Trust purchases recycled cartridges
- **Procurement –** sustainability has been embedded in all Trust tendering processes and the East of England procurement hub always includes requests for environmental sustainability policies in all tenders and scores on this
- **Recycled waste –** in 2015/16 the Trust recycled 213 tonnes of waste compared to previous year of 240 tonnes. The recycled waste comprised of WEEE, IT equip, wood, confidential & non-confidential paper waste, cardboard, cooking oil, metal scrap, batteries and old uniforms.
- **Travel –** the Trust promotes use of hire cars for long business journeys and will investigate use of electric cars for lease (fleet) purposes in due course. A pool hire car is also to be trialled for communal use by staff going on and off site for meetings at other locations.

2. Accountability report

2.1 Governors' report

2.1.1 Responsibilities

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

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

2.1.2 Composition

The council of governors is composed of 14 elected public governors, five elected staff governors and six partner nominated governors. The term of office for all governors is three years.

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

Mrs Mary Allan[5]
Mr David Beaven[1]
Mrs June Carpenter (lead governor until 30 November 2015)
Canon Cedric Catton [2]
Mrs Jean Cawrse[6]
Mr Ian Collyer
Mrs Justine Corney
Dr David Frape
Mrs Jayne Gilbert
Mrs Jayne Kelly[4]
Mr Barry Moult
Dr Steve Ohlsen (lead governor from 1 December 2015)
Mrs Jan Osborne
Dr Joe Pajak
Mrs Margaret Rutter[5]
Mrs Liz Steele
Mrs Adrienne Wakeling[3]
Mr Stuart Woodhead

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

Mrs Jenny Barker[5]
Mrs Jane Chilvers
Mr Nick Finch
Mr Peter Harris
Mrs Lesley Lang[2]
Mrs Lindsay Pike

[1] Ceased to be a governor in November 2015
[2] Resigned from council of governors in November 2015
[3] Resigned from council of governors in May 2015
[4] Joined council of governors in May 2015, Resigned in December 2015
[5] Joined council of governors in January 2016
[6] Joined council of governors in January 2016, resigned in March 2016

Partner governors – nominated by partner organisations of WSFT

Mrs Judy Cory	Friends of West Suffolk Hospital
Dr Mark Gurnell	University of Cambridge
Mr David Howells[8]	West Suffolk College also representing University Campus Suffolk
Mrs Laraine Moody[8]	West Suffolk College also representing University Campus Suffolk
Mr Jon Eaton	West Suffolk Consortium for Voluntary Organisations
Councillor Rebecca Hopfensperger[7]	Suffolk County Council
Councillor Sarah Stamp[7]	Suffolk County Council
Councillor Sara Mildmay-White	St Edmundsbury Borough Council, also representing Forest Heath District Council, Mid-Suffolk District Council and Babergh District Council

[7] Councillor Rebecca Hopfensperger was appointed in July 2015 taking up the seat previously held by Councillor Sarah Stamp

[8] Mrs Laraine Moody was appointed in June 2015 taking up the seat previously held by Mr David Howells

Governor attendance at council of governors meetings 2015/16

There were five formal meetings of the Council of Governors: 14 May 2015, 11 August 2015, 15 September 2015 (Annual Members Meeting), 18 November 2015, 9 February 2015, with the following Governor attendance:

Name	Title	Attendance (out of 5 meetings)
Mrs Mary Allan	Public governor	**1**(of 1)[5]
Mrs Jenny Barker	Staff governor	**1**(of 1)[5]
Mr David Beaven	Public governor	**0**(of 3)[1]
Mrs June Carpenter	Public governor	**4**
Canon Cedric Catton	Public governor	**1**(of 1)**[2]**
Mrs Jean Cawrse	Public governor	**1**(of 1)[6]
Mrs Jane Chilvers	Staff governor	**4**
Mr Ian Collyer	Public governor	**4**
Mrs Justine Corney	Public governor	**5**
Mrs Judy Cory	Partner governor	**4**
Mr Jon Eaton	Partner governor	**3**
Mr Nick Finch	Staff governor	**4**
Dr David Frape	Public governor	**5**
Mrs Jayne Gilbert	Public governor	**4**
Dr Mark Gurnell	Partner governor	**2**
Mr Peter Harris	Staff governor	**3**
Mr David Howells	Partner governor	**1**(of 1)[8]
Councillor Rebecca Hopfensperger	Partner governor	**2**(of 3)[7]
Mrs Jayne Kelly	Public governor	**2**(of 3)[4]
Mrs Lesley Lang	Staff governor	**0**(of 3)**[2]**
Cllr Sara Mildmay-White	Partner governor	**3**
Mrs Laraine Moody	Partner governor	**2**(of 4)[8]
Mr Barry Moult	Public governor	**5**
Dr Steve Ohlsen	Public governor	**5**
Mrs Jan Osborne	Public governor	**3**
Dr Joe Pajak	Public governor	**5**
Mrs Lindsay Pike	Staff governor	**4**

Name	Title	Attendance (out of 5 meetings)
Mr Roger Quince	Chair	**5**
Mrs Margaret Rutter	Public governor	**1**(of 1)[5]
Cllr Sarah Stamp	Partner governor	**0**(of 1)[7]
Mrs Liz Steele	Public governor	**5**
Mrs Adrienne Wakeling	Public governor	**0**(of 0)[3]
Mr Stuart Woodhead	Public governor	**4**

[1] Ceased to be a governor in November 2015
[2] Resigned from council of governors in November 2015
[3] Resigned from council of governors in May 2015
[4] Joined council of governors in May 2015, Resigned in December 2015
[5] Joined council of governors in January 2016
[6] Joined council of governors in January 2016, resigned in March 2016
[7] Councillor Rebecca Hopfensperger was appointed in July 2015 taking up the seat previously held by Councillor Sarah Stamp
[8] Mrs Laraine Moody was appointed in June 2015 taking up the seat previously held by Mr David Howells

In attendance at these meetings were: Dr John Benson, non-executive director (2); Mrs Jan Bloomfield, executive director of workforce & communications (1); Mrs Nichole Day[a], executive chief nurse (1); Dr Stephen Dunn, chief executive (5); Mr Jon Green, executive chief operating officer (5); Mr Neville Hounsome, non-executive director (5); Mr Gary Norgate, non-executive director (4); Mrs Rowan Procter[b], interim executive chief nurse (2); Mr Steve Turpie, non-executive director (1); Mrs Rosie Varley, non-executive director (2)

[a] Mrs Nichole Day was seconded from the Trust in November 2015
[b] Mrs Rowan Procter was appointed interim chief nurse in November 2015

2.1.3 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.

2.1.4 Governors and directors working together

Governors and directors have developed a professional working relationship, on both a formal and informal basis. A number of governors attend/observe the monthly board of directors meetings. This gives them an insight into and understanding of the performance of the Trust, particularly from a quality and finance perspective and provides an insight into the role and performance of the non-executive directors (NEDs).

Non-executive directors present a summary of the finance report and quality and performance report at the council of governors meetings.

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

A joint Council of Governors and Trust Board workshop took place in September 2015. The purpose of this was to discuss models for integrated care organisations (ICOs) and future site plans.

A further joint council of governors and board workshop took place in March 2016 to review WSFT's draft operational plan for 2016/17.

The lead governor has continued to arrange informal meetings of governors and NEDs which has been beneficial in developing a good working relationship. Similarly informal meetings have been established between the governors and executive directors. These help give the governors a greater insight into and understanding of the roles and responsibilities of each director and how they work as a team.

Governors contribute to WSFT's annual report, which includes the quality report as well as the annual plan review (APR).

Governors continue to take part in the weekly quality walkabouts. These are led by the chief executive or chairman and include an executive director or NED on each occasion. This gives governors a greater understanding of services across the organisation, as well as providing an opportunity for them to interact with patients, staff and directors.

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

To support governors in their role a range of training and development sessions have been held during the year.

- Induction session - health and care structures and accountability; NHS contracting and payment systems; economic regulator – Monitor; quality governance; quality and safety regulator – CQC; WSFT overview and future plans (21 April 2015)
- Joint council of governors and board workshop – models for integrated care and future site plans (24 September 2015)
- Governor training day – holding to account with external trainer (14 November 2015)
- Governor training – finance and business skills with director of resources (18 and 24 February 2016 same content on both dates)
- Joint council of governors and board workshop – operational plan 2016-17 (17 March 2016)
- Governor training day - triangulation and assessment of assurance regarding the performance of the Board; the role of the governors in NED recruitment & appointment and in NED performance appraisals with external trainer (12 April 2016).

2.1.5 Membership

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

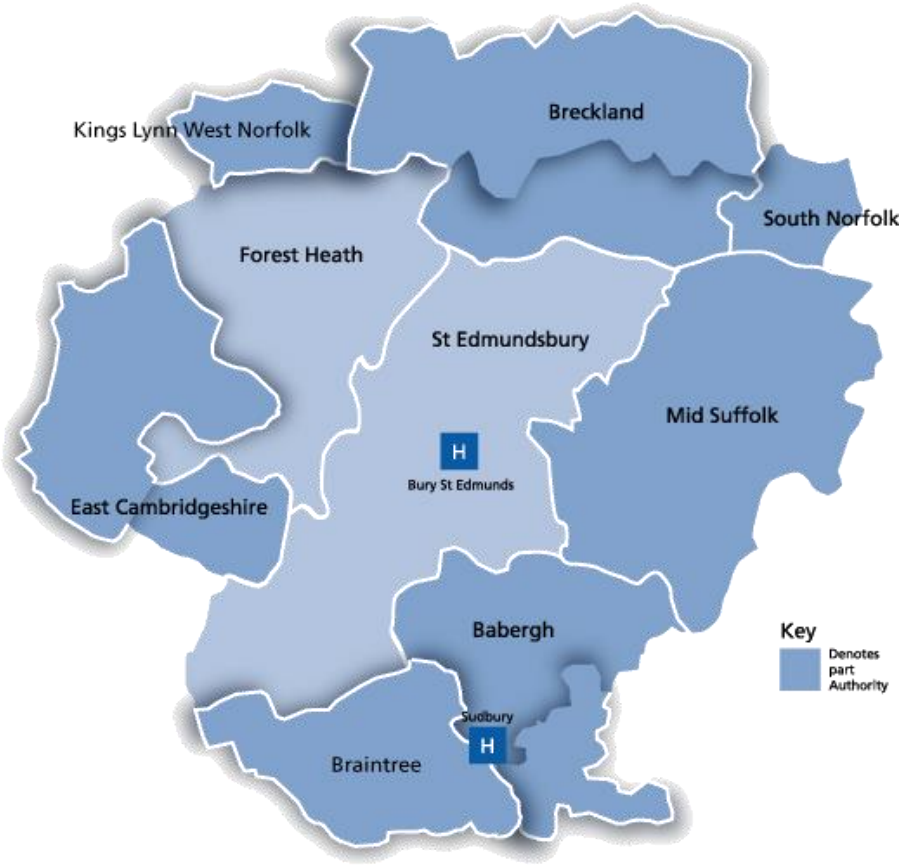
Public membership

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 WSFT staff 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.

Membership numbers

As at 31 March 2016 there were; 5,634 public members and 3,639 staff members.

Membership strategy

WSFT's membership strategy is reviewed on an annual basis by the engagement committee for consideration by the council of governors and approval by the board of directors.

We aim to maintain and, where possible, increase our public membership and to ensure that staff membership is maintained at an appropriately high level. 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 continue to use 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 and views of WSFT.

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

Criteria	Current (Mar 2016)	Target (Mar 2017)
1. Achievement of the recruitment target:		
a. Total number of public members	**5634**	5550
b. Staff opting out of membership	**<1%**	<1%
2. Achieve a representative membership for our membership area, Priorities for action:		
a. Age – recruitment of under 50s	**1023**	1150
b. Engagement and recruitment events in all market towns of membership area (Thetford, Newmarket, Stowmarket, Haverhill and Sudbury)	**-**	100%
3. An engaged membership measured by:		
a. Number of member events held April 2015 – March 2017	**3**	6
b. Member attendance – total all events	**534***	600*
c. Annual members' meeting attendance	**315**	200

* Includes people attending annual members' meeting.

During the past year the Trust held three 'special interest' events on services provided by WSFT. These have proved extremely popular with a total of 534 people attending the three events. These events have also been used to provide feedback on the services provided by WSFT.

Staff governors report 2015/16

Over the past year the staff governors have continued to work with and support staff from all areas within the Trust. This included holding drop-in sessions and attending departmental meetings which have proved to be effective ways of communicating with staff - promoting open and frank conversations. Some of the staff governors were interviewed by the care quality commission (CQC) prior to their visit in March 2016. Staff governors have continued to sit on various committees with the public and partner governors, such as the nominations committee, and have undertaken external training in managing bullying.

The staff governors have indicated that they feel their role is well supported by the chief executive and management team and they are continuing to build a good relationship with staff.

Contact procedures for members

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

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

2.1.6 Nominations committee

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

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

In June 2015 the nominations committee reviewed the feedback from the appraisals of the chair and NEDs and key messages that would be fed back to each individual.

In October 2015 the nominations committee reviewed the appraisal process for the chair and NEDs and also the remuneration of the chair and NEDs. A recommendation was then made to and approved by the council of governors.

In January 2016, the nominations committee recommended to the council of governors that a current NED be reappointed for a second term of three years without competition. This recommendation was made taking into account the principle that had previously been agreed that at the end of the first term, unless board competencies had significantly changed, or the performance of the current post-holder gave cause for concern, they should be reappointed for a further term. The council of governors approved the recommendation.

In order to ensure continuity of the skill set of the board and stagger the end of term dates for NEDs in the future it was proposed that the first term for a NED should remain as three years, but the second term should vary between two and four years, subject to a recommendation from the nominations committee. The council of governors approved this recommendation.

Taking the above into account the nominations committee also proposed recommending to the council of governors that the second term of a NED, who was also chair of the audit committee,

should be extended by a year. The council of governors approved this recommendation and also a proposal that this term should be extended by a further year (i.e. two years in total) subject to annual review.

Attendance at nominations committee meetings 2015/16

Name	Title	Attendance (out of 3)
Roger Quince (chair)	Chairman	3
June Carpenter	Public governor (member until November 2015, as lead governor)	2 (of 2)
Nick Finch	Staff governor	2
Jayne Gilbert	Public governor	3
Sara Mildmay-White	Partner governor	1
Barry Moult	Public governor	3
Steve Ohslen	Public governor (member from December 2015, as lead governor)	1 (of 1)
Joe Pajak	Public governor	3

Meeting dates: 30 June 2015; 8 October 2015; 16 January 2016

2.2 Directors' report

2.2.1 Responsibilities

The board of directors functions as a unitary corporate decision-making body. Non-executive directors 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 executive directors and part-time non-executive directors; the latter chosen because of their experience and skills relevant to the organisation's needs. The role of the board is to set the strategic aims, vision, values and standards of conduct for the Trust and to be responsible for ensuring that management delivers the Trust's strategy and operations against that framework.

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

2.2.2 Composition

(a) Non-executive directors

Mr Roger Quince – NED and chairman
(Appointed: from 1 December 2011 (authorisation as FT) until 31 December 2015; reappointed 1 January 2016 until 31 December 2017)

Areas of special interest/responsibility: chair of quality & risk committee; chair charitable funds committee; member of scrutiny committee, remuneration committee and chair of the governors' nominations, appointments & remuneration committee. Roger is chairman of the board of directors and council of governors of WSFT and an advisor to the council of governors of Cambridge University Hospitals NHS Foundation Trust.

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 B.1.1)

Dr John Benson – NED
(Appointed: from 1 December 2011 (authorisation as FT) until 18 April 2015; reappointed 19 April 2015 until 18 April 2017)

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 general practice and director of undergraduate GP education, University of Cambridge School of Clinical Medicine.

Independent director – Yes (see Section 4.8)

Mr Neville Hounsome – NED
(Appointed: from 1 January 2015 until 31 December 2017)

Areas of special interest/responsibility: lead NED for corporate risk committee; lead NED for security; member of remuneration committee, audit committee and quality & risk committee; NED link to HR director

Neville is currently group HR director for Hyde Housing Association. He has previously held senior HR positions with May Gurney plc, Norfolk Constabulary and McCain Foods (UK) Ltd.

Independent director – Yes (satisfies criteria of code of governance B.1.1)

Mr Gary Norgate – NED
(Appointed: 1 September 2013 until 31 August 2016; reappointed 1 September 2016 until 31 August 2019)

Areas of special interest/responsibility: chair of scrutiny committee; second lead for corporate risk committee; remuneration committee, audit committee and charitable funds committee. As an IT professional sits on the steering committee overseeing the development of the new electronic patient record system.

With a doctorate in corporate governance Gary has a special interest in board effectiveness and the management of change.

Gary is vice president of UK Professional Services, BT plc. He has previous NED experience with Cambridge Community Services NHS Trust and Suffolk Mental Health Partnership NHS Trust.

Independent director – Yes (satisfies criteria of code of governance B.1.1)

Mr Steven Turpie – NED and deputy chair
(Appointed: from 1 December 2011 (authorisation as FT) until 28 February 2014; reappointed 1 March 2014 – 28 February 2017; reappointed 1 March 2017 – 29 February 2019)

Areas of special interest/responsibility: chair of audit committee; member of remuneration committee and deputy chair of the Trust. NED lead for procurement and paediatrics. NED link to director of resources.

Steve is a qualified accountant with substantial experience in large global commercial enterprises.

Steve runs his own management consultancy and was previously group head of sourcing & procurement for Zurich Insurance Group and prior to that has held senior finance positions with Aviva, Cable and Wireless and Barclaycard. Steve is also chair of trustees for Brightstars, a charity that supports disabled children and young people.

Independent director – Yes (satisfies criteria of code of governance B.1.1)

Mrs Rosie Varley – NED and senior independent director
(Appointed: from 1 December 2011 (authorisation as FT) until 31 March 2015; reappointed 1 April 2015 until 31 March 2017)

Areas of special interest/responsibility: chair of remuneration committee; NED lead for patient experience committee; second lead for clinical safety and effectiveness committee; member of quality & risk committee, scrutiny committee and audit committee. NED lead for whistleblowing and safeguarding.

Rosie brings wide-ranging experience in health, social care, education and regulation. She is chair of the General Dental Council's appointments committee and one of the OCPA public appointments' assessors. Until October 2012 Rosie was 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 St Benedict's RC Upper School, and chair of the board of trustees of SENDAT (Special Education and Disability Academy Trust). She is also 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 B.1.1)

(b) Executive directors

Dr Stephen Dunn – 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 November 2014 from the NHS Trust Development Authority where he was regional director of delivery and development for the south.

Stephen's previous experience was as a director of policy & strategy, NHS Midlands and East; director of strategy & provider development, NHS East of England; senior civil servant, Department of Health. He is also a visiting professor of health policy at the London School of Economics, and a visiting professor of economics at the University of the West of England.

Mr Craig Black – executive director of resources

Areas of responsibility: finance, capital investment, commissioning, IT, information and performance, estate and environment. Deputy chief executive of WSFT.

Craig joined the Trust in April 2011 from Cambridge University Hospitals NHS Foundation Trust, where he was director of commissioning.

Previously Craig was deputy director of finance at The Ipswich Hospital NHS Trust.

Mrs Rowan Procter – interim executive chief nurse

Areas of responsibility: joint operational responsibility with the chief operating officer and medical director for the operational management and delivery of all clinical services. Also professional leadership, nursing strategy and nurse management, professional education, clinical governance and quality improvement, risk management; integrated governance, complaints and litigation, chaplaincy and volunteers and director of prevention and control (DIPC).

Rowan was appointed as interim executive chief nurse in November 2015.

Rowan has over 20 years nursing experience in the NHS as nurse specialist, ward manager, emergency department sister and a lead nurse for safeguarding children & vulnerable adults. Her most recent roles were as a programme director for NHS Strategic Projects Team and associate director at The Ipswich Hospital NHS Trust.

Mrs Nichole Day – executive chief nurse *(on secondment, as from 2 November 2015)*

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

Nichole has over 27 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 20 years.

Mr Jon Green – chief operating officer

Areas of responsibility: responsible for performance management and joint operational responsibility with the medical director and chief nurse for the operational management and delivery of all clinical services. Also responsible for transformation and service/business development. Board lead for emergency planning and preparedness.

Jon joined the Trust in June 2013 from Kettering General NHS Foundation Trust and prior to this he was general manager for Whittington Health London. He joined the NHS in 2005 under the gateway for leadership scheme having previously been an officer in the Royal Navy.

Dr Pamela Chrispin – executive medical director

Areas of responsibility: joint operational responsibility with the chief operating officer and chief nurse for the operational management and delivery of all clinical services. Also responsible for clinical audit; clinical networks; clinical research; GP liaison; post-graduate education and overarching responsibility for patient safety. Pam is the responsible officer for revalidation and Caldicott Guardian.

Pam was appointed as executive medical director in June 2014, having previously been medical director of East of England Ambulance Service NHS Trust and deputy medical director and consultant in anaesthesia & intensive care at the WSFT.

Pam also works one day per week as a consultant for East Anglian Air Ambulance.

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 a board governor at West Suffolk College, management-side chair of the Regional Social Partnership Board, chair of the East of England HR Directors' Network and patron of Suffolk West NHS Retirement Fellowship.

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

* Non-voting director

2.2.3 Register of interests

All Directors are required 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.

2.2.4 Appointment of chairman and non-executive directors

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

The nomination, appointments and remuneration committee of the council of governors makes a recommendation for appointment for a non-executive director to the council of governors. This committee comprises the chair of WSFT, four public governors (including the lead governor) one staff governor and one partner governor. The committee is chaired by the Trust chair, except when considering the appointment, remuneration and terms and conditions of the Trust chair, when it is chaired by the lead governor.

Non-executive directors appointments are normally for a term of three years. Following their first term, and subject to satisfactory appraisal, a non-executive director will normally be reappointed for a second term without competition. This assumes board competency requirements have not significantly changed. Following this second term, and subject to satisfactory appraisal, a non-executive director is eligible for consideration by the council of governors for a further term of office. Vacant non-executive directors' positions will be subject to an openly-contested process with appointment by the council of governors.

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

Disclosures of the remuneration paid to the chairman, non-executive directors and senior managers are given in the accounts.

2.2.5 Evaluation of the board of directors' performance

Attendance at board of directors meetings 2015/16

Name	Title	Attendance (out of 9)
Roger Quince	Chairman	9
John Benson	Non-executive director	8
Craig Black	Executive director of resources	9
Jan Bloomfield	Executive director workforce & communications	8
Pam Chrispin	Executive medical director	7
Nichole Day	Executive chief nurse *(on secondment from 2 November 2015)*	5 (of 6)
Stephen Dunn	Chief executive	9
Jon Green	Chief operating officer	8
Neville Hounsome	Non-executive director	7
Gary Norgate	Non-executive director	9
Rowan Procter	Interim chief nurse *(appointed November 2015)*	3 (of 3)
Steven Turpie	Non-executive director	8
Rosie Varley	Non-executive director	9

Meeting dates
24 April 2014, 22 May 2015, 26 June 2015, 31 July 2015, 25 September 2015, 23 October 2015, 27 November 2015, 29 January 2016, 26 February 2016.

Drawing on best practice from the commercial sector the board undertakes regular review of its governance arrangements.

WSFT's governance structure ensures 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.

The escalation arrangements within the governance structure ensure timely and effective escalation from directorates and specialist committees to the board via the trust executive group. The 'red risk' report, 'red complaints' report, serious incidents requiring investigation (SIRI) report and the aggregated report (reviewing all data from quality indicators to identify organisational themes) are standing agenda items on the board and include escalation of risks from board sub-committees and other sources.

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

The chief executive is subject to annual formal appraisal by the chairman. Executive directors are subject to annual appraisal by the chief executive which informs development plans. Evidence of performance against objectives is monitored by the board of directors through the remuneration committee, performance management arrangements and the board assurance framework.

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

2.2.6 Audit committee

Membership of this committee is made up of non-executive directors and is chaired by a NED with appropriate financial expertise. The committee has overarching responsibility for monitoring specific elements of the systems and processes relating to governance, including financial systems, records and controls; financial information; compliance with law, guidance and codes of conduct; independence of internal and external audit; and the control environment (including measures to prevent and detect fraud). The committee is responsible for providing an opinion as to the adequacy of the integrated governance arrangements and board assurance framework.

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

External audit

BDO LLP (BDO), WSFT's external auditors, report to the council of governors through the audit committee. BDO's accompanying report on the financial statements is based on its examination conducted in accordance with the audit code for NHS foundation trusts, as issued by Monitor, independent regulator of foundation trusts. Their work includes a review of our internal control structure for the purposes of designing their audit procedures.

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

The council of governors appointed the external auditors on 12 February 2013. The term of the appointment is three years, with the option for extension for up to two more years. The cost of statutory services for the 2015/16 financial year was £59,000 (2014/15; £59,000).

Non-audit work may be performed by the external auditors where the work is clearly audit related and the external auditors are best placed to do that work. For all such assignments the audit committee will be advised, which will ensure that objectivity and independence is safeguarded. No such work was undertaken in 2015/16.

Internal Audit

RSM, WSFT's internal auditors, are responsible for undertaking the internal audit functions on behalf of the Trust. The Head of Internal Audit reports to each meeting of the Audit Committee on the audit activity undertaken.

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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

Attendance at audit committee meetings

Name	Title	Attendance (out of 5)
John Benson	Non-executive director	5
Neville Hounsome	Non-executive director	4
Gary Norgate	Non-executive director	5
Steven Turpie	Non-executive director (chair)	4
Rosie Varley	Non-executive director	5

Meeting dates: 24 April, 2015, 22 May, 2015, 31 July 2015, 23 October 2015 and 29 January 2016.

2.2.7 Quality governance framework

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

Details of improvements which we have made in patient safety are given elsewhere in this report and in section 2.4 (annual governance statement and section 3 (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 delivery and monitor quality.

The board of directors reviews the arrangements in place to deliver 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 risk assessment framework submission to Monitor.

2.2.8 Details of consultation

WSFT consulted members of staff and the public on its draft masterplan to guide development in the short- to medium-term on the site of the hospital at Hardwick Lane. The need for a masterplan is referred to in St. Edmundsbury Borough Council's Bury St. Edmunds Vision 2031 - paragraph 12.9 and policy BV22. This can be viewed via:
http://www.westsuffolk.gov.uk/planning/Planning_Policies/local_plans/upload/1-Bury-St-Edmunds-Vision-2031.pdf

The masterplan was published for a four-week consultation, beginning on 23/03/15 and ending on Monday 20/04/15. This included:

1. An advert in the Bury Free Press (and associated free papers) on 20 and 27 March
2. Letters to local stakeholders - posted on 12/03/15 to circa 970 residents from areas adjoining the hospital
3. A web page published on 12/03/15 - this provided members of the public with a facility to view all documents associated with the draft masterplan and the ability to feedback comments on line www.wsh.nhs.uk/masterplanning
4. A public exhibition was held on 02/04/15 in the WSH committee room between 2:00pm and 8:00pm where representatives of the Trust were available to explain the masterplan and answer questions. The event was attended by circa. 70 members of staff and the public.

23 responses were received from the public and/or staff. The feedback received was included in the statement of community involvement and the masterplan was revised to incorporate changes, where appropriate.

The master plan was presented to St. Edmundsbury Borough Council sustainable working group in June 2015, and approved at full council committee in July 2015.

Consultation with local groups and the public and patient involvement activities

During 2015/16 the patient & carer experience group has continued to strengthen divisional accountability for patient experience improvement. It has worked hard to maintain a collaborative approach with patients and staff working together to identify learning and areas for improvement from patient feedback. Representatives from Healthwatch Suffolk and Suffolk Family Carers are also members of the group.

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

WSFT engages with the public, in particular 'seldom heard groups', through attendance at meetings such as the Healthwatch equality & diversity group and through the annual Suffolk Disability Day. This annual forum is an opportunity for the Trust to learn about the needs of various of people with disabilities from all walks of life and is attended by a senior nurse and human resources representatives.

WSFT has a number of user groups, e.g. cancer services user group and cardiology services user group, which are supported by clinical staff and are involved in providing feedback on current services and service developments. The cancer services user group holds an open forum annually to gain patient views on services to identify areas for improvement. A further 'Freedom to Speak Up' day was held in March 2016 and provided patients and carers with several ways to give feedback of their experiences of our services.

During the year our FT members have participated in questionnaires to help us understand which quality metrics are important to them. This has helped inform our priorities for quality improvement.

Our patients, Our hospital, Our future, *together*, our strategic framework for the future outlines the actions we need to take to move forward as an award-winning hospital, continuing to provide safe, high-quality care for our patients.

The *together* strategic framework was the subject of the biggest consultation in the history of our hospital – engaging a third of our staff, our patients and our community on our proposed vision, three priorities and seven ambitions. We involved our governors, volunteers and Friends of West Suffolk Hospital groups, wrote to our 5,600 public members and over 40 NHS bodies and partner organisations.

We are very grateful for everyone's willingness to share their views and experiences. We listened and responded by making changes which are outlined in a summary report: *Our strategic framework consultation response*. The report can be found, along with the full consultation strategic framework, by visiting: www.wsh.nhs.uk/together. Going forward we will continue to refer to the full consultation document which includes greater detail around our priorities and ambitions.

2.2.9 Foundation trust code of governance compliance

WSFT has applied the principles of the NHS foundation trust code of governance on a comply or explain basis. The NHS foundation trust code of governance, most recently revised in July 2014, is based on the principles of the UK corporate governance code issued in 2012.

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

It is relevant to note that although Dr John Benson is a nominated appointment by the University of Cambridge, his reappointment as a NED was reviewed and approved by the Council of Governors in November 2014. This review considered his relevant skills and experience, including his ability to provide independent challenge to the Trust. As such he is considered to be an independent director, despite his nominated status.

2.2.10 Other disclosures

Statement regarding the annual report and accounts

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

Companies act disclosures

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

- Important events since the end of the financial year affecting WSFT
- An indication of likely future developments
- Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees
- Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests

- Actions taken in the financial year to encourage the involvement of employees in WSFT's performance
- Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of WSFT.

WSFT has applied policies during the financial year for:

- Giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities
- Continuing the employment of, and arranging appropriate training for, employees who have become disabled persons during the period
- The training, career development and promotion of disabled employees.

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.

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.

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

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.

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 2015/16 or the comparative year.

	2015/16		2014/15	
	Number	**£000**	Number	£000
Total non-NHS trade invoices paid in the year	**44,872**	**62,398**	46,121	53,288
Total non-NHS trade invoices paid within target	**31,666**	**38,261**	41,567	44,458
Non-NHS trade invoices paid within target (%)	**71%**	**61%**	90%	83%
Total NHS trade invoices paid in the year	**1,490**	**26,856**	1,529	10,530
Total NHS trade invoices paid within target	**893**	**21,489**	1,257	7,385
NHS trade invoices paid within target (%)	**60%**	**80%**	82%	70%

2.3 Regulatory ratings

Monitor updates foundation trusts' ratings each quarter and in 'real time' to reflect regulatory action they take. The regulatory rating system used during 2015/16 is the risk assessment framework (RAF).

The RAF was developed during 2015/16 to assess FTs based on their financial sustainability risk rating. The financial sustainability risk rating (FSRR) incorporates the following measures of financial robustness and efficiency:

- **Liquidity:** days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown
- **Capital servicing capacity:** the degree to which the organisation's generated income covers its financing obligations
- **Income and expenditure (I&E) margin:** the degree to which the organisation is operating at a surplus/deficit
- **Variance from plan in relation to I&E margin:** variance between a foundation trust's planned I&E margin in its annual forward plan and its actual I&E margin within the year.

Calculating financial sustainability risk rating (FSRR) for NHS foundation trusts - 2015/16

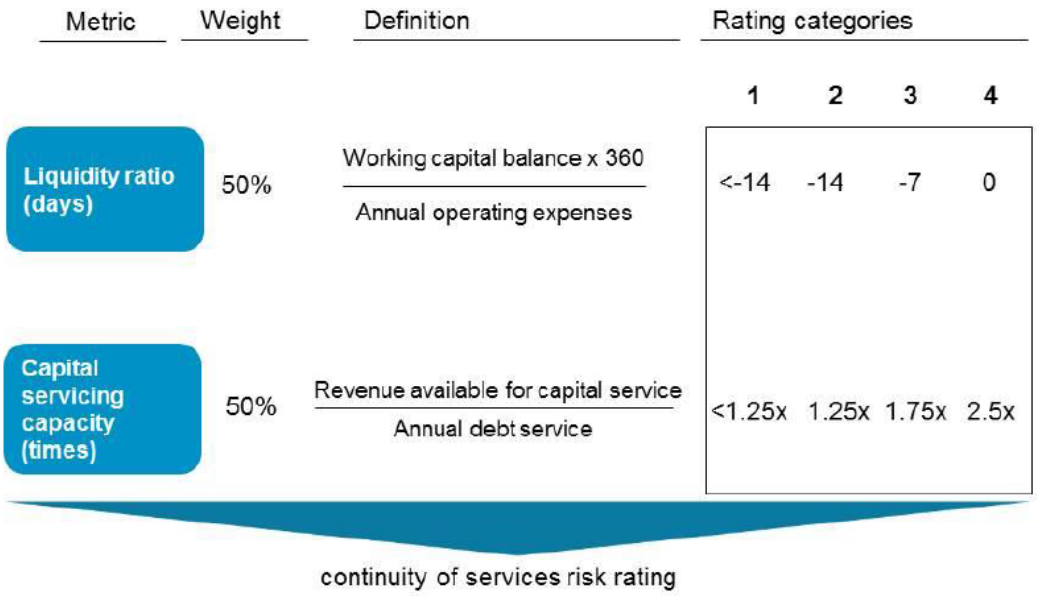
	Financial criteria	Weight (%)	Metric	Rating categories**			
				1*	2***	3	4
Continuity of services	Balance sheet sustainability	25	Capital service capacity (times)	<1.25x	1.25 - 1.75x	1.75-2.5x	>2.5x
	Liquidity	25	Liquidity (days)	<(14) days	(14)-(7) days	(7)-0 days	>0 days
Financial efficiency	Underlying performance	25	I&E margin (%)	≤(1)%	(1)–0%	0-1%	>1%
	Variance from plan	25	Variance in I&E margin as a % of income	≤(2)%	(2)-(1)%	(1)-0%	≥0%

Prior to introduction of the FSRR, FTs were assessed based on the continuity of services risk rating (CoSRR) which focused on liquidity and debt service.

Risk assessment framework

Continuity of service risk rating	1 Significant risk 2 Material risk 2* Level of risk is material but stable 3 Emerging or minor concern 4 No evident concerns
Governance rating	Rated 'green' if no issues are identified and 'red' where Monitor are taking enforcement action. *Where Monitor have identified a concern at a trust but not yet taken action, they provide a written description stating the issue at hand and the action they are considering.*

Calculating the continuity of services risk rating for NHS foundation trusts – 2014/15



Calculating the risk rating

Risk rating		Capital service capacity			
		1	2	3	4
Liquidity	1	1	2/2*	2/2*	3
	2	2/2*	2/2*	3	3
	3	2/2*	3	3	4
	4	3	3	4	4

Performance against plan

In line with our plan we achieved a financial sustainability risk rating (FSRR) of 1 for 2015/16.

2015/16	Annual plan	Q1	Q2	Q3	Q4
Financial sustainability risk rating (FSRR)	1	1	1	2	1
Governance risk rating	Green	Green	Green	Green	Green

2014/15	Annual plan	Q1	Q2	Q3	Q4
Continuity of service risk rating	1	1	1	2	1
Governance risk rating	Green	Under investigation	Under investigation	Under investigation	Green (No evident concerns)

The Trust has met all national targets in 2015/16 with the exception of:

- **Maximum waiting time of four hours in ED from arrival to admission, transfer or discharge.**

  After a challenging start to the year in April 2015 we recovered performance to achieve the target in Q1, Q2 and Q3. During Q2 improvement in patient flow allowed a ward to be closed enabling a 'deep clean' programme to be developed to all wards. Such a programme has not been achieved for the last five years. We experienced challenges during December which continued through January materially impacting on performance (93.5%). Performance further deteriorated through February (91.3%) and March (89.4%). Key factors impacting the drop in performance included our ability to effectively respond to:

  - High levels of attendances and increased admission
  - Out-of-hospital delays impacted on discharge, particularly for patients requiring social care packages in the home and continuing health care (CHC) patients.

  The out-of-hospital delays peaked in late March when the official delayed transfers of care (DTOCs) were running at three times the level experienced in the same period last year. It is also material that community beds experienced a sharp rise in DTOCs. We continue to work within the Trust and with partners to identify alternative methods of meeting patients' out-of-hospital needs, particularly with social care colleagues. This approach also ensures learning and improvement in these areas.

2.4 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 Monitor.

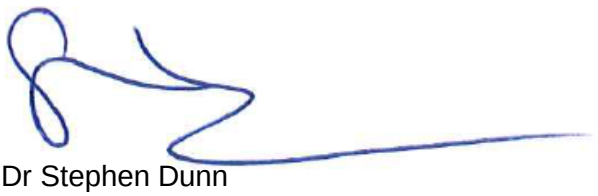
Under the NHS Act 2006, Monitor has directed West Suffolk NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the accounts direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs 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
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance 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/her 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*.



Dr Stephen Dunn
Chief executive

26 May 2016

2.5 Annual governance statement

West Suffolk NHS Foundation Trust annual governance statement – 1 April 2015 to 31 March 2016

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 on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of West Suffolk NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in West Suffolk NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

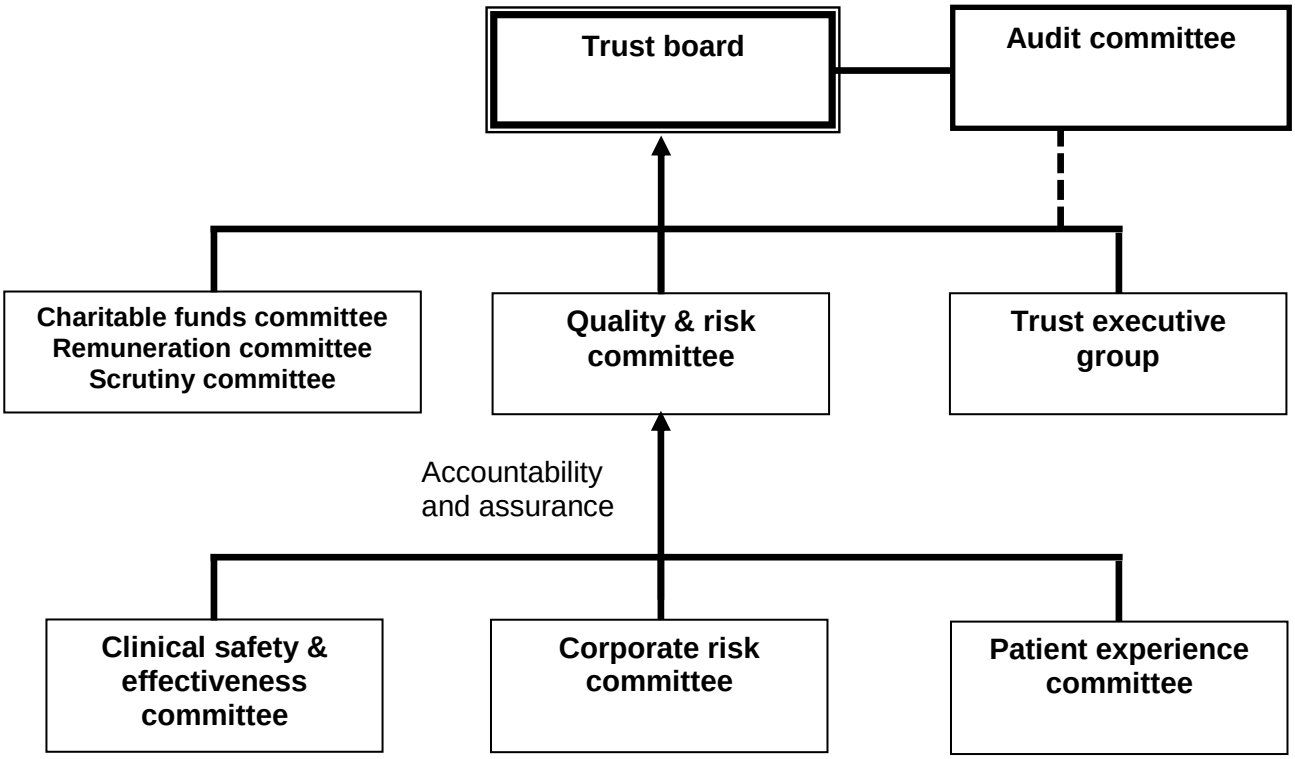
The system of internal control is underpinned by compliance with the Trust's terms of authorisation and the requirements of regulatory bodies relevant to FTs. The Trust has a risk management policy and strategy which make it clear that managing risk is a key responsibility for the Trust and all staff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

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

The audit committee provides an independent and objective view of WSFT's internal control environment and the systems and processes by which the Trust leads, directs and controls its functions in order to achieve organisational objectives, safety, and quality of services, and in which they relate to the wider community and partner organisations. The audit committee independently reviews the effectiveness of risk management systems, ensuring that all significant risks are properly considered and communicated to the board of directors. It reviews implementation of the board assurance framework to assure itself that risks are being appropriately identified and managed and appropriate assurance obtained.

The audit committee is supported by the quality & risk committee which monitors and reviews the WSFT's quality performance relating to patient safety, clinical outcome, clinical effectiveness, and patient experience. This includes infection control and the review of feedback to the Trust on individuals' experience, including patient and staff surveys and complaints. The committee also oversees the management of corporate risk, including information governance, research governance and health & safety.

Chart 1: Governance structure



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 scrutiny committee supports the board of directors by reviewing and advising on key developments to support the business objectives. This includes overseeing the processes for the Trust's strategy review and site development plan.

The nursing & governance directorate facilitates risk management activities in 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 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 controls and assurances include:

- Performance management framework
- Monthly quality and performance reports and performance dashboard. These include the Trust's priorities for improvement in the quality report, analysis of patient experience, incidents and complaints, review of serious incidents, and ward-level quality performance
- Monthly financial performance reports
- Quarterly self-certification against the compliance framework
- Quarterly peer review against delivery of the CQC registration requirements
- Quarterly quality and performance reports by directorates to the quality & risk committee
- Quarterly quality and performance reports to the council of governors. This provides information which is similar to that reviewed by the board of directors on a monthly basis
- Assurances provided through the work of the clinical safety & effectiveness committee, corporate risk committee and patient experience committee
- Reports from the quality & risk committee, scrutiny committee and the audit committee received by the board
- Assurances provided through the work of internal and external audit, the Care Quality Commission, Monitor, the NHS Litigation Authority, patient-led assessments of the care environment (PLACE), and accountability to the council of governors
- The work of clinical audit, whose scope includes national audits, audits arising from national guidance such as NICE, confidential enquiries and other risk and patient safety-related topics
- Weekly quality walkabouts, including executive directors, non-executive directors 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 following, which are covered in more detail in this annual report, are examples of the product of our risk and control environment:

- **Care Quality Commission (CQC)** – positive feedback from planned inspection in March 2016
- **Good performance against national targets**, meeting all national targets in 2015/16 with the exception of A&E four hour wait
- **Low hospital standardised mortality ratio (HSMR)**
- **Top hospital for quality of care 2011 and 2012 and shortlisted in 2013, 2014 and 2015** awarded by independent healthcare intelligence company CHKS
- **Emergency stroke outreach team (ESOT) was presented with the top prize in the stroke care category of the Patient Safety and Care Awards**
- **Clinical decision unit (CDU) named as one of three finalists in the project of the year category in the 2015 Health Estates and Facilities Management Association awards**
- **Latest sentinel stroke national audit programme (SSNAP) data rates WSH as a level A (highest)**
- **Diagnosis rates in west Suffolk for early stage cancers are the best in the country**
- **Patients with acute kidney injury (AKI) are receiving faster more effective care thanks to new measures introduced to help staff identify and treat the condition more quickly**
- **Fracture patients are benefitting from shorter waiting times and fewer visits to hospital thanks to the success of an innovative virtual clinic**

- **PLACE (patient-led assessment of the care environment) assessment put WSH above the national average for cleanliness and food**
- **Good Friends and Family scores** – consistently above national average scores for inpatients, outpatients, A&E and maternity services
- **2015 national staff survey ranks West Suffolk Hospital as the region's best** with the trust's score in the highest (best) 20% when compared with trusts of a similar type.
- **Excellent reputation for teaching** – both undergraduate and graduate

But, we also have some challenges:

- **Maximum waiting time of four hours in ED from arrival to admission, transfer or discharge.** We experienced challenges during December which continued through January materially impacting on performance (93.5%). Performance further deteriorated through February (91.3%) and March (89.4%). Key factors impacting the drop in performance included our ability to effectively respond to high levels of attendances and increased admission, and out-of-hospital delays impacting on discharge, particularly for patients requiring social care packages in the home and continuing healthcare (CHC) patients. We continue to work within the Trust and with partners to identify alternative methods of meeting patients' out-of-hospital needs, particularly with social care colleagues. This approach also ensures learning and improvement in these areas
- The Trust failed to achieve a planned loss of £5.5m in 2015/16 with a **final year end deficit of £9.8m**. This is considered in more detail in the conclusion of the annual governance statement as a significant control issue.

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

Board assurance framework summary

Category of risk	Description of risk	Potential impacts being mitigated by controls and future plans
Quality	Risk of reputation damage due to quality or service failure. The board has been very focused on the fact that during 2015/16 we reported three 'never events' relating to surgical procedures	Loss of public and GP confidence that leads to reduced referrals as a consequence of public choice. Restricted authorisation / licensing by regulators
	Implementation of Suffolk community services	Post-transfer risks include service quality and performance, financial viability and consortium stability
Urgent care	Changes to the provision of services in light of national or regional recommendations – centralisation within major centres	Potential loss of essential (mandated) services. Lack of clinical sustainability due to activity levels. Financial loss from service provision impacting on sustainability of the Trust
	Failure to work within local health economy (LHE) to control emergency activity and/or adequately prepare for winter	Patient safety. Reputational impact and poor patient experience/satisfaction. Loss of income due to 70% tariff for emergency activity and limited ability to provide additional elective activity. Negative impact on staff morale. Cumulative impact of contract penalties (A&E targets, stroke targets and ambulance turnaround). Impact on other targets e.g. RTT and cancer as unable to admit elective activity

Category of risk	Description of risk	Potential impacts being mitigated by controls and future plans
Environment, effectiveness and continuous improvement	Implementation of estates strategy to provide a building environment suitable for patient care and adequately maintained with regard to backlog maintenance	Ageing building environment suitability for patient care which could lead to reputation damage and loss of income. Unknown financial impact if reputational consequences. Risk of improvement notices if fail to effectively maintain building(s). Potential reputation risk of disposal strategy
	Delivery of reconfigured pathology services, including implementation of the new Clinisys system	Impact on access to patient information to support patient care which leads to patient harm and/or increased delays
	Failure to identify and deliver CIPs (cost improvement plans) that ensure delivery of clinical and non-clinical services in the most efficient way possible	Quality and ability to deliver safe services. Non-compliance with national standards, targets and terms of authorisation leading to breach of licence (CQC and/or Monitor). Impact on cash flow. Inability to generate sufficient surplus to support capital investment. Reputational harm from adverse media coverage – loss of confidence
	Implementation of e-Care to replace existing patient administration system (PAS)	A driver for the implementation of e-Care is quality improvement; however implementation itself presents a clear risk to patient safety and the operational effectiveness of the Trust
Workforce	Ability to meet workforce plan linked to the Trust's strategic plan	Failure to achieve reduction of staff costs as part of financial plans. Quality and safety and reputation impact. Adverse employee relations and staff motivation. CQC regulatory action. Withdrawal of Royal College recognition
	Staff responsiveness to current economic / environmental challenges	Impact of change upon staff morale and responsiveness including resistance may lead to impact upon current discretionary efforts of staff. Poor staff engagement hinders delivery of service change
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 or licencing by regulators. Fines and civil awards. Loss of confidence. Capacity to deal with regulatory reviews (including CQC or Monitor)
	Data quality to support clinical and corporate decision-making	Quality of patient care compromised by ill-informed decisions. Loss of confidence and credibility of the Trust at local and national levels. Fines and potential prosecution for falsely reporting Trust's performance. Unable to bill CCG for activity against contract. Unable to meet external reporting requirements, including monitoring against national targets
	External financial constraints impact on Trust's sustainability through tariff, contract and pattern of service provision in the local health economy	Quality and ability to deliver safe services. Non-compliance with national standards, targets and terms of authorisation leading to breach of licence (CQC or Monitor). Impact on cash flow and income and expenditure. Inability to generate sufficient surplus to support capital investment. Local position leads to tension between local health economy partners

WSFT is fully compliant with the registration requirements of the Care Quality Commission.

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 evidence of the effectiveness of controls that manage the risks to the organisation achieving its principal objectives and that these have been reviewed.

The annual governance statement is also informed by the Trust's evaluation of compliance with the CQC standards and preliminary feedback from the planned CQC inspection in March 2016.

The board assurance framework was reviewed and updated routinely during 2015/16 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.

The board assurance framework was subject to independent review by internal audit during 2015/16 which provided a 'green' rating.

In considering the principal risks to compliance with the NHS foundation trust conditions of authorisation we have had particular regard to the:

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

and performance report for the board supports an open reporting culture and includes the results from the Friends and Family Test, the NHS safety thermometer, which covers falls and pressure ulcers, infection control and patient and staff experience surveys building up a picture of care quality on our wards. The range of indicators provides early warning of deterioration in performance and potential negative impact on quality. The finance and workforce report has been strengthened during 2015/16 including divisional reporting, cash position and performance against cost improvement programmes.

Information governance

WSFT's information governance assessment report overall score for 2015/16 was 80%. The Trust achieved a score of at least two for all requirements, within a range of zero (worst) to three (best).

WSFT reported one level 2 data breach to the Information Commissioner's Office (ICO) in May 2015. The incident involved unauthorised access to a computer by an individual. Remedial action has been taken and no further action has been identified by the ICO.

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*.

WSFT places a high priority on the 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 quality priorities. New 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 council 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 council of governors, and both bodies receive reports routinely on complaints, patient and staff feedback surveys, incident reporting trends and any on-going actions to address concerns identified. The quality & risk committee has the delegated authority to review actions 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 Healthwatch Suffolk.
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 risk framework, commissioning for quality & innovations (CQUINs) and local priorities.

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. The board of directors takes further assurance from the external auditor's review of the quality report, including the testing of data provided in the 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 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. WSFT's strategic objectives are derived from the priorities determined in the Trust's strategy.

The board of directors has put in place a robust escalation framework which ensures timely and effective escalation from divisions and specialist committees to the Board.

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

In accordance with the public sector internal audit standards in 2013, internal audit provides the Trust with an independent and objective opinion to the accounting officer, the board of directors and the audit committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

Internal audit issued 16 reports relating to 2015/16, the 'opinion levels' are summarised below:

Opinion level	Number
Red	1
Amber-red	3
Amber-green	4
Green	6
Advisory	2

The red opinion relates to the consultant job planning review.

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

For the 12 months ended 31 March 2016, the head of internal audit's opinion for WSFT is that "the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective."

On an exception basis external audit reports that the annual report and accounts are true and fair as well as on the adequacy of the Trust's management arrangements to ensure economy, efficiency and effectiveness in its use of resources.

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

Conclusion

In considering any significant control issues the following were recognised:

- **Financial sustainability**
  Whilst the Trust submitted a plan to make a loss of £5.5m in 2015/16, this was underpinned by the following assumptions:

  - The Trust planning to make a CIP of 5.5% of turnover
  - The staffing budget being consistent with the funded bed base which does not include any escalation beds. Where we have to open additional capacity without any associated increase in income this creates a cost pressure.

  WSFT's final year-end deficit was £9.8m with a financial sustainability risk rating (FSRR) of 1 (lowest rating) for 2015/16.

  We continue to suffer the adverse impact of a doubling of the number of delayed transfers of care and a concomitant increase in the number of 'out-of-hospital' delays. This both increases our costs and reduces our ability to deliver our income plan.

  While the financial challenges the WSFT faces are common with the wider NHS, the board is committed to the delivery of financial sustainability. The longer-term plan is to deliver enhanced clinical and financial performance through the integration of services across the health economy. We continue to participate in system-wide discussions focusing on the creation of an integrated care organisation alongside the development of the local sustainability and transformation plan.

I am confident that the internal control systems are operating well and that the work we have done to maintain and develop our risk management systems will help us to consolidate this position in the future. The Trust is committed to the continuous improvement of processes of internal control and assurance.

Dr Stephen Dunn
Chief executive
26 May 2016

2.6 Remuneration report

Annual statement on remuneration

During 2015/16 the senior management responsibilities within the executive director roles have been consolidated, based on changes made in the previous year. The remuneration committee and board of directors used these changes to increase the effectiveness of the senior management and provide greater resilience within the management structure. No further major decisions on senior managers' remuneration were made during 2015/16.

Senior managers' remuneration policy

Senior managers pay consists of the following elements:

- Senior managers salary is reviewed on an annual basis by the remuneration committee. The objectives of the committee are set out below
- Benefits in kind – in line with the Trust policy for all employees senior employees are eligible to access salary sacrifice schemes such as lease cars and computer equipment. These may be considered as benefits in kind and are declared to HM Revenue & Customs and tax is paid on these sums as appropriate.

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 and will usually meet at least annually. Minutes are taken and a report submitted to the board of directors showing the basis for the recommendations. No meetings of the committee were held during 2015/16. During 2014/15 all non-executive directors attended the one meeting which took place.

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. Through these arrangements the committee must be satisfied that the remuneration for senior managers is reasonable, including any senior manager paid more than £142,500. 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.

Policy on payment for loss of office

Approval for any non-contractual severance payments should be obtained from the remuneration committee and Monitor following submission of a business case. In respect of individuals earning over £100,000 any severance payment should include a provision requiring the repayment of the severance payment where the individual returns to work for the NHS in England within twelve months and/or before the expiry date of the period for which they have been compensated (as measured in equivalent months/part-months of salary). In such circumstances the employee would be required to repay any un-expired element of his/her compensation. This would be reduced to take account of any appointment to a lower grade post or reduced hours basis and reflect net salary.

Annual report on remuneration

In the financial year the directors costs reduced to £909k from £1,039k. This decrease was due to the effects of changes in directors during the year. There were no exit packages paid to board members either in the 2015/16 financial year or the comparative year.

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV - 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.

WSFT made contributions totalling £12,196k (2014/15 £10,899k) 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 £24,063 (2014/15 £27,421). The ratio of the midpoint of the banded remuneration of highest paid director to this figure is 7:1 (2014/15 6:1). This is calculated based on all staff employed as at 31 March 2016.

In 2015-16, 19 (2014/15, 12) employees received remuneration in excess of the highest-paid director.

Remuneration ranged from £13,328 to £198,098 (2014/15 £14,136 to £190,299). Total remuneration includes salary, benefits in kind and non-consolidated performance-related pay. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Both directors and governors are able to reclaim expenses necessarily incurred during the course of their duties. Details of these are shown below. The numbers include individuals who have acted in their capacity as director or governor for any part of the financial year. In both 2015/16 and 2014/15 there were no more than 13 directors at any time.

	2015/16		2014/15	
	Directors	Governors	Directors	Governors
Total number in office during the year	13	32	15	33
Total number receiving expenses	4	11	8	7
Aggregate total of expenses paid during the year (£)	4,314	2,342	4,339	1,956

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.

The table below includes an amount in respect of the increase in pension entitlements of each executive director. It is based on a formula determined by HMRC which combines both the increase in pension payable and lump sum payable. This is then compared to the same calculation for the previous year adjusted by an inflation figure to give a real terms increase. The sum shown does not represent an amount that the director has received in the year; it shows the amount that their pension entitlement has increased by.

Table A – Remuneration

Name and title	Year to 31 March 2016				Year to 31 March 2015			
	Salary paid (bands of £5000)	Benefits in kind rounded to nearest £100	Increase in pension entitlement (bands of £2500)	Total (bands of £5000)	Salary paid (bands of £5000)	Benefits in kind rounded to nearest £100	Increase in pension entitlement (bands of £2500)	Total (bands of £5000)
	£000	£	£000	£000	£000	£	£000	£000
Mr R Quince – Chairman	35 – 40	-	-	35 – 40	35 – 40	-	-	35 – 40
Dr J Benson – Non-executive director	10 – 15	-	-	10 – 15	10 – 15	-	-	10 – 15
Mr G Simons – Non-executive director (note 1)					5 – 10	-	-	5 – 10
Mr S Turpie – Non-executive director	10 – 15	-	-	10 – 15	10 – 15	-	-	10 – 15
Mrs R Varley – Non-executive director	10 – 15	-	-	10 – 15	10 – 15	-	-	10 – 15
Mr G Norgate – Non-executive director	10 – 15	-	-	10 – 15	10 – 15	-	-	10 – 15
Mr N Hounsome – Non-executive director	10 – 15	-	-	10 – 15	0 – 5	-	-	0 – 5
Dr S Dunn – Chief executive (note 2)	160 – 165	2100	30 – 32.5	195 - 200	65 – 70	-	17.5 – 20.0	85 – 90
Mr C Black – Executive director of resources	125 – 130	3,800	52.5 – 55.0	180 – 185	120 – 125	2,600	52.5 – 55.0	180 – 185
Mr J Green - Chief operating officer	110 – 115	-	45.0 – 47.5	155 – 160	110 – 115	-	45.0 – 47.5	155 – 160
Mr S Graves – Chief executive (note 3)					65 – 70	-	35.0 – 37.5	100 – 105
Mr D O'Riordan – Medical director (note 4)					120 – 125	6,400	32.5 – 35.0	160 – 165
Dr P Chrispin – Medical director (note 5)	90 - 95	-	0	90 - 95	75 - 80	-	-	75 – 80
Ms J Bloomfield – Executive director workforce & communications	90 – 95	0	10 – 12.5	100 - 105	90 – 95	1,100	2.5 – 5.0	95 – 100
Ms R Procter – Executive director chief nurse (note 6)	40 – 45	0	40 - 42.5	80 - 85				
Ms N Day – Executive director chief nurse (note 7)	55 – 60	800	7.5 – 10.0	65 – 70	95 – 100	1,100	5.0 – 7.5	100 – 105

Table B – Pension benefits to 31 March 2016

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 2016 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2016 (bands of £5,000)	Cash equivalent transfer value at 31 March 2016	Cash equivalent transfer value at 31 March 2015	Real increase / (decrease) in cash equivalent Transfer Value (note 8)
	£000	£000	£000	£000	£000	£000	£000
Dr S Dunn	0 – 2.5	0	50 – 55	0	525	498	21
Mr C Black	2.5 – 5	0 – 2.5	30 – 35	90 – 95	489	453	30
Ms J Bloomfield	0 – 2.5	0 – 2.5	35 – 40	115 – 120	742	712	21
Ms N Day	0 – 2.5	0 – 2.5	35 – 40	105 – 110	635	608	20
Ms R Procter	0 – 2.5	0 – 2.5	15 - 20	45 - 50	257	228	26
Mr J Green	0 – 2.5	0 – 2.5	15 - 20	40 - 45	251	221	27

Note

1 G Simons' NED term ended November 2014
2 S Dunn was appointed as Chief Executive Director on 3 November 2014
3 S Graves resigned wef 31 July 2014
4 D O'Riordan stepped down as a director on 30 November 2014
5 P Chrispin was appointed as medical Director on 2 June 2014
6 R Procter was appointed as interim from November 2015
7 N Day on secondment from November 2015
8 Real increases reflect the increase after allowing for inflation of 1.2% as prescribed by the NHS Pensions Agency

Dr Stephen Dunn
Chief Executive

2.7 Staff report

2.7.1 Our staff

WSFT is one of the largest employers in Suffolk, employing 3,298 whole-time equivalent staff in March 2016. WSFT firmly believes in the benefits of working in partnership with staff and the trade unions, and this was highlighted during 2015/16 with the following activities:

- In 2015 the Trust undertook its largest ever face-to-face consultation with our staff on our strategic framework, '*Our patients, our hospital, our future, together'*, and its seven ambitions
- Staff governors continue to support staff to discuss challenges and achievements and report back on these.
- As part of the Trust's health & wellbeing programme and in partnership with staff the book club continues to thrive and is now run electronically. In addition, the staff Christmas carols choir met throughout December singing carols for staff and patients across the hospital site. In partnership with Cambridge Health at Work the Trust launched the care first service in 2015, allowing staff 24/7 access to support in both their work and personal lives, with easy access through a telephone and website portals. The Trust continues to have an onsite occupational health service, with direct access for staff to a physiotherapist, counselling and flu vaccinations
- West Suffolk Hospital Charity continues to support the health and wellbeing programme of the Trust and held a fourth very successful 'It's a Bury Knockout' competition in 2015. This saw seven staff teams compete with other teams from across the west Suffolk community, as well as run stalls and volunteer. During 2015 the Charity also organised a group sky dive, predominantly consisting of staff, as well as Walk for Wards
- An active flu campaign failed to improve uptake of the flu vaccine among staff (2014: 62.34%, 2015: 53.9%)
- We have continued to support the trade union convenor role
- In consultation with our staff-side partners we agreed a resourcing paper to support the implementation of e-Care
- The executive director of workforce and communications is the management-side chair of the regional social partnership forum and chair of the regional human resources directors network
- 2015 saw a joint in-depth consultation process take place with Suffolk Community Health staff following a successful bid to bring community services into a joint partnership arrangement with The Ipswich hospital NHS Trust and Norfolk Community Health and Care NHS Trust. Consultation included local briefing sessions, email communications, newsletters, the offer of one to one sessions etc. The staff successfully transferred on 1st October 2015
- We continue to develop our partnership working through the following committees:
    - Trust council
    - Trust negotiating committee (general staff)
    - Trust negotiating committee (medical and dental)
    - Travel plan steering group
    - Health & wellbeing steering group.

2.7.2 Average number of employees (whole time equivalent (WTE) basis)

	Permanent number	Other number	2015/16 Total number	2014/15 Total number
Medical and dental	343	54	**397**	374
Administration and estates	633	74	**707**	579
Healthcare assistants and other support staff	614	74	**688**	629
Nursing, midwifery and health visiting staff	878	44	**922**	886
Scientific, therapeutic and technical staff	377	10	**387**	316
Agency and contract staff	-	24	**24**	15
Total average numbers	**2,845**	**279**	**3,124**	**2,799**
Of which:				
Number of employees (WTE) engaged on capital projects	46	32	**78**	59

2.7.3 Breakdown at year end of the number of male and female staff

	Male	Female	Total
Directors	8	4	12
Other senior managers	0	0	0
Employees	682	2,957	3,639

2.7.4 Sickness absence data

The Trust has systems and processes in place to manage both long- and short-term sickness absence, in accordance with best practice and legislative requirements. The performance for the year is as follows:

Measure	Value
Average FTE 2015	2,767.20
FTE-days available	622,619
FTE-days lost to sickness absence	23,269
Average of 12 months (2015 calendar year)	3.74%
Average sick days per FTE	8.4

Source: based on data from ESR, period covered January to December 2015

Data items: ESR does not hold details of normal number of days worked by each employee. (Data on days lost and days available produced in reports are based on a 365-day year.) The number of FTE-days available has been estimated by multiplying the average FTE for 2015 by 225. The number of FTE-days lost to sickness absence has been estimated by multiplying the estimated FTE-days available by the average sickness absence rate. The average number of sick days per FTE has been estimated by dividing the estimated number of FTE-days sick by the average FTE. Sickness absence rate is calculated by dividing the sum total sickness absence days (including non-working days) by the sum total days available per month for each member of staff.

2.7.5 Equality and diversity

WSFT is committed to the provision of high quality, safe care for all members of the communities we serve and to the further development of a culture where all people are valued and respected for their individual differences as evidenced by our strategic framework *Our patients, Our hospital, Our future, together*'.

In 2011 we developed our single equality scheme, in line with national legislation (2010 Equality Act and Public Sector Equality Duty (PSED)). Since 2012 however we have incorporated this into the Department of Health recommended NHS equality delivery system (EDS). The EDS allows us to identify specific local objectives, whilst also meeting the CQC essential standards and the NHS constitution. Since the autumn of 2013 we have been implementing our action plan, and review these objectives as part of the EDS annually.

The EDS focuses on a set of 18 outcomes, grouped into four goals:

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

The in-depth analysis of the EDS goals and outcomes, as well as looking at the Trust's core business objectives, has enabled the development of five specific Trust objectives. These are:

1. To comply with the 2010 Equality Act, including the public sector duties, in respect of the three aims of the general duty and the Trust's obligations under the specific duties
2. To improve information and data collected, in respect of protected characteristics, to ensure that the right services are delivered, and in order to improve patient experience and staff satisfaction for all. This will include:
    - Review of information gathered on the electronic staff record (ESR) in respect of protected characteristics
    - Review of the current patient information system(s) – to look at ways to improve the recording and reporting of protected characteristics
3. To focus on the patient experience and care of older age patients (including those with dementia), and those patients with learning disabilities by:
    - Monitoring the experience of elderly patients and those with dementia against the dignity in care recommendations
    - Completing dementia screening and assessment for patients over 75 years of age and facilitating specialist referral as necessary
    - Completing an assessment of the Trust's position against the East of England quality assurance framework for learning disabilities and implementation of the associated improvement plan
4. To further engage with staff, particularly those with protected characteristics, by the setting up of a specific focus group made up of staff members covering all protected characteristics (where possible). The focus group will then inform the Trust equality & diversity (E&D) technical group as to equality and diversity issues
5. To review the Trust's 'Patients First' standards to ensure that they encompass EDS objectives 3 and 4, and to ensure they contribute to an improved understanding of the standards and the management of those who are unable/unwilling to meet those standards.

These are reviewed on an annual basis by the Trust board as part of the annual equality report. A major review is planned for 2016, in line with EDS recommendations.

The equality & diversity technical group review the Trust's performance against our objectives, as well as reviewing equality impact assessment reports. The annual equality report is published on the Trust website, which includes the workforce race equality scheme (WRES).

The data shows all current employees and public members broken down by certain protected characteristics:

Employees and public members protected characteristics

	Staff in post			Public members		
	2015/16	**2014/15**	**2013/14**	**2014/15**	**2013/14**	**2012/13**
Age						
16	**0**	0	1	**0**	0	1
17-21	**73**	68	65	**30**	41	49
22+	**3,566**	2,993	3,078	**5,464**	5,317	5280
Not Specified	**-**	-	-	**140**	144	129
Total	**3,639**	3,063	3,144	**5,634**	5,502	5,459
Ethnicity						
White	**3,066**	2,701	2,776	**5,320**	5,280	5,234
Mixed	**31**	27	24	**25**	21	23
Asian or Asian British	**247**	239	232	**69**	69	67
Black or Black British	**24**	20	22	**23**	22	22
Other ethnic group	**33**	33	34	**48**	26	16
Not Stated	**76**	41	50	**149**	84	97
Undefined	**162**	2	6	**-**	-	-
Total	**3,639**	3,063	3,144	**5,634**	5,502	5,459
Gender						
Female	**2,957**	2,444	2,499	**2,323**	3,154	2,392
Male	**682**	619	645	**3,311**	2,348	3,067
Total	**3,639**	3,063	3,144	**5,634**	5,502	5,459
Disability						
No	**1,261**	917	852	**-**	-	-
Not declared	**327**	331	346	**-**	-	-
Undefined	**1,969**	1,739	1,882	**4,884**	4,708	4619
Yes	**82**	76	64	**750**	794	840
Total	**3,639**	3,063	3,144	**5,634**	5,502	5459

Employee data is sourced from the electronic staff record (ESR) and membership data is sourced from the Trust's membership database. Data as at 01.04.2016.

In September 2015, approximately 430 staff from Suffolk Community Health tuped into WSFT as part of the community contract.

Disability and equal opportunities policies

WSFT is committed to a policy of equal opportunities in employment and service delivery. Everyone who comes to the Trust, either as a patient or visitor, or who works in the Trust, or applies to work in the Trust, should be treated fairly and valued equally.

Our Trust policies and strategies: the equality delivery system, recruitment and retention of people with disabilities and equal opportunities policies, all support this focus and full details can be found on the Trust's website.

2.7.6 Health and safety report

WSFT's health and safety performance is reported to and monitored by the health and safety committee who then escalates 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 continues to be developed and promoted Trust-wide. The risk register is a tool for capturing, prioritising and managing the significant risks and is integral to the Trust's risk management framework.

The risk register allows all divisions to manage, monitor and review their own risks.

The responsibility lies with each departmental manager to ensure all of their operational risks are captured on the Datix risk register. Datix risk register training is provided by the health, safety and risk manager.

During the period April 2015 to March 2016 over 60 members of staff were trained in the fundamental principles of health and safety and risk assessment. This has improved the quality and quantity of risk assessments and has helped to promote the use of the risk register.

In January 2015 a new approach to undertaking workplace inspections was introduced Trust-wide. All health and safety link persons are now required to become qualified with the RSPH Level 2 award in health and safety. This qualification gives the link person the knowledge and understanding to undertake the department's full workplace inspection. Once completed, the inspection is captured on the risk register so actions can be monitored. 99 members of staff have now gained this qualification.

Reporting of incidents, diseases and dangerous occurrence regulations 2013 (RIDDOR)
During the period April 2015 to March 2016 a total of 21 incidents were reported to the Health and Safety Executive as required under RIDDOR. This is an increase of four incidents from the previous year. The main categories were health and safety which increased by two incidents and slips, trips and falls which increased by one incident.

There was a reduction of two incidents for both moving and handling (to 8) and violence and aggression (to 2).

Out of the 21 incidents reported to the HSE, 13 incidents (62%) were due to being off work for more than seven days following an incident. The health and safety committee reviews incident trends, including RIDDORs to ensure that appropriate learning takes place and action is taken.

The Trust continues to improve standards to help reduce the number of moving and handling incidents, including:

- Handling patients and safe handling of loads policy and procedure
- All front-line staff attend mandatory moving and handling training via e-learning and classroom sessions
- Moving and handling advisor and trainer resource
- Moving and handling keyworkers on each ward
- All wards and departments are required to have moving and handling risk assessments.

RIDDOR description	2015/16
Caused during the moving and handling of patients	6
Occurred during the moving and handling of a load	2
Result of slip, trip or fall	5
Violence and aggression	2
Struck against fixed object	2
Suspected asbestos exposure	1
Needlestick injury from contaminated needle	1
Contact with hot material or substance	1
Occupational disease	1

Incident reporting system
The Datix incident reporting system is used to capture all clinical and non-clinical incidents. Non-clinical incidents include reports of personal accidents, violence and aggression, abuse and harassment, fire, and security breaches. All incidents no matter the grade are investigated and reported according to the Trust's incident policy and procedure. Actions taken as a result of investigations are communicated through the divisional governance groups. The board of directors receives a monthly report summarising incident trends and action.

For the period April 2015 to March 2016 there were 169 violence, abuse and harassment incidents - an increase of 22 from the previous year. These incidents take into account physical assaults, verbal abuse, harassment and physically threatening behaviour towards staff by patients. Of the 64 physical assaults reported, 54 were recorded as having a clinical cause. Clinical-caused incidents are incidents whereby the patient is not aware or has no control of their actions. This can be postoperative due to having a general anaesthetic or, more commonly, the patient is suffering from dementia or is cognitively impaired.

There were 1,381 reported incidents of personal accident/ill health during 2015/16. This is an increase of 71 incidents (5%) from the previous year. This figure includes staff, patients, visitors and others and is broken down into specific incident categories, which include slips/trips/falls, contact with an object, contact with a sharp, lifting and handling, self-harm, exposure to a harmful substance, contact with electricity and a category of 'other'. Further detail of learning and action is provided in section 6 (Quality report).

2.7.7 Occupational health report / occupational health & wellbeing service

Occupational health & wellbeing vision:
"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."

Cambridge Health at Work provides a full range of occupational health services. The service continues to strive to improve service quality and effectiveness, working with teams and specialties across the organisation. As well as serving members of WSFT staff, the service has contracts with other sectors including agriculture, biotechnology, housing, light engineering, pharmaceuticals, research and development, education, and software, as well as to local councils. This income generation helps to reduce the cost per capita for NHS staff. Our focus is on ensuring those we care for are safe, healthy and productive. We have been working closely with WSFT's leadership team to develop a wellbeing strategy with particular focus on avoiding lifestyle health harms and reducing work-related mental ill health. We achieved a higher than national take-up rate for this year's flu vaccination programme.

Public health responsibility deal

WSFT signed up to several public health responsibility deal pledges and will forward a report to the Department of Health regarding progress as follows:

Health at work pledge - chronic conditions
To support the policy for improving employee attendance, WSFT continues to employ an occupational health physiotherapist and two moving and handling advisors. The physiotherapist and moving and handling advisors continue to carry out in-depth specialist assessments of the employee in the workplace. This facilitates appropriate treatment and management of staff with musculoskeletal injuries and reduces the potential for chronic illness and long-term sickness absence. Validated outcome measures are used to assess fitness to work when required. The OH physiotherapist is skilled at carrying out functional capacity evaluations which are specialised in-depth assessments to evaluate fitness to work. Both the OH physiotherapist and manual handling advisors are trained to carry out display screen evaluations which assess working ergonomics. With staff consent the OH physiotherapist will work closely with the OH department nurse advisors, doctors and manual handling advisors to ensure a multidisciplinary team approach.

An occupational health nurse advisor (OHNA) and HR officer continue to meet monthly to identify those employees who have been absent from work due to sickness for more than three months. The purpose of these meetings is to ensure that the employee is receiving the appropriate support and actions have been initiated.

The occupational health and wellbeing service has developed case management guidance, triggered following two weeks of sickness absence by an employee. On receipt of information received from the manager an OHNA contacts the employee to discuss their condition and identify any support or initiative that may be required.

'First aid counselling' continues to be carried out by the occupational health & wellbeing service. Since March 2015 WSFT has been using Care First which is a 24-hour support service offering advice, information and counselling for all staff who are able to self-refer, either online or by phone, free of charge. In addition the occupational health & wellbeing service can refer staff for face-to-face counselling sessions in the locality where deemed most appropriate.

OH standards
WSFT's occupational health & wellbeing service achieved in-house accreditation for standards for occupational health services (SEQOHS) in December 2012. In 2014 the service merged with Cambridge Health at Work and is accredited as a single organisation. The service passed its annual renewal in April 2015.

Health at work pledge - healthier staff restaurants
Information on the nutritional content of food remains available for all food served in the staff Time Out restaurant (with exception of daily specials). To encourage healthy eating fresh fruit is sold at cost price and healthier options are always available. Advice on allergens is available on request in the restaurant and employees can access information via the health & wellbeing site on the intranet to make an informed choice regarding their meal. Information includes calories, salt and fat content. The daily menu includes information on the healthy option of the day.

The catering department has a 5* food hygiene rating and has also been presented with an 'Eat Out Eat Well Gold Award' for Healthier Choice which was presented by the Environmental Health Department, St Edmundsbury Council, which was also the first that they have awarded.

The department has also been awarded the Catering Mark Bronze award by the Soil Association for food and beverages served to staff, visitors and our patients. No harmful additives or trans-fats are contained within anything that is served and the meat used is traceable back to the farm which meets

legal animal welfare standards. At least 75% of the food is freshly prepared and all the eggs are free range. All of which improves the food offered.

Information contained on the patient menu offers patients choices depending on their individual health requirements of healthy option, enriched diet, puree diet and soft diet. Specific diets such as low-fat and gluten-free are all provided through a special menu. In addition there is a choice of small, standard or large portions.

Health at work pledge - staff health checks
All employees can request lifestyle screening, which includes blood pressure, weight and cholesterol checks, by the occupational health & wellbeing service. This is advertised within the health and wellbeing section of the WSFT's intranet.

Physical activity pledge - physical activity in the workplace
WSFT belongs to the Cycle to Work scheme and promotes cycling to work. A total of 289 employees have joined the scheme since it started in 2011 with 36 over the last financial year. Car sharing is encouraged to reduce the Trust's carbon footprint and a park-and-ride or -walk scheme continues, working with Bury Rugby Club.

More than 20 employees regularly attend Tae Kwon Do sessions which take place twice a week.

WSFT worked in partnership with St Edmundsbury Borough Council to facilitate the 4th 'It's a Bury Knockout' where members of staff and local businesses entered a team for a fun challenge. Various stalls were also set up and the day had a summer fete atmosphere bringing the community together. Now in its fifth year, 'It's a Bury Knockout' will return to Hardwick Heath on 24 July 2016.

The Trust's health & wellbeing intranet section signposts employees to local leisure and fitness clubs. The Trust has corporate membership with local health clubs. Posters and internet messages have been displayed.

2.7.8 Staff survey

The following report includes commentary on the National Staff Survey (2015). It contains detail on staff engagement and survey response rates, top and bottom rankings scores (key factors), and key areas for improvement and future priorities and target areas.

National staff survey and staff engagement 2015

The figure below shows how West Suffolk NHS Foundation Trust compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The Trust's score of 3.93 was in the highest (best) 20% when compared with trusts of a similar type.

	WSFT score 2015	National average 2015	WSFT score 2014	WSFT score 2013
Overall staff engagement	**3.93**	3.79	3.90	3.82

Overall staff engagement has been calculated using the questions that make up key findings 1, 4 and 7.

	2015	National average	2014	National average	+/- last year	Acute trusts
KF1. Staff recommendation of the organisation as a place to work or receive treatment	**4.05**	3.76	3.97	3.67	**+0.8**	Highest (best) 20%
KF4. Staff motivation at work	**3.98**	3.94	3.94	3.86	**+0.04**	Above (better than) average
KF7. Staff ability to contribute towards improvement at work	**71%**	69%	73%	68%	**-2%**	Average

Approach to staff engagement
WSFT continues to place staff engagement as one of its top priorities in its workforce strategy. Motivated and involved staff are at the forefront of enabling the Trust to know what is working well and how we can better improve our services for the benefit of patients and the public. The Trust encourages open and honest communication throughout the organisation.

A number of methods have been developed to encourage all staff to feel that they can contribute:

- The core brief – monthly briefing cascade
- Monthly team briefings
- Monthly medical staff bulletin for consultants and junior doctors
- Staff conversation events – facilitated by staff governors
- The weekly staff newsletter, 'Greensheet'
- The Buzz – an electronic community communication area via the intranet
- InfoX – a confidential electronic channel to raise issues and concerns
- The 'Bright Ideas' scheme
- Staff awards – annual 'Shining Lights' awards, monthly 'Putting you First' award, and 'The Michael Williams Shield' recognising the WSFT porter of the year.

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	
2012 sample	2,818	798	430	54%	9% (deterioration)
2013 sample	2,955	797	453	57%	3% (improvement)
2014 sample	2,956	798	419	53%	4% (decrease)
2015 sample	**3,068**	**850**	**462**	**54%**	**1% (increase)**

Top and bottom five ranking scores
The 2015 staff survey report has 32 key findings. Overall the Trust has achieved the following:

Best 20% for:	7 key findings
Better than average for:	13 key findings
Average for:	5 key findings
Worse than average for:	4 key findings
Worst 20% for:	3 key findings

This table highlights the five key findings for which West Suffolk NHS Foundation Trust compares most and least favourably with other acute trusts in England.

	2015		2014		Target trend (up / down)	Improvement /deterioration (% since 2013)	Trust KF result against other trusts
	WSFT	Nat. Avg.	WSFT	Nat. Avg.			
Top five ranking scores							
KF1. Staff recommendation of the organisation as a place to work or receive treatment	**4.05**	3.76	3.98	3.67	+	+0.07	Highest (best) 20%
KF3. Percentage of staff agreeing that their role makes a difference to patients / service users	**92%**	90%	-	-		NA	Highest (best) 20%
KF14. Staff satisfaction with resourcing and support	**3.45**	3.30	-	-		NA	Highest (best) 20%
KF19. Organisation and management interest in, and action on, health and wellbeing	**3.70**	3.57	-	-		NA	Highest (best) 20%
KF8. Staff satisfaction with level of responsibility and involvement	**3.99**	3.91	3.97	-	+	+0.02	Highest (best) 20%
Bottom five ranking scores							
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	20%	14%	18%	14%	+	**+2%**	Highest (worst) 20%
KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	14%	37%	47%	55%	-	**-33%**	Lowest (worst) 20%
KF11. Percentage of staff appraised in last 12 months	81%	86%	79%	84%	+	**+2%**	Lowest (worst) 20%
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	88%	90%	89%	90%	-	**-1%**	Below (worse than) average
KF28. Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month	32%	31%	36%	34%	-	**-4%**	Above (worse then) average

Action plan for areas of concern and future priorities

The 2015 staff survey reveals that the Trust could improve in five areas as identified in the key findings (KF). We also need to be mindful of the areas where we are in danger of falling below the average. The following action plan has been produced to address the issues raised:

Key factor	Proposed actions

KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	Actions in are overseen by the Mandatory Training Steering Group.
	
	• Combine managing challenging behaviours training with conflict resolution. The training includes the handling of patients ranging from confused to aggressive in a physical situation enabling staff to react appropriately to a situation
	• Proactive measures will be in place from week commencing 07/03/2016 which will involve the following:
	  ○ When the Restrictive Physical Intervention Team is called to an incident, the patient information will go to a zero tolerance panel
	  ○ Risk assessment of patient is made and the patient has a flag on their notes
	  ○ Flags will alert staff if patient has been violent in past and will define if negative behaviour was due to treatment such as detox, or whether it is due to medication or dementia
	• This will enable staff to take additional precautions as well as to equip them with the tools and knowledge if an incident occurs.

KF27. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	The 'Freedom to Speak Up Freedom to Improve' campaign was introduced in at the Trust leadership summit in December 2015. The campaign has been put in place to encourage staff to speak up if they see poor behaviour or safety issues. • One of the main points in the campaign is to encourage staff to speak up when they see bullying or rudeness • Provides advice on how to deal with this behaviour on a one-to-one level. • All managers are Freedom to Speak Up guardians to encourage staff to raise issues with their or any other manager within the Trust • The option exists for Staff to raise issues with trusted partners or trade union representatives • The Trust will be altering the current whistle blowing policy to bring it in line with planned national policy changes.
KF11. Percentage of staff appraised in last 12 months	To improve appraisal take-up the Trust approach to appraisal is being reviewed. In addition the Trust will need to incorporate the community staff into our processes. • A group has been set up to lead appraisal review and identify key areas of improvement to the process, policy and paperwork • Appraisers and appraisees will be asked to contribute their views regarding the process • The Trust will review the feasibility of developing an electronic tool to be used for 360 degree surveys as the current process is labour intensive • The Trust appraisal process currently incorporates two initiatives which are knowledge and skills framework (KSF) and Patient Values, with also the proposed health and wellbeing and leadership behaviours. Need to identify whether the KSF to be discussed at appraisal • To further develop the monitoring process and record compliance in the electronic staff record (ESR) and report at various levels on a monthly basis, cascading down to the lowest level of management to ensure compliance • Develop the use of ESR Enhanced to record appraisal and implement self service which will provide a number of benefits including the revalidation process for nursing staff • Training programme will need to be reviewed for all of the enhancements.

KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	An action plan was implemented prior to the staff survey last year. There have also been updates to that plan which have been included below. There have been changes to the way staff report incidents, and this may have had an effect on the number of incidences being reported. Information and training to be reviewed and line managers to encourage and support staff in reporting issues. Of the 132 staff that saw potential harm, 11 (7.4%) did not report it and a similar percentage (6.8%) did not feel the organisation treats these reports confidentially. Errors not reported are evenly spread through the clinical divisions, with the surgical division indicating that reports are not treated confidentially.
	
	• Combine managing challenging behaviours training with conflict resolution. The training includes the handling of patients ranging from confused to aggressive in a physical situation enabling staff to react appropriately to a situation
	• Proactive measures will be in place from week commencing 07/03/2016 which will involve the following:
	  ○ When the restrictive physical intervention team is called to an incident, the patient information will go to a zero tolerance panel
	  ○ Risk assessment of patient is made and the patient has a flag on their notes
	  ○ Flags will alert staff if patient has been violent in past and will define if negative behaviour was due to treatment such as detox, or whether it is due to medication or dementia
	• This will enable staff to take additional precautions as well as to equip them with the tools and knowledge if an incident occurs.

2.7.9 Pension liabilities for ill health retirement

There were two ill health retirements during the year to 31 March 2016 (2015: six); the additional pension liability borne by NHS Pensions was estimated as £66,000 (2015: £397,000).

2.7.10 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. It also has a nominated Local Counter Fraud Specialist whose role is to provide support and advice on all matters relating to fraud and to be a point of contact for fraud reporting. The Trust has established a Fraud Awareness Group which reports to the Quality and Risk Committee. The role of the group is to monitor the work undertaken on fraud awareness and ensure that actions are taken to reduce the risk of fraud and corruption taking place.

2.7.11 Off-payroll engagements

As required by HM Treasury per PES (2012)17, the Trust must disclose information regarding "off-payroll" engagements.

For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last for longer than six months.

	Number
Number of existing engagements as of 31 March 2016	10
Of which:	
Engagements that have existed for less than one year at time of reporting.	4
Engagements that have existed for between one and two years at time of reporting.	3
Engagements that have existed for between two and three years at time of reporting.	0
Engagements that have existed for between three and four years at time of reporting.	0
Engagements that have existed for four or more years at time of reporting.	3

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought. All invoices relating to off payroll engagements are subject to authorisation though the normal expenditure control processes.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than six months

	Number
No. of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	4
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	4
No. for whom assurance has been requested	4
Of which:	
No. for whom assurance has been received	3
No. for whom assurance has not been received	1 *
No. that have been terminated as a result of assurance not being received.	0

* *The requested assurance will be obtained before the contractor undertakes any future work*

There were no off-payroll engagements of board members and/or senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016.

2.7.12 Expenditure on consultancy

During 2015/16, the Trust spent £1,022k on consultancy costs, which included £454k on strategic advice on tendering of community service and £235k on theatre and outpatient delivery programme.

3. Quality report

3.1 Chief executive's statement

I am delighted to introduce this year's Quality Report on behalf of West Suffolk NHS Foundation Trust, an organisation I am immensely proud to lead. This has been another year of significant achievement in terms of improving the quality of the care that we offer. However we have faced some very significant challenges over the 12-month period along with all acute trusts in the NHS. We have seen demand for urgent and emergency care increase again so that record-breaking numbers have attended our emergency department (ED) over the winter months. Moving patients out of hospital to more appropriate settings once they are medically fit remains challenging given the limited availability of step down care in homes and other facilities. The need to work outside the hospital across the community to unlock hospital beds for those who most need them remains urgent.

We continue to follow our strategy as set out in the document, '*Our Patients, Our Hospital, Our Future, together'* and integrating care services is an important theme in this. In October 2015 we were awarded the contract to provide community services for Suffolk in partnership with Ipswich Hospital NHS Trust and other partners. We have since had our contract extended beyond the original 12-months so that we will provide these services until October 2017. The challenge now is to achieve the service transformation possibilities that this arrangement presents and to work with our clinical commissioning group and other partners towards ever closer relationships in an integrated care system for west Suffolk.

We monitor the quality of our services in a variety of ways at a ward and clinic level as well as taking an overview of quality and a monitoring approach at board level. In March 2016 our services were inspected by the Care Quality Commission which will provide us with external verification of our ongoing self-assessment of quality. We worked hard this year to prepare for that visit and whatever the outcome, we look forward to receiving further insights into the care our patients are experiencing and how it might be improved.

In this report you can read about how we did during 2015/16 as well as the priorities for the year ahead. One area where we have made considerable progress is in identifying and treating acute kidney injury (AKI) which has been a priority for the Trust this year. As a direct result of our efforts we have recorded a 40 per cent decrease in AKI-related deaths since 2012 and this has demonstrated the power of focussing in on single, specific safety issues across the whole hospital. We have seen targets achieved and improvements made across a range of other safety areas including the management of sepsis, the use of the world health organisation (WHO) surgical safety checklist, prevention of blood clots, diabetes and healthcare associated infections.

It is important for our patients and our staff that we can be confident that the treatments we provide here are effective. We want the interventions that we make to relieve symptoms and prevent their re-occurrence as much as possible and we measure 'clinical effectiveness' in detail across our services. We can see that our outcomes are some of the best in the country in a number of key areas including critical care, stroke services, detection of cancer, hip fracture and joint replacement and anaesthetics. We will continue to build on this, bringing more and more of our services into the top quartiles of national performance.

We are also concerned about the experience our patients have of their care and we have worked hard on new ways of working with patients to listen carefully to what their needs are. In December 2015 we launched a campaign with our staff and patients called 'Freedom to Speak Up', which actively encourages people to tell us wherever they see either poor care that needs improving or excellent care that needs recognising. In March of this year we held a special feedback day for patients where hundreds of our daily visitors were asked to give their views on all aspects of the care we provide. We monitor patient experience partly through the friends and family test and this year we exceeded our target that 90 per cent of patients would recommend us to friends and family. We have

consistently performed in the high 90s for this measure and this is an endorsement of the great efforts we have made to be a comfortable, caring and compassionate hospital as well as a safe and effective one.

We continue to challenge ourselves with regard to quality and you can read in this report where we have had some issues in meeting the targets we set last year, for instance in the reduction of avoidable pressure ulcers, as well as the priorities we have to improve quality during 2016/17. I hope that this will reassure you that quality is our very top priority. It is what we are all here to achieve and at West Suffolk Hospital I know we are delivering improvements every year while retaining our drive to keep making progress.

It is our staff who deliver the outcomes we achieve and I would like to thank them sincerely for their outstanding results and efforts this year. Feedback from the 2015 NHS staff survey was very positive and saw us score in the top 20% of trusts nationally in seven important areas: most notably, more staff recommend West Suffolk Hospital as a place to work and to receive treatment than at any other acute hospital in East Anglia, something we are immensely proud of.

Like many hospitals across the country we came under significant financial pressure during the year which ended with us being £9.8m in deficit. This was slightly worse than we had expected and we are working hard inside and outside the organisation to identify where whole system changes and productivity improvements can be made to bring us back into balance.

I can confirm that to the best of my knowledge the information contained in the Quality Report 2015/16 is accurate and has received the full approval of the Trust board.

Dr Stephen Dunn
Chief Executive

3.2 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.

Our vision and priorities align with our partners, including West Suffolk Clinical Commissioning Group, whose mission is to deliver the highest quality health service in west Suffolk through integrated working. Through this vision we put quality at the heart of everything we do.

The board monitors quality through its performance management arrangements on a monthly basis. The board also receives assurance regarding quality within the organisation through the quality & risk committee and its three subcommittees which ensure quality is delivered in a coordinated way 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. This is achieved through reviewing compliance with national requirements, promoting best practice and ensuring effective 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 improvement strategy and Patients First initiative.

3.3 Quality priorities for 2016/17

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

In order to determine the priorities for 2016/17, progress against previous priorities and the information gained from the full range of indicators have been reviewed. In addition, consideration has been given to other quality issues arising nationally and locally, along with discussion with our service users and public foundation trust members. Through the commissioning process the CCG has identified performance targets for quality and innovation and these have directly influenced the way in which we measure performance against our priorities.

The quality priorities for 2016/17 are linked to the relevant ambitions within the strategic framework and will allow us to measure the quality of services we provide across both acute and community settings.

The draft priorities were subject to review with internal and external stakeholders. This included assessment of alignment with commissioners and engagement with public representatives such as our governors and Healthwatch.

1. Deliver personal care

Nationally, the Friends and Family Test (FFT) continues to be seen as a barometer of patients' overall satisfaction with care. WSFT will continue to maintain its focus on increasing our response rates and ensure effective learning during 2016/17.

Noise at night is identified as a priority as this consistently scores poorly in our inpatient survey responses. We will continue to gather qualitative and quantitative data to inform our actions to improve performance in this area. This will include minimising patient moves during the night and the associated noise and disruption this can cause.

We will develop a framework and toolkit to support shared decision making taking into account the resources available through the 'Right Care' programme.

In addition, it is important to continually review and expand the range of activities undertaken to engage with our patients and obtain their feedback. We already review feedback from a range of sources including public feedback websites and independent organisations. We aim to build on this through a range of patient and care feedback mechanisms.

Hospital admission provides an opportunity for healthcare professionals to identify carers and help people acknowledge that they are in a caring role. It is important that carers should be given a choice as to whether or not they are willing and able to provide the necessary support and care required. Supporting carers' wellbeing is not only in their interests but also those of the person they care for. Information and focused support, e.g. when a diagnosis is made, or preparing for hospital discharge of the person they care for, can improve health outcomes and experience for carers.

Deliver measurable improvements in the patient experience

- Sustain and improve Friends and Family Test performance:
    - Ensure we consistently achieve 90% of patients recommending our services to their friends and family
    - Achieve improvement in FFT response rates in outpatients against the baseline of 2015/16
- Reduce noise at night through targeted reduction in the number of non-clinical moves at night - baseline Q1
- Measurable improvement in patients' perception of involvement in care and treatment as a result of initiatives to improve shared decision making
- Ensure we support carers as measured by the 'caring for carers' feedback survey - sustaining our performance and consistently achieving 90% for the questions relating to carers feeling supported and confident
- Working with Suffolk County Council and clinical commissioning group partners to improve patient access to paediatric speech and language services compared with October 2015 (start of community contract)

2. Deliver safe care

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

WSFT aims to improve on our achievements to date of reducing harm to patients whilst they are in hospital. We will focus on the reduction of falls on our inpatient wards through the implementation of the National Institute for Health and Care Excellence (NICE) guidance '*Falls: assessment and prevention of falls in older* people'. We continue with our priority to eliminate all avoidable hospital-acquired pressure ulcers. This will be achieved by improving practice based on learning from investigation of pressure ulcer incidents.

Venous thromboembolism (VTE) is the term used to describe deep vein thrombosis (blood clot occurring in a deep vein, most commonly in the legs) and pulmonary embolism (where such a clot travels in the blood and lodges in the lungs) which can cause considerable harm or death. VTE is associated with periods of immobility and can largely be prevented if appropriate preventative measures are taken.

During 2016/17 WSFT will continue to focus on the improved identification and management of risks to patient safety, primarily those related to identification of factors indicating imminent deterioration of patients, sepsis (infection that has entered the blood stream) and acute kidney injury (previously known as kidney failure). The board is committed to the national 'Sign-up to safety' campaign. Progress against this campaign forms the focus of our ambition to deliver safe care through compliance with agreed pathways based on best practice for AKI, sepsis, and diabetes.

An overarching measure of effectiveness and clinical outcome is a reduction in deaths in our population (mortality) by helping people to live longer. Our aim is to maintain strong performance and consistently achieve a mortality ratio which is lower than expected. We will achieve this by improving the identification of preventable deaths and taking action if we find areas where improvements are required.

Reduce the incidence of hospital-associated harm on inpatient wards

- Ensure that there are no more than 16 avoidable hospital-associated C. *difficile* infection cases during 2016/17
- Maintain the incidence of avoidable pressure ulcers, avoidable inpatient falls and hospital acquired VTE below the baseline for 2014/15
- Based on national benchmark improve the identification of preventable deaths based on the baseline of 2015/16.

Consistently deliver improvements in the care we provide to our patients

- Improve reliability of AKI diagnosis, treatment and monitoring for inpatients – during the year improving performance against the baseline of 2015/16
- Improve reliability of sepsis screening and treatment for emergency admissions – during the year improving performance against the baseline of 2015/16
- Improve performance in the care of diabetes patients as measured by the national inpatient diabetic audit.

3.4 Statements of assurance from the board

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. These statements provide assurance in three key areas:

- Our performance against essential standards and delivery of high quality care, for example our registration status with the 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 2015/16 WSFT provided and/or sub-contracted 54 relevant health services. WSFT has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 was £185.5m which represents 88.2% of the total income generated from the provision of relevant health services by WSFT for 2015/16.

Information about the quality of these services is obtained from a range of sources which address the three quality domains described earlier (safety, 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.

During 2015/16 West Suffolk Clinical Commissioning Group and Ipswich & East Suffolk Clinical Commissioning Group awarded the NHS contract for community services to West Suffolk NHS Foundation Trust, working in partnership with The Ipswich Hospital NHS Trust and Norfolk Community Health and Care NHS Trust.

Suffolk Community Healthcare services have not altered, meaning that existing staff have remained in place. The contract covers a range of adult community services, specialist children's services and community hospitals.

Community services in summary:

- Deliver community-based services to people of all ages across Suffolk
- Provide services to local clinical commissioning groups, hospitals, community healthcare organisations in Norfolk, Suffolk and Cambridgeshire and Suffolk County Council
- Serve the population of Suffolk, with the exception of the Waveney area
- Deliver services in a variety of settings including people's own homes, care homes, community hospital inpatient units and clinics, day centres, schools, GP surgeries and health centres
- Employ around 1,400 staff, including nurses, healthcare assistants, occupational therapists, physiotherapists, specialist clinicians, generic workers, technicians, administrators and support staff.

Table A: Sources of quality intelligence

Deliver personal care	Deliver safe care

• CQC self-assessment, intelligent monitoring and CQC visits
• Trust-wide compliance monitoring, including:
  • patient environment
  • patient experience
  • same sex accommodation
  • pain management
  • nutrition
• Complaints and PALS thematic analysis
• Patient and staff feedback, including local and national surveys and patient/staff forums and communication
• Quality walkabouts and 'back to the floor' visits by board members and governors
• Feedback from FT members and Governors
• 'Freedom to Speak Up' patient feedback day
• Community conversations.
	• CQC self-assessment, intelligent monitoring and CQC visits
	• Trust-wide compliance monitoring, including:
	  • infection control, including hand hygiene
	  • pressure ulcers, falls and VTE
	  • Stroke care
	  • mortality
	  • re-admission
	• Incident and claims analysis and national benchmarking (e.g. NRLS)
	• External regulatory and assessment body inspections and reviews, such as peer reviews
	• National safety alerts
	• Infection control, including high impact interventions
	• Quality walkabouts
	• Clinical benchmarking data from Dr Foster Intelligence
	• National and local clinical audits
	• Self-assessment against national standards and reports, for example NICE guidance
	• Patient reported outcome measures (PROMs)

Participation in clinical audits and confidential enquiries

During 2015/16 34 national clinical audits and nine clinical outcome review programmes (previously known as confidential enquiries) covered NHS services that West Suffolk NHS Foundation Trust provides.

During 2015/16 West Suffolk NHS Foundation Trust participated in 100% of national clinical audits and 100% of clinical outcome review programmes which it was eligible to participate in.

The national clinical audits and national confidential enquires that WSFT was eligible to participate in during 2015/16 are listed in annex A.

The national clinical audits and national confidential enquires that WSFT participated in, and for which the data was completed during 2015/16, are listed alongside the number of the cases submitted to each audit or enquiry as a percentage of the number of registered cases requried by the terms of that audit or enquiry listed in annex A.

The reports of 22 national clinical audits and 62 local clinical audits were reviewed by the provider in 2015/16 and WSFT intends to take the actions detailed in annex A to improve the quality of health care provided.

Research and development

The number of patients receiving NHS services provided or sub-contracted by WSFT in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 171. This is a reduction in the level of recruitment achieved in 2014/15 when 332 patients were

recruited. An improvement plan is in place and we anticipate an increase in recruitment during 2016/17.

In 2015/16 WSFT was involved in conducting 55 (open to recruitment) commercial and non-commercial studies (compared to 57 in 2014/15). 18 of these were closed during the reporting period.

A number of factors impacted on recruitment levels including reduction in the number of suitable studies, general reduction in study sample sizes, staffing changes and difficulty in recruiting research nurses. In mitigation action has been taken to strengthen leadership for R&D activities and recruit additional research nurses.

Goals agreed with commissioners

A proportion of WSFT income in 2015/16 was conditional on achieving 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 relevant health services through the Commissioning for Quality and Innovation payment framework (CQUIN).

In 2015/16 WSFT had nine CQUIN goals covering the following areas:

- Acute kidney injury – set information shared with GP
- Sepsis – screening; and severe, red flag & septic shock patients – antibiotics in 1 hour
- Dementia and delirium – Screening, Staff Training and Care of Carer
- Urgent and emergency care
- 7 day working - patient experience, consultant review time, handover process, psychiatric liaison and diagnostics
- Frail elderly – screening, pathways and information shared with GP
- WS portfolio scheme – assistantships.

The total value CQUIN performance funding in 2015/6 was £3,233,370 (compared with £3,349,504 in 2014/15). The CQUIN indicative goals for 2016/17 will include the following national CQUINs:

- Staff, health and Wellbeing: wellbeing, musculoskeletal and stress; healthy food for staff, visitors and patients; and frontline staff – flu vaccinations.
- Sepsis: emergency department – screening and treatment; and inpatients – screening and treatment.
- Cancer waits: urgent GP referral for suspected cancer to first treatment in 62 days; and root cause analysis (RCA) on long waiters (>104 days) and clinical harm review.
- Antimicrobial resistance and stewardship: reduction in anti-biotic consumption; and empiric review of antibiotic prescriptions.

What others say about us

WSFT is required to register with the Care Quality Commission and its current registration status is unconditional. The CQC has not taken enforcement action against WSFT during 2015/16.

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

WSFT was the subject of a formal CQC inspection in March 2016 as part of the national programme of inspection of all acute NHS trusts. The final outcome of this inspection has not been issued and is expected in June 2016.

Part of the evidence provided by WSFT was our self-assessment against the five key questions used by the Care Quality Commission in their inspections of services (key lines of enquiry - KLOEs):

1. Are they safe?
2. Are they effective?
3. Are they caring?
4. Are they responsive to people's needs?
5. Are they well-led?

WSFT self-assessment CQC KLOEs

	Safe	Effective	Caring	Responsive	Well-led
Urgent and emergency services	Requires Improvement	Good	Good	Good	Good
Medical care (including older people's care)	Good	Requires Improvement	Good	Good	Good
Surgery	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Requires Improvement	Outstanding
Maternity and gynaecology	Good	Good	Good	Good	Requires Improvement
Services for children and young people	Good	Outstanding	Good	Outstanding	Good
End of life care	Good	Good	Good	Good	Good
Outpatients & diagnostic imaging	Good	Good	Good	Outstanding	Good

Community inpatients	Good	Good	Outstanding	Good	Good
Services for children & young people	Good	Good	Good	Good	Good
End of life care	Good	Good	Outstanding	Good	Good
Community services for adults	Good	Good	Good	Good	Good

Key aspects of quality and evidence underpinning our self-assessment include:

Safe

- ***Low mortality rate*** – evidence through Dr Foster independent analysis
- ***High level of participation in national audits*** – *Annex A of quality report*
- ***Early adopter within 'Sign up to safety campaign'*** – focus on diabetes, AKI and sepsis
- ***Reduction in AKI deaths*** - 40% since 2012
- ***Targeted improvement in identification and management of patients with sepsis*** – *achieved 100% screening for emergency patients in Q4*
- ***Learning from 'never events'*** – invited review by Royal College of Surgeons found a "culture that promoted the reporting of incidents and encouraged learning"
- ***Quality and ward dashboard*** - drives improvement action
- ***Year-on-year reductions in healthcare-associated infections (HCAIs)*** and improved antimicrobial stewardship
- ***Cleaning Industry Management Standard (CIMS) award*** - First hospital in Europe to achieve this
- ***Ensuring safe staffing*** - we now have over a hundred more doctors and nurses than we had last year
- ***Effective system for incident reporting and learning*** – recognised through staff survey and through improvement against quality priorities
- ***Learning from complaints*** – includes care, training and patient information.

Effective

- ***Outstanding outcomes for local health economy*** - cancer and heart disease mortality; stroke patients directly admitted to a stroke unit within 4 hours; emergency admission rate for older people
- ***Our DAWN AC performance is in the top 20% of sites worldwide*** DAWN AC is one of the most widely used computer-dosage programs for oral anticoagulant
- ***Our stroke unit is better than the big centres and one of the best in the region and country*** *– latest national audit data places WSFT in the top 10% nationally*
- ***Our rate of in-hospital cardiac arrests is low*** – supported to timely identification of deteriorating patients
- ***Best regional hospital*** - children's care, diabetes and Caesarean section rates
- ***Strong outcomes in surgery*** – fractured hip; emergency surgery care
- ***Anaesthetic department was second in the UK to receive national accreditation from the Royal College*** - excellent performance across a variety of key areas, including the overall care pathway for patients who need anaesthesia with a particular emphasis on patient safety and overall patient experience
- ***Outstanding critical care outcomes (ICNARC)*** - audit of patient outcomes from adult, general critical care units (intensive care and combined intensive care/high dependency units) covering England, Wales and Northern Ireland
- ***Diagnostic imaging underpins our outcomes*** - first unit in the region to achieve ISAS accreditation
- ***Good pathway working:***
    - ED attendances – low attendance rates overall, and for children
    - End of life care – high percentage of deaths in usual place of residence
    - Dementia – e.g. low rate of emergency admission
    - Tooth decay – low rate of admission in children <5 years
    - working with the CCG to improve diabetes care across west Suffolk.

Caring

- ***Friends and family would recommend us*** – consistently high performance
- ***Fantastic chaplaincy*** – 30 volunteers, outreach into community and working with the hospice
- ***Bizzi bags introduced for children in the outpatients waiting area*** - like party bags with crayons, etc. and are a good infection prevention solution rather than having a box of toys
- ***Improving the patient experience*** - free Wifi across the Trust for patients, family and friends; twiddle muffs, calm carts, coloured beakers; timely call bell; noise at night; longest 'Memory Walk' in the country
- ***Ensuring a dementia-friendly environment*** – improvement to environments and facilities supported by dementia champions; patient activities' volunteers; support for staff to respond to dementia; and *'*Forget Me Not' campaign
- ***First system to produce its own shared decision-making guides***
- ***Promote and support innovation*** – Rose's 'vital' innovation wins national patient experience award; library knowledge and skills; introduced a telephone reminder system to reduce the number of patients who miss appointments; patient pagers introduced in outpatients for times when there are unavoidable delays
- ***Volunteers*** – 400+ from all ages supporting patients, carers and staff
- ***Healthy, nutritious food -*** food prepared on site and locally sourced
- ***Clinical photography department*** - only the fourth service in the country to achieve the Institute of Medical Illustrators (IMI) Quality Assurance Standards (QAS) level two accreditation***.***

Responsive

- ***Delivering quick access requires continual focus*** – consistent delivery of access and treatment targets
- ***More resilient ED performance this year*** – during Q2, improvement in patient flow allowed a ward to be closed enabling a 'deep clean' programme to be developed to all wards

- ***Great trauma & orthopaedics reputation*** - joint 1st in peer group for first to follow up appointments; joint 3rd in peer group for elective length of stay; best in peer group for seven out of top 10 HRG re length of stay; day case rates good, could be better
- ***Consistently good performance for cancer targets*** – two week wait GP urgent referral to being seen by consultant; 31 days from diagnosis to first definitive treatment; 62 days from GP referral to first definitive treatment
- ***Fast service access*** – arthritis, audiology, ophthalmology, and ENT
- ***Maintained access targets*** - despite increasing referrals and demand for diagnostics.

Well-led

- ***Hello my name is..*** - supporting our culture of Putting You First we encourage staff to make it the norm for everyone who works in WSH to start every interaction with this small gesture, but one that really makes a difference
- ***Our staff go the extra mile*** - to deliver excellent care to patients, drive through service improvements and support people to live healthy lives
- ***Committed clinical leaders*** – driving quality improvement for patients and staff
- ***Pride in teaching and*** **training** - excellent training record and medical school visits
- ***Junior doctors are supported and active*** - developed a more efficient way to identify potential discharges over the weekend
- ***Visible leadership*** – from the board and senior managers
- ***Staff recommending WSH as a place to work: 82% (8th) and staff recommending WSH as place to receive care: 93% (5th)*** - clear relationship between staff who feel engaged and happy and good patient outcomes
- ***We are not complacent*** – 'Freedom to speak up, freedom to improve' campaign
- ***An experienced and stable board*** with clear strategy and priorities - board of directors of WSFT won 'NHS board of the year' award at the East of England NHS Leadership Recognition Awards
- ***Board focuses on big issues and risks*** - e-Care and improved documentation; service and financial sustainability; impact of Transforming Pathology Partnership (TPP) investment on quality; never events; new risks with community services; upgrading the estate and infection control
- ***Investing in our hospital*** - for the future and planning a new hospital for the longer term
- ***Clear strategy: Our patients, Our hospital, Our future, together*** - over a third of our staff had a face-to-face briefing and local stakeholders signed up to our strategy as part of the biggest consultation in our history last spring
- ***Successful tender for community services*** *with The Ipswich NHS Trust and Norfolk Community Health and care NHS Trust and working with the CCG on integration*
- ***Strong focus on quality*** – demonstrated through accreditation and committed to continuous quality improvement.

The CQC team feedback during the assessment on examples of good practice and the quality of care that we provide to our patients every day. We are taking the following action to address the issues identified in our self-assessment and in response to the preliminary feedback from the CQC's visit in March 2016:

- ***Mental capacity act (MCA) and deprivation of liberty safeguards (DoLS)*** – WSFT's policy has been updated to clarify the assessment period before the decision is made to apply for a deprivation of liberty safeguard. A 'quick guide to MCA & DoLS' has been developed for staff, targeted training for key staff is being delivered and a review and update of the Trust website and information resources for DOLS and MCA has been undertaken
- ***Mixed sex accommodation in recovery when used as a step-down critical care area*** – we have updated the bed capacity report to capture and review these patients as part of the operational bed management meetings which take place three times a day. Escalation arrangements ensure that potential breaches are recorded and investigated
- ***Clarity of information / escalation flow for governance*** - a staff briefing for governance has been developed which includes clarification of the membership of committees with a rationale for

attendees and the difference between a management committee and an assurance committee. This information has been cascaded to staff through the divisions and incorporated into the risk module of mandatory training for all staff

- ***Arrangements between the emergency department (ED) and medical/surgical teams*** - clinical directors have considered the policy and procedures for engagement of medical/surgical teams with ED, including escalation during periods when operational capacity is challenging, recognising that optimal experience and flow for patients presenting in ED is achieved through effective communication and collaboration between the department and medical/surgical teams
- ***Cultural issues within maternity*** – we have introduced a leadership programme for services and teams and maternity services has been identified as a priority as part of this roll-out. In addition, a representative from the Royal College of Midwives has delivered a workshop to the midwives about wellbeing in the workplace
- ***Capturing ideas from all staff*** – we are building on a range of initiatives through the 'Freedom to speak up, freedom to improve' campaign which empowers staff to challenge practices and make changes locally. The Trust's leadership event in December 2015 has developed into a bi-annual event which builds on the initiatives in place using these to improve engagement strategies by ensuring we provide a systematic link between continuous improvement and our seven ambitions, providing equitable access to raise ideas and capturing and supporting projects as part of the Trust's transformation programme.

Awards and accolades

WSFT board named as 'NHS board of the year' in regional awards
The Board of Directors of WSFT has picked up the 'NHS board of the year' award at the East of England NHS Leadership Recognition Awards held at Duxford Air Museum. The title was awarded in recognition of the effective leadership it provides and its commitment to the highest quality of patient care. The hospital provides high quality, award-winning care and consistently high standards of operational performance. This includes meeting every cancer target and recording low mortality rates as well as ranking as one of the best in the country for stroke care and treatment for hip fracture patients.

Rose's 'vital' innovation wins national patient experience award
An innovative tray design by a West Suffolk Hospital nursing assistant to make it easier for patients to clean their hands and get a good night's sleep has won a national award. The RoseVital tray won the 'environment of care' category in the Patient Experience Network awards 2015. The tray is the brainchild of Rosario Preston and was trademarked by the Trust before being rolled out across the hospital. It carries the words "please use me before every meal" with an arrow pointing to hand wipes and "please use me at night" indicating earplugs and an eye mask.

2015 national staff survey ranks West Suffolk as the region's best
The latest staff survey shows that West Suffolk Hospital is the best in East Anglia for being recommended by its staff. A key finding of the survey showed that more staff at the Trust would recommend it as an employer or as a place to receive treatment than at any of the region's other hospitals. The Trust also received positive feedback from staff o a range of other key areas scoring in the top 20% of trusts nationally against seven criteria.

West Suffolk Hospital the first in Europe to receive cleaning award
WSFT was the first hospital in Europe to achieve a prized international accreditation in recognition of the excellent cleaning service provided by its housekeeping team. The department was presented with the Cleaning Industry Management Standard (CIMS) award with honours, after demonstrating it meets the highest standards during a two-day inspection.

Hip fracture care among the best in the country
The results of the national hip fracture database audit for 2015 have placed the hospital as the best-performing in the region and one of the best in England for the treatment provided to patients with a

break to the hip joint, known as a fractured neck of femur. The audit looks at a range of success measures including the time it takes to get to theatre for surgery and a set of critical care and outcome criteria.

Hospital catering awarded quality standard in recognition of high standards
The catering department at West Suffolk Hospital has been re-awarded an international accreditation in recognition of the high standards of hygiene, production, safety and service it provides to patients and visitors. The hospital has been given the ISO 9001 – 2008 standard by the LRQA following a rigorous inspection that looked in detail at the way the department is run. The hospital will be reassessed every six months to make sure it continues to meet the criteria.

Macmillan Unit at West Suffolk Hospital re-awarded national accreditation
The Macmillan Unit at West Suffolk Hospital has been re-awarded a national accreditation in recognition of the high quality service it provides for cancer patients. The hospital has been presented with the Macmillan Quality Environment Mark (MQEM) following a visit from assessors at the end of last year. The award shows that the unit is welcoming and accessible, provides choice and respects privacy and dignity as well as supporting comfort and wellbeing.

Data quality

WSFT submitted records during 2015/16 to the secondary uses service (SUS) for inclusion in the hospital episode statistics (HES) which are included in the latest published data. The percentage of records in the published data which included the patients' valid NHS number was:

Valid NHS number	WSFT	East Anglia area team	National
Admitted patient care	**99.7%**	99.4%	99.2%
Outpatient care	**99.9%**	99.7%	99.4%
Accident and Emergency care	**98.7%**	95.1%	95.3%

(The above figures cover April 2015 to Jan 2016 inclusive – taken from HSCIC SUS data quality dashboard)

WSFT's patient administration system (PAS) is unable to automatically source NHS numbers from the national spine (database), therefore this task is done manually.

The percentage of records in the published data which included the patients' valid general medical practice code was:

Valid general medical practice code	WSFT	East Anglia area team	National
Admitted patient care	**100%**	99.9%	99.9%
Outpatient care	**100%**	99.9%	99.8%
Accident and emergency care	**100%**	99.8%	99.1%

(The above figures cover April 2015 to Jan 2016 inclusive – taken from HSCIC SUS data quality dashboard)

WSFT's information governance assessment report overall score for 2015/16 was 80% (satisfactory). The Trust achieved a score of at least level 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 not subject to the payment by results (PbR) clinical coding external audit during the reporting period.

Local audit was undertaken and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were:

Data field - inpatients	Error rate
Primary diagnosis	3%
Secondary diagnosis	5%
Primary procedure	5%
Secondary procedure	5%

The audit sample was 205 finished consultant episodes (FCEs) from medical, surgical and woman and child health services.

The results of this audit should not be extrapolated further than the actual sample audited.

3.5 Performance against 2015/16 priorities

This section of the quality report provides a summary of performance against last year's quality priorities. These are described against the relevant ambitions from the Trust's strategic framework.

Deliver personal care	Deliver measurable improvements in the patient experience
Deliver safe care	Reduce the incidence of hospital-associated harm on inpatient wards
	Deliver improvements in the care we provide to our patients

For each priority a summary is provided of the rationale for selection, current status, steps taken to improve performance and further initiatives to be implemented during 2016/17. Unless otherwise stated the data provided is sourced from internal reporting arrangements.

The report also describes progress against the quality priorities identified for community services in Suffolk.

Community services quality priorities
Measures (a) Improve the way we manage people who have fallen to ensure the best possible outcome for them (b) Provide an improved dementia care service for patients and carers affected by complex physical healthcare conditions and cognitive impairment (c) Review the information we give to patients and their families and improve the material we offer them to enhance recovery and reduce anxiety.

Deliver personal care	Deliver measurable improvements in the patient experience

Measures

(a) Ensure we consistently achieve 90% of patients recommending our services to their friends and family

(b) Reduce noise at night as measured by the inpatient survey

(c) Increase our range of patient and carer feedback methods to ensure we effectively identify and address areas for improvement.

(a) Ensure we consistently achieve 90% of patients recommending our services to their friends and family

Description of the issue and rationale for selection

Nationally, the Friends and Family Test (FFT) continues to be seen as a barometer of patients' overall satisfaction with care. More challenging targets are being introduced year-on-year in respect of required response rates and the extension of the test into additional specialties. WSFT will continue to maintain its focus on this during 2015/16 to ensure the targets set within commissioning for quality and innovation (CQUIN) are met.

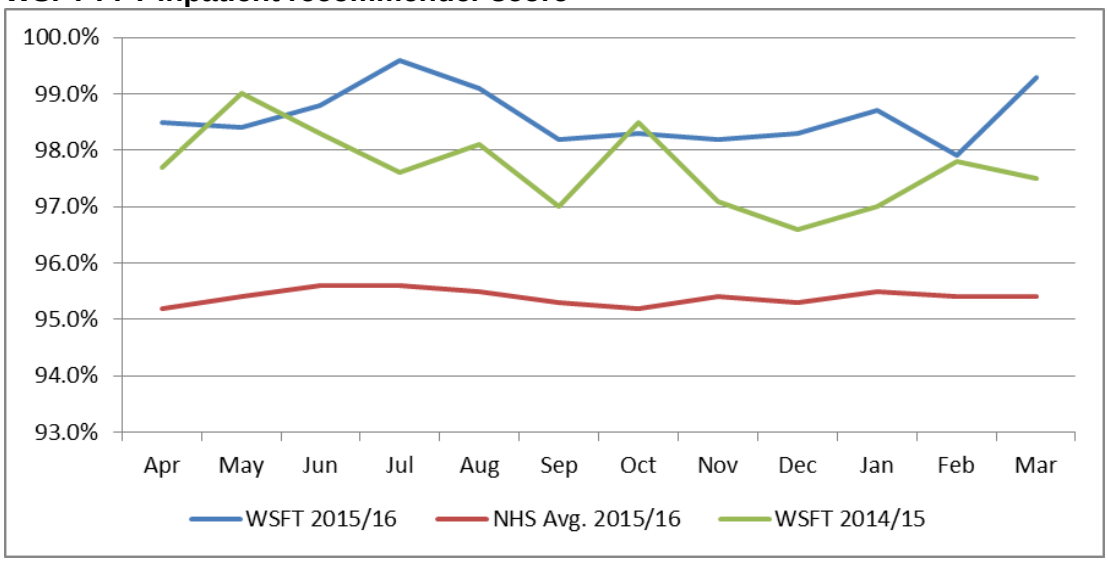
Action taken during 2015/16

- The FFT question is integral to our patient satisfaction surveys across inpatient, day case, maternity and outpatient services
- Whilst the FFT was not part of any CQUIN requirements, our focus for this year was to improve the uptake of surveys in outpatient areas.

Current status

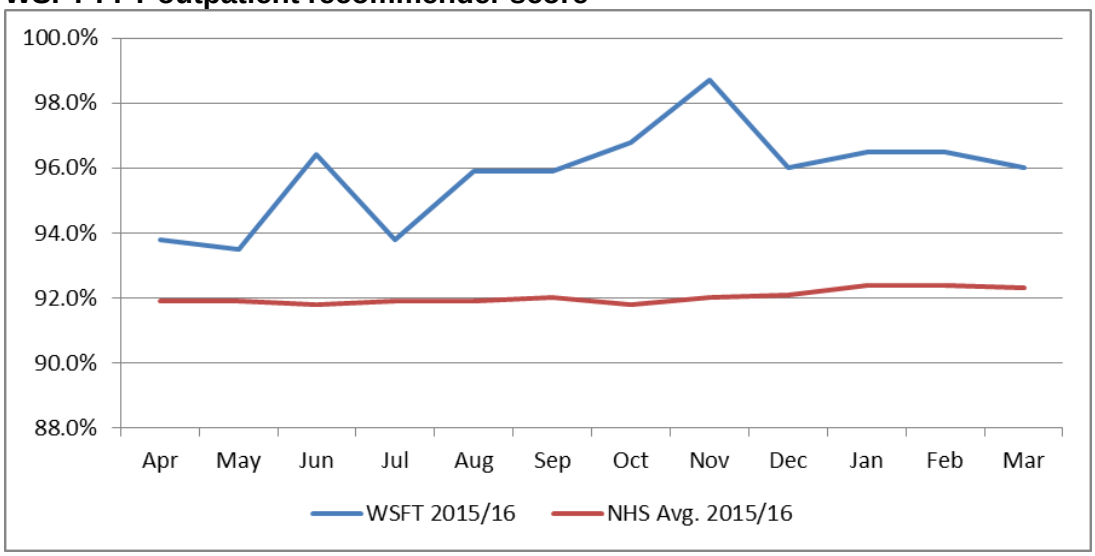
We met our target of 90% of patients recommending our service to friends and family for each month of 2015/16 for inpatients, outpatients, ED and maternity. We also consistently performed better than the national average for all areas. We also improved our performance compared to 2014/15 for inpatients. National comparative data for March 2016 in the recommender charts is not yet published.

WSFT FFT inpatient recommender score



Source: NHS England

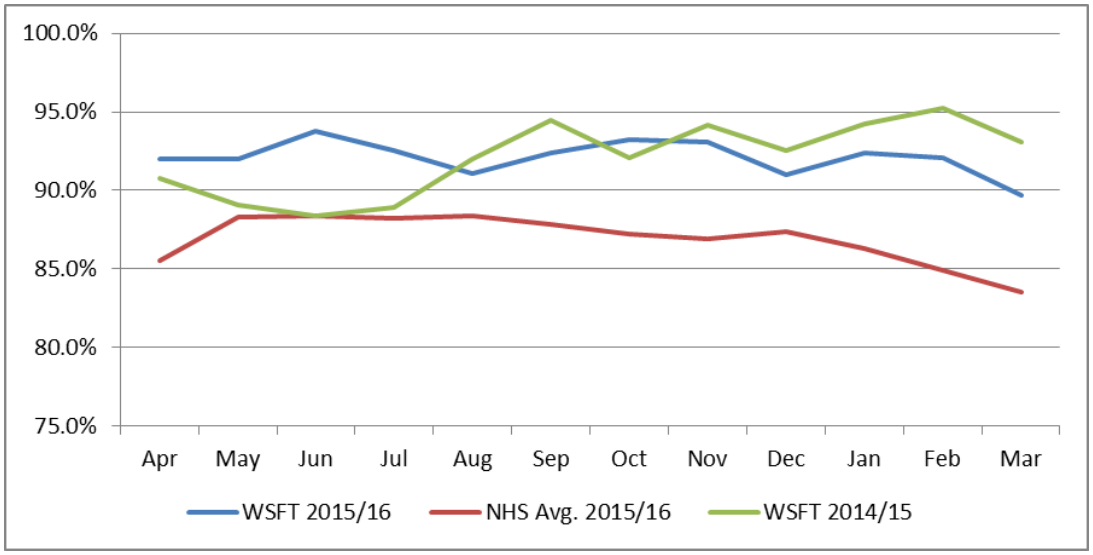
WSFT FFT outpatient recommender score



Source: NHS England (data not collected during 2014/15)

An increase in FFT responses in the main outpatient department has also been achieved during the year.

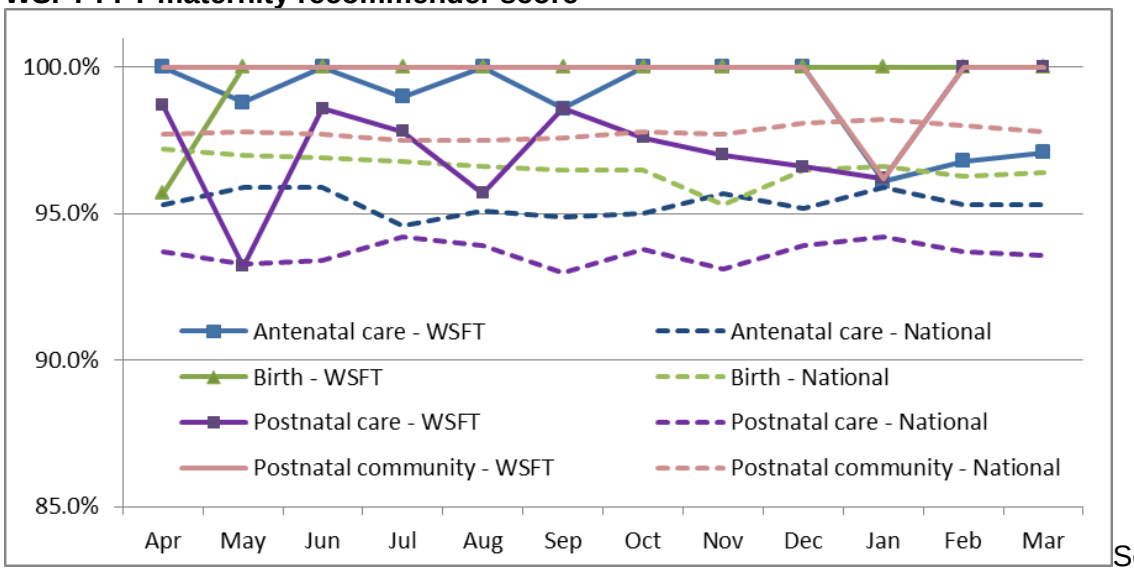
WSFT FFT ED recommender score



Source: NHS England (for 2014/15 Meridian)

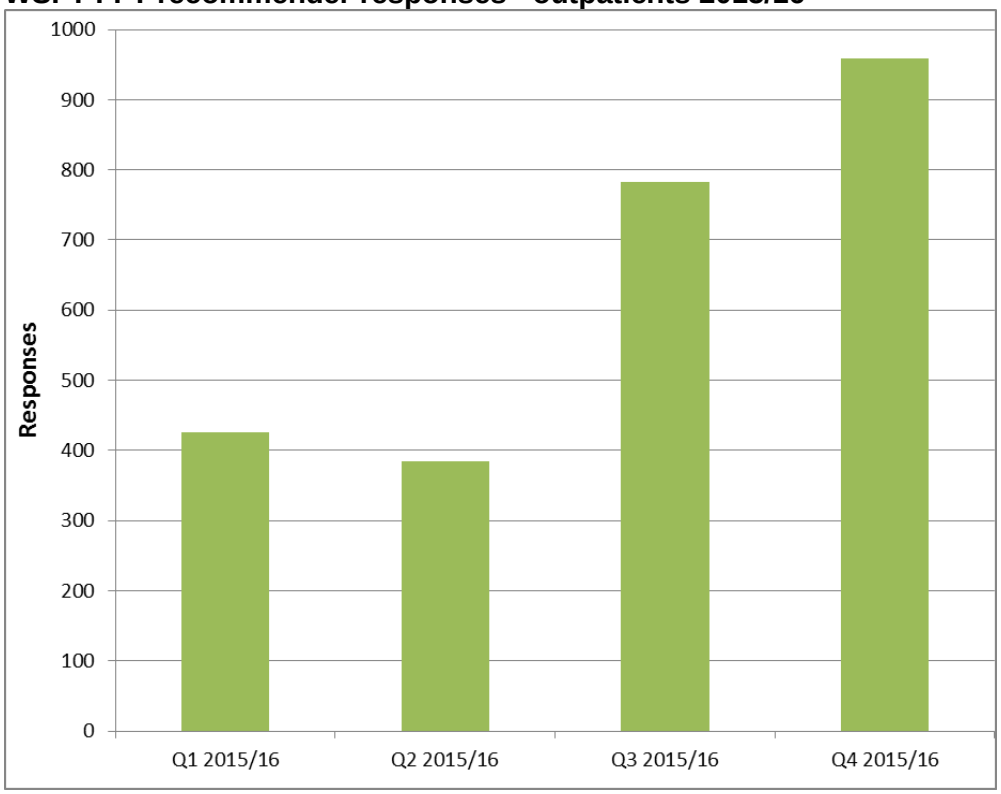
The maternity FFT considers four ‘touch points’ in care: antenatal; birth; postnatal; and postnatal community. We consistently scored better than the national average across all area with antenatal, birth and postnatal community scoring 100% in the majority of months.

WSFT FFT maternity recommender score



Source: NHS England

WSFT FFT recommender responses - outpatients 2015/16



Source: Meridian

Action to be implemented in 2016/17

- Continue to increase response rate in outpatient areas
- Determine methods of obtaining FFT responses from our hard-to-reach groups, such as patients with learning disabilities
- Use promotional material in public places across the Trust to encourage responses
- Develop different methods of returning questionnaires, such as drop-off boxes, to obtain more feedback.

(b) Reduce noise at night as measured by the inpatient survey

Description of the issue and rationale for selection
Noise at night is identified as a priority as this consistently scores poorly in our inpatient survey responses. We will continue to gather qualitative and quantitative data to inform our actions to improve performance in this area. This will include minimising patient moves during the night and the associated noise and disruption this can cause.

Action taken during 2015/16
A noise at night task and finish group was established to focus on the reduction of environmental and patient related elements of noise. These include:

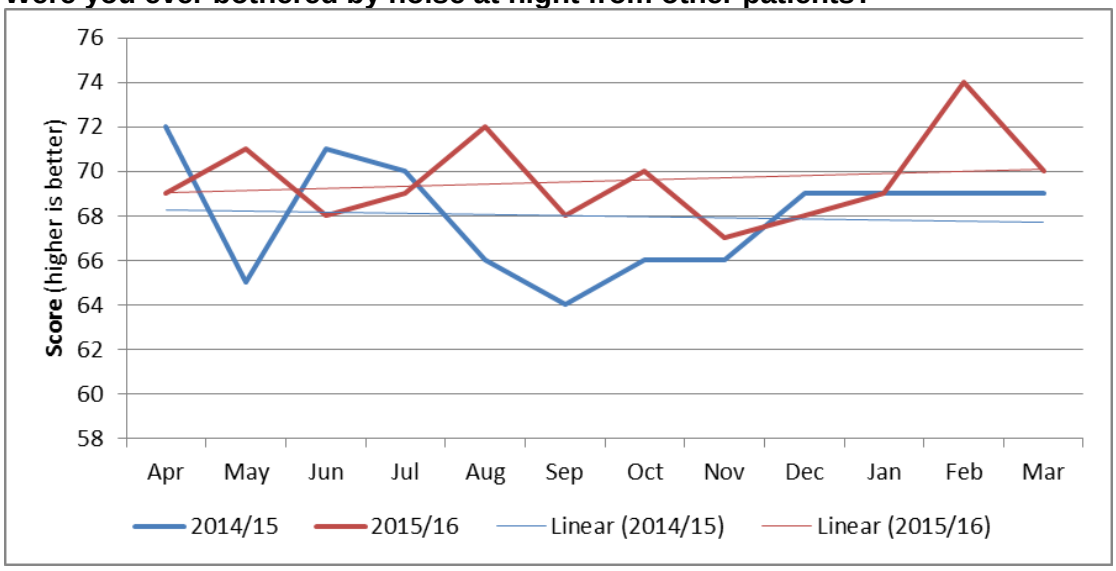
- Introduction of RoseVital trays across the Trust to provide all patients with ear plugs to use at night
- Trial of decaffeinated and milky drinks round at night
- Reduce volume of call bells at night
- 'Calm carts' filled with items to soothe in use on ward G4
- Soft closing bins in place in ward areas
- Involvement of volunteers to provide company for patients to promote settled behaviour.

Patient moves at night:

- We have refined our data collection of patient moves at night which shows an increase in patient moves at night during the last four months of 2015/16.

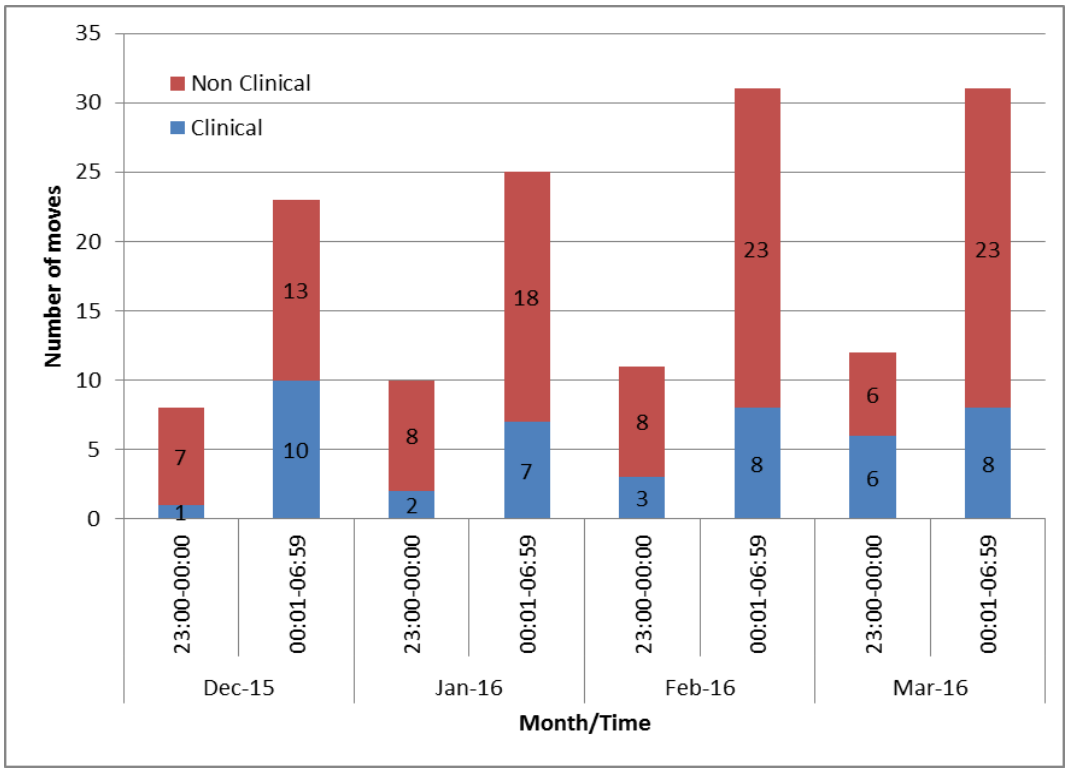
Current status
The trend line for being 'bothered by noise at night' as measured by the inpatient survey shows a gradual improvement during 2015/16, and improved performance when compared with 2014/15.

Were you ever bothered by noise at night from other patients?



Source: Meridian

Bed moves trend 2016



Source: Patient administration system

Action to be implemented in 2016/17

- Trial nursing staff wearing scrubs at night to mimic pyjamas to help patients distinguish between night and day
- Introduce 'calm carts' on three further wards
- Further develop our monitoring framework for moves at night and to focus on this to reduce noise at night.

(c) Increase our range of patient and carer feedback methods to ensure we effectively identify and address areas for improvement

Description of the issue and rationale for selection

It is important to continually review and expand the range of activities undertaken to engage with our patients and obtain their feedback. We already review feedback from a range of sources including public feedback websites and independent organisations. We aim to build on this through a range of patient and carer feedback mechanisms.

Action taken during 2015/16

- Increased the number of iPads in use for the patient survey
- Held a further event to gain patient feedback in the form of a 'Freedom to speak up' day
- Developed a questionnaire for complainants to give their view of the complaints process
- Introduction of comment cards in emergency department and assessment areas
- Our carer feedback forms were added to hospital's website
- Suffolk Family Carers supply pre-paid returns envelopes in packs to encourage feedback form returns
- A volunteer has been recruited to support our family carer Support worker to give out carers packs containing feedback forms .

Current status
Patients and visitors were able to provide feedback during a day-long feedback event which took place on Wednesday 2 March 2016. The 'Freedom to speak up' event aimed to give everyone using the Trust's services the chance to share their opinions – both good and bad – so that we can improve further.

Lots of different activities took place throughout the day to make it easy for people to give their views, regardless of which part of the hospital they were using, including:

- The chatterbox cab: a London taxi converted into a video booth. The driver asked people questions and a short film will be put together for use at staff training sessions
- A 'listening ear' drop-in session with Stephen Dunn, chief executive which took place in the PALS office at the front of the hospital between 2pm and 4pm was open to all
- Ward manager drop-ins on each ward between 2pm and 4pm to listen to concerns and compliments from patients and relatives.

PALS manager Cassia Nice, who organised the event, said: "We arranged this freedom to speak up day to make it even easier for people to share their views on the care they have received, whether good or bad. We encouraged as many people to come along as possible so that we could find ways to further improve in the future."

Action to be implemented in 2016/17
- Review how we respond to feedback on public websites
- Continue to implement new initiatives to improve the range of feedback methods
- To rebrand our Patient Advice & Liaison Service (PALS) to re-educate patients, carers and staff on the contribution and values of the service.

Deliver safe care	Reduce the incidence of hospital-associated harm on inpatient wards

Measures

(a) Ensure that there are no more than 16 hospital-associated C. *difficile* infection cases between April 2015 and March 2016
(b) Reduce the incidence of avoidable pressure ulcers and avoidable inpatient falls against the baseline of 2014/15
(c) Improve compliance with the World Health Organisation (WHO) surgical safety checklist against the baseline of 2014/15
(d) Achieve 75% uptake of the flu vaccination for all relevant staff.

(a) Ensure that there are no more than 16 hospital-associated C. *difficile* infection cases between April 2015 and March 2016

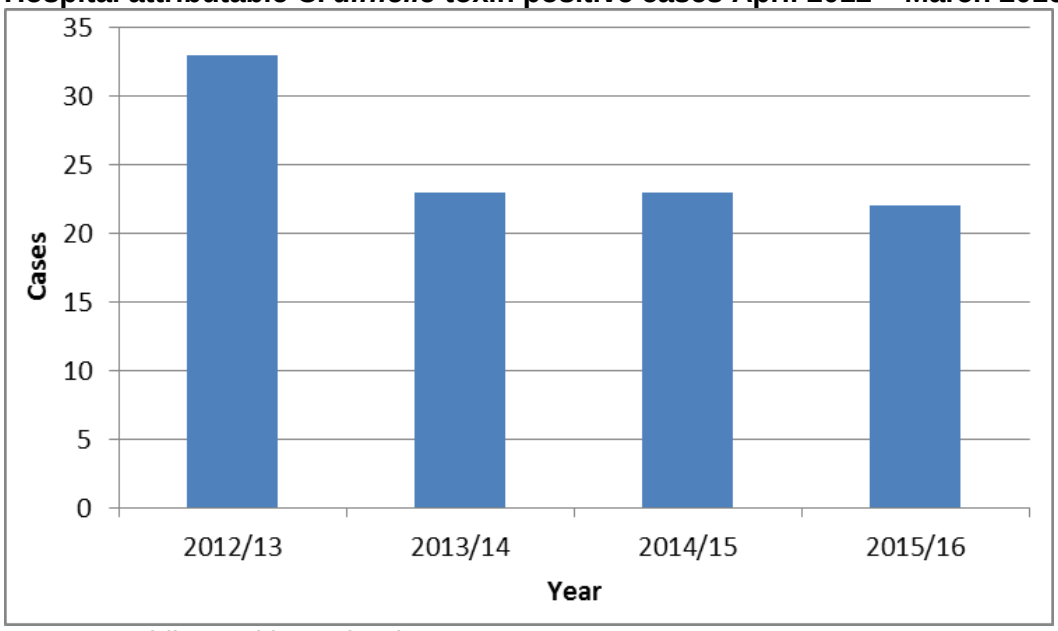
Description of the issue and rationale for selection
Reducing hospital-associated infections continues to be one of the main priorities for our patients and the public. In addition, it remains a key priority for the NHS as a whole and for our commissioners. Within the Trust we continue to strive for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

Action taken during 2015/16

- Ongoing quarterly audits of antibiotic prescribing with an expectation of 95% compliance. Compliance is fed back to wards and is presented at Directorate Governance meetings
- Post infection reviews are undertaken on all hospital-associated C. *difficile* infections and necessary actions identified and implemented
- Patients requiring broad spectrum antibiotic treatment receive probiotics. This intervention continues to have a significant impact on reducing the number of C. *difficile* infections cases recorded by the Trust
- The operational plan for the isolation unit on ward F12 requires that a bed is kept available at all times to allow transfer of a new case of C. *difficile* infection as soon as this is identified.
- MicroGuide was launched and is available to all prescribers to improve access to the Trust antibiotic guidelines at the bedside
- The Trust held an antibiotic awareness week to improve understanding and antibiotic stewardship
- an assessment of wards with only two single rooms for isolation was Andertaken by Bioquell in November 2015 to identify availability for development
- In July and August 2015 an opportunity arose to decant, clean and hydrogen peroxide fog (HPV) 9 of the acute wards and this was completed.

Current status

Hospital attributable C. *difficile* toxin positive cases April 2012 – March 2016



Source: Public Health England

There have been a total of 22 C. *difficile* toxin positive cases during 2015/16 exceeding the nationally set objective. However, of the 22 cases, 12 have been confirmed by the CCG as non-trajectory for which no lapses in care were identified. Therefore, with a total of 10 trajectory cases, the WSFT achieved its internal target of fewer than 16 cases for which lapses in care were identified.

Action to be implemented in 2016/17

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

(b) Reduce the incidence of avoidable pressure ulcers and avoidable inpatient falls against the baseline of 2014/15

Description of the issue and rationale for selection

WSFT aims to improve on our achievements to date of reducing harm to patients whilst they are in hospital. We will focus on the reduction of falls on our inpatient wards through the implementation of the NICE guidance '*Falls: assessment and prevention of falls in older* people'. We will continue with our priority to eliminate all avoidable hospital-acquired pressure ulcers. This will be achieved by improving practice-based on learning from investigation of pressure ulcer incidents.

(i) Falls

Action taken during 2015/16

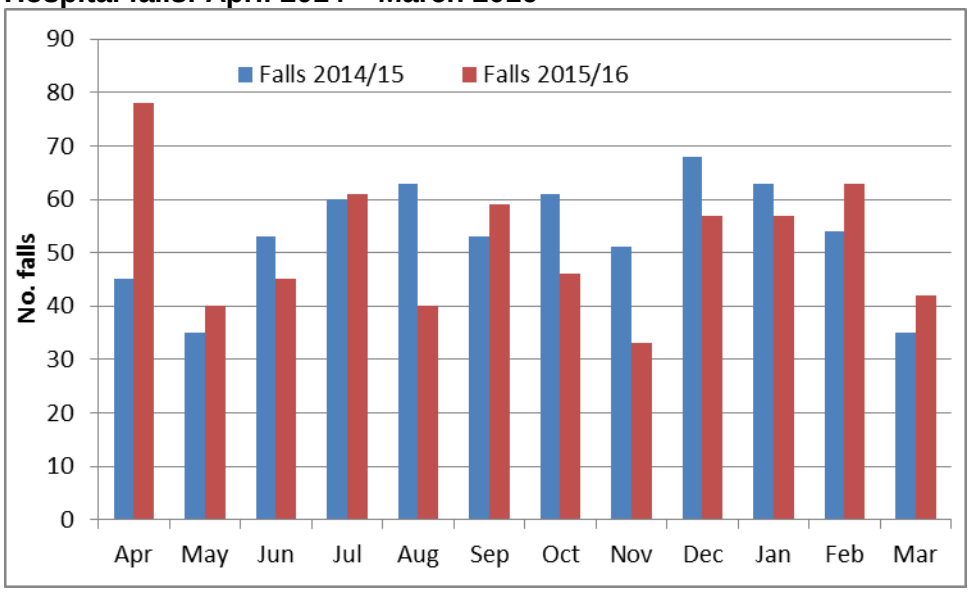
- The majority of non-elective wards have had patient motion sensors fitted in the toilets to alert staff when at-risk patients are on the move. This has significantly reduced the number of falls in toilets

- Lying and standing blood pressure has been a particular focus this year, and as a result we are achieving improved compliance with NICE guidance
- Introduced the use of scoop stretchers on all wards to aid retrieval of patients who have fallen and sustained an injury.

Current status:

There were fewer falls in 2015/16 (621) compared to 2014/15 (641).

Hospital falls: April 2014 – March 2016



Source: Datix

All falls that result in 'major' or 'catastrophic' harm are assessed to determine if they are avoidable. During 2015/16 four falls have been confirmed as avoidable. We have achieved our quality priority as this is a reduction in avoidable falls compared to 2014/15, when eight falls were assessed as avoidable.

Action to be implemented in 2016/17

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

(ii) Avoidable pressure ulcers

Action taken during 2015/16

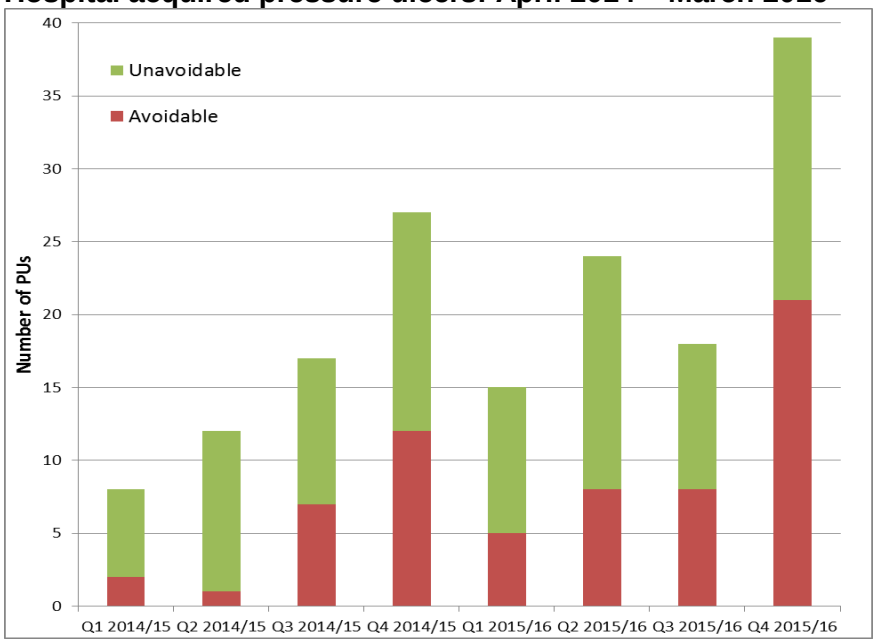
- Introduction of medi honey products for the treatment and management of grade one pressure damage and moisture damage
- Review of pressure ulcer prevention policy in line with NICE guidance
- Established links with community tissue viability nurse (TVN) who attends WSFT pressure ulcer prevention group meetings
- Established a peer review process for pressure ulcer incidents with local acute and community tissue viability teams
- Established links for peer support with London area tissue viability network
- Developed e-learning package for nurse induction
- Involved in international stop the pressure day

- Trialled body pressure mapping sensor equipment
- Shared learning of actions from root cause analysis (RCA) investigations by ward staff attendance at RCA meetings and dissemination of learning through meetings, newsletters and networks.

Current status:
WSFT did not achieve the quality priority for hospital acquired pressure ulcers (HAPUs). A total of 96 HAPUs were reported during 2015/16, an increase compared to 2014/15 (64).

Reported levels for each quarter in 2015/16 are higher than the corresponding quarter for 2014/15. However, there is a marked increase for Q4 with 39 HAPUs reported compared to 27 in 2014/15. The peak incidence occurred during February 2016 (17) compared with January 2015 (20), reflecting the operational pressure experienced in each year.

Hospital acquired pressure ulcers: April 2014 – March 2016



Source: Datix

Analysis of HAPU grades indicates the largest rise during 2015/16 was in grade 2 (lower severity - 73) compared to grades 3 and 4 (higher severity – 23). One grade 4 pressure ulcer was reported in September 2015: the first one to have occurred in the Trust since 2010. This was deemed unavoidable following investigation.

Further analysis of the increase in HAPUs reported during 2015/16 is currently being undertaken. The review will include assessment of the number of patients who developed HAPUs that were on an end-of-life pathway and whether this was a contributory factor.

Action to be implemented in 2016/17
- Re-establish WSFT pressure ulcer focus groups
- Review of hybrid foam/alternating pressure mattresses
- Enhance the Trust's tissue viability link nurse network and training
- Highlight the benefits of repose pressure relieving equipment
- Review the heel pressure ulcer management pathway including the vascular surgery team
- Develop a paediatric pressure ulcer prevention policy
- Review of heel pressure ulcer prevention equipment
- Take a more proactive role in international stop the pressure day

- Undertake an observational audit of a patient's journey through the Trust looking at pressure ulcer prevention.

(c) Improve compliance with the World Health Organisation (WHO) surgical safety checklist against the baseline of 2014/15

Description of the issue and rationale for selection
Surgical never events are the most commonly reported types of never event in the English NHS. The Trust has taken action to improve practices based on events that took place during 2014/15 and has identified this as a priority for monitoring for the year ahead. The focus of monitoring is compliance with the World Health Organisation (WHO) surgical safety checklist. The tool enables the theatre team to demonstrate reliable performance of a series of safety checks that have been shown to reduce surgical mortality and morbidity.

Action taken during 2015/16

- A review of the safer surgery pathway audit programme was undertaken. The content of the audits were restructured; an additional marking audit was implemented as well as the addition of monitoring elements for team brief and team debrief within the observational audit. These items will be included in future monitoring.

  All the audits are undertaken on a monthly basis and reported quarterly:

  1. WHO checklist observation audit
  2. WHO checklist documentation audit
  3. Prescription for surgery audit
  4. Surgical marking audit.

- Improved communication of safer surgery audit results, including:

  1. Circulation of audit results to all clinical staff within surgery quarterly
  2. Display of the results and actions in both main theatres and day surgery unit (DSU) along with the safer surgery pathway audit programme
  3. Reporting of the results quarterly to the surgical division governance steering group
  4. Audit summary posters summarising the results and actions of each audit
  5. Quarterly safer surgery pathway audit meetings.

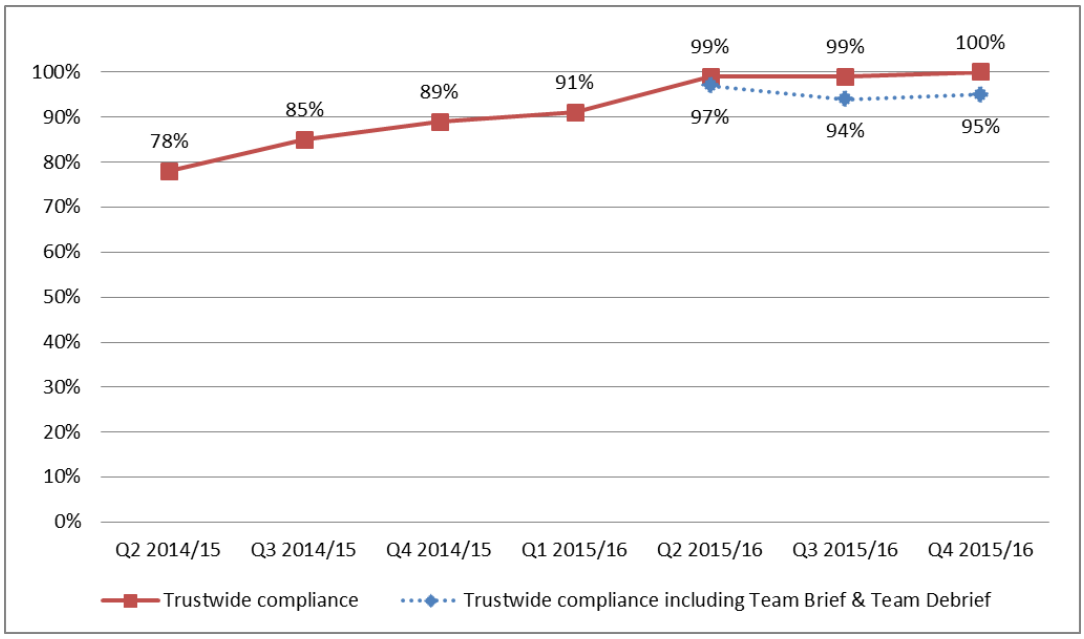
Current status
WSFT participates in four audits relating to the WHO safer surgery. The observational, documentation and surgical marking audits are carried out by every speciality in the surgical and women and children's divisions one day per month in main theatre and DSU.

The results for these are summarised in the charts below.

The observational audit demonstrates an improvement against baseline in 2014/15 - audit results for Q4 showing performance of 100%.

The criteria of the safer surgery audit were developed in Q2 2015/16 to include reporting of team brief and team debrief (represented by the blue line in the chart). With the added criteria of team brief and team debrief, performance for Q4 is 95%.

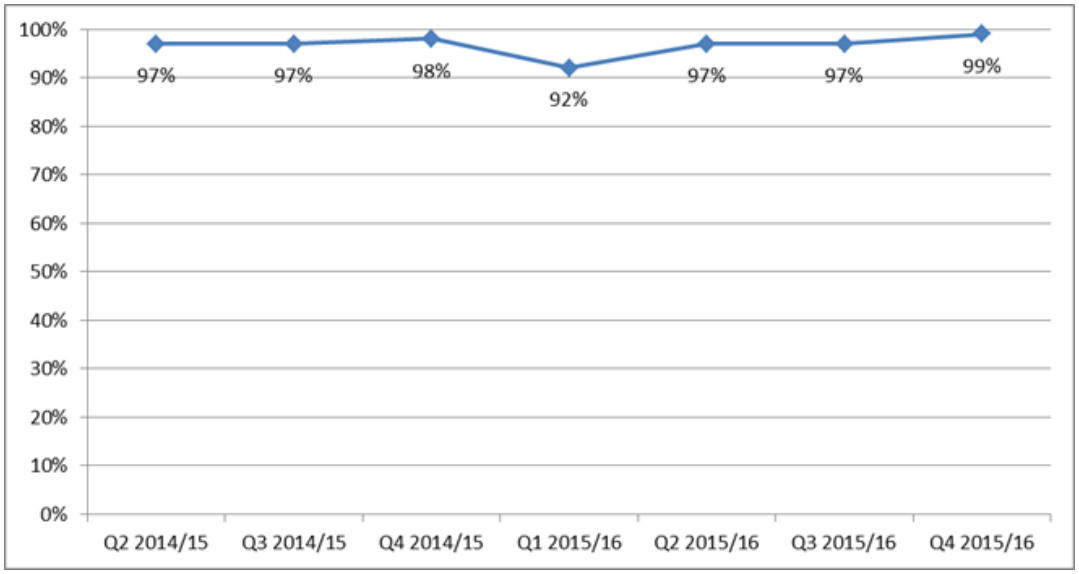
WHO observational audit results



Source: Local audit

The documentation audit compliance remains static, although performance of 99% was achieved in Q4 2015/16. Additional actions identified as part of these audits are captured within the surgical division action plan.

WHO documentation audit results

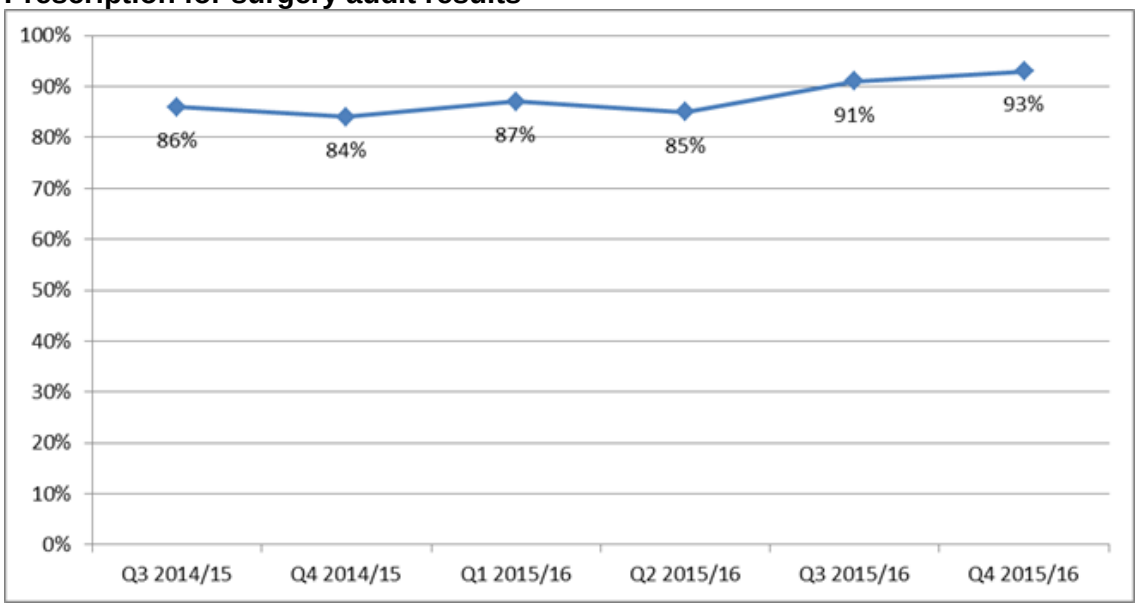


Source: Local audit

In addition to the above audits the surgical division carry out an audit related to the compliance for completing a prescription for surgery form. The audit requires four standards to be completed: procedure prescription; side of surgery; OPCS code completed; and correct OPCS recorded.

The purpose of this audit is to demonstrate that at the point that the patient was booked for surgery, the correct procedure, side and codes were identified to enable the waiting list team to correctly book the procedure within the theatre booking system (OPERA). Overall the data shows an improvement compared to 2014/15, although performance dipped in Q2 to 85%.

Prescription for surgery audit results



Source: Local audit

Action to be implemented in 2016/17

- Implementation of the safer surgery audit programme for 2016/17, including reporting new surgical marking component of audit
- New administration of the prescription for surgery audit on e-Care
- Implement a breakdown of elective and emergency reporting surgery for the WHO observation audit results
- Further develop training for surgical teams to carrying out the WHO checklist safer surgery process and monitoring of safer surgery practice.

(d) Achieve 75% uptake of the flu vaccination for all relevant staff

Description of the issue and rationale for selection

Every year, influenza vaccination is offered to NHS staff as a way to reduce the risk of staff contracting the virus and transmitting it to their patients. Influenza is a highly transmissible infection. The patient population found in hospitals is much more vulnerable to the severe effects of flu and healthcare workers may transmit the illness to patients if they are mildly or sub-clinically infected. There are reports of influenza outbreaks within hospitals and other care settings where transmission from healthcare workers to patients is likely to have facilitated the spread of the disease. Additionally, frontline healthcare workers are more likely to be exposed to the influenza virus, particularly during the winter months when some of their patients are infected. Influenza can also adversely impact on staff absence which in turn may impact on staffing levels within hospital. Flu vaccination programmes will also support the health and wellbeing of staff.

Action taken during 2015/16

- WSFT flu campaign led by occupational health
- Peer flu fighters in clinical areas trained to give flu vaccinations to colleagues
- Employment of a registered nurse to support the flu campaign and give flu vaccinations to clinical staff during all shifts
- Increased visibility of the campaign across the Trust.

Current status
We did not meet our target of 75% uptake of the flu vaccination for all relevant staff.

53.9% of our staff received vaccinations. This compares with the national benchmark of 50.8% of frontline staff.

Action to be implemented in 2016/17
- Increase number of vaccinations ordered
- Continue with the use of a temporary member of staff to provide flu vaccinations to clinical staff during all shifts
- Improve overall uptake by peer flu fighters by introducing incentives
- Continue poster campaign using key leaders in the Trust to promote flu vaccination.

Deliver harm-free care	Deliver improvements in the care we provide to our patients

Measures

(a) Improve reliability of AKI diagnosis, treatment and monitoring for inpatients – during the year improving performance against the baseline measurement from quarter 1
(b) Improve reliability of sepsis screening and treatment for emergency admissions – during the year improving performance against the baseline measurement from quarter 1
(c) Improve performance in the care of diabetes patients as measured by the national inpatient diabetic audit during 2015
(d) Maintain better than nationally expected risk-adjusted mortality by implementing systematic reviews of all inpatient deaths to learn and make improvements to care.

Description of the issue and rationale for selection of measures
During 2015/16 WSFT focused on the improved identification and management of risks to patient safety, primarily those related to identification of factors indicating imminent deterioration of patients, sepsis (infection that has entered the blood stream) and acute kidney injury (previously known as kidney failure). The Board committed to the national 'Sign-up to safety' campaign and approved an improvement plan for the initiative. The delivery of this plan forms the focus of our ambition to deliver reliable care through compliance with agreed pathways based on best practice for AKI, sepsis and diabetes.

(a) Improve reliability of AKI diagnosis, treatment and monitoring for inpatients – during the year improving performance against the baseline measurement from quarter 1

Description of the issue and rationale for selection
As part of the national CQUIN relating to AKI, the focus has been on AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge. This has been measured through the percentage of patients with AKI treated in an acute hospital whose discharge summary includes:

- Stage of AKI (a key aspect of AKI diagnosis)
- Evidence of medicines review having been undertaken (a key aspect of AKI treatment)
- Type of blood tests required on discharge for monitoring (a key aspect of post-discharge care)
- Frequency of blood tests required on discharge for monitoring (a key aspect of post-discharge care).

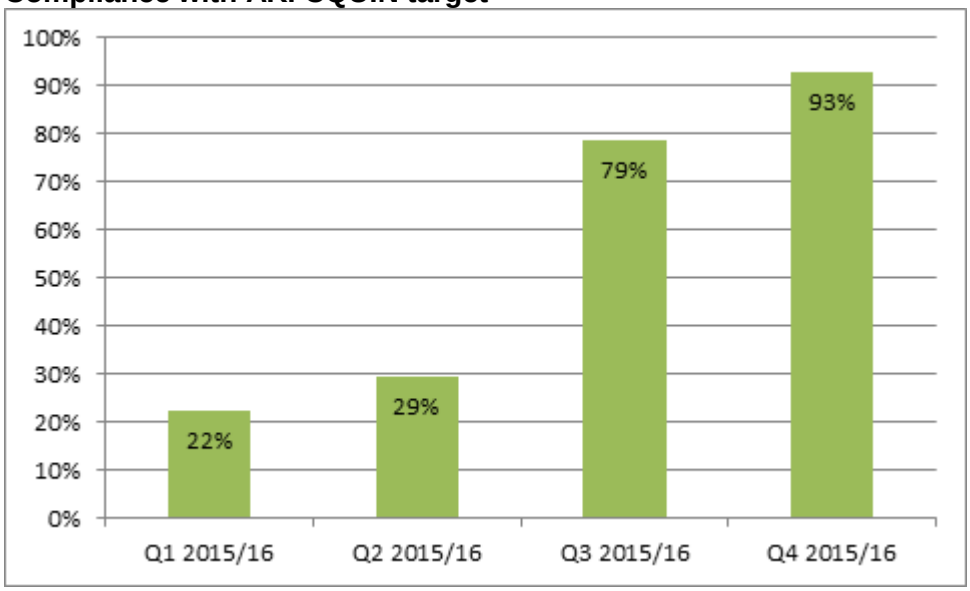
Action taken during 2015/16

- A review of 25 sets of notes a month has been completed with patients who have been identified as have AKI staging 1-3
- An additional field was added to the EPRO system which produces discharge letters to enable clinicians to complete the four areas required within the CQUIN reporting
- Patients with an AKI staging are discussed as part of the daily handover process, to ensure they are reviewed
- Quarterly review of patients admitted to critical care identified that patients are managed appropriately in relation to AKI.

Current status

Overall we have made improvement in the requirements of the AKI CQUIN against the Q1 baseline. Significant progress has been made from the beginning of the year achieving 93% compliance by Q4.

Compliance with AKI CQUIN target



Source: Local audit

Action to be implemented in 2016/17

- Improve monitoring of patients with AKI as part of e-Care to enable prompt treatment
- Review of the management of patients with a AKI stage 3.

(b) Improve reliability of sepsis screening and treatment for emergency admissions – during the year improving performance against the baseline measurement from quarter 1

Description of the issue and rationale for selection

The survive sepsis campaign identified that 1 in 10 may die if suffering from sepsis in its least severe form. Severe sepsis claims around 1 in 3 patients' lives, and in septic shock the chances of survival are only 1 in 2. Some of these deaths may be prevented by early recognition and immediate intervention. The sepsis six is a set of interventions that should be completed within the first hour and can double the chances of a patient's survival.

As part of the sepsis work identified for 2015/16 the Trust concentrated on identification of patients with sepsis (screening) who are admitted as an emergency admission. In addition to this, information

was collected to see if, following identification, patients received intravenous antibiotics (IVAB) within one hour in accordance with national recommendations.

Action taken during 2015/16

- Increased monitoring to achieve compliance with the CQUIN requirements was undertaken with the aim to achieve an improvement on Q1 baseline
- Review of CQUIN in Q3 relating to screening to ensure the data was reflective of patients meeting the criteria of red flag sepsis, severe sepsis.
- Sepsis patients within critical care monitored quarterly
- Concise RCAs completed in relation to patients presenting with neutropenic sepsis, a review group put in place with an action plan that is monitored and submitted to the CCG.

Achievements during 2015/16

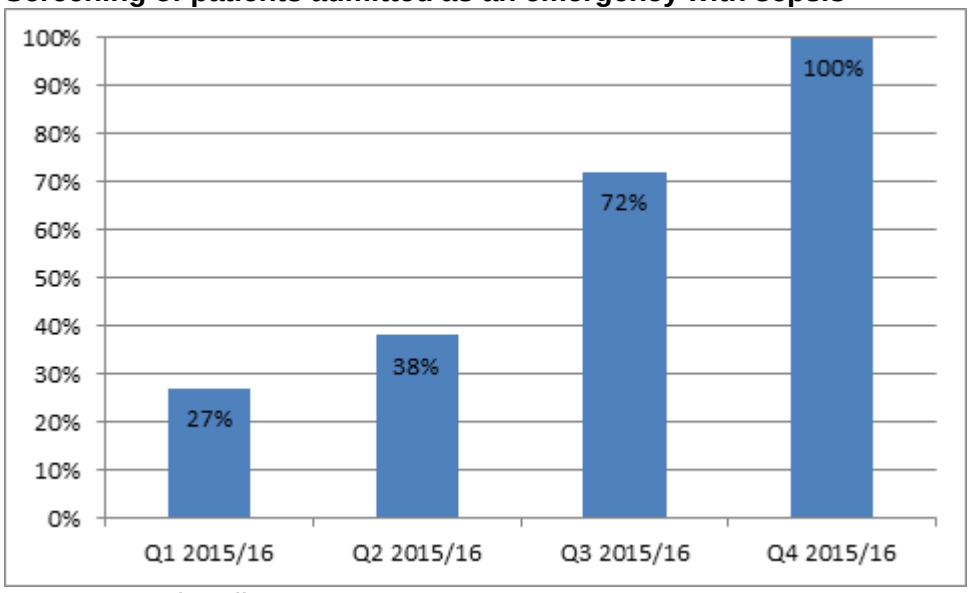
- Improved recognition of emergency patients presenting with sepsis
- Increase patients presenting with sepsis receiving IVAB within one hour
- Improved recognition and management of patients with neutropenic sepsis.

Current status

(a) Screening

Data was collected as part of the national CQUIN programme relating to the management of sepsis. The chart below reflects screening performance for patients admitted as an emergency. This includes admissions via the emergency department (ED), acute medical unit (AMU) or the surgical admissions unit (SAU). There has been a significant improvement in the screening of patients with sepsis from the baseline in Q1, achieving 100% compliance in Q4.

Screening of patients admitted as an emergency with sepsis

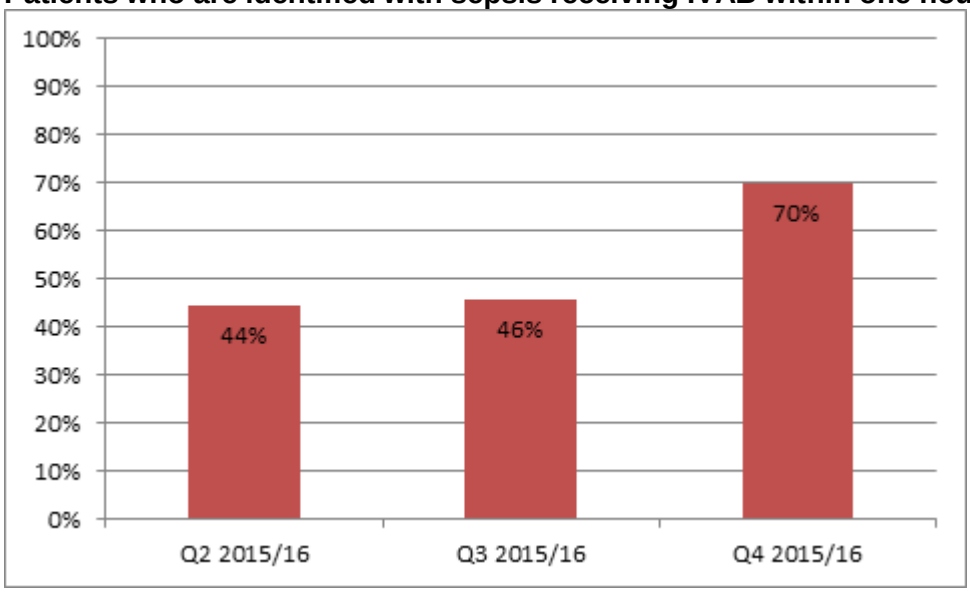


Source: Local audit

(b) IV antibiotic

In addition to the screening, data was collected on patients who had confirmed sepsis and the compliance in administering IVAB within the one hour timeframe. There has been an improvement from the baseline which was collected in Q2 to our current position in Q4.

Patients who are identified with sepsis receiving IVAB within one hour



Source: Local audit

In addition to the patients admitted as an emergency, patients considered as high risk have been reviewed to establish compliance with sepsis management guidelines. These included patients admitted with suspected neutropenic sepsis who predominantly required admission following administration of chemotherapy treatment and patients admitted to critical care with severe sepsis.

In the patients admitted with suspected neutropenic sepsis there has been an improvement in the administration of IVAB within one hour from 79% in Q1 to 92% in Q4. Recommendations that have been implemented from the reviews include:

- Pre-alert process implemented to emergency department (ED)
- Updated information cards for patients to give staff when presenting to ED
- Acute oncology nurses supporting ED with neutropenic patients
- Training of staff to access long-term intravenous lines (port-o-cath, peripherally inserted central catheters)
- Implement patient group directives to enable nursing staff to administer IVAB independently.

The review of patients admitted to critical care with severe sepsis included both emergency admissions and patients who were inpatients. The audit indicated 55% of patients received IVAB within one hour and 93% within two hours of admission. 100% of patients received a senior review within four hours of admission. Recommendations from this work included:

- Improvement in the delivery of IVAB within one hour
- Presentation of findings to all staff groups.

Action to be implemented in 2016/17

- Review and implementation of new sepsis guidance from NICE
- Expansion of CQUIN data requirements relating to identification and treatment of inpatients with sepsis
- Further audits within critical care to monitor improvement from 2015 audit.

(a) Improve performance in the care of diabetes patients as measured by the national inpatient diabetic audit during 2015

Description of the issue and rationale for selection
In 2010, it was estimated that there were approximately 3.1 million people aged 16 or over with diabetes (both diagnosed and undiagnosed) in England. By 2030, this figure is expected to rise to 4.6 million, with 90% of those affected having type 2 diabetes. Patients with diabetes account for 20% of the patients admitted to WSH. The monitoring and treatment of patients with diabetes is essential to minimize complications and reduce length of stay.

Action taken during 2015/16
- Participation in the national inpatient diabetic audit with its focus on avoidable complications, harm, patient experience and patient feedback
- On-going review and updating of policies and guidelines
- Updated intranet page to support staff
- Implementation of new drug chart to enable safer administration of insulin
- Training completed for implementation of Novo Biomedical connectivity system. The system implementation has been delayed due to compatibility with e-Care and point-of-care testing team support.

Current status
The inpatient audit results were published in March 2016 and are being reviewed by the diabetic team to identify any key actions required from the audit results.

Guidelines and policies are being updated to ensure they reflect recent changes to NICE guidance. The Trust intranet has been updated to reflect additional information relating to diabetes and implementation of the new Novo Biomedical connectivity system. The initial implementation of the connectivity system has been delayed due to compatibility with the Trust's new electronic patient record (e-Care). The training has been completed and phased implementation is taking place with full connectivity capability being delivered as part of the e-Care implementation.

Action to be implemented in 2016/17
- Implementation of Novo Biomedical connectivity system. This will enable the diabetic team to be aware of all bedside monitoring, ensuring all patients who record unusually high or low blood sugar levels are systematically escalated to the diabetic specialist nurses
- Identify KPI relating to connectivity and diabetic patient care.

(b) Maintain better than nationally expected risk-adjusted mortality by implementing systematic reviews of all inpatient deaths to learn and make improvements to care

Description of the issue and rationale for selection
Hospital standardised mortality ratio (HSMR) and summary hospital-level mortality indicator (SHMI) are key mortality measures which are also considered to be indicators of system-wide safety and effectiveness.

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. The data used to calculate SHMI includes all deaths in hospital plus those deaths occurring within 30 days of discharge from hospital.

The SHMI is intended to be a single, consistent measure of mortality rates. It shows whether the number of deaths linked to an organisation is more or less than would be expected, when considered in light of average national mortality figures, given the characteristics of the patients treated there. It also shows whether the difference is statistically significant.

Action taken during 2015/16

- Closer monitoring of compliance with internal mortality tool
- Established mortality surveillance group and peer review process
- Strengthened review of Dr Foster data, including additional reviews from alerts within mortality surveillance group.

Current status

WSFT has been monitoring the internal mortality tool which enables consultants to review all inpatient deaths and identify elements of preventability and areas of learning.

The table provides an indication of the number of deaths reviewed compared to the total number of deaths within WSFT.

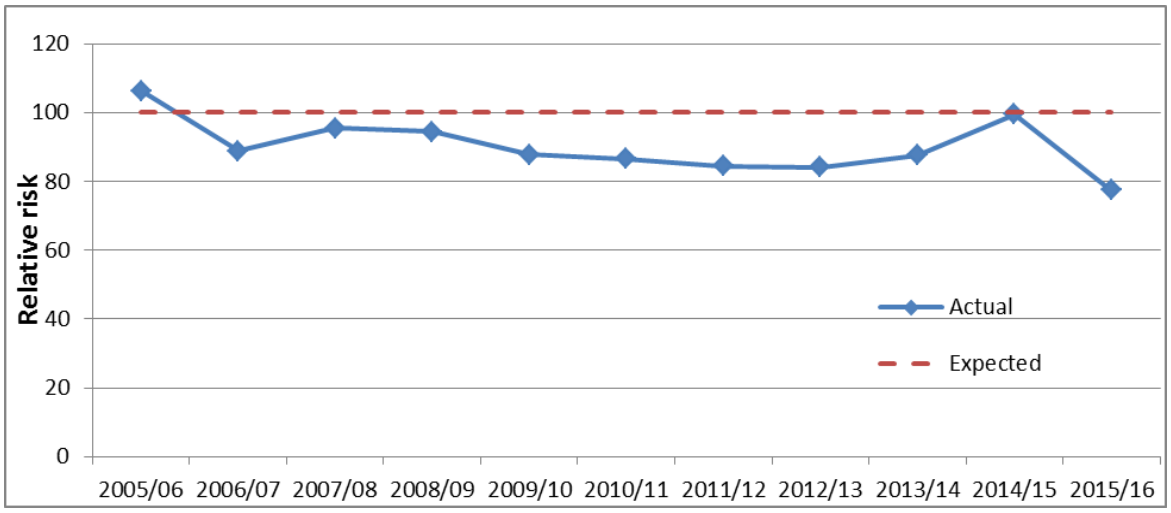
Mortality reviews

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16
Total deaths	80	73	71	55	70	52	66	72	79	108	91
Cases reviewed	57	60	58	37	39	32	50	51	41	50	59
% reviewed	71%	82%	82%	67%	56%	62%	76%	71%	52%	46%	65%

Source: WSFT mortality review database. March mortality reviews are in progress and therefore not included within this report.

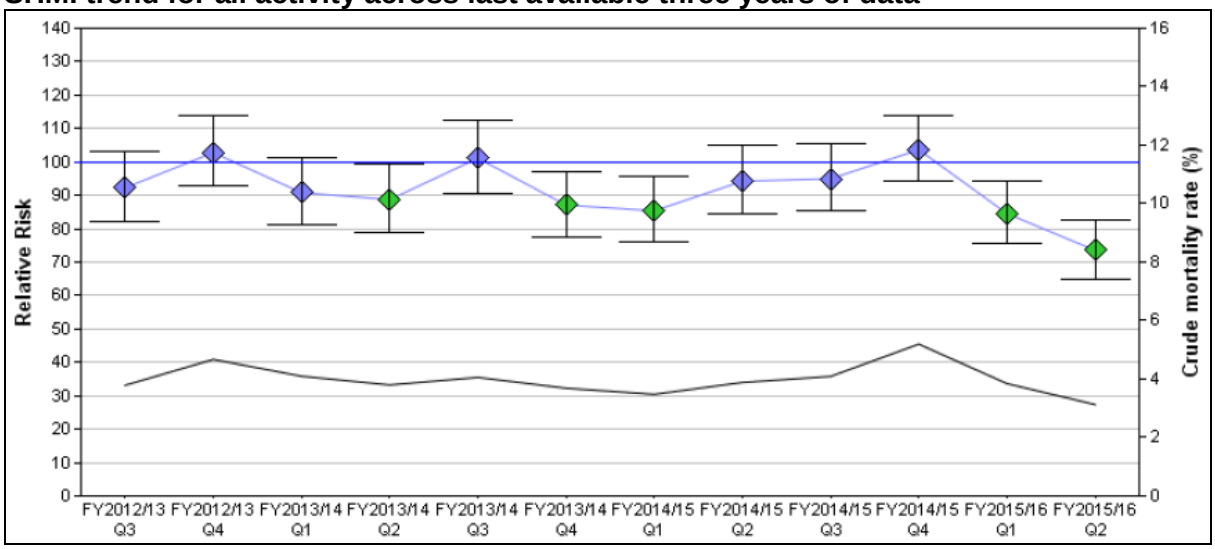
WSFT continues to achieve a HSMR and SHMI that are below the expected rate.

HSMR trend 2005/06 to 2015/16



Source: Dr Foster

SHMI trend for all activity across last available three years of data



Key: Green – statistically 'lower than expected'. Blue – statistically 'as expected'
Source: Dr Foster

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

In January 2016 WSFT responded to a request from NHS England in relation to mortality reviews that take place and how preventable deaths are identified and reviewed. This was part of a national programme in relation to preventable deaths which, based on two studies, indicated that on average about 4% of hospital deaths were potentially avoidable.

When the data tool is applied to WSFT, a typical acute trust with 940 deaths per year, it predicted that we should expect around 29 deaths to have more than a 50/50 chance that death was attributable to problems in healthcare. During 2015 the Trust identified seven such cases. Based on this information a more effective system for local mortality review and incident reporting could potentially identify 22 additional opportunities for investigation and learning each year.

Action to be implemented in 2016/17

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

Community services quality priorities

Measures

(a) Improve the way we manage people who have fallen to ensure the best possible outcome for them
(b) Provide an improved dementia care service for patients and carers affected by complex physical healthcare conditions and cognitive impairment
(c) Review the information we give to patients and their families and improve the material we offer them to enhance recovery and reduce anxiety.

(a) Improve the way we manage people who have fallen to ensure the best possible outcome for them

Description of the issue and rationale for selection
With 30% of people aged 65 and over and 50% of people aged 80 and over falling at least once a year, the cost to the NHS is £2.3 billion a year. For individuals, falls can lead to injuries such as fractures, pain, loss of independence, and even death. With older people living longer, fall incidents are set to rise by 2% annually and that could potentially lead to more falls-related injuries such as fractures. In Suffolk, the number of people aged 65 and over is projected to increase by 49%, and a 90% growth in those aged over 85 by 2021.

We are committed to identifying adults who are at risk of falls and fractures, with particular focus on those aged 65 and over and those aged 50 to 64 admitted to our community hospitals who are judged by a clinician to be at higher risk of falling because of an underlying condition. The aim of this priority was to identify those at risk of falls, provide falls assessments, and provide appropriate rehabilitation so that these individuals return to their normal state or as close as possible to the norm. This will help them to have an improved quality of life and contribute directly or indirectly economically. This priority is linked to National Institute for Health and Care Excellence (NICE) guidelines CG161 and NICE quality standard (QS 86).

Current status
We have clear processes to identify falls and fractures risks for both our community healthcare teams and our inpatient community hospitals.

Sometimes falls are inevitable due to the person's complex medical conditions, such as dementia. In our community hospitals we look after our at-risk patients in rooms with good visibility and often provide one-to-one care if it is warranted. In October 2015, a falls and fragility fracture task and finish group was created to develop and agree a formal framework and strategy.

Action taken during 2015/16
- We worked closely with other stakeholders and the CCGs to share resources, prevent duplication and ensure timely assessments and appropriate referral processes so the patient receives a seamless quality of service
- The East of England Ambulance Service NHS Trust sends falls notifications of patients not taken to hospital to the care co-ordination centre. These notifications are forwarded to the local area teams who triage them to the appropriate clinicians to provide assessment and rehabilitation interventions
- We do our utmost to prevent falls in our community hospitals and this includes the use of sensor mats that alert staff if a patient moves. We have upgraded our assistive technology system so that staff are now alerted through the nurse call system showing the number of

the room. The system also has the facility to record how long the person has been waiting before someone attends to them.

Action to be implemented in 2016/17

- Focus on clinical assessments and staff training
- Develop and deliver a falls training programme for all community and care home staff, to include falls champions in each area
- Review policy, procedures and protocols to ensure NICE compliance
- Develop a service model for falls
- Increase interface geriatrician sessions in Felixstowe, Ipswich, Aldeburgh, Stowmarket and Eye by improving communication with clinical staff so that more patients are referred to them.

(b) Provide an improved dementia care service for patients and carers affected by complex physical healthcare conditions and cognitive impairment

Description of the issue and rationale for selection

We aspire to act on the patient/carer voice. Families and carers want to feel more knowledgeable, supported and empowered to easily access care, support and advice via a consistent contact point. Community services piloted models of service delivery which echo the requirements of those living with dementia and long-term physical healthcare challenges.

Current status

During the past nine months a dementia link practitioner role has been developed to enable provision of enhanced services for patients who have dementia and long-term complex physical healthcare needs. Two members of staff were seconded into the named worker role to provide services to patients and carers in order to improve memory, orientation and day-to-day living activities.

One practitioner developed a pilot service in east Suffolk and the other in west Suffolk. Over 270 patients and carers received a service ensuring they had a named dementia link practitioner.

The range of services offered include:

- Distribution of fluid intake charts to prompt people to drink
- Education about nutrition
- Prompt cards to aid people to remain independent
- Loan of assistive technology equipment
- Engaging patients with a wide range of home healthcare services
- Listening and providing information about dementia.

Feedback has been obtained from 10% of those receiving the service, GPs and other dementia care specialist services. The feedback has been very positive and encouraging.

The dementia link practitioners also provided a support service to community services dementia care champions in our inpatient units and community health teams.

One practitioner is continuing to provide an enhanced service for people with dementia in six community health teams in east Suffolk. The other practitioner has returned to the Bury St Edmunds (rural) community team and is piloting a project to enable us to assess whether an enhanced dementia care service can be offered to all patients with dementia and long-term physical conditions via each community health team.

(c) Review the information we give to patients and their families and improve the material we offer them to enhance recovery and reduce anxiety

Description of the issue and rationale for selection
Patient experience is a key element of quality alongside providing clinical excellence and safer care. How we deliver care has an impact on the experience our patients have. This is from the way we answer phone calls, to how we explain assessments that may be necessary and how we agree plans of care.

Staff recognise the need to provide opportunities for patients to tell us about their experiences.

Patient feedback is very important, as not listening to patients has been identified as a root cause of poor care in NHS services. During 2015/16 we have extended use of the Friends and Family Test (FFT) to all patients across the service and have continued the Patient Voices work we started last year in the community hospitals. Incident reports and complaints are also taken into account.

Research has demonstrated that staff experience impacts directly on patient experience. With this in mind, a staff version of the Friends and Family Test has been developed nationally.

The questions from this survey ask: “as a member of staff working in the service, would you recommend the services provided by Suffolk Community Healthcare to family or friends?” Secondly, “would you recommend working within the service to family and friends?” The feedback patients and their relatives and carers have provided has allowed the senior leadership team and staff to look with ‘fresh eyes’.

This, in many cases, has challenged accepted assumptions and perceptions. Improvements to services have directly resulted from ‘hearing’ these voices.

Current status
Results from the FFT are now displayed on a national website and responses to the question “would you recommend SCH services to family and friends” falling into the ‘very likely’ or ‘likely’ categories are given as a percentage of total responses. The latest results displayed on the national database for SCH are:

- Community hospitals 98%
- Community nursing 100%
- Rehabilitation and therapy Services 100%
- Specialist services 100%
- Community healthcare other 97%

Average scores for the NHS in England are around 77%. In order to gain greater depth and quality 36 Patient Voices video interviews have been carried out with patients, their relatives and carers, and with the staff providing their care.

3.6 Other quality indicators

A range of nationally mandated quality indicators is reported in annex B.

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 West Suffolk CCG. Performance against agreed indicators is monitored by the board on a regular basis.

National targets

	2015/16 Target	2015/16 Actual	2014/15 Actual	2013/14 Actual	2012/13 Actual
C. *difficile* - hospital attributable (trajectory cases)	16	**22 (10) ***	23 (21) *	23 (22) *	33 (33)
18-week maximum wait from point of referral to treatment (patients on an incomplete pathway)	92%	**96.25%**	96.97%	99.74%	99.96%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	95%	**94.26%**	93.54%	95.31%	91.84%
62-day urgent GP referral to treatment wait for first treatment - all cancers	85%	**88.05%**	88.01%	90.35%	88.00%
62-day wait for first treatment from NHS cancer screening service referral	90%	**95.68%**	95.10%	98.13%	99.56%
31-day wait for second or subsequent treatment - surgery	94%	**100%**	100%	100%	100%
31-day wait for second or subsequent treatment - anti-cancer drug treatments	98%	**99.87%**	100%	100%	100%
31-day diagnosis to treatment wait for first treatment - all cancers	96%	**100%**	100%	99.92%	100%
Two-week wait from referral to date first seen comprising all urgent referrals (cancer suspected)	93%	**98.46%**	98.52%	97.24%	94.43%
Two-week wait from referral to date first seen comprising all urgent referrals for symptomatic breast patients (cancer not initially suspected)	93%	**98.28%**	97.19%	98.19%	95.81%

* figures in brackets exclude cases that West Suffolk CCG deemed to be non-trajectory (no identified lapses in care): one case in 2013/14; two cases 2014/15; and 12 cases 2015/16

As can be seen from the targets and indicators performance, we have continued recent good performance. We have continued to deliver strong performance against the 18-week incomplete pathways and cancer targets and met all national targets in 2015/16 with the exception of:

- **Maximum waiting time of four hours in ED from arrival to admission, transfer or discharge**

  After a challenging start to the year in April 2015 we recovered performance to achieve the target in Q1, Q2 and Q3.

  During Q2, improvement in patient flow allowed a ward to be closed enabling a ‘deep clean’ programme to be developed to all wards. Such a programme has not been achieved for the last five years.

We experienced challenges during December which continued through January materially impacting on performance (93.5%). Performance further deteriorated through February (91.3%) and March (89.4%). Key challenges impacting the drop in performance included our ability to effectively respond to:

- High levels of attendances and increased admission
- Out-of-hospital delays impacting on discharge, particularly for patients requiring social care packages in the home and continuing healthcare (CHC) patients.

The out-of-hospital delays peaked in late March when the official delayed transfers of care (DTOCs) were running at three times the level experienced in the same period last year.

It is also material that community beds experienced a sharp rise in DTOCs.

We continue to work within the Trust and with partners to identify alternative methods of meeting patients out-of-hospital needs, particularly with social care colleagues. This approach also ensures learning and improvement in these areas.

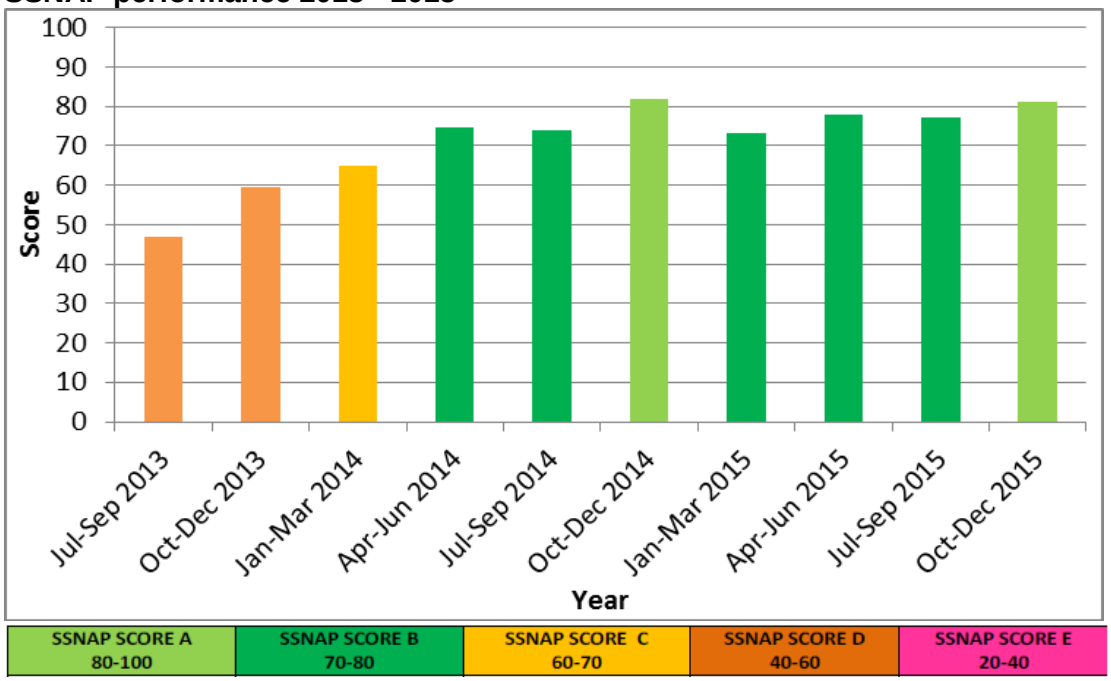
Stroke targets

Contractual during 2015/16 WSFT continued to be monitored against locally-agreed stroke targets. Performance against these is detailed below:

	2015/16 Target	2015/16 Actual	2014/15 Actual	2013/14 Actual	2012/13 Actual
65% 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%	**66.67%**	72.50%	71.08%	63.83%
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%	**88.00%**	97.25%	96.17%	84.42%
80% of stroke patients spending at least 90% of their stay on a stroke unit	80%	**89.83%**	89.50%	90.25%	81.50%
>60% people who have a TIA and are high risk (ABCD 2 score 4 or more) are scanned and treated within 24 hours of 1st contact but not admitted	60%	**65.92%**	81.42%	75.92%	66.75%
Stroke - proportion of patients admitted to an acute stroke unit within 4 hours of hospital arrival	90%	**83.67%**	85.92%	89%	75.16%
Proportion of patients in atrial fibrillation, presenting with stroke and where clinically indicated will receive anti-coagulation	60%	**97.25%**	79.08%	67.67%	73.67%
Stroke - % of stroke patients with access to brain scan within 24 hours	100%	**98.89%**	99.50%	98.33%	95.92%
Stroke - proportion of stroke patients and carers with a joint health and social care plan on discharge	85%	**97.33%**	96.50%	91.92%	75.25%
% of patients eligible for thrombolysis, thrombolysed within 4.5 hours	100%	**100%**	99.83%	100%	100%

The focus national and within WSFT has been on performance against the national sentinel stroke national audit programme (SSNAP). WSFT has seen consistent improvement its SSNAP performance. In the latest audit WSFT achieved a top-rated 'A' score and was in the top 10% nationally for stroke teams routinely admitting patients.

SSNAP performance 2013 - 2015



Source: SSNAP

Effectiveness measures

The Trust has continued to perform well against effectiveness measures.

	2015/16	2014/15	2013/14	2012/13	2011/12	National Average
Hospital Standardised Mortality Rate (HSMR)	* 77.54	98.42	88.67	83.23	86.8	100
Death in low-risk diagnosis groups	**67.5**	136.99	92.73	48.32	100.41	100
Length of stay - relative risk	* 87.35	92.37	94.27	99.12	88.9	100
Readmissions - relative risk	**101.98**	103.55	97.96	96.34	98.5	100

* statistically 'lower than expected', other measures are statistically 'as expected'

Source: Dr Foster Intelligence

Lord Carter's review of provider productivity identified WSFT as the most efficient acute provider of its size and the fourth most efficient in the country.

Incident reporting and learning

WSFT has continued to build and strengthen the arrangements for managing serious incidents requiring investigation (SIRIs). 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 during 2015/16 was 43 (52 in 2014/15). These can be broken down into incidents which cross a number of themes including:

- Slips/trips/falls (12)
- Intrauterine / neonatal death (7)
- Infection prevention (5)
- Delay in treatment (4)
- Failure to monitor / escalate (4)
- Unexpected death (3)
- Unrecognised or unexpected complication (2)
- Wrong site surgery [never event] (2)
- Inappropriate treatment (1)
- Retained foreign object post-procedure [never event] (1)
- Confidential information breach (1)
- Failure to act upon test results (1).

The Trust proactively encourages staff at all levels to engage with the investigation of SIRIs and significant learning continues to take place. Many of the issues identified within each of the SIRI investigations are fed back to specialist working groups where there is ongoing emphasis on, for example:

- Documentation in patient records
- Escalation of the deteriorating patient
- Completion of escalation, plan and resuscitation status (EPARS) forms.

During 2015/16 three never events were reported and subject to detailed investigation.

The first never event occurred in April 2015 where a peripherally inserted central catheter (PICC) line was incorrectly inserted into a patient's artery and used for the administration of chemotherapy.

This met the criteria of a 'surgical - wrong site' never event. The patient did not suffer long-term harm as a result of the incident. Learning from the investigation included:

- Local guidance for PICC line insertion has been introduced
- Ongoing peer review and skills update for PICC line insertion have been implemented
- Change in practice: ultrasound guided PICC insertion should be standard practice unless exception can be clinically justified and is documented
- Development of PICC line information card for patients.

The second never event occurred in June 2015 when a patient was being treated with intravitreal injections in their eye and was undergoing a course of treatment. This met the criteria of a 'wrong site surgery' never event. The patient did not suffer any harm. Learning from the investigation included:

- Development of documented local guidelines and pathway for the referral for intraocular injection
- Intraocular injection prescription form has been reviewed and updated
- Introduction of consent audit for intravitreal injections.

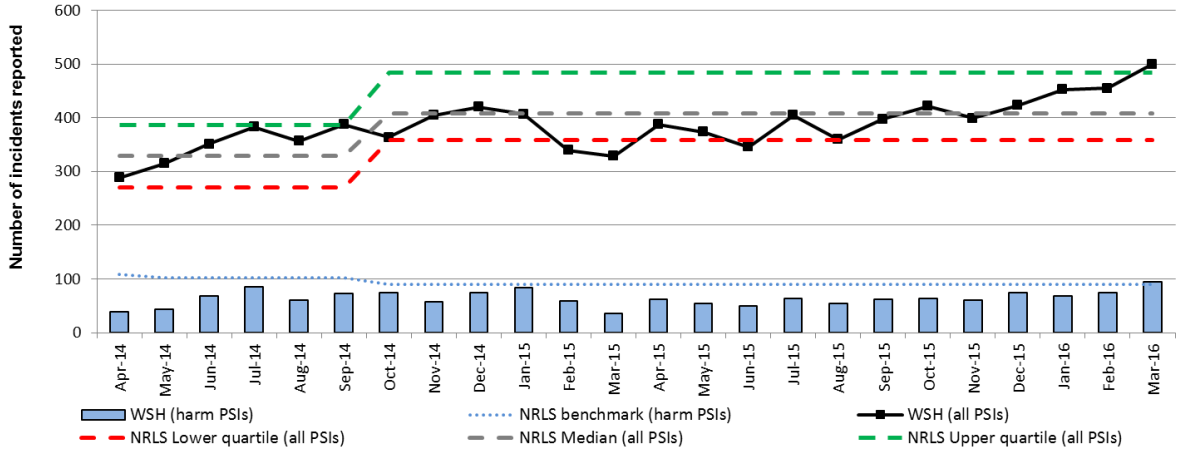
The third never event occurred in December 2015 when a swab was not appropriately removed following surgery. This met the criteria of a 'Retained foreign object post-procedure' never event. Learning from the investigation included:

- Review availability of laparoscopic theatre equipment and the number of procedures scheduled requiring the same theatre equipment, within the limitations of the electronic theatres system

- Review the 15-minute break in the theatre schedule between theatre lists
- Provide further guidance on compliance requirements for ‘count before you close’.

The Trust’s web-based electronic incident reporting system (Datix) supports multidisciplinary incident reporting which includes a high level of reporting near misses, no harm and minor harm incidents. Reporting of these ‘green’ incidents is seen as a key driver for identification and management of risks to prevent more serious harm incidents.

Patient safety incident (PSI) reporting



Between August 2015 and March 2016 the number of PSIs has increased from the lower quartile to the upper quartile. The board reviews this data on a monthly basis and recognises the increased reporting rate as a positive reflection of an open culture within the organisation which supports learning from incidents.

The Trust is required to upload all PSIs to the national reporting and learning system (NRLS). This is used to benchmark our performance against other NHS providers. Further data is provided in annex B of this report.

Duty of candour (DOC)

The DOC is a direct response to recommendation 181 of the Francis Inquiry report into Mid-Staffordshire NHS Foundation Trust. DOC is required for all safety incidents which have resulted in moderate, severe harm or death and prolonged psychological harm.

In November 2014 DOC was legislated and required NHS organisations to:

a) Have a face-to-face discussion with the patient or relevant person following a safety incident resulting in moderate harm or above
b) Provide written communication following the face-to-face discussion with the patient, to include:
   - An account of the known facts about the incident
   - Details of any enquiries to be undertaken
   - The results of any enquiries into the incident
   - An apology.

The aim of this regulation is to ensure health service bodies are open and transparent when an incident happens.

WSFT’s incident system (Datix) is used to record patient safety incidents and automatically notifies key members of staff when an incident of moderate harm or above is reported. These incidents are reviewed by senior nursing and medical staff to confirm the grading and to ensure DOC is achieved.

The compliance with achieving verbal DOC is monitored through the clinical governance team and reported on a monthly basis to the board. The written element of DOC is monitored through the clinical governance team and captured within the incident record.

'Sign up to safety' priorities for 2016/17

As part of the 'sign up to safety' initiative we identified key areas of improvement relating to patient safety. Within each of these areas we provided 90-day work plans on how the improvements were going to be achieved. A significant part of this work was to capture these improvements through measurement metrics for each clinical element. Although a number of the metrics are collected, a number were identified for collection when the Trust introduced e-Care, an electronic patient records system. As part of the implementation of e-Care, clinical staff have identified what data would be required to support reporting of the sign up to safety measurement metrics. The e-Care project is due to be implemented in May 2016 and will enable the Trust to capture elements of quality data which are currently not available.

In addition to the quality improvement pledges related to specific areas of improvement, the Trust identified additional areas of work relating to patient safety. These form the basis of the sign up for safety priorities for 2016/17.

- **Increase our incident reporting levels**
  - Implement trigger-related reporting in accordance with royal colleges and governing bodies for clinical specialties
- **Learn from all levels of incident reporting**
  - Review all incidents reported on a daily basis
  - Report thematic issues as part of an aggregated report on a monthly basis
  - Implement a structured, concise root cause analysis process for moderate harm incidents
- **Centrally capture patient morbidity and mortality and share learning across all specialties**
  - Implement a central mortality database
  - Develop and implement a structured peer mortality review process
  - Improve identification of preventable deaths
- **Share our learning with our patients and their families**
  - Share investigation outcomes and changes in practice with patients and their families
  - Ensure our incident investigations capture and respond to concerns raised by patients and their families
- **Share our learning through Trust induction, junior doctor teaching, learning events and other relevant forums**
  - Review how patient safety is communicated through our Trust induction and mandatory training
  - Present incident investigations and learning through post-graduate teaching sessions
  - Present incident investigations as part of divisional governance meetings
- **Report patient safety measures to the board and through the organisation**
  - Develop a combined deteriorating patient dashboard, capturing agreed measurement metrics identified within the improvement plan.

Quality walkabouts

WSFT has conducted quality walkabouts in a number of clinical areas and departments with members of the board of directors and governors. These have focused on issues that have been identified as part of the CQC quality assurance process, themes identified within other organisations' CQC reports, learning from incidents and workplace inspections. The visits allow clinical and non-clinical staff to discuss current projects, changes and issues which have been identified and addressed in relation to quality. The feedback from the visits has been positive, with staff feeling that areas of concern have been addressed promptly, areas of innovation promoted and a 'fresh eyes' approach welcomed.

The quality walkabout process has been formalised during the last year with the ward manager, service manager, matron and general manager of all areas receiving a formal feedback and action plans if required. During 2015/16 a number of quality walkabouts have taken place following board meetings to enable the executive and non-executive directors to go into clinical areas and talk to staff and patients about the quality of care and patient experience elements. This has also allowed issues discussed during board meetings to be further explored.

As part of the preparation work for the CQC, the executive team requested that all wards and departments were visited and key issues were addressed as part of every visit. These included:

- Medication security
- Resuscitation trolley checks
- Escalation plan and resuscitation status (EPARS) form completion
- Fluid storage.

In addition to the key areas of review the quality walkabouts identified other consistent themes that needed to be addressed:

- Storage of equipment and ward stock
- Maintenance of ward areas
- Quality and date compliance of patient information leaflets
- Staff compliance with Trust policies.

An essential element of the quality walkabouts is to ensure that there is a response in relation to the issues raised by the ward or divisional team but also support to empower the areas to escalate the concerns.

Issues addressed and improvements from the quality walkabouts include:

- Improved medication security and appropriate risk assessments completed
- Improved compliance with resuscitation equipment checks
- Improved storage of intravenous fluids
- Review of storage in clinical areas and removal/archiving of documentation
- Updated patient information
- Updated/relevant posters and information in clinical areas
- Removal of broken /unused equipment
- Improved response to maintenance issues in patient-facing areas
- Changes to non-invasive ventilation (NIV) bay F10 to improve privacy and dignity for patients
- Increased staff compliance with bare below elbow and uniform policy.

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 (PHSO).

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 and carer experience group.

WSFT received 236 formal complaints during 2015/16. This represents a decrease in numbers compared to 2014/15 when 321 complaints were received. The board monitors complaints and learning on a monthly basis as part of the quality reporting arrangements.

At the time of reporting, 88% of complaints received during 2015/16 were resolved with the first response. There were five meetings arranged between staff and complainants during 2015/16 to assist with resolving concerns, either prior to any written response or following an initial written response.

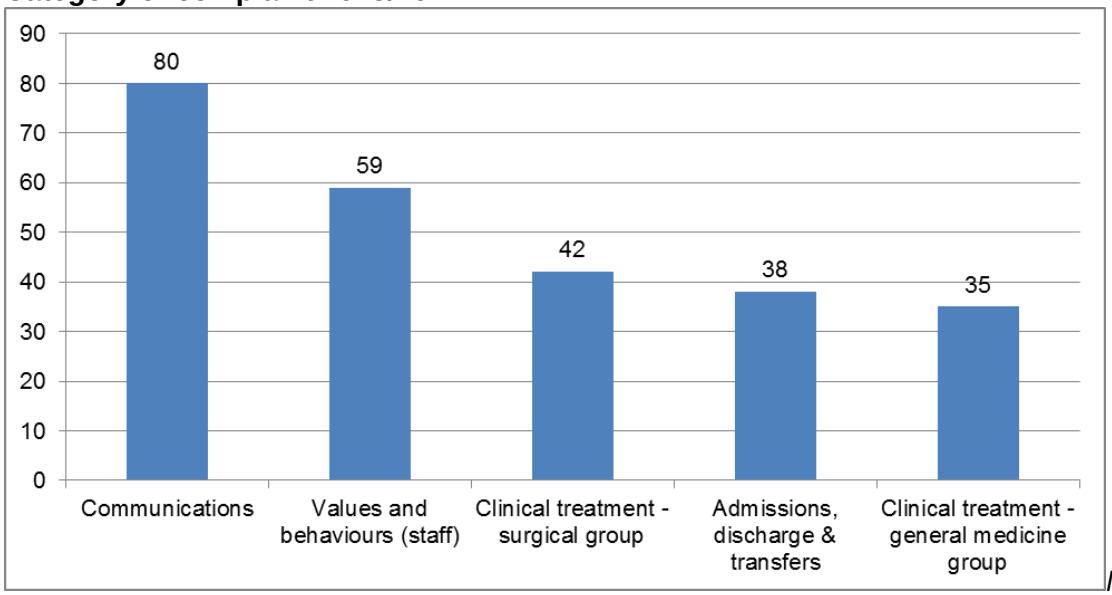
Complainants who are dissatisfied with the Trust's response can refer their concerns directly to the PHSO for an independent review. During 2015/16 six complaints were referred to the PHSO, compared to five during 2015/16.

In 2015/16 the PHSO completed its review of three complaints:

- One complaint was partly upheld - the Trust produced a comprehensive action plan, paid financial redress, wrote to the complainant with an apology and informed Monitor and the CQC of the PHSO findings
- Two complaints were partly upheld and as a result the Trust wrote to the complainant to apologise and paid financial redress.

The main themes and trends from complaints are described below:

Category of complaint 2015/16



Note: the numbers identified in the chart above 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 PHSO. Learning from complaints has supported WSFT's quality priorities and other service improvements including:

- New process for referring women for IVF treatment whereby 'essential criteria' will be stamped on referrals, minimising the chance of inappropriate referrals and undue distress
- Paediatric pathway has been developed for babies less than 3 months old attending the ED to ensure more appropriate, timely paediatric assessments take place
- Additional signage displayed in car park A to alert patients and visitors to the risks of the entry/exit barrier

- Outpatient department Induction document has been revised to ensure patients are always called for their appointment, even if they are listed as 'did not attend' to minimise miscommunication.

There were a number of complaints that were also investigated through RCA/SIRI methodology and the actions identified through these investigations are being progressed and reported via this route.

During 2015/16 a review of the complaints process was conducted based on the PHSO and Healthwatch publication 'My Expectations' published in November 2014. This resulted in actions to make our process more patient-centred. These included the development of a questionnaire to complainants to establish their satisfaction of the complaints process.

Managing compliments

A total of 579 compliments have been formally received by WSFT. This figure does not include letters/cards complimenting staff that are received on the wards and not shared with the complaints office.

There were many general letters of thanks for the care received, support given, empathy, professionalism and dedication. Themes also included excellent staff attitude and skills and excellent communication skills.

A quote from one such letter from a patient:

"…we were treated with professionalism, care, kindness, friendliness and support, second to none by all the team and everyone he came into contact with. We are extremely grateful and feel extremely fortunate to have such an outstanding hospital as the West Suffolk…"

National patient survey results
Feedback from national as well as local surveys is used to monitor service performance and focus quality improvement.

National inpatient survey
The national survey results for 2015 have not yet been published. The Trust scored 8.2 out of 10 in the 2014 inpatient survey which is equal to the previous year's score. The majority of questions scored the same as last year with one question's score being significantly improved. This question was "Was your admission date changed by the hospital?"

Areas of improvement have been identified and these are to reduce noise at night, same sex bathroom/ shower use and to ensure patients are able to give their views on the quality of their care.

National maternity survey 2015
During the summer of 2015, a questionnaire was sent to all women who gave birth in February 2015 with 158 responses received:

	Patient response	Compared with other trusts
Labour and birth	8.8 out of 10	About the same
Staff during labour and birth	8.5 out of 10	About the same
Care in hospital after the birth	7.8 out of 10	About the same

National children and young people survey 2015
The results of the survey are based on the experiences of nearly 19,000 children and young people who received inpatient or day case care during July, August and September 2014.

	Question responses compared with other trusts		
	Worse	About the same	Better
Going to hospital	0	2	0
The hospital	0	7	2
Hospital staff	0	8	0
Speaking with patients and providing information	0	12	0
Facilities for parents and carers	0	2	0
Pain	0	1	0
Operations and procedures	0	3	0
Being prepared to leave hospital	0	6	0
Overall experience	0	2	0

National staff survey 2015

The 2015 staff survey report has 32 key findings. Overall the Trust has achieved the following:

Best 20% for	7 key findings
Better than average for	13 key findings
Average for	5 key findings
Worse than average for	4 key findings
Worst 20% for	3 key findings

The 2015 NHS staff survey places WSH in the top 20% of trusts nationally in 7 key areas, including:

- **KF1** - staff recommendation of the organisation as a place to work or receive treatment
- **KF3** - percentage of staff agreeing that their role makes a difference to patients and service users
- **KF14** - staff satisfaction with resourcing and support
- **KF19** - organisation and management interest in, and action on, health and wellbeing
- **KF8** - staff satisfaction with level of responsibility and involvement
- **KF2** - staff satisfaction with the quality of work and patient care they are able to deliver
- **KF5** - recognition and value of staff by managers and the organisation.

The 2015 NHS staff survey places WSH in the bottom 20% of trusts nationally in 3 key areas:

- **KF22**. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
- **KF27**. Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse
- **KF11**. Percentage of staff appraised in last 12 months

The national NHS staff survey provides a very useful source of data on a number of issues, especially staff engagement, staff views on quality of care, willingness to raise concerns and to recommend the services of the organisation (the friends and family test). This together with other data will enable us to identify key workforce and service issues and develop a strategy for dealing with the priorities. A full action plan will be developed to identify actions as a result of the survey, including the following key factors:

	Trust score 2014	Trust score 2015	
KF26 % staff experiencing harassment, bullying or abuse from staff in last 12 months	22%	**23% Below (better than) average**	+1%
KF2. % believing the organisation provides equal opportunities for career progression / promotion	88%	**90% Above (better than) average**	+2%

The figure below shows how WSFT compares with other acute trusts on an overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged. The Trust's score of 3.90 was in the highest (best) 20% when compared with trusts of a similar type.

	Trust score 2014	Trust score 2015	National average 2015
Overall staff engagement	3.90	**3.93 #**	3.79

Highest (Best) 20% - possible scores range from 1 to 5

Further detail of the staff survey, including action being taken, is provided in the staff report of the Trust's annual report 2015/16 (page 68).

3.7 Development of the quality report

WSFT has continued its commitment to listening to the views of our service users and foundation trust members in developing the priorities set out in the quality report and its format and content.

During 2014/15 we have built on our understanding of the views of FT members' and users' quality priorities through FT membership engagement events and questionnaires. The results of this feedback are reflected in the format and content of this quality report.

In preparing the quality report we also sought the views of:

- West Suffolk CCG
- Suffolk Health Scrutiny Committee
- Healthwatch Suffolk
- Our governors.

Commentary from these parties is detailed in annex C. As a result of the feedback received, changes were made to simplify the language used in the document and provide appropriate explanation of abbreviations or phrases.

Annex A: Participation in clinical audit

This annex provides detailed information to support the clinical audit section of the quality report.

Table A: National clinical audits

Category	Name of national clinical audit	Eligible	Participated	No. of cases submitted	%
Acute	Case mix programme (CMP): intensive care national audit & research centre (ICNARC)	Yes	Yes	583	100
	Emergency use of oxygen	Yes	Yes	30	100
	Major trauma: the trauma audit & research network (TARN)	Yes	Yes	304	98[1]
	National complicated diverticulitis audit (CAD)	No	No	-	-
	National emergency laparotomy audit (NELA)	Yes	Yes	161	96
	National joint registry (NJR)	Yes	Yes	1034	100
	Procedural sedation in adults (care in emergency departments)	Yes	Yes	38	100
	Vital signs in children (care in emergency departments)	Yes	Yes	107	100
	VTE risk in lower limb immobilisation (care in emergency departments)	Yes	Yes	21	100
Blood & transplant	Patient blood management (PBM) in Scheduled Surgery	Yes	Yes	27	100
	Use of blood in haematology	Yes	Yes	22	100
	Use of blood in lower gi bleeding	Yes	Yes	20	100
Cancer	National audit of oesophago-gastric cancer (NAOGC)	Yes	Yes	33	100
	National bowel cancer audit project (NBOCAP)	Yes	Yes	145	100
	National lung cancer audit (NLCA)	Yes	Yes	146	100
	National prostate cancer audit (NPCA)	Yes	Yes	237	100
Heart	Acute coronary syndrome or acute myocardial infarction (MINAP)	Yes	Yes	268*	100
	Cardiac rhythm management (CRM)	No	No	-	-
	Congenital heart disease (paediatric cardiac surgery)	No	No	-	-
	Coronary angioplasty/national audit of PCI	No	No	-	-
	National adult cardiac surgery audit	No	No	-	-
	National cardiac arrest audit (NCAA)	Yes	Yes	61*	98
	National heart failure audit	Yes	Yes	225*	100
	National vascular registry	Yes	Yes	0	100
	Pulmonary hypertension audit	No	No	-	-
Long term conditions	Chronic kidney disease in primary care	No	No	-	-
	Inflammatory bowel disease (IBD) programme	Yes	Yes	44	100
	National diabetes audit (NDA)	Yes	Yes	1376	100
	National diabetes foot care audit (NDFA)	Yes	Yes	56	100
	National diabetes inpatient audit (NaDIA)	Yes	Yes	77	100
	National paediatric diabetes audit (NPDA)	Yes	Yes	169	100
	National pregnancy in diabetes audit (NPID)	Yes	Yes	10	100
	Renal replacement therapy (renal registry)	No	No	-	-
	Rheumatoid and early inflammatory arthritis	Yes	Yes	32	100
Mental health	Prescribing for ADHD in children, adults and adolescents (POMH)	No	No	-	-
	Prescribing for bipolar disorder (use of sodium valproate) (POMH)	No	No	-	-
	Prescribing for substance misuse: alcohol detoxification (POMH)	No	No	-	-
Older	Fracture liaison service audit (FLS-DB)	Yes	Yes	0[2]	-

Category	Name of national clinical audit	Eligible	Participated	No. of cases submitted	%
people	National audit of inpatient falls (NAIF)	Yes	Yes	30	100
	National hip fracture database (NHFD)	Yes	Yes	308	100
	Sentinel stroke national audit programme (SSNAP) clinical audit	Yes	Yes	319*	100
	UK Parkinson's audit	No	No	-	-
Other	Elective surgery (national PROMs programme)	Yes	Yes	541[3]	71
	National audit of intermediate care	No	No	-	-
	National ophthalmology audit	Yes	Yes	0[4]	-
	UK cystic fibrosis registry	No	No	-	-
Women & children's health	Neonatal intensive and special care (NNAP)	Yes	Yes	395	100
	Paediatric asthma	Yes	Yes	33	100
	Paediatric intensive care audit network (PICANet)	No	No	-	-

[1] The number of injured patients submitted to the trauma audit & research network database is compared to the number of patients identified in the HES (hospital episode statistics) dataset, therefore percentage of cases submitted is subject to change.

[2] The fracture liaison service audit requires a partnership of acute and community services. A system to record data between the services is currently being developed.

[3] PROMS data from October 2015 – March 2016 is awaiting publication from the health & social care information centre, therefore figures are subject to change.

[4] The national ophthalmology audit requires the use of Medisoft software, which is incompatible with our current software. A solution is currently being investigated.

* The data collection period for 2015/2016 is still open; therefore figures reported are subject to change.

Table B: Clinical outcome review programmes participation

Category	Name of clinical outcome review programme	Eligible	Participated	No. of cases submitted	%
Acute	Acute pancreatitis (medical and surgical clinical outcome review programme)	Yes	Yes	3	100
	Mental health in general hospitals (medical and surgical clinical outcome review programme)	Yes	Yes	5	100
	Non invasive ventilation (medical and surgical clinical outcome review programme)	Yes	Yes	0	100
Mental health	National confidential inquiry into suicide and homicide for people with mental illness (NCISH)	No	No	-	-
Women & children's health	Chronic neurodisability (child health clinical outcome review programme)	Yes	Yes	0	100
	Young people's mental health (child health clinical outcome review programme)	Yes	Yes	0	100
	Maternal mortality and morbidity confidential enquiries (maternal, newborn and infant clinical outcome review programme (MBRRACE-UK))	Yes	Yes	0	100
	Maternal mortality surveillance (maternal, newborn and infant clinical outcome review programme (MBRRACE-UK))	Yes	Yes	1	100
	Perinatal mortality and morbidity confidential enquiries (maternal, newborn and infant clinical outcome review programme (MBRRACE-UK))	Yes	Yes	0	100
	Perinatal mortality surveillance (maternal, newborn and infant clinical outcome review programme (MBRRACE-UK))	Yes	Yes	4	100

For audits with 0 cases submitted this will indicate that WSFT is participating but has not at the time of reporting been asked to submit any specific cases

Table C: Action from national audit reports

Title	Summary of actions taken
Assessing for cognitive impairment in older people in the emergency department	The Royal College of Emergency Medicine report shows that WSFT meets the national recommendation for using and documenting a structured tool for cognitive impairment (CI) assessment. Areas that meet or exceed national performance but require improvement are: • All patients over the age of 75 have at least one early warning score assessment • All patients over the age of 75 are assessed for CI in the emergency department • The findings of CI assessment are provided to the relevant admitting services for admitted patients • The findings of CI assessment are provided to the patient's GP if new onset or in the event of any deterioration • Information regarding CI is provided to the patient's carers at the time of admission to hospital or discharge back to their usual place of residence unless this information was available from these sources. Actions taken include: • Encourage staff to document early warning score assessment • Incorporate documentation of cognitive impairment into staff induction training and provide staff with a reminder list • Discuss feasibility of incorporating mini mental state test onto e-Care.
Biological therapies UK inflammatory bowel disease (IBD) audit	The inflammatory bowel disease biological therapies report shows: • Crohn's disease patients – time from diagnosis to initial treatment is 4 years, which is the same as the national average • At initial treatment patients, on average, score 14 on the Harvey Bradshaw Index, indicating moderate disease. National results show patients on average also have moderate disease but score on the lower end of the rating • 29% (2/7) patients achieve remission, compared to 68% of patients nationally • 27% (4/15) of patients are on concomitant immunosuppression at start of treatment compared to 53% of patients nationally • 10% (1/10) OF patients have an adverse event recorded at 3 month follow-up compared to 8% of patients nationally • 0% of patients have PROMS completed at start of treatment compared to 30% nationally, however this is not a compulsory element of the audit. All recommendations have been met.
Gastrointestinal haemorrhage – time to get control?	The aim of the NCEPOD gastrointestinal (GI) study is to identify the remediable factors in the quality of care provided to patients treated for a GI bleed who received 4 or more units of blood. Hospitals are required to submit details of a maximum of 5 cases, which are then peer reviewed for inclusion in the report. 24 relevant recommendations were made, all of which have been met.

Title	Summary of actions taken
Initial management of the fitting child in the emergency department	The Royal College of Emergency Medicine report shows that WSFT meets national recommendations for: • Managing all children who are fitting on arrival as per APLS or EPLS algorithm • Taking a careful eye witness history to ascertain possible cause and document in the patient's clinical record • Checking blood glucose of actively fitting children and document in the patient's clinical record. The provision of parent information leaflets for all children discharged from the ED needs to be improved, however it does exceed national performance. All recommendations have been met. Ongoing action to improve documentation that advice leaflets have been given to parents or carers through teaching, training and audit.
Maternal deaths and morbidity surveillance 2011-2013	The maternal deaths 2011-13 report identified that: • 9 per 100,000 women died up to six weeks after the end of their pregnancy • 14 per 100,000 women died between six weeks and one year after the end of their pregnancy • 23% of women who died between six weeks and one year after pregnancy died from mental-health related causes. One in seven of the women died by suicide. All recommendations have been met.
Mental health in the emergency department	The Royal College of Emergency Medicine report shows that WSFT meets national recommendations for ensuring that an appropriate facility is available for the assessment of mental health patients in the ED, which meets all standards set by the psychiatric liaison accreditation network (PLAN). Areas that meet or exceed national performance but require improvement are: • Patients who have self-harmed should have a risk assessment in the ED • Previous mental health issues should be documented in the patient's clinical record • A mental state examination (MSE) should be recorded in the patient's clinical record • The provisional diagnosis should be documented in the patient's clinical record • From the time of referral, a member of the mental health team will see the patient within one hour. One standard did not meet national performance, which was documenting the details of referral or follow-up arrangements in the patient's clinical record. Action taken and psychiatric liaison nurses will now record the time of patient assessment on Symphony. This standard will be re-audited in August 2016.

Title	Summary of actions taken

National audit of cardiac rehabilitation (NACR)	The results show that nationally female patients are under-represented in cardiac rehabilitation compared to the number eligible. In WSH 22% of patients were female. The report shows that there is an urgent need for CR programmes to offer services that are more attractive to female patients generally and older post-MI patients specifically.
	
	The results for West Suffolk Hospital also show that:
	• The percentage of first and second assessments exceed the national average (assessment 1 – WSH=89% national average=76%, assessment 2 – WSH=75% national average=53%)
	• The average waiting time for referral to start of cardiac rehabilitation is on target or just breaching wait time
	  ○ 27 days for MI and PCI patients, compared to the recommended 28 days (east of England average is 35 days)
	  ○ 46 days for CABG patients, compared to the recommended 42 days (east of England average is 50 days)
	• The average waiting time for patients from initiating event to pre-cardiac rehabilitation is below target, however it exceeds the national average and is recognised as a national problem
	• The duration of cardiac rehabilitation is above the minimum recommendation of eight weeks, except for MI/PCI which is below eight weeks on average.
	
	All recommendations have been met.

National audit of inpatient falls	The national inpatient falls report highlights that WSFT does not currently provide the following:
	• A policy that includes the requirement that GPs should be informed of inpatient falls/identified falls risks
	• A multifactorial risk assessment and intervention with:
	  ○ A formal assessment of cognition
	  ○ A formal assessment for delirium
	  ○ An assessment of history of blackouts or syncope
	  ○ An evaluation of vision
	  ○ A care plan to support the patient with cognitive impairment
	  ○ A delirium management plan
	  ○ Provision of written information on falls in any non-English language
	• A bed rails audit
	• A non-executive director who has specific roles/responsibilities for leading falls prevention.
	
	10/12 recommendations met. two partially met: All patients aged over 65 years are assessed for visual impairment and have a continence care plan. Action to include these in next policy review.

Title	Summary of actions taken
National audit of oesophago-gastric cancer (NAOGC)	The national oesophago-gastric cancer report shows that WSFT had >90% case ascertainment compared to the number of expected cases. Results show WSFT: • 1% had a missing referral source • 14% were emergency admissions • 50% of stents were recorded in the audit • 92% of stents were recorded in HES Six relevant recommendations were made, five of which have been met. Action taken to submit report of endoscopy stent insertions to national audit of oesophago-gastric cancer.

National Bowel Cancer Audit (NBOCAP)	The National Bowel Cancer Audit report shows that WSFT had 87% case ascertainment compared to the number of expected cases.
	
	Results show WSFT patients:
	• 100% had complete pre-treatment staging, compared to 68% regionally and 84% nationally
	• 100% had a recorded performance status, compared to 49% regionally and 68% nationally
	• 99% data completeness for patients having major surgery, compared to 62% regionally and 80% nationally
	• 99% were seen by a clinical nurse specialist, compared to 90% regionally and 93% nationally
	• 68% underwent major resection. Of the 32% that didn't undergo major resection:
	  ○ 3% had too little cancer
	  ○ 17% had too much cancer/ were too frail
	  ○ 12% did not meet any of the above criteria
	• Of the 68% that underwent major resection:
	  ○ 90-day mortality is 4.4%, compared to 3.5% regionally (within limit)
	  ○ 64% stay in hospital for over 5 days, compared to 71% regionally and 69% nationally
	  ○ 18.7% have an unplanned readmission within 90 days, compared to 18.9% regionally
	  ○ 35% have laparoscopic surgery, compared to 57% regionally and 57% nationally
	  ○ Two-year mortality is 24%, compared to 24.4% regionally
	• 28% of patients that had surgery had a stoma after 18 months, compared to 48% regionally and 50% nationally.
	
	All recommendations have been met.

Title	Summary of actions taken
National cardiac arrest audit (NCAA)	The national cardiac arrest audit report shows the incidence of, and outcome from, in-hospital cardiac arrests for April 2014 to March 2015. Actions taken include: • Complete reviews on patients who sustain cardiac arrest in hospital • Undertake clinical audit of patients over 85 years of age that are for CPR • Create staff training modules for resuscitation and outreach deteriorating patient • Ensure Resuscitation Policy includes information regarding responsibility of completing cardiac arrest recording document • Conduct a re-audit of escalation plan and resuscitation status (EPARS).
National emergency laparotomy audit (NELA)	The national emergency laparotomy audit report shows that WSFT is the best performing hospital in the East of England, with 8 out of 10 criteria being met for over 80% of patients. These included CT reported before surgery, risk documented pre-operatively, arrival in theatre in timescale appropriate to urgency, pre-operative review by consultant surgeon and anaesthetist, consultant surgeon and anaesthetist present in theatres, and direct post-operative admission to critical care. Areas that require improvement are: • Consultant surgeon review <12 hours of emergency admission. WSFT met this criteria for approximately 48% of patients. This is in line with the national median result • Assessment by Medicine for the Care of Older People (MCOP) specialist in patient >70 years. WSFT did not met this criteria any patients. Only 7 out of 178 participating hospitals achieved >50%. Actions taken include: • Consultant surgeons to ensure all patients reviewed within 12 hours of admission on morning and evening ward rounds and that this is clearly documented • Job plan process and ward plan using EPRO, to flag up patients over 70 for review by designated MCOP specialist • Consultant surgeons to undertake documentation of risk of death and complications on patient consent form.

Title	Summary of actions taken
National heart failure audit	The national heart failure audit report shows that WSFT met the participation requirement by submitting more that 70% of the HES-reported heart failure discharges (105% achieved). Results show that: • 91% of heart failure patients received an echo • 39% of heart failure patients had input from a consultant cardiologist • 60% of heart failure patients had input from a specialist. Actions taken include: • Increase referral of patients with heart failure to the heart failure specialist nurses (which has improved from previous audits) by using posters in wards to raise awareness and creation of referral process on EPRO • Discuss issue of incorrect coding of heart failure at coding/management meetings.
National hip fracture database (NHFD)	The national hip fracture database report shows that WSFT is the best performing hospital in the region and one of the best in England. Results show that 90% of patients have their operation within 36 hours of admission compared with the national average of 77.6% and the remaining 10% receive surgery within 40 hours. WSFT also achieved 84.6% on best practice tariff compared to a national average of 63.3%. All recommendations have been met.
National lung cancer audit (NLCA)	The national lung cancer audit report shows that in WSFT: • 100% of patients cases were discussed at MDT • 65% of patients had pathological diagnosis • 18.3% non-small-cell lung cancer, not otherwise specified rate • 90.5% of patients were seen by nurse specialist • 48.9% of patients had anti-cancer treatment • 16.7% of patients with non-small-cell lung cancer, not otherwise specified had surgery • 50% of patients with non-small-cell lung cancer stage IIIB/IV and PS 0-1 had chemotherapy • 82.4% of patients with small-cell lung cancer had chemotherapy.

Title	Summary of actions taken
National neonatal audit programme (NNAP)	The national neonatal audit programme report shows in WSFT: • 100% (n=4) of babies born at less than 29 weeks gestation have their temperature taken within an hour of birth, compared to 94% nationally. 25% of babies had a temperature below 36°C, compared to 12.4% nationally • 60% (n=53) of mothers of babies born between 24 and 34 weeks gestation were recorded as having received antenatal steroids, compared to 85% nationally • 88% (n=25) of eligible babies were recorded as having retinopathy of prematurity (ROP) screening 'on time' in accordance with national guidance, compared to 93% nationally. 96% of eligible babies were recorded as having ROP screening at some point • 66% (n=9) of eligible babies were receiving their mother's milk at the time of their discharge from neonatal care, compared to 60% nationally • 96% (n=242) of parents had a consultation with a senior member of the neonatal team within 24 hours of admission, compared to 89% nationally • In the eastern neonatal network 8% (n=6056) of eligible babies were transferred to a different neonatal unit, compared to 10% nationally. Of these transfers: o 84% were within the eastern neonatal network, compared to 83% nationally o 16% were made outside the eastern neonatal network, compared to 17% nationally • 69% (n=340) of eligible babies had a blood culture performed, 77% of which had recorded results and clinical signs • 14% (n=340) of eligible babies had a cerebrospinal fluid (CSF) culture performed, 92% of which had recorded pathogens • 88% (n=16) of eligible babies had a neurodevelopmental 2 year follow up recorded, compared to 54% nationally. 12 relevant recommendations were made. 4 have been met, 7 partially met and 1 not met. Actions to review clinical care pathway of antenatal steroid administration with obstetricians, improve post-discharge follow-up, ensure data is entered onto Badger, and discuss support provision for individuals responsible for managing NNAP data.
National pregnancy in diabetes (NPID)	The results show that nationally women generally enter pregnancy poorly prepared. In the east of England, of the pregnant women with diabetes: • 54.3% had Type 1 diabetes, compared to 46.3% nationally • 36.4% had Type 2 diabetes, compared to 42.2% nationally • 9.3% were categorised as 'other', compared to 11.5% nationally. All recommendations have been met.

Title	Summary of actions taken
National prostate cancer audit (NPCA)	The national prostate cancer audit report shows that WSFT has 13% case ascertainment compared to the number of expected cases. Of the included cases: • 36% had performance status completed • 0% had ASA completed • 90% had PSA completed • 81% had Gleason score completed • 10% had TNM completed • 71% had more than one planned treatment recorded. Actions taken include: • Develop a template to record presenting symptoms, PS and ASA score at the first TRUSS clinic • Record and collect >1 TNM stage information on eligible patients with prostate cancer • Share recorded data with MDT clinicians for review of completeness and quality • Cross-map patient pathway events with relevant NPCA data points by urology pathway project manager.
Patient blood management in adults undergoing elective, scheduled surgery	The NHS blood & transfusion patient blood management report shows: • 82% (n=14) of patients had pre-operative anaemia management, compared to 46% nationally • 100% (n=1) of patients received one unit of blood pre-operatively, compared to 28% nationally • 75% (n=4) of patients had a record of anticoagulant or antiplatelet medication (excluding aspirin) prior to surgery, compared to 63% nationally • 67% (n=4) of patients had an intra-operative transfusion where at least one PBM measure has been attempted, compared to 83% nationally • 33% (n=2) of patients had an intra-operative transfusion where all PBM measures had been attempted, compared to 16% nationally • 14% (n=3) of patients' post-operative transfusions were considered appropriate, compared to 24% nationally • 61% (n=11) of patients received one unit of blood pre-operatively, compared to 38% nationally • 92% (n=12) of patients had a post-operative transfusion where at least one PBM measure had been attempted, compared to 85% nationally • 15% (n=2) of patients had a post-operative transfusion where all PBM measures were attempted, compared to 8% nationally. Actions to: • Conduct annual transfusion audit. • Provide Pre-Assessment Unit with patient information leaflets about anaemia and blood transfusion. • Review and develop red cell guidelines. • Review Pre-Assessment Unit process for pre-operative assessment to include checklist to highlight concerns of anticipated blood loss.

Title	Summary of actions taken
Perinatal confidential enquiry	The aims of the perinatal confidential enquiry report were to assess: • Adherence to clinical guidelines (RCOG green-top / NICE) • The standard of obstetric and midwifery care throughout the care pathway • The role of the bereavement midwife and the community midwife • The role of post-mortem and placental histology review, including the role of the perinatal pathologist • Access to and impact of psychosocial counselling/care. Actions taken include: • Review provision of staff knowledge and training in specialist bereavement care with the development of the bereavement suite • Ensure use of partogram to monitor the progress of the labour of women with an intrauterine death is included in updated clinical guideline.
Perinatal mortality surveillance report for births from January to December 2013	The perinatal mortality surveillance report identified that WSFT's stabilised and adjusted stillbirth, neonatal or extended perinatal mortality rate falls within the amber band (up to 10% higher than the average for the comparator group). Action taken to remind staff to discuss options for post-mortem examination with parents.
Sepsis – just say sepsis	The aim of the NCEPOD sepsis study is to identify and explore remediable factors in the process of care for patients with sepsis. Hospitals are required to submit details of a maximum of five cases, which are then peer reviewed for inclusion in the report. 21 relevant recommendations were made, all of which have been met.

Local audit report summary actions are detailed on the WSFT website:
http://www.wsh.nhs.uk/Governance/ClinicalAudit.aspx

Annex B: Nationally mandated quality indicators

This section sets out the data made available to WSFT by the Health and Social Care Information Centre (HSCIC) for a range of nationally mandated quality indicators.

(a) Preventing people dying and enhancing quality of life for people with long-term conditions

Summary hospital-level mortality indicator (SHMI)

	Jul 12 – Jun 13	Jul 13 – Jun 14	Jul 14 – Jun 15
WSFT (confidence intervals)	89.76 (84.9 to 94.83)	90.78 (111.98 to 89.3)	93.49 (98.41 to 88.75)
National average	100	100	100
Highest NHS trust	115.63	119.82	120.89
Lowest NHS trust	62.59	54.07	66.05

Source: Dr Foster

WSFT considers that this data is as described as the SHMI rates are reported to the Trust board monthly along with an analysis of other mortality information. These indicate that WSFT is performing well in regard to maintaining mortality below the expected level.

Patient deaths with palliative care coded at either diagnosis or specialty level

	Jul 12 – Jun 13	Jul 13 – Jun 14	Jul 14 – Jun 15
WSFT	19.53%	26.34%	19.71%
National average	20.65%	24.79%	26.31%

Source: Dr Foster

WSFT considers that this data is as described and shows WSFT's rate is slightly below the national average. WSFT intends to take, and has taken, a range of actions to monitor and improve performance in this area as part of our mortality reviews, and so the quality of our services. These are described in section 5 of this report.

(b) Patient reported outcome measures scores (PROMS)

	2012/13	2013/14	2014/15	2015/16 (Apr-Sep)
Groin hernia surgery				
WSFT (EQ-5D Index)	0.093	0.104	0.111	0.137
National average (EQ-5D Index)	0.085	0.085	0.084	0.088
Varicose vein surgery				
WSFT (EQ-5D Index)	0.100	0.052	0.052	0.124
National average (EQ-5D Index)	0.093	0.093	0.095	0.104
Hip replacement surgery (primary)				
WSFT (EQ-5D Index)	0.400	0.445	0.427	0.547
National average (EQ-5D Index)	0.438	0.436	0.437	0.454
Knee replacement surgery (primary)				
WSFT (EQ-5D Index)	0.350	0.301	0.327	0.334
National average (EQ-5D Index)	0.318	0.323	0.315	0.238

Source: HSCIC

WSFT considers that this data is as described as PROMS data is issued quarterly. Results for the first six months of 2015/16 demonstrate WSFT is performing above the median for England for all four indicators. All results are reviewed to ensure that plans are in place to systematically deliver good performance.

(c) Patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust

	2013/14	2014/15	2015/16 (up to Feb)
Aged 0 to 15	12.62%	5.75%	6.88%
Aged 16 or over	14.38%	15.50%	16.68%

Source: WSFT patient administration system (PAS)

WSFT considers that this data is as described. No comparative national data is available for the periods reported.

WSFT will continue to review readmissions and identify themes arising from the information gained. This work will focus on improvements to inpatient pathways across the health system.

(d) Responsiveness to the personal needs of its patients

	2013	2014	2015
WSFT	70.4	68.6	70.2
National average	68.1	68.7	68.9
Highest NHS trust	84.4	84.2	86.1
Lowest NHS trust	59.3	54.4	59.1

Source: HSCIC

WSFT considers that this data is as described as each year WSFT participates in a national inpatient survey. WSFT receives a benchmark report that compares the results with those of other trusts. The 'responsiveness to personal needs' score is an average weighted score of 5 questions within the survey relating to responsiveness to inpatients' personal needs (score out of 100). Review of this data shows that WSFT is performing better than the national average and has either equalled (in 2014) or performed better than (in 2013) the national average over the last three years.

(e) Staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their friends or family

If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	2014	2015
WSFT (agree + strongly agree)	78	84
England: acute trusts (agree + strongly agree)	66	70

Source: Picker Institute

WSFT considers that this data is as described as the data is analysed independently. Each year WSFT participates in a national staff survey. WSFT receives a benchmark report that compares the results with those of other trusts. When given the statement "if a friend or relative needed treatment I would be happy with the standard of care provided by this organisation" the percentage of staff employed by, or under contract to the Trust during the reporting period who indicated they agreed or strongly agreed scored higher than the England average for acute trusts. Review of this data shows that WSFT is performing better than the national average in 2014 and 2015 and has improved performance locally from last year.

(f) Patients who were admitted to hospital and who were risk assessed for venous thromboembolism

	2013/14	2014/15	2015/16 (Apr to Dec)
WSFT	99.25%	99.63%	99.29%
National average	95.76%	96.09%	95.79%

Source: NHS England

WSFT considers that this data is as described as WSFT measures this data monthly and it is reported in the board quality dashboard and the ward quality dashboards. This measure is reported externally each month as part of a national data set and to the local commissioners.

WSFT has taken a range of actions to improve this score, and so the quality of its services, and we intend to sustain performance above the national average by maintaining rigorous communication and performance monitoring processes.

(g) Rate per 100,000 bed days of cases of *C.difficile* infection reported within the Trust amongst patients aged 2 or over

	2012/13	2013/14	2014/15	2015/16
WSFT	25.6	17.9	16.7	16.4 *
National average	17.3	14.7	15.1	Not yet Published

Source: Health Protection Agency (HPA).
* Trust PAS and infection prevention data up to March 2015

WSFT considers that this data is as described as the *C. difficile* infection rate is consistent with the data reported to the board on a monthly basis and described in section 5 of the quality report.

(h) Number and, where available, rate of patient safety incidents reported within the Trust, and the number and percentage of such patient safety incidents that resulted in severe harm or death

Patient safety incidents (total)

	WSFT number and rate/1000 bed days	Median (all acute non-specialist trusts) rate/1000 bed days	Comparison to peer group
Apr ’14 – Sept ’14	1,948 (31.9 / 1000 bed days)	32.38 / 1000 bed days	Middle 50% of trusts
Oct ‘14 – Mar ‘15	2,112 (30.46 / 1000 bed days)	35.34 / 1000 bed days	Middle 50% of trusts
Apr ’15 – Sept ’15	2,243*	Not yet published	Not yet published
Oct ‘15 – Mar ‘16	2,635*	Not yet published	Not yet published

Data sources: NRLS and *local incident system

Patient safety incidents resulting in severe harm or death

	WSFT number and % of total reported	Average (all acute non-specialist trusts) % of total reported	Comparison to peer group
Apr ’14 – Sept ’14	14 (0.7%)	0.5%	Above peer group average
Oct ‘14 – Mar ‘15	11 (0.5%)	0.5%	At peer group average
Apr ’15 – Sept ’15	10*	Not yet published	Not yet published
Oct ‘15 – Mar ‘16	16*	Not yet published	Not yet published

Data source: NRLS and *local incident system

WSFT considers that this data is as described as the reporting rates are consistent with the data received by the board on a monthly basis and described in this report within the summary of incident reporting and learning.

WSFT intends to take and has taken a range of actions to improve the rate and percentage for these indicators, and so the quality of its services. These are described in the report within the summary of incident reporting and learning.

Annex C: Comments from third parties

WSFT council of governors

The Council of Governors, with support from the hospital management, is embracing its role to represent both the interests of the Trust as a whole and the interests of the local west Suffolk public.

The Governors are keen to harness the power of our local community and use the Trust's position in the wider Suffolk economy to promote local interests.

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

During 2015/16 we have strengthened our work through:

- **Engagement with members and public:**
  - Regular contact with patients and their supporters
  - Capturing patients' feedback, at monthly Courtyard Cafe feedback surveys, sharing this with hospital management and receiving updates on action taken
  - Encouraging the public to join as members of the Foundation Trust and engaging with our 5,500 public members to take an interest in the hospital
  - Providing support for external public meetings such as Probus and delivering talks at such events
  - Involved in planning for major public awareness event at West Suffolk College to increase awareness of WSFT role in supporting the prevention agenda
  - Supporting regular clinical talks for Foundation Trust members and the public.
- **Review of care and services provided:**
  - Taking part in 'Quality Walkabouts' enables Governors to talk to staff (and patients) about implementation of changes and what actions have or have not been followed up
  - Taking part in hospital inspections to support preparation for CQC review.
- **Working with the board:**
  - Meeting with CQC lead inspectors prior to CQC inspection to discuss how well led we felt the Trust was, and discuss the key operational aspects of how effective WSFT is in delivering safe and high quality patient care
  - Regular attendance at Trust Board meetings, where we are encouraged to ask questions- and report back to all Governors on outcomes of these discussions
  - Attending Board meetings has also educated Governors on key clinical areas such as safeguarding, children services, role of Early Intervention Team and nature of the Community contract
  - Working with the Non-Executive Directors (NEDs) to strengthen quality assurance processes within the Trust
  - Regular attendance at Workshops organised by the Trust enabling a close review of the development of the new Strategic Framework and Integrated Care Organisation plans and to understand the financial constraints of the Operational Plan
  - Completed on schedule the appraisals of all NEDs.
- **Development of knowledge and skills:**
  - Set up of Governors' Skills Audit, analysis and recommendations to Council and Executive to provide agreed training programme
  - Attending training events organised by the Trust to support learning and development
  - Attendance at the Eastern Regional Governors meeting
  - Attendance at the second national NHS Providers 'Development Day for Governors'
  - Informal meetings of Governors, arranged by the Lead Governor, to ensure effective working relationships and preparations for meetings.

Governors and Directors have worked to develop a shared understanding of the challenges facing the Trust, and to develop strategies to address these. Governors have been consulted and contributed to the Trust vision as encapsulated in the key documents - 'Our Strategic Framework of the Future' and 'Operational Plan 2016/17'.

The regular contact between Governors and Directors for these initiatives, as well as other activities, has allowed Governors to work more closely with Directors and helped to improve the understanding of their respective roles.

Governors continue to have a good relationship with the Executive Directors and Non-executive Directors and are able to openly discuss issues and concerns.

We 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.

We are proud of what our hospital has contributed to the local healthcare economy and hope WSFT is allowed to develop the excellent plans for integrated care services alongside its partners in the local CCGs, other hospitals, mental health services, community services and social services.

West Suffolk Clinical Commissioning Group

West Suffolk Clinical Commissioning Group, as the commissioning organisation for West Suffolk NHS Foundation Trust, confirms that the Trust has consulted and invited comment regarding the Quality Account for 2015/2016. This has occurred within the agreed timeframe and the CCG is satisfied that the Quality Account incorporates all the mandated elements required.

The CCG 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.

West Suffolk Clinical Commissioning Group is 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/care experience is delivered across the organisation.

This Quality Account demonstrates the commitment of the Trust to improve services. The Clinical Commissioning Group endorses the publication of this account.

Barbara McLean
Chief Nursing Officer

Suffolk health scrutiny committee

As has been the case in previous years, the Suffolk Health Scrutiny Committee does not intend to comment individually on NHS Quality Accounts for 2016. This should in no way be taken as a negative response. The Committee has, in the main, been content with the engagement of local healthcare providers in its work over the past year. The committee has taken the view that it would be appropriate for Healthwatch Suffolk to consider the content of the quality accounts for this year, and comment accordingly.

County Councillor Michael Ladd
Chairman of the Suffolk Health Scrutiny Committee

Healthwatch Suffolk

Healthwatch Suffolk is growing in strength and member numbers and as such is gathering and developing a rich and robust data base of evidence. We therefore welcome the opportunity to comment on West Suffolk NHS Foundation Trust (WSFT) Quality Accounts for the year 2015/16 from, what we consider to be, an informed position.

Data from the Healthwatch Suffolk Feedback Centre rates West Suffolk NHS Foundation Trust as 4 [out of a possible 5] stars. We are pleased to see that some actions to be implemented in 2016/17 will address areas that continue to be of concern. The accounts demonstrate where the investigation of serious incidents, “never events" and learning from complaints has led to improved practice. WSFT are to be congratulated on their awards and accolades; innovations like “The Rose Vital Tray” and “Bizzi Bags” for children in Out Patients, enhancing the patient experience while at the same time addressing infection control issues.

It is also our experience that WSFT have responded promptly and positively when we have drawn to their attention specific patient complaints and/or concerns, resulting in changes in practice.
We acknowledge how difficult it is to strike the balance between completing, what are quite prescriptive accounts, and presenting a clear picture to the reader. In so doing, we believe the accounts are quite difficult at times to understand. Some of the specialist language, phrases and the writing style used make it more complicated than it need be and therefore difficult for most non-specialists to understand. Bearing in mind the patient’s right to choice, these accounts should help them decide and so clearer, non-specialist language and style would help that process. Similarly, some actions lack clarity and detail e.g. Mortality Reviews. By contrast, the Community Services section is written in everyday language, with priorities and actions clearly detailed. We would also like to have seen greater participation in clinical research providing patients with an opportunity to access the latest drugs and innovations in treatment.

The accounts may have been enhanced with more comparative/benchmarking against other trusts and examples of shared learning across organisations. Identifying and agreeing on priorities for improvement would have benefited from greater use of patients’ views, and for organisations such as Healthwatch to contribute to establishing priorities for next year. Healthwatch Suffolk would welcome the opportunity to work with WSFT in the coming year to contribute to the process of preparing the accounts and establishing priorities for improvement.

Annex D: 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 to prepare Quality Accounts for each financial year.

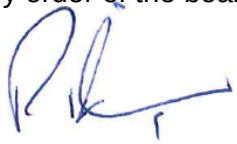
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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 2015/16 and supporting guidance;
- 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 2015 to 24 May 2016
    - papers relating to quality reported to the board over the period April 2015 to 24 May 2016
    - feedback from commissioners dated 18 May 2016
    - feedback from governors dated 12 May 2016
    - feedback from Suffolk Healthwatch dated 19 May 2016
    - feedback from overview and scrutiny committee dated 6 May 2016
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 16 May 2016
    - the national patient survey 21 May 2015
    - the national staff survey 23 February 2016
    - the head of internal audit's annual opinion over the Trust's control environment dated 21 April 2016
    - CQC intelligent monitoring report dated 1 May 2015
- 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
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

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
26 May 2016

Dr Stephen Dunn
Chief executive

Annex E: Independent auditor's report to the council of governors of West Suffolk NHS Foundation Trust on the quality report

We have been engaged by the Council of Governors of West Suffolk NHS Foundation Trust to perform an independent limited assurance engagement in respect of West Suffolk NHS Foundation Trust's quality report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

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

Respective responsibilities of the directors and independent chartered accountant

The directors are responsible for the content and preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual' issued by 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' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified 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 supporting guidance 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 consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual', and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2015 to May 2016;
- papers relating to the quality reported to the Board over the period April 2015 to May 2016;
- feedback from commissioners, dated 18 May 2016;
- feedback from governors, dated 5 May 2016;
- feedback from Local Healthwatch organisations, dated 17 May 2016;
- feedback from Suffolk County Council's Overview and Scrutiny Committee, dated 6 May 2016;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 16 May 2016;

- the latest national patient surveys, Children and Young People, Inpatients and Maternity, dated 1 July 2015, 21 May 2015 and 15 December 2015 respectively;
- the latest national staff survey dated 2015; and
- the Head of Internal Audit's annual opinion over the Trust's control environment for 2015/16

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these 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 Council of Governors of West Suffolk NHS Foundation Trust as a body, to assist the Council 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 2016, to enable the Council of Governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent limited 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 Council of Governors as a body and West Suffolk NHS Foundation Trust for our work or this report except 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 smaller 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 of these criteria, 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 the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

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 2016:

- 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' and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified 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 supporting guidance.

Lisa Clampin
For and on behalf of BDO LLP
Ipswich, UK
27 May 2016

Annex F: Glossary

Acute Kidney Injury (AKI)

Acute Kidney Injury (AKI) has now replaced the term acute renal failure and a universal definition and staging system has been proposed to allow earlier detection and management of AKI.

Clostridium *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.

CQC

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England.

The CQC's purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve.

The CQC's role is to monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety, and to publish findings, including performance ratings to help people choose care.

The **CQC intelligent monitoring tool** has been developed to give our inspectors a clear picture of the areas of care that need to be followed up within an NHS acute trust or a specialist NHS trust. The system is built on a set of indicators that look at a range of information including patient experience, staff experience and performance. The indicators relate to the five key questions we will ask of all services: are they safe, effective, caring, responsive, and well-led?

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.

EPRO

EPRO is a web-based clinical information management system which supports deployment of discharge summaries while also managing patient records and providing reporting capabilities.

HSMR

Hospital standardised mortality ratio (HSMR) is calculated as a ratio of the actual number of deaths to the expected number of

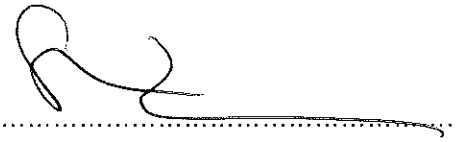
	deaths among patients in acute care hospitals. An HSMR equal to 100 suggests that there is no difference between the hospital's mortality rate and the overall average rate; greater than 100 suggests that the local mortality rate is higher than the overall average; and less than 100 suggests that the local mortality rate is lower than the overall average.
MEWS	Modified early warning score (MEWS) is a simple physiological scoring system suitable for use at the bedside that allows the identification of patients at risk of deterioration.
Monitor	Monitor is the sector regulator for health services in England. Monitor's job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. Monitor exercises a range of powers granted by Parliament which includes setting and enforcing a framework of rules for providers and commissioners, implemented in part through licences issued to NHS-funded providers.
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). NCEPOD promotes improvements in health care. They publish reports derived from a vast array of information about the practical management of patients.
Never event	Never events are a sub-set of SIRIs and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.
NRLS	The national reporting and learning system is a national database of confidentially-reported 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.
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 WSFT's quality priorities.
RCA	A root cause analysis (RCA) is a structured investigation of an incident to ensure effective learning to prevent a similar event happening.

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, additional local information can be recorded and analysed.
Sepsis	In sepsis, the body's immune system goes into overdrive, setting off a series of reactions including widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean the blood supply to vital organs such as the brain, heart and kidneys is reduced. If not treated quickly, sepsis can eventually lead to multiple organ failure and death. '**Sepsis Six'** is a set of six tasks including oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring - to be instituted within one hour by non-specialist practitioners at the front line.
SHMI	Summary hospital-level mortality indicator (SHMI) is the ratio between the actual number of patients who die following treatment at an acute care hospital and the number that would be expected to die on the basis of average figures across England, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.
SIRI	Serious incidents requiring investigation (SIRIs) in healthcare are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again. When an incident occurs it must be reported to all relevant bodies.
VTE	Venous thrombo-embolism, or blood clots, are a complication of immobility and surgery.

Foreword to the accounts

West Suffolk NHS Foundation Trust

These accounts, for the year ended 31 March 2016, have been prepared by West Suffolk NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed 

Name Dr Stephen Dunn
Job title Chief Executive
Date 26 May 2016

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

We have audited the financial statements of West Suffolk NHS Foundation Trust (the Trust) for the year ended 31 March 2016 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 2015/16 issued by the Independent Regulator of NHS Foundation Trusts ('Monitor').

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of affairs of West Suffolk NHS Foundation Trust's affairs as at 31 March 2016 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16; and
- have been prepared in accordance with the National Health Service Act 2006.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of the Chief Executive's Responsibilities as the Accounting Officer, the Accounting Officer is 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 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 Financial Reporting Council's (FRC's) Ethical Standards for Auditors.

This report is made solely to the Council of Governors of West Suffolk NHS Foundation Trust, as a body, in accordance with paragraph 5.2 of Audit Code for NHS Foundation Trusts 2014. Our audit work has been undertaken so that we might state to the Council of Governors of West Suffolk NHS Foundation 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 NHS Foundation Trust as a body, for our audit work, for this report or for the opinions we have formed.

Scope of our 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 West Suffolk NHS Foundation 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 and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Our assessment of risks of material misstatement

In arriving at our opinion on the financial statements, the risks of material misstatement that had the greatest effect on our audit, and the principal procedures we applied to address them, were as set out below.

Risk	How the scope of our audit responded to the risk
NHS revenue recognition NHS revenue is the most significant income stream for the Trust and is at most risk from material error and fraud. There is a risk that NHS revenue may be materially incomplete, inaccurate or inappropriately recognised.	Our response: • We reviewed and considered the design and implementation of controls in place for the revenue system covering NHS income streams. • We reviewed the signed contracts for the Trust's significant commissioners and verified a sample of variations to these contracts. • We reviewed a sample of credit notes received after year end to ensure they were valid. • We ensured that all NHS income was accounted for in line with the revenue recognition policy adopted by the Trust. • We reviewed the outcomes of the national Intra-NHS Agreement of Balances process to ensure that all NHS income and receivables were confirmed as matched and for any mismatches exceeding £250k and agreed to supporting evidence to corroborate the Trust's position and accounting treatment.
Community Care Contract Management judgement in respect of the nature of this new contractual arrangement was required in order to determine the accounting treatment for the Community Care Contract in the first year. The treatment was potentially complex. There is a risk that inappropriate accounting treatment is adopted by the Trust resulting in a material amount of income and expenditure misstated within the financial statements.	Our response: • We reviewed the contract in place between the Trust and West Suffolk CCG. • We reviewed the contract in place between the Trust and The Ipswich Hospital NHS Trust. • We reviewed management's assessment of the accounting treatment with reference to applicable accounting standards in order to form an opinion on whether their conclusions and accounting treatment applied were appropriate.

Risk	How the scope of our audit responded to the risk
Financial Sustainability The Trust recorded a deficit of £9.8m for the year ended 31 March 2016, and has forecast a deficit of £15.0m for the year ended 31 March 2017. The Trust is currently scored by Monitor as presenting the highest level of financial risk possible in its grading system for Foundation Trusts. There is a significant risk to the Trust's ability to achieve financial sustainability in the medium term.	Our response: • We considered the Trust's financial performance in the year to 31 March 2016, and achievement of control totals and planned Cost Improvement Programme schemes. • We reviewed the Trust's governance arrangements for financial and Cost Improvement Programme performance management. • We tested the feasibility of profit and loss and cashflow forecasts for the year ended 31 March 2017. • We assessed the availability of additional borrowing under the Trust's current borrowing facilities. • We reviewed the Trust's arrangements for engaging and working with its local partners to develop transformation plans designed to achieve financial stability in the medium term.

Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in both planning the scope of our audit and in evaluating the results of our work.

The materiality for the financial statements as a whole was set at £4.30 million. This has been determined with reference to the benchmark of gross expenditure (of which it represents 2%) which we consider to be one of the principal considerations for the Council of Governors in assessing the financial performance of the Trust.

We agreed with the Audit Committee to report to it all material corrected misstatements and all uncorrected misstatements we identified through our audit with a value in excess of £170,000, in addition to other audit misstatements below that threshold that we believe warranted reporting on qualitative grounds.

Opinion on other matters on which we are required to report

In our opinion:

- the parts of the remuneration report subject to audit in the Annual Report have been properly prepared in accordance with the Foundation Trust Annual Reporting Manual; being:
    - the fair pay multiple
    - the table of salaries and allowances of senior managers
    - the table of pension benefits of senior managers
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we report by exception - Use of Resources

The National Audit Office's Code of Audit Practice requires us to report to you if we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Our assessment of arrangements is made by reference to the overall criterion: *In all significant respects, the audited body had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.*

West Suffolk NHS Foundation Trust has a general duty under paragraph 63 of Chapter 5 of the National Service Act 2006 to exercise the functions of the Trust effectively, efficiently and economically. Paragraph 1 of Schedule 10 of the National Health Service Act 2006 and the National Audit Office's Code of Audit Practice require that we satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

For the year ended 31 March 2016 the Trust reported a deficit of £9.8m (£5.4m in 2014/15), exceeding the originally planned deficit of £5.5m by £4.3m. In addition, the Trust was rated a '1' (significant level of financial risk) on Monitor's financial risk rating scale, as at 31 March 2016. The Trust is forecasting a worsening deficit position for 2016/17 of £15m.

Although the Trust has made progress in terms of engaging with local partners to develop its plans to achieve the transformation required for financial sustainability, as well as beginning to implement improvements to financial and Cost Improvement Programme performance management, it has yet to determine the expected impact of its planned improvements on its medium term financial forecasts. Significant uncertainties remain regarding the Trust's ability to meet its financial challenges in the medium term.

In our opinion, except for the effects of the matter described above the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

Other Matters on which we report by exception

We have nothing to report in respect of the following:

Under the ISAs (UK and Ireland), we report to you if, in our opinion, information in the Annual Report is:

- materially inconsistent with the information in the audited financial statements, or
- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the NHS Foundation Trust acquired in the course of performing our audit; or
- is otherwise misleading.

In particular, we are required to consider whether we have identified any inconsistencies between our knowledge acquired during the audit and the directors' statement that they consider the annual report is fair, balanced and understandable and whether the annual report appropriately discloses those matters that we communicated to the audit committee which we consider should have been disclosed.

Under the National Audit Office's Code of Audit Practice we report to you if we have exercised special auditor powers in connection with the issue of a public interest report or we have made a referral to the regulator under Schedule 10 of the National Health Service Act 2006.

Under the National Audit Office's Code of Audit Practice 2015 we are required to report to you if we have been unable to satisfy ourselves that:

- proper practices have been observed in the compilation of the financial statements; or
- the Annual Governance Statement meets the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual and is not 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.

Qualified 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 National Audit Office's Code of Audit Practice 2015 except that, as noted above, we have been unable to satisfy ourselves that West Suffolk NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources in all significant respects.

BDO LLP

Lisa Clampin

for and on behalf of BDO LLP

Registered auditor

Ipswich, UK

27 May 2016

Statement of Comprehensive Income for the year ended 31 March 2016

	Note	2015/16 £000	2014/15 £000
Operating income from patient care activities	3	186,327	152,304
Other operating income	4	23,925	20,939
Total operating income		**210,252**	**173,243**
Operating expenses	5, 6	(218,457)	(176,858)
Operating deficit		**(8,205)**	**(3,615)**
Finance income		23	22
Finance expenses		(194)	(76)
PDC dividends payable		(1,426)	(1,753)
Net finance costs		**(1,597)**	**(1,807)**
Deficit for the year		**(9,802)**	**(5,422)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	10.5	-	(4,747)
Total comprehensive expense for the period		**(9,802)**	**(10,169)**

All income and expenditure arises from continuing operations.

Statement of Financial Position as at 31 March 2016

	Note	31 March 2016 £000	31 March 2015 £000
Non-current assets			
Intangible assets	9	10,876	7,193
Property, plant and equipment	10	61,923	62,447
Trade and other receivables	11	273	340
Other financial assets		1,688	-
Total non-current assets		**74,760**	**69,980**
Current assets			
Inventories		2,825	2,718
Trade and other receivables	11	11,191	9,332
Non-current assets for sale and assets in disposal groups		1,400	-
Cash and cash equivalents	12	2,601	3,253
Total current assets		**18,017**	**15,303**
Current liabilities			
Trade and other payables	13	(21,692)	(19,232)
Other liabilities		(1,892)	(295)
Borrowings	14	(130)	(65)
Provisions		(84)	(62)
Total current liabilities		**(23,798)**	**(19,654)**
Total assets less current liabilities		**68,979**	**65,629**
Non-current liabilities			
Trade and other payables	13	(912)	(912)
Borrowings	14	(18,205)	(5,035)
Provisions		(202)	(220)
Total non-current liabilities		**(19,319)**	**(6,167)**
Total assets employed		**49,660**	**59,462**
Financed by			
Public dividend capital		59,232	59,232
Revaluation reserve		2,151	2,151
Income and expenditure reserve		(11,723)	(1,921)
Total taxpayers' equity		**49,660**	**59,462**

The notes on pages 157 to 174 form part of these accounts.

Name Dr Stephen Dunn
Position Chief Executive
Date 26 May 2016

Statement of Changes in Equity for the year ended 31 March 2016

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**59,232**	**2,151**	**(1,921)**	**59,462**
Deficit for the year	-	-	(9,802)	**(9,802)**
Taxpayers' and others' equity at 31 March 2016	**59,232**	**2,151**	**(11,723)**	**49,660**

Statement of Changes in Equity for the year ended 31 March 2015

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2014 - brought forward	**59,041**	**8,958**	**1,441**	**69,440**
Deficit for the year	-	-	(5,422)	**(5,422)**
Other transfers between reserves	-	(18)	18	**-**
Revaluations	-	(4,747)	-	**(4,747)**
Transfer to retained earnings on disposal of assets	-	(2,042)	2,042	**-**
Public dividend capital received	191	-	-	**191**
Taxpayers' and others' equity at 31 March 2015	**59,232**	**2,151**	**(1,921)**	**59,462**

Statement of Cash Flows for the year ended 31 March 2016

	Note	2015/16 £000	2014/15 £000
Cash flows from operating activities			
Operating deficit		(8,205)	(3,615)
Non-cash income and expense:			
Depreciation and amortisation	5.1	4,263	5,274
Impairments and reversals of impairments		411	335
(Gain)/loss on disposal of non-current assets	5.1	40	(1,388)
Income recognised in respect of capital donations		(186)	(335)
Increase in receivables and other assets		(2,023)	(337)
Increase in inventories		(107)	(135)
Increase in payables and other liabilities		4,507	1,465
Decrease in provisions		-	(62)
Net cash generated from/(used in) operating activities		**(1,300)**	**1,202**
Cash flows from investing activities			
Interest received		25	22
Purchase and sale of financial assets		(1,688)	-
Purchase of intangible assets		(5,248)	(2,834)
Purchase of property, plant, equipment and investment property		(4,901)	(3,432)
Sales of property, plant, equipment and investment property		426	4,000
Receipt of cash donations to purchase capital assets		186	335
Net cash used in investing activities		**(11,200)**	**(1,909)**
Cash flows from financing activities			
Public dividend capital received		-	191
Movement on loans from the Department of Health		13,235	3,600
Other interest paid		(190)	(71)
PDC dividend paid		(1,197)	(1,894)
Net cash generated from financing activities		**11,848**	**1,826**
Increase/(decrease) in cash and cash equivalents		**(652)**	**1,119**
Cash and cash equivalents at 1 April	12	**3,253**	**2,134**
Cash and cash equivalents at 31 March	12	**2,601**	**3,253**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
Monitor is responsible for issuing an accounts direction to NHS foundation Trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS foundation Trusts shall meet the accounting requirements of the Foundation Trusts Annual Reporting Manual (FT ARM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2015/16 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (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.

Note 1.2 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.3 Going concern
After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. In addition, the Trust has a borrowing arrangement in place with the Department of Health to support its liquidity position. For this reason, the directors continue to adopt the going concern basis in preparing the accounts.

Note 1.4 Income
Income 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 income for the Trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits
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 annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable the Trust to identify its share of the scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised 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.

Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently using the relevant valuation method, as stated below.
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. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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. Valuation is determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost
- Dwellings – depreciated replacement cost
- Plant and machinery – depreciated replacement cost
- Information technology – depreciated replacement cost
- Furniture and fittings – depreciated replacement cost

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the *FT ARM*, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable i.e.:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Useful Economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Land	-	-
Buildings, excluding dwellings	10	68
Dwellings	8	49
Plant & machinery	5	29
Transport equipment	7	7
Information technology	3	10
Furniture & fittings	5	8

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the Trust intends to complete the asset and sell or use it
• the Trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
• the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful economic life of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Intangible assets - internally generated		
Information technology	5	15
Intangible assets - purchased		
Software	2	7

Note 1.9 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as "fair value through income and expenditure", loans and receivables.

Financial liabilities are classified as "fair value through income and expenditure".

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and "other receivables". These are recognised at fair value.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only 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.

Note 1.10 Provisions

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation Trust is disclosed at note 15 but is not recognised in the NHS foundation Trust's accounts.

Note 1.11 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.12 Value added tax

Most of the activities of the NHS foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.13 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2015/16.

Note 1.14 Standards, amendments and interpretations in issue but not yet effective or adopted

The following are the material accounting standards and amendments issued by the IASB but not yet adopted in these financial statements and the dates they are expected to come into effect.

IAS 16 (amendment) and IAS 38 (amendment) – depreciation and amortisation	2016/17
IAS 1 (amendment) – disclosure initiative	2016/17
IFRS 15 Revenue from contracts with customers	2017/18
IFRS 9 Financial Instruments	2018/19

Note 1.15 Critical accounting estimates and judgements
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.

Note 2 Operating Segments

The Trust reports to the Board on a monthly basis the performance on a directorate level. In considering segments with a total income of 10%, or more of the Trust's total income, the Trust has identified five reportable segments. The main source of income for the Trust is from commissioners in respect of healthcare services from CCGs who are under common control and classified as a single customer. Net assets are not reported to the Board so therefore have been excluded for the purposes of this note.

The Trust reports to the Board by directorate down to an operating contribution.

2015/16	Medicine £000's	Surgery £000's	Womens and Childrens £000's	Corporate £000's	Community Services £000's	Other £000's	Total £000's
Income	61,838	58,513	21,513	21,381	31,952	15,055	**210,252**
Expenditure	(55,408)	(47,275)	(14,642)	(23,714)	(31,952)	(45,466)	**(218,457)**
Contribution	**6,430**	**11,238**	**6,871**	**(2,333)**	**0**	**(30,411)**	**(8,205)**

2014/15	Medicine £000's	Surgery £000's	Womens and Childrens £000's	Corporate £000's	Community Services £000's	Other £000's	Total £000's
Income	57,117	57,533	21,073	22,290	0	15,230	**173,243**
Expenditure	(52,122)	(44,632)	(14,268)	(22,057)	0	(43,779)	**(176,858)**
Contribution	**4,995**	**12,901**	**6,805**	**233**	**0**	**(28,549)**	**(3,615)**

These segments represent the management structure in the organisation, which now include community services.

The Trust was commissioned to provide community services in Suffolk from 1 October 2015. The care is delivered in partnership with Ipswich Hospital Trust and also through a contract with Norfolk Community Healthcare. The total income from community services in the year was £32m, with associated pay costs of £5.9m and non-pay costs of £26.1m.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2015/16 £000	2014/15 £000
Acute services		
Elective income	32,916	32,039
Non elective income	50,100	47,998
Outpatient income	34,415	32,861
A & E income	6,972	6,295
Other NHS clinical income	30,041	31,800
Community services		
Community services income from CCGs and NHS England	29,880	-
Other services		
Private patient income	1,594	934
Other clinical income	409	377
Total income from activities	**186,327**	**152,304**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2015/16 £000	2014/15 £000
CCGs and NHS England	184,329	150,937
Other NHS foundation Trusts	-	56
Non-NHS: private patients	1,484	896
Non-NHS: overseas patients (chargeable to patient)	105	38
NHS injury scheme (was RTA)	409	377
Total income from activities	**186,327**	**152,304**
Of which:		
Related to continuing operations	186,327	152,304

Note 4 Other operating income

	2015/16	2014/15
	£000	£000
Research and development	588	549
Education and training	6,016	7,036
Receipt of capital grants and donations	-	341
Charitable and other contributions to expenditure	661	379
Non-patient care services to other bodies	9,811	6,633
Profit on disposal of non-current assets	-	1,388
Income in respect of staff costs where accounted on gross basis	1,035	-
Other income	5,814	4,613
Total other operating income	**23,925**	**20,939**
Of which:		
Related to continuing operations	23,925	20,939
Further analysis of other income:		
Car parking	1,345	1,308
Estates recharges	2,224	1,212
Pharmacy sales	56	31
Staff accommodation rentals	468	430
Catering	1,418	1,313
Other	303	319
Total	**5,814**	**4,613**

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its Provider License, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2015/16	2014/15
	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	187,232	151,370
Income from services not designated as commissioner requested services	23,020	21,873
Total	**210,252**	**173,243**

Within the 2015/16 financial statements, management has taken the view to define the following as commissioner requested services: all NHS clinical income billable to NHS England and CCGs.

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, relates to the provision of non protected services.

The Trust has complied with the requirement of section 43(2A) of the NHS act 2006 (As amended by the Health and Social Care Act 2012) in that income from the provision of goods and services for the purposes of the Health Service in England is greater than its income from the provision of goods and services for any other purposes. The levels of other income received by the Trust has had little or no impact upon its provision of goods and services for the purposes of the Health Service in England.

Note 5.1 Operating expenses

	2015/16	2014/15
	£000	£000
Purchase of healthcare from non NHS bodies	406	438
Employee expenses - executive directors	810	941
Remuneration of non-executive directors	99	98
Employee expenses - staff	129,170	115,845
Supplies and services - clinical	44,289	17,579
Supplies and services - general	3,323	3,176
Establishment	2,358	3,186
Transport	923	815
Premises	4,245	5,002
Increase/(decrease) in provision for impairment of receivables	(5)	17
Inventories written down	-	58
Inventories consumed	19,567	17,031
Rentals under operating leases	2,135	1,472
Depreciation on property, plant and equipment	2,698	3,680
Amortisation on intangible assets	1,565	1,594
Impairments	411	335
Audit fees payable to the external auditor audit services- statutory audit	59	59
Clinical negligence	3,986	2,981
Loss on disposal of non-current assets	40	-
Legal fees	182	65
Consultancy costs	1,022	928
Internal audit costs	93	90
Training, courses and conferences	504	572
Hospitality	30	35
Insurance	177	165
Other services e.g. external payroll	183	336
Other	187	360
Total	**218,457**	**176,858**
Of which:		
Related to continuing operations	218,457	176,858

Note 5.2 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £0.5m (2014/15: £0.5m).

Note 6 Employee benefits

	Permanent	Other	2015/16 Total	2014/15 Total
	£000	£000	£000	£000
Salaries and wages	98,496	8,137	**106,633**	95,571
Social security costs	7,502	821	**8,323**	7,753
Employer's contributions to NHS pensions	10,985	1,211	**12,196**	10,857
Agency/contract staff	-	7,522	**7,522**	4,477
Total gross staff costs	**116,983**	**17,691**	**134,674**	**118,658**
Recoveries in respect of seconded staff	(1,126)	(91)	**(1,217)**	-
Total staff costs	**115,857**	**17,600**	**133,457**	**118,658**
Of which				
Costs capitalised as part of assets	2,063	1,414	**3,477**	**1,872**

Note 6.1 Retirements due to ill-health

During 2015/16 there were 2 early retirements from the Trust agreed on the grounds of ill-health (6 in the year ended 31 March 2015). The estimated additional pension liabilities of these ill-health retirements is £66k (£397k in 2014/15).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 6.2 Directors' remuneration

The aggregate amounts payable to directors were:

	2015/16	2014/15
	£000	£000
Salary	813	844
Taxable benefits	7	10
Employer's pension contributions	89	93
Total	**909**	**947**

Further details of directors' remuneration can be found in the remuneration report.

Note 7 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

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. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

- 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.

- 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.

Note 8 West Suffolk NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where West Suffolk NHS Foundation Trust is the lessee.

	2015/16 £000	2014/15 £000
Operating lease expense		
Minimum lease payments	2,135	1,472
Contingent rents	-	-
Less sublease payments received	-	-
Total	2,135	1,472

	31 March 2016 £000	31 March 2015 £000
Future minimum lease payments due:		
- not later than one year;	1,467	1,318
- later than one year and not later than five years;	2,677	2,203
- later than five years.	192	73
Total	4,337	3,594
Future minimum sublease payments to be received	-	-

Note 9.1 Intangible assets - 2015/16

	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2015 - brought forward	11,654	2,536	14,190
Additions	258	4,990	5,248
Gross cost at 31 March 2016	11,912	7,526	19,438
Amortisation at 1 April 2015 - brought forward	6,997	-	6,997
Provided during the year	1,565	-	1,565
Amortisation at 31 March 2016	8,562	-	8,562
Net book value at 31 March 2016	3,350	7,526	10,876
Net book value at 1 April 2015	4,657	2,536	7,193

Note 9.2 Intangible assets - 2014/15

	Internally generated information technology £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2014 - as previously stated	10,344	1,012	11,356
Prior period adjustments	-	-	-
Gross cost at 1 April 2014 - restated	10,344	1,012	11,356
Additions	807	2,027	2,834
Reclassifications	503	(503)	-
Valuation/gross cost at 31 March 2015	11,654	2,536	14,190
Amortisation at 1 April 2014 - as previously stated	5,403	-	5,403
Provided during the year	1,594	-	1,594
Amortisation at 31 March 2015	6,997	-	6,997
Net book value at 31 March 2015	4,657	2,536	7,193
Net book value at 1 April 2014	4,941	1,012	5,953

Note 10.1 Property, plant and equipment - 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - brought forward	**8,070**	**44,508**	**2,961**	**678**	**13,935**	**4,219**	**135**	**74,506**
Additions	-	2,063	-	1,958	408	22	-	**4,451**
Transfers to assets held for sale	(1,400)	-	-	-	-	-	-	**(1,400)**
Disposals	-	-	-	-	(3,511)	-	-	**(3,511)**
Valuation/gross cost at 31 March 2016	**6,670**	**46,571**	**2,961**	**2,636**	**10,832**	**4,241**	**135**	**74,046**
Accumulated depreciation at 1 April 2015 - brought forward	**-**	**-**	**-**	**-**	**8,787**	**3,235**	**37**	**12,059**
Provided during the year	-	1,467	113	-	773	324	21	**2,698**
Impairments	-	411	-	-	-	-	-	**411**
Disposals	-	-	-	-	(3,045)	-	-	**(3,045)**
Accumulated depreciation at 31 March 2016	**-**	**1,878**	**113**	**-**	**6,515**	**3,559**	**58**	**12,123**
Net book value at 31 March 2016	**6,670**	**44,693**	**2,848**	**2,636**	**4,317**	**682**	**77**	**61,923**
Net book value at 1 April 2015	**8,070**	**44,508**	**2,961**	**678**	**5,148**	**984**	**98**	**62,447**

Note 10.2 Property, plant and equipment - 2014/15

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2014 - as previously stated	**10,576**	**48,112**	**3,471**	**956**	**16,010**	**4,201**	**84**	**83,410**
Additions	-	2,426	-	678	547	291	51	**3,993**
Reclassifications	-	949	-	(956)	6	1	-	**-**
Revaluations	(2,506)	(6,979)	(510)	-	-	-	-	**(9,995)**
Disposals	-	-	-	-	(2,628)	(274)	-	**(2,902)**
Valuation/gross cost at 31 March 2015	**8,070**	**44,508**	**2,961**	**678**	**13,935**	**4,219**	**135**	**74,506**
Accumulated depreciation at 1 April 2014 - as previously stated	**-**	**2,295**	**77**	**-**	**10,585**	**3,202**	**23**	**16,182**
Provided during the year	-	2,464	77	-	818	307	14	**3,680**
Impairments	-	335	-	-	-	-	-	**335**
Revaluations	-	(5,094)	(154)	-	-	-	-	**(5,248)**
Disposals	-	-	-	-	(2,616)	(274)	-	**(2,890)**
Accumulated depreciation at 31 March 2015	**-**	**-**	**-**	**-**	**8,787**	**3,235**	**37**	**12,059**
Net book value at 31 March 2015	**8,070**	**44,508**	**2,961**	**678**	**5,148**	**984**	**98**	**62,447**
Net book value at 1 April 2014	**10,576**	**45,817**	**3,394**	**956**	**5,425**	**999**	**61**	**67,228**

Note 10.3 Property, plant and equipment financing - 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016								
Owned	6,670	41,674	2,848	2,636	3,576	671	7	**58,082**
Donated	-	3,019	-	-	741	11	70	**3,841**
NBV total at 31 March 2016	**6,670**	**44,693**	**2,848**	**2,636**	**4,317**	**682**	**77**	**61,923**

Note 10.4 Property, plant and equipment financing - 2014/15

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2015								
Owned	8,070	41,385	2,961	678	4,424	968	11	**58,497**
Donated	-	3,123	-	-	724	16	87	**3,950**
NBV total at 31 March 2015	**8,070**	**44,508**	**2,961**	**678**	**5,148**	**984**	**98**	**62,447**

Note 10.5 Revaluations of property, plant and equipment

The properties comprising the West Suffolk NHS Foundation Trust estate were valued in full as at 31 March 2015 by an external valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuations were prepared in accordance with the requirements of the RICS Valuation – Professional Standards: December 2014, the International Valuation Standards and International Financial Reporting Standards. The valuations of these properties were on the basis of Fair Value, equated to Market Value. For in-use properties these were primarily derived using the Depreciated Replacement Cost (DRC) method and subject to the prospect and viability of the continued occupation and use.

The Trust's accounting policy is to revalue Tangible Fixed Assets at least once every five years unless there is a material movement beforehand. In discussions with the Trust's Valuer, the Trust has concluded that there has not been a material movement in the asset valuation over and above the additions already recognised in the balance sheet. This situation will be reviewed again in 2016/17 to determine if a revaluation needs to be recognised at 31 March 2017.

Note 11 Trade receivables and other receivables

	31 March 2016 £000	31 March 2015 £000
Current		
Trade receivables due from NHS bodies	5,675	4,000
Receivables due from NHS charities	-	138
Provision for impaired receivables	(50)	(55)
Prepayments (non-PFI)	724	1,255
Accrued income	-	23
Interest receivable	-	2
PDC dividend receivable	55	284
VAT receivable	340	379
Other receivables	4,447	3,306
Total current trade and other receivables	**11,191**	**9,332**
Non-current		
Other receivables	273	340
Total non-current trade and other receivables	**273**	**340**

Note 11.1 Analysis of impaired receivables

	31 March 2016	31 March 2015
Ageing of non-impaired receivables past their due date		
0 - 30 days	4,235	1,787
30 - 60 Days	381	78
60 - 90 days	152	373
90 - 180 days	237	484
Over 180 days	693	289
Total	**5,698**	**3,011**

Note 12 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	31 March 2016 £000	31 March 2015 £000
At 1 April	**3,253**	**2,134**
Net change in year	(652)	1,119
At 31 March	**2,601**	**3,253**
Broken down into:		
Cash at commercial banks and in hand	106	114
Cash with the Government Banking Service	2,495	3,139
Total cash and cash equivalents as in SoFP	**2,601**	**3,253**
Total cash and cash equivalents as in SoCF	**2,601**	**3,253**

Note 13 Trade and other payables

	31 March 2016 £000	31 March 2015 £000
Current		
NHS trade payables	4,680	2,568
Other trade payables	6,935	7,030
Capital payables	1,256	1,706
Social security costs	1,276	1,096
Other taxes payable	1,240	1,164
Other payables	1,616	1,754
Accruals	4,689	3,914
Total current trade and other payables	**21,692**	**19,232**
Non-current		
Other payables	912	912
Total non-current trade and other payables	**912**	**912**

Note 14 Borrowings

	31 March 2016 £000	31 March 2015 £000
Loans from the Department of Health	130	65
Total current borrowings	**130**	**65**
Non-current		
Loans from the Department of Health	18,205	5,035
Total non-current borrowings	**18,205**	**5,035**

Note 15 Clinical negligence liabilities

At 31 March 2016, £55,462k was included in provisions of the NHSLA in respect of clinical negligence liabilities of West Suffolk NHS Foundation Trust (31 March 2015: £40,469k).

Note 16 Contractual capital commitments

	31 March 2016 £000	31 March 2015 £000
Property, plant and equipment	10,210	1,531
Intangible assets	12,083	-
Total	**22,293**	**1,531**

Capital commitment in relation to property plant and equipment relates to a new sterilisation building and car park.
Capital commitment on intangible assets relates to the e-care project.

Note 17.1 Financial assets

	Available for sale £000	Loans and receivables £000	Total £000
Assets as per SoFP as at 31 March 2016			
Trade and other receivables excluding non financial assets	-	10,119	**10,119**
Other financial assets	1,688	-	**1,688**
Cash and cash equivalents at bank and in hand	-	2,601	**2,601**
Total at 31 March 2016	**1,688**	**12,720**	**14,408**

	Loans and receivables £000
Assets as per SoFP as at 31 March 2015	
Trade and other receivables excluding non financial assets	6,880
Cash and cash equivalents at bank and in hand	3,253
Total at 31 March 2015	**10,133**

Note 17.2 Financial liabilities

	Other financial liabilities £000
Liabilities as per SoFP as at 31 March 2016	
Borrowings excluding finance lease and PFI liabilities	18,335
Trade and other payables excluding non financial liabilities	17,559
Provisions under contract	286
Total at 31 March 2016	**36,180**

	Other financial liabilities £000
Liabilities as per SoFP as at 31 March 2015	
Borrowings excluding finance lease and PFI liabilities	5,100
Trade and other payables excluding non financial liabilities	17,044
Provisions under contract	282
Total at 31 March 2015	**22,426**

Note 17.3 Maturity of financial liabilities

	31 March 2016 £000	31 March 2015 £000
In one year or less	17,845	17,391
In more than one year but not more than two years	-	130
In more than two years but not more than five years	-	623
In more than five years	18,335	4,282
Total	**36,180**	**22,426**

Note 18 Related parties

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 other entities for which the Department is regarded as the parent Department. These entities (with the exception of The Pathology Partnership) are:

	Receivables		Payables	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
The Pathology Partnership	510	2,658	593	3,876
NHS England (formerly East Anglia Area Team)	839	350	-	-
Health Education England	697	500	-	-
Cambridge University Hospitals NHS Foundation Trust	331	-	1,227	1,215
Total	**2,377**	**3,508**	**1,820**	**5,091**

	Income		Expenditure	
	2015/16 £000	2014/15 £000	2015/16 £000	2014/15 £000
NHS West Suffolk CCG	106,281	105,431	-	-
NHS Ipswich And East Suffolk CCG	46,228	14,882	-	-
NHS South Norfolk CCG	14,177	13,050	-	-
Health Education England	5,295	5,664	-	-
NHS Cambridgeshire And Peterborough CCG	2,968	3,131	-	-
NHS England (formerly East Anglia Area Team)	13,827	11,647	-	-
Cambridge University Hospitals NHS Foundation Trust	953	-	1,620	1,665
NHS Litigation Authority	-	-	4,152	2,981
Total	**189,729**	**153,805**	**5,772**	**4,646**

The Trust part owns (12.5%) investment in the Pathology Partnership. The partnership is hosted by Cambridge University Hospitals NHS FT.

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 £661,000 was received from the charitable fund during the year.