NHS
West Suffolk
NHS Foundation Trust

Annual report and accounts

2016/17

Putting you first

West Suffolk NHS Foundation Trust

Annual Report and Accounts 2016/17

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

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

1.1.1 A message from the chairman and chief executive

We are delighted to introduce our annual report for the year 2016/17.

This year we faced some unprecedented challenges but were able to deliver some significant achievements thanks to our outstanding staff. We remain a high-performing hospital for the quality of our care and this is recognised in a number of national surveys of outcome data. Our latest accolades are described on page 16 and they are a tribute to the excellent staff who work tirelessly to continuously improve our services.

A changing health economy
The environment we operate in continues to change as NHS England seeks 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. The further development of sustainability and transformation plans (STPs) and the move towards integrated care systems (ICSs) are two of the national drivers that our Trust is already involved with and we remain fully committed to further integration of services for the benefit of our west Suffolk population.

In December 2016 we were given permission to form an alliance of providers to develop and run community services for Suffolk for the longer term. This means that in partnership with Ipswich Hospital NHS Trust, Suffolk County Council, Suffolk GP Federation and Norfolk and Suffolk NHS Foundation Trust, we will be transforming community services so that they are fully aligned with the needs of their local populations. The aim is to provide a seamless integration between different types of care. We know there is much more to do to genuinely transform services and we are in a better position to get on with this work now that we have the support to develop long term plans.

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 £3.3 million in deficit (before adjusting for the Pathology Partnership (tPP) impairment of £4.8m). While this was better than our plan at the start of the year, we are working hard inside and outside the organisation to identify where whole system changes and productivity improvements can be made.

Quality
We are proud of the quality of our services and during 2016/17 we were benchmarked as being a top performing hospital in the NHS in a number of key areas. West Suffolk has the best rates of early cancer diagnosis in the country (NHS atlas of variation) and correspondingly good outcomes for treating the disease. This is a major benefit for our communities and a fantastic achievement by healthcare professionals in our hospital and primary care services.

Stroke services have undergone major reconfigurations across the country and are under constant national scrutiny. Our service here was threatened with closure a number of years ago but has now delivered some of the best outcomes in the country according to the stroke sentinel national audit programme (SSNAP).

The care of patients with hip fracture has been transformed in recent years thanks to research that has identified the key things that we need to get right to get patients back on their feet and back to their best again. The national hip fracture database measures the success of services in this area and the 2017 report shows that we are the highest rated service in the east of England and one of the best in the country. Hip fracture is one of the most common serious injuries in older people and often results in long hospital stays and prolonged rehabilitation. Getting this service right is therefore vital for the people we serve in this part of the world and we are extremely proud to be leading the way in this area.

Our patient surveys demonstrate that most of the time we do get things right and 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 (section 3).

We demonstrated good performance against the national standards, meeting these targets in 2016/17 with the exception of: maximum waiting time of four hours in the emergency department (ED) from arrival to admission, transfer or discharge; 18 week maximum wait from point of referral to treatment (patients on an incomplete pathway); and two week wait from referral to date first seen comprising all urgent referrals for symptomatic breast patients (cancer not initially suspected).

The pathology service delivered to the WSFT by The Pathology Partnership (tPP) has been a cause for concern during 2016/17 in terms of both quality and financial performance. A new clinically led structure has been implemented for services in the east of the partnership. The North East Essex and Suffolk Pathology Services (NEESPS) includes West Suffolk, Colchester and Ipswich hospitals and is managed locally as a stand-alone network. The Trust's share of the loss incurred by tPP was £4.8m.

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. Over Christmas we experienced the highest level of pressure that we can remember with very high numbers of patients requiring urgent admission into an inpatient bed. This affected our ability to deliver the four hour standard for either admitting or discharging patients after arrival at ED and our performance this year is described on page 123 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 struggled to maintain our target of meeting this standard for 92% of our patients and have experienced a particular problem this financial year with monitoring our performance accurately. This is a result of the introduction of our new electronic patient record e-Care in May 2016 which led to difficulties in measuring waiting times across the Trust.

Our excellent staff
Our staff survey provides solid evidence over a long period of time that our staff are positive about working here and feel well engaged in the organisation. In the 2016 survey we were actually the top rated trust in the country for staff engagement. More staff recommend us as a place to work and as a place to receive treatment than 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 76 of this report.

Updating our IT system
In May 2016, after undertaking extensive preparations, we implemented a new single integrated electronic patient record, e-Care, to improve the quality and safety of services and support the delivery of our vision. The new system means that we can manage demand more effectively and provide safer, more effective care for patients. Implementation of these systems is notoriously challenging, however we were able to get through our launch successfully thanks to the efforts of staff working on the project team and in our clinical services. The launch of e-Care impacted on our ability to report performance against a number of quality standards, including the referral to treatment (18 week) standard. During 2016/17 reporting against this standard has been based on estimates. Working with our digital partner, Cerner, we have made significant progress to improve reporting and

plan to have all aspects in operation to allow reporting of June 2017 activity. However we are now on a journey to develop e-Care into a system that supports us to transform the way we work and deliver the benefits we know it is capable of.

A global digital exemplar
In August 2016 we heard that the Trust would become a 'global digital exemplar' after submitting a proposal to NHS England setting out our vision for the digitisation of healthcare and how we could use additional investment to benefit our patients. This means that we will receive up to £10 million in additional funding to progress faster with our programmes and share our learning with other hospitals. This follows a highly competitive process in which 26 of the country's most digitally advanced trusts were invited to compete for funding and we are pleased to be recognised as one of the most forward thinking NHS organisations in this area.

The future and our vision
This has been the second year of delivery for our strategic framework, '*Our patients, our hospital, our future, together'*, and its seven ambitions. The document remains relevant as we pursue our goals for the population we serve. One area of progress and focus this year has been the development of our health and wellbeing strategy for our staff and patients. We have employed a public health expert, Dr Helena Jopling who has extensive experience in working in population health and her insight and leadership is vital to the work we plan to undertake in this area.

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 undergraduate 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.

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 My WiSH 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, with us, 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.

WSFT was awarded foundation trust status in December 2011. 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. Community services covers a range of adult community services, specialist children's services and community hospitals and:

- 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 WSFT 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.

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

We provide a number of outreach services to our population across 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).

As part of our early intervention team (EIT) we developed a service during 2016/17 to provide personal care to patients in their home. Delivered by a reablement support worker this forms part of a wider service working on admission prevention.

WSFT is also responsible for the provision of adult speech and 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 2,987 whole-time equivalent staff in March 2017.

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.

In Suffolk and north east Essex, the NHS, general practice and local government have come together to develop a five year sustainability and transformation plan (STP). The STP is a unified plan to improve the health and care of our local people and bring the system back into a financially sustainable position. All partners are passionate about creating a plan which will deliver our vision for people across Suffolk and north east Essex to live healthier, happier lives by having greater choice, control and responsibility for their health and wellbeing. We are linking closely with other STPs within neighbouring areas, such as the Waveney area of Suffolk which has joined Great Yarmouth, and the mid and west Essex areas which are working on STPs across south Essex and Hertfordshire. We need to ensure we align with these neighbouring plans to ensure there are no significant patient safety and access issues.

Developing an integrated care system (ICS) for the west of Suffolk is a key part of our STP planning. The development of a provider alliance formed from community services, acute hospital, adult social care, mental health services and primary care will be the vehicle through which we will deliver our community services contract. The formation of this alliance will be the first phase towards a fully functioning ICS that will evolve over time to include commissioning functions. To mitigate engagement and operational risks the provider alliance is operating in shadow form, testing integrated locality models building on the health and care integration already established. We will operate locality shadow boards with shared governance financial frameworks, gradually phasing in more services from the whole system.

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 2016/17 to ensure that it provided an adequate evidence base to support the effective and focussed 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 2.5).

Incident reporting

During 2016/17 the number of patient safety incidents reported showed a general increase to be at 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 and its subcommittees. WSFT actively engages with its foundation trust membership and the public through regular talks and events.

WSFT is a member of the NHS Resolution'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 NHS Improvement (NHSI) under the National Health Service Act 2006:

- Chief executive's responsibilities certificate (section 2.4)
- 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 2.6 (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 (DH) to support its liquidity position. For this reason, the directors continue to adopt the going concern basis in preparing the accounts.

The Trust is in deficit because its costs exceed income. The Trust has borrowed £44.8 million from the DH for capital investment and working capital. The planned deficit for 2017/18 is £5.9 million which is a significant concern but is not unusual in the NHS acute sector currently. All liabilities are ultimately underwritten by the DH as confirmed by statute therefore the Trust accounts are prepared on a going concern basis.

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 (BAF) 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 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. 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
- self-certification against the compliance framework
- self-assessment against delivery of the Care Quality Commission (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
- assurances provided through the work of the clinical safety and effectiveness committee, corporate risk committee and patient experience committee
- reports from the quality and risk committee, scrutiny committee and the audit committee received by the board
- assurances provided through the work of internal and external audit, the CQC, NHS Improvement, the NHS Resolution, patient-led assessments of the care environment (PLACE), and accountability to the council of governors
- the work of clinical audit, whose scope includes national audits, audits arising from national guidance such as National Institute for Health and Care Excellence (NICE), confidential enquiries and other risk and patient safety-related topics
- weekly quality walkabouts, including executive directors, non-executive directors and governors
- risk assessments and analysis of the risk register and BAF
- 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 rigorous CQC inspection in March 2016 as part of the national programme of inspection of all acute NHS trusts and the final report was issued in August 2016. The CQC concluded that patients using WSFT receive 'outstanding' care from staff who go "the extra mile". The CQC awarded the Trust – which provides services at both West Suffolk and Newmarket hospitals – an overall rating of 'good', while rating the care provided as 'outstanding'. The report is the best of all hospitals in the eastern region (based on review of CQC reports for relevant trusts). In their report, the inspectors highlighted several specific examples of outstanding practice and also some areas for improvement. Further detail can be found in quality report (section 3).

Our services

WSFT provides a range of patient services:

Indicators	2016/17	2015/16	2014/15	2013/14	2012/13
Inpatient planned	**3,899**	4,291	4,290	4,275	4,026
Inpatient non-planned	**32,868**	31,383	30,173	28,517	28,494
Day cases	**29,534**	29,392	28,210	25,889	22,895
Outpatient attendances (inc. ward attenders)	**217,501**	239,675	228,384	216,597	176,650
Outpatient procedures	**106,279**	106,032	161,317	102,989	93,445
ED attendances	**66,862**	64,979	62,106	59,485	59,305

Due to the implementation of a new electronic patient administration system (e-Care) our counting methodology has changed. This is reflected in the 2016/17 activity provided in the table above, and makes year-on-year comparisons unreliable.

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

Before adjusting for the Pathology Partnership (tPP) impairment of £4.8m, WSFT recorded a deficit of £3.3m for the year 2016/17 which is £1.7m better than our planned control total of £5.0m.

	2016/17 £000	2015/16 * £000	2014/15 £000	2013/14 £000	2012/13 £000
Operating income	**254,933**	209,588	172,589	172,714	166,988
Operating costs	**(252,407)**	(213,994)	(171,998)	(169,793)	(158,627)
EBITDA** surplus	**2,526**	(4,406)	591	2,921	8,361
Depreciation, dividend and other costs	**(5,853)**	(5,861)	(7,075)	(6,531)	(6,827)
Fixed asset impairments***	**(4,815)**	(410)	1,062	(30)	(22)
Retained earnings	**(8,142)**	(10,677)	(5,422)	(3,640)	1,512

* The 2015/16 financial performance has been restated due to a change on maternity income

** 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 2016/17 figure includes the Trust's impairment of the investment in tPP - £4.8m

Note that since 1 October 2015 WSFT has hosted community services which have increased both the income and expenditure by around £63m in a full year.

An award-winning hospital

The following section outlines our many achievements during 2016/17.

Awards and accolades

'Outstanding' rating for care

Patients using WSFT receive 'outstanding' care from staff who go "the extra mile", the Care Quality Commission (CQC) found following a rigorous three-day inspection in March 2016. It gave the Trust – which provides services at both West Suffolk and Newmarket hospitals – an overall rating of 'good'", while rating the care provided as 'outstanding'. The report is the best of all hospitals in the eastern region (based on review of CQC reports for relevant trusts).

In their report, the inspectors highlighted several specific examples of outstanding practice, which included:

- excellent performance in national audits, which routinely place the trust amongst the top 15 in the country. Stroke performance was a particular highlight.
- two consultant paediatricians learning hypnosis to reduce the need to sedate children who need an MRI or CT scan.
- the respect shown by porters when transporting patients to the mortuary.
- consultant paediatricians setting up outreach clinics in GP practices and holding telephone clinics so that patients can receive more convenient treatment closer to home.
- the work of the hospital's 'virtual fracture team', which makes sure fractures are diagnosed as quickly as possible in the emergency department (ED).
- staff dropping off take home medications or going the extra mile to provide decaffeinated tea bags for patients.
- an ED receptionist giving CPR after a patient collapsed.
- staff arranging a linked funeral service for a widow who could not leave the hospital.
- the work done by the pharmacy to provide take home medication for patients.
- the results of an independent assessment which shows the Trust was the most efficient small acute provider and the fourth most efficient provider in the country.

In its report, the CQC particularly praised staff at the hospital, saying they place the patient at the centre of the care they provide and describing them as "open, helpful and dynamic". The positive feedback the hospital receives from patients and visitors was also commended, along with the safety of services and the infection control processes which are in place.

West Suffolk named as one of 'top hospitals' for safe, effective care
WSFT has been named as one of the country's top hospitals for providing safe, effective and high quality care for the second year running. The hospital was one of 40 from across the country to receive the accolade from independent healthcare intelligence company CHKS during its Top Hospitals 2016 awards ceremony in London in May 2016. It came following detailed analysis of 22 key areas covering clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. Judges looked at a variety of data, including length of stay, hospital acquired infections, inpatient surveys and emergency readmission rates, before deciding which hospitals would receive the award. For the sixth consecutive year, WSFT was also one of just five hospitals shortlisted in the quality of care category. The Trust won the title in 2011 and 2012.

West Suffolk NHS Foundation Trust to become a 'centre of global digital excellence'
WSFT is to become a prestigious 'centre of global digital excellence' after successfully bidding for a share of £100m in funding to further improve the way technology is used to benefit patients. The hospital was invited to bid for the money by NHS England after it was identified as one of the country's 26 'most digitally advanced' trusts following the introduction of its electronic patient record, e-Care, earlier this year.

Over the next two years, up to £10 million of funding will be invested in accelerating the hospital's existing plans to develop further its e-Care system. This will see the system fully integrated with those used by GPs, other hospitals such as Addenbrooke's, social services and other care providers so that everyone can share the same records, in turn avoiding duplication while making life easier for clinicians. In addition, a secure patient portal will be created to give patients access to their personal health records, allow them to view test results and send messages to their doctor, ensuring they are fully involved in their own care.

Hip fracture care among the best in the country
The National Hip Fracture Database rates WSFT as top in the east of England for the care patients receive when attending with a hip fracture, and sixth nationally, up three places from last year. Hip fracture is the most common serious injury in older people, often resulting in lengthy hospital stays with only a minority of patients regaining their previous abilities and often needing long-term care.

An integrated staff team, including specialists from the emergency department, orthopaedics, elderly medicine and physiotherapy, work hard to deliver in line with best clinical practice guidelines. The team has introduced regular virtual fracture clinics at WSH, a key part of the care given to patients attending with musculoskeletal injuries, where they assess patient needs together to identify immediate care needs and ensure they see the right specialist at the earliest opportunity.

WSFT achieved 85.1% in the best practice tariff, the highest in the east region, against a national average of 65.6%. Records show that:

- 100% of patients received a bone health assessment (national average 97.2%)
- 88.2% of patients had surgery on the day of, or day after, admission (national average 71.5%)
- 80.2% of patients were mobilised out of bed on the day after surgery (national average 76.1%)
- The average overall length of stay in days was 17 (national average 21.1 days)

Top award for hospital's patient meals
The Trust received a prized national accolade for its dedication to serving fresh, ethical and sustainable food to patients, visitors and staff. WSH was presented with the Soil Association's Food for Life Catering Mark bronze award for the meals it serves in the Courtyard café and Time Out restaurant. The award shows that the hospital uses fresh ingredients which meet nutritional guidelines and are free from additives and harmful trans-fats. All of the meat used by the hospital conforms with UK animal welfare standards and has earned the Red Tractor farm assurance quality mark, while fish is certified by the Marine Stewardship Council and eggs are free range. To achieve the award, the hospital's catering team reviewed its recipes and changed some of its ingredients, such as swapping milk powder for fresh milk in its cauliflower cheese. They also worked with their butcher to change the seasoning in their sausages, while increasing the meat content of the sausage rolls which are sold to staff so that they now contain over 80% pork.

Trust improves again in staff survey results
WSFT has strengthened its position as the hospital in the East Anglia that is the most highly rated by its staff, according to the results of the 2016 NHS staff survey. Asked questions about whether they would recommend the hospital as a place to work or receive treatment, 88% of staff agreed that care of patients is the Trust's top priority. The national average was 76%. When asked if they would recommend the Trust for treatment of a friend or relative 85% of staff agreed that they would compared with a national result of 70%.

The Trust is the highest performing in the country for staff engagement. It is also a leading trust for the extent to which staff look forward to going to work and being enthusiastic and absorbed in their jobs.

Investment in equipment and facilities

Launch of new electronic patient record
WSH underwent an unprecedented overhaul of its IT system with the launch in May 2016 of a new multi-million pound electronic patient record. Called e-Care, the state-of-the art, standardised IT system will transform the way services are managed and run at the hospital. It has brought all available information about each patient into one place, making it easy to access from anywhere in the Trust while improving safety, preventing duplication and reducing costs. The new system has enabled the hospital to monitor patients much more closely while managing its capacity more carefully.

It makes it simpler for staff to double check information, which means they will no longer need to ask patients the same questions several times. At a cost of around £19 million, e-Care is the biggest single investment the Trust has ever made in IT.

New parking facilities for patients, staff and visitors
WSFT has taken steps to address a number of issues with the availability of car parking at its WSH. In February 2017 an additional 400 parking spaces were opened at the hospital following a £2 million investment in this and a range of improvement works. Extra spaces for staff help them to avoid parking their cars on roads surrounding the hospital.

After liaising with patient representatives, the Trust amended the tariff for parking to make a modest contribution towards the capital investment. It has also addressed a regular complaint from patients that short-stay visits are charged at an excessively high rate by introducing a new tariff for a one hour stay. Additional spaces for disabled drivers who carry a blue badge have been created, along with specially-designated wheelchair-supported access spaces that provide better access for those unable to walk.

Trust opens care home beds in Bury St Edmunds
In February 2017 WSFT officially opened a new suite of beds at King Suite, part of Glastonbury Court care home in Bury St Edmunds. The King Suite is a 20-bed inpatient service managed by hospital staff, which is able to offer medically-fit patients from West Suffolk Hospital a period of optimisation, reablement and recovery, before they are discharged home. Based in a separate wing at Glastonbury Court, a care home run by Care UK, patients benefit from single rooms, en-suite bathrooms and access to a lounge, dining room and grounds. They are encouraged to get up and dressed, enjoy social activities, therapy sessions and receive visitors at any time that suits them.

New private physiotherapy service
WSFT has launched a new private physiotherapy service to help people recover from injury and enhance their wellbeing. Called West Suffolk Physio, the new service, based in Hillside Road, Bury St Edmunds, is staffed by a team of NHS-trained physiotherapists who also work at West Suffolk Hospital.

The innovative new service is a tailor-made private option for people who want to top up on what can be offered by existing NHS physiotherapy services from the hospital. It also gives more choice for people who want to pay for a service that is quickly accessible and convenient for them. Any income generated by the service is reinvested into NHS services provided by the Trust.

Therapists at West Suffolk Physio can assess and treat a wide spectrum of joint, soft tissue and nerve related problems as well as offering specialist interventions and advice in relation to respiratory conditions, rehabilitation after surgery, continence problems, mobility and falls and pain management. As well as providing treatments at the purpose-built Hillside Road centre, physiotherapists from the service will visit people in their homes if this is more practical for the client rather than coming to the clinic.

Patients praise fast new prostate treatment
A patient who received treatment with a revolutionary new laser at WSH has praised the care he received and the speed of his recovery after returning home just 24 hours after the procedure. The patient was treated with the state-of-the-art GreenLight laser after being diagnosed with an enlarged prostate, which was constricting the flow of urine from the bladder. Clinicians use the laser to target excess tissue, in turn easing any blockages and helping the patient return to normal. WSH was the second hospital in East Anglia to introduce this.

Social, community and human rights issues

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

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.

1.2.3 Future business plans

Sustainability and transformation plans (STPs)

A key issue driving our financial challenge is the increase in demand for service. We have in place a strong, visible, collective leadership and a well-structured programme of work to address this, and to focus on our key clinical priorities around reducing health inequalities and unwarranted variation.

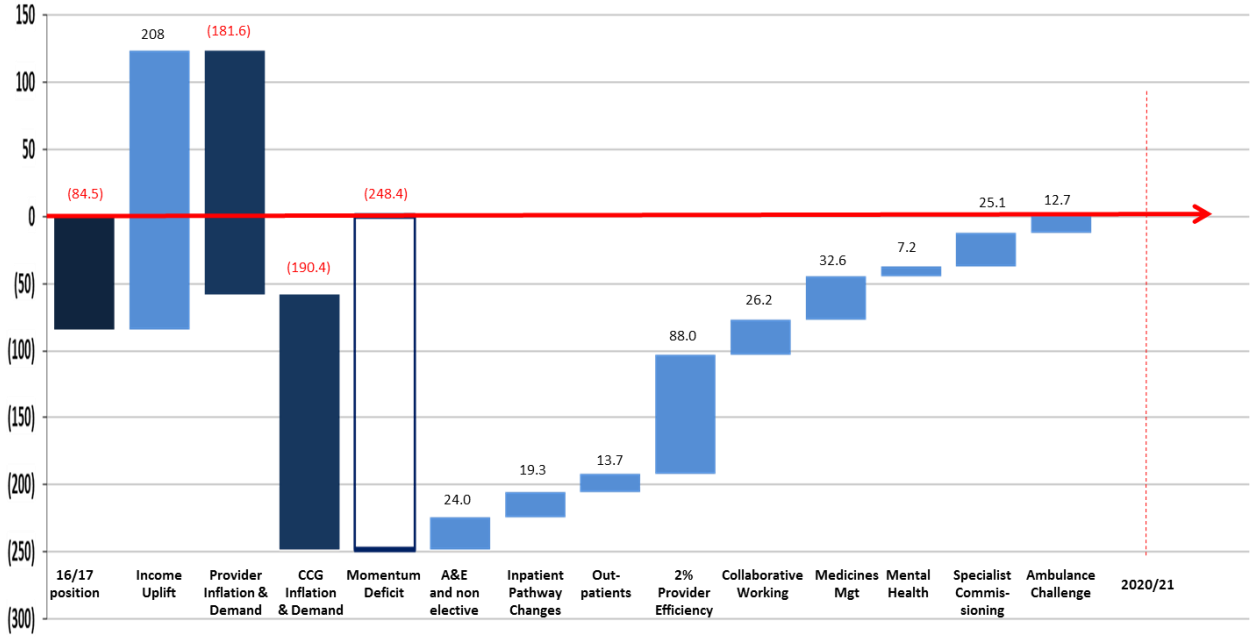
The long-term goal and key focus within our STP is the design and mobilisation of two integrated care systems (ICSs), one to serve Ipswich and east Suffolk, and the other focussing on west Suffolk. These bring acute hospital, community, social care, mental health and primary care partners across Suffolk together to form an integrated financial and management delivery framework which will transform outcomes and experience for patients. Care will be based around localities and neighbourhoods, rather than around organisations.

As part of our journey towards this new way of working we have established two alliances covering those footprints to bring health and care services together to provide one coordinated care response that is underpinned by prevention, self-care, early intervention, reablement and rehabilitation rather than long-term treatment and lifelong service dependency. Our STP was submitted to NHS England in October this year and we are now working with commissioners and providers to embed the plans within our contractual and operational planning processes. It is clear that there are benefits for our population if we align our goals and actions and share knowledge and skills. The STP summarises the work to date and outlines how our system-wide plan can be delivered across organisations, how the known and emerging risks can be managed, and how by working together we believe we can improve the quality and safety of care provided.

Developing an ICS for the west of Suffolk is a key part of our STP planning. The development of a provider alliance formed from community services, acute hospital, adult social care, mental health services and primary care will be the vehicle through which we will deliver our community services contract. The formation of this alliance will be the first phase towards a fully functioning ICS that will evolve over time to include commissioning functions. To mitigate engagement and operational risks the provider alliance is operating in shadow form, testing integrated locality models building on the health and care integration already established. We will operate locality shadow boards with shared governance financial frameworks, gradually phasing in more services from the whole system.

The financial bridge (figure 1) describes the transformation journey to improve quality and safety and achieve a sustainable financial position. Our main focus is mitigating growth in demand.

Figure 1: STP financial bridge



Key programmes of work have been established to deliver the STP vision and improve the health and care services provided for our citizens. These programmes build on existing schemes that the Suffolk and north east Essex teams have been working on and we have now been able to share ideas and plans across the footprint to maximise the benefits offered to our patients and the system.

Figure 2: Delivering the STP Vision

Self Care & Independence, and Community Based Care				Hospital Reconfiguration and Transformation			Collaborative Working across the System	
Safer Stronger Resilient Communities	Integrated out of hospital care	Mentally Healthy Communities	Primary Care Transformation	New Models of Care	Improving Care Pathways	Ipswich & Colchester Hospital Partnerships	Managed Care	Collaborative Working across Commissioners
• Shaping primary and community care to reduce demand for acute hospital and "bed based" care systems • Working with partner organisations to improve safety, resilience, and strengthen communities • Reduce need for follow up by the acute hospital through better management and "safe landing" within primary and community care • Reduce primary care variation, including for prescribing and referrals				• Re-shaping acute care to respond to resilient community work stream outputs • Aligning clinical systems and processes across all three sites where possible / appropriate • Reducing variation across the acute sites			• Shared clinical teams, systems and processes across the system • Shared back office functions • Shared and consistent commissioning and contracting approach	

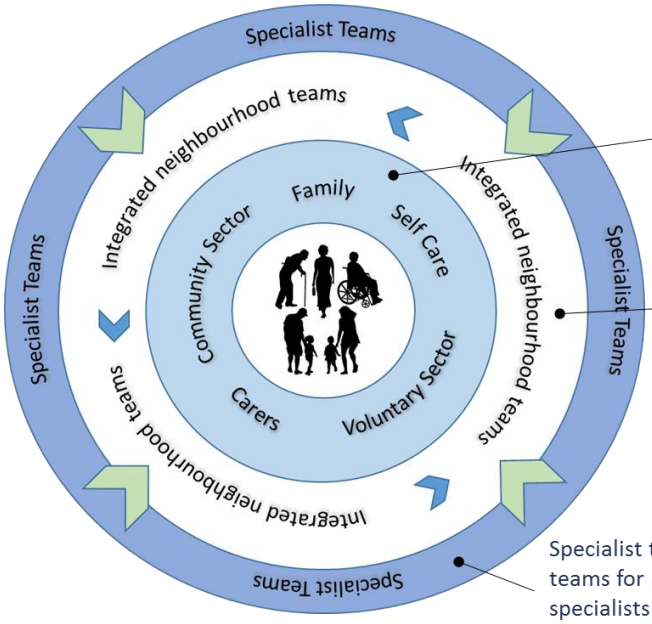
By delivering the STP vision (figure 2) we aim to build stronger and more resilient communities which support our citizens to maintain independence as they take responsibility for managing their own health and wellbeing. This will enable people to stay in their own home longer, reduce demand for social care packages, nursing and care home placements, and long hospital stays. This will create happier, less isolated, more empowered and independent citizens. In turn it will deliver system-wide benefits as we work together with community and social care partners to make the best use of our resources.

With the right knowledge and support, people can make a difference to their lives and those of their families.

Our future care system - adults

We will move to a place based care system with a much greater focus on proactive care and critical links to primary care and the urgent care system. True coordinated care wraps around the patient / service user and coordinates care for them rather than passing them from service to service. This importantly includes users with long term conditions (LTCs).

Figure 3: Future care system - adults



Key focus on self care – using the Supporting Lives, Connecting Communities model to encourage an asset based response, introducing clear information for people with LTCs so that they know how to manage exacerbations and when to call for help, taking the learning from Local Area Co-ordination about the value of creating stronger linkages for people in the community sector.

Our Connect Integrated neighbourhood teams: Trialling a different configuration of primary care to manage demand differently and free up GP time for proactive management of LTCs and complex needs, exploring joint management, a more integrated offer for rehab and reablement.

Specialist team input will be co-ordinated by our neighbourhood teams for a set period of time as part of a care plan/pathway. Some specialists will still be county wide and some we will want to create a more locality based service. Specialist teams will work with neighbourhood teams to offer education and skills transfer to enable them to provide greater support for the population

Our future care system - children

We recognise that children's services draw on a complex support system across health, social care, community and education. A critical alignment is primary care and the optimisation of pathways between community and acute as required to put the children first.

Figure 4: Future care system - children

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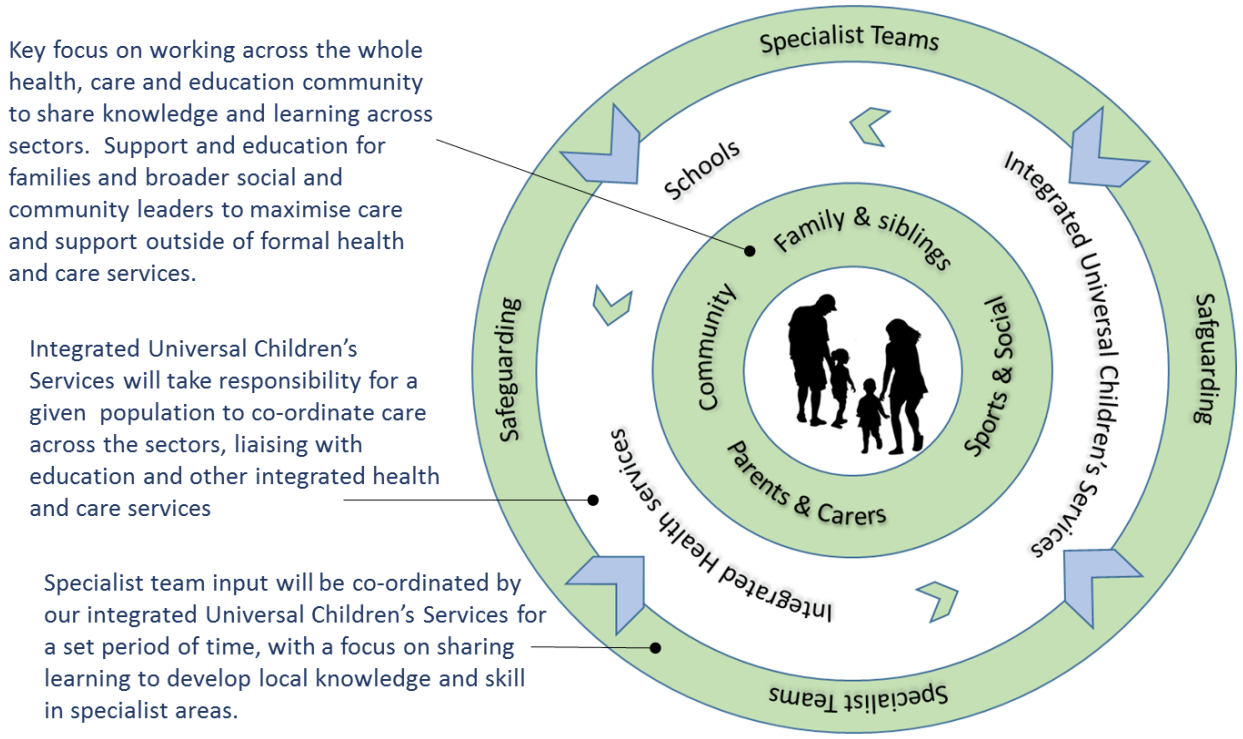


In response to the 'Five Year Forward View', a strategy based on the primary and acute care system (PACS) model for delivery in west Suffolk has been developed with four main objectives, which are central to the wider public sector reform agenda in Suffolk:

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 system (ICS) model with the CCG and other partners.

The transformation plans for 2017/18 continue the themes initiated in the previous year and 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) and transformation of community services. These are both considered in more detail at the end of this section. We are currently developing a fully integrated transformation team across the acute, community and the CCG to take forward these plans in an efficient and co-ordinated manner.

(i) Demand management

The integrated transformation team will focus on two separate portfolios of work, each under the direction of a team leader.

- **West Suffolk integrated care programme**
  Within the umbrella of this programme are two separate programmes of work:
  - the reactive programme is focussed on urgent and emergency care demand management and 24/7 admission avoidance schemes.
  - the Proactive Programme is focussed on better management of long term conditions through the roll out of integrated neighbourhood teams and effective discharge strategies.

- **West Suffolk planned care and demand management programme**
  This programme will undertake joint reviews across a number of clinical pathways. The proposed programme currently includes musculoskeletal, ophthalmology, gastro, dermatology, ENT and audiology, urology and pain management.

(ii) Business development

The Trust and CCG have developed a strong collaborative working arrangement, both contractually and operationally. This is leading to the development of a system-wide approach to business development. Over the coming year formal reviews and updates to the original service level five year strategies will be undertaken as part of our business planning process.

(iii) Efficiency

WSFT is working with KPMG as part of the national financial improvement programme (FIP) commissioned by NHSI. The programme will critically challenge our existing cost improvement and efficiency programmes, identify additional opportunities from a range of other initiatives and support delivery at pace. Through this approach the programme will support delivery of our control total in-year and establish a programme to ensure long term sustainability.

- **Project theatres**: we have an on-going theatre efficiency programme but despite this have recognised an underlying capacity shortfall. As a result the focus for project theatres over the coming year will be a review of the theatre timetable to increase session length and capacity through better use of available resources.

- **Project outpatients**: following the deployment of e-Care we have had a year of stabilisation and embedding our new systems and processes. Through the FIP programme we will now seek to maximise overall outpatient efficiency and productivity.

Community services

Our partnership of community service providers, led by the Trust has continued to deliver community services within a consortium. This contract will cease on 30 September 2017 and we are currently progressing through a 'most capable provider' process to secure the community services contract for the next 7-10 years. We are responding to this process as a West Suffolk Alliance, comprised of WSFT, Suffolk GP Federation, Norfolk and Suffolk Foundation Trust (mental health services) and Suffolk County Council. The formation of the alliance and our intention to work in a collaborative partnership was set out in our operational plan and STP submission. The formation of the West Suffolk Alliance is the critical first step towards an ICS for west Suffolk. This is aligned with our long-term strategy to provide more integrated, joined-up services that remove the barriers which can obstruct patient care delivery. This will include piloting the Buurtzorg model of service delivery. This is a unique district nursing model which has gained international acclaim for being entirely nurse-led and cost effective.

WSFT has been identified as a prestigious centre of **global digital excellence (GDE)** after successfully bidding for a share of £100 million in funding to further improve the way technology is used to benefit patients. The hospital was invited to bid for the money by NHS England after it was identified as one of the country's 26 most digitally advanced trusts following the introduction of its electronic patient record, e-Care, earlier this year. Over the next two years the funding will be invested in accelerating the hospital's existing plans to develop further its e-Care system. This will see the system fully integrated with those used by GPs, social services, other hospitals and care

providers so that everyone can share the same records, avoiding duplication and making life easier for clinicians.

The Trust's vision for a digital future reflects the organisation's transformation goals, priorities and ambitions. WSFT does not see digitisation as an end in itself but as an enabler. Therefore, we will align all information management and technology initiatives with the outcomes and benefits we aspire to achieve through our transformation and benefits realisation programme. We have a clear organisational strategy, discussed with and countersigned by colleagues across the care economy and the wider public sector.

As a centre of GDE, WSFT will deliver enhanced quality of care and seamless services across our whole health and social care economy. The aims of the programme are three-fold and represent our five-year vision:

- **A transformation-led digital acute trust** – the programme will provide WSFT with a robust, fully digital platform which is paperless at point of care, resulting in operational efficiencies and improvements in quality of care. Real-time access to accurate information about patients and their care plans, and enterprise-wide scheduling will ensure seamless and safe handover of care across care settings. Evidence-based decision support such as early warnings for AKI and sepsis will optimise care and prevent illness. Efficiency improvements such as device integration will allow more time for direct patient care. Effective use of medications through improved decision support, compliance and reconciliation across settings will deliver safer patient care
- **Supporting the goals of the ICS** - the programme aims to support fully the goals of the emerging west Suffolk ICS. A digitally mature acute trust is essential for achieving the goals of the wider care community. The complete deployment of e-Care combined with wider system integration will allow the Trust to provide an efficient and effective risk stratification approach to patient management. For example, Suffolk has an older than average population, resulting in increasing demand for services versus affordability. By applying a risk stratification approach and targeting segments of the population (e. g. over 85s), we can intervene in a way that abates demand. A centralised business intelligence and analytics function across the ICS will allow us to perform the sophisticated data analysis which is essential to delivering effective risk stratification
- **Promoting our exemplar digital community** – working with our electronic patient record partner, Cerner, we will establish ourselves as a model digital community within two years. We will build on our strong foundations and extend our already recognised model approach to other organisations both nationally and globally. We will contribute to the increased digital maturity of our local partners, including neighbouring acute hospitals, community services, mental health, ambulance and social care, by providing mentorship in all aspects of deployment, including leadership, informatics and intellectual property (IP) development. We will contribute to delivering digital maturity in both Cerner and non-Cerner sites alike through the sharing of experiences, approaches and solutions. We will achieve this goal through strengthening existing partnerships such as those with Cerner, the Eastern Academic Health Science Network (ESHSN) and our teaching partner Cambridge University. We will also build new partnerships locally and internationally with other exemplar sites or IP development partnerships.

Lord Carter's provider productivity work programme

The PricewaterhouseCoopers (PwC) benchmarking report commissioned in 2014 assessed 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 (February 2016) which has calculated the Trust'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 fourth 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. The 2017-18 plan assumes a CIP target of 4.0% which broadly reflects Lord Carter's initial findings.

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 unlock 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 the NHS supply chain, Crown Commercial Services and the NHS procurement hub to ensure best value is 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 and commitments agreements offer the best opportunities for the Trust in line with its size and spend.

Agency rules

The two main clinical staff groups where agency staff are used are doctors and nurses. When the initiative was first implemented it was difficult to fill these bookings as the agencies resisted and did not put forward staff to fill the shifts. However, we are now seeing the following benefits:

- We are getting a better response to adverts for substantive posts in terms of Trust doctors and junior doctor training posts
- We are beginning to see agency doctors asking to join our internal bank and we are advertising to join our medical bank.

The Trust recognises the risks to deliverability of the agency ceiling target and we are working towards mitigating that risk by working in collaboration with neighbouring trusts through the East of England Procurement Hub.

Capital planning

The Trust has a five-year risk assessed capital strategy which focusses 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 ranking process which assesses the benefits of investment against four criteria: compliance with the estate strategy; operational/clinical need; financial impact; and statutory compliance. The assessment ensures that:

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

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

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

Sustainability

As an NHS organisation and as a spender of public funds we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and effective use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health, both in the immediate and long term, even in the context of the rising cost of natural resources.

In order to fulfil our responsibilities for the role we play, WSFT has its sustainability mission statement located in our sustainable development management plan (SDMP):

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

As a part of the NHS, public health and social care system, it is our duty to contribute towards the ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) by 2020. It is our aim to meet this target, relative to patient activity, by reducing our carbon emissions using 2007 as the baseline year.

One of the ways in which an organisation can embed sustainability is through the use of a SDMP. The sustainable development steering group updated our SDMP in March 2017, for presentation to the Board, so our plans for a sustainable future are understood within the organisation and clearly laid out.

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the good corporate citizenship (GCC) tool. Our first GCC self-assessment was in August 2016, scoring 45% compared with the national average of 53%. WSFT's areas of strength were workforce, models of care and travel. Completing our sustainable development action plan for 2017 will enable us to improve the GCC self-assessment score to above 50% in all eight areas. However, it should be noted that the GCC tool is currently being reviewed to be more accessible and align with the United Nations sustainable development goals.

Areas for improvement

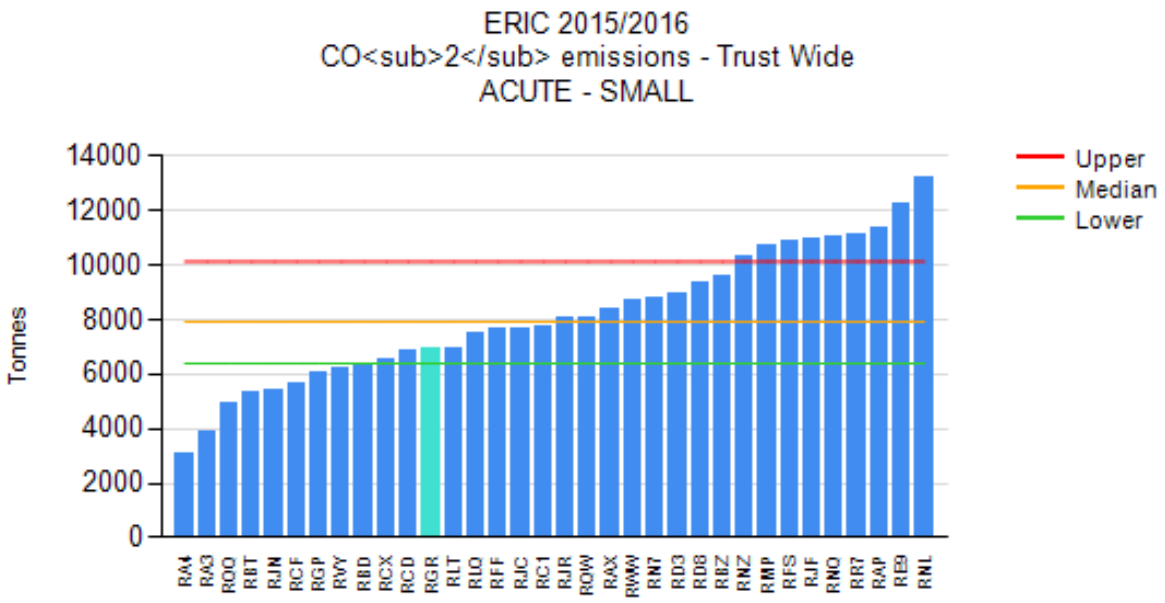
Area	How will we achieve it?	Measuring success
Carbon and energy target Our target is to be a low carbon quality healthcare environment that is sustainable, resilient, and safeguards high quality patient care. We aim to reduce our CO2e emissions by 34% by 2020 from 2007 baseline relative to activity	• Ensure the combined heat and power plant is running at optimum levels • Continue to reduce unnecessary usage • Planned major projects, such as sterile services and the residences, will make use of energy efficient technology and have a positive impact on our carbon footprint • Provide training to ensure that every member of staff is able and encouraged to take responsibility for energy consumption and carbon reduction	• Annual reporting through carbon reduction commitment scheme • Annual sustainability report to the Board • Consumption levels monitored monthly • Estates key performance indicators (KPIs)

Area	How will we achieve it?	Measuring success
Built Environment Built environments should be designed to encourage sustainable development and low carbon usage in every aspect of their operation. This includes resilience to the effects of climate change, energy management strategies and a broader approach to sustainability including transport, service delivery and community engagement	• Ensure the combined heat and power plant is running at optimum levels • Continue to reduce unnecessary usage • Planned major projects, such as sterile services and the residences, will make use of energy efficient technology and have a positive impact on our carbon footprint • Provide training to ensure that every member of staff is able and encouraged to take responsibility for energy consumption and carbon reduction	• Energy efficiencies will be reflected in utility performance • Staff and patient feedback • Good Corporate Citizen assessment
Water We use approximately 164,000 m3 of water a year across the site. Apart from normal domestic use, we use water in catering, instrument sterilisation, endoscopy and renal dialysis. Our target is to maintain water usage levels, within a 10% variation, despite increased activity and consolidation of Sterile Services to this site	• Increase staff awareness on using water responsibly • Ensure leaks are reported and dealt with promptly • Water efficient appliances to be specified for new or replacement projects	• Monitor usage • Report against activity • ERIC data and Trust annual report • Estates KPIs • Good Corporate Citizen assessment
Waste Our targets are to reduce the total amount of waste relative to activity, increase opportunities for reuse and recycling and ensure that waste is segregated appropriately.	• Improved training for all staff on the various waste streams • Advice for staff, patients and visitors on the environmental and financial benefits of recycling • Continue to work with suppliers to reduce packaging • Continue to work with waste contractors to reduce waste to landfill and increase recycling • Provide dry, mixed recycling points in the staff restaurant • Develop opportunities to reuse furniture within the Trust and the wider community.	• Regular audits • Quarterly waste report • ERIC data • Contractor reports • Good Corporate Citizen assessment
Procurement Sustainable development is assessed, considered, implemented and monitored in procurement decision making to: • minimise waste associated with our activities • ensure procurement is conducted in an ethically sound manner • promote equality and diversity	• Risk assess key suppliers' impacts against our sustainable development targets • Embed life time costing model • Continue to improve our stock management • Support small and medium sized enterprises (SMEs) • Train and develop our staff in the principles of sustainability and sustainable procurement	• NHS Standards of Procurement (reference 6.4 and 6.5) • Good Corporate Citizen • Procuring for Carbon Reduction (P4CR)

Area	How will we achieve it?	Measuring success
Workforce Development Our target is to make West Suffolk Hospital a great place to work: • Train, educate and motivate staff to be the best. • Nurture leadership at all levels. • Build on our excellent teaching and research base. • Encourage involvement and contribution of ideas. • Promote an open culture where staff can voice concerns without fear. • Encourage staff to achieve healthy work life balance. • Recognise and reward great performance.	• We will encourage all staff to adopt a healthy lifestyle and support their physical and mental wellbeing via effective human resources and occupational health policies and practice. • Continue to develop the Freedom to Speak Up campaign.	• Staff surveys • Staff development reviews • Good Corporate Citizen assessment
Models of Care Our target is to: • deliver year-on-year improvements in the patient experience • Maintain our position in the top 10% of hospitals with the lowest mortality.	• Focus on key indicators of harm; including pressure ulcers, falls, hospital acquired infections, medical errors and readmissions • Promote standardisation of practice • Train, educate and support staff to deliver safe and effective care • Breakdown the barriers in how services are provided to deliver more joined-up care • Ensure patients are given the right care, in the right place, at the right time • Use e-Care to support the sharing of information across primary, community and secondary care	• Good Corporate Citizen assessment • Patient and family surveys • Benchmarking against other acute hospitals
Community Engagement As a local hospital at the centre of our community, in addition to the health economy we will ensure that we play a full part in the West Suffolk Forum, the Suffolk Health and Wellbeing Board and work with our councils, partner trusts and other stakeholders.	• We must ensure that we help and support our local communities to be involved in our ambitions for WSH. As one of the largest employers in west Suffolk we have a leadership role as a model employer. Wherever possible, we must encourage local apprenticeships and businesses. For example, by sourcing local, healthy food and working with our councils to do more for our communities. • We will also consider how we can further enhance the patient experience and the support that we give to vulnerable patients by exploring other imaginative community roles such as ‘dementia buddies’ and ‘falls friends’.	• Good Corporate Citizen assessment • Patient and family surveys

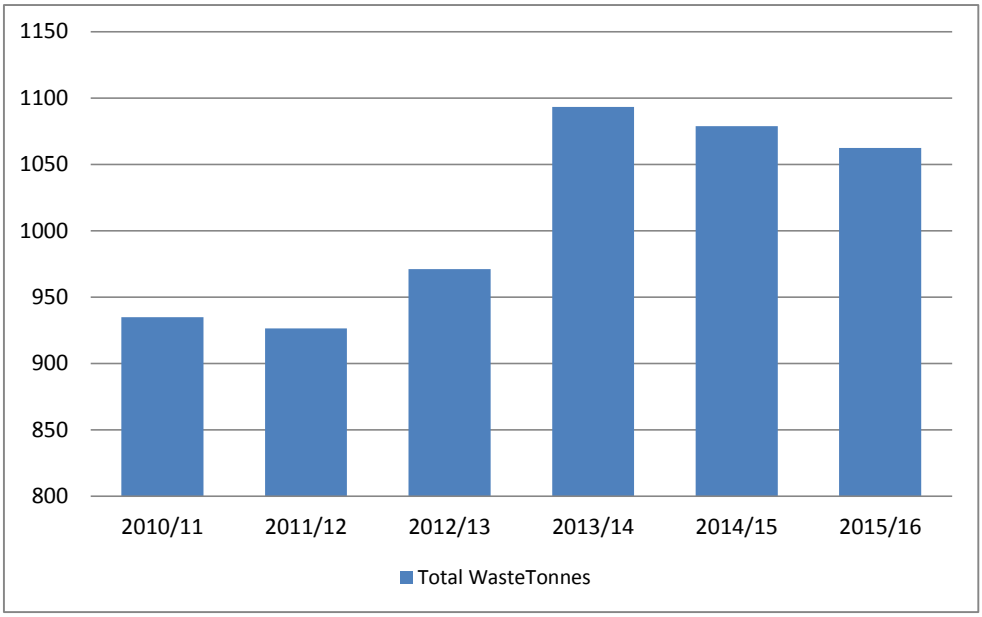
Area	How will we achieve it?	Measuring success
Travel and Transport Our target is: • overall reduction in business mileage • increasing use of alternative sustainable travel options	• Make more use of video conferencing facilities • Where possible, Trust replacement vehicles will be of lower carbon emissions than their predecessors • Continue to work with community partners to improve opportunities for sustainable travel • Improve facilities on site for cyclists, additional storage and shower facilities • Review the grey fleet mileage and carbon footprint • Review driving for work policy and business travel expenses policy • Develop the use of Enterprise car share scheme • Promote existing car share and cycle2work schemes to staff	• Car park barrier data • Record and report business miles through IT system • Monthly bicycle audit • Annual staff and visitor travel surveys • Travel Plan reviews
Adaptation Adaptation means responding to both the projected and current impacts of climate change and adverse weather events. Adaptation for the health and care system is twofold: • Climate change could negatively impact the physical and mental health and wellbeing of the UK population. The health and care system needs to be prepared for different volumes and patterns of demand. • Climate change could impact the operational delivery of the health and care system. The system infrastructure (e.g. buildings, communications, emergency service vehicles, models of care) and supply chain (e.g. fuel, food and care supplies) need to be prepared for and resilient to weather events and other crises.	• The Trust has undertaken risk assessments and carbon reduction Plans are in place in accordance with emergency preparedness and civil contingency requirements as based on UK climate projections 2009. The projections show that although reducing greenhouse gas emissions is critical to avoid the most dangerous effects of climate change, past emissions mean that some changes are now inevitable whatever we do – with summers over 2°C hotter in southern England by the 2040s. It is therefore vital that we plan and prepare for these changes. • UK climate change risk Assessment 2012 predicts an increase in the frequency and intensity of weather related hazards including heat waves and floods.	• Risk assessments on the Trust risk register • Adaptation plan links to the business continuity plan • Report Adaptation plan progress in the Trust annual report • Good Corporate Citizen assessment

How are we doing?



RGR- West Suffolk NHS Foundation Trust

Total waste (clinical and non-clinical)



Data source – quarterly waste returns. Note 2013/14 includes a significant increase in confidential and domestic waste.

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
Mrs June Carpenter (interim lead governor from August 2016, substantive lead governor from February 2017)
Mr Ian Collyer
Mrs Justine Corney
Dr David Frape
Mrs Jayne Gilbert
Mr Barry Moult
Mr Charles Nevitt [(1)]
Dr Steve Ohlsen[(2)] (lead governor until July 2016)
Mrs Jan Osborne
Dr Joe Pajak
Mrs Margaret Rutter
Mr Mick Smith [(3)]
Mrs Liz Steele
Mr Stuart Woodhead

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

Mrs Jane Chilvers
Mr Nick Finch
Mr Peter Harris
Mrs Jenny McLaughlin
Mrs Lindsay Pike

[(1)] Joined council of governors in August 2016
[(2)] Joined council of governors in April 2016
[(3)] Resigned from council of governors in July 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	West Suffolk College also representing University Campus Suffolk
Mrs Laraine Moody	West Suffolk College also representing University Campus Suffolk
Mr Jon Eaton[4] *(position currently vacant)*	West Suffolk Consortium for Voluntary Organisations
Councillor Rebecca Hopfensperger	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

[4]Resigned from council of governors in February 2017

Governor attendance at council of governors meetings 2016/17

There were five formal meetings of the Council of Governors: 12 May 2016, 8 August 2016, 13 September 2016 (Annual Members Meeting), 16 November 2016, 8 February 2017, with the following Governor attendance:

Name	Title	Attendance (out of five meetings)
Mrs Mary Allan	Public governor	**2**
Mrs June Carpenter	Public governor	**5**
Mrs Jane Chilvers	Staff governor	**2**
Mr Ian Collyer	Public governor	**4**
Mrs Justine Corney	Public governor	**4**
Mrs Judy Cory	Partner governor	**5**
Mr Jon Eaton	Partner governor	**3** (of 4)[1]
Mr Nick Finch	Staff governor	**4**
Dr David Frape	Public governor	**4**
Mrs Jayne Gilbert	Public governor	**5**
Dr Mark Gurnell	Partner governor	**3**
Mr Peter Harris	Staff governor	**3**
Councillor Rebecca Hopfensperger	Partner governor	**2**
Mrs Jenny McLaughlin	Staff governor	**4**
Cllr Sara Mildmay-White	Partner governor	**4**
Mrs Laraine Moody	Partner governor	**2**
Mr Barry Moult	Public governor	**5**
Mr Charles Nevitt	Public governor	**3** (of 3)[2]
Dr Steve Ohlsen	Public governor	**0** (of 1)[3]
Mrs Jan Osborne	Public governor	**2**
Dr Joe Pajak	Public governor	**4**
Mrs Lindsay Pike	Staff governor	**4**
Mr Roger Quince	Chair	**4**
Mrs Margaret Rutter	Public governor	**3**
Mr Mick Smith	Public governor	**5** [4]
Mrs Liz Steele	Public governor	**4**
Mr Stuart Woodhead	Public governor	**4**

[1] Resigned from council of governors in February 2017
[2] Joined council of governors in August 2016
[3] Resigned from council of governors in July 2016
[4] Joined council of governors in April 2016

In attendance at these meetings were: Dr John Benson, non-executive director (2); Mr Craig Black, executive director of resources (3); Mrs Jan Bloomfield, executive director of workforce and communications (1); Dr Pam Chrispin[(a),] executive medical director (2); Dr Stephen Dunn, chief executive (3); Mr Jon Green, executive chief operating officer (2); Mr Neville Hounsome, non-executive director (4); Dr Nick Jenkins[(b)], executive medical director (1); Mr Gary Norgate, non-executive director (1); Mrs Rowan Procter, executive chief nurse (3); Mr Steve Turpie, non-executive director (3); Mrs Rosie Varley, non-executive director (3).

[(a)]Dr Pam Chrispin left the Trust in November 2016
[(b)]Dr Nick Jenkins was appointed as executive medical director in November 2016

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 and 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).

NEDs 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 Board workshop took place in February 2017. The focus of this was community services and the integrated care system (ICS).

The lead governor has continued to arrange informal meetings of governors and NEDs which has been beneficial in developing a good working relationship.

At joint workshops, presentations and formal and informal meetings governors contribute to the WSFT's forward plan. Governors also contribute to WSFT's annual report, which includes the quality report.

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. Governors also take part in monthly environmental walkabouts, the purpose of which are to support the department managers in ensuring that the Trust's corporate identity and values are represented accurately.

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 executive directors and NEDs. A report on how these issues are being addressed is provided to the council of governors meeting.

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

- Joint council of governors and Board workshop – community contract and accountable care organisation (23 February 2017)
- Governor training day – recap on previous training, introduction to NHS quality and NHS finance, role of the Board in light of the well-led framework and the STP process, with external trainer (7 March 2017)
- Throughout the year governor visits to pharmacy, radiology and physiotherapy services have also taken place.

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:	Alton, Berners, Boxford, Brett Vale, Brook, Bures St Mary, Chadacre, Dodnash, Glemsford and Stanstead, Great Cornard (North Ward), Great Cornard (South Ward), Hadleigh (North Ward), Hadleigh (South Ward), Holbrook, Lavenham, Leavenheath, Long Melford, Lower Brett, Mid Samford, Nayland, North Cosford, Pinewood, South Cosford, Sudbury (East Ward), Sudbury (North Ward), Sudbury (South Ward), Waldingfield.
Braintree:	Bumpstead, Hedingham and Maplestead, Stour Valley North, Stour Valley South, Upper Colne, Yeldham
Breckland:	Conifer, East Guiltcross, Harling and Heathlands, Mid Forest, Thetford-Abbey, Thetford-Castle, Thetford-Guildhall, Thetford-Saxon, Watton, Wayland, Weeting, West Guiltcross
East Cambridgeshire:	Bottisham, Burwell, Cheveley, Dullingham Villages, Fordham Villages, Isleham, Soham North, Soham South, The Swaffhams
Forest Heath:	All Saints, Brandon East, Brandon West, Eriswell & the Rows, Exning, Great Heath, Iceni, Lakenheath, Manor, Market, Red Lodge, St Marys, Severals, South.
Ipswich	Alexandra, Bixley, Bridge, Castle Hill, Gainsborough, Gipping, Holywells, Priory Heath, Rushmere, St John's, St Margaret's, Sprites, Stoke Park, Westgate, Whitehouse, Whitton.
King's Lynn and: West Norfolk	Denton
Mid Suffolk:	Bacton & Old Newton, Badwell Ash, Barking & Somersham, Bramford & Blakenham, Claydon & Barham, Debenham, Elmswell & Norton, Eye, Fressingfield, Gislingham, Haughley & Wetherden, Helmingham & Coddenham, Hoxne, Mendlesham, Needham Market, Onehouse, Palgrave,

	Rattlesden, Rickinghall & Walsham, Ringshall, Stowmarket Central, Stowmarket North, Stowmarket South, Stowupland, Stradbroke & Laxfield, The Stonhams, Thurston & Hessett, Wetheringsett, Woolpit, Worlingworth.
South Norfolk:	Bressingham and Burston, Diss and Roydon
St Edmundsbury:	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, Withersfield
Suffolk Coastal	Aldeburgh, Deben, Felixstowe East, Felixstowe North, Felixstowe South, Felixstowe West, Framlingham, Fynn Valley, Grundisburgh, Hacheston, Kesgrave East, Kesgrave West, Kirton, Leiston, Martlesham, Melton, Nacton & Purdis Farm, Orford & Eyke, Peasenhall & Yoxford, Rendlesham, Saxmundham, The Trimleys, Tower, Wenhaston & Westleton, Wickham Market, Woodbridge.
Waveney	Beccles North, Beccles South, Blything, Bungay, Carlton, Carlton Colville, Gunton & Corton, Halesworth, Harbour, Kessingland, Kirkley, Lothingland, Normanston, Oulton, Oulton Broad, Pakefield, Southwold & Reydon, St Margaret's, The Saints, Wainford, Whitton, Worlingham, Wrentham.

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 2017 there were 6,168 public members and 3,658 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	Actual January 2017	Target (March 2019)
1. Achievement of the recruitment target: a. Total number of public members b. Staff opting out of membership	 **5,946** **<1%**	 6,000 <1%
2. Achieve a representative membership for our membership area, Priorities for action: a. Age – recruitment of under 50s b. Engagement and recruitment events in all market towns of membership area (Thetford, Newmarket, Stowmarket, Haverhill and Sudbury)	 **1,176** **20%**	 1,250 100%
3. An engaged membership measured by: a. number of member events held April 2015 – March 2017 b. member attendance – total all events c. annual members' meeting attendance (each year)	 **5** **880** **261**	 6 600* 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.

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

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

In July 2016 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 2016 the nominations committee agreed a process for recruitment to two NED positions which would become vacant in March and April 2017. The remuneration of the chair and NEDs was also reviewed. A recommendation was then made to and approved by the council of governors. The appointment of two NEDs was subsequently approved at a closed session of the council of governors meeting in February 2017. At this meeting the council of governors also supported the appointment by the Board of a board advisor.

In February 2017 the nominations committee agreed a proposal for the recruitment of a new chair, as this position would become vacant in December 2017. This was followed by a meeting in March 2017 to agree the process and timetable.

Attendance at nominations committee meetings 2016/17

Name	Title	Attendance (out of four)
Roger Quince (chair)	Chairman	3 *
June Carpenter	Public governor (lead governor from August 2015)	3
Justine Corney [1]	Public governor	2(of 2)
Nick Finch	Staff governor	3
Sara Mildmay-White	Partner governor	4
Barry Moult [2]	Public governor	3 (of 4)
Steve Ohslen [3]	Public governor (lead governor)	1 (of 1)
Joe Pajak [4]	Public governor	1 (of 2)
Stuart Woodhead	Public governor	3

Meeting dates: 7 July 2016; 19 October 2016; 23 February 2017; 13 March 2017

[1] Justine Corney replaced Jo Pajak in February 2017
[2] Barry Moult replaced June Carpenter when she became lead Governor in August 2016
[3] Steve Ohlsen resigned as a governor in July 2016
[4] Jo Pajak resigned from the Nominations Committee in December 2016
* The Chairman did not attend the meeting on 13 March as he had declared an interest

2.2 Directors' report

2.2.1 Responsibilities

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

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

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

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

2.2.2 Composition

(a) Non-executive directors

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 and risk committee; chair charitable funds committee; member of scrutiny committee, remuneration committee and chair of the governors' nominations, appointments and 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 *(end term of office on 28 February 2017)*
(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 and effectiveness committee; member of the remuneration committee, audit committee and quality and 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 Note 1)

Dr Richard Davies – NED
(Appointed: from 1 March 2017 until 28 February 2020)

Areas of special interest/responsibility: lead NED for the clinical safety and effectiveness committee; member of the remuneration committee, audit committee and quality and risk committee; NED link to medical director.

Richard was appointed to the board through Cambridge University; he is a general practitioner and has worked since 2004 in a variety of roles within the Cambridge University School of Clinical Medicine; including as director of GP studies, organising teaching in general practice for medical students on the standard and graduate courses. In 2013 he was appointed Sub Dean in the Clinical School, with a particular responsibility for student welfare. He continues to divide his time between his clinical practice as a GP and his academic work in the Clinical School.

Independent director – yes (see Note 1)

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 and risk committee; NED link to HR director

Neville is an executive coach, outplacement and generalist HR consultant. He has previously worked as a senior HR executive for Hyde Housing (a leading, London based housing association), Norfolk Constabulary, McCain Foods and May Gurney Plc.

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 customer experience at 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 until 28 February 2017; reappointed 1 March 2017 until 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 and 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; senior independent director (SID); NED lead for patient experience committee; second lead for clinical safety and effectiveness committee; member of quality and risk committee, scrutiny committee, audit committee and human factors group. 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. 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. She is a former NHS trust and regional chair, and NHS appointments commissioner.

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)

Note 1
Dr Richard Davies, and Dr John Benson, who he replaced are nominated appointment by the University of Cambridge. The appointment as a NED is reviewed and approved by the Council of Governors. This review considered relevant skills and experience, including his ability to provide independent challenge to the Trust. As such the role is considered to be an independent director, despite his nominated status.

(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 and strategy, NHS Midlands and East; director of strategy and 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.

He was previously deputy director of finance at both Cambridge University Hospitals FT and Ipswich Hospital.

Craig has 25 years' experience within the NHS. Having graduated from the National Financial Management Training Scheme he has worked in health authorities, a community and mental healthcare trust and a primary care trust, as well as a number of acute hospitals in Surrey and East Anglia.

Mrs Rowan Procter – 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 for nurses, midwives and allied health professionals, nursing strategy and nurse management, professional education, clinical governance and quality improvement, safeguarding children and vulnerable adults, 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 and was successful in her substantive appointment in July 2016.

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 and 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 from 2 November 2015 and left the Trust in November 2016)*

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 *(until November 2016)*

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 and intensive care at the WSFT.

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

Dr Nick Jenkins - executive medical director *(appointed November 2016)*

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. Nick is the responsible officer for revalidation and Caldicott Guardian.

Nick is a consultant in emergency medicine and joined the Trust in October 2016 from Warrington and Halton NHS Foundation Trust, where he was Deputy Medical Director. Prior to this he was a secondary care specialist for Haringey Clinical Commissioning Group.

Nick was on the NHS Leadership Academy Executive Fast Track Programme and is an Honorary Senior Lecturer, Brunel University.

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 co-opted board governor at West Suffolk College, governor at Sybil Andrews Academy, 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 director appointments are normally for a term of three years. Following their first term, and subject to satisfactory appraisal, a non-executive director will normally be reappointed for a second term without competition. This assumes board competency requirements have not 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 2016/17

Name	Title	Attendance (out of 11)
Roger Quince	Chairman	11
John Benson	Non-executive director	8 (of 9)
Craig Black	Executive director of resources	9
Jan Bloomfield	Executive director workforce and communications	11
Pam Chrispin	Executive medical director	6 (of 7)
Richard Davies	Non-executive director	2 (of 2)
Stephen Dunn	Chief executive	9
Jon Green	Chief operating officer	9
Neville Hounsome	Non-executive director	11
Nick Jenkins	Executive medical director	4 (of 5)
Gary Norgate	Non-executive director	11
Rowan Procter	Executive chief nurse	9
Steven Turpie	Non-executive director	10
Rosie Varley	Non-executive director	11

Meeting dates
1 Apr 2016, 29 April 2016, 27 May 2016, 24 June 2016, 29 July 2016, 30 September 2016, 28 October 2016, 25 November 2016, 27 January 2017, 3 March 2017, 31 March 2017

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

WSFT's governance structure ensures reports are received by the board through a dedicated board committee with oversight for quality and risk (the quality and risk committee). The minutes of each

meeting of the quality and 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', 'Serious incident, inquests, complaints and claims report' and the 'Aggregated quality report' 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.

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

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 reappointed the external auditors on 8 February 2017 for the financial years 2017/18 to 2019/20. The cost of statutory services for the 2016/17 financial year was £59,000 (2015/16; £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 2016/17.

Internal audit

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

System of internal control

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

Attendance at audit committee meetings

Name	Title	Attendance (out of 5)
John Benson	Non-executive director	2
Neville Hounsome	Non-executive director	4
Gary Norgate	Non-executive director	5
Steven Turpie	Non-executive director (chair)	5
Rosie Varley	Non-executive director	5

Meeting dates: 29 April, 2016, 24 May, 2016, 29 July 2016, 28 October 2016 and 27 January 2017.

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 2.6 (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 the NHS Improvement's quality governance framework as part of the annual governance review; this includes a review of relevant assurances within the board assurance framework. During 2016/17 the Board used the new 'well-led' framework published by NHSI and CQC as the basis of this review. This will be used to inform external evaluation of the board and governance of the trust.

2.2.8 Details of consultation

WSFT did not consult with members of staff or the public regarding the site master plan during 2016/17.

Consultation with local groups and the public and patient involvement activities

During 2016/17 the patient and carer experience group has continued to strengthen divisional accountability for patient experience improvement. It has worked 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 and carer experience group and governors are members of key committees and groups e. g. patient experience committee, clinical safety and effectiveness committee, divisional governance steering groups, maternity services liaison committee, nutritional steering group, diabetes group and blood transfusion committee.

WSFT has a number of patient user and support groups in which service users are supported by staff to be involved in current services and service developments. The patient experience team also participated in NHS England's 'Experiences of Care Week' in March 2017 which involved various activities throughout the week:

- Colouring sheets and wordsearches designed for both adults and children to provide entertainment
- Discussions on the topic of 'what does 'good care' mean to you?'
- Feedback collection asking patients what we did well and what could be improved
- Promotion of family carer involvement initiatives

During the year our FT members were invited to sign up as 'patient representatives', taking an active role in decisions about the hospital. They also expressed an interest in developing further patient user groups which the patient experience team will work with them to form over the coming year.

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 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.

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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.

	2016/17		2015/16	
	Number	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	58,347	134,516	44,872	62,398
Total non-NHS trade invoices paid within target	26,089	76,160	31,666	38,261
Non-NHS trade invoices paid within target (%)	**45%**	**57%**	**71%**	**61%**
Total NHS trade invoices paid in the year	1,732	73,058	1,490	26,856
Total NHS trade invoices paid within target	619	59,902	893	21,489
NHS trade invoices paid within target (%)	**36%**	**82%**	**60%**	**80%**

2.3 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.

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

2.4 NHS Improvement's single oversight framework

NHS Improvement's single oversight framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence. The single oversight framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's r*isk assessment framework* (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

WSFT has been placed in segment 2, the second best category. This segmentation information is the trust's position as at 7 April 2017. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources
The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the single oversight framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	4	3
	Liquidity	4	3
Financial efficiency	I&E margin	4	4
Financial controls	Distance from financial plan	4	1
	Agency spend	2	2
Overall scoring		**4**	**3**

In February 2017, NHS Improvement opened an investigation into concerns about WSFT, including: our forecast outturn, cost improvement plan (CIP) delivery and failure to accept the proposed control totals for 2017/18 and 2018/19. The investigation did not identify any evidence that the issues relating to the forecast overspend demonstrated governance concerns which were sufficient to put the trust in breach of its licence, and did identify that actions had now been taken to recover the financial position and to enable achievement of the 2016/17 control total of £5.0m.

2.5 Statement of accounting officer's responsibilities

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

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require West Suffolk NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis *required by those Directions*. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of West Suffolk NHS Foundation Trust and of its income and expenditure, 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 *Department of Health Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by *NHS Improvement*, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (*and the Department of Health Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance 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 *the NHS Foundation Trust Accounting Officer Memorandum*.

Dr Stephen Dunn
Chief executive
26 May 2017

2.6 Annual governance statement

West Suffolk NHS Foundation Trust annual governance statement – 1 April 2016 to 31 March 2017

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of 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 2017 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

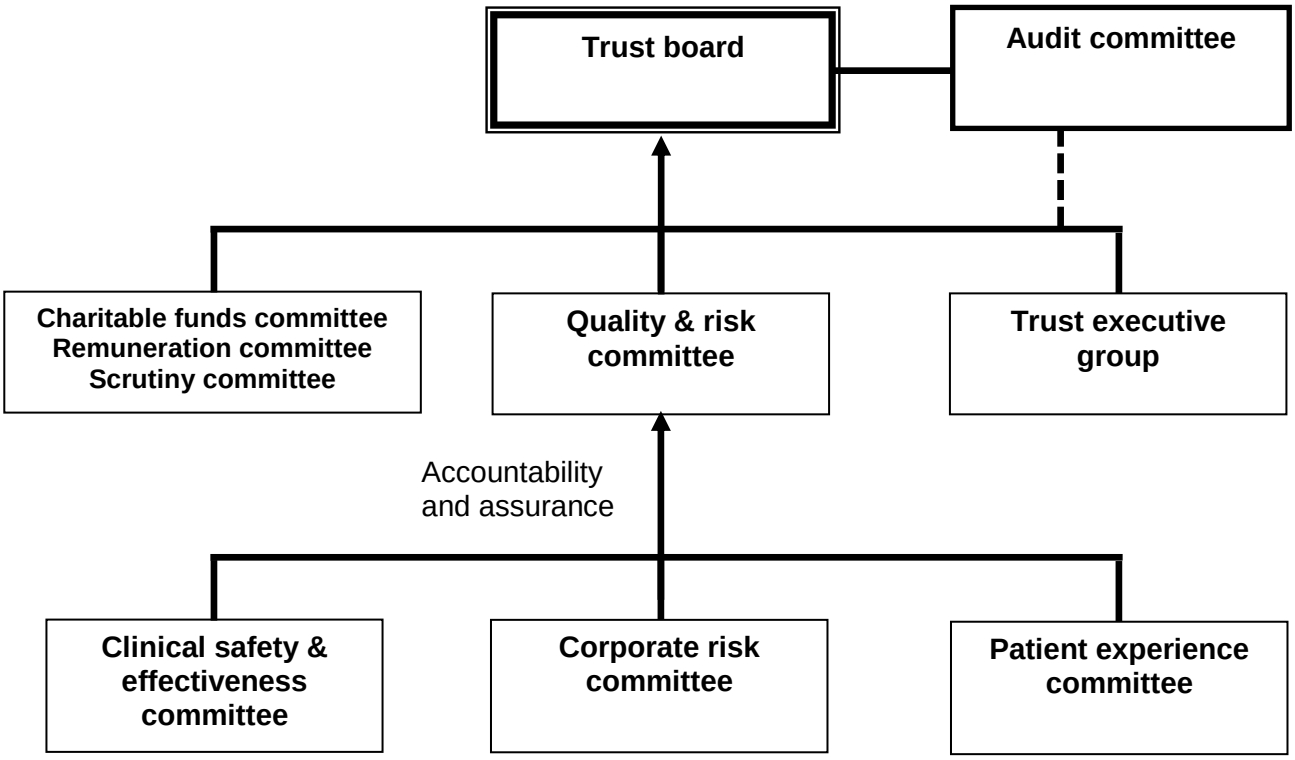
The system of internal control is underpinned by compliance with the Trust's terms of authorisation and the requirements of regulatory bodies relevant to FTs. The Trust has a risk management policy and strategy which make it clear that managing risk is a key responsibility for the Trust and all staff 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 and 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 and safety. To ensure timely reporting and escalation of risks the three subcommittees of the quality and risk committee provide a summary at the next board meeting of issues and risks for escalation.

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 council of governors has a statutory duty to hold the non-executive directors individually and collectively to account for the performance of the board of directors.

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 and 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. The board has considered its tolerance for risk and agreed its risk appetite. This is reflected in the risk matrix within the Trust's risk management strategy.

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 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. The report also reviews the Trust's incident reporting rate as a measure that reporting is openly encouraged and handled across the Trust
- Monthly financial performance reports
- Self-certification against the compliance framework
- Compliance with the delivery of the CQC registration requirements is tested through self-assessment as well as monitoring of relevant performance and benchmarking data
- Quarterly quality and performance reports by directorates to the quality and risk committee
- Quarterly quality and performance reports to the council of governors
- Assurances provided through the work of the clinical safety and effectiveness committee, corporate risk committee and patient experience committee
- Reports from the quality and 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, NHS Improvement, the NHS Resolution, patient-led assessments of the care environment (PLACE), and accountability to the council of governors
- The work of clinical audit, whose scope includes national audits, audits arising from national guidance such as 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
- Quality of performance information tested through triangulation of data with internal and external sources as well as through the work of internal and external audit.

All policies relating to risk management are accessible and available to the public and staff on the Trust intranet with supporting information available for staff under the risk management department section of the intranet. Key risks are reported to the board and council of governors as part of the papers discussed in public, enabling public stakeholders to be sighted on potential risks which impact on them.

Through these mechanisms we aim to embed risk management in the activities the Trust undertakes. The following, which are covered in more detail in this annual report, are examples of the product of our risk and control environment:

- Care Quality Commission (CQC) – an overall rating of "good", while rating the care provided as "outstanding".
- Good performance against national targets, meeting national targets in 2016/17 with the exception of:
    - Maximum waiting time of four hours in ED from arrival to admission, transfer or discharge
    - 18 week maximum wait from point of referral to treatment (patients on an incomplete pathway)

    - Two week wait from referral to date first seen comprising all urgent referrals for symptomatic breast patients (cancer not initially suspected)
- Low hospital standardised mortality ratio (HSMR) and summary hospital-level mortality indicator (SHMI)
- Named as one of the country's 'top hospitals' for safe, effective care
- Awarded status of "centre of global digital excellence"
- Hip fracture care among the best in the country
- Top award for hospital's patient meals
- Improved again in national staff survey results as the hospital in the East that is the most highly rated by its staff. The staff survey also showed the Trust is the highest performing in the country for staff engagement
- Latest sentinel stroke national audit programme (SSNAP) data rates WSH as a level A (highest) and the 6th best in the country
- The 'NHS atlas of variation' shows diagnosis rates in west Suffolk for early stage cancers are the best in the country (for the last three years)
- PLACE (patient-led assessment of the care environment) assessment put WSH above the national average for cleanliness
- Good Friends and Family scores – consistently above national average scores for inpatients, outpatients, A&E and maternity services
- Excellent reputation for teaching – both undergraduate and graduate (Health Education England).

But, we also have some challenges:

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

  Performance against the four hour target during 2016/17 was extremely challenging - flow through the hospital affected our ability to deliver and escalation beds were consistently open for long periods of time.

  Recognising the challenge and in planning for winter we put in place a number of initiatives to support and improve patient flow:

    - The SAFER bundle is a combined set of simple rules for adult inpatient wards. It is designed to improve patient flow and prevent unnecessary waits and was a major focus as the hospital prepared for winter. Ward F7 launched the bundle and all wards were required to self-assess against the bundle and establish how they currently meet the criteria
    - The medical division worked hard to secure a ward area to open as the winter escalation ward (WEW) in preparation for the challenging months ahead. We commissioned 20 beds at Glastonbury Court to create a rehabilitation facility in the community. This relocated 20 medically fit patients and we have then moved 20 patients from ward G9 to their new location on G5. This allowed G9 to be used as the WEW over the winter period
    - 'Go Green this Winter' encouraged staff to adapt and change the way they work in order to identify where unnecessary patient waiting occurs. This was launched as a Trust wide campaign in order to do all we can to reduce patients' length of stay and improve processes for discharging them
    - The Go Green and information teams worked together to create a red to green data dashboard, which is accessible for staff on the Trust's intranet. Staff are able to review the data on a regular basis to see how we are delivering against the Go Green campaign. The dashboard collects data that includes: the number of 'red' or 'green' patients, planned dates of discharge, patients discharged before or after midday.

  The campaign also focussed on working with staff to reduce deconditioning of patients by encouraging them to sit up, get dressed and keep moving. Exercises like this, as well as the identification of both internal and external constraints to patient flow including delayed transfers of care, transport issues, to take out medicine delays, and awaiting care package/placement issues, for example, are resulting in solutions based approaches across multiagency teams to how we might do things differently.

- **18 week** maximum wait from point of referral to treatment (patients on an incomplete pathway)

  The launch of e-Care in May 2016 impacted on our ability to report performance against a number of quality standards, including the referral to treatment (18 week) standard. During 2016/17 reporting against this standard has been based on estimates as we have been unable to accurately track activity at the patient level.

  We now have a functional patient tracking list (PTL) within e-Care and work is underway both manually and via automated scripts to address underlying data quality issues. Working with our digital partner, Cerner, we have made significant progress to improve reporting and plan to have all aspects in operation to allow reporting of June 2017 activity.

  The estimated incomplete referral to treatment (RTT) performance has been impacted by capacity issues in several services and it is extremely disappointing that a number of patients have waited over 52 weeks for treatment. With an effective PTL now in place we have put in place procedures to actively manage treatment plans to ensure these are expedited for patients with excessive waits.

- **Two week wait** from referral to date first seen comprising all urgent referrals for symptomatic breast patients (cancer not initially suspected)

  Trust performance against this GP urgent referral to first seen within two week wait remained very challenging during 2016/17. This was driven by a number of factors, including:

  - Ongoing increase in numbers of referrals
  - Staffing difficulties constrained the flexibility in the service and limited opportunities to create additional outpatients clinics
  - Reduction in capacity during the e-Care launch period.

  In response to the challenges the service has taken action to:

  - Open additional clinics to meet the increasing demand
  - Active recruitment to the vacant position
  - Strengthened controls to track and prioritise patients to avoid breaches
  - Working with CCG GP lead to audit appropriateness of two week wait referrals.

  The standard is now on trajectory for sustained recovery against the 93% target (93.41% and 94.02% performance in March and April 2017 respectively).

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	Quality or service failure, leading to reputation damage, reduced activity/income and/or regulatory action	Poor care and treatment of patients. Loss of public and GP confidence that leads to reduced referrals as a consequence of public choice. Restricted authorisation / licensing by regulators
	Future options and integration of Suffolk Community Services	Service quality and performance, financial viability and alliance stability

Category of risk	Description of risk	Potential impacts being mitigated by controls and future plans
Urgent care	Failure to work with local health and care system to manage emergency activity or plan prepare for winter	Patient safety. Reputational impact and poor patient experience/satisfaction. Loss of sustainability and transformation funding. Negative impact on staff morale. Impact on other targets e. g. RTT and cancer as unable to admit elective activity
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). Ability to fund the capital programme
	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. Withdrawal of service accreditation by regulators. Financial risk as part owner
	Failure to identify and deliver cost improvement and transformation plans that ensure delivery of clinical and non-clinical services to deliver the financial plan	Quality and ability to deliver safe services. Non-compliance with national standards, targets and terms of authorisation leading to breach of regulator licence (CQC and/or NHSI). Impact on cash flow. Inability to generate sufficient surplus to support capital investment. Reputational harm from adverse media coverage – loss of confidence
	e-Care adoption, transformation and benefits realisation	Delivery risk to patient safety and the operational effectiveness of the Trust. Ability to report patient care and activity both timely and accurate. Quality, service and financial impact of failure to deliver planned improvements and benefits
Workforce	Delivery of the workforce plan with an engaged and motivated workforce	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. 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	External financial constraints impact on Trust's sustainability through tariff, contract and pattern of service provision in the LHE	Quality and ability to deliver safe services. Non-compliance with national standards, targets and terms of authorisation leading to breach of licence (CQC or NHSI). Impact on cash flow and income and expenditure. Inability to generate sufficient surplus to support capital investment. Local position leads to tension between local health economy partners. Loss of sustainability and transformation funding to the local health system
	Delivery of Sustainability and Transformation Plan (STP) for Suffolk and North East Essex footprint	Ability to deliver safe and sustainable services for local population. Local position leads to tension between local health economy partners. Loss of sustainability and transformation funding to the local health system. Loss of confidence in WSFT and west Suffolk system

The key risks to the Trust which materialised during the year are described in the conclusion of the annual governance statement. This includes a summary of mitigation action and an assessment of the future risk.

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

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 and risk committee and audit committee provide an annual report to the board on their activities and performance
- Reporting lines and accountabilities between the board, its subcommittees and the executive team - are considered as part of the annual governance review and clear reporting and escalation channels exist between the board and executive team
- Submission of timely and accurate information to assess risks to compliance with the Trust's licence – 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 2016/17 including divisional reporting and performance against cost improvement programmes.

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. This includes undertaking equality impact assessments to provide assurance that consultations relating to changes to any of our functions and services are not discriminatory. Where any remedial action is identified by the assessment, we develop and implement an action plan to address this.

The 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.

The Trust's risk and control framework as described in this statement ensure that the board can confirm the validity of its corporate governance statement as required under NHS Foundation Trust condition 4(8)(b). The executive directors consider risks to compliance with these conditions and report to the board areas where action is required. The corporate governance statement is reviewed by the board of directors at a public meeting. This was last reviewed by the board at its meeting on 24 June 2016.

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

The Trust has a range of processes in place to ensure that resources are used economically, efficiently and effectively. This includes clear and effective management and supervision arrangements for staff, regular reporting to the Board on quality, operational performance and finance, with further review and scrutiny at meetings of the scrutiny committee, quality and risk committee and operational fora.

The Trust during the year was assessed as "good" by the CQC. This confirms that the organisation's systems and standards of governance have been designed to deliver an effective system of internal control, with effective flow of risk and compliance issues to the board and assurance committees.

The Trust has an agreed risk-based annual audit programme with its internal auditors. These audit reports are aimed at evaluating the Trust's effectiveness in operating in an efficient and effective manner and are focussed on reviewing its operational arrangements for securing best value and optimum use of resources in respect of the services the organisation provides.

Before adjusting for the £4.8m tPP impairment, in 2016/17 WSFT reported a deficit of £3.3m, which is £1.7m better than our planned control total of £5.0m. The plan for 2017/18 is a deficit of £5.9m. To deliver the planned deficit a cost improvement programme of £13.3m needs to be delivered. WSFT is working with KPMG as part of the national financial improvement programme (FIP2) commissioned by NHSI. The programme will critically challenge our existing cost improvement and efficiency programmes, identify additional opportunity from a range of other initiatives and support delivery at pace. Through this approach the programme will support delivery of our control total in-year and establish a programme to ensure long term sustainability.

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 CQC's inspection report in August 2016.

The board assurance framework was reviewed and updated routinely during 2016/17 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 2016/17.

Information governance

As part of NHS information governance rules, details of serious incidents involving data loss or a breach of confidentiality have to be reported. All level 2 incidents must be reported to the Information Commissioner's Office (ICO). WSFT has not reported any level 2 data breaches during 2016/17.

WSFT carried out an assessment of its compliance with NHS Digital's information governance toolkit for 2016/17, the outcome of which was a compliance score of 80%. The Trust achieved a score of at least two for all requirements, within a range of zero (worst) to three (best).

Patients and the public can be reassured that the Trust takes security and patient confidentiality very seriously. Data security risks are managed and controlled through a range of measures. This includes a dedicated IT cyber security group that manages data security issues and controls reporting up to an information governance steering group. The membership of which includes the executive medical director (WSFT's Caldicott Guardian) and executive director of resources (WSFT's senior information risk owner).

WSFT was not affected by the WannaCry cyber-attack. All our clinical patient services remained running as normal. As a precautionary measure we temporarily shut down some systems and put restrictions in place for some email traffic.

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 Quality Accounts for each financial year. *NHS Improvement (in exercise of the powers conferred on 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 the regulator'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 and 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, NHSI's single oversight framework, commissioning for quality and 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. The chief nurse is the executive lead for quality reporting.

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 and 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 and risk committee. The patient experience committee reviews the data from the patient experience surveys and provides feedback to the quality and risk committee. The clinical safety and effectiveness and patient experience committees inform the quality and 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.

In addition to this internal prioritisation and review, the quality report is considered by our governors and external partners to ensure that it reflects a balanced view of WSFT's performance.

WSFT assures the quality and accuracy of its elective waiting time data through a regular validation process internally, with additional checks by the information team to ensure the data reported is accurate, which includes ensuring all 52 week breaches have been confirmed by the service, checks on large movements and triangulation with other recording systems. Further independent assurances are made through internal and external audits of data quality, national validation programmes and third party support from specialist organisations with validation expertise. As reported above the implementation of e-Care impacted on our ability to report data during 2016/17, including elective waiting time data. Action to address these reporting difficulties is in place to allow reporting of June 2017 activity.

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 and risk committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The board of directors' role is to determine the overall strategic direction and to provide active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed. 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.

As part of the annual governance review the board has considered and amended the terms of reference of the quality and risk committee. The audit committee has strengthened its role in monitoring clinical audit. This includes assurance regarding the suitable selection/participation in local and national audits as well as action to address identified learning.

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 2016/17, the 'opinion levels' are summarised below:

Level of assurance	Number
Advisory	2
Substantial	2
Reasonable	11
Partial	3

None	0

No internal audit reports were graded as red ('no assurance'). The three 'Partial assurance' reports related to:

- **CIP – transformation delivery** - the key factor contributing to the partial assurance opinion was the lack of control in place to prevent double counting of savings between the CCG and Trust which could lead to a shortfall in cashable savings required to meet either organisation's control total. In addition it was found that there were issues in the quality, quantity and timeliness of project documentation and there was a lack of progress reporting from the transformation programme group to the trust executive group
- **Community services – equipment services** - whilst there are policies and procedures to govern ordering, fulfilment, delivery and payment of these items there remains a number of issues around the data quality of the inventory listing, lack of controls over peripheral stock stores and a significant backlog in servicing of large volumes of equipment which is being used within the Community. It was also noted that these issues were not being escalated and discussed regularly at the Provider Management Group or being recorded on the Community Services risk register
- **Income and debt management** - areas of weakness included out of date Debt Management Policy and inconsistent adherence to procedures regarding the issue of debt recovery letters and timely referrals to debt collection agencies. Additionally, the recording of the debt status in Integra and lack of reporting to the Board contributed to our negative assurance opinion in this area.

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 2017, 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.

Other external assurance is provided by CQC inspection and communication, clinical governance reports, including the information included in the monthly integrated report and outcome of the clinical audit programme, external benchmarking data and the results of inspections by external organisations.

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:

- **Pathology services**
  The pathology service delivered to WSFT by The Pathology Partnership (tPP) has been a cause for concern during 2016/17 in terms of both quality and financial performance.

  The Medicine Healthcare Regulatory Authority (MHRA) undertook a planned inspection of the blood transfusion service operated within the hospital by tPP. The inspection highlighted several areas of concern and we are working closely with the inspection team to ensure action is taken with tPP to address the issues identified which include staffing and quality management systems. Plans to restructure tPP were formally announced in late February. The new structure has been

implemented for services in the east of the partnership. The North East Essex and Suffolk Pathology Services (NEESPS) includes West Suffolk, Colchester and Ipswich hospitals and is managed locally as a stand-alone network, with the hub laboratory remaining at Ipswich Hospital and Colchester Hospital University NHS Foundation Trust acting as host. The NEESPS is clinically led by four specialty clinical leads in each of the four service areas: Cellular Pathology; Chemistry; Haematology and Blood Transfusion' and Microbiology. The board will carefully monitor progress to mitigate this risk during 2017/18. The Trust's fixed asset impairments for 2016/17 include our share of the loss incurred by the tPP - £4.8m.

- **Cost improvement programme (CIP) performance**
  While the Trust has exceeded its control total for the year by £1.6m this relied on a significant number of non-recurring schemes - £6m of the total CIP (£12.5m).

  In June 2016 a revised control total for WSFT was agreed with NHSI. In order to deliver the control total an additional stretch-CIP was developed of £3.9m. While the stretch CIP was recognised as challenging, compounded by it being agreed part way through the year, performance against the CIP was inadequate. This resulted in an over reliance on non-recurring schemes to achieve the year-end position. An internal audit of the stretch-CIP identified only partial assurance.

  To strengthen control of the CIP process we will be working with KPMG, as part of the national financial improvement programme (FIP), to find more savings opportunities; ensure cost savings happen at pace with Trust ownership; and make the savings stick through permanent culture change. We have also reviewed executive director responsibilities to ensure capability and capacity is applied to strategic plans as part of the CIP.

- **e-Care reporting**
  In May 2016, we launched a new multi-million pound electronic patient record called e-Care. This was an unprecedented overhaul of our IT systems. While the launch was a significant success there has been an impact on our ability to report performance against a number of quality standards, for example the referral to treatment (18 week) standard and risk assessment for venous thromboembolism. Some of our internal reporting has also been affected and we put in place arrangements to capture information to monitor and challenge quality performance to ensure gaps are covered, for example through matrons' rounds. Working with our digital partner, Cerner, we have made significant progress to improve reporting and plan to have all aspects in operation to allow reporting of June 2017 activity. We have also identified that information on the discharge summary does not always accurately reflect what has actually been prescribed and dispensed. We are working with local general practitioners to mitigate any risk to patients and with Cerner to implement a technical solution.

  The national standard for '18 week maximum wait from point of referral to treatment' is one of the mandated indicators for testing by the external audit as part of the limited assurance review of the Quality Report. Our reliance on estimated reporting during 2016/17 meant that the auditors were unable to test the reporting and have issued a qualified opinion on the quality report relating to this indictor.

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 2017

2.7 Remuneration report

The Trust has identified the individuals in a senior position who have authority or control to direct major activities to be the Executive and Non-Executive members of the Board.

The purpose of the remuneration report is to provide a statement to stakeholders on the decisions of the remuneration committee relating to the executive directors of the board of directors. In preparing this report, the Trust has ensured it complies with the relevant sections of the Companies Act 2006 and related regulations and elements of the NHS Foundation Trust Code of Governance.

The following parts of the remuneration and staff report are subject to audit: single total figure table of remuneration for each senior manager, pension entitlement table and other pension disclosures for each senior manager, fair pay disclosures, payments to past senior managers (if relevant), payments for loss of office (if relevant), staff report: exit packages (if relevant), staff report: analysis of staff numbers, and staff report: analysis of staff costs.

Annual statement on remuneration

New appointments were made to the roles of executive chief nurse and executive medical director. Decisions on their remuneration were based on available benchmarking information from the NHS Providers survey. Directors are employed on service contracts whose provisions are consistent with those relating to other employees within the Trust. There are no components within the remuneration relating to performance measures or bonuses.

Senior managers' remuneration policy

Senior managers' pay consists of the following elements:

- Senior managers' 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 and 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 a non-executive director (Mrs R Varley). The chief executive, executive director workforce and communications and trust secretary may be present to advise but not for any discussions concerning their personal remuneration at the discretion of the remuneration committee's chair.

A quorum will consist of the committee'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. Two meetings of the committee were held during 2016/17. All non-executive directors were in attendance for both meetings.

Senior managers' (executive directors') pay is annually reviewed by the remuneration committee. The committee is presented with benchmarking information to demonstrate where each executive director's salary sits alongside similar posts in the NHS market in the context of pay awards to other staff groups. Decisions to 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 arrangements for managing the remuneration policy for senior managers will be strengthened during 2017/18 to include consultation with relevant staff fora.

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.

Service contracts obligations

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 increased to £931k from £909k. This change was due to the effects of changes in directors during the year. There were no exit packages paid to board members either in the 2016/17 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.

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.

	2016/17		2015/16	
	Directors	Governors	Directors	Governors
Total number in office during the year	15	27	13	32
Total number receiving expenses	8	8	4	11
Aggregate total of expenses paid during the year (£)	4,328	1,448	4,314	2,342

Fair pay disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the Trust in the financial year 2016/17 was £160k- £165k (2015-2016, £155k - £160k). This was seven times (2015/16, seven times) the median remuneration of the workforce, which was £23,935 (2015/16, £24,063). This is calculated based on all staff employed and salaries as at 31 March 2017.

In 2016/17, 8 (2015/16, 19) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £207,111 to £15,080 (2015/16 £13,328 to £198,098).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

The following tables reflect the remuneration for the senior staff (table A) and pension entitlements for the senior staff (table B). . As NEDs do not receive pensionable remuneration, there are no entries in respect of pensions for NEDs. Pension entitlement 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.

The figures in tables A and B, as well as the items in the remuneration and staff reports as required by the foundation trust annual reporting manual, have been subject to external audit.

Table A – Remuneration

Name and title	Year to 31 March 2017				Year to 31 March 2016					
	Salary paid (bands of £5000)	Expense payments (taxable) to nearest £100	Increase in pension entitlement (bands of £2500)	Total (bands of £5000)	Salary paid (bands of £5000)	Expense payments (taxable) to nearest £100	Original Increase in pension entitlement (bands of £2500)	Restated Increase in pension entitlement (bands of £2500)	Original Total (bands of £5000)	Restated Total (bands of £5000)
	£000	£	£000	£000	£000	£	£000	£000	£000	£000
Mr R Quince – chairman	40 – 45	100	-	40 – 45	35 – 40	-	-	-	35 – 40	35 – 40
Dr J Benson – non-executive director (Note 1)	10 – 15	-	-	10 – 15	10 – 15	-	-	-	10 – 15	10 – 15
Mr S Turpie – non-executive director	10 – 15	-	-	10 – 15	10 – 15	-	-	-	10 – 15	10 – 15
Mrs R Varley – non-executive director (Note 2)	10 – 15	-	-	10 – 15	10 – 15	-	-	-	10 – 15	10 – 15
Mr G Norgate – non-executive director	10 – 15	-	-	10 – 15	10 – 15	-	-	-	10 – 15	10 – 15
Mr N Hounsome – non-executive director	10 – 15	-	-	10 – 15	10 – 15	-	-	-	10 – 15	10 – 15
Dr R Davies - non-executive director (Note 3)	0 - 5	-	-	0 - 5						
Dr S Dunn – chief executive	155 – 160	3,000	37.5 - 40	195 - 200	160 - 165	2,100	30 – 32.5	30 – 32.5	195 - 200	195 - 200
Mr C Black – executive director of resources	125 – 130	5,800	52.5 - 55	185 - 190	125 – 130	3,800	52.5 - 55.0	55 - 57.5	180 - 185	185 - 190
Mr J Green - chief operating officer	110 – 115	-	45 - 47.5	160 - 165	110 – 115	-	45.0 – 47.5	45.0 – 47.5	155 - 160	160 - 165
Dr P Chrispin – medical director (Note 4) *	55 - 60	-	-	55 - 60	90 - 95	-	-	-	90 - 95	90 - 95
Ms J Bloomfield – executive director workforce and communications	95 – 100	200	70 -72.5	165 - 170	90 – 95	-	10 - 12.5	15 - 17.5	100 - 105	105 - 110
Ms R Proctor – executive chief nurse *	105 - 110	-	77.5 - 80	180 - 185	40 – 45	-	40 - 42.5	40 - 42.5	80-85	80-85
Ms N Day – executive chief nurse (Note 5) *	55 – 60	-	10 - 12.5	65 - 70	55 – 60	800	7.5 - 10	10 - 12.5	65 – 70	65 – 70
Dr N Jenkins – executive medical director (Note 6) *	80 - 85	-	70 - 72.5	150-155						

There are no components within the remuneration relating to performance measures or bonuses in 2016/17 or 2015/16
The 2015/16 increase in pension entitlements and the totals have been restated due to errors identified during the 2016/17 audit.

Table B – Pension benefits

Name	Real increase / (decrease) in pension at pension age (bands of £2,500)	Real increase / (decrease) in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2017 (bands of £5,000)	Lump Sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash equivalent transfer value at 1 April 2017	Real increase / (decrease) in cash equivalent Transfer Value	Cash equivalent transfer value at 31 March 2016
	£000	£000	£000	£000	£000	£000	£000
Dr S Dunn (Note 7)	0 – 2.5	0 – 2.5	55 – 60	0 – 5	557	32	525
Mr C Black (Note 8)	2.5 – 5.0	0 – 2.5	35 – 40	90 – 95	529	40	489
Mr J Green (Note 8)	0 – 2.5	0 – 2.5	15 – 20	40 – 45	284	33	251
Ms J Bloomfield	2.5 - 5.0	7. 5 - 10.0	40 – 45	125 – 130	827	85	742
Ms R Procter (Note 8)	2.5 - 5.0	2.5 - 5.0	20 – 25	50 – 55	306	49	257
Ms N Day	0 – 2.5	0 - 2.5	35 – 40	110 – 115	666	32	635
Dr N Jenkins (Note 8)	7.5 - 10.0	12.5 - 15.0	20 – 25	55 – 60	305	95	210

Note

1. J Benson left February 2017
2. R Varley left March 2017
3. R Davies started as a NED on the 1 March 2017
4. P Chrispin retired as executive medical director November 2016
5. N Day was on secondment from November 2015 and left the Trust in November 2016
6. N Jenkins was appointed as executive medical director on 17 November 2016
7. Lump Sum is zero as a member of 2008 Section and 2015 Section which does not provide an automatic lump sum
8. Lump Sum increase may be zero or low as now a member of 2015 Scheme which does not provide an automatic lump sum

* Remuneration includes time spent on clinical work which is not possible to quantify

Dr Stephen Dunn
Chief executive

2.8 Staff report

2.8.1 Our staff

WSFT is one of the largest employers in Suffolk, employing 3,658 staff in March 2017. WSFT firmly believes in the benefits of working in partnership with staff and the trade unions, and this was highlighted during 2016/17 with the following activities:

- Staff governors continue to support staff to discuss challenges and achievements and report back on these
- As part of the Trust's health and wellbeing programme a new staff choir has been introduced called Lift!. Staff receive financial assistance in the form of low interest loans which are arranged by an external organisation. The Trust continues to have an onsite occupational health service, with direct access for staff to a physiotherapist, counselling and flu vaccinations. Staff have the opportunity to join local gyms at a discounted rate
- My Wish - West Suffolk Hospital Charity continues to support the health and wellbeing programme of the Trust and held a fifth very successful 'It's a Bury Knockout' competition in 2016. This saw five staff teams compete with other teams from across the west Suffolk community, as well as run stalls and volunteer. During 2016 the Charity also organised a 262ft abseil, predominantly consisting of staff
- An active flu campaign improved the uptake of the flu vaccine among staff (2015: 53.9%, 2016: 65%)
- We have continued to support the trade union convenor role
- 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
- 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 and wellbeing steering group.

2.8.2 Staff costs

	2016/17			2015/16
	Permanent	**Other**	**Total**	**Total**
	£000	**£000**	**£000**	**£000**
Salaries and wages	104,583	10,222	**114,805**	106,633
Social security costs	10,094	930	**11,024**	8,323
Employer's contributions to NHS pensions	12,112	1,119	**13,231**	12,196
Pension cost - other			**-**	-
Other post-employment benefits			**-**	-
Other employment benefits			**-**	-
Termination benefits		185	**185**	-
Temporary staff (including agency)		5,820	**5,820**	7,522
Total gross staff costs	**126,789**	**18,276**	**145,065**	**134,674**
Recoveries in respect of seconded staff			**-**	(1,217)
Total staff costs	**126,789**	**18,276**	**145,065**	**133,457**
Of which				
Costs capitalised as part of assets	1,938	911	2,849	3,477

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

	Permanent Number	Other Number	2016/17 Total Number	2015/16 Total Number
Medical and dental	368	44	**412**	397
Ambulance staff	-	-	**-**	-
Administration and estates	697	85	**782**	707
Healthcare assistants and other support staff	637	43	**680**	688
Nursing, midwifery and health visiting staff	895	46	**941**	922
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	444	11	**455**	387
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Agency and contract staff	-	37	**37**	24
Bank staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**3,041**	**266**	**3,307**	**3,124**
Of which: Number of employees (WTE) engaged on capital projects	48	23	**71**	78

2.8.4 Reporting of compensation schemes - exit packages 2016/17

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	**-**
£10,001 - £25,000	2	-	**2**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	1	-	**1**
>£200,000	-	-	**-**
Total number of exit packages by type	**3**	**-**	**3**
Total resource cost (£)	£185,000	£0	**£185,000**

There were no compensation schemes- exit packages in 2015/16

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

	Male	Female	Total
Executive directors (inc. CEO)	4	2	6
Non-executive directors	6	1	7
Employees	692	2,966	3,658

2.8.6 Sickness absence data

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

Measure	Value
Average full time equivalent (FTE) 2016	3,070
FTE-days available (based on 225 days per year)	690,656
FTE-days lost to sickness absence	27,530
Average of 12 months (2016 calendar year)	3.99%
Average sick days per FTE	9

Source: based on sickness data from ESR BI, period covered January - December 2016

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 2016 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.

2.8.7 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 focusses 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 and 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 and 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		
	2016/17	2015/16	2014/15	2016/17	2014/15	2013/14
Age						
16	0	0	0	1	0	0
17-21	61	73	68	34	30	41
22+	3,597	3,566	2,993	5,963	5,464	5,317
Not Specified	0	0	0	170	140	144
Total	3,658	3,639	3,063	6,168	5,634	5,502
Ethnicity						
White	3,078	3,066	2,701	5,565	5,320	5,280
Mixed	37	31	27	28	25	21
Asian or Asian British	263	247	239	72	69	69
Black or Black British	22	24	20	23	23	22
Other ethnic group	36	33	33	69	48	26
Not Stated	66	76	41	411	149	84
Undefined	156	162	2	0	0	0
Total	3,658	3,639	3,063	6,168	5,634	5,502
Gender						
Female	2,966	2,957	2,444	3,716	2,323	3,154
Male	692	682	619	2,452	3,311	2,348
Total	3,658	3,639	3,063	6,168	5,634	5,502
Disability						
No	1,387	1,261	917	0	0	0
Not declared	286	327	331	0	0	0
Undefined	1,897	1,969	1,739	5,434	4,884	4,708
Yes	88	82	76	734	750	794
Total	3,658	3,639	3,063	6,168	5,634	5,502

Employee data is sourced from ESR BI and membership data is sourced from the Trust's membership database. Data as at 01.04.2017.

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.

2.8.8 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 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 2016 to March 2017 27 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.

Workplace inspections are undertaken by health and safety link persons who are qualified with the RSPH Level 2 award in health and safety. This qualification gives the link person the knowledge and understanding to undertake the inspection. Once completed, the inspection is captured on the risk register so actions can be monitored. 126 members of staff have now gained this qualification.

Reporting of injuries, diseases and dangerous occurrence regulations 2013 (RIDDOR)

During the period April 2016 to March 2017 a total of 20 incidents were reported to the Health and Safety Executive as required under RIDDOR. This is a decrease of one incident from the previous year. The main decrease was in the category of Health and Safety (2 incidents).

There were no RIDDOR reportable incidents for slips, trips and falls involving patients or needlestick incidents. However there was an increase in the category of 'moving and handling' from eight to 10 incidents.

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.

Of the 20 incidents reported to the HSE, 17 incidents (81%) 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.

RIDDOR description	2016/17
Moving and handling incidents	10
Asbestos incidents	1
Health and safety incidents	1
Slips, trips and falls (staff)	6
Violence and aggression	2

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 2016 to March 2017 there were 206 violence, abuse and harassment incidents - an increase of 33 from the previous year. These incidents take into account physical assaults, verbal abuse, harassment and physically threatening behaviour towards staff by patients. Out of the 206 incidents reported there were 75 physical assaults, 65 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. While any increase in incidents of this nature is a concern, WSFT is still the lowest in the region for reported incidents of this nature. During 2017/18 we will be trialling new training to support staff in managing challenging behaviour.

There were 1,605 reported incidents of personal accident/ill health during 2016/17. This is an increase of 224 incidents (14%) 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 3 (quality report).

2.8.9 Occupational health report / occupational health and wellbeing service

Occupational health and wellbeing vision:
"Deliver a professional, quality occupational health and wellbeing service to the West Suffolk NHS Foundation Trust and become an essential component in the quality service delivered to the local community by taking a public health approach to occupational health and wellbeing".

Cambridge Health at Work working in special partnership with WSFT 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. Cambridge Health at Work (CHaW) is SEQOHS accredited and is the only training centre in the region for OH physicians. Working closely with CHaW our focus is on ensuring those who work for WSFT are safe, healthy and productive in their work. The CHaW team continue to support the management of sickness absence and ensure those joining our Trust are fit and able to undertake their roles. It has been an exciting year for NHS workforce health with the introduction of staff health and wellbeing CQUINs, derived from the NHS Five Year Forward View. Working in partnership, sharing expertise we have introduced health checks and a weight management programme for staff, reduced the promotion of food high in

sugar and fat sold on the premises and achieved 65% uptake of the flu vaccination by the WSFT workforce. This is higher than national take-up rate and 11% improvement on last year's performance.

We strive to achieve the target of 70% of our headcount being vaccinated this coming winter and believe we will achieve it using learning from 2016/17. CHaW has launched a new online resource (website supported by extensive social media engagement) of information and sign-posting for staff experiencing work related ill health and positive messaging to support education on avoiding health harms. We have also seen significant use of the Trust's employee assistant programme (EAP) provided by our partner Care First. The EAP delivers 24/7 telephone advice and counselling service, face to face counselling, support following a major traumatic event and an information service on legal, financial and social matters.

We have actively participated in and supported the East of England Streamlining Programme over the last two years. The programmes objective is to reduce the time to hire for staff joining each Trust in the region. Agreement across all occupational health services has been achieved for a standard immunisation and clearance protocol and for the sharing of the employee's health record when that individual transfers to another Trust in the region, with consent in an appropriate secure way.

In 2017/19 our focus is on reaching, engaging, educating and supporting the WSFT workforce particularly around eating and drinking well, sleeping well, moving more, stress less and being smoke free. We are committed to preventing and responding to ill health within our workforce in an effective caring way.

2.8.10 Staff survey

The following report includes commentary on the National Staff Survey (2016). 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.

Staff engagement

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 3.97 was in the highest (best) 20% when compared with trusts of a similar type.

WSFT is also the top scoring acute trust in England for overall staff engagement.

	WSFT score 2016	National average 2016	WSFT score 2015	WSFT score 2014	WSFT score 2013
Overall staff engagement	**3.97**	3.81	3.93	3.90	3.82

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

	2016	National average	2015	National average	+/- last year	Acute trusts
KF1. Staff recommendation of the organisation as a place to work or receive treatment	**4.10**	3.76	4.05	3.76	**+0.05**	Highest (best) 20%
KF4. Staff motivation at work	**4.00**	3.94	3.98	3.94	**+0.02**	Highest (best) 20%
KF7. Staff ability to contribute towards improvement at work	**72%**	70%	71%	69%	**+1%**	Above (better than) 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	
2014 sample	2,956	798	419	53%	4% (decrease)
2015 sample	3,068	850	462	54%	1% (increase)
2016 sample	**3,494**	**1,250**	**624**	**50%**	4% (decrease)

Top and bottom five ranking scores
The 2016 staff survey report has 32 key findings. Overall the WSFT has achieved the following:

	Number of key findings	
Ranking	2016	2015
Best 20% for:	**14**	7
Better than average for:	**7**	13
Average for:	**6**	5
Worse than average for:	**5**	4
Worst 20% for:	**0**	3

This table highlights the five key findings for which WSFT compares most and least favourably with other acute trusts in England.

	2016		2015		Target trend (up / down)	Improvement /deterioration (% since 2015)	Ranking
	WSFT	Nat. Avg.	WSFT	Nat. Avg.			
Top five ranking scores							
KF1. Staff recommendation of the organisation as a place to work or receive treatment	**4.10**	3.76	4.05	3.76	+	**+0.05**	Highest (best) 20%
KF21. % believing the organisation provides equal opportunities for career progression / promotion	**92%**	87%	90%	87%	-	**+2%**	Highest (best) 20%
KF14. Staff satisfaction with resourcing and support	**3.46**	3.33	3.45	3.30	+	**+0.01**	Highest (best) 20%
KF5. Recognition and value of staff by managers and the organisation	**3.61**	3.45	3.54	3.42	+	**+0.07**	Highest (best) 20%
KF8. Staff satisfaction with level of responsibility and involvement	**4.03**	3.92	3.99	3.91	+	**+0.04**	Highest (best) 20%
Bottom five ranking scores							
KF22. % experiencing physical violence from patients, relatives or the public in last 12 mths	**16%**	15%	20%	14%	+	**-4%**	Above (worse than) average
KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 mths	**29%**	27%	27%	28%	-	**+2%**	Above (worse than) average
KF11. % appraised in last 12 mths	**82%**	87%	81%	86%	+	**+1%**	Below (worse than) average
KF29. % reporting errors, near misses or incidents witnessed in last mth	**90%**	90%	88%	90%		**+2%**	Below (worse than) average
KF18. % attending work in last 3 mths despite feeling unwell because they felt pressure	**58%**	56%	60%	59%	-	**-2%**	Above (worse than) average

Action plan for areas of concern and future priorities

Recognising WSFT's strong performance the 2016 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. A full action plan has yet to be presented to the board for agreement as it is still being formalised. Updates on the action plan are sent to the board as well as the patient experience committee to monitor progress. There are also plans to publish a summary action plan to staff with updates throughout the year.

Results to the staff survey at divisional level are to be published to general managers of the respective divisions providing them with the necessary information to manage localised issues.

Key Factor	Proposed Actions

KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	This issue was raised in 2015 staff survey and again in 2016. Actions put in place are being maintained and has seen a reduction from 20% to 16% in the last year. The following has been put in place to date:
	
	• 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 were put in place from 7/03/2016 which involved 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.

KF25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	As part of KF22 the managing challenging behaviours training being combined with conflict resolution training will assist staff in managing relatives and patients during these situations.
KF11. Percentage of staff appraised in last 12 months	This issue was raised in 2015 staff survey and again in 2016. Actions put in place are still being maintained. There has been an increase from 81% to 82% which is an indicator that actions are having an impact. New actions have been put in place: • Update of appraisal paperwork, policy and skills plus training session to ensure appraisal process is easy to follow and regular training is accessible to managers • Managers will be reminded of their responsibility to update the workforce information team once an appraisal has been completed as this does not always take place which has a negative impact on the accuracy of reporting information • A selection of managers to be asked for their feedback on the proposed new paperwork in order to ensure this is as user-friendly as possible, which will then ensure appraisals can be completed efficiently.

Key Factor	Proposed Actions
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month	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 directorates, with the surgical directorate indicating that reports are not treated confidentially. An action plan was implemented prior to the staff survey last year. The plan has been updated to reflect the issues raised: • Information and training for staff on incident reporting to be reviewed. Line managers to encourage and support staff in openly reporting issues • Confidentiality and other factors of incident reporting are being addressed through clarification of the reporting process, and review of teaching, learning and benefits to staff, patients and organisation. Further support has been put into place including intranet resource and gathering staff feedback (Survey Monkey) within the work plan • Review and strengthen feedback mechanisms about changes made in response to reported errors • Implement strategies to support increased levels of incident reporting as measured by the national reporting and learning system (NRLS) benchmark.
KF18. Percentage of staff attending work in the last three months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	This issue has been considered by the occupational health service and has been broken down into four sections, reflecting the four questions asked of staff as part of KF18. In three areas WSFT are above the national average. Strategies are being considered to support staff who 'put pressure on themselves to come to work when not feeling well enough'.

2.8.11 Pension liabilities for ill health retirement

There were eight ill health retirements during the year to 31 March 2017 (2016: two); the additional pension liability borne by NHS Pensions was estimated as £166,000 (2016: £66,000).

2.8.12 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.

2.8.13 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 Mar 2017, for more than £220 per day and that last for longer than six months:

	Number
Number of existing engagements as of 31 March 2017	21
Of which:	
Engagements that have existed for less than one year at time of reporting	7
Engagements that have existed for between one and two years at time of reporting	8
Engagements that have existed for between two and three years at time of reporting	5
Engagements that have existed for between three and four years at time of reporting	1
Engagements that have existed for four or more years at time of reporting	-

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 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months:

	Number
Number of new engagements, or those that reached six months in duration between 1 April 2016 and 31 March 2017	7
Number of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and national insurance obligations	7
Number for whom assurance has been requested	7
Of which:	
Number for whom assurance has been received	2
Number for whom assurance has not been received	5
Number that have been terminated as a result of assurance not being received	-

The Trust has reviewed off payroll arrangements and from 6/4/17 all arrangements have been terminated or moved to payroll unless they are assessed as meeting HMRC's requirements to be paid gross. There were no off-payroll engagements of board members and/or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017. During 2016/17, the Trust spent £833k on consultancy costs (2015/16 £1,022k).

3. Quality report

3.1 Chief executive's statement

I am delighted to introduce this year's Quality Account on behalf of West Suffolk NHS Foundation Trust.

This has been one of the most challenging years we have ever faced in terms of demand for our services and our emergency and medical services were severely tested over the Christmas period. In spite of this I am delighted to be able to report another year of significant achievement in terms of the quality of care that we provide for our patients. In August 2016 we were given an overall rating of 'good' by the Care Quality Commission and were rated as 'outstanding' for care. This was a huge achievement for the hospital and its staff and we are all immensely proud of our report and the positive stories about our services and many innovations that it contains.

We continue to follow our strategy as set out in the document, *"Our Patients, Our Hospital, Our Future, together"* and the integration of services is an important theme in this. In December 2016 we were given approval to develop an alliance of providers to continue to provide community services for Suffolk. This will enable us to strengthen our partnerships and transform services so that the acute hospital works as one team with other services such as health visiting, psychiatry and social care. I believe that this is vital to make services sustainable for west Suffolk and protect our NHS in this part of the world for future generations.

In last year's report we outlined the need to reduce the number of patients spending time in an acute hospital bed when they are fit enough to be in a more supportive and homely environment. I was really proud to open our new care facility on King Suite at Glastonbury court care home in Bury St Edmunds in February. This 20-bed inpatient service has enabled us to discharge patients who are medically fit out of West Suffolk Hospital into a first-rate care home environment that will support their recovery and re-ablement. This has made more beds available for people who need them at the acute hospital as well as helping patients get back to their homes or places of future residence as quickly as possible.

It is important for our patients and our staff that we can be confident that the treatments we provide 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.

The National Hip Fracture Database rated WSFT as the best in the east of England for the care of patients needing treatment for a fractured hip and 6th best in the country. This is the most common serious injury in older people and often results in lengthy hospital stays with only a minority of patients regaining their previous abilities. Our integrated team works hard to deliver against best clinical practice guidelines and it has been very pleasing that they have been recognised in the outcome measures they are achieving. WSFT achieved 85.1% against national best practice criteria compared to the national average of 65.6%.

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. We monitor patient experience partly through the friends and family test and this year we exceeded our target that 90% 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.

Our charity often supports us in enhancing patient experience and this year has been no exception. Among the many generous donations to our hospital, we were able to benefit from a special bereavement room for families to use following the tragic loss of a baby. This enables them to be together and receive support in a calm and comfortable space which can transform their experience at an immensely difficult time. The room was made possible by the £25,000 that My WiSH Charity was able to donate and we remain hugely grateful for this generosity.

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, as well as the priorities we have to improve quality during 2017/18. 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.

In May 2016, we launched a new multi-million pound electronic patient record called e-Care. This was an unprecedented overhaul of our IT systems. While the launch was a significant success there has been an impact on our ability to report performance against a number of quality standards, for example the referral to treatment (18 week) standard and risk assessment for venous thromboembolism. Some of our internal reporting has also been affected and we put in place arrangements to capture information to monitor and challenge quality performance to ensure gaps are covered, for example through matrons' rounds. Working with our digital partner, Cerner, we have made significant progress to improve reporting and plan to have all aspects in operation to allow reporting of June 2017 activity.

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 2016 NHS staff survey was the best it has ever been and we were the highest rated Trust in the country for staff engagement. The vast majority of our staff would recommend WSFT as both a place to work and a place to receive treatment, something we are immensely proud of.

I can confirm that to the best of my knowledge the information contained in the quality report 2016/17 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 and risk committee and its three subcommittees which ensure quality is delivered in a coordinated way to support safe, effective and patient-focussed healthcare. The subcommittees are:

(a) Clinical safety and 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 2017/18

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 2017/18, 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 2017/18 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. 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.

During 2016 we saw deterioration in a small number of areas of our national patient survey results. We have focussed improvement on these key areas within our quality priorities.

Historically we have performed well against access targets for patients receiving elective care. During 2016/17 we maintained good access performance across a range of indicators but performance against the 18 week target did reduce. We are therefore focusing our efforts to ensure that we deliver improved access during 2017/18.

Deliver measurable improvements in the patient experience

- Sustain and improve Friends and Family Test performance ensuring we consistently achieve 90% of patients recommending our services to their friends and family
- Improve performance against the baseline of 2016 for the following questions from the national patient survey:
    - Doctors and nurses talking in front of patients as if they were not there
    - Patients being asked to give their views on quality of care
- Improve patient experience of access to surgery against the baseline of 2016/17, as measured by 18 week target performance.

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 avoidable pressure ulcers on our inpatient wards. This will be achieved by improving practice based on learning from investigation of pressure ulcer incidents.

The winter escalation ward which closed in April will be used as a decant facility between May and September 2017. This will allow essential maintenance and environmental improvements to be made to our ward areas. The programme of works includes: deep cleaning of 18 wards and departments as well as dementia friendly improvements, fire compartmentation works and maintenance of floors. The focus of the work is support the delivery of safe, high quality care in environments which reflect our patients' and visitors' needs.

During 2017/18 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 and sepsis.

During 2017/18, trusts will be required to collect and publish specified information on deaths. This will be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards). Changes to the Quality Accounts regulations will require that the data we publish be summarised in Quality Accounts from June 2018, including evidence of learning and action as a result of this information and an assessment of the impact of actions that a provider has taken. An important part of this work will be improving how we engage relatives of deceased patients in these reviews.

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 2017/18
- Reduce the incidence of avoidable pressure ulcers below the baseline for 2016/17
- Implement the programme of work to improve our ward environments during 2017/18

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 2016/17
- Improve reliability of sepsis screening and treatment for emergency admissions – improving performance during 2017/18
- Demonstrate a systematic approach to identifying inpatient deaths which may have been caused by a problem in care. Demonstrate that learning has resulted and that the actions taken in response have had a measurable impact on quality or safety

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 2016/17 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 2016/17 was £219.4m which represents 89.2% of the total income generated from the provision of relevant health services by WSFT for 2016/17.

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 and East Suffolk Clinical Commissioning Group awarded the NHS contract for community services to WSFT, working in partnership with The Ipswich Hospital NHS Trust and Norfolk Community Health and Care NHS Trust.

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 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 and CQC visits
	• Trust-wide compliance monitoring, including:
	  • infection control, including hand hygiene
	  • pressure ulcers, falls and venous thromboembolism (VTE)
	  • Stroke care
	  • mortality
	  • re-admission
	• Incident and claims analysis and national benchmarking
	• 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)
	• Mortality reviews

Participation in clinical audits and confidential enquiries

During 2016/17 35 national clinical audits and nine clinical outcome review programmes covered NHS services that WSFT provides.

During 2016/17 WSFT participated in 94% of national clinical audits and 100% of clinical outcome review programmes which it was eligible to participate in.

The national clinical audits and clinical outcome review programmes that WSFT participated in, and for which the data was completed during 2016/17, 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 11 national clinical audits and 59 local clinical audits were reviewed by the provider in 2016/17 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 2016/17 that were recruited to participate in National Institute for Health Research (NIHR) portfolio or commercial research studies approved by a research ethics committee will exceed 500. This is an increase of 150% compared to 2015/16 when 208 patients were recruited. This one off step improvement was the result of the 2015/16 research transformation plan.

In 2016/17 WSFT participated in 74 NIHR portfolio or commercial research studies; compared to 55 in 2015/16 - 18 studies closed during the reporting period.

The Research Operational Committee (ROC) is now chaired by the Research Clinical Director. Going forward 2017/18, WSFT aims to build upon a balanced portfolio of studies: Observational, Interventional and Commercial, and to engage more research naïve specialities.

Goals agreed with commissioners

A proportion of WSFT income in 2016/17 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).

The CQUIN indicative goals for 2016/17 included following national and local 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
- Antimicrobial resistance and stewardship: reduction in antibiotic consumption; and empiric review of antibiotic prescriptions
- System-wide frailty – collaborative working on a system vision, action plan and education for frail patients.

The total value CQUIN funding in 2016/7 was £3,433,256 (compared with £3,233,370 in 2015/16).
The CQUIN indicative goals for 2017/18 will include the following national and local CQUINs:

- Staff, health and wellbeing: wellbeing, musculoskeletal and stress – via the staff survey, staff perception of the effect of work; healthy food for staff, visitors and patients; and frontline staff – flu vaccinations
- Sepsis: emergency department and inpatients – screening; emergency department and inpatients treatment plus antibiotic prescription review
- Antimicrobial resistance and stewardship: reduction in antibiotic consumption
- Mental health needs in emergency department: collaborative working with mental health trust and partners
- Consultant advice and guidance service to GPs
- Services and all first outpatient appointment slots to be published on e-Referral
- Proactive and safe discharge for patients aged 65 and over – aim to their usual place of residence: collaborative working
- Starts 2018: Preventing ill health – inpatient tobacco and alcohol screening, advice, refer/treat
- Suffolk Transformation Programme support.

The total CQUIN funding value for 2017-18 is to be confirmed.

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 2016/17. WSFT has not participated in special reviews or investigations by the CQC during the reporting period.

WSFT is required to register with the **Care Quality Commission (CQC)** and its current registration status is unconditional. During 2016/17 the Trust extended its registration to include a new location (Kings Suite, Glastonbury Court) and a new regulated activity 'Personal Care'. WSFT is anticipated to further extend the scope of its registration within 2017/18 as the development of accountable care organisations (ACO) in Suffolk progress.

WSFT was the subject of a rigorous three day CQC inspection in March 2016 as part of the national programme of inspection of all acute NHS trusts and the final report was issued in August 2016. The CQC concluded that patients using WSFT receive "outstanding" care from staff who go "the extra mile". The CQC awarded the Trust – which provides services at both West Suffolk and Newmarket hospitals – an overall rating of "good", while rating the care provided as "outstanding". The report is the best of all hospitals in the eastern region (based on review of CQC reports for relevant trusts). In their report, the inspectors highlighted several specific examples of outstanding practice which included:

- Excellent performance in national audits, which routinely place the trust amongst the top 15 in the country. Stroke performance was a particular highlight
- Two consultant paediatricians learning hypnosis to reduce the need to sedate children who need an MRI or CT scan
- The respect shown by porters when transporting patients to the mortuary
- Consultant paediatricians setting up outreach clinics in GP practices and holding telephone clinics so that patients can receive more convenient treatment closer to home
- The work of the hospital's 'virtual fracture team', which makes sure fractures are diagnosed as quickly as possible in the emergency department (ED)
- Staff dropping off take-home medications or going the extra mile to provide decaffeinated tea bags for patients
- An ED receptionist giving CPR after a patient collapsed
- Staff arranging a linked funeral service for a widow who could not leave the hospital
- The work done by the pharmacy to provide take home medication for patients
- The results of an independent assessment which shows the Trust was the most efficient small acute provider and the fourth most efficient provider in the country.

In its report, the CQC particularly praised staff at the hospital, saying they place the patient at the centre of the care they provide and describing them as "open, helpful and dynamic". The positive feedback the hospital receives from patients and visitors was also commended, along with the safety of services and the infection control processes which are in place.

The CQC ratings grid is set out below for the West Suffolk Hospital, Newmarket Community Hospital and the overall WSFT. 36 areas were rated as Good, four had a rating of 'Requires Improvement' and five were rated as 'Outstanding'.

West Suffolk Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Good	☆ Outstanding	☆ Outstanding	Good	Good	☆ Outstanding
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	☆ Outstanding	Good	Requires improvement	☆ Outstanding	Good
Maternity and gynaecology	Good	Good	Good	Good	Requires improvement	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
End of life care	Good	Requires improvement	☆ Outstanding	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Good	Good
Overall	Good	Good	☆ Outstanding	Good	Good	Good

Newmarket Community Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

West Suffolk NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Good	Good	☆ Outstanding	Good	Good	Good

The four areas highlighted as 'requiring improvement' were Urgent and Emergency Care (Safe), Critical Care (Responsive), Maternity and Gynaecology (Well led) and End of Life Care (Effective). The issues and actions taken to address these are summarised below.

Urgent and Emergency Care (Safe)

Paediatric staffing and facilities were identified as an area for improvement and an executive option appraisal was prepared. Staffing levels have been increased as part of development of self-contained Paediatric Unit including collaborative working with Paediatric teams for out of hours cover. The paediatric area within the Emergency Department (ED) is now staffed by paediatric trained nurses between 8:00 to 0:00 while overall staffing levels in the ED have been increased by more than 28 whole time equivalent staff (including new posts and filling existing vacancies). A programme of work has been agreed which will improve the facilities in which paediatric care is delivered. A programme of work has been agreed to improve the facilities in which paediatric care is delivered. The operational policy for the management and referral to the clinical decision unit (CDU) has been updated, this addresses the issues highlighted regarding mixed sex accommodation. The implementation of e-Care has improved the quality and consistency of record keeping. Learning from incidences and complaints has been developed with the use of simulation within the emergency department. Both compliments and complaints are shared with all staff by various methods including email, staff notice boards and daily team catch-ups at the start of the day by the unit manager.

Critical Care (Responsive)
Critical Care undertook a survey reviewing staff knowledge of same sex accommodation (SSA) standard and used the feedback to clarify and structure the departmental standing operating procedures (SOPs) for privacy and dignity and avoidance of SSA breaches. The Trust bed capacity report was amended to capture 'wardable' patients with an extended stay in recovery and feed this data into the operational bed management meetings. The Datix incident reporting system has been updated to capture SSA breaches and Critical Care 'capacity' incidents to allow thematic analysis and learning.

Maternity and Gynaecology (Well led)
Over the last 18 months we have strengthened the management structure to ensure that both service manager posts have been appointed. In addition the interim Head of Midwifery/Nursing put into place a robust leadership programme, which included a workshop run by the Royal College of Midwives. In 2016/17 the Trust launched a range of Trust wide leadership activities that built on the initial leadership summit in December 2015. This includes workshops aimed at Band 7s and 6s e.g. the 'Expert Navy programme' run by the Nursing Directorate and the '2030 Programme'. All these activities are open to members of the Midwifery Division. The Trust has established the 'Freedom to Speak Up Guardian' role'. This is an individual who staff can approach with any concerns about the workplace including patient care or staff issues. The Guardian will then signpost individuals accordingly.

The Women and Children Divisional quality and performance dashboard has been strengthened and is reported in greater detail to the Board on a monthly basis.

End of Life Care (Effective)
Vacancies within the end of life team have been filled. The Trust is also working jointly with St Nicholas Hospice, sharing two consultant posts across the organisations, to promote integrated working across both sites for the benefit of patients and their families. A bid for Macmillan funding was successful to implement 7 day nursing cover and this is planned to launch in autumn 2017. This will ensure that patients and their families have access to a palliative care clinical nurse specialist (CNS) at a weekend, particularly for those families who cannot attend during the week due to work and family commitments. Although there is currently and will continue to be a 24/7 on call service provided by the hospice/hospital consultants, having the CNS's in the hospital will provide additional support to the wards on dealing with symptom control for this cohort of patients.

Amendments to the Trust's EPARS (Escalation Plan and Resuscitation Status) policy were reviewed by an external, independent reviewer to confirm compliance with current national guidance. The EPARS sub-group of the Trust's Deteriorating Patient Committee have been coordinating the transfer from paper-based record to an electronic form on e-Care and a planned audit will provide evidence of implementation. The Adult Safeguarding Lead post continually reviews the staff competencies, understanding and training and a comprehensive matron-led audit programme ensures staff compliance with all aspects of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

The **Medicine Healthcare Regulatory Authority (MHRA)** undertook a planned inspection of the blood transfusion service operated within the hospital by the Pathology Partnership (tPP). The inspection highlighted several areas of concern and we are working closely with the inspection team to ensure action is taken by tPP to address issues identified which include staffing and quality management systems. Plans to restructure tPP were formally announced in late February. The new structure has been implemented for services in the east of the partnership. The North East Essex and Suffolk Pathology Services (NEESPS) includes West Suffolk, Colchester and Ipswich hospitals and is managed locally as a stand-alone network, with the hub laboratory remaining at Ipswich Hospital and Colchester Hospital University NHS Foundation Trust acting as host. The NEESPS is clinically led by four specialty clinical leads in each of the four service areas: Cellular Pathology; Chemistry; Haematology and Blood Transfusion' and Microbiology. The board will carefully monitor progress to mitigate this risk during 2017/18.

Awards and accolades

West Suffolk named as one of the 'top hospitals' for safe, effective care
WSFT has been named as one of the country's 'top hospitals' for providing safe, effective and high quality care for the second year running. The hospital was one of 40 from across the country to receive the accolade from independent healthcare intelligence company CHKS during its Top Hospitals 2016 awards ceremony in London in May 2016. It came following detailed analysis of 22 key areas covering clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. Judges looked at a variety of data, including length of stay, hospital acquired infections, inpatient surveys and emergency readmission rates, before deciding which hospitals would receive the award. For the sixth consecutive year, West Suffolk was also one of just five hospitals shortlisted in the quality of care category. The trust won the title in 2011 and 2012.

WSFT to become a "centre of global digital excellence"
WSFT is to become a prestigious "centre of global digital excellence" after successfully bidding for a share of £100m in funding to further improve the way technology is used to benefit patients. The hospital was invited to bid for the money by NHS England after it was identified as one of the country's 26 "most digitally advanced" trusts following the introduction of its electronic patient record, e-Care, earlier this year.

Over the next two years, up to £10 million of funding will be invested in accelerating the hospital's existing plans to develop further its e-Care system. This will see the system fully integrated with those used by GPs other hospitals such as Addenbrooke's, social services and other care providers so that everyone can share the same records, in turn avoiding duplication while making life easier for clinicians. In addition, a secure patient portal will be created to give patients access to their personal health records, allow them to view test results and send messages to their doctor, in turn ensuring they are fully involved in their own care.

Hip fracture care among the best in the country
The National Hip Fracture Database rates WSFT (WSFT) as top in the east of England for the care patients receive when attending with a hip fracture, and sixth nationally, up three places from last year. Hip fracture is the most common serious injury in older people, often resulting in lengthy hospital stays with only a minority of patients regaining their previous abilities and often needing long-term care.

An integrated staff team, including specialists from the emergency department, orthopaedics, elderly medicine and physiotherapy, work hard to deliver against best clinical practice guidelines. The team has introduced regular virtual fracture clinics at West Suffolk Hospital, a key part of the care given to patients attending with musculoskeletal injuries, where they assess patient needs together to identify immediate care needs and ensure they see the right specialist at the earliest opportunity. WSFT achieved 85.1% in the best practice tariff, the highest in the east region, against a national average of 65.6%. Records show that:

- 100% of patients received a bone health assessment (national average 97.2%)
- 88.2% of patients had surgery on the day of, or day after, admission (national average 71.5%)
- 80.2% of patients were mobilised out of bed on the day after surgery (national average 76.1%)
- The average overall length of stay in days was 17 (national average 21.1 days)

Top award for hospital's patient meals
The Trust received a prized national accolade for its dedication to serving fresh, ethical and sustainable food to patients, visitors and staff. West Suffolk hospital was presented with the Soil Association's Food for Life Catering Mark bronze award for the meals it serves in the Courtyard Café and Time Out restaurant. The award shows that the hospital uses fresh ingredients which meet nutritional guidelines and are free from additives and harmful trans-fats. All of the meat used by the hospital conforms with UK animal welfare standards and has earned the 'Red Tractor' farm assurance quality mark, while fish is certified by the Marine Stewardship Council and eggs are free range. To achieve the award, the hospital's catering team reviewed its recipes and changed some of its

ingredients, such as swapping milk powder for fresh milk in its cauliflower cheese. They also worked with their butcher to change the seasoning in their sausages, while increasing the meat content of the sausage rolls which are sold to staff so that they now contain over 80% pork.

Trust improves again in staff survey results
WSFT has strengthened its position as the hospital in the east that is the most highly rated by its staff, according to the results of the latest NHS staff survey. Asked questions about whether they would recommend the hospital as a place to work or receive treatment, 88% of staff agreed that care of patients is the Trust's top priority. The national average was 76%. When asked if they would recommend the Trust for treatment of a friend or relative 85% of staff agreed that they would compared with a national result of 70%.

The Trust is the highest performing in the country for staff engagement. We are also a leading trust for the extent to which staff look forward to going to work and being enthusiastic and absorbed in their jobs.

Data quality

WSFT submitted records during 2016/17 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	**99.3%**	99.2%	99.3%
Outpatient care	**99.6%**	99.5%	99.5%
Accident and Emergency care	**97.7%**	98.2%	96.7%

(The above figures cover April 2016 to Jan 2017 inclusive – taken from HSCIC SUS data quality dashboard)

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%**	100%	99.9%
Outpatient care	**100%**	100%	99.8%
Accident and emergency care	**100%**	99.8%	99.0%

(The above figures cover April 2016 to Jan 2017 inclusive – taken from HSCIC SUS data quality dashboard)

WSFT's information governance assessment report overall score for 2016/17 was 81% (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 NHS Digital's information governance toolkit (IGT)
- Working with our digital partner, Cerner, to improve reporting from e-Care and deliver plan to have all aspects in operation to allow reporting of June 2017 activity.

WSFT was not subject to the payment by results (PbR) clinical coding external audit during the reporting period 2016/17. 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	4.4%
Secondary diagnosis	3.8%
Primary procedure	2.8%
Secondary procedure	5.6%

The audit sample was 251 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 2016/17 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
	Consistently 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 2017/18. Unless otherwise stated the data provided is sourced from internal reporting arrangements.

Deliver personal care	Deliver measurable improvements in the patient experience

Measures

(a) Sustain and improve Friends and Family Test (FFT) 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

(b) Reduce noise at night through targeted reduction in the number of non-clinical moves at night - baseline Q1 of 2016/17

(c) Measurable improvement in patients' perception of involvement in care and treatment as a result of initiatives to improve shared decision making

(d) 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

(e) 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).

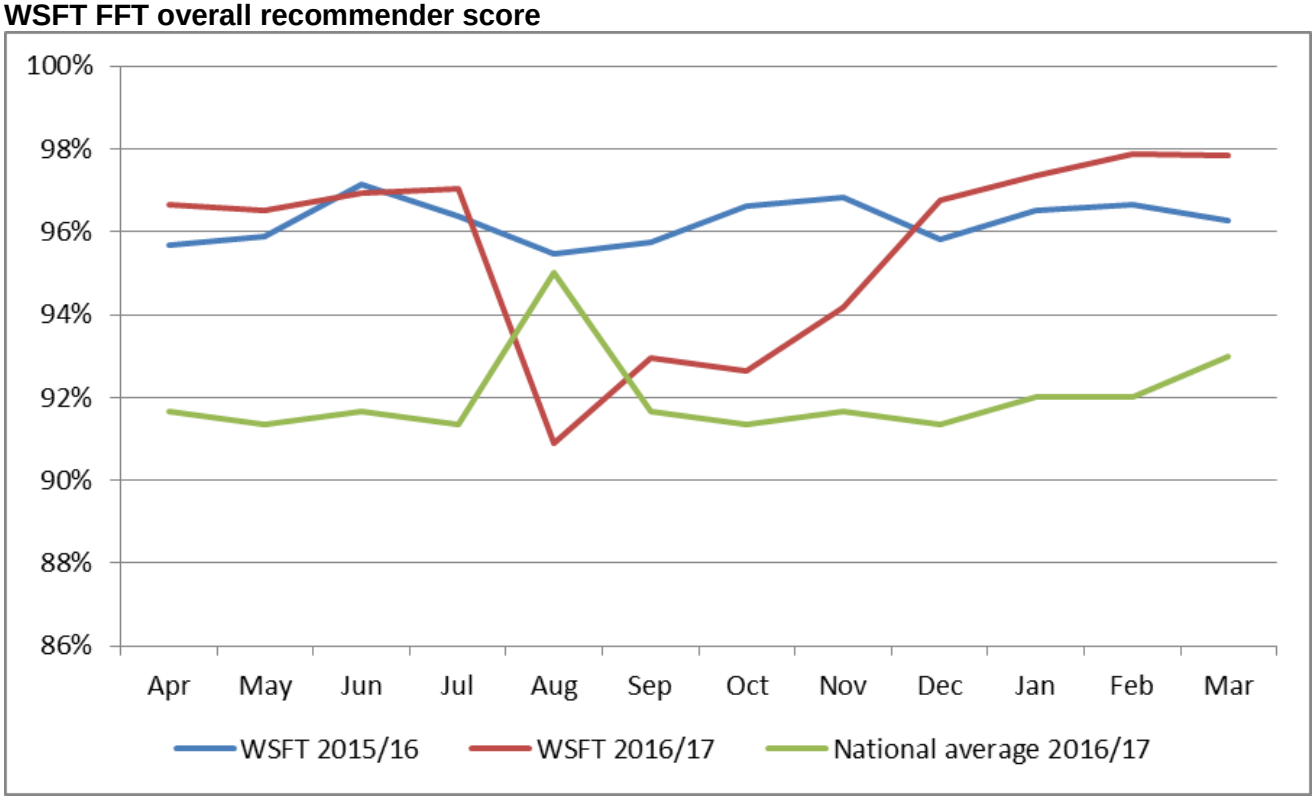
(a) Sustain and improve Friends and Family Test (FFT) performance:
- Ensure we consistently achieve 90% of patients recommending our services to their friends and family
- Achieve improvement in FFT response rates in outpatients against the baseline of 2015/16

Description of the issue and rationale for selection
Nationally, the FFT continues to be seen as a barometer of patients' overall satisfaction with care. WSFT will continue to maintain its focus on this during 2017/18 to ensure experience of care is at the highest possible standard, ensuring feedback is used to drive positive changes.

Action taken during 2016/17
- The FFT question is integral to our patient satisfaction surveys across all services provided by WSFT
- 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 2016/17 for inpatients, outpatients, day case patients, ED, paediatrics and maternity combined. We also consistently performed better than the national average.

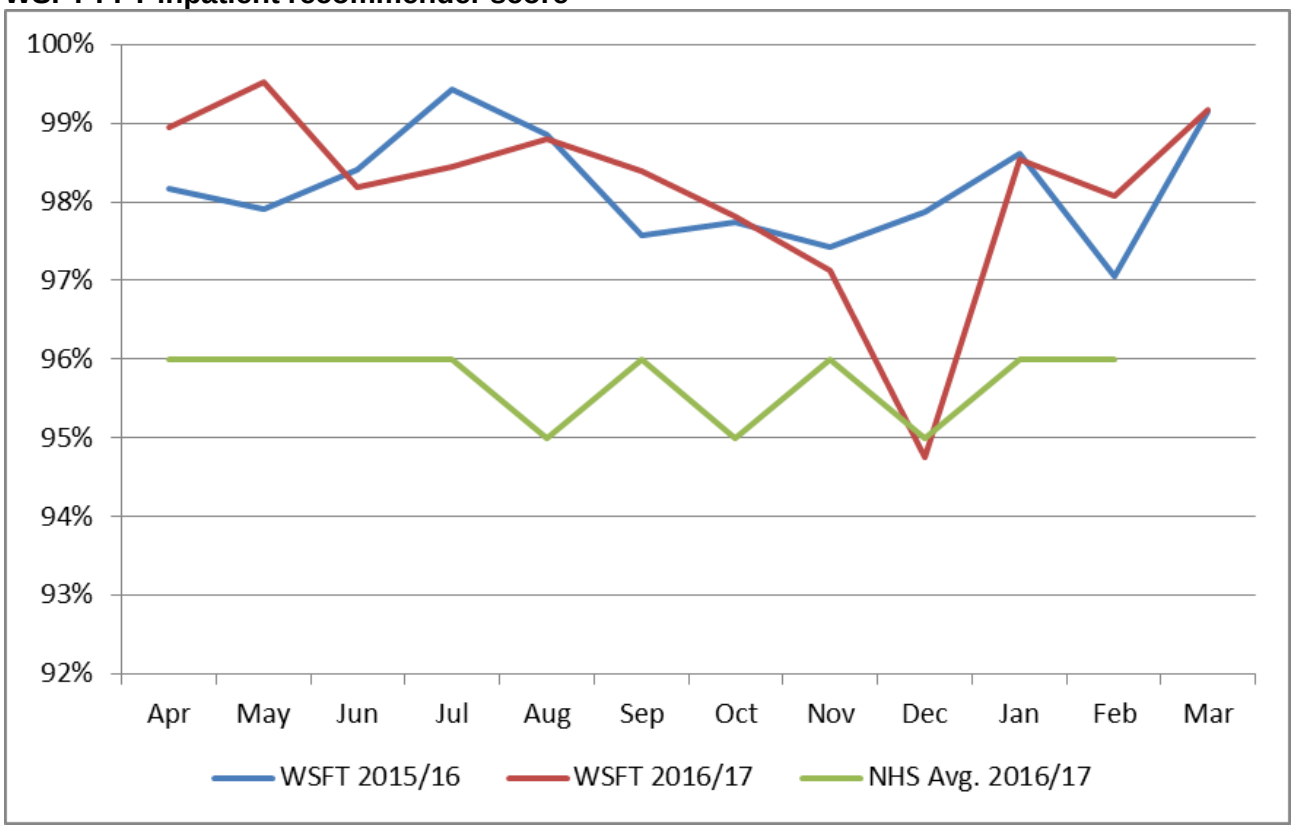
WSFT FFT overall recommender score



Source: NHS England

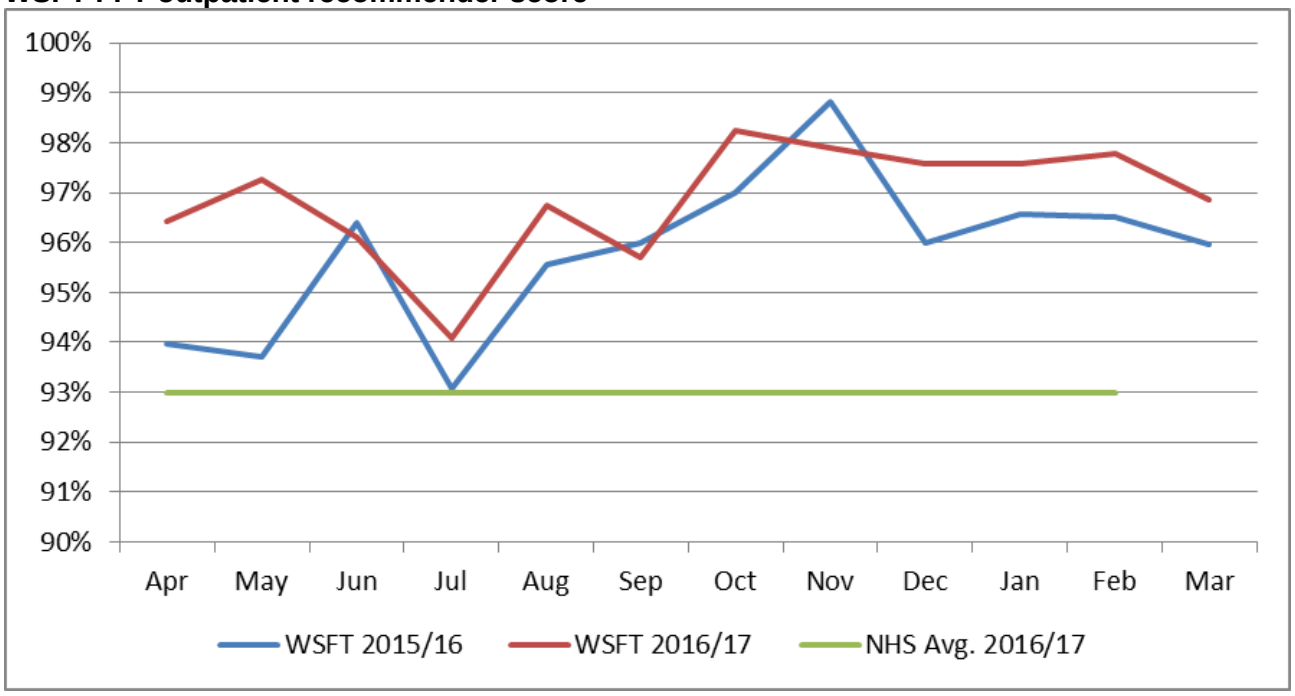
The reduction in August 2016 was largely driven by a change in the methodology for data collection in the emergency department. The position was recovered over the subsequent months.

WSFT FFT inpatient recommender score



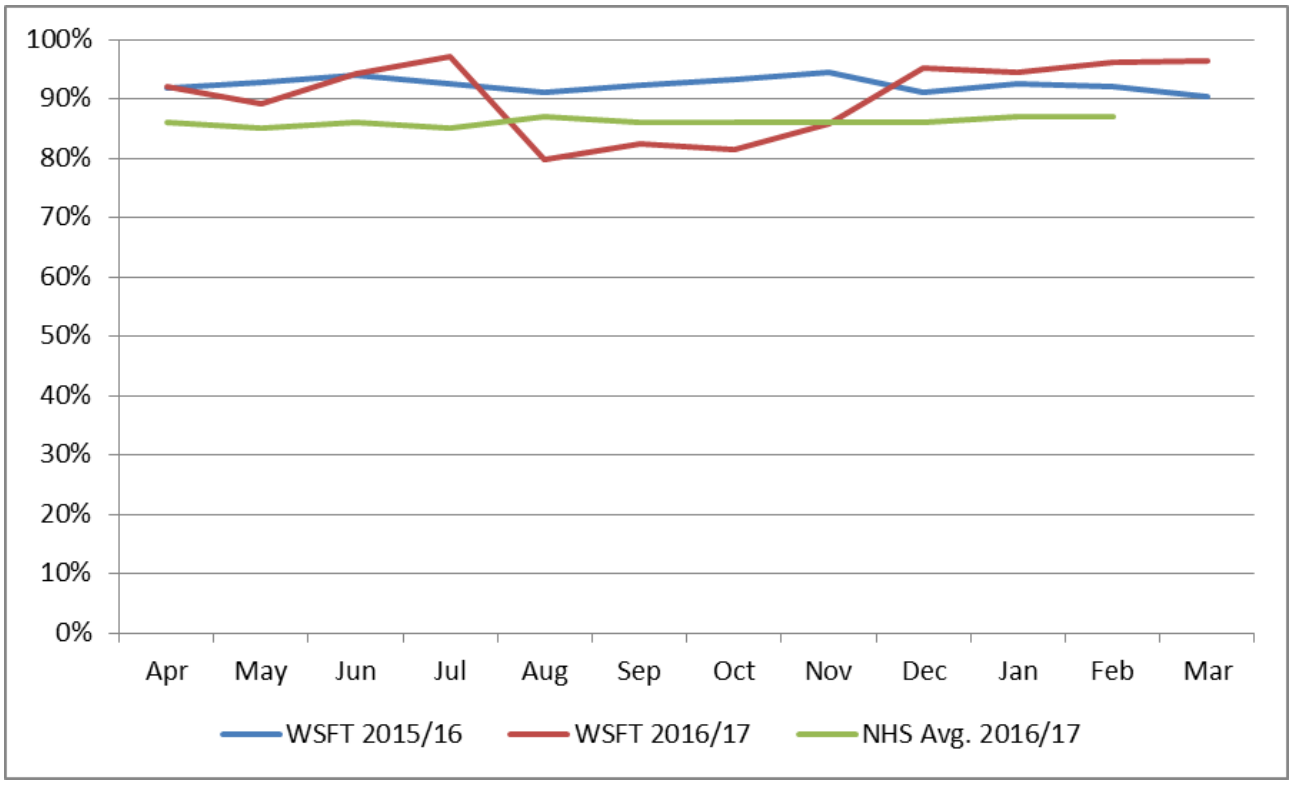
Source: NHS England

WSFT FFT outpatient recommender score



Source: NHS England

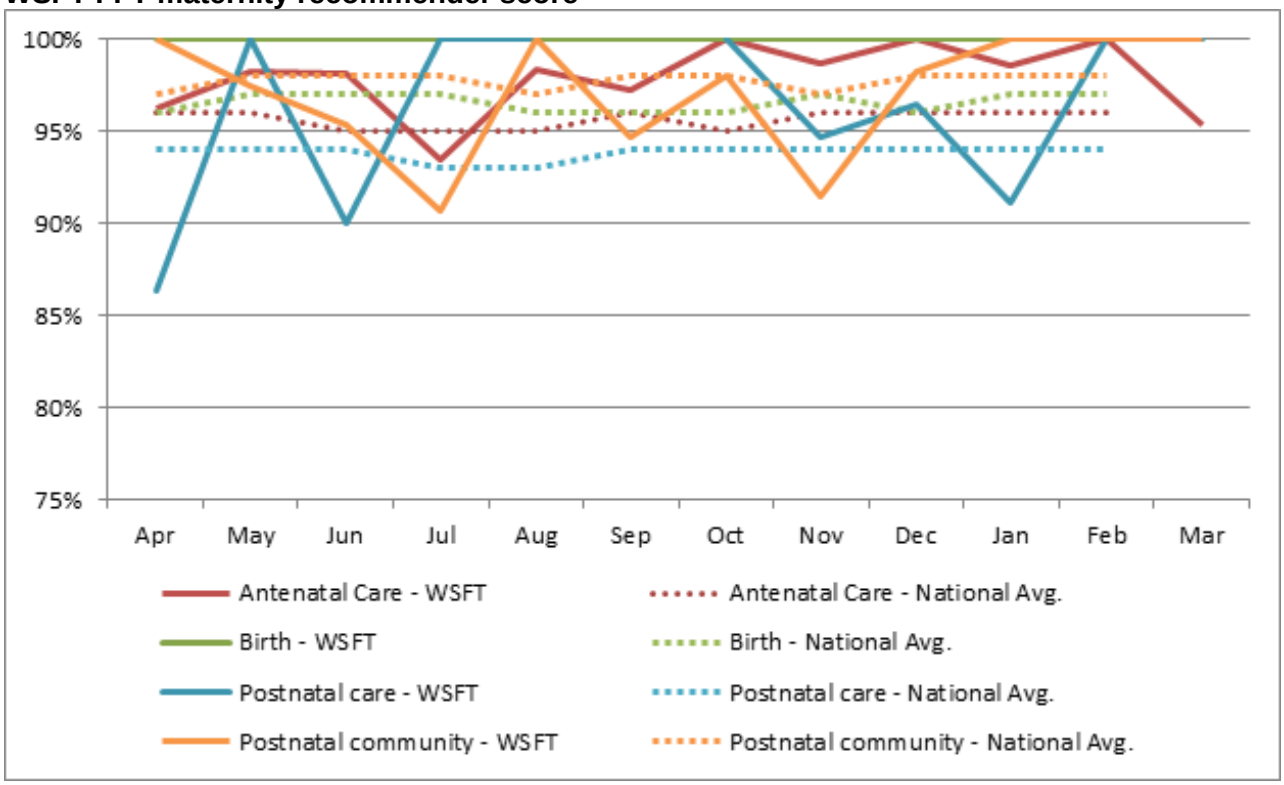
WSFT FFT ED recommender score



Source: NHS England

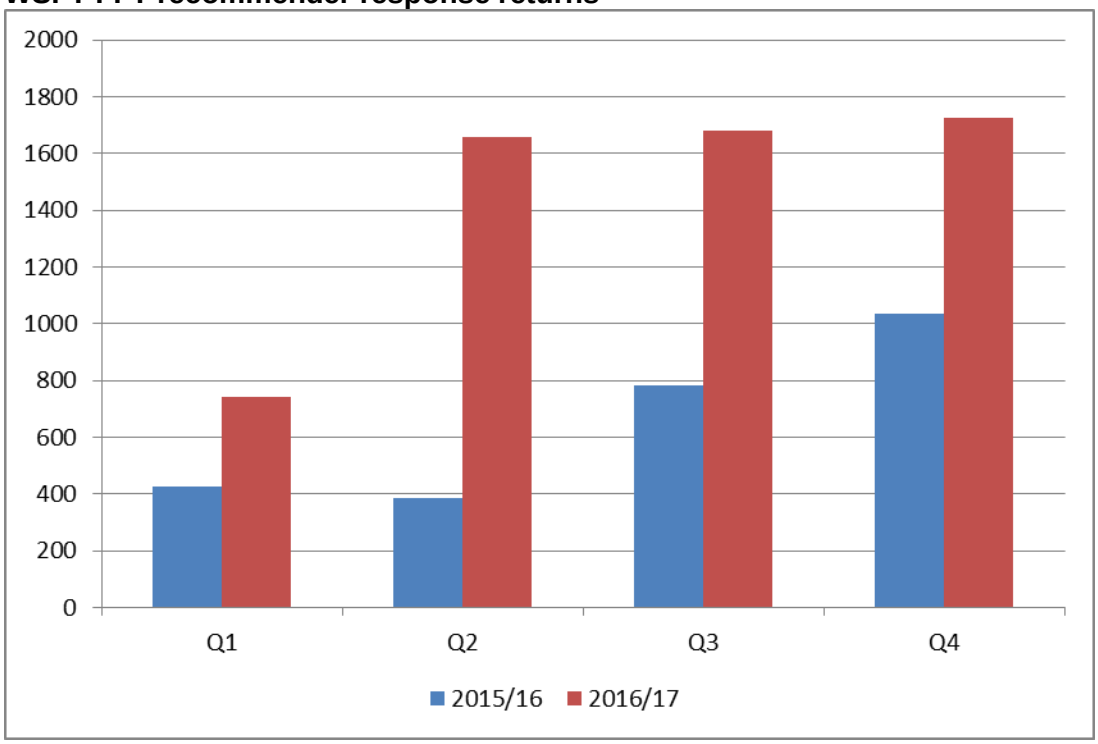
The maternity FFT considers four 'touch points' in care: antenatal; birth; postnatal; and postnatal community. For the majority of months we scored better than the national average across all areas with antenatal, birth and postnatal community scoring 100% in the majority of months.

WSFT FFT maternity recommender score



Source: NHS England

WSFT FFT recommender response returns



Source: Meridian

Action to be implemented in 2017/18

- 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.

(b) Reduce noise at night through targeted reduction in the number of non-clinical moves at night - baseline Q1 of 2016/17

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 2016/17

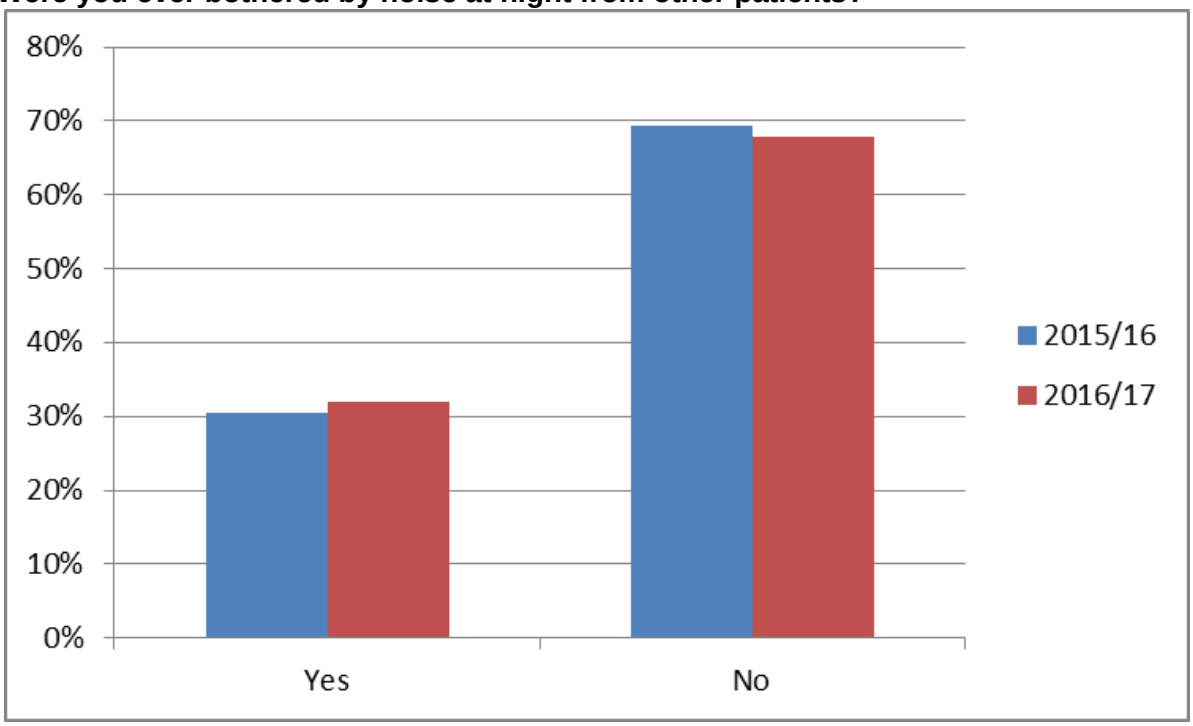
The following initiatives were continued throughout the year:

- 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 (an area which has a high number of dementia patients)
- Soft closing bins in place in ward areas
- Involvement of volunteers to provide company for patients to promote settled behaviour.

Local surveys were also conducted to analyse issues with noise at night, showing that only 8.5% of inpatients found the noise unacceptable. The majority of noise was caused by other patients snoring and medical equipment. These local surveys will continue to run on an ad-hoc basis.

Current status
The score has deteriorated slightly this year. Further patient feedback and audit is being collected to understand how we can improve in this area.

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



Source: Meridian

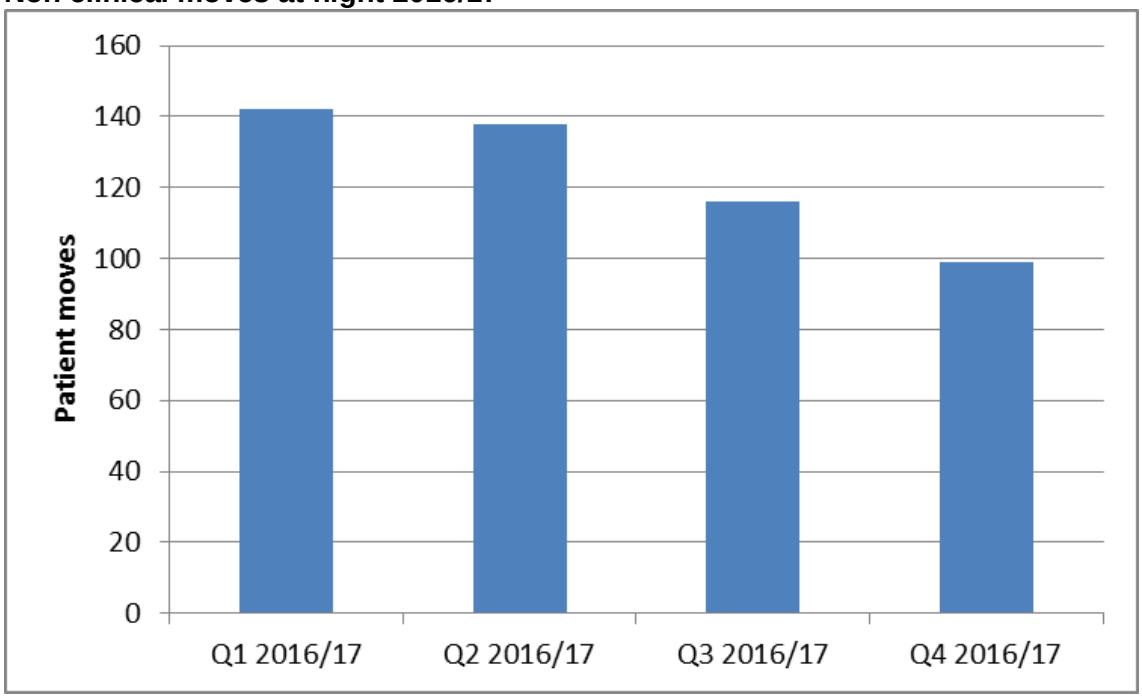
We performed similarly to other 'bestbuy' hospitals on questions around noise at night in the CQC National Inpatient Survey 2015. 'Bestbuy' hospitals are a group of hospitals built using the same structural design during the same period and therefore have similar footprints.

	Bothered by noise at night from other patients	Bothered by noise at night from hospital staff
West Suffolk NHS Foundation Trust	**6.0/10 About the same**	**7.9/10 About the same**
Frimley Health NHS Foundation Trust	6.1/10 About the same	8.0/10 About the same
Hinchingbrooke Hospital	6.7/10 About the same	8.4/10 About the same
James Paget University Hospitals NHS Foundation Trust	6.4/10 About the same	8.0/10 About the same
Queen Elizabeth Hospital King's Lynn	5.8/10 About the same	7.7/10 About the same

Source: CQC Inpatient Survey 2015

Through the continued focus of the operational site team during 2016/17 we have achieved the targeted reduction of non-clinical moves at night. The number of moves reduced each quarter during the year with a total reduction of 30% from Q1 to Q4 - from 142 moves in Q1 to 99 in Q4.

Non clinical moves at night 2016/17



Action to be implemented in 2017/18

- 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) Measurable improvement in patients' perception of involvement in care and treatment as a result of initiatives to improve shared decision making

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 2016/17

- Shared decision making checklist designed for use in outpatient departments
- Health coaching has been rolled out across many areas of the Trust, encouraging patients to take ownership of their health and to work with the NHS to improve their outcome
- Questionnaires for people making complaints have been consistently collected, asking people to give their views on the way their complaint was handled
- Patient Advice and Liaison Service (PALS) enquiries have increased, some months by 100%
- A patient and family carer survey Task and Finish Group took place to agree priorities in obtaining feedback from our service users
- Work is underway to assess the hospitals 'family carer-friendly' status alongside Suffolk Family Carers.

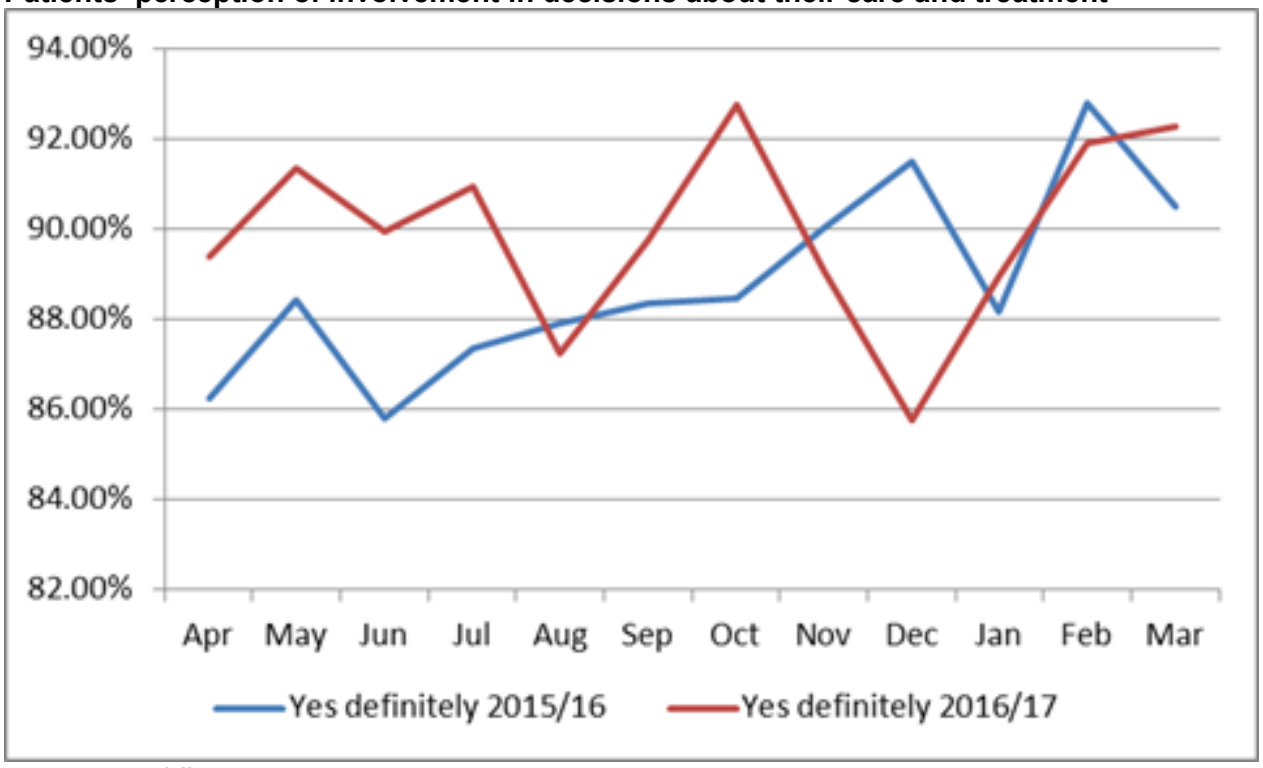
Current status
Patients' perception of involvement in decisions about their care and treatment has improved throughout the majority of the year with the exception of four months. The overall annual score for 2015/16 was 92.85% and for 2016/17 this improved very slightly to 93.00%.

We performed similarly to other 'Bestbuy' hospitals of the same footprint and local Trusts on a question relating to involvement in decisions in the CQC National Inpatient Survey 2015:

	Involvement in decisions for being involved as much as they wanted to be in decisions about their care and treatment
West Suffolk NHS Foundation Trust	**7.8/10** **About the same**
Frimley Health NHS Foundation Trust	7.7/10 About the same
Hinchingbrooke Hospital	7.9/10 About the same
James Paget University Hospitals NHS Foundation Trust	7.9/10 About the same
Queen Elizabeth Hospital King's Lynn	7.8/10 About the same
Cambridge University Hospitals	6.9/10 About the same
Ipswich Hospital NHS Trust	7.5/10 About the same

Source: CQC Inpatient Survey 2015

Patients' perception of involvement in decisions about their care and treatment



Source: Meridian

Patients and visitors were able to provide feedback during our 'Experiences of Care Week' which took place between 20-24 March 2017. The 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.

Patients and visitors were asked 'what does good care mean to you' with answers such as:

- Kindness
- Empathy
- Compassion
- Understanding
- Listening
- Caring
- Help
- Comfort
- Patience.

The patient experience team designed both adult and child-friendly colouring sheets and word searches for our outpatient departments as well as conducting 'Thank you Thursday' where the team collected over thirty compliments from people in relation to our services:

> "Daughter came in very poorly and all of us, not just my daughter, were looked after extremely well. Made us feel comfortable and safe. Staff were fab."

Almost 100 people gave their views about the care at WSFT with only 12% of the feedback reflecting a negative experience, mostly relating to issues with parking. WSFT has taken steps to address a number of issues with the availability of car parking at its WSH. In February 2017 an additional 400 parking spaces were opened at the hospital following a £2 million investment in this and a range of improvement works. Extra spaces for staff help them to avoid parking their cars on roads surrounding the hospital. After liaising with patient representatives, the Trust amended the tariff for parking to make a modest contribution towards the capital investment. It has also addressed a regular complaint from patients that short-stay visits are charged at an excessively high rate by introducing a new tariff for a one hour stay. Additional spaces for disabled drivers who carry a blue badge have been created, along with specially-designated wheelchair-supported access spaces that provide better access for those unable to walk.

Action to be implemented in 2017/18

- Establish patient user groups and 'expert patients' across the Trust
- Promote the 'big thank you', an opportunity for patients to thank individual staff members
- Conduct six-monthly patient engagement events
- Involve family carers in assessing how carer-friendly the hospital is, including involving family carers in decisions about their loved ones care.

(d) 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

Description of the issue and rationale for selection

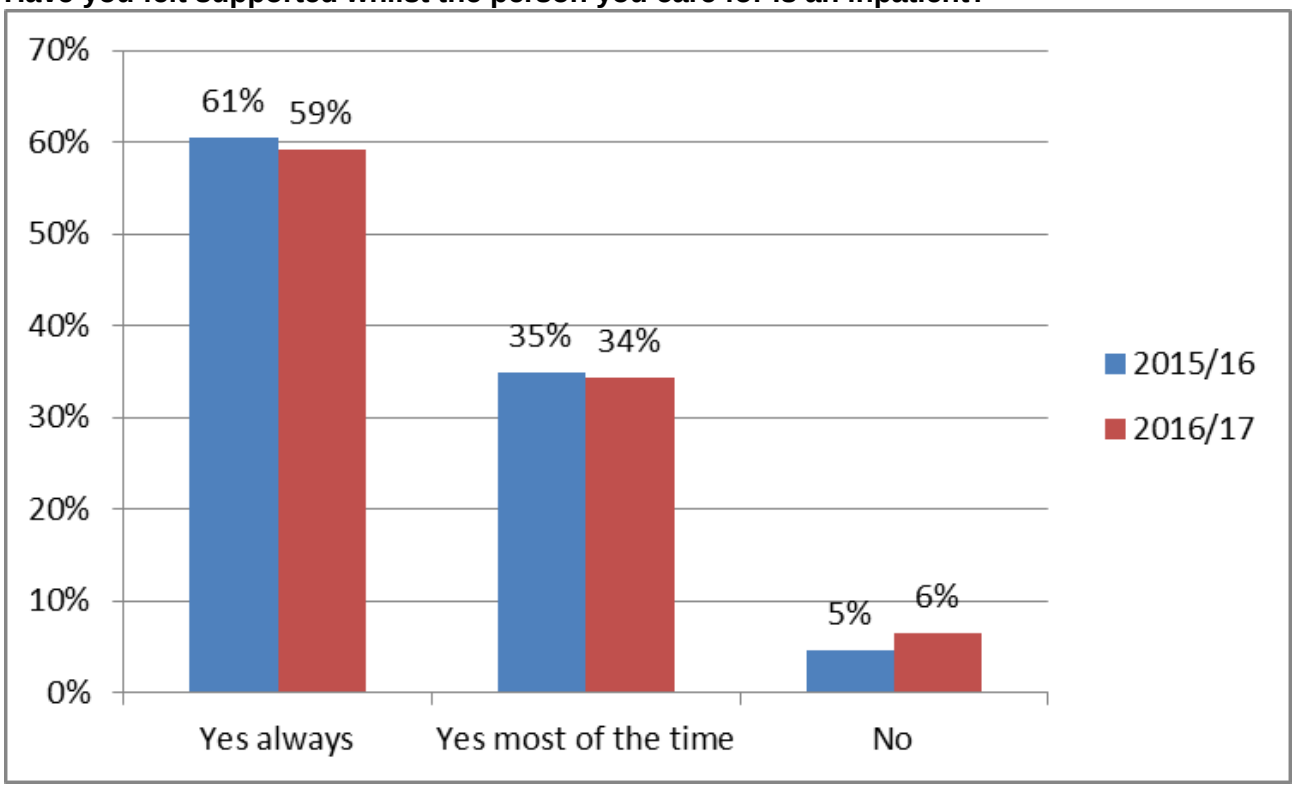
Involving family carers in the care of their loved ones is shown to improve a patient's recovery. Family carers should be recognised for the support they offer the patient and in turn the impact this care has on preventing admission to hospital. Family carers will also have a good understanding of the individual's needs which will aid staff in assisting with recovery. It is of utmost importance that family carers are fully involved in a patient's care throughout and the Trust works hard to meet this priority.

Action taken during 2016/17

- Family carer support worker continues to offer support to family carers throughout the Trust, as well as the specialist nursing team
- Introduction of car park concession for family carers of inpatients
- In partnership with Suffolk Family Carers working to award clinical areas bronze, silver or gold 'family carer-friendly' status.

Current status

Have you felt supported whilst the person you care for is an inpatient?



Source: Meridian

The score has very marginally deteriorated since the last financial year with similar numbers of family carer feedback forms returned. As previously mentioned, there is work ongoing with Suffolk Family Carers to award clinical areas based on the support they give to family carers.

This project will span several months which will in turn raise the profile of supporting family carers, with the Trust aiming for a gold-standard service when the second round of assessments are undertaken later in 2018.

Action to be implemented in 2017/18

- Working with Suffolk Family Carers to award clinical areas 'family carer-friendly' status based on the support they give to family carers
- Raise the profile of supporting family carers, within the Trust - aiming for a gold-standard service when the second round of assessments are undertaken later in 2018.

(e) 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).

Description of the issue and rationale for selection

Speech and Language Therapy (SLT) service provision for children and young people has been under continued pressure in Suffolk for a number of years. This pressure has been due to an increasing number of children needing to access support from the service; something that is similarly seen across the country with around 10% of children and young people having some form of speech, language and communication need within the population.

When the community contract transferred to WSH in October 2015, there were a number of children waiting longer than expected to receive intervention. While the service continued to support assessments within an appropriate timescale, the caseload numbers of children needing ongoing therapy was high.

The Trust raised this as an area of concern with the commissioners of the service, Suffolk East and West Clinical Commissioning Groups and Suffolk County Council. Agreement was reached to consider a different commissioning framework and the community team worked alongside the commissioners to progress this. At the same time, additional funding was agreed to respond to the back log of children waiting for therapy intervention whilst the service redesign options were explored.

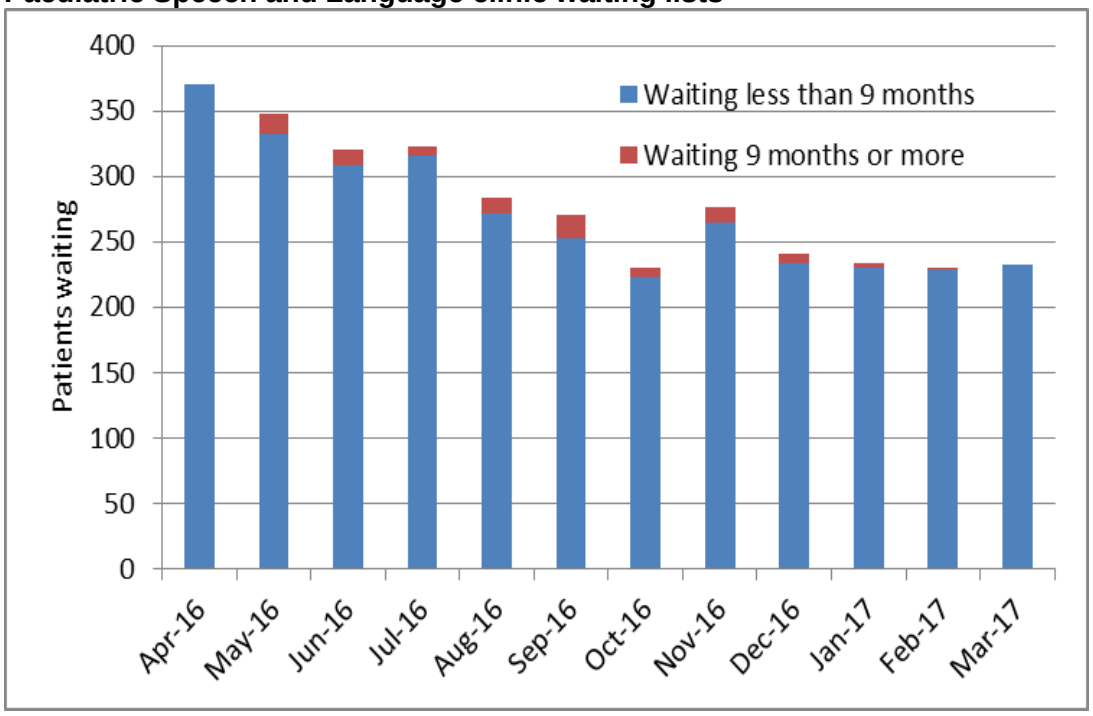
Action taken during 2016/17

- Service engagement and active participation with the SLT service redesign project. This has involved attendance at a number of task and finish groups and being a core member of the redesign steering group
- Internal service meetings to consider implications of redesign and also to consider options to address back log
- Securing additional funding to employ additional locum capacity to reduce the number of children waiting longer than planned for intervention
- Working with Suffolk County Council assistant director of commissioning and public health colleagues to develop a service modelling tool to inform current and future commissioning options
- Review of caseload and options for service intervention
- Engagement with other partners such as Early Help and Health Visiting Service Leads and Schools Choice within Suffolk County Council
- Service workshops held to support SLT staff engagement and involvement with service response and redesign.

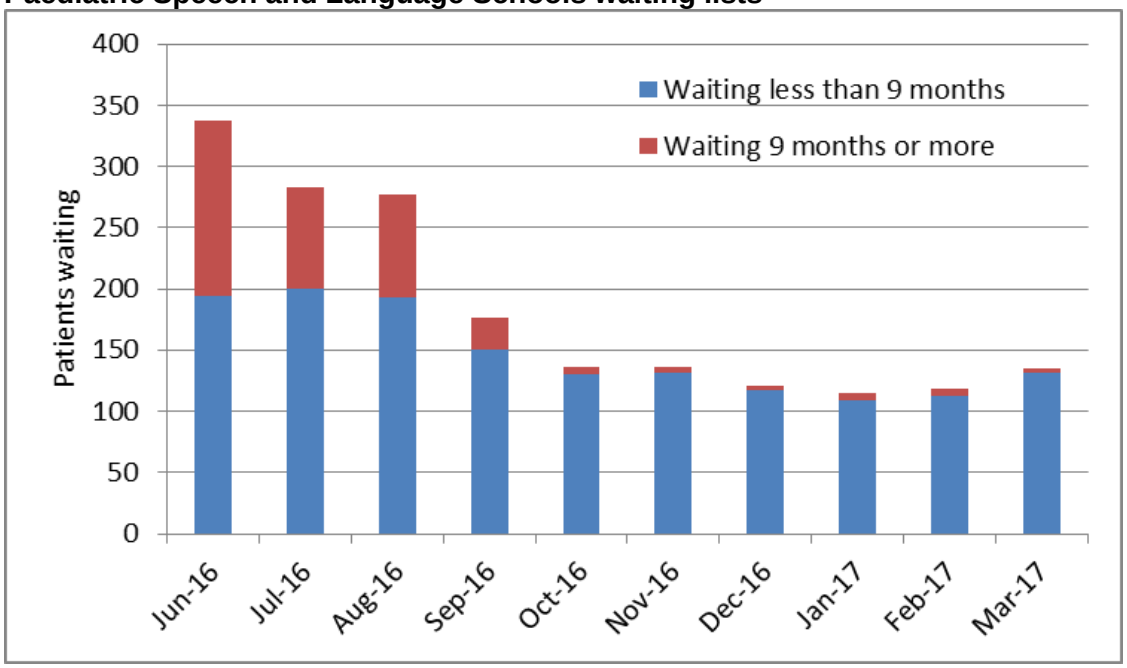
Current status

The service has reduced the length of waits for both community clinics and mainstream schools as can be seen in the tables below. There are now far fewer children waiting more than nine months for therapy intervention - three in March 2017 compared with 155 in June 2016. This reduction has been greatest for the mainstream school children - three in March 2017 compared to 143 in June 2016.

Paediatric Speech and Language clinic waiting lists



Paediatric Speech and Language Schools waiting lists



Data for April and May 2016 is not available

Action to be implemented in 2017/18

- Formal agreement to be obtained for revised commissioning framework and service provision for implementation from 1 October 2017
- Communication plan to be agreed
- Service delivery transition and implementation plan for new framework to be developed, once formal agreement on model achieved.

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

Measures

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

(a) Ensure that there are no more than 16 hospital-associated C. *difficile* infection cases between April 2016 and March 2017

Description of the issue and rationale for selection

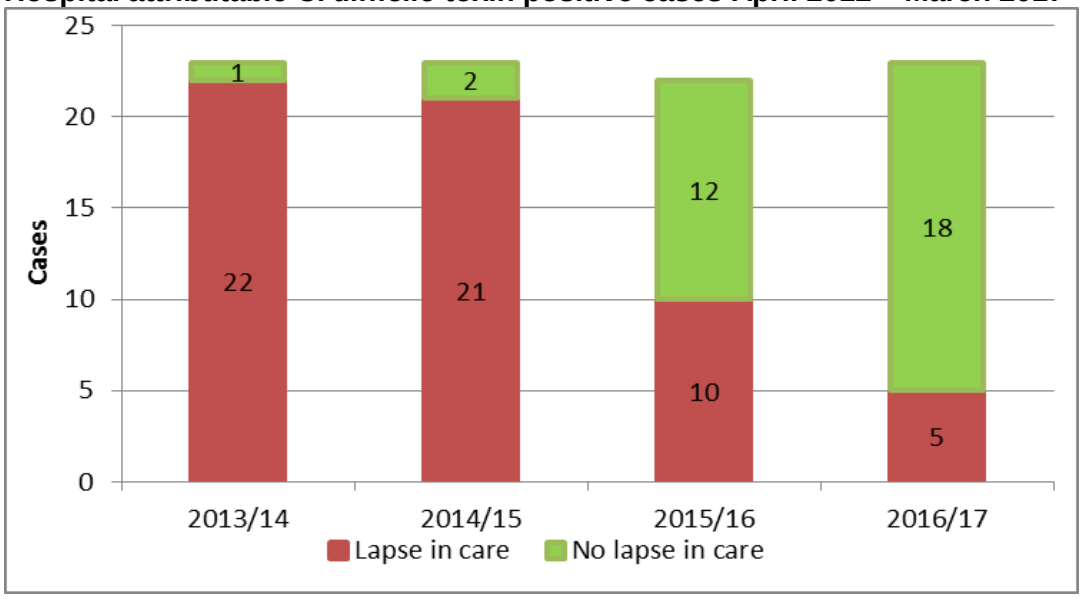
Reducing hospital-associated infections continues to be one of the main priorities for our patients and the public. In addition, it remains a key priority for the NHS as a whole and for our commissioners. Within the Trust we continue to strive for further improvement, with a focus on the timely identification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

Action taken during 2016/17

- Ongoing quarterly audits of antibiotic prescribing with an expectation of 98% 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, meticillin resistant Staphylococcus aureus (MRSA) and meticillin sensitive Staphylococcus aureus (MSSA) blood stream infections associated with the Trust 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 is fully launched for users
- The Trust held an antibiotic awareness week in November 2016 to improve understanding and antibiotic stewardship
- Agreement that all new ward developments will have automatic doors to bays, all single rooms will have en suite facilities. The Trust has two potential projects where this will be implemented an integrated cardiac care facility and a new acute medical assessment ward
- Trust-wide learning implemented following the identification of an MRSA bacteraemia agreed as a contaminant and thus deemed avoidable that blood cultures cannot be delegated to phlebotomists to collect and must be taken by clinical team who can escalate any necessary actions
- Dedicated infection prevention nurse with responsibility for the Trusts community contract.

Current status

Hospital attributable C. *difficile* toxin positive cases April 2012 – March 2017



Source: Local data

There have been a total of 23 C. *difficile* toxin positive cases recorded during 2016/17. Of the 23 cases, 18 have been confirmed by the CCG as non-trajectory for which no lapses in care were identified (one case which occurred in March ’17 is provisionally allocated as non-trajectory pending final CCG decision). Therefore, with a total of five trajectory hospital-associated cases, the WSFT achieved its target of fewer than 16 trajectory cases for which lapses in care were identified. We have consistently improved performance, with fewer cases deemed to be as a result of lapses in care for the last four years.

Action to be implemented in 2017/18

- Installation of doors to bays in new clinical areas to improve the ability to isolate patients
- Review of the antibiotic guidelines to increase compliance with the National CQUIN for antibiotic stewardship. Quarterly audit programme to be amended to include greater detail around the review of antibiotics
- Additions to current e-Care system to support appropriate antibiotic reviews are in development.
- Proposal to use the current escalation ward as a decant ward to facilitate rolling programme of 'deep cleaning'
- Increase the number of portable hand washing sinks to support hand hygiene
- To increase and develop the inclusivity of infection prevention across the acute Trust and the community services within our remit.

(b) Maintain the incidence of avoidable pressure ulcers, avoidable inpatient falls and hospital acquired venous thromboembolism (VTE) below the baseline for 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 learning from investigation of pressure ulcer incidents.

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. It affects approximately 1 in every 1,000 of the UK population and is a significant cause of mortality, long-term disability and chronic ill-health problems.

(i) Reduce avoidable pressure ulcers

Action taken during 2016/17

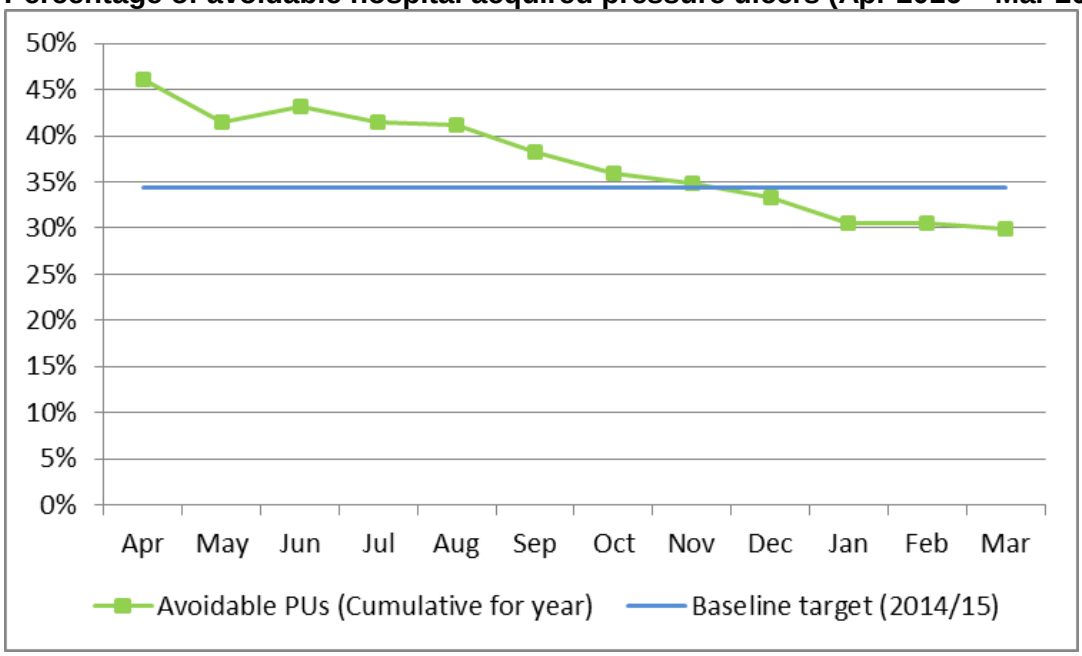
- Shared learning of actions from root cause analysis (RCA) investigations by ward staff, attendance at RCA meetings and dissemination of learning through meetings, newsletters and networks
- WSFT pressure ulcer focus groups were re-established
- Introduction of hybrid pressure relieving mattresses
- Review the heel pressure ulcer management pathway including the vascular surgery team
- Use of 'React to Red Skin' campaign designed to raise awareness of the steps which staff can take to minimise the chance of their patients developing the pressure sores.

Current status

The Trust quality priority to reduce the incidence of avoidable hospital acquired pressure ulcers (HAPU) against baseline of 2014/15 has been measured as percentage avoidability to take into account the increase in total HAPU reported. A total of 186 HAPUs were reported during 2016/17, an increase compared to 95 in 2015/16 and 64 in 2014/15.

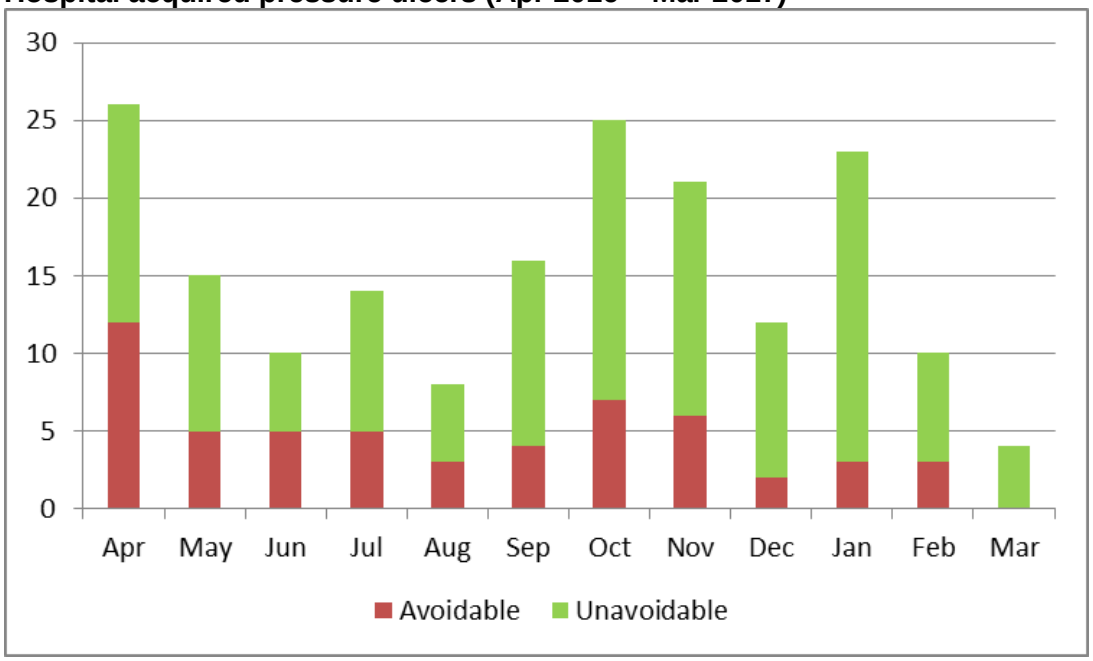
The percentage of HAPU deemed avoidable following review was recorded as 34% in 2014/15, during 2016/17 this was reduced to 30%. As can be seen from the chart the cumulative position for the year was achieved by month on month improvement during the year.

Percentage of avoidable hospital acquired pressure ulcers (Apr 2016 – Mar 2017)



Source: Local data

Hospital acquired pressure ulcers (Apr 2016 – Mar 2017)



Source: Local data

Although the numbers of HAPU remains high, the percentage which are deemed avoidable is reducing. This could be influenced by a number of factors, including our patients being increasingly frail and vulnerable to tissue damage despite all preventative actions taking place.

Action to be taken in 2017/18

- **Managing compliance with SSKIN bundle:**
  - Grade 2 concise RCAs to be completed by ward managers and approved by matrons, with spot checks by tissue viability
  - Grade 3 RCAs to be completed by ward managers and approved by tissue viability
  - Suspected deep tissue injury standard operating procedure to be produced and monitored for compliance.

- **Improve quality of incident reporting** - to ensure a structured approach to the management of Grade 2, 3 and 4 pressure ulcers including organisational learning and monitoring of agreed actions. Ensure West Suffolk CCG receive monthly pressure ulcer data and quality report.
- **Clinical photography** – review the service to support best practice in PU management.
- **Education and training** - to provide appropriate and regular training to all members of the workforce responsible for pressure ulcer prevention and treatment:
    - Provide mattress guides on each ward providing detailed summary of all replacement mattresses
    - Work with IT to reconfigure e-Care's skin / wound assessment to make more user friendly
    - Matron and tissue viability lead to offer ward based, competency led training sessions
    - Tissue viability intranet site to be updated with appropriate links
    - Educate and support staff to feel confident and competent to assess and treat grade 1, 2 and 3 pressure ulcers
    - Develop new e-learning package for nursing mandatory study day to match competencies
    - Tissue viability team to oversee competency assessment process in their area using own identified system for recording completion of staff competencies
    - Quarterly report to tissue viability detailing competency levels on each ward
    - Link practitioners and tissue viability nurses to provide focussed and targeted training and reassessment of competencies as required.
- **Equipment management** - to ensure the correct equipment is available in a timely fashion and used appropriately to manage pressure ulcer prevention and treatment:
    - Review incident reports involving pressure area equipment and slide sheets
    - Present incidence of mattress and slide sheet unavailability to Pressure Ulcer Prevention Group (PUPG) monthly
    - Advise PUPG monthly of any alternating pressure mattress/slide sheet issues
    - Escalate any concerns re: equipment management to PUPG
    - Review of the heel pressure relieving equipment available in the Trust
- **Reporting** - to develop a structured reporting framework for the PUPG:
    - Quarterly reporting on progress against the action plan to Clinical Safety and Effectiveness Committee (CSEC)
    - PUPG to receive summary of learning incorporating RCA results of any Grade 3/4 pressure ulcers
    - Continual development of ‘React to Red Skin’ campaign. This is a national pressure ulcer prevention campaign that is committed to educating as many people as possible about the dangers of pressure ulcers and the simple steps that can be taken to avoid them.

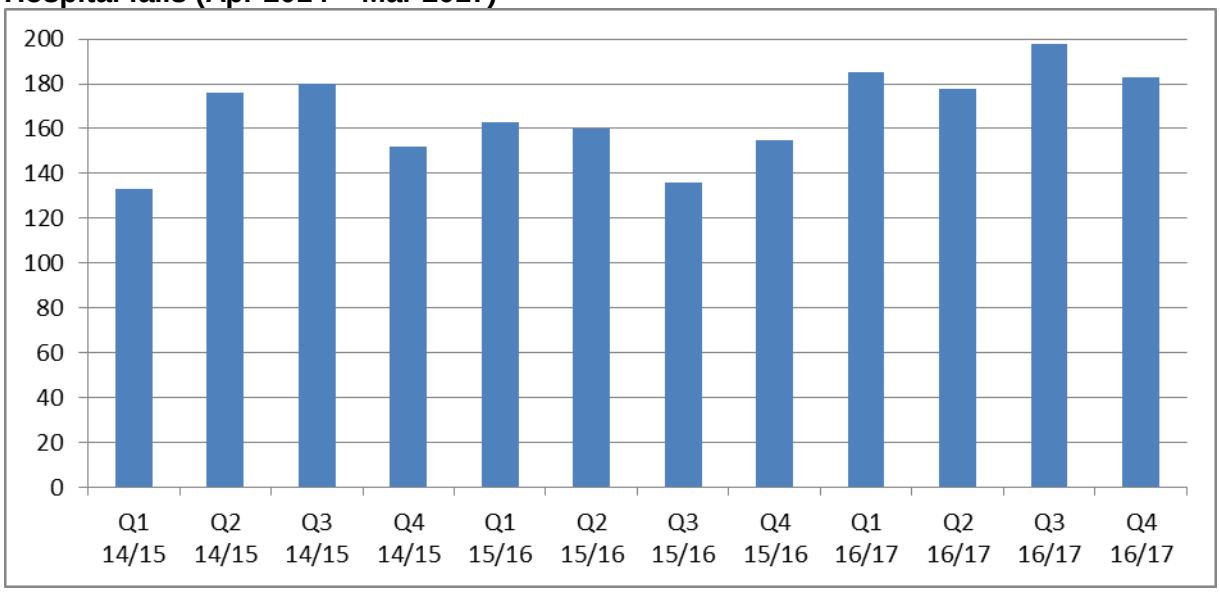
(ii) Reduce avoidable inpatient falls

Action taken during 2016/17

- Grouping patients with a high risk of falls and bay working has been encouraged to ensure patients are observed at all times. Desks have been fitted on some wards just outside bay doors to ensure all patients in the bay can be seen when documentation is being completed.
- Lying and standing blood pressure (BP) has been a particular focus this year, and as a result we are achieving improved compliance with NICE guidance. Further work is required to ensure all patients at risk of falls receive lying and standing BP on three consecutive days
- Medication reviews are carried out, medicines known to add higher risk of falls are being reviewed and are removed where possible
- Focus on hydration to help reduce confusion in the elderly
- Use e-Care, our new electronic patient record, to improve:
    - Comprehensive medical review for patients at risk of falls
    - Medication review to reduce polypharmacy
    - Lying and standing BP
- Focus on assessment of spinal injury post fall, in line with NICE guidance.

Current status
There have been an increased number of falls in 2016/17 (744) compared to 2015/16 (621) and 2014/16 (641). Since the introduction of e-Care in May 2016 we have been unable to measure falls per 1,000 bed days so we have been unable to determine whether increased capacity has been a factor influencing the increase in falls.

Hospital falls (Apr 2014 – Mar 2017)



Source: Datix

All falls that result in serious harm ('major' or 'catastrophic') are assessed to determine if they are avoidable. 10 falls with serious harm were reported during 2016/17, three of these have been confirmed as avoidable, six confirmed as unavoidable and one pending final confirmation. The preliminary investigation, undertaken by the matron and consultant, of this case indicates it will be deemed unavoidable.

We have therefore achieved our quality priority of reducing the number of avoidable falls resulting in serious harm. In 2016/17 we reported three, compared with four in 2015/16 and eight in 2014/15.

Action to be taken during 2017/18

- Participation in the National Falls Audit
- Meet regularly with falls lead for Ipswich Hospital, compare numbers of falls and share good practice
- Review falls numbers and trends at falls group, identifying learning to support quality improvement

(iii) Reduce hospital acquired VTE

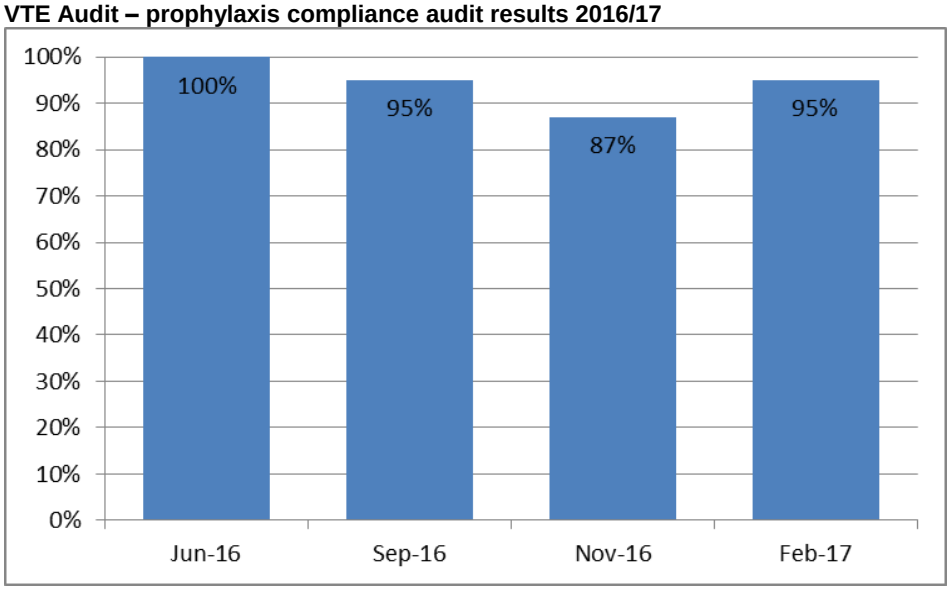
The overarching objective of the NHS England National VTE Prevention programme is to reduce avoidable harm and death from hospital-associated thrombosis by ensuring that VTE prevention is embedded in NHS care. The Trust has provided monthly data on VTE risk assessment uptake and quarterly data on root cause analysis (RCA) of hospital acquired thrombosis (HAT) since the implementation of the CQUIN and this remained on the Trust quality data-set when the CQUIN was concluded.

The Trust is currently unable to report against this quality priority due to reporting difficulties with e-Care (electronic patient record). As a consequence of the move to e-Care the pathway for identification of HAT has changed. Currently e-Care does not allow classification of the 72 hour / 90 days element and therefore data quoted for 2016/17 is obtained purely from the deceased patient pathway. The Trust Information team is working with Cerner to develop a methodology to allow identification of this latter group for 2017/18 data.

Action taken during 2016/17

- VTE assessment moved onto e-Care electronic records
- “Hard stop” in e-Care makes VTE risk assessment mandatory
- Electronic prescription of VTE prevention which provides benefits both in terms of legibility but also access to the dosing guidelines which are embedded within the prescription chart
- Simplification of the dosing guideline for patient’s weight. This is a follow up action following learning from RCAs in 2015/16
- Quarterly junior doctor audit measuring practice against standards set by Trust Policy and NICE guidelines with results included in Trust quality report and circulated with actions to general managers, service managers, matrons, ward managers and lead ward consultants. Results and actions are also discussed at divisional governance steering groups
- Spot audit of Trust-wide compliance with risk assessment undertaken in March 2017 to set a baseline for monthly paper-based audit.

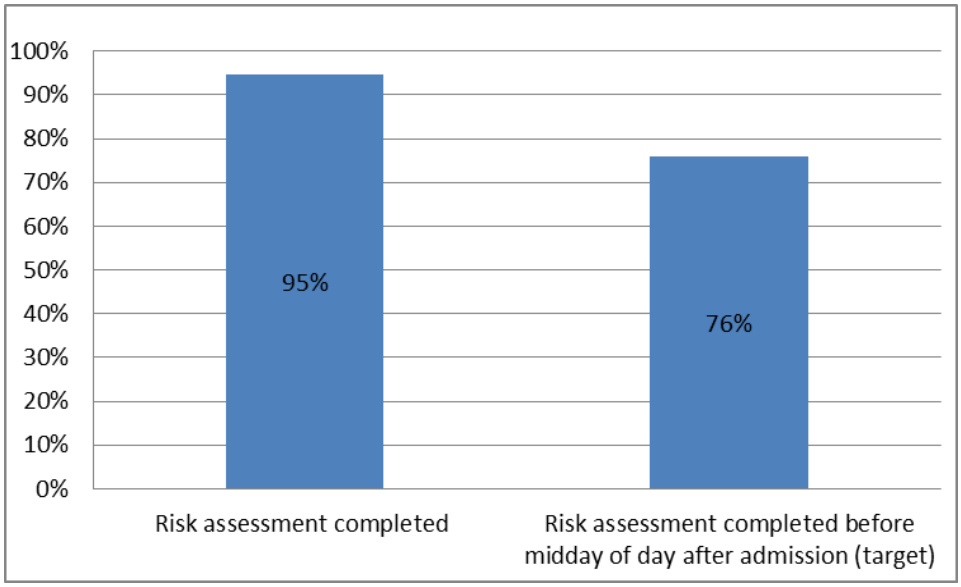
VTE Audit – prophylaxis compliance audit results 2016/17



Source: Local clinical audit

The November 2016 result showed a significant decline in VTE prophylaxis compliance due to misinterpretation of exclusion criteria by a clinical auditor. The audit was re-run in February 2017 after auditors were briefed on the audit criteria which showed improvement

VTE risk assessment audit 2016/17



Source: Local audit

Data on VTE risk assessment is a national contractual data-set requirement via the Unify upload. The 2016/17 audit showed 76% compliance within the definition of 'risk assessment completed before midday of admission' and 95% compliance with the requirement for all patients to have a risk assessment in place. The Trust's overall performance, at 95%, is consistent with the national average (Source: NHS England 2015/16).

Previous data (prior to implementation of e-Care) demonstrated approximately 99% compliance. In April 2017, the Trust implemented a patient safety dashboard on e-Care which allows users to track patient's real-time progress against key patient safety indicators and milestones such as modified early warning score (MEWS), VTE, EPARS, and other risk factors for inpatient areas. It is anticipated that this will improve the performance against the VTE indicators.

All cases where a patient has died within hospital and a pulmonary embolism (PE) is recorded on the death certificate are subject to review by the Trust's clinical lead for VTE (a consultant oncologist and clinical director for specialist medicine). There were 10 cases in 2016/17 including those where the admitting diagnosis was a suspected PE. These reviews confirmed that all patients had the appropriate prophylaxis care.

Actions to be implemented in 2017/18

- Issue of updated policy for extended VTE
- Implementation of a paper-based pathway for recording of VTE risk assessment data to provide assurance whilst electronic reporting from e-Care is being addressed.
- Review data requirements and reporting from e-Care to ensure all patients with a hospital acquired VTE are reviewed
- Update of policies for elements related to stroke patients
- Develop further the VTE death reviews to ensure they are reported within the learning from deaths group
- Patient safety dashboard on e-Care to track patient's real-time progress against VTE risk for inpatient areas.

(c) Based on national benchmark improve the identification of preventable deaths based on the baseline of 2015/16

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 have until recently been 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 2016/17

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

In the last quarter of 2016/17 there has been a growing focus nationally on NHS trusts' ability to review patient deaths to a high standard and to identify deaths with a degree of preventability. The Trust has continued its work to improve the quality and timeliness of reviews of inpatient deaths and how the data is recorded on the mortality database. Deaths with a degree of preventability have been reviewed by the mortality surveillance group. An important part of this work going forward will be to ensure that we meaningfully and compassionately engage bereaved families and carers.

The mortality database continues to be developed and following some initial issues with compatibility with e-Care, the data reported has been accurate since June 2016.

Current status

The table shows the number of deaths in the trust over the last year and the number which have been subject to case record review. During 2016/17 we have consistently increased the number of mortality reviews completed. Overall 76% of deaths had a mortality review completed during 2016/17 (Apr to Dec 2016), compared to 65% in 2015/16.

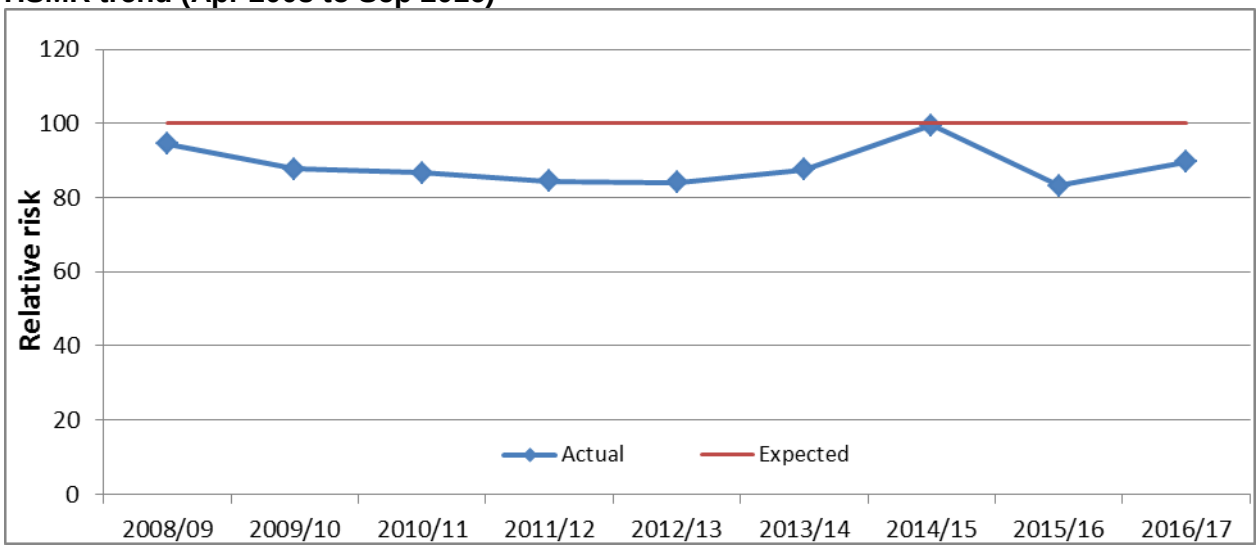
Mortality reviews completed 2016/17

	Q1 2016/17	Q2 2016/17	Q3 2016/17
Total deaths	275	213	294
Cases reviewed	157	177	261
% reviewed	57%	83%	89%

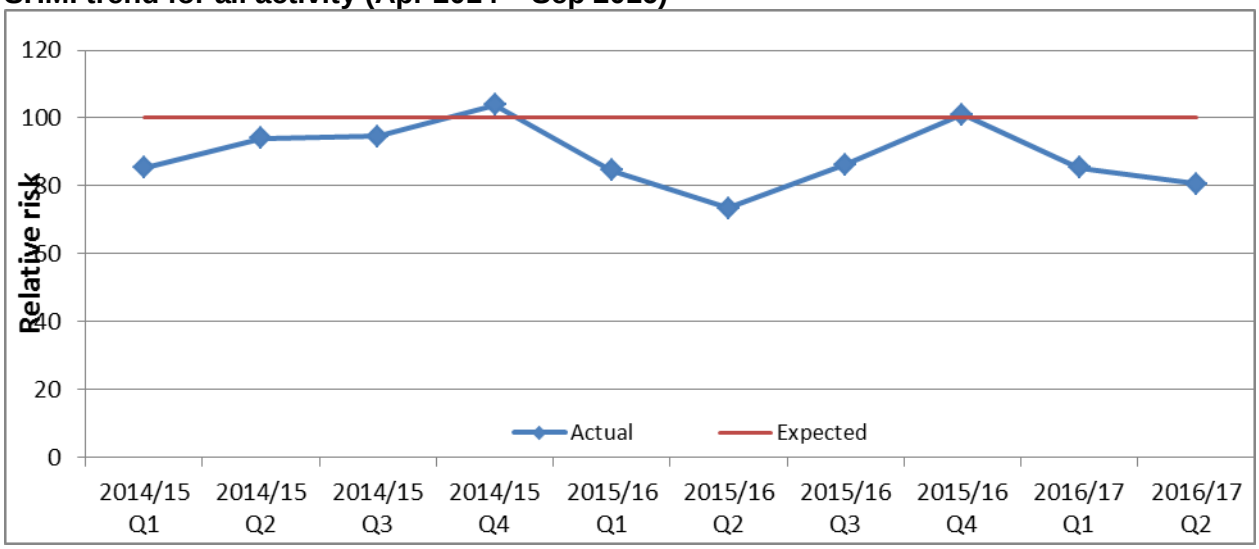
Source: WSFT mortality review database

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

HSMR trend (Apr 2008 to Sep 2016)



SHMI trend for all activity (Apr 2014 – Sep 2016)



Source: Dr Foster Intelligence

In August 2016 the Trust provided information requested by the Care Quality Commission (CQC) about people who had died as an inpatient, particularly those with learning disabilities, and how any preventability to their deaths had been identified. This information fed into a report published by the CQC in December 2016 - *Learning, Candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*. The report highlighted the variation between trusts nationally and challenged the robustness of mortality review within all organisations.

As a result, the National Quality Board has published national guidance which requires WSFT to build our existing arrangements to further strengthen our governance of learning from deaths and make sure that the safety improvements we identify are implemented and have a measurable impact on patients.

Action to be implemented in 2017/18

In line with the national requirements, we will:

- Make sure our support for families and carers after the death of a loved one in our care is as good as it can be
- Involve families and carers, as much as they want to be, in our reviews of inpatient deaths
- Increase the amount of protected time senior staff have to review deaths to the highest standard
- Report clearer and more detailed information on deaths in hospital, and what we have learned from reviewing them, to the Board
- Describe the safety improvements we have made in next year's annual quality report and show how we have measured them to make sure they are working.

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

Measures

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

Description of the issue and rationale for selection of measures
WSFT has maintained its 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 AKI (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 of 2015/16

Description of the issue and rationale for selection
As part of the national CQUIN 2015/16 relating to AKI, the focus was on AKI diagnosis, treatment in hospital and the plan of care to monitor kidney function after discharge. This was 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 2016/17
The planned improvements for 2016/17 focussed on improved monitoring of patients with AKI as part of e-Care to enable prompt treatment. This work was also intended to support review of the management of patients with an AKI stage 3.

This work has not been able to be reported due to the implementation of Winpath Enterprise, pathology IT system and the delay in the implementation of ordercomms within e-Care. The initial issues with the Winpath system related to the algorithm requiring historical knowledge to calculate the stage of AKI. Patients who presented with a new AKI could be calculated correctly; however those with existing renal disease could not be calculated correctly.

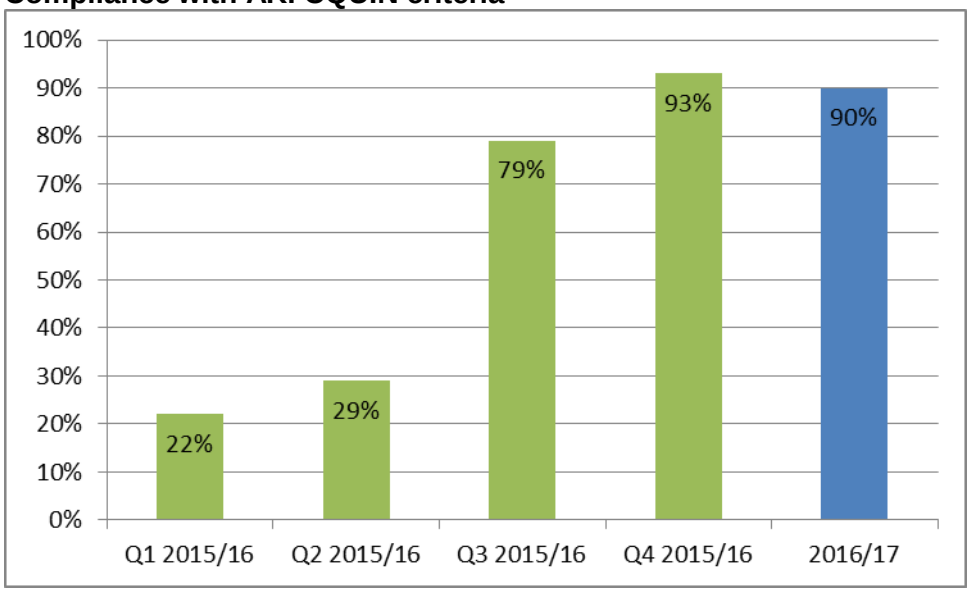
The impact from a patient's perspective is unlikely to have impacted on the care they received as patients who presented with a new AKI were identified correctly and those with existing disease would potentially have received an increased level of care.

The impact has been on the Trust ability to identify and report on the care provided to patient with a Stage 3 AKI. To provide assurance an audit has been carried out relating to the CQUIN criteria that was applied in the 2015/16 and is described above.

A review of 50 patient records has been completed for 2016/17 with patients who have been identified as having a diagnosis of AKI stage 3.

Current status
The audit of 2016/17 patients shows that the high level of compliance achieved in Q4 2015/16 has been maintained (with a slight reduction to 90% compliance from 93% for Q4 2015/16). This audit is based on the AKI CQUIN criteria from 2015/16. There has been an improvement in the aggregated performance during 2015/16 when compared to the results for 2016/17. This shows that improved standards of practice achieved by the end of 2015/16 have been maintained.

Compliance with AKI CQUIN criteria



Source: Local clinical audit

Action to be implemented during 2017/18

- Review of management of patients with AKI stage 3
- Identify reporting strategy for reporting AKI stage 3 patients
- Improve monitoring of patients with AKI as part of e-Care to enable prompt treatment, including: stage of AKI, type of blood tests required on discharge for monitoring and frequency of blood tests required on discharge for monitoring.

(b) Improve reliability of sepsis screening and treatment for emergency admissions – during the year improving performance against the baseline of 2015/16

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 work identified for 2016/17 the Trust expanded on the work they had done in 2015/16 where they concentrated on the screening of patients admitted with sepsis to the Emergency Department or by direct emergency admission to any unit (e.g. medical assessment unit) or an acute

ward. This work included identifying if patients received intravenous antibiotics (IVAB) within one hour in accordance with national recommendations.

During 2016/17 the CQUIN requirement included screening of patients for sepsis who are admitted as an emergency, however, in addition this has been expanded to include inpatients who, following admission, develop sepsis. Within both the emergency admission and inpatients datasets, those patients identified as meeting the requirements of severe/red flag sepsis are reviewed to check if they received IVAB within one hour as an emergency admission or 90 minutes for inpatients. For patients who do require IVAB data is collected to establish if they received an empiric review within three days of them being prescribed.

As part of the sepsis work identified for 2016/17 the Trust concentrated on the identification of patients who develop sepsis at any point in their hospital stay. Additional work included monitoring of patients admitted to critical care, deaths as a result of sepsis and the management of neutropenic sepsis.

Action taken during 2016/17

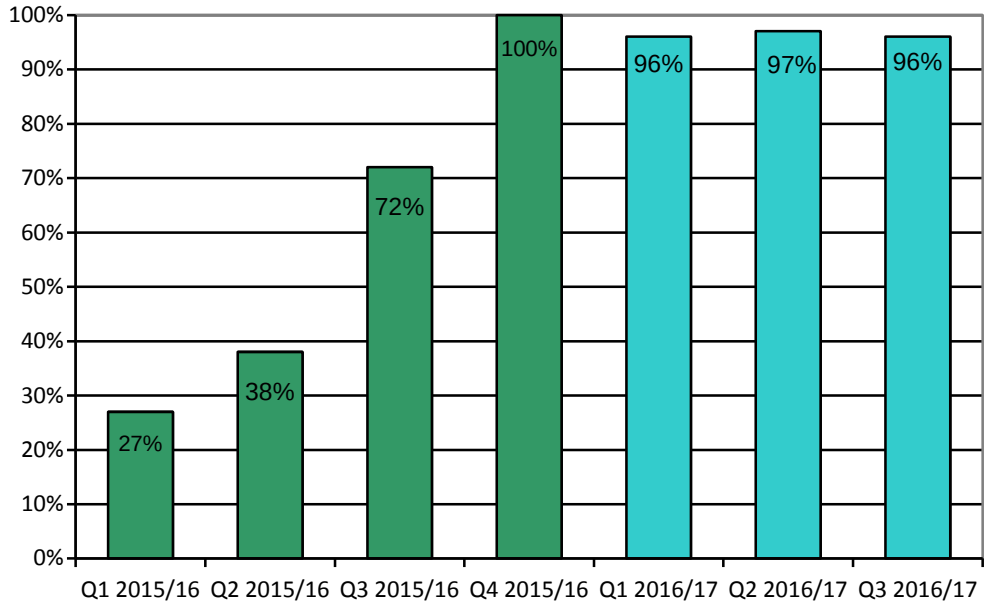
- Review and implementation of new sepsis guidance from NICE and ensure this will be linked within e-Care and OrderComms at the point of go live. OrderComms is an electronic system for ordering of tests and investigations
- Due to expansion of CQUIN data there was a requirement for audit of the identification and treatment of inpatients with sepsis. This required development of the existing audit tool
- Continuation of the critical care audits so that patients with sepsis are reviewed quarterly
- Concise RCAs are completed in relation to patients presenting with neutropenic sepsis, a review group is in place and an action plan that is monitored and submitted to the CCG as part of the quality assurance meetings.

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). The screening of patients with sepsis has been maintained above 95% for each quarter in 2016/17. Data for Q4 2016/17 is not yet available.

Screening of patients admitted as an emergency with sepsis

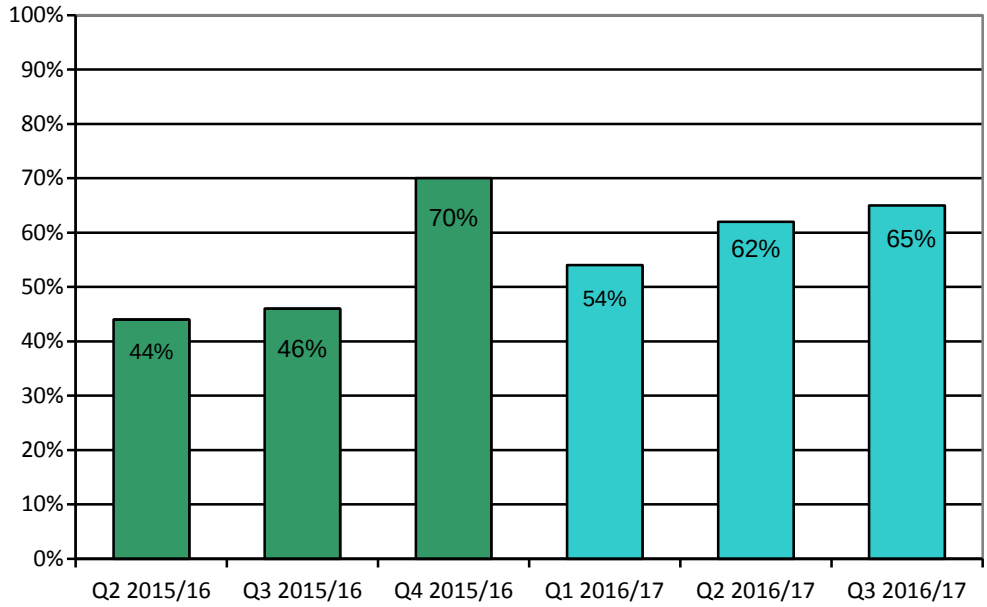


Source: Local clinical audit

(b) IV antibiotic (IVAB)

In addition to the screening, data was collected on patients who had confirmed sepsis and the compliance in administering IVAB within the set target time (one hour or 90 minutes as appropriate) of identification of suspected severe sepsis. Although the performance achieved in Q4 2015/16 has not been maintained throughout 2016/17 performance has showed sustained improvement which is significantly better than Q2 and Q3 for 2015/16.

Patients who are identified with sepsis receiving IVAB within one hour



Source: Local clinical audit (data collection started in Q2 2015/16)

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.

Neutropenic sepsis is now routinely monitored and reviewed, requiring all patients who do not receive IVAB within one hour to have a concise RCA completed. On average 20 patients with suspected sepsis present to the hospital each month and we have achieved overall compliance of 85% of these patients receiving IVAB within one hour. Action to identify improvement is identified from the RCA investigations.

Action to be implemented in 2017/18

- Continue to collect data relating to both emergency admissions and inpatients in accordance with the CQUIN requirements. During 2017/18 the Trust will audit and report on compliance with new CQUIN requirements for inpatients with sepsis to have antibiotic review after 72 hours.
- Further training on sepsis for all areas with enhanced focus on the importance of timely administration of IVAB within one hour of suspected sepsis
- Identify a new clinical lead for sepsis due to changes in medical roles
- Identify a senior nurse to focus on the implementation of sepsis and regularly audit and implement changes to develop staff knowledge and skills in both the recognition of sepsis and the importance of timely treatment
- Review the neutropenic sepsis pathway to sustain performance above 95% for patients receiving IVAB within one hour
- Continue audit of sepsis admission to critical care to ensure improvements are identified and introduced

- Implementation of the sepsis algorithm through e-Care to enable patient with 'Red flag sepsis' to be identified and treated within the recommended timeframes.

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

Description of the issue and rationale for selection
The Diabetes UK: State of the Nation report was published in July 2016. This reinforced that diabetes is the fastest-growing health threat facing our nation. Over three million people are living with diabetes in England. If their condition is well managed they can live long, fulfilling lives. However, in early 2016 the Public Accounts Committee found: "an unduly unhealthy picture of the state of diabetes services in England". There are significant variations in care for people with diabetes. Too often people with diabetes are not receiving the support they need to help them manage their condition and reduce their risk of devastating and costly complications

The case for change is ever clearer. During 2015 and 2016, several national diabetes audit reports were published covering care processes and treatment targets, inpatients, children and young people, pregnancy and, for the first time, the National Diabetes Foot Care Audit (NDFA). These audits show that a staggering one in six people occupying a hospital bed now has diabetes. Amputation rates vary widely from place to place. It is the exception rather than the rule if young people receive all of their key checks.

Action taken during 2016/17
- Participation in the national inpatient diabetic audit with its focus on avoidable complications, harm, patient experience and patient feedback
- 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
- Identified performance indicators relating to connectivity and diabetic patient

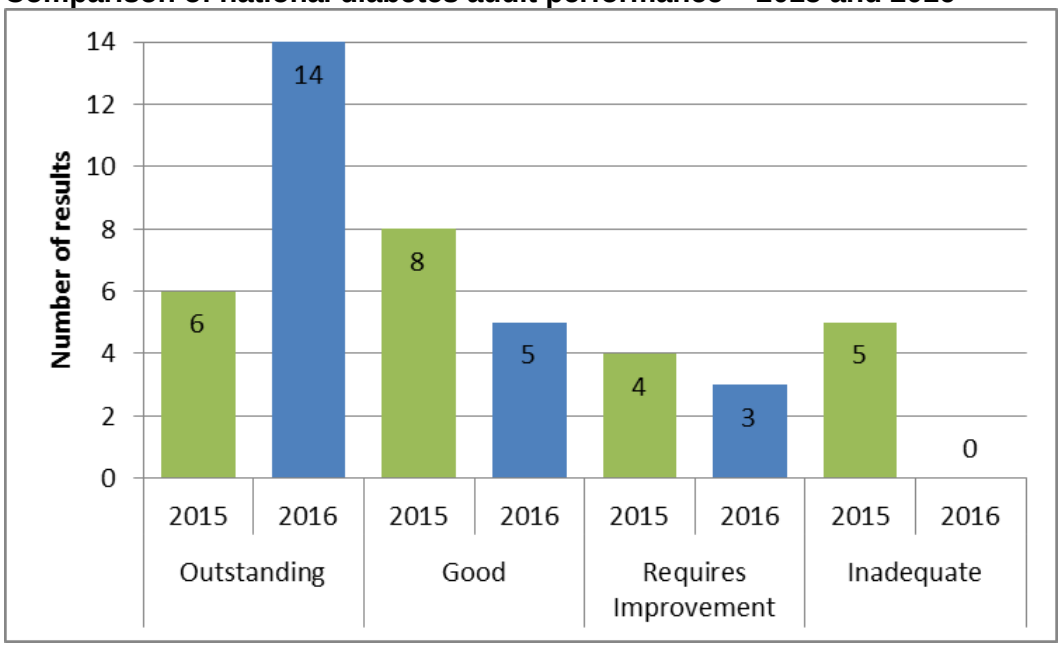
The Novo Biomedical connectivity system has been implemented across the Trust, however, due to compatibility issues with e-Care the connectivity element of the system has not been fully implemented. The e-Care team is working with the diabetic team to support the glucometers and the prescribing of insulin on e-Care.

Current status
The 2016 inpatient audit results for WSH show considerable improvement compared to 2015 performance. The recommendations from the report have been reviewed by the diabetic team and actions have been identified to facilitate further improvement.

The audit for 2016 identified 16 areas of outstanding performance and no areas of inadequate performance (compared with six outstanding and five inadequate areas in 2015). The areas of outstanding performance included:

- Consultant, dietitian and podiatrist hours spent providing inpatient care per week per diabetes patient
- Appropriate patients being visited by a member of the diabetes team and the multidisciplinary diabetic foot team
- Low levels of medication errors – prescription, medication management and insulin errors
- Low levels of hypoglycaemic episodes
- Patients indicated that the choice of meals was 'always' or 'almost always' suitable
- Patients reported that they could take control of their diabetes care while in hospital
- Patients reported that all or most of the staff caring for them were aware that they had diabetes
- Patients reported that staff were able to answer their questions.

Comparison of national diabetes audit performance – 2015 and 2016



Source: National inpatient diabetic audit

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 2017/18

- Implement Novo Biomedical connectivity system to enable the diabetic team to be aware of all bedside monitoring and ensure all patients who record unusually high or low blood sugar levels are systematically escalated to the diabetic specialist nurses
- Implement a diabetic foot care assessment in e-Care.

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.

Community services priorities for 2016/17 were a continuation of those identified in the previous year and were based on discussions with our stakeholders, staff and patients and agreed by the community services board. These priorities span the three domains of quality: patient safety, clinical effectiveness and patient experience. Progress against these priorities has been measured and monitored via the community services performance team which helps staff to be more involved in measuring their performance and monitoring progress against targets. Progress was also reviewed at relevant governance committees.

(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
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 a 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 our community healthcare teams and our inpatient community hospitals. Sometimes falls are inevitable due to the person's complex medical conditions such as dementia. A Falls and Fragility Fracture Task and Finish Group was created last year to develop and agree a formal framework and strategy; this has now been agreed and implemented.

Action taken during 2016/17
- We continued to work 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 continues to send falls notifications to the Care Co-ordination Centre of patients not taken to hospital. These notifications are forwarded to the local area teams who triage them to the appropriate clinicians who 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 and how long the person has been waiting before someone attends to them
- There has been a changing demand on community teams moving through 2016/17 with an ever increasing cohort of frail patients. There is a concerted effort towards tackling these challenges head on whilst continuing to maintain patient safety. The staff continue to assess falls risk and manage repeat fallers using individualised care plans. We are investigating different and innovative ways of working in collaborative ways with other organisations to streamline scarce resources.

Action to be implemented in 2017/18
- Progress and resolve 'cross boundary' patient concerns
- Review all documentation and add to SystemOne
- Closer working with fracture clinic to ensure all patients requiring a DEXA scan are referred.

(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
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. We now have one member of staff seconded into the named worker role to provide services to patients / carers in order to improve, memory, orientation and day to day living activities.This practitioner continued to run the service during 2016/17 over the whole county ensuring that as many patients as possible requiring the service have a named dementia link practitioner. Feedback from health care providers and patients continues to be very positive and encouraging.

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.

The community teams continue to audit their practice to ensure we create a dementia friendly environment. Developments included providing more activities for patients, navigation guides, learning how to adapt the community wards and home environment to reflect some of the work that has been undertaken by the host organisations. The community health teams have dementia champions who are kept up to date with new and innovative ways of supporting patients in our community hospitals.

(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 2016/17 we have extended use of the “Friends and Family Test” (FFT) to all patients across the service. Incident reports and complaints are also taken into account.

Current status
Results from the FFT are now displayed on our local and a national website and responses to the question “Would you recommend our services to family and friends” falling into the ‘very likely’ or ‘likely’ categories are given as a percentage of total responses. The latest result displayed on the national database for Suffolk community services is 98%.

The community contract has continued to report on the friends and family test results and feeds this back into the community health teams and hospital inpatient units to provide learning. There has been a drive this year to focus on discharge to assess pathway within two of the community teams and hospitals with the aim for patients to rehabilitate and make decisions about their ongoing needs outside of the acute environment. This is still in the pilot phase and results are being collated.

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

	2016/17 Target	2016/17 Actual	2015/16 Actual	2014/15 Actual	2013/14 Actual
C. *difficile* - hospital attributable (trajectory cases)	16	**23 (5)** [1]	22 (10) *	23 (21) *	23 (22) *
18 week maximum wait from point of referral to treatment (patients on an incomplete pathway)	92%	**92.55%** [2]	96.25%	96.97%	99.74%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	95%	**86.89%** [3]	94.26%	93.54%	95.31%
62-day urgent GP referral to treatment wait for first treatment - all cancers	85%	**85.92%**	88.05%	88.01%	90.35%
62-day wait for first treatment from NHS cancer screening service referral	90%	**97.85%**	95.68%	95.10%	98.13%
31-day wait for second or subsequent treatment - surgery	94%	**100.00%**	100%	100%	100%
31-day wait for second or subsequent treatment - anti-cancer drug treatments	98%	**100.00%**	99.87%	100%	100%
31-day diagnosis to treatment wait for first treatment - all cancers	96%	**99.92%**	100%	100%	99.92%
Two week wait from referral to date first seen comprising all urgent referrals (cancer suspected)	93%	**94.78%**	98.46%	98.52%	97.24%
Two week wait from referral to date first seen comprising all urgent referrals for symptomatic breast patients (cancer not initially suspected)	93%	**88.54%**	98.28%	97.19%	98.19%

[1] 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; 12 cases 2015/16 and 18 cases 2016/17

[2] Based on estimated performance. As indicated in the CEO introduction e-Care implementation has impacted on aspects of reporting including this standard

[3] Covers a 50 week period and excludes two weeks in May when e-care was being implemented

As can be seen from the targets and indicators performance, we have continued recent good performance and met all national targets in 2016/17 with the exception of:

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

  Performance against the four hour target during 2016/17 was extremely challenging - flow through the hospital affected our ability to deliver and escalation beds were consistently open for long periods of time.

  Recognising the challenge and in planning for winter we put in place a number of initiatives to support and improve patient flow:

- The SAFER bundle is a combined set of simple rules for adult inpatient wards. It is designed to improve patient flow and prevent unnecessary waits and was a major focus as the hospital prepared for winter. Ward F7 launched the bundle and all wards were required to self-assess against the bundle and establish how they currently meet the criteria
- The medical division worked hard to secure a ward area to open as the winter escalation ward (WEW) in preparation for the challenging months ahead. We commissioned 20 beds at Glastonbury Court to create a rehabilitation facility in the community. This relocated 20 medically fit patients and we have then moved 20 patients from ward G9 to their new location on G5. This allowed G9 to be used as the WEW over the winter period
- 'Go Green this Winter' encouraged staff to adapt and change the way they work in order to identify where unnecessary patient waiting occurs. This was launched as a Trust wide campaign in order to do all we can to reduce patients' length of stay and improve processes for discharging them
- The Go Green and information teams worked together to create a red to green data dashboard, which is accessible for staff on the Trust's intranet. Staff are able to review the data on a regular basis to see how we are delivering against the Go Green campaign. The dashboard collects data that includes: the number of 'red' or 'green' patients, planned dates of discharge, patients discharged before or after midday.

The campaign also focussed on working with staff to reduce deconditioning of patients by encouraging them to sit up, get dressed and keep moving. Exercises like this, as well as the identification of both internal and external constraints to patient flow including delayed transfers of care, transport issues, to take out medicine delays, and awaiting care package/placement issues, for example, are resulting in solutions based approaches across multiagency teams to how we might do things differently.

- **18 week maximum wait from point of referral to treatment (patients on an incomplete pathway)**

  The launch of e-Care in May 2016 impacted on our ability to report performance against a number of quality standards, including the referral to treatment (18 week) standard. During 2016/17 reporting against this standard has been based on estimates as we have been unable to accurately track activity at the patient level.

  We now have a functional patient tracking list (PTL) within e-Care and work is underway both manually and via automated scripts to address underlying data quality issues. Working with our digital partner, Cerner, we have made significant progress to improve reporting and plan to have all aspects in operation to allow reporting of June 2017 activity.

  The estimated incomplete referral to treatment (RTT) performance has been impacted by capacity issues in several services and it is extremely disappointing that a number of patients have waited over 52 weeks for treatment. With an effective PTL now in place we have put in place procedures to actively manage treatment plans to ensure these are expedited for patients with excessive waits.

- **Two week wait from referral to date first seen comprising all urgent referrals for symptomatic breast patients (cancer not initially suspected)**

  Trust performance against this GP urgent referral to first seen within two week wait remained very challenging during 2016/17. This was driven by a number of factors, including:

  - Ongoing increase in numbers of referrals
  - Staffing difficulties constrained the flexibility in the service and limited opportunities to create additional outpatients clinics
  - Reduction in capacity during the e-Care launch period.

  In response to the challenges the service has taken action to:

- Open additional clinics to meet the increasing demand
- Active recruitment to the vacant position
- Strengthened controls to track and prioritise patients to avoid breaches
- Working with CCG GP lead to audit appropriateness of two week wait referrals.

The standard is now on trajectory for sustained recovery against the 93% target (93.41% and 94.02% performance in March and April 2017 respectively).

Stroke services

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

Stroke services at WSFT continue to improve according to the latest SSNAP scores, with the Trust rated joint 6th nationally out of 144 trusts routinely admitting stroke patients in England and Wales. In results for August to November 2016, WSFT's stroke services were rated an A overall, with a total score of 87; the hospital's highest overall rating yet. According to the Royal College of Physicians, which manages the programme, 'To achieve an 'A' in SSNAP reports indicates world class performance'. The most impressive result for the hospital was within its Speech and Language Therapy (SALT) department, which received an A; the team's highest rating ever.

Contractual stroke targets 2016/17

	Target	Actual
% of patients scanned within 1 hour of clock start	77%	**74.62%**
% of patients scanned within 12 hours of clock start	96%	**97.00%**
% of patients admitted directly to Stroke Unit within 4 hours of clock start	75%	**74.01%**
>80% treated on a stroke unit >90% of their stay	90%	**88.47%**
% of patients treated by a stroke skilled early supported discharge team	80%	**46.14%**
% of patients assessed by a stroke specialist consultant physician within 24 hours of clock start.	80%	**84.87%**
% of applicable patients who are assessed by a nurse and at least one therapist within 24 hours, all relevant therapists within 72 hours and have rehabilitation goals agreed within 5 days of clock start.	75%	**78.36%**
% of eligible service users given thrombolysis	100%	**83.52%**
All stroke survivors to have a 6 month follow up assessment.	50%	**57.59%**

Effectiveness measures

The Trust has continued to perform well against effectiveness measures.

	2016/17	2015/16	2014/15	2013/14	2012/13	National Average
Hospital Standardised Mortality Rate (HSMR)	* 89.79	77.54	98.42	88.67	83.23	100
Death in low-risk diagnosis groups	**85.94**	67.5	136.99	92.73	48.32	100
Length of stay - relative risk	* 87.31	87.35	92.37	94.27	99.12	100
Readmissions - relative risk	**102.90**	101.98	103.55	97.96	96.34	100

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

Source: Dr Foster Intelligence

Lord Carter's review (February 2016) 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 2016/17 was 87 (43 in 2015/16). This considerable increase was mainly as a consequence of the requirement to report all Grade 3/4 pressure ulcers as an SI which was not in place in 2015/16 (when only Grade 4 pressure ulcers were reported).These can be broken down into incidents which cross a number of themes including:

- Pressure ulcer 31
- Sub-optimal care of the deteriorating patient 12
- Maternity/Obstetric incident 12
- Slips/trips/falls 10
- Treatment delay 7
- HCAI/Infection control 7
- Diagnostic incident including delay 3
- Medication 1
- Surgical/invasive procedure 1
- Substance misuse whilst inpatient 1
- Commissioning 1
- Medical equipment/ devices/disposables 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:

- Safer surgery
- Management of the deteriorating patient with in the emergency department
- Pressure ulcers

During 2016/17 three never events were reported and subject to detailed investigation.

The first never event occurred in June 2016 where a patient underwent a laparoscopic hysterectomy. During the procedure a piece of the Johannes bowel forceps broke off and was retained within the patient. The incident was identified whilst the patient was in recovery as the sterile services department contacted the main theatre department and made them aware that a piece of the forceps was missing. Patient was x-rayed and it was confirmed the piece of surgical instrument was within her abdomen. Patient returned to theatre where laparoscopy was performed and the item removed

This met the criteria of a 'retained foreign object post-procedure' never event. The patient did not suffer long-term harm as a result of the incident. Learning from the investigation included:

- Additional checks for all surgical equipment to confirm integrity at the end of the surgical case to be documented on the WHO surgical checklist
- Immediate mitigations relating to the specific piece of kit
- Development of a human factors group (action wider than this incident).

The second never event occurred in November 2016 where a patient was admitted for induction of labour. As labour progressed an epidural was requested for pain relief and the on call anaesthetist was asked to attend to insert this. Following the insertion it was noted that the epidural giving set had

incorrectly been attached to the intravenous cannula. The infusion was immediately stopped and remedial actions taken. After delivery mother and baby remained on Labour Suite for further observation and there was no permanent harm as a result of the error to mother or baby.

This met the criteria of a 'Wrong route administration of medication' never event. Learning from the investigation included:

- To introduce non luer-lock infusion sets (ISO approved) with compatible pumps when both are available
- Review guidelines and update to ensure consistency
- Change to epidural chart to include connection check. Include requirement to check connection at handover when staff change. Communicate changes in process to midwifery staff
- Amend induction process to ensure it reflects the content received by doctors who join the service on the regular rotation
- Midwife and paediatrician to complete reflection on practice.

The third never event occurred in January 2017 where the wrong patient underwent a punch biopsy following Colposcopy examination. The error was noted whilst the patient was still in the treatment room. An apology and explanation was given by the consultant in attendance and the patient gave verbal consent to the appropriate treatment being undertaken. The level of harm for this incident has been agreed at the Day 5 review was no harm.

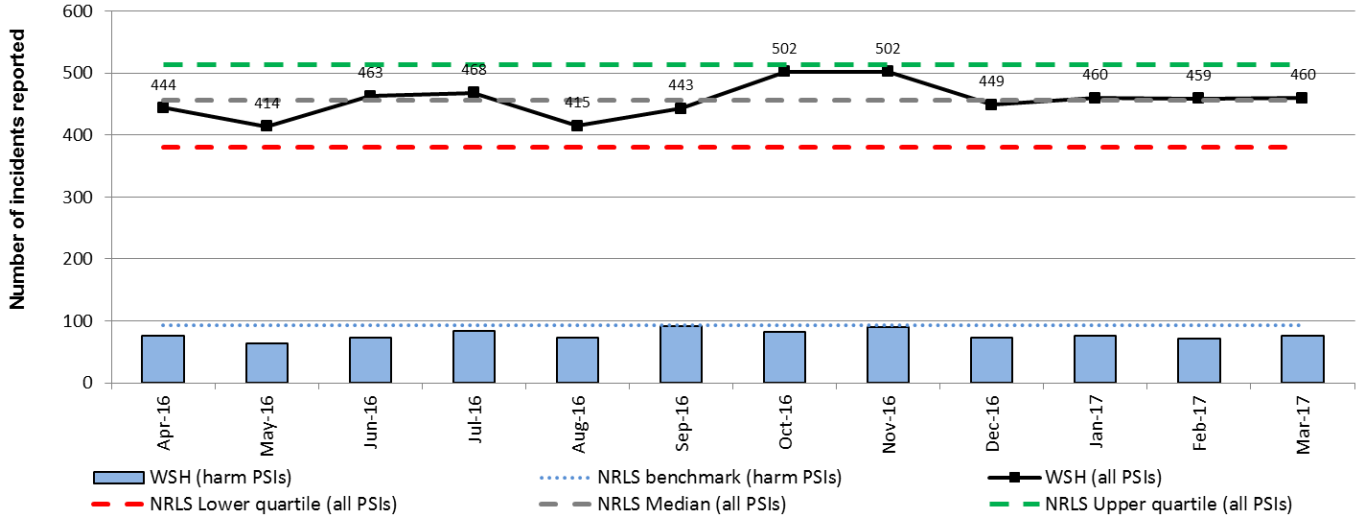
This met the criteria of a 'Wrong site surgery' never event in relation to a patient who had a procedure in outpatients. The investigation is still ongoing.

Immediate mitigations included:

- Communications from medical director to all consultants ensuring that patients are positively identified prior to consultation and treatment. This was also sent to nursing staff across the Trust.

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



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.

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

The 'sign up to safety' initiative was launched in 2014 and as part of this work 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, the electronic patient records system.

As part of the implementation of e-Care, clinical staff identified what data would be required to support reporting of the 'sign up to safety' measurement metrics. The e-Care project was implemented in May 2016 and although a number of measures can be reported, there is ongoing review to enable all elements to be reported. 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

      There has been progress in relation to this and there have been reporting triggers agreed within day surgery unit (DSU), main theatres and critical care. Further areas will be identified during 2017/18 to support reporting of patient safety incidents.

- 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

  During 2016/17 we have implemented a daily report to enable us to review all incidents reported within the last 24 hrs. This has helped us identify where grading may not be reflective of the incident or to explore incidents irrelevant of grading further. The report that goes to the board on a monthly basis now includes thematic issues. The governance team has developed a process and concise report for all incidents graded as moderate harm, this has been implemented across the Trust and supports the DOC process.

- 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

    This is described within the mortality area of the quality accounts and the trust has implemented an internal mortality database and process to review all inpatient deaths. This process enables clinicians to identify if they feel there has been an element of preventability in relation to a patient's death and where this is considered significant a review is managed through the incident reporting mechanisms.

    In conjunction with the mortality database a mortality surveillance group has been implemented for cases to be presented and discussed. This is also the forum where clinical alerts raised within Dr Foster data are reviewed. The Trust is considering how to adopt the Royal College of Physicians structured judgement review (SJR) methodology as part of the recent guidance on death reviews.

- 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

    The governance team has been working with patients and their relatives to ensure we share the outcome of investigations but also involving the families at an early point in the investigation to ensure any concerns they may have are captured within the investigation.

- 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

    There is ongoing work in relation to participation within the Trust induction of staff groups and their understanding of governance and incident reporting. Progress has been made in the presentation of the outcome of incident investigation, these are presented as part of the junior doctor post graduate medical education (PGME) programme on a quarterly basis and within the nursing team as part of the Nursing and Midwifery Council meeting. There is ad-hoc teaching provided at divisional audit meeting or training days for staff groups.

- 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.
    There has been limited progress in developing the combined dashboard relating to the deteriorating patient. A number of the elements are presented individually and some of the information is not currently available due to e-Care.

Action to be implemented in 2017/18:

- Increase our incident reporting levels through further development of trigger reporting
- Learn from all levels of incident reporting and share this learning consistently throughout the Trust
- Continue to improve and share our learning with our patients and their families
- Consider further opportunities to provide teaching in relation to governance and incident reporting
- Review reporting available from e-Care and review the requirement for a deteriorating patient dashboard.

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 focussed 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 provides formal feedback with the ward manager, service manager, matron and general manager. On occasions the areas have been asked to provide action plans to address issues identified and enable follow up as part of the quality walkabout process.

As part of the quality walkabout a number of key areas are consistently reviewed. These included:

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

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
- Updated patient information
- Updated/relevant posters and information in clinical areas
- Removal of broken or unused equipment
- Improved response to maintenance issues in patient-facing areas
- One way glass screens implemented on G8 to improve privacy and dignity
- 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 lessons learned are also reviewed by the patient and carer experience group.

WSFT received 226 formal complaints during 2016/17. This represents a decrease in numbers compared to 2015/16 when 236 complaints were received and to 2014/15 (321). 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 2016/17 were resolved with the first response (the same as during 2015/16). There were 13 meetings arranged between staff and complainants during 2016/17 to assist with resolving concerns, either prior to any written response or following an initial written response.

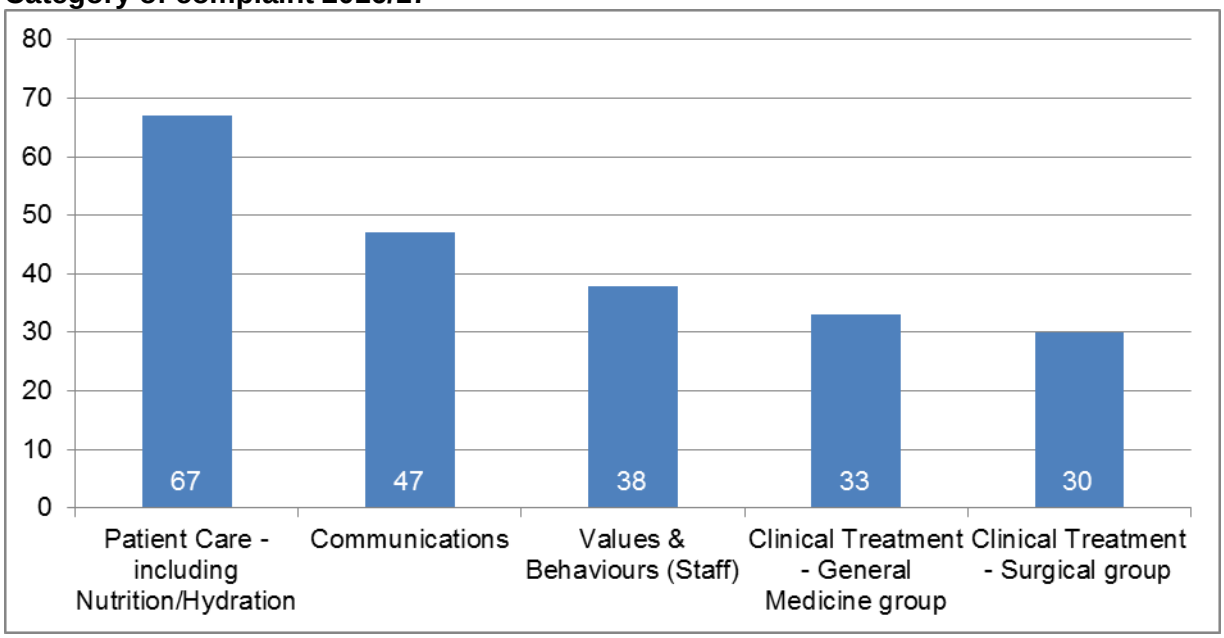
Complainants who are dissatisfied with the Trust's response can refer their concerns directly to the PHSO for an independent review. During 2016/17 nine complaints were referred to the PHSO, compared to six during 2016/17.

In 2016/17 the PHSO completed its review of four complaints:

- One complaint was partly upheld resulting in a payment of £200 and implementation of an action plan
- One complaint was partly upheld resulting in a further letter of apology and implementation of an action plan
- Two complaints were not upheld

The main themes and trends from complaints are described below:

Category of complaint 2016/17



Note: the numbers identified in the chart above do not total the numbers of complaints received, as many complaints have more than one category.

This result is a significant change on the previous year, whereby 'patient care' did not feature in the top five. Complaints about admissions and discharges have decreased resulting in this category diminishing from the top five most common categories.

Upon investigation, the most common sub-category of this is 'care needs not adequately met' (23) with no particular themes within this data in relation to area, however, 17 of these relate to nursing care.

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:

- Additional fields added to e-Care to ensure verbal discussions with patients regarding removal of intravenous (IV) lines are documented
- Contributory information for staffing review resulting in increase in staffing on Ward G3
- Improved communication regarding sedation in the endoscopy unit; ensuring patients are aware they are receiving conscious sedation not anaesthetic.

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.

Managing compliments

A total of 367 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 patient experience team.

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:

"All the staff involved with my husband and father couldn't have been more kind and helpful at what was a very distressing time for us. You do a fantastic job and we cannot thank you enough."

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 2016 have not yet been published. However the results have been published comparing us to other organisations using the same survey provider, and the results indicate a decline from our own score last year. We have however performed better than other organisations on eight questions, most of which related to cleanliness and quality of food.

Areas of improvement have been identified and these are to review the communication impact of the use of workstations on wheels, patients feeling able to talk to someone and feedback their views and lack of information to patients and relatives about leaving hospital as well as relating to medications.

The Emergency Department and Children and Young Persons national surveys are currently underway.

National staff survey 2016

The WSFT once again improved in the latest NHS staff survey results strengthening its position as the hospital in the east that is the most highly rated by its staff, according to the results of the latest NHS staff survey. Asked questions about whether they would recommend the hospital as a place to work or receive treatment, 88% of staff agreed that care of patients is the Trust's top priority. The national average was 76%. When asked if they would recommend the Trust for treatment of a friend or relative 85% of staff agreed that they would compared with a national result of 70%. WSFT remains in the top 20% of all similar NHS Trusts for staff engagement and has improved on its score for the previous year. It is also a leading trust for the extent to which staff look forward to going to work and being enthusiastic and absorbed in their jobs.

KF26 percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

The WSFT KF26 results for 2016 is 25%. When compared to all acute trusts WSFT is considered as average. The results were broken down as follows:

15b	Not experienced harassment, bullying or abuse from managers	91 %
15c	Not experienced harassment, bullying or abuse from other colleagues	80 %

KF21 percentage of staff believing the organisation provides equal opportunities for career progression / promotion

The results regarding KF21 for 2016 is 92%. When compared to all acute trusts WSFT is in the highest (best) 20%.

Workforce Race Equality Standard (WRES)

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority

Ethnic (BME) staff, as required for the Workforce Race Equality Standard.
In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.

			Our Trust in 2016	Average (median) for acute trusts	Our Trust in 2015
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	28%	27%	29%
		BME	24%	26%	28%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	23%	24%	21%
		BME	31%	27%	40%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	92%	88%	91%
		BME	80%	76%	68%
Q17b	In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White	6%	6%	6%
		BME	18%	14%	16%

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 2016/17 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 and 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

National clinical audit	Host organisation	Eligible	Participated	%
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	Yes	Ongoing[1]
Adult Asthma	British Thoracic Society	Yes	Yes	100
Adult Cardiac Surgery	National Institute for Cardiovascular Outcomes Research (NICOR)	No	No	-
Asthma (paediatric and adult) care in emergency departments	Royal College of Emergency Medicine	Yes	Yes	100
Bowel Cancer (NBOCAP)	Royal College of Surgeons	Yes	Yes	Ongoing[1]
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	No	-
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)	Yes	Yes	Ongoing[1]
Chronic Kidney Disease in primary care	Informatica Systems Ltd	No	No	-
Adult Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	No	-
Paediatric Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	No	-
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	No	-
Diabetes (Paediatric) (NPDA)	Royal College of Paediatrics and Child Health	Yes	Yes	100
Elective Surgery (National PROMs Programme)	Health & Social Care Information Centre (HSCIC)	Yes	Yes	Ongoing[1]
Endocrine and Thyroid National Audit	British Association of Endocrine and Thyroid Surgeons (BAETS)	Yes	Yes	Ongoing[1]
Fracture Liaison Service (FLS-DB) (Falls and Fragility Fractures Audit Programme FFFAP)	Royal College of Physicians	Yes	Yes	Ongoing[1]
Hip Fracture Database (NHFD) (Falls and Fragility Fractures Audit Programme FFFAP)	Royal College of Physicians	Yes	Yes	Ongoing[1]
Falls (Falls and Fragility Fractures Audit Programme FFFAP)	Royal College of Physicians	Yes	Yes[2]	-
Head and Neck Cancer Audit	Saving Faces – The Facial Surgery Research Foundation	No	No	-
Inflammatory Bowel Disease (IBD) programme	British Society of Gastroenterology /Royal College of Physicians	Yes	Yes	100
Learning Disability Mortality Review Programme (LeDeR Programme)	University of Bristol	No	No	-
Major Trauma Audit	Trauma Audit and Research Network (TARN)	Yes	Yes	Ongoing[1]
National Audit of Dementia	Royal College of Psychiatrists	Yes	Yes	100
National Audit of Pulmonary Hypertension	Health & Social Care Information Centre (HSCIC)	No	No	-
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)	Yes	Yes	Ongoing[1]

National clinical audit	Host organisation	Eligible	Participated	%
Pulmonary Rehabilitation (National Chronic Obstructive Pulmonary Disease (COPD) Audit programme)	Royal College of Physicians	No	No	-
Secondary Care (National Chronic Obstructive Pulmonary Disease (COPD) Audit programme)	Royal College of Physicians	Yes	No[3]	
Patient Blood Management in Scheduled Surgery (National Comparative Audit of Blood Transfusion Programme)	NHS Blood and Transplant	Yes	Yes	100
National Diabetes Core Audit (NDA) (National Diabetes Audit – Adults)	Health and Social Care Information Centre (HSCIC)	Yes	Yes	100
National Diabetes Footcare Audit (NDFA) (National Diabetes Audit – Adults)	Health and Social Care Information Centre (HSCIC)	Yes	Yes	Ongoing[1]
National Diabetes Inpatient Audit (NaDIA) (National Diabetes Audit – Adults)	Health and Social Care Information Centre (HSCIC)	Yes	Yes	100
National Pregnancy in Diabetes Audit (NPID) (National Diabetes Audit – Adults)	Health and Social Care Information Centre (HSCIC)	Yes	Yes	Ongoing[1]
National Emergency Laparotomy Audit (NELA)	The Royal College of Anaesthetists	Yes	Yes	Ongoing[1]
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	Yes	Ongoing[1]
Hip Replacement (National Joint Registry) (NJR)	Healthcare Quality Improvement Partnership (HQIP)	Yes	Yes	100
Knee Replacement (National Joint Registry) (NJR)	Healthcare Quality Improvement Partnership (HQIP)	Yes	Yes	100
National Lung Cancer Audit (NLCA)	Royal College of Physicians	Yes	Yes	Ongoing[1]
National Neurosurgery Audit Programme	Society of British Neurological Surgeons	No	No	-
National Ophthalmology Audit	Royal College of Ophthalmologists	Yes	Yes[4]	-
National Prostate Cancer Audit (NPCA)	Royal College of Surgeons	Yes	Yes	Ongoing[1]
National Vascular Registry	Royal College of Surgeons of England	Yes	Yes	Ongoing[1]
Neonatal Intensive and Special Care (NNAP)	Royal College of Paediatrics and Child Health	Yes	Yes	Ongoing[1]
Nephrectomy Audit	British Association of Urological Surgeons (BAUS)	No	No	-
Oesophago-Gastric Cancer (NAOGC)	Royal College of Surgeons	Yes	Yes	Ongoing[1]
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds	No	No	-
Paediatric Pneumonia	British Thoracic Society	Yes	Yes	100
Percutaneous Nephrolithotomy (PCNL)	British Association of Urological Surgeons (BAUS)	No	No	-
Congenital Heart Disease – Adult (Prescribing Observatory for Mental Health (POMH-UK))	Royal College of Psychiatrists	No	No	-
Monitoring of Patients Prescribed Lithium (Prescribing Observatory for Mental Health (POMH-UK))	Royal College of Psychiatrists	No	No	-

National clinical audit	Host organisation	Eligible	Participated	%
Rapid Tranquilisation (Prescribing Observatory for Mental Health (POMH-UK))	Royal College of Psychiatrists	No	No	-
Radical Prostatectomy Audit	British Association of Urological Surgeons (BAUS)	No	No	-
Renal Replacement Therapy (Renal Registry)	UK Renal Registry	No	No	-
Rheumatoid and Early Inflammatory Arthritis	Northgate	Yes	Yes[2]	-
Sentinel Stroke National Audit Programme (SSNAP) Clinical Audit	Royal College of Physicians	Yes	Yes	Ongoing[1]
Severe Sepsis and Septic Shock (care in emergency departments)	Royal College of Emergency Medicine	Yes	Yes	100
Specialist Rehabilitation for Patients with Complex Needs	London North West Healthcare NHS Trust	No	No	-
Stress Urinary Incontinence Audit	British Association of Urological Surgeons (BAUS)	No	No	-
Adult UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	No	No	-
Paediatric UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	No	No	-

1 Data collection is ongoing therefore the percentage of cases submitted against registered cases required in 2016/17 is currently unavailable

2 Audits included in the Quality Accounts list however there was no data collection in 2016/17

3 The Trust is registered to participate in the Secondary Care COPD Audit however there is pending handover of clinical lead in respiratory medicine to act as audit lead for the project and therefore no data is currently being submitted

4 The National Ophthalmology Audit requires the use of Medisoft software, which is incompatible with our current software. The Surgical Division and IT are currently working on finding a solution as there is no resource to collect data manually. This delayed start has been added to the Trust Risk Register and agreed with the National Ophthalmology Audit provider

Table B: Clinical outcome review programmes participation

Clinical outcome review programme	Host organisation	Eligible	Participated	%
Chronic Neurodisability (Child Health Clinical Outcome Review Programme)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	100
Young People's Mental Health (Child Health Clinical Outcome Review Programme)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	100
Maternal Mortality and Morbidity Confidential Enquiries (Maternal, Newborn and Infant Clinical Outcome Review Programme)	MBRRACE-UK – National Perinatal Epidemiology Unit (NPEU)	Yes	Yes	Ongoing[1]
Maternal Mortality Surveillance Confidential Enquiries (Maternal, Newborn and Infant Clinical Outcome Review Programme)	MBRRACE-UK – National Perinatal Epidemiology Unit (NPEU)	Yes	Yes	Ongoing[1]
Perinatal Mortality and Morbidity Confidential Enquiries (Maternal, Newborn and Infant Clinical Outcome Review Programme)	MBRRACE-UK – National Perinatal Epidemiology Unit (NPEU)	Yes	Yes	Ongoing[1]
Perinatal Mortality Surveillance Confidential Enquiries (Maternal, Newborn and Infant Clinical Outcome Review Programme)	MBRRACE-UK – National Perinatal Epidemiology Unit (NPEU)	Yes	Yes	Ongoing[1]
Acute Pancreatitis (Medical and Surgical Clinical Outcome Review Programme)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes[2]	-

Clinical outcome review programme	Host organisation	Eligible	Participated	%
Mental Health in General Hospitals (Medical and Surgical Clinical Outcome Review Programme)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	100
Non Invasive Ventilation (Medical and Surgical Clinical Outcome Review Programme)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	100
Suicide, Homicide and Sudden Unexplained Death	National Confidential Inquiry into Suicide and Homicide (NCISH) – University of Manchester	No	No	-
Suicide in Children and Young People	National Confidential Inquiry into Suicide and Homicide (NCISH) – University of Manchester	No	No	-
Management and Risk of Patients with Personality Disorder prior to Suicide and Homicide	National Confidential Inquiry into Suicide and Homicide (NCISH) – University of Manchester	No	No	-

[1] Data collection is ongoing therefore the percentage of cases submitted against registered cases required in 2016/17 is currently unavailable

[2] Audits included in the Quality Accounts list however there was no data collection in 2016/17

Table C: Action from national audit reports

Name of national clinical audit	Summary of actions taken
National Diabetes Inpatient Audit 2015	A baseline assessment has been completed against the report recommendations. Actions to review whether to add severe hypoglycaemia, inpatient diabetic ketoacidosis (DKA) and hypersmolar hyperglycaemic state (HHS) on the corporate risk register and to reinstate the Diabetes Task and Finish Group.
National Emergency Laparotomy Audit (NELA) Report 2016	A baseline assessment has been completed against the report recommendations. Results identified improvement was required for WSFT patients arrival to theatre in timescale appropriate to urgency. Action in place to implement a dedicated out of hours theatre for emergencies.
National Heart Failure Audit 2014-15	A baseline assessment has been completed against the report recommendations. All relevant recommendations have been met by the cardiology service.
National Audit of Cardiac Rehabilitation Statistical Report 2016	A baseline assessment has been completed against the report recommendations. All relevant recommendations have been met by the cardiac rehabilitation service.
National Prostate Cancer Audit 2016 Report	NPCA have subsequently stated that the report is currently under review due to data issues identified by NCRAS where approximately 1,800 men were missing from the dataset. Therefore, due to the review of the NPCA report no further actions are required.
National Comparative Audit of Red Cell and Platelet Transfusion in Adult Haematology Patients	Actions taken to develop a transfusion consent document and transfusion plan on e-Care, educate staff to record weight on transfusion prescription charts, change process so red blood cell transfusions are approved by Haematology service, and provide an education session for the Macmillan department about national transfusion guidelines.
NCEPOD Mental Health in General Hospitals 'Treat as One'	A baseline assessment has been completed against the report recommendations. Areas of partial compliance with recommendations are due to commissioning arrangements for the Psychiatric Liaison Service.
National COPD Audit Programme: Secondary Care Outcomes Report 2014	A baseline assessment has been completed against the report recommendations. Action to record additional patient respiratory information on admission to be implemented by new COPD lead when appointed.
Myocardial Ischaemia National Audit Project (MINAP) 2014-15 Report	A baseline assessment has been completed against the report recommendations. All relevant recommendations have been met by the cardiology service.
National Neonatal Audit Programme (NNAP) 2016 Annual Report	A baseline assessment has been completed against the report recommendations. Actions taken to discuss results and areas for improvement with Paediatricians and Obstetricians and develop a 2 year follow up leaflet for parents.

Name of national clinical audit	Summary of actions taken
National Diabetes Inpatient Audit 2016	A baseline assessment has been completed against the report recommendations. Actions to implement diabetic foot care assessment in e-Care, provide training sessions for staff regarding electronic prescribing and appoint a technician to connect blood glucose monitors to the Diabetes Centre which will alert the Diabetes Team of any low or high blood glucose readings for immediate response.

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	Jul 15 – Jun 16
WSFT (confidence intervals)	89.76 (84.9 to 94.83)	90.78 (111.98 to 89.3)	93.49 (98.41 to 88.75)	87.22 (92.03 to 82.61)
National average	100	100	100	100
Highest NHS trust	115.63	119.82	120.89	117.12
Lowest NHS trust	62.59	54.07	66.05	69.39

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	Jul 15 – Jun 16
WSFT	19.53%	26.34%	19.71%	32.54%
National average	20.65%	24.79%	26.31%	29.56%

Source: Dr Foster

WSFT considers that this data is as described and shows WSFT's rate is slightly above 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	2016/17 (Apr – Sep)
Groin hernia surgery					
WSFT (EQ-5D Index)	0.093	0.104	0.111	0.128	0.112
National average (EQ-5D Index)	0.085	0.085	0.084	0.088	0.089
Varicose vein surgery					
WSFT (EQ-5D Index)	0.100	0.052	0.052	0.081	0.012
National average (EQ-5D Index)	0.093	0.093	0.095	0.095	0.099
Hip replacement surgery (primary)					
WSFT (EQ-5D Index)	0.400	0.445	0.427	0.490	0.420
National average (EQ-5D Index)	0.438	0.436	0.437	0.438	0.449
Knee replacement surgery (primary)					
WSFT (EQ-5D Index)	0.350	0.301	0.327	0.287	0.283
National average (EQ-5D Index)	0.318	0.323	0.315	0.320	0.337

Source: HSCIC

WSFT considers that this data is as described as PROMS data is issued quarterly. All results are reviewed to ensure that plans are in place to systematically deliver good performance. The 2016/17 data remains provisional and may be based on small sample sizes.

(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	2016/17 (Apr – Dec '16)
Aged 0 to 15	12.62%	5.75%	6.88%	1.41%
Aged 16 or over	14.38%	15.50%	16.68%	7.30%

Source: 2013-16: WSFT patient administration system (PAS)
2016/17: Dr Foster Intelligence

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	2016
WSFT	70.4	68.6	70.2	72.9
National average	68.1	68.7	68.9	69.6
Highest NHS trust	84.4	84.2	86.1	86.2
Lowest NHS trust	59.3	54.4	59.1	58.9

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 five 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 performed better than the national average in three of the last four 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	2016
WSFT (agree + strongly agree)	78	84	85
England: acute trusts (agree + strongly agree)	66	70	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 since 2014 and has improved performance locally each year.

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

	2013/14	2014/15	2015/16
WSFT	99.25%	99.63%	99.46%
National average	95.76%	96.09%	95.76%

Source: NHS England

WSFT considers that this data is as described. Due to reporting issues we have been unable to provide figures for 2016/17. 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	16.3	16.4
National average	17.4	14.7	15.0	14.9

Source: Health Protection Agency (HPA).

Due to reporting issues we have been unable to produce figures for 2016/17 which provide a rate of C.*difficile* infection per 100,000 bed days. WSFT considers that this data is as described as the *C. difficile* infection cases 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	2,006 (30.76 / 1000 bed days)	38.25 / 1000 bed days	Lower quartile of Trusts
Oct ‘15 – Mar ‘16	2,260 (32.5 / 1000 bed days)	39.31 / 1000 bed days	Lower quartile of Trusts
Apr ’16 – Sept ’16	2,517 (36.2 / 1000 bed days)	40.02 / 1000 bed days	Middle 50% of trusts
Oct ‘16 – Mar ‘17	2,722*	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	7 (0.3%)	0.4%	Below peer group average
Oct ‘15 – Mar ‘16	16 (0.8%)	0.4%	Above peer group average
Apr ’16 – Sept ’16	12 (0.5%)	0.4%	Above peer group average
Oct ‘16 – Mar ‘17	23*	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 on *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 on *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 recognise and fully support the Board of Directors' commitment to improving the already high standard of care for our patients.

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.

During 2016/17 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 more than 5,600 public members to take an interest in the hospital
  - Providing support for planning and delivery of external public meetings and events, including annual members meeting and medicine for members.

- **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.

- **Working with the board:**
  - 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 and developments
  - Working with the non-executive directors (NEDs) a two way exchange of intelligence gathered and areas for improvement
  - Regular workshops focused on key developments within the operational plan
  - Completed on schedule the appraisals of all NEDs.

- **Development of knowledge and skills:**
  - Agreed training and develop programme
  - Attending training internal and external events to support learning and development
  - Informal meetings of Governors, arranged by the Lead Governor, to ensure effective working relationships and preparations for meetings.

A good working relationship exists between the governors and board which ensures that information is available to support the constructive contribution of the governors. For example the operational plan.

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. The positive relationship between governors and the board helps to makes to West Suffolk Hospital a special place for patients, the public and staff.

West Suffolk Clinical Commissioning Group

Ipswich and East Suffolk Clinical Commissioning Group and West Suffolk Clinical Commissioning Group, as the commissioning organisations for West Suffolk NHS Foundation Trust, confirm that the Trust has consulted and invited comment regarding the Quality Account for 2016/2017. This has occurred within the agreed timeframe and the CCGs are satisfied that the Quality Account incorporates all the mandated elements required.

The CCGs have 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.

Ipswich and East Suffolk Clinical Commissioning Group and West Suffolk Clinical Commissioning Group, are currently working with clinicians and managers from the Trust and with local service users to continue to improve services to ensure quality, safety, clinical effectiveness and good patient/care experience is delivered across the organisation.

This Quality Account demonstrates the commitment of the Trust to improve services. The Clinical Commissioning Groups endorse 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 2017. 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 (HWS) welcomes the opportunity, once again, to comment on West Suffolk NHS Foundation Trust (WSFT) Quality Accounts for the year 2016/17. It is encouraging to see the Trust has achieved an overall “Good” rating from the Care Quality Commission (CQC) despite the significant challenges it, and the NHS in general, has faced during the year. The rating is broadly in line with our own findings from the HWS Feedback Centre which rates WSFT as 4 (out of a possible 5) stars.

WSFT is to be commended for its awards and accolades during 2016/17, including being top in the east of England for Hip Fracture Care and being ranked by an independent healthcare intelligence company as amongst the top in the country for providing safe and effective care. High praise indeed that The Soil Association has recognised WSFT’s dedication to providing fresh and sustainable food that is nutritionally sound, a valued contribution to improve health outcomes for patients, carers, visitors and staff. It is also exciting to know that WSFT has successfully bid for funds to develop technology confirming its position as a “centre of global digital excellence”.

The report covers performance against last year’s priorities well in the main. HWS recognise the difficulties the introduction of a new electronic patient record system has had on WSFT’s ability to

capture some data. This does not appear to have impacted too greatly on figures as for the most part the accounts demonstrate that priority areas for improvement from 2015/16 have been achieved. The Trust continues to investigate serious incidents and "never events" and to apply the learning from them. The accounts reflect plans developed by individual departments to address shortcomings and areas of concern specifically highlighted in the CQC findings. We are glad to see more patients were recruited to research studies compared to 2015/16. Research and development opportunities provide access to the latest treatment and drug innovations and contribute to enhanced patient outcomes. It is encouraging to see the Trust continues to involve Suffolk Family Carers in relation to the ward environment and supporting carers. It is also encouraging to see actions in place to address the difficulties accessing Paediatric Speech and Language services, an area of concern that predates WSFT taking over the provision of Community Services.

The Quality priorities identified for 2017/18 for the Trust and Community services are broadly the same as for 2016/17 with some minor amendments and additions. The report outlines the actions to be implemented in order to achieve them, however, HWS believes some of the priorities could have been more challenging, for instance avoidable C. difficile infections cases although we understand some priorities are constrained by the requirement of the service specification, significant improvement on last year is unlikely if the numbers remain the same.

We look forward to proactively engaging with WSFT and contributing to the decision around the quality priorities for 18/19 and hope that our views (solely informed by local service users) will be sought earlier in the process next year.

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.

NHS Improvement 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 2016/17 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 2016 to 26 May 2016
    - papers relating to quality reported to the board over the period April 2016 to 26 May 2016
    - feedback from commissioners dated 09/05/2017
    - feedback from governors dated 11/05/2017
    - feedback from local Healthwatch organisations dated 19/05/2017
    - feedback from Overview and Scrutiny Committee dated 27/04/2017
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 10/05/2017
    - the 2015 national patient survey 08/06/2016
    - the 2016 national staff survey 07/03/2017
    - the Head of Internal Audit's annual opinion of the trust's control environment dated 31/03/2017
    - CQC inspection report dated 04/08/2016
- 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
- as the trust is currently not reporting performance against the indicator 18 week maximum wait from point of referral to treatment (patients on an incomplete pathway) due to reporting difficulties from e-Care, the directors have a plan in place to remedy this and return to allow reporting of June 2017 activity
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting 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 2017

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 assurance engagement in respect of West Suffolk NHS Foundation Trust's quality report for the year ended 31 March 2017 (the 'quality report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- 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 auditor

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 NHS Improvement.

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 the Detailed Requirements for External Assurance for Quality Reports for Foundation Trusts 2016/17 issued by NHS Improvement in February 2017 ("the Guidance"); 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 Guidance.

We read the quality report and consider whether it addresses the content requirements of the NHS foundation trust annual reporting manual and supporting guidance, 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 2016 to March 2017;
- papers relating to quality reported to the Board over the period April 2016 to March 2017;
- feedback from commissioners, dated May 2017;
- feedback from governors, dated May 2017
- feedback from Local Healthwatch organisations, dated May 2017;
- feedback from the Overview and Scrutiny Committee dated April 2017
- The Trust's complaints reports published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2017
- the latest national patient survey, dated June 2016;
- the latest national staff survey dated March 2017;

- Care Quality Commission inspection, dated August 2016
- the Head of Internal Audit's annual opinion over the trust's control environment for 2016/17

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 them 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 2017, to enable the Council of Governors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the 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 affect 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 and supporting guidance.

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.

Basis for qualified conclusion

Our testing completed over the "percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period" indicator has identified errors in relation to the accuracy of the data recorded that lead us to conclude that the indicator has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

Qualified conclusion

Based on the results of our procedures, with the exception of the matter reported in the basis for qualified conclusion paragraph above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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 the Detailed Requirements for External Assurance for Quality Reports for Foundation Trusts 2016/17 issued by NHS Improvement in February 2017; 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.

BDO LLP
Chartered Accountants
Ipswich, UK
31 May 2017

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.

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.

DEXA (DXA) scan

DEXA (DXA) scans are used to measure bone density and assess the risk of bone fractures. They're often used to help diagnose bone-related conditions, such as osteoporosis, or assess the risk of developing them.

Total body DEXA scans can also be used to measure body composition (the amount of bone, fat and muscle in the body). This type of scan is routinely used in children, but is still a research application in adults.

Dr Foster Intelligence

Dr Foster Intelligence provides comparative information on health and social care services.

EPARS

The purpose of the EPARS (Escalation Plan and Resuscitation Status) form is to ensure that patients admitted to the trust (with the exception of day case patients), all have an escalation and treatment plan in place. This ensures that all health care professionals are aware of patient's treatment and degree of escalation and de-escalation when coming into contact with the patient.

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 thromboembolism, or blood clots, are a complication of immobility and surgery.

4. Accounts for 2016/17

Contents Page

Foreword to the accounts

West Suffolk NHS Foundation Trust

These accounts, for the year ended 31 March 2017, 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 2017**

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF WEST SUFFOLK FOUNDATION TRUST

We have audited the financial statements of West Suffolk NHS Foundation Trust (the Trust) for the year ended 31 March 2017 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 2016/17 issued by the Regulator of NHS Foundation Trusts ('NHS Improvement').

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 2017 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 2016/17; 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 4.2 of the National Audit Office's Code of Audit Practice 2015 and Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of 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.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

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
Revenue recognition	Our response:
NHS revenue is the most significant income stream for the Trust and is at most risk from material error and fraud.	· We reviewed and considered the design and implementation of controls in place for the revenue system covering material income streams.
The Trust also has material non-NHS revenue streams.	· We reflected the heightened risk level in our sample sizes when we carried out sample based testing to confirm the existence and accuracy of revenue.
There is a risk that revenue may be materially inaccurate or inappropriately recognised.	· We reviewed the signed contracts for the Trust's significant commissioners and verified a sample of variations to these contracts through the Intra-NHS Agreement of Balances process.
	· We checked that income tested 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 either confirmed as matched or, for any mismatches exceeding £250k, had been appropriately accounted for by agreement to supporting evidence to corroborate the Trust's position.

Risk	How the scope of our audit responded to the risk
Valuation of land and buildings	Our response:
The reliance on judgements and assumptions as part of valuation processes results in a high level of estimation uncertainty associated with the balance.	· We reviewed the instructions provided to the Trust's valuer and considered the valuer's skills and expertise in order to assess their suitability as an expert used by management
There is a risk of material misstatement if inappropriate or inaccurate estimates or assumptions are used in the review of these fair values.	· We considered whether the basis of valuation used for different classes of assets valued in year was appropriate, based on their usage
	· We reviewed valuation movements against indices of price movements for similar classes of assets and followed up valuation movements that appeared unusual through enquiries made of the Trust and directly with the valuer.
	· We considered the reasonableness of assumptions made by the valuer in forming the valuation and determining the useful economic lives of assets valued using Trust specific and sector knowledge and indices.
Pathology Partnership (tPP)	Our response:
tPP continued to make losses in the year. This and associated governance concerns have led to restructuring of the arrangement after year end.	· We reviewed the Trust's calculation of any required impairment and it's accounting treatment of losses and asset impairment against the requirements of the Group Accounting Manual (GAM) and underlying international financial reporting standards.
Any changes to the structure of the organisation may have a material impact on corresponding transactions and balances recognised in the financial statements, in particular the valuation of the investment and the impairment estimate. There is a risk that such transactions and balances are not accounted for correctly.	· We reviewed the financial forecasts of tPP when considering the impairment.
	· We ensured that the associated transactions had been appropriately recognised in the financial statements.
	· We considered the future arrangements of the partnership and the impact that this had on the underlying investment.

Risk	How the scope of our audit responded to the risk
Financial Sustainability (relating to Use of Resources responsibilities) The Trust recorded a deficit of £8.1m for the year ended 31 March 2017, and has forecast a deficit of £5.9m for the year ending 31 March 2018 and £2.5m deficit for the year ending 31 March 2019. The Trust's Cost Improvement Programme savings requirement increases from £12.5m to £13.3m then £18.3m respectively over the three years. The Trust is currently scored by NHS Improvement as presenting the second highest level of financial risk 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 2017, and achievement of control totals and planned Cost Improvement Programme schemes. · We reviewed the Trust's arrangements for financial and Cost Improvement Programme performance management for the year ended 31 March 2017. · We considered the feasibility of the operational plan and the reasonableness of the assumptions used in developing the Trust's medium term financial plans, specifically for the years ending 31 March 2018 and 31 March 2019.

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 £4.5 million. This has been determined with reference to the benchmark of gross expenditure (of which it represents 1.75%) 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 £180,000, 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 accorda
  - 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

Auditor's responsibilities

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.*

Basis for qualified conclusion

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 2017 the Trust reported a deficit of £8.1m after receiving £7.1m of Sustainability and Transformation Funding (STF) and incurring £5m of impairments. The underlying and comparable financial deficit for 2016/17 is, therefore, £10.2m compared to £9.8m deficit in 2015/16 and a control total of £11.1m deficit for 2016/17. This deficit was after achievement of £12.5m of Cost Improvement Programme (CIP) savings in 2016/17 (2015/16: £9.8m).

The Trust is forecasting a deficit for 2017/18 of £11.1m before receipt of £5.2m of STF and after assumed achievement of an increased target of £13.3m CIP savings. This is a deterioration compared to 2016/17. After risk assessing its 2017/18 potential CIP schemes, the Trust has determined a £1.8m shortfall against the £13.3m requirement, adding further pressure to the underlying position.

The Trust is forecasting a deficit for 2018/19 of £7.7m before receipt of £5.2m of STF and after assuming achievement of a notably increased target of £18.3m CIP savings. This deficit is an improvement compared to 2016/17 and 2017/18 but the level of CIP savings required to achieve this outcome is 59% higher than the risk-assessed £11.5m currently anticipated for 2017/18 and is consequently judged to be of a transformational level.

The Trust recognises this challenge and is actively working with KPMG, commissioned by NHS Improvement, to assist the Trust in developing and implementing a Financial Improvement Programme designed to secure financial sustainability in the medium term. However, there are still significant risks regarding the sufficiency of resource capacity and capability within the Trust to secure the necessary change to achieve financial sustainability in the medium term and current forecasts through to 2018/19 do not bring the Trust back to breakeven.

NHS Improvement's Single Oversight Framework rates Trusts in a number of areas including finance and use of resources, scoring providers 1 (best) to 4 against each metric. The Trust's Financial Reporting risk rating is 3 and is expected to remain at this level for 2017/18 and 2018/19.

The Trust has a clear strategy and commitment amongst its leadership to deliver the necessary action to improve its underlying deficit position and is taking action designed to achieve this, in particular through strengthening its CIP management arrangements. However, whilst the Trust considers that arrangements sufficient to address the increased CIP challenges in 2017/18 and 2018/19 will be put in place, as at 31 March 2017 the implementation of these actions was at an early stage and significant uncertainties remain regarding the Trust's resource capacity and capability to deliver the necessary actions and achieve financial sustainability in the medium term.

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2016, with the exception of the matters reported in the basis for qualified conclusion paragraph above, we are satisfied that, in all significant respects, West Suffolk NHS Foundation Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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 West Suffolk 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 NHS Improvement.

Audit 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.

Lisa Clampin
for and on behalf of BDO LLP
Registered auditor
Ipswich, UK
31-May-17

BDO LLP is a limited liability partnership registered in England and Wales (with registered number OC305127).

Statement of Comprehensive Income for the year ended 31 March 2017

	Note	2016/17 £000	Restated 2015/16 £000	Original 2015/16 £000
Operating income from patient care activities	3	223,216	185,452	186,327
Other operating income	4	31,265	23,925	23,925
Total operating income from continuing operations		**254,481**	**209,377**	**210,252**
Operating expenses	5	(262,132)	(218,417)	(218,417)
Operating deficit from continuing operations		**(7,651)**	**(9,040)**	**(8,165)**
Finance income		24	23	23
Finance expenses		(28)	(194)	(194)
PDC dividends payable		(940)	(1,426)	(1,426)
Net finance costs		**(944)**	**(1,597)**	**(1,597)**
Gains/(losses) of disposal of non-current assets		453	(40)	(40)
Deficit for the year		**(8,142)**	**(10,677)**	**(9,802)**
Other comprehensive income				
Will not be reclassified to income and expenditure:				
Revaluations		1,566	-	-
Other recognised gains and losses		(65)	-	-
Total comprehensive expense for the period		**(6,641)**	**(10,677)**	**(9,802)**

Statement of Financial Position as at 31 March 2017

	Note	31 March 2017 £000	Restated 31 March 2016 £000	Original 31 March 2016 £000
Non-current assets				
Intangible assets	10	15,611	10,876	10,876
Property, plant and equipment	11	74,053	61,923	61,923
Trade and other receivables	12	-	273	273
Other financial assets		-	1,688	1,688
Total non-current assets		**89,664**	**74,760**	**74,760**
Current assets				
Inventories		2,693	2,825	2,825
Trade and other receivables	12	18,345	11,191	11,191
Non-current assets for sale and assets in disposal groups		-	1,400	1,400
Cash and cash equivalents	13	1,352	2,601	2,601
Total current assets		**22,390**	**18,017**	**18,017**
Current liabilities				
Trade and other payables	14	(23,434)	(21,692)	(21,692)
Other liabilities	14.1	(1,325)	(2,767)	(1,892)
Borrowings	15	(534)	(130)	(130)
Provisions		(61)	(84)	(84)
Total current liabilities		**(25,354)**	**(24,673)**	**(23,798)**
Total assets less current liabilities		**86,700**	**68,104**	**68,979**
Non-current liabilities				
Trade and other payables	14	-	(912)	(912)
Borrowings	15	(44,375)	(18,205)	(18,205)
Provisions		(181)	(202)	(202)
Total non-current liabilities		**(44,556)**	**(19,319)**	**(19,319)**
Total assets employed		**42,144**	**48,785**	**49,660**
Financed by				
Public dividend capital		59,232	59,232	59,232
Revaluation reserve		3,621	2,151	2,151
Income and expenditure reserve		(20,709)	(12,598)	(11,723)
Total taxpayers' equity		**42,144**	**48,785**	**49,660**

The notes on pages 166 to 191 form part of these accounts.

Name Dr. Stephen Dunn
Position Chief Executive
Date **26 May 2017**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**59,232**	**2,151**	**(12,598)**	**48,785**
Deficit for the year	-	-	(8,142)	**(8,142)**
Other transfers between reserves	-	(31)	31	**-**
Revaluations	-	1,566	-	**1,566**
Other recognised gains and losses	-	(65)	-	**(65)**
Taxpayers' and others' equity at 31 March 2017	**59,232**	**3,621**	**(20,709)**	**42,144**

Statement of Changes in Equity for the year ended 31 March 2016 **Restated**

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**59,232**	**2,151**	**(1,921)**	**59,462**
Deficit for the year	-	-	(10,677)	**(10,677)**
Taxpayers' and others' equity at 31 March 2016	**59,232**	**2,151**	**(12,598)**	**48,785**

Statement of Changes in Equity for the year ended 31 March 2016 **Original**

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 - brought forward	**59232**	**2151**	**-1921**	**59462**
Deficit for the year	-	-	(9,802)	**(9,802)**
Taxpayers' and others' equity at 31 March 2016	**59,232**	**2,151**	**(9,802)**	**(9,802)**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows for the year ended 31 March 2017

	Note	2016/17 £000	Restated 2015/16 £000	Original 2015/16 £000
Cash flows from operating activities				
Operating deficit		(7,651)	(9,040)	(8,165)
Non-cash income and expense:				
Depreciation and amortisation	5	5,101	4,263	4,263
Net impairments	6	4,815	411	411
Income recognised in respect of capital donations		(399)	(186)	(186)
(Increase)/decrease in receivables and other assets		(6,792)	(2,023)	(2,023)
(Increase)/decrease in inventories		132	(107)	(107)
Increase/(decrease) in payables and other liabilities		(688)	5,382	4,507
Increase/(decrease) in provisions		(48)	-	-
Other movements in operating cash flows		(5)	-	-
Net cash generated used in operating activities		**(5,535)**	**(1,300)**	**(1,300)**
Cash flows from investing activities				
Interest received		24	25	25
Purchase and sale of financial assets		(3,127)	(1,688)	(1,688)
Purchase of intangible assets		(6,315)	(5,248)	(5,248)
Purchase of property, plant, equipment and investment property		(13,860)	(4,901)	(4,901)
Sales of property, plant, equipment and investment property		2,168	426	426
Receipt of cash donations to purchase capital assets		-	186	186
Net cash generated used in investing activities		**(21,110)**	**(11,200)**	**(11,200)**
Cash flows from financing activities				
Movement on loans from the Department of Health- additions		26,756	13,300	13,235
Movement on loans from the Department of Health- repayments		(281)	(65)	-
Capital element of finance lease rental payments		(26)	-	-
Interest paid on finance lease liabilities		(4)	-	-
Other interest paid		(20)	(190)	(190)
PDC dividend paid		(1,029)	(1,197)	(1,197)
Net cash generated from financing activities		**25,396**	**11,848**	**11,848**
Decrease in cash and cash equivalents		**(1,249)**	**(652)**	**(652)**
Cash and cash equivalents at 1 April		**2,601**	**3,253**	**3,253**
Cash and cash equivalents at 31 March	13	**1,352**	**2,601**	**2,601**

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. 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.

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.

Going concern

These accounts have been prepared on a going concern basis.

The Trust is in deficit because its costs exceed income. The deficit in 2016/17 is £8.1 million. The Trust has borrowed £37.3 million from the Department of Health (DH) for capital purposes, £5.0 million from DH for working capital and a further £2.5 million from DH in relation to the Pathology Partnership creditor balances.

The planned deficit for 2017/18 is £5.9 million which is also the agreed control total with Department of Health. The Trust has asked DH for £2.0 million additional cash in 2017/18 for distress financing in addition to the planned capital borrowing although the Trust plans to repay the distress financing within the same financial year.

The Trust's deficit position is a significant concern but is not unusual in the NHS acute sector currently. All liabilities are ultimately underwritten by DH as confirmed by statute therefore these accounts are prepared on a going concern basis.

Note 1.1 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 1.2 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. It is not possible for the Trust to identify its share of the underlying 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 1.3 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 1.4 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control, 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, eg, plant and equipment, then these 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 at valuation:
Property- fair value where available. If there is no market value information or the Trust does not have access to the market because of statutory restricitions, assets are valued at current value in existing in use. In practice this means many assets are valued at depreciated replacement cost.
Plant and Equipment- depreciated historic cost
Land- fair value where available. If the Trust does not have access to the market because of statutory restricitions, land is valued at current value in existing in use.
Intangible Assets- fair value. If no market information available depreciated replacement cost.

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 or IFRS 5.

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 *DH GAM* , impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating 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 ie:

- 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	4	75
Dwellings	18	54
Plant & machinery	5	29
Transport equipment	7	7
Information technology	3	20
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 1.5 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, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or 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	20
Intangible assets - purchased		
Software	2	20

Note 1.6 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, ie, when receipt or delivery of the goods or services is made.

Financial Assets
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 assets are categorised as loans and receivables.

Receivables
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 receivables comprise cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Financial Liabilities
Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Financial liabilities are classified as other financial liabilities.

All 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 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.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through the use of a bad debt provision.

Overdue debts are assessed according to age and updated information from the other party. A risk based impairment allowance is made and where necessary this will be for the full value of the debt.

Note 1.7 Leases

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.8 Provisions

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 16 but is not recognised in the Trust's accounts.

Note 1.9 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 Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, 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 of the audit of the annual accounts.

Note 1.10 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.15 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

Note 1.16 Standards, amendments and interpretations in issue but not yet effective or adopted
IFRS16, the new leases standard, will not be implemented until 2019/20 at the earliest. This new standard is likely to increase the assets recognised on the balance sheet currently accounted for as operating leases as well as increased borrowing relating to those assets.

Note 1.17 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 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.

Specifically the material estimates in the 2016/17 accounts include:

- recoverable deposits on community equipment. The Trust pays a deposit to an external company for equipment issues to patients in the community. If the equipment is returned and the company is able to re-use it the deposit is returned. Based on experience in 2016/17 it is assumed that 67.3% of deposits outstanding at the balance sheet date will be recovered which equates to £3.6 million.
- as part of the Community contract the Trust leases a number of properties from NHS Property Services (NHSPS). The Trust is in ongoing discussions with NHSPS about the lease costs and the Trust has made an assumption about the final outcome of these discussions at year-end. The Trust has accounted for £2.3m less than the invoices received from NHSPS.
- the investment in the Pathology Partnership was £1.7 million at the end of 2015/16. During 2016/17 this increased to £4.8 million but an impairment review at the end of 2016/17 concluded that the valuation should be revised to £0 and it has therefore been impaired accordingly. This is because of the uncertainty surrounding the estimated market price of the investment.

- the Trust employs a professional valuer to value all land and buildings and estimate their useful economic lives which are used to calculate depreciation. The value of these assets at 31 March 2017 is £59.7 million.

Note 2 Operating Segments

The Trust reports to the Board on a monthly basis the performance on a divisional 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 commisisoners 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.

	Medicine	Surgery	Women and Children	Corporate	Community	Other	Total
2016/17	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Income	63,406	60,292	21,647	28,944	62,567	17,625	254,481
Expenditure	(56,710)	(48,101)	(15,030)	(32,380)	(62,567)	(47,344)	(262,132)
Contribution	**6,696**	**12,191**	**6,617**	**(3,436)**	**0**	**(29,719)**	**(7,651)**

Restated

	Medicine	Surgery	Women and Children	Corporate	Community	Other	Total
2015/16	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Income	61,838	58,513	20,638	21,381	31,952	15,055	209,377
Expenditure	(55,408)	(47,275)	(14,642)	(23,714)	(31,952)	(45,466)	(218,457)
Contribution	**6,430**	**11,238**	**5,996**	**(2,333)**	**0**	**(30,411)**	**(9,080)**

Original

	Medicine	Surgery	Women and Children	Corporate	Community	Other	Total
2015/16	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
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)**

The prior period adjustment on income relates to deferred income from West Suffolk CCG for the maternity care pathway.

These segments represent the management structure in the organisation.

The Trust was commissioned to provide community services in Suffolk from 1 October 2015 and has continued to do so throughout 2016/17.

The care is delivered in partnership with Ipswich Hospital NHS Trust and also through a contract with Norfolk Community Healthcare.

This note analyses total income by management unit within the organisation. The following note analyses patient care and non patient care income separately. Please note that total income for Community services includes both patient care income and an element of the non patient care income.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2016/17 £000	Restated 2015/16 £000	Original 2015/16 £000
Acute services			
Elective income	32,275	32,916	32,916
Non elective income	53,714	50,100	50,100
Outpatient income	33,287	34,415	34,415
A & E income	7,215	6,972	6,972
Other NHS clinical income	33,321	29,166	30,041
Community services (patient care income only)			
Community services income from CCGs and NHS England	59,300	29,880	29,880
Community services income from other commissioners	2,298	-	-
All services			
Private patient income	1,495	1,594	1,594
Other clinical income	311	409	409
Total income from activities	**223,216**	**185,452**	**186,327**

The prior period adjustment on income relates to deferred income from West Suffolk CCG for the maternity care pathway.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2016/17 £000	2015/16 £000	2015/16 £000
CCGs and NHS England	219,112	183,454	184,329
Local authorities	2,298	-	-
Non-NHS: private patients	1,350	1,484	1,484
Non-NHS: overseas patients (chargeable to patient)	145	105	105
NHS injury scheme (was RTA)	311	409	409
Total income from activities	**223,216**	**185,452**	**186,327**
Of which:			
Related to continuing operations	223,216	185,452	186,327

The prior period adjustment on income relates to deferred income from West Suffolk CCG for the maternity care pathway.

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2016/17	2015/16
	£000	£000
Income recognised this year	145	105
Cash payments received in-year	98	64
Amounts added to provision for impairment of receivables	47	-
Amounts written off in-year	-	1

Note 4 Other operating income

	2016/17	2015/16
	£000	£000
Research and development	662	588
Education and training	6,566	6,016
Receipt of capital grants and donations	399	-
Charitable and other contributions to expenditure	823	661
Non-patient care services to other bodies	10,146	9,811
Sustainability and Transformation Fund income *	7,125	-
Income in respect of staff costs where accounted on gross basis	959	1,035
Other income	4,585	5,814
Total other operating income	**31,265**	**23,925**
Of which:		
Related to continuing operations	31,265	23,925

	2016/17	2015/16
Included in Other Income	**£000**	**£000**
Car Parking	1,385	1,345
Estates	784	2,224
Pharmacy	348	56
Accommodation	461	468
Catering	1,501	1,418
Other	106	303
Total	**4,585**	**5,814**

* Sustainability and Transformation Fund Income is received following approval by NHS England, NHS Improvement, Department of Health and HM Treasury on delivery of quarterly milestones for agreed financial control totals, access to treatment standards and transformation.

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:

		Restated	Original
	2016/17	2015/16	2015/16
	£000	£000	£000
Income from services designated (or grandfathered) as commissioner requested services	223,216	185,452	186,327
Income from services not designated as commissioner requested services	31,265	23,925	23,925
Total	**254,481**	**209,377**	**210,252**

Note 4.2 Profits and losses on disposal of property, plant and equipment

The Trust disposed of two assets in Sudbury during 2016/17; Walnuttree and St. Leonard's. The services that were previously provided from these sites are now delivered from the Sudbury Healthcare Centre which is leased from NHS Property Services.

	2016/17
	£000
Total Disposal Proceeds	2,100
Net Book Value of Assets Disposed of	(1,647)
	453

Note 5 Operating expenses

	2016/17	2015/16
	£000	£000
Services from CCGs and NHS England	960	-
Services from other NHS bodies	137	-
Purchase of healthcare from non NHS bodies	1,253	406
Employee expenses - executive directors	657	810
Remuneration of non-executive directors	108	99
Employee expenses - staff	141,559	129,170
Supplies and services - clinical	60,661	44,289
Supplies and services - general	3,627	3,323
Establishment	3,559	2,358
Transport	1,232	923
Premises	4,355	4,245
Increase/(decrease) in provision for impairment of receivables	780	(5)
Inventories written down	63	-
Drug costs	19,733	19,567
Rentals under operating leases	4,106	2,135
Depreciation on property, plant and equipment	3,521	2,698
Amortisation on intangible assets	1,580	1,565
Net impairments	4,815	411
Audit fees payable to the external auditor *		
audit services- statutory audit	53	59
other auditor remuneration (external auditor only)	6	-
Clinical negligence	5,817	3,986
Legal fees	181	182
Consultancy costs	2,050	1,022
Internal audit costs (non staff- provided by external supplier)	126	93
Training, courses and conferences	698	504
Hospitality	4	30
Insurance	184	177
Other services, eg external payroll	216	183
Losses, ex gratia & special payments	64	-
Other	27	187
Total	**262,132**	**218,417**
Of which:		
Related to continuing operations	262,132	218,417
Related to discontinued operations	-	-

* Amounts excluding (irrecoverable) VAT as follows:	2016/17 £000	2015/16 £000
audit services- statutory audit	44	49
other auditor remuneration (external auditor only)	5	-

This additional disclosure on audit costs is a requirement of the Government Accounting Manual.

Note 5.1 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £1m (2015/16: £0.5m).

Note 6 Impairment of assets

	2016/17 £000	2015/16 £000
from:		
Changes in market price	-	411
Other	4,815	-
Total net impairments	**4,815**	**411**

An impairment review of the investment in the Pathology Partnetship (tPP) has concluded the investment should be impaired to £0. tPP has not met its recoverable plan and has continued to make a loss in 2016/17. Going forward services for this Trust will be provided by Colchester Hospital University NHS Foundation Trust. The impairment is charged to the Corporate operating segment.

Note 7 Employee benefits

	2016/17 Total £000	2015/16 Total £000
Salaries and wages	**114,805**	106,633
Social security costs	**11,024**	8,323
Employer's contributions to NHS pensions	**13,231**	12,196
Termination benefits	**185**	-
Temporary staff (including agency)	**5,820**	7,522
Total gross staff costs	**145,065**	**134,674**
Recoveries in respect of seconded staff	**-**	(1,217)
Total staff costs	**145,065**	**133,457**
Of which		
Costs capitalised as part of assets	2,849	3,477

Note 7.1 Retirements due to ill-health

During 2016/17 there were 8 early retirements from the Trust agreed on the grounds of ill-health (2 in the year ended 31 March 2016). The estimated additional pension liabilities of these ill-health retirements is £166k (£66k in 2015/16).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

NHS Pension Scheme

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 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 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.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 9 Operating leases

Note 9.1 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 FT is the lessee.

	2016/17	2015/16
	£000	£000
Operating lease expense		
Minimum lease payments	4,106	2,135

	31 March 2017	31 March 2016
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,488	1,467
- later than one year and not later than five years;	2,073	2,677
- later than five years.	87	192
Total	**3,648**	**4,336**
Future minimum sublease payments to be received	-	-

The 2016/17 lease costs in this note includes the properties on licence from NHS Property Services used for the delivery of Community Services. No leases have been signed for these properties so £0 has been included in future commitments. Total expenditure in 2016/17 for occupation of these properties was £2.2 million. The properties have been occupied by the Trust since October 2015 and the total disputed value of that period is £2.3 million.

Note 11.1 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**6,670**	**46,571**	**2,961**	**2,636**	**10,828**	**4**	**4,241**	**135**	**74,046**
Additions	-	4,715	42	9,204	410	-	29	-	**14,400**
Reclassifications	-	1,198	-	(1,198)	(139)	-	139	-	**-**
Revaluations	-	(2,274)	141	-	-	-	-	-	**(2,133)**
Disposals / derecognition	-	(279)	-	-	(600)	-	-	-	**(879)**
Valuation/gross cost at 31 March 2017	**6,670**	**49,931**	**3,144**	**10,642**	**10,499**	**4**	**4,409**	**135**	**85,434**
Accumulated depreciation at 1 April 2016 - brought forward	**-**	**1,878**	**113**	**-**	**6,511**	**4**	**3,559**	**58**	**12,123**
Provided during the year	-	1,669	66	-	1,448	-	317	21	**3,521**
Revaluations	-	(3,520)	(179)	-	-	-	-	-	**(3,699)**
Disposals/ derecognition	-	(26)	-	-	(538)	-	-	-	**(564)**
Accumulated depreciation at 31 March 2017	**-**	**1**	**-**	**-**	**7,421**	**4**	**3,876**	**79**	**11,381**
Net book value at 31 March 2017	**6,670**	**49,930**	**3,144**	**10,642**	**3,078**	**-**	**533**	**56**	**74,053**
Net book value at 1 April 2016	**6,670**	**44,693**	**2,848**	**2,636**	**4,317**	**-**	**682**	**77**	**61,923**

Note 11.2 Property, plant and equipment - 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - as previously stated	**8,070**	**44,508**	**2,961**	**678**	**13,931**	**4**	**4,219**	**135**	**74,506**
Additions	-	2,063	-	1,958	408	-	22	-	**4,451**
Transfers to/ from assets held for sale	(1,400)	-	-	-	-	-	-	-	**(1,400)**
Disposals / derecognition	-	-	-	-	(3,511)	-	-	-	**(3,511)**
Valuation/gross cost at 31 March 2016	**6,670**	**46,571**	**2,961**	**2,636**	**10,828**	**4**	**4,241**	**135**	**74,046**
Accumulated depreciation at 1 April 2015 - as previously stated	**-**	**-**	**-**	**-**	**8,783**	**4**	**3,235**	**37**	**12,059**
Accumulated depreciation at 1 April 2015 - restated	**-**	**-**	**-**	**-**	**8,783**	**4**	**3,235**	**37**	**12,059**
Provided during the year	-	1,467	113	-	773	-	324	21	**2,698**
Impairments	-	411	-	-	-	-	-	-	**411**
Disposals / derecognition	-	-	-	-	(3,045)	-	-	-	**(3,045)**
Accumulated depreciation at 31 March 2016	**-**	**1,878**	**113**	**-**	**6,511**	**4**	**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 Intangible assets - 2016/17

	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**11,912**	**7,526**	**19,438**
Additions	2,576	3,739	**6,315**
Reclassifications	7,526	(7,526)	**-**
Gross cost at 31 March 2017	**22,014**	**3,739**	**25,753**
Amortisation at 1 April 2016 - brought forward	**8,562**	**-**	**8,562**
Provided during the year	1,580	-	**1,580**
Amortisation at 31 March 2017	**10,142**	**-**	**10,142**
Net book value at 31 March 2017	**11,872**	**3,739**	**15,611**
Net book value at 1 April 2016	**3,350**	**7,526**	**10,876**

Note 10.1 Intangible assets - 2015/16

	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2015 - as previously stated	**11,654**	**2,536**	**14,190**
Additions	258	4,990	**5,248**
Valuation/gross cost at 31 March 2016	**11,912**	**7,526**	**19,438**
Amortisation at 1 April 2015 - as previously stated	**6,997**	**-**	**6,997**
Amortisation at 1 April 2015 - restated	**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**

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	20
Development expenditure	5	20
Other	5	20
Intangible assets - purchased		
Software	2	20
Licences & trademarks	2	5

Note 11.3 Property, plant and equipment financing - 2016/17

	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 2017								
Owned	6,670	46,938	3,144	10,642	2,141	416	4	**69,955**
Finance leased	-	-	-	-	-	111	-	**111**
Donated	-	2,992	-	-	937	6	52	**3,987**
NBV total at 31 March 2017	**6,670**	**49,930**	**3,144**	**10,642**	**3,078**	**533**	**56**	**74,053**

Note 11.4 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 11.5 Revaluations of property, plant and equipment

The Trust's independent valuer revalued the Trust's land and buildings as at 31 March 2017.

The properties comprising the West Suffolk NHS Foundation Trust estate were valued in full as at 31 March 2017 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.

Useful Economic lives of property, plant and equipment

The valuer also reviewed the useful economic lives of the Trust buildings.

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives by category of asset are detailed in note 1.4.

Note 12.1 Trade receivables and other receivables

	31 March 2017 £000	31 March 2016 £000
Current		
Trade receivables due from NHS bodies	8,698	5,675
Receivables due from NHS charities	72	-
Other receivables due from related parties	780	-
Provision for impaired receivables	(830)	(50)
Deposits and advances	3,609	-
Prepayments (non-PFI)	1,019	724
Accrued income	958	-
PDC dividend receivable	144	55
VAT receivable	1,377	340
Other receivables	2,518	4,447
Total current trade and other receivables	**18,345**	**11,191**
Non-current		
Other receivables	-	273
Total non-current trade and other receivables	**-**	**273**

Note 12.2 Analysis of financial assets

	31 March 2017	31 March 2016
	Trade and other receivables	Trade and other receivables
Ageing of impaired financial assets	**£000**	**£000**
0 - 30 days	16	-
30-60 Days	683	-
60-90 days	123	-
90- 180 days	42	4
Over 180 days	130	46
Total	**994**	**50**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	464	265
30-60 Days	136	293
60-90 days	168	173
90- 180 days	(152)	217
Over 180 days	470	566
Total	**1,086**	**1,514**

£882k of the non-impaired financial assets past their due date are owed by NHS organisations.

Note 13 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.

	2016/17	2015/16
	£000	£000
At 1 April	**2,601**	**3,253**
Net change in year	(1,249)	(652)
At 31 March	**1,352**	**2,601**
Broken down into:		
Cash at commercial banks and in hand	46	106
Cash with the Government Banking Service	1,306	2,495
Total cash and cash equivalents as in SoFP	**1,352**	**2,601**
Total cash and cash equivalents as in SoCF	**1,352**	**2,601**

Note 14 Trade and other payables

	31 March 2017 £000	31 March 2016 £000
Current		
Receipts in advance	45	-
NHS trade payables	3,537	4,680
Other trade payables	6,169	6,935
Capital payables	1,332	1,256
Social security costs	1,577	1,276
Other taxes payable	1,273	1,240
Other payables	1,786	1,616
Accruals	7,715	4,689
Total current trade and other payables	**23,434**	**21,692**
Non-current		
Other payables	-	912
Total non-current trade and other payables	**-**	**912**

Note 14.1 Other liabilities

	31 March 2017 £000	Restated 31 March 2016 £000	Original 31 March 2016 £000
Current			
Deferred grants income	301	-	-
Deferred goods and services income	1,024	875	-
Other deferred income	-	1,892	1,892
Total other current liabilities	**1,325**	**2,767**	**1,892**

The prior period adjustment on other liabilities relates to deferred income from West Suffolk CCG for maternity care pathway income.

Note 15 Borrowings

	31 March 2017 £000	31 March 2016 £000
Current		
Loans from the Department of Health	507	130
Obligations under finance leases	27	-
Total current borrowings	**534**	**130**
Non-current		
Loans from the Department of Health	44,303	18,205
Obligations under finance leases	72	-
Total non-current borrowings	**44,375**	**18,205**

Note 16 Clinical negligence liabilities

At 31 March 2017, £61,773k was included in provisions of the NHSLA in respect of clinical negligence liabilities of West Suffolk NHS Foundation Trust (31 March 2016: £55,462k).

Note 17 Contractual capital commitments

	31 March 2017 £000	31 March 2016 £000
Property, plant and equipment	4,938	10,210
Intangible assets	9,921	12,083
Total	**14,859**	**22,293**

Note 18 Financial assets

	Loans and receivables £000
Assets as per SoFP as at 31 March 2017	
Trade and other receivables excluding non financial assets	16,635
Cash and cash equivalents at bank and in hand	1,352
Total at 31 March 2017	**17,987**

£8.7 million of the Truust's financial assets relates to income owed from other NHS organisations.

At the end of 2015/16 £5.7 million relate to income owed by other NHS organisations.

Of the remaining balance at 31/3/17, £3.6 million relates to deposits recoverable when community equipment is returned based on the likely proprtion that will be returned.

The remainder of the balance is money owed from non NHS organisations. The collection of this debt is monitored closely and the balance is impaired or written off when collection looks unlikely.

There are no individually material debts owed by non NHS organisations and the risk profile of the asset is assessed as low which is the same as in 2015/16.

	Loans and receivables £000	Available-for-sale £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	**12,720**	**1,688**	**14,408**

Note 18.1 Financial liabilities

	Other financial liabilities £000
Liabilities as per SoFP as at 31 March 2017	
Borrowings excluding finance lease and PFI liabilities	44,810
Obligations under finance leases	99
Trade and other payables excluding non financial liabilities	18,762
Provisions under contract	242
Total at 31 March 2017	**63,913**

Borrowing excluding finance lease is from Department of Health at a fixed rate.

Within trade and other payables excluding non financial liabilities, £8.4 million relates to liabilities with other NHS and governmental organisations. There are no identified risks with the balance of payables which are almost exclusively UK based. This is the same as 2015/16.

	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
Other financial liabilities	-
Provisions under contract	286
Total at 31 March 2016	**36,180**

Note 18.2 Maturity of financial liabilities

	31 March 2017 £000	31 March 2016 £000
In one year or less	19,610	17,845
In more than one year but not more than two years	1,631	-
In more than two years but not more than five years	10,519	-
In more than five years	32,153	18,335
Total	**63,913**	**36,180**

Note 19 Related parties

The Department of Health is regarded as a related party. During the period West Suffolk NHS Foundation Trust has had a number of significant transactions with other entities for which the Department is regarded as the parent Department. These entities are:

	Receivables		Payables	
			Restated	Original
	31 March 2017	31 March 2016	31 March 2017	31 March 2016	31 March 2016
	£000	£000	£000	£000	£000
Norfolk Community Healthcare NHS Trust	70	335	491	12	12
Ipswich Hospital NHS Trust	369	210	1,136	1,331	1,331
NHS West Suffolk CCG	-	884	845	1011	74
NHS Ipswich and East Suffolk CCG	71	766	92	-	-
NHS South Norfolk CCG	362	-	-	1	1
NHS Cambridgeshire and Peterborough CCG	261	-127	237	-	-
Health Education England	60	697	71	2	2
NHS England	4,911	839	-	1,042	1,042
NHS Litigation Authority	-	-	4	-	-
NHS Property Services	15	53	66	1,237	1,237
The Pathology Partnership	495	510	-	593	593
Total	**6,614**	**4,167**	**2,942**	**5,229**	**4,292**

	Income			Expenditure	
		Restated	Original		
	2016/17	2015/16	2015/16	2016/17	2015/16
	£000	£000	£000	£000	£000
Norfolk Community Healthcare NHS Trust	214	150	150	21,128	10,321
Ipswich Hospital NHS Trust	1,196	350	350	12,630	6,197
NHS West Suffolk CCG	110,695	105,406	106,281	299	65
NHS Ipswich And East Suffolk CCG	76,567	46,228	46,228	92	-
NHS South Norfolk CCG	14,544	14,177	14,177	1	-
NHS Cambridgeshire and Peterborough CCG	3,186	2,968	2,968	29	-
Health Education England	5,852	5,295	5,295	32	-
NHS England	20,525	13,827	13,827	1,033	561
NHS Litigation Authority	-	-	-	5,998	4,152
NHS Property Services	84	90	90	2,216	1,217
The Pathology Partnership	1,720	3,025	3,025	3,966	5,412
Total	**234,583**	**191,516**	**192,391**	**47,424**	**27,925**

The Trust has also received revenue and capital payments from the My Wish Charity. The Trust Board members are also the Trustees of My Wish charity. A total of £137k was received from the charitable fund during the year.

The Trust has disclosed transactions with NHS bodies where the income, expenditure, receivable or payable balance is over £2 million.

Note 20 Non Adjusting Post Balance Sheet Event

The Trust's pathology services have been provided by the Pathology Partnership (tPP) since May 2014. This has been in partnership with:

West Suffolk Hospital NHS Foundation Trust
Ipswich Hospital NHS Trust
Colchester Hospital University NHS Foundation Trust
East & North Hertfordshire NHS Foundation Trust
Cambridge University Hospitals NHS Foundation Trust
Hinchingbrooke Health Care Trust

This Trust was assessed as being 12.5% of this structure.

From 1 May 2017 the structure of that delivery has changed and pathology services for this Trust are now provided in a smaller partnership arrangement with:

West Suffolk Hospital NHS Foundation Trust
Ipswich Hospital NHS Trust
Colchester Hospital University NHS Foundation Trust

This Trust is assessed as being 24.77% of this new structure although it is still part of a wider tPP arrangement involving all the former partner organisations.

In 2017/18 the accounting arrangements for this service delivery will be carefully considered in view of the change from May 2017. Specifically the need for accounting for the arrangement as an Associate under IAS 28 will be considered.