NHS
West Suffolk
NHS Foundation Trust

Annual report and accounts

2017/18

Putting you first

West Suffolk NHS Foundation Trust

Annual Report and Accounts 2017-18

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

1.1.1 A message from the chair and chief executive

We are delighted to introduce the annual report for the West Suffolk NHS Foundation Trust (WSFT) for the 2017/18 year.

Like the rest of the NHS, we have faced a challenging year. Demand has continued to increase, as it does year on year, and to greater levels than predicted; we saw a 6% increase in emergency department attendances alone compared to the previous year. That's nearly 3,800 more patients in a single year. That has, inevitably, impacted on our performance in some areas like the national four-hour emergency department standard and our referral to treatment times.

But, what has made us exceptionally proud is that despite the huge pressures placed on our staff and our system to care for more people than ever before, we have managed to not only maintain but improve on the quality of care we're giving to patients in many areas of our work.

Delivering compassionate and quality care

That commitment to quality was acknowledged in our latest Care Quality Commission (CQC) inspection, where we were rated as outstanding - only the seventh (and smallest) general and acute hospital to receive this accolade. Inspectors said: *'On all the wards we visited, staff displayed a culture of compassion and positivity, and had a genuine desire to want to provide the best possible care to patients.'* This is an amazing achievement.

We have exceeded all of our standards for patients being likely to recommend us as a place to receive care. Looking at patient experience feedback and what it tells us is a true indicator of the quality of care we're providing to people, so this is fantastic to see and an absolute credit to our staff. We also came top of the national tables for comparable trusts for staff recommending the Trust as a place to work or receive care in the NHS Staff Survey 2017.

The present and the future

The year has also seen us form one of two new alliances across the county, which are designed to make health and social care services simpler for people. Our alliance in the west has seen us welcome community health services into the Trust, and we are working closely with Norfolk and Suffolk NHS Foundation Trust (NSFT), Suffolk County Council and the Suffolk GP Federation to try and deliver a fully integrated health and social care system for Suffolk patients. This is a hugely exciting time; the aim will be to provide more coordinated, holistic and preventative care that empowers people to play a central role in managing their own health and wellbeing.

We have continued on our journey as a Global Digital Exemplar trust; we are now two years into the e-Care (our electronic patient care record system) journey and it is easy to forget just how much we have implemented over this time. We are seen as one of the leading digital trusts in the UK and receive visits from trusts across the country (and indeed the world) to learn from us. We have also launched our new vital signs monitors, which measure blood pressure, temperature, oxygen saturation and pulse and all other required parameters to enable immediate calculation of Early Warning Scores (EWS). By scanning a barcode on the patient's wrist, these readings are placed directly into e-Care so that staff no longer have to manually input them – as well as saving time, it helps to improve patient safety by reducing human-error risks. We've also launched our 'patient

portal', with 400 patients actively using it. The portal provides patients with access to key components of their health record from home, allowing them to view things like blood test results and upcoming appointments, and ultimately enables them to take greater responsibility for their own health. These are just a few examples – we know there is much more to come.

We've also had some outstanding clinical achievements. Earlier in the year, the National Hip Fracture Database (NHFD) rated us as being in the top three hospitals in England, Wales and Northern Ireland for meeting best practice criteria for patients treated for a hip fracture. We achieved 94.3% against the best practice criteria in 2017, against an average of 57.1%. Our stroke services regularly achieve high ratings in the Sentinel Stroke National Audit Programme (SSNAP) scores, and we consistently achieve high early detection of cancer, and our performance for all cancer targets is ahead of the national threshold. Our infection prevention and control is good, with C. Diff infections and MRSA cases remaining within our target thresholds. We have put in place, with our clinical directors and new consultant in public health, an exemplar learning from deaths framework.

The challenge

Finances continue to be a hot-topic of discussion not just at WSFT but across the NHS. It is no small achievement that we met our financial control total for the year, which in turn meant we received some additional funding from the national sustainability and transformation fund (STF). Our year end position was deficit of £0.3m, against a planned deficit of £5.9m. We know we will continue to be asked to do more with less across the coming years, and this will remain one our biggest challenges moving forward.

It has been a busy 12-months, and no one here at WSFT is under any illusion that the coming 12-months will be any less so. But we know that we, with our incredible, hard-working, dedicated staff, will continue to do everything we can to deliver high-quality patient care – 24/7, 365 days a year.

Sheila Childerhouse
Chair
25 May 2018

Dr Stephen Dunn
Chief executive
25 May 2018

1.1.2 About our Trust – a summary

The 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.

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

In October 2017, West Suffolk Clinical Commissioning Group and Ipswich and East Suffolk Clinical Commissioning Group awarded the community services contract to WSFT and the Ipswich Hospital NHS Trust based on a geographical split across Suffolk. These community services:

- deliver community-based services to people of all ages across the west of 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 west Suffolk, with the exception of certain services which are delivered across Suffolk
- 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 500 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 is 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, and 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 contributed to our 'outstanding' CQC rating
- **Build a joined up future** - we need to reduce non-elective demand and 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 our patients' 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 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, their families and carers.

Working with partners will be important in achieving these ambitions across a diverse population with differing needs. 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, not just treating it.

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

Whilst we have always acknowledged that our staff are our most important asset, in response to 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 supports the delivery of safe and effective care.

Our sites and services

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. WSFT operates a streaming service embedded and co-located within the emergency department. Patients who attend the emergency department during the operating hours of the streaming service are assessed and directed to either the emergency department or the primary care unit, meaning they access the service that best addresses their healthcare need.

A range of nursing and therapy services are provided by our community health teams and specialist community teams; these services are provided in patients' own homes, health clinics/centres and community buildings, including a clinical assessment and prescribing service for a county wide community wheelchair service, working with community therapists and a community neurological nurse specialist. We have taken on responsibility for Newmarket Hospital, a community hospital in Suffolk with approximately 20 beds. These in-patient beds provide rehabilitation care to patients referred by GPs, or who are transferred from an acute hospital as a step-down facility prior to discharge. The community hospital also has a radiology service and outpatient clinics which receive

visiting clinicians from WSH. In addition, some of our community teams use Newmarket Hospital as a base.

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

We provide a number of outreach services to our population across a number of sites in Newmarket, Botesdale, Thetford, Stowmarket, Haverhill, Sudbury, Needham Market and Watton. This includes outpatient clinics and some diagnostic imaging – Newmarket Hospital (x-ray), Sudbury Community Health Centre (x-ray) and Thetford Healthy Living Centre (ultrasound). Linked to our early intervention team (EIT), we also have in place a service to provide personal care to patients in their home. Delivered by a reablement support worker this forms part of a wider service working on admission prevention.

The community midwifery teams operate out of administrative bases in: Blackbourn midwifery team Stanton Health Centre; Castle Hill midwifery team, Thetford Healthy Living Centre; Forest Heath midwifery team, Mildenhall Health Clinic and Newmarket Hospital; Gainsborough midwifery team, Sudbury Community Health Centre; Haverhill midwifery team, Haverhill Health Centre; Lark midwifery team, Forbes Business Centre, Bury St Edmunds.

WSFT is also responsible for, via a contract with the East and West Suffolk clinical commissioning groups, the provision of adult community healthcare teams, adult speech & language therapy (SALT), and community paediatric services as well as specialist nurses and therapists in Parkinson's, neurology, epilepsy, cardiac rehabilitation, chronic obstructive pulmonary disease (COPD) service, heart failure and pulmonary rehabilitation services.

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

Our staff

We are one of the largest employers in Suffolk, employing 3,814 staff as of March 2018.

We firmly believe in the benefits of working in partnership with staff and trade unions.
Further detail is included in section 2.7 (staff report), including work we are doing regarding the employment of the disabled.

Our partners

The Trust works closely with other public, private and voluntary stakeholders. These include West Suffolk Clinical Commissioning Group, Suffolk County Council and Cambridge University as well as other local NHS providers, clinical commissioning groups (CCGs), Suffolk GP Federation and Care UK.

In Suffolk and north east Essex, the NHS, general practice and local government came together in 2016 to develop a five-year sustainability and transformation partnmership (STP). The STP is a unified approach and subsequent plan to improve the health and care of our local people and bring the system back into a financially sustainable position. In early 2017 a more formalised STP Partnership Board was formed. Our partnership includes all NHS organisations within the footprint including the ambulance service, local government, other health sector bodies, local hospices and community and voluntary sector organisations. Leadership for the STP is drawn from across these stakeholders.

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. If the Trust no longer existed health services funded by DH would still be provided. 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 £62.8 million from DH at 31 March 2018 (£44.8 million at 31 March 2017) for capital investment, working capital and revenue support. In addition, the Trust has borrowed £2.4 million from a commercial loan provider for capital investment. These figures exclude borrowing associated with finance leases. The planned deficit for 2018/19 is £13.8 million, which whilst a significant concern, 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.

1.2 Performance analysis

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

The Trust's annual business planning cycle is informed by the performance management framework to ensure future objectives address area of risk or uncertainty. Similarly the strategic and operational plans for the Trust inform the performance management framework to ensure that the Board is sighted on indicators that are relevant to future plans. An example of this during 2017-18 has been the focus of the Board in accessing more in-depth information on the quality and performance of community services.

1.2.1 Performance management framework

The Trust has a board assurance framework (BAF) in place that sets out the principal risks to the delivery of the Trust's strategic 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 as follows:

Performance monitoring:

- Monthly quality and performance reports and performance dashboard. These include the Trust's priorities for improvement in the quality report; analysis of patient experience, incidents and complaints; review of serious incidents; and ward-level quality performance
- Monthly financial performance reports
- Monthly quality and performance reports by directorates to executives
- Quarterly quality and performance reports to the council of governors
- Quarterly reports to the Board setting out quality improvement and learning from deaths
- Quarterly reports to the Board from the freedom to speak up guardian and guardian of safe working
- Risk assessments and analysis of the risk register and BAF

Governance framework:

- 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

- self-assessment against delivery of the Care Quality Commission (CQC) registration requirements
- assurances provided through the work of internal and external audit, the CQC, NHS Improvement, NHS Resolution, patient-led assessments of the care environment (PLACE), and accountability to the Council of Governors

Engagement and measurement:

- Weekly quality walkabouts, including executive directors, non-executive directors and governors
- External regulatory and assessment body inspections and reviews, including Royal Colleges, post-graduate Dean reports, accreditation inspections and Health and Safety Executive (HSE) reports
- Benchmarking for clinical indicators
- The work of clinical audit, which within its scope includes national audits, audits arising from national guidance such as National Institute for Health and Care Excellence (NICE), confidential enquiries and other risk and patient safety-related topics.

1.2.2 Principal activities and achievements

Care Quality Commission (CQC) registration

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

Our biggest achievement this year was being awarded an 'Outstanding' rating by the Care Quality Commission (CQC), one of just seven general hospitals in the country at the time to hold this title. Following the November 2017 inspection, the Trust was rated outstanding for being caring, effective and well-led, and good for being safe and responsive. Inspectors said staff: 'truly respected and valued patients and individuals and empowered them as partners in their care, practically and emotionally, by offering an exceptional and distinctive service.' Further detail can be found in the quality report (section 3).

Our services

We provide a range of patient services:

Indicators	2017/18	2016/17	2015/16	2014/15	2013/14
Inpatient planned	3,730	3,917	4,291	4,290	4,275
Inpatient non-planned	32,505	33,174	31,383	30,173	28,517
Day cases	30,824	30,105	29,392	28,210	25,889
Outpatient attendances (inc. ward attenders)	249,460	239,413	239,675	228,384	216,597
Outpatient procedures	82,880	87,474	106,032	161,317	102,989
Emergency department attendances	70,918	67,176	64,979	62,106	59,485

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

In the six months since WSFT was awarded the contract, our community teams in the west of Suffolk have had more than twenty three thousand new referrals, a hundred thousand face-to-face patient contacts and sixteen thousand telephone contacts as well as delivering 7,978 pieces of equipment.

Further detail of our performance regarding quality and local or national targets is provided in the quality report (section 3). The annual governance statement (section 2.6) describes arrangements for quality governance within WSFT.

Our financial performance

We recorded a deficit of £0.3m for the year 2017/18 which is £5.6m better than our planned control total of £5.9m. The deficit was reduced by the receipt of sustainability and transformation funding (STF).

	2017/18 £000	2016/17 * £000	2015/16 £000	2014/15 £000	2013/14 £000
Operating income	**252,778**	254,933	209,588	172,589	172,714
Operating costs	**(245,906)**	(251,016)	(213,994)	(171,998)	(169,793)
EBITDA** surplus	**6,872**	3,917	(4,406)	591	2,921
Depreciation, dividend and other costs	**(7,159)**	(6,961)	(5,861)	(7,075)	(6,531)
Fixed asset impairments***	**0**	(4,815)	(410)	1,062	(30)
Retained earnings	**(287)**	(7,859)	(10,677)	(5,422)	(3,640)

* The 2016/17 financial performance has been restated due to a prior period adjustment on implicit finance leases

** 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 - On 1 October 2015 WSFT began providing community services in Suffolk which increased income and expenditure by around £63m in a full year. From 1 October 2017 Ipswich Hospital NHS Trust began providing community services in the east of Suffolk, which decreased income and expenditure at WSFT by around £18m.

1.2.3 Principal risks and uncertainties

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

Board assurance framework (BAF)

The BAF was regularly reviewed during 2017/18 to ensure that it provided an adequate evidence base to support the effective and focused management of the principal risks to meeting strategic objectives. The BAF illustrates the escalation processes to the board 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 are reviewed by the Board of directors. The Board reviews the potential impacts of these risks and considers the robustness of the existing controls and future plans to mitigate these. Assurance of the effectiveness of these controls and plans is also reviewed. A summary of the BAF is provided within the annual governance statement (section 2.5).

Incident reporting

During 2017/18 the number of patient safety incidents reported showed a general increase. Community services joining the Trust in October 2017 influenced this increase. The Board reviews this data on a monthly basis and recognises a higher 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.

The Trust 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

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

Performance and quality improvement 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 reviews from divisions and wards, with action-planning at these levels. Delivery of improvement at an operational level is managed through directorate executive quality and performance meetings but is also tested through observational visits by Board members and governors as part of weekly quality walkabouts. A programme of internal peer assessment also supports continuous quality improvement against 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. The Trust 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 (NHSR CNST).

Mandatory service risk

The Trust's board of directors was satisfied that:

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

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

Risk of any other non-compliance with licence

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

Contractors and suppliers

We are 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 us to keep up with developing markets, benchmark products and services, and build close relationships with suppliers. During the year we, along with three other procurement partners, were successful in bidding for the contract to deliver three of the Department of Health's Category Towers. This new organisation is equally owned by the four partner organisations.

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

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

Additional disclosures required by the financial reporting manual (FReM)

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

- Chief executive's responsibilities certificate (section 2.5)
- 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 2.7 (remuneration report).

Audit committee's review of the annual report and accounts

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

An award-winning hospital

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

Awards and accolades

Our biggest achievement this year was being awarded an 'outstanding' rating by the Care Quality Commission (CQC), one of just seven general hospitals in the country at the time to be rated at this level.

What the Care Quality Commission said about us

Following the November 2017 inspection, the Trust was rated outstanding for being caring, effective and well-led, and good for being safe and responsive.

Inspectors said staff: 'truly respected and valued patients and individuals and empowered them as partners in their care, practically and emotionally, by offering an exceptional and distinctive service.'

Despite a challenging year, CQC inspectors said staff had risen to the occasion. Referring to conversations had with patients and their families, they said: 'Feedback from people who used the services, those who are close to them, and stakeholders, was continually positive about the way staff treated people. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.'

The report also praised the Trust for its excellent cancer recognition and treatment times, and for having an excellent staff talent programme tailored to supporting leaders across all levels of the organisation – not just those traditionally seen as being senior figures.

Of the organisation's leadership team, the CQC noted that the Trust had 'compassionate, inclusive and effective leadership at all levels', and that staff felt they were well supported to make positive changes and innovations

They also said: 'On all the wards we visited, staff displayed a culture of compassion and positivity, and had a genuine desire to want to provide the best possible care to patients.'

Our additional accolades

We have also seen a number of accolades across the year of which we're very proud, from all areas of the Trust.

We have added to our already extensive collection of awards, receiving: Baby Friendly and Family Carer Friendly Hospital Awards; a Hypo Awareness Week Excellence Award; a Quality in Care (QiC) Diabetes Award; Lifetime Achievement and Apprentice of the Year awards at the Bury Free Press Business Awards (for Jan Bloomfield, director of workforce and communications, and Abigail Johnson, clinic administrator respectively); Best Doctor Award for Dr Lucy Grove, community consultant paediatrician, at the prestigious national 2017 WellChild Awards; and chief executive Dr Stephen Dunn was named as number eight in the Health Service Journal's annual assessment of the top 50 NHS trust chief executives.

In addition, we were shortlisted for Anaesthesia Team of the Year in the British Medical Journal (BMJ) awards, and the Staff Engagement Award at the prestigious Health Service Journal national awards.

We've also retained our success in the national NHS Staff Survey, coming top of the national tables for staff recommending us as a place to work or receive care. Our Trust scored the highest rating in the country (4.12) against other acute hospital trusts in England (average score 3.76) for staff being likely to recommend it to others.

We're also very proud of the clinical achievements we've seen. In March 2017 the National Hip Fracture Database (NHFD) rated the Trust as being in the top three hospitals in England, Wales and Northern Ireland for meeting best practice criteria for patients treated for a hip fracture – achieving 94.3% against a national average of 57.1%. We've also had some of the best early detection of cancer rates in the country for the last three years, and we're among the top 10 in the country for hip, knee and joint replacement outcomes.

We remain incredibly grateful to each and every member of staff who has helped us reach these incredible achievements.

Social, community, anti-bribery and human rights issues

The West Suffolk NHS Foundation Trust, 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.

The Trust 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.

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

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

In September 2017, the chief operating officer, as accountable emergency officer reported to NHS England and the CCG that the Trust had 'substantial compliance with core standards'; the Trust had a number of core standards in the process of a substantial innovative and dynamic review and upgrade**.** WSFT has an identified lead non-executive director for EPRR.

Compliance level	Evaluation and testing conclusion
Full	Arrangements are in place the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not fully address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

The substantial compliance level indicated that the Trust had a number of core standards to which improvement work was required. Whilst this statement was a change from the 'full compliance' reported in the previous year, improvement work has been undertaken and EPRR capability assessment in March 2018 reported 'full compliance'. This improvement was achieved six months ahead of plan.

1.2.4 Future business plans

Sustainability and transformation partnership (STP)

The Suffolk and north east Essex STP plan has three main elements: self-care and independence; community based care; and hospital care. The vision is that people across east and west Suffolk and north east Essex live healthier, happier lives by having greater control and responsibility for their health and wellbeing. We have agreed the following outcomes for our system:

- Improved health and care outcomes for patients
- A focus on individual needs and empowering and supporting self-care
- Clinically owned and led models of care that are developed in partnership with service users
- Services that are built around localities with seamless organisational boundaries.

The long-term goal and key focus within our STP is the design and mobilisation of an integrated care system (ICS), which will operate at STP level and provide a strategic commissioning function for the whole STP footprint. Within this ICS three alliances are being developed - one each for east Suffolk, west Suffolk and north east Essex.

Since October 2017 WSFT has been providing both acute and community services under an alliance arrangement with partners operating under a memorandum of understanding (MOU). The alliance brings together the acute hospital, community health services, social care, mental health and Suffolk GP Federation 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.

The strategy for the alliance builds on the Connect programme of work, which is a place-based model of care, bringing together statutory and non-statutory organisations, grouped into six geographical localities, arranged around natural communities, building resilience and strengthening the local service offer wherever possible. Each locality has a neighbourhood team consisting of health and social care teams who work together to provide a person centred, holistic care offer.

Each locality is part of a wider neighbourhood network, which includes specialist health and care services, plus community groups, borough councils, housing and the voluntary and community sector (VCS).

The alliance is setting a strategy and implementation plan that sets out its priorities, timelines for change and ambition for the west Suffolk system. This is being co-developed by all key partners and will reflect the feedback previously given by patients, the public and people who use our services.

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

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

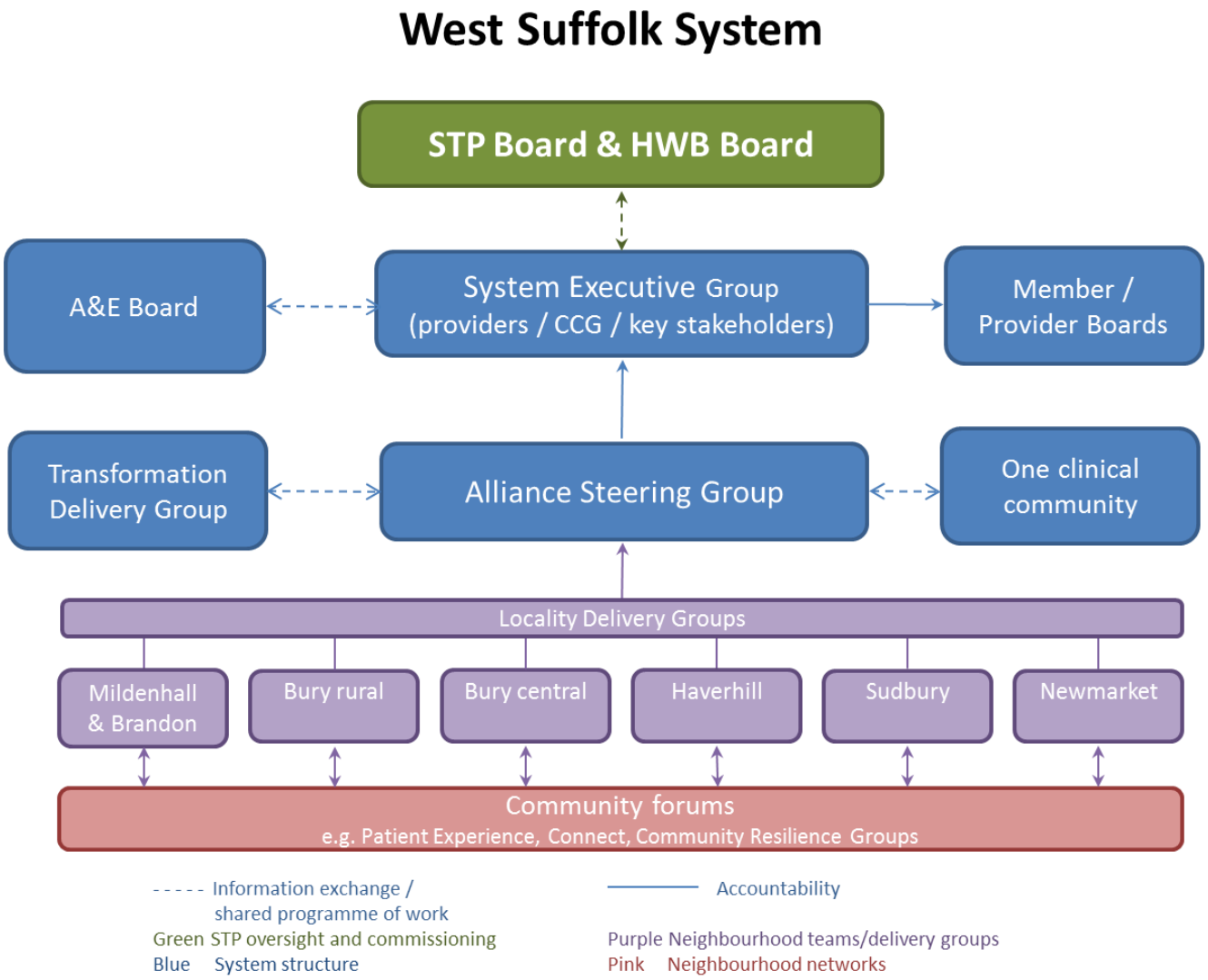
- Oversee and ensure integration across the health and care system
- Oversee and ensure the successful evolution from alliance to fully functioning ICS
- Support move to local commissioning.

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

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

Figure 1 sets out the agreed working arrangements and governance structure for the west Suffolk system.

Figure 1: West Suffolk alliance operational/decision making framework



Delivering the vision

During 2018 we will strengthen and embed the alliance, taking the opportunity to align contracts within the alliance wherever possible. We anticipate operating the alliance in shadow form from the end of 2018, to then become a fully formed integrated provider alliance by the end of 2019.

The Trust has adapted its governance in preparation for these changes by creating governor roles for primary care partners. Our ambition is to build our care model, together with partners, around communities, maximising opportunities for integration at every step.
We will move from a health and care system that is reactive and fragmented, towards one that is pro-active, holistic and preventative, in which people are empowered to play a central role in managing their care. Our transformation plans aim to bring health and care services together to support the provision of one co-ordinated care response that is underpinned by prevention, self-care, early intervention and re-ablement rather than long term treatment and lifelong service dependency.

Our alliance strategy has four main objectives, which are central to the wider public sector reform agenda in Suffolk:

- People manage their own health and social care with the right support when needed
- Our communities are easy and supportive places to live with a health or care need
- Higher cost interventions are replaced with lower cost interventions
- Our health and care providers are led by one clinical community.

Our service model

The key operational components of our service model are set out below:

- Neighbourhood networks: These networks include local people, groups, organisations, service users, voluntary and community sector (VCS) and statutory services which people use to improve or maintain their vision of a good life. Health and care services will have a key role in the provision of preventative services to people.

- Integrated neighbourhood teams (INTs): The INTs' role is to ensure health and care interventions are planned, proactive, and reduce the need for crisis and urgent intervention. The INTs will include a core range of generalist services from community health, adult social care, primary care and mental health all brought together as one co-located team within each locality.

- Urgent care: For people who require an urgent care response largely by secondary care the INTs will co-ordinate care to ensure that people are treated promptly by the most appropriate service, and then discharged and returned swiftly back to their own home from West Suffolk Hospital.

- Specialist interventions: Some services such as interface geriatricians, specialist admission avoidance services, neurology services, community and acute hospitals and specialist dementia advice will be organised on a wider geography.

- Pro-active and preventative care: A key focus is to ensure that we take every opportunity to encourage people to be well and keep active, to take responsibility for managing their own health, and empower self-management of any health need.

- Community resilience: This describes the development programme led in public health to support communities to support themselves. This takes on aspects of self-care, enabling people to be as independent as possible (including recovery from a health condition) by using the assets available to them personally and in their local community. This also encompasses the broader resilience of communities to provide social, cultural and leisure activities for their people; such activities are relevant to the wider determinants of health and wellbeing and can relate to, for example, social isolation, physical and mental stimulation and local access to services.

The Connect programme

The Connect programme describes the range of efforts across the statutory, voluntary and community sector to develop a coordinated approach in defined geographic localities (the Connect areas), to improving and maintaining the health and wellbeing of individuals and communities.

The Connect programme is well established, with progress made in many areas resulting in greater joint working between statutory, voluntary and community services. We have seen greater cooperation and working with primary health care, join up through integrated neighbourhood team meetings, and greater linkage with the voluntary and community sector through, amongst other things, social prescribing.

The localities for the west of Suffolk have been agreed as: Newmarket, Haverhill, Sudbury, Brandon/Mildenhall, Bury town and Bury rural. These groupings can be thought of as a 'hub and spoke' with the system leadership as (the 'hub') and the six locality areas (the 'spokes').

Each locality has within it a defined grouping of GP practices; an integrated neighbourhood team (INT) and is built on and around a neighbourhood network including borough councils, housing, police and community groups. The neighbourhood and locality model needs to be cognisant of the borders

and boundaries that surround these localities, particular from areas where the flow of patients into our services can be significant e.g. Stowmarket and Thetford.

The west Suffolk system has also made a commitment to testing the Buurtzorg model. This model hails from the Netherlands and is a holistic community nursing model that wraps all health and personal care needs around the patient through one team who are responsible for all of the patients' needs.

The Buurtzorg model test will help to inform our design for integration between health and care practitioners and identify opportunities for further enhancing the integrated neighbourhood team model. It is envisaged the test will have a positive impact on self- care and for some patients reduce long term need.

We have pooled our transformation resources from acute, community and CCG settings to create one transformation/re-design team that has combined responsibility for all the programmes of work across organisational boundaries and interfaces. In recognition of the scale of our programme, and to ensure maximum participation of staff we have allocated schemes and projects to particular Connect localities as shown below.

Our transformation workstreams:

- System flow (transfers of care)
- Integrated therapies
- Pathways / specialist services:
    - Learning difficulties
    - Dementia
    - Falls
    - Speech and language
    - Heart failure
    - Respiratory
- Community beds
- Connect enablers:
    - Organisational development
    - Trusted assessment
    - Clinical information advisory group
- Neighbourhood nursing and care team test & learn

During 2017-18 we engaged KPMG as part of the national **financial improvement programme** (FIP2). As a result of the work undertaken with KPMG we have identified eight cross-cutting workstreams that have been set up and are progressing into delivery. All of these schemes have a senior responsible officer (SRO) who is ultimately accountable for delivery.

- Flow (length of stay) - a programme of work with six clinically-led workstreams with the aim to reduce inpatient length of stay and improve patient flow through implementation of multiple initiatives; in support of delivering emergency department (ED) and inpatient services safely
- Operating theatres - the key objective is to increase productivity within operating theatres, measured primarily by increasing the number of cases per theatre list
- Medical productivity – a number of areas have been reviewed focusing on job planning for consultants. The aim is to reduce the variation of clinical admin PA allocation between consultants for selected specialities
- Grip and control (annual leave) - the Trust has a policy in place to allow annual leave to be within a 12-16% threshold of the workforce on any given day. This threshold allows for all staff members to take their leave and at the same time ensure services are staffed and delivered in line with plans. If this threshold is not followed pressures in staffing services can occur which have a direct impact on patient experience, staff morale and financial stability
- Bay-based nursing - the proposed model alters staffing ratios and arranges nurses according to the layout of wards. Non-registered nurses are assigned to a single bay, and are

responsible for the patients within that bay for the entirety of their shift. If they have to leave their bay for any reason, a registered nurse will cover that bay for the time that the assigned nurse is away

- Clinical nurse specialists - the aim is to have this specialist group provide at least 80% of time on clinical, patient-related activities. The 80% is a benchmark set by the Trust and is in line with other NHS trusts which have embarked on this initiative. This will contribute to an additional 709 hours of clinical time per week to be dedicated to patient-oriented activities.
- Outpatients - the outpatients' steering group is leading on a range of initiatives that will realise cost savings through increased efficiency, leading to greater productivity in outpatients' services. The initiatives include a greater focus on data, optimising capacity, reviewing the booking process (underpinned by technology) and reviewing the access policy. Clinic slot utilisation and clinic templates are the biggest areas for efficiency savings. With a more strategic view, the group is also considering starting the discussion on partial booking, but this can only take place once the electronic rota system is filly embedded.
- Administrative and clerical - a review of staff groups based on pay bands and whole time equivalent took place in May 2017. From this review it was identified that the Trust has a higher number of staff in administrative and clerical roles, especially at a band 4 level, when compared to peers. This review is being taken forward through a centrally-led project which is looking at how technology could be used to influence the clinical administration of the hospital, and free up more time for staff. In addition to this work, a review of admin and clerical roles will take place in the Trust across clinical and corporate areas.

We have recruited to the programme management office (PMO) to support integrated care and planned care programmes as well as CIP planning and delivery as a result of the FIP2 work with KPMG.

The **integrated care programme** is a proactive programme to avoid unnecessary admissions to hospital and a reactive programme to maximise patient flow and avoid delays. Initiatives include:

- Red to Green/SAFER – ensures timely patient review and escalation of action to support patient flow
- #EndPJParalysis – raises awareness of the importance of getting our patients up, dressed and moving to reduce the risk of deconditioning
- GP/Primary care streaming – ensuring appropriate review of patients presenting at our ED
- Stranded patients review – assess reasons for delay for inpatients that have been in hospital for seven days or more
- Discharge to optimise and assess (D2OA) – this is a joint venture provided in partnership with Suffolk County Council, and is essentially a care bridging service to prevent delays in a patient's discharge if there is a delayed start date for their out-of-hospital package of care
- Trusted assessor – our discharge planning team is working closely with care homes to implement the trusted assessor model which will negate the need for care homes to come in and assess patients
- Red bag scheme - the bag contains important medical information, medication and personal items packed by care home staff, and transferred to the hospital via ambulance colleagues. The red bag keeps all of a patient's important information in one place, with the aim of speeding up the handover time between ambulance and hospital and providing a smoother and less stressful experience for the patient.

The **planned care programme** focuses on ensuring patients are treated in the most appropriate care setting and reducing variations in care pathways across the health system to avoid resource wastage. The focus for development includes:

- 100 day challenge - this national programme is designed for primary and secondary care to jointly test ways of improving patient experience and speeding up access to elective care. It focuses on three areas - rethinking referrals, shared decision making and transforming outpatients.

- Right care programme – 'RightCare' is about the whole health system taking an evidence based approach to focus on key areas that will improve health outcomes for the population, reduce unwarranted variation in care and save money. The benchmark data packs have been received and reviewed by three specialties - respiratory, neurology and cardiovascular diseases (CVD) to identify opportunity for improvement
- Diabetes prevention programme - this NHS programme is a joint initiative led by NHS England, Public Health England and Diabetes UK and aims to deliver services which identify people with non-diabetic hyperglycemia who are at risk of developing type 2 diabetes
- Treatment and care funding – diabetes management - this NHS England led programme aims to help improve the outcomes of patients with diabetes in two key areas:
    - increased attendance on education courses to improve understanding and self-management in individuals with diabetes
    - Improve achievement levels for the three core diabetes treatment targets, namely blood glucose control (HbA1c), blood pressure and cholesterol levels
- Integrated pain management service (IPMS) - in west Suffolk pain management is currently provided by two providers - Suffolk GP Federation and West Suffolk Hospital. We are working with Suffolk GP Federation to merge these services into an IPMS. The IPMS will remove duplication and streamline existing pathways to seamlessly provide a range of education, therapeutic and medical services for patients suffering from acute and persistent pain
- Ophthalmology - a change to the delivery of eye care services is in progress to enable a sustainable and affordable clinical model for the growing elderly population of Suffolk. It aims to integrate eye services for the patient through a strategic partnership model of care, where the consultants can direct where work should appropriately be undertaken and the clinical skill level required in the community
- Stroke - a baseline review has been undertaken and a wider review is starting across the sustainability and transformation partnership (STP) footprint. The aim is to enhance what we already have, and to future-proof stroke services rather than embark on any major reconfiguration
- Demand management - this work programme is aiming to pull together and support the delivery of a range of schemes to support demand management e.g. improving advice and guidance between clinicians in different care settings and changing the way outpatient consultations are delivered
- Patient choice – we will relaunch the revamped patient choice policy with relevant communication and training to all staff in patient engagement and adherence with the policy.

Despite the efficiency savings and additional capacity opened during winter 2017-18 we saw unprecedented increases in ED attendances, with emergency admissions up more than 6% compared to the same period in 2016-17. This significant increase in activity impacted on delivery of the ED performance standard due to physical capacity constraints of the estate (both in ED and inpatient areas), and availability of medical and nursing staff. As part of the Trust's surge capacity response we have had to repurpose our protected elective ward to accommodate emergency demand. This has impacted on delivery of RTT recovery plans due to cancellation of the majority of our routine elective activity through January and February 2018.

Capacity plans for winter 2018-19 include:

- completion of phase one of the acute admission unit (AAU) build by December 2018
- use of the cardiology inpatient area to provide inpatient escalation capacity (this area will become available in November 2018 when the new cardiology suite is commissioned)
- ongoing UK and overseas recruitment programme to provide additional nurse staffing for the additional capacity
- review of ED demand by hour and day of the week to establish the medical staffing requirements to support ongoing increased levels of activity
- continue to work with system partners on schemes for admission avoidance and to reduce discharge delays. This includes strengthening our community focus with integrated neighbourhood teams – a test and learn pilot for Buurtzorg is currently underway along with

greater integration of specialist acute and community teams e.g. therapies, COPD and paediatrics.

The Trust 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. Although the project was due to commence in December 2016 delays in receipt of the funding mean that the project did not start until April 2017. The project has a two year duration and will conclude in December 2018 although the delivery of some components will continue to March 2019. The project is being delivered in four pillars: the first is focused on the development of e-Care electronic patient record (EPR) solution, the second on the development of services across the wider health community; the third covers the Trust role nationally as part of the NHS GDE programme and the final pillar is to deliver new digital infrastructure as a key enabler.

The Trust's vision for a digital future has not changed as it continues to be a primary enabler for the organisation's transformation goals, priorities and ambitions. The integration of community health services into the Trust in October 2017 is now driving a realignment of information management and technology initiatives with the outcomes designed to drive transformation, benefit realisation and a fully integrated patient journey. This realignment is tightly coupled to the Trust's organisational strategy, and 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 its whole health and social care economy. The aims of the programme are three-fold and represent a five-year vision:

- A transformation-led digital 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 acute kidney injury (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. Many of these including digital care pathways, early warnings, device integration and improved use of medication management, some of which are already in place either in part of in full.

- Supporting the goals of the integrated care system (ICS) - The programme aims to fully support the goals of the emerging west Suffolk ICS. A digitally mature Trust is essential for achieving the goals of the wider care community, although the Trust acknowledges digital maturity in community health services requires the same high level of both digital and service integration being delivered by the GDE programme. A key enabler is the continued deployment of e-Care combined with wider system integration, such as the population health package being initiated in 2018 that 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 that is essential to delivering effective risk stratification

- Promoting our exemplar digital community – Working with our electronic patient record partners we will establish ourselves as a model digital community within three 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, defined as 'blueprinting' with the GDE Programme. We will achieve this goal through strengthening existing partnerships such as with digitally advanced suppliers, 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 April 2016 to March 2019 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
- Ensuring 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 commitment 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 medical staff and nurses. During 2017/18 we have used the agencies on the CPP Framework preferred supplier list for nursing staff developed in conjunction with the East of England Procurement Hub. This initiative has helped us to bring down the cost of agency nurses to the NHS Improvement (NHSI) capped rates.

We have also established a preferred supplier list for agencies supplying medical staff, however, this staff group is a more scarce resource than nursing staff and presents a greater challenge to achieve the same success rates.

In 2017/18 the Trust successfully recruited staff into IT and PMO posts that historically had been filled with agency staff and this initiative will be continued into 2018/19.

The drive for 2018/19 that is being encouraged by NHSI is for trusts to consider establishing collaborative bank systems by working with neighbouring trusts to pool bank resources. It was recommended that this initiative would be facilitated by the local procurement hubs, although it should be led by the trusts themselves. This work will start during 2018/19.

Capital planning

The Trust has a five-year risk assessed capital strategy which focuses on addressing backlog issues and essential clinical developments in the acute and community sectors. 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 a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

In order to fulfil our responsibilities for the role we play, we have the following 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."***

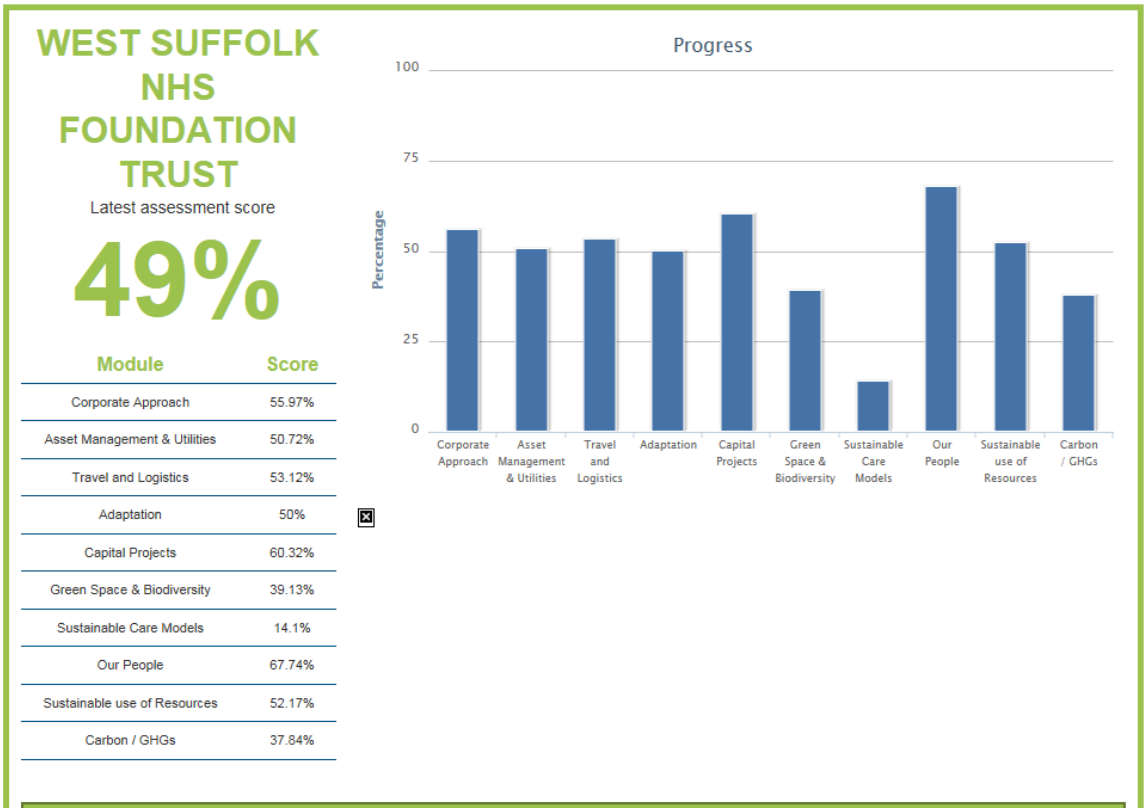
As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline), equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions, relative to activity, by 34% by 2020/21 using 2007/08 as the baseline year.

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

the Trust to contribute to the delivery of Government sustainable development aims, policy, strategy and targets.

One of the ways in which an organisation can embed sustainability is through the use of an sustainable development management plan (SDMP). The Board reviewed our SDMP in the last 12 months so our plans for a sustainable future are well known 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 sustainable development assessment tool (SDAT). The last time we used the SDAT was in December 2017, scoring 49%. As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.



Module	Score
Corporate Approach	55.97%
Asset Management & Utilities	50.72%
Travel and Logistics	53.12%
Adaptation	50%
Capital Projects	60.32%
Green Space & Biodiversity	39.13%
Sustainable Care Models	14.1%
Our People	67.74%
Sustainable use of Resources	52.17%
Carbon / GHGs	37.84%

Our organisation is contributing to the following sustainable development goals (SDGs).

Adaptation

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples in recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our board approved plans address the potential need to adapt the delivery of the organisation's activities and infrastructure to climate change and adverse weather events. Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change.

The Trust is very aware of its responsibilities to ensure all planning includes measures to address climate-induced hazards. The Trust's emergency plans for severe weather include such awareness, and the overarching command and control capability has a programme of training and exercising to reinforce this.

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

- West Suffolk Clinical Commissioning Group
- Bury Local Links (Active Travel)
- Suffolk Growth Programme Board (Small and Medium Enterprises Project).
- East of England Procurement Hub

Examples of partnership working include:

- Patients in west Suffolk are benefitting from a glaucoma service provided by WSFT in partnership with West Suffolk Clinical Commissioning Group and Newmedica.

  Set up two years ago, patients have a simple puff test to see if they're at risk of developing glaucoma when they visit the opticians, and are then referred to the community glaucoma service, run in partnership with Newmedica, for additional tests if they are required.

  The Newmedica team works closely with hospital consultants to review around 100 to 120 patient test results every week in a 'virtual glaucoma clinic' allowing for faster diagnosis and treatment. Consultants are now free to spend more time with patients who require direct face-to-face consultant review.

  New referrals can be tested out in the community; this is saving around 80% of patients' time, with only around 20% of these new patients needing to meet a consultant in hospital.

  Dr Christopher Browning, chair of the West Suffolk Clinical Commissioning Group, said: "This community glaucoma service is certainly benefiting patients, who are receiving good care as well as having the peace of mind that their eyes are being checked in a clinical setting. This is another example of how delivering more services in the community can deliver positive results for patients and give hospital consultants more time to deal with the most serious cases."

- To link in with a key performance indicator (KPI) of procuring 30% of goods and services from small and medium enterprises (SMEs), the purchasing department is working with the Suffolk Growth Programme Board (GPB) which is undertaking work to map current public sector procurement processes and practices.

  The Suffolk GPB wishes to further develop its knowledge base of what is procured locally; where and why local procurement is successful; and identifying case studies where possible to improve the roll-out of successful initiatives.

- Bury local links is a Suffolk County Council initiative which helps organisations of all sizes promote sustainable transport in the work place by providing practical advice and resources to help businesses implement sustainable travel solutions. In July 2017 a joint cycle to work event was held which culminated in the opening of a new cycle path link to the hospital. In November 2017 The Trust was presented with a Silver Award recognising progress on the Travel Action Plan and promotions and events that have been held.

Energy

Resource		2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	21,137,142	20,414,927	22,915,910	25,043,563
	tCO_2e	4,435	4,272	4,789	5,310
Oil	Use (kWh)	2,713,205	2,751,124	2,823,162	1,101,600

	tCO_2e	868	879	895	360
Electricity	Use (kWh)	5,701,356	4,032,393	3,699,138	2,417,143
	tCO_2e	3,531	2,318	1,912	1,077
Total Energy CO_2e		8,834	7,469	7,596	6,747
Total Energy Spend		£1,371,195	£1,097,061	£1,073,831	£924,333.38

Note Quince House (Sterile Services and office block at WSH) included in energy data from August 2017 - gas consumption 1,122,000 kWh and electricity consumption 344,000kWh. Oil used is for April to October 2017 for WSH site.

	2014/15	2015/16	2016/17	2017/18
Fossil energy **input** to the CHP system (kWh)	13,424,039	17,269,775	16,998,484	15,942,272
Electrical energy **output** of CHP system (kWh)	4,484,830	5,804,997	5,656,174	5,262,992
Thermal energy **output** of CHP system (kWh)	3,770,000	6,178,000	6,448,000	2,700,000*

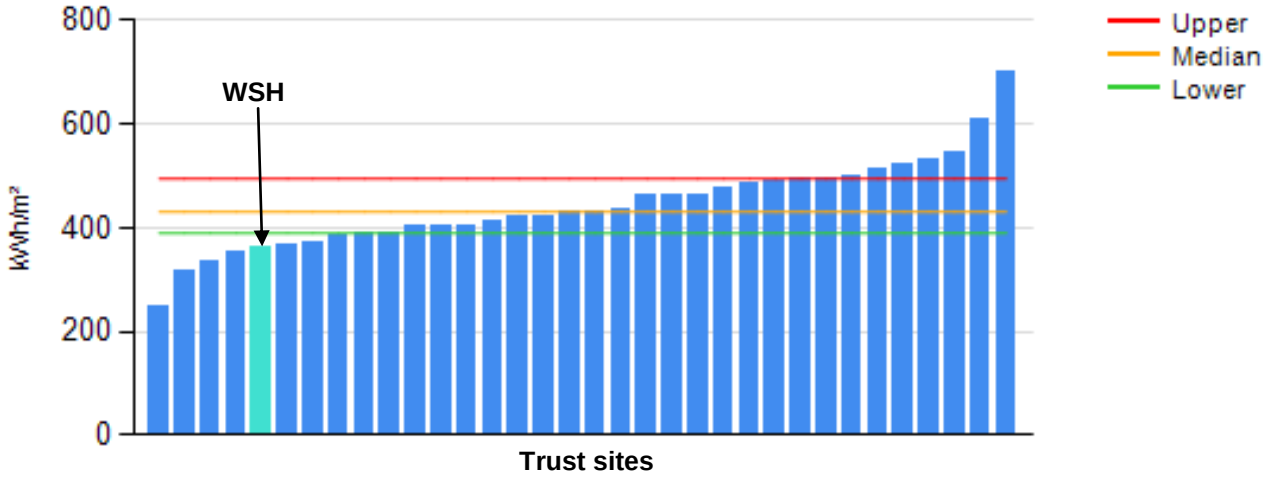
Source of data 2014- 2016 - ERIC returns to the Health and Social Care Information Centre.
*Note the CHP heat meter failed in August 2017 leading to a lower than expected reading.

Actions that helped maintain the level of carbon emissions, even with the increase in activity were:

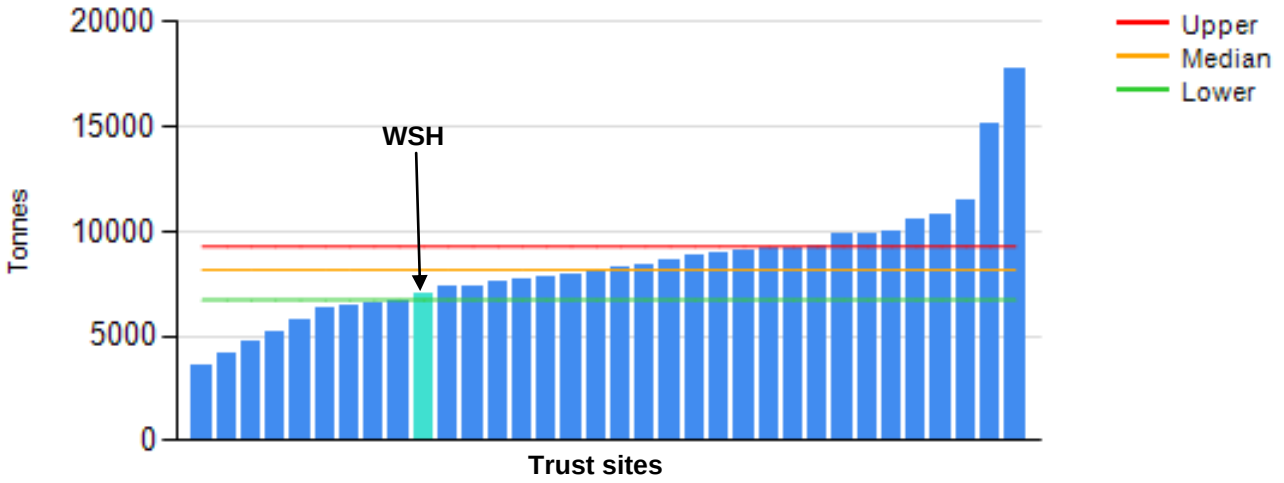
- Continuation of operation of the site's Combined Heat & Power (CHP) unit 24/7
- Improved energy efficient engineering plant currently being installed under the Trust backlog programme
- Continued use of PC Power Saver system which turns off PC safely overnight if left on
- Increase in recycling schemes.

The CRC cost for 2017/18 is approx. £9,500 less than in 2016/17 despite an increase in the carbon cost (£/tC02) from £17.20 to £17.50 per tCO2, this is due to the efficient running of the CHP.

ERIC 2016-17 - Site energy consumed per occupied floor area (Trust wide – acute small)



ERIC 2016-17 – CO_2 emissions (Trust wide – acute small)



Paper

The movement to a paperless NHS can be supported by staff reducing the use of paper at all levels, this reduces the environmental impact of paper, reducing cost of paper to the NHS and can help improve data security.

Paper		2014/15	2015/16	2016/17	2017/18
Volume used	Tonnes	52	55	48	45
Carbon emissions	tCO_2e	48	52	46	43

The introduction of e-Care, together with the installation of new Canon photocopiers across the Trust which delete any documents not printed within the same working day have led to a continued reduction in A4 paper use.

Travel

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

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

Re-use

The re-use of goods and community equipment in the NHS has several key co-benefits. As well as reducing cost to the NHS, it also reduces emissions from procuring and delivering new goods and can provide social value if items are re-used in the community.

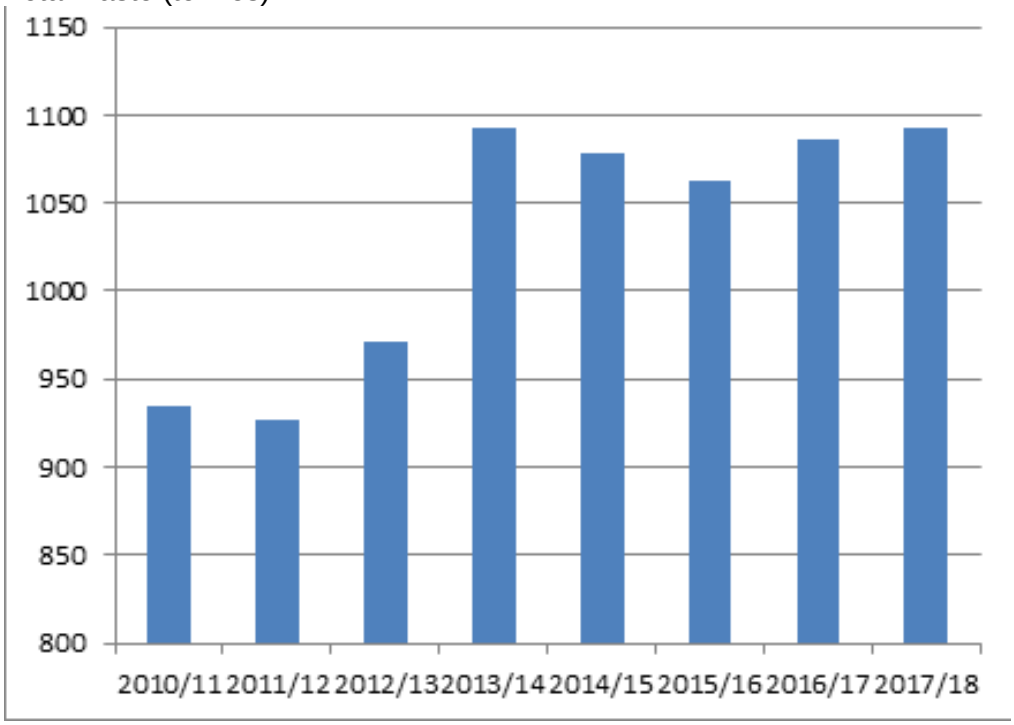
A link to the 'Warp It' reuse portal was launched in November 2016; this allows colleagues to advertise surplus furniture and stationery for reuse with in the Trust. The Warp It group has grown to 200 members and in addition to avoided re-procurement costs of £20,799 in 2017/18, have avoided 2,165kg of waste and saved 8450kg CO2e emissions.

Waste

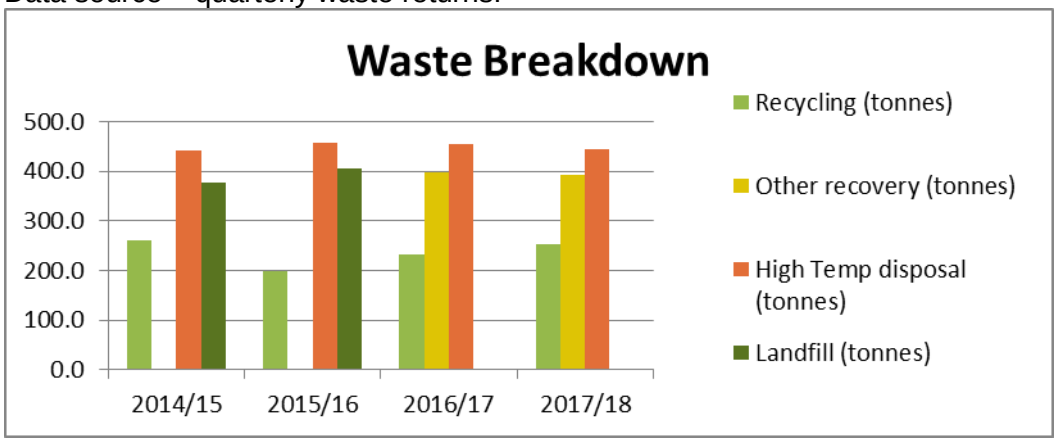
Total Waste (clincial and non clinical)

Waste		2014/15	2015/16	2016/17	2017/18
Recycling	(tonnes)	261.43	198.67	231.96	254.14
	tCO_2e	5.49	3.97	4.87	5.53
Other recovery	(tonnes)	0.00	0.00	398.76	393.94
	tCO_2e	0.00	0.00	8.37	8.57
High Temp disposal	(tonnes)	441.12	457.35	455.06	444.10
	tCO_2e	97.05	100.16	100.11	97.70
Landfill	(tonnes)	376.16	406.46	0.00	0.00
	tCO_2e	91.94	99.35	0.00	0.00
Total Waste (tonnes)		**1078.71**	**1062.48**	**1085.78**	1092.18
% Recycled or Re-used		24%	19%	21%	23%
Total Waste tCO_2e		**194.48**	**203.48**	**113.36**	111.80

Total waste (tonnes)



Data source – quarterly waste returns.



A plastic bottle recycling trial ran in the Time Out Restuarant and Courtyard Café from January 2017 to March 2018. Approximately five tonnes of plastic bottles were recycled as part of the trial.
The Trust has a target of recycling 30% of its total waste. In 2016/17 21% of waste was recycled.

Finite resource use – Water

Water		2014/15	2015/16	2016/17	2017/18
Mains Water	m^3	63,952	69,442	71,300	95,780*
	tCO_2e	58	63	65	87
Water & Sewage Spend	£	£156,010	£145,115	£148,800	£192,239*

Source of data 2014 – 2016 - ERIC returns to the Information Centre.
***Note** There is a billing issue with the water supplier and 2017/18 data may be subject to change.

Other initiatives.

Reusable water bottles have been made available to all staff, with hydration stations set up on all wards. This will ensure that staff are able to remain hydrated throughout their shifts and should also impact on the number of single use plastic water bottles used.

The 22 March 2018 marked NHS Sustainability Day and there was a stand focusing on waste and recycling in the staff restaurant. Eight-eight colleagues came to find out more about the Trust's approach to recycling and reuse.

On 16 March 2018 groups of staff volunteered to take part in the Great British Spring Clean by undertaking a litter pick at the WSH. The hospital grounds look neat and tidy, thanks to our hardworking estates team, but there was still a job to be done. Litter was sorted into recyclable and non-recyclable sacks, which were collected by the council from the hospital site.

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

Peter Alder[2]
Mary Allan
Florence Bevan[2]
June Carpenter (lead governor)
Ian Collyer[3]
Justine Corney
David Frape[1]
Jayne Gilbert
Gordon McKay[2]
Barry Moult
Jayne Neal[2]
Charles Nevitt[4]
Adrian Osborne[2]
Jan Osborne[1]
Joe Pajak
Margaret Rutter
Jane Skinner[2]
Mick Smith[1]
Liz Steele[1]
Stuart Woodhead[1]

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

Jane Chilvers[1]
Peta Cook[2]
Nick Finch[1]
Peter Harris[1]
Javed Imam[2]
Amanda Keighley[2]
Jenny McLaughlin[1]
Lindsay Pike[1]
Garry Sharp[2]
Martin Wood[2]

[1] Governor until elections November 2017
[2] New Governor elected November 2017
[3] Resigned from Council of Governors July 2017
[4] Resigned from Council of Governors October 2017

Partner governors – nominated by partner organisations of WSFT

Judy Cory	Friends of West Suffolk Hospital
Dr Mark Gurnell	University of Cambridge
Dr Andrew Hassan[5]	West Suffolk Clinical Commissioning Group
Laraine Moody	West Suffolk College also representing University Campus Suffolk
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

[5] Joined council of governors in February 2018

Governor attendance at council of governors meetings 2017/18

There were six formal meetings of the Council of Governors: 11 May 2017, 10 August 2017, 12 September 2017 (Annual Members Meeting), 10 October 2017, 16 November 2017, 21 February 2018, with the following Governor attendance:

Name	Title	Attendance (out of six meetings)
Peter Alder[2]	Public governor	1 (of 1)
Mary Allan	Public governor	5
Florence Bevan[2]	Staff governor	1 (of 1)
June Carpenter (lead governor)	Public governor	6
Jane Chilvers[1]	Staff governor	3 (of 5)
Ian Collyer[3]	Public governor	0 (of 1)
Peta Cook[2]	Staff governor	1 (of 1)
Justine Corney	Public governor	5
Judy Cory	Partner governor	4
Nick Finch[1]	Staff governor	2 (of 5)
David Frape[1]	Public governor	3 (of 5)
Jayne Gilbert	Public governor	5
Mark Gurnell	Partner governor	3
Peter Harris[1]	Staff governor	1 (of 5)
Andrew Hassan[5]	Partner governor	1 (of 1)
Rebecca Hopfensperger	Partner governor	0 (of 5)
Javed Imam[2]	Staff governor	0 (of 1)
Amanda Keighley[2]	Staff governor	1 (of 1)
Jenny McLaughlin[1]	Staff governor	0 (of 5)
Gordon McKay[2]	Public governor	1 (of 1)
Sara Mildmay-White	Partner governor	5
Laraine Moody	Partner governor	3
Barry Moult	Public governor	4
Jayne Neal[2]	Public governor	1 (of 1)
Charles Nevitt[4]	Public governor	2 (of 3)
Adrian Osborne[2]	Public governor	1 (of 1)
Jan Osborne[1]	Public governor	3 (of 5)
Joe Pajak	Public governor	5
Lindsay Pike[1]	Staff governor	1 (of 5)

Name	Title	Attendance (out of six meetings)
Margaret Rutter	Public governor	3
Garry Sharp[2]	Staff governor	1 (of 1)
Jane Skinner[2]	Public governor	1 (of 1)
Mick Smith[1]	Public governor	2 (of 5)
Liz Steele[1]	Public governor	6
Martin Wood[2]	Staff governor	1 (of 1)
Stuart Woodhead[1]	Public governor	4 (of 5)

[1] Governor until elections November 2017
[2] New Governor elected November 2017
[3] Resigned from Council of Governors July 2017
[4] Resigned from Council of Governors October 2017

In attendance at these meetings were: [a]Roger Quince, chair (4); [b]Sheila Childerhouse, chair (1) Dr Richard Davies, non-executive director (5); [c]Helen Beck, interim chief operating officer (2); Craig Black, executive director of resources (1); Dr Stephen Dunn, chief executive (2); Angus Eaton, board advisor (1); [d]Neville Hounsome, non-executive director (4); Dr Nick Jenkins, executive medical director (2); Gary Norgate, non-executive director (4); Rowan Procter, executive chief nurse (3); Alan Rose, non-executive director (4).

[a] Roger Quince left the Trust in December 2017
[b] Sheila Childerhouse was appointed as chair in January 2018
[c] Helen Beck was appointed as interim chief operating officer in May 2017
[d] Neville Hounsome left the Trust in December 2017

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 chair.

Joint council of governors and board workshops took place in May 2017 and March 2018. Both of these focussed on the Sustainability & Transformation Partnership (STP) and in March 2018 the operational plan was also presented and discussed.

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 this 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 chair and also 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 is 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 workshops – Sustainability & Transformation Partnership (STP) and operational plan (18 May 2017 and 27 March 2018)
- Governor training day with external trainer – introduction to the role of the council of governors and NHS quality and NHS finance, role of the Board in light of the well-led framework and role of the governors in member and public engagement (3 February 2018)
- Two finance training sessions were delivered in April 2018
- Governor visits to the sterile service department have taken place and visits to the pharmacy and other areas of the hospital are being planned.

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 2018 there were 6,045 public members and 4,271 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. 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 member recruitment initiatives. As well as recruiting new members this has provides valuable feedback from patients and the public on their experiences and views of WSFT.

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

Criteria	**Current** March 2018	**Target** (Mar 2019)
1. Achievement of the recruitment target: a. Total number of Public members b. Staff opting out of membership	 **6045** **<1%**	 6000 <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)	 **1165** **40%**	 1250 100%
3. An engaged membership measured by: a. number of member events held April 2017 - March 2019 b. member attendance – total all events c. annual members' meeting attendance (each year)	 **3** **437*** **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 437 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 to update members on news at the Trust, and 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 chair, except when considering the appointment, remuneration and terms and conditions of the Trust chair, when it is chaired by the lead governor.

In June 2017 the nominations committee agreed that the position for a NED which would become available on 1 January 2018 should be offered to the current board advisor. This recommendation was approved at a closed session of the council of governors in August 2017.

At this meeting 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. They also reviewed the remuneration of the NEDs and agreed a process for future years.

The process for the recruitment of a new chair, whose position became vacant as from 1 January 2018, was undertaken from March 2017. A number of governors took part in this recruitment process and five members of the nominations committee were on the final interview panel. A successful appointment was made based on the panel's recommendation and approval at a closed session of the council of governors in October 2017.

In November 2017 the committee reviewed the feedback from mid-term appraisals for the two NEDs who had been appointed as from 1 April 2017.

Attendance at nominations committee meetings 2017/18

Name	Title	Attendance (out of three)
Roger Quince (chair)	Chair	3
June Carpenter	Public governor (lead governor from August 2015)	2
Justine Corney	Public governor	3
Nick Finch	Staff governor	1
Sara Mildmay-White	Partner governor	3
Barry Moult	Public governor	2
Stuart Woodhead	Public governor	2

Meeting dates: 22 June 2017; 10 August 2017; 16 November 2017

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 chair *(term of office ended on 31 December 2017)* (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 of charitable funds committee; member of scrutiny committee, remuneration committee and chair of the governors' nominations, appointments and remuneration committee. Roger is chair 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)
Mrs Sheila Childerhouse – NED and chair (Appointed: from 1 January 2018 until 31 December 2020) **Areas of special interest/responsibility**: chair of quality and risk committee; member of charitable funds committee, scrutiny committee, remuneration committee and chair of the governors' nominations, appointments and remuneration committee. Sheila is chair of the board of directors and council of governors of WSFT and also chair of the STP chairs group. Until recently Sheila was chair of Anglian Community Enterprise (ACE) and a non-executive director of East of England Ambulance Service NHS Trust. Previously she was chair of NHS Norfolk and Waveney and chair of Queen Elizabeth Hospital, Kings Lynn. She is a trustee of the East Anglia's children's hospice (EACH) and works as an executive coach. Independent director – yes (satisfies criteria of code of governance B. 1.1)
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; and lead NED for learning from deaths, end of life, children's services and EPRR. 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 Angus Eaton - NED
(Appointed: 1 January 2018 until 31 December 2020)

Areas of special interest/responsibility: chair of remuneration committee; lead for corporate risk committee; and lead NED for health and wellbeing programme.

Angus is a solicitor with wide executive and board experience. Currently, he is the UK Strategy and Transformation Director at Aviva and a board director of Aviva's Turkish Life Joint Venture. Previous experience includes: MD Aviva's UK Commercial General Insurance business; Chief Risk Officer, Aviva's UK and Ireland general insurance business; Aviva Group Regulatory and Operational risk director and Group Legal Director

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

Mr Neville Hounsome – NED *(term of office ended on 31 December 2017)*
(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 and senior independent director
(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; member of remuneration committee, audit committee and chair of charitable funds committee. As an IT professional sits on the steering committee overseeing the development of the new electronic patient record system; and lead NED for whistleblowing and procurement.

With a doctorate in corporate governance Gary has a special interest in board effectiveness and the management of change. He also has a special interest in ensuring WSFT maintains and fully exploits its status as a global digital exemplar, harnessing the power of digitisation to drive sustainable improvements in both patient and commercial outcomes.

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 Alan Rose – NED
(Appointed 1 April 2017 until 31 March 2020)

Areas of special interest/responsibility: member of audit committee, scrutiny committee, quality & risk committee, remuneration committee, patient experience committee, clinical safety and effectiveness committee; and lead NED for safeguarding adults, security, RTT and patient experience and public engagement.

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

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 28 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)

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

(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 a trustee of Brightstars, a registered charity that supports 5-19 year old children and young people with additional needs, a director of Helpforce Community and Honorary Commander of RAF Lakenheath.

Mr Craig Black – executive director of resources / deputy chief executive

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

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.

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. He is a CQC Executive Reviewer.

Mr Jon Green – chief operating officer *(until 1 May 2017)*

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.

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 infection prevention and control (DIPC). Rowan is also CQC lead for the Trust.

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 Helen Beck – interim chief operating officer *(from 1 May 2017)* **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. Helen joined the Trust in September 2014 as deputy chief operating officer, having previously held positions at Cambridge University Teaching Hospital as senior operational manager and theatre manager. Helen has 33 years' experience in the NHS and is a registered general nurse with a diploma in theatre nursing.
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, 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 chair and non-executive directors

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

The nomination, appointments and remuneration committee of the council of governors makes a recommendation for appointment for a non-executive director to the council of governors. This committee comprises the chair of WSFT, 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 changed.

Following this second term, and subject to satisfactory appraisal, a non-executive director can be considered by the council of governors for a further term of office subject to annual renewal. Vacant non-executive directors' positions will be subject to an openly-contested process with appointment by the council of governors.

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

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

2.2.5 Evaluation of the board of directors' performance

Attendance at board of directors meetings 2017/18

Name	Title	Attendance (out of 10)
Roger Quince[(a)]	Chair	6 (of 7)
Sheila Childerhouse[(b)]	Chair	3 (of 3)
Helen Beck[(c)]	Interim chief operating officer	10
Craig Black	Executive director of resources	10
Jan Bloomfield	Executive director workforce and communications	10
Richard Davies	Non-executive director	9
Stephen Dunn	Chief executive	10
Angus Eaton[(d)]	Board Advisor / Non-Executive Director	9
Jon Green[(e)]	Chief operating officer	0 (of 1)
Neville Hounsome[(f)]	Non-executive director	7 (of 7)
Nick Jenkins	Executive medical director	10
Gary Norgate	Non-executive director	10
Rowan Procter	Executive chief nurse	9
Alan Rose	Non-executive director	10
Steven Turpie	Non-executive director	9

[(a)] Roger Quince left the Trust on 31 December 2017
[(b)] Sheila Childerhouse was appointed as Chair from 1 January 2018
[(c)] Helen Beck was appointed as interim chief operating officer from 1 May 2017
[(d)] Angus Eaton was appointed as a non-executive director from 1 January 2018 (board advisor from 1 April 2017)
[(e)] Jon Green left the Trust on 1 May 2017
[(f)] Neville Hounsome left the Trust on 31 December 2017

Meeting dates
28 April 2017, 26 May 2017, 30 June 2017, 28 July 2017, 29 September 2017, 3 November 2017, 1 December 2017, 26 January 2018, 2 March 2018, 29 March 2018

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

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

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

2.2.6 Audit committee

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

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

External audit
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 NHSI, independent regulator of foundation trusts.

The responsibility of the Trust's external auditors is to independently audit the financial statements and the part of the remuneration report to be audited in accordance with relevant legal and regulatory requirements and International Standards on Auditing (UK and Ireland). 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 2017/18 financial year was £59,000 (2016/17; £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 2017/18.

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 6)
Roger Quince[(a)]	Chair	4 (of 4)
Sheila Childerhouse[(b)]	Chair	2 (of 2)
Richard Davies	Non-executive director	5
Angus Eaton[(d)]	Non-executive director	4
Neville Hounsome[(f)]	Non-executive director	4 (of 4)
Gary Norgate	Non-executive director	6
Alan Rose	Non-executive director	6
Steven Turpie	Non-executive director **(chair)**	6

[(a)] Roger Quince left the Trust on 31 December 2017
[(b)] Sheila Childerhouse was appointed as Chair from 1 January 2018
[(d)] Angus Eaton was appointed as a non-executive director from 1 January 2018 (board advisor from 1 April 2017)
[(f)] Neville Hounsome left the Trust on 31 December 2017

Meeting dates: 28 April 2017, 26 May 2017, 28 July 2017, 3 November 2017, 26 January 2018, 2 March 2018

2.2.7 Well-led framework

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

Details of improvements that we have made in patient safety are given elsewhere in this report 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 it undertakes; this includes a review of relevant assurances within the board assurance framework. During 2017/18 the Board used the 'well-led' framework published by NHSI and CQC as the basis of this review. Based on the internal work undertaken and the CQC's well-led rating of WSFT as Outstanding, the Board and NHSI have agreed that external evaluation of the board and governance of the Trust will take place in 2019-20.

2.2.8 Details of consultation

WSFT did not consult with members of staff or the public regarding the site master plan during 2017/18.

The Trust engaged with members of the public, patients and staff members in relation to plans to develop the main concourse entrance of the hospital. Face-to-face feedback collection was undertaken as well as production of an online survey, which was made available in the public domain, including to staff.

Foundation Trust governors also conducted feedback sessions in the Courtyard Café to obtain feedback about this area.

Patients, members of the public and family carers were also engaged in feedback collection relating to changes in parking charges, specifically weekly charges and those to family carers. A focus group took place and feedback survey was made available in the public domain.

During 2017/18 the patient experience agenda has continued to grow within the Trust with a well-established patient and carer experience group. 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.

Positive foundations have also been laid to form our first central patient representative group, VOICE, made up of family representatives, members of the public and patients. To obtain expressions of interest to join this special group, we contacted our network of volunteers and foundation trust members, and also spoke to patients and visitors.

WSFT has participated in a number of engagement activities over the year, including:

- Experience of care week - conducted workshops across community and hospital settings; collecting feedback from patients, relatives and members of the public on their experiences
- PALS pop-up shop - stands promoting what PALS do and how they can support patients, relatives, members of the public and staff
- #hellomynameisday

As part of the #hellomynameisday, the organisation arranged for Chris Pointon, husband of the late Dr Kate Grainger and co-founder of the national Hello my name is campaign, to spend the afternoon at the organisation. Feedback was collected asking our patients whether staff introduced themselves and Chris took part in speaking with some of our patients about the special work Kate undertook throughout her life. Chris also spoke about the importance of the campaign at the leadership five o'clock club.

Engagement work also took place with our patients around the new e-Care patient portal, allowing people access to parts of their medical records. Patients were involved in the design of the portal including contributing decisions about when results should be released.

2.2.9 Other disclosures

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.

Political donations
WSFT did not make any political donations during 2017/18.

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 paid £177.61 interest under the Late Payment of Commercial Debts (Interest) Act 1998 in 2017/18 (2016/17 £0).

	2017/18		2016/17	
	Number	**£000**	**Number**	**£000**
Total non-NHS trade invoices paid in the year	56,779	128,590	58,347	134,516
Total non-NHS trade invoices paid within target	21,168	69,998	26,089	76,160
Non-NHS trade invoices paid within target (%)	**37%**	**54%**	**45%**	**57%**
Total NHS trade invoices paid in the year	2,087	73,198	1,732	73,058
Total NHS trade invoices paid within target	435	61,004	619	59,902
NHS trade invoices paid within target (%)	**21%**	**83%**	**36%**	**82%**

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

Dr Stephen Dunn
Chief executive
25 May 2018

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 risk 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 18 April 2018. 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.

		2017/18 scores			2016/17 scores		
Area	**Metric**	**Q4**	**Q3**	**Q2**	**Q1**	**Q4**	**Q3**
Financial sustainability	Capital service capacity	2	4	4	4	3	4
	Liquidity	2	3	3	4	3	4
Financial efficiency	I&E margin	2	4	4	4	4	4
Financial controls	Distance from financial plan	1	1	1	1	1	4
	Agency spend	1	1	1	1	2	2
Overall scoring		**2**	**3**	**3**	**3**	**3**	**3**

2.5 Statement of accounting officer's responsibilities

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

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS 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 and Social Care 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 and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance 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
25 May 2018

2.6 Annual governance statement

West Suffolk NHS Foundation Trust annual governance statement – 1 April 2017 to 31 March 2018

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 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

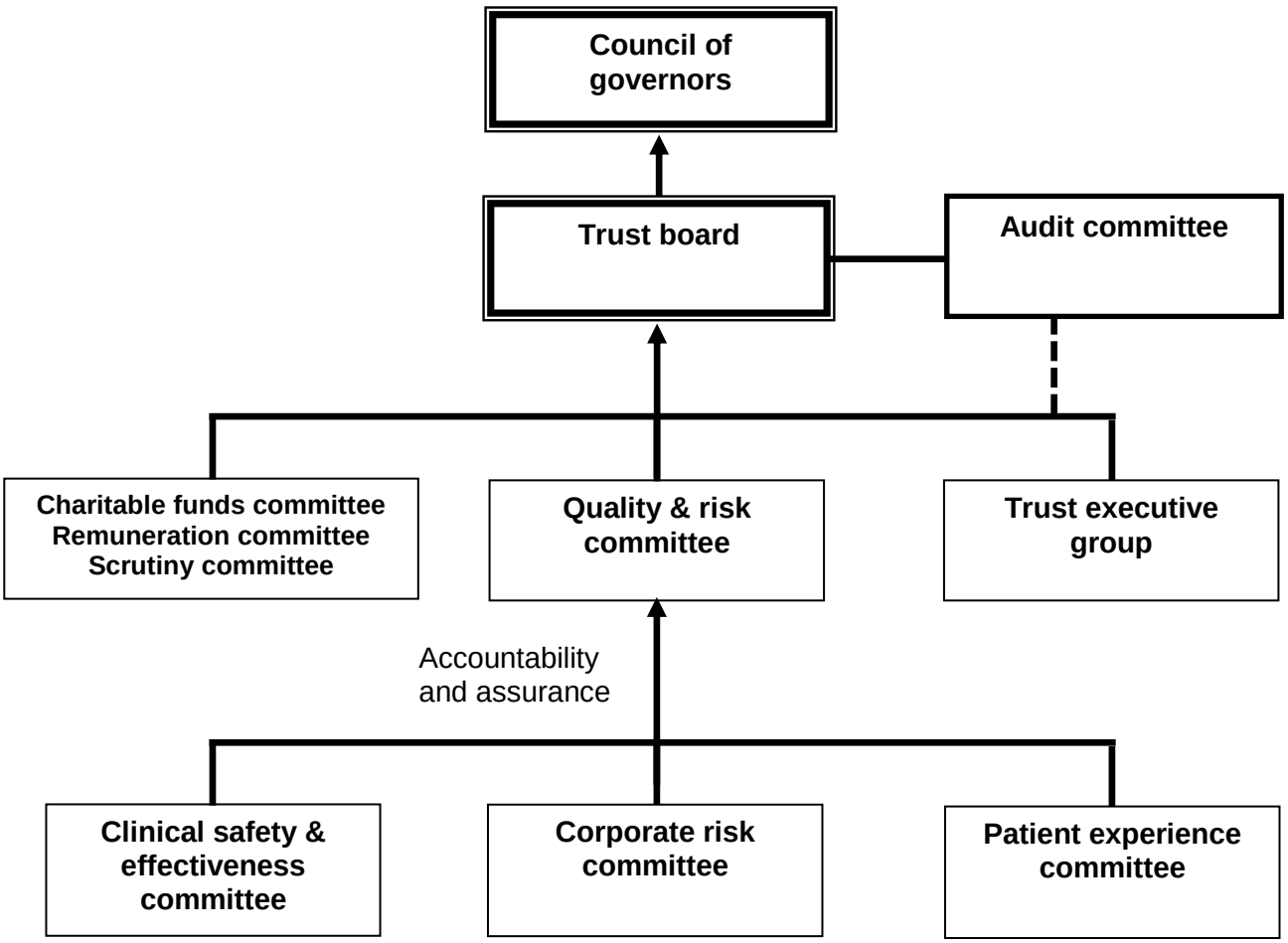
The system of internal control is underpinned by compliance with the Trust's terms of authorisation and the requirements of regulatory bodies relevant to FTs. The Trust has a risk management policy and strategy which make it clear that managing risk is a key responsibility for the Trust and all staff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

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

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

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

Figure 2: Accountability framework



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

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

The nursing & governance directorate facilitates risk management activities in the Trust. Full details of this work are contained in the Trust's risk management policy.

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

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

The risk and control framework

The risk management strategy and policy sets out the key responsibilities for managing risk within the organisation. The board has considered and agreed the principles regarding the risk that the Trust is prepared to seek, accept or tolerate in the pursuit of its objectives and has reflected these in the risk management strategy. The Board has a cautious risk appetite when it comes to compliance and

regulatory issues. Where the laws, regulations and standards are about the delivery of safe, high quality care, it will make every effort to meet regulator expectations and comply with them and will challenge them only if there is strong evidence or argument to do so.

Risk is assessed at all levels in the organisation from the board of directors to individual wards and departments. This ensures that both strategic and operational risks are identified and addressed. Risk assessment information is held in an organisation-wide risk register.

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

- Performance management framework
- Monthly quality and performance reports and performance dashboard. These include the Trust's priorities for improvement in the quality report, analysis of patient experience, incidents and complaints, review of serious incidents, and ward-level quality performance
- Monthly financial performance reports
- Self-certification against the compliance framework
- Self-assessment against delivery of the CQC registration requirements
- Quarterly quality improvement reporting, including learning from deaths
- Quarterly quality and performance reports to the council of governors
- Assurances provided through the work of the clinical safety & effectiveness committee, corporate risk committee and patient experience committee, including emergency preparedness and data security
- Reports from the quality & risk committee, scrutiny committee and the audit committee received by the board
- Assurances provided through the work of internal and external audit, the Care Quality Commission, NHS Improvement, the NHS Litigation Authority, patient-led assessments of the care environment (PLACE), and accountability to the council of governors
- The work of clinical audit, whose scope includes national audits, audits arising from national guidance such as NICE, confidential enquiries and other risk and patient safety-related topics
- Weekly quality walkabouts, including executive directors, non-executive directors and governors
- Risk assessments and analysis of the risk register and board assurance framework
- Benchmarking for clinical indicators
- Freedom to speak up guardian and Safe Working Guardian for junior doctors appointed during 2017
- External regulatory and assessment body inspections and reviews, including Royal Colleges, post graduate dean reports, accreditation inspections and Health and Safety Executive (HSE) reports.

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

- **Care Quality Commission (CQC)** –an overall rating of "outstanding"
- **Good performance against national targets**, meeting national targets in 2017/18 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)
- **We have added to our already extensive collection of awards, receiving:**
    - Baby Friendly and Family Carer Friendly Hospital Awards

    - Hypo Awareness Week Excellence Award
    - Quality in Care (QiC) Diabetes Award
    - Lifetime Achievement and Apprentice of the Year awards at the Bury Free Press Business Awards (for Jan Bloomfield, director of workforce and communications, and Abigail Johnson, clinic administrator)
    - Best Doctor Award for Dr Lucy Grove, community consultant paediatrician, at the prestigious national 2017 WellChild Awards
    - chief executive Dr Stephen Dunn was named as number eight in the Health Service Journal's annual assessment of the top 50 NHS trust chief executives
- **Shortlisted for Anaesthesia Team of the Year** in the British Medical Journal (BMJ) awards, and the **Staff Engagement Award** in the prestigious Health Service Journal national awards ceremony
- **Retained our success in the national NHS Staff Survey**, coming top of the national tables for staff recommending it as a place to work or receive care. Our Trust scored the highest rating in the country (4.12) against other acute hospital trusts in England (average score 3.76) for staff being likely to recommend it to others. Staff at all levels are routinely encouraged to share quality improvement ideas
- **Clinical achievements** include:
    - The National Hip Fracture Database (NHFD) rated the Trust as being in the top three hospitals in England, Wales and Northern Ireland for meeting best practice criteria for patients treated for a hip fracture
    - best early detection of cancer rates in the country for the last three years
    - among the top 10 in the country for hip, knee and joint replacement outcomes
    - Latest sentinel stroke national audit programme (SSNAP) data rates WSH as a level A (highest)
- **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
- **Board's annual review against NHSI's well-led framework** – action identified from this annual review is used to strengthen governance and accountability. The CQC's overall 'Outstanding' rating for the well-led domain support the assessment process.

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 2017-18 was extremely challenging - flow through the hospital affected our ability to deliver, with planned escalation capacity unable to meet the level of actual demand seen requiring 'surge' beds to be open for prolonged periods.

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

  - established escalation capacity with two assessment bays on ward F8 (acute assessment area) opened 24/7 and the winter escalation ward on G9
  - introduced a surgical ambulatory emergency care (AEC) service to sit alongside the medical AEC service
  - established a discharge waiting area, including capacity for patients on beds.

  These arrangements were in addition to the plans and procedures we had put in place during the year by embedding Red2Green as a day-to-day part of what we do. In turn this was supported by a series of initiatives to help our patients get fit and well as soon as possible e.g. ending PJ paralysis to get patients up and moving, and our support to go home service. The support to go home service saved us more than 150 bed days in its first month. In January 2018 we held our fourth 'perfect week' with both clinical and non-clinical areas pulling together to focus on supporting patient flow throughout the hospital, in order to maintain high quality standards of care and positive patient experience. A joint-initiative was also implemented to help care home

residents receive quicker and more effective care should they need to come into hospital. Care home residents in east and west Suffolk are set to benefit from the new 'Red Bag' scheme; the bag contains important medical information, medication and personal items packed by care home staff, and transferred to the hospital via ambulance colleagues.

Weekly multi-disciplinary team (MDT) reviews are also held for stranded patients (inpatients that have been in hospital for seven days or more), and those patients with the longest length of stay (31 days or more). This is part of a wider programme of work to ensure that the care we provide to patients is as coordinated and efficient as possible, to avoid unnecessary delays for inpatients, and helping us to provide emergency department (ED) and inpatient services safely over winter and beyond.

The Trust also set an aspiration and ambition for each ward to discharge at least two 'golden' patients out of their total daily discharges before 10.00am each day. Patients should be discharged either out of hospital or to the discharge waiting area.

We have reflected on the lessons from winter 2017-18 and are already putting in place plans for next winter to ensure that we create bed capacity aligned with staffing plans, grip process and capacity within the emergency department and the organisation as a whole; we are also working with system partners to ensure plans are effectively integrated.

- **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 2017-18 we addressed these difficulties and established a functional patient tracking list (PTL) within e-Care. Availability of patient level data has informed targeted action to significantly improve referral to treatment (RTT) performance during the year – from 79.7% in May '17 to 89.6% in Feb '18.

  In response to winter pressures, like many hospitals we significantly reduced our elective programme in January and February 2018. This impacted on performance and has meant that we have had to review our original plans and improvement trajectory. Plans are being finalised to recover the 92% RTT standard by October 2018.

- **Financial sustainability** continues to be a challenge not just at WSFT but across the NHS

  It is no small achievement that we met our financial control total for 2017-18, which in turn meant we received some additional funding from the national sustainability and transformation fund (STF). Our year end position was deficit of £0.3m, against a planned deficit of £5.9m. Longer term financial turnaround is dependent upon economy-wide solutions, but there remain significant challenges within the Trust to manage local efficiencies and costs whilst delivering quality services.

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 integration of community services as part of the west Suffolk system Alliance	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 adequately 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	Failure to implement estates strategy to provide a building environment suitable for patient care and adequately maintained with regard to backlog maintenance incorporating the acute and community estate	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
	Failure to deliver reconfigured pathology services as part of North East Essex and Suffolk Pathology Services (NEESPS)	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. Mitigations include shared governance arrangements with partners
	Failure to identify and deliver cost improvement and transformation plans that ensure sustainable clinical and non-clinical services while delivering the agreed control total	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 leading to loss of confidence
	Failure of e-Care and NHS GDE adoption to achieve transformation and deliver 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	Failure to deliver the workforce plan with an engaged and motivated workforce	Failure to achieve reduction of staff costs as part of financial plans. Quality, 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 west Suffolk system	Quality and ability to deliver safe services. Non-compliance with national standards, targets and terms of authorisation leading to breach of licence (CQC or 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

Category of risk	Description of risk	Potential impacts being mitigated by controls and future plans
	Failure to deliver Sustainability and Transformation Plan (STP) for Suffolk and North East Essex: a. Nature and creation of rules and models for STP, ACS and ICS which have potential to disadvantage the west Suffolk system through allocation of monies b. Sustainability model for service provision through west Suffolk ICS to mitigate escalating demand with flat resources	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

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

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

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

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The board assurance framework provides 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 January 2018.

The board assurance framework was reviewed and updated routinely during 2017/18 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.

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

- Effectiveness of governance structures – which are subject to annual review and recommendations for improvement monitored through an agreed action
- Responsibilities of directors – directors objectives and performance are regularly monitored by the remuneration committee

- Responsibilities of subcommittees - are considered as part of the annual governance review and the quality & risk committee and audit committee provide an annual report to the board on their activities and performance
- Reporting lines and accountabilities between the board, its subcommittees and the executive team - are considered as part of the annual governance review and clear reporting and escalation channels exist between the board and executive team
- Submission of timely and accurate information to assess risks to compliance with the Trust's licence – the board reviews relevant submissions to NHSI
- 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 2017/18 including divisional reporting and performance against cost improvement programmes.

Information governance

WSFT's information governance assessment report overall score for 2017/18 was 81%. The Trust achieved a score of at least two for all requirements, within a range of zero (worst) to three (best).

WSFT has reported three level 2 data breaches to the Information Commissioner's Office (ICO) in 2017/18. These incidents involved:

- Lost or stolen paperwork (1)
- Unauthorised access or disclosure (2)

Remedial action was taken by the Trust in response to the incidents and no further action has been identified by the ICO.

Annual quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare 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 strives to deliver the principles outlined in NHSI's well-led framework and its eight key lines of enquiry (KLOEs):

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

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

Scrutiny of the information contained within these indicators and its implication as regards patient safety, clinical outcomes and patient experience takes place at the quality & risk committee. There are a number of committees and executive groups with direct responsibility for key aspects of the quality agenda reporting to the quality & risk committee. The patient experience committee reviews the data from the patient experience surveys and provides feedback to the quality & risk committee. The clinical safety & effectiveness and patient experience committees inform the quality & risk committee on relevant performance relating to the Trust's quality strategy and quality improvement plan. This is underpinned by quality walkabouts and continuous monitoring of defined quality indicators.

The inter-relationship between the indicators in the quality report and other measures of the Trust's performance (financial and operational) is reviewed monthly by the board of directors. Reviews of data quality and the accuracy, validity and completeness of all Trust performance information fall within the remit of the audit committee, which is informed by the reviews of internal and external audit and internal management assurances. The board of directors takes further assurance from the external auditor's review of the quality report, including the testing of data provided in the report.

Review of effectiveness

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

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

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

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

In accordance with the public sector internal audit standards in 2017, internal audit provides the Trust with an independent and objective opinion to the accounting officer, the board of directors and the audit committee on the degree to which risk management, control and governance support the achievement of the Trust's agreed objectives.

Internal audit issued 15 reports during 2017/18, the 'opinion levels' are summarised below:

Level of assurance	Number
Advisory report – no assessment made of the level of assurance	3
Substantial assurance - controls are suitably designed, consistently applied and operating effectively.	4
Reasonable assurance - identified issues that need to be addressed	6
Partial assurance - action is needed	2
No assurance - urgent action is needed	0

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

- **Business continuity and disaster recovery** - the key factors contributing to the partial assurance opinion were the pending publication of relevant strategies and plans, staff awareness and that while a testing schedule had been agreed this had yet to be fully implemented
- **Data quality: 18 weeks referral to treatment and diagnostic waits** - at the time of the review the corporate access policy had not been finalised or approved by the Executive. The Trust continued to have problems with the data warehouse and reporting, they were working to address the issues but at the time of our audit (November 2017), these had not been resolved and solutions relied on manual input from staff. Manual validation checks were carried out for some, but not all, patients on the patient tracking lists (PTL) by services and the information team. Data quality and recording issues arising were fed back in an ad hoc manner which meant that lessons learnt were not shared across teams and services. During the review errors in clock stops were observed and a significant delay in making a decision regarding a patient's care pathway were identified.

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 2018, the head of internal audit's opinion for WSFT is that "The organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".

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

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

Conclusion

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

- **Pathology services**
  The pathology service delivered to the WSFT by The Pathology Partnership (tPP) has been a cause for concern during 2017/18 in terms of quality.

  The Medicine Healthcare Regulatory Authority (MHRA) undertook a planned inspection of the blood transfusion service operated within the hospital by tPP in January 2017. The inspection highlighted some deficiencies with the service at WSFT. These primarily related to quality assurance in the laboratory management processes and computer system. We took immediate action to review our service with tPP and have since worked with North East Essex & Suffolk Pathology Services (NEESPS); who took over the service in May 2017. We created a robust improvement action plan which we're continuing to deliver in close collaboration with the MHRA. We have been re-inspected three times since the initial inspection, and though we still have further work to do, mainly relating to concerns around staffing and the validation of systems and equipment, we have continued to satisfy inspectors that we provide a service that is safe.

- **e-Care reporting and RTT performance**
  In May 2016, the Trust launched a 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 was an expected 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 as well as the production of discharge summaries. Some of our internal reporting was also 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 delivered significant improvements to reporting but control issues remained during 2017/18.

  Our reliance on estimated reporting during part of 2017/18 for the national standard for '18-week maximum wait from point of referral to treatment' is a cause for concern. Recovery of the patient tracking list (PTL) and reporting arrangements have been achieved but we continue to address the RTT activity challenge. The reporting of incomplete pathways is one of the mandated indicators for external audit as part of their limited assurance reporting on the Quality Report.

  Plans are being finalised to ensure no patients wait longer than 52 weeks by end of June 2018 and to recover the 92% RTT standard by October 2018.

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
25 May 2018

2.7 Remuneration report

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

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

The following parts of the remuneration 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, staff report: exit packages, staff report: analysis of staff numbers, and staff report: analysis of staff costs.

Annual statement on remuneration

There were no new appointments to executive roles during 2017/18. 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 employees pay any additional tax due as appropriate.

Remuneration Committee

The aim of the remuneration committee is to make appropriate recommendations to the board on the Trust's remuneration policy and the specific remuneration and terms of service of the chief executive, executive directors, and other staff as determined by the board.

The committee will:

- Advise the Board about appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior employees including:
  - All aspects of salary (including any performance-related elements/bonuses)
  - Provisions for other benefits, including pensions and cars
  - Arrangements for termination of employment and other contractual terms
- Make recommendations to the Board on the remuneration and terms of service of executive directors and senior employees to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff
- Scrutinise the proper calculation of termination payments taking account of such national guidance as is appropriate, advise on and oversee appropriate contractual arrangements for such staff
- Monitor and evaluate the performance of individual executive directors (and as agreed by the Board other senior employees) including:
  - Establish the objectives of the chief executive and review the performance of the chief executive against these objectives

    - Scrutinise the objectives of the executive directors (to be established by the chief executive) and review performance reports on the executive directors prepared by the chief executive
- Scrutinise the recommendations of the Clinical Excellence Awards Committee
- Review the Terms of Reference of the Committee every two years
- Report the frequency of meetings and the members of the Remuneration Committee in the Trust's Annual Report of the Trust
- The Committee shall report in writing to the Board the basis for its recommendations.

The committee comprises the chairman and NEDs of the board of directors. The committee is chaired by a non-executive director; Mr. N. Hounsome during 2017/18 and Mr. A Eaton from April 2018. 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 2017/18. All non-executive directors were in attendance for both meetings except for Mr. G Norgate who was unable to attend the meeting held in December 2017.

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 £150,000. In addition, each director can receive the NHS cost of living pay rise which is based on the national NHS pay award. In recent years the Department of Health has advised the chairman on the expected level. The arrangements for managing the remuneration policy for senior managers will be strengthened during 2018/19 to include engagement with staff and public governors.

The Trust does not have a performance related pay scheme. The committee, however, has the delegated authority to pay one off discretionary payments in exceptional circumstances. The chief executive presents an annual report on executive directors' performance (in the case of the chief executive this is presented by the 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 NHSI 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 £1,111k from £931k. A significant element of this increase is the full year impact of the changes to directors in 2016/17. There were no exit packages paid to board members either in the 2017/18 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.

	2017/18		2016/17	
	Directors	Governors	Directors	Governors
Total number in office during the year	16	36	15	27
Total number receiving expenses	6	10	8	8
Aggregate total of expenses paid during the year (£)	16,010	1,986	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 2017/18 was £165k- £170k (2016-2017, £160k - £165k). This was seven times (2016/17, seven times) the median remuneration of the workforce, which was £24,547 (2016/17, £23,935). This is calculated based on all staff employed and salaries as at 31 March 2018.

In 2017/18, 9 (2016/17, 8) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £249,218 to £15,362 (2016/17 £207,111 to £15,080).

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.

Table A – Remuneration

Name and title	Year to 31 March 2018					Year to 31 March 2017			
	Salary paid (bands of £5000)	Expense payments (taxable) to nearest £100	Other Expenses 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	Increase in pension entitlement (bands of £2500)	Total (bands of £5000)
	£000	£	£	£000	£000	£000	£	£000	£000
Mrs H Beck - Interim Chief Operating Officer (Note 1)	90 – 95	-	-	150 - 152.5	240 - 245	-	-	-	-
Dr J Benson – Non Executive Director (Note 2)	-	-	-	-	-	10 – 15	-	-	10 – 15
Mr C Black – Executive Director of Resources	125 – 130	6,600	-	52.5 - 55	185 - 190	125 – 130	5,800	52.5 - 55	185 - 190
Ms J Bloomfield – Executive Director Workforce & Communications	95 – 100	300	-	65 - 67.5	165 - 170	95 – 100	200	70 -72.5	165 - 170
Mrs S Childerhouse - Chairman (Note 3)	10 - 15	-	-	-	10 - 15	-	-	-	-
Dr P Chrispin – Medical Director (Note 4)	-	-	-	-	-	55 - 60	-	-	55 - 60
Dr R Davies - Non Executive Director (Note 5)	10 - 15	-	-	-	10 - 15	0 - 5	-	-	0 - 5
Ms N Day – Executive Director Chief Nurse (Note 6)	-	-	-	-	-	55 – 60	-	10 - 12.5	65 - 70
Dr S Dunn – Chief Executive	165 - 170	6,700	-	125 - 127.5	295 - 300	155 – 160	5,200*	37.5 - 40	195 - 200
Mr A Eaton - Non Executive Director (Note 7)	0 - 5	-	-	-	0 - 5	-	-	-	-
Mr J Green - Chief Operating Officer (Note 8)	5 - 10	-	-	10 – 12.5	20 - 25	110 – 115	-	45 - 47.5	160 - 165
Mr N Hounsome – Non Executive Director (Note 9)	5 - 10	-	-	-	5 - 10	10 – 15	-	-	10 – 15
Dr N Jenkins - Medical Director (Note10)	165 - 170	-	8,000	165 - 167.5	335 - 340	80 - 85		70 - 72.5	150-155
Mr G Norgate – Non Executive Director	10 - 15	-	-	-	10 - 15	10 – 15	-	-	10 – 15
Ms R Procter – Executive Director Chief Nurse	110 - 115	-	-	47.5 - 50	155 - 160	105 - 110	-	77.5 - 80	180 - 185
Mr R Quince – Chairman (Note 11)	30 - 35	-	-	-	30 - 35	40 – 45	100	-	40 – 45
Mr A Rose - Non Executive Director (Note 12)	10 - 15	-	-	-	10 - 15	-	-	-	-
Mr S Turpie – Non Executive Director	10 - 15	-	-	-	10 - 15	10 – 15	-	-	10 – 15
Mrs R Varley – Non Executive Director (Note 13)	-	-	-	-	-	10 – 15	-	-	10 – 15

* Misstated last year as £3,000

No additional performance pay and bonuses were paid in 2017/18 or 2016/17

Table B – Pension benefits to 31 March 2018

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 2018 (bands of £5,000)	Lump Sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash equivalent transfer value at 1 April 2018	Real increase / (decrease) in cash equivalent Transfer Value	Cash equivalent transfer value at 31 March 2017
	£000	£000	£000	£000	£000	£000	£000
Mrs H Beck	5.0 - 7.5	20 - 22.5	30 - 35	95 - 100	750	177	567
Mr C Black (Note 15)	2.5 – 5.0	0 – 2.5	35 – 40	95 – 100	597	63	529
Ms J Bloomfield	2.5 - 5.0	7.5 - 10.0	45 – 50	135 – 140	939	104	827
Dr S Dunn (Note 14)	5.0 - 7.5	0 – 2.5	60 – 65	0 – 5	667	105	557
Mr J Green (Note 15)	5 – 7.5	10 – 12.5	20 – 25	50 – 55	403	117	284
Dr N Jenkins (Note 15)	7.5 - 10.0	15.0 - 17.5	30 – 35	70 – 75	426	118	305
Ms R Procter (Note 15)	0 - 2.5	2.5 - 5.0	20 – 25	55 – 60	356	48	306

Notes

1. H Beck started as Interim Chief Operating Officer May 2017
2. J Benson left February 2017
3. S Childerhouse was appointed as Chairman in January 2018
4. P Chrispin retired as medical Director November 2016
5. R Davies started as a NED in March 2017
6. N Day left November 2016
7. A Eaton started as a NED in January 2018
8. J Green left May 2017
9. N Hounsome left December 2017
10. N Jenkins was appointed as Medical Director November 2016. This remuneration includes payment for clinical sessions.
11. R Quince left December 2017
12. A Rose started as a NED in April 2017
13. R Varley left March 2017
14. Lump Sum is zero as a member of 2008 Section and 2015 Section which does not provide an automatic lump sum
15. Lump Sum increase may be zero or low as now a member of 2015 Scheme which does not provide an automatic lump sum

Dr Stephen Dunn
Chief executive
25 May 2018

2.8 Staff report

2.8.1 Our staff

WSFT is one of the largest employers in the west of Suffolk, employing 3,814 staff as of March 2018. WSFT firmly believes in the benefits of working in partnership with staff and the trade unions, and this was highlighted during 2017/18 with the following activities:

- The 2017 national staff survey confirmed that WSFT is the best trust in the country (for any comparable acute trust) for staff recommending the organisation as a place to work and receive treatment. In additional, 93% of staff said they thought their role made a difference to patients (national average 90%)
- A Freedom to Speak Up guardian for the Trust, and Safe Working Guardian for junior doctors, were both appointed during 2017
- 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 Mental Health & Wellbeing Strategy was developed and launched
- Staff continue to receive financial assistance in the form of low interest loans which are arranged by an external organisation, and have access to an onsite occupational health service, including a physiotherapist, counselling and flu vaccinations. Staff have the opportunity to join local gyms at a discounted rate
- My Wish Charity, which supports West Suffolk Hospital, continues to support the health and wellbeing programme of the Trust including:
    - Booby Walk (in aid of breast cancer)
    - West Suffolk Spin cycle ride
    - Dog Show & country Fair
    - First ever Bury St Edmunds Marathon.
    - 'It's a Bury Knockout' competition in 2017
- An active flu campaign improved the uptake of the flu vaccine among staff (2015: 53.9%, 2016: 65% and 2017: 71%)
- 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

	Permanent	Other	2017/18 Total	2016/17 Total
	£000	£000	£000	£000
Salaries and wages	118,227	1,557	**119,784**	114,805
Social security costs	11,832	-	**11,832**	11,024
Apprenticeship levy	579	-	**579**	-
Employer's contributions to NHS pensions	14,146	-	**14,146**	13,231
Termination benefits	53	-	**53**	185
Temporary staff		4,905	**4,905**	5,820
Total gross staff costs	**144,837**	**6,462**	**151,299**	**145,065**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**144,837**	**6,462**	**151,299**	**145,065**

Of which				
Costs capitalised as part of assets	2,423	1,091	**3,514**	2,849

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

	Permanent Number	Other Number	2017/18 Total Number	2016/17 Total Number
Medical and dental	389	38	**427**	412
Ambulance staff	-	-	**-**	-
Administration and estates	662	57	**719**	782
Healthcare assistants and other support staff	666	82	**748**	693
Nursing, midwifery and health visiting staff	942	77	**1,019**	965
Scientific, therapeutic and technical staff	489	8	**497**	455
Total average numbers	**3,148**	**262**	**3,410**	**3,307**
Of which:				
Number of employees (WTE) engaged on capital projects	54	14	**68**	71

2.8.4 Reporting of compensation schemes - exit packages 2017/18

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	1	-	**1**
£10,001 - £25,000	1	-	**1**
£25,001 - 50,000	1	-	**1**
Total number of exit packages by type	**3**	**-**	**3**
Total resource cost (£)	55,000	£0	**55,000**

There were three compensation schemes - exit packages in 2016/17, with a total resource cost of £185,000.P

There were no non-compulsory departure payments in 2017/18 and none in 2016/17.

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

	Male	Female	Total
Executive directors (including CEO)	3	3	6
Non-executive directors (including Chair)	5	1	6
Other senior managers (band 8d and above)	7	4	11
Employees	700	3,108	3,814

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:

Figures Converted by DH to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE 2017	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
3,133	25,928	8.3	1,143,533	42,061

Source: NHS Digital - Sickness Absence and Publication - based on data from the ESR Data Warehouse Period covered: January to December 2017

Data items: ESR does not hold details of normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365 – day year. The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365 (with a further adjustment where the figures are based on less than 12 months' data). The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure (with a further adjustment where the figures are based on less than 12 months' data). Average Annual Sick Days per FTE has been estimated by dividing the estimated number of FTE – days sick by the average FTE, and multiplying by 225 (the typical number of working days per year).

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 development of a culture of inclusion where all people are valued and respected for their individual differences as evidenced by our strategic framework *Our patients, our hospital, our future, together*'.

A single comprehensive equality and diversity action plan has been developed for the trust covering the Workforce Race Equality Standard (WRES), the Equality Delivery Scheme 2 (EDS2), equality and diversity issues arising from the national staff survey and the Social Partnership Forum collective call to action on tackling bullying in the NHS. This approach has allowed us to develop specific local objectives and address the requirements of the 2010 Equality Act and Public Sector Equality Duty (PSED), the NHS constitution and CQC criteria.

Six equality and diversity objectives have been identified. Staff and the local community have been engaged on these and their associated actions and implementation is being overseen by our Equality and Diversity Steering Group. The six objectives are:

- Improve the patient experience and care of older age patients (including those with dementia)
- Promote and support inclusive leadership at all levels of the trust
- Tackle bullying and harassment of and by staff and support staff to respectfully and successfully challenge problem behaviours
- Embed equality and diversity in mainstream business processes
- Improve information and data collected, in respect of protected characteristics
- Ensure that the recruitment interview process is bias free

The objectives and action plan are reviewed on an annual basis by the Trust board as part of the annual equality report. The annual equality report is published on the Trust website, along with information about WRES, EDS2 and our 2017/18 Gender Pay Gap Report.

The data shows all current employees and public members broken down by protected characteristics (data is not available for all of the characteristics protected by the Equality Act):

Employees and public members protected characteristics

	Staff in post			Public Members		
	2017/18	2016/17	2015/16	2017/18	2016/17	2015/16
Age						
16	0	0	0	0	1	0
17-21	49	61	73	65	34	30
22+	3,765	3,597	3,566	5,854	5,963	5,464
Not Specified	0	0	0	126	170	140
Total	3,814	3,658	3,639	6,045	6,168	5,634
Ethnicity						
White	3,182	3,078	3,066	5,391	5,565	5,320
Mixed	40	37	31	28	28	25
Asian or Asian British	264	263	247	90	72	69
Black or Black British	27	22	24	23	23	23
Other ethnic group	39	36	33	30	69	48
Not Stated	257	66	76	483	411	149
Undefined	5	156	162	0	0	0
Total	3,814	3,658	3,639	6,045	6,168	5,634
Gender						
Female	3,111	2,966	2,957	3,684	3,716	2,323
Male	703	692	682	2,361	2,452	3,311
Total	3,814	3,658	3,639	6,045	6,168	5,634
Disability						
No	1,557	1,387	1,261	0	0	0
Not declared	356	286	327	0	0	0
Undefined	1,798	1,897	1,969	5,386	5,434	4,884
Yes	103	88	82	659	734	750
Total	3,814	3,658	3,639	6,045	6,168	5,634

Employee data is sourced from ESR BI and membership data is sourced from the Trust's membership database (data as at 1/4/2018).

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 supporting people who are trans policy and equal opportunities policy, all support this focus.

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 risk register. Risk register training is provided by the health, safety and risk manager and the risk officer.

During the period April 2017 to March 2018 32 members of staff were trained in the fundamental principles of health, safety and risk assessment. This has improved the quality and quantity of risk assessments and has helped to promote the use of the risk register.

Workplace inspections are undertaken by health and safety link persons who are qualified with the Royal Society for Public Health (RSPH) Level 2 award in health and safety. This qualification gives the link person the knowledge and understanding to undertake the inspection. Once completed, the inspection is captured on the risk register so actions can be monitored. 158 members of staff have now gained this qualification.

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

During the period April 2017 to March 2018 a total of 24 incidents were reported to the Health and Safety Executive as required under RIDDOR. This is an increase of three incidents from the previous year. The main increase was in the category of Health and Safety (6 incidents).

There were no RIDDOR reportable incidents for slips, trips and falls involving patients or needlestick incidents. There was a slight decrease in the category of 'moving and handling' from eleven to nine incidents. Even though this category saw a decrease in incidents it was still the highest reporting category for RIDDOR.

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 24 incidents reported to the HSE, 21 incidents (88%) 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	2017/18
Moving and handling incidents	9
Violence and Aggression	2
Health and safety incidents	6
Slips, trips and falls (staff)	7

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 2017 to March 2018 there were 167 violence, abuse and harassment incidents - a decrease of 39 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 167 incidents reported there were 54 physical assaults, 53 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 new training to support staff in managing challenging behaviour was introduced.

There were 1,523 reported incidents of personal accident/ill health during 2017/18. This is a decrease of 82 incidents (5%) from the previous year. This figure includes staff, patients, visitors and others and is broken down into specific incident categories, which include slips/trips/falls, contact with an object, contact with a sharp, lifting and handling, self-harm, exposure to a harmful substance, contact with electricity and a category of 'other'. Further detail of learning and action is provided in section 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 Safe, Effective, Quality Occupational Health Service (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 WSFT with achieving the staff health and wellbeing CQUINs, derived from the NHS Five Year Forward View. Working in partnership, sharing expertise we continue to provide a tailored programme for staff, reduced the promotion of food high in sugar and fat sold on the premises and achieved 71% uptake of the flu vaccination by the WSFT workforce which includes the community.

We have already begun planning for the flu campaign for winter 2018-19 and believe we will achieve the 75% uptake target. The CHaW online resources (website supported by extensive social media engagement) of information and sign-posting for staff continue to be well received. We have also seen very positive 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 are delighted to have introduced a dedicated wellbeing coordinator to help facilitate and coordinate all of the initiatives now in place and new exciting opportunities we hope to capitalise on in the coming year. Working closely we are committed to delivering the WSFT health & wellbeing strategy and a programme of improving and protecting the health of our workforce.

2.8.10 Staff survey

The following report includes commentary on the National Staff Survey (2017). 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 3.95 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 2017	National average 2017	WSFT score 2016	WSFT score 2015	WSFT score 2014
Overall staff engagement	**3.95**	3.79	3.97	3.93	3.90

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

	2017	National average	2016	National average	+/- last year	Acute trusts
KF1. Staff recommendation of the organisation as a place to work or receive treatment	**4.12**	3.75	4.10	3.77	**+0.02**	Highest (best) 20%
KF4. Staff motivation at work	**3.96**	3.92	4.03	3.94	**-0.07**	Above (better than) average
KF7. Staff ability to contribute towards improvement at work	**71%**	70%	73%	70%	**-2%**	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
- Freedom to Speak up / Freedom to Improve
- Exec Weekly drop-ins
- Exec and environmental walkabouts
- Weekly staff briefing
- Monthly medical staff bulletin for consultants and junior doctors
- Staff conversation events – facilitated by staff governors
- The weekly staff newsletter, ‘Greensheet’ and weekly ‘Staff Briefing’ email
- The Buzz – an electronic community communication area via the intranet
- Quality Leadership events
- InfoX – a confidential electronic channel to raise issues and concerns
- Five o’clock club
- The ‘Bright Ideas’ scheme
- Staff awards – annual ‘Shining Lights’ awards, monthly ‘Putting you First’ award, new Trust thank you cards, and ‘The David Dumbleton Porter of the Year award’ recognising the WSFT porter of the year
- Staff health and wellbeing group
- Staff engagement on corporate social media, e.g. Twitter.

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	
2015 sample	3,068	850	462	54%	2015 sample
2016 sample	3,494	1,250	624	50%	2016 sample
2017 sample	**3,664**	**1,250**	**599**	**47.9%**	**2017 sample**

Top and bottom five ranking scores

The 2017 staff survey report has 32 key findings. Overall the WSFT has achieved the following:

	Number of key findings		
Ranking	**2017**	**2016**	**2015**
Best 20% for:	**16**	14	7
Better than average for:	**10**	7	13
Average for:	**2**	6	5
Worse than average for:	**1**	5	4
Worst 20% for:	**3**	0	3

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

	2017		2016		Target trend (up / down)	Improvement /deterioration (% since 2016)	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	**4.12**	3.75	4.10	3.77	+	**+0.02**	Highest (best) 20%
KF3. % of staff agreeing that their role makes a difference to patients / service users	**93%**	90%	91%	90%	+	**+2%**	Highest (best) 20%
KF30. Fairness and effectiveness of procedures for reporting errors, near misses and incidents	**3.86**	3.73	3.82	3.72	+	**+0.04**	Highest (best) 20%
KF15. % of staff satisfied with the opportunities for flexible working patterns.	**58%**	51%	55%	51%	+	**+3.00**	Highest (best) 20%
**KF26. % of staff experiencing harassment, bullying or abuse from staff in last 12 months*	**20%**	25%	25%	25%	+	**+5%**	Lowest (best) 20%
Bottom five ranking scores							
KF22. % experiencing physical violence from patients, relatives or the public in last 12 months	**18%**	15%	16%	15%	-	**-2%**	Highest (worst) 20%
KF25. % experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	**28%**	28%	29%	27%	-	**+1%**	Average
KF11. % appraised in last 12 months	**75%**	86%	81%	87%	-	**-6%**	Lowest (worst)

							20%
KF29. % reporting errors, near misses or incidents witnessed in last month	**87%**	90%	89%	90%	-	**-2%**	Lowest (worst) 20%
* ***KF24****. % of staff / colleagues reporting most recent experience of violence*	**65%**	66%	67%	67%	-	**+2%**	Below (worse than) average

* *Lower scores are better,* decimal scores are on a scale of 1-5, 5 being highest.

Action plan for areas of concern and future priorities

Recognising WSFT's strong performance the 2017 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 violence from patients, relatives or the public in last 12 months.
 	
KF24. % of staff /colleagues reporting most recent experience of violence.
	These key factors were raised in previous surveys and the following actions have been identified:
	• The combination of Managing Challenging Behaviours training and Conflict Resolution is complete. This includes handling patients ranging from confused to aggressive in a physical 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. Training and support will also be used to encourage reporting of experience of violence.

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 the last 12 months.	The following actions have been completed: • Update Appraisal paperwork, policy and training. • Remind managers of responsibilities for updating the Workforce Information Team
KF29. Percentage of staff reporting errors, near misses or incidents witnessed in the last month.	The following actions have been competed: • Redesign investigation process • More emphasis on learning process • Particular areas to receive further training

KF18. Percentage of staff attending work in the last 3 months despite, feeling unwell because they felt pressure from their manager, colleagues or themselves.	The following actions have been completed: • Publication of key points from Improving Employee Health, Wellbeing and Attendance Policy and highlighting roles and responsibilities

2.8.11 Pension liabilities for ill health retirement

There was one ill health retirement during the year to 31 March 2018 (2017: eight); the additional pension liability borne by NHS Pensions was estimated as £70,147 (2017: £166,000).

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 (LCFS) whose role is to provide support and advice on all matters relating to fraud and to be a point of contact for fraud reporting. The LCFS reports to the Audit committee.

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 2018, for more than £245 per day and that last for longer than six months:

No. of existing engagements as of March 2018	9
Of which:	
No. that have existed for less than one year at the time of reporting.	4
No. that have existed for between one & two years at time of reporting.	1
No. that have existed for between two and three years at time of reporting.	3
No. that have existed for between three and four years at time of reporting.	1
No. that have existed for four or more years at time of reporting.	0

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months.

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	3
Of which:	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	3
No. engaged directly (via PSC contracted to department) and are on the departmental payroll	0
No. of engagements reassessed for consistency/ assurance purposes during the year	21
No. of engagements that saw a change to IR35 status following the consistency review.	20

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	1
No. of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements.	35

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.

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 2017 and 31 March 2018.

During 2017/18, the Trust spent £2,587k on consultancy costs (2016/17 £833k). Consultancy is commissioned when the Trust does not have its own internal resource or expertise to undertake the work in-house or when specific additional resource is required for a project. During the year, this included expenditure on the Financial Improvement Programme (FIP2).

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.

Quality matters to us, truly. You'll be able to read more about what we've achieved, what we still need to improve on, and our quality ambitions for the coming year in this report, but I want to touch upon some elements here. As a Board we will always make our decisions based on what we think will help provide the best quality of care to our patients, and we're incredibly lucky that that ethos is also reflected in our nearly 4,000 staff and volunteers.

That commitment to quality was acknowledged in our latest Care Quality Commission (CQC) inspection, where we were rated as outstanding - only the seventh (and smallest) general and acute hospital to receive this accolade. They said: *'On all the wards we visited, staff displayed a culture of compassion and positivity, and had a genuine desire to want to provide the best possible care to patients.'* This is an amazing achievement.

We want our patients, their families, and our local community to be confident in the care they will receive here at the Trust. Of course, being outstanding does not mean we are perfect.

Despite a whole hospital and system focus on patient flow #Red2Green, the SAFER bundle, and ambulatory care; despite investing in 20 extra community beds and starting to provide community services and social care services; despite shaving a day off the length of stay in medicine and working with the county council to have the lowest delayed transfers of care in the region; despite all this we have seen a very pressured year and a very stressful winter, with year on year increases in demand greater than predicted - we saw a 6% increase in emergency department attendances alone compared to the previous year. That's nearly 3,800 more patients in a single year.

Unfortunately, like the rest of the NHS, we weren't immune to that extra demand. Our performance against the national four-hour A&E standard was 95%, 91%, 87% and 85% from quarter one to quarter four respectively (though we remain one of the top-three highest performers in Midlands and East for this standard). We had to cancel a significant number of non-emergency elective operations, which has seen our cancellation figures rise above where we wanted them to be. In turn, this has had a knock-on effect on our referral to treatment (RTT) standard, which was 86% for the year and is a drop on the previous year which was 93%.

We also know that our staff have felt pressure on the wards. We have often had to move staff from one ward to another in order to ensure that we have enough staff to run a ward at a level we consider safe. Whilst we are actively recruiting, and are looking forward to 55 new nurses joining us in the spring/summer, we know we still need more people on the ground and that the NHS nationally is struggling with this same challenge.

We're disappointed that, as a result in part of those staffing pressures, we have missed some of our quality goals this year. We've seen more hospital acquired pressure ulcers and more inpatient falls than we would expect.

But we are also exceptionally proud that, despite all the pressure, our staff have maintained much of the high standards of quality that we expect of ourselves. That's just the west Suffolk way.
We have exceeded all of our standards for patients being likely to recommend us as a place to receive care. Looking at patient experience feedback and what it tells us is a genuine indicator of the quality of care we're providing to people, so this is fantastic to see and an absolute credit to our staff. We also came top of the national tables for comparable trusts for staff recommending the Trust as a place to work or receive care in the NHS Staff Survey. We firmly believe that happy staff means happy patients, so we're truly delighted about that.

We've also achieved some outstanding clinical achievements. Earlier in the year, the National Hip Fracture Database (NHFD) rated us as being in the top three hospitals in England, Wales and Northern Ireland for meeting best practice criteria for patients treated for a hip fracture. We achieved 94.3% against the best practice criteria in 2017, compared to an average of 57.1%. Our stroke services regularly achieve high ratings in the Sentinel Stroke National Audit Programme (SSNAP) scores, we consistently achieve high early detection of cancer, and our performance for all cancer targets is ahead of the national threshold. Our infection prevention and control is good, with C. Diff infections and MRSA cases remaining within our target thresholds. We have put in place, with our clinical directors and new consultant in public health, an exemplar learning from deaths framework.

And there have been other high points:

- we've welcomed community services to the West Suffolk team, which is the start of an exciting way of working to deliver a fully integrated health and social care system for Suffolk patients
- we've embarked on our ambition to create a fully integrated cardiac centre, supported by our My WiSH charity's biggest ever appeal, which will see us provide enhanced care closer to home for our cardiac patients
- we've launched phase two of e-Care, our electronic patient record, and introduced new vital signs monitors across the hospital which pull patient observations and stats directly into the patient record to help save time and reduce human error
- we've seen new innovations created by staff – like our staff nurse Kate's idea to use green coloured cups for medicines so they aren't mistakenly thrown away
- we've launched schemes that are helping our patients get home more quickly, like our #EndPJParalysis campaign to get people up, dressed and moving and reduce deconditioning, and our fantastic 'support to go home' service that puts earlier care packages in place for our patients.

It has been a challenging 12-months, and no one here at WSFT is under any illusion that the coming 12-months will be any less so. But I know that I, and our incredible, hard-working, dedicated staff without whom none of these achievements would be possible, will continue to deliver high-quality patient care to the best of their ability – 24/7, 365 days a year.

I can confirm that to the best of my knowledge the information contained in the quality report 2017-18 is accurate and has received the full approval of the Trust Board.

Dr Stephen Dunn
Chief executive
25 May 2018

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 the west of 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 2018-20

The quality priorities for 2018-20 have been identified using a different method from previous years. The shape and nature of the organisation is changing, as is our relationship with our partners and our community. Striving to provide excellent reactive care and keeping up with demand is no longer enough. We are already working differently by developing integrated acute and community services with our partners in the west Suffolk alliance model. As our wider integrated care system starts to take shape, the importance of working collaboratively to devolve all but the most necessary care out of the hospital setting will intensify. The Trust is also increasingly recognising the role it can (and has to) play in improving health and wellbeing, by embracing disease prevention, contributing to local economic development and helping to build resilient communities. We need to succeed in doing all this in the context of ever-more constrained resources.

The quality priorities have therefore been developed by asking our specialists, listening to what our partners and community tell us, and looking outwards for how we can help other organisations achieve their own goals. With a strong emphasis on delivering safe care, we are developing these quality priorities as part of an organisational quality plan, which will form part of a suite of documents being developed to describe the Trust's approach to healthcare quality and setting the direction for improving quality through to 2020. These include:

1. An overarching quality strategy
2. A quality improvement (QI) framework
3. A quality plan - the 2018-20 quality priorities
4. An experience of care strategy
5. A patient safety strategy

We are working with subject matter experts within the Trust to set stretching improvement trajectories for the identified measures for each of the aims. These improvement trajectories will be informed by baseline data, available national benchmarking and an assessment of our previous and current improvement activity.

Quality priorities for 2018-20

Deliver personal care: deliver measurable improvements in the patient experience	
Aims	Measured by
Improve shared decision making	% improvement in shared decision making
Implementation of choosing wisely UK recommendations	Evidence of implementation of the recommendations
Patient, family and carer voice is represented throughout the organisation	Patient satisfaction / Experience of care strategy QI plan measures
Patient and family involvement in assurance and improvement	Patient satisfaction / Experience of care strategy QI plan measures
Deliver safe care: set goals and measure quality improvement for key indicators of harm	
Aims	Measured by
Increase the compliance with risk assessment for venous thromboembolism (VTE). Improve the coverage of risk-based VTE prophylaxis. Reduce the incidence of hospital-acquired VTE	% improvement in risk assessments. % improvements in prophylaxis. % reduction in hospital-acquired thromboembolism
Reduce the incidence and severity of pressure ulcers acquired in our care (hospital and community)	% reduction in number of pressure ulcers (rate per 1000 occupied bed days and number of pressure ulcers). % reduction in severity of hospital and community acquired pressure ulcers. Improvement in days between hospital acquired pressure ulcers. Engagement with NHS Improvement pressure ulcer collaborative
Reduce harm from falls	% reduction in number of falls with harm (rate per 1000 occupied bed days and number of falls). Improvement in days between falls with harm
Improve nutrition in inpatients and patients with long term conditions cared for in the community	% compliance with a designed tool to measure nutritional care. Engagement with NHS Improvement nutrition collaborative
Improve fluid management in inpatients (acute and community)	% compliance with a tool designed to measure fluid management
Reduce the incidence of acute kidney injury	% reduction in incidence of acute kidney injury
Timely treatment of patients with sepsis	% improvement in number of people diagnosed with sepsis that receive timely treatment. % improvement in number of people with sepsis who receive antibiotics within one hour of arrival
Deliver joined-up care: explore and develop more effective models of care, engaging with our partners and community	
Aims	Measured by
Getting it right first time (GIRFT)	GIRFT metrics across all trusts and workstreams accessed via NHS Improvement
Deliver innovative, integrated and sustainable models of care within our community	Integrated Neighbourhood Team Suffolk test and learn Buurtzorg pilot results
Improve usefulness and timeliness of discharge summaries	Qualitative feedback from GPs. % improvement in the number of discharge summaries issued within 24hrs

Support a healthy start: promote a healthy pregnancy and ensure every child has the best start in life	
Aims	Measured by
Involvement and engagement with the maternity and neonatal safety initiative	% compliance with a designed tool to measure the quality of labour ward handover. % improvement with smoking cessation rate at delivery
Support a healthy life: deliver public health, support self-care and tackle poor health	
Aims	Measured by
Increase advice and referrals to services to help address unhealthy behaviours	% improvement in number of smokers screened, given advice, prescribed nicotine replacement therapy (NRT) and referred to Stop Smoking Suffolk. % improvement in number of people drinking in an at risk category screened & given advice. Partnership working with lifestyle services
Support aging well: deliver care that supports choice and is delivered at the right time in the right place	
Aims	Measured by
Improve quality of care for people who lack mental capacity	Patient satisfaction / experience of care strategy QI plan measures. % improvement in completed mental capacity assessments
Support all our staff: support staff to flourish and learn whilst delivering high quality services	
Aims	Measured by
Improvements in the number and quality of staff appraisals	% improvement in number of staff with an active appraisal. % improvement in quality of appraisals

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 participation in clinical trials.

Review of services

During 2017-18, WSFT provided and/or sub-contracted 65 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 2017-18 was £216.1m, which represents 85.5% of the total income generated from the provision of relevant health services by WSFT for 2017-18.

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.

In October 2017, West Suffolk Clinical Commissioning Group and Ipswich and East Suffolk Clinical Commissioning Group awarded the Community Services contract to WSFT and the Ipswich Hospital NHS Trust based on a geographical split across Suffolk.

Community services in summary:

- Deliver community-based services to people of all ages across the west of 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 west Suffolk, with the exception of certain services which are delivered across Suffolk
- 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 500 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 2017-18, 42 national clinical audits and eight clinical outcome review programmes covered NHS services that WSFT provides.

During 2017-18, WSFT participated in 95% 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 2017-18, 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 9 national clinical audits and 39 local clinical audits were reviewed by the provider in 2017-18 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 relevant health services provided or sub-contracted by West Suffolk NHS Foundation Trust in 2017-18 who were recruited during 2017-18 to participate in National Institute for Health Research (NIHR) Portfolio or commercially adopted research studies approved by a Research Ethics Committee exceeded 680.

Seven-day services

The Trust has a well-represented seven-day services group leading the service development and improvement plan. The Trust already operates a full seven-day service for both the emergency department (ED) and inpatients across a wide range of clinical areas in order to manage weekend admissions. Future quality improvement is focused on:

- Standard 2: time to consultant review - significant changes have been made to job plans in the current cycle to bring us closer to achieving this standard. With continued focus and changes over the coming years will enable us to reliably meet this standard
- We already achieve standards 5 (access to diagnostics) and 6 (access to consultant -directed interventions) and expect to maintain this compliance
- Standard 8: on-going review - this standard remains the most challenging to resource and recruit.

We are able to highlight many areas of excellent practice in relation to non-elective work across seven days. For example, we have recently been identified as one of the best performing hospitals in England for the hip fracture best practice tariff; our end of life care was rated outstanding by the CQC; our national emergency laparotomy audit data is very good and we are proud to have a Summary Hospital-level Mortality Indicator (SHMI) consistently below one.

Goals agreed with commissioners

A proportion of WSFT income in 2017-18 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 (CQUIN) payment framework.

The CQUIN indicative goals for 2017/19 include the following national and local CQUINs:

- Staff health & wellbeing: a) responses via the National Staff Survey on wellbeing provision; and musculoskeletal issues or stress caused by work; b) healthy food & drinks for staff, visitors and patients; and c) staff flu vaccinations
- Sepsis: emergency department & inpatients – screening and treatment, plus antibiotic prescription review
- Antimicrobial resistance and stewardship: reduction in anti-biotic consumption, overall and specific
- Mental health needs in emergency department: collaborative working with mental health trust
- Clinician pre-referral Advice & Guidance service to GPs via eRS
- Services and all first outpatient appointment slots to be published on eRS, to allow appropriate booking

- Proactive & safe discharge for patients aged 65 and over: aim within 7 days to their usual place of residence: collaborative working
- Emergency Care Data Set: IT system update for improved reporting in the emergency department
- Preventing ill health – inpatient tobacco and alcohol screening, advice, refer/treat
- Suffolk Transformation Programme support.

The total CQUIN funding value for 2017-18 is £3,428,060.

What others say about us

WSFT is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional. The CQC has not taken enforcement action against WSFT during 2017-18. WSFT has not participated in special reviews or investigations by the CQC during the reporting period. During 2017-18, the Trust extended its CQC registration to include West Suffolk community services as part of our new integrated contract.

WSFT was the subject to an inspection of the following core services; End of Life care and Outpatients. The CQC also undertook a well-led review of the Trust which included interviews with executive directors, non-executive directors and governors. This occurred between 9th November and 1st December 2017.

The CQC concluded the rating of the Trust improved and rated it as 'outstanding' because 'Safe' remained good, 'Effective' improved to outstanding, 'Caring' remained outstanding and 'Responsive' and 'Well-led' were good. Trust level leadership was rated outstanding. In the core services, end of life improved to outstanding and Outpatients remained good. WSFT is the only acute Trust in the east and one of seven general hospitals in England to be given the highest overall rating.

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

- There were clear escalation plans and improved performance in clinical audit
- National guidance and best practice was embedded in the service and there was clear, strong leadership that was widely respected by staff
- Staff truly respected and valued patients as individuals and empowered them as partners in their care, practically and emotionally, by offering an exceptional and distinctive service
- The end of life service had a strong, visible person-centred culture
- Comprehensive and successful leadership strategies were in place to ensure and sustain service delivery and to develop the desired culture
- Leaders had a deep understanding of issues, challenges, and priorities in their service, and beyond
- The trust celebrated safe innovation and there was a clear, systematic, and proactive approach to seeking out and embedding new and more sustainable models of care
- The SPCT developed a staff rotation scheme in partnership with a local hospice that enabled staff to shadow each other in their respective care settings to gain knowledge and share expertise in end of life care
- The trust had employed a Macmillan education nurse on a two-year contract who was influential in offering a broad range of training and external stakeholder engagement to raise end of life issues across the trust and within the local community
- Consultant cover had improved since the last inspection in March 2016. The staff team felt that this had made a significant improvement in terms of meeting the needs of end of life patients as well as supporting the SPCT and wider staff team
- The SPCT team sensitively and professionally promote cornea donation amongst the patients and families of end of life care patients. The team work closely with the tissue donation teams to provide this service
- The trust had made significant improvements to its Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) process since the last inspection. Staff had improved knowledge

around the use and implementation of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

In its report, the CQC again 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” in both outpatients and end of life care. 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. They also mentioned senior leaders were visible and approachable. All the staff they spoke with told them that the executive team were approachable with an open door policy. Staff felt well supported by the senior team who addressed concerns and enabled them to make positive changes to service delivery locally. Members of the senior team visited areas of the Trust regularly.

The CQC ratings are set out below for West Suffolk Hospital, Newmarket Community Hospital and the WSFT overall. In comparison to the 2016 grid Maternity has been split from Gynaecology and Outpatients split from Diagnostic Imaging (the later of the two splits are not included in the grid, as they have not been inspected since the change). As of October 2017, WSFT manage community health services and this is represented below (however as Newmarket is the only location that has been inspected no other services have been included. 30 areas are rated as ‘Good’, three are rated as ‘Requires Improvement’ (all rated in August 2016) and six were rated as ‘Outstanding’.

Due to the change in inspection process, the rating tables explain what has been inspected and changes that have occurred:

Rating table key

Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires Improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

West Suffolk Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Medical care (including older people's care)	Good Aug 2016	Outstanding Aug 2016	Outstanding Aug 2016	Good Aug 2016	Good Aug 2016	Outstanding Aug 2016
Surgery	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Critical care	Good Aug 2016	Outstanding Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Outstanding Aug 2016	Good Aug 2016
Maternity	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Requires improvement Aug 2016	Good Aug 2016
Services for children and young people	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
End of life care	Good ➔➔ Nov 2017	Good ↑ Nov 2017	Outstanding ➔➔ Nov 2017	Good ➔➔ Nov 2017	Outstanding ↑ Nov 2017	Outstanding ↑ Nov 2017
Outpatients	Good ➔➔ Nov 2017	Not rated	Good ➔➔ Nov 2017	Good ➔➔ Nov 2017	Good ➔➔ Nov 2017	Good ➔➔ Nov 2017
Overall*	Good ➔➔ Nov 2017	Outstanding ↑ Nov 2017	Outstanding ➔➔ Nov 2017	Good ➔➔ Nov 2017	Good ➔➔ Nov 2017	Outstanding ↑ Nov 2017

Community Health Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health inpatient services	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall*	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

West Suffolk NHS Foundation Trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good Nov 2017	Outstanding ↑ Nov 2017	Outstanding ➔➔ Nov 2017	Good ➔➔ Nov 2017	Outstanding ↑ Dec 2017	Outstanding ↑ Dec 2017

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

There are three areas highlighted as 'requiring improvement' - Urgent and Emergency Care (Safe), Critical Care (Responsive) and Maternity (Well-led). None of these areas were re-inspected in 2017, but improvements have been made to address concerns raised in the August 2016 inspection.

Urgent and Emergency Care (Safe)

Paediatric facilities are being developed within the existing emergency department (ED) footprint; this development has enabled us to create a secure and separated paediatric area which facilitates appropriate observation. We continue to focus on staffing levels and this is being supported by the review of recruitment and development needs for both nursing and medical staff as part of a wider review of ED. This review forms part of the executive-led ED task and finish group, which is also linking with the inpatient paediatric work. There is continued collaborative working with the inpatient paediatric team with plans to ensure there is 24/7 paediatric cover in line with national guidelines. We also continue to focus improvement on the recognition of deteriorating patients as well as the care of patients with mental health needs.

Critical Care (Responsive)

- Following a survey in 2016-17 reviewing staff knowledge of same sex accommodation standard, the Critical Care departmental standing operating procedures (SOPs) for privacy & dignity and avoidance of same sex accommodation breaches were clarified and structured
- The Trust bed capacity report captures 'wardable' patients with an extended stay in recovery and feeds this data into the operational bed management meetings. Critical Care is still managing some breached patients due to bed pressures and these are reported to the Clinical Commissioning Group (CCG). The patient flow team actively look to re-ward patients from Recovery and Critical Care
- The Datix incident reporting system captures same sex accommodation breaches and Critical Care 'capacity' incidents to allow thematic analysis and learning
- The Critical Care department is also an active member of the local Critical Care Network. An action plan for further improvement from an inspection in 2017 is monitored by the network.

Maternity (Well led)

The Head of Midwifery/Nursing is now a permanent position and has built a strong team to support her. The maternity quality and performance dashboard has been strengthened and is reported in greater detail to the Board on a monthly basis. This dashboard is shared with the CCG and there is a close working relationship between both teams. There is a Trust-wide range of leadership activities, which includes workshops aimed at Band 7 and 6 staff (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 a "Freedom to Speak Up Guardian", an individual who staff can approach with any concerns about the workplace including patient care or staff issues. The Guardian then signposts individuals accordingly. In 2018-19 the Trust is recruiting 'Trusted Partners', Trust staff who volunteer to provide independent information, advice and support to other employees. They support the Trust's commitments to Freedom to Speak Up and a culture of inclusion.

Medicines and Healthcare Products Regulatory Agency (MHRA) inspection

We continue to work with **North East Essex and Suffolk Pathology Services (NEESPS)** to address regulatory and accreditation concerns. The MHRA undertook a wide-ranging inspection of the blood transfusion service on 18 and 19 January 2018. While the visit recognised that improvements have been made it identified that further work is required to address staffing and validation of IT/equipment. Plans to address these concerns have been agreed and delivery will be subject to further regulatory inspection during 2018.

Awards and accolades

Our biggest achievement this year was being awarded an Outstanding rating by the Care Quality Commission (CQC), one of just seven general hospitals in the country at the time to hold this rating.

What the Care Quality Commission said about us

Following the November 2017 inspection, the Trust was rated outstanding for being caring, effective and well-led, and good for being safe and responsive. Inspectors said staff: 'truly respected and valued patients and individuals and empowered them as partners in their care, practically and emotionally, by offering an exceptional and distinctive service.'

Despite a challenging year, CQC inspectors said staff had risen to the occasion. Referring to conversations had with patients and their families, they said: 'Feedback from people who used the services, those who are close to them, and stakeholders, was continually positive about the way staff treated people. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity.' The report also praised the Trust for its excellent cancer recognition and treatment times, and for having an excellent staff talent programme tailored to supporting leaders across all levels of the organisation – not just those traditionally seen as being senior figures.

Of the organisation's leadership team, the CQC noted that the Trust had 'compassionate, inclusive and effective leadership at all levels', and that staff felt they were well supported to make positive

changes and innovations. They also said: 'On all the wards we visited, staff displayed a culture of compassion and positivity, and had a genuine desire to want to provide the best possible care to patients.'

Our additional accolades

We have also seen a number of other accolades across the year of which we're very proud, from all areas of the Trust. We have added to our already extensive collection of awards, receiving:

- Baby Friendly and Family Carer Friendly Hospital Awards
- a Hypo Awareness Week Excellence Award
- a Quality in Care (QiC) Diabetes Award
- Lifetime Achievement and Apprentice of the Year awards at the Bury Free Press Business Awards (for Jan Bloomfield, director of workforce and communications, and Abigail Johnson, clinic administrator)
- Best Doctor Award for Dr Lucy Grove, community consultant paediatrician, at the prestigious national 2017 WellChild Awards
- Chief executive Dr Stephen Dunn was named as number eight in the Health Service Journal's annual assessment of the top 50 NHS trust chief executives.

In addition, we were shortlisted for Anaesthesia Team of the Year in the British Medical Journal (BMJ) awards, and the Staff Engagement Award in the prestigious Health Service Journal national awards ceremony.

We've also retained our success in the national NHS Staff Survey, coming top of the national tables for staff recommending WSFT as a place to work or receive care. WSFT scored the highest rating in the country (4.12) against other acute hospital trusts in England (average score 3.76) for staff being likely to recommend it to others.

We're also very proud of the clinical achievements we've seen. The National Hip Fracture Database (NHFD) rated the Trust as being in the top three hospitals in England, Wales and Northern Ireland for meeting best practice criteria for patients treated for a hip fracture – achieving 94.3% against a national average of 57.1%. We've also had some of the best early detection of cancer rates in the country for the last three years, and we're among the top 10 in the country for hip, knee and joint replacement outcomes.

We remain incredibly grateful to each and every member of staff who has helped us reach these incredible achievements.

Data quality

WSFT submitted records during 2017-18 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	Midlands and East (East)	National
Admitted patient care	**99.6%**	99.6%	99.4%
Outpatient care	**99.8%**	99.6%	99.5%
Accident and Emergency care	**98.7%**	98.7%	97.3%

(The above figures cover April 2017 to Jan 2018 inclusive – taken from NHS Digital 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	Midlands and East (East)	National
Admitted patient care	**100%**	99.9%	99.9%
Outpatient care	**100%**	100%	99.8%
Accident and emergency care	**100%**	99.5%	99.3%

(The above figures cover April 2017 to Jan 2018 inclusive – taken from NHS Digital SUS+ data quality dashboard)

WSFT's information governance assessment report overall score for 2017-18 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.

WSFT was not subject to the Payment by Results (PbR) clinical coding external audit during the reporting period 2017-18. A 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	6.2%
Secondary diagnosis	3.2%
Primary procedure	3.3%
Secondary procedure	4.5%

The audit sample was 210 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 2017-18 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 2018-19. 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 performance ensuring we consistently achieve 90% of patients recommending our services to their friends and family

(b) Improve performance against the baseline of 2016 for the following questions from the national patient survey:
  (i) Doctors and nurses talking in front of patients as if they were not there
  (ii) Patients being asked to give their views on quality of care

(c) Improve patient experience of access to surgery against the baseline of 2016-17, as measured by 18 week target performance.

Description of the issue and rationale for selection of measures

Nationally, the Friends and Family Test (FFT) continues to be recognised 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. 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 therefore focused our efforts to ensure that we delivered improved access during 2017-18.

(a) Sustain and improve Friends and Family Test performance ensuring we consistently achieve 90% of patients recommending our services to their friends and family

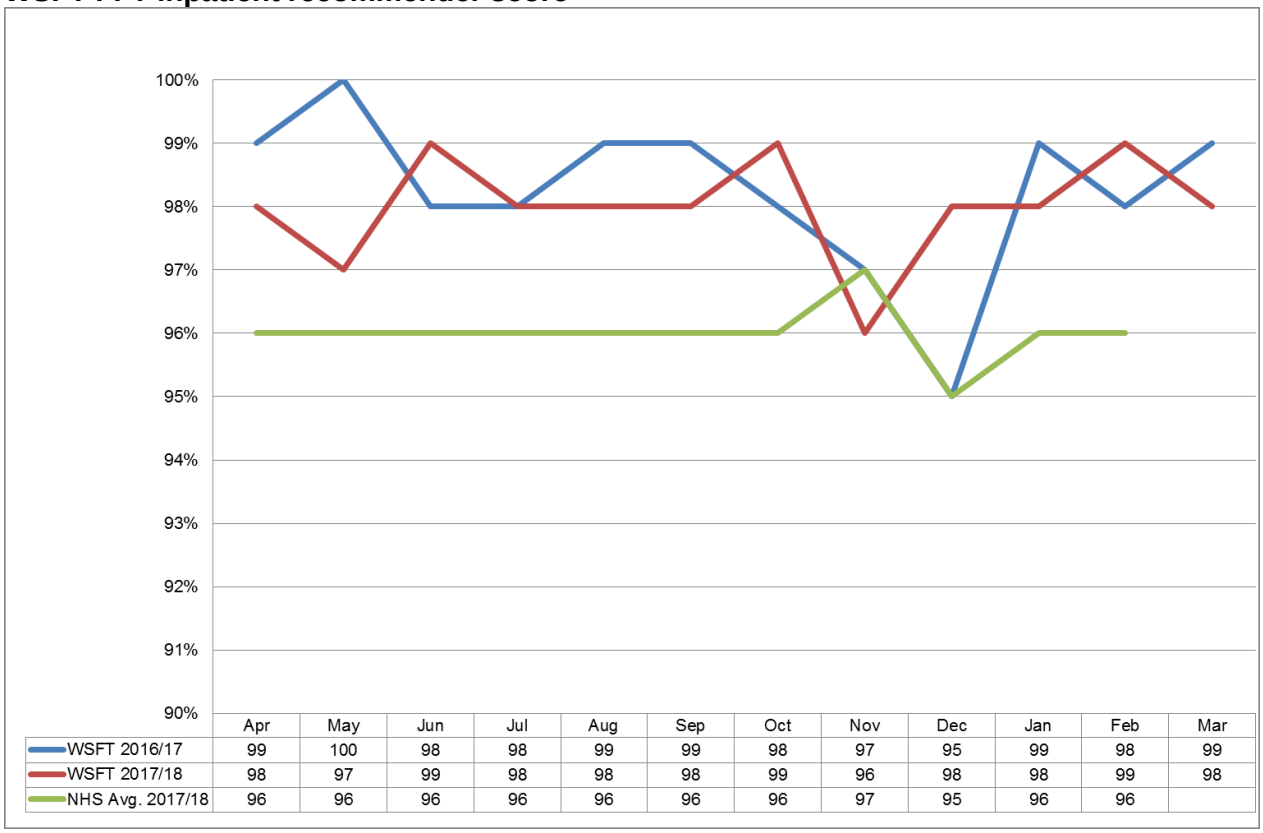
Description of the issue and rationale for selection
Nationally, the FFT continues to be recognised as a barometer of patients' overall satisfaction with care. WSFT will continue to maintain its focus on this during 2018-19 to ensure experience of care is at the highest possible standard, making sure feedback is used to drive positive changes.

Action taken during 2017-18
- The FFT question is integral to our patient satisfaction surveys across all services provided by WSFT
- Ensuring community services are fully integrated into our FFT processes

Current status
We met our target of 90% of patients recommending our service to friends and family for each month of 2017-18 for inpatients, outpatients, day case patients, ED and paediatrics. Unfortunately during one month the birth maternity touchpoint did not reach this target, this recovered the following month.

It is noteworthy that we consistently performed better than the national average on all other months and services.

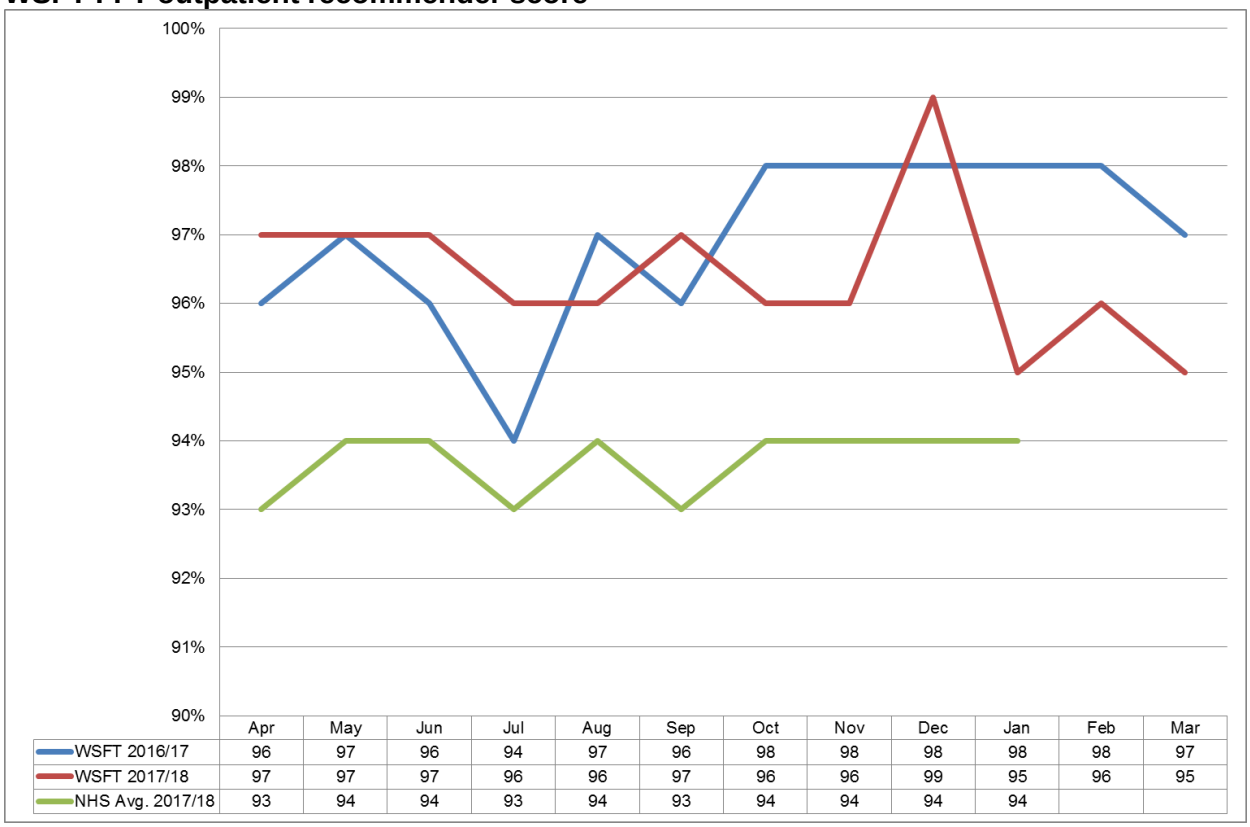
WSFT FFT inpatient recommender score



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
WSFT 2016/17	99	100	98	98	99	99	98	97	95	99	98	99
WSFT 2017/18	98	97	99	98	98	98	99	96	98	98	99	98
NHS Avg. 2017/18	96	96	96	96	96	96	96	97	95	96	96	

Source: NHS England

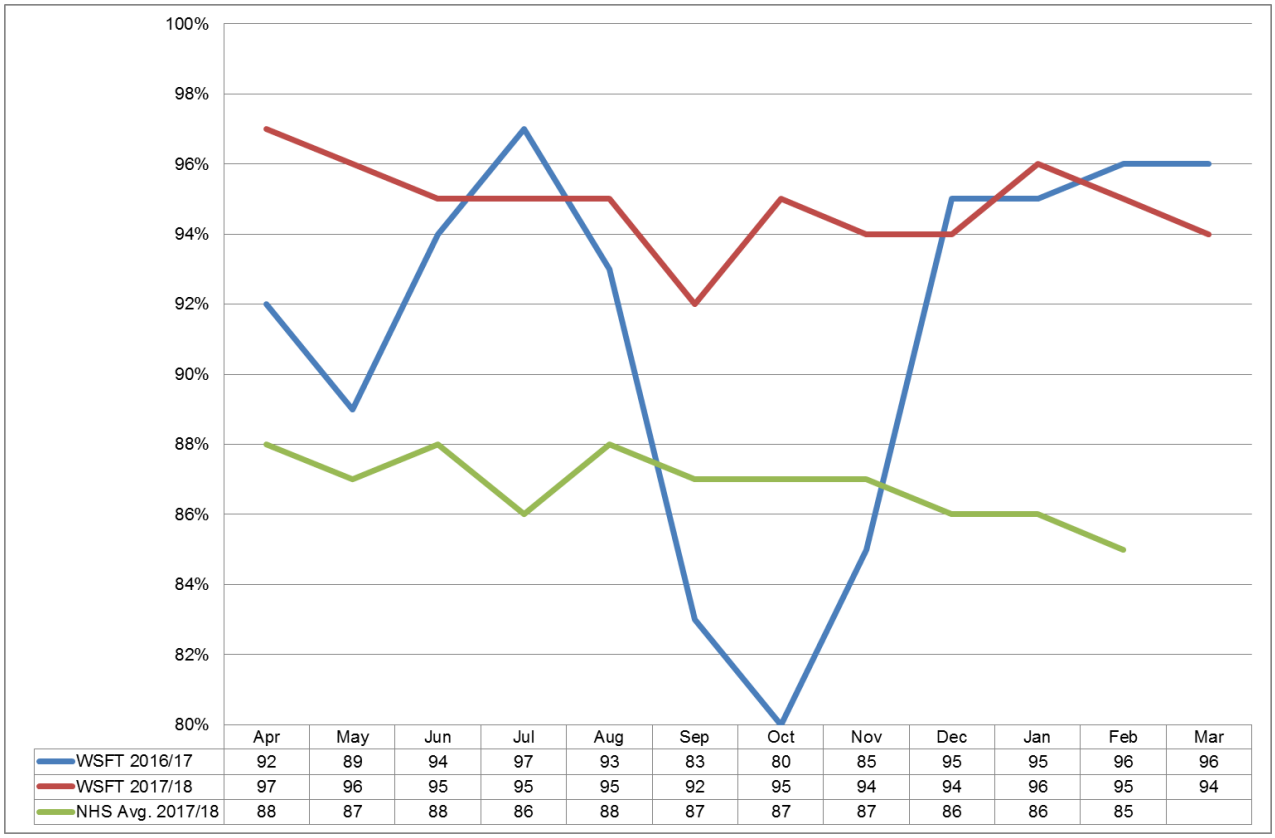
WSFT FFT outpatient recommender score



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
WSFT 2016/17	96	97	96	94	97	96	98	98	98	98	98	97
WSFT 2017/18	97	97	97	96	96	97	96	96	99	95	96	95
NHS Avg. 2017/18	93	94	94	93	94	93	94	94	94	94		

Source: NHS England

WSFT FFT ED recommender score

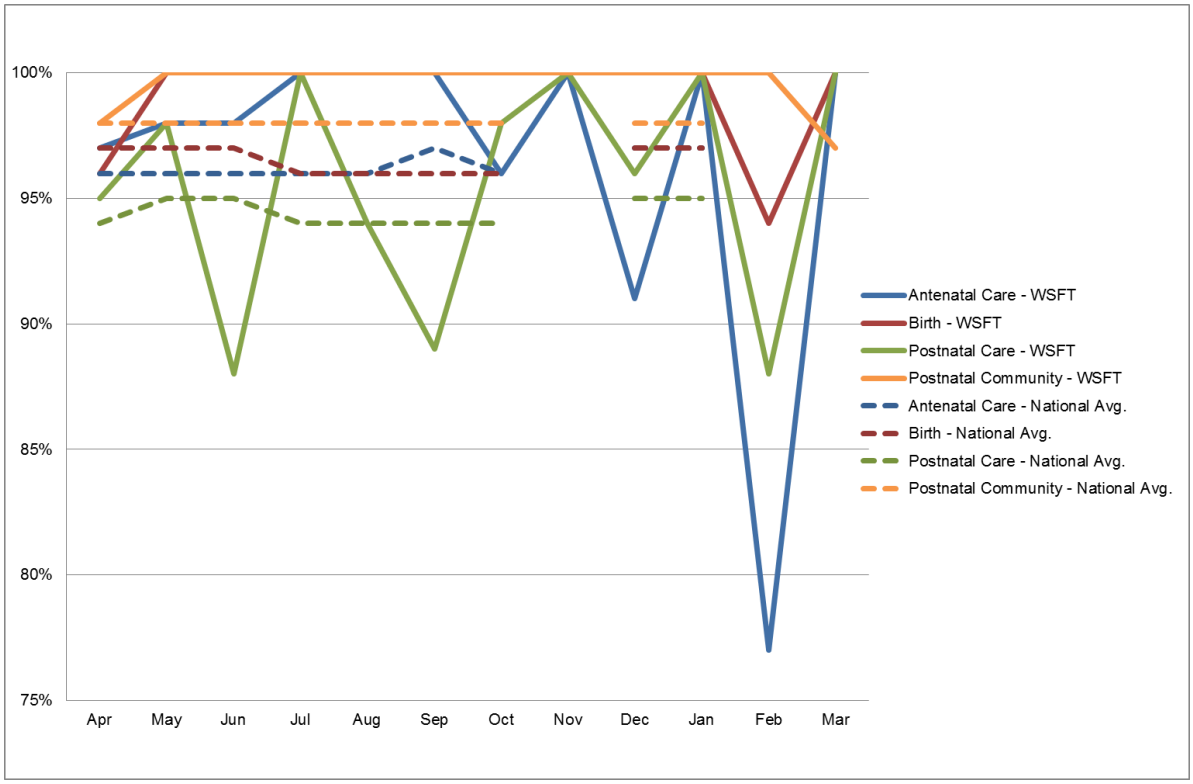


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
WSFT 2016/17	92	89	94	97	93	83	80	85	95	95	96	96
WSFT 2017/18	97	96	95	95	95	92	95	94	94	96	95	94
NHS Avg. 2017/18	88	87	88	86	88	87	87	87	86	86	85	

Source: NHS England

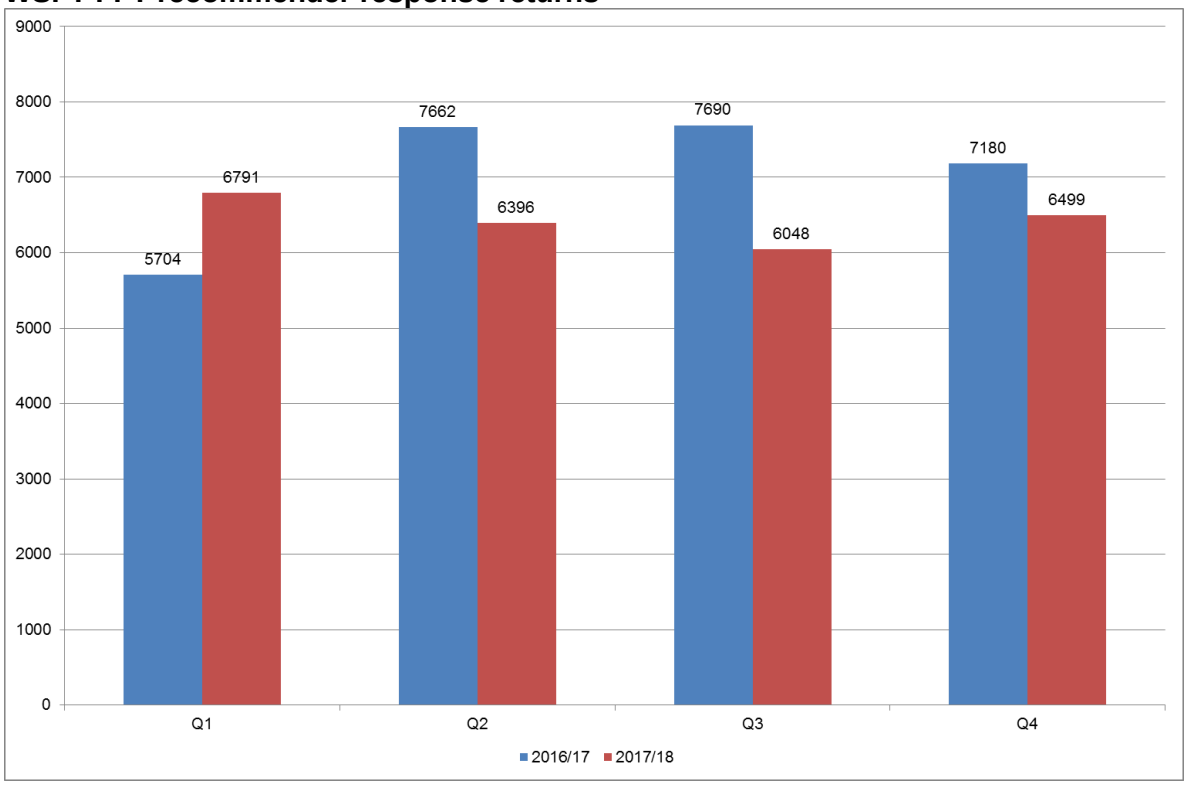
WSFT FFT maternity recommender score

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. A relatively small feedback sample was gathered in February and it was pleasing that performance recovered in March.



Source: NHS England

WSFT FFT recommender response returns



Source: Meridian

Action to be implemented in 2018-19

- Explore electronic collection of patient surveys
- Increase updates from the patient experience team to services in terms of the numbers of surveys submitted
- Continue to increase the response rate in outpatient areas

(b) Improve performance against the baseline of 2016 for the following questions from the national patient survey:

(i) Doctors and nurses talking in front of patients as if they were not there
(ii) Patients being asked to give their views on quality of care

(i) Doctors and nurses talking in front of patients as if they were not there

Description of the issue and rationale for selection

On release of the CQC inpatient survey 2016, concerns were raised around the decline in the Trust's own score in comparison with the previous year on the subject of patients feeling doctors and nurses spoke in front of them as though they were not there.

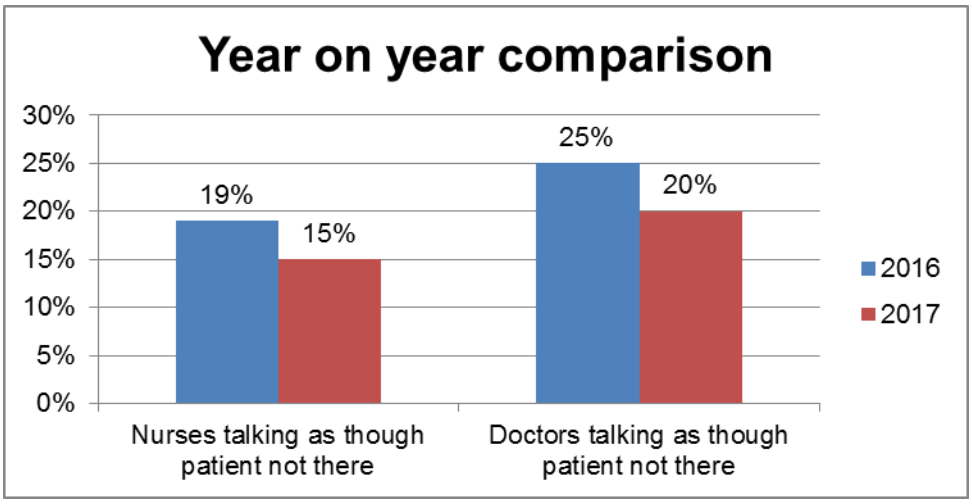
Due to the implementation of e-Care and workstations on wheels, the Trust felt it was important to ensure this did not negatively impact on delivering personal care and conducted a number of measures to address this at an early stage of e-Care implementation.

Action taken during 2017-18

- Additional question added to the inpatient satisfaction surveys asking whether patients felt staff spoke in front of patients as though they were not there
- A patient focus group was conducted in the simulation lab to test the impact of the workstations on wheels, agreeing best practice for their use

Current status

Initial results from Picker Institute for both the 2016 and 2017 inpatient surveys indicate that an improvement has been made since 2016:



Note: a lower percentage represents a more positive patient experience

Results of the new question added to the Trust's inpatient survey show that 95% of patients responding that staff did not speak in front of them as though they were not there. These figures reflect a total of 4,226 inpatients surveyed throughout 2017-18.

Actions to be implemented in 2018-19

- A good computer etiquette video is being developed in conjunction with West Suffolk College for use in staff training
- A good computer etiquette paper guide is also being developed

(ii) Patients being asked to give their views on quality of care

Description of the issue and rationale for selection

The CQC national inpatient survey 2016 revealed that patients felt they were not given sufficient opportunity to give views on the quality of the care they received.

Action taken during 2017-18

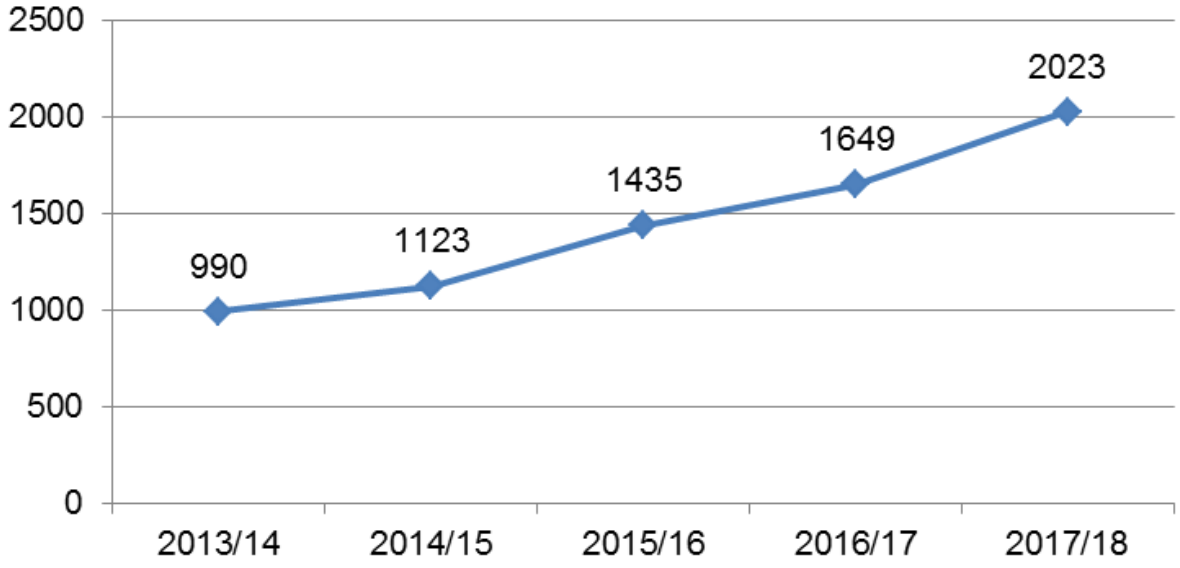
- Promotion of the organisation's Patient Advice & Liaison Service (PALS) resulting in an increase of over 400 additional enquiries being raised
- Experience of care week held in April collecting feedback from patients and visitors about the care they or their loved one received
- Courtyard Café sessions with governors obtaining feedback from patients and visitors

Current status

Whilst we do not yet have sight of the national inpatient survey 2017, this score was noted to have deteriorated from the results in 2015. It is felt that this is likely to be due to adecrease in patient surveys being collected resulting in inpatients not feeling able to voice their views at the time of their admission.

There have been improvements however in the rate at which PALS has been able to assist patients. Every PALS enquiry is recorded and feedback shared with the relevant areas to ensure improvements are made.

Number of PALS enquiries per financial year



Action to be implemented in 2018-19

- Fully establish the Trust's VOICE group
- Promote increased patient survey collection on discharge
- Explore use of electronic devices to submit feedback
- Continue to promote PALS
- Conduct an annual experience of care week
- Develop a mystery shopper programme
- Roll out feedback stations across the organisation

- Develop filmed patient stories
- Implement 'leading with compassion' initiative

(c) Improve patient experience of access to surgery against the baseline of 2016-17, as measured by 18 week target performance

Description of the issue and rationale for selection
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 therefore focused our efforts to ensure we delivered improved access during 2017-18.

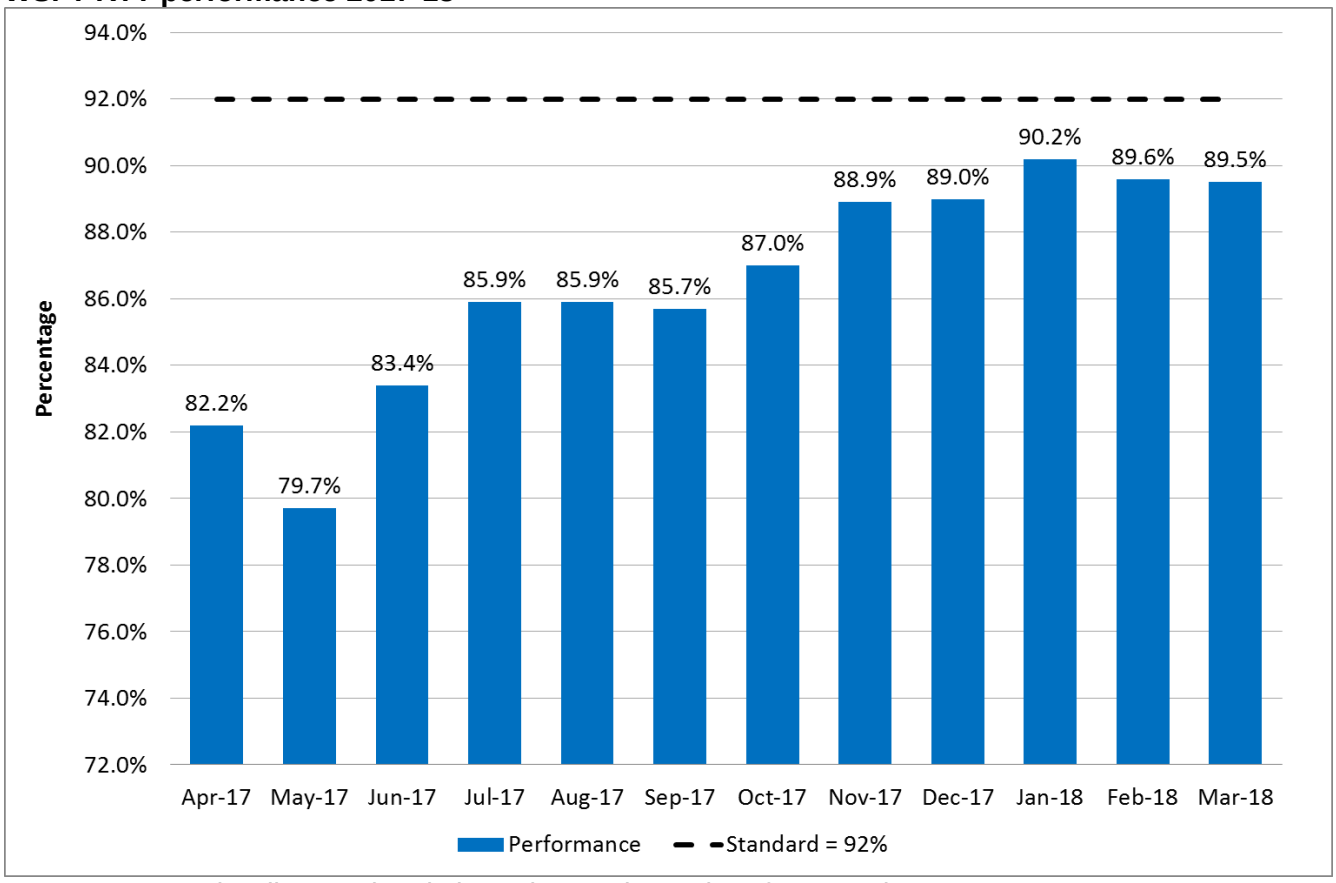
Action taken during 2017-18

- During 2017-18 we addressed reporting difficulties and established a functional patient tracking list (PTL) within e-Care
- Availability of patient level data has informed targeted action to significantly improve referral to treatment (RTT) performance
- Completed clinical harm review for patients waiting more than 52 weeks.
- Specialty level action has been targeted to improve access in key areas including: trauma and orthopaedics, ENT plastics, urology, vascular, ophthalmology and gynaecology. The clinical teams have led this work to deliver improved access for patients.

Current status

The chart below shows the significant performance improvement during the year – increasing from 79.7% of patients accessing treatment with 18 weeks in May '17 to 89.5% in Mar '18.

WSFT RTT performance 2017-18



Source: e-Care (April 2017 data is based on estimated performance)

In response to winter pressures, like many hospitals we significantly reduced our elective programme in January and February 2018. This impacted on performance and has meant that we have had to review our original plans and improvement trajectory. Plans are being finalised to recover the 92% RTT standard by October 2018.

Action to be implemented in 2018-19

- Deliver plans to ensure no patients wait longer than 52 weeks by end of June 2018
- Deliver plans to recover the 92% standard for RTT performance by the end of October 2018.

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 2017-18
(b) Reduce the incidence of avoidable pressure ulcers below the baseline from 2016-17
(c) Implement the programme of work to improve our ward environments during 2017-18

Description of the issue and rationale for selection of measures

WSFT aims to improve on 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 was used as a decant facility between May and September 2017. This allowed essential maintenance and environmental improvements to be made to our ward areas. The programme of works included: 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 being to support the delivery of safe, high quality care in environments which reflect our patients' and visitors' needs.

(a) Ensure that there are no more than 16 avoidable hospital-associated C. difficile infection cases during 2017-18

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.

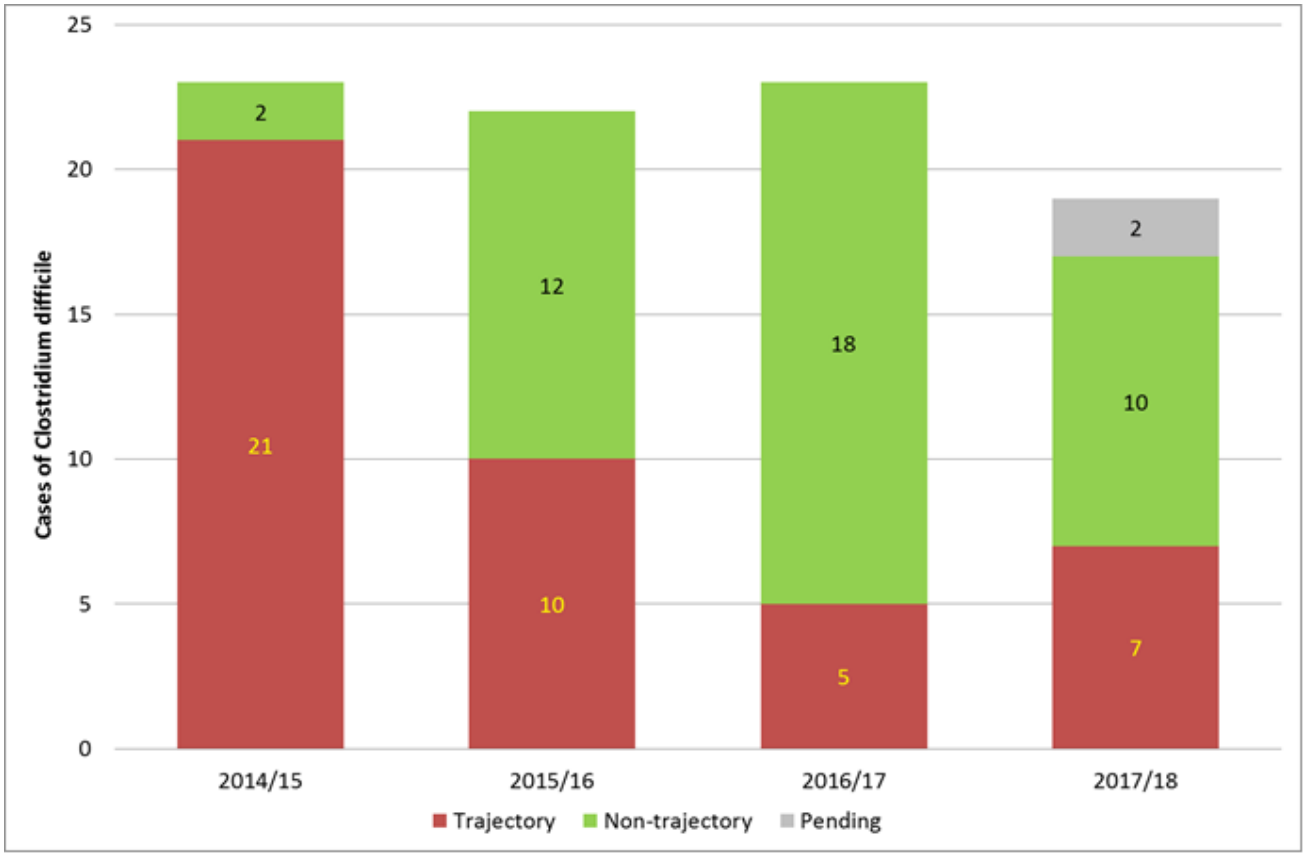
Action taken during 2017-18

- Continuation of the programme for the 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 in the Community Hospitals to support hand hygiene
- To increase and develop the inclusivity of infection prevention across the acute Trust and the community services within our remit.

Current status

There were a total of 19 C. difficile toxin positive cases recorded during 2017-18. Of the 19 cases, ten have been confirmed by the CCG as non-trajectory (for which no lapses in care were identified), seven have been deemed trajectory (for which lapses in care were identified) and two are pending conclusion of the CCG review.



Source: Local data

Action to be implemented in 2018-19

- Procurement exercise planned to review portable sinks with a view to increasing stock
- Review of mandatory training offering to provide a higher level of detail around Clostridium difficile
- Installation of doors to bays in new Cardiac Unit clinical areas to improve the ability to isolate patients
- Continued review of the antibiotic guidelines to increase compliance with the National CQUIN for antibiotic stewardship.
- Working with CCG colleagues to provide an STP wide approach to the control and management of C difficile.

(b) Reduce the incidence of avoidable pressure ulcers below the baseline from 2016-17

Description of the issue and rationale for selection

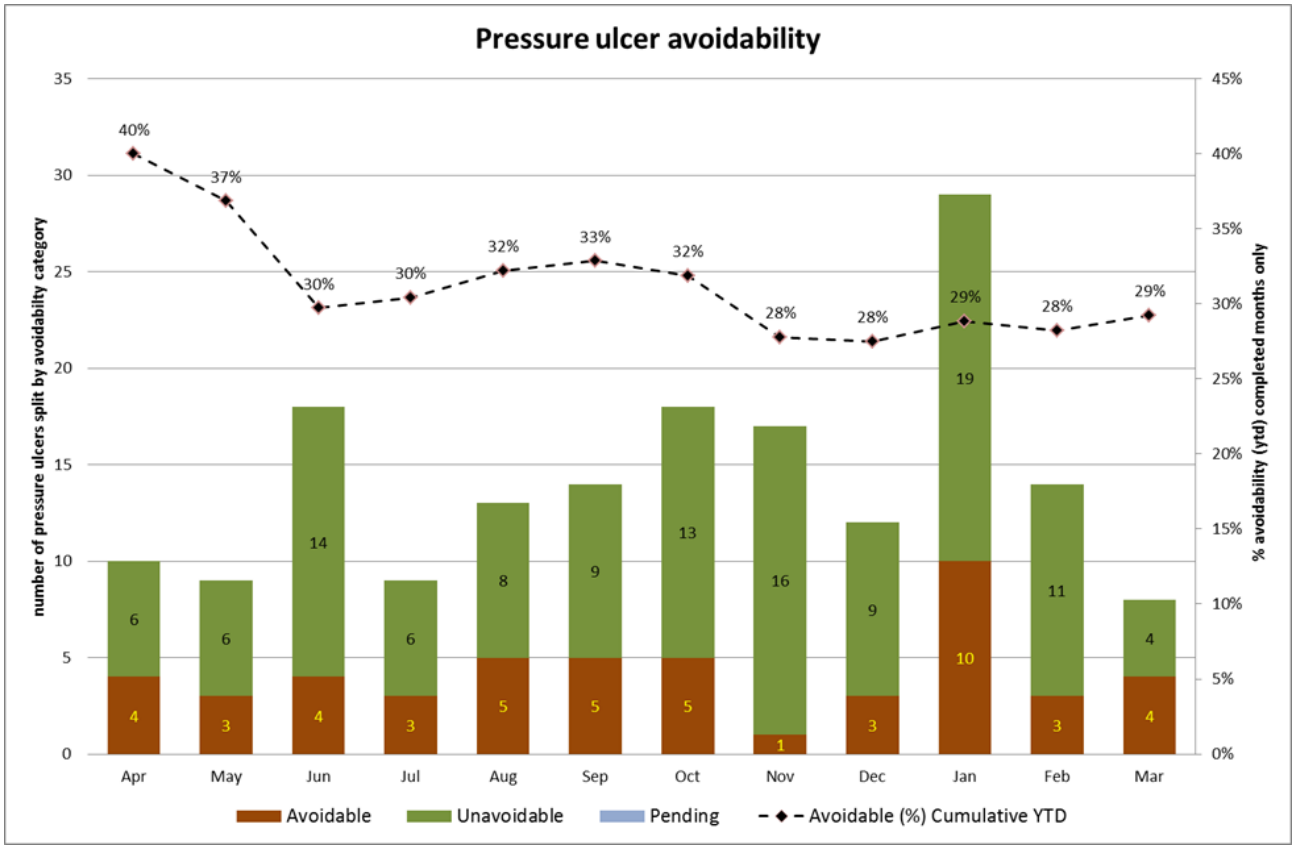
WSFT aims to improve on our achievements to date of reducing harm to patients whilst they are in hospital. We will focus on the reduction of avoidable pressure ulcers on our inpatient wards. This will be achieved by improving practice based on learning from investigation of pressure ulcer incidents.

Action taken during 2017-18

Continued implementation of the comprehensive 2016-17 work programme with additional actions including:

- Heel heroes initiative to raise awareness of pressure area management on inpatient wards
- Tissue Viability service now at capacity and running a full time 8am to 6pm service
- We have developed changes in e-Care to support greater accuracy in recording of information
- Tissue viability commitment to education and engagement through training sessions, including targeted ward based training and 'ward walks' in partnership with industry when appropriate
- Development of skin care pressure area management in Maternity Services through an adapted risk assessment tool and training package which will roll out into regular training and updates on aspects of pressure area care
- Increasing general engagement with departments through monthly bulletin and joint training and working together with other specialists
- Sharing success and best practice across the Trust.

Current status



Source: Datix

We have improved performance in 2017-18 with an overall avoidability of 29%, compared to 30% in 2016-17.

Action to be implemented in 2018-19

- The Tissue Viability team continue to maintain visibility and support ward teams
- The Tissue Viability team are promoting pressure ulcer prevention via bite size teaching sessions and one to one education, promoting awareness to improve staff knowledge and practice in promoting skin health and integrity
- Active promotion by TVNs and Senior Matrons of elements of the SKIN bundle, specifically focussing on promoting regular position changes and appropriate use of reassure reliving equipment
- Ongoing focus on the 'heel heroes' campaign, promoting heel protection and ensuring teams are aware of those patients who have increased risk of developing damage
- Staff engagement via the pressure ulcer prevention focus group, aiming to put pressure ulcer prevention at the forefront of care
- Senior Matrons continue to monitor the implementation of pressure ulcer prevention and have commenced using the ‘Perfect Ward‘ to ensure appropriate risk assessments and care plans are in place
- Ongoing promotion to use the correct continence products and educating staff not to use procedure sheets inappropriately to minimise moisture damage
- Reduction of stock of procedure sheets across all wards
- Active encouragement to achieve timely investigations and learning from incidents by Head of Nursing
- Tissue Viability team are exploring the grading system used for end of life patients.

(c) Implement the programme of work to improve our ward environments during 2017-18

Description of the issue and rationale for selection

The winter escalation ward which closed in April was used as a decant facility between May and September 2017. This allowed essential maintenance and environmental improvements to be made to our ward areas. The programme of works included: 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 being to support the delivery of safe, high quality care in environments which reflect our patients’ and visitors’ needs.

Action taken during 2017-18

- Starting in May 2017, G9 was used as the decant ward to allow deep clean and remedial works (including fire compartmentation) for: G8, F10, F12, F9, F7, F6, F5, F3 and F4
- The programme was completed by mid-November 2017 to allow G9 to be cleaned and ready for use as the winter escalation ward.

Current status

- Starting in May 2017, G9 was used as the decant ward to allow deep clean and remedial works (including fire compartmentation) for: G8, F10, F12, F9, F7, F6, F5, F3 and F4. The programme was completed by mid-November 2017 to allow G9 to be cleaned and ready for use as the winter escalation ward. G9’s availability as a decant ward facilitated compartmentation works, as well as replacement of the link corridor flooring.
- In addition the following projects have enabled improvements to patient and staff areas:
    - Ceiling and lighting was replaced on G3. G5 had general maintenance and decoration improvements.
    - The Primary Care streaming project has enabled us to improve decorations, flooring, ceilings and installation of daylight LED lighting in the Emergency Department.
    - The urology project has enabled improvements for therapies, diabetics, lung function. Gastro and the Urology team.

Action to be implemented in 2018-19

- Phase 3 Primary care streaming - replacement flooring, decorations & LED lighting. The flooring and decorations will be extending to fracture clinic
- Continue the link corridor flooring repairs/replacement programme
- Final phase of urology project to support Joint Advisory Group on gastrointestinal endoscopy (JAG) compliance
- Labour suite refurbishment (to be completed in 2019-20)
- Phase 1 AAU (phase 2 to be completed in 2019-20)

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 from 2016-17

(b) Improve reliability of sepsis screening and treatment for emergency admissions – improving performance during 2017-18

(c) 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

Description of the issue and rationale for selection of measures

During 2017-18 WSFT continued 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.

Trusts were required to collect and publish specified information on deaths during 2017-18. 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 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 is improving how we engage the relatives of deceased patients in these reviews.

(a) Improve reliability of acute kidney injury (AKI) diagnosis, treatment and monitoring for inpatients – during the year improving performance against the baseline from 2016-17

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).

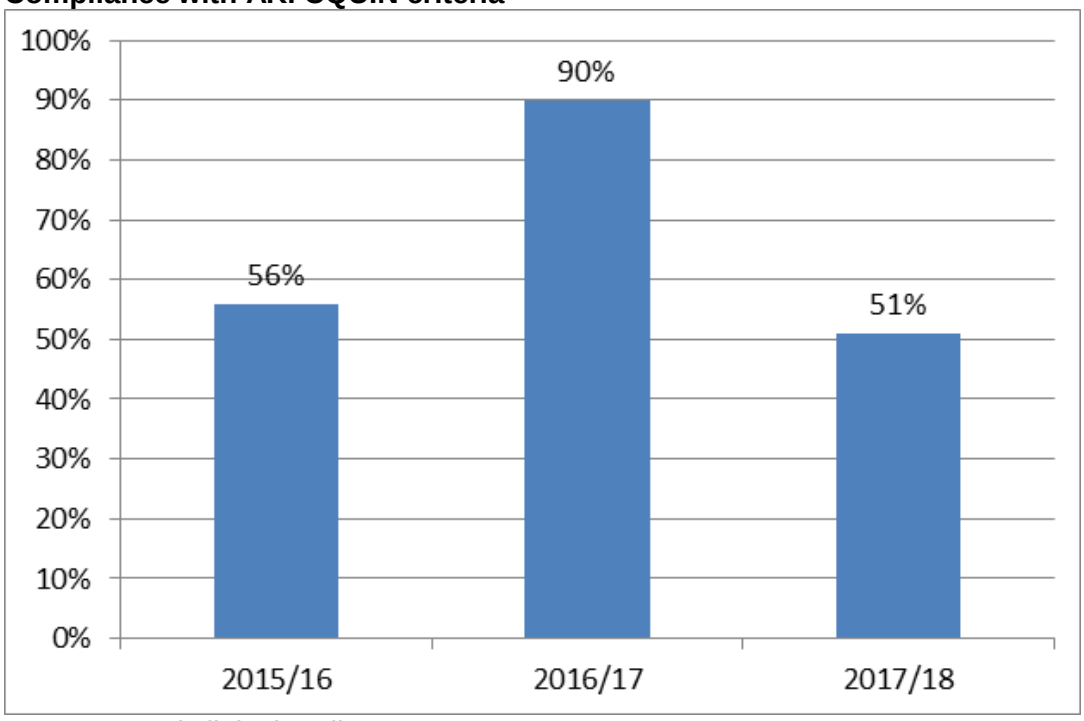
Action taken during 2017-18
The planned improvements for 2017-18 focussed on improved monitoring of patients with AKI as part of e-Care to enable prompt treatment. This work was also intended to support review of the management of patients with an AKI stage 3. This has only been partially achieved with the implementation of Winpath Enterprise, pathology IT system but a delay in the implementation of ordercomms within e-Care. The initial issues with the Winpath system have now been resolved and all patient results, whether acute or chronic, have been fixed.

These changes as well as e-Care development now inform the medical team of a potential AKI and the AKI 7 information is included in the alert:
1. Daily bloods
2. Measure urine output
3. Stop nephrotoxic drugs
4. Appropriate fluid challenge
5. Maintain normal blood pressure
6. Consider imaging and exclude obstruction
7. Senior review and consideration of specialist review

This process has increased the standards of care received for patients suffering from AKI and as a result, the number of specialist referrals has decreased and are all appropriate.

Current status
The 2017-18 audit shows a decline in compliance with the AKI CQUIN criteria; however the audit completed was more comprehensive than in previous years. The 2017-18 audit included 2,270 AKI patients compared to the previous audit samples of 50 patients. Although the results show a decline compared with the previous year, improvements to the system only occurred mid-year. Within e-Care daily monitoring of performance is now possible to ensure we sustain improvement. The AKI group are already enhancing these changes within the electronic patient record and the alerting system.

Compliance with AKI CQUIN criteria



Source: Local clinical audit

Action to be implemented during 2018-19

- Incorporate AKI and fluid balance as a Trust priority and develop a task and finish group to further develop AKI and the reporting structure
- Better fluid management
- Clearer discharge summaries
- More comprehensive documentation of AKI management

(b) Improve reliability of sepsis screening and treatment for emergency admissions – improving performance during 2017-18

Description of the issue and rationale for selection
During 2017-18 WSFT continued 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.

Action taken during 2017-18

- Continue to collect data relating to both emergency admissions and inpatients in accordance with the CQUIN requirements. During 2017-18, the Trust audited and reported 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. Further training has been established and sepsis training is now embedded in all deteriorating courses delivered by the Trust's resuscitation training team.
- Identified a new clinical lead for sepsis due to changes in medical roles. The sepsis group now meet as a combined group incorporating both neutropenic sepsis as well as general sepsis. This group is now also a member of the deteriorating patient group which acts as a conduit for escalation. This also ensures there is clear clinical leadership of the group. There has been an improved attendance to the group both operationally and clinically following the changes made in October 2017.
- Identified a senior nurse to focus on the implementation of sepsis treatment and management and regularly audit and implement changes to develop staff knowledge and skills in both the recognition of sepsis and the importance of timely treatment. The sepsis training delivered by the outreach team has increased staff awareness. As part of the development of sepsis treatment and management and the level of audit responsibility and training, there is development of the sepsis nurse role, of which we are awaiting final banding approval prior to advertising the role.
- The Trust has continued to be challenged by neutropenic patients attending the emergency department when they are unable to attend direct to the Macmillian unit. A review of the neutropenic sepsis pathway to sustain performance above 95% for patients receiving IV antibiotics within one hour was undertaken and learning from the root cause analysis (RCAs) was used to further develop and refine the pathway. This involved a review of the documentation of the telephone triage completed by the acute oncology nurse specialists within FirstNet (the ED electronic patient record) and the communication of this decision flow was reviewed.
- Implementation of the sepsis algorithm through e-Care to enable patients with 'Red flag sepsis' to be identified and treated within the recommended timeframes. This has been completed, however further education and training is being delivered as there are still areas for improvement.

Current status

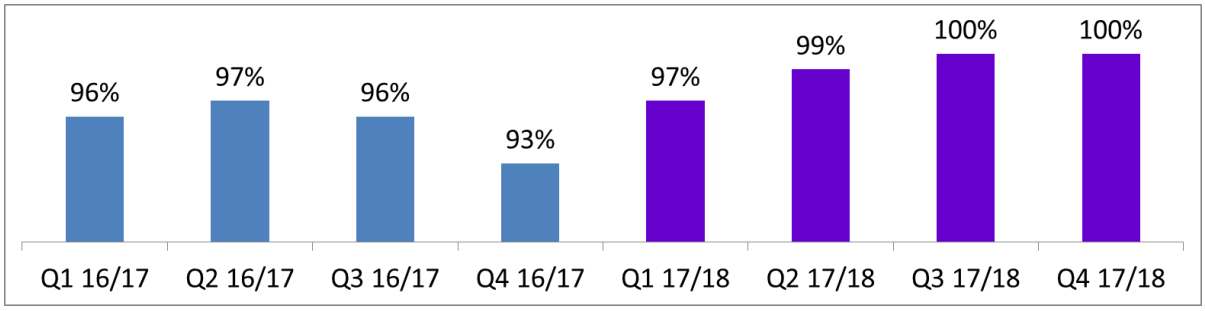
Four indicators are reported:

- Screening all patients for Sepsis
- IV antibiotic treatment in 1 hour for high risk (severe/red flag) sepsis patients
- Prescription review within 72 hours
- Neutropenic sepsis % of patients with door to needle time of 1 hour or less

Screening all patients for Sepsis

Screening is for all patients who come in to ED (& any other emergency unit) and all inpatients – both adult and paediatric. When relevant symptoms are added together this prompts the need for consideration as 'suspected' sepsis and this is noted on the patient record (and/or since e-Care alerts started – an alert is generated).

The national target for 2017-18 is 90%, which has been met for the last two years. This has been aided by the e-Care 'suspected' sepsis alerts now in place.



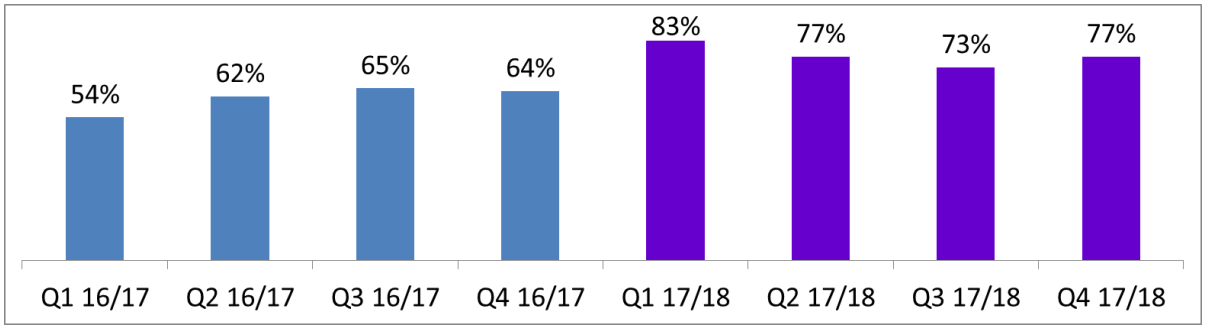
Source: Local audit

Treatment – IV antibiotic in 1 hour for high risk (severe/red flag) sepsis patients

Treatment is for all ED (& any other emergency unit) patients and inpatients with a high risk (severe/red flag) sepsis – both adult and paediatric.

The definition for 2017-18: IV antibiotics given within 1 hour of **'diagnosis'** of high risk (severe) sepsis. This is an updated definition, in 2016-7 the definition for ED was: within 1 hour of **'arrival'**; for New inpatients - within 1 hour of the decision to treat; for existing inpatients – within 90 minutes.

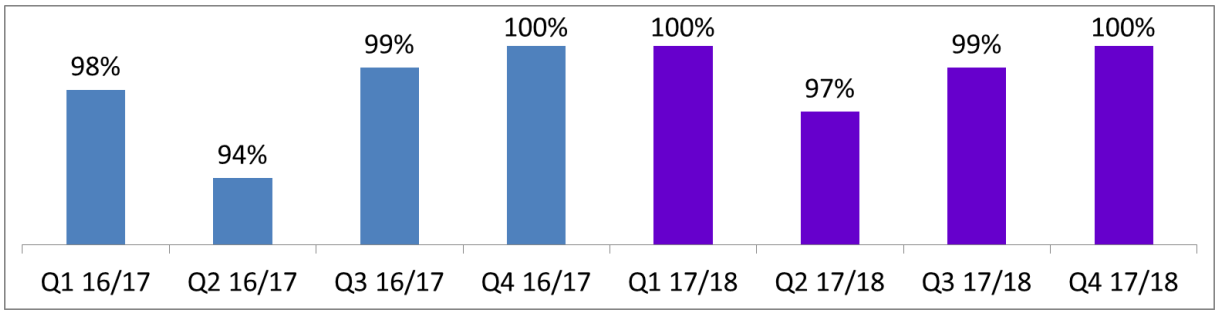
The national target 2017-18 is 90%, the audit has not reached the target in either year. Action to improve performance include an e-Care 'severe sepsis' alert in place to prompt immediate action including prescription generation and treatment given without delay.



Source: Local audit

Prescription review within 72 hours

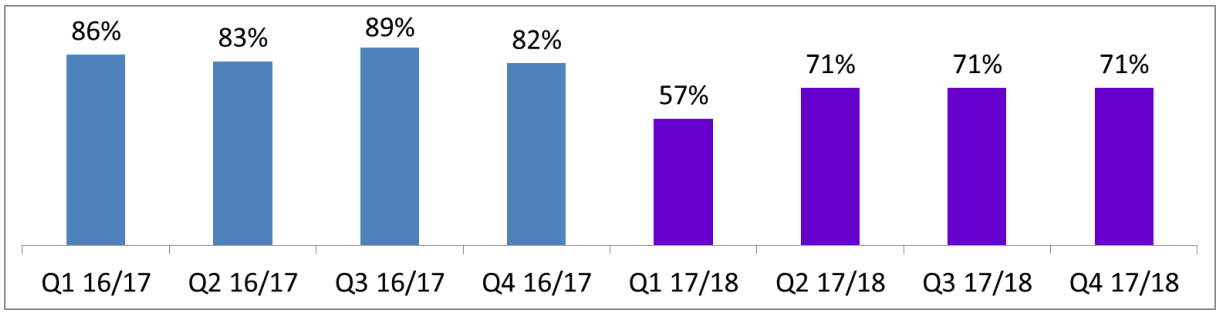
Prescription review requires that for all those patients who received an IV antibiotic, their prescription is reviewed within 72 hours. The national target is 90% and this has always been achieved.



Source: Local audit

Neutropenic sepsis % of patients with door to needle time of 1 hour or less

Neutropenic sepsis is now routinely monitored and reviewed, requiring all patients who do not receive IV antibiotics within one hour to have a concise RCA completed. On average 20 patients with suspected sepsis present to the hospital each month. Performance in 2017-18 was lower than in 20116-17. Actions to identify improvement are identified from the RCA investigations.



Source: Local monitoring (all applicable patients)

Action to be implemented in 2018-19

- Further improvement in both the identification and treatment of both severe sepsis and neutropenic sepsis in both those attending emergency care areas and hospital inpatients
- Continued training on sepsis for all areas of the organisation, with enhanced focus on the importance of recognition and the timely administration of IV antibiotic within one hour of sepsis diagnosis
- Improved and sustained performance for receiving IV antibiotic within one hour of diagnosis
- Establishment of a sepsis and AKI senior nurse role incorporating audit, education and case reviews within the scope of this role. This was progressed last year however will be vital in order to progress and develop further.

(c) 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

Description of the issue and rationale for selection

During 2017-18, trusts were required to collect and publish specified information on deaths. This will be reported 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.

Action taken during 2017-18

In May 2017, the Board approved a programme of work which included:

- adoption of a trust policy on Learning from Deaths
- recruitment of medical reviewers to perform objective reviews of patient care using an evidence-based method
- measures to increase the involvement of relatives and carers in improvements resulting from learning from deaths
- changes to the way in which information about problems in care associated with deaths in the trust is reported

Throughout 2017-18, the Trust has continued to operate its previous approach to mortality review while the multidisciplinary Learning from Deaths (LfD) Group has overseen a change programme to meet the new guidance fully. The previous approach was for consultants to review the care themselves for people who died in their care. Learning which was generated was acted on in the local clinical setting. Preventable deaths were peer reviewed by a clinical director and discussed at the monthly LfD group meetings. Where a problem in care may have caused harm, cases were investigated under the Serious Incident Framework.

In February 2018, a dedicated team of medical reviewers started work to review all deaths on behalf of the trust, using the Royal College of Physicians' structured judgment review method. Every family is invited to speak to a medical reviewer to raise any concerns about the standard of care their relative received. The vast majority of families so far have taken up this offer. The reviewers then take the family's views into consideration when they perform their review.

If the medical reviewer judges the care to have been poor or very poor overall, an initial meeting will be held with an executive director and the clinical team to decide whether the case requires investigation as an incident. If so, the Serious Incident Framework will be triggered. If not, the case will be referred back to the clinical team for discussion and to identify and embed learning and actions.

Specific actions undertaken during 2017-18 as a consequence of the learning from deaths process are set out below.

During 2017-18 1,060 of West Suffolk NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 224 in the first quarter
- 217 in the second quarter
- 292 in the third quarter
- 316 in the fourth quarter.

By 26 April 2018, 899 case record reviews and 17 investigations have been carried out in relation to 899 of the deaths.

In 17 cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- Five in the first quarter
- Eight in the second quarter
- Three in the third quarter
- One in the fourth quarter

One death representing 0.1% of the 1,060 patient deaths during the reporting period was judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- None of the deaths which occurred in the first quarter
- One representing 0.5% of the number of deaths which occurred in the second quarter
- None of the deaths which occurred in the third quarter
- None of the deaths which occurred in the fourth quarter.

No case record reviews or investigations were completed after 31 March 2017 which related to deaths which took place before the start of the reporting period.

Eight representing 0.7% of the previous reporting period (2016/17) of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

These numbers have been estimated using the following pathway.

Cases in which the named consultant considers there to have been any degree of preventability are peer-reviewed by a clinical director, and after review a decision taken whether to downgrade or not.

Cases not downgraded after peer review follow the Trust serious incident (SI) investigation and reporting pathway.

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

- in the Trust, people who are vulnerable because of mental illness were not assessed well for their risk of self-harm or suicide and the Missing Person's procedure can be difficult to follow
- clinical teams need a clear rationale for locating medical patients on surgical wards (referred to as "outlying") and a method for assessing whether patients' care could suffer if they were outliers
- oxygen is not always prescribed and administered accurately
- the Trust needs more effective ways to plan for patients' discharge from hospital when safeguarding concerns have been raised
- a medicine which can cause respiratory depression was given to someone who already had respiratory insufficiency
- the falls assessment the Trust currently uses is not sensitive to the complex needs of some patients
- the term 'medically fit for discharge', whilst clinically accurate, is misleading for patients and families because it infers that discharge will happen imminently, which very often is not the case
- our use of spirometry and the recognition of the importance of abnormal spirometry results needs to be improved
- when a patient starts to deteriorate, it is important to continue to:
    - maintain good clinical documentation
    - review the decisions previously made about resuscitation and escalation of care if they are no longer responding to treatment
- on occasion, resuscitation status has not been accurately recorded on the electronic patient record
- in one case of bleeding in a patient who was anticoagulated, evidence based care was not followed
- in occasion, death certificates have not been completed accurately
- acute kidney injury and fluid management are not always well managed
- in one case, treatment of acute aortic dissection was delayed.

Actions taken in 2017-18 as a consequence of what has been learnt during 2017-18.

Issue	Description of action
Assessment of people with mental illness for risk of self-harm Ease of use of the Missing Person's procedure	A task and finish group was formed to review the appropriate policies to support the care of this vulnerable group. The Missing Persons policy has been amended. The crucial change to the policy is that, when making an assessment of risk after a person has gone missing, whatever the risk score that the assessment tool returns, if a member of staff continues to feel concerned about the missing person's welfare and safety, the level of search can be escalated. Work continues on this policy to make sure it is applicable in all our care settings, not just the West Suffolk Hospital. The group are also drafting a new policy for the welfare of people presenting with self-harm, in partnership with colleagues from Norfolk and Suffolk NHS Foundation Trust.
Need for a clear rationale for locating medical patients on surgical wards (referred to as "outlying") and a method for assessing whether patients' care could suffer if they were outliers	A task and finish group has been formed, chaired by the deputy chief operating officer. A clinical guideline has been drafted.
Oxygen is not always prescribed and administered accurately	Oxygen management was audited; the audit results showed that oxygen prescribing is not well done. A quality improvement project will be initiated, led by the Drugs and Therapeutics Committee.
More effective ways to plan for patients' discharge from hospital when safeguarding concerns have been raised	The safeguarding team worked with staff and the social workers team to develop "best interest forms" for use in this scenario. The forms are available electronically, the process has been agreed with social care colleagues and communication to hospital teams has been completed.
Medicine which can cause respiratory depression should not be given to people who already have respiratory insufficiency	The details of this case have been shared with the medical and surgical divisions. The contraindications to the medication in question have been highlighted in the monthly pharmacy bulletin.
The falls assessment the trust currently uses is not sensitive to the complex needs of some patients	A new electronic 'safety and orientation' assessment has been created. This is completed alongside the first vital signs that a nurse takes on transfer into a clinical area. The assessment allows the nurse to understand the complex needs of patients within 15 minutes of arrival, and take appropriate measures, such as the use of side rails and Wanderguard requirements. The assessment is available for use in all wards and departments.
The term 'medically fit for discharge', whilst clinically accurate, is misleading for patients and families because it infers that discharge will	The case has been presented to the Nursing and Midwifery Council and to the medical division for dissemination of learning

Issue	Description of action
happen imminently, which very often is not the case	
Our use of spirometry and the recognition of the importance of abnormal spirometry results needs to be improved	A referral guideline is being written by the respiratory specialists
When a patient starts to deteriorate, it is important to continue to: • maintain good clinical documentation • review the decisions previously made about resuscitation and escalation of care if they are no longer responding to treatment.	The base ward nursing staff received feedback on this case, emphasising the importance of clear documentation. The case was presented to the medical division to raise awareness of the need to review resuscitation status when clinical status changes It will also be used as a teaching case for training doctors to use our electronic patient record system, to demonstrate how the message centre can be used to communicate between teams which are sharing a patient's care
Bleeding in a patient who was anticoagulated – anticoagulation not reversed at time of admission	The case has been presented to medical teams and the emergency department as refresher training
Delayed treatment of acute aortic dissection	An education article has been written for the digital quality and safety bulletin (see below) The case has been presented to junior doctors for refresher training.

Actions proposed to be taken in 2018-19, as a consequence of what has been learnt during 2017-18.

Issue	Description of action
The term 'medically fit for discharge', whilst clinically accurate, is misleading for patients and families because it infers that discharge will happen imminently, which very often is not the case	This case will also be written up and presented in the first edition of a new digital quality and safety bulletin which is being developed and expected to go live at the end of Q1 2018-19
Our use of spirometry and the recognition of the importance of abnormal spirometry results needs to be improved	We will assess the need for an outreach spirometry service for patients needing spirometry who are not on a specialist respiratory ward
Resuscitation status is not always accurately recorded on the electronic patient record	A project on improving resuscitation recording has been incorporated into the 2018-19 electronic patient record optimisation programme
Acute kidney injury and fluid management are not always well managed	A optimisation project on how the electronic patient record system can facilitate better fluid management and better management of acute kidney injury

Issue	Description of action
Death certificates are not always completed accurately	A medical training seminar will be given on completing death certificates
The falls assessment the Trust currently uses is not sensitive to the complex needs of some patients	The use of the new safety and orientation assessment will be audited

The impact of the actions described taken in 2017-18 were as follows:

Apart from in the ways already described, the impact of these actions has not been measured yet. Many of the actions are still in hand and the majority have been triggered by rare events, which we would not expect to recur in high enough numbers to see a measureable improvement (due to the noise created by random variation).

Our approach to learning from deaths is evolving and we are actively looking for ways in which to measure impact; in particular we are looking for ways to measure improvements more agilely and less resource intensively than relying on manual audit. It is likely that our electronic patient record system can support this. We have appointed a new Head of Quality Improvement who will work closely with the clinical governance team and the Head of Performance to make better use of the information we currently gather. We are also working with our family representative and patient experience manager to consider how family members could help us measure impact, and how we could employ qualitative methods when numbers would not be informative.

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

	2017-18 Target	2017-18 Actual	2016-17 Actual	2015-16 Actual	2014-15 Actual
C. *difficile* - hospital attributable trajectory cases [1]	16	19 (7)	23 (5)	22 (10)	23 (21)
18 week maximum wait from point of referral to treatment (patients on an incomplete pathway) [2]	92%	**86.42%**	92.55%	96.25%	96.97%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge [3]	95%	**89.33%**	86.89%	94.26%	93.54%
62-day urgent GP referral to treatment wait for first treatment - all cancers	85%	**86.68%**	85.92%	88.05%	88.01%
62-day wait for first treatment from NHS cancer screening service referral	90%	**94.90%**	97.85%	95.68%	95.10%
31-day wait for second or subsequent treatment - surgery	94%	**100%**	100.00%	100%	100%
31-day wait for second or subsequent treatment - anti-cancer drug treatments	98%	**100%**	100.00%	99.87%	100%
31-day diagnosis to treatment wait for first treatment - all cancers	96%	**99.94%**	99.92%	100%	100%
Two week wait from referral to date first seen comprising all urgent referrals (cancer suspected)	93%	**94.62%**	94.78%	98.46%	98.52%
Two week wait from referral to date first seen comprising all urgent referrals for symptomatic breast patients (cancer not initially suspected)	93%	**96.66%**	88.54%	98.28%	97.19%
Maximum 6-week wait for diagnostic procedures	99%	**99.92%**	96.40%	91.68%	98.94%

[1] Figures in brackets exclude cases that West Suffolk CCG deemed to be non-trajectory (no identified lapses in care). Two cases for 2017-18 are pending CCG final opinion.
[2] 2016-17 and April 2017 data is based on estimated performance.
[3] 2016-17 data covers a 50 week period as excludes two weeks in May 2016 when e-Care was implemented

As can be seen from the targets and indicators performance, we have continued recent good performance and met all national targets in 2017-18 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 2017-18 was extremely challenging - flow through the hospital affected our ability to deliver, with planned escalation capacity unable to meet the level of actual demand seen requiring 'surge' beds to be open for prolonged periods.

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

- established escalation capacity with two assessment bays on ward F8 (acute assessment area) opened 24/7 and the winter escalation ward on G9
- introduced a surgical ambulatory emergency care (AEC) service to sit alongside the medical AEC service
- established a discharge waiting area, including capacity for patients on beds.

These arrangements were in addition to the plans and procedures we had put in place during the year by embedding Red2Green as a day-to-day part of what we do. In turn this was supported by a series of initiatives to help our patients get fit and well as soon as possible e.g. ending PJ paralysis to get patients up and moving, and our support to go home service. The support to go home service saved us more than 150 bed days in its first month. In January 2018 we held our fourth 'perfect week' with both clinical and non-clinical areas pulling together to focus on supporting patient flow throughout the hospital, in order to maintain high quality standards of care and positive patient experience. A joint-initiative was also implemented to help care home residents receive quicker and more effective care should they need to come into hospital. Care home residents in east and west Suffolk are set to benefit from the new 'Red Bag' scheme; the bag contains important medical information, medication and personal items packed by care home staff, and transferred to the hospital via ambulance colleagues.

Weekly multi-disciplinary team (MDT) reviews are also held for stranded patients (inpatients that have been in hospital for seven days or more), and those patients with the longest length of stay (31 days or more). This is part of a wider programme of work to ensure that the care we provide to patients is as coordinated and efficient as possible, to avoid unnecessary delays for inpatients, and helping us to provide emergency department (ED) and inpatient services safely over winter and beyond.

The Trust also set an aspiration and ambition for each ward to discharge at least two 'golden' patients out of their total daily discharges before 10.00am each day. Patients should be discharged either out of hospital or to the discharge waiting area.

We have reflected on the lessons from winter 2017-18 and are already putting in place plans for next winter to ensure that we create bed capacity aligned with staffing plans, grip process and capacity within the emergency department and the organisation as a whole; we are also working and work with system partners to ensure plans are effectively integrated.

- **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 2017-18 we addressed these difficulties and established a functional patient tracking list (PTL) within e-Care. Availability of patient level data has informed targeted action to significantly improve referral to treatment (RTT) performance during the year – from 79.7% in May '17 to 89.6% in Feb '18.

  In response to winter pressures, like many hospitals we significantly reduced our elective programme in January and February 2018. This impacted on performance and has meant that we have had to review our original plans and improvement trajectory. Plans are being finalised to recover the 92% RTT standard by October 2018.

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 have maintained an overall A rating from August 2016 to November 2017, continuing to demonstrate world class performance for our patients that require stroke specific care. The stroke team have encountered challenges during the year, including recruitment of nursing and audit staff and IT issues. It is testimony to their commitment that we have managed to maintain this high standard.

Contractual stroke targets

	Target	2017-18	2016-17
% of patients scanned within 1 hour of clock start	77%	**78.01%**	**74.62%**
% of patients scanned within 12 hours of clock start	96%	**96.07%**	**97.00%**
% of patients admitted directly to Stroke Unit within 4 hours of clock start	75%	**75.62%**	**74.01%**
>80% treated on a stroke unit >90% of their stay	90%	**92.32%**	**88.47%**
% of patients treated by a stroke skilled early supported discharge team	48%	**48.32%**	**46.14%**
% of patients assessed by a stroke specialist consultant physician within 24 hours of clock start.	80%	**88.78%**	**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%	**85.33%**	**78.36%**
% of eligible service users given thrombolysis	100%	**100%**	**83.52%**
All stroke survivors to have a 6 month follow up assessment.	59%	**59%**	**57.59%**

Incident reporting and learning

WSFT has continued to build upon and further strengthen the arrangements for managing serious incidents requiring investigation (SIRIs). The board takes the lead on this process and all SIRIs have an executive sign off. This includes a review of the management, investigation and learning from SIRIs on a monthly basis. With a learning report going to the clinical safety and effectiveness committee (CSEC) on a quarterly basis where these are reviewed in greater depth, including any associated action plans. The total number of SIRIs reported during 2017-18 was 118 (87 in 2016-17). There has been a considerable increase in reporting and this was mainly as a consequence of inclusion of community services data from October 2017. The Trust has worked hard to increase incident reporting as previously we have been seen as a low reporter.

These can be broken down into incidents which cross a number of themes including:

Pressure ulcers: ▪ 'Hospital acquired' ▪ 'Community – In our care'	 49 23
Treatment delay	8
Sub-optimal care of the deteriorating patient	8
Slips/trips/falls	7
Maternity/Obstetric/Neonatal incident	7
HCAI/Infection control	7
Confidential information leak/information governance breach	3
Medication	2
Diagnostic incident including delay	3
Surgical/invasive procedure	1
	118

The Trust proactively encourages staff at all levels to engage with the investigation of SIRIs and significant learning continues to take place. All 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 within the emergency department
- Pressure Ulcers
- Falls
- Communication
- Human Factors and Situational awareness factors

During 2017-18, there was one **never event** reported and subject to detailed investigation.

A patient had taken an unintentional overdose of methotrexate by using subcutaneous methotrexate injections on a Monday and taking oral methotrexate tablets on a Friday over a four week period. This was discovered following a review taking place after the patient had accessed the rheumatology help line at WSH. The root cause of this incident was human error when the methotrexate prescription details were entered on the GP electronic health record system. This information was entered as a repeatable oral methotrexate prescription rather than as a "non-prescribed" medicine record of the use of sub-cutaneous methotrexate. The incorrect oral repeatable prescription was then subsequently ordered by the patient after a hospital rheumatology department appointment, where the patient understood that they should start oral methotrexate.

Although this was not a result of a WSH incident, the WSH reported and managed the incident in conjunction with the GP surgery and CCG.

The definition of the Never Event category for this incident relates to overdose of methotrexate for non-cancer treatment overdose refers to:

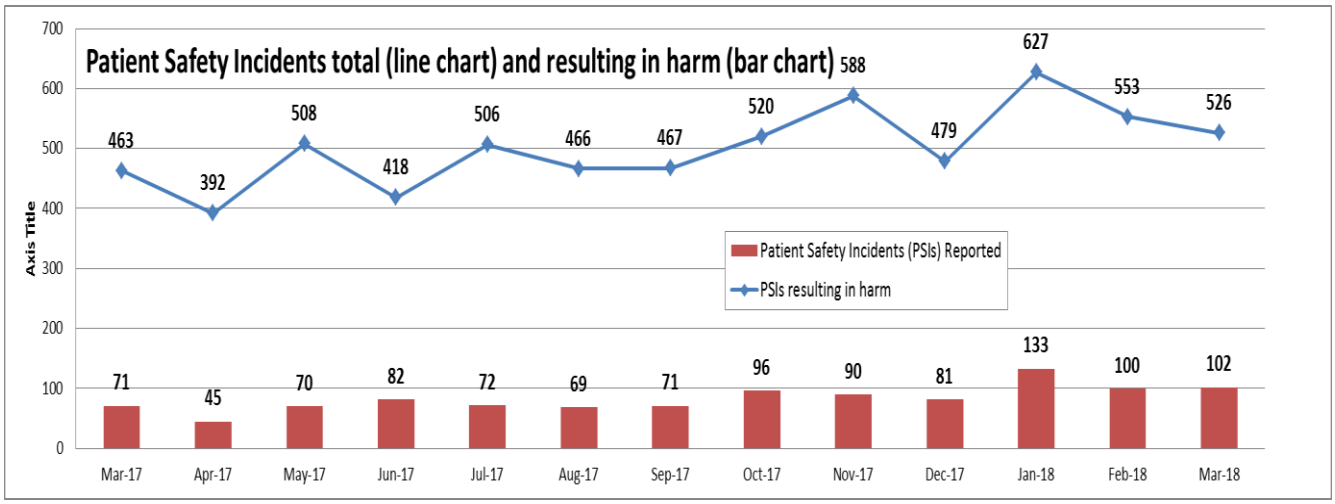
> When a patient receives methotrexate, via any route, for non-cancer treatment which results in more than the intended weekly dose being taken, despite the care setting having an electronic prescribing and administration system, or in primary care an electronic prescribing and dispensing system, in place

Lessons learnt as a result include:

- The split prescribing responsibility for methotrexate, with different processes for oral and sub cutaneous methotrexate prescribing, leads to the need for complex recording processes to manage these patients in both primary and secondary care
- The investigation team was not able to access practice documentation recording the induction training provided to new GP's confirming awareness of appropriate use of the electronic health record systems
- Apparent lack of standard documented Standard Operating Procedures (SOP's) for the management of complex medication within West Suffolk GP practices
- Communication with patients regarding the advice on taking methotrexate needs to be explicit – not just referring to Monday injection and Friday tablets. For patient safety, all conversations must include the drug name. It is accepted that some patients struggle with the names of the medication that they are prescribed. Patients must be advised that they should only ever take methotrexate by one route and no more than once a week.

Patient safety incident (PSI) reporting

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.



Source: Datix

The board reviews this data on a monthly basis and recognises the increased reporting rate as a positive reflection of an open culture within the organisation which supports learning from incidents.

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

Duty of candour (DOC)

The DOC is a direct response to recommendation 181 of the Francis Inquiry report into Mid-Staffordshire NHS Foundation Trust. DOC is required for all safety incidents which have resulted in moderate, severe harm or death and prolonged psychological harm. In November 2014, DOC was legislated and required NHS organisations to:

a) Have a face-to-face discussion with the patient or relevant person following a safety incident resulting in moderate harm or above
b) Provide written communication following the face-to-face discussion with the patient, to include:

- An account of the known facts about the incident
- Details of any enquiries to be undertaken
- The results of any enquiries into the incident
- An apology.

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

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

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

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 many different issues including those 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. These also include, where appropriate, discussions with patients and their families. 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 presence of senior staff on the walkabouts also helps to address and raise issues in a timely manner.

The quality walkabout process provides formal feedback with the ward manager, service manager, matron and general manager. 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
- Cleanliness and infection control
- Resuscitation trolley checks
- Checking of compliance and displaying up to date information
- 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.

The quality walkabouts enabled staff to raise concerns directly with senior leaders and governors. This has received positive feedback from staff and we continue to plan the programme on a quarterly basis which in 2018-19 will also include community services. As well as feeding back the findings to the area visited the board and governors receive a quarterly summary of walkabout activity and learning.

Nursing teams have gone digital with a new app to make ward inspections quicker, easier and more effective - **Perfect Ward** is a smart app to support ward inspections, so those completing audits can now score questions, capture photos and write free-text comments straight into the app, meaning information is quick to record and up-to-date. Information is stored in the app rather than on the phone used, so it's always secure. Capturing the information directly on phones or tablets also means there's no longer a need to write up and send reports afterwards, saving valuable time. As soon as an inspection is complete, everyone with the app can be alerted and see the results. With automated reporting, it's also much easier to compare performance and track improvements at ward level. There are five different audits available in the app; documentation, observation, patient experience, staff and infection prevention and control. Matrons, ward managers, service managers, general managers, pharmacy, executive directors and the infection prevention team all have access to Perfect Ward, and are using it to complete all ward audits at the West Suffolk Hospital, as well as Rosemary Ward in Newmarket Hospital, and the Kings Suite at Glastonbury Court.

Complaints management

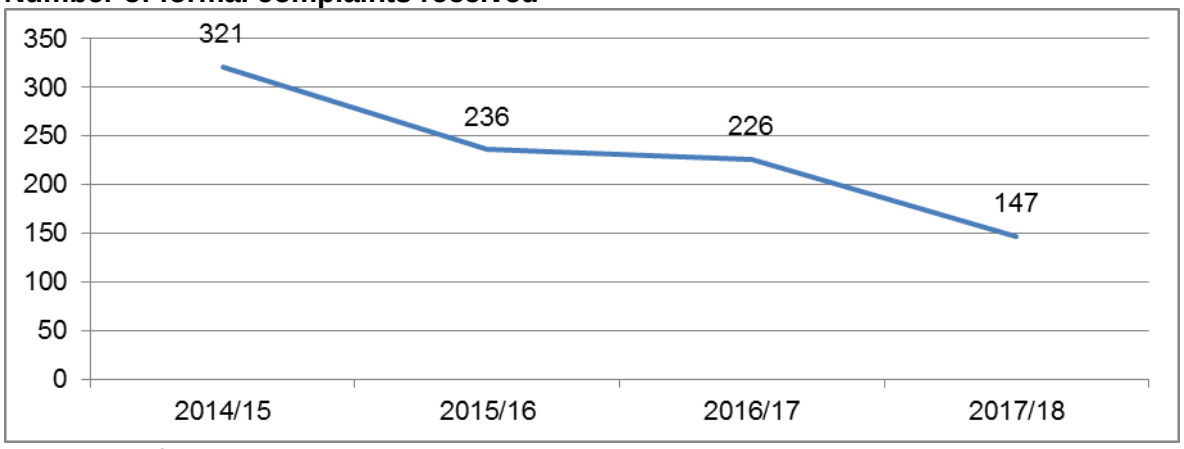
WSFT is committed to providing an accessible, fair and effective means of communication for those persons who wish to express their concerns with regard to the care, treatment or service provided by the Trust.

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, associate directors, clinical directors 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 and patient experience committee.

WSFT received 147 formal complaints during 2017-18. This represents a decrease in numbers compared to previous years, as demonstrated below. The Board monitors complaints and learning on a monthly basis as part of the quality reporting arrangements.

Number of formal complaints received



Source: Datix

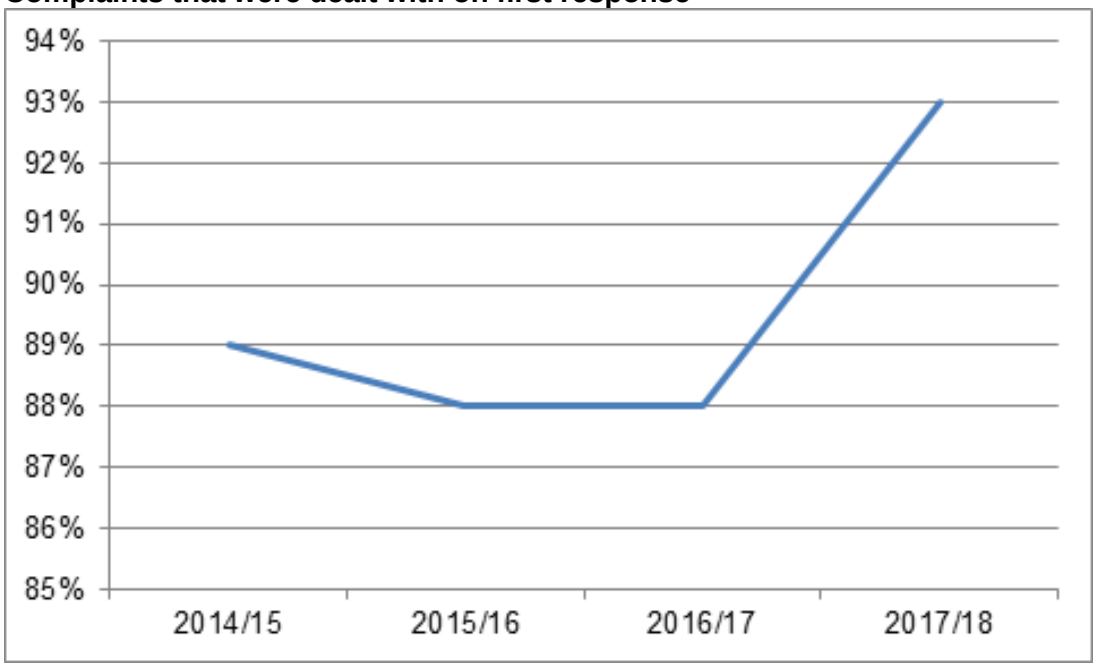
During 2016-17, the patient experience team recognised that not all people making complaints wish for their concerns to be dealt with or responded to in the same way; it is important to give choice and

involve people in their or their loved one's care. Processes were therefore adapted in 2017-18 to deliver a more personal service for handling complaints, some of the changes included:

- Introduction of a triage process on receipt of formal complaints, determining at an early stage whether a meeting would be useful for the complainant
- Where appropriate, discussing concerns with the complainant on the telephone when the complaint is first received, in order to agree the most satisfactory approach to dealing with their complaint
- Involving staff in the most appropriate way of dealing with a complaint at the outset of the investigation in order to assist satisfactory resolution
- Maintaining communication with complainants throughout the investigation by setting up a new email address.

The action taken throughout the year appears to have had the desired effect, resulting in a greater complainant satisfaction percentage. The graph below demonstrates the percentage of complaints that were dealt with on first response. It is disappointing that at times during the year we were unable to provide the complaint responses as quickly as we would have liked. The timeliness of complaint responses is reported to the Board each month.

Complaints that were dealt with on first response



Source: Datix

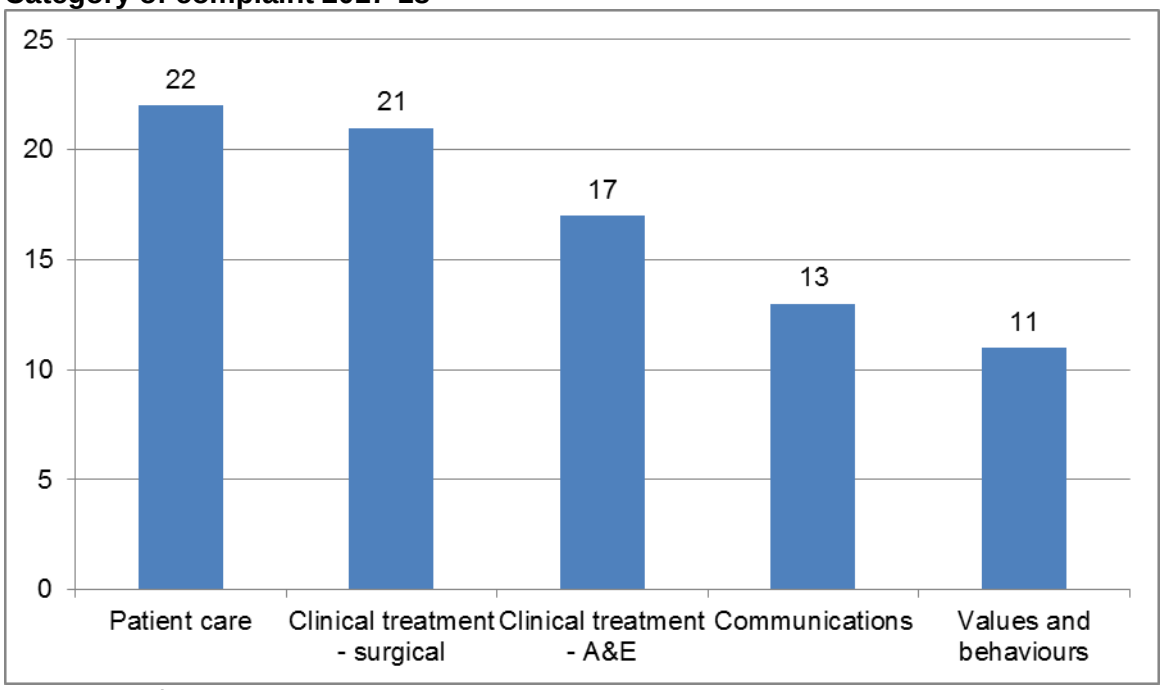
Complainants who are dissatisfied with the Trust's response can refer their concerns directly to the PHSO for an independent review. During 2017-18, seven complaints were referred to the PHSO, compared to nine during 2016-17.

In 2017-18, the PHSO completed its review of six complaints:

- Two complaints were partially upheld and resulted in an apology from the Trust and an action plan.
- Two complaints were partially upheld and resulted in an apology from the Trust, compensation of £500 and an action plan.
- Two complaints were not upheld

The main themes and trends from complaints are described below.

Category of complaint 2017-18



Source: Datix

Please note that the numbers identified in the chart above list only primary concerns, many complaints have multiple categories.

This result is a significant change on the previous year, whereby 'patient care' featured as the primary category in 67 complaints. This also demonstrates an improvement in complaints around communication, which in previous years has featured heavily as a concern for our patients and their loved ones (in 2016-17, 33 complaints were categorised primarily as 'communications').

Upon investigation the most common sub-category of 'patient care' was 'care needs not adequately met' (10), with seven of these relating to a general lack of satisfactory nursing care with several mentioning that the wards were very busy and appeared understaffed.

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

- Mandatory study day introduced for all registered nurses and nursing assistants working in the emergency department relating to caring for patients with dementia
- Review of standard appointment letters resulting in improvements to paper wastage on a large scale
- Introduction of a new patient safety 'rounding tool' in the emergency department, including hourly pain checks
- Staff training for working with patients with learning disabilities

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 632 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.

National CQC patient surveys

The CQC carry out a variety of patient surveys, the most frequent of which occurs annually. Feedback from national as well as local surveys is used to monitor service performance and focus on quality improvement.

- Inpatient survey 2016 (annual)

Inpatient services scored significantly better on two questions:

- How would you rate the hospital food?
- Did hospital staff discuss with you whether additional equipment or adaptions were needed in your home?

Patients reporting having to share the same bathroom or shower area with patients of the opposite sex revealed the Trust as the poorest performing of all NHS organisations that took part in the survey.

Overall the Trust performed as follows:

Question	Score 2015	Lowest trust score achieved	Highest trust score achieved	Score 2016	Diff
Overall, did you feel you were treated with respect and dignity while you were in hospital?	9.3	8.5	9.8	9.2	↓
During your time in hospital did you feel well looked after by hospital staff?	9.2	8.3	9.7	9.1	↓
During your hospital stay, were you ever asked to give your views on the quality of your care?	1.9	0.9	4.4	1.2	↓
Did you see, or were you given, any information about how to complain to the hospital about the care you received?	2.6	1.4	5.0	2.6	→

The Trust's overall score was 8.3, 0.1 lower than last year. The lowest overall score achieved by any Trust was 7.4 whilst the highest was 9.2.

2017 results will not be available until summer 2018.

- Emergency department survey 2016 (biennial)

The emergency department scored 'about the same' on all questions.

Key areas for improvement in comparison to 2014 results were:

- Waiting over four hours to be seen
- Patients not clearly being told why tests were required
- Appropriate pain relief given within good time

- Maternity survey 2017 (biennial)

Maternity services scored significantly better on one question:

- Thinking about the care you received after the birth of your baby, were you treated with kindness or understanding?

Scores were 'about the same' on all other indicators, with none rated significantly worse than other organisations.

Overall the Trust scored significantly better than its 2015 scores on three questions:

- If you needed attention during labour and birth, were you able to get a member of staff to help you within a reasonable time?
- If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you within a reasonable time?
- Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness or understanding?

- Children and young people survey 2017

Children and young people's services scored significantly better on eight questions:

For parents and carers:
- The ward had the appropriate equipment or adaptations their child needed
- The room or ward their child stayed on was clean
- They were told what would be done before their child's operation or procedure
- Received an explanation about how the operation or procedure had gone
- Received enough information about their child's new medication
- Told what would happen next after their child left hospital

For children and young people:
- They were told what would be done before their operation or procedure
- They were told who to contact if they were worried about anything when they got home

Scores were significantly worse on two questions:

For parents and carers:
- Given a choice of admission date

For children and young people:
- Feeling the ward they stayed on was suitable for their age

National staff survey 2017

The WSFT has seen a slight drop in response rate in the latest NHS staff survey results, but maintains a strong position as the hospital that nationally is the most highly rated by its staff, according to the latest NHS staff survey.

Staff recommendation of the organisation as a place to work or receive treatment has the highest score of any comparable acute trust in England of 4.12 (national average of 3.76).

The percentage of staff agreeing that their role makes a difference to patients / service users increased to 93% – among the top 20% of acute trusts, with a national average was 90%.

Asked questions about whether they would recommend the hospital as a place to work or receive treatment, 87% 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 86% of staff agreed that they would compared with a national result of 71%. WSFT remains in the top 20% of all similar NHS Trusts for staff engagement. It is also a leading trust for the extent to which staff look forward to going to work and being enthusiastic about and absorbed in their jobs.

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

The WSFT KF26 result has reduced to 20%, compared with the national average of 25%. 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	85 %

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 2017	Average (median) for acute trusts	Our Trust in 2016
KF25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	27%	27%	28%
		BME	42%	28%	24%
KF26	Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	19%	25%	23%
		BME	30%	27%	31%
KF21	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White	89%	87%	92%
		BME	82%	75%	80%
Q17b	Not experienced discrimination from manager/team leader or other colleagues	White	6%	7%	6%
		BME	16%	15%	18%

3.7 Development of the quality report

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

During 2017-18 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	%
Adult Cardiac Surgery	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	-
Adult Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	-
Assessment of Side Effects of Depot and LA Antipsychotic Medication Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists	No	N/A	-
Bowel Cancer (NBOCAP)	Royal College of Surgeons	Yes	Yes	Ongoing[1]
Cardiac Rhythm Management (CRM)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	-
Case Mix Programme (CMP)	Intensive Care National Audit and Research Centre (ICNARC)	Yes	Yes	Ongoing[1]
National Audit of Percutaneous Coronary Interventions (PCI)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	-
Cystectomy	British Association of Urological Surgeons (BAUS)	No	N/A	-
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]
Falls (Falls and Fragility Fractures Audit Programme FFFAP)	Royal College of Physicians	Yes	Yes	100
Female Stress Urinary Incontinence	British Association of Urological Surgeons (BAUS)	Yes	Yes	Ongoing[1]
Fractured Neck of Femur (care in emergency departments)	Royal College of Emergency Medicine (RCEM)	Yes	Yes	100
Head and Neck Cancer Audit	Saving Faces – The Facial Surgery Research Foundation	No	N/A	-
Hip Fracture Database (NHFD) (Falls and Fragility Fractures Audit Programme FFFAP)	Royal College of Physicians	Yes	Yes	Ongoing[1]
Hip Replacement (National Joint Registry) (NJR)	Healthcare Quality Improvement Partnership (HQIP)	Yes	Yes	Ongoing[1]
Inflammatory Bowel Disease (IBD) Registry	Inflammatory Bowel Disease Registry	Yes	No[2]	0
Knee Replacement (National Joint Registry) (NJR)	Healthcare Quality Improvement Partnership (HQIP)	Yes	Yes	Ongoing[1]
Learning Disability Mortality Review Programme (LeDeR Programme)	University of Bristol	No	N/A	-
Major Trauma Audit	Trauma Audit and Research Network (TARN)	Yes	Yes	Ongoing[1]
Myocardial Ischaemia National Audit Project (MINAP)	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	Yes	Ongoing[1]

National clinical audit	Host organisation	Eligible	Participated	%
National Audit of Anxiety and Depression	Royal College of Psychiatrists	No	N/A	-
National Audit of Breast Cancer in Older People (NABCOP)	Royal College of Surgeons	Yes	Yes	Ongoing[1]
National Audit of Dementia	Royal College of Psychiatrists	Yes	Yes[3]	-
National Audit of Intermediate Care (NAIC)	NHS Benchmarking	Yes	Yes	100
National Audit of Oesophago-Gastric Cancer (NAOGC)	Royal College of Surgeons	Yes	Yes	Ongoing[1]
National Audit of Psychosis	Royal College of Psychiatrists	No	N/A	-
National Audit of Seizures and Epilepsies in Children and Young People	Royal College of Paediatrics and Child Health	No	N/A	-
National Bariatric Surgery Registry (NBSR)	British Obesity and Metabolic Surgery Society (BOMSS)	No	N/A	-
National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC)	Yes	Yes	Ongoing[1]
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	British Society for Rheumatology (BSR)	Yes	Yes[3]	-
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	London North West Healthcare NHS Trust	No	N/A	-
National Diabetes Core Audit (NDA)	Health and Social Care Information Centre (HSCIC)	No	N/A	-
National Diabetes Footcare Audit (NDFA)	Health and Social Care Information Centre (HSCIC)	Yes	Yes	Ongoing[1]
National Diabetes Inpatient Audit (NaDIA)	Health and Social Care Information Centre (HSCIC)	Yes	Yes	100
National Emergency Laparotomy Audit (NELA)	The Royal College of Anaesthetists	Yes	Yes	Ongoing[1]
National End of Life Care Audit	Royal College of Physicians	Yes	Yes[3]	-
National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research (NICOR)	Yes	Yes	Ongoing[1]
National Lung Cancer Audit (NLCA)	Royal College of Physicians	Yes	Yes	Ongoing[1]
National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists	Yes	Yes	100
National Ophthalmology Audit	Royal College of Ophthalmologists	Yes	No[4]	-
National Pregnancy in Diabetes Audit (NPID)	Health and Social Care Information Centre (HSCIC)	Yes	Yes	Ongoing[1]
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	British Association of Urological Surgeons (BAUS)	Yes	Yes	Ongoing[1]
Neurosurgical National Audit Programme	Society of British Neurological Surgeons	No	N/A	-
Paediatric Congenital Heart Disease (CHD)	National Institute for Cardiovascular Outcomes Research (NICOR)	No	N/A	-
Paediatric Intensive Care Audit Network (PICANet)	University of Leeds	No	N/A	-

National clinical audit	Host organisation	Eligible	Participated	%
Pain in Children (care in emergency departments)	Royal College of Emergency Medicine (RCEM)	Yes	Yes	100
Percutaneous Nephrolithotomy	British Association of Urological Surgeons (BAUS)	Yes	Yes	Ongoing[1]
Prescribing for Bipolar Disorder (Use of Sodium Valproate) Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists	No	N/A	-
Primary Care (National Chronic Obstructive Pulmonary Disease (COPD) Audit programme)	Royal College of Physicians	No	N/A	-
Procedural Sedation in Adults (care in emergency departments)	Royal College of Emergency Medicine (RCEM)	Yes	Yes	100
Pulmonary Rehabilitation (National Chronic Obstructive Pulmonary Disease (COPD) Audit programme)	Royal College of Physicians	No	N/A	-
Radical Prostatectomy	British Association of Urological Surgeons (BAUS)	No	N/A	-
Re-Audit of Red Cell & Platelet Transfusion in Adult Haematology Patients (National Comparative Audit of Blood Transfusion Programme)	NHS Blood and Transplant	Yes	Yes	100
Secondary Care (National Chronic Obstructive Pulmonary Disease (COPD) Audit programme)	Royal College of Physicians	Yes	Yes	Ongoing[1]
Sentinel Stroke National Audit Programme (SSNAP) Clinical Audit	Royal College of Physicians	Yes	Yes	Ongoing[1]
Transfusion Associated Circulatory Overload (TACO) (National Comparative Audit of Blood Transfusion Programme)	NHS Blood and Transplant	Yes	Yes	100
UK National Haemovigilance Scheme	Serious Hazards of Transfusion (SHOT)	No	N/A	-
UK Parkinson's Audit	Parkinson's UK	Yes	Yes	100
Urethroplasty	British Association of Urological Surgeons (BAUS)	No	N/A	-
Use of Depot/LA Antipsychotics for Relapse Prevention Prescribing Observatory for Mental Health (POMH-UK)	Royal College of Psychiatrists	No	N/A	-

1 Data collection is ongoing therefore the percentage of cases submitted against registered cases required in 2017-18 is currently unavailable

2 Implementation of data collection for the Inflammatory Bowel Disease Registry has been delayed due to participation in the Addenbrooke's biologics research, the development of IBD MDT meetings, additional clinics to review patient's medication, and staff sickness. It has been agreed that support will be provided to assist future participation.

3 Included in the Quality Accounts list however there was no data collection in 2017-18

4 The National Ophthalmology Audit requires the use of Medisoft software, which is incompatible with e-Care. The Open Eyes platform has been agreed as a solution to facilitate participation and is part of the proposed work schedule of the Global Digital Excellence funding programme. The delayed start has been agreed with the National Ophthalmology Audit provider.

Table B: Clinical outcome review programmes participation

Clinical outcome review programme	Host organisation	Eligible	Participated	%
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]
Cancer in Children, Teens and Young Adults (Medical and Surgical Clinical Outcome Review Programme)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	100
Heart Failure (Medical and Surgical Clinical Outcome Review Programme)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	100
Perioperative Diabetes (Medical and Surgical Clinical Outcome Review Programme)	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Yes	Yes	100
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	-
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	-

[1] Data collection is ongoing therefore the percentage of cases submitted against registered cases required in 2017-18 is currently unavailable

Table C: Action from national clinical audit reports

Name of national clinical audit	Summary of actions taken
National Ophthalmology Database Audit (NOD) 2017	Recommendations reviewed by the Ophthalmology Clinical Lead. The National Ophthalmology Audit requires the use of Medisoft software, which is incompatible with e-Care. The Open Eyes platform has been agreed as a solution to facilitate participation and is part of the proposed work schedule of the Global Digital Excellence funding programme. The delayed start has been added to the Trust Risk Register and agreed with the National Ophthalmology Audit provider.
Consultant Sign-Off RCEM 2016-17 Audit	Recommendations reviewed by an Emergency Department Consultant. Action taken to send staff instructions on how to complete the ED Consultant Review Form.
National Audit of Dementia (NAD) 2017	Recommendations reviewed by the Dementia Lead Nurse. Actions to arrange provision of dementia champions to support staff at all times, promote the use of delirium screening to medical staff and to promote the use of the Abbey Pain score to nursing staff.
NCEPOD Acute Non-Invasive Ventilation	Recommendations reviewed by the Lead Respiratory Consultant. Action to update Trust non-invasive ventilation guidelines.
National Diabetes Transition Audit (NDTA) Report 2017	Recommendations reviewed by the Paediatric Diabetes Team. All recommendations met and no further actions identified.
Fracture Liaison Service Database (FLS-DB) Clinical Audit April 2017	Recommendations reviewed by Fracture Liaison Service Specialist Nurses. Information Team reviewed their reports to ensure all patients aged 50 years and over with a new fragility fracture were identified in the monthly report. Arrangements were made with the DXA service and Fracture Liaison Service to ensure DXA reports were received more regularly.
National Heart Failure Audit Report 2015-16	Recommendations reviewed by the Cardiology Clinical Lead. All recommendations met and no further actions identified.
National Paediatric Diabetes Audit (NPDA) 2012-15 Report Part 2: Hospital Admissions and Complications	Recommendations reviewed by the Paediatric Diabetes Team. All recommendations met and no further actions identified.

Local audit report summary actions are detailed on the WSFT website:
https://www.wsh.nhs.uk/Corporate-information/Information-we-publish/Annual-reports.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 13 – Jun 14	Jul 14 – Jun 15	Jul 15 – Jun 16	Jul 16 – Jun 17
WSFT (confidence intervals)	90.78 (111.98 to 89.3)	93.49 (98.41 to 88.75)	89.76 (84.9 to 94.83)	89.29 (92.48 to 89.05)
Banding [1]	-	-	-	2
National average	100	100	100	100
Highest NHS trust	119.82	120.89	115.63	122.77
Lowest NHS trust	54.07	66.05	62.59	72.61

Source: Dr Foster

[1] SHMI values for each trust are published along with bandings indicating whether a trust's SHMI is '1 - higher than expected', '2 - as expected' or '3 - lower than expected'. For any given number of expected deaths, a range of observed deaths is considered to be 'as expected'. If the observed number of deaths falls outside of this range, the trust in question is considered to have a higher or lower SHMI than expected.

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, as the result is below the 100 expected level.

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

	Jul 13 – Jun 14	Jul 14 – Jun 15	Jul 15 – Jun 16	Jul 16 – Jun 17
WSFT	26.34%	19.71%	32.54%	31.1%
National average	24.79%	26.31%	29.56%	35.9%

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 the 'Performance against 2017-18 priorities' section of this report.

(b) Patient reported outcome measures scores (PROMS)

	2014-15	2015-16	2016-17	2017-18 (Apr – Sep)
Groin hernia surgery				
WSFT (EQ-5D Index)	0.111	0.128	0.111	0.120
National average (EQ-5D Index)	0.084	0.088	0.086	0.089
Varicose vein surgery				
WSFT (EQ-5D Index)	0.052	0.081	-0.019	0.018
National average (EQ-5D Index)	0.095	0.095	0.092	0.096
Hip replacement surgery (primary)				
WSFT (EQ-5D Index)	0.427	0.490	0.455	Data not published
National average (EQ-5D Index)	0.437	0.438	0.445	
Knee replacement surgery (primary)				
WSFT (EQ-5D Index)	0.327	0.287	0.338	Data not published
National average (EQ-5D Index)	0.315	0.320	0.324	

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 2017-18 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

	2014-15	2015-16	2016-17	2017-18
Aged 0 to 15	5.75%	6.88%	-	-
Aged 16 or over	15.50%	16.68%	-	-

Source: 2014-16: WSFT patient administration system (PAS)
2016-17 and 2017-18 – Unable to report data information systems

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. The launch of e-Care in May 2016 impacted on our ability to report performance against a number of quality standards, including readmissions. We are working with our digital partner, Cerner, to deliver further improvements to reporting and enabling full reporting of this data during 2018-19.

(d) Responsiveness to the personal needs of its patients

	2014	2015	2016	2017
WSFT	68.6	70.2	72.9	69.7
National average	68.7	68.9	69.6	68.1
Highest NHS trust	84.2	86.1	86.2	85.2
Lowest NHS trust	54.4	59.1	58.9	60.0

Source: HSCIC

WSFT considers that this data is as described as each year WSFT participates in a national inpatient survey. 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	2017
WSFT (agree + strongly agree)	78	84	85	86
England: acute trusts (agree + strongly agree)	66	70	70	71

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

	2014-15	2015-16	2016-17	2017-18
WSFT	99.63%	99.46%	86.62%	92.12%
National average	96.09%	95.76%	95.61%	95.27%

Source: NHS England

WSFT considers that this data is as described. WSFT has taken a range of actions to improve this score since go-live with e-Care in May 2016, and so the quality of its services, and we intend to achieve 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

	2014-15	2015-16	2016-17	2017-18
WSFT	16.3	16.4	17.3	14.4
National average	15.0	14.9	13.2	Not yet published

Source: Health Protection Agency (HPA)

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 ’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	2,617 (36.39 / 1000 bed days)	40.14 / 1000 bed days	Middle 50% of trusts
Apr ’17 – Sept ’17	2,743*	Not yet published	Not yet published
Oct ‘17 – Mar ‘18	3,307*	Not yet published	Not yet published

Data sources: NHS Improvement (NRLS) and *Local incident system

From October 2017 the number of patient safety incidents reported increased as a consequence of new Community services the joining the Trust.

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 ’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	20 (0.7%)	0.4%	Above peer group average
Apr ’17 – Sept ’17	12 (0.4%)*	Not yet published	Not yet published
Oct ‘17 – Mar ‘18	19 (0.6%)*	Not yet published	Not yet published

Data source: NHS Improvement (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 Board and Trust management, is embracing its role to represent both the interests of the Trust as a whole and the interests of the population in the west of Suffolk. 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 Suffolk health and care system to promote and integrate services for the local population.

During 2017/18 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 6,000 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.
  - Taking part in "Environmental Walkabouts" enables Governors to view the hospital and community facilities from a viewpoint of patients and visitors, such as matters of cleanliness, ease of access, direction boards and information panels/notices.

- **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
  - Engagement with the CQC inspection team as part of the planned inspection which rated the Trust as 'Outstanding'
  - Holding the board to account through the NEDs by requesting assurance on areas of concern; such as pathology services as well as quality, operational and financial performance
  - During 2017-18 appointed two NEDs and the new Chair.

- **Development of knowledge and skills:**
  - Agreed training and develop programme, including externally facilitated induction programme following governor elections
  - 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.

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 the West Suffolk Hospital and community services very special for patients, the public and staff. The governors recognise the importance of the developing relationship with the West Suffolk Alliance to manage and deliver community services and facilities in the west of Suffolk. The governors recognise the importance of developing their relationship with patients and staff that utilise and serve these valuable services outside the West Suffolk Hospital.

West Suffolk Clinical Commissioning Group

West Suffolk Clinical Commissioning Group, as the commissioning organisation for West Suffolk NHS Foundation Trust confirm that the Trust has consulted and invited comment regarding the Quality Account for 2017/2018. This has occurred within the agreed timeframe and the CCG is satisfied that the Quality Account incorporates all the mandated elements required.

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

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

Lisa Nobes
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 2018. 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) is pleased to be invited to comment on WSFT Quality Accounts this year. The trust is to be congratulated on achieving an “outstanding” rating by the CQC. Overall WSFT has done well to achieve continued improvements despite the unprecedented service demands during the past year. Our own information from the HWS Feedback Centre rates WSFT as 4 stars (from a possible 5) for overall performance.

The report acknowledges the impact of the increased demand on performance against priority targets. It is unsurprising that some targets, quality goals were missed and a significant amount of non emergency operations were cancelled as a result of the increased pressure throughout the Trust.

Despite this, performance continued to improve in areas of End of Life Care and Audit; Delayed Transfer of Care ; the second phase of electronic patient records continues to be rolled out and integration of Community Services into the Trust's portfolio of services provides a promising future for patient care. National Accolades and Awards continue to be noteworthy in particular the clinical awards.

It is encouraging to see that in identifying quality priorities for 2018-20 there is recognition of the Trust's role in prevention and improving health and wellbeing for instance priorities promoting a healthy pregnancy and supporting aging well. HWS looks forward to engaging with WSFT on areas of priorities and target setting in the future.

Looking ahead, we welcome the Trust's most recent developments around patient and staff engagement, and its commitment to working more closely with us in 2018-19.

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 2017-18 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 2017 to 25 May 2018
    - papers relating to quality reported to the board over the period April 2017 to 26 May 2018
    - feedback from commissioners dated 21/5/18
    - feedback from governors dated 17/5/18
    - feedback from local Healthwatch organisations dated 14/5/18
    - feedback from Overview and Scrutiny Committee dated 30/4/18
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 3/5/18
    - the 2016 national patient survey 31/5/2017
    - the 2017 national staff survey 6/3/2018
    - the Head of Internal Audit's annual opinion of the Trust's control environment dated 30/4/18
    - CQC inspection report dated 23/01/2018
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the quality report has been prepared in accordance with 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

Sheila Childerhouse
Chair
25 May 2018

Dr Stephen Dunn
Chief executive
25 May 2018

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 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge
- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

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

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by 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 in the *Detailed requirements for external assurance for Quality Reports 2017/18* issued by NHS Improvement in February 2018; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance and the six dimensions of data quality set out in the *Detailed requirements for external assurance on Quality Reports*.

We read the quality report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and 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 the following:

- board minutes for the period April 2017 to May 2018
- papers relating to quality reported to the board for the period April 2017 to May 2018
- feedback from West Suffolk CCG, dated May 2018
- feedback from governors, dated May 2018
- feedback from local Healthwatch organisations, dated May 2018
- feedback from the Overview and Scrutiny Committee, dated May 2018
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2017
- the latest national inpatient survey, dated 31 May 2017

- the latest national staff survey, dated 2017
- Care Quality Commission inspection report, dated 23 January 2018
- the Head of Internal Audit's annual opinion over the Trust's control environment, dated May 2018.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of West Suffolk NHS Foundation Trust as a body, 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 2018, to enable the Council of Governors to demonstrate 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 against supporting documentation
- comparing the content requirements of the NHS foundation trust annual reporting manual to the categories reported in the quality report
- 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 that 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.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- 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 in the *Detailed requirements for external assurance for quality reports 2017/18*; 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.

David Eagles, Partner
For and on behalf of BDO LLP
Ipswich

25 May 2018

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.
NHSI	NHS Improvement (NHSI) is the sector regulator for health services in England. NHSI's job is to protect and promote the interests of patients by ensuring that the whole sector works for their benefit. NHSI 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.

West Suffolk NHS Foundation Trust

Annual accounts for the year ended 31 March 2018

Contents Page

Foreword to the accounts

West Suffolk NHS Foundation Trust

These accounts, for the year ended 31 March 2018, 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 Officer**
Date **25 May 2018**

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

Opinion on financial statements

We have audited the financial statements of West Suffolk NHS Foundation Trust (the Trust) for the year ended 31 March 2018 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 notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union and as interpreted and adapted by the 2017-18 Government Financial Reporting Manual as contained in the Department of Health and Social Care Group Accounting Manual 2017-18, and the NHS Foundation Trust Annual Reporting Manual 2017-18 issued by the Regulator of NHS Foundation Trusts ('NHS Improvement').

In our opinion the financial statements:

· give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended;

· have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017-18; and

· have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion on financial statements

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

· the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or

· the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Key Audit Matters

Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) we identified, including those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Matter	How we addressed the matter in the audit
Revenue recognition Most NHS income is subject to reconciliation and formal agreement with other NHS bodies through the Agreement of Balances (AOB) process. There is a risk, however, that other non NHS income and NHS income which is not on block contracts is not completely and accurately reflected in the financial statements, whether as a result of fraud or error.	We substantively tested an extended sample of material non-NHS income streams to supporting documentation to confirm that income has been accurately recorded and earned in the year. We reviewed the process for resolving discrepancies between the Trust and other NHS bodies through the agreement of balances process, and management's estimate of amounts receivable where there are contract disputes, subsequently investigating all discrepancies and disputed amounts above £250k. We agreed a sample of income with other NHS bodies back to contract amounts. We ensured that all income items tested had been accounted for in line with the Trust's revenue recognition policy.
Accounting for the Community Care contract During the year, the Trust amended its arrangement with NHS West Suffolk CCG and NHS Ipswich and East Suffolk CCG for the provision of a number of community healthcare services. There is a risk that this is not done accurately, resulting in an inappropriate amount of revenue being transferred between the Trusts.	We reviewed the treatment and reasoning proposed by the Trust and the contract documentation for the arrangement to ensure that the activity was being appropriately and accurately accounted for. This involved: · Considering whether or not there is a joint arrangement in place and, if so, then assessing whether joint control is in place as defined by IFRS11 – Joint Arrangements · Reviewing the accounting transactions to ensure that they are in line with the correct accounting treatment based on the conclusions drawn above.
Fair valuation of Property, Plant and Equipment Property, plant and equipment is the most significant asset in the Trust's balance sheet. At this year end the Trust has made an assessment of whether there has been a variation in the value of land and buildings since the last valuation point, and has applied an indexation uplift as required to ensure there is no material misstatement of asset values. The valuation of land and buildings is complex and is subject to a number of assumptions and judgements. A small movement in these assumptions can have a material impact on the financial statements.	We reviewed the instructions provided to the valuer and considered the valuer's skills and expertise in order to determine the extent to which we could rely on the management expert. We reviewed the indices provided by the valuer against available market information, and considered whether the value of land and buildings as advised by the valuer was within the range of our expectations. We considered the need for any further valuations in the current year.

Our application of materiality

We apply the concept of materiality both in planning and performing our audit, and in evaluating the effect of misstatements. We consider materiality to be the magnitude by which misstatements, including omissions, could influence the economic decisions of reasonable users that are taken on the basis of the financial statements. Importantly, misstatements below these levels will not necessarily be evaluated as immaterial as we also take account of the nature of identified misstatements, and the particular circumstances of their occurrence, when evaluating their effect on the financial statements as a whole.

The materiality for the financial statements as a whole was set at £4.4 million (2017 £4.5 million). This was determined with reference to the benchmark of gross expenditure (of which it represents 1.75%) (2017 – 1.75%) which we consider to be one of the principal considerations for the Council of Governors in assessing the financial performance and position 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 £176,000 (2017- £180,000) in addition to other audit misstatements below that threshold that we believe warranted reporting on qualitative grounds.

Overview of the scope of our audit

The Trust operates as a single entity with no significant subsidiary bodies or other controlled undertakings. Accordingly our audit was conducted as a full scope audit of the Trust.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on the Remuneration and Staff Report

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes ;
- the tables of exit packages and related notes;
- the analysis of staff numbers and related notes; and
- the pay multiples and related narrative notes.

In our opinion the parts of the Remuneration Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2017-18.

Matters on which we are required to report by exception

Qualified conclusion on use of resources

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, with the exception of the matter reported in the Basis for qualified conclusion on use of resources section of our report, we are satisfied that, in all significant respects, the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion on use of resources

For the year ended 31 March 2018 the Trust reported a deficit of £0.3m (2016/17: restated deficit of £7.9m). This represents a considerable improvement on the original control total set for 2017/18 by NHS Improvement of £11.1m. The financial position has improved in a number of areas, although challenges remain in others.

The planned deficit control total for 2018/19 set by NHS Improvement is £13.8 million. The Trust has agreed to work to this control total.

The Trust does not yet have plans to secure a return to a breakeven position in the foreseeable future. This is evidence of weakness in arrangements to ensure that the Trust has deployed its resources to achieve sustainable outcomes for taxpayers and local people.

Other matters on which we are required to report by exception

Under Schedule 10 of the National Health Service Act 2006 and the National Audit Office's Code of Audit Practice we 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.

We also 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.

We have nothing to report in these respects.

Responsibilities of the Accounting Officer

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, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Council of Governors either intends to liquidate the Trust or to cease operations, or has no realistic alternative but to do so.

The Accounting Officer is also responsible for ensuring that the resources of the Trust are used economically, efficiently and effectively.

Auditor's responsibilities for the audit of the financial statements

In respect of our audit of the financial statements our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located at the Financial Reporting Council's website at: https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Auditor's other responsibilities

We are also required under section 21(3)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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.

As set out in the Matters on which we are required to report by exception section of our report there are certain other matters which we are required to report to you by exception.

Certificate

We certify that we have completed the audit of the accounts 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 Code of Audit Practice issued by the National Audit Office.

Use of our report

This report is made solely to the Council of Governors of West Suffolk NHS Foundation Trust, as a body, in accordance with part 5 of the Local Audit and Accountability Act 2014 and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015. 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 and the Council of Governors as a body, for our audit work, for this report or for the opinions we have formed.

For and on behalf of BDO LLP, Statutory Auditor
Ipswich, UK
25-May-18

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

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Statement of Comprehensive Income for the year ended 31 March 2018

	Note	2017/18 £000	Restated 2016/17 £000
Operating income from patient care activities	3	215,994	223,216
Other operating income	4	36,866	31,265
Operating expenses (non pay)	5	(103,161)	(119,356)
Employee Benefits	7	(147,785)	(142,216)
Operating surplus/(deficit) from continuing operations		**1,914**	**(7,091)**
Finance income		33	24
Finance expenses		(1,096)	(304)
PDC dividends payable		(1,067)	(940)
Net finance costs		**(2,130)**	**(1,220)**
Other gains / (losses)		(71)	453
(Deficit) for the year		**(287)**	**(7,858)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	12	4,635	1,566
Other recognised gains and losses		-	(65)
Total comprehensive income / (expense) for the period		**4,348**	**(6,357)**

Statement of Financial Position as at 31 March 2018

	Note	31 March 2018 £000	Restated 31 March 2017 £000
Non-current assets			
Intangible assets	10	23,852	15,611
Property, plant and equipment	11	94,170	78,321
Trade and other receivables	13	3,925	1,554
Total non-current assets		**121,947**	**95,486**
Current assets			
Inventories		2,712	2,693
Trade and other receivables	13	21,413	16,791
Cash and cash equivalents	14	3,601	1,352
Total current assets		**27,726**	**20,836**
Current liabilities			
Trade and other payables	15	(26,135)	(23,434)
Borrowings	16	(3,114)	(1,498)
Provisions		(94)	(61)
Other liabilities		(963)	(1,325)
Total current liabilities		**(30,306)**	**(26,318)**
Total assets less current liabilities		**119,367**	**90,004**
Non-current liabilities			
Borrowings	16	(65,391)	(46,890)
Provisions		(124)	(181)
Total non-current liabilities		**(65,515)**	**(47,071)**
Total assets employed		**53,852**	**42,933**
Financed by			
Public dividend capital		65,803	59,232
Revaluation reserve		8,021	3,621
Income and expenditure reserve		(19,972)	(19,920)
Total taxpayers' equity		**53,852**	**42,933**

The notes on pages 162 to 189 form part of these accounts.

Dr. Stephen Dunn
Chief Executive
Date **25 May 2018**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	**59,232**	**3,621**	**(19,920)**	**42,933**
(Deficit) for the year	-	-	(287)	**(287)**
Revaluations	-	4,635	-	**4,635**
Transfer to retained earnings on disposal of assets	-	(14)	14	**-**
Public dividend capital received	6,571	-	-	**6,571**
Other reserve movements	-	(221)	221	**-**
Taxpayers' equity at 31 March 2018	**65,803**	**8,021**	**(19,972)**	**53,852**

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

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016 - brought forward	**59,232**	**2,151**	**(12,598)**	**48,785**
Prior period adjustment	-	-	505	**505**
Taxpayers' equity at 1 April 2016 - restated	**59,232**	**2,151**	**(12,093)**	**49,290**
(Deficit) for the year - restated	-	-	(7,858)	**(7,858)**
Other transfers between reserves	-	(31)	31	**-**
Revaluations	-	1,566	-	**1,566**
Other recognised gains and losses	-	(65)	-	**(65)**
Taxpayers' equity at 31 March 2017	**59,232**	**3,621**	**(19,920)**	**42,933**

Information on reserves

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

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		1,914	(7,091)
Non-cash income and expense:			
Depreciation and amortisation	5	5,029	5,741
Net impairments	6	-	4,815
Income recognised in respect of capital donations	4	(102)	(399)
(Increase) in receivables and other assets	13.1	(7,119)	(6,792)
(Increase) / decrease in inventories		(19)	132
(Decrease) in payables and other liabilties		(433)	(688)
(Decrease) in provisions		(24)	(48)
Other movements in operating cash flows		(899)	(5)
Net cash (used in) operating activities		**(1,653)**	**(4,335)**
Cash flows from investing activities			
Interest received		28	24
Purchase and sale of financial assets / investments		-	(3,127)
Purchase of intangible assets	10	(9,483)	(6,315)
Purchase of property, plant, equipment and investment property	11	(11,386)	(13,860)
Sales of property, plant, equipment and investment property		16	2,168
Net cash (used in) investing activities		**(20,825)**	**(21,110)**
Cash flows from financing activities			
Public dividend capital received		6,571	-
Increase in loans from the Department of Health and Social Care	16	18,488	26,756
Repayment of loans from the Department of Health and Social Care		(507)	(281)
Increase in other loans		2,501	-
Repayment of other loans		(73)	-
Capital element of finance lease rental payments		(291)	(954)
Interest paid on finance lease liabilities		(179)	(276)
Other interest paid		(847)	(20)
PDC dividend (paid)		(936)	(1,029)
Net cash generated from financing activities		**24,727**	**24,196**
Increase / (decrease) in cash and cash equivalents		**2,249**	**(1,249)**
Cash and cash equivalents at 1 April - brought forward		**1,352**	**2,601**
Prior period adjustments			**-**
Cash and cash equivalents at 31 March	14	**3,601**	**1,352**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation
NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 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 2017/18 is £0.3 million. This includes £9.6 million Sustainability and Transformation Funding (STF) which is dependent on operational and financial performance. Of this £5.3 million was awarded at the year end based on our financial performance compared to our control total which was a deficit of £11.1 million before STF.

The Trust has borrowed £46.8 million from the Department of Health (DH) for capital purposes, £13.4 million from DH for working capital and revenue deficit support plus a further £2.5 million from DH in relation to the Pathology Partnership creditor balances. In addition the Trust has borrowed £2.4 million from Siemens for the Catheterisation Laboratory Project. £3.3 million associated with finance lease borrowing has also been recognised in the accounts.

The planned deficit for 2018/19 is £16.6 million, the Trust has not agreed a control total with Department of Health. The Trust has asked DH for £8.5m million additional cash in 2018/19 for distress financing in addition to the planned revenue and capital borrowing.

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 1.2 Critical judgements in applying accounting policies
The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

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 2017/18 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 2017/18 it is assumed that 70.81 % of deposits outstanding at the balance sheet date will be recovered which equates to £5.9 million.
- Community Services. The Trust has disputed £0.9m of invoices from another NHS Trust and has not recognised these costs in the financial position. Discussions on how this can be resolved are ongoing.
- the Trust employs a professional valuer to value all land and buildings and estimate their useful economic lives which are used to calculate depreciation. Assets are revalued by the valuer as a minimum every five years. In order to avoid a significant misstatement in 2017/18 in the absence of a full valuation, indices recognised by the valuer and shared with the auditors in advance have been applied to asset values. The next full valuation is due in 2019/20. The value of these assets before depreciation at 31 March 2018 is £79.8 million.

Note 1.3 Interests in other entities
The Trust has a 25% share in Collaborative Procurement Partnership limited liability partnership (LLP) with three other NHS organsitaions. The LLP was established in 2017/18 and is not yet material to the Trust and has therefore not been reflected in the accounts.

Note 1.4 Income
Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits
Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services
Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment
Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Note 1.7.2 Measurement
Valuation
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: valued as a specialised property; 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 restrictions, land is valued at current value in existing in use.
● Intangible Assets: fair value. If no market information is available, then depreciated replacement cost is used.

An item of property, plant and equipment which is surplus to requirements 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 Trust 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'.

Note 1.7.3 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.
The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.4 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	2	10
Buildings, excluding dwellings	3	103
Dwellings	15	75
Plant & machinery	2	25
Transport equipment	7	7
Information technology	2	10
Furniture & fittings	5	8

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 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 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.

Note 1.8.2 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. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic lives 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
Information technology- internally generated	4	20
Software- purchased	4	20

Note 1.9 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 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 or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

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

Classification and measurement

Financial assets are categorised as loans and receivables

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: cash, NHS receivables, accrued income and other receivables.

Loans and 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.

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.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from discounted cash flow analysis/other.

Impairment of financial assets

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

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 - through the use of a bad debt provision.

Note 1.11 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.11.1 The Trust as lessee
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

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

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

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 1.11.2 The Trust as lessor

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.12 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Trust is disclosed at note 17 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

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 and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.14 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 2017/18.

Note 1.16 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 9 Financial Instruments

Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. The main impact of IFRS 9 on the Trust is expected to be the timing of impairment on trade receivables; currently overdue debt is reviewed and specific provision is made for debts that are considered to be at risk of not being recoverable. Under IFRS 9 the Trust will need to impair the debt at the time it is raised based on expected credit losses. The highest risk category of debt for the Trust is overseas pataients. Most of this debt is recovered reasonably quickly but an element does have to be written off. Annual income for overseas patients is usually of the order of £140,000 so the changes to comply with IFRS are not expected to have a material impact.

IFRS 14 Regulatory Deferral Accounts

Not yet EU-endorsed and is now considered unlikely to be.

Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.

IFRS 15 Revenue from Contracts with Customers

Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted. This standard requires that contract income can only be recognised when certain criteria have been met. The vast majority of Trust income is from NHS commisisoning bodies. The contracts are usually time based or relate to the delivery of a specified level of patient activity and in that case the Trust already recognises the income only when the activity has been delivered.

IFRS 16 Leases

Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted. The Trust is party to a significant number of lease contracts as lessee. Some of these leases are classified as finance leases and therefore reflected on the balance sheet but many are classified as operating leases and therefore not currently on the balance sheet as an asset or borrowing. It is likely that under IFRS 16 the right to use many assets currently classified as operating leases will be included on the balance sheet as well as the associated borrowing.

IFRS 17 Insurance Contracts

Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted. This is not expected to have a material impact on the Trust.

IFRIC 22 Foreign Currency Transactions and Advance Consideration

Application required for accounting periods beginning on or after 1 January 2018. This is not expected to have a material impact on the Trust.

IFRIC 23 Uncertainty over Income Tax Treatments

Application required for accounting periods beginning on or after 1 January 2019. This is unlikely to have a material impact on the Trust.

Note 2 Operating Segments

The Trust reports to the Board, which is considered to be the Chief Operating Decision Maker, on a monthly basis the performance at 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 on a segmental basis 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
2017/18	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Income	67,870	57,981	23,859	34,204	53,241	15,705	252,860
Expenditure	(57,754)	(49,481)	(15,238)	(27,580)	(53,568)	(49,526)	(253,147)
Contribution	**10,116**	**8,500**	**8,621**	**6,624**	**(327)**	**(33,821)**	**(287)**

Restated

	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)	(34,269)	(62,567)	(45,662)	(262,339)
Contribution	**6,696**	**12,191**	**6,617**	**(5,325)**	**0**	**(28,037)**	**(7,858)**

Original

	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)**

The prior period adjustment on income relates to the recognition of implicit finance leases.

These segments represent the management structure in the organisation.

The Trust was commissioned to provide community services in Suffolk from 1 October 2015 for two years. From 1 October 2017 Ipswich Hospital NHS Trust was commissioned to provide community services mostly in East Suffolk and this Trust continued to provide services for Suffolk.

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. The prior period adjustment has no impact on patient care income.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	Restated 2016/17 £000
Acute services		
Elective income	32,534	32,275
Non elective income	55,696	53,714
First outpatient income	14,080	13,218
Follow up outpatient income	18,730	20,069
A & E income	8,546	7,215
High cost drugs income from commissioners	13,743	12,464
Other NHS clinical income	20,216	20,857
Community services		
Community services income from CCGs and NHS England	43,914	59,300
Income from other sources (e.g. local authorities)	5,450	2,298
All services		
Private patient income	2,648	1,495
Other clinical income	437	311
Total income from activities	**215,994**	**223,216**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	13,748	13,192
Clinical commissioning groups	193,665	205,920
Other NHS providers	3,551	-
NHS other	46	-
Local authorities	1,899	2,298
Non-NHS: private patients	2,648	1,350
Non-NHS: overseas patients (chargeable to patient)	121	145
NHS injury scheme	316	311
Total income from activities	**215,994**	**223,216**
Of which:		
Related to continuing operations	215,994	223,216

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2017/18	2016/17
	£000	£000
Income recognised this year	121	145
Cash payments received in-year	101	98
Amounts added to provision for impairment of receivables	20	47
Amounts written off in-year	28	-

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	508	662
Education and training	7,067	6,566
Receipt of capital grants and donations	102	399
Charitable and other contributions to expenditure	-	823
Non-patient care services to other bodies	14,535	10,146
Sustainability and transformation fund income	9,568	7,125
Rental revenue from operating leases	114	-
Income in respect of staff costs where accounted on gross basis	49	959
Other income	4,923	4,585
Total other operating income	**36,866**	**31,265**
Of which:		
Related to continuing operations	36,866	31,265

Other income includes £1.9m car parking (16/17 £1.4m) and £1.6m catering income (16/17 £1.5m).

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider 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:

	2017/18	2016/17 Original
	£000	£000
Income from services designated as commissioner requested services	215,994	223,216
Income from services not designated as commissioner requested services	36,866	31,265
Total	**252,860**	**254,481**

Note 5 Operating expenses

	2017/18	Restated 2016/17	Original 2016/17
	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	17,682	1,097	1,097
Purchase of healthcare from non-NHS and non-DHSC bodies	-	1,253	1,253
Staff and executive directors costs	147,785	142,216	142,216
Remuneration of non-executive directors	114	108	108
Supplies and services - clinical (excluding drugs costs)	30,432	60,442	60,661
Supplies and services - general	3,475	2,427	3,627
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	20,761	19,733	19,733
Inventories written down	111	63	63
Consultancy costs	2,590	2,050	2,050
Establishment	3,539	3,559	3,559
Premises	4,522	4,355	4,355
Transport (including patient travel)	1,584	1,232	1,232
Depreciation on property, plant and equipment	3,759	4,161	3,521
Amortisation on intangible assets	1,270	1,580	1,580
Net impairments	-	4,815	4,815
Increase/(decrease) in provision for impairment of receivables	(699)	780	780
Increase/(decrease) in other provisions	-	-	-
Audit fees payable to the external auditor			
audit services- statutory audit	54	53	53
other auditor remuneration (external auditor only)	5	6	6
Internal audit costs	126	126	126
Clinical negligence	6,399	5,817	5,817
Legal fees	103	181	181
Insurance	163	184	184
Research and development	-	-	-
Education and training	605	698	698
Rentals under operating leases	5,952	4,106	4,106
Car parking & security	315	219	-
Hospitality	22	4	4
Losses, ex gratia & special payments	11	64	64
Grossing up consortium arrangements	-	-	-
Other services, eg external payroll	233	216	216
Other	33	27	27
Total	**250,946**	**261,572**	**262,132**
Of which:			
Related to continuing operations	250,946	261,572	262,132
Related to discontinued operations	-	-	-

The audit fees disclosed are gross of VAT. The net figures are £45k for the statutory audit and £4k for other external auditor remuneration.

All internal audit costs are non staff related as the services is provioded by an external firm.

Note 5.1 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2016/17: £1m).

Note 6 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Other	-	4,815
Total net impairments	**-**	**4,815**

Note 7 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	119,784	114,805
Social security costs	11,832	11,024
Apprenticeship levy	579	-
Employer's contributions to NHS pensions	14,146	13,231
Termination benefits	53	185
Temporary staff (including agency)	4,905	5,820
Total staff costs	**151,299**	**145,065**
Of which		
Costs capitalised as part of assets	3,514	2,849

Note 7.1 Retirements due to ill-health

During 2017/18 there was 1 early retirement from the Trust agreed on the grounds of ill-health (8 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £70k (£166k in 2016/17).

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

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The 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 employee and employer representatives as deemed appropriate.

Where employees are ineligible to apply to the NHS Pension Scheme they are able to apply to the National Employment Savings Trust (NEST). NEST is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008. NEST Corporation, the Trustee that runs the NEST scheme, is a non-departmental public body. It's accountable to Parliament through the Department for Work and Pensions but is generally independent of government in its day-to-day decisions. Being a public body means that there are no owners or shareholders. As a Trustee, the scheme is run in the interests of the members.

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 is the lessee.

	2017/18	2016/17
Operating lease expense	**£000**	**£000**
Minimum lease payments	5,952	4,106
Total	**5,952**	**4,106**

	31 March 2018	31 March 2017
Future minimum lease payments due:	**£000**	**£000**
- not later than one year;	1,067	1,488
- later than one year and not later than five years;	1,608	2,073
- later than five years.	17	87
Total	**2,692**	**3,648**
Future minimum sublease payments to be received	-	-

The 2017/18 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.

Note 10 Intangible assets - 2017/18

	Software licences £000	Internally generated information technology £000	Intangible assets under constructio £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	**-**	**22,014**	**3,739**	**25,753**
Additions	1,490	4,147	3,874	**9,511**
Reclassifications	-	3,739	(3,739)	**-**
Gross cost at 31 March 2018	**1,490**	**29,900**	**3,874**	**35,264**
Amortisation at 1 April 2017 - brought forward	**-**	**10,142**	**-**	**10,142**
Provided during the year	-	1,270	-	**1,270**
Amortisation at 31 March 2018	**-**	**11,412**	**-**	**11,412**
Net book value at 31 March 2018	**1,490**	**18,488**	**3,874**	**23,852**
Net book value at 1 April 2017	**-**	**11,872**	**3,739**	**15,611**

Note 10.1 Intangible assets - 2016/17

	Software licences £000	Internally generated information technology £000	Intangible assets under constructio £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**-**	**11,912**	**7,526**	**19,438**
Additions	-	2,576	3,739	**6,315**
Reclassifications	-	7,526	(7,526)	**-**
Valuation / gross cost at 31 March 2017	**-**	**22,014**	**3,739**	**25,753**
Amortisation at 1 April 2016 - as previously stated	**-**	**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 11.1 Property, plant and equipment - 2016/17

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**6,670**	**46,571**	**2,961**	**2,636**	**10,828**	**4**	**4,241**	**135**	**74,046**
Prior period adjustments	-	703	-	-	4,486	-	-	-	**5,189**
Valuation / gross cost at 1 April 2016 - restated	**6,670**	**47,274**	**2,961**	**2,636**	**15,314**	**4**	**4,241**	**135**	**79,235**
Additions	-	4,715	42	9,204	773	-	29	-	**14,763**
Revaluations	-	(2,274)	141	-	-	-	-	-	**(2,133)**
Reclassifications	-	1,198	-	(1,198)	(139)	-	139	-	**-**
Disposals / derecognition	-	(279)	-	-	(600)	-	-	-	**(879)**
Valuation/gross cost at 31 March 2017	**6,670**	**50,634**	**3,144**	**10,642**	**15,348**	**4**	**4,409**	**135**	**90,986**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**1,878**	**113**	**-**	**6,511**	**4**	**3,559**	**58**	**12,123**
Prior period adjustments	-	193	-	-	451	-	-	-	**644**
Accumulated depreciation at 1 April 2016 - restated	**-**	**2,071**	**113**	**-**	**6,962**	**4**	**3,559**	**58**	**12,767**
Provided during the year	**-**	**1,669**	**66**	**-**	**2,088**	**-**	**317**	**21**	**4,161**
Revaluations	-	(3,520)	(179)	-	-	-	-	-	**(3,699)**
Disposals/ derecognition	-	(26)	-	-	(538)	-	-	-	**(564)**
Accumulated depreciation at 31 March 201	**-**	**194**	**-**	**-**	**8,512**	**4**	**3,876**	**79**	**12,665**
Net book value at 31 March 2017	**6,670**	**50,440**	**3,144**	**10,642**	**6,836**	**-**	**533**	**56**	**78,321**
Net book value at 1 April 2016	**6,670**	**45,203**	**2,848**	**2,636**	**8,352**	**-**	**682**	**77**	**66,468**

Note 11.2 Property, plant and equipment financing - 2017/18

	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 2018								
Owned - purchased	6,850	63,608	3,323	8,871	1,555	1,462	-	**85,669**
Finance leased	-	477	-	-	3,300	715	-	**4,492**
Owned - donated	-	3,144	-	-	828	2	35	**4,009**
NBV total at 31 March 2018	**6,850**	**67,229**	**3,323**	**8,871**	**5,683**	**2,179**	**35**	**94,170**

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

		Restated			Restated			
	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 - purchased	6,670	46,938	3,144	10,642	2,141	416	4	**69,955**
Finance leased	-	510	-	-	3,758	111	-	**4,379**
Owned - donated	-	2,992	-	-	937	6	52	**3,987**
NBV total at 31 March 2017	**6,670**	**50,440**	**3,144**	**10,642**	**6,836**	**533**	**56**	**78,321**

The net book values for 2016/17 have been restated in respect of the prior period adjustment noted in note 22. The finance lease element of buildings (excluding dwellings) and plant and machinery are now identified separately.

Note 12 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.

The DRC basis of valuation seeks to determine the current cost of replacing an asset with its modern equivalent asset less deductions for physical deterioration and all relevant forms of obsolescence and optimisation.

Property, Plant and Equipment on the balance sheet has a carrying amount of £94,170,000, within this £70,552,000 is considered to be specialised property. This includes the hospital site and residences.

The key assumptions that are most likely to affect the valuations are:
- Cost data: The valuer uses actual cost data where it is available however this is adjusted to reflect price changes since the construction date and any differences between those costs and the costs that would be incurred in constructing the modern equivalent asset. Where actual cost data is not available the valuer relies on published construction price data. Published price data is an estimate of the costs that would be incurred in constructing a modern equivalent asset and may differ to the costs that would actually be incurred in practice. If the cost data were 5% higher this would have an impact on the value of specialised properties recorded in the balance sheet of an increase of £2,380k.
- Adjustments for obsolescence: Once the cost of constructing a modern equivalent asset has been determined an adjustment is made to reflect the difference between the modern equivalent and the actual asset being valued. This adjustment is made by the valuer based on his knowledge and experience, it takes into account physical deterioration, functional obsolesce and economic obsolesce. Had the adjustment for obsolescence been 2% higher than the valuer assumed, this would have an impact on the value of specialised properties recorded in the balance sheet of a decrease of £2,382k.

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.

In consultation with Gerald Eve LLP, indices have been applied to land and buildings to update the 31 March 2017 valuation. The indices used were the Building Cost Information Service (BCIS) Tender Price Index for Q1 2018 for the buildings index and the Urban Development Land Value Index - Eastern Region for the land index. The impact of the indices is an increase to the valuation as follows:

	2017/18	2016/17
	£000	£000
Land	180	0
Buildings	4,455	1,566
	4,635	**1,566**

Note 13.1 Trade receivables and other receivables

	31 March 2018 £000	Restated 31 March 2017 £000
Current		
Trade receivables	5,890	9,550
Capital receivables (including accrued capital related income)	745	-
Accrued income	10,890	958
Provision for impaired receivables	(167)	(830)
Deposits and advances	1,953	2,055
Prepayments (non-PFI)	868	1,019
Interest receivable	5	-
PDC dividend receivable	13	144
VAT receivable	1,169	1,377
Corporation and other taxes receivable	47	-
Other receivables	-	2,518
Total current trade and other receivables	**21,413**	**16,791**
Non-current		
Deposits and advances	3,925	1,554
Total non-current trade and other receivables	**3,925**	**1,554**
Of which receivables from NHS and DHSC group bodies:		
Current	14,275	8,842
Non-current	-	-

Note 13.2 Credit quality of financial assets

	31 March 2018	31 March 2017
	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	1,406	42
Over 180 days	124	130
Total	**1,530**	**994**
Ageing of non-impaired financial assets past their due date		
0 - 30 days	3,147	464
30-60 Days	445	136
60-90 days	634	168
90- 180 days	1,160	(152)
Over 180 days	546	470
Total	**5,932**	**1,086**

£2.3 million of the non-impaired financial assets past their due date are owed by NHS organisations.

Note 14 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.

	2017/18	2016/17
	£000	£000
At 1 April	**1,352**	**2,601**
Net change in year	2,249	(1,249)
At 31 March	**3,601**	**1,352**
Broken down into:		
Cash at commercial banks and in hand	21	46
Cash with the Government Banking Service	3,580	1,306
Total cash and cash equivalents as in SoFP	**3,601**	**1,352**
Total cash and cash equivalents as in SoCF	**3,601**	**1,352**

Note 15 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	6,027	9,706
Capital payables	4,034	1,332
Accruals	10,809	7,660
Receipts in advance (including payments on account)	-	45
Social security costs	1,751	1,577
Other taxes payable	1,385	1,273
Accrued interest on loans	125	55
Other payables	2,004	1,786
Total current trade and other payables	**26,135**	**23,434**
Of which payables from NHS and DHSC group bodies:		
Current	3,444	3,727
Non-current	-	-

Note 16 Borrowings

	31 March 2018 £000	Restated 31 March 2017 £000
Current		
Loans from the Department of Health and Scoial Care	2,084	507
Other loans	216	-
Obligations under finance leases	814	991
Total current borrowings	**3,114**	**1,498**
Non-current		
Loans from the Department of Health and Scoial Care	60,706	44,303
Other loans	2,212	-
Obligations under finance leases	2,473	2,587
Total non-current borrowings	**65,391**	**46,890**

Note 17 Clinical negligence liabilities

At 31 March 2018, £64,194k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of West Suffolk NHS Foundation Trust (31 March 2017: £61,773k).

Note 18 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	11,991	4,938
Intangible assets	7,021	9,921
Total	**19,012**	**14,859**

Note 19 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements), analysed by the period during which the payment is made:

	31 March 2018 £000	31 March 2017 restated £000	31 March 2017 £000
not later than 1 year	2,405	2,344	3,504
after 1 year and not later than 5 years	7,585	9,602	14,659
paid thereafter	661	1,049	1,059
Total	**10,651**	**12,995**	**19,222**

The restatement of financial commitments relate to the capitalisation of implicit finance leases from managed service agreements. The capital element of the financial commitments now form part of the finance lease obligations.

Note 20 Financial instruments

Note 20.1 Carrying values of financial assets

	Loans and receivables	
	31 March 2018	31 March 2017 (restated)
Assets as per SoFP	**£000**	**£000**
Trade and other receivables excluding non financial assets	23,408	16,635
Cash and cash equivalents at bank and in hand	3,601	1,352
Total at 31 March 2018	**27,009**	**17,987**

£14.3 million of the Trust's financial assets relates to income owed from other NHS organisations.

At the end of 2016/17 £8.8 million related to income owed by other NHS organisations.

Of the remaining balance at 31/3/18, £5.9 million relates to deposits recoverable when community equipment is returned based on the likely proportion that will be returned.

The remainder of the balance is money owed from non NHS organisations. The collection of this debt is monitored closely and the balance is impaired or written off when 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 2016/17.

Note 20.2 Carrying value of financial liabilities

	Other financial liabilities	
	31 March 2018	31 March 2017 (restated)
Liabilities as per SoFP	**£000**	**£000**
Borrowings excluding finance leases and PFI liabilities	65,218	44,810
Obligations under finance leases	3,287	3,578
Trade and other payables excluding non financial liabilities	20,655	18,762
Provisions under contract	218	242
	89,378	**67,392**

Borrowing excluding finance lease is from Department of Health at a fixed rate apart from £2.4m from a commercial loan provider which is also at a fixed rate.
Within trade and other payables excluding non financial liabilities, £3.4 million relates to liabilities with other NHS organisations. There are no identified risks with the balance of payables which are almost exclusively UK based. This is the same as 2016/17.

Note 20.3 Fair values of financial assets and liabilities

The fair value of the financial instruments is based on discounted cash flow analysis but this is not considered to be significantly different to the initial transactions recognised.

Note 21.4 Maturity of financial liabilities

	31 March 2018	31 March 2017 (restated)
	£000	**£000**
In one year or less	23,863	20,573
In more than one year but not more than two years	10,653	2,219
In more than two years but not more than five years	16,952	12,094
In more than five years	37,910	32,506
Total	**89,378**	**67,392**

Note 21 Related parties

	Receivables		Payables	
	2018	2017	2018	2017
	£000	£000	£000	£000
Norfolk Community Healthcare NHS Trust	22	70	85	491
Ipswich Hospital NHS Trust	573	369	430	1,136
Colchester Hospital University NHS Foundation Trust	222	4	571	15
NHS West Suffolk CCG	1,812	-	728	845
NHS Ipswich and East Suffolk CCG	128	71	196	92
NHS South Norfolk CCG	745	362	123	-
NHS Cambridgeshire and Peterborough CCG	121	261	8	237
Health Education England	714	60	-	71
NHS England	7,239	4,911	44	-
NHS Litigation Authority	-	-	4	4
NHS Property Services	36	15	667	66
The Pathology Partnership	-	495	-	-
Total	**11,612**	**6,618**	**2,856**	**2,957**

	Income		Expenditure	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Norfolk Community Healthcare NHS Trust	70	214	11,091	21,128
Ipswich Hospital NHS Trust	4,837	1,196	8,352	12,630
Colchester Hospital University NHS Foundation Trust	1,429	13	5,648	30
NHS West Suffolk CCG	126,453	110,695	181	299
NHS Ipswich And East Suffolk CCG	51,494	76,567	153	92
NHS South Norfolk CCG	15,188	14,544	-	1
NHS Cambridgeshire and Peterborough CCG	3,292	3,186	17	29
Health Education England	6,734	5,852	17	32
NHS England	23,273	20,525	5	1,033
NHS Resolutions (formerly NHS Litigation Authority)	-	-	6,554	5,998
NHS Property Services	105	84	2,774	2,216
The Pathology Partnership	888	1,720	1,112	3,966
Total	**233,763**	**234,596**	**35,904**	**47,454**

The Trust is the Corporate Trustee of My Wish Charity. During the year the Charity spent on behalf of the Trust £450k (2016/17: £183k) on revenue items and a further £340k (2016/17: £137k) on capital items. At the year end the Charity owed the Trust £108k (2016/17 £72k)

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

Note 22 Prior period adjustments

During the year the Trust undertook a review of its significant managed service agreements. As a result of this review a number of implicit finance leases were identified. These primarily related to plant and equipment used in the provision of the relevant service. These agreements have been in place for a number of years and as they are material these have been reflected in the financial statement as prior period adjustments (PPA).

	2017/18
	£000
Increase in net book value of Property, Plant and Equipment	4,268
Increase in current liabilities	(964)
Increase in non current liabilities	(2,515)
Increase in Income and expenditure reserve	789

A further PPA was required to reanalyse the prior year figure for deposits and advances. These were previously classified as current assets but a proportion should have been reported as non-current assets.

Note 23 Events after the reporting date

There are no identified adjusting or non-adjusting events after the reporting date with a material impact on the financial reporting.